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

November 28, 2025

Kristin Sousa
Assistant Secretary and State Medicaid Director
Rhode Island Executive Office of Health and Human Services
3 West Road, Virks Building
Cranston, RI 02920

Dear Director Sousa:

The Centers for Medicare & Medicaid Services (CMS) is approving Rhode Island's request to extend its section 1115 demonstration entitled, "Rhode Island Comprehensive Demonstration" (Project Number 11-W-00242/1) in accordance with section 1115(a) of the Social Security Act (the Act). This approval is effective January 1, 2026, through December 31, 2030, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire.

Approval of the extension application continues to build on the demonstration foundational goals of 1) paying for value, not volume; 2) coordinating physical, behavioral, and long-term health care; 3) rebalancing the delivery system away from high-cost settings; and 4) promoting efficiency and transparency. CMS has determined that the Rhode Island demonstration is likely to assist in promoting the objectives of Medicaid by increasing access to high-quality, medical assistance, including access to home and community-based services and dental services. In addition, the state intends to continue to support beneficiaries with the extension of the Substance Use Disorder (SUD) component of the demonstration to assist in promoting the objectives of the Medicaid statute by increasing access to high-quality, clinically appropriate treatment for beneficiaries with a SUD while they are short-term residents in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD). This approval is in alignment with State Medicaid Director Letter (SMDL) #17-003 RE: Strategies to Address the Opioid Epidemic.[1]

CMS's approval is subject to the limitations specified in the attached waiver and expenditure authorities, special terms and conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from the Medicaid state plan requirements only to the extent that those requirements have been specifically listed as waived or not applicable to expenditures under the demonstration.

CMS acknowledges that chapter 1 of subtitle B of title VII of Public Law 119-21, which CMS refers to as the Working Families Tax Cut (WFTC) legislation, makes additional changes to the Medicaid and CHIP programs. To the extent that any of those changes will affect the authorities

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf

within this demonstration, CMS will partner with Rhode Island to ensure compliance with and successful implementation of changes as described in the WFTC legislation during this demonstration period.

Extent and Scope of the Demonstration Extension

Approval of this request will extend most authorities, expand coverage of the managed care dental benefit, remove inactive authorities, and incorporates several technical updates to the STCs.

Extension of Existing Waiver Authorities

Below is a list of all waiver authorities in the Rhode Island demonstration. Two of the waivers listed below (Number 3 – Freedom of Choice and Number 6 Proper – Proper and Efficient Administration) allow Rhode Island to mandate certain Medicaid state plan populations into managed care.

1) **Amount, Duration, and Scope**
   Continued authority to allow the state to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, by providing additional services to beneficiaries enrolled in certain managed care arrangements.

2) **Comparability of Eligibility Standards**
   Continued authority to allow the state to apply standards different from those specified in the Medicaid state plan for determining eligibility, including, but not limited to, different income counting methods.

3) **Freedom of Choice**
   Continued authority to enable the state to restrict freedom of choice of provider for individuals in the demonstration by requiring enrollment in a managed care delivery systems. The majority of Rhode Island Medicaid beneficiaries are enrolled in managed care. No waiver of freedom of choice is authorized for family planning providers.

4) **Retroactive Eligibility**
   Continued authority to allow the state to exclude individuals from receiving coverage for up to three months prior to the date that an application for assistance is made. However, the state must provide retroactive eligibility for the 1902(l)(4)(A) populations (pregnant women and infants under age 1 described in subsection (a)(10)(A)(i)(IV) and children described in subsection (a)(10)(A)(i)(VI) or subsection (a)(10)(A)(i)(VII)) and aged, blind, or disabled (ABD) individuals.

5) **Payment Review**
   Continued authority, to the extent the state would otherwise need, to perform prepayment review for expenditure under programs for self-directed care by individual beneficiaries.

6) **Proper and Efficient Administration**
Continued authority to allow the state to enter into contracts with a single Prepaid Ambulatory Health Plan (PAHP) for the delivery of dental care under the RIte Smiles Program without regard to the choice requirements of 42 C.F.R. §438.52.

Extension of Existing Expenditure Authorities

1) **Extended Family Planning Program**
Continued authority to provide family planning and family planning-related benefits to women of childbearing age with income at or below 253 percent of the FPL who lose Medicaid or CHIP Targeted Low Income Pregnant Women eligibility at the conclusion of their 12-month postpartum period. (Budget Population 5 [EFP]).

2) **Uninsured Pregnant Women**
Continued authority for the state to cover pregnant women who have income between 190 and 253 percent of the FPL using title XIX funding if the state's title XXI funds are exhausted. (Budget Population 6a [Pregnant Expansion]).

3) **Insured Pregnant Women**
Continued authority for the state to cover pregnant women who have income between 190 and 253 percent of the FPL. (Budget Population 6b [Pregnant Expansion]).

4) **Elders at Risk for Long-Term Care (LTC)**
Continued authority to provide a limited set of Home and Community-Based Services (HCBS) to adults aged 65 and over who are at risk for needing LTC, have income at or below 250 percent of the FPL, and are in need of HCBS. (Budget Population 10 [Elders 65 and over]).

5) **Serious Emotional Disturbance (SED) / Intellectual or Developmental Disability (IDD) Children.**
Continued authority for the state to provide a limited set of services authorized under 1905(a) for children with SED and/or I/DD who would meet the supplemental security income (SSI) disability standards if only the children's income and resources were counted. (Budget Population 14 [SED/IID children]).

6) **Adults with Disabilities at Risk for LTC**
Continued authority for the state to provide a limited set of HCBS for adults with disabilities with income at or below 400 percent of the SSI federal benefit rate (FBR) with income and resource limits above the Medicaid limits. (Budget Population 15 [Adults with disabilities at risk for long-term care]).

7) **Youth At Risk for Medicaid**
Continued authority for coverage of detection and early intervention services for at-risk young children not eligible for Medicaid who have incomes up to 300 percent of SSI, including those with special health care needs, such as SED, behavioral challenges and/or medically dependent conditions, who may be safely maintained at home with appropriate levels of care. (Budget Population 17 – Youth At Risk For Medicaid).

8) **Adults with Alzheimer's or Related Dementia**
Continued authority for a limited set of HCBS for adults aged 19-64 who have been diagnosed with Alzheimer's disease or a related dementia as determined by a physician, who are at risk for LTC admission, who are in need of HCBS, and whose income is at or below 250 percent of the FPL. (Budget Population 20 – Alzheimer Adults).

9) **HCBS for 1915(c) Waiver-like Groups**
Continued authority for the state to provide HCBS to 1915(c)-like waiver populations. (Budget Populations 11/12/13).

10) **Premium Assistance of Private Insurance**
Continued authority to pay for part or all of the cost of private insurance premiums and cost sharing for eligible individuals which are determined to be cost-effective using state-developed tests that may differ from otherwise applicable tests for cost-effectiveness. (Budget Services 2 [RIte Share]).

11) **Marketplace Subsidy Program**
Continued authority to provide premium subsidies for parents and caretakers with incomes above 133 percent of the FPL through 175 percent of the FPL who purchase health insurance through the Marketplace. Subsidies are provided on behalf of individuals who: (1) are not Medicaid eligible; (2) are eligible for the advance premium tax credit (APTC); and (3) whose income is above 133 percent of the FPL through 175 percent of the FPL.

12) **Peer Recovery Specialist Program**
Continued authority for the Peer Recovery Specialist Program, which has been separated from the Family Youth Support Partner Program and established as a stand-alone authority to serve adults with behavioral-health or substance-use disorders. (Budget Services 6a).

13) **Family/ Youth Support Partner Program**
Continued authority for the Family/Youth Support Partner Program which provides services to improve functioning within family and community settings to children under 21 years of age and their caregiver. (Budget Services 6b).

14) **Behavioral Health Services**
Continued authority for the Behavioral Health Link Program which provides a triage center and mobile outreach services for crisis stabilization. (Budget Services 9).

15) **SUD IMD Authority**
Continued authority for SUD services to be provided to short-term residents in an IMD as outlined in the SUD State Medicaid Director Letter (SMDL) dated November 1, 2017 (SMD #17–003)[2]. (Budget Services 11).

[2] https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf

16) **1915(i)-like Home Stabilization**
Continued authority to operate a 1915(i)-like Home Stabilization Services Program. Under this program, the state provides home find services and home tenancy services for Medicaid beneficiaries who meet 1915(i)-like needs-based criteria. The STCs require the state to follow all 1915(i) rules for this program. (Budget Services 12).

17) **HCBS for At-Risk Youth**
Continued authority for HCBS for high-risk Medicaid eligible youth who are at risk for out-of-home care or hospitalization. (Budget Services 4).

18) **Expedited Eligibility for Long Term Care (LTC) Benefits/ Self-Attestation of Income**
Continued authority that allows the state to provide a limited set of LTC benefits for beneficiaries who self-attest to financial eligibility factors.

Notable Updates to the Demonstration

1) Expand the RIte Smiles Program to Adults

The state has had long-standing expenditure authority to operate the RIte Smiles managed care dental program for children. As part of the extension, CMS is approving the state's request to expand the RIte Smiles program to all adult Medicaid beneficiaries. RIte Smiles operates under a pre-paid ambulatory health plan. Based on the program's demonstrated success in improving access to and quality of dental care for children,[3] the state requested and CMS is approving this expansion to adults.

2) Differentiate the Peer Recovery Specialist Program from the Family/ Youth Support Partner Program

The extension approval creates separate expenditure authorities for the Peer Recovery Specialist (PRS) Program and the Family/Youth Support Partner (FYSP) Program for purposes of clarity among providers and beneficiaries. The programs were previously combined under one authority. PRS and FYSP are distinct provider types with separate qualifications and service models. Both programs serve beneficiaries with behavioral health needs. PRS provides support for adults with mental health needs and/or SUD who are having trouble maintaining stability and integrating in the community. FYSP offers services to children under age 21 with behavioral health needs, and their caregivers, to improve functioning within family and community settings. According to the state, creating two distinct programs will help providers and beneficiaries better understand the program for which they would be eligible and will assist the state in reporting and tracking expenditures for each program. This change does not impact eligibility criteria, available services, or eligible providers.

[3] Page 57 of Rhode Island extension request available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ri-comprehensive-demonstration-extension-pa.pdf

3) Update Home and Community Based Services (HCBS) Requirements

CMS is authorizing technical revisions to the STCs to align with the most recent HCBS program and monitoring requirements. For example, the STCs have been updated to capture all HCBS requirements such as beneficiary protections, person-centered service planning, conflict of interest protections, and self-direction. These changes also include updates to Attachments B, C, D, and E. The state requested to remove preventive services from Attachment B because all preventive services are either provided via the state plan or were never implemented due to state budget constraints. Attachment C "Assessment and Coordination Organization" has been removed because the state accomplishes the goals set out in the attachment by adhering to all HCBS requirements such as conflict-free case management and by reporting on HCBS quality measures. The state requested to make revisions to Attachment D: "Level of Care Criteria" to reflect the level of care determination policy that the state utilizes. Finally, Attachment E "Evidentiary Review Guidance for HCBS" is no longer needed because all performance measure requirements are included in STC 4.10. The state confirmed that the HCBS technical revisions have no impact on current beneficiaries.

Since 2009, when Rhode Island consolidated its 1915(c) waivers into its section 1115 demonstration, the state has had authority under section 1115(a) to waive the Medicaid "reasonable promptness" requirements and allow implementation of waiting periods for HCBS waiver-like LTC services. However, this authority is more appropriately classified as a "Title XIX Requirement Not Applicable" associated with the HCBS expenditure authority. As part of the extension approval, CMS and the state agreed to make this technical update.

4) Remove Inactive Expenditure Authorities

CMS is approving the state's request to remove inactive expenditure authorities to promote transparency and provide an accurate description of the demonstration. For various reasons, multiple expenditure authorities are no longer necessary and, therefore, have been removed. The following is a summary of why the authorities have been removed:

- Three authorities (1. Pregnant Women with income up to 190 percent of the FPL and Children with income up to 261 percent of the FPL (Budget Population 3), 2. Family Home Visitation Program, and 3. the CHIP Expenditure Authority) all transitioned to the Medicaid state plan;
- Five authorities (1. Substitute Care, 2. Beckett Aged Out, 3. Expenditures for Healthy Behaviors Incentives, 4. Home-Base Primary Care Services, and 5. Telephonic Psychiatric Consultation Services) were never implemented because of lack of state legislative authority;
- Three authorities(1. Insured Adults with Mental Illness, 2. HIV, and 3. Non-Working Disabled Adults) are no longer necessary since the passage of the Affordable Care Act because the state reported that all individuals who had received coverage under these expenditure authorities became eligible under the Medicaid state plan Adult Group;
- Two authorities (1. Designated State Health Program and 2. Dental Case Management Pilot) were time limited and have expired;
- One authority, Children with Special Health Care Needs (CSHCN) Alternative (Alt.), was not necessary because all children met the requirements of a different expenditure authority;

- One authority, Recovery Navigation Program, is no longer active. The state pursued a different model of care to divert individuals from emergency department care; and
- One authority, Window Replacement, is being removed since the state reported it has no historical experience submitting claims for the service.

Requests Withdrawn by the State

Rhode Island officially withdrew the following requests:

- Pre-release supports and Medicaid coverage for incarcerated Medicaid-enrolled adults and youth up to 90 days prior to returning to the community;
- Health-related social needs and a related request to fund the evaluation of community-based collaboratives;
- Contingency management pilot program to support recovery efforts for individuals with substance use disorders; and
- Expanded eligibility for complementary alternative medicine.

Budget Neutrality

This demonstration project is extended using CMS's current approach to determining budget neutrality as described in CMS SMDL #24-003.[4] However, CMS acknowledges that section 71118 of subchapter C of chapter 1 of subtitle B of title VII of Public Law 119-21, which CMS refers to as the WFTC legislation, adds a new subsection (g) to section 1115 of the Act with budget neutrality requirements that will apply beginning January 1, 2027, to CMS approvals of section 1115 Medicaid demonstration project applications, renewals, or amendments.[5] CMS intends to provide additional information prior to January 1, 2027 about the section 1115(g) requirements.

CMS has long required, as a condition of demonstration approval, that demonstrations be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs likely would have been in that state absent the demonstration.[6] The demonstration extension is projected to be budget neutral to the federal government. In requiring demonstrations to be budget neutral, CMS is constantly striving to achieve a balance between its interest in preserving the fiscal integrity of the Medicaid program and its interest in facilitating state innovation through section 1115 approvals. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration (the "without waiver" [WOW] costs). The state will be held to the budget neutrality monitoring and general financial requirements as outlined in the STCs.

[4] https://www.medicaid.gov/federal-policy-guidance/downloads/smd24003.pdf
[5] https://www.congress.gov/bill/119th-congress/house-bill/1/text
[6] https://www.medicaid.gov/medicaid/section-1115-demonstrations/budget-neutrality/index.html

Rebasing Without Waiver Baselines
Under this demonstration, for existing Medicaid Expenditure Groups (MEGs) that were implemented, CMS calculated the WOW baseline by using a weighted average of the state's historical WOW per-member-per-month (PMPM) baseline and its recent actual PMPM costs. The projected demonstration expenditures associated with each MEG in the WOW baseline (except MEGs with aggregate cost limits) have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for the new approval period. Using the President's Budget trend rate aligns the demonstration trend rate with federal budgeting principles and assumptions.

Hypothetical Budget Neutrality Treatment
Under its current approach to budget neutrality, CMS generally treats expenditures for populations or services which could have otherwise been covered via the Medicaid state plan, or other title XIX authority, such as a section 1915 waiver, as "hypothetical" for the purposes of budget neutrality. In these cases, CMS adjusts budget neutrality to account for the spending which the state could have hypothetically provided through the Medicaid state plan or other title XIX authority. CMS does not, however, currently allow for budget neutrality savings accrual as a result of including hypothetical populations or services in section 1115 demonstration projects. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent budget neutrality "supplemental test" for hypothetical expenditures. These supplemental budget neutrality tests subject the hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, during negotiations. If the state's "with waiver" (WW) hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending with savings elsewhere in the demonstration or to refund the FFP to CMS.

The Marketplace Subsidy Program, Elders and Alzheimer Adults at Risk for LTC, and Adults with Disabilities at Risk for LTC MEGs will be treated as hypothetical for budget neutrality purposes. For each of these MEGs, CMS calculated the WOW baseline (which refers to the projected expenditures that could have occurred absent the demonstration and which is the basis for the budget neutrality expenditure limit for each approval period). The projected demonstration expenditures associated with each of these MEGs in the WOW baseline (except MEGs with aggregate cost limits) have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for the new approval period. Using the President's Budget trend rate aligns the demonstration trend rate with federal budgeting principles and assumptions.

With Waiver Only Budget Neutrality
The state's Family/Youth Support Partner Program MEG are costs not otherwise matchable that require budget neutrality "savings" to offset the expenditures. As discussed above, the state requested to report this program separately from the Peer Recovery Specialist Program (PRS) to improve accuracy and financial tracking, as the Family/Youth Support Partner Program and PRS programs differ in the populations they serve, the services provided, and provider eligibility.

Mid-Course Correction
CMS has also updated its approach to mid-course corrections to budget neutrality calculations in this demonstration extension approval to provide flexibility and stability for the state over the life

of a demonstration. This update identifies, in the STCs, a list of circumstances under which a state's baseline may be adjusted based on actual expenditure data to accommodate circumstances that are either out of the state's control (for example, if expensive new drugs that the state is required to cover enter the market); and/or the effect is not a condition or consequence of the demonstration (for example, unexpected costs due to a public health emergency); and/or the new expenditure (while not a new demonstration-covered service or population that would require the state to propose an amendment to the demonstration) is likely to further strengthen access to care (for example, a legislated increase in provider rates). CMS also explains in the STCs what data and other information the state should submit to support a potentially approvable request for an adjustment. CMS considers this a more rational, transparent, and standardized approach to permitting budget neutrality modifications during the course of a demonstration.

Monitoring and Evaluation

The demonstration achieved mixed progress toward its demonstration goals. For example, there was positive progress for several areas, including paying for value rather than volume, coordinating physical, behavioral, and long-term health care, and rebalancing the delivery system away from high-cost settings through the Behavioral Health (BH) Link program. Specifically, the Interim Evaluation Report[7] showed increased coordination between the BH Link Triage Center and the BH Link Hotline for crisis stabilization and short-term treatment for BH conditions, as evidenced by the establishment of a one-stop 24/7 call center and mobilization of outreach liaisons throughout the community. The Interim Evaluation Report showed significantly lower average annual Medicaid spending for members using Peer Recovery Specialist and Family/Youth Support Partners (PRS/FYSP) services compared to baseline ($8,603 versus $24,740 average annual spend per member)[8]. Additionally, for the substance use disorder (SUD) component of the demonstration, the most recent Monitoring Report[9] showed at least a five percent increase between quarters in outpatient services, intensive outpatient and partial hospitalization services, and inpatient stays when comparing month three of the previous quarter to month one of the current quarter. The same monitoring data also showed at least a 19 percent decrease in residential and inpatient services for the same comparison periods.

However, there are also opportunities for improvement. For example, as noted in the Interim Evaluation report, BH Link users had statistically significant higher risk-adjusted rates of hospitalization, IMD service use, readmissions, emergency department (ED) visits, and 30-day follow-up after an ED visit for BH compared to non-users with BH diagnoses. The Interim Evaluation found that BH Link users incurred, on average, nearly $10,000 more in Medicaid spending per quarter than the comparison group. These higher levels of Medicaid spending and utilization among BH Link users may reflect both an increased need for services and increased service utilization. The state is currently working with its Accountable Entities and Managed Care Organizations to improve operational efficiency and remove barriers to care for members with behavioral health needs. Additionally, the state launched Certified Community Behavioral

[7] See Rhode Island's Interim Evaluation Report, available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ri-comp-demo-cms-approved-interim-eval-rpt.pdf

[8] The state did not control for the PHE in their analyses; therefore, it is not possible to know the interaction between the PHE and the reductions in utilization and spending.

[9] See Rhode Island's SUD Quarterly Monitoring Report, available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ri-comp-demo-sud-qrtly-monitor-rpt-oct-dec-2024-b.pdf

Health Clinics (CCBHCs) in October 2024, which are expected to broaden access to care for behavioral health services across the state.

Under this extension, the state is required to continue conducting systematic monitoring and robust evaluation of the demonstration. In collaboration with CMS, the state must undertake ongoing demonstration monitoring, including submission of relevant metric data and narrative updates describing progress in implementing all components of the demonstration. The evaluation will support a comprehensive assessment of whether the demonstration components are effective in achieving the desired outcomes for its beneficiaries and providers, as well as the state's overall Medicaid program.

Consideration of Public Comments

CMS posted the extension application on Medicaid.gov for public comment on January 6, 2023, through February 5, 2023, and received a total of 13 comments, of which 10 were related to the demonstration. CMS posted the addendum to the extension application on Medicaid.gov for public comment on June 8, 2024, through July 7, 2024, and received a total of eight comments, of which seven were related the demonstration. CMS received a total of 21 comments during the two public comment periods of which four were not relevant to the demonstration extension. The remaining 17 comments were overall in favor of the extension and addendum requests. Comments were received from provider organizations, advocacy organizations, research organizations, medical providers, and individuals.

Seven of the comments during the original extension public comment period pertained to elements that CMS approved as part of the March 21, 2024 amendment request and were discussed in the amendment approval letter.[10] For example, commenters supported updating the pregnant women expenditure authorities to include 12-months of postpartum coverage and modifying the educational requirements to increase the number of home stabilization providers.

One commenter voiced support for expanding the RIte Smiles program for adults. Other commenters supported the state continuing authorities such as the Extended Family Planning Program. Another commenter voiced support for continued investment in addressing behavioral health needs such as through the SUD authority, Peer Recovery Support program, Family/Youth Support Program, and the BH Link program. The commenter also supported the state's decision to move the Family Home Visitation program authority to the Medicaid state plan.

Three commenters shared concerns regarding the state's request to continue the waiver of retroactive eligibility. The commenters raised concerns that the state had not properly evaluated the effect of the waiver of retroactive eligibility. The demonstration extension STCs require the state to comprehensively evaluate the waiver of retroactive eligibility.

After careful review of the public comments submitted during the federal comment period and information received from the state public comment period, CMS has concluded that the demonstration is likely to assist in promoting the objectives of Medicaid.

[10] Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ri-comphnsve-dmnstrtn-aprvl.pdf

Other Information

CMS's approval of this demonstration is conditioned upon compliance with the enclosed set of expenditure authorities and STCs defining the nature, character and extent of anticipated federal involvement in the demonstration. The award is subject to CMS receiving written acceptance of this award within 30 days of the date of this approval letter. Your project officer for this demonstration is Alex Desatoff, who is available to answer any questions concerning your section 1115 demonstration and his contact information is as follows:

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Centers for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Alexei.Desatoff@cms.hhs.gov.

If you have questions regarding this approval, please contact Karen LLanos, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at Karen.Llanos@cms.hhs.gov.

Sincerely,

Dan Brillman
Deputy Administrator, CMS
Director, Center for Medicaid and CHIP Services

Enclosure

cc: Joyce Butterworth, State Monitoring Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER AUTHORITY

NUMBER: 11-W-00242/1

TITLE: Rhode Island Comprehensive Demonstration

AWARDEE: Rhode Island Executive Office of Health and Human Services

Under the authority of the Section 1115(a)(1) of the Social Security Act ("the Act"), the following waivers are granted to enable Rhode Island (referred to herein as the state or the State) to operate the Rhode Island Comprehensive Demonstration. These waivers are effective beginning January 1, 2026, and are limited to the extent necessary to achieve the objectives below. These waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs) set forth in the accompanying document.

As discussed in the Centers for Medicare & Medicaid Services' (CMS) approval letter, the Secretary of Health and Human Services has determined that the Rhode Island Comprehensive Demonstration, including the granting of the waivers described below, is likely to assist in promoting the objectives of title XIX and XXI of the Act.

Except as provided below with respect to expenditure authority, all requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project for the period beginning January 1, 2026, through December 31, 2030.

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

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

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

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

3. Freedom of Choice **Section 1902(a)(23)(A)**

To enable the state to restrict freedom of choice of provider for individuals in the demonstration. No waiver of freedom of choice is authorized for family planning providers.

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

To enable the state to exclude individuals in the demonstration from receiving coverage for

up to 3 months prior to the date that an application for assistance is made.

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

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

To the extent that the state would otherwise need to perform prepayment review for expenditures under programs for self-directed care by individual beneficiaries.

6. Proper and Efficient Administration **Section 1902(a)(4)**

To permit the state to enter into contracts with a single Prepaid Ambulatory Health Plan (PAHP) for the delivery of dental services under the RIte Smiles Program without regard to the choice requirements of 42 C.F.R. §438.52.

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: 11-W-00242/1

TITLE: Rhode Island Comprehensive Demonstration

AWARDEE: Rhode Island Executive Office of Health and Human Services

Under the authority of section 1115(a)(2) of the Social Security Act ("the Act"), expenditures made by Rhode Island for the items identified below, which are not otherwise included as matchable expenditures under section 1903 of the Act shall, for the period from January 1, 2026, through December 31, 2030, unless otherwise specified, be regarded as expenditures under the state's title XIX plan. All requirements of the Medicaid statute will be applicable to such expenditure authorities, except those specified below as not applicable to these expenditure authorities.

The following expenditure authorities and the provisions specified as "not applicable" may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable Rhode Island to operate the above-identified section 1115(a) demonstration.

1. Expenditures Related to Eligibility Expansion.

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

[Note: Budget populations 1, 2, 3, and 4, which are described in the demonstration's special terms and conditions and are affected by the demonstration, are covered under the Medicaid state plan. Budget populations 1, 2, 3, and 4 are not listed in the expenditure authorities below; however, they are subject to the waivers listed above. Demonstration populations/Budget Populations 11, 12, and 13 (related to 217-like groups) are described in expenditure authority 2 below. There are no references to Budget Populations 7, 8, 9, 16, 18, 19, or 21 because these are outdated and were removed as part of the 2025 extension approval.]

a. **Budget Population 5 [Extended Family Planning (EFP)]:** Expenditures for family planning services under the Extended Family Planning program, for women of childbearing age whose family income is at or below 253 percent of the FPL who lose Medicaid or CHIP Targeted Low Income Pregnant Women eligibility at the conclusion of their 12-month postpartum period. The benefits do not meet Minimum Essential Coverage (MEC) requirements under 26 U.S.C. § 5000A(f) and 45 C.F.R. Part 156, Subpart G.

b. **Budget Population 6a [Pregnant Expansion]:** Women who, at the time of initial application: (a) are uninsured pregnant women; (b) have no other coverage; (c) have family incomes above 190 and up to 253 percent of the FPL; (d) receive benefits only by virtue of the Comprehensive demonstration; (e) meet U.S. citizenship or satisfactory immigration requirements; and (f) are covered using title XIX funds if title XXI funds are

exhausted. Expenditures for Medicaid state plan benefits to extend the postpartum eligibility period from the end of the month in which the 60th postpartum day occurs to the end of the 12th month following the end of the pregnancy. This authority is only needed if the XXI funds are exhausted.

c. **Budget Population 6b [Pregnant Expansion]:** Women who, at the time of initial application: (a) are pregnant women; (b) have other coverage; (c) have family incomes above 190 and up to 253 percent of the FPL; (d) receive benefits only by virtue of the comprehensive demonstration; and (e) meet the U.S. citizenship or satisfactory immigration requirements. Expenditures for Medicaid state plan benefits to extend the postpartum eligibility period from the end of the month in which the 60th postpartum day occurs to the end of the 12th month following the end of the pregnancy.

d. **Budget Population 10 [Elders 65 and over]:** Expenditure authority for a limited set of home and community-based services (HCBS) for elders 65 and over who are at risk for needing LTC with income at or below 250 percent of the FPL who are in need of HCBS. The benefits do not meet MEC requirements.

e. **Budget Population 14 [Serious Emotional Disturbance (SED)/Intellectual or Developmental Disability (I/DD) Children]:** Expenditure authority for a limited set of services authorized under 1905(a) for children with SED and/or I/DD, who are not otherwise Medicaid or CHIP eligible, who need care in either a psychiatric residential treatment facility (PRTF) or residential treatment services authorized under the Rhode Island Medicaid State plan, and who would meet the SSI disability standards if only the child's income and resources were counted. These children do not receive SSI cash payments due to family income and resource limits. The benefits do not meet MEC requirements.

f. **Budget Population 15 [Adults with disabilities at risk for long-term care]:** Expenditures for a limited set of HCBS for adults living with disabilities with incomes at or below 400 percent of the SSI Federal Benefit Rate (FBR) with income and resource levels above the Medicaid limits. The benefits do not meet MEC requirements.

g. **Budget Population 17 [Youth at risk for Medicaid]:** Expenditures for coverage of detection and early intervention services for at-risk young children not eligible for Medicaid who have incomes up to 300 percent of SSI, including those with special health care needs, such as SED, behavioral challenges and/or medically dependent conditions, who may be safely maintained at home with appropriate levels of care. The benefits do not meet MEC requirements.

h. **Budget Population 20 [Alzheimer adults]:** Expenditure authority for a limited set of HCBS for adults aged 19-64 who have been diagnosed with Alzheimer's disease or a related dementia as determined by a physician, who are at risk for LTC admission, who are in need of HCBS, and whose income is at or below 250 percent of the FPL. The benefits do not meet MEC requirements.

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

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

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

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

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

3. **Budget Services 2 [RIte Share].** Expenditures for part or all of the cost of private insurance premiums and cost sharing for eligible individuals which are determined to be cost-effective using state-developed tests that may differ from otherwise applicable tests for cost-effectiveness.

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

5. **Demonstration Benefits.**
   a. Expenditures for benefits specified in Attachment A of the STCs provided to demonstration populations, which are not otherwise available in the Medicaid State Plan.
   b. Expenditures for the provision of HCBS as identified in Attachment B that are not otherwise available under the approved state plan, after accounting for beneficiary share of post-eligibility cost of care.
   c. Expenditures for home and community-based services as identified in Attachment B for Medicaid-eligible youth who are at risk for out-of-home care or hospitalization **(Budget Services 4)**.

6. **Long-Term Care Benefits Pending Verification of Financial Eligibility Criteria for New LTC Applicants.** Expenditures for a limited set of LTC benefits for individuals who self-attest to financial eligibility factors as specified in STC 4.14**.**

7. **Expenditures for Peer Recovery Specialist Program (Budget Services 6a).** Expenditures to deliver services, as outlined in STC 13 using a Peer Recovery Specialist who provides an

array of interventions that help prevent relapse, reduce the severity of disability, improve and restore function, and promote long-term recovery for individuals with a mental health and/or substance use disorder for those individuals who have trouble stabilizing in the community and/or are in need of supports to maintain their stability in the community.

8. **Expenditures for Family/Youth Support Partner Program (Budget Services 6b).** Expenditures to deliver services using a Family/Youth Support Partner who provides an array of interventions that support socialization, long-term recovery, wellness, self-advocacy, and connections to the community, as well as offer services, as outlined in STC 14, that will focus on supporting children under 21 years of age and their caregivers to improve the child's functioning within family and community settings and prevent institutional placements.

9. **Expenditures for Behavioral Health Link Program (Budget Services 9).** Expenditures to deliver the services within one Behavioral Health Link (BH Link) triage center, to support crisis stabilization and short-term treatment for individuals experiencing a behavioral health (mental health or substance use disorder) crisis, as outlined in STC 15.

10. **Residential and Inpatient Treatment for Individuals with Substance Use Disorder (Budget Services 11).** Expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment and/or withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

11. **Expenditures for 1915(i)-like Home Stabilization Services (Budget Services 12).** Expenditures for home stabilization services described in STC 5.3.

Title XIX Requirements Not Applicable to Budget Population 5 [Extended Family Planning]:

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

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

Title XIX Requirements Not Applicable to Budget Populations 10 [Elders 65 and older], 14 [SED/IDD Children], 15 [Adults with Disabilities At Risk for LTC], 17 [Youth At Risk for Medicaid], and 20 [Alzheimer Adults]

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

To enable Rhode Island to provide a limited benefit package.

Title XIX Requirement Not Applicable to Expenditure Authority 5(b) Demonstration Benefits - HCBS

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

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00242/1

TITLE: Rhode Island Comprehensive Demonstration

AWARDEE: Rhode Island Executive Office of Health and Human Services

1. PREFACE

The following are the Special Terms and Conditions (STCs) for the "Rhode Island Comprehensive Demonstration" section 1115(a) Medicaid demonstration (hereinafter "demonstration"), to enable the Rhode Island Executive Office of Health and Human Services (hereinafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

The STCs related to the programs for those populations affected by the demonstration are effective January 1, 2026, through December 31, 2030, unless otherwise specified.

The STCs have been arranged into the following subject areas:

1. Preface
2. Program Description and Objectives
3. General Program Requirements
4. Eligibility and Enrollment
5. Demonstration Programs and Benefits
6. Cost Sharing
7. Delivery System
8. Self-Direction
9. Extended Family Planning Program
10. RIte Smiles
11. Marketplace Subsidy Program
12. Substance Use Disorder (SUD) Program and Benefits
13. Peer Recovery Specialist (PRS) Program
14. Family/Youth Support Partner (FYSP) Program
15. Behavioral Health Link (BH Link) Program
16. Monitoring and Reporting Requirements
17. Evaluation of the Demonstration
18. General Financial Requirements
19. Monitoring Budget Neutrality for the Demonstration
20. Schedule of Deliverables for the Demonstration

Additional attachments have been included to provide supplementary information and guidance for specific STCs:

Attachment A: Managed Care and Fee for Service Demonstration Only Benefits
Attachment B: Home and Community-based Service Definitions
Attachment C: Level of Care Criteria
Attachment D: Evaluation Design [Reserved]
Attachment E: SUD Implementation Plan
Attachment F: Behavioral Health Link Component Services
Attachment G: Behavioral Health Link Payment Methodology

2. PROGRAM DESCRIPTION AND OBJECTIVES

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

Rhode Island's previous section 1115 demonstration programs, RIte Care and RIte Share, were subsumed under this demonstration, in addition to the state's previous section 1915(b) Dental Waiver and the state's previous section 1915(c) home and community-based services (HCBS) waivers.

The Rhode Island Comprehensive demonstration includes the following distinct components:

a. The Managed Care component provides Medicaid state plan benefits as well as supplemental benefits as identified in Attachment A to most recipients eligible under the Medicaid state plan, including the new adult group. Benefits are provided through comprehensive mandatory managed care delivery systems.

b. The Extended Family Planning component provides access to family planning and referrals to primary care services for women whose family income is at or below 200 percent of the federal poverty level (FPL), and who lose Medicaid or CHIP Targeted Low Income Pregnant Women eligibility under RIte Care at the conclusion of their 12-month postpartum period. Effective January 1, 2014, eligibility was raised to 253 percent of the FPL. See Section 9 for more detailed requirements.

c. The RIte Share premium assistance component enrolls individuals who are eligible for Medicaid/CHIP, and who are employees or dependents of an employee of an employer that offers a "qualified" plan into the ESI coverage.

d. The Rhody Health Partners component provides Medicaid state plan and demonstration benefits through a managed care delivery system to aged, blind, and disabled beneficiaries who have no other health insurance. Effective November 1, 2013, the Rhody Health Partners expanded to all qualified aged, blind, and disabled beneficiaries whether they have other health insurance or not. Effective January 1, 2014, the New Adult Group was enrolled in Rhody Health Partners. The amount, duration, and scope of these services may vary and limitations must be set out in the state plan, these STCs, or in demonstration changes implemented using the processes described in 3.6 of these STCs.

e. The Home and Community-Based Services (HCBS) component provides services similar to those authorized under sections 1915(c) and 1915(i) of the Act to individuals who need HCBS either as an alternative to institutionalization or otherwise based on medical need. Since March 21, 2024, (date of CMS's approval of the state's September 12, 2023, section 1115 demonstration

amendment application) and pursuant to section 3715 of the Coronavirus Aid, Relief, and Economic Security Act or the CARES Act, Pub. L. No. 116-136 (2020), the state has been authorized to provide 1915(c)-like Personal Care Services (PCS) in acute care hospital settings under its existing HCBS expenditure authorities (budget populations 10, 11, 12, 13, 15, and 20 and expenditure authorities 5(b) and 5(c).

f. The RIte Smiles Program is a managed dental benefit program for all Medicaid beneficiaries.

In 2013, CMS renewed the Comprehensive demonstration through December 31, 2018. This renewal included changes to support the state's implementation of the Affordable Care Act (including coverage of the new adult group for adults with incomes at or below 133 percent of the FPL), the expansion of the state's HCBS, and the conversion from an aggregate cap to a per member per month budget neutrality model.

On February 8, 2018, CMS approved the category III change (an amendment) request from the state to give Rhode Island the authority to create two new programs: Recovery Navigation Program (RNP) and Peer Recovery Specialist Program (PRS). These programs were designed to offer services to Medicaid beneficiaries with certain chronic diseases and conditions. RNP was a recovery-oriented environment that connected individuals with necessary resources such as detoxification treatments, care management, and/or other recovery services. The Peer Recovery Specialist (PRS) is a credentialed health care professional who provides an array of interventions that promote socialization, long-term recovery, wellness, self-advocacy, and connections to the community.

On July 11, 2018, the state requested expenditure authority to receive FFP for services delivered to beneficiaries diagnosed with an Opioid Use Disorder (OUD) and other Substance Use Disorders (SUD) residing in an Institution for Mental Diseases (IMD). The state's goal to implement these initiatives will increase access to critical levels of care for Opioid Use Disorder (OUD) and other Substance Use Disorder (SUD), increase the use of evidence-based, SUD specific patient placement criteria and to set standards for residential treatment provider qualifications across the state.

The IMD expenditure authority allows some larger SUD residential treatment providers to assist the state in alleviating some of the access challenges that Rhode Island faces for ASAM III.1 – III.5 and III.7 levels of care.

In its 2018 extension application, the state also requested authority for and received approval of the following programs as part of the December 20, 2018, extension approval:

1) Expansion of Eligibility for Children with Serious Emotional Disturbance (SED) who require residential treatment;
2) Family Home Visiting Services Program;
3) Home-based primary care services
4) Expansion of peer supports;
5) Behavioral Health Link Pilot Program; and the
6) Dental Case Management Pilot program.

On February 6, 2020, CMS approved a section 1115(a) amendment authorizing telephonic psychiatric consultation services to expand access to behavioral health services and home stabilization services (home find services and home tenancy services) to address housing instability for Medicaid beneficiaries at risk for institutionalization.

On March 21, 2024, CMS approved a section 1115(a) amendment authorizing 1915(c)-like personal care

services in acute care hospital settings as well as state requests that the state included in its December 22, 2022, section 1115(a) extension application. These approved requests included long-term authority for virtual HCBS flexibilities that were previously approved under Attachment K COVID-19 PHE authority, authority for HCBS remote supports and monitoring, an increase in the income level for HCBS waiver-like services for adults with disabilities at risk for long-term care, changing the provider education requirements for home stabilization services, expanding the postpartum continuous eligibility period to 12 months, and updating certain FPL figures to reflect the modified adjusted gross income (MAGI) conversion.

On December 12, 2024, CMS approved an amendment and temporary extension through June 30, 2025, of the demonstration. The amendment clarified that family planning services must be for the purpose of preventing or delaying pregnancy. The amendment identified Sexually Transmitted Infection (STI) diagnosis and treatment as a family planning-related service. On June 10, 2025, CMS approved a temporary extension of the demonstration through December 31, 2025.

On November 24, 2025, CMS approved an extension of the demonstration that includes several technical updates such as expanding the RIte Smiles program to include all Medicaid beneficiaries, not only children; removing outdated expenditure authorities that were never implemented or were moved to state plan authority; and clarifying the distinction between the Peer Recovery Specialist Program and the Family/Youth Support Partner Program.

3. GENERAL PROGRAM REQUIREMENTS

3.1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

3.2. **Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3.3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

3.4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a

modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 3.7 of this section) as a result of the change in FFP.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

3.5. **State Plan Amendments**. The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

3.6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below, except as provided in STC 3.3.

3.7. Amendment Process. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including, but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 3.12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

c. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a

result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

d. An up-to-date CHIP allotment worksheet, if necessary.

e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and monitoring reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

3.8. **Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS from the Governor of the state in accordance with the requirements of 42 CFR 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit a phase-out plan consistent with the requirements of STC 3.9.

3.9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct redeterminations of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures. The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 435.916(d)(1). For individuals determined ineligible for Medicaid and CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the

procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable advance notice requirements and fair hearing rights described at 42 CFR 431, Subpart E. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230.

e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

3.10. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waiver or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS's determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

3.11. Adequacy of Infrastructure. The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

3.12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the public notice procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State plan, when any program changes to the demonstration, either through amendment as set out in STC 3.7 or extension, are proposed by the state.

3.13. Federal Financial Participation (FFP). No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

3.14. Administrative Authority. When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

3.15. Common Rule Exemption. The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

4. ELIGIBILITY AND ENROLLMENT

4.1. Populations Affected and Eligible under the Demonstration. All Medicaid state plan populations are in the demonstration. In addition, the populations for which expenditure authority is granted are also enrolled in the demonstration.

Mandatory and optional Medicaid and CHIP state plan groups derive their eligibility through the Medicaid State Plan or CHIP State Plan and are subject to all applicable Medicaid laws and regulations except as expressly waived under authority granted by this demonstration. Those groups made eligible by virtue of the expenditure authorities expressly granted in this demonstration are subject to all applicable Medicaid and CHIP laws and regulations except as expressly identified as not applicable under expenditure authority granted by this demonstration.

4.2. **Eligibility Determinations – ABD Related**. Eligibility determinations for ABD related populations in the community must follow the income and resource methodologies of the SSI program and the current Medicaid state plan.

4.3. **Eligibility/Post-Eligibility Treatment of Income and Resources for Institutionalized Individuals.** In determining eligibility for institutionalized individuals, the state must use the rules specified in the currently approved Medicaid state plan. All individuals receiving institutional services must be subject to post-eligibility treatment of income rules set forth in section 1924 of the Act and 42 CFR 435.733.

4.4. **Categorically Needy Individuals at the Highest Level of Care.** The state will use institutional eligibility and post eligibility rules for an individual who would only be eligible in the institution in the same manner as specified under 42 CFR 435.217, 435.236, 435.726, and section 1924 of the Act, to the extent that the state operates a program under the demonstration using authority under section 1915(c) of the Act.

4.5. **Categorically Needy Individuals at the High Level of Care.** The state will use institutional eligibility and post eligibility rules for individuals who would not be eligible in the community because of community deeming rules in the same manner as specified under 42 CFR 435.217, 435.236, 435.726, and section 1924 of the Act, to the extent that the state operates a program under the demonstration using authority under section 1915(c) of the Act.

4.6. **Medically Needy at the High and Highest Level of Care.** The state may apply the medically needy income standard. Individuals requiring habilitation services will be eligible to receive those services with a High or Highest Level of Care. The state will otherwise use institutional eligibility rules, including the application of spousal impoverishment eligibility rules.

4.7. **Personal Needs Allowance.** The state may increase the monthly personal needs allowance by $400 for certain persons categorically eligible or eligible as medically needy for Medicaid-funded long-term services and supports. These individuals will have resided in a nursing facility for 90 consecutive days, excluding those days that may have been used for the sole intent and purpose of short term rehabilitation; are transitioning from a nursing facility to a community residence, and are assessed to be unable to afford to remain in the community unless the personal needs allowance is increased. This would not apply to individuals who are residing in a nursing facility and whose income is being used to maintain a current community residence.

4.8. **Program for All-Inclusive Care for the Elderly (PACE).** For participants at the "highest" level of care, the state will use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified under 42 CFR 435.217, 435.236, 435.726 and section 1924 of the Act, if the state had section 1915(c) waiver programs. For participants at the "high" level of care, the state will use institutional eligibility and post eligibility rules for individuals who would not be eligible in the institution in the same manner as specified under 42 CFR 435.217, 435.236, 435.726 and section 1924 of the Act, if the state had section 1915(c) waiver programs.

4.9. Individuals Receiving 1915(c) or 1915(i)-like Home and Community Based Services:

a. **HCBS Electronic Visit Verification System.** The state will demonstrate initial compliance and ensures ongoing compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) and home health services in accordance with section 12006 of the 21st Century CURES Act.

b. Needs-based Criteria. The state assures that there are needs-based criteria for receipt of services in nursing facilities, intermediate care facilities for individuals with intellectual disabilities, and/or long-term care hospitals, and Medicaid waivers offering HCBS to individuals who meet institutional level of care, that are more stringent than the minimum needs-based criteria required to receive 1915(i)-like services.

4.10. HCBS Beneficiary Protections:

a. **Person-Centered Service Planning.** The state assures there is a person–centered service plan for each individual determined to be eligible for HCBS under the demonstration. The person–centered service plan must be developed using a person–centered service planning process in accordance with 42 CFR 441.301(c)(1) and the resulting written person–centered service plan must meet requirements set forth at 42 CFR 441.301(c)(2) The person–centered service plan is reviewed and revised, as appropriate, based upon reassessment of functional

need as required by 42 CFR 441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the beneficiary.

b. **HCBS Conflict of Interest.** The state assures compliance with the HCBS conflict of interest protections set forth at 42 CFR 441.301(c)(1)(vi) and 441.730(b). The state agrees that the entity that authorizes the services is external to the agency or agencies that provide the HCBS services. The state also agrees that appropriate separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.

c. **HCBS Settings Requirements.** The state must assure compliance with the characteristics of HCBS settings as described in 42 CFR 441.301(c)(4) in accordance with implementation/effective dates as published in the Federal Register.

d. **HCBS Delivered via Managed Care.** The state, either directly or through its MCO contracts must ensure that participants' engagement and community participation is supported to the fullest extent desired by each participant.

e. Beneficiaries may change managed care plans if their residential or employment support provider is no longer available through their current plan.

f. **HCBS Delivered with Self-Direction.** Each beneficiary eligible for long term services and supports will have informed choice on their option to self-direct LTSS, have a designated representative direct LTSS on their behalf, or select traditional agency-based service delivery. Both level of care and person-centered service planning personnel will receive training on these options

4.11. **Quality Strategy for 1915(c)-like and 1915(i)-like HCBS.** For services that could have been authorized to individuals under a 1915(c) HCBS waiver or 1915(i) HCBS state plan amendment, the state must develop and implement a Quality Improvement Strategy that encompass LTSS specific measures set forth in the federal managed care rule at 42 CFR 438.330 and in accordance with 42 CFR 441.301, 441.302 and 441.745(b). The Quality Improvement Strategy must meet the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in §1915(c) Home and Community–Based Waivers. Specifically, the state is required to develop performance measures to address the following assurances and requirements:

a. **Administrative Authority.** The state must have performance measures to demonstrate that the State Medicaid Agency (SMA) retains ultimate administrative authority and responsibility for the operation of the HCBS program by exercising oversight of the functions delegated to other state and local/regional non-state agencies (if appropriate) and contracted entities.

b. **Eligibility based on Section 1115 Requirements.** Performance measures are required for the following: a) that an evaluation for HCBS eligibility is provided to all applicants for whom there is reasonable indication that HCBS services may be needed in the future, b) the processes and instruments described in the approved demonstration for determining HCBS eligibility are applied appropriately, and c) while the state is still required to re-evaluate the eligibility of enrolled individuals at least annually or more frequently if specified in the demonstration, a performance measure is not required to demonstrate compliance with this requirement.

c. **Qualified Providers.** The state must have performance measures to demonstrate each of the following: a) that the state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to their furnishing HCBS services, b) that the state monitors non-licensed/non-certified providers to assure adherence to demonstration requirements, and c) that the state implements policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved demonstration.

d. **Service Plans.** The state must have performance measures to demonstrate each of the following: a) service plans address all individuals' assessed needs (including health and safety risk factors) and personal goals, either by the provision of HCBS services or through other means, b) service plans are updated/revised at least annually or when warranted by changes in participant's needs, c) services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan, and d) participants are afforded choice between/among HCBS services and providers.

e. **Health and Welfare.** The state must have performance measures to demonstrate each of the following: a) that on an ongoing basis it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death, b) that it has an incident management system in place that effectively resolves incidents and prevents further similar incidents to the extent possible, c) that state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusions) are followed, and d) that the state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved demonstration.

f. **Financial Accountability.** The state must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the HCBS program. The state must have performance measures to demonstrate that: a) claims are coded and paid for in accordance with the reimbursement methodology specified in the approved demonstration and only for services rendered, and b) it provides evidence that rates remain consistent with the approved rate methodology throughout the demonstration period.

g. **HCBS Settings Requirements.** The state must have performance measures to demonstrate that settings meet the home and community-based setting requirements in accordance with 42 CFR 441.301(c)(4).

h. The state must submit the Quality Improvement Strategy (QIS) to CMS for review and acceptance within 90 days following approval of the demonstration.

i. The state will develop two sets of performance measures: one set to evaluate the general HCBS program and one set to evaluate the Home Stabilization Services Program. Both sets of performance measures must be submitted to CMS for review and acceptance within 90 days following approval of the demonstration.

4.12. 1915(c) and 1915(i)-like HCBS General Program Reporting Requirements:

a. **Enrollment**. The state must annually report to CMS the projected number of individuals to be enrolled in the HCBS demonstration and the actual number of unduplicated individuals

enrolled in the HCBS demonstration in the previous year. This report is due within 90 days after the end of each Demonstration Year.

b. **Deficiencies.** The state must report annually to CMS on the deficiencies found during the monitoring and evaluation of the HCBS performance measures and assurances, an explanation of how these deficiencies have been or are being corrected, as well as the steps that have been taken to ensure that these deficiencies do not reoccur. The state must also report on the number of substantiated instances of abuse, neglect, exploitation and/or unexplained death in the HCBS demonstration, the actions taken regarding the incidents and how they were resolved. Submission to CMS is due no later than 6 months following the end of each Demonstration Year.

c. **Evidence**. The state will submit a report to CMS, following receipt of an Evidence Request letter and report template from CMS, no later than 21 months prior to the end of the approved demonstration period. The state's evidence report must include evidence on the status of the approved HCBS quality performance measures and assurances that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in §1915(c) Home and Community–Based Waivers. Following receipt of the state's evidence report, CMS will review the evidence to determine whether the performance measures and requirements have been met and will issue a draft report to the state. The state will have 90 days to respond to the draft report. CMS will consider the state's response and will issue a final report of our findings to the state 60 days following receipt of the state's response to the draft report.

4.13. 1915(i)-like Home Stabilization Services Program Reporting;

a. **Enrollment**. The state must annually report to CMS the projected number of individuals to be enrolled in the 1915(i)-like Home Stabilization Services Program and the actual number of unduplicated individuals enrolled in the program in the previous year. This report is due no later than 90 days after the end of each Demonstration Year.

b. **Evidence**. The state will submit a report to CMS, following receipt of an Evidence Request letter and report template from CMS, no later than 21 months prior to the end of the approved demonstration period. The state's evidence report must include evidence on the status of the approved HCBS quality performance measures for the 1915(i)-like Home Stabilization Services Program, that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in §1915(c) Home and Community–Based Waivers. Following receipt of the state's evidence report, CMS will review the evidence to determine whether the performance measures and requirements have been met and will issue a draft report to the state. The state will have 90 days to respond to the draft report. CMS will consider the state's response and will issue a final report of our findings to the state 60 days following receipt of the state's response to the draft report.

4.14. **Expedited LTC Eligibility.** The state may accept self-attestation of the financial eligibility criteria for new LTC applicants for a maximum of ninety (90) days. Eligible individuals would be required to complete the LTC Clinical and Financial Application for LTC services. After Clinical Eligibility criteria has been verified by the state, the individual would provide a self-attestation of the LTC financial eligibility criteria to receive a limited benefit package of community based LTSS for up to 90 days pending the determination of the full LTC financial application. The limited benefit package

includes a maximum of twenty (20) hours weekly of personal care/homemaker services and/or a maximum of three (3) days weekly of Adult Day Care Services and/or limited skilled nursing services based upon assessment. Upon determination of the approval of the full LTC financial application, the individual will receive the full LTC benefit package. The limited community based LTSS services is available for up to ninety (90) days or until the eligibility for LTC decision is rendered, whichever comes first.

5. DEMONSTRATION PROGRAMS AND BENEFITS

5.1. **General.** Benefits provided through this demonstration program are as follows:

a. RIte Care. Benefits are the full scope of benefits set forth in the approved state plan and this demonstration. Benefits are delivered through managed care organizations or managed care delivery systems, with the exception of certain services paid by the state on a fee-for-service basis, as outlined in the applicable managed care contract. Benefits that are available to RIte Care enrollees under this demonstration include all benefits listed in Attachment A and under the Medicaid State Plan.

b. Alternative Benefit Plan. The Adult Group receives benefits provided through the state's approved alternative benefit plan (ABP) state plan amendment (SPA), which are effective, as of the effective date in the approved ABP SPA. Individuals in the Adult Group may receive, as part of their ABP under this demonstration, Expenditure Authority services such as those benefits specified in Attachment A of the STCs.

c. Extended Family Planning Program. Family planning services and referrals to primary care services are provided to eligible recipients at or below 253 percent of the FPL who lose Medicaid or CHIP Targeted Low Income Pregnant Women eligibility at the conclusion of their 12-month postpartum period. See Section 9 for more detailed requirements.

d. HCBS. Long term care services are provided when medically necessary to certain individuals eligible under the Medicaid state plan. As indicated above, the Adult Group will receive benefits provided through the state's approved ABP SPA. Benefit packages include long-term care and home and community-based services based on medical necessity and an individual's person-centered plan of care. Benefit packages for all individuals who meet the highest or high level of care criteria will include access to HCBS as described and defined in Attachment B, subject to any waiting list as described in STC 5.6.

e. Limited Benefit Packages. Individuals in Budget Populations 10, 14, 15, 17, and 20 are eligible for limited benefits under the demonstration. Benefit packages may include, but are not limited to, limited pharmacy, physical health, or mental health services.

5.2. 1915(i)-like Home Stabilization Services.

a. **Eligibility**. Home Stabilization Services will be available to individuals who meet at least one of the following health needs-based criteria and is expected to benefit from the provision of Home Stabilization Services:

i. The individual is assessed to have a mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including

ability to live independently without support) resulting from the presence of a mental illness; and/or

ii. Any complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support).

AND

iii. The individual has at least one of the following risk factors:

1. History of eviction and/or unstable housing (an individual must establish one of the following: notices from landlords/housing authorities to resolve issues, month-to-month housing agreements, couch surfing arrangements, or housing costs exceeding income/resources).
2. History of frequent turnover of in-home caregivers, where within the last 12 months the individual utilized 3 or more different in-home caregiver provider agencies and the current placement is not appropriate for the individual.
3. History of institutionalization in a medical or penal facility including hospitals, Intermediate Care Facilities for People with Intellectual Disability (ICF/ID), skilled nursing facilities, penal institutions nursing homes, Nursing Homes or other LTC housing, state hospitals, and any correctional facilities.
4. Past or present substance use that interfered with ability to pay rent, maintain apartment according to lease, or created interpersonal issues that jeopardized housing.

5.3. Home Stabilization Description of Services

a. Home Stabilization Services are designed to ensure timely access to appropriate, high quality services for individuals who require support to establish or maintain a home. The goals of Home Stabilization Services include promoting living in the community successfully and reducing unnecessary institutionalization, addressing social determinants of health, and promoting a person-centered, holistic approach to care.

b. The state will use the Home Stabilization Certification Standards to certify providers to deliver either time-limited home tenancy teaching services for individuals who require support in obtaining and maintaining a home, or time- limited home find services to individuals who require support in finding and transitioning to housing. Home Tenancy Services and Home Find Services cannot be provided concurrently to a beneficiary and shall not be rendered for a total of more than 24 months.

c. Home Tenancy Services include:

i. Coordinating and linking recipients to supports that assist in early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations;

ii. Connecting the individual to education and training on the role, rights, and responsibilities of the landlord and tenant, as well as reinforcement of lessons to maximize the skills learned;

iii. Providing supports to assist the individual in developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy;

iv. Providing supports to assist the individual in resolving disputes with landlords/neighbors to reduce the risk of eviction or other adverse action;

v. Assistance with linking the individual with community resources to prevent eviction when housing is, or may be jeopardized;

vi. Providing supports to assist the individual with the housing recertification process;

vii. Coordinating with the tenant to review, update, and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers;

viii. Connecting the individual to training and resources that will assist the individual in being a good tenant and lease compliance, including on-going support with activities related to household management, as well as reinforcement of lessons to maximize the skills learned.

d. Home Find Services include:

i. Conducting tenant screening and housing assessments that identify the participants' preferences and barriers related to successful tenancy as part of the person-centered plan;

ii. Developing an individualized housing support plan based on housing assessment;

iii. Supports to assist the individual with the housing application and search process;

iv. Assist the individual in identifying resources to cover moving and start-up expenses and assist in arranging for and supporting the details of the move;

v. Ensuring that the living environment is safe and ready to move- in;

vi. Developing a housing support crisis plan.

e. The state will not cover the following services:

i. Payment of rent or other room and board costs;

ii. Capital costs related to the development or modification of housing;

iii. Expenses for utilities or other regular occurring bills;

iv. Goods or services intended for leisure or recreation;

v. Duplicative services from other state or federal programs; and

vi. Services to individuals in a correctional institution or an IMD.

f. The state will review and approve each certified Home Stabilization Services provider's housing assessment tool.

g. Once a beneficiary is determined eligible for these services, the state must require that the provider submit to EOHHS a request for prior authorization to provide time-limited services to the individual.

h. The state must require that the Home Stabilization Providers develop relationships with case managers from other community-based services and supports, including but not limited to healthcare providers, community mental health providers, permanent supportive housing providers, and community action programs. Home Stabilization services are intended to meet gaps in the provision of existing services and are intended to support housing retention; providers may not duplicate case management or home care services that are currently being provided in the community.

i. The state must provide training to Medicaid providers that addresses the scope of services, the Home Stabilization Services provider certification process, and the referral, authorization and billing requirements. This information must be available in person, in provider communications and provided through updates on the EOHHS website.

5.4. Home Stabilization Provider Qualifications

a. The state must require that any Home Stabilization Services provider meet the Certification Standards for Home Stabilization Services codified in the Rhode Island Administrative Code at 210-RICR-20-00-1 and the state must require Home Stabilization Services providers to demonstrate compliance with Medicaid payment policies and provider certification standards.

b. The state must require that any Home Stabilization Services provider staff person providing direct support to clients must complete ongoing provider trainings offered by designees of the Rhode Island Continuum of Care, such as the Rhode Island Coalition for the Homeless, on topics that may include but are not limited to: Housing First, HIPAA, culturally informed care, Homeless Management Information System (HMIS), Motivational Interviewing, care coordination, and tenant's rights.

c. Supervisors of staff providing home find services and home tenancy services must have a Licensed Independent Clinical Social Worker (LICSW), Master of Social Work (MSW), Registered Nurse (RN), or other master's level degree.

Table 1: Home Stabilization Provider Qualifications

Provider	Education and Experience (minimum)	Skills (preferred)	Services
Home Stabilization Services Provider	High School Diploma or General Educational (GED) Test and at least: with one (1) year of lived or professional experience; OR Bachelor's degree in a human/social services field.	Knowledge of principles, methods, and procedures of services included under Home Stabilization Services meant to support the client's ability to obtain and maintain residence in independent community settings.	Home Find Services and Home Tenancy Services

5.5. Long-Term Care and HCBS Individuals eligible as aged, blind or disabled (ABD) under the Medicaid state plan will receive benefits for institutional and home and community-based long term care services including an option for self-direction. Primary care for this population may be provided through mandatory or voluntary managed care or FFS programs. Based on a level of care determination, individuals eligible as ABD under the Medicaid state plan can fall into the following groups: 1) highest or 2) high.

a. Highest level of care. Individuals who are determined based on medical need to require the institutional level of care will receive services through nursing homes, long term care hospitals or intermediate care facilities for the mentally retarded (ICF/MR). Beneficiaries meeting this level of care will have the option to choose community-based care including services as defined in Attachment B.

b. High level of care. Individuals who are determined based on medical need to benefit from either the institutional level of care or a significant level of home and community-based services will have access to HCBS as defined in Attachment B.

c. Primary and acute care services for Medicaid ABD eligible individuals meeting the highest or high level of care may be provided through managed fee-for-service (FFS). Individuals who are dually eligible for Medicare and Medicaid will receive primary and acute care services through Medicare FFS, a Medicare Advantage Plan, through the Program of All Inclusive Care for the Elderly (PACE), or other managed fee-for-service. This STC does not preclude the state from entering into other contract arrangements with entities that can provide these services. All individuals receiving HCBS must receive level of care evaluations, functional assessments, and person-centered service planning. Historically, these functions have only been available in face-to-face meetings. While in-person meetings will remain the default approach, beneficiaries now have the option to elect to receive evaluations, assessments, and service planning telephonically or virtually. Telephonic and/or virtual options are available when medically appropriate and in accordance with the individual's service plan. When scheduling meetings for level of care evaluations, functional assessments, and/or person-centered planning, the state will ask individuals who request a virtual meeting whether they are able to use the technology to participate in a virtual meeting and what assistance they may need to do so. If the individual requires assistance before or during the meeting, the staff facilitating the meeting will offer that assistance (e.g., information on how to log into the meeting or the correct steps to access functions like screen sharing, etc.). As part of the Case

Management service, all individuals, including those who choose to participate in virtual person-centered service planning, will receive an in-person contact at least once every six (6) months if this meets the individual's needs and preserves the health and welfare of the individual.

5.6. **Waiting List for HCBS.** Should a waiting list for LTSS develop, the state must provide services for individuals classified in higher levels of care categories before providing services to individuals classified in lower categories. Specifically, participants receiving services must continue to receive services unless their condition improves and they move to a lower level of care category. Also, participants and applicants in the highest category are entitled to services and must not be put on a waiting list for institutional services. (If a community placement is not initially available, they may be put on a wait list for transition to the community.)

5.7. **Long-Term Care Enrollment.** For those participants residing in an institution at the point of the initial implementation of the demonstration in January 2009, the state must apply pre-demonstration level of care criteria to those individuals unless the participant transitions to the community because he or she: (a) improves to a level where he or she would no longer meet the pre- demonstration institutional level or care, or (b) the individual chooses community care over institutional care. Once that participant is residing in the community, all future level of care redeterminations will be based on the new level of care criteria established for the purposes of this demonstration.

5.8. **Program for All-inclusive Care for the Elderly (PACE).** PACE is subsumed under this section 1115 demonstration program and will remain an option for qualifying demonstration eligibles, that is, those that meet the High or Highest level of care determinations. The state assures that demonstration eligibles who may be eligible for the PACE program are furnished sufficient information about the PACE program in order to make an informed decision about whether to elect this option for receipt of services. The state will comply with all Federal requirements governing its current PACE program, and any future expansion or new PACE program, in accordance with section 1934 of the Social Security Act and regulations at Part 460 of Title 42 of the Code of Federal Regulations.

5.9. Long-Term Care Insurance Partnership. The state must implement a Long-Term Care Insurance Partnership Program as described in the Rhode Island state plan. Under the Long-Term Care Insurance Partnership Program, an individual who is a beneficiary under a qualified long-term care insurance policy is given a resource disregard equal to the amount of insurance benefit payments made to or on behalf of the individual. The state does not seek adjustment or recovery from the individual's estate for the amount of assets or resources disregarded.

6. COST SHARING

6.1. Cost sharing imposed upon individuals enrolled in the demonstration is consistent with the provisions of the approved state plan. Demonstration populations may be charged premiums that do not exceed the premiums specified below.

6.2. Any premiums or copay requirements are specified in the Medicaid state plan. Demonstration populations may be charged premiums that do not exceed the premiums specified in the approved state plan.

7. DELIVERY SYSTEM

7.1. **Long-Term Care Services.** Institutional and community-based long-term care services are delivered through one of the following delivery systems:

a. Managed Long Term Services and Supports. Beneficiaries will have access to long-term care services and supports through their enrollment in managed care or PACE.

b. Fee-for-service. Beneficiaries will be able to access long-term care services through a fee-for-service system. Under this system, a beneficiary can choose the Medicaid participating agency or provider who will deliver the service(s). In turn, for those services requiring authorization or that are "out-of-plan," the agency/provider bills the Medicaid agency for services authorized in the individual's service plan .

c. Self-direction. Self-direction is an option for beneficiaries who are eligible for and receiving home and community based services and supports. Additional requirements are listed in STC Section 8.0 Self-Direction.

7.2. **Primary and Acute Care Services.** Primary and acute care services will be delivered through the managed care, pre-paid dental ambulatory health plans, PACE, Premium Assistance, or FFS.

7.3. **Contracts.** On those occasions that contracts with public agencies are not competitively bid, those payments under contracts with public agencies shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

7.4. **Freedom of Choice.** An enrollee's freedom of choice of providers through whom the enrollee may seek services may be limited. This applies to all populations enrolled in the comprehensive demonstration. No waiver of freedom of choice is authorized for family planning providers.

7.5. **Process for the Review and Approval of Contracts.** The state, its MCOs, Prepaid Inpatient Health Plans (PIHPs), and Prepaid Ambulatory Health Plans (PAHPs), Non-Emergency Medical Transportation (NEMT) PAHPs and any subcontractor delegated to perform activities under the managed care contract, must comply with the managed care regulations published in 42 CFR part 438, except as expressly waived or specified as not applicable to an expenditure authority.

8. SELF-DIRECTION

8.1. **Required Elements of Self-Direction.** The state must meet the following requirements to operate its self-direction program for HCBS..

8.2. **Self-Direction Option.** Rhode Island has two Self-Direction programs for Home and Community-Based Services participants. The Personal Choice program is available to individuals who are at least eighteen (18) years old who meet the High or Highest nursing facility level of care as described in Attachment C. The "Self-Directed for I/DD" program is available to individuals who are at least eighteen (18) years old, with intellectual or developmental disabilities, who meet the level of care for Intellectual/Developmental Disability Services at any tier (A through E) as described in Attachment C.

8.3. **Paid Providers of Services.** For individuals participating in Self-Direction, the following individuals may be paid providers of self-directed services and supports and may be hired by the participant or the

individual's representative: any individual who is capable of providing the assigned tasks, meets the requirements of the position, is freely chosen by the participant, and is *not* the participant's spouse or a representative as defined in STC 8.15. Parents and other non-spouse relatives of the participant may be paid providers of services as long as they meet the above requirements.

a. Participants retain the right to: 1) train their employees in the specific areas of services and supports needed; 2) have those services and supports furnished in a manner that comports with the participants' personal, cultural, and/or religious preferences; and 3) access other training provided by or through the state for their employees so that they can meet any additional qualifications required or desired by the participants.

8.4. **Information Furnished to Participants.** The following information must be provided to participants: principles and benefits of participant direction; participants' rights, roles and responsibilities, including how to identify and report critical incidents such as abuse, neglect, and exploitation; self-direction election form; description of other feasible alternatives; fiscal/employer agent contact information; grievance and appeal process and forms; the role and responsibilities of the fiscal/employer agent; the role and responsibilities of a support broker (for the Self-Direction for I/DD program only); and participant-directed planning. Case managers from the conflict-free case management (CFCM) agency will provide the information to participants.

8.5. **Assessment.** Self-directed participants all receive the same functional assessment as non-self-directed HCBS participants: Personal Choice participants receive an initial functional assessment from the Executive Office of Health and Human Services and annual reassessments are conducted by conflict-free case management (CFCM) agencies, while Self-Direction for I/DD Participants receive an initial functional assessment and reassessments at least once every five (5) years from the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH). These are assessments of an individual's needs, strengths, and preferences for services, as well as any risks that may pose a threat of harm to the individual. The assessments include information about the individual's health condition, personal goals and preferences, functional limitations, age, school, employment, household and other factors that are relevant to the authorization and provision of services. In addition to this assessment, for Personal Choice participants only, the CFCM shall also complete a nursing assessment and an assessment by a mobility specialist. The assessment information supports the development of the person-centered plan and individual budget.

8.6. **Person-Centered Planning.** The state must utilize a person-centered and directed planning process, intended to identify the strengths, capacities, preferences, needs, and desired outcomes of the participant. A person-centered plan is developed by the individual with the assistance of the conflict-free case management (CFCM) agency and those individuals the participant chooses to include. The person-centered plan includes the services and supports needed to support the participant to live safely, in the least restrictive setting. A back-up plan must be developed and incorporated into the person-centered plan to assure that the needed assistance will be provided in the event that the regular services and supports identified in the person-centered plan are temporarily unavailable. The back-up plan may include other individual assistants, agency services, or natural supports. The state shall have a process that permits participants to request a change to the person-centered plan, if the participant's health circumstances necessitate a change, but in any event, the person-centered plan will be reviewed and updated annually. Entities or individuals responsible for the development of the person-centered plan cannot provide other direct demonstration services to the participant.

8.7. **Employer Authority.** Participants have the opportunity to exercise informed choice and control and have the authority to conduct the functions listed below over the individuals providing them with the HCBS demonstration services authorized in the person-centered plan. In this demonstration, the participant functions as the employer of record of employees who provide direct services and supports to the participant. Participants have the authority to:

a. Recruit workers;

b. Hire and discharge staff (common law employer);

c. Specify staff qualifications including methods to conduct background checks if the method varies from the typical provider qualifications;

d. Determine staff duties;

e. Schedule staff;

f. Train and Supervise staff; and

g. Evaluate staff performance.

8.8. **Budget Authority.** Participants in the "Personal Choice" and "Self-Directed for I/DD" programs also have the opportunity to exercise choice and control over a specified amount of funds in their participant-directed budget. Under the budget authority, the participant has decision-making authority and management responsibility for the participant-directed budget from which the participant authorizes the purchase of HCBS services and supports that are authorized in the person-centered plan. Participants have authority to:

a. Schedule when services are provided.

b. Determine the amount paid for each service in accordance with the state's policies.

c. Identify service providers and refer for enrollment.

d. Review and approve provider invoices or timesheets, as applicable.

8.9. Self-Directed Budget.

a. The Personal Choice program utilizes individual budgets for participants. An individual budget is the amount of funds described in an individualized spending plan available to the participant to self-direct. The individual budget is developed using a person-centered planning process; based on actual service utilization and cost data and derived from reliable sources; developed using a consistent methodology that is open to public inspection; and reviewed according to a specified method and frequency. If an individual budget is established, a change in the budget may also result in a change to the person-centered plan if the participant chooses to increase or decrease supports.

b. For participants in the Self-Direction for I/DD program, budgets are based on the individual's level of care determination/functional assessment, which determine the individual's "Tier" level as described in Attachment C. Budgets also reflect participants' living situations (e.g., independent, Shared Living, residential habilitation, etc.) and may be adjusted based on specific requests by the individual. Such requests must be aligned with service needs described in the individual's person-centered plan.

8.10. Information and Assistance in Support of Participant Direction (Supports Brokerage) for the Self-Direction for I/DD Program Only. Service/function that assists the participant (or the participant's family or representative, as appropriate) in arranging for, directing, and managing services. Serving as the agent of the participant or family, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs, and accessing identified supports and services. Practical skills training is offered to enable families and participants to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring personal care workers, managing workers, and providing information on effective communication and problem-solving. The service/function includes providing information to ensure that participants understand the responsibilities involved with directing their services. The extent of the assistance furnished to the participant or family is specified in the person-centered plan. This service does not duplicate other waiver services, including conflict-free case management.

8.11. **Conflict-Free Case Management (CFCM) Agencies.** The state shall provide each participant with a conflict-free case management (CFCM) agency to assist in the development of a person-centered plan, provide regular health and wellness check-ins and monthly monitoring, and conduct functional need reassessments for Personal Choice participants in conjunction with the annual review of the person-centered plan. (Functional need reassessments for individuals in Self-Direction for I/DD are conducted by BHDDH.) In addition, the CFCM agency will assist the participant in assuring that services are being provided in accordance with the goals, needs and wants articulated in the person-centered plan. The participant has access through the CFCM agency, support broker, and/or fiscal intermediary to; participant orientation, training, preparation, and support of all participant functions; participant assistance in spending plan development and monitoring; and ongoing monitoring of participant satisfaction, health and safety. The scope of services available through these entities will be available to all self-directed participants, although the entity authorized to provide them may vary depending on the certification, regulations, or contract standards implemented by the agency administering the self-directed program serving a particular LTSS eligible population. All such entities - CFCM agency, fiscal intermediary, and self-directed support broker - must operate in compliance with the applicable contract, regulations, or certification standards the state establishes for such supports and services available to participants.

8.12. **Financial Management Services.** The state shall provide financial management services (FMS) that assists the family or participant to: (a) manage and direct the disbursement of funds contained in the participant-directed budget; (b) facilitate the employment of staff by the family or participant, by performing as the participant's agent such employer responsibilities as processing payroll, withholding federal, state, and local tax and making tax payments to appropriate tax authorities; and, (c) performing fiscal accounting and making expenditure reports to the participant or family and state authorities. All FMS entities are licensed by the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals. As part of that licensure, FMS entities must submit annual audited financial statements, audit findings and any recommendations, including corrective action plans. FMS entities must contract with an independent certified public accountant to conduct the annual audit. FMS entities must have written policies and procedures for assessing individual satisfaction with services and supports

received, individual choice regarding services received, and individual involvement in monitoring and directing the provision of services. EOHHS and BHDDH meet quarterly with FMS entities, review individual budgets, and monitor for under-utilization of services. All self-direction participants participate in HCBS satisfaction surveys, which provide opportunities to give feedback on the performance of the FMS entity directly to the state.

8.13. **Services to be Self-Directed.** Participants who elect the self-direction opportunity shall have the option to self-direct some of the long-term services and supports under the demonstration. The services, goods, and supports that participants can self-direct are limited to the HCBS, listed in Attachment B. For the "Personal Choice" program, only personal care and homemaker services are eligible for self-direction. For the "Self-Direction for I/DD" program, participants may self-direct the following services: assistive technology, homemaker, behavior analysis and management, non-medical transportation, peer support, personal care, private duty nursing, remote supports/monitoring, respite, shared living, support broker services, and therapies (counseling, PT/OT/SLP). "Personal Choice" and "Self-Direction for I/DD" both allow for self-direction of goods and services. For Self-Direction for I/DD, services, goods, and supports that are not subject to employer and budget authority, (i.e., where participants do not have hiring authority and do not become the employer of record over these services, goods or items), shall still be included in the calculations of participants' budgets. Participants' budget plans shall reflect the plan for purchasing these needed services, goods and supports.

8.14. **Individual Directed Goods and Services.** For participants in the "Personal Choice" and "Self-Directed" for I/DD programs, individual directed goods and services may be purchased from accumulated funds ("savings") as approved in the individual budget plan. Goods and services must relate to a need or goal identified in the person-centered plan. Accumulated funds or savings may be carried over from month to month, and year to year, only if designated for a specific good or service. If the goods or services are not purchased at the time indicated in the budget plan, the state shall recoup any unspent and un-earmarked funds at designated intervals and according to procedures established by the state. Goods and services that can be individually directed are defined in Attachment B HCBS Definitions.

8.15. **Participant Direction by Representative.** In some situations, the state provides for the direction of services by a representative. The representative is a person designated by the participant to assist the participant in managing some or all of the requirements of the self-direction program. The representative may be a legal representative of the participant or a non-legal representative freely chosen by the participant. Non-legal representatives do not have authority to make decisions on behalf of the participant. Should a non-legal representative be chosen as a representative, the representative may only perform tasks to manage the self-direction program and support the participant in making their own decisions.

Legal representatives may have authority to make decisions on behalf of the participant, in accordance with the terms of their guardianship or power of attorney. However, like non-legal representatives, legal representatives' role in self-direction is focused on management of the self-direction program, and designation as a self-direction representative does not by itself authorize decision-making on behalf of the participant.

Both legal and non-legal representatives may not be paid for directing services and must pass a screening that indicates the representative's ability to perform the functions and act in a manner clearly consistent with the best interests of the participant and must pass a criminal background check.

A participant who demonstrates the inability to self-direct his or her services and supports, whether due to misuse of funds, consistent non-adherence to program rules, or an ongoing health and safety risk, shall be required to select a representative to assist him or her with the responsibilities of self-direction. If a participant refuses to or is unable to select a representative, or if a participant loses a representative (if already required for participation) and cannot locate a replacement, the participant will be required to transfer to a non-self-directed traditional service delivery system. A CFCM case manager will assist the participant in the transition to the traditionally delivered service system to ensure continuity of care.

8.16. **Independent Advocacy.** Each participant shall have access to an independent advocate or advocacy system in the state. This function is performed by individuals or entities that do not provide direct services, perform assessments, or have monitoring, oversight or fiscal responsibilities for the demonstration.

8.17. **Person-Centered Plan Monitoring.** The CFCM case manager shall, at a minimum, make semi-annual in-person visits to the participant and conduct monthly telephone contacts with the participant, a provider serving the participant, the participant's legal representative, or other individual identified as appropriate for contact in the person-centered plan. More frequent calls or visits in place of calls shall occur when requested or indicated by concern. The CFCM agency's nurse and Mobility Specialist complete assessments at least annually for Personal Choice participants. Such visits are considered and count as a CFCM contact. The case manager and/or CFCM agency is available to the participant upon request and/or upon identification of a potential health/safety concern.

8.18. **Expenditure Safeguards.** The FMS reports monthly or quarterly to the participant and the CFCM case manager, and quarterly to the state, on the budget disbursements and balances. If more than twenty percent (20%) underutilization of authorized services is discovered, the case manager shall work with the participant in determining the reason and crafting a solution, such as a new worker or a reassessment of participant needs.

8.19. **Termination of Self-Direction.** A participant may voluntarily disenroll from the self-directed option at any time and return to a traditional service delivery system. A participant may also be involuntarily disenrolled from the self-directed option for cause. A participant who has demonstrated a continuous inability to self-direct his or her services and supports, as evidenced by misuse of funds, consistent non-adherence to program rules or an ongoing health and safety risk, shall be required to select a representative to assist the participant with the responsibilities of self-direction. Involuntary disenrollment can occur if an individual required to select a representative fails to or is unable to do so. If a participant voluntarily or involuntarily disenrolls from the self-directed service delivery option, the state has safeguards in place to ensure continuity of services. The participant's CFCM case manager shall assist the individual to update their person-centered plan to reflect the change from self-direction and to identify and connect the individual to new sources of care as needed. The case manager shall make appropriate referrals to providers for traditional (not self-directed) services or other programs based on the participant's choices and needs. When applicable, the participant's support broker shall also support the individual with this transition.

8.20. **Fair Hearing.** Participants may request a fair hearing in the case of an adverse action, including involuntary disenrollment from self-direction; denial of the participant's choice of provider or service; denial, reduction, suspension or termination of a service, including denial of goods and services; and

when a requested adjustment to the budget is denied or the amount of the budget is reduced. Participants shall receive written notice from, as applicable, EOHHS, BHDDH, or their CFCM agency of any adverse action. Written notices shall describe the adverse action, the reason for the adverse action, the individuals' appeal rights, and how to request a fair hearing to appeal the adverse action. Participants may request accommodations to support their participation in a fair hearing and are notified of the availability of free legal services to assist them.

8.21. **Additional Populations and Services.** At such time as the state elects to add additional populations or services to the self-direction option, the state will notify CMS of this election by sending a letter to CMS. If, however, the state's proposal to add populations or services exceeds or changes the expenditure authorities of section 1915(c), 1915(i) or 1915(j), the state will follow the process for amendment requests.

9. EXTENDED FAMILY PLANNING PROGRAM

9.1. **Eligibility Requirements.** Family planning and family planning-related services and supplies are provided to individuals that are redetermined eligible for the program on an annual basis. The state must enroll only individuals, meeting the eligibility criteria below into the demonstration who have a family income at or below 253 percent of the FPL and who are not otherwise enrolled in Medicaid or Children's Health Insurance Plan (CHIP). Individuals losing Medicaid or CHIP pregnancy coverage at the conclusion of 12 months postpartum and who have a family income at or below 253 percent of the FPL at the time of annual redetermination are auto enrolled in the Extended Family Planning group.

9.2. **Primary Care Referral.** Primary care referrals to other social service and health care providers as medically indicated are provided; however, the costs of those primary care services are not covered for enrollees of this demonstration. The state must facilitate access to primary care services for participants and must assure CMS that written materials concerning access to primary care services are distributed to demonstration participants. The written materials must explain to the participants how they can access primary care services.

9.3. **Disenrollment from the Extended Family Planning Program.** If an individual becomes pregnant while enrolled in the Extended Family Planning Program, she may be determined eligible for Medicaid State Plan or the CHIP Targeted Low Income Pregnant Women group under the CHIP State plan. The state must not submit claims under the demonstration for any woman who is found to be eligible under Medicaid or the CHIP Targeted Low Income Pregnant Women group in the CHIP State plan. In addition, individuals who receive a sterilization procedure and complete all necessary follow-up procedures will be disenrolled from the Extended Family Planning Program.

9.4. Family Planning Program Benefits. Family planning services and supplies described in section 1905(a)(4)(C) of the Act and are limited to those services and supplies whose primary purpose is family planning to prevent or delay pregnancy and which are provided in a family planning setting. Family planning services and supplies are reimbursable at the 90 percent matching rate, including:

a. Approved methods of contraception;

b. Screening for sexually transmitted infection (STI) or sexually transmitted disease (STD) during a family planning visit, Pap smears and pelvic exams;

Note: The laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs/STDs blood count and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.

c. Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the state's provider enrollment requirements (subject to the national drug rebate program requirements); and

d. Contraceptive management, patient education, and counseling.

9.5. **Family Planning-Related Benefits.** Family planning-related services and supplies are defined as those services provided as part of or as follow-up to a family planning visit or a visit to the family planning setting for diagnosis and treatment pursuant to a family planning visit such as contraceptive counseling and are reimbursable at the State's regular Federal Medical Assistance Percentage (FMAP) rate. Such services are provided because a "family planning-related" problem was identified and/or diagnosed during a routine or periodic family planning visit or because the patient presents in a family planning setting and receives a service(s) or supplies pursuant to a family planning visit. Examples of family planning-related services and supplies include:

a. Colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit.

b. Treatment of STIs/STDs, except for HIV/AIDS and hepatitis, when the STI/STD is screened pursuant to a routine or periodic family planning visit. A follow-up visit or encounter for the treatments, such as drugs and subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines, may be covered.

c. STI/ STD diagnosis and treatment pursuant to a family planning visit such as contraceptive counseling.

d. Drugs/treatment for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, where these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/ drugs may also be covered.

e. Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting.

f. Treatment of major complications (including anesthesia) arising from a family planning procedure such as:

i. Treatment of a perforated uterus due to an intrauterine device insertion;

ii. Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or

iii. Treatment of surgical or anesthesia-related complications during a sterilization procedure.

9.6. **Services.** Services provided through the Extended Family Planning program are paid either through a capitated managed care delivery system or fee for service (FFS).

10. RITE SMILES

10.1. **RIte Smiles.** The RIte Smiles Program is a managed dental benefit program that was previously operated under a waiver pursuant to section 1915(b) of the Act. Beneficiaries eligible for this program are Medicaid-eligible children and young adults born on or after May 1, 2000. Once the state submits and receives approval of its PAHP contract amendment and completes its readiness review, the state may enroll all adult Medicaid beneficiaries into RIte Smiles. The state expects to expand RIte Smiles to all Medicaid beneficiaries in July 2026. The managed care delivery system continues under this demonstration, having transitioned from the state's former section 1915(b) managed care waiver. Under this demonstration, the state will continue to administer the program through a pre-paid ambulatory health plan contract. The benefit design will remain the same under this demonstration.

11. MARKETPLACE SUBSIDY PROGRAM

11.1. The state may claim as allowable expenditures under the demonstration the payments made through its state-funded program to provide premium subsidies for parents and caretaker relatives of Medicaid eligible and enrolled child(ren) with incomes above 133 percent of the FPL through 175 percent of the FPL who purchase health insurance through the Marketplace. The payments made by the Marketplace Subsidy Program shall not exceed 50 percent of the QHP's reduced premium amount, where the premium has been reduced each month by a) any federal tax credits a beneficiary is eligible for, and b) the amount a Medicaid beneficiary would have paid as his or her Medicaid monthly premium amount as of December 31, 2013, (between $61 and $92 per month), as demonstrated in the formula below.

*Maximum allowable payment by Marketplace Subsidy Program = 50% * (QHP Monthly Premium – Federal Tax Credits – 12/31/2013 Medicaid Monthly Premium Amount)*

11.2. Subsidies will be provided on behalf of individuals who: (1) have a child eligible for and enrolled in RIte Care; (2) are enrolled in a Marketplace plan that does not meet RIte Share requirements; and (3) whose income is above 133 percent of the FPL and at or below 175 percent of the FPL. For example, eligible individuals could be enrolled in a high deductible Marketplace plan, as such a plan would not meet RIte Share requirements.

12. SUBSTANCE USE DISORDER (SUD) PROGRAM AND BENEFITS

12.1. **SUD Program Benefits.** Effective upon CMS's approval of the SUD Implementation Plan, the demonstration benefit package for Medicaid beneficiaries will include SUD treatment services, including services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under section 1903 of the Act. The state will be eligible to receive FFP for Medicaid beneficiaries who are short-term residents in IMDs under the terms of this demonstration for coverage of medical assistance, including OUD/SUD services, that would otherwise be matchable if the beneficiary were not residing in an IMD once CMS approves the state's Implementation Plan. The state will aim for a statewide average length of stay of 30 days or less in residential treatment settings.

Under this demonstration beneficiaries will have access to high quality, evidence-based OUD/SUD treatment services across a comprehensive continuum of care, ranging from residential and inpatient treatment to ongoing chronic care for these conditions in cost-effective community-based settings.

12.2. SUD Implementation Plan and Health IT Plan

a. The state's SUD Implementation Plan, initially approved for the period from January 1, 2019, through December 31, 2025, remains in effect for the approval period from January 1, 2026, through December 31, 2030, and is affixed to the STCs as Attachment E. Any future modifications to the approved Implementation Plan will require CMS approval. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral. The approved SUD Implementation Plan describes the strategic approach and a detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of this SUD demonstration project:

i. *Access to Critical Levels of Care for OUD and other SUDs*: Coverage of OUD/SUD treatment services across a comprehensive continuum of care including: outpatient; intensive outpatient; medication assisted treatment (medication as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state); intensive levels of care in residential and inpatient settings; and medically supervised withdrawal management, within 12-24 months of demonstration approval:

ii. *Use of Evidence-based SUD-specific Patient Placement Criteria:* Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of demonstration approval;

iii. *Patient Placement*: Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of demonstration approval;

iv. Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities: Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in Chapter 10 of the Rhode Island Rules and Regulations for the Licensing of Behavioral Healthcare Organizations. The state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;

v. *Standards of Care:* Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;

vi. *Standards of Care*: Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12- 24 months of demonstration approval;

vii. *Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for SUD/OUD:* An assessment of the availability of providers in the critical levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of demonstration approval;

viii. *Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and SUD/OUD*: Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;

ix. *Improved Care Coordination and Transitions between levels of care:* Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of demonstration approval.

x. *SUD Health IT Plan*: Implementation of a Substance Use Disorder Health Information Technology Plan which describes technology that will support the aims of the demonstration. Further information which describes the milestones and metrics as detailed in STC 12.2(b) and Attachment E.

b. *SUD Health Information Technology Plan ("Health IT Plan").* The SUD Health IT Plan applies to all states where the Health IT functionalities are expected to impact beneficiaries within the demonstration. As outlined in SMDL #17-003, states must submit to CMS the applicable Health IT Plan(s), to be included as a section(s) of the associated Implementation Plan (see STC 12.2(a)), to develop infrastructure and capabilities consistent with the requirements outlined in the SUD demonstration-type.

The Health IT Plan describes how technology can support outcomes through care coordination; linkages to public health and prescription drug monitoring programs; establish data and reporting structure to monitor outcomes and support data driven interventions. Such technology should, per 42 CFR 433.112(b), use open interfaces and exposed application programming interfaces and ensure alignment with, and incorporation of, industry standards adopted by the Office of the National Coordinator for Health IT in accordance with 42 CFR part 170, subpart B.

i. The state must monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines and report on its progress to CMS within its Annual Monitoring Report (see STC 16.5).

ii. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

iii. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally recognized standards.

iv. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally recognized ISA standards.

v. Components of the Health IT Plan include:

1. The Health IT Plan must describe the state's alignment with Section 5042 of the SUPPORT Act requiring Medicaid providers to query a Qualified Prescription Drug Monitoring Program (PDMP).[1]
2. The Health IT Plan must address how the state's Qualified PDMP will enhance ease of use for prescribers and other state and federal stakeholders.[2] States should favor procurement strategies that incorporate qualified PDMP data into electronic health records as discrete data without added interface costs to Medicaid providers, leveraging existing federal investments in RX Check for Interstate data sharing.
3. The Health IT Plan will describe how technology will support substance use disorder prevention and treatment outcomes described by the demonstration.
4. In developing the Health IT Plan, states should use the following resources.

- States may use federal resources available at Health IT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and "Section 34: Opioid Epidemic and Health IT" (https://www.healthit.gov/playbook/health-information-exchange/).
- States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP interoperability, electronic care plan sharing, care coordination, and behavioral health-physical health

[1] Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.

[2] *Ibid.*

integration, to meet the goals of the demonstration.

- States should review the Office of the National Coordinator's Interoperability Standards Advisory (https://www.healthit.gov/isa) for information on appropriate standards which may not be required per 42 CFR part 170, subpart B for enhanced funding, but still should be considered industry standards per 42 CFR 433.112(b)(12).

12.3. **Unallowable Expenditures Under the SUD Expenditure Authority.** In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:

a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

13. PEER RECOVERY SPECIALIST (PRS) PROGRAM

13.1. The Peer Recovery Specialist Program will have a Peer Recovery Specialist (PRS) work with a beneficiary to offer a unique vantage point and the skills of someone who has succeeded in managing a serious behavioral health condition. The key objective of this program is to provide individuals with a support system to develop and learn healthy living skills. Recovery support services are expected to help prevent relapse, reduce the severity of a disability, improve and restore function and promote long-term recovery.

13.2. The service is restorative in nature for individuals with mental health and/or substance use disorders needing support to maintain stability in the community. PRS operate under a "Recovery Oriented Systems of Care" model. They use a strengths-based approach with the primary goal being to assist individuals in achieving sustained recovery and restoration.

13.3. The PRS offers peer services that focus on people with a mental health and/or substance use disorder who are having trouble stabilizing in the community and/or are in need of supports to maintain their stability in the community. This population includes but is not limited to Medicaid-eligible individuals who are experiencing, or are at risk of, hospitalization, overdose, homelessness or are in the hospital after an overdose or are in a detox setting. It also includes people recently released from institutions such as hospitals and prison.

13.4. **Services.** Recovery support services include peer support to foster personal responsibility and self-determination, provide tools and education focused on health and wellness, and build skills to engage and communicate with providers and systems of care. These peer supports will assist, educate, and encourage participants and their family members to be active advocates for services that promote healthier outcomes. Specific examples of PRS activities include, but are not limited to, the following:

a. Supporting individuals in accessing community-based resources; recovery, health and wellness supports; and employment services;

b. Guiding individuals in developing and implementing recovery, health and wellness, and employment plans. Serving as a role model for the integration of recovery, health and wellness, and employment;

c. Educating individuals regarding services and benefits available to assist in transitioning into and staying in the workforce;

d. Navigating state and local systems (including addiction and mental health treatment systems);

e. Mentoring individuals as they develop strong foundations in recovery and wellness;

f. Promoting empowerment and a sense of hope through self-advocacy by sharing personal recovery experiences; and

g. Serving as an integral member of an individual's recovery and wellness team.

13.5. **Peer Recovery Specialist.** The state must require a Peer Recovery Specialist meet the following criteria:

a. Credentialed by the Rhode Island Certification Board (RICB) as a Peer Recovery Specialist, pursuant to the standards available at http://www.ricertboard.org/. RICB credentialing standards meet minimum standards of the International Certification and Reciprocity Consortium (IC&RC).

b. Peer support services will be provided by a Peer Recovery Specialist and include group and individual coaching, and education on the recovery process. Peer Recovery Specialists must meet the qualifications in the CMS State Medicaid Director Letter, #07-011, https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD081507A.pdf.

c. Acknowledges they have a mental illness or substance use disorder and has received or is currently receiving treatment and/or community support for it. People who have experience with an on-going and/or personal experience with a family member, including their child, with a similar mental illness and/or substance use disorder are also qualified to be a PRS.

13.6. The state must require that the Peer Recovery Specialist work under the direction of a licensed health care practitioner or under the direction of a non-clinical PRS Supervisor. Non-clinical PRS Supervisors must be certified as a PRS and have worked at least 2 years providing PRS services.

13.7. Peer Recovery Specialist services must be billed by a Medicaid-enrolled provider of services through standard claiming procedures.

14. Family/Youth Support Partner (FYSP) Program

14.1. The Family/Youth Support Partner (FYSP) Program offers services to children under 21 years of age and their caregivers related to supporting a child with behavioral health condition and/or developmental disability to improve functioning within family and community settings. The FYSP service focuses on mitigating a behavioral health condition defined through the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or supporting individuals with a developmental disability, and on stabilizing the child to promote well-being of the child and limiting the impact of unmet health-related social needs. The goal is for the child to continue to be living in the community with services rather than being institutionalized in a short- or long- term residential treatment facility or hospital. The key objectives of this program are to provide children and their caregivers with a support system to develop and learn healthy living skills and to prevent

hospitalization or short- or long- term residential treatment that results from a child's (under age 21) behavioral health condition and/or developmental disability.

14.2. The FYSP works with a beneficiary to offer a unique vantage point and the skills of an adult with personal and/or professional experience caring for a child or with another family member with a similar behavioral health disorder and/or developmental disability. In addition to providing wellness supports, the FYSP utilizes their own experiences to act as a role model, teacher, and guide who both encourages and empowers the beneficiary and their caregivers to succeed in recovery and leading a healthy productive lifestyle.

14.3. **Services.** Specific examples of FYSP work include, but are not limited to, the following:

a. Supporting individuals in accessing community-based resources; recovery, health and wellness supports; education services and employment support;

b. Guiding individuals in developing and implementing recovery, health and wellness plans. Serving as a role model for the integration of recovery, health and wellness;

c. Educating individuals regarding services and benefits available to assist the child and their caregivers in meeting treatment plan goals;

d. Navigating state and local systems, including treatment systems, the child protective system, juvenile justice systems and the education system;

e. Using lived experience to help children and their caregivers to understand and develop the skills to address behavioral health conditions and/or developmental disabilities within a family and community setting;

f. Mentoring children as they develop strong foundations in recovery and wellness;

g. Promoting empowerment and a sense of hope through self-advocacy by sharing personal recovery experiences; and

h. Serving as an integral member of a child's recovery and wellness team.

14.4. **Family/Youth Support Partner.** The state must require a Family/Youth Support Partner meet the following criteria.

a. Family Partners:

i. Must be 21 years of age;

ii. 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

iii. Minimum of a high school diploma or GED.

b. Youth Partners:

i. Must be 21 years of age; and

ii. Have a high school diploma or equivalent with 2 years of experience working with children/youth OR a relevant Associate's degree with 1 year of experience working with children/youth OR a Bachelor's degree in a relevant field.

c. The state must require that the FYSP be supervised by a licensed health care practitioner who is available at all times to provide support and consultation.

15. Behavioral Health Link (BH Link) Program

15.1. The Behavioral Health Link (BH Link) program began in the first quarter of January 2020 as one triage center to support crisis stabilization and short-term treatment for Medicaid beneficiaries experiencing a behavioral health (mental health and/or substance use disorder) crisis. This triage center must provide access to a specialized emergency behavioral healthcare services other than emergency departments. As of January 2019, there is only one provider that can receive reimbursement for this service, which will operate 24 hours a day, 7 days a week. The state may implement this program on a less than statewide basis. If the state finds this program is found to be cost effective, the state will increase the number of BH Link triage centers.

15.2. The BH Link is a licensed behavioral healthcare facility that provides services consistent with a licensed community mental health center. Physician- or nurse-approved protocols for the provision of emergency medical and emergency behavioral healthcare will be available for staff at the center as needed.

15.3. The BH Link triage center will provide screening/evaluations, treatment, crisis intervention—including local mobile outreach, case management, assessment, treatment coordination, 23-hour observation beds, discharge planning, warm hand-offs to community providers, and medications. Attachment F contains the component services that are provided through the BH Link.

15.4. The BH Link triage center will provide services to include physician services, medication prescribing and management, skilled nursing, behavioral health services provided by qualified Mental Health Professionals, comprehensive assessment and triage, crisis stabilization and management, behavioral disorder evaluations, treatment identification and facilitation, system navigation, case management, engagement and follow-up care post initial assessment, and discharge coordination. All of these services will be available on site directly from staff 24/7 or through telemedicine. In addition, staff from the triage center who respond to crises in the community through a mobile intervention will have access to all triage staff.

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

15.6. The BH Link triage center will receive a bundled rate that may be billed no more than once per client per 24-hour period. The bundled rate will include physician services, medication prescribing and management, skilled nursing, behavioral health services provided by qualified Mental Health Professionals, comprehensive assessment and triage, crisis stabilization and management, behavioral disorder evaluations, treatment identification and facilitation, system navigation, case management,

engagement and follow-up care post initial assessment, and discharge coordination. The bundled rate methodology has been incorporated as Attachment G of the STCs.

16. MONITORING AND REPORTING REQUIREMENTS

16.1. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) 30 calendar days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) 30 calendar days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non–compliant submissions of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable. The extension request must explain the reason why the required deliverable was not submitted, the steps the state has taken to address such issue, and the state's anticipated date of submission. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action plan as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non–compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

16.2. **Deferral of Federal Financial Participation from IMD claiming for Insufficient Progress Toward Milestones.** Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Annual Monitoring Report. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar year and each calendar year thereafter until CMS has determined sufficient progress has been made.

16.3. **Submission of Post-Approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs, unless CMS and the state mutually agree to another timeline.

16.4. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all section 1115 demonstration, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

16.5. **Monitoring Reports.** The state must submit one Annual Monitoring Report each demonstration year (DY) that is due no later than 180 calendar days following the end of the DY. The state must submit a revised Annual Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. CMS might increase the frequency of monitoring reporting if CMS determines that doing so would be appropriate. CMS will make on-going determinations about reporting frequency under the demonstration by assessing the risk that the state might materially fail to comply with the terms of the approved demonstration during its implementation and/or the risk that the state might implement the demonstration in a manner unlikely to achieve the statutory purposes of Medicaid. See 42 CFR 431.420(d)(1)-(2).

The Annual Monitoring Report will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Annual Monitoring Report must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve and must be provided in a structured manner that supports federal tracking and analysis.

a. **Operational Updates**. Per 42 CFR 431.428, the Annual Monitoring Report must document any policy or administrative difficulties in operating the demonstration. The Annual Monitoring Report shall provide sufficient information to document key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Annual Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. **Performance Metrics**. The performance metrics will provide data to demonstrate the state's progress towards meeting the demonstration's goals and any applicable milestones. Per 42 CFR 431.428, the Annual Monitoring Report must document the impact of the demonstration on beneficiaries' outcomes of care, quality and overall cost of care, and access to care, as applicable. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals. The Annual Monitoring Report must provide detailed information about deviations from CMS's applicable metrics technical specifications, relevant methodology, plans for phasing in metrics, and data or reporting issues for applicable metrics, in alignment with CMS guidance and technical assistance.

The state and CMS will work collaboratively to finalize the list of metrics to be reported on in the Annual Monitoring Report. The demonstration's monitoring metrics must cover categories to include, but not be limited to, eligibility, utilization of services, quality of care and health outcomes, and grievances and appeals. The state must report these metrics for all demonstration populations. Demonstration monitoring reporting does not duplicate or replace reporting requirements for other authorities, such as Home and Community Based Services and Managed Care authorities.

In addition, in alignment with applicable CMS guidance, the state is expected to report monitoring metrics specific to the key policies being tested in the demonstration, including but not limited to, SUD, SMI/SED, the waiver of retroactive eligibility, and the family planning program. For the SUD and SMI/SED components, the state's monitoring must cover metrics in alignment with CMS guidance and the demonstration's milestones as outlined in the SUD State Medicaid Director Letter (SMDL) dated November 1, 2017 (SMD #17–003) and/or the SMI/SED SMDL dated November 13, 2018 (SMDL #18-011).

The reporting of these monitoring metrics may also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, or geography) and by demonstration component, as appropriate. Subpopulation reporting can support identifying any gaps in quality of care and health outcomes, and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population.

c. **Evaluation Activities and Interim Findings.** Per 42 CFR 431.428, the Annual Monitoring Report must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

16.6. **SUD Mid-Point Assessment.** The state must contract with an independent entity (herein referred to as the Independent Assessor) to conduct an independent Mid-Point Assessment and submit to CMS by December 31, 2028. This timeline will allow for the Mid-Point Assessment to capture approximately the first two and a half years of program data, accounting for data run-out and data completeness. In addition, if applicable, the state should use the prior approval period experiences as context, and conduct the Mid-Point Assessment in light of the data from any such prior approval period(s). In the design, planning and execution of the Mid-Point Assessment, the state must require that the Independent Assessor consult with key stakeholders such as, representatives of MCOs, health care providers, beneficiaries, community groups, and other key partners.

a. The state must require that the assessor provide a Mid-Point Assessment to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations, and any recommendations. If requested, the state must brief CMS on the Mid-Point Assessment. The state must submit a revised Mid-Point Assessment within 60 calendar days after receipt of CMS's comments, if any.

b. Elements of the Mid-Point Assessment must include:

1. An examination of progress toward meeting each milestone and timeframe approved in the Implementation Plan;
2. A determination of factors that affected achievement on the milestones and performance metric gap closures to date;
3. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;
4. For milestones or targets identified by the Independent Assessor as at medium to high risk of not being met, recommendations for adjustments in the state's Implementation Plan, or to pertinent factors that the state can influence that will support improvement.

16.7. **Corrective Action Plan Related to Monitoring.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a correction action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS might withdraw an authority, as described in STC 3.10, if metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals and desired directionality, and the state has not implemented corrective action, and the circumstances described in STC 3.10, are met. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

16.8. **Close-Out Report**. Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

i. The Close-Out Report must comply with the most current guidance from CMS.

ii. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim or Summative Evaluation Reports stipulated in STCs 17.7 and 17.8, respectively.

iii. The state will present to and participate in a discussion with CMS on the Close–Out Report.

iv. The state must take into consideration CMS's comments for incorporation into the final Close-Out Report.

v. A revised Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS's comments.

vi. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 16.1.

16.9. **Monitoring Calls.** CMS will convene no less frequently than quarterly, monitoring calls with the state.

i. The purpose of these calls is to discuss ongoing demonstration operations and implementation which align with the state's demonstration monitoring reports, including (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, eligibility and access, and progress on evaluation activities.

ii. These calls will follow the structure of and focus on the topics in the Annual Monitoring Report.

iii. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

iv. The state and CMS will jointly develop the agenda for the calls.

16.10. **Post Award Forum.** Pursuant to 42 CFR 431.420(c), within six months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent Annual Monitoring Report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Annual Monitoring Report associated with the year in which the forum was held.

17. EVALUATION OF THE DEMONSTRATION

17.1. **Cooperation with Federal Evaluators and Learning Collaborative.** As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f). This may also include the state's participation – including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration

operations, as applicable – in a federal learning collaborative aimed at cross-state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 16.1.

17.2. **Independent Evaluator.** The state must use an independent entity (herein referred to as the Independent Evaluator) to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The Independent Evaluator must sign an agreement to conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

17.3. **Evaluation Design.** The state must submit, for CMS comment and approval, an Evaluation Design with implementation timeline no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be developed in accordance with the STCs and any applicable CMS evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi- experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations.

The state is strongly encouraged to use the expertise of the Independent Evaluator in the development of the Evaluation Design. The Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 17.7 and 17.8.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component, unless otherwise agreed upon by the state and CMS. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. The amendment components of the Evaluation Design must also be reflected in the state's Interim and Summative Evaluation Reports, described below.

17.4. **Evaluation Design Approval and Updates.** The state must submit a revised Evaluation Design within 60 calendar days after receipt of CMS' comments, if any. Upon CMS approval of the Evaluation Design, the document will be included as Attachment D to these STCs and posted to Medicaid.gov. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within 30 calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each Annual Monitoring Report. Once CMS approves the Evaluation Design, if the state wishes to make changes, and the changes are substantial in scope, the state must submit a revised evaluation design to CMS for approval; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in an Annual Monitoring Report.

17.5. **Evaluation Questions and Hypotheses.** Consistent with the STCs and applicable CMS guidance, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key

demonstration policy components that support understanding of the demonstration's impact and its effectiveness in achieving the demonstration's goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as eligibility and various measures of access, utilization, costs, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance for the demonstration policy components. The evaluation is expected to use applicable demonstration monitoring and other data on the provision of and beneficiary utilization of demonstration and other applicable services. Proposed measures should be selected from nationally recognized sources and national measures sets, where possible. Measures sets could include the Consumer Assessment of Health Care Providers and Systems (CAHPS), the Medicaid and CHIP Core Sets of Health Care Quality measures, commonly referred to as the Child and Adult Core Sets, the Behavioral Risk Factor Surveillance System (BRFSS) survey, or measures endorsed by National Quality Forum (NQF).

The state must develop robust evaluation questions and hypotheses related to each demonstration initiative, and per applicable CMS guidance. Specifically:

a. Hypotheses for the SUD component of the demonstration must align with the goals of the program, including increasing rates of identification and initiation of and engagement in treatment as well as adherence to and retention in treatment, reducing overdose deaths, reducing utilization of emergency departments and inpatient hospitalizations as well as readmissions to the same or higher levels of care, and improving access to care for physical health conditions.

b. Hypotheses for the waiver of retroactive eligibility must relate to (but are not limited to) the following outcomes: enrollment and enrollment continuity; whether individuals enroll when they are healthy rather than doing do when they are sick or need care; and medical debt and financial wellbeing. The evaluation must examine changes in provider uncompensated care costs and utilization of services from providers receiving uncompensated care funding. The evaluation must also assess potential barriers to enrollment and timely renewal.

c. Hypotheses for the family planning and family planning-related services programs must focus on program participation, including awareness of and access to family planning and family planning-related services. Hypotheses must also address, for example, utilization of family planning (e.g., utilization of contraceptive by method effectiveness) and family planning-related services, maternal and infant health outcomes (e.g., maternal morbidity, unintended pregnancies, and rates of preterm and low birthweight births), as well as experience of care.

As part of its evaluation efforts, the state must also conduct an overall demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation and Medicaid health services expenditures. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey or interviews to assess, for instance, beneficiary understanding of the demonstration policy components and beneficiary experiences with access to and quality of care. To better understand whether implementation of certain key demonstration policies happened as envisioned during the

demonstration design process and whether specific factors acted as facilitators of—and barriers to—implementation, the state is strongly encouraged to undertake a robust process/implementation evaluation. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Finally, the state may collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, or geography). Such stratified data analyses can provide a fuller understanding of gaps in access to and quality of care and health outcomes, as well as help inform how the demonstration's various policies support improving outcomes.

17.6. **Evaluation Budget.** A budget for the evaluations must be provided with the Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluations such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the designs are not sufficiently developed, or if the estimates appear to be excessive.

17.7. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). The draft Interim Evaluation Report must be developed in alignment with the approved Evaluation Design, and in accordance with the requirements outlined in these STCs and applicable CMS guidance.

a. The Interim Evaluation report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.

b. For demonstration authority or any component within the demonstration that expires prior to the overall demonstration's expiration date, and depending on the timeline of the expiration/phase-out, the Interim Evaluation Report must include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. When applying for an extension of the demonstration, the Interim Evaluation Report should be posted to the state's website with the application for public comment. If the state does not request an extension for the demonstration, the Interim Evaluation Report is due one year prior to the end of the demonstration. For demonstration phase-outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit a revised Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report, if any.

e. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.

17.8. **Summative Evaluation Report.** The state must submit the draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period

represented by these STCs. The draft Summative Evaluation Report must be developed in alignment with the approved Evaluation Design, and in accordance with the requirements outlined in these STCs and applicable CMS guidance.

a. The state must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft Summative Evaluation Report, if any.

b. Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid website within 30 calendar days.

17.9. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

17.10. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, or the Summative Evaluation Report.

17.11. **Public Access**. The state shall post the final documents (e.g., Annual Monitoring Reports, Close-Out Report, Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.

17.12. **Additional Publications and Presentations.** For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.

18. GENERAL FINANCIAL REQUIREMENTS

18.1. **Allowable Expenditures.** This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

18.2. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration

expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state and include the reconciling adjustment in the finalization of the grant award to the state.

18.3. **Sources of Non-Federal Share.** As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms, and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

18.4. **State Certification of Funding Conditions.** As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met;

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the

non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

18.5. **Financial Integrity for Managed Care Delivery Systems.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.

b. For non-risk-based PIHPs and PAHPs, arrangements comply with the upper payment limits specified in 42 CFR 447.362, and if payments exceed the cost of services, the state will recoup the excess and return the federal share of the excess to CMS.

18.6. **Requirements for Health Care-Related Taxes and Provider Donations.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

18.7. **State Monitoring of Non-federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 16.1. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

18.8. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in section 19:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

18.9. **Program Integrity.** The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

18.10. **Medicaid Expenditure Groups.** Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 4: Master MEG Chart

MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
ABD Adults No TPL	Main	X		X	Budget Population 1: ABD individuals with no third party liability
ABD Adults TPL	Main	X		X	Budget Population 2: ABD individuals with third party liability
RIte Care	Main	X		X	Budget Population 3: Parents and caretakers up to 133 percent FPL; Pregnant women with incomes up to 190 percent of the FPL; Children whose family incomes are up to 261 percent of the FPL; and Budget Populations 6(a) and 6(b): Pregnant Expansion.
CSHCN	Main	X		X	Budget Population 4: Children who qualify for Medicaid under SSI, children under 21 who are under State Adoption Agreements, Individuals under 21 for whom the state is assuming full financial responsibility, TEFRA section 134 children.
New Adult Group	Main	X		X	Adults with incomes at or below 133 percent of the FPL.
Youth Risk Medic	Main			X	Budget Population 17 [Youth at risk for Medicaid] Coverage of detection and early intervention services for at-risk young children not eligible for Medicaid who have incomes up to 300 percent of SSI, including those with special health care needs, such as SED, behavioral challenges

MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
					and/or medically dependent conditions, who may be safely maintained at home with appropriate levels of care.
Core/Prev Services	Main			X	Budget Services 4: HCBS as identified in Attachment B for Medicaid eligible youth who are at risk for out-of-home care or hospitalization.
Peer Recovery (Formerly known as Peer Recovery and FYSP)	Main			X	Budget Services 6a: Services, as outlined in STC 13 using a Peer Recovery Specialist who provides an array of interventions that help prevent relapse, reduce the severity of disability, improve and restore function, and promote long-term recovery for individuals with a mental health and/or substance use disorder for those individuals who have trouble stabilizing in the community and/or are in need of supports to maintain their stability in the community
FYSP (Formerly known as Peer Recovery and FYSP)	Main			X	Budget Services 6b: Expenditures to deliver services using a FYSP who provides an array of interventions that support socialization, long-term recovery, wellness, self-advocacy, and connections to the community, as well as offer services, as outlined in STC 14, that will focus on supporting children under 21 years of age and their caregivers to improve the child's functioning within family and community settings and prevent institutional placements.
Behavioral Health Link	Main			X	Budget Services 9: Expenditures to deliver the services within one BH Link triage center, to support crisis stabilization and short-term treatment for individuals experiencing a behavioral

MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
					health (mental health or substance use disorder) crisis, as outlined in STC 15.
Home Stabilization Services	Main			X	Budget Services 12: Expenditures for 1915(i)-like home stabilization services described in STC 5.3.
SED	Main			X	Budget Population 14 [SED/IDD children]: Expenditure authority for a limited set of services authorized under 1905(a) for children with SED and/or I/DD, who are not otherwise Medicaid or CHIP eligible, who need care in a PRTF or residential treatment services authorized under the Rhode Island Medicaid state plan, and who would meet the SSI disability standards if only the child's income and resources were counted. These children do not receive SSI cash payments due to family income and resource limits.
217-like Group	Hypo 1	X		X	Budget Population 11: Expenditures for 217-like Categorically Needy Individuals receiving HCBS-like services & PACE-like participants Highest need group. Budget Population 12: Expenditures for 217-like Categorically Needy Individuals HCBS and PACE-like participants in the High need group. Budget Population 13: Expenditures for 217-like Medically Needy receiving HCBS-like services in the community (High and Highest group). Medically Needy PACE-like participants in the community.
Marketplace Subsidy Program	Hypo 2	X		X	Premium subsidies for parents and caretakers with incomes above 133 percent of the FPL

MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
					through 175 percent of the FPL who purchase health insurance through the Marketplace Subsidies will be provided on behalf of individuals who: (1) are not Medicaid eligible; (2) are eligible for the APTC; and (3) whose income is above 133 percent of the FPL through 175 percent of the FPL.
SUD IMD	Hypo 3	X		X	Budget Services 11: Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and/or withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an IMD.
Family Planning Group	Hypo 4	X		X	Budget Population 5: Extended Family Planning program, for women of childbearing age whose family income is at or below 253 percent of the FPL who lose Medicaid or CHIP Targeted Low Income Pregnant Women eligibility at the conclusion of their 12-month postpartum period.
Elders and Alzheimer Adults At Risk for LTC	Hypo 5	X		X	Budget Population 10: Expenditures for a limited set of HCBS for elders 65 and over who are at risk for needing LTC with income at or below 250 percent of the FPL who are in need of HCBS. Budget Population 20: Expenditures for a limited set of HCBS for adults aged 19-64 who have been diagnosed with Alzheimer's disease or a related dementia as determined by a physician, who are at risk for LTC admission, who are in need of HCBS, whose income is at or below 250 percent of the FPL.

MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
AD Risk for LTC	Hypo 6	X		X	Budget Population 15 [Adults with disabilities at risk for long-term care]: Expenditures for a limited set of HCBS for adults living with disabilities with incomes at or below 400 percent of the SSI FBR with income and resource levels above the Medicaid limits.

BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver; WW – with waiver

18.11. **Reporting Expenditures and Member Months.** The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00242/1). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. **Cost Settlements.** The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. To assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. **Pharmacy Rebates.** Because pharmacy rebates are included in the base expenditures used to determine the budget neutrality expenditure limit, the state must report the portion of pharmacy rebates applicable to the demonstration on the appropriate forms CMS-64.9 WAIVER and 64.9P waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double counting). The state must have a methodology for assigning a portion of pharmacy rebates to the demonstration in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which identifies pharmacy

rebate amounts with DYs. Use of the methodology is subject to the approval in advance by CMS, and changes to the methodology must also be approved in advance by CMS. Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.

d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in section 19, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. **Member Months.** Using the Budget Neutrality Monitoring Tool, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information

f. **Budget Neutrality Specifications Manual.** The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 5: MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
ABD Adults No TPL	Report all expenditures for Budget Population 1: ABD individuals with no third party liability.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/2014	12/31/2030
ABD Adults TPL	Report all expenditures for Budget Population 2:	N/A	Follow standard CMS 64.9 Category of	Date of service	MAP	Y	1/1/2014	12/31/2030

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
	ABD individuals with third party liability.		Service Definitions					
RIte Care	Report all expenditures for Budget Population 3: Parents and caretakers up to 133 percent FPL; Pregnant women with incomes up to 190 percent of the FPL; children whose family incomes are up to 261 percent of the FPL; and Budget Populations 6(a) and 6(b): Pregnant Expansion.	N/A	Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/2014	12/31/2030
CSHCN	Report all expenditures for Budget Population 4: Children who qualify for Medicaid under SSI, children under 21 who are under State Adoption Agreements; Individuals under 21 for whom the state is assuming full financial responsibility ; and TEFRA	N/A	Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	1/16/2009	12/31/2030

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
	section 134 children.							
Elders and Alzheimer Adults At Risk for LTC	Report all expenditures for Budget Population 10: Expenditures a for a limited set of HCBS for elders 65 and over who are at risk for needing LTC with income at or below 250 percent of the FPL who are in need of HCBS. Budget Population 20: Expenditures for a limited set of HCBS for adults aged 19-64 who have been diagnosed with Alzheimer's disease or a related dementia as determined by a physician, who are at risk for LTC admission, who are in need of HCBS care services, whose	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/2026	12/31/2030

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
	income is at or below 250 percent of the FPL.							
AD Risk for LTC	Report all expenditures for Budget Population 15 [Adults with disabilities at risk for long-term care]: Expenditures for a limited set of HCBS for adults living with disabilities with incomes at or below 400 percent of the SSI FBR with income and resource levels above the Medicaid limits.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	1/16/2009	12/31/2030
Youth Risk Medic	Report all expenditures for Budget Population 17 [Youth at risk for Medicaid]: Coverage of detection and early intervention services for at-risk young children not eligible for Medicaid who have incomes up to 300 percent of SSI, including those with	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	N	1/16/2009	12/31/2030

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
	special health care needs, such as SED, behavioral challenges and/or medically dependent conditions, who may be safely maintained at home with appropriate levels of care.							
New Adult Group	Report all expenditures for Adults with income at or below 133 percent of the FPL.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/2014	12/31/2030
Core/Prev Services	Report all Budget Services 4: Expenditures for HCBS as identified in Attachment B for Medicaid eligible youth who are at risk for out-of-home care or hospitalization.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	N	1/16/2009	12/31/2030
Peer Recovery	Report all Budget Services 6a: Expenditures to deliver services, as outlined in STC 13 using a Peer Recovery Specialist who provides an array of	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	N	1/1/2019	12/31/2030

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
	interventions that help prevent relapse, reduce the severity of disability, improve and restore function, and promote long-term recovery for individuals with a mental health and/or substance use disorder for those individuals who have trouble stabilizing in the community and/or are in need of supports to maintain their stability in the community.							
FYSP	Report all Budget Services 6b: Expenditures to deliver services using a Family/Youth Support Partner who provides an array of interventions that support socialization, long-term recovery, wellness, self-	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	N	1/1/2026	12/31/2030

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
	advocacy, and connections to the community, as well as offer services, as outlined in STC 14, that will focus on supporting children under 21 years of age and their caregivers to improve the child's functioning within family and community settings and prevent institutional placements.							
Behavioral Health Link	Report all Budget Services 9 Expenditures for Behavioral Health Link Program to deliver the services within one BH Link triage center, to support crisis stabilization and short-term treatment for individuals experiencing a behavioral health (mental health or	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	N	1/1/2019	12/31/2030

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
	substance use disorder) crisis, as outlined in STC 15.							
Home Stabilization Services	Report all Budget Services 12: expenditures for 1915(i)-like home stabilization services described in STC 5.3.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	N	2/06/2020	12/31/2030
SED	Budget Population 14 [SED/IDD children]: Report all expenditures for a limited set of services authorized under 1905(a) for children with SED and/or I/DD, who are not otherwise Medicaid or CHIP eligible who need care in a PRTF or residential treatment services authorized under the Rhode Island Medicaid state plan and who would meet the SSI disability standards if only the child's income and	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	N	1/01/2019	12/31/2030

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
	resources were counted. These children do not receive SSI cash payments due to family income and resource limits.							
217-like Group	Report all expenditures for Budget Population 11: Expenditures for 217-like Categorically Needy Individuals receiving HCBS-like services & PACE-like participants Highest need group. Budget Population 12: Expenditures for 217-like Categorically Needy Individuals receiving HCBS and PACE-like participants in the High need group. Budget Population 13: Expenditures for 217-like Medically Needy receiving HCBS-like	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	1/16/2009	12/31/2030

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
	services in the community (High and Highest group). Medically Needy PACE-like participants in the community.							
Marketplace Subsidy Program	Report all expenditures for Marketplace Subsidy payments made through its state-funded program to provide premium subsidies for parents and caretakers with incomes above 133 percent of the FPL through 175 percent of the FPL who purchase health insurance through the Marketplace Subsidies will be provided on behalf of individuals who: (1) are not Medicaid eligible; (2) are eligible for the APTC; and (3) whose income is above 133	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	1/01/2014	12/31/2030

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
	percent of the FPL through 175 percent of the FPL.							
SUD IMD	Report all Budget Services 11: Residential and Inpatient Treatment for Individuals with Substance Use Disorder. Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and/or withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an IMD.	See STC 12.3	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	1/01/2019	12/31/2030
Family Planning Group	Report all Budget Population 5: Extended Family Planning program, for women of childbearing age whose family income is at or below 253	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	1/16/2009	12/31/2030

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
	percent of the FPL who lose Medicaid or CHIP Targeted Low Income Pregnant Women eligibility at the conclusion of their 12-month postpartum period.							
ADM	Report all additional administrative costs that are directly attributable to the demonstration and are not described elsewhere and are not subject to budget neutrality	N/A	Follow standard CMS 64.10 Category of Service Definitions	Date of payment	ADM	N	1/16/2009	12/31/2030

ADM – administration; DY – demonstration year; MAP – medical assistance payments; MEG – Medicaid expenditure group

18.12. **Demonstration Years.** Demonstration Years (DY) for this demonstration are defined in the table below.

Table 6: Demonstration Years

Demonstration Year 18	January 1, 2026 to December 31, 2026	12 Months
Demonstration Year 19	January 1, 2027 to December 31, 2027	12 Months
Demonstration Year 20	January 1, 2028 to December 31, 2028	12 Months
Demonstration Year 21	January 1, 2029 to December 31, 2029	12 Months
Demonstration Year 22	January 1, 2030 to December 31, 2030	12 Months

18.13. **Claiming Period.** The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

18.14. **Future Adjustments to Budget Neutrality.** CMS reserves the right to adjust the budget neutrality expenditure limit;

a. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

18.15. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process**. In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 18.15(c). If approved, an adjustment

could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. After acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

   i. Provider rate increases that are anticipated to further strengthen access to care;

   ii. CMS or state technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

   iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

   iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

   v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

   vi. High cost innovative medical treatments that states are required to cover; or,

   vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

   i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,

   ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

19. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

19.1. **Limit on Title XIX Funding.** The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have

received in the absence of the demonstration. The limit consists of a Main Budget Neutrality Test and one or more Hypothetical Budget Neutrality Tests as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

19.2. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 4, Master MEG Chart and Table 5, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

19.3. **Calculation of the Budget Neutrality Limit and How It Is Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

19.4. **Main Budget Neutrality Test.** The Main Budget Neutrality Test allows the state to show that approval of the demonstration has not resulted in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as "WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of the limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. The Composite Federal Share for this test is calculated based on all MEGs indicated as "Both."

Table 7: Main Budget Neutrality Test

MEG	PC or Agg*	WOW Only, WW Only, or BOTH	Trend Rate	DY 18 CY 2026	DY 19 CY 2027	DY 20 CY 2028	DY 21 CY 2029	DY 22 CY 2030
ABD Adults No TPL	PC	Both	4.9%	$3,316.04	$3,478.53	$3,648.98	$3,827.78	$4,015.34

MEG	PC or Agg*	WOW Only, WW Only, or BOTH	Trend Rate	DY 18 CY 2026	DY 19 CY 2027	DY 20 CY 2028	DY 21 CY 2029	DY 22 CY 2030
ABD Adults TPL	PC	Both	4.9%	$2,732.85	$2,866.76	$3,007.23	$3,154.58	$3,309.15
RIte Care	PC	Both	6.2%	$543.51	$577.21	$613.00	$651.01	$691.37
CSHCN	PC	Both	4.9%	$2,635.36	$2,764.49	$2,899.95	$3,042.05	$3,191.11
New Adult Group	PC	Both	5.2%	$860.15	$904.88	$951.93	$1,001.43	$1,053.50
Core/Prev Services	Agg	WW only	N/A	The state must have savings to offset these expenditures.				
Youth Risk Medic	Agg	WW only	N/A	The state must have savings to offset these expenditures.				
Peer Recovery	Agg	WW only	N/A	The state must have savings to offset these expenditures.				
FYSP	Agg	WW only	N/A	The state must have savings to offset these expenditures.				
Behavioral LINK	Agg	WW only	N/A	The state must have savings to offset these expenditures.				
SED	Agg	WW only	N/A	The state must have savings to offset these expenditures.				
Home Stabilization Services	Agg	WW only	N/A	The state must have savings to offset these expenditures.				

*PC = Per Capita, Agg = Aggregate

19.5. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a

condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

19.6. **Hypothetical Budget Neutrality Test 1: 217-Like Group, [Expenditure Authority 2a/b/c (Budget Population 11, 12, 13]** ***Highest needs group, High needs group, Medically needy.*** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 8: Hypothetical Budget Neutrality Test 1

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 18 CY 2026	DY 19 CY 2027	DY 20 CY 2028	DY 21 CY 2029	DY 22 CY 2030
217-Like Group	PC	Both	4.9%	$5,221.34	$5,477.19	$5,745.57	$6,027.10	$6,322.43

19.7. **Hypothetical Budget Neutrality Test 2: Marketplace Subsidy Program,** ***Premium subsidies for parents and caretakers with income above 133 percent of the FPL through 175 percent of the FPL.*** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 2. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 2 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 9: Hypothetical Budget Neutrality Test 2

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 18 CY 2026	DY 19 CY 2027	DY 20 CY 2028	DY 21 CY 2029	DY 22 CY 2030
Marketplace Subsidy Program	PC	Both	5.2%	$45.13	$47.48	$49.95	$52.55	$55.28

19.8. **Hypothetical Budget Neutrality Test 3: SUD IMD, [Expenditure Authority 10, (Budget Services 11)]** ***Residential and Inpatient Treatment for Individuals with Substance Use Disorder.*** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 3. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality

expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 3 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 10: Hypothetical Budget Neutrality Test 3

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 18 CY 2026	DY 19 CY 2027	DY 20 CY 2028	DY 21 CY 2029	DY 22 CY 2030
SUD IMD	PC	Both	6.2%	$2,243.48	$2,382.58	$2,530.30	$2,687.18	$2,853.79

19.9. **Hypothetical Budget Neutrality Test 4: Family Planning Group, [Expenditure Authority 1b (Budget Population 5)] Eligible recipients at or below 250 percent of the FPL who lose Medicaid eligibility at the conclusion of their 60-day postpartum period and who are not otherwise enrolled in Medicaid or Children's Health Insurance Plan (CHIP).** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 4. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 4 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 11: Hypothetical Budget Neutrality Test 4

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 18 CY 2026	DY 19 CY 2027	DY 20 CY 2028	DY 21 CY 2029	DY 22 CY 2030
Family Planning Group	PC	Both	5.2%	$18.16	$19.10	$20.09	$21.13	$22.23

19.10. **Hypothetical Budget Neutrality Test 5: Elders and Alzheimer Adults At Risk for LTC, [Expenditure Authority 1d and 1h, (Budget Population 10 and Budget Population 20)] Limited HCBS for elders 65** ***and over who are at risk for needing LTC with income at or below 250 percent of the FPL who are in need of HCBS and limited HCBS for aged 19-64 who have been diagnosed with Alzheimer's disease or a related dementia as determined by a physician, who are at risk for LTC admission, who are in need of HCBS, and whose income is at or below 250 percent of the FPL.*** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 5. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW

Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 5 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 11: Hypothetical Budget Neutrality Test 5

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 18 CY 2026	DY 19 CY 2027	DY 20 CY 2028	DY 21 CY 2029	DY 22 CY 2030
Elders and Alzheimer Adults At Risk for LTC	PC	Both	5.0%	$422.86	$444.00	$466.20	$489.51	$513.99

19.11. **Hypothetical Budget Neutrality Test 6: Adults with disabilities at risk for long-term care, [Expenditure Authority 1f (Budget Population 15)]** ***HCBS waiver like services for adults living with disabilities with incomes at or below 400 percent of the SSI Federal Benefit Rate (FBR) with income and resource levels above the Medicaid limits.*** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 4. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 6 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 11: Hypothetical Budget Neutrality Test 6

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 18 CY 2026	DY 19 CY 2027	DY 20 CY 2028	DY 21 CY 2029	DY 22 CY 2030
AD Risk for LTC	PC	Both	5.6%	$1,369.42	$1,446.11	$1,527.09	$1,612.61	$1,702.92

19.12. **Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by Rhode Island on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed

to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

19.13. **Budget Neutrality Monitoring Tool.** Per 42 CFR 431.428, the state must document the financial performance of the demonstration. The state must provide quarterly budget neutrality status updates that meet all reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs (including the submission of corrected budget neutrality data upon request), using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing the demonstration's actual expenditures to the budget neutrality expenditure limits described in the Monitoring Budget Neutrality for the Demonstration section. The quarterly budget neutrality status updates are due no later than 60 calendar days following the end of each demonstration quarter, and are subject to the deferral as described in STC 16.1. CMS will provide technical assistance, upon request.[3]

19.14. **Exceeding Budget Neutrality**. CMS will enforce the budget neutrality agreement over the demonstration period, which extends from 01/01/2026 to 12/31/2030. The Main Budget Neutrality Test for this demonstration period may incorporate carry-forward savings, that is, net savings from up to 10 years of the immediately prior demonstration effective period(s) (01/01/2014 to 12/31/2023). If at the end of the demonstration approval period the Main Budget Neutrality Test, and the Hypothetical Budget Neutrality Tests, have been exceeded, the excess federal funds will be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

19.15. **Budget Neutrality Savings Cap.** The amount of savings available for use by the state during this demonstration period will be limited to the lower of these two amounts: 1) the savings amount the state has available in the current demonstration period, including carry-forward savings as described in STC 19.12, or 2) 15 percent of the state's projected total Medicaid expenditures in aggregate for this demonstration period. This projection will be determined by taking the state's total Medicaid spending amount in its most recent year with completed data and trending it forward by the President's Budget trend rate for this demonstration period. Fifteen percent of the state's total projected Medicaid expenditures for this demonstration period is $3,167,804,483.

19.16. **Corrective Action Plan.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

[3] Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

Table 12: Budget Neutrality Test Corrective Action Plan Calculation

Demonstration Year	Cumulative Target Definition	Percentage
DY 18	Cumulative budget neutrality limit plus:	2.0 percent
DY 18 through DY 19	Cumulative budget neutrality limit plus:	1.5 percent
DY 18 through DY 20	Cumulative budget neutrality limit plus:	1.0 percent
DY 18 through DY 21	Cumulative budget neutrality limit plus:	0.5 percent
DY 18 through DY 22	Cumulative budget neutrality limit plus:	0.0 percent

20. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION

Deliverable	Timeline	STC Reference
Evaluation Design	No later than 180 calendar days after approval of the demonstration. Revised no later than 60 days after receipt of CMS comments.	STCs 17.3 and 17.4
Interim Evaluation Report	One year prior to the end of the demonstration period, or when the extension application is submitted, whichever is sooner. Revised no later than 60 calendar days after receipt of CMS comments.	STC 17.7
Summative Evaluation Report	No later than 18 months after the end of the demonstration period. Revised no later than 60 calendar days after receipt of CMS comments.	STC 17.8
Annual Monitoring Report	No later than 180 calendar days after the end of each demonstration year.	STC 16.5
Quarterly Budget Neutrality Report	Due 60 calendar days after the end of each quarter, except 4th quarter.	STC 19.13

ATTACHMENT A
Managed Care and Fee For Service Demonstration Only Benefits

These benefits are not provided under the Rhode Island Medicaid State Plan, but only under the demonstration, including risk based managed care programs.

Individual/group education, parenting and childbirth education classes
Tobacco cessation services for non-pregnant beneficiaries

ATTACHMENT B
Home and Community-Based Service Definitions

The services available under this demonstration are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with demonstration objectives of avoiding institutionalization. The service definitions outlined here specify the scope of available services. The scope describes the purpose of the service, the types of activities that comprise the service, including, as applicable, any goods that will be furnished to a demonstration participant who receives the service. As appropriate, the service definition may include additional parameters that apply to or affect the provision of the service.

CORE SERVICES - Core services are only eligible to members that have a High or Highest level of care.

Assisted Living Services
Personal care and supportive services (homemaker, meal preparation) that are furnished to participants who reside in a setting that meets the HCBS setting requirements and includes 24-hour on- site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming, and medication assistance (to the extent permitted under State law). These services may not be billed separately. Services that are provided by third parties must be coordinated with the assisted living provider.

Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not to be made for 24- hour skilled care. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Services furnished are required to meet a beneficiary's LTSS needs in a manner that promotes self-reliance, dignity and independence. Services may be provided in settings licensed by the state at various levels that reflect their capacity to provide different kinds of Medicaid services, depending on a beneficiary's level of care needs based on their licensure authority and capacity to provide specific packages of services to Medicaid beneficiaries with varying levels of acuity needs.

Provider Qualifications:
Assisted Living Facilities must be licensed by the Rhode Island Department of Health and certified as Medicaid Assisted Living Facilities by the Executive Office of Health and Human Services.

Assistive Technology
Assistive technology means an item, piece of equipment, service animal or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes:

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

Provider Qualifications
Providers must be Developmental Disability Organizations licensed by the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals.

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.

Provider Qualifications:
Behavior analysis and management will be provided by individuals with the following qualifications:

- Board-Certified Behavior Analysts or Board-Certified Assistant Behavior Analysts; or

- Licensed mental health professionals (including Psychologists; Licensed Independent Clinical Social Workers; Licensed Clinical Social Workers; Licensed Mental Health Counselors and Licensed Mental Health Counselor Associates; Licensed Marriage and Family Therapists and Licensed Marriage and Family Therapist Associates); or
- Individuals with a master's degree in one of the licensed mental health fields noted above with supervision by a licensed mental health professional with one of the qualifications noted above.

Conflict-Free Case Management
Services that assist participants in gaining access to needed waiver and state plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.

Case managers are responsible for preparing the participant's person-centered plan, by working with the participant and their planning team to identify all services and supports needed for the participant to meet their assessed needs. Case managers are also responsible for ongoing monitoring of the provision of services included in the individual's person-centered plan; contact requires a response from the individual in order to be considered monitoring. On an annual basis and when there are significant changes in a participant's circumstances, case managers conduct reassessment of functional needs. On an annual basis and when there are significant changes in a participant's circumstances, case managers review person-centered plans and work with the participant and their planning team to make appropriate changes to the plan.

Case management may be delivered using telehealth or other electronic methods of case management delivery if this meets the individual's needs and preserves the health and welfare of the individual. All individuals, including those who choose to receive case management through an electronic delivery method, will receive an in-person contact *at least* once every six (6) months. If the individual's initial or annual assessment shows they need an in-person contact more than once every 6 months, or if it is the individual's preference to receive in-person contact more frequently, the case manager must provide an in-person contact more frequently than every 6 months.

<u>Provider Qualifications:</u>
Conflict-Free Case Management agencies must be certified by EOHHS as Conflict-Free Case Management agencies. To be certified, agencies must provide to EOHHS policies that address how the agency selects, screens, hires, and trains personnel. This includes the agency's process for initial and ongoing training designed to ensure that case managers shall have the necessary range of knowledge, skills, and abilities to provide high quality conflict-free case management services.

Requirements for individual case managers include that case managers be:

- Capable of ensuring that participants receive person-centered services in the least restrictive and most appropriate setting in accordance with their needs and preferences, as required by State and federal law and the U.S. Supreme Court Olmstead decision.
- Capable of facilitating a participant's person-centered planning process, supporting them to direct the process to the fullest extent possible.
- Case managers must attend a state-sponsored training to provide the foundational skills for case management.

Community Transition Services

Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for their own living expenses.

Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; (f) necessary home accessibility adaptations; and, (g) activities to assess need, arrange for and procure need resources.

Community transition services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community transition services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

<u>Provider Qualifications:</u>

Providers must be Fiscal Intermediaries certified by the Executive Office of Health and Human Services.

Consultative Clinical and Therapeutic Services

Clinical and therapeutic services that assist unpaid and/or paid support staff in carrying out individual treatment/support plans, that are not covered by the Medicaid State Plan, and that are necessary to improve the individual's independence and inclusion in their community. The service may include

assessment, the development of a home treatment/ support plan, training and technical assistance to carry out the plan and monitoring of the individual and the provider in the implementation of the plan. This service may be delivered in the individual's home or in the community as described in the person-centered plan.

Provider Qualifications:
Consultation activities are provided by professionals in nursing, psychology, nutrition, counseling and behavior management.

- Nursing professionals are licensed Registered Nurses.
- Psychology professionals are licensed psychologists or individuals with a master's degree in psychology with supervision by a licensed psychologist.
- Nutrition professionals are licensed dieticians.
- Counseling professionals are licensed mental health professionals, including Licensed Independent Clinical Social Workers; Licensed Clinical Social Workers; Licensed Mental Health Counselors and Licensed Mental Health Counselor Associates; Licensed Marriage and Family Therapists and Licensed Marriage and Family Therapist Associates. They may also include individuals with a master's degree in one of the counseling fields noted above with supervision by a licensed mental health professional with one of the qualifications noted above.
- Behavior management professionals are Board-Certified Behavior Analysts or Board-Certified Assistant Behavior Analysts.

Homemaker Services
Services that consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemaker services will not be delivered as a separate service to individuals who receive Adult Foster Care (Shared Living) or Assisted Living services.

Provider Qualifications:
A homemaker is a trained non-professional worker who performs general household tasks services in the home. Providers who bill for homemaker services must be licensed by the Rhode Island Department of Health as a Home Care agency.

Homemakers providing services through the Personal Choice self-direction program may not be the participant's representative, spouse,

financial power of attorney, or Social Security Representative Payee.
Homemakers in the Personal Choice program must:

- Be at least 18 years of age
- Authorized to work in the United States
- Complete training:
    - If the homemaker is known to the participant, the participant may choose to provide in-home training, request that the homemaker undergo mandatory orientation and training, or a combination of in-home training and selected courses from the mandatory orientation and training.
    - If the homemaker is introduced to the Personal Choice program through the registry, the homemaker is required to undergo mandatory orientation and training before the homemaker is listed on the registry.
    - Participants may request that their homemaker complete continuing education courses offered by EOHHS or its designee. Homemakers may also voluntarily complete continuing education courses.
    - Receive a cardiopulmonary resuscitation (CPR) and First Aid certification, renewed every two (2) years, in order to be listed on the registry. Exceptions may be made if the homemaker is a Certified Nursing Assistant (CNA) or has an active CPR/First Aid certification.

Home Delivered Meals

The delivery of hot meals and shelf staples, including chilled or frozen meals and culturally appropriate meals, to the participant's residence. Meals are available to an individual who is unable to care for their nutritional needs because of a functional dependency/disability and who requires this assistance to live in the community. Meals provided under this service will not constitute a full daily nutritional requirement. Participants may receive up to one (1) hot or chilled meal per day or up to five (5) frozen meals provided in a single delivery. Meals must provide a minimum of one-third of the current recommended dietary allowance. Provision of home delivered meals will result in less assistance being authorized for meal preparation for individual participants, if applicable. Home-delivered meals will not be provided for meals for which the participant is already receiving any service that includes the task of meal preparation.

<u>Provider Qualifications:</u>
Home-delivered meal providers must be licensed by the Rhode Island Department of Health as Food Service providers.

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

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.

Provider Qualifications:

- Licensed mental health professionals (including Licensed Psychologists; Licensed Independent Clinical Social Workers; Licensed Clinical Social Workers; Licensed Mental Health Counselors and Licensed Mental Health Counselor Associates; Licensed Marriage and Family Therapists and Licensed Marriage and Family Therapist Associates); or

- Individuals with a master's degree in one of the mental health professional fields noted above with supervision by a licensed mental health professional with one of the qualifications noted above.

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

Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater

independence and personal choice. Services are furnished consistent with the participant's person-centered plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Additionally, meals cannot be provided at the same time as another service that may provide meal prep or meal services.

A participant's person-centered services and supports plan may include two or more types of non-residential habilitation services. However, different types of non-residential habilitation services may not be billed during the same period of the day.

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

The habilitation service is reviewed as part of the person-centered plan at least annually as part of the case management service.

Provider Qualifications:
Providers must be Developmental Disability Organizations licensed by the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals.

Supported Employment – Individual Supported Employment
Supported employment - individual employment support services are the ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state's minimum wage, at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals. Supported employment services can be provided through many different service models. Some of these models can include evidence-based supported employment for individuals with mental illness, or customized employment for individuals with significant disabilities. Supported employment individual employment supports may also include support to establish or maintain self-employment, including home-based self-employment. Supported employment services are individualized and may include any combination of the following services: job exploration, vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits and work-incentives planning and management, transportation, asset development and career advancement services, and other workplace support services including services not specifically related to job skill training that enable the waiver participant to be

successful in integrating into the job setting.

Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or 2. Payments that are passed through to users of supported employment services.

The person-centered plans developed as a component of the case management service will include descriptions of all applicable employment-related supports that the participant receives. These person-centered plans are reviewed no less than annually, and the supported employment services in those plans are reviewed and updated as needed in the context of those plan reviews. In addition, case managers conduct specific monitoring and respond to specific questions regarding supported employment at the six-month mark in the year and include supported employment in the monthly case management monitoring process as well.

Provider Qualifications:
Providers must be licensed by the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals as Developmental Disability Organizations (DDOs) and specifically be licensed to provide employment services.

Individual providers of supported employment services must be certified employment specialists who have completed the same trainings as Direct Support Professionals (DSPs), with the exception of individuals who only provide job exploration services, who do not need to be certified but who must complete specific trainings.

Supported Employment – Small Group Employment Support
Supported employment - small group employment support are services and training activities provided in regular business and industry settings for groups of two (2) to eight (8) workers with disabilities. Small group employment support does not include services provided in facility-based work settings. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in integrated employment in the community. The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which an individual is compensated at or above the minimum wage, but

not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Supported employment small group employment supports may include any combination of the following services: job analysis, training and systematic instruction, transportation, and career advancement services. Other workplace support services may include services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting. Supported employment small group employment support must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces. Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment services; or 2. Payments that are passed through to users of supported employment services.

The person-centered plans developed as a component of the case management service will include descriptions of all applicable employment-related supports that the participant receives. These person-centered plans are reviewed no less than annually, and the supported employment services in those plans are reviewed and updated as needed in the context of those plan reviews. In addition, case managers conduct specific monitoring and respond to specific questions regarding supported employment at the six-month mark in the year and include supported employment in the monthly case management monitoring process as well.

Provider Qualifications:
Providers must be licensed by the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals as Developmental Disability Organizations (DDOs) and specifically be licensed to provide employment services.

Group Supported Employment services are provided by certified employment specialists who have completed the same trainings as Direct Support Professionals (DSPs).

Non-Medical Transportation
Service offered to enable demonstration participants to gain access to demonstration and other community services, activities and resources, as specified by the participant’s person-centered plan. This service is offered

in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State Plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services under the demonstration are offered in accordance with the participant's person-centered plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized. Except that the transportation must be to allow the participant to gain access to activities detailed in the person-centered plan, this service is not limited to specific situations. Transportation is not paid separately when it is provided as part of another covered service that the participant is receiving. The only service where all transportation is expected to be provided under a different core service is Residential Habilitation. Other core services include transportation in narrower circumstances, and therefore transportation may still be billed separately outside of those circumstances. Supported employment includes transportation within the provision of supported employment itself – such as between job sites over the course of the day – but does not include transportation between the individual's residence and their job. Shared living generally includes provision of transportation to gain access to activities in the person-centered plan but does not include transportation to or from a participant's job. Consequently, even if a person receives Shared Living services or participates in Supported Employment, transportation between their home and their job may be billed separately as the non-medical transportation benefit. Similarly, rates for Integrated Day Habilitation include transportation to activities that are part of the Integrated Day Habilitation services, and therefore separate billing for transportation in that context is not permitted, but transportation between the participant's home and the Integrated Day Habilitation location may be billed separately.

Provider Qualifications:
Developmental Disability Organizations licensed by the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals may provide non-medical transportation. DDO staff must have a valid driver's license, and vehicles must be registered and insured.

Occupational Therapy, Physical Therapy, and Speech-Language Therapy
The purpose of these services is to maintain the individual's condition and functional level.

Provider Qualifications:
Services will be delivered by licensed Occupational Therapists, Physical Therapists, and Speech-Language Pathologists (also known as Speech Therapists), respectively.

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

Provider Qualifications:
Peer support specialists must have lived experience, either as a person living with a particular health condition or disability, or as a family caregiver for a person with such a condition. Peer support specialists must complete training as required by the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals.

Personal Care
A range of assistance to enable participants to accomplish tasks that they would normally do for themselves if they did not have a disability. Personal care includes assistance in performing Activities of Daily Living (bathing, dressing, toileting, transferring, maintaining continence). Personal care also includes assistance in performing Instrumental Activities of Daily Living (personal hygiene; grocery shopping; using the telephone or other communication tools; medication management; money management; and supervision of participants as provided in the participant's person-centered plan). Personal care includes supervision of participants, as provided in the person-centered plan, as well as assistance and support to communicate and fully engage face-to-face with others in the community, including to support engagement in community activities as well as to communicate with medical professionals.

This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Only those personal care services that take the form of verbal cueing may be delivered using telehealth or other electronic

methods of service delivery. Personal care services may be furnished within and/or outside the participant's home.

Personal care services may be provided on an episodic or on a continuing basis and may be provided by a Personal Care Attendant or Direct Support Professional.

Personal care services may be delivered in an acute care hospital setting if these services are: described in the participant's person-centered service plan; provided to meet needs of the participant that are not met through the provision of hospital services; not a substitution for services that the hospital is obligated to provide through its conditions of participation or under federal or state law, or under another applicable requirement; and designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the participant's functional abilities such that receipt of the service will assist the individual in returning to the community. The same rate will be paid for personal care provided during an acute care hospitalization as for services provided in the home or community setting. The state will avoid duplication by limiting approved personal care hours to the amount needed to provide those services not provided by the hospital, as described above.
Personal care will not be paid separately for participants who receive personal care through the Adult Foster Care or Assisted Living services, because those services' rates account for provision of personal care and to pay separately would be duplicative. The state has distinct billing codes for personal care services, homemaker services, and combined personal care and homemaker services. When homemaker services are provided incidental to personal care services, the "combined" code is used. The rate for the "combined" code is the same as the rate for personal care alone, and providers are directed to use the combined code where both services are delivered, rather than billing both personal care and homemaker codes.

Provider Qualifications:
Personal Care Attendants (PCAs) employed by Home Care agencies must be licensed by the Rhode Island Department of Health as Nursing Assistants.

PCAs providing services through the Personal Choice self-direction program may not be the participant's representative, spouse, financial power of attorney, or Social Security Representative Payee. PCAs in the Personal Choice program must:
- Be at least 18 years of age
- Authorized to work in the United States
- Complete training:

  - If the PCA is known to the participant, the participant may choose to provide in-home training, request that the PCA undergo mandatory orientation and training, or a combination of in-home training and selected courses from the mandatory orientation and training.
  - If the PCA is introduced to the Personal Choice program through the registry, the PCA is required to undergo mandatory orientation and training before the PCA is listed on the registry.
  - Participants may request that their PCA complete continuing education courses offered by EOHHS or its designee. PCAs may also voluntarily complete continuing education courses.
- Receive a cardiopulmonary resuscitation (CPR) and First Aid certification, renewed every two (2) years, in order to be listed on the registry. Exceptions may be made if the PCA is a Certified Nursing Assistant (CNA) or has an active CPR/First Aid certification.

Direct Support Professionals (DSPs) serving participants with I/DD:
DSPs working for a DDO must be 18 years old and have a high school diploma or GED. All DSPs working for a licensed DDO must complete training related to human rights, HIPAA, ethics, incident reporting, abuse and neglect, fire safety, and other training related to the specific support they will be providing to individuals, such as behavioral intervention strategies, community mapping, employment trainings, and person centeredness trainings.

DSP working for individuals in the “Self-Direction for I/DD” program must be 18 years old and have a high school diploma or GED. Training is provided by the employer to their staff. Employers can have their staff attend specific trainings that relate to the individuals/ employer’s support needs.

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

<u>Provider Qualifications</u>
Providers must be Durable Medical Equipment providers certified by Medicare.

Private Duty Nursing
Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of state law. These services are provided to a participant at home or in a community setting.

Provider Qualifications:
Nurses must be licensed by the Rhode Island Department of Health. Nurses may be Licensed Practical Nurses or Registered Nurses.

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

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

Provider Qualifications:
Providers must be Developmental Disability Organizations licensed by the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals.

Remote Supports and Monitoring
Also known as surveillance monitoring, remote supports uphold independence by combining technology for service delivery with limited contact with trained staff when the participant requires assistance. For individuals who may need 24-hour support but who do not always need hands-on support from an on-site staff person, this service will facilitate access to more support than would be possible if all the support were delivered in person. Access to more hours of support (delivered remotely) will allow the individual to remain in or move into a more independent living situation. In addition, supports such as live two-way communication will allow people to engage in community activities without in-person staff, with greater independence.

As part of the person-centered planning process, in consultation with the case manager, individuals will determine which services they choose to receive through remote supports rather than in-person supports. Provided, however, that the individual's choice of whether to receive remote supports rather than in-person supports is subject to any assessment of the

individual's functional needs to protect the individual's health, safety, and well-being. In consultation with the case manager, where individuals choose to have a combination of in-person and remote supports for a particular service, the person-centered service plan will identify the times of day during which each will be provided to ensure that there is no overlap in delivery of the same service both remotely and in person.

Technology Services include: Motion sensing system; Live video feed and or audio feed; Web-based monitoring system; Sensor detection monitoring systems; and/or Another device that facilitates live two-way communication. All technology will need to be HIPAA-compliant. Radio frequency identification will be a component of some remote support equipment, used to track the equipment and thereby provide a location of an individual as well as to detect falls. Motion sensing system and sensor detection monitoring systems will only be used inside the home. Other technology services can be used inside or outside the home.

Participants will be given information to support their decision-making regarding whether to use remote supports. Services will be detailed in the individual's Individual Service Plan based on the individual's preferences and a risk assessment to determine if the service will meet the individual's support needs. In cases where an individual's needs could potentially be met by either a Personal Emergency Response System (PERS) or a Remote Support Technology Service, the person-centered plan will state which is being used to meet the particular need. An individual may use PERS to meet certain needs while using Remote Supports for others, but an individual may not receive both services to address the same need.
Any monitoring will only be deployed with the express agreement of the individual. If an individual resides with someone else, the other resident will also need to agree for the monitoring to be deployed. Individuals will have control over their devices and be able to turn off any remote support/monitoring technology. Providers of Remote Supports will inform individuals of this option and teach individuals how to turn off the equipment if they so choose. Cameras will not be placed bathrooms and may only be placed in bedrooms or other locations where dressing is expected to occur when it is necessary for the individual's health and safety and the individual agrees to this placement. Devices will be placed based on the participant's person-centered plan, which will identify the type and purpose of remote monitoring and support devices/equipment and generally describe the locations where monitoring equipment will be placed. The person-centered plan will describe the minimum amount of monitoring needed to ensure the participant's safety and maximize their independence.

Providers will offer 24-hour on-call services with real time audio/visual or other live 2-way communication and offer an in-person response if necessary to resolve a call.

Providers of Remote Supports will have check-ins with the participant on a bi-weekly basis for the first 2 months to ensure the individual is feeling safe and comfortable with the use of remote supports. These providers' check-ins will be either on-site or remote as documented in the individual's service plan. The individual's case manager will also check in on a monthly basis and ask questions regarding the supports the individual is receiving.

Service providers will need to ensure that there is a plan in place for individuals if there is a failure with the technology. They will need to ensure that individuals have back up batteries and that staff is available to go out in person when there is a power failure or have a plan in place with other unpaid supports to assist. These plans will be detailed in the individual's person-centered service plan.

Provider Qualifications:
Providers must be licensed as Developmental Disabilities Organizations by the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals.

Respite
Service provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Respite may be provided in the participant's home or in the respite provider's home. In the case of emergency respite (provided in the case of the unexpected absence of the participant's primary caregiver, for example, due to a medical emergency), respite may also be provided in an Adult Foster Care or Residential Habilitation setting. Federal financial participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the state that is not a private residence.

Provider Qualifications:
For services provided to individuals with I/DD, respite is provided by a licensed Developmental Disability Organization. The respite provider must be 18 years old and have a high school diploma or GED. Providers must complete training on CPR and first aid, confidentiality, ethics, and incident reporting.

For services provided to other HCBS participants, respite is provided by agencies certified by the Executive Office of Health and Human Services.

Respite program coordinators for such agencies must have a Bachelor's or Associate's degree in human services or related field or three to five years of appropriate and related experience, as well as at least one year of experience working with a similar population. Respite workers must be at least 18 years old and have satisfactory background checks. Workers may not have a legal obligation to support the participant or live in the same household as the participant. Workers must have a satisfactory background check as well as a driver's license and satisfactory driving record.

Shared Living (Adult Foster Care)
Personal care and supportive services (e.g., homemaker, attendant care, companion, medication oversight (to the extent permitted under state law)) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. The total number of individuals (including participants served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed two.

Participants may only receive one resident support service at a time to ensure there is no overlap or duplication in residential services. Therefore, separate payment is not made for any resident support service furnished to a participant receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

Payments for adult foster care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement.

<u>Provider Qualifications:</u>
Payment for adult foster care services does not include payments made, directly or indirectly, to any individual who is a legal guardian, who has a financial power of attorney, and/or who is legally responsible for the participant (i.e., the participant's spouse).

Shared Living provider agencies operating under the RIte at Home program must be certified by the Executive Office of Health and Human Services. The RIte at Home program serves individuals who meet the High or Highest nursing facility level of care, as described in Attachment C.

Shared Living provider agencies serving participants with intellectual/developmental disabilities (I/DD) through Shared Living Arrangements or Whole Life Shared Living Arrangements must be licensed as Developmental Disability Organizations by the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals. Individual shared living providers serving participants with I/DD must also have a high school diploma or GED and participate in training on:

- The roles and responsibilities of shared living arrangement providers and the rights of adults with I/DD.
- Human Rights
- Ethics
- Behavior management
- Fire safety
- CPR and first aid
- Confidentiality
- How to recognize the neglect and mistreatment of adults with I/DD, including reporting requirements to BHDDH and appropriate law enforcement agencies.
- Abuse detection and prevention

Supports for Self-Direction (Support Broker)
The Support Broker assists the participant (or the participant's family or representative, as appropriate) in arranging for, directing, and managing services. Serving as the agent of the participant or family, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs, and accessing identified supports and services. Practical skills training is offered to enable families and participants to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring personal care workers, managing workers, and providing information on effective communication and problem-solving. The service/function includes providing information to ensure that participants understand the responsibilities involved with directing their services. The extent of the assistance furnished to the participant or family is specified in the service plan. This service does not duplicate other waiver services, including case management.

Provider Qualifications:
Support Brokerage services are provided by Developmental Disability Organizations licensed by the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals. Support Brokers must complete trainings related to assisting individuals to recruit/hire/train/fire staff when necessary.

Supports for Self-Direction (Financial Management Services)
Financial Management Services assist the family or participant to: (a) manage and direct the disbursement of funds contained in the participant-directed budget; (b) facilitate the employment of staff by the family or participant, by performing as the participant's agent such employer responsibilities as processing payroll, withholding federal, state, and local tax and making tax payments to appropriate tax authorities; and, (c)

performing fiscal accounting and making expenditure reports to the participant or family and state authorities.

Provider Qualifications:
For services provided to individuals with I/DD, FMS is provided by a Developmental Disability Organization licensed by the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals. For services provided to individuals enrolled in Personal Choice, FMS is provided by entities certified by the Executive Office of Health and Human Services.

ATTACHMENT C
Level of Care Criteria

Rhode Island has two "Levels of Care" applicable to individuals who need Nursing Facility services or whose needs are less intensive but similar in nature to the needs of those who need Nursing Facility services:

- Individuals who meet the "Highest Need" Nursing Facility Level of Care, whose HCBS are authorized as "1915(c)-like" services. This population may choose to receive services in a Nursing Facility or to receive HCBS.

- Individuals who meet the "High Need" Nursing Facility Level of Care, whose HCBS are authorized as "1915(i)-like" services. This population is eligible to receive HCBS.

Assessments and Reassessments for "Nursing Facility Level of Care"

a. An individual enrolled in the High Need group who, at reassessment or a change in status, meets any of the Highest Needs eligibility criteria shall be enrolled in the Highest Needs group.

b. Re-Evaluation of Needs for an individual in the Highest Needs Group: When the Department of Human Services determines that an individual is admitted to a nursing facility or meets the Highest Needs Group level of care, the Nurse Consultant designates those instances in which the individual's medical information indicates the possibility of significant functional and/or medical improvement within two (2) months. Notification is sent to the individual, to his/her authorized representative, and to the Nursing Facility that a Nursing Facility level of care has been approved, but functional and medical status will be reviewed again in thirty (30) to sixty (60) days. At the time of the review, the Nurse Consultant must first confirm that the individual remains a resident of the nursing facility. For an individual remaining in a nursing facility, the Nurse Consultant reviews the most recent Minimum Data Set and requests any additional information necessary to make one of the following determinations:

    1. The individual no longer meets a Highest Needs Group level of care. In this instance, the Long Term Care Office is notified of the Highest Needs Group Level of Care denial, and the Long Term Care Unit sends a discontinuance notice to the individual, to his/her authorized representative if one has been designated, and to the nursing facility. Prior to being sent a discontinuance notice, the individual will be evaluated to determine if the individual qualifies for the High Needs group.

2. The individual continues to meet the appropriate level of care, and no action is required.

c. An individual residing in the community who is in the Highest or High Need group will have, at a minimum, an annual assessment.

Nursing Facility Level of Care Determination Policy

Definitions

A. Extensive Assistance (Talk, Touch, and Lift): Individual performs part of the activity, but caregiver provides physical assistance to lift, move, or shift individual.
B. Total Dependence (All Action by Caregiver): Individual does not participate in any part of the activity
C. Limited Assistance (Talk and Touch): Individual highly involved in the activity, but received physical guided assistance and no lifting of any part of the individual.

Nursing Facility Highest Need Group

An individual who meets any of the following eligibility criteria shall be eligible and enrolled in the Highest Needs group:

1. An individual who requires extensive assistance or total dependence with at least one of the following Activities of Daily Living (ADL):
    - Toilet use
    - Bed mobility
    - Eating
    - Transferring

AND who requires *at least* limited assistance with any other ADL.

OR

2. An individual who lacks awareness of needs or has moderate impairment with decision-making skills AND one of the following symptoms/conditions, which occurs frequently and is not easily altered:
    - Wandering
    - Verbally Aggressive Behavior Resisting Care
    - Physically Aggressive Behavior
    - Behavioral Symptoms requiring extensive supervision

OR

3. An individual who has at least one of the following conditions or treatments that requires skilled nursing assessment, monitoring, and care on a daily basis:
    - Stage 3 or 4 Skin Ulcers
    - Ventilator/Respirator
    - IV Medications
    - Naso-gastric Tube Feeding
    - End Stage Disease
    - Parenteral Feedings
    - 2nd or 3rd Degree Burns
    - Suctioning
    - Gait evaluation and training

OR

4. An individual who has an unstable medical, behavioral, or psychiatric condition(s), or who has a chronic or recurring condition that requires skilled nursing assessment, monitoring, and care on a daily basis related to, but not limited to, at least one of the following:
    - Dehydration
    - Internal Bleeding
    - Aphasia
    - Transfusions
    - Vomiting
    - Wound Care
    - Quadriplegia
    - Aspirations
    - Chemotherapy
    - Oxygen
    - Septicemia
    - Pneumonia
    - Cerebral Palsy
    - Dialysis Respiratory Therapy
    - Multiple Sclerosis
    - Open Lesions
    - Tracheotomy
    - Radiation Therapy
    - Gastric Tube Feeding
    - Behavioral or Psychiatric conditions that prevent recovery

OR

5. An individual who does not meet at least one of the above criteria may be enrolled in the Highest Needs Group when the Executive Office of Health and Human Services determines that the individual has a critical need for long-term care services due to special circumstances that may adversely affect the individual's health and safety.

Nursing Facility High Need Group

An individual who meets any of the following eligibility criteria shall be eligible and enrolled in the High Need group:

1. An individual who requires at least limited assistance on a daily basis with at least two of the following ADLs:
    - Bathing/Personal Hygiene
    - Dressing
    - Eating
    - Toilet Use
    - Walking/Transfers
2. An individual who requires skilled teaching on a daily basis to regain control of, or function with, at least one of the following:
    - Gait training
    - Speech
    - Range of motion
    - Bowel or bladder training
3. An individual who has impaired decision-making skills that requires constant or frequent direction to perform at least one of the following:
    - Bathing
    - Dressing
    - Eating
    - Toilet Use
    - Transferring
    - Personal hygiene
4. An individual who exhibits a need for a structured therapeutic environment, supportive interventions, and/or medical management to maintain health and safety.

Rhode Island also has Level of Care criteria specific to Intellectual/Developmental Disabilities (I/DD).

DD/ID Needs-Based Service Tier Classifications and Options		
Tier	**Service Options**	**Available Supports**
Tier D and E (Highest): ***Extraordinary Needs***	1. Living with family/caregiver 2. Independent Living 3. Shared Living 4. Community Support Residence 5. Group Home/ Specialized Group Home	1. Community Residential Support and/or access to overnight support services 2. Integrated Employment Supports 3. Integrated Community and/or Day supports 4. Transportation
Tier C (Highest): ***Significant Needs***	1. Living with family/caregiver 2. Independent Living 3. Shared Living 4. Community Support Residence 5. Group Home	1. Community Residential Support and/or access to overnight support services 2. Integrated Employment Supports 3. Integrated Community and/or Day supports 4. Transportation
Tier B (High): ***Moderate Needs***	1. Living with family/ caregiver 2. Independent Living 3. Community Support Residence 4. Shared Living 5. *Group Home	1. Community Residential Support and/or access to overnight support services 2. Integrated Employment supports 3. Integrated Community and/or Day supports 4. Transportation
Tier A (High): ***Mild Needs***	1. Living with Family/Caregiver 2. Independent Living 3. Community Support Residence 4. **Shared Living 5. *Group Home	1. Community Residential Support and/or Access to overnight support services 2. Integrated Employment supports 3. Integrated Community and/or Day Supports 4. Transportation
* Tier A or B individuals will have access to residential services in a group home if they meet at least one defined exception. ** Tier A will have access to Shared Living services if they meet at least one defined exception.		

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

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

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

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

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

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

ATTACHMENT D
Evaluation Design (Reserved)

ATTACHMENT E
SUD Implementation Plan

Approved: December 20, 2018

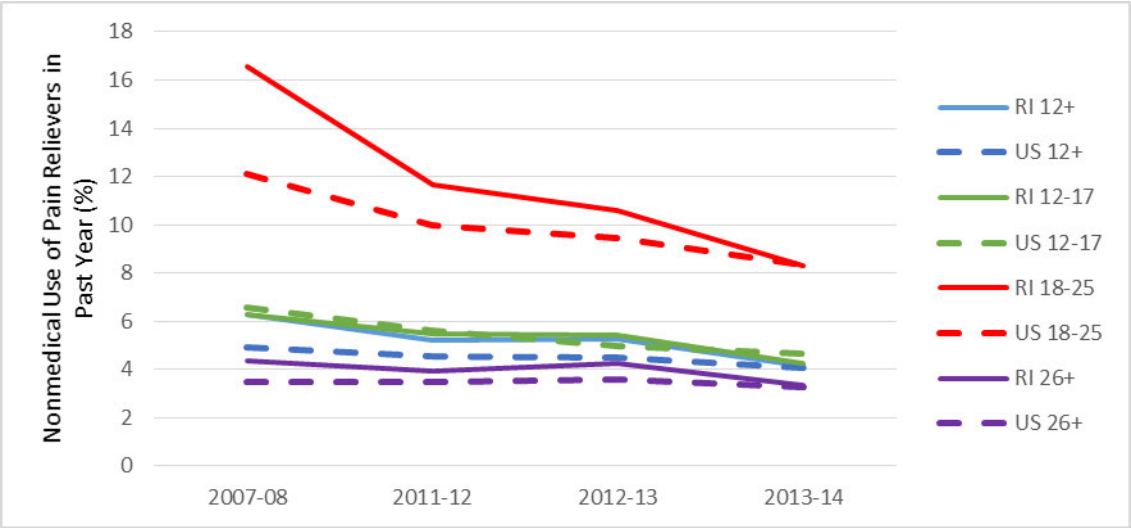
Introduction

The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) oversees a comprehensive array of treatment services across the full continuum of care through licensed SUD providers including outpatient services, intensive outpatient services, medication assisted treatment, intensive levels of care in residential and inpatient settings, and medically supervised withdrawal management. BHDDH oversees a wide range of other services that focus on prevention, intervention, or recovery support. These include Peer Recovery Specialists services, and non-Medicaid, grant-funded Recovery Centers and Recovery Housing. Increasing access to all levels of care, including recovery support services, is one of EOHHS' primary goals. BHDDH is currently working with a provider to develop a telephonic crisis hotline that will be operated 24 hours per day, 7 days per week, as well as a triage center and mobile outreach that will allow individuals in crisis or in need of services to be triaged to the appropriate level of care. For this to be successful, capacity for residential SUD treatment and peer services needs to be built. This is a key factor to improving rates of identification, initiation and engagement for the treatment and care of those with OUD and SUD diagnoses.

While RI is making great strides in serving individuals with SUD and OUD, there is a serious opioid crisis in the state that BHDDH, the Department of Health, Law enforcement and several other stakeholders are working to address. Figure 1 below shows that between 2007 and 2008, and between 2011 and 2012, nonmedical use of pain relievers in the past year was more prevalent in RI among 18 to 25-year-olds relative to national averages. Between 2012 and 2013, RI adults aged 26+ had higher rates of nonmedical use of pain relievers in the past year compared to national averages. However, given a steady decline, the most recent data from the period of 2013 through 2014 indicate that RI is consistent with national averages across all age groups for nonmedical use of pain relievers.

Figure 1. RI vs. US Nonmedical Use of Pain Relievers in Past Year by Age Group, 2007-2014[23]

[23] *Source: National Survey on Drug Use and Health (NSDUH)*



Rhode Island has experienced a 50% increase in overdose deaths between 2011 and 2016. Similar to states across the country, deaths caused by prescription drugs have leveled. RI has seen a decrease of 40% since 2011, deaths from illicit drugs have risen by 250% and deaths caused by a combination of illicit drugs and prescription opioids are up by 33% since 2011. Overdose deaths due to illicit drugs being mixed with Fentanyl have increased 20-fold since 2009 and is exacerbating the overdose crisis. As of December 12, 2016, there were 1,471 reports of overdose, of which 57 resulted in death, 1,152 had been discharged from the hospital at the time of the report and 262 had been admitted to the hospital but not discharged. Heroin was the cause of 58% of the overdoses.

Statewide, about 3 in 4 people who die of an overdose are men (70% are male and 30% are female). All age groups are affected, but most overdoses occur among adults. The highest percentage of individuals who have overdosed are between the ages of 25 and 34 (33%), followed by 35-44 (21%), 45-54 (18%), 18-24 (16%), 55-64 (8%) and 2% of the population under 18 and over 65. In addition, based on overall demographic information from the United States Census, the communities most impacted by fatal overdose are more racially and ethnically diverse than the state average.

There is a disproportion number of individuals being released from the Rhode Island Adult Correctional Institute who die from an overdose within one year of release (2014-2015). The Department of Corrections has partnered with a local SUD provider to offer MAT within the prison walls and to facilitate the continuation of these treatment post release.
The Rhode Island Overdose Prevention and Intervention Task Force, which is co-chaired by the Directors of the BHDDH and the Department of Health, has created an Action Plan to address the state's overdose crisis. The plan focuses on four strategies: prevention, rescue, treatment and recovery, and outlines a public education and community outreach plan to end the stigma of addiction. As a result of this statewide collaboration, most of the milestones required for the SUD Waiver have been achieved. However, EOHHS and BHDDH have a number of activities to undertake to ensure that Medicaid beneficiaries are provided with a full continuum of care for people with SUD and MH conditions. Increased use of Peer Recovery Specialists and the

establishment of the BH Link triage centers, hotline, and mobile outreach will be critical to improving Medicaid beneficiaries' access to care, at all levels. EOHHS and BHDDH have requested a waiver of the IMD rule for SUD to increase capacity at residential facilities. Over the next fiscal year, it is a shared goal of EOHHS and BHDDH to implement these three initiatives and to continue the current processes as described below.

Two new services that EOHHS has recently received authority for are the Recovery Navigation Program (RNP) and the Peer Recovery Specialists. The RNP is a nonclinical program that does not provide treatment but serves as an alternative setting to the Emergency Room for individuals with Substance Use Disorders. It also has staff who, if the patient chooses to, will connect these patients to treatment services. The hours of operation for this program must meet the needs of the population the vendor is choosing to serve. A Peer Recovery Specialist is a credentialed behavioral health care professional who provides an array of interventions that promote socialization, long-term recovery, wellness, self-advocacy, and connections to the community. The services focus on people with a mental health and/or substance use disorder who are having trouble stabilizing in the community and/or are in need of supports to maintain their stability in the community. This includes but is not limited to Medicaid-eligible individuals who are experiencing, or are at risk of, hospitalization, overdose, homelessness or are in the hospital after an overdose, are homeless or are in a detox setting. It would also include people recently released from institutions such as hospitals and prisons.

In the 1115 Waiver Extension Request, EOHHS requested the authority for the Behavioral Health Link Triage Center (BH Link), a 24/7 triage center providing mental health and substance use disorder treatment, medical monitoring, peer support, case management and, if needed, emergency prescribing to individuals in crisis for mental health and/or substance use disorders. BH Link services will be provided by a BHDDH-licensed Behavioral Healthcare Organization. Similar to the RNP, the intent is to provide a safe alternative to the Emergency Department but unlike RNP, BH Link can provide treatment such as motivational interviewing and other interventions to help individuals in crisis due to substance use disorders or mental health issues stabilize and then link them up to more long-term services in the community. BH Link will also manage the state's behavioral health hotlines through grant funding which provides telephonic triage and information to individuals with behavioral health issues.

Milestone #1: Access to critical levels of care for OUD and other SUDs
Specifications:

To meet this milestone, the state Medicaid program must provide coverage of the following services:

- Outpatient Services;
- Intensive Outpatient Services;
- Medication assisted treatment (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state);
- Intensive levels of care in residential and inpatient settings; and
- Medically supervised withdrawal management

Coverage of General Outpatient services

8. Current State:

Unless otherwise noted, the following Licensed Outpatient treatment services are authorized through the RI Medicaid State Plan and are available in all catchment areas of RI:

- Alcohol and/or drug assessment
- Behavioral health (SUD, MH and COD) individual, family and group counseling and therapy
- Intensive outpatient and partial hospitalization services
- Medication assisted treatment (MAT): Methadone maintenance, Naltrexone, Buprenorphine, and Centers of Excellence for Opioids (COE)
- Opioid Treatment Program Health Home
- Peer recovery specialists (Expenditure Authority through Comprehensive 1115 Waiver)
- Detox: ASAM Level II-D

9. Future State:

EOHHS and BHDDH are currently pursuing federal authority through its 1115 Waiver to receive federal matching funds for a Behavioral Health Link (BH Link) Triage Center and have secured grant funding to establish a hotline and mobile outreach for behavioral health crises that will operate 24 hours per day, seven days per week. Through referrals and warm handoffs, this is intended to increase access to the existing outpatient and peer services.

Coverage of Intensive Outpatient and Partial Hospitalization Treatment Services

10. Current State:

BHDDH-Licensed Intensive Outpatient and partial hospitalization treatment services are available in all catchment areas of RI and are offered to individuals assessed to need ASAM Levels 2.1 and 2.5.

11. Future State:

EOHHS and BHDDH are currently pursuing federal authority through its 1115 Waiver to receive federal matching funds for a Behavioral Health Link (BH Link) Triage Center and have secured ongoing SAMHSA block grant funding that will be sustained throughout the demonstration period to establish a hotline and mobile outreach for behavioral health crises that will operate 24 hours per day, seven days per week. BH Link services will be provided by a BHDDH-licensed Behavioral Healthcare Organization. Through referrals and warm hand-offs, this is intended to increase access to the existing intensive outpatient services. The following services will be provided at BH Link:

- Crisis Management and Stabilization
- Psychiatric Consultation Services
- Connections to Treatment, Recovery Supports, and Recovery Housing
- Clinical Assessment
- Peer Support
- System Navigation
- Mobile Crisis Response

- Care Management
- Emergency Medication Prescribing
- Continued Engagement and Connection to Follow-Up Services
- Skilled Nursing

Coverage of Medication Assisted Treatment (MAT)

12. Current State:

Currently, there are 14 Centers of Excellence for Opioid (COE) locations that help address complex MAT issues for primary care providers (similar to the Hub & Spoke model of Vermont). There are also 19 Opioid Treatment Locations (OTP) that offer Methadone, Naltrexone, Buprenorphine and OTP Health Home (see SPA TN# RI-16-006) services. There is currently no waiting list at any MAT service at any of the OTP locations, COE sites, or Prescribing Buprenorphine providers.

13. Future State:

EOHHS and BHDDH are currently pursuing federal authority through its 1115 Waiver to receive federal matching funds for a Behavioral Health Link (BH Link) Triage Center and have secured grant funding to establish a hotline and mobile outreach and inductions for behavioral health crises that will operate 24 hours per day, seven days per week. Through referrals and warm handoffs, this is intended to increase access to the existing MAT services. It is anticipated that as more Peer Recovery Specialists become trained, they will also increase access to MAT as they assist their clients in navigating the recovery process. As part of a recent award from a DLT grant application, a Train the Trainer program on Medication Assisted Recovery Support services (MARSS) for Peer Recovery Specialists will be offered free of charge to all certified peers in the state.

Coverage of intensive levels of care in residential and inpatient settings

14. Current State:

BHDDH uses the ASAM placement criteria for all BHDDH-licensed (Non-Hospital) SUD levels of care. Residential and inpatient services are offered to meet ASAM levels III.5, III.3, and III.I. There is a total of 280 residential beds in RI, 186 of which are for men, 48 for women (of these, 12 are for pre- and postpartum women and their young children), and 46 are co-ed. There are currently approximately 100 individuals waiting for placement into a residential bed. In addition to the ASAM levels of care, medically supervised withdrawal management is available throughout the state.

15. Future State:

EOHHS and BHDDH are pursuing federal authority to receive federal matching funds for members with substance use disorders (SUD) that require treatment at an Institution for Mental Diseases (IMD) to ensure that beneficiaries do not have to wait for a placement into a residential bed. This authority will allow for greater capacity, accessibility, and positive outcomes for beneficiaries. It is anticipated that this waiver authority will attract new

residential providers, which will further increase the number of available beds in the state. Using grant dollars, the state will offer startup funds for new, high-performing providers to offer these services to special populations in need. Several existing providers have shared an interest in utilizing the startup funds for new programming that would eliminate our current wait list and improve access to this level of care.

As more Peer Recovery Specialists are trained and certified, beneficiaries will receive increased support when transitioning between the various levels of care in the SUD continuum. Currently the state contracts with one provider to provide certification training several times a year as well as internship opportunities. Another provider receiving some grant funding has opted to provide training towards certification as well, which will allow us to expand the number of trainings offered and increase the number of peers certified to provide warm handoffs between levels of care. The goal is to increase the percentages of individuals connecting from one level of care to another; including MAT and recovery support services.

Milestone #2: Widespread use of evidence-based, SUD-specific patient placement criteria Specifications:

To meet this milestone, the state Medicaid agency must ensure that the following criteria are met:

- Providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, e.g., the ASAM Criteria, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines; and
- Utilization management approaches are implemented to ensure that (a) beneficiaries have access to SUD services at the appropriate level of care, (b) interventions are appropriate for the diagnosis and level of care, and (c) there is an independent process for reviewing placement in residential treatment settings.

Providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines

16. Current State:

The RI Division of Behavioral Healthcare at BHDDH routinely monitors and reviews all licensed behavioral healthcare programs for adherence to state Rules and Regulations for the Licensing of Behavioral Healthcare Organizations. In the Rhode Island Rules and Regulations for all Licensing of Behavioral Healthcare Organizations, Section 23.1-23.7.2 and Section 24.0 require all Licensed Behavioral Healthcare programs to screen potential clients for appropriateness and eligibility, and to use a multidimensional biopsychosocial assessment tool to identify treatment needs and interim services for the appropriate ASAM level of care. Although all providers are not required to use the same biopsychosocial assessment, all assessments that are used must include some common elements deemed critical for clinical appropriateness. These elements are clearly laid out in BHO regulation Section 24.0. Section 40. 14.1 requires the utilization of the ASAM Placement Criteria for the determination of the individual's appropriate level of care.

BHDDH also requires that provider trainings utilize the ASAM National Practice Guidelines for the use of medications in the treatment of addiction involving opioid use.

17. Future State:

BHDDH will continue to monitor and review all licensed behavioral healthcare programs to ensure that they are assessing treatment needs based on a multidimensional biopsychosocial assessment tool and providing services that meet client's the appropriate ASAM level of care.

Implementation of a utilization management approach such that (a) beneficiaries have access to SUD services at the appropriate level of care

18. Current State:

EOHHS and BHDDH currently operate utilization management through a few avenues, which allows for opportunities to provide technical assistance and to monitor appropriate levels of placement. The Medicaid Managed Care Organizations (MCOs), BHDDH auditing teams, and clinical peer reviews allow for continuous monitoring and adherence to appropriate ASAM levels of placement. Utilization reviews include mental health as well as SUD programs to ensure that co-occurring disorders are properly diagnosed and treated.

19. Future State:

Managed Care Organizations will continue to provide utilization reviews and prior authorizations for all residential, IOP and partial hospital levels of care. EOHHS and BHDDH will continue to monitor and provide technical assistance to ensure quality screening and appropriate service referrals. The new BH LINK program will not only improve access to care but will also be another mechanism to determine that an individual in need of SUD treatment will be placed in the appropriate ASAM level placement.

Implementation of a utilization management approach such that (b) interventions are appropriate for the diagnosis and level of care

20. Current State:

As described above, EOHHS and BHDDH currently operate utilization management through a few avenues, including retrospective records-based reviews, which allows for opportunities to provide technical assistance and to monitor appropriate levels of placement. Behavioral Health Organization regulations require all Licensed Behavioral Health programs to screen potential clients for appropriateness and eligibility, and to use a multidimensional biopsychosocial assessment tool to diagnose individuals and identify treatment needs and interim services that meet ASAM level of care criteria. Utilization reviews include mental health as well as SUD programs to ensure that co-occurring disorders are properly diagnosed and treated. The NGO-Independent Peer Review program also has a process to review records retrospectively and to offer technical assistance as needed. The confidential reviews of each ASAM level of care receiving Block Grant funding is then written up and reviewed by the Director of BHDDH annually.

21. Future State:

Medicaid MCOs will continue to provide utilization reviews and preauthorizes this level of care and authorization. EOHHS and BHDDH will continue to monitor and provide technical assistance to ensure quality screening and assessment of individuals prior to placement in levels of care. The Independent Peer review committee will continue reviewing random samples of Block grant recipients providing treatment at all listed ASAM levels of care.

Implementation of a utilization management approach such that (c) there is an independent process for reviewing placement in residential treatment settings

22. Current State:

The Substance Abuse and Mental Health Services Administration (SAMHSA) requires all states receiving Substance Abuse Prevention and Treatment Block Grant (SAPT) funds to develop an Independent Peer Review process that assesses the efficacy, quality, and appropriateness of SUD treatment services, including placement in appropriate levels of care. BHDDH contracts with an independent entity to administer this process, which utilizes a team of clinical supervisors working in BHDDH-licensed SUD programs. Reports are submitted on an annual basis to BHDDH.

23. Future State:

BHDDH will continue to work with its Independent Peer Review contractor to ensure there is an independent process for reviewing placement in residential treatment settings.

Summary of Actions Needed:

There are no further actions needed to meet this milestone. EOHHS and BHDDH will continue current utilization management practices moving forward.

Milestone #3: Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications

Specifications:

To meet this milestone, state Medicaid agencies must ensure that the following criteria are met:

- Implementation of residential treatment provider qualifications (in licensure requirements, policy manuals, managed care contracts, or other guidance) that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding the types of services, hours of clinical care and credentials of staff for residential treatment settings;
- Implementation of a state process for reviewing residential treatment providers to assure compliance with these standards; and
- Implementation of a requirement that residential treatment facilities offer MAT on-site or facilitate access off site.

Residential treatment provider qualifications (in licensure requirements, policy manuals, managed care contracts, or other guidance) that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding the types of services, hours of clinical care and credentials of staff for residential treatment settings

24. Current State:

BHDDH used the nationally recognized, evidence-based ASAM SUD program standards to set residential treatment provider qualifications, along with SAMSHA's Treatment Improvement Protocols (TIPs) #45 and the ASAM National Practice Guidelines for the use of medications in the treatment of addiction involving opioid use. The provider qualifications and requirements for Residential Services are identified in Section 40.0 of the Rhode Island Rules and Regulations for the Licensing of Behavioral Healthcare Organizations. Regulations include staffing ratios, credentials, and minimal hours of clinical care.
All licensed residential providers are contracted with the MCOs and must meet their requirements for staff qualifications and hours of service, which typically align with the rules and regulations established by the state. Residential services, screenings, and assessments for appropriate level of care are available 24 hours per day, 7 days per week. Residential staff are required to meet staff credentialing and appropriate level of clinical supervision, as defined in state regulations. Technical assistance is provided by BHDDH at the time of auditing. In addition, BHDDH improves residential levels of care quality through required training in ASAM levels of care and the use of SAMHSA TIP 45.

25. Future State:

Coaching, mentoring, and training on co-occurring disorders, funded by the State Innovation Model (SIM) grant, will be provided to support an informed and educated workforce with the goal of working to improve recognized evidence based practices to fidelity. Providers will continue to be required to use ASAM to determine what services are appropriate for their clients and to provide those needed services. Technical assistance will continue to be provided during reviews to adhere to SAMHSA TIP 45 and other publications on providing quality care in all SUD treatment settings. Licensed behavioral healthcare providers will continue to use ASAM National Practice Guidelines for the use of medications in the treatment of addiction involving opioid use. BHDDH staff will continue to monitor staffing through quality audits and HR reporting.

State process for reviewing residential treatment providers to assure compliance with these standards

26. Current State:

BHDDH regularly conducts licensing audits and operates a direct telephone line, 24 hours per day, seven days per week, to log complaints and reports of incidents related to its behavioral healthcare system. When these complaints are deemed significant a formal investigation is conducted. Some of these investigations result in a required action from the provider ranging in severity from submission of, and compliance with, a corrective action plan, to the loss or suspension of license and potentially the closure of the program. BHDDH provides ongoing technical assistance and education to providers to ensure compliance with the qualifications and to reduce the need for regulatory action.

27. Future State:

BHDDH will continue to operate the telephone line, regularly conduct audits, and provide support and training to providers. BHDDH will continue to track information from these processes to establish state trends and patterns.

Residential treatment facilities offer MAT on-site or facilitate access off site

28. Current State:

All facilities in Rhode Island are contractually required to provide and coordinate MAT services either on-site or have a Memorandum of Understanding (MOU) with a provider that does so on their behalf.

29. Future State:

BHDDH will continue the contractual requirements and regularly audit, review, support and train on MAT. MAT peer recovery specialist will be imbedded in residential programming to assist with MAT coordination and education.

Summary of Actions Needed:

There are no further actions needed to meet this milestone.

Milestone #4: Sufficient provider capacity at each level of care, including MAT
Specifications:

To meet this milestone, state Medicaid agencies must complete an assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical levels of care listed in Milestone 1. This assessment must determine availability of treatment for Medicaid beneficiaries in each of these levels of care, as well as availability of MAT and medically supervised withdrawal management, throughout the state. This assessment should help to identify gaps in availability of services for beneficiaries in the critical levels of care.

Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in critical levels of care throughout the state

30. Current State:

MAT outpatient services and intensive outpatient services are available without any wait throughout the state. There are currently over 12,000 people on MAT. Residential services have a current wait list and identified underserved areas have been targeted for future growth. There is currently no wait list for Medically Supervised Withdrawal Management utilizing MAT.

31. Future State:

Utilizing the State Opioid Response (SOR) grant funds, BHDDH will release Requests for Proposals to support the startup of new SUD residential treatment facilities for women and dependent children, a male facility for those with co-occurring disorders and a gender-specific ASAM level III.1 for transitional males. This is intended to increase the capacity to serve these populations and reduce the length of waiting lists for residential treatment.

BHDDH will continue to support trainings available on ASAM National Practice Guidelines for the use of medications in the treatment of addiction involving opioid use. BHDDH will also provide a Train the Trainer Medication Assisted Recovery Service training to Peer Recovery

Specialists. Through contract performance measures, BHDDH receives quarterly reports on the current trained provider pool for Peer Recovery Specialists.

Summary of Actions Needed:

Capacity for gender specific residential SUD treatment must be increased. The IMD waiver will allow some larger SUD residential treatment providers to assist the state in alleviating some of the access challenges that RI faces for these particular levels of care (ASAM III.1 – III.5).

Milestone #5: Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD

Specifications:

To meet this milestone, state Medicaid agencies must ensure that the following criteria are met:

- Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse;
- Expanded coverage of and access to naloxone for overdose reversal; and
- Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs.

Opioid prescribing guidelines along with other interventions to prevent prescription drug abuse

32. Current State:

State regulations require all residential and MAT facilities to review the Prescription Drug Monitoring Program (PDMP) prior to admission. The Rhode Island Department of Health (RIDOH) has implemented all opioid prescribing guidelines and oversees the PDMP. Key attributes of the PDMP are mandatory reporting of all retail and institutional pharmacies dispensing 25 prescriptions or more in a month; reporting requirements pertain to drugs in Schedules II-IV; mandatory enrollment of all practitioners; 72-hour data collection interval; unsolicited reports to prescribers, pharmacists, law enforcement and licensing boards with the release of information authorized for law enforcement officials, licensing/regulatory boards, patient or parent of minor child, prescribers and dispensers; and mandatory access for all opioid treatment programs prior to a patient's advancement to a new take home phase. All eligible prescribers are compliant with the regulation requiring registration with the PDMP. [24]

33.

Additionally, there are several controls that EOHHS has implemented to minimize the risk of inappropriate opioid overprescribing, including:

- The preferred drug list where long acting opioids are non-referred agents;
- Editing in the claims processing systems which will only allow for refills after 85% of the days' supply of the point of service (POS) claim has passed;

[24] [24] http://www.namsdl.org/prescription-monitoring-programs.cfm; retrieved 4/30/2016.

- Editing in the claims processing system which communicates to the pharmacist at POS when there is therapeutic duplication and requires intervention from the pharmacist before the claim will process;
- Claims processing support of RI legislation that limits opioid naïve patients to 20 doses or 30 morphine milligram equivalents at POS; and
- Retrospective utilization review initiatives look for opioid use in combination with other medications, diagnosis and prescribers.

The following interventions to prevent prescription drug use are also being implemented through a federal CDC Prescription Drug Overdose Prevention for States Grant and Supplement to the Department of Health:

Enhance and Maximize the PDMP:

- Top prescribers receive in office academic detailing from a Department of Health employee who is dedicated to PDMP and opioid prescribing education efforts.
- Annually two CME events are offered by RIDOH on responsible prescribing topics.
- A Clinical Alert feature was added to PDMP to identify risky prescribing patterns. Prescribers receive a notification if a patient has a combination of an opioid and benzodiazepine prescription, has been on an opioid for longer than 90 days, or has a prescription from more than four prescribers and filled prescriptions at more than four pharmacies during a six-month period.
- Integration into EHRs have been piloted to integrate PDMP into EHRs and pharmacy systems.

Community/Data Interventions:

- Drug Overdose data is publicly available on a dashboard website. (www.preventoverdoseRI.org)
- A multidisciplinary Drug Overdose Death Review Team is convened quarterly to identify possible future interventions to prevent additional overdose deaths.
- Paid media campaigns messaging. Addiction is a Disease and Recovery is Possible have expanded statewide. Naloxone data collection, training, storage, and distribution has occurred statewide. There is no current sustainable way to purchase Naloxone in RI.
- A law enforcement pilot program in West Warwick connects people to treatment/recovery services in lieu of criminal justice involvement. There is an embedded clinician within the West Warwick Police Department who does community outreach, training on substance use disorder to the department, and is able to respond to with police officers to calls related to substance use.
- The BHDDH peer recovery specialist program has been expanded into DOC, street outreach, and ED.
- BHDDH Support Line availability was expanded to offer services 24 hours' day/7 days a week.

Policy Evaluation:

- Evaluation of four policies relevant to drug overdose has been conducted and guides future programmatic decisions.

Rapid Response:

- Mini-grants ($5,000) are available quarterly to community-based organizations to implement data driven, education or prevention interventions based off of the recommendations of the death review team.

CDC Enhance Opioid Overdose Surveillance Grant

- Extract medical examiner cases of overdose death and enter into national, standardized reporting system: Violent Death Reporting System
- Improve timeliness of 48-hour overdose reporting system and ME data
- Improve EMS drug overdose data

BJA Harold Rogers PDMP grant

- Develop, implement, and evaluate online, interactive training course on identifying women of child bearing age that may have opioid use disorder

34. Future State:

Continue to defer to RIDOH to monitor PDMP. Auditors will review records to ensure PDMP reviews are occurring at licensed BHOs in all their programs treating mental health and SUDs.

Expanded coverage of and access to naloxone for overdose reversal

35. Current State:

One of the four (4) strategies within the Governor's Overdose Intervention and Prevention Task Force is to expand coverage and access to Naloxone. BHDDH and RIDOH developed a Naloxone distribution plan using the RI Medical Corp to help get the Naloxone out to high-risk areas and has been doing so since 2016 using a variety of grants to fund its purchase and distribution. RI has a timely distribution plan of getting naloxone to area "Hotspots" by utilizing Peer Recovery Specialists in a Mobile Outreach Recovery Effort program called "MORE". Every Wednesday, peers are dispatched to areas that have high numbers of non-fatal and fatal overdoses that are reported in from the 11 local hospitals.

36. Future State:

BHDDH and RIDOH will utilize the State Opioid Response (SOR) grant and State Targeted Opioid Response (STR) grant to continue to purchase and manage the distribution of Naloxone throughout the State in high risk areas and to first responders and others who come in contact with those in need.

Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs.

37. Current State:

RIDOH has implemented all opioid prescribing guidelines set forth by the CDC and is the Department that oversees the PDMP program. RIDOH has piloted EHR integration of PDMP into EHRs and pharmacy databases through the state Health Information Exchange (HIE). Other efforts are described in more detail in the SUD Health IT Plan.

38. Future State:

RIDOH will continue providing academic detailing on the PDMP and prescribing guidelines to prescribers identified as being out of compliance with prescribing regulations or guidelines, and RIDOH will continue to expand integrations as referenced in the SUD Health IT Plan.

Summary of Actions Needed:

RIDOH will encourage large healthcare systems and pharmacy chains to utilize the PDMP EHR Integration option through the HIE and will continue to pursue strategies to make Naloxone distribution or availability sustainable to first responders and others who may need it.

Milestone #6: Improved care coordination and transitions between levels of care

Specifications:

To meet this milestone, state Medicaid agencies must implement policies to ensure residential and inpatient facilities link beneficiaries, especially those with OUD, with community-based services and supports following stays in these facilities.

Policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities

39. Current State:

RI has taken strides to provide care coordination for physical health by implementing the Opioid Treatment Program Health Homes. Additionally, the implementation of Centers of Excellence for Opioids improved care coordination between physical health, mental health and MAT services.

40. Future State:

Through contracts with providers, BHDDH will encourage the use of Peer Recovery Specialists trained in Medication Assisted Recovery (MARs) to reside in residential placements in order to assist clients in their transition plans between levels of care by providing transportation and warm hand offs. For example, Peers will either accompany or contact individuals leaving residential treatment on MAT to ensure they get to their first outpatient MAT appointment as well as helping them navigate the broader nonclinical recovery support systems in their local communities. BHDDH is also expanding funding to recovery centers throughout the state to enhance community connections for those in recovery.

Summary of Actions Needed:

BHDDH needs to work with providers to focus attention on their client's needs for community support and integration when they are discharged from outpatient, MAT and residential programs.

Implementation Administration

Questions regarding Rhode Island's SUD Implementation Plan should be directed to:
Linda Mahoney, Administrator and State Opioid Treatment Authority (SOTA)
401-462-3056
Linda.mahoney@bhddh.ri.gov

Relevant Documents

The Governor's Overdose Prevention Action Plan is available at http://preventoverdoseri.org/our-action-plan/. This website is an initiative of the Rhode Island Governor Gina Raimondo's Overdose Prevention and Intervention Task Force, in collaboration with the Rhode Island Department of Health (RIDOH), the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), and Brown University School of Public Health.

Attachment A: SUD Health Information Technology (IT) Plan

Overview:

Rhode Island is well-positioned to support and monitor the efforts of this waiver with existing health information technology infrastructure at all levels. Rhode Island has relatively high electronic health record adoption, and a statewide Health Information Exchange, CurrentCare. There are numerous activities underway that will continue to enhance the state's technical infrastructure. Further detail on the initiatives described below is provided in the Relevant Documents section:

- **State Innovation Model (SIM) Grant Health Information Technology activities:**
    - Healthcare Quality Measurement Reporting and Feedback System – A statewide centralized electronic clinical quality measurement reporting and feedback system which will import electronic health record data from providers across the state, calculate a wide range of quality measures, and report the results at the provider, practice, ACO, and hospital level back to the providers, as well as send reports to payers and other organizations as requested by providers. This system will also be capable of calculating more advanced hybrid (claims and clinical) quality measures as they evolve.
    - EOHHS Data Ecosystem – Centralized and modern health and human services data warehouse for aggregating data sets, modeling data, and self-service reporting for state employees through the analytic platform Power Business Intelligence (Power BI). The Ecosystem is enabling state analysts to be able to better understand how Rhode Islanders interact with state government services, and could be used to help make PDMP data more accessible for data analysis. The EOHHS Data Ecosystem is being built off of the state's All Payer Claims Database, known as HealthFacts RI. Work is already underway using this data to evaluate the differences in cost and utilization for individuals diagnosed with OUD before and after receiving MAT.
    - Consumer Engagement Platform – Centralized document repository and form delivery system connected to the HIE which will enable patients or provider care teams to use a web-based interface to share patient-generated data or to complete forms. This will initially allow for the upload of advance directives and completion of social determinants of health screening tools. Planning is already underway to add SBIRT screenings, and other forms or screenings can be added in the future.
    - Care Management Dashboards – RI SIM funded the implementation of Care Management Dashboards at all Community Mental Health Organizations in the state. These dashboards provide a real-time status of patients being admitted to or discharged from acute-care hospitals (emergency department and inpatient). These dashboards have

also been implemented at all Opioid Treatment Programs in the state through another funding source.

- **HITECH IAPD activities:**
    - **RI's Health Information Exchange (CurrentCare)** is supported through a multi-payer PMPM contribution, including RI Medicaid and the RI State Employees health plan, to sustain and enhance the statewide HIE. RI's HIE is opt-in, meaning individuals must consent to have their data collected as well as shared by the HIE. Policies and procedures exist to enable sharing of 42 CFR Part 2 data through an additional consent process at the Part 2 covered facility. Data from Part 2 covered facilities is stored separately and redisclosure language is displayed prior to accessing Part 2 data from the HIE.
    - **HIE-Enabled Overdose Prevention Project** is a 5-component initiative to further enhance the HIE to combat the opioid crisis. The specific components include:
        - Emergency Department Smart Notifications to easily identify those at risk for SUD/OUD disorder and frequent ED use
        - Integration of EMS Data into the HIE
        - SBIRT Platform (Integrated into the SIM Consumer Engagement Platform)
        - PDMP/EHR Integrations
        - Intelligent Overdose Alert to notify providers of potential overdose upon admission to ED or use of EMS services
- **HealthFacts RI, RI's All Payer Claims Database (APCD)** – The Medicaid All Payer Claims Database is a module of RI's Medicaid Enterprise System. Per state law, all payers with at least 3,000 members must contribute medical and pharmacy claims, provider files, and eligibility files to the APCD. The data are aggregated and direct identifiers are removed. The APCD is used to support multi-payer data analytics to better understand cross-system utilization and incidence of disease.

Rhode Island has sufficient health IT infrastructure at every appropriate level to achieve the goals of the demonstration.

While not all of the above activities are specifically part of the SUD Health IT Plan, many of the activities will help to support the implementation of the SUD Health IT Plan. This SUD Health IT Plan is aligned with the State Medicaid Health IT Plan (SMHP), and will help to further enhance RI's overall technical infrastructure and capacity to evaluate the impact of the demonstration over the duration of the demonstration period.

As with all HIT investments, the state will continue to assess the applicability of the standards referenced in the ISA and 45 CFR 170 Subpart B and use appropriate mechanisms to ensure relevant standards are used. These methods may include, for example, inclusion in vendor contracts, inclusion in legislation or regulation, and/or inclusion in Medicaid Managed Care contracts.

The specific milestones to be achieved by developing and implementing a SUD Health IT Plan include:

- Enhancing the health IT functionality to support PDMP interoperability; and

Enhancing and/or supporting clinicians in their usage of the state's PDMP. Prescription Drug Monitoring Program Functionalities

Criterion 1: Enhanced interstate data sharing in order to better track patient specific prescription data

41. Current State:

The RIDOH PDMP is a member of the National Association of Boards of Pharmacy's (NABP) PDMP Interconnect, which links Rhode Island to other member-state PDMPs to facilitate interstate sharing of dispensing information. As of July 2018, RIDOH PDMP is connected with 20 states for patient-specific prescription data sharing within the PDMP.

42. Future State:

Continue to use the NABP PDMP Interconnect to make connections with as many other state PDMPs as possible. The RIDOH PDMP Data Manager has been in contact with 10 additional state PDMP administrators and one additional state is expected to connect by the end of 2019. Please note that there are major barriers to connecting with many others states, and that RIDOH has reached agreement with all readily willing states. Some of these barriers include other state PDMPs existing in different departments (i.e. law enforcement rather than health), different state laws in place to determine who may see PDMP data (i.e. RI allows delegates to view data as well, while in some states that is prohibited), different state policy on which states they will be willing to connect with (i.e. only bordering states), and differing state security protocols and concerns. It is anticipated that connecting with the remaining states will be more onerous than it was to connect to the 20 that are already in place.

Criterion 2: Enhanced "ease of use" for prescribers and other state and federal stakeholders

43. Current State:

There are numerous activities currently underway to help both prescribers and pharmacists more easily use data from the PDMP. EOHHS/Medicaid in coordination with the RIDOH PDMP program has contracted with RI's State Designated HIE entity, the Rhode Island Quality Institute (RIQI) to facilitate the integration of PDMP data with EHRs for prescribers and pharmacists. This was piloted and has gone live in RI's largest hospital system, Lifespan. Additionally, an alert feature was added to the PDMP in May of 2017 to notify prescribers when a patient has a potentially dangerous prescription (i.e., co-prescription of opioid and benzodiazepine and MME over 91) or has been to five (5) or more prescribers and five (5) or more pharmacists in a 6-month period. Lastly, RIDOH contracted with a PDMP vendor, Appriss, to work with CVS (which accounts for about 50% of all pharmacies in RI) to directly integrate PDMP data with CVS's pharmacy system. CVS began testing the new integration in March 1, 2018 and went live in all CVS stores in August of 2018.

44. Future State:

EOHHS and the RIDOH PDMP program will continue to work with the RIQI to implement additional PDMP-EHR integrations, and offer this opportunity to those practices/providers/pharmacies in Rhode Island that are interested and capable of having their EHR or pharmacy system support a PDMP integration. This EHR integration option will increase utilization of the PDMP by both providers and pharmacists by making it easier to access, reduce

the time it takes out of the workflow to check the PDMP, and making it more intuitive and integrative to use.

45. Summary of Actions Needed:

EOHHS' HIT Specialist will work with RIDOH to develop a PDMP EHR Integration Fact Sheet which will inform providers about the value, opportunity and steps needed to connect their EHR through the HIE to the PDMP. The fact sheet will be distributed through the PDMP website and through the RIDOH Health Connections newsletter in late 2018. Additionally, RIQI will reach out to the other hospital systems and a number of provider practices, prioritizing the largest group practices and those seeing a large number of Medicaid beneficiaries, to solicit interest and identify EHR technical capabilities. EOHHS and RIDOH will work with RIQI to complete at least three additional EHR integrations by the end of 2019. The success of this activity is contingent upon identifying three additional health care entities interested in this integration effort and having their EHR vendor technically capable and willing to implement this integration through the HIE.

Criterion 3: Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange

46. Current State:

As stated above, the RIDOH PDMP is currently connected to RI's Health Information Exchange infrastructure operated by RIQI using the Appriss API method. The API allows for data to be passed in real time through the HIE to the EHR without being stored at the HIE, and also allows for full audit data to be recorded in the PDMP database.

47. Future State:

RIDOH will continue the connectivity between the PDMP and the Health Information Exchange using the API method, as well as add an additional method of integration through the HIE (NCPDP). The NCPDP method will allow for sharing of PDMP data with EHRs that may not be capable of using the API method, and will also allow for the use and storing of PDMP data within the HIE. The NCPDP method is less ideal because it does not allow for an automated logging and audit function to store use data in the PDMP database, which is critical for maintaining compliance with the state law. In order to accommodate these requirements, additional design will be required to support auditing and reporting functions through the HIE.

48. Summary of Actions Needed:

EOHHS and RIDOH will work with RIQI and Appriss to implement a NCPDP connection through the HIE by June 30, 2019, which will allow the storing of PDMP data for patients who have consented to participate in CurrentCare, or for use in the HIE Enabled Overdose Prevention Project described previously. As stated above, EOHHS HIT staff and the RIDOH PDMP Data Manager will continue to work with RIQI to implement several additional PDMP/EHR data integrations based on the interest and readiness of hospital and provider practices.

Criterion 4: Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns

49. Current State:

RIDOH's PDMP Data Manager can run some limited reports of clinician prescribing patterns within the Appriss product. These reports have been used to reach out to clinicians and provide academic detailing about the prescribing of opioids.

50. Future State:

The PDMP database will be fully modeled, integrated with and available through the EOHHS Data Ecosystem. The EOHHS Data Ecosystem is newly developed integrated data system which links data sets from across EOHHS agencies to enable self-service analytics for operations and performance management in a user-friendly manner to nimbly assess and respond to changing policy and operational needs while controlling total costs. By linking PDMP data with Medicaid claims data through the EOHHS Data Ecosystem and by using the APCD, EOHHS data analysts in coordination with the PDMP Data Manager will be better able to assess clinician prescribing patterns as it relates to long-term opioid use.

51. Summary of Actions Needed:

EOHHS and RIDOH already have a data sharing agreement in place to allow for the incorporation of the PDMP data into the EOHHS Data Ecosystem. Analytic projects using the EOHHS Data Ecosystem are proposed to the EOHHS Ecosystem Governing Board which is made up of EOHHS Agency Directors or their designees. RIDOH and EOHHS will propose the development of PDMP dashboards and reports within the EOHHS ecosystem's Power BI tool to track long-term opioid use and correlations to clinicians to support the ability to pursue targeted outreach. Assuming this project is approved by the Governing Board in 2019, the PDMP data will be integrated into the EOHHS Data Ecosystem, and the EOHHS Analytics team will work with the RIDOH PDMP Data Manager to develop a series of dashboards and reports within the Power BI tool to track long-term opioid use and correlations to clinicians to support the ability to pursue targeted outreach.

Current and Future PDMP Query Capabilities

Criterion 5: Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the state's master patient index (MPI) strategy with regard to PDMP query)

52. Current State:

53. The ability to match patients receiving opioid prescriptions with patients already in the PDMP occurs using the PDMP vendor's (Appriss) patient matching algorithm. Matching for some patients that may show up in the PDMP can be especially complex, since high risk patients may have multiple aliases.

It is important to note that RI does not have one central statewide master patient index across its integrated databases. Several different systems such as the APCD, HIE and PDMP and each

have their own built in MPI implemented by each respective vendor. The EOHHS Data Ecosystem also has its own MPI across the state agency databases that are part of this system. Currently when a user looks up a patient in the PDMP that may match multiple records, all records are viewable for the user. It is then up to the user to open each potential record, consider if they reflect one or multiple patients, and combine the prescription history together to make a treatment plan. This is not ideal for the workflow, but better than hiding the records, because with a mismatch the entire record is still available to the user.

54. Future State:

RIDOH will continue to operate using the PDMP vendor's unique patient identification algorithm and when the PDMP is incorporated into the EOHHS Data Ecosystem, EOHHS and RIDOH will identify the match rate and may be able to explore whether the EOHHS Data Ecosystem's ability to match patients can provide additional matching support to the PDMP. It is important to note because the matching algorithm in the EOHHS Data Ecosystem is for analytic purposes and not patient care, it may not be as strict, since some mismatches are acceptable in an analytics environment.

55. Summary of Actions Needed:

Pursuant to approval by the EOHHS Data Ecosystem Governing Board as described in Criterion 4, EOHHS's Deputy Director of Analytics and RIDOH's PDMP Data Manager will collaborate to assess the performance of the existing matching algorithm and determine if there is any opportunity to improve the matching process in the PDMP by using the MPI in the EOHHS Data Ecosystem, and develop a recommendation. Additionally, the EOHHS HIT Specialist will work with the PDMP Data Manager and RIQI staff to analyze the number of ambiguous matches that occur when sending a query from EHRs through the HIE infrastructure to the PDMP, and identify if opportunities exist to use the HIE matching process to improve the PDMP.

Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes

Criterion 6: Develop enhanced provider workflow / business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow

56. Current State:

All controlled substance prescribers, OTP and SUD residential treatment providers are required by regulation to check the PDMP prior to prescribing, and on an annual basis thereafter, or as needed. OTP and SUD residential treatment providers are also required to check the PDMP at admission, prior to considering MAT take-home status changes, and at minimum every 3 months. As stated in Criterion 2, the Lifespan hospitals worked with RIQI to integrate accessing the PDMP through their EHR through the workflow of prescribing an opioid.

Providers/stakeholders would also like to be able to query the PDMP any time during a visit through an easily accessible link or button, but this capability is not yet available through the Lifespan integration into their Epic EHR.

Knowing that Emergency Department (ED) providers are especially concerned and challenged in treating patients that may be at risk for SUD/OUD and opioid overdose, EOHHS is currently

working with RIQI. on the implementation of the ED Smart Notifications (EDSN) project to identify ED patients immediately upon admission who are at risk of opioid use disorder or opioid overdose and/or have a high 7- and/or 30- day ED visit history. This effort will be piloted with the state's largest hospital system, Lifespan, so that when a patient registers at any of three of the Lifespan EDs, an ADT registration will be sent to RIQI, RIQI will run a predictive algorithm (currently being developed) which will include querying the PDMP in real time, as well as querying RIQI's care management ADT database (which includes ADTs from all RI Hospitals) and the HIE to determine if the patient is at risk. For those patients identified to be at risk, RIQI will send a risk flag along with summary information related to the risk (i.e. patient had >91 MME, check the PDMP) to be displayed in the EHR's ED track board (ED patient list). This will dramatically improve the workflow of ED clinicians when treating at-risk patients. The EDSN project will help deliver important data in real time to the ED clinicians without them having to take the time and effort to search for information across the EHR, HIE, and PDMP.

57. Future State:

BHDDH and RIDOH will continue existing requirements for providers to check the PDMP. In an effort to ensure that all EHR integrations meet the identified workflow needs, EOHHS, RIDOH, and RIQI will work with provider organizations to ensure that when the PDMP is integrated into the providers' EHRs, the integration supports, where technically feasible, both checking the PDMP as part of the prescribing controlled substance workflow as well as at any time during a visit.

The EDSN will be implemented in all adult, acute emergency departments for the 2 largest hospital systems contingent upon the second hospital agreeing to participate.

58. Summary of Actions Needed:

EOHHS' HIT Specialist has reached out to Lifespan to request that both components of the integration are configured per the stakeholder feedback. The addition of a readily accessible button to check the PDMP at any time during a visit is already being tested for a go live this year. Additionally, EOHHS' HIT staff (HIT Specialist and State HIT Coordinator) will work with RIQI to ensure all future EHR integrations include both workflow components unless there is a major issue with the technical feasibility of doing so due to the partner's EHR vendor. Lastly, EOHHS's HIT staff will work with RIQI to launch the EDSN product in all Lifespan adult emergency departments and initiate work with one other interested hospital in 2019.

Criterion 7: Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription

59. Current State:

60. All controlled substance prescribers, OTP and SUD residential treatment providers are required by regulation to check the PDMP prior to prescribing and on an annual basis thereafter, or as needed. Additionally, OTP and SUD residential treatment providers are required to check the PDMP prior to or at admission prior to considering MAT take-home status changes, and at minimum every 3 months. The PDMP patient report has several features which make review of the prescription history easier to read, including some key data at the top to help quickly identify risk of dangerous prescriptions (i.e. MME, number of prescribers, number of pharmacies). These

same indicators are also present in the patient report that is delivered through the pilot EHR integration with Lifespan.

61.

62. Future State:

BHDDH and RIDOH will continue existing requirements for providers to check the PDMP. The key indicators will continue to be supplied at the top of the PDMP report for ease of use for prescribers. As discussed in Criterion 6, EOHHS and RIQI will work together to ensure that the PDMP query can occur effortlessly in the prescribing workflow for future EHR Integrations.

63. Summary of Actions Needed:

EOHHS HIT staff will work with RIQI to ensure all future EHR integrations include a prescribing workflow component unless there is a major issue with the technical feasibility of doing so due to the partners' EHR vendor.

Criterion 8: Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.

64. Current State:

SUD care delivery and care coordination is currently supported in part by sharing data through RI's statewide HIE, CurrentCare. In addition to patients needing to enroll in CurrentCare (consenting to have their data sent to CurrentCare and consenting to whom it can be shared with, see Relevant Documents section), patients who receive care at 42 CFR Part 2 covered facilities can provide an additional consent at that site permitting their data from the Part 2 covered facility to be sent to CurrentCare and stored separately. CurrentCare data can then be accessed by authorized CurrentCare users who choose to check to see if the patient has any Part 2 data and after having reviewed required redisclosure language. This allows other treating providers to be aware of the patient medical history and treatment provider at other SUD and/or health care delivery sites.

In addition to this, RIQI operates several Care Management Services using the HIE infrastructure. For these services, under business associate agreements, RIQI obtains all ADT transactions from all RI acute care hospitals. Practices choosing to subscribe to RIQI's Care Management services then provides a list of all active patients they would like to track relative to ED and hospital admissions and discharges. RIQI will notify practices when their patients are admitted to or discharged from a RI ED or hospital regardless of whether the patient has consented to participate in CurrentCare. The two major services under this arrangement are Care Management Dashboards (real time dashboards of patient ED/hospital use) and Care Management Alerts (alerts delivered by Direct messaging about ED/hospital use). All OTPS and Community Mental Health Organizations in the state currently subscribe to these services which help to support coordination of care, especially since SUD treatment providers rarely receive communication from the hospitals about their patients.

All HIE services (Care Management as well as CurrentCare) run data through the HIE's Master Patient Index to ensure that health information from multiple sources can be aggregated into a longitudinal record for the patient. This matching algorithm has a very high success rate.

65. Future State:

To ensure that data can be shared appropriately to impact the delivery of SUD services, the following future state is envisioned:

- All SUD treatment sites have applicable staff provisioned, and trained to actively use CurrentCare to review medical history on enrolled patients
- All SUD treatment sites promote consent to participate in CurrentCare and the consent for 42 CFR Part 2 data sharing through CurrentCare to their patients
- All SUD treatment sites contribute data on consented patients to CurrentCare where their EHR capability exists.
- All SUD treatment sites continue to subscribe to Care Management Services to receive timely ED/hospital utilization data
- Department of Corrections enrolls patients in CurrentCare and shares data with CurrentCare.

66. Summary of Actions Needed:

EOHHS HIT staff will work with RIDOH staff and BHDDH staff to incorporate into the State's 2019 HIE contract with RIQI the following provisions:

- RIQI will provision and train all applicable users for access to CurrentCare data at SUD treatment sites
- RIQI will ensure all SUD treatment sites have the tools and training to offer enrollment in CurrentCare to all patients, and where applicable, manage the consent for sharing of 42 CFR Part 2 data with CurrentCare
- RIQI will establish data feeds from all non-connected SUD treatment sites to CurrentCare, where readiness and EHR capability exists
- RIQI will establish data feeds from the Department of Corrections EHR when readiness and capability exists

EOHHS through the Medicaid MCOs and BHDDH through regulatory oversight will request that all SUD treatment sites commit to the following through the demonstration period:

- Encourage all SUD treatment sites to use CurrentCare, and encourage them to incorporate use of CurrentCare Viewer for medical history into the workflow
- Encourage providers to offer enrollment to CurrentCare and, where applicable, consent for sharing of 42 CFR Part 2 data through CurrentCare

The milestones anticipated for 2019 are as follows:

- All SUD treatment sites who have agreed to sign the data use agreement are able to access CurrentCare
- All SUD treatment sites offer enrollment to CurrentCare at check-in
- All SUD treatment sites that contribute data to CurrentCare ask for additional consent for sharing of 42 CFR Part 2 data where applicable
- Additional two SUD treatment sites succeed with establishing a new interface to share data with CurrentCare assuming EHR vendor readiness and capabilities exist
- All SUD treatment sites continue to maintain Care Management Services subscriptions

- Department of Corrections data feed to CurrentCare is live and operational assuming readiness and capability exists

Overall objective for enhancing PDMP Functionality & Interoperability

Criterion 9: Leverage the above functionalities / capabilities / supports (in concert with any other state health IT, TA or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing – and to ensure that Medicaid does not inappropriately pay for opioids

67. Current State:

68. In addition to the activities and functionalities that are described above, there are several controls that EOHHS has implemented to minimize the risk of inappropriate opioid overprescribing, including:

- The preferred drug list where long acting opioids are non-referred agents;
- Editing in the claims processing systems which will only allow for refills after 85% of the days' supply of the point of service (POS) claim has passed;
- Editing in the claims processing system which communicates to the pharmacist at POS when there is therapeutic duplication and requires intervention from the pharmacist before the claim will process;
- Claims processing support of RI legislation that limits opioid naïve patients to 20 doses or 30 morphine milligram equivalents at POS; and
- Retrospective utilization review initiatives look for opioid use in combination with other medications, diagnosis and prescribers.

69. Future State:

EOHHS continues the claims system controls and leverages a fully modeled PDMP database, integrated with and available through the EOHHS Data Ecosystem. By linking PDMP data with Medicaid claims data through the EOHHS Data Ecosystem and by using the APCD, EOHHS data analysts in coordination with the PDMP Data Manager will be better able to assess clinician prescribing patterns as it relates to long-term opioid use. This information will provide EOHHS with the information it needs to determine whether there are additional controls that need to be implemented.

70. Summary of Actions Needed:

RIDOH and EOHHS will propose the development of PDMP dashboards and reports within the EOHHS ecosystem's Power BI tool to track long-term opioid use and correlations to clinicians to support the ability to pursue targeted outreach to the EOHHS Ecosystem Governing Board. Assuming this project is approved by the Governing Board in 2019, the PDMP data will be integrated into the EOHHS Data Ecosystem, and the EOHHS Analytics team will work with the RIDOH PDMP Data Manager to develop a series of dashboards and reports within the Power BI tool to track long-term opioid use and correlations to clinicians to support the ability to pursue targeted outreach.

Implementation Administration
The state's point of contact for the SUD Health IT Plan is:
Amy Zimmerman, State HIT Coordinator
401-462-1730
Amy.zimmerman@ohhs.ri.gov

Relevant Documents

- Rhode Island State Innovation Model (SIM) Test Grant Operational Plan, April 25, 2018
- CurrentCare Guidebook

Attachment B - State Medicaid Health Information Technology Plan 2017

State Medicaid Health Information Technology Plan

SMHP Update

Submitted: February 10, 2017

SMHP REVISION HISTORY

Date	Author	Version	Change Reference
June 28, 2011	Whitridge Assoc.	Draft 1.0	
July 12, 2011	Whitridge Assoc.	Final 1.0	
November 16, 2011	Whitridge Assoc.	1.1	Incorporated CMS Suggested changes
December 3, 2014	EOHHS	Update	Flexibility Rule Addendum submitted and approved
February 9, 2016	EOHHS	Update	2015-2017 Modified Meaningful Use Addendum submitted and approved
February 10, 2016	EOHHS	Draft 2.0	

Table of Contents

Executive Overview – Background & Purpose

The Centers for Medicare and Medicaid Services (CMS), as part of the provisions of the American Recovery and Reinvestment Act of 2009, have set forth requirements that states must meet in order to qualify for 90% Federal matching funds for administration of their Medicaid EHR Incentive Programs. This document, the Rhode Island State Medicaid HIT Plan (SMHP), represents one of these key requirements. The document describes the State of Rhode Island's current and future Health IT activities, as well as the path or 'roadmap' to their attainment, in support of the Medicaid EHR Incentive Program. In accordance with CMS guidelines, this SMHP is comprised of five main sections:

A. HIT Landscape Assessment – The 'As-Is' Environment
B. HIT Future Vision – The 'To-Be' Environment
C. Activities Necessary Administer and Oversee the Medicaid EHR Incentive Program
D. The State's Audit Strategy
E. The State's HIT Roadmap

Using the above sections as a framework, the document describes the State's current planning with respect to payment administration, meaningful use, adopt/implement/upgrade considerations, eligibility, and financial oversight/program integrity.

This 2.0 version is an update to Rhode Island's SMHP which was submitted in November 2011 and approved by CMS in June 2012. It includes program changes approved during the last quarter of 2015, as well as program additions being requested in RI's IAPD-U which was submitted in December 2016 which are in process of being reviewed by CMS. It should also be noted that Rhode Island has participated in the 13 State MAPIR Collaborative since the start of the Medicaid EHR Incentive program. Rhode Island's MAPIR system has been processing applications since June 2011 and made its first Rhode Island Medicaid EHR Incentive payment in September 2011. Since then, and as of end of December 2016, the program has paid 1,294 applications with a total of $35m distributed to Rhode Island Medicaid eligible providers and hospitals.

The diagram on the following page depicts the progress we have made with providers participating in the program and how far along they are with meeting meaningful use.

RI Medicaid EHR Incentive Payment Breakdown as of December 31, 2016

	Count	Total	EP Count	EP	EH
Paid for Adopt	90	$2,609,092	90	$1,834,586	$774,506
Paid for Implement	162	$3,350,421	162	$3,350,421	$0
Paid for Upgrade	358	$8,415,387	358	$7,387,925	$1,027,462
Total Paid Yr 1 AIU	610	$14,374,899	610	$12,572,932	$1,801,967
Yr 1 Paid MU	28	$7,074,716	21	$425,002	$6,649,714
Yr 2 Payments for Meaningful Use - Stage 1	322	$9,168,817	314	$2,567,013	$6,601,804
AIU > MU Conversion Rate	57%		55%		
Yr3 Payments for Meaningful Use Stage 1	196	$3,265,716	188	$1,544,173	$1,721,543
Yr3 Payments for Meaningful Use Stage 2	3	$22,667	3	$22,667	$0
MU Yr2 > MU Yr3 Conversion Rate	62%		61%		
Yr4 Payments for Meaningful Use Stage 2 & Flexiblity	97	$793,337	97	$793,337	$0
MU Yr3 > MU Yr4 Conversion Rate	49%		51%		

A. Current HIT Landscape – The "As-Is" Assessment

A.1 Extent of EHR Adoption

The Rhode Island Medicaid EHR Incentive program has well exceeded its initial estimate of the number of eligible providers that were going to enroll in the program and adoption and meaningful use a certified electronic health record. At the beginning of the EHR Incentive Program, we estimated that 10% (300) of the approximately 3,000 eligible providers in the state would participate, because of the 30% Medicaid patient volume threshold. Since 2016 is the last year to enroll in the program we are now estimating that 23% (700) of the state's eligible providers are participating in the Medicaid EHR Incentive Program in Rhode Island.

As of December 2016, our state has 930 providers participating in the Medicare EHR Incentive and 632 participating in the Rhode Island Medicaid EHR Incentive program. Rhode Island has a total of 1,562 providers earning an EHR Incentive payments, which shows that providers are accepting HIT as a tool to aid the practice of medicine. This demonstrates that a large number of the state's providers are making the effort to move toward meaningful use.

Rhode Island has eleven acute care hospitals throughout the state, of which nine are participating in both Medicare and Medicaid programs and one could only participate with the Medicare program because they lacked the 10% Medicaid patient volume requirement. Meanwhile, another hospital in our state was in receivership for several years and was recently acquired by a national healthcare organization. We have been in contact with the hospital to determine if they qualify to participate with the program and encourage them to attest for program year 2016 before the March 30, 2017 deadline.

A1.1.1 FQHC and EHR Adoption

In Rhode Island nine out of ten FQCH organizations are participating in the Rhode Island Medicaid EHR Incentive program. These nine organizations have 29 practice locations throughout the state and serve our neediest individuals with medical dental and behavioral health

care services. As a result of FQHC participation, 43% of all eligible providers participating in the Rhode Island Medicaid EHR Incentive program are FQHC providers. As noted,

FQHC providers are actively taking part in RI's EHR's incentive program as evidenced by the some of the metrics listed below:

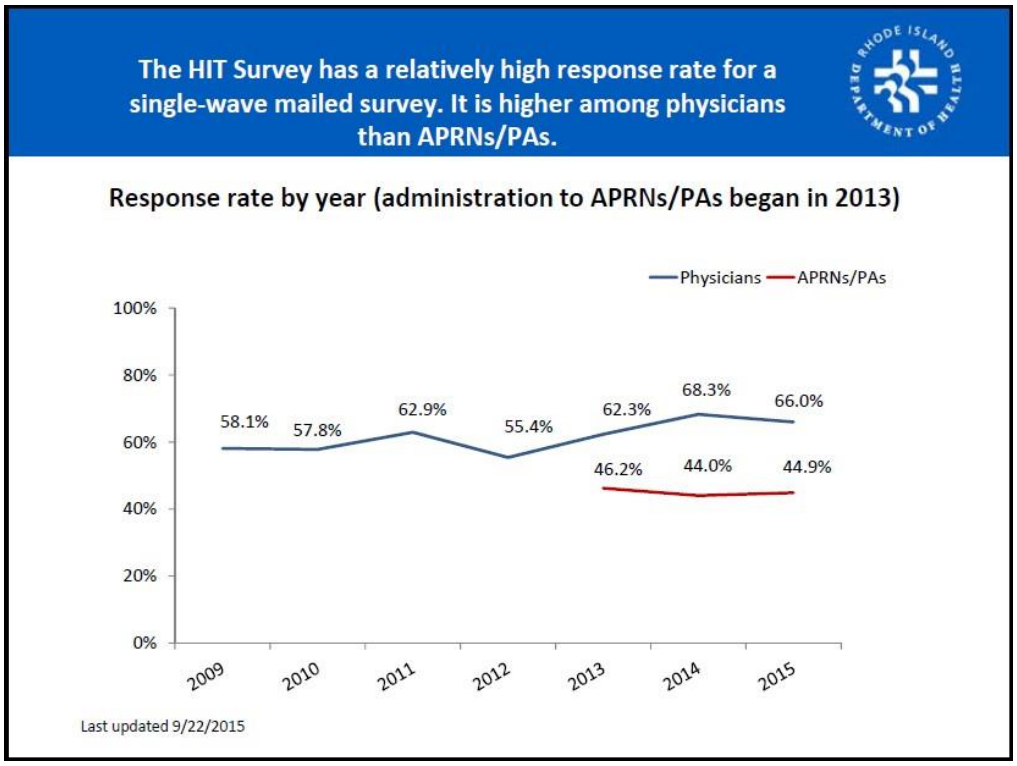
- 89% of the FQHC providers participating have attested to Meaningful Use and are active in the program.
- Of all the EP payments made as of December 31, 2016, FQHCs have earned $8.7m from the Rhode Island Medicaid EHR Incentive program. That amount covers 25% of what was disbursed to all providers including eligible hospitals and 48% of all eligible providers.
- An FQHC organization was the first to attest to meaningful use for Dentists in our state in 2015.

A1.2 State HIT/HIE Self-Assessment Survey Results

With direction from the Department of Health and the Executive Office of Health & Human Services, HealthCentric Advisors (HCA) is contracted to perform a bi-annual survey of how healthcare providers are utilizing their EHR and the state's health information exchange known as CurrentCare within their practice operations. The objective of the survey is to measure the overall trends associated with HIT adoption and use and more specifically to identify how clinicians use technology while caring for patients, what the greatest barriers are, what will help to enable increased use. The survey was last conducted in 2015, and the data was analyzed in 2016. Additionally, based on survey results and the evolving landscape, the intent is to modified the survey and administer it again in the spring of 2017.

The survey is electronically administered to all RI licensed independent practitioners (LIPS)such as physicians, physician assistants and advanced practice registered nurses (a.k.a. nurse practitioners. The 2015 survey was changed to add patient engagement questions and measures that would evaluate basic and advanced EHR usage.

As can be seen in the graph below, the 2015 HIT Survey response rate remained steady with at least two thirds of our physician population completing the survey.



This survey measured EHR usage among those who responded, but we also calculate a combined measure of the responders and non-responders using the assumption that non-responders had not adopted HIT. The intent of reporting providers who do not respond to the survey as not using an EHR was to help incent providers to fill out the survey since this information is publically reported on the Department of Health's website. Despite that we know this combined measure is a gross underestimate of EHR adoption and that there are providers with EHRs that do not respond to the survey. This is confirmed by other data points (see Inventory results). Given that it is increasingly clear many non-respondents have adopted EHRs, we may want to eliminate reporting on the combined measure.

Despite the different measures of adoption, it is clear that HIT in the state is becoming integrated into provider's practices. Close to 90% of the providers participating in the survey indicated they have an EHR and close to 82% are e-prescribing with their EHRs.

The 2015 results provide a point-estimate of HIT adoption among physicians for the four publicly-reported measures.

Use of EHRs and e-prescribing, among respondents and all physicians

Measure	Survey Respondents (N=2,572)		All Physicians (N=3,898)	
	Population	Score	Population	Score
1. Physicians with EHRs, n (%)	2,572	2,290 (89.0%)	3,898	2,290 (58.8%)
2. EHR functionality use (0-100), median	2,290	75.0	--	--
3. Patient engagement EHR use (0-100), median	2,290	35.7	--	--
4. Physicians who are e-prescribing, n (%)	2,377	1,944 (81.8%)	3,703	1,944 (52.5%)

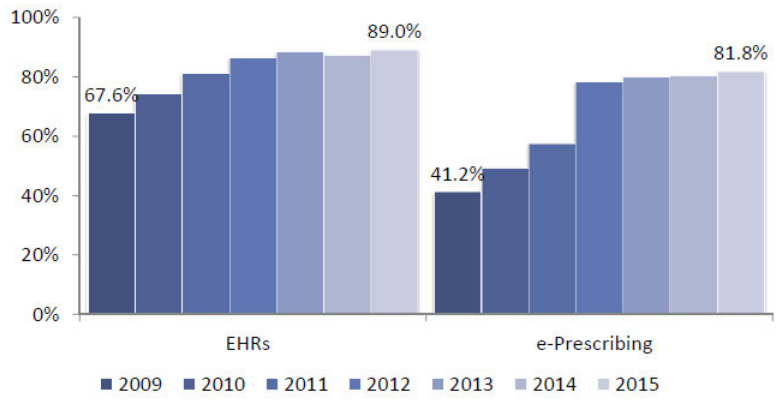
Non-respondents were reported as NOT using health information technology

Last updated 9/22/2015

2015 was the first year we measured the use of the EHR for patient engagement, and found that 35.7% were using their EHR in this way. The survey also showed that EHR and e-prescribing usage has steadily increased over the past six years.

Adoption of EHRs and use of e-prescribing have been increasing since 2009. EHR adoption increased by nearly 31.6% and e-prescribing by 98.5%.

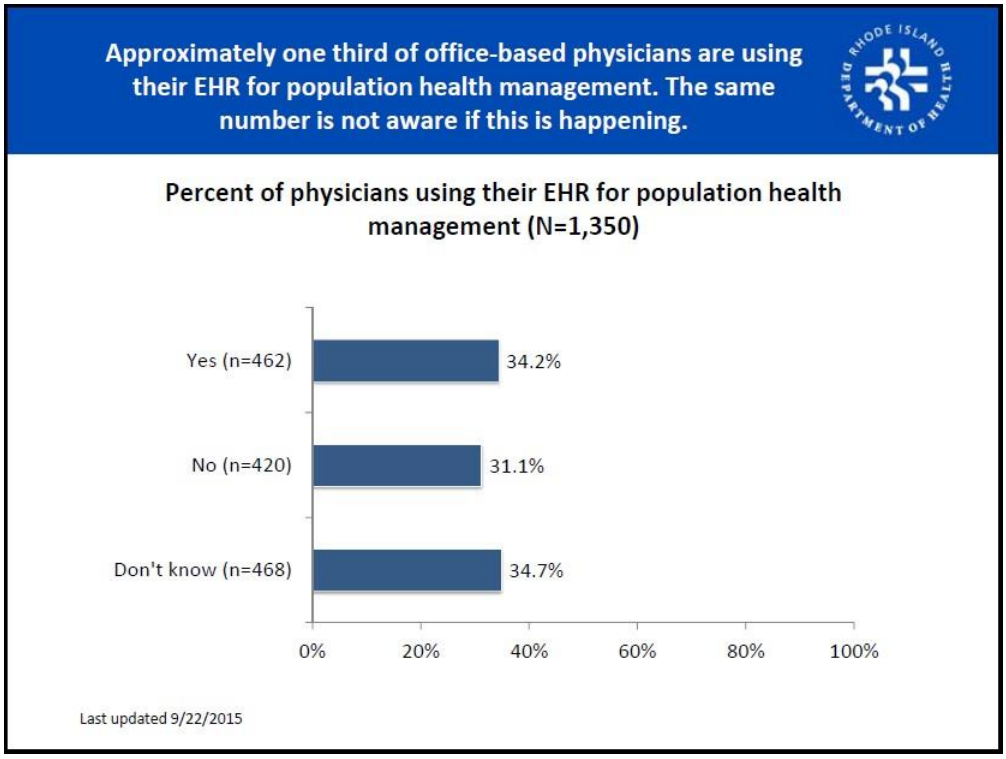
Survey respondents' use of EHRs and e-prescribing



Last updated 9/22/2015

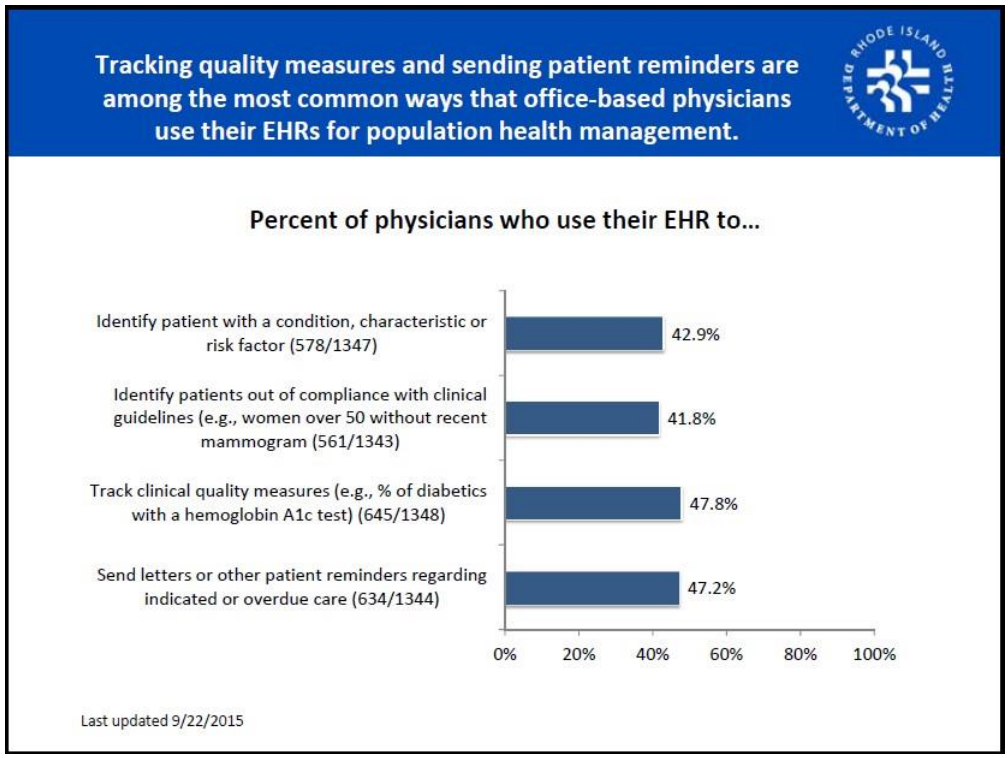
A1.3 Physicians Utilizing EHRs for Population Health Management

Survey questions were not specific to every meaningful use or clinical quality measure, but touched upon basic population health functions and clinical quality measures that most EHRs had to offer. The diagram below shows to what degree our providers believe they are using their EHR for population health.

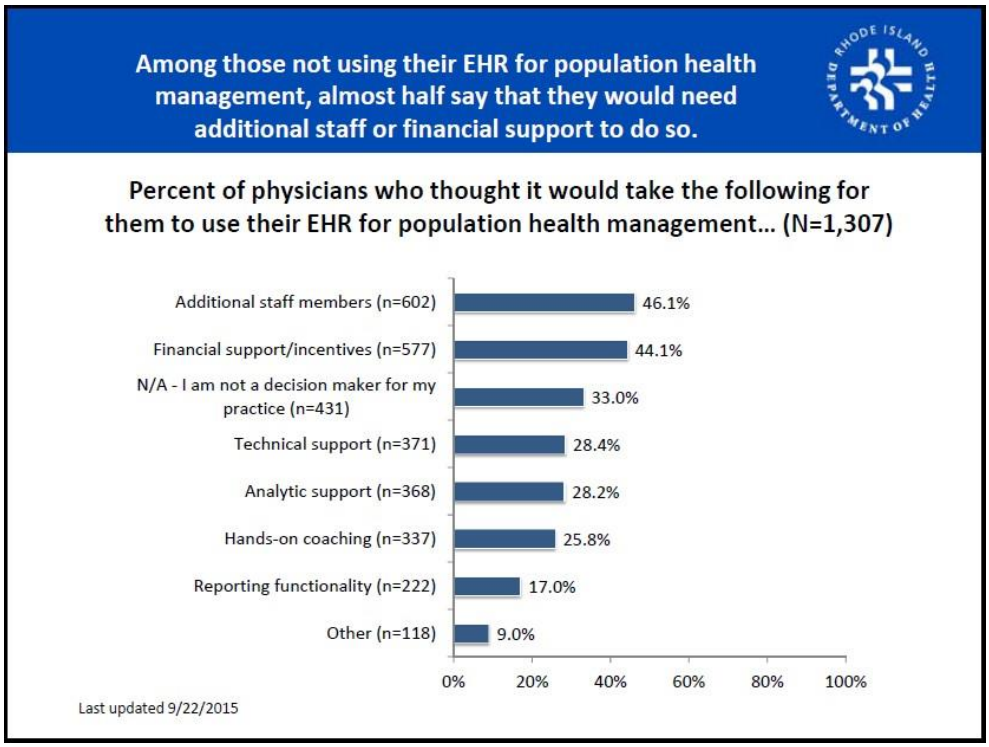


Among those who responded to this question, close to 35% indicated that they are using their EHR for population health, an increase of 7.8% since 2014. In addition, those who did not know if they were using their EHR for population health decreased by 7.1% which indicates that there is a shift in the delivery system toward recognizing population health and to managing patient populations with EHR technology.

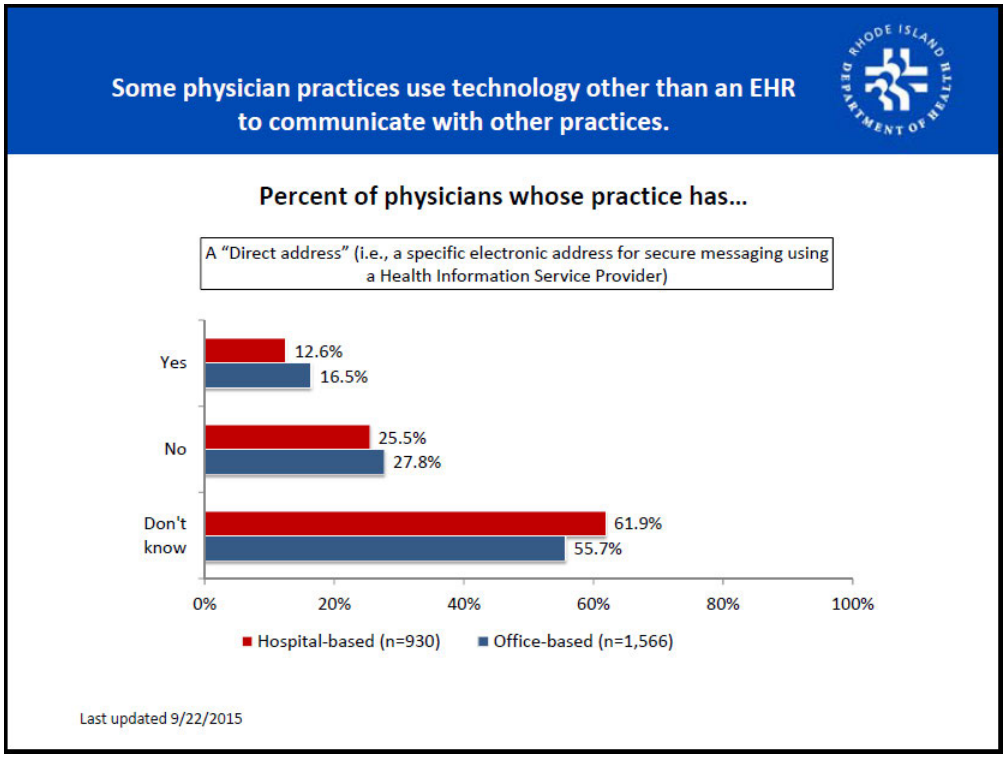
One of the goals of the physician survey was to identify providers' ability to utilize the EHR for tracking quality measures and population health. Less than half of respondents were utilizing their EHR to monitor quality, population health, and patient reminder messaging. Our hope is that these amounts will increase in the years to come.



We also measured the barriers preventing providers from using their EHR for population health. The primary reason was that they felt they needed additional staff or financial support to embark on this effort.



In this same survey we found that 63% of office based practices utilize a website to communicate general practice information and education. Only 16.5% of the office-based and 12.6% of hospital-based providers reported having a "Direct" message email address. We suspect this metric is under-reported based on the fact that 55.7% of office-based providers and 61.9% of hospital-based providers did not know whether they had a Direct message address.

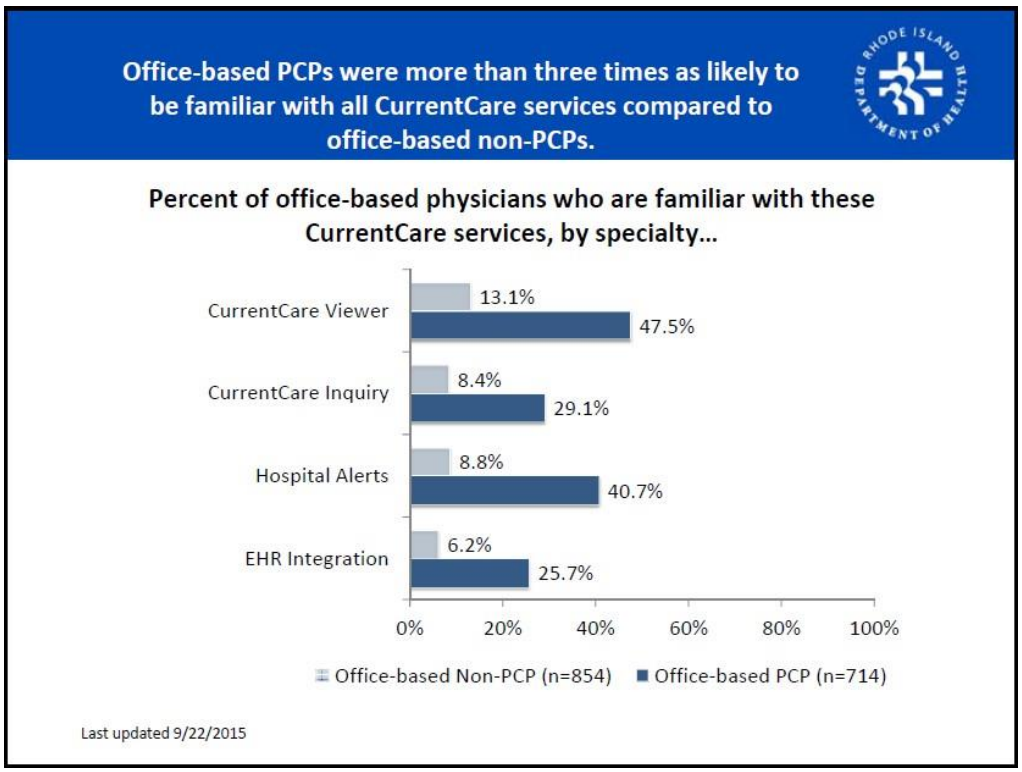


Providers were also asked how they most frequently communicated with their patients. Seven method of communication were listed including: Telephone, US Mail, Patient Portal, Email, Fax, Text Messaging, and Video Calling/Conferencing. Although 93% of the providers indicated they communicated with their patients via telephone; 24.4% also indicated that they utilize a patient portal to communicate with their patients.

A1.4 Physicians Utilizing HIE

The HIT Survey also queried respondents about how they utilize the HIE (CurrentCare) and their knowledge of available HIE services. Office-based primary care physicians had a much higher HIE utilization rate compared to office-based non-primary care physicians. This was expected since the initial HIE marketing efforts were focused heavily on primary care practices. It is anticipated that specialists' knowledge and use of the HIE will improve in the next survey, because the HIE organization (RIQI) which also served as the Regional Extension Center, received a Transforming Clinical Practice Initiative grant which is focused on helping over 1,000 RI specialists prepare for value based purchasing in health care. As part of RIQI's work with

specialists, they are educating and working to engage the specialists in using the HIE services available in the state.



The survey also indicated that there was no increase in the familiarity with HIE services from 2014 to 2015. This clearly indicates a need to revitalize the marketing and outreach efforts around the HIE services that exist in the state.

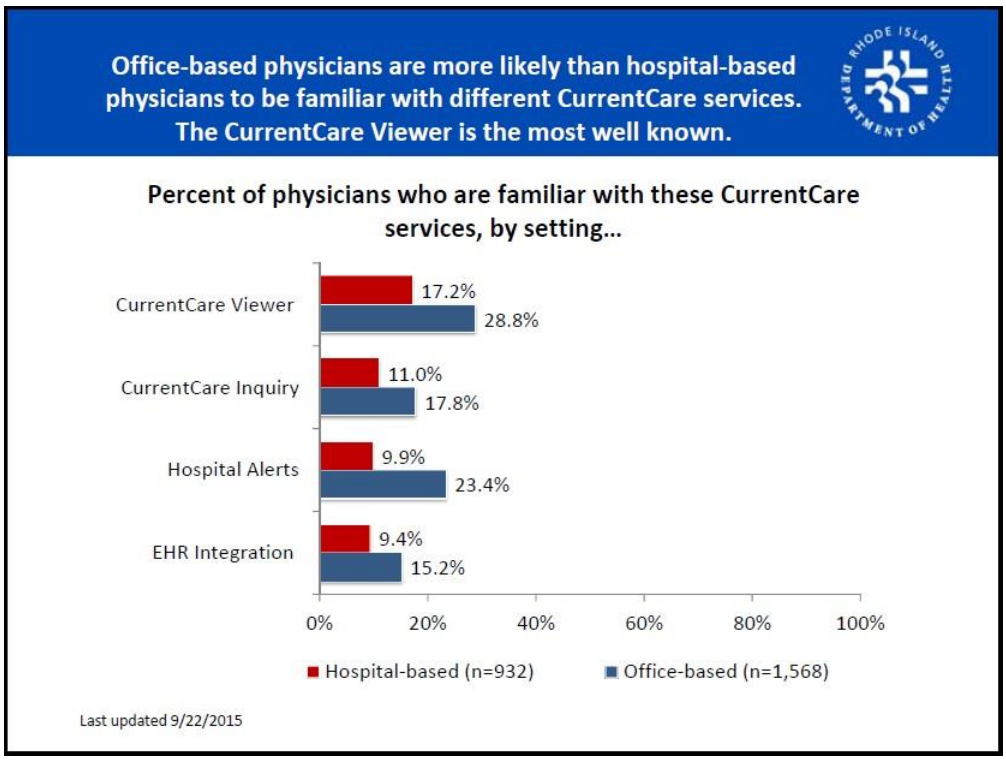
The CurrentCare Viewer is a Web-based portal that provides up-to-date clinical information for consented patients from CurrentCare's data-sharing partners. Patients' records include lab test results, medication history, imaging results, problem list and diagnosis, vital signs and other data points recorded in a CCD, as well as information about physician, hospital and emergency room visits. The CurrentCare Viewer gives providers access to a rapidly expanding clinical database where practices can access a patient's latest health history to help make the best possible, most informed decisions at the point of care and reduce duplicative testing.

In addition, CurrentCare Hospital Alerts provides real time notification to primary care providers and care teams when a patient is admitted to, discharged from, or transferred within an emergency department or hospital. Hospital Alerts allow for timely follow-up care that can help improve outcomes, reduce costly re-admissions, and strengthen the patient-provider relationship.

CurrentCare/EHR Integration occurs at some practices and allows for data from CurrentCare to be shared with the provider directly through their EHR. The advantage of this is that the

provider does not have to leave the EHR workflow to view CurrentCare data. RIQI works with both the EHR vendors as well as provider organizations in determining and prioritizing if and when a provider organization's EHR can share data with CurrentCare.

Survey results indicate that almost 30% of RI's office based providers know about the features of CurrentCare. It will be important to address this metric and focus on increasing awareness and knowledge of the benefits HIE services can provide to providers and the patients they serve.



A1.5 Statewide Healthcare Inventory Survey performed by RIDOH

In 2015 the RIDOH conducted a Statewide Healthcare Inventory Survey as part of a legislative initiative to better understand the healthcare system in Rhode Island. This survey was designed in collaboration with the HIT Survey described previously in an effort to ask the right questions of the right people and reduce the burden of surveys conducted by state agencies. Whereas the HIT survey is meant for licensed independent practitioners to respond to, the statewide healthcare inventory is most often filled out by the office manager. A key component of the inventory was HIT adoption and use, and the inventory was able to collect indicative information about HIT use in facilities and practices of all types.

Paired with the HIT Survey, the inventory results can be used as a basis for our roadmap for how Rhode Island can improve HIT adoption rates. According to the first health care inventory

survey which was administered also in 2015, Rhode Island's EHR adoption across hospitals was 92.3%, across outpatient specialty locations was 72.7%, and across primary care locations was 82.6%. It is clear that while Rhode Island's average EHR adoption rate across all locations was 77.2%, which is close to the national average of 78%, efforts to increase EHR adoption need to be focused on specialists and behavioral health facilities or providers. Additionally, these rates align more with the HIT survey rates of survey respondents. The table shows EHR adoption rates by location type, illustrating the gaps in EHR adoption rates.

EHR Adoption Rates, Statewide Healthcare Inventory, 2015

Survey	Total Locations	Response Rate	EHR Adoption Rate
Hospital	13	100%	92.3%
Nursing Facility	89	100%	80.9%
Outpatient Specialty	418	60%	72.7%
Primary Care	311	94.5%	82.6%
Behavioral Health	48	79.2%	39.6%
Psychologists	108	88.9%	33.3%
Psychiatrists	49	100%	24.5%
Notes: Not all respondents answered the EHR adoption questions; there is possible overlap between the outpatient specialty and psychologists survey results; and some outpatient specialty practices are co-located with hospitals.			

A.2 Broadband & Internet Access

In general, given the high population density, compact size, and urban nature of the State, access to broadband services within Rhode Island is excellent. A number of recent initiatives have served to foster adoption and access. According to Broadband RI (BBRI), broadband is available for 97% of the state of Rhode Island. However, in the most urban areas 29% of Rhode Islanders do not subscribe to the Internet.

From 2010 – 2014, $4.52 million of federal funding went to establish the Broadband RI (BBRI) initiative with the Rhode Island Economic Development Corporation (RIEDC). BBRI works to create new opportunities by expanding broadband use and digital literacy across Rhode Island. BBRI programs address public awareness and education about broadband and develop plans to increase broadband adoption and usage.

Also with federal support, OSHEAN (Ocean State Higher Education Economic Development and Administrative Network) is deploying 389 miles of high-speed optical fiber throughout the state and Ocean State Libraries is adding 600 new computers and 12 mobile computing labs to the state's public computing resources.

A.3 Rhode Island FQHC HIT Landscape & HRSA Funding Streams for HIT

There are eight FQHC grantees in Rhode Island which serve 152,000 patients, of which 56.8% are covered by Medicaid. 100% of the FQHCs have EHRs and 88% are PCMHs.

Rhode Island does not have a recipient of the July 2016 Health Center Controlled Network (HCCN), but the FQHCs did receive Delivery System Health Information investments (DSHII) awards in September 2016 for $509,026 to support HIT investments to support value-based care.

A.4 Indian Health Center & Veterans Administration

The Narragansett Indian Health Center is the single IHC in the State. The IHC has adopted certified EHR technology in 2012 for two providers. Since then, the two providers have left the IHC, but they continue to utilize the certified EHR Technology with the providers hired through a contractor. Their plan is to hire a full time physician, and continue to utilize certified EHR technology and eventually become meaningful users of their certified EHR.

The Veterans Administration operates a medical center in Providence. The medical center delivers a broad range of services in medicine, surgery, and behavioral sciences and is currently operating 73 beds. The medical center has approximately 150 board certified physicians and a total of 1038 full-time equivalent employees who complete the health care delivery team of professional, technical, administrative, and support personnel. Veterans can also avail themselves of primary care and some specialty services at the VA Community-Based Outpatient Clinics in Middletown, RI.

RIQI has been working with the Veterans Administration around the sharing of health information given there are a number of patients who are treated both within the VA system and by community providers. HIE data from CurrentCare is currently available to the VA providers through the current care viewer. RIQI has also successfully completed the Department of Veteran's Affairs (VA) certification testing to access VA data in a federated manner. The ability to access VA data through CurrentCare is expected to be fully implemented in the next month. Additionally, RIQI is working with the VA to allow VA data to be persisted, in order that RI providers that access CurrentCare data from within their EHRs, can also access the VA data.

A.5 Key Stakeholder State Government Organizations Impacting Health IT

Over the past five years, the state of Rhode Island has made a substantial investment in the advancement of health information technology (HIT) and, as a result, has made significant progress in planning, designing, and implementing healthcare information technology initiatives to improve the quality, safety, and value of healthcare. HIT has been and remains an identified healthcare priority for the Governor, the state's Secretary for Executive Office of Health and Human Services (EOHHS), Director of Health (DOH), the Health Insurance Commissioner (OHIC), and the state's Medicaid Director. In 2015, Governor Gina M. Raimondo, along with

Senator Sheldon Whitehouse, launched the Governor's Working Group for Healthcare Innovation, a statewide initiative to innovate healthcare by improving patient care and health outcomes, and lowering cost for all Rhode Islanders. The diagram below summarizes the goals of this initiative. Additional details can be found at: http://governor.ri.gov/initiatives/healthcare/

A.5.1 Rhode Island Executive Office of Health & Human Services

The Executive Office of Health and Human Services (EOHHS) serves as the State Medicaid Agency (SMA) for the State of Rhode Island and is the umbrella organization that oversees and manages publicly funded health and human services in Rhode Island. As part of this role, EOHHS is directly responsible for Medicaid as well as some healthcare innovation initiatives such as SIM Model Test Grant initiatives, Integrated Care initiatives, Medicaid Provider and Beneficiary Oversight, Care Management, and fiscal reporting and oversight. EOHHS has contracted with Hewlett-Packard Enterprise Services (HPE) to provide Medicaid MIS deployment and support and Medicaid claims processing services. In addition, Neighborhood Health Plan and United Health Care serve as Medicaid's managed care organizations and serve approximately 90% of Medicaid beneficiaries.

The Executive Office of Health and Human Services is driving several initiatives to ensure that Rhode Islanders -- especially our most vulnerable populations -- have access to high quality health and social services that are affordable and sustainable.

While the Affordable Care Act has helped cut Rhode Island's uninsured rate in half, rising healthcare costs remain a concern for Rhode Island families, businesses, taxpayers and healthcare providers. Rhode Island is building on the strong foundation established by the Working Group to Reinvent Medicaid to spark innovation across our healthcare system to improve patient care and health outcomes, and lower costs for all Rhode Islanders. In 2015, Governor Raimondo's Working Group for Healthcare Innovation, chaired by Health and Human Services Secretary Elizabeth Roberts, developed recommendations to improve the state's healthcare system, support better health outcomes, lower costs and provide businesses with more predictability.

That same year, EOHHS received a $20 million State Innovation Model (SIM)Test Grant to implement and test its State Health Care Innovation Plan. As part of SIM, Rhode Island has developed a population health plan based on the results of community health assessments, including the integration of primary care and behavioral health. In addition, the state will fund the following projects to support practice transformation and state data infrastructure needs, as agreed upon by the SIM Steering Committee:

- Community Health Teams
- Child Psychiatric Access Program
- Patient Centered Medical Home (PCMH) Kids program
- Behavioral Health Transformation
    - SBIRT training and screening
    - Integrated Behavioral Health Program with Patient Centered Medical Homes
    - Community Mental Health Center practice transformation
- Healthcare Quality Measurement Reporting and Feedback System
- State Data Ecosystem
- Statewide Common Provider Directory
- HealthFacts RI – RI's All-Payer Claims Database
- Patient Engagement Tools/Advanced Illness Care Initiative

Additional details on the SIM projects are in the SIM Operational Plan, available at: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/State%20Innovation%20Model/RISIMOperationalandIPHPlan.pdf

The SIM grant is helping the state to augment its HIT infrastructure by supporting the continuing development of an all-payer claims database, developing a statewide common provider directory, a statewide healthcare quality measurement reporting and feedback system, patient engagement tools, and EOHHS data ecosystem.

Rhode Island's SIM Steering Committee requested that a SIM Technology Reporting Workgroup be created to determine whether to fund a statewide quality measure reporting and feedback system. The group assessed clinical quality measurement reporting capabilities within our state, which were relatively low as also evidenced by the HIT survey. The workgroup developed a recommendation to the SIM Steering Committee to proceed with establishing a statewide clinical quality measurement reporting and feedback system. The Steering Committee approved the project, and EOHHS will be issuing an RFP in early 2017 to identify a vendor. The SIM Technology Reporting Workgroup will reconvene to serve as the governance committee for this system responsible for protecting patient privacy and defining additional business requirements. This system is being built based on an aligned set of clinical quality measures to be used by payers in contracting along with other measures that need to regularly be reported on by providers. There was a concerted effort to include the meaningful use measures in the aligned measure set, though they do not fully overlap. Additionally, this system will be built in a manner

in which it can be used by providers to meet their attestation to meeting the Meaningful use clinical quality measures.

The Rhode Island All Payer Claims Database (APCD), HealthFacts RI, is jointly managed by the Executive Office of the Health and Human Services, the Department of Health, the Office of the Health Insurance Commissioner, and HealthSource RI. The APCD collects and stores payer enrollment data, medical claims, pharmacy claims, and provider data on a monthly basis. The APCD will be used to ensure transparency of information about the quality, cost, efficiency, and access of Rhode Island's healthcare delivery system with a special focus on Medicaid access monitoring. SIM funding has established the foundation of the APCD which has allowed us to understand the breadth of the value for Medicaid operations as a primary user of the APCD.

Rhode Island has taken extensive precautions to protect patient privacy, while ensuring that the data is still longitudinal and useful to agencies, legislators, and researchers.

- No patient names, social security numbers or addresses are available in the database – to anyone. A specialized vendor, which is firewalled from the state, assigns individuals a scrambled unique identifier that cannot be traced back to identifying information.
- Publically available data on the HealthFacts RI website will include only high-level summaries of key public health facts deemed safe for release by the Department of Health and as stipulated by regulations. No one will be able to identify individuals from this data.
- In order for non-state employees to have access to sensitive fields or individual claims, they must sign privacy agreements that prevent publication of identifiable data. In addition, requests must get approval from the state's Data Release Review Board, which reviews requests that could potentially identify individuals.
- All eligible residents were notified of their right to opt-out of the database, completely and permanently. Only 2% of people chose this option. Historical data (2011-2013) for about 130,000 people were automatically removed because these people had either moved, become uninsured, died, or were otherwise unable to be contacted.

In addition to the activities described above, the EOHHS, as the State Medicaid Agency, has primary responsibility for state-level funding, staffing, and oversight related to the development of this State Medicaid HIT Plan (SMHP), Implementation Advance Planning Document (IAPD) annual or as needed updates, as well as the administration of the Medicaid EHR Incentive Program described in Section C in this document.

A.5.2 Rhode Island Department of Health

The Rhode Island Department of Health (DOH) provides critical oversight and liaison functions that ensure alignment of the State's HIT/EHR initiatives with strategies, policies, and clinical guidelines established at the state government level. In this role, DOH works closely with

EOHHS, the State's designated RHIO known as Rhode Island Quality Institute, and other entities such as HealthCentric Advisors who advise on health care quality and other related issues.

In 2015, Dr. Nicole Alexander-Scott was appointed as the Director of Rhode Island's Department of Health by Governor Gina Rimando. Following the HIT efforts of the previous directors, Dr. Alexander-Scott continues to direct the state's public health planning efforts to use technology to improve the quality and safety of care.

The Department of Health manages several key HIT initiatives to support data-focused public health and the EHR Incentive Program. These include:

- *KIDSNET Childhood Immunization Registry* – This meaningful use registry supports the mandatory reporting of childhood immunizations, and the creation of immunization records and administration schedules to support primary care providers. This registry helps EPs and EHs meet the Public Health meaningful use objective.

- *Syndromic Surveillance Registry* – This meaningful use registry supports the communication of early symptomology of patients presenting at the emergency rooms throughout the state, to assist in early intervention and public health response in the case of public health emergencies. This registry supports EHs in meeting the Public Health meaningful use objective.

- *Electronic Lab Reporting* – This meaningful use registry supports the communication of reportable disease from labs to the Department of Health. The Department of Health uses the National Electronic Disease Surveillance System (NEDSS). This registry supports EHs in meeting the Public Health meaningful use objective.

- *Prescription Drug Monitoring Program (PDMP)* – Pharmacies in the state are required to report the dispensing of Schedule II, III, IV, and V medications within 24 hours to the PDMP. The PDMP provides a web-based provider portal for providers and their delegates to review the controlled substances dispensed to their patients before issuing new or continuing prescriptions.

The RIDOH also has hired a Public Health Meaningful Use and Informatics Coordinator to assist with the planning and coordination of Meaningful Use activities that support the Medicaid EHR Incentive Program, including HIE initiatives. This individual works closely with the state's HIT coordinator, the SIM HIT Specialist and the Medicaid EHR Incentive Program Manager who are all located at EOHHS. The Rhode Island Department of Health (DOH) provides critical oversight and liaison functions that ensure DOH's alignment with other HIT efforts across the state.

A.5.3 Department of Behavioral Healthcare Developmental Disabilities and Hospitals (BHDDH)

The Department of Behavioral Healthcare Developmental Disabilities and Hospitals (BHDDH) has been a strong partner in promoting Health Information technology and the use of Currentcare among the community mental health centers (CMHOs). Most CMHOs have adopted or implemented EHRs. Several years ago, BHDDH partnered with EOHHS and RIQI, the State's Designated Entity for HIE to develop a process and approach to allow 42 CFR part 2 data (confidentiality of alcohol and drug abuse patient record data) become part of CurrentCare. To help achieve, this BHDDH promulgated through regulations a standard Currentcare 42 CFR part 2 consent form to be used by all CMHOs. This consent form is in addition to the standard Currentcare enrollment form. BHDDH has promoted the use of Currentcare to the CMHOs. BHDDH has been critical in advancing the sharing of health information between behavioral health care providers and physical health care providers. RI remains the only state where 42 CFR part 2 data is currently part of a statewide HIE. Additionally, through SIM funding, all community mental health centers will have real time access via a dashboard, updated every 45 minutes, to identify when their patients are admitted to or discharged from any Emergency Department or hospital in RI. This is a separate service from Currentcare and does not rely on individuals BHDDH received and grant from SAMSHA to implement SBIRT screening across the state and as part of that grant, BHDDH proposes to leverage Currentcare and its connectivity to help centralize the capture of SBIRT results and make share the SBIRT screening results among a patients treating provider.

A.5.4 Office of Health Insurance Commissioner (OHIC)

The Office of the Health Insurance Commissioner provides the state oversight on healthcare insurance providers within the state.

OHIC is responsible for:

- Guarding the solvency of health insurers;
- Protecting the interests of consumers;
- Encouraging policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and

- Viewing the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.

OHIC is committed to making RI's healthcare system more affordable and easier to use. That's why OHIC has set standards that will support primary care, transform healthcare delivery, and change the way we pay for care. OHIC plays an important role in supporting HIT adoption by regulating commercial health insurers with standards that require advanced practice methodologies only supported by the use of and EHR and the State's Health Information Exchange, CurrentCare. The Health Insurance Commissioner also serves as an ex-officio, non-voting member of the RIQI Board of Directors.

OHIC also supports the Care Transformation Collaborative (CTC, formerly the R.I. Chronic Care Sustainability Initiative, or CSI-RI). Standing at the forefront of Rhode Island primary care practice transformation in RI, CTC is an all-payer program that promotes care for patients through the patient-centered medical home (PCMH) model.

A.6 HIT/E Relationships with Other Key Stakeholder Entities

A.6.1 Rhode Island Quality Institute (RIQI) 's Center for Improvement Science (Formerly Regional Extension Center but often still referred to as the REC)

RI's Regional Extension Center (REC), which was operated by RIQI, is now formerly known as RIQI's Center for Improvement Science. Although RIQI change the name when the ONC's Regional Extension Center funding ended, many in the community still know it as and refer to it as the Regional Extension Center or REC. The REC offers our provider community with Health IT technical assistance, education, guidance, and information on best practices to support and accelerate health care providers' efforts to become meaningful users of Electronic Health Records (EHRs). RIQI's Relationship Managers meet with providers to help them plan their conversion to a certified EHR. Their services go beyond the implementation of new technology by alerting provider practices about incentives or increased reimbursements from payers, i.e. Medicaid or Blue Cross/Blue Shield, as well as promoting, educating and helping providers engage with HIE services. The REC provides one on one technical assistance as well as group education sessions for providers to share their experiences. In addition, they conduct webinars on specific topics such as conducting Security Risk Assessments and protecting patient health information.

The REC recently enhanced their website presence for providers who want to strengthen their HIT efforts. In early 2015, the REC revised their website (http://www.docehrtalk.org/Home.aspx) to focus utilizing Health IT tools and functions to support practice transformation efforts. One of the major goals of the REC is to help providers understand the benefits of the State's HIE (CurrentCare*),* Meaningful Use and how moving

towards EHR adoption will help them succeed. REC services include providing guidance and technical assistance on meeting Meaningful Use, becoming a NCQA's Patient Centered Medical Home, selecting and adopting EHRs, preparing for EHR Incentive audits, assuring privacy and security and conducting a security risk assessment participating in CurrentCare, and using Direct messaging.

Providers who join the REC and obtain their assistance are more likely to meet meaningful use than those providers who do not join. Moreover, the REC's professional network with Health IT vendors, payers, and a majority of health care provider practices proves to be valuable for the providers they serve and the entire healthcare system. Having access to firsthand experience with advances that work well or not work well, prepares a practices with Health IT endeavors they are about to address.

The REC and RIQI are frequent grant awards recipients. In mid-2015, the ONC awarded a two-year, $2.7 million grant that is supporting the Sharing Health Information for Transitions in Care (SHIFT in Care) project. Leveraging the existing capabilities of RIQI's CurrentCare and REC services will provide the opportunity to expand the capacity for statewide exchange of health information. The grant supports the integration of electronic health records (EHRs) from long-term/post-acute care (LTPAC) facilities, leading to the ability to alert primary care and other providers in the community when patients are admitted to or discharged from long-term care facilities in the state.

> In the fall of 2015, the RIQI was awarded two other grants. A one-year, $100,000 grant to support the Rhode Island Behavioral and Medical Information Exchange project. This initiative will connect behavioral health providers who are ineligible for federal health IT incentives to CurrentCare to expand and improve their ability to electronically send, receive, find and use health information in a manner that is appropriate, standardized, secure, timely, and reliable.
>
> The second grant is a four year $8.3m Transforming Clinical Practice Initiative award that will provide technical assistance to help equip clinicians in Rhode Island with tools, information, and network support needed to improve quality of care, increase patients' access to information, and spend health care dollars more wisely. As a Practice Transformation Network, RIQI's goal is to support 1,500 clinicians to expand their quality improvement capacity, learn from one another, and achieve common goals of improved care, better health, and reduced cost. The network will provide practice transformation assistance, care coordination tools and services, and performance measurement, reporting and evaluation to help participating clinicians meet the initiative's phases of transformation and associated milestones, clinical and operational results.

In 2015, EOHHS contracted with the REC to try and engage and provide technical assistance to eligible providers in RI who had not yet enrolled to participate in the Medicaid EHR incentive program or who had enrolled but had not continued to participate in the program. The overarching goal was to assist Medicaid providers understand how to reach meaningful use and continue to advance to the next stage and program years. The seven measurable tasks that the REC completed in the contract were:

- Assess 100 Medicaid providers to determine the reason they are not progressing through meaningful use, and provide assistance to reducing those barriers
- Create and deliver educational materials for these providers
- Outreach to all Medicaid providers about the RI Medicaid EHR Incentive program via newsletters and Medicaid provider updates
- Provide education events on topics that were identified as barriers to achieving Meaningful Use (e.g. transitions of care, security risk assessments)
- Assist and educate providers about program audit preparation
- Execute program recruitment efforts
- Provide direct, on-site technical assistance to provider practices

The REC has helped RI's provider community and continues to make a large impact on the HIT goals the State of Rhode Island is pursuing.

The REC is staffed with Relationship Managers who assist practices in redesigning workflow to support implementation of their certified EHR. They share best practices among the practices and help them overcome procedural and technological obstacles. They also educate practices on how to adhere to HIPAA requirements and reduce their risk of a breach. The Relationship Managers are also NCQA Content Expert certified and have prepared many practices to meet Patient-Centered Medical Home (PCMH) certification. Their guidance through the critical process of converting paper-based records to an electronic system have made an impact to EHR Adoption. At the same time, they discover the best ways to incorporate CurrentCare (HIE) tools into each practice's workflow.

One of the real benefits of the REC is their dedication to education and training. This is the core-value that the REC provides to practices. They actively work to help providers get the most out of their health IT investment as the HIT market rapidly evolves and develops.

A.6.2 HealthCentric Advisors (HCA)

HealthCentric Advisors (HCA) is a healthcare consulting firm headquartered in Providence, Rhode Island and provides services that synchronize healthcare operations and healthcare technology. HCA, formerly RI's Quality Improvement Organization, now serves as New England's Regional Quality Innovation Network Quality Improvement (QIN-QIO) organization, having been awarded a 5-year contract by the Centers for Medicare & Medicaid Services (CMS). Their teams of clinical, analytic and quality improvement experts provide tools, education and assistance to support providers in Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont.

HCA also delivers improved patient care healthcare models and solutions to Assisted Living, Home Health, Hospitals, Nursing Homes, and to Physician and Ambulatory Care practices. Their services include:

- Data Analytics for Quality Improvement reporting

- Practice transformation that directs health care providers towards Meaningful Use, Patient Centered Medical Home, PQRS, and EHR system conversions.
- Safe Transition program improves a practice's ability to move a patient from one healthcare setting to another. HCA frequently improves practice care transitions by implementing evidence-based interventions developed with feedback from stakeholders from all care settings.

EOHHS and the Department of Health contract with HCA to perform the annual physician Health IT Survey that provides a snapshot of how healthcare technology is used by providers in Rhode Island, which was described in section A.1.2. Additionally, the CEO of HCA serves on the Board of the Rhode Island Quality Institute, staff from HCA assist the State's HIT Coordinator in convening RI's hospital CIO's on a quarterly basis to share among themselves and with the state, important information and feedback HIT initiatives, trends and needs across the state.

A.7 Health Information Exchange Organization

A.7.1 Rhode Island Quality Institute (RIQI)- RI's State Designated Health Information Exchange Organization

The Rhode Island Quality Institute (RIQI) is a not-for-profit organization that was founded in 2001 through a collaboration of leaders in the RI community, with an established mission to significantly improve the quality, safety, and value of healthcare in RI. This collaboration includes consumers, consumer advocacy groups, integrated delivery systems and community hospitals, health insurers, physicians, professional associations, the Medicare Quality Innovation Network Quality Improvement (QIN-QIO) organization, behavioral health professionals, community health centers, skilled nursing and long-term care facilities, employers, academia, and RI state government officials. In 2004 at the request of and in collaboration with RIQI, the RI Department of Health (DOH) applied for and received funding from the Agency for Healthcare Research and Quality (AHRQ) to be one of six states nationally to be awarded a $5 million, six-year "State and Regional Demonstration Project in Health Information Technology" contract. The goal of this initiative was to develop a statewide health information exchange system that would integrate patient health data from various healthcare organizations, to create longitudinal record and make it accessible to the patients authorized healthcare providers in order to allow providers to provide high quality health care by having the information they need at the point of care as well as to allow them to manage their patient population and reduce gaps in care.

Through a RFP process that was completed in 2007, RIQI was designated as the State's Health Information Exchange (HIE) Organization, to complete the building of as well as operate Rhode Island's the Statewide Health Information Exchange (HIE), known as CurrentCare. CurrentCare is a secure electronic system which allows doctors and other care givers immediate access to a patient's up-to-date health information in order to provide the best possible and most comprehensive care.

Rhode Island Quality Institute is a leader in health information technology committed to improving the quality of healthcare in Rhode Island. As the state's Health Information Organization (HIO), RIQI is responsible for developing, implementing, and operating the statewide HIE. RIQI, which had also been designated by the Governor to serve as the State's Designated Entity (SDE) for the ARRA HIE funds in 2010, works closely with the SMA in developing the HIE Strategic & Operational Plan for the State of Rhode Island. Great strides have been made with the development of CurrentCare. With a concerted effort from the Secretary of Health and Human Services in 2013 and the RIQI Board of Directors, a $1 Per Member, Per Month (PMPM) voluntary multi HIE funding model initiative was agreed upon and includes public, private and self-insured payers throughout the state. This HIE funding sustainability model has been an approach after which other states are attempting to model their HIE efforts.

RIQI had also been selected as one of the seventeen Beacon Communities and based on the State's HIT participation with CurrentCare, they were able to demonstrate that HIT is a critical tool in improving health care outcomes. The fact that RIQI has successfully obtain numerous major grant initiatives, which are all synergistic provides them with unique opportunities to closely collaborate with Medicaid and its EHR incentive program participants.

RIQI has also been nationally recognized for promoting and integrating the use of Direct Messaging into their infrastructure. RIQI has leveraged direct messaging by relying on that as the standard for transmitting CCDs to and from CurrentCare.

A.7.2 CurrentCare – Rhode Island's Health Information Exchange (operated the RIQI)

Many individuals see several doctors, take multiple medications, and go to several locations for medical tests. CurrentCare ensures that all of an enrolled patient's healthcare providers have the information they need to coordinate the best possible care. Most significantly, CurrentCare contributes to the reduction of medical errors, prevention of avoidable hospitalizations and emergency room visits and improved care coordination between providers.

CurrentCare operates as a centralized HIE. Health care data on enrolled individuals is sent to and stored in CurrentCare by data submitting partners (labs, hospitals, provider offices, radiology, pharmacies via Surescripts etc.), creating a longitudinal health care record for that patient. Providers can access the information with the consent of individual by logging into the Currentcare Viewer (portal) or through their own EHR if bidirectional exchange capabilities have been established.

The use and operation of CurrentCare is governed by the Rhode Island Health Information Exchange Act of 2008. As expressed in the HIE Act, the State of Rhode Island views CurrentCare as the means to promote patient-centered care, allow widespread utilization of electronic

health records by health care providers, improve the quality, safety and value of health care, keep health information secure and confidential, and progress toward meeting public health goals.

Participation in CurrentCare participation is voluntary for both patients and health care providers. Individuals need to consent and actively enroll to have their Health information be shared via CurrentCare. Additionally, health information may only be released from CurrentCare in one of the following three scenarios:

1. In an emergency, to the treating provider(s)
2. With the consent of the patient
3. To a public health authority for those purposes in the interest of the public's health

Furthermore, when a patient enrolls in Currentcare, they are required to identify (consent) to who can access their CurrentCare record. There are three options available: in an emergency only, all treating providers (like HIPPA) or only certain providers (identified by the patient) and in an emergency. As evidenced above the types of potential data users are limited in the law. Last year the HIE Act of 2008 was modified to allow health insurers to access CurrentCare for care management (when patients choose all treating providers which accounts for 98 % of those enrolled) and for quality improvement purposes. The statute was also amended to clearly articulate that patients' can authorize the sharing of their data to caretakers, family members and others of the patients choosing.

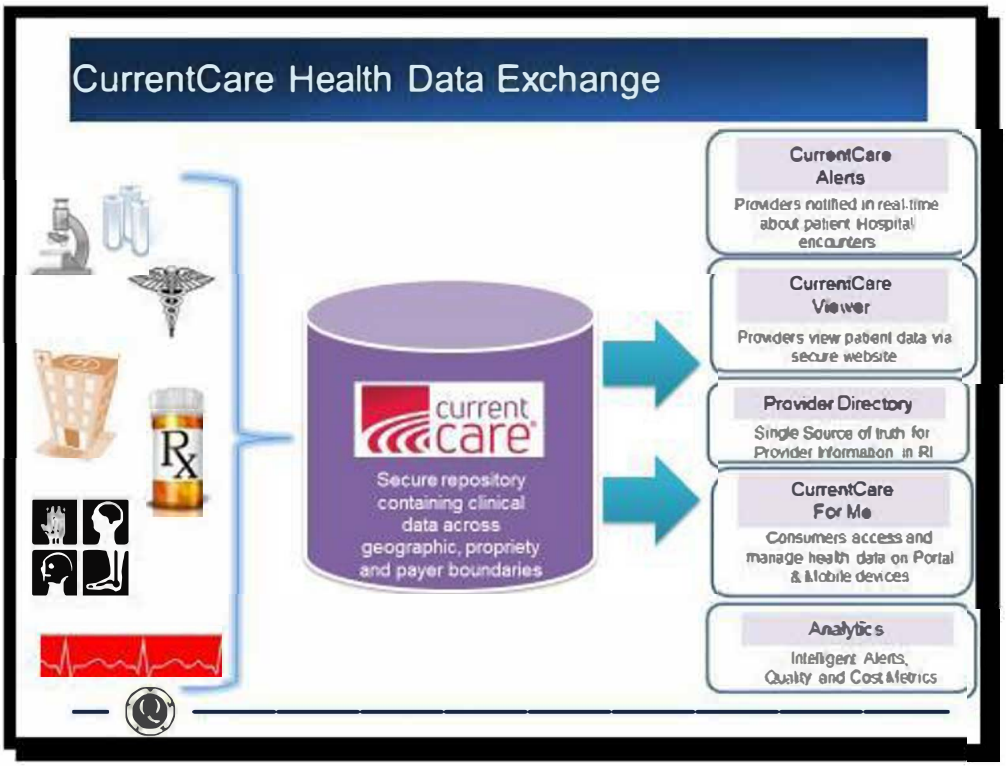
Health care Providers who participate in CurrentCare have signed a data sharing agreement with RIQI which includes a HIPAA compliant agreement.

CurrentCare for Me: Consumers now have the ability to access their own data in CurrentCare to view lab results, prescribed medications, condition information, and office-visit summaries, along with the ability to view and download their entire health record in either HTML or CCD formats. This is enabled through a patient portal known as "CurrentCare For Me (CurrentCare4ME)". Individuals can also request to see who has accessed their CurrentCare (though that is not yet part of CC4Me). RIQI is also working on a project entitled "no wrong Door" which would be enabling single sign on to all of a patient's patient portals. It is anticipated that CurrentCare for me will help drive CurrentCare enrollment. As more patients enroll in CurrentCare, more data accumulates and more providers have access to health data to coordinate care, Rhode Islanders will benefit from better, more efficient healthcare.

Funding to continue CurrentCare development and operations is largely based on a multi-payer model. The model is based on payers and self-funded employers contributing a $1 per member per month (PMPM) based on their number of lives they cover for health insurance. This supports a fair share approach to funding the state's HIE. All of the state's major commercial healthcare insurance providers contribute along with approximately 23 large private self-

funded organizations who provide their employees' health coverage. Naturally, Medicaid pays their share based on the number of Medicaid covered lives and this portion is and has been eligible for a FFP 90/10 share. It is important to note that Medicaid's contribution in this multi-payer model varied based on the amount of dollars that are appropriated for State match. As a result of Medicaid expansion including more individuals then initially expected, the Medicaid PMPM has varied and has ranged from 75 cents to 85 cents per member per month. In addition to the PMPM funding, RIQI has been successful in obtaining grants that continue to build new services off of CurrentCare and its HIE infrastructure. This includes TCIP and SIM dollars along with other ONC grants and some private foundation funding.

CurrentCare has come a long way since it started it's HIE endeavor in 2007. As shown in the diagram below, CurrentCare has the ability to exchange many types of health information over a secure network. The goal is to enhance the patient care for the provider and the patient.



CurrentCare promotes the sharing of a large amount of data received from many providers in the state and more recently from surrounding states. Such accomplishments include but is not limited to obtaining:

- 90% of the Rhode Island prescription data from retail pharmacies in the state. This greatly enhances a provider's ability to reconcile patient medications.
- 90% of the lab results which are coming from both hospital laboratories as and the majority if independent clinical laboratories in the state.
- EKG Imaging and Diagnostic Imaging reports from numerous imaging facilities and hospitals throughout the state and beyond

- 100% of RI's admit discharge and transfer data (ADT feeds). All acute care hospitals send their ADT data in real time.

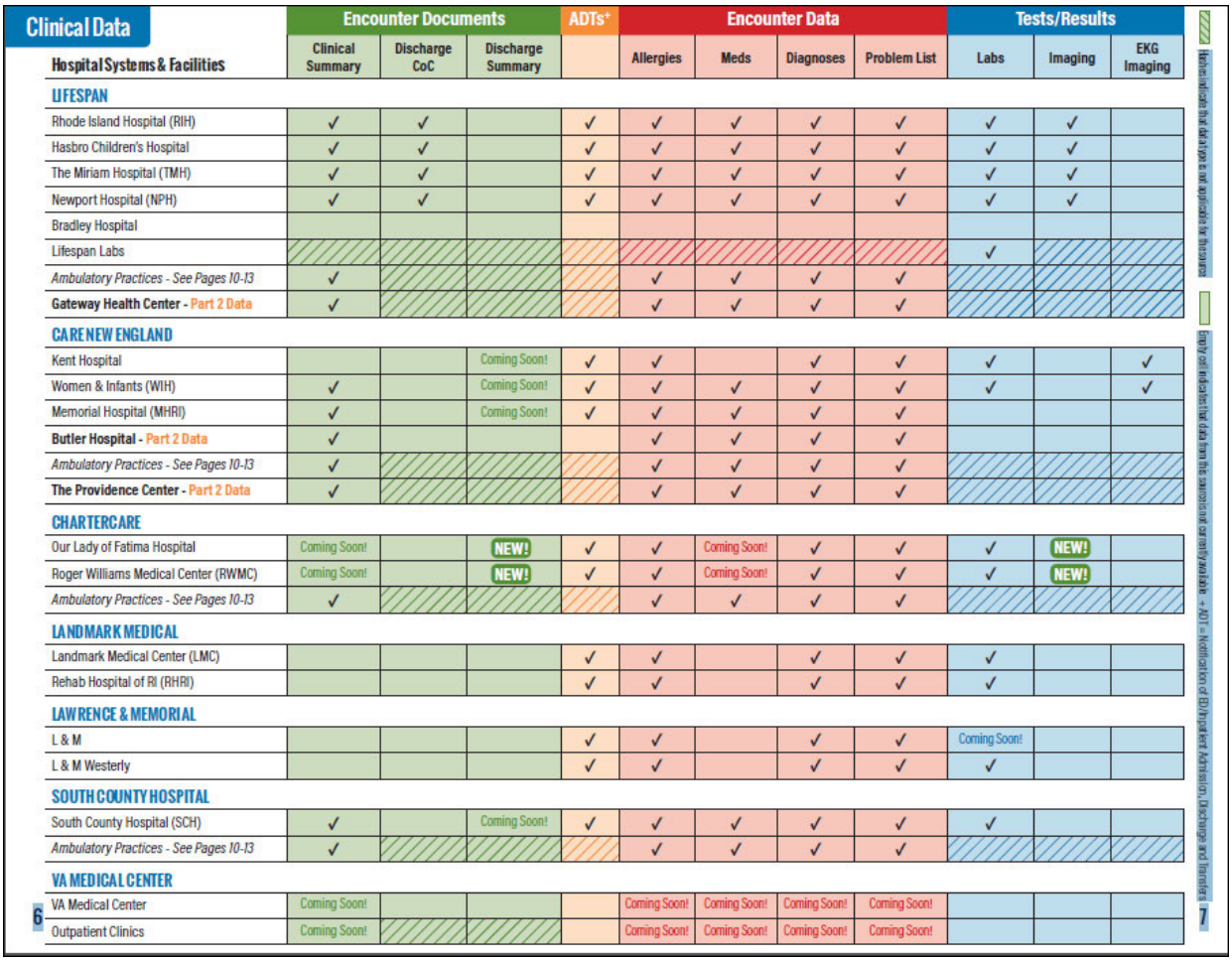
Hospital Alerts, one of RIQI's HIE services, can notify a provider when their patient has an been admitted, discharged, or transferred to an emergency room and/or hospital. The real benefit for the provider is that they can have immediate information to help provide more coordinated care and reduce re-admission rates by reaching out to the hospital and or patient to discuss the patient's situation, medications and diagnosis. This proactive sharing of care information allows providers to determine if the patient needs to remain in the ED and or be admitted to an acute care facility. This service is available to all providers. Who subscribe for their patients who are enrolled in Currentcare. Additionally, since providers wanted this service to be available for their entire patient panel. RIQI has created the ability provide ED/Hospital Alerts to a provider for their entire patient panel by implementing BAAs with the hospitals and those providers interested in purchasing this service.

Importantly, CurrentCare is also able to Continuity of Care documents from 16 EHRs platforms:

Allscripts	Cerner	GECentricity	Netsmart
Amazing Charts	Epic	Greenway	NextGen
Athenahealth	Essentia	MEDITECH	Intergy
Polaris/Epichart	eClinicalWorks	PointClickCare	MatrixCare

and is receiving Continuity of Care documents from a majority of the acute care hospitals in the state. The CCD allows providers to view problem and medication lists, allergies and sometimes vitals, procedures, and other practice specific information in a longitudinal summary. In addition, several large behavioral health providers have access to information regarding substance abuse when patients have consented to share this information with CurrentCare. A growing number of the EHRs in the state are able to bi-directionally share data with CurrentCare allowing providers to be able to access CurrentCare data from within their own EHR.

The CurrentCare Guidebook is a wonderful resource that RIQI developed to communicate who its data sharing partners are and what they are contributing, as well when new data types and/or data sharing partners are likely be on-boarded next. The link for the guidebook is: http://www.currentcareri.org/Portals/0/Uploads/Documents/CurrentCare%20Information%20Sources.pdf



Clinical Data

Hospital Systems & Facilities	Encounter Documents: Clinical Summary	Encounter Documents: Discharge CoC	Encounter Documents: Discharge Summary	ADTs+	Encounter Data: Allergies	Encounter Data: Meds	Encounter Data: Diagnoses	Encounter Data: Problem List	Tests/Results: Labs	Tests/Results: Imaging	Tests/Results: EKG Imaging
LIFESPAN											
Rhode Island Hospital (RIH)	✓	✓		✓	✓	✓	✓	✓	✓	✓	
Hasbro Children's Hospital	✓	✓		✓	✓	✓	✓	✓	✓	✓	
The Miriam Hospital (TMH)	✓	✓		✓	✓	✓	✓	✓	✓	✓	
Newport Hospital (NPH)	✓	✓		✓	✓	✓	✓	✓	✓	✓	
Bradley Hospital											
Lifespan Labs									✓		
Ambulatory Practices - See Pages 10-13	✓				✓	✓	✓	✓			
Gateway Health Center - Part 2 Data	✓				✓	✓	✓	✓			
CARE NEW ENGLAND											
Kent Hospital			Coming Soon!	✓	✓		✓	✓	✓		✓
Women & Infants (WIH)	✓		Coming Soon!	✓	✓	✓	✓	✓	✓		✓
Memorial Hospital (MHRI)	✓		Coming Soon!	✓	✓	✓	✓	✓			
Butler Hospital - Part 2 Data	✓				✓	✓	✓	✓			
Ambulatory Practices - See Pages 10-13	✓				✓	✓	✓	✓			
The Providence Center - Part 2 Data	✓				✓	✓	✓	✓			
CHARTERCARE											
Our Lady of Fatima Hospital	Coming Soon!		NEW!	✓	✓	Coming Soon!	✓	✓	✓	NEW!	
Roger Williams Medical Center (RWMC)	Coming Soon!		NEW!	✓	✓	Coming Soon!	✓	✓	✓	NEW!	
Ambulatory Practices - See Pages 10-13	✓				✓	✓	✓	✓			
LANDMARK MEDICAL											
Landmark Medical Center (LMC)				✓	✓		✓	✓	✓		
Rehab Hospital of RI (RHRI)				✓	✓		✓	✓	✓		
LAWRENCE & MEMORIAL											
L & M				✓	✓		✓	✓	Coming Soon!		
L & M Westerly				✓	✓		✓	✓	✓		
SOUTH COUNTY HOSPITAL											
South County Hospital (SCH)	✓		Coming Soon!	✓	✓	✓	✓	✓	✓		
Ambulatory Practices - See Pages 10-13	✓				✓	✓	✓	✓			
VA MEDICAL CENTER											
VA Medical Center	Coming Soon!				Coming Soon!	Coming Soon!	Coming Soon!	Coming Soon!			
Outpatient Clinics	Coming Soon!				Coming Soon!	Coming Soon!	Coming Soon!	Coming Soon!			

Hashes indicate that data type is not applicable for this system

Empty cell indicates that data from this system is not currently available

+ADT – Notification of Emergency Department Admission, Discharge and Transfer

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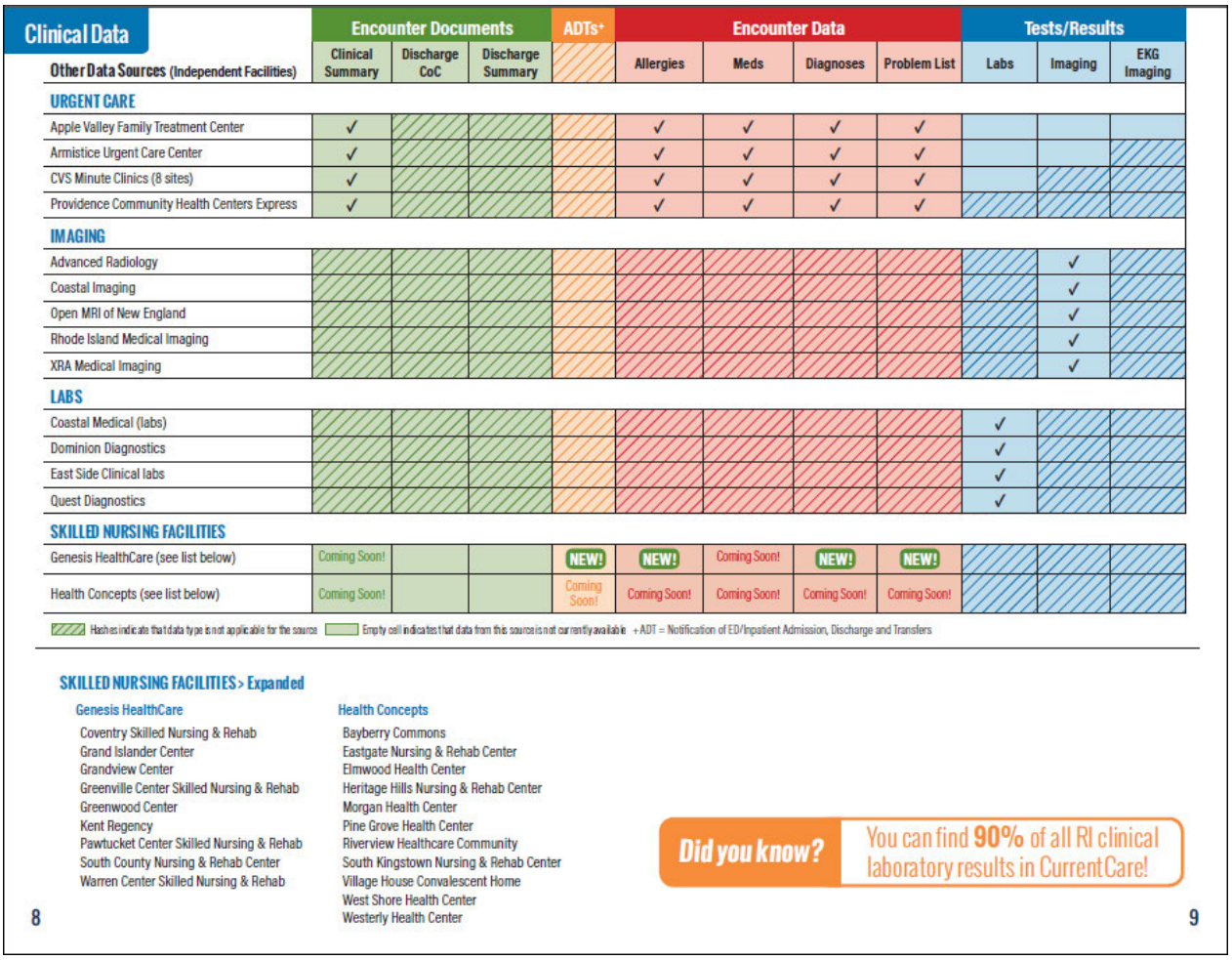


Clinical Data

Other Data Sources (Independent Facilities)	Encounter Documents: Clinical Summary	Encounter Documents: Discharge CoC	Encounter Documents: Discharge Summary	ADTs+	Encounter Data: Allergies	Encounter Data: Meds	Encounter Data: Diagnoses	Encounter Data: Problem List	Tests/Results: Labs	Tests/Results: Imaging	Tests/Results: EKG Imaging
URGENT CARE											
Apple Valley Family Treatment Center	✓				✓	✓	✓	✓			
Armistice Urgent Care Center	✓				✓	✓	✓	✓			
CVS Minute Clinics (8 sites)	✓				✓	✓	✓	✓			
Providence Community Health Centers Express	✓				✓	✓	✓	✓			
IMAGING											
Advanced Radiology										✓	
Coastal Imaging										✓	
Open MRI of New England										✓	
Rhode Island Medical Imaging										✓	
XRA Medical Imaging										✓	
LABS											
Coastal Medical (labs)									✓		
Dominion Diagnostics									✓		
East Side Clinical labs									✓		
Quest Diagnostics									✓		
SKILLED NURSING FACILITIES											
Genesis HealthCare (see list below)	Coming Soon!			NEW!	NEW!	Coming Soon!	NEW!	NEW!			
Health Concepts (see list below)	Coming Soon!			Coming Soon!	Coming Soon!	Coming Soon!	Coming Soon!	Coming Soon!			

Hashes indicate that data type is not applicable for the source. Empty cell indicates that data from this source is not currently available. +ADT = Notification of ED/Inpatient Admission, Discharge and Transfers

SKILLED NURSING FACILITIES > Expanded

Genesis HealthCare
- Coventry Skilled Nursing & Rehab
- Grand Islander Center
- Grandview Center
- Greenville Center Skilled Nursing & Rehab
- Greenwood Center
- Kent Regency
- Pawtucket Center Skilled Nursing & Rehab
- South County Nursing & Rehab Center
- Warren Center Skilled Nursing & Rehab

Health Concepts
- Bayberry Commons
- Eastgate Nursing & Rehab Center
- Elmwood Health Center
- Heritage Hills Nursing & Rehab Center
- Morgan Health Center
- Pine Grove Health Center
- Riverview Healthcare Community
- South Kingstown Nursing & Rehab Center
- Village House Convalescent Home
- West Shore Health Center
- Westerly Health Center

Did you know? You can find **90%** of all RI clinical laboratory results in CurrentCare!

8 9

A.7.3 The Role of MMIS in the Current Environment

RI's Medicaid Management Information systems (MMIS) is an integral part of the state's HIT Initiatives. It supports and integrates with MAPIR, given that RI is part of the 13 state collaborative that uses MAPIR as the state's EHR incentive program attestation system. Additionally, the MMIS system generates a quarterly file of all Medicaid enrollees and sends to RIQI so that it can be matched against the CurrentCare enrollee file. This allows the state to track the percent of Medicaid beneficiaries that are enrolled in Currentcare and to try and determine strategies for increasing enrollment in Currentcare among the Medicaid population. Currently about 38% of Medicaid beneficiaries are enrolled in Currentcare. This compares to 46% for the state overall. Lastly, MMIS is used to support the state's All Payer Claims Database (APCD) known as HealthFactsRI by submitting all of the Medicaid claims the APCD.

A.7.4 State Activities to facilitate HIE and EHR Adoption

State activities to facilitate HIE and EHR Adoption are described in Sections A.5 and A.6

A.8. State HIT Coordinator

RI's State HIT Coordinator position is located within EOHHS and facilitates the coordination of Health IT initiatives across the state that supports health care reform through promoting the adoption of Electronic Health Records, participation in the EHR Incentive Program, development, implementation and the utilization of the Health Information Exchange Services (HIE) across the state as well as the development of the state's All Payer Claims Database and other relevant HIT projects. The State HIT Coordinator also serves as the state's point of contact to Federal Agencies focused on HIT and/or HIE initiatives. In addition, the Health IT Coordinator is the EOHHS liaison for the state's Regional Health Information Organization (RHIO) the Rhode Island Quality Institute (RIQI).

> The State HIT Coordinator is working to align statewide HIT efforts across and within Rhode Island, and oversees the state's Medicaid EHR Incentive Program and its program manager. The State HIT Coordinator also oversees the state's SIM HIT work plan, and serves on additional multi-agency HIT projects, such as the APCD Interagency Staff Workgroup and the Provider Directory Advisory Commission.

The operational functions of the Rhode Island Medicaid EHR Incentive program have been under the supervision of the State HIT Coordinator at EOHHS Since 2013. At that time, the decision was made to separate the audit function for this program and have the audit function be the responsibility of EOHHS's Office of Program Integrity (see chart below).

A.9. Medicaid Activities That May Impact the EHR Incentive Program

> There are numerous efforts underway to continue to align and coordinate various initiatives and efforts within Medicaid and across EOHHS. EOHHS has recently clarified its organizational structure and has created a Data and Analytics Team which is separate from the its Implementation and Policy Team. Although the HIT work cuts across both areas, The State HIT Coordinator position is officially part of the Data and Analytics Team. While the state HIT coordinator works with many initiatives across EOHHS, its agencies and the state, locating the position within this unit helps to foster ongoing efforts to assure that HIT and HIE efforts continue to influence and become a critical aspect of all Medicaid activities and vice versa. As RI Medicaid moves towards implementing Accountable Entities and its heath system transformation system program, Medicaid staff have consulted with the EHR incentive program manager, the State's SIM HIT specialist (who also reports to the state HIT Coordinator) and the state HIT Coordinator. Additionally, RI's Medicaid program will be undergoing a MITA 3 self-

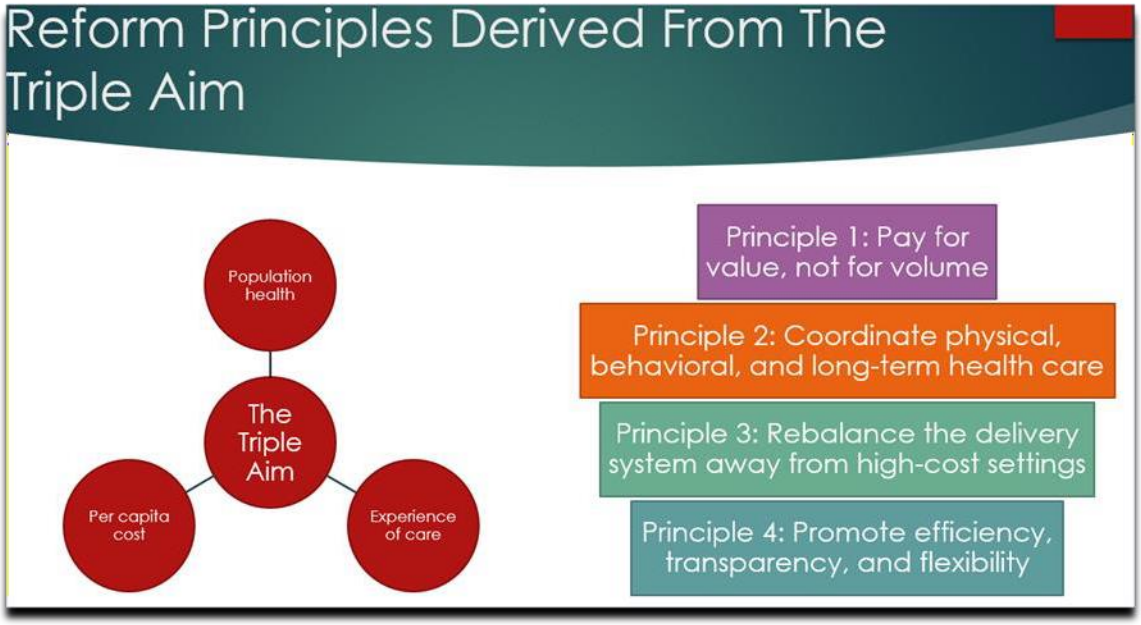
assessment and the above HIT staff will participate where appropriate to assure the EHR incentive program is represented and any resulting work is accomplished over time

A.9.1. RI Bridges (UHIP)

RI Bridges (formerly known as Unified Health Infrastructure Project, UHIP) is designed to be a single technical platform that supports eligibility and enrollment for Medicaid, the state's health insurance exchange known as HealthSource RI, and most recently many of the other state's human service programs (SNAP, TANIF, etc.) by collecting consumer information in a through a centralized system. RI Bridges is an interagency initiative between HealthSource RI, the Executive Office of Health and Human Services (EOHHS), and the Office of the Health Insurance Commissioner (OHIC). Although there have been significant unanticipated challenges during the initial deployment of RI Bridges, these challenges have not impacted the operations of the HER Incentive program. Moreover, a significant amount of time and energy is going into improving and fixing the aspects of RI Bridges that were not working correctly.

A.9.2. Re-inventing Medicaid in Rhode Island

In February 2015, Governor Raimondo established the Working Group for Reinventing Medicaid with the duty to review the current Medicaid program and recommend specific quality improvement and cost containment measures for redesigning Medicaid[11]. The group identified many shortcomings of the current program, including misaligned incentives across the delivery system, fragmented and non-coordinated service delivery, and an inability to address social determinants of health, that ultimately result in high costs and less than favorable outcomes. The Working Group's final report includes ten goals based on four principles: 1) Pay for value, not for volume; 2) Coordinate physical, behavioral, and long-term healthcare; 3) Rebalance the delivery system away from high-cost settings; and 4) Promote efficiency, transparency, and flexibility. The working group recognized the importance of leveraging Health Information Systems and Technology to ensure the delivery of high quality and coordinated care. Goal 7 of the working group specifically addresses this and indicates that specifically states that "One of the most critical pieces to achieving a successful coordinated care health system is the proper use of available health information technology. Rhode Island is leading the way in supporting patients and providers with CurrentCare, a secure electronic network that gives authorized medical professionals access to their enrolled patients' most up to date health information, including lab results, medications, and hospital visits". Given the above, the report sets a target such that **75 percent of Medicaid members will be enrolled in CurrentCare by 2018**. And states that the "broadening adoption of sophisticated electronic health record (EHR) systems will also help provide this kind of connectivity and data-sharing". Additional information is available at: http://reinventingmedicaid.ri.gov/



A.10. State Laws and Regulations

In the 2016 state legislative session, a bill was passed to amend the Health Information Exchange Act of 2008. Two changes were made to the law. The first changed clarified that individuals enrolled in Currentcare can choose to have their Currentcare record shared with individuals they designated such as caregivers and family members. The second change allowed for health insurers to see their members' CurrentCare data for the purpose of care management or quality improvement activities.

Also in the 2016 state legislative session a bill was passed to amend the prescription drug monitoring program (PDMP) law to allow for data to be shared with technology vendors. Before this change, EHR and/or HIE integration with the PDMP through electronic interfaces was not legally allowed under the statute. With this law now in place, HIE integration activities with the PDMP are ramping up.

Other than the above, there have not been any statutory changes or regulations that impact the implementation of EHRs or the EHR Incentive Program. EOHHS requires no additional authority to administer the EHR Incentive Program other than to obtain budget authority to use and distribute EHR incentive program funding and for a state match appropriation.

A.11. HIT/HIE Activities that Cross State Borders

Rhode Island participates in the 13 state MAPIR collaborative, which has and continues to provide significant cost savings to the state for administrating the EHR Incentive Program. This multi-state effort allows information sharing including best practices among the partner states.

Additionally, Rhode Island's HIE, CurrentCare, has begun to engage in cross border data sharing efforts. As a result of some hospital mergers, RIQI is now collecting data from Connecticut (Lawrence & Memorial hospital and soon to be acquired by Yale New Haven hospital). RIQI is also working with the SouthCoast health system (in southeastern MA) to obtaining ADT feeds as well as other data. Such efforts expand the utility and value of CurrentCare not just for Rhode Island but to the other states as well.

A.12. State Immunization Registries & Public Health Surveillance Databases

The Rhode Island Department of Health (RIDOH) is an active and valuable partner to EOHHS in advancing state HIT goals and in supporting the public health components of the EHR Incentive Program. RIDOH has the electronic capability to support some but not all of the public health meaningful use objectives that providers are asked to attest to. The Department of Health's Public Health Informatics and Meaningful Use Coordinator works with and coordinates across the various public health programs which a related public health meaningful use objective. Additionally, RIDOH is evaluating if other program databases, such as the states birth defects registry could be considered "other registries" under the meaningful use program. The status of each of current public health programs which EPs or EHs need to attest to are described below.

A.12.1 Accepting Electronic Immunization Files

KIDSNET is a secure child health database links and integrates information from 10 different public health program for every child born in Rhode Island as well as those that move to the state. It serves much like an HIE for child public health programs. In addition to serving as the state's childhood immunization registry, it also contains relevant individual level data from vital records, all 3 newborn screening programs (metabolic, hearing and developmental screening), birth defects registry data, home visiting data, early intervention data, and data from the supplemental nutrition programs for women, infants and children (WIC). KIDSNET allows pediatricians, other authorized health care providers, and RIDOH program staff to access information to ensure that all children in Rhode Island are as healthy as possible by getting the right health screenings and preventive care at the right time.

Currently, KIDSNET, which is RI's immunization registry can only accept data on patients 18 or younger. KIDSNET accepts Immunization HL7 2.5.1 messages from provider's EHR systems, and has and continues to onboard EPs and EHs if they vaccinate at least one patient 18 years old or younger in reporting period. All other EPs and EHs can claim an exclusion for the immunization registry component of the public health objective. RIDOH is seeking to expand the immunization registry component of KIDSNET, turning it into a life-long registry as well as create bidirectional interface with CurrentCare.

EOHH works closely with the KIDSNET program staff. Designated KIDSNET staff oversee and manage the immunization onboarding process, and communicates progress with the EHR Incentive Program Manager so that he can verify for the programs pre audit process which EPs and EHs have been able meet applicable Meaningful Use requirements. KIDSNET staff request that registration of intent for the Immunization meaningful use Stage 2 objective is received no later than the 60th day from the start of the eligible provider or hospital's reporting period. The RIDOH staff work with the EP or EH to test that HL7 immunization messages are successfully being sent to KIDSNET and to establish and/or maintain ongoing immunization HL7 messaging.

A.12.2 Electronic Syndromic Surveillance Files

The RI DOH has the capacity to accept Syndromic Surveillance data from emergency room hospital admissions in HL7 format as they occur. Hospitals who want to participate register their intent with the RIDOH and work with the RIDOH staff through the onboarding process to test and send ongoing HL7 syndromic surveillance messages.

A.12.3 Electronic Lab Results and Reportable Diseases

RI DOH's Division of Infectious Disease and Epidemiology currently accepts electronic laboratory results data related to reportable diseases from eligible hospitals and clinical laboratories in HL7 format. Similar to syndromic surveillance, registration and test messaging or ongoing submission of reportable diseases is required.

A.12.4 Cancer Registry

RIDOH's cancer registry is maintained by the Hospital Association of Rhode Island (HARI). There is no electronic reporting capability at this time, although there have been some initial discussions about how to collect the depth and complexity of data that HARI currently collects on paper. One of the major barriers which is diminishing over time is that the EHR adoption rate among oncologists is perceived to be lower than other specialists.

A.13. State HIT-Related Grants

A.13.1. SIM Test Grant

In 2015, Rhode Island was one of 24 states to receive a State Innovation Model (SIM) Test Grant from the federal Centers for Medicare and Medicaid Services (CMS). The state received $20 million with the expectation that the funds would be used to transform the way healthcare is delivered and paid for – and to improve Rhode Island's population health. SIM's funds are investing in three categories of activities: improving the primary care and behavioral health infrastructure, engaging patients in positive health behaviors and self-advocacy, and expanding the ability of providers and policy makers to use and share data. Rhode Island's SIM believes that by transitioning to a system of value-based care that addresses social and environmental determinants of health, SIM can support Rhode Island in enhancing the physical and behavioral health of the population, improving the experience of care, and spending our healthcare dollars in a smarter way.

Rhode Island SIM is led by a team of staff from several state departments, including the Executive Office of Health and Human Services, and its member agencies and programs (Medicaid, and the Departments of Health (DOH), Human Services (DHS), Children Youth and Families(DCYF), and Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH). SIM participants also include the Office of the Health Insurance Commissioner (OHIC), and HealthSource RI (HSTI). SIM is officially governed by a Public- Private Steering Committee made up of a diverse range of stakeholders, including providers, insurance carriers, patient advocates, and community organizations. We encourage stakeholders and interested individuals to participate in the various working groups that SIM convenes on specific topics related to healthcare transformation.

The vision of the Rhode Island SIM Test Grant represents the desired future state resulting from a transition to value-based care in the state. Our vision statement, borrowed from the Triple Aim, reads: Continuously improving Rhode Islanders' experience of care (including quality and satisfaction), enhancing the physical and behavioral health of all Rhode Island's population, and smarter healthcare spending. There is a strong focus on HIT investments as part of the SIM grant, including several of the projects discussed in other sections of this plan (statewide common provider directory, care management dashboards, HealthFacts RI eCQM Reporting and measurement system, EOHHS EcoSystem). SIM has also provided funding for EOHHS to hire an HIT Specialist who works as part of the SIM staff team but is supervised by the State HIT Coordinator and is located within EOHHS. The HIT Specialist assists the State HIT Coordinator with the management of HIT contracts under SIM and strategic planning for HIT within Rhode Island.

A.13.2. Department of Health Grants

The RIDOH receives numerous grants to help support public health information systems, especially for Electronic Lab Reporting (ELR), Syndromic Surveillance, and the Prescription Drug Monitoring Program (PDMP). EOHHS coordinates with RIDOH through the Meaningful Use/Public Health Informatics Coordinator to align HIT strategies across EOHHS agencies.

A.13.3. SBIRT Grant

The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) received an $8,291,875, 5 year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) which began in October 2016. This grant will promote the use of Screening, Brief Intervention, Referral and Treatment (SBIRT) throughout Rhode Island, with a goal of conducting 250,000 screenings over the five-year period.

A key component of this grant included investing a portion of the funding in Health Information Technology that allows for screenings to be conducted electronically and shared among treating providers. BHDDH is collaborating with SIM to contract with a consolidated operations vendor for both SBIRT and SIM Community Health Team (CHT) activities. The contracted vendor will conduct an HIT assessment of the capabilities of SBRIT screening sites (PCP practices, EDs, CHTs etc.). This will help inform how to appropriately and effectively capture and share SBIRT screening results. The current plan is to build a screening tool module as part of the HIE, but this strategy is subject to change if the implementation sites do not have a need for the module (already capture this data in their EHR etc.).

B. To-Be Assessment – The Future HIT/HIE Landscape

B.1. Five Year Vision Overview

Over the next five years, we are looking to achieve five main goals:

1. Continue a positive trend toward adoption of Electronic Health Records, with 90% of hospitals, primary care providers, and outpatient specialists adopting CEHRT by 2021.
2. Achieve a 75% meaningful use conversion rate among RI Medicaid Eligible Providers (from AIU to MU) by 2021.
3. Continue to increase the number of Rhode Islanders participating in Currentcare, with:
   A. 90% of Rhode Islanders having a Currentcare record by 2021
   B. 80% of all Medicaid beneficiaries with a Currentcare record by 2021.
4. Continue to increase the value of the Health Information Exchange by increasing awareness and use of the CurrentCare, with 75% of physicians knowing of and using CurrentCare by 2021.
5. Continue to expand Health Information Exchange services and increase the interoperability among the state's HIT services (includes HIE services and EHRs and other HIT systems such as APCD) where appropriate, with a goal of increasing efficiency and utility while decreasing duplication.

B.2. HIT Future Initiatives (includes several beginning to be implemented)

EOHHS is continuing to invest in state HIT systems that help support practice transformation, inform policy, and support operational needs for the state and the community. The goal is to support the data and analytics needs of both state agencies and the healthcare community. Additional detail of the enhancements to be made follows.

B.2.1 Electronic Clinical Quality Measurement Reporting and Feedback System

Clinical Quality Measurement (CQM) reporting and feedback is a critical component in quality improvement efforts, in transforming the health care system and has and continues to be an important part of the Medicaid EHR incentive program. Providers often have to report similar yet different quality measures to measure the same outcome, and they need to report them to numerous different entities. Providers, ACOs and facilities in Rhode Island have noted the number and variety of reporting requirements is likely to continue to increase under a value based payment system.

Numerous sources support the assumption that analytic resources and capabilities are insufficient in the state to empower providers and organizations to most effectively use their ever-growing and extremely valuable data. Furthermore, numerous organizations in the state are working toward creating their own quality measurement systems that will meet their needs, including payers, practices, and practice transformation organizations.

Given the above environment and given that the initial SIM HIT plan had anticipated the need for a statewide eCQM reporting and feedback system, the SIM Steering Committee convened a SIM Technology Reporting Workgroup to verify whether a statewide Clinical Quality Measurement reporting and feedback system was needed and would be desired in RI.

The SIM Technology Reporting Workgroup was comprised of payers, quality improvement organizations, the state's designated HIO, data and analytic staff from large provider practices, and a few practicing providers and state staff. After several meetings the SIM Technology Workgroup recommended funding the development of a statewide electronic quality reporting system with the goals of:

- Improving the quality of care for patients and driving improvement in provider practices by giving feedback to providers, provider organizations and hospitals about their performance based on quality measures
- Producing more valuable and accurate quality measurements based on complete data from the entire care continuum
- Leveraging centralized analytic expertise to provide valuable and actionable reports for providers and to drive improvements in population health
- Reducing the duplicate reporting burden upon providers and provider organizations by having a common platform for reporting
- Publically reporting quality measurements in order to provide transparency and support patient engagement in making informed healthcare decisions
- Using existing databases, resources and/or systems that meet the various stakeholders needs, rather than building from scratch

The workgroup has determined that in order to achieve these goals, the system would need serve as a common platform for quality measurement, quality improvement, and reporting. It would need to be able to accomplish the following, at a minimum:

- Easily capture data (electronically) in a standard and consistent manner (no extra work for providers)
- Calculate measures based upon the SIM harmonized measure set and relevant national measure sets, including those used in the meaningful use program

- Become a Qualified Clinical Data Registry (QCDR) to allow the reporting of results directly to CMS, NCQA, and the payers, and fulfill additional reporting obligations on behalf of providers
- Benchmark providers at the provider level and the provider organization level
- Consist of detailed, individual level data from multiple sources matched to a single person, and make that data available to providers to improve individualized care while appropriately protecting confidentiality
- Share analyses and results back to providers, provider organizations, payers, state government, and, eventually, the public

This project will begin to focus on collecting data from practices with Electronic Health Records (EHRs). In addition, the state must set up a governance structure with adequate community and provider engagement to determine what data is shared to whom and how it is shared. EOHHS just has issued and RFP for the development and ongoing operations of this system. EOHHS envisions the system will be developed and operated by a third party data intermediary, especially given the system is anticipated to serve all providers for a number of different programs over time. As this work gets underway, there will be an analysis of how to streamline work and interface this system with MAPIR such that over time providers do not need to enter their MU CQMs into MAPIR.

B.2.2. HealthFacts RI Conversion

The first phase of HealthFacts RI, Rhode Island's All Payer Claims Database went live in February 2016. This tool contains the most comprehensive collection of health care claims data that the state has ever had. It will illuminate how Rhode Islanders use the healthcare system, the effectiveness of policy interventions, and the health of our communities.

The most powerful feature of HealthFacts RI is that it collects, organizes, and analyzes health care data from nearly all major insurers who cover at last 3,000 individuals in Rhode Island. The existing RI APCD is currently a stand-alone database, hosted and stored externally by an outside vendor and managed by multiple state agencies.

Given the analytic value the APCD has to Medicaid, specifically including EOHHS/Medicaid to integrate data-driven, evidence-based programmatic decisions into its daily Medicaid operations, and to ensure sustainability for effective reform initiatives beyond SIM funding. EOHHS has proposed to leverage these existing APCD processes and infrastructure by converting the RI APCD into a Medicaid IT Enterprise module, through the following activities:

- Enhancing the database with data elements for Medicaid Program monitoring, reporting and evaluation purposes;
- Converting the existing database into a Medicaid IT Enterprise module and moving it into a state-operated, Medicaid IT Enterprise environment;
- Transitioning management and control of the database solely to the Medicaid Program, with operational support from other agencies; and
- Building new analytic capabilities that are not yet developed, using Medicaid Enterprise tools.

The HealthFacts RI module will enable analytic functionalities necessary for RI Medicaid to meet federal reporting requirements, measure provider performance to evaluate payment reform initiatives, operate the Program more efficiently, and achieve Medicaid's health system transformation goals. Specifically, the database will provide:

- Comprehensive views of former and current Medicaid beneficiaries through longitudinal, cross-payer utilization, provider, and payment data;
- Payment and utilization comparisons for provider benchmarking and rate restructuring purposes;
- Data to evaluate and inform healthcare reform efforts for Medicaid in relation to SIM initiatives;
- Comparative cross-payer utilization and payment data to evaluate Section 1115 Medicaid Research and Demonstration waivers, in accordance with federal requirements; and
- Access to an integrated, longitudinal utilization and payment dataset for Medicaid-Medicare dual-eligibles.

Additionally, the database will streamline Medicaid analytic capabilities by:

- Re-using the Medicaid Enterprise-wide, state-licensed analytic platform;
- Building nimble, broad and deep Medicaid analytic capability that is currently unavailable to Medicaid program managers and decision makers; and
- Leveraging cost effective, interoperable data architecture that promotes future integrations and avoids vendor lock-in by installing the database in a state-hosted Enterprise environment and maximizing Medicaid state and federal investments to date.

With access to claims, enrollment and provider data from multiple payers, as well as value-added enhancements that will be applied for Medicaid purposes, the HealthFacts RI module will allow for necessary reporting and analytics, such as comparative analysis and benchmarking that would otherwise not be possible.

B.2.3. Statewide Common Provider Directory

The ability to obtain and keep up to date information on health care providers including practice and payer affiliations is very challenging. Numerous health care organizations in the state create and maintain their own provider directory to the best of their ability but there is often no consistent method for keeping the data updated, resulting in different data in different organizational provider directories. Furthermore, many provider directories do not track affiliations and organizational hierarchies which are needed for analytics such as when providers were under operating under different payment models.

As part of the State's SIM HIT plan, the state proposed to develop a single statewide common provider directory. Since RI's state designated entity for HIE, RIQI was already well underway in building a provider directory with affiliations and organizational relationships for CurrentCare, EOHHS decided to contract with RIQI to leverage the work done to date, and have them serve s as the vendor to build maintain and operate the Statewide Common Provider Directory. This directory will consist of detailed provider demographics as well as identifying both relationships between providers and organizations and organizational hierarchies. This organization hierarchy being built into the provider directory is unique and is an essential aspect to being able to maintain not only provider demographic and contact information, but their relationships to practices, hospitals, ACOs, and health plans. The intent of this project is to:

- Allow for the mastering and maintenance of provider information and organizational relationships to only occur once in the state in a central location;
- Use the web-based tool that was developed to allow a team of RIQI staff to manage and maintain provider import files and data survivorship rules, error check flagged inconsistencies or mapping questions, and manually update provider data or enter new providers;
- Develop and institutionalize the appropriate data mastering and maintenance system to allow for useful data export via a flat file.
- Provide iterative data exports that allow for hospitals, payers, and state agencies to incorporate the centrally-mastered provider data within their own databases; and
- Increase ability for consumers and providers to have up to date and accurate information about providers by having a consumer portal and a provider portal.

As part of EOHHS contract, RIQI will increase the number of provider files imported and provided a number of data exports. Discussion are underway to assess the ability to import Medicaid provider's files as well as to determine how Medicaid can use the data from the statewide common provider directory and Medicaid's ability to receive and use a mastered file.

Other deliverables include operational support to continuously master and verify the data, provide required infrastructure support, and develop a public facing website. The public facing websites are still under development and the anticipated go-live mid-2017.

Over the next five years, the provider directory will need to be continually developed to serve a growing number of needs, including but not limited to support accurate referrals, serving as a single update point for providers that then disseminates updates to interested parties, supporting analytics activities, and helping consumers choose insurance plans.

B.2.4. Integrated Health and Human Services Data Ecosystem

Rhode Island lacks a modern system for integrating person-level information across our EOHHS agencies (Medicaid, the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH), the Department of Children, Youth and Families (DCYF), the Department of Human Services (DHS), and the Department of Health (RIDOH)), and then turning that holistic information into action. These agencies share a mission of providing essential services, safety net support, and public health promotion, while often serving the same people and collecting large amounts of data on these beneficiaries. If we are able to combine and better analyze these data, we can obtain critical information about the needs of our population, the effectiveness of our programs, and how to responsibly spend valuable public resources.

With funding from SIM, Rhode Island will take informed, project-based steps that reflect iterative learning and sophistication to build our new data ecosystem using the agile processes and methodology in order to integrating data across our agencies and driving policy with those data. Rhode Island is planning a light, simple and adaptive solution.

Our approach will build on an ongoing assessment of our entire data ecosystem, which includes our current Medicaid data warehouse and our processes for collecting, managing, and using data, as well as lessons learned from other states. Funding from SIM may be able to support some of the initial work for this project, though it is anticipated that the ecosystem will become another modular component of RI's Medicaid enterprise system and will support answering policy and evaluative questions needed to improve the work of the Medicaid program. EOHHS is beginning to identify what if any existing infrastructure can be leveraged for this purpose, and how this system would relate HealthFacts RI and Currentcare given differing and fairly stringent statutory requirements around sharing of PHI. EOHHS anticipates issuing and RFP to select a vendor to create the ecosystem data warehouse by collecting only the required data elements to answer a specific policy question. Using the agile methodology will allow each policy question to serve as the basis for an agile sprint. EOHHS will also

work with the vendor to develop a complete modernization staffing and structure plan to guide the state during the transition to full ownership of the solution.

B.2.5. Care Management Dashboards

Transforming the health care system requires providers to know when their patients have been admitted to or discharged from the ED or Hospital. The ability to promptly share this information is expected to facilitate targeted, appropriate clinical interventions, improve care coordination and reduce re-admissions. Given this, and the work that RIQI already had engaged in not only to send a hospital alerts via direct messaging to a provider, but also to create a real time dashboard showing a providers which of their patients were in a RI ED or acute care hospital in real time, EOHHS has decided to sue SIM dollars to funding RIQI to implement this real-time communication system at all of between Rhode Island's Community Mental Health Organizations (CMHOs), as well as for the Medicaid's community health team which is coordinating are for Medicaid FFS beneficiaries. RI's CMHOS are mutually responsible for the care of approximately 8500 publicly insured individuals with serious mental illness This prompt information sharing is expected to facilitate targeted, appropriate clinical interventions, improve care coordination and reduce re-admissions. Ongoing funding for operation of the dashboard will come through a PMPM cost to the CMHCs.

B.2.6. Ongoing HIE Development

RIQI, serving as the State's designated HIE Entity is continuing to develop additional technology tools to assist healthcare providers increase their efficiencies in providing care to patients throughout their care continuum. Some of these tools are separate frim Currentcare and can be implemented for an entire provider's patient panel not just those enrolled in CurrentCare) using BAA agreements. In doing so RIQI seeks to leveraging the existing technical infrastructure used for CurrentCare but firewalls off the data where needed. Additionally, RIQI is continuously working to increase in HIE enrollment, adoption and use as noted below.

The work to integrate various data types from RI's adult behavioral health hospital into the CurrentCare environment continues with an emphasis on enabling Observation Result (ORU) or Lab related data. This effort, funded by an ONC Interoperability Grant, will also integrate Admission Discharge and Transfer (ADT) and Continuity of Care Documents (CCDs) from the behavioral health hospital. The initial phase of this project includes a technical effort to incorporate these data-types into CurrentCare for enrolled individuals. The subsequent phase of this project will be to engage Community Mental Health Organizations (CMHO's) to adopt the use CurrentCare (such as CurrentCare Viewer and Alerts), especially given that they often have a hard time getting this data from the behavioral health hospital in a timely manner.

RIQI is also focusing on working with long term and post-acute care facilities (LTPAC). While there was a previous effort to engage with LTPACs (around 2010 funded by special Medicaid Transformation grant dollars) the majority of LTPACs did not have EHRs and the effort to engage them with CurrentCare was not able to be sustained after grant

funding ended. Considering that most LTPACs have an HER, and that there are primarily two EHR vendors supporting RI's LTPACs, technical discussions with Matrix Care and Point-Click-Care are underway to integrate ADT data along with CCDs into the CurrentCare environment. This effort is funded by a separate ONC grant. integration of these data types from these organizations is an integral part of Transition of Care (TOC).

Although, RIDOH serves as the regulator for the RI's Regional Health Information Organization (RHIO), EOHHS is the state agency which now designates the State's RHIO and oversees the RHIO designation contract. the designation contract outlines annual deliverables to encourage continued development and these deliverables align with those that need to be met for HIE enhanced match funding. These deliverables are organized in 5 categories and evolve each year to include new focus areas and identified high priority needs. The 5 categories are:

1. Increase Enrollment in CurrentCare
2. Increase Data Availability in CurrentCare
3. Improve Data Access and Utilization
4. Engage Consumers by Leveraging the CurrentCare Infrastructure
5. Leverage CurrentCare for Population and Public Health
6. Maintain CurrentCare

Setting deliverables for RIQI each year will continue. As some deliverables are completed, state leadership determines new goals to be added under the above categories. This process ensures that the state is constantly encouraging innovation and further development for CurrentCare and able to monitor the progress over time.

B.2.7. Expanded HIE Activities

EOHHS is requesting enhanced Federal Financial Participation for several projects to further enhance HIE services in Rhode Island under the expanded opportunities in SMD #16-003. This includes the following projects which are also detailed in RI's IAPD-U that was submitted in December and is pending approval:

- **Advanced Emergency Department Alerting -** Embed HIE data into the EHRs of all hospital EDs in Rhode Island so that the data can be easily accessible to ED providers and to have the HIE data pre-analyzed so that it can alert to ED providers to patients at risk of certain conditions like substance use disorders. All hospitals in RI are already sending ADT data on all patients (not just those enrolled in CurrentCare) to the Rhode Island Quality Institute, the state's designated Health Information Organization (HIO). These data are shared under HIPAA Business Associate Agreement with RIQI, and go beyond the consent-based HIE to include all

patients with treating relationships to the hospitals. The embedded data will consist of an alert flag in the ED tracker board which will highlight PDMP information, treating relationships with PCP or community mental health organizations, ED utilization history, relevant clinical history, and risk modeling based upon the design requested by clinicians in the ED.

- **Connecting the Statewide EMS Reporting System to the HIE** - Establish a bi-directional connection between the statewide EMS reporting system operated by the Department of Health and CurrentCare in order to assist with the transition of care from the EMT to the hospital as well as inform the PCP and other providers. Implementing this functionality will require funding to support RIDOH in paying their EMS software vendor to establish a bi-directional connectivity which would allow EMTs to access information from CurrentCare on patients they are responding to, as well as have run report data electronically included in CurrentCare and therefore be accessible to the patient's medical providers through a variety of methods (alert, CCD sent to a providers EHR, CurrentCare viewer).
- **Connecting the Medicaid Community Health Team to the HIE -** Establish a data feed from CareLink's Eccovia Solutions ClientTrack system to CurrentCare which sends care management records automatically to the HIE once documentation is complete
- **Develop, Implement and promote the use of an Electronic (e)Referral System -** Design, develop and implement an electronic referral system to facilitate referrals between EPs and EHs and other Medicaid providers which is connected to or leverages the provider directory's underlying data and infrastructure.
- **Expand RI's Current Childhood Immunization Registry to Include Adults –** Although the Rhode Island Department of Health (RIDOH) has had a childhood immunization registry since 1997, as of 2015, Rhode Island was one of only three states that does not include adults in its immunization registry. Currently EPs and EHs that do not administer vaccines to children or adolescents take an exemption for the immunization reporting MU objective.
- **Connect KIDSNET Immunization Registry to the HIE -** KIDSNET, RIDOH's integrated child health information system, which includes the childhood immunization registry; vital record birth data; newborn developmental, heel stick, and hearing screening information; WIC program data; and early intervention data does not interface or connect to CurrentCare. Creating some bi-directional exchange capabilities between KIDSNET, including the adult immunization registry, and the HIE would be facilitate the electronic data sharing to and from the immunization registry (providers could send the data to the HIE which could then share it with the statewide immunization registry or vice versa). Additionally, all of the other important health and social determinants data contained in KIDSNET could be integrated into CurrentCare for enrolled children,

making this data available to providers' EHRs through a bi-directional exchange with CurrentCare or helping to reduce provider portal overload and have the data be viewable through CurrentCare viewer instead of having to go to the standalone KIDSNET portal.

- **Develop a Registry Module for the HIE** - Build a registry module on the HIE which allows for extensible care coordination add-ons to the HIE data for public health and health information exchange purposes. This registry module will operate as a data sharing tool for HIPAA covered entities under a BAA with the RIQI as the RHIO, and thus will support data sharing for all patients, regardless of their participation status in the HIE.

The information that would be part of these registries are data types that EHRs struggle with capturing because they are not well structured or may be relevant only in Rhode Island. The data is essential to the effective treatment and care coordination of patients. Each data type mentioned above, is at its most basic level, an advanced form which requires a provider or patient to input information and in some cases may compute results for the user. Because of these commonalities, RI is proposing to build a registry module rather than individual registries for each use case. This registry module would be able to efficiently support all three proposed uses as well as future additional uses and could serve as a specialized registry for Meaningful Use.

The registry module will consist of an advanced form builder which would be used by the technical support staff to create forms for the users. The results of these forms can then be shared via Direct secure messaging or through the HIE if the patient is a participant. Three use cases are identified to support this initial build: SBIRT registry module to support the SBIRT grant discussed previously, eMOLST registry to support the RIDOH Medical Order for Life Sustaining Treatment form, and Shared Care Plan registry to support the work for community health teams.

B.2.8. Enhancements to CurrentCare for Me

Patient engagement is an important component of a transformed health care system and patient portals and other HIT tools can help support patients in actively monitoring their own health. Recognizing that patients may easily have numerous patient portals attached to different EHRs, and that patients may be interested in seeing what is in their Currentcare record, RIQI has worked with their software vendor to develop CurrentCare for Me (CC4ME). CC4ME allows enrolled individuals to access their Currentcare record and in the future to be able to add patient generated data such as family history, advanced directives etc. More specifically, RIQI is working to enable CC$ME to include:

- The ability to upload consumer generated data such as health assessments
- Digital health device data
- Advance Directives/MOLST documents
- Medical history.

- Test messages about Admission, Discharge or Transfer alerts for caregiver proxies.

RIQI is also considering including patient-centered shared decision making, advanced illness care planning and behavior change support tools. Tools being considered would be evidence-based incorporating readiness to change, social determinants of health and health confidence.

Lastly, RIQI is in the early conceptual design phase of a "No Wrong Door" approach to patient portals. This concept would allow patients to seamlessly navigate their multitude of patient portals without having to sign in to each portal separately.

B.2.9. Assisting Providers with Meeting Meaningful Use

Given that 2016 was the last year to register for the Medicaid EHR incentive program, there is no longer need to focus on bringing new providers to the EHR Incentive Program. Also, EOHHS has decided to end its contract with RIQI to provide technical assistance and outreach to Medicaid providers related to the Medicaid EHR incentive program. RIQI continuously offered its services and many Medicaid providers have already taken advantage of these services. With that said, the interest in these services was waning and it did not seem prudent to continue the contract. Providers needing assistance can still work with RIQI or other practice transformation organizations in the state on a fee for service basis. Additionally, other statewide HIT projects, such as the Electronic Clinical Quality Measurement Reporting and Feedback System and the Provider Directory, will support providers in meeting some of their Meaningful Use goals. The Medicaid EHR incentive program will continue to use the HIT Survey to achieve a greater understanding of the barriers to meeting Meaningful Use and strategize methods of assisting providers, especially where it may involve enhancements to our HIT infrastructure.

B.2.10. PDMP HIE/EHR Integration

With legislative changes in the 2016 legislative session, it is now legally allowable for Prescription Drug Monitoring Program (PDMP) data to be shared with providers and their EHR vendors. This has opened the door for integrations between the PDMP and CurrentCare, as well as between the PDMP and providers' EHRs. SAMHSA and CDC have both awarded grants to the RIDOH to facilitate some of this connectivity.

In collaboration with EOHHS, RIDOH will be working with RIQI to use the CurrentCare infrastructure to connect the PDMP to EHRs for all the providers' patients, not just those enrolled in CurrentCare. This will dramatically reduce the expense to providers to connect to the PDMP and facilitate an efficient way to leverage existing technology. The

first connections are expected to be completed by September 2017, with a goal for continual grant-funded integrations through the end of 2018.

B.2.11. Future Development of MAPIR

Rhode Island will continue to participate in the 13 State MAPIR collaborative to support EP and EH attestations for the EHR Incentive Program. Since 2011, Rhode Island has participated in MAPIR and based on the recently CMS approved MAPIR IAPD, RI has been approved 90/10 funding until September 2018.

Our goal is to continue to participate in the MAPIR Collaborative until the program sunsets in 2021. Based on the value-added results we have experienced in the past six years; we are confident that the MAPIR collaborative will continue with CMS's support. We appreciate the support our MAPIR collaborative and MAPIR development team provides by ensuring release changes comply with statute and regulations approved by CMS. Typically, the MAPIR team has developed and deployed system modifications within a three to six-month timeframe. This includes system quality assurance testing both on the core and individual state levels.

Upgrades to MAPIR will follow the MAPIR collaborative schedule, allowing time for customizations if needed. Importantly, as the Electronic Clinical Quality Measurement Reporting and Feedback System is being considered and discussed amongst the collaborative.

B.2.12. Future HIE Governance Structures

The governance of Rhode Island's HIE is not anticipated to change significantly and continues to exist at several levels. RIQI is the state's designated RHIO has a board of directors compromised of a diverse set of health care leaders in the state including representatives from hospitals, systems, payers, private providers, employers, business community, consumer groups, long term and home health care and government (as ex office non-voting members). There are also some board level committees which then present full recommendations to the board for approval (operating, legal, nominating, sustainability). RIQI also has a number of community based advisory committees that make recommendations about Currentcare and other RIQI HIE services to RIQI leadership. These committees include consumer advisory, Currentcare advisory, Currentcare user group, provider directory advisory, and employer advisory.

RIQI also works closely with state officials. There are weekly calls with the state HIT coordinator and SIM HIT specialist to monitor projects, align initiatives and troubleshoot any areas needed. Meeting are also being set up between the public health informatics

coordinator and RIQI staff to monitor specific projects under way the RIDOH. On a quarterly basis RIQI leadership meets with cabinet level state officials including the Secretary and Deputy Secretary from EOHHS, the Health Insurance Commissioner, the Director of Health and the state Medicaid director. These meetings are to assure that the state's priorities and RIQI's priorities and strategies align at all levels. Lastly, the SIM steering committee which is the governing body for SIM project introduces another form of governance over those projects which are from the SIM HIT plan. The SIM HIT plan clearly aligns with the other statewide HIT efforts being supported and driven by EOHHS. Although the HIE governance may sound cumbersome it is important to remember that RI is a small state and many of the same individuals serve on these various committees, and that the State HIT coordinator, the SIM HIT specialist, the RIDOH public health informatics coordinator and the Medicaid EHR Incentive Program Manager all work closely with each other, with RIQI, and with other community partners to keep the HIT projects aligned, synergistic and avoid any duplication.

B.2.13. Next 12 Months: Improving CEHRT Adoption

There is considerable pressure on payers to support practice transformation, value-based payment arrangements, and patient centered medical homes. This pressure continues to trickle down to the providers who are seeking CEHRT to remain relevant with providers. It is also likely that MACRA and MIPS payment adjustments will serve as a major motivator.

Although EOHHS will not be funding any specific practice transformation efforts to encourage CERHT adoption, there are numerous activities occurring in the state, including several of the RIQI grants described earlier, SIM initiatives, activities undertaken by HIC on care transformation and activities undertake by HealthCentric Advisors as the QIN-QIO. RIQI and HCA serve as experts in the state to help support how adoption of CEHRT supports practice transformation efforts and to provide extra assistance to providers who may not know where to start.

B.2.14. Leveraging FQHC HRSA HIT/EHR Funding

All FQHCs in the state have adopted Certified EHR Technology. If HRSA HIT/EHR funding opportunities occur over the next five years which encourage collaborating with state agencies or the HIE, EOHHS will support the FQHCs in applying for the opportunities and achieving their goals where possible.

B.2.15. Assessing and Providing Technical Assistance to Medicaid Providers - see B.2.9

B.2.16. Populations with Unique Needs

As part of the states SIM test grant, an initial population health plan has been developed. This plan is a work in progress and is seeking to integrated information related to social determinants of health into numerous projects including some HIT initiatives (Currentcare for Me, provider directory, ED alerting etc.). Additionally, there has and continues to be a strong focus on integrate the delivery of physician and behavioral health and this includes needing to having this information integrated in EHRs and The state's HIE. RI was the first and perhaps still the only state to have been able to integrate behavioral health and substance use data into CurrentCare to assure appropriate care is delivered to this population. As HIT efforts continue to address the needs of various unique populations, this section of the plan will be updated further.

B.2.17. Leveraging HIT-Related Grant Awards

Wherever possible, Rhode Island has leveraged HIT-related grant awards from federal agencies, and also sought IAPD funding for applicable items. Program staff at EOHHS, OHIC, RIDOH, and BHDDH are constantly on the lookout for additional funding opportunities which may support meeting state goals.

RIQI has also been extremely successful at receiving federal and private foundation grant awards that have supported continual HIE development, practice transformation activities that support adoption to CEHRT, and innovation opportunities that expand the breadth of our HIE work.

In the coming year, EOHHS will also be seeking foundation grants to support the 10% state match of some of the HIE projects described in section B.2.

B.2.18. Anticipated Needs: State Laws and Regulations

EOHHs, OHIC and RIDO have initiated discussions related to changing RI's consent model for Currentcare. The model being considered is referred to as "consent to view/disclose" and would allow all providers to send their data to Currentcare and individuals would need to consent to who the data could be disclosed to. Currently there is a legal analysis underway at both the state and RIQI to determine if statutory changes are needed to the HIE act of 2008, if regulatory changes are needed or if it is just a matter of

policy changes. If statutory changes are needed, EOHHs is prepared to work with the governor's office to have legislation introduced to achieve this. Such a change would allow Currentcare to be leveraged a used for a significant amount of public health purposes including serving and a CEHRT component for public health reporting of MU requirements.

In the 2016 legislative session, a bill was passed which requires the update and administrative simplification of all existing regulations. This will include updating the HIE and HealthFacts RI regulations. This opportunity will be used to clarify and simplify some components of the regulations which have proven to be unintentional barriers. For example, the HealthFacts RI regulations have limited the sharing of certain data elements which do not necessarily put privacy at risk and could prove valuable to analysts.

There has been some initial discussion with SIM technical assistance staff at ONC about the integration of claims and clinical records. There are legislative barriers which prevent this integration in Rhode Island, notably that HealthFacts RI is a de-identified data set with extensive sharing restrictions, and the HIE is only a partial clinical data (due to having slightly less than half of the state enrolled). These restrictions would not necessarily serve all the needs that could be met with an integrated claims and clinical system on all patients (such as risk assessment on an entire patient panel).

EOHHS will continue to discuss the options for legislative change with stakeholders in the community and determine if there is consensus to seek these types of changes to our HIT legislation.

C. Administrative Oversight of the EHR Incentive Program

C.1. Verification of Eligible Providers

C.1.1. Eligible Providers

Eligible providers are categorized into two broad groups- Eligible Professionals (EP) and Eligible Hospitals (EH). To receive the initial payment, EPs and EHs must adopt, implement or upgrade (AIU) to Certified EHR technology, meet a specified Medicaid patient volume, and be one of the eligible professionals or facilities. To receive subsequent annual payments, EPs and EHs must demonstrate meaningful use of the EHR technology. The eligibility requirements and the state's methods for verifying that they are met follows final rule CFR42 requirements.

C.1.2. Eligibility Requirements and Verification of Eligible Professionals

Eligible Professionals are individuals who are fully enrolled in the Rhode Island Medicaid program, are free from sanctions, do not render more than 90% of their covered services in a hospital (non-hospital-based); and are licensed or eligible to practice their profession in the state as one of the following:

1. A physician,
2. A pediatrician,
3. A dentist,
4. A certified nurse-midwife,
5. A nurse practitioner, or
6. A physician assistant who practices in a rural health clinic (RHC) that is led by a physician assistant.

To receive an incentive payment, eligible professionals must first register at the CMS Registration and Attestation System (R&A) and indicate that they want to apply for a Rhode Island Medicaid EHR Incentive. The R&A then sends a B6 file to the Rhode Island MMIS. It is then matched to the Medicaid provider's NPI to locate whether an active Medicaid provider record exists within the MMIS. Between MAPIR and the provider account in the MMIS, it is determined whether the provider is an eligible professional (EP) based on the Medicaid provider type and specialty.

If a match is found, MAPIR creates a record and sends an email to the provider email address provided in the B6 file to invite the provider to attest for the RI Medicaid EHR

Incentive. This email has a link for the eligible professionals to log into MAPIR via the MMIS web portal. If a match is not found, the provider will not receive an email from our system and will not be able to enter an attestation. Our program administrative staff will contact the provider and inform them that they need to register as a Medicaid provider in order to participate in the program. In the first few years in the program, this was typical with a Nurse Practitioners who do not bill their services directly to Medicaid, however, once the provider completes the Medicaid registration in the MMIS, the provider will be able to participate in the program. This approach strengthens our ability to prevent fraud and abuse and prevent anyone from access the system without validity.

C.1.3. Eligibility Requirements And Verification of Eligible Hospitals

Eligible hospitals are acute care hospitals, critical access hospitals and children's hospitals. Like EPs, eligible hospitals first register at the National Level Registry. The R&A determines if the hospital/applicant is an eligible hospital based on the following:

- Acute Care and Critical Access Hospitals- have a CMS Certification Number (CCN) with the last 4 digits of 0001 – 0879 or 1300 – 1399.
- Children's Hospital-have a CCN with the last 4 digits of 3300 – 3399.

Once the hospital has been determined eligible, the R&A sends the registration to the eligible hospital. It is matched by MAPIR to the MMIS like the EPs and a record is created in MAPIR if a match is found.

C.1.4. Identification of Hospital-Based Providers

As described in C.1.2, the MMIS provider record is used to determine whether or not eligible providers are hospital-based by confirming the provider type and specialty.

C.1.5. Verification of Overall Content of Provider Attestations

As described in B.10 the EHR Incentive Program Manager oversees the execution and operations of the RI Medicaid EHR Incentive Program. This position is primarily responsible for ensuring that providers are meeting the CMS guidelines as set forth in the final rule. More specifically this position oversees program outreach activities, policy development and implementation of MAPIR to support the various stages of MU attestation, and pre-payment review and approval. The Program Manager is currently provided by Conduent (previously Xerox Healthcare) and is contracted by EOHHS.

C.1.6. Communication to Providers

Communication to providers about the EER incentive program happens through various channels and is primarily the responsibility of the program manager. Outreach to providers occurs through a monthly Medicaid provider newsletter which is developed by HPE team who is RI's Medicaid fiscal agent. The EHR Incentive program manager, HPE staff that support MAPIR, and RIQI will develop articles or communicate program updates about MAPIR and the EHR incentive program as part of the Medicaid Monthly newsletter.

Under a contract with EOHHS (aka, RI Medicaid), RIQI has been providing technical assistance to Medicaid providers by assisting them to meet and attest to meaningful use. They provide ongoing communication, conduct training and webinars to the provider community. Additionally, RIQI supplies a great deal of information about meeting AIU and meaningful use that is available from their website's provider knowledge center section. EOHHS also has a dedicated website pages that provides up to date program information to the provider community. Lastly, if there is an important announcement or deadline, the program manager will send a blast email to those participating in the program to inform them of important events, program changes and deadlines.

C.2. Calculating Patient Volume

C.2.1. Patient Volume Requirements for Eligible Professionals

To qualify for an incentive payment EPs must meet the required Medicaid patient volume or medically needy volume if practicing predominately at a Rural Health Clinic or a Federally Qualified Health Center. Patient volume is calculated by dividing the number of Medicaid encounters by the total number of patient encounters over a continuous, 90-day period in the prior calendar year, or, effective, 1/1/2013 for the 2013 program year and beyond, a 90-day period in the preceding 12 months during attestation.

For the purposes of this program, an encounter is any one day where Medicaid paid for all or part of the service or Medicaid paid the co-pays, cost-sharing, or premiums for the service. However, effective January 1, 2013 for program year 2013 and beyond, that definition was expanded to include all encounters with a Medicaid enrolled patient, paid or unpaid. EPs can attest to the required patient volume using encounters attributable to Medicaid that are services rendered on any one day to a Medicaid enrolled individual regardless of payment liability. This will include zero pay claims and encounters with patients in Title XXI funded Medicaid expansions and in the state of Rhode Island that includes CHIP program encounters. CHIP encounters are not identifiable because they do operate separately from the Medicaid Title IX program. As noted in the diagram below Eligible Professionals are required to meet Patient Volume thresholds.

Non Hospital Based Eligible Professionals	90-day Medicaid Patient Volume Percentage Requirement
Physician	30%
Pediatrician	20%
Dentist	30%
Certified Nurse Midwife	30%
Nurse Practitioner	30%
Physician Assistant in a Rural Health Clinic so led by a Physician Assistant	30%

Note: Eligible professionals practicing at least 50% of the time in an RHC or FQHC can include "needy individuals" in the Medicaid numerator when calculating patient volume. EPs that practice at an RHC or FQHC can use encounters attributable to needy volume. EPs have the option to choose whether they will use their individual patient volume or their group's patient volume to determine if they have met the required Medicaid patient volume.

C.2.2. CHIP Patient Volume Reduction for Program Years 2011 & 2012

As is the case in many other states, Rhode Island's Medicaid program beneficiaries utilize the same identification cards for Medicaid and CHIP, so there is no way for a provider to distinguish which program the beneficiary is in. As noted in the final rule (page 44489 - 44490 of the Federal Register/Vol. 75, No. 144/July 28, 2010/Rules and Regulations), the methodology for estimating Medicaid patient volume is based on Medicaid and not CHIP enrollment. To address this inability to distinguish Medicaid/CHIP enrollment on the basis of available data, CMS has prescribed an approach to adjust patient volumes for impacted providers who apply for the program.

At the start of the Medicaid EHR Incentive program, the final rule required state programs to implement a rule that would reasonably remove any Children's Health Insurance Program (CHIP) activity from the Medicaid Patient Volume because CHIP was not considered a Title IX program. The CHIP reduction would be applied to the Medicaid Patient Volume numerator. This reduction was applied to all EPs, however those providers who did not provide care to children could elect to not apply the reduction should it place them below the patient volume threshold requirement and provide proof that the patients they encountered were not younger than 18 years.

For 2011 & 2012 a CHIP reduction factors were developed using the total number of CHIP child beneficiaries in each county and the total number of Medicaid child beneficiaries in each county. By dividing the two amounts, percentage reductions were computed for each of the five Rhode Island counties. The 2011 and 2012 percentages were based on enrollment data as of December 31, 2010 and December 31, 2011, respectively.

RI CHIP Reduction Rates		
County	**2011**	**2012**
Bristol	12.3%	18.3%
Kent	13.1%	17.6%
Newport	11.4%	14.8%
Providence	10%	12.7%
Washington	11.3%	16.8%

CHIP Reduction Example:
Over a 90-day period in the previous calendar year a pediatrician claims to have a total of 2,468 encounters and 747 of those encounters were for Medicaid beneficiaries. The practice is located in Providence County and will incur a CHIP reduction of 10%. The following calculation will be performed to determine the adjusted Medicaid Patient Volume requirement:
747 - (747 * 10%) = 672
672/2,468 = .2722 = 27%
27% adjusted Medicaid Patient Volume will qualify the pediatrician for 2/3 of the total incentive payment amount.

In 2013 CMS issued FAQ 7537 (click on hyperlink) that allowed states without a standalone CHIP program can include CHIP encounters as part of their Medicaid patient volume. As a result, the CHIP reduction was eliminated for program on or after 2013.

C.2.3. Attestations using Individual Patient Volume

Each attestation the provider can decide to determine program eligibility on an individual or group basis. The individual option is based on the provider's NPI entered in MAPIR and their program year application. As noted earlier, providers must meet a 30% (20% for Pediatricians) Medicaid Patient volume threshold.

MAPIR will allow the provider to enter the 90-day period from either the previous calendar year or twelve months preceding the attestation date. In addition, MAPIR will ask the applicant to enter patient volumes for all the provider's practice locations for the specified time period and whether each location utilized certified EHR Technology. To complete the Patient Volume attestation, the applicant is asked to enter the Medicaid encounters (numerator) and total encounters (denominator) for the individual provider. MAPIR will not allow the application to proceed if the percentage falls below the threshold. However, MAPIR rounds upward if the amounts fall within 0.5%.

C.2.4. Attestations using Group Patient Volume

As noted in the final rule § 495.306 (h), clinics or group practices are permitted to calculate patient volume at the group practice/clinic as defined in the Medicaid MMIS. The MAPIR system allows enrollees to enter their patient volumes using their group practice affiliation based on the Group's NPI as defined in the MMIS.

The practice EPs must use only one methodology (Individual, Group or Patient Panel) in each program year. The practice group must use the entire practice's patient volume and not limit it in anyway. Should an EP practice in both group and outside the group practice, then the practice patient volume will include only those encounters associated with the group.

C.2.5. Attestations using Patient Panel

On a case by case level, we will allow providers to attest using a patient panel approach. The EP will need to submit a patient roster listing for a 90-day period that shows more than 30% of patients on their panel are Medicaid beneficiaries.

While MAPIR is scalable to allow patient panel attestations, we have elected not to activate this option because of its infrequency. However, should we find patient panel attestation increase in occurrence, we would then consider activating this option in MAPIR. In addition, if a provider or provider group find it easier to submit a patient

panel, they can submit a request in writing and we will accept a patient panel listing as part of their patient volume attestation.

C.2.6. Volume Requirements for Eligible Hospitals

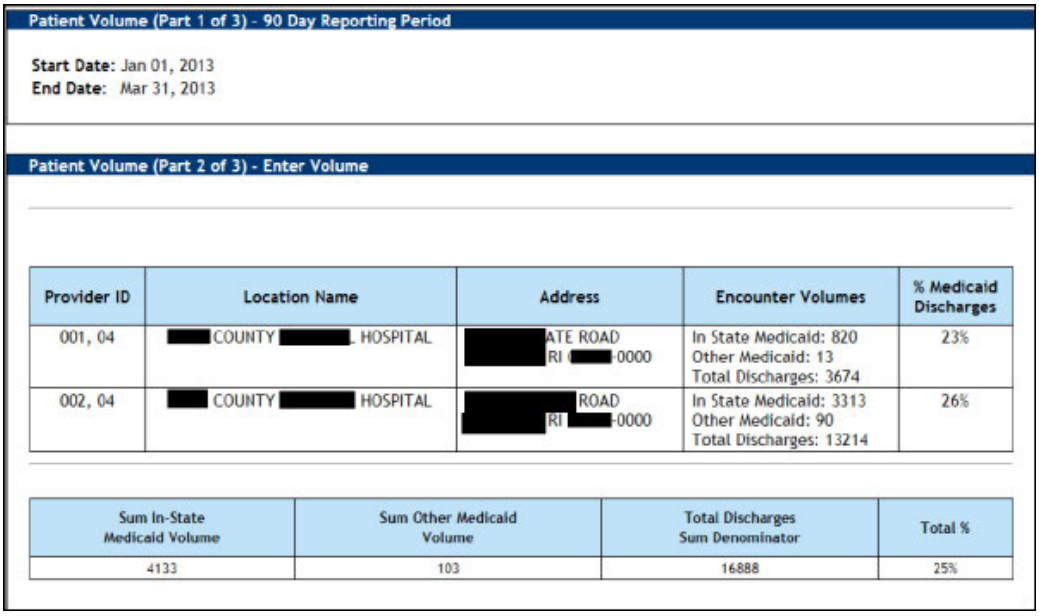
Acute care hospitals and critical access hospitals must have an average length of patient stay of 25 days or fewer and have at least a 10% Medicaid patient volume. Children's hospitals do not have a patient volume requirement.

The calculation for patient volume is the Total Medicaid patient encounters in any representative continuous 90-day period in the previous hospital fiscal year / divided by Total patient encounters in that same 90-day period] * 100. For purposes of calculating hospital patient volume, the following are considered Medicaid encounters:

- From 2011 – 2012, services rendered to an individual per inpatient discharges where Medicaid or a Medicaid demonstration project under section 1115 paid for part or all of the service or part of their premiums, co-payments, and/or cost-sharing.
    - However, starting in 2013, as long as the individual was an active Medicaid beneficiary at the time of discharge, they would be considered a Medicaid encounter;

- From 2011 – 2012, services rendered to an individual in an emergency department on any one day where Medicaid or a Medicaid demonstration project under section 1115 of the Act either paid for part or all of the service; or part of their premiums, co-payments, and/or cost sharing.
    - However, starting in 2013, as long as the individual was an active Medicaid beneficiary at the time at the time when services were rendered to an individual in an emergency department, they would be considered a Medicaid encounter;

Eligible Hospitals can attest a combined patient volume for both inpatient discharges and services rendered in an emergency department or for any one previously mentioned categories as long as the numerator and denominator are calculated in the same manner. On the following page is a screenshot of an example of a Hospital Patient Volume attestation from MAPIR.



Patient Volume (Part 1 of 3) - 90 Day Reporting Period

Start Date: Jan 01, 2013
End Date: Mar 31, 2013

Patient Volume (Part 2 of 3) - Enter Volume

Provider ID	Location Name	Address	Encounter Volumes	% Medicaid Discharges
001, 04	[redacted] COUNTY [redacted] HOSPITAL	[redacted] ATE ROAD [redacted] RI [redacted]-0000	In State Medicaid: 820 Other Medicaid: 13 Total Discharges: 3674	23%
002, 04	[redacted] COUNTY [redacted] HOSPITAL	[redacted] ROAD [redacted] RI [redacted]-0000	In State Medicaid: 3313 Other Medicaid: 90 Total Discharges: 13214	26%

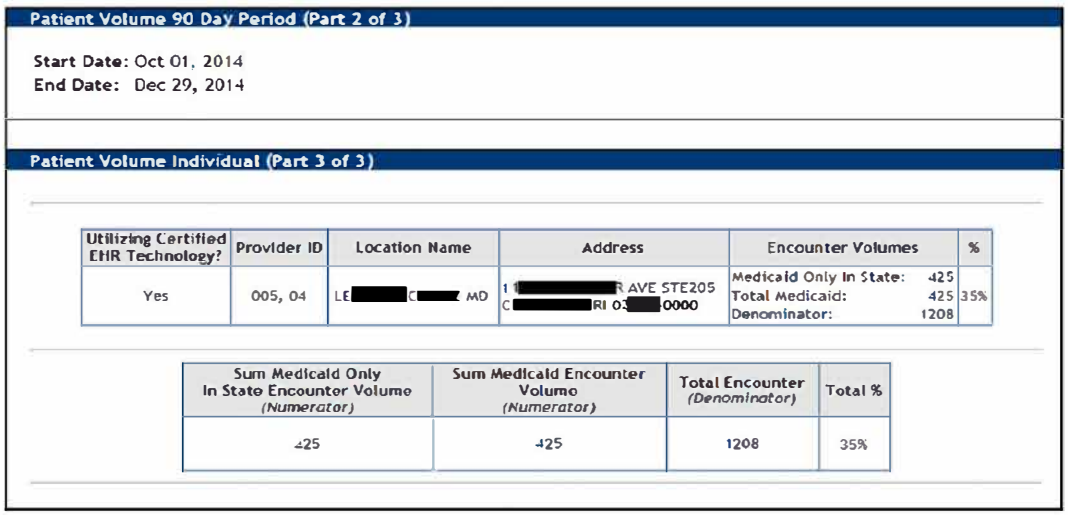
Sum In-State Medicaid Volume	Sum Other Medicaid Volume	Total Discharges Sum Denominator	Total %
4133	103	16888	25%

As noted on our SMHP Addendum submitted on January 15, 2016, Eligible Hospitals will attest on a calendar year basis starting in 2015. In previous years, EHs attested meaningful use based on the Federal Fiscal Year (October – September). As a result, our program will accept 2015 meaningful use attestations with patient volumes from October 1, 2014 to December 31, 2015.

C.3. Verifying Patient Volume

C.3.1. Verification of Patient Volume for Eligible Professionals

Whether an application has an individual or a group patient volume entry, each application is required to enter a 90-day Medicaid patient volume amount and a 90-day total patient volume amount. The screen shot below is an example of the patient volume entry screen for an application:



Patient Volume 90 Day Period (Part 2 of 3)

Start Date: Oct 01, 2014
End Date: Dec 29, 2014

Patient Volume Individual (Part 3 of 3)

Utilizing Certified EHR Technology?	Provider ID	Location Name	Address	Encounter Volumes	%
Yes	005, 04	LE[redacted] C[redacted] MD	1 [redacted] R AVE STE205 C[redacted] RI 0[redacted] 0000	Medicaid Only In State: 425 Total Medicaid: 425 Denominator: 1208	35%

Sum Medicaid Only In State Encounter Volume *(Numerator)*	Sum Medicaid Encounter Volume *(Numerator)*	Total Encounter *(Denominator)*	Total %
425	425	1208	35%

Once the application is submitted a data query request is sent to MMIS for the 90-day patient volume period based on an individual or group practice attestation. The Patient Volume query counts total encounters for attesting provider in Rhode Island's MMIS database, which consist of 'Fee for Service' and 'Managed Care' Medicaid claims data. The query used varies by attesting provider application type; EP/EH/EP-Individual/EP-Group. Encounter calculations are further refined to insure only unique data points are observed within attesting provider's given Patient Volume date range.

As further defined in our Audit Strategy, this first level of review compares the query results against the "Medicaid Only In State" amount to determine if the amounts align. Should the amounts not align, the next step is to request a detailed patient volume listing from the provider or provider group that reflects their 90-day patient volume attestation. A detailed patient volume listing is usually requested for provider types that submit claims under a supervising physicians in which the query cannot effectively return a reasonable or auditable amount. Circumstances in which cause disparities with our first level of review are typically from

- Behavioral Health Providers who bundle their claims and all service dates (encounters) cannot be counted.
- Nurse Practitioners and Certified Nurse Midwives may bill under a supervising physician.

- Providers who bill on a Global Billing rate are likely to have more encounters than what was planned for billing.

More claims are submitted because amounts could be billed to a supervising physician, claims are bundled common to behavioral health providers.

During the prepayment review process, the patient volume listings are evaluated to ensure that the patient volume meets the threshold requirements. We also perform a sample validation of Medicaid beneficiaries from this listing to confirm the patient was active at the time of the encounter date. A second level of patient volume listing review is also performed by the Program Integrity group when a patient volume falls below the 30% or 20% threshold or if it is within 3% above the threshold.

C.3.2. Verification of Volume for Eligible Hospitals

The administrative staff verify that acute care hospital meets the average length of stay of less than 25 days' requirement by using the cost reports submitted to Medicaid for rate setting purposes.

Similar to Eligible Professional Patient Volume attestations, MAPIR query counts total encounters for attesting provider in Rhode Island's MMIS database, which consist of 'Fee for Service' and 'Managed Care' Medicaid claims data. The query used varies by attesting provider application type; EP/EH/EP-Individual/EP-Group. Encounter calculations are further refined to insure only unique data points are observed within attesting provider's given Patient Volume date range.

The query results are compared to the attestation during the pre-payment review process. Similar to the EP attestation, a patient volume listing is requested if the query result does not align to the amounts on the MAPIR attestation screen. This listing will be evaluated to ensure that the patient volume meets the threshold requirements. We also perform a sample validation of Medicaid beneficiaries from this listing to confirm the patient was active at the time of the encounter date. In addition, a second level of patient volume listing review is also performed by the Program Integrity group when a patient volume falls below the 10% threshold or if it is within 3% above the threshold.

C.3.3. Verification That Eligible Professionals Meet the Practices Predominantly Requirement

In most cases, our FQHC's meet the initial 30% Medicaid patient volume requirements. However, if there is an instance where they need to use the practice predominately option to meet the 30% requirement, we will request a "Needy Individual" patient volume listing from the provider or provider group for the given 90-day patient volume period. This list will be used to validate this portion of the patient volume requirement.

C.3.4. Verifying AIU – Adopt, Implement or Upgrade Certified EHR Requirements

MAPIR accepts provider attestations for the AIU component of the incentive payment. During registration, MAPIR requires providers/applicants to attest that they have adopted, implemented or upgraded to a certified EHR technology and to provide a valid EHR certification number. MAPIR verifies the certification number through an interface with Office of the National Coordinator's (ONC) Certified Health IT Product List (CHPL). If the certification number is invalid, MAPIR will not allow the application to proceed.

Providers are also required to upload copy of a business record that demonstrates the provider has purchased or contracted with a third party the EHR system. The administrative team reviews the business record during prepayment review before authorizing payment.

A business record for the documentation for ***purchased*** systems must include the following elements:

- The provider's name
- The system name and version
- The financial obligation
- A timeframe for adopt, implement or upgrade

Examples of documentation for *purchased* systems are:

- Copy of a paid invoice from the CEHRT vendor;
- Executed upgrade agreements for which a cost and timeframe are stated;
- A CEHRT vendor letter ***only*** if it contains the provider name, the system name and version, the financial obligation, a timeframe for adopt, implementation or upgrade, and is signed by the vendor. The vendor letter in essence becomes a legally binding document such as a contract or agreement.

A business record for the documentation for ***"free"*** EHR systems may include:

- A copy of the license agreement with the CEHRT system.
- A copy of the EHR system's screen that displays at a minimum the provider's name and the name of the free CEHRT software.
- A vendor letter is acceptable if it contains the practice name and/or the provider's name; the name of the software and the version of the software.
- The "welcome email/letter" that is sent by the CEHRT vendor upon signing up.

A business record for documentation of arrangements in which the EHR system from another practice is used:

- A copy of the agreement between the owner of the system and the applicant indicating the name and version of the software
- A screenshot from the EHR system indicating the software's name and version

C.3.5. Verifying Meaningful Use Requirements

To receive payments for meaningful use eligible providers must demonstrate meaningful use of their EHR technology.

From 2011 – 2013 Meaningful Use Requirements were as follows:
EPs had to report on 20 of 25 Meaningful Use Objectives which include 15 core and 5 out of 10 menu measures for Stage 1, but for Stage 2 EPs had to report 17 core and 3 out of 6 menu measures. In addition, all meaningful use attestations required at least six clinical quality measurements (CQM) to be reported from the certified EHR technology.

EHs and CAHs had to report on 19 of 24 Meaningful Use Objectives which included 12 core measures and 5 out of 10 menu measure. In addition, all 15 CQM measures needed to be reported from their certified EHR technology. EHs who had attested for meaningful use via the Medicare EHR Incentive program were deemed eligible for the Medicaid meaningful use EHR incentive payment and can receive payments from both Medicare and Medicaid.

Meaningful Use reporting periods for the first year of MU reporting was for any 90-day period. Subsequent years a full year (365 days) of meaningful use reporting was required for each program year.

On December 15, 2015, Meaningful Use requirements were modified. CMS issued a final rule that reduced the meaningful use measure requirement for program years 2015 – 2017. The meaningful use measures were set to Stage 2 level requirements for all

meaningful use attestations, reduced the number of measures to ten and eliminated the menu set measures. For program year 2015, providers were able to attest for 90-days of meaningful use and if they were scheduled to do Stage 1 for 2015, they could attest meaningful use with alternate measures.

In spring 2016, MAPIR was upgraded to accept the 2015-2017 Modified Meaningful Use rule changes. An SMHP addendum for this change was submitted to CMS on February 9, 2016.

C.3.6. Proposed Changes to the MU Definition

There are no proposed changes to the MU Definition as permissible per rule-making at this time.

C.3.7. Verification of Providers' Use of CEHRT

As described in C.8., MAPIR verifies the certification number through an interface with Office of the National Coordinator's (ONC) Certified Health IT Product List (CHPL). If the certification number is invalid, MAPIR will not allow the application to proceed.

C.3.8. Collection of Providers' Meaningful Use Data

For the past 5 years, Rhode Island has contracted with HPE to provide MAPIR, the state level registration tool for the RI Medicaid EHR Incentive program. MAPIR is a web-based application that allows providers and/or their delegates to complete EHR Incentive Attestations. MAPIR was designed and developed by a thirteen multistate collaborative workgroup to accept applications and distribute payments to eligible providers.

We do not anticipate changing the method of data collection at this time, with the possible exception for the collection of electronic clinical quality measures which may be collected for some providers through the Electronic Clinical Quality Measurement Reporting and Feedback System described earlier.

C.4. Alignment of Data Collection and Analysis Processes

As mentioned above, as part of RI's SIM efforts, the state embarked on and facilitated a measure alignment process. the purpose of this initiative was to create a harmonized set of measures in order to streamline and reduce the total number of different measures providers need to report on. EOHHS contracted with Ballit Associates to facilitate the community process which engaged a large number of provider and payer stakeholders. In order to scope the project, the aligned measure set was developed to be used for by payers with providers in contracting. Representatives from Medicaid participated in this process and as a result there were some measures identified to be specific Medicaid measures. The process included looking at many existing measures sets used by providers including meaningful use (MU) measures. The final measure set include a core and a menu set of measures. Not all of the final measures chosen align with MU but many do. The menu set is updated annually and will continue to evolve over time. As described previously in this document, the state is also embarking in developing a ECQM reporting and feedback system which will obtain data directly from EHRs, calculate a variety of measures including the aligned measure set and all MU measures, benchmark and feedback the measures to providers and their organizations and send them to those agencies for whom they need to be reported to. This process will help to standardize data collection and analysis across program and in a manner which has not previously been done.

C.4.1. IT Systems Used to Implement the EHR Incentive Program

As described in C.12. Rhode Island uses MAPIR as its IT system to implement the EHR Incentive Program. MAPIR integrates with the state's Medicaid Management Information System (MMIS) and receives files from CMS' Registration and Attestation (R&A) system, a.k.a. the NLR (National Level Registry).

Eligible providers or their designees access MAPIR using Rhode Island's MMIS provider web portal. During registration they are asked to attest that they meet all the requirements for payment and to upload documentation that supports their attestation. The EHR incentive payment administrative team reviews the submitted documentation as well as other information that validates the provider's eligibility. The administrative team then authorizes or denies payment based on their review. MAPIR sends a file to the CMS R&A system for validation and payment approval. If the provider has been approved to receive a payment, the R&A validates the provider has not received payment in another state or from Medicare, and notifies the state to proceed with paying the provider. MAPIR then electronically pays the provider using the MMIS financial system.

The MAPIR system will provide the majority of the necessary technical functions to implement the EHR Incentive Program. MAPIR integrates with the State's MMIS and links to the CMS Registration and Attestation System (R&A). The R&A has the functionality to guard against duplicate provider payments.

Data transfers and interfaces between MAPIR, the R&A, and MMIS will determine provider applicant eligibility. Upon submission of a completed registration for a Medicaid EHR Incentive payment. Upon program administrative approval, the MMIS will issue the incentive payment to eligible professionals and hospitals once program regulations for payment have been met. Our MAPIR system will track and monitor application and payment information. MAPIR also communicates with registrants on the status of their application via an email address provided by the applicant.

MAPIR has an application user interface for providers who want to submit an EHR Incentive application and an administrative user interface for use by Rhode Island Medicaid EHR Incentive Program support staff. Providers have one point of access via the secure Medicaid Provider Portal. The portal is a communication, data exchange and self-service tool for the Rhode Island Medicaid provider community. Additionally, Rhode Island's Medicaid EHR Incentive Program staff is able to use MAPIR to track application and decision status, enter notes and upload electronic documents to provider applications, and if necessary, generate provider correspondence. When a payment approval has been made, a file (D16) is sent to the R&A, which will then confirm and register the payment from CMS and authorize the state to make the Medicaid EHR Incentive payment. To complete the application process, the MMIS generates an electronic EHR incentive payment that can be identified with a 247 reason code on the providers' RI Medicaid remittance advice.

C.4.2. IT & MAPIR System Changes for Implementation

MAPIR is configurable to our state's systems environment and is customized with state-specific requirements. In the next five years, MAPIR will need to upgraded to support any changes in the EHR Incentive Program requirements and potentially to connect to other new State HIT Infrastructure such as the clinical quality measurement reporting and feedback system.

C.5. IT Timeframe for Systems Modifications

Since 2011, the MAPIR collaborative and MAPIR development team ensure that release changes comply with statute and regulations approved by CMS and based on past experience, the MAPIR team was able to develop and deploy system modifications within a three to six-month timeframe. This includes system quality assurance testing both on the core and individual state levels.

Moreover, the collaborative conducts weekly meetings to discuss program changes and how they will be addressed within MAPIR. We also communicate any defects the system may have and the MAPIR development team will correct the problem within several weeks with a patch or upgrade.

C.6. Interface with the CMS NLR

The MAPIR systems' interface with the CMS NLR is complete.

C.7. Accepting Registration Data from the CMS NLR

The MAPIR system accepts registration data from the CMS NLR through a daily interface.

C.8. Websites for Enrollment and Program Information

MAPIR is a web-based application that assists providers with enrollment and attestation. The EHR Incentive Program provides other information to providers on the EOHHS website, available at:
http://www.eohhs.ri.gov/ProvidersPartners/ElectronicHealthRecordsEHRIncentiveProgram.aspx

C.9. Anticipated Modifications to the MMIS

There are currently no anticipated modifications to the MMIS that will impact the EHR Incentive. However, should an MMIS change impact MAPIR, the MAPIR Collaborative, the MAPIR development team and all local state MAPIR support teams are informed of any changes and address any MMIS or MAPIR issues that could arise.

C.10. Call Centers/Help Desks

Our Fiscal Agent, HPE, who oversees our MMIS administration and support, is available as a first level triage should providers have questions about access to MAPIR or program requirements. The program manager is the second level triage for issues that cannot be resolved by the first level. The program manager has technical support from HPE should back door corrections are needed for MAPIR and/or the MMIS.

C.11. Appeals & Administrative Redetermination

Providers may request appeals regarding eligibility determinations, incentive payments, and determinations regarding the demonstration of adopting, implementing, or upgrading and meaningfully using certified EHR technology using MAPIR.

Appeals will initially be handled via the re-determination function in MAPIR. Once a provider has followed the appropriate steps, the administrative staff will assess the information and render an Administrative Re-determination. Decisions that stand as originally rendered, yet are still disputed by the provider, will be referred to the Agency's Office of the General Counsel and required to follow the state's administrative procedure for formal appeals.

In most disputes an informal discussion is first recommended. This discussion allows the state HIT coordinator who oversee the EHR incentive program to discuss the situation with the provider and program staff and determine if there is any resolve within the confines of the federal program regulations. If the outcome is still unsatisfactory to the provider an informal and/or formal administrative appeals are offered. The informal appeal allows both parties along with legal counsel to present their case. Should the state render an unfavorable decision, a formal appeal can be requested in writing and within 15 calendar days of a written notice. The appealing party must send this written request to the Office of Appeals and include a "Request for a Formal Hearing" form (DHS-121). Should an unfavorable decision be rendered, the provider can pursue the final step and request the decision be appealed and entered by the hearing officer for judicial review. A complaint with the Superior Court must be filed within thirty (30) days of the date of the formal decision in accordance with RIGL 42-35-15.

C.12. Assuring that Federal Funding is Accounted for Properly

EOHHS has a fiscal unit and team that works to assure that all federal funding is accounted for properly. The EHR incentive program has its own federal as well as state match accounts and all charges for this program are charge to those accounts. There are processes in place so that when vendors such as HP or RIQI submit bills, a program person reviews and signs off on the bills prior to them being paid. Any staff, such as the state HIT Coordinator whose time is partially allocated to this program tracks their time in 15-minute increments as part of EOHHS Medicaid cost allocation.

C.13. Anticipated Frequency of EHR Incentive Payments

C.13.1. Process to Issue Incentive Payments

Payments are issued according to existing MMIS processes. EPs and EHs meeting program requirements will be paid an incentive payment unless they have been sanctioned or excluded from receiving payments or previously received payment from Medicare or another state.

The following table shows the activities and actors associated with issuing a payment.

Disbursing EHR Incentive Payments			
Activity	System Activity	Personnel Activity	Personnel Involved
Verify Payment Meets Requirement	Attestations information are verified against program requirements prior to submission and payment	EP or EH attest to meeting program requirements	Eligible Professional (EP), Eligible Hospital (EH), EHR Incentive Program Staff
Verify Assignment is Voluntary	With an electronic signature, MAPIR captures information for EPs who have assigned their incentive payment to verify that the assignment was voluntary.	The EP/EH attests at the SLR, MAPIR, if the payment is voluntary. If not, payment is withheld and EP/EHs can change Payee selection at the CMS R&A system	Eligible Professional, Eligible Hospital
Confirm Payment with CMS' R&A prior to disbursing payment	MAPIR interfaces with the R&A and sends a D16 payment notification file. MAPIR receives a payment confirmation (D18) to proceed with EHR Incentive payment. This activity prevents payments being made by another State or Medicare	Not Applicable	Not Applicable
Disburse Payment	MAPIR issues an electronic incentive payment via an MMIS Remittance Advice with a 247 Reason Code	Payee TIN/Assignee receives payment as noted on the EP/EH incentive application	Payee Assignee

C.13.2. Incentive Payments for Eligible Professionals

Eligible professionals can receive an annual payment over six years for the adoption, implementation and meaningful use of an EHR technology. Payments are made once in a calendar year, however EPs do not have to apply for payments in consecutive years and are allowed to skip payment years.

Eligible professionals can register to receive the payment directly or reassign payment to a Medicaid enrolled group provider with which they have contractual arrangement that allows the group to bill and receive payment for the EP's covered professional services.

The following chart displays the payment amount for AIU and meaningful use that is available during the program.

Payment Year	Maximum Payment	EHR Attestation Requirement
Year 1	$21,250	Adopt, Implement, Upgrade or 90 consecutive days of Meaningful Use
Year 2	$8,500	90 or 365 consecutive days of Meaningful Use
Year 3	$8,500	365 consecutive days of Meaningful Use
Year 4	$8,500	365 consecutive days of Meaningful Use
Year 5	$8,500	365 consecutive days of Meaningful Use
Year 6	$8,500	365 consecutive days of Meaningful Use
Total	**$63,750**	

Note: Due to program rule changes, Program Year 2014 & 2015 only required a demonstration of 90 days of Meaningful Use. In addition, annual payment amounts are reduced by 2/3 for pediatricians whose patient volume falls below 30%, but is over 20%.

For payment years two through six, EPs will attest to Meaningful Use according to the applicable rule. EPs will attest to two years of Stage 1 measures, followed by two years of Stage 2 measures. EPs that skip a year will also have two years at each stage. Requirements for subsequent stages have yet to be determined. The online application will be updated to comply with all changes in rule.

D.13.3. Incentive Payments for Eligible Hospitals

Incentive payments to eligible hospitals are based on a complex formula in which a base incentive amount of $2,000,000 for each hospital is modified by the number of Medicaid discharges, bed days and other factors. Eligible hospitals can receive incentive payments over 3 years. The allocation of the aggregate hospital incentive payment will be 50% in the first participation year, 40% in the second, and 10% in the third. Hospitals participating in multiple states must choose only one state to receive payments from. Additionally, hospitals meeting Medicare meaningful use requirements are deemed eligible for Medicaid incentive payments and can receive payments for both Medicare and Medicaid.

MAPIR calculates the incentive payment for hospital based on the data entered by the hospitals. For verification, the administrative staff compares the submitted data to the data taken directly from the hospital cost reports. Any discrepancies between the submitted cost report and what was entered in their MAPIR attestation are resolved before incentive payments are issued.

The Rhode Island Medicaid EHR Incentive Payment hospital aggregate incentive amount calculation will use the equation outlined in the proposed rule, as follows:

> (Overall EHR Amount) times (Medicaid Share) where **Overall EHR Amount** Equals
>
> {Sum over 4 year of [(Base Amount plus Discharge Related Amount Applicable for Each Year) times Transition Factor Applicable for Each Year]} times **Medicaid Share** Equals
>
> {(Medicaid inpatient-bed-days plus Medicaid managed care inpatient-bed-days) divided by [(total inpatient-bed days) times (estimated total charges minus charity care charges) divided by (estimated total charges)]}

The amounts for the above formula are pulled from the Eligible Hospital's cost report for the first year of participation and verified by the review staff prior to payment. Should the year's cost report data fields used to calculate the total hospital incentive be adjusted or corrected will require an update to the incentive payment amount. Each application year, MAPIR offers the attester to enter revised cost report entries and will automatically adjust the total EHR Incentive for the hospital.

C.13.4. Other Considerations

Not at this time.

C.13.5. Reporting Medicaid EHR Incentive Payments to CMS

Within each quarter, Rhode Island Medicaid EHR Incentive payments are report to the CMS 64 report. Payments to eligible hospitals, FQHCs and eligible professionals are reported separately.

C.13.6. Incentive Payment Recoupment

In the event RI Medicaid EHR Incentive program determines that disbursements have been inappropriately or inaccurately made, the existing refund process will be leveraged to recover the funds. MAPIR currently has the ability to perform an adjustment transaction to certain program year's application or to all program years the provider has participated. MAPIR will create a transaction file for the recoupment which will result in an Accounts Receivable (AR) record that will be associated with the appropriate provider. The provider would then be requested to directly refund the appropriate incentive amount. To date there have been no payment recoupments. This likely due to having implemented an intensive prepayment audit and verification process conducted by the EHR program manager. In several instances the program manager has had to recommend providers abort their application because they did not pass the prepayment audit process. this has occurred after the program manager has worked extensively with the provider to determine if they have sufficient evidence to pass the pre-audit. Examples of a provider have had to either be denied payment or abort their application include inability to verify and prove sufficient patient volume, or sufficient documentation for a security risk assessment.

C.13.7. Assuring the Recipient of Medicaid Provider Payments

MAPIR is our system that manages our RI Medicaid EHR Incentive program and is fully integrated with our MMIS. If a provider is not entered as an active Medicaid provider, they will not be able to apply for a RI Medicaid EHR Incentive. If a provider does want to apply, they will need to register as a Medicaid provider via the MMIS registration system.

C.13.8. Assuring Payments Used to Promote the Adoption of Certified EHR Technology

MAPIR validates each application of its ONC EHR certification during the application process. As previously mentioned, our program requests a copy of a paid invoice or written validation that the provider has access to the certified EHR technology. After payments are issued, we circulate electronic communication or provide events to educate our provider community on how they can meet meaningful use.

C.13.9. Dispersing EHR Incentive Payments through Medicaid Managed Care Plans

Usually on a bi-weekly basis, Rhode Island Medicaid electronically disperses the EHR Incentive payments directly through its MMIS system and does not disperse the payments through Medicaid Managed Care Plans.

C.13.10. Assurance that Calculations and Incentives Are Consistent with Statute and Regulations

With our 13-state MAPIR collaborative and access to our CMS regional manager, we are provided with solid guidance that assures we are in compliance with regulations. Rhode Island is very active with the Community of Practice programs, monthly CMS All-State calls and CMS quarterly and annual meetings. In addition, the program manager and the MAPIR collaborative share regulation information that come through the CMS listserv or during the proposed rule-making process.

In addition, our MAPIR collaborative and MAPIR development team ensure that release changes comply with statute and regulations approved by CMS. For instance, the upcoming 2017 release 6.0 will allow our provider community to attest to Stage 3 meaningful use regulations approved on January 1, 2017.

C.14. Role of Existing Contractors with Implementation

The relation of existing contractors with the implementation of the EHR Incentive Program is noted throughout this SMHP. In summary is a list of contractors and the services they implement for our program(s):

- HPE provides technical support for MAPIR and the MMIS.
- Conduent, formally known as Xerox Healthcare, provides EHR Incentive oversight and assures that the program meets regulations set forth by CFR42.
- Rhode Island Quality Institute (RIQI) provides support and outreach to our provider community and have been a great contributor to helping providers meet meaningful use with their certified EHR technology.
- HealthCentric Advisors assists us with understanding our HIT landscape with their bi-annual physician technology surveys.

C.15. Assumptions

CMS will continue to develop and support the National Level Repository, provider outreach and help desk support through the end of the program and that MAPIR will be able to continue to interface with the NLR

ONC will continue to certify CEHRT and EHR vendors will continue to develop their products and pursue certification

Sufficient state match will be appropriated to EOHHS to support the EHR incentive program.

HP will continue to serve as the Medicaid Fiscal agent. The current contract ends in December 2017 and there are three extensions before a re-procurement is required, unless the state chooses not to execute on an optional year. If the vendor changes the state will need to assess how to continue with the EHR incentive program.

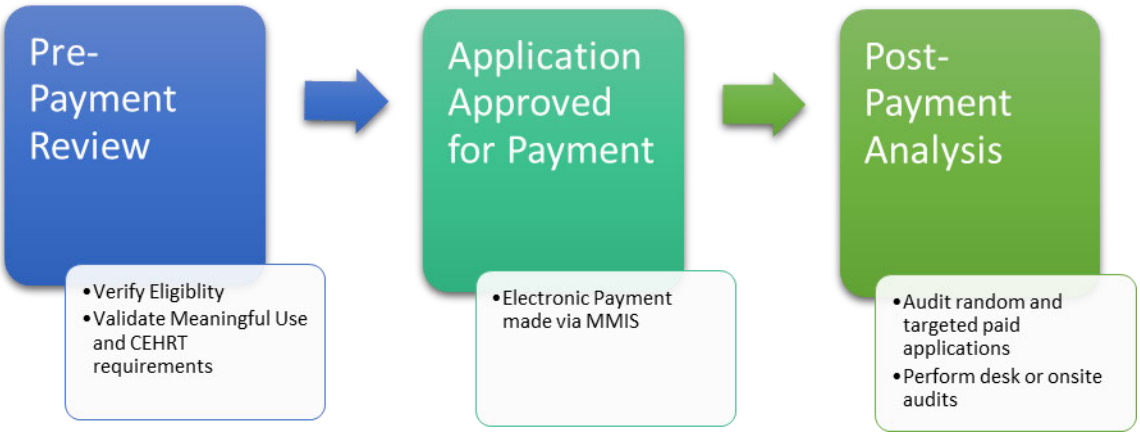
RIQI will continue to serve as the states regional health information exchange organizations and operate CurrentCare.

D. Audit Strategic Plan

D.1. Audit Methods

D1.1. Introduction

An effective audit capability is critical to the success of the EHR Incentive Program. This is evidenced by the numerous CMS requirements that either address the audit function by name, or by the many instances of "ensure," "assure," and "verify" used to describe the required level of substantiation. Rhode Island EOHHS operates a comprehensive set of audit activities, conducted during pre- and post-payment of Medicaid EHR Incentive applications. This approach provides the level of assurance necessary for the program changes and complexities. The following graphic presents the flow of audit activities surrounding the issuance of eligible professional and hospital incentive payments.



The overall set of business processes proposed for Rhode Island Medicaid EHR Incentive Program (as presented in Section C of the SMHP) reflect a balance between efficiently issuing incentive payments while not issuing inappropriate incentive payments, and protecting against fraud and abuse. The set of audit activities we perform make every attempt to understand both ends of this spectrum.

It is the intent for Rhode Island's Medicaid EHR Incentive Program audit activities to limit the burden of program participation on eligible professionals and hospitals. Reliance on pre-payment system verifications minimizes disruptions to the daily operations of program participants. On the same premise, post-payment audit verifications will also be carried out in the least intrusive manner possible. However, we will not sacrifice the due diligence necessary to gain an understanding of participant

compliance with program requirements. Our goal, for example, is to perform appropriate desk audits and if necessary conduct an on-site audit so that we can be the least intrusive to our provider community.

D.1.2. Implementation Steps for Audit

MAPIR provides numerous pre-payment verification and auditing controls and supports the level of program integrity as outlined per the CMS Guidelines. Specific program integrity features are embedded throughout the program's business processes and the audit sub-process also addresses requirements identified in the guidelines. Pre-payment system verifications in combination with random and targeted post-payment audits ensure overall program integrity. Rhode Island EOHHS' Program Integrity office will conduct post payment audit. The first audit strategy was submitted and approved in October 2013.

At the start of the RI Medicaid EHR Incentive Program, provider attestations were reviewed with a pre-payment review. While this increased the time for payment, issues were addressed in the forefront for each application, especially the obvious ones. Our mission with the program was to trust and validate and not to pay and chase. With an influx of applications to be reviewed by limited staff, we eventually submitted a formal Audit Strategy to CMS in early 2013 as noted in the chart below.

Audit Implementation Tasks	Start Date	End Date
MAPIR Installed – Start of Pre-Payment Review	July 2011	July 2011
Initiated Pre-payment review as defined within in SMHP	July 2011	Ongoing
SMHP Version 1 Approval	June 2010	January 2012
Audit Strategy Development and Approval Version 1	January 2013	April 2013
EHR Incentive Audit Staff hired by Office of Program Integrity	March 2013	June 2013
Random and Targeted Desk Audits	August 2013	Ongoing
Initiate Post Payment Desk Audits	September 2013	Ongoing

D.1.3. Approach to Pre-Payment and Post Payment Audit Activities

The following describes the pre- and post-payment audit activities.

- Pre-Payment Audit Activities rely on the following:
  - Automation between MAPIR and the MMIS
  - Validation of participants' certified EHR systems providing reliable Meaningful Use and Clinical Quality Measures data
  - Access to internal and external sources of data.

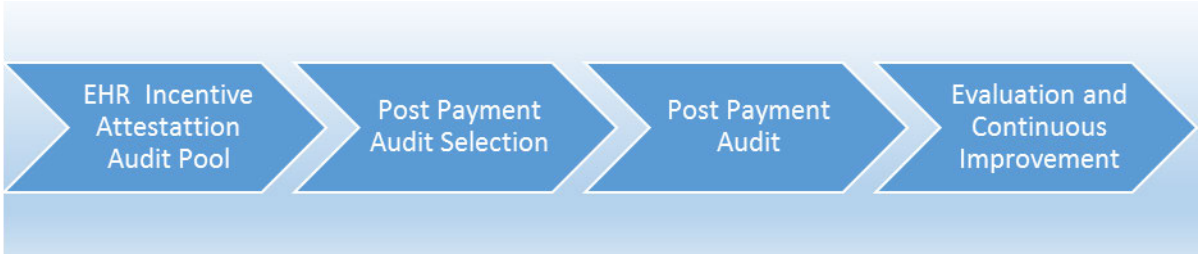
- **Post-Payment Audit Activities** will be conducted on a random and targeted basis to assess provider compliance. The post payment audit selection process and audit activities will largely be manual processes performed by the Office of Program Integrity.

A key to the effectiveness of the EHR Incentive Program will be the extent to which the pre- and post-payment audit activities work together to ensure participant compliance with program requirements. The eligibility verification process detailed in the next section covers the full set of pre-payment audit activities.

Internal and external data sources for prepayment and post payment audit activities include; Rhode Island's MMIS system, claims, encounters and provider information for eligible providers and eligible hospitals. Hospital cost report data submitted to CMS will be cross referenced. New sources of external and internal data and data sources may be identified while the program is in place. Further details of the audit can be found in the CMS approved audit strategy that was submitted separately and is not available for public use.

D.1.4. Targeted Post Payment Audits

The audit selection pool for post-payment audit will be risk based and composed of providers identified during pre-payment checks that had marginal Medicaid volume. Risk based elements will be identified to assess which AIU and MU measures are likely to be subject to incorrect information. A risk assessment scoring is utilized to identify those providers who are subject to a Rhode Island Medicaid EHR Incentive audit.



Basic Audit Methodology

D.1.5. Eligibility Verification Process

Eligibility Requirements	EP	EH	Statute	Final Rule	Pre-payment Verification Process and Data Elements	Post-payment Verification
1. EP or EH must be one of the permissible professional or hospital types	✓	✓	42 USC § 1396b(t)(2) (A-B)	§ 495.368 (a)(1)(i) Combating fraud and abuse	Verify that the applicant's provider type meets eligibility requirements. Based on provider type, MAPIR restricts non-eligible providers from applying. However, staff will verify the applicant's provider type in the MMIS provider file. Staff will verify that Physician Assistants (PA) who apply meet the requirement of leading a FQHC or RHC. Staff will attain evidence to confirm FQHC/RHC is so led by a PA.	Random and targeted desk audits or onsite audit activities

Eligibility Requirements	EP	EH	Statute	Final Rule	Pre-payment Verification Process and Data Elements	Post-payment Verification
2. EP or EH must be licensed to practice in the State	✓	✓		§ 495.368 (a)(1)(i) Combating fraud and abuse	MAPIR validates licensure from the Rhode Island MMIS Active licensure can be validated with Rhode Island's Department of Health's license website	Random and targeted desk audits or onsite audit activities
3. EP or EH must be a Medicaid provider in that State.	✓	✓		§ 495.304 (a) Medicaid provider scope and eligibility	MAPIR verifies against the MMIS provider file. If it does not exist, an application cannot be entered.	Random and targeted desk audits or onsite audit activities
4. EP or EH cannot be excluded, sanctioned, or otherwise deemed ineligible to receive payments from the State (i.e. incentive payment made by another State)	✓	✓		§ 495.368 (a)(1)(i) Combating fraud and abuse	MAPIR verifies the MMIS provider file. Additional verification is conducted with CMS' R&A system prior to release of payment.	Random and targeted desk audits or onsite audit activities
5. EP must have at least a 30% Medicaid patient volume (or 20% for pediatricians), unless s/he is practicing predominantly in an FQHC or RHC	✓		42 USC § 1396b(t)(2)(A)	§ 495.304(c)(1) Medicaid provider scope and eligibility	The Medicaid numerator for all EPs will be verified via a MAPIR Query request to the Medicaid MMIS claims database and compared to the EP's application. Staff will contact other states should the applicant's out of state Medicaid patient volume requires validation.	Random and targeted desk audits or onsite audit activities
6. EP must have at least a 30% needy individual patient volume, if s/he is practicing predominantly in an FQHC or RHC	✓		42 USC § 1396b(t)(2)(A)	§ 495.304(c)(3) Medicaid provider scope and eligibility	Should the Medicaid patient volume not meet the required threshold, a needy individual patient volume listing will be requested from the EPs and reviewed prior to payment.	Random and targeted desk audits or onsite audit activities
7. EPs must have more than 50% of his/her patient encounters occur at a FQHC or RHC in a six-month period during the prior calendar year to practice predominantly in an FQHC or RHC	✓			§495.366 (b)(4) Financial oversight and monitoring of expenditures	If necessary, a patient encounter listing from the FQHC/RHC will be requested and reviewed prior to payment.	Random and targeted desk audits or onsite audit activities
8. EH must have at least 10% Medicaid patient volume (acute care hospital only)		✓	42 USC § 1396b(t)(2)(B)	§ 495.304(e)(1) Medicaid provider scope and eligibility	The Medicaid numerator for all EHs will be verified via a MAPIR Query request to the Medicaid MMIS claims database and compared to the EH's application.	Random and targeted desk audits or onsite audit activities
9. EP must not be hospital-based (no more than 90% of his/her Medicaid claims are inpatient with a POS 021)	✓		42 USC § 1395w-4. (a)(o)(1)(C)(i-ii)	§ 495.304 (c) Medicaid provider scope and eligibility	Verification via an MMIS query request that compares POS 021 claims against all claims and ensures that participating providers fall are below 90%. If not, they will be targeted for a post payment audit.	Random and targeted desk audits or onsite audit activities

Eligibility Requirements	EP	EH	Statute	Final Rule	Pre-payment Verification Process and Data Elements	Post-payment Verification
10. EP must practice in a PA-led FQHC or RHC if s/he is a Physician Assistant (PA)	✓		42 USC § 1396b(t)(3)(B)	§ 495.304(b) Medicaid provider scope and eligibility	Staff will verify that Physician Assistants who apply meet the requirement of leading a FQHC or RHC that is PA led.	Random and targeted desk audits or onsite audit activities
11. EH must have an average length of stay of 25 days or less to be considered an acute care hospital		✓		§ 495.332(b)(5) State Medicaid HIT plan requirements	Verification through submitted cost report.	Random and targeted desk audits or onsite audit activities
12. EP or EH must adopt, implement, or upgrade (AIU) certified EHR technology capable of meeting meaningful use	✓	✓	42 USC § 1396b(t)(6)(ii)	§ 495.366 (c) Financial oversight and monitoring of expenditures	Verify attested to status of Adopted, Implemented, Upgrade for the EHR system. The state will accept uploaded documentation that identifies the specific certified EHR technology and coincides with the CMS Certification number provided on the application. The certified EHR technology has been acquired or purchased with the CEHRT vendor, or with third party arrangement. Signed contract and recently paid invoices from the CEHRT are requested.	Random and targeted desk audits or onsite audit activities
13. EP or EH must meaningfully use (MU) certified EHR technology	✓	✓	42 USC § 1396b(t)(6)(ii)	§ 495.366 (c) Financial oversight and monitoring of expenditures	Meaningful Use Reports must be uploaded with the application. Reports must include numerator and denominator measures for Core, Menu and CQM measure sets.	Random and targeted desk audits or onsite audit activities
14. Managed care providers must not receive EHR incentive payment that exceeds 105 percent of their capitated rate if Medicaid is the payer, unless incentives are documented and actuarially sound.	✓		42 CFR 438.6(c)(5)(iii) Special contract provisions. 42 CFR 438.6(c)(4)(B)(iv) Documentation.	§ 495.366 (e)(7) Financial oversight and monitoring of expenditures (See also § 438.6 (c)(v)(5)(iii))	MCOs are not making incentive payments to providers under Rhode Island's Medicaid EHR Incentive program.	Random and targeted desk audits or onsite audit activities

D.2. Identification and Tracking Overpayments

Tracking overpayments to providers is addressed in this section. Incentive payments made inappropriately or fraudulently obtained will be recouped using the existing agency recoupment process. The Agency will comply with CMS guidelines that require the Medicaid Agency to track the total dollar amount of overpayments identified by the State as a result of oversight activities conducted during the fiscal year.

A primary goal of the EHR Incentive Program processing procedure is to limit overpayments to a minimal number, and therefore to a limited amount. The activities that occur during the Eligibility Verification process are designed to prevent overpayments. The Agency acknowledges that regardless of the system, some overpayments or inappropriate may be made. Therefore, audit post-payment activities conducted are intended to identify overpayments. The Agency has a systematic ability to track overpayments on an individual provider basis, and to report on overpayments in the aggregate for a specified time period.

D.3. Fraud and Abuse Mitigation

Potential fraud and abuse issues that relate to the EHR Incentive Program will be investigated by the Office of Program Integrity (OPI). Fraud is defined as any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself or some other person. For example, in the case of the EHR Incentive Program, fraud may include the intentional inclusion of false information on the registration and attestation form. Abuse is any practice that is inconsistent with sound fiscal, business or medical practices, and that results in an unnecessary cost to Medicaid. Abuse also includes when a provider misstates a part of their application and attestation form.

OPI will take one of two actions, depending upon whether fraud or abuse is detected:

- **Fraud:** When fraud is suspected, the Program Integrity Group will conduct an investigation. This may include internal discussions with involved parties. If the group finds a credible suspicion of fraud, findings will be summarized and referred to the Medicaid Fraud Department and the Rhode Island Attorney General's office for further investigation.

- **Abuse:** These cases are reviewed and decided upon internally by the Program Integrity Group after an investigation. This will involve activities such as internal discussions with involved parties, discussions with the provider under

review, review of existing data, and review of existing documentation. If the group detects abuse, an administrative action such as requiring a Corrective Action Plan (CAP) and/or recovery of the incentive payment(s) based on the nature of the finding will be initiated.

When fraud or abuse is detected, the group will determine what actions are required on a case-by-case basis. CAPs would be developed for providers who are determined to have violated regulatory compliance. Recoupment activities will pursue any overpayments from fraud or abuse. The provider may also be subject to disenrollment from the Medicaid program and listing on the federal and state sanction provider list.

We anticipate that meaningful use audit findings will be issued on a 'pass-fail' basis. Providers will have an opportunity to remediate identified issues within a 60-day time window; if they are unable to remediate issues, the incentive payment recoupments processes described above will be invoked with respect to penalties. If the audit finds that there was a false attestation by the provider who completed it, a refund amount will be determined and incentive funds, relative to the appropriate incentive stage, must be refunded. If these steps are not completed, providers may face sanction and/or prosecution as per existing processes.

D.4. Leveraging Existing Data Sources

The use of various data sources to verify the eligibility and accuracy of provider information is described in the table in Section D.1.5. These data sources include MMIS, Department of Health Licensure Database, and the CMS R&A system, and various uploaded documents from the attesting provider.

D.5. Sampling Methodology

This topic is addressed in a separately submitted audit strategy that is approved by CMS.

D.6. Reducing Provider Burden

Being part of the MAPIR collaborative and having the MAPIR system in place for the past six years, we have significantly reduced provider burden during the application process. Here is how:

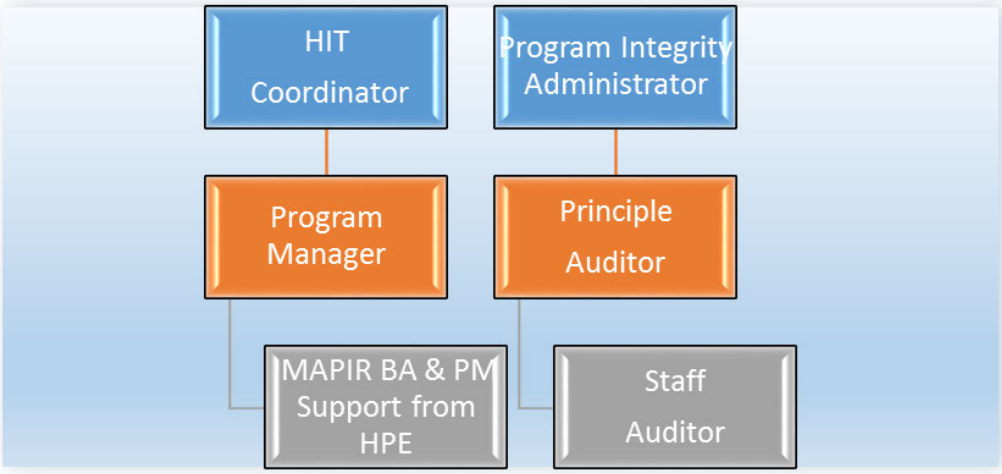
- MAPIR and MMIS connectivity – Providers cannot participate in the program if they are not in the Medicaid MIS system as an active Medicaid Provider. Furthermore, and when it is necessary, MAPIR validates MMIS information during the application entry process.
- MAPIR Status Control – With MAPIR the SRA has the ability to change the status of an application prior to payment. So if there is an entry error, the application can be re-opened and the applicant can make the necessary modifications and re-submit their application.
- Electronic Payments made through the MMIS – Once the application is approved for payment in MAPIR, MAPIR will send a payment file request to CMS for approval. Once an approval is approved MAPIR will send a file to the MMIS to make an electronic EHR Incentive payment on the provider's remittance advice.
- Audits Tracked in MAPIR – The audit staff is utilizing the audit functions available within MAPIR. This function reduces redundancies in the audit process that may pose an additional burden to the provider. It also helps us avoid asking questions that are already in the MAPIR system. This capability improves our desk audit function.

We have also reduced provider burden by allowing our state's REC to assist providers who are struggling to meet meaningful use and assist the provider community with workflow changes. The regional managers from the REC would also encourage our providers to apply for the EHR Incentive and help them with their submission. Their efforts have greatly reduced provider burden and over time, providers were able to consistently meet meaningful use.

D.7. Program Integrity Operations

Rhode Island has a separate Office of Program Integrity (OPI) which ensures compliance, efficiency, and accountability within the health and human services programs administered by the State of Rhode Island by detecting and preventing fraud, waste, and program abuse and ensuring that state and federal dollars are spent appropriately, responsibly, and in accordance with applicable laws.

The Office of Program Integrity is also committed to identifying fraud, waste and abuse in Medicaid and in all health and human service programs. The OPI actively pursues any leads indicating fraudulent practices and uses them as a source to begin investigations. To increase our effectiveness, the OPI is partnering with Medicare and Medicaid insurance companies to share information about fraudulent activity and to conduct joint investigations. Their oversight of the Rhode Island Medicaid EHR Incentive program plays a significant role and has dedicated staff to audit the program and ensure payments made are within the regulations of the program. Below is a hierarchical staff diagram that shows a separation between operational and audit oversight that is strictly enforced. While we share information with rule changes and system updates, the operational staff does not partake in the audit functions.



The roles of organizational staff are described below:

Administrator – Office of Program Integrity – Ensures program oversight and is responsible for the EHR program audit staff performance. In early 2013, the Rhode Island Executive Office of Health and Humans Services (EOHHS) formed the Office of Program Integrity similar to an internal audit team that provides regulatory oversight and prevents fraud and abuse within all Medicaid programs.

Principle Auditor – This position oversees the EHR Incentive audit functions, conducts higher risk EHR incentive program audits and reviews audits performed by the staff

auditor. The Principal Auditor is also responsible for developing and maintaining the RI Medicaid EHR Incentive Program Audit Strategy. Currently this position is serving as the only auditor for the program since the staff auditor position is vacant.

Staff Auditor – this position assists by performing EHR Incentive audits for all providers who are participating in the program. This position evaluates applications based on a defined risk assessment as defined within the CMS approved EHR Incentive Program's Audit Strategy. In most cases, the auditor performs desk audits, but will perform onsite audits when required. This position is currently vacant.

State Health IT Coordinator –Responsible for overall management of the RI Medicaid EHR Incentive Program Oversees except for the audit functions. Works collaboratively with the auditors and program integrity administratively to coordinate overall program efforts, communicate programs changes or challenges, and review program progress.

EHR Incentive Program Manager – Oversees the daily operations of the RI Medicaid EHR Incentive Program. This position ensures that providers are meeting the CMS guidelines set forth in the final rule, oversees program outreach, policy development and implementation, and payment review and approval. This position works closely with the principal auditor when questions arise, to assure proper documentation is uploaded and to discuss any questions related to prepayment audit processes. This position is a Xerox employee.

HPE MAPIR Business Analyst – provides technical support for the MAPIR system and is a Hewlett Packard Enterprise employee. This position troubleshoots front end or backend EHR Incentive application issues within our MAPIR system. The business analyst is involved with testing and upgrading MAPIR to meet program regulatory requirements. In addition, this position requires ongoing collaboration with the MAPIR Collaborative. This positions works with the principal auditor to assure the proper functioning of the audit racking system within MAPIR.

HPE MAPIR Project Manager – provides administrative oversight for any large system implementation and upgrades to MAPIR and is a Hewlett Packard Enterprise employee. The MAPIR Project Manager is also responsible with requesting project task approval from the Health IT Coordinator when projects arise for the program. Works with the audit team as needed to assure proper functioning of MAPIR as it relates to audit functions

E. Medicaid HIT Roadmap

E.1. Where we are today and where we expect to be in Five Years

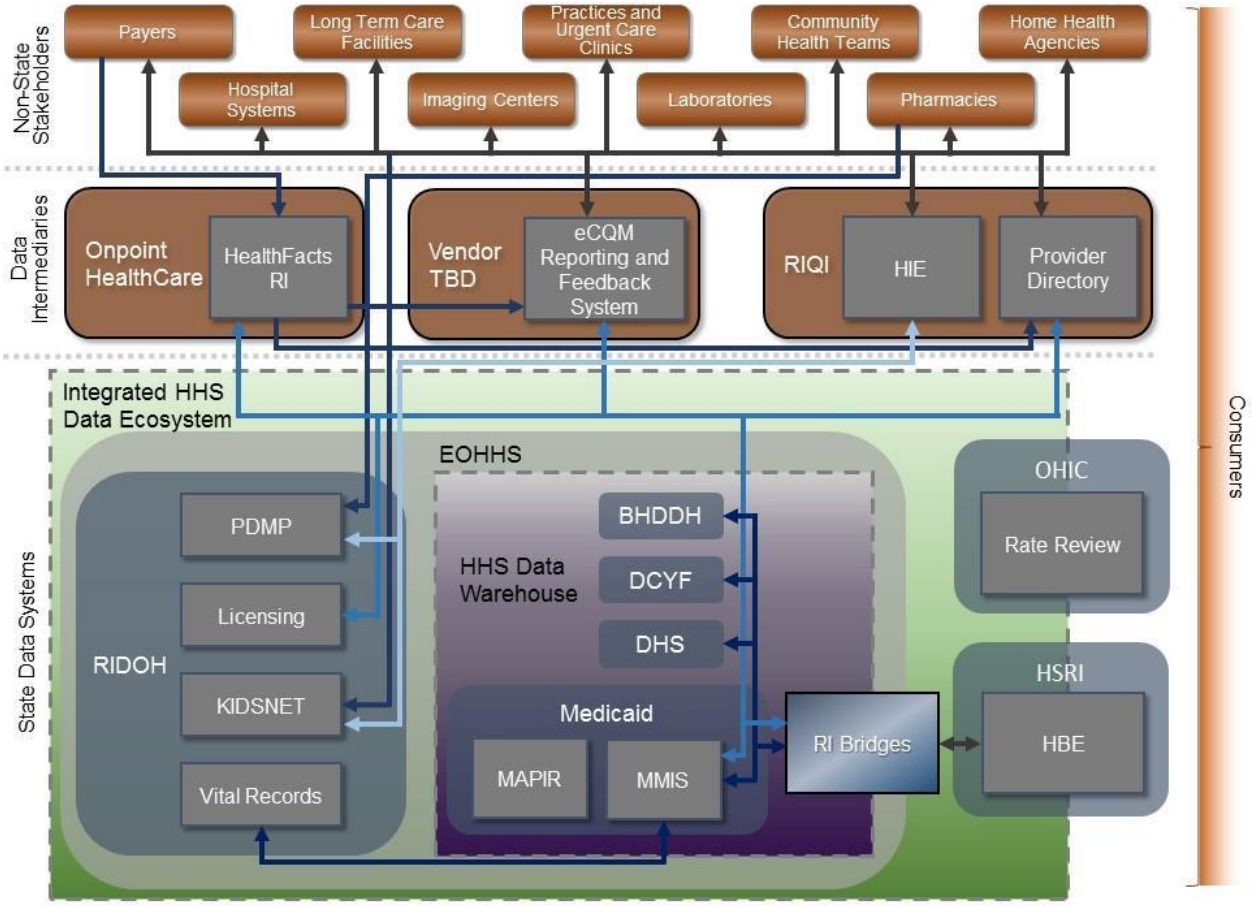
As described in section A in more detail, Rhode Island has invested considerable resources into establishing HIT systems to support a variety of business needs for state government and for community stakeholders. The diagram below shows a snapshot of many of these systems as of the end of 2016. Communication pathways are typically unidirectional and from one system to another. Consumers interact either directly or indirectly through staff at agencies and organizations with these systems.

As we look toward 2021 and our ideal state, there are several strategic projects that are yet to be fully defined. Additional information about these high priority projects will help solidify RI's approach to the expansion and integration of RI's overall HIT environment. Once the following information is available, a longer term strategy and ideal state will become clearer:

- Who will be the vendor for the eCQM Reporting and Feedback System and how will they interface with the state's HIT ecosystem
- What are the components of the EOHHS State Data Ecosystem that needs to be developed in order to fully serve the state's policy and operational needs, versus what components already exist and can leveraged or modified to meet the intended goal
- Whether legal and or regulatory changes can be made to remove some of the barriers to health information exchange that the state faces today, and to promote the ability to link claims and clinical data for operational and analytic uses

The future state will continue to evolve over time as these questions are answered. EOHHS 's focus will remain on increasing statewide interoperability both within and external to state government, improving the services and utility of existing HIT systems, and improving the collective ability of Rhode Islanders of all type to use data to improve the quality of care.

Despite the unknowns outlined above, EOHHS is prepared to and has begun to invest in achieving additional HIT infrastructure for 2021 as diagrammed below.



The "Future state" schematic above clearly identifies several components and features that are planned but not yet developed and or integrated into the overall picture. These include:

- Establishing an Integrated HHS Data Ecosystem.
- Establishing The eCQM Reporting and Feedback System
- Connecting HealthFacts RI and possibly CurrentCare to the eCQM Reporting and Feedback System.
- Having the HIE connected to the PDMP at RIDOH
- Having the statewide common Provider Directory supplying data to HealthFacts RI, the eCQM Reporting and Feedback System, MMIS, RI Bridges, HSRI and RIDOH Licensure.

E.2. Expectations for EHR technology and HIE Adoption Over Time with Annual Benchmarks

GOAL 1: 90% of hospitals, primary care providers, and outpatient specialists adopting CEHRT by 2021.

Annual Benchmarks:

Baseline	2017	2018	2019	2020	2021
59%	65%	75%	80%	85%	90%

GOAL 2: Achieve a 75% meaningful use conversion rate among RI Medicaid Eligible Providers (from AIU to MU) by 2021.

Annual Benchmarks:

Baseline	2017	2018	2019	2020	2021
55%	60%	65%	68%	70%	75%

GOAL 3A: 90% of Rhode Islanders having a CurrentCare Record by 2021

Annual Benchmarks:

Baseline	2017	2018	2019	2020	2021
46%	54%	62%	71%	80%	90%

GOAL 3B: 90% of all Medicaid beneficiaries having a CurrentCare Record by 2021

Annual Benchmarks:

Baseline	2017	2018	2019	2020	2021
38%	50%	62.5%	75%	77.5%	80%

GOAL 4: Increase awareness and use of CurrentCare, with 75% of physicians knowing of and using CurrentCare by 2021

Annual Benchmarks:

Baseline	2017	2018	2019	2020	2021
30%	39%	48%	57%	66%	75%

GOAL 5: Increase Interoperability among the state's HIT services where appropriate.

Annual Benchmarks:

Year	Benchmark
2017	Prescription Drug Monitoring Program (PDMP) integration with the HIE.
2018	Kidsnet Immunization Registry integration with the HIE.
2019	One additional integration, TBD.
2020	One additional integration, TBD.
2021	One additional integration, TBD.

E.3. Benchmarks for Audit and Oversight Activities

GOAL: Each year, complete pre-payment application review for all RI Medicaid EHR Incentive applications.

Annual Benchmarks:

Baseline	2017	2018	2019	2020	2021
100%	100%	100%	100%	100%	100%

GOAL: Each year, we plan to complete post payment application audits for 10-12% of the RI Medicaid EHR Incentive applications. As the program sunsets in 2021 and most providers have completed their six years of attestations, we expect a decrease of audits especially for program years 2020 and 2021.

Annual Benchmarks:

Baseline	2017	2018	2019	2020	2021
12%	10-12%	10-12%	10%	8-10%	6-8%

ATTACHMENT F

Behavioral Health Link Component Services

Approved: December 20, 2018

Service	Service Description	Practitioner	Practitioner Qualifications	Limitations
Crisis Intervention/Assessment Services	Refers to short term emergency mental health services that are available on a twenty-four-hour basis, seven days a week. Behavioral health emergency, crisis intervention, and crisis stabilization services are immediate and short-term behavioral healthcare interventions provided to individuals experiencing an emergency or crisis situation. These services continue until the crisis is stabilized or the individual is safely transferred or referred for appropriate stabilization and/or ongoing treatment.	Qualified Mental Health Professional	BHDDH Rules and Regulation further defines "Qualified Mental Health Professional" (QMHP) as an individual with a minimum of a Master's Degree in a clinical practice or a license as a Registered Nurse and have a minimum of thirty (30) hours of supervised face-to-face emergency services contact experience as a psychiatric emergency service worker in Rhode Island.	None
Nursing	Office or other outpatient visit for the evaluation and management of established patient.	RN	Licensed Registered Nurse in the state of Rhode Island.	None
Psychiatric diagnostic evaluation with medication services	Psychiatrist/Nurse Practitioner conducting a psychiatric evaluation and prescribing medication in accordance with that individuals needs/diagnosis.	MD or Advanced Nurse Practitioner	MD or APRN Licensed in the state of Rhode Island.	None
Community Psychiatric Supported Treatment (CPST)	Community Psychiatric Supported Treatment (CPST) is provided to community-based clients and collaterals by professional mental health staff in accordance with an approved treatment plan	Staff providing CPST shall, at a minimum, be a Registered Nurse or have an	Licensed Registered Nurse in the state of Rhode Island or have an Associate's Degree in a human service field.	None

	for the purpose of insuring the client's stability and continued community tenure by monitoring and providing medically necessary interventions to assist them in managing the symptoms of their illness and dealing with their overall life situation, including accessing needed medical, social, educational and other services necessary to meeting basic human needs.	Associate's Degree in a human service field.		
Peer Recovery Services	The Peer Recovery Specialist's role as a behavioral and physical healthcare professional is to provide interventions that promote socialization, long-term recovery, wellness, self-advocacy, development of natural supports, prevent relapse, and connectedness to one's community. The Peer Recovery Specialist does not replace any other behavioral or physical health professionals; it complements the existing array of support services.	Certified Peer Recovery Specialist (CPRS)	To be a Certified Peer Recovery Specialist (CPRS) an individual must be credentialed by the Rhode Island Board for Certification of Chemical Dependency Professionals (RIBCCDP) as a Peer Recovery Specialist. RIBCCDP credentialing standards meet minimum standards of the International Certification and Reciprocity Consortium (IC&RC). RIBCCDP standards for Peer Recovery Specialist are: • Education: High school diploma or equivalency. • Training: 46 hours of training with 10 hours each in the domains of Advocacy, Mentoring and Education, and Recovery/Wellness Support and	None

			16 hours in the domain of Ethical Responsibility. • Experience: 500 hours of volunteer or paid work experience specific to the domains. • Supervision: A total of 25 hours of supervision specific to the domains. Supervision must be provided by an organization's documented and qualified supervisory staff per job description. • Examination: Applicants must pass the RIBCCDP Peer Recovery Examination. • Code of Ethics: The applicant must agree, in writing, to abide by the code of ethics. • Recertification: 20 hours of continuing education earned every 2 years including 6 hours in ethics.	

ATTACHMENT G

Behavioral Health Link Payment Methodology

Approved: November 19, 2019

Introduction

BH Link is a specific set of services offered to individuals that are in crisis due to a substance use disorder and/or a mental health condition. These specific services are paid under one bundled rate, to support recovery-oriented environments dedicated to stabilizing individuals and linking them to the appropriate level of substance use disorder and/or mental healthcare treatment and/or recovery services within a less-intensive and less-costly setting of care than is furnished in a hospital setting. Accordingly, Rhode Island Medicaid established the protocols herein to define the claimable BH Link expenditures.

BH Link Program Bundled Rate

Only those providers that meet the criteria set forth in STC 15 may be reimbursed for BH Link services. A provider may not receive separate reimbursement for a BH Link service for the same individual for which a BH Link bundled rate was claimed. Medicaid providers delivering other Medicaid-covered services outside of the BH Link service bundle may bill in accordance with the state's Medicaid billing procedures. When providing services to individuals with mental health and/or substance use disorders, it may be necessary to provide the service multiple times before treatment is sought or is successful. Therefore, this bundle may be billed once daily per Medicaid beneficiary with no restriction on the number of times per month, so long as it does not exceed once per day. The following provides a description of how the rate methodology was developed. The methodology reflects an average number of units per day, recognizing that some stays will encompass a higher number of units and some stays will encompass a lower number of units. A stay is defined as an intake and discharge from the triage center. It can last no longer than 23 hours.

The BH Link bundled rate that was established by EOHHS is based on the rates paid to providers to deliver similar services on a fee-for-service basis. Rates from the current community mental health centers for case management, and the assessment, nursing monitoring and psychiatric services were utilized to inform the development of this rate. As explained in the chart below, the bundled rate is the sum of each product that resulted from multiplying each component rate by an anticipated average number of units for a BH Link participant. When submitting a claim for the BH Link bundled rate, providers must include service-level detail to document how many units of each service was delivered to an individual. The claim will be paid at the header level, and shadow billed component services will not receive separate reimbursement and be paid at zero. For a provider to receive the total reimbursement of $598.50, they must perform a crisis assessment. The crisis assessment triggers the payment. Typically, the assessment will be followed with case management and monitoring services or psychiatric interventions such as an evaluation or the prescribing of medication. The BH Link bundled rate will be reviewed at least annually for economy and efficiency and recalculated by EOHHS as necessary. Any rate changes to the BH Link services must be reviewed and approved by CMS to verify reasonableness, efficiency and effectiveness. The BH Link rate does not include costs related to room and board or any other unallowable facility cost, or non-covered Medicaid services.

BH Link Triage Center Rate Composition					
Service	Rate/Unit	Duration of unit	Projected Average Number of Units	Projected Average Total Time	Cost
Crisis Assessment	$150.00	60 Minutes	1	60 minutes	$150.00
Nursing/monitoring	$7.50	5 Minutes	24 units	120 minutes	$180.00
Case Management	$21.25	15 Minutes	7 units	105 minutes	$150.50
Psychiatrist (Evaluation and management)	$118	25 Minutes	1	25 minutes	$118.00
Total					$598.50