CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00242/1**

TITLE: **Rhode Island Comprehensive Section 1115 Demonstration**

AWARDEE: **Rhode Island Executive Office of Health and Human Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Rhode Island Comprehensive section 1115(a) Medicaid demonstration ("demonstration"), as approved under authority of section 1115 of the Social Security Act, (the Act). The parties to this agreement are the Rhode Island Executive Office of Health and Human Services (state) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The amended STCs are effective the date of approval, unless otherwise specified. All previously approved section 1115(a) demonstration STCs, waivers, and expenditure authorities are superseded by the STCs set forth below and accompanying waivers and expenditure authorities. All previously approved Category II changes shall apply during the extension period. This demonstration is approved through December 31, 2018.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Title XIX Program Flexibility
V. Eligibility and Enrollment
VI. Benefits
VII. Cost Sharing
VIII. Delivery System
IX. Self-Direction
X. Extended Family Planning
XI. RIte Smiles
XII. Designated State Health Programs (DSHP)
XIII. Healthy Behaviors Incentives Program
XIV. Payments To Federally Qualified Health Centers For Uninsured Populations
XV. General Reporting Requirements
XVI. General Financial Requirements Under Title XIX
XVII. General Financial Requirements Under Title XXI
XVIII. Monitoring Budget Neutrality for the Demonstration
XIX. Evaluation of the Demonstration / Quality Assurance and Improvement

XX. Measurement of Quality of Care and Access to Care Improvement
XXI. Schedule of Deliverables for the Demonstration Period

The following attachments have been included to provide supplemental information and guidance for specific STCs. The following attachments are incorporated as part of this Agreement.

Attachment A: Managed Care Demonstration Only Benefits
Attachment B: Core and Preventive Home and Community-based Service Definitions
Attachment C: Assessment and Coordination Organization
Attachment D: Level of Care Criteria
Attachment E: Quarterly Report Progress Template and Instructions
Attachment F: Evidentiary Review Guidance for Conducting Quality Reviews of HCBS Waiver Programs
Attachment G: Comprehensive Quality Strategy (reserved)
Attachment H: Healthy Behaviors Incentives Program Description (reserved)
Attachment I: Evaluation Plan (reserved)
Attachment J: List of FQHCs

II. 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."

Toward this end, Rhode Island's Comprehensive demonstration establishes a new State-Federal compact that provides the State with substantially greater flexibility than is available under existing program guidelines. Rhode Island will use the additional flexibility afforded by the waiver to redesign the State's Medicaid program to provide cost-effective services that will ensure that beneficiaries receive the appropriate services in the least restrictive and most appropriate setting.

Under this demonstration, Rhode Island operates its entire Medicaid program subject to the financial limitations of this section 1115 demonstration project, with the exception of: 1) disproportionate share hospital (DSH) payments; 2) administrative expenses; 3) phased-Part D contributions; and 4) payments to local education agencies (LEA) for services that are furnished only in a school-based setting, and for which there is no third party payer.

With those four exceptions, all Medicaid funded services on the continuum of care – from preventive care in the home and community to care in high-intensity hospital settings to long-term and end-of life-care whether furnished under the approved state plan, or in accordance with waivers or expenditure authorities granted under this demonstration or otherwise, are subject to the requirements of the demonstration. 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 effective January 1, 2014. Benefits are provided through comprehensive mandatory managed care delivery systems. 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 section IV of these STCs.

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 eligibility under RIte Care at the conclusion of their 60-day postpartum period. Effective January 1, 2014, eligibility will be raised to 250 percent of the FPL. See Section X 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. Effective through December 31, 2013, 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 Options and Connect Care Choice Community Partners component will expand to all qualified aged, blind, and disabled beneficiaries whether they have other health insurance or not. Effective January 1, 2014, the New Adult Group will be 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 section IV of these STCs.

e. The Connect Care Choice component provides Medicaid state plan benefits to aged, blind, and disabled beneficiaries who have no other health insurance, through a primary care case management system. 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 section IV of these STCs.

f. The Home and Community-Based Service component provides services similar to those authorized under sections 1915(c) and 1915(i) of the Act to individuals who need home and community based services either as an alternative to institutionalization or otherwise based on medical need.

g. The RIte Smiles Program is a managed dental benefit program for Medicaid eligible children born after May 1, 2000.

h. Rhody Health Options is a managed care delivery system for Medicaid only and Medicare Medicaid eligibles that integrates acute and primary care and long term care services and supports.

i. Connect Care Choice Community Partners is an optional delivery system for Adult, Blind and Disabled Medicaid and Medicare Medicaid eligibles that utilizes a community health team and a Coordinating Care Entity to integrate Medicaid benefits.

In 2013, CMS renewed the Comprehensive demonstration through December 31, 2018. This renewal includes 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 home and community based services (HCBS), and the conversion from an aggregate cap to a per member per month budget neutrality model.

III. GENERAL PROGRAM REQUIREMENTS

1. **Concurrent Operation.** The state's title XIX state plan as approved; its title XXI state plan, as approved; and this Medicaid section 1115 demonstration entitled "Rhode Island Comprehensive Demonstration," will continue to operate concurrently for the demonstration period.

2. **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, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

3. **Compliance with Medicaid and Children's 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, must apply to the demonstration.

4. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy directive, come into compliance with any changes in Federal 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.

5. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**

   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, modified budget

neutrality and allotment neutrality agreements for the demonstration as necessary to comply with the change. The modified agreements will be effective upon the implementation of the change.

b. If mandated changes in the Federal law require state legislation, the changes must take effect on the day that the state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

6. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments for programmatic changes affecting populations who would not be eligible under the state plan as of November 1, 2008 (state plan populations). Nor will the state be required to submit state plan amendments for programmatic changes that affect other populations and are defined in STC 18 as Category I or Category II changes. The state will be required to submit either a state plan amendment or an amendment to the demonstration as applicable for Category III changes.

   Changes relating to disproportionate share hospital (DSH) payments and coverage and payment of services furnished by local educational agencies (LEAs) require state plan amendments because these are excluded from the demonstration.

   Rhode Island will be responsible for submitting state plan amendments to bring into compliance provisions of the current state plan that are inconsistent with Federal law or policy.

7. **Extension of the Demonstration.** If the state intends to request demonstration extensions under sections 1115(e) or 1115(f), the state must observe the timelines contained in those statute provisions. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the chief executive officer of the state must submit to CMS either a demonstration extension request or a transition and phase-out plan consistent with the requirements of paragraph 8.

   As part of the demonstration extension request, the state must provide documentation of compliance with the public notice requirements outlined in paragraph 14, as well as include the following supporting documentation:

   a. Demonstration Summary and Objectives. The state must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed, and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes requested along with the objective of the change and desired outcomes must be included.

   b. Special Terms and Conditions (STCs). The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address duplicate areas, the STCs need not be documented a second time.

c. Waiver and Expenditure Authorities. The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

d. Quality. The state must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and state quality assurance monitoring, and any other documentation of the quality of care provided under the demonstration.

e. Compliance with the Budget Neutrality Agreement. The state must provide financial data (as set forth in the current STCs) demonstrating the State's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the state to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In addition, the state must provide up-to-date responses to the CMS Financial Management standard questions.

f. Draft on Evaluation Status and Findings. The state must provide a narrative summary of the evaluation design, status including evaluation activities and findings to date, and plans for evaluation activities during the expansion period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available. The state must report interim research and evaluation findings for key research questions as a condition of renewal.

g. Compliance with Transparency Requirements at 42 CFR §431.412. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 14, as well as include the following supporting documentation:

   i. *Demonstration Summary and Objectives.* The state must provide a summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

   ii. *Special Terms and Conditions.* The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

   iii. *Waiver and Expenditure Authorities*. The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

iv. *Quality*. The State must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO), state quality assurance monitoring and quality improvement activities, and any other documentation of the quality of care provided under the demonstration.

v. *Compliance with the Budget Neutrality*. The state must provide financial data (as set forth in the current STCs) demonstrating that the state has maintained and will maintain budget neutrality for the requested period of extension. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of President's budget and historical trend rates at the time of the extension.

vi. *Interim Evaluation Report.* The state must provide an evaluation report reflecting the hypotheses being tested and any results available.

vii. *Demonstration of Public Notice 42 CFR §431.408*. The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR §431.408 including the post-award public input process described in 42 CFR §431.420(c) with a report of the issues raised by the public during the comment period and how the state considered the comments when developing the demonstration extension application.

8. Demonstration Transition and 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 its notification letter and a draft transition and phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft 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 its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised phase-out plan.

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

c. 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 administrative reviews of Medicaid eligibility prior to the

termination of the program for the affected beneficiaries including any individuals on demonstration waiting lists, and ensure ongoing coverage for those beneficiaries determined eligible for ongoing coverage, as well as any community outreach activities including community resources that are available. The state must adhere to waiting list requirements outlined in STC 34.

d. Transition and Phase-out Procedures. The state must comply with all notice requirements found in 42 CFR §431.206, §431.210, and §431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category. 42 CFR section 435.916.

e. Exemption from Public Notice Procedures 42.CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of title XIX and XXI would be served or under circumstances described in 42 CFR section 431.416(g).

f. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

9. Expiring Demonstration Authority. For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a demonstration expiration plan to CMS no later than 6 months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

a. Expiration Requirements. The state must include, at a minimum, in its demonstration expiration 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 administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

b. Expiration Procedures. The state must comply with all notice requirements found in 42 CFR § 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR § 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category.

c. Federal Public Notice. CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR § 431.416 in order to solicit public input

on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.

d. FFP. FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling participants.

10. **CMS Right to Amend, Terminate or Suspend for Cause.** CMS may amend, suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines, following a hearing, that the state has materially failed to comply with the terms of the project. CMS must promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge CMS' finding that the state materially failed to comply.

12. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time that it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of titles XIX or XXI. CMS must promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the demonstration, including services and administrative costs of disenrolling participants.

13. **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.

14. **Public Notice and Consultation with Interested Parties.** The state must continue to comply with the state Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) for any category III program changes to the demonstration, including, but not limited to, those referenced in paragraph 18 of Section IV, Program Flexibility.

15. **Post Award Forum.** Within six months of the demonstration's implementation and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 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 can use either its Medicaid Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of the STC. The state must include a summary in the quarterly report, as specified in STC 93, associated with the quarter

in which the forum was held. The state must also include the summary in its annual report as required by STC 94.

16. **FFP.** No Federal administrative or service matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

17. **Transformed Medicaid Statistical Information Systems Requirements (T-MSIS).** The State shall comply with all data reporting requirements under Section 1903(r) of the Act, including but not limited to Transformed Medicaid Statistical Information Systems Requirements. More information regarding T-MSIS is available in the August 23, 2013 State Medicaid Director Letter.

IV. TITLE XIX PROGRAM FLEXIBILITY

Rhode Island has flexibility to make changes to its demonstration based on how the changes align with the categories defined below and the corresponding process in this Section paragraph 18, "Process for Changes to the Demonstration." The categories of changes described below are for changes to the program as described in the STCs. Initiatives described in the STCs are approved upon approval of the demonstration.

18. **Categories of Changes and General Requirements for Each Category.** When making changes, the state must characterize the change in one of the three following categories below. CMS has 15 business days after receiving notification of the change (either informally for Category I or formally for Categories II and III) to notify the state of an incorrect characterization of a programmatic change. To the extent the state and CMS are unable to reach mutual agreement on the characterization of the programmatic change, the CMS characterization shall be binding and non-appealable as to the procedure to be followed.

    a. Category I Change. Is a change which is administrative in nature for which the state has current authority under the state plan or demonstration, and which does not affect beneficiary eligibility, benefits, overall healthcare delivery systems, payment methodologies or cost sharing. The state must notify CMS of such changes either in writing or orally in the periodic review calls and update reports as specified in the General Reporting Section paragraphs 92 through 94. Implementation of these changes does not require approval by CMS.

    Examples of Category I changes include, but are not limited to:

    - Changes to the instruments used to determine the level of care.
    - Changes to the Assessment and Coordination Organization Structure.
    - Changes to general operating procedures.
    - Changes to provider network methodologies (provider enrollment procedures, but not delivery system changes).
    - Changes to prior authorization procedures.

- Adding any HCBS service that has a core definition in the Instructions/Technical Guidance under section1915(c) if the state intends to use the core definition.
- Modifying an HCBS service definition to adopt the core definition.

b. Category II Change. Is a change that could be made as a state plan amendment or through authority in sections 1915(b), 1915(c), 1915(i) or 1915(j) without any change in either the STCs, or the section 1115 waiver and expenditure authorities. These changes may affect benefit packages, overall healthcare delivery systems (including adding populations to managed care), cost sharing levels, and post-eligibility contributions to the cost of care. Such changes do not, however, include changes that affect beneficiary eligibility (including changes to the level of spenddown eligibility). The state must comply with its existing state plan amendment public notice process prior to implementation. The state must also notify CMS in writing of Category II changes prior to implementation, and must furnish CMS with appropriate assurances and justification, that include, but are not limited to, the following:

i. That the change is consistent with the protections to health and welfare as appropriate to title XIX of the Act, including justification;
ii. That the change results in appropriate efficient and effective operation of the program, including justification and response to funding questions;
iii. That the changes would be permissible as a state Plan or section 1915 waiver amendment; and that the change is otherwise consistent with sections 1902, 1903, 1905, and 1906, current Federal regulations, and CMS policy; and
iv. Assessment of the cost of the change.

CMS will not provide Federal matching funds for activities affected by unapproved but implemented Category II changes.
Examples of Category II changes include, but are not limited to:

- Changes to the ICF/IDD, hospital, or nursing home level of care criteria that are applied prospectively (not to existing long term care or HCBS recipients);
- Adding any HCBS service for which the state intends to use a definition other than the core definition; the service definition must be included with the assurances;
- Modifying any HCBS service definition, unless it is to adopt the core definition;
- Adding an “other” HCBS service that does not have a core definition; the service definition must be included with the assurances;
- Removing any HCBS service that is at that time being used by any participants;
- Change/modify or end RIte Share premium assistance options for otherwise eligible individuals;
- Changes to payment methodologies for Medicaid covered services including, but not limited to, DRG payments to hospitals or acuity based payments to nursing homes;
- Healthy Behaviors Incentives;

- Addition or elimination of optional state plan benefits;
- Changes in the amount, duration, and scope of state plan benefits that do not affect the overall sufficiency of the benefit;
- Benefit changes in accordance with the flexibility outlined in current Medicaid regulations, as amended on July 15, 2013 at 78 FR 42160 (and any subsequent amendments);
- Cost-Sharing Changes up to the limits specified in Medicaid cost-sharing regulations published on July 15, 2013, unless otherwise defined in the STCs.

c. Category III Change. Is a change requiring modifications to the current waiver or expenditure authorities including descriptive language within those authorities and the STCs, and any other change that is not clearly described within Categories I and II. In addition, a programmatic change may be categorized as a Category III change by the state to obtain reconsideration after unsuccessfully pursuing approval of the change under Category II. The state must comply with the section 1115 demonstration public notice process as described in paragraph 14 of these STCs. The state must notify CMS in writing of Category III changes, and submit an amendment to the demonstration as described in paragraph 19, "Process for Changes to the Demonstration." Category III changes shall not be implemented until after approval of the amendment by CMS.

Examples of Category III changes:

- All Eligibility Changes;
- Changes in EPSDT;
- Spend-down level changes;
- Aggregate cost-sharing changes that are not consistent with Medicaid cost-sharing flexibility (would exceed 5 percent of family income) in current Medicaid regulations;
- Benefit changes that are not in accordance with current Medicaid regulations; and
- Post-eligibility treatment of income; and
- Amendments requesting changes to the budget neutrality limits.

19. Process for Changes to the Demonstration. The state must submit the corresponding notification to CMS for any changes it makes to the demonstration as characterized in the Category I, II or III definitions section depending on the level of change. CMS will inform the state within 15 business days of any correction to the State's characterization of a change, which shall be binding and non-appealable as to the procedure for the change. The state must also have a public notice process as described below for Category II and III changes to the demonstration.

a. Process for Category I Changes. The state must notify CMS of any change to the demonstration defined as a Category I change 30 calendar days before implementing the change. The state must also report these changes in the quarterly and annual reports for purposes of monitoring the demonstration. The state does not need CMS approval for changes to the demonstration that are Category I changes.

If CMS determines at any time subsequent to state implementation of a Category I change that it is not consistent with state assurances, or is contrary to Federal statutes, regulations, or CMS policy, CMS reserves the right to request prompt state corrective action as a condition of continued operation of the demonstration. If the state does not take appropriate action, CMS reserves the right to end the demonstration per Paragraph 10 of these STCs.

b. Process for Category II Changes. The state will notify CMS of any change to the demonstration defined as a Category II change. This notification will include assurances that the change is consistent with Federal statutes, regulations, and CMS policy. No Federal funding shall be available for unapproved demonstration activities affected by a Category II change.

The state must submit the notification and assurances 45 calendar days prior to the date set by the state for implementing the change. CMS will not provide federal matching funds for unapproved Category II changes. After receipt of the State's written notification, CMS will notify the state:

i. Within 45 calendar days of receipt if the assurances supporting the change are approved; or
ii. Within 45 calendar days of receipt if the assurances do not establish that the change is consistent with federal statutes, regulations, and CMS policy. As part of the notification, CMS will describe the missing information, necessary corrective actions, and/or additional assurances the state must pursue to make the change consistent.
iii. During days 46 and beyond, CMS will be available to work with the state. During this time period, the state can provide to CMS additional justification or assurance in order to clarify the appropriateness of the change.
iv. During days 46 through 75, the state, upon taking appropriate action, must submit a written statement to CMS indicating how the state has addressed CMS concerns on the assurances. Within 15 calendar days of the date of the additional submission, CMS will notify the state if the assurances are approved.
v. By day 90, if the assurances have not been approved by CMS, the state may obtain reconsideration by pursuing the change again as a revised Category II change if the state has additional information, or as a Category III change.
vi. If CMS determines at any time subsequent to state implementation of an approved Category II change that the assurances are no longer valid, CMS shall request prompt state corrective action as a condition of continued operation of the demonstration.
vii. After implementation, FFP is available for approved changes.

c. Process for Category III Changes. The state must submit an amendment to the demonstration as defined in the paragraphs below.

i. 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 from CMS. Amendments to the

demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph (ii) below. The state will notify CMS of proposed demonstration changes at the monthly monitoring call, as well as in the written quarterly report, to determine if a formal amendment is necessary.

ii. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must be reviewed by the Federal Review Team and must include, but are not limited to, the following:

1. An explanation of the public process used by the state consistent with the requirements of paragraph 14 to reach a decision regarding the requested amendment;

2. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure cap. Such analysis must include current "with waiver" and "without waiver" status on both a summary and detailed level through the current extension 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;

3. An up-to-date CHIP Allotment Neutrality worksheet;

4. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation including a conforming title XIX and/or title XXI state plan amendment if necessary; and

5. A description of how the evaluation design will be modified to incorporate the amendment provisions.

V. ELIGIBILITY AND ENROLLMENT

20. Populations Affected and Eligible under the Demonstration.

The following populations listed on the tables below will receive coverage through the service delivery systems under the Comprehensive demonstration.

Mandatory and optional Medicaid and/or CHIP state plan groups described in Table 1 below derive their eligibility through the Medicaid State Plan 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, describe in Table 2 below, are subject to Medicaid and/or

CHIP laws, regulations and policies except as expressly identified as not applicable under expenditure authority granted by this demonstration.

Any Medicaid State Plan Amendments to the eligibility standards and methodologies for these eligibility groups, including the conversion to a MAGI standard January 1, 2014, will apply to this demonstration.

Mandatory and Optional Medicaid State Plan Groups

Table 1. Mandatory and Optional Medicaid State Plan Groups			
Demonstration population number	***Population description***	***Funding Stream***	***CMS-64 Eligibility Group Reporting***
Budget Population 1	Aged, blind, and disabled individuals with no third party liability.	Title XIX	ABD no TPL
Budget Population 2	Aged, blind, and disabled individuals with third party liability.	Title XIX	ABD TPL
Budget Population 3	Effective through December 31, 2013, pregnant women with incomes up to 185 percent of the federal poverty level (FPL) and children whose family incomes are up to 250 percent of the FPL who are not otherwise eligible under the approved Medicaid state plan. Effective through December 31, 2013, expenditures for parents and caretaker relatives who are not otherwise eligible under the approved Medicaid state plan with incomes that is up to 175 percent of the FPL.	Title XIX	RIte Care

Table 1. Mandatory and Optional Medicaid State Plan Groups			
Demonstration population number	***Population description***	***Funding Stream***	***CMS-64 Eligibility Group Reporting***
Budget Population 3 (continued)	Effective January 1, 2014, parents and caretakers up to 133 percent FPL. Effective January 1, 2014, pregnant women with incomes up to 185 percent of the FPL and children whose family incomes are up to 250 percent of the FPL who are not otherwise eligible under the approved Medicaid state plan.	Title XIX	RIte Care
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 (Katie Beckett up to age 19).	Title XIX	CSHCN
Budget Population 14	Women screened for breast or cervical cancer under CDC's National Breast and Cervical Cancer Early Detection Program.	Title XIX	BCCTP
Budget Population 22	Effective January 1, 2014, expenditures for adults the new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119.	Title XIX	New Adult Group

Children's Health Insurance Program (CHIP) State Plan Group

Table 2. CHIP State Plan Group			
Demonstration population number	***Population description***	***Funding Stream***	***CMS-64 Eligibility Group Reporting***
Budget Population 7	Optional targeted low-income children ages 8 through 18 with incomes up to 250% of the FPL.	Title XXI	CHIP Children

Demonstration Expansion Groups

Table 3. Demonstration Expansion Groups			
Demonstration population number	***Population description***	***Funding Stream***	***CMS-64 Eligibility Group Reporting***
Budget Population 5	Effective through December 31, 2013, women of childbearing age whose family income is at or below 200 percent of the FPL who lose Medicaid eligibility at 60 days postpartum who do not have access to creditable health insurance. Continued program eligibility for these women will be determined by the twelfth month after their enrollment in the program. Effective January 1, 2014, women of childbearing age whose family income is at or below 250 percent of the FPL who lose Medicaid eligibility at 60 days postpartum. Continued program eligibility for	Title XIX	EFP

Table 3. Demonstration Expansion Groups			
Demonstration population number	***Population description***	***Funding Stream***	***CMS-64 Eligibility Group Reporting***
Budget Population 5 (continued)	these women will be determined by the twelfth month after their enrollment in the program. Effective through December 31, 2013, expenditures for family planning services for enrollees in the Extended Family Planning program whose family incomes are between 200 and 250 percent of the FPL for services that are furnished from January 1, 2009, through the date upon which their eligibility for the program is determined using the new net income criteria of 200 percent of the FPL.	Title XIX	EFP
Budget Population 6	Budget Population 6a. Individuals who, at the time of initial application: (a) are uninsured pregnant women; (b) have no other coverage; (c) have net family incomes between 185 and 250 percent of the FPL; (d) receive benefits only by virtue of the Comprehensive demonstration; (e) meet the citizenship and identity requirements specified in the Deficit Reduction Act of 2005;	Title XIX	Pregnant Expansion

Table 3. Demonstration Expansion Groups			
Demonstration population number	***Population description***	***Funding Stream***	***CMS-64 Eligibility Group Reporting***
Budget Population 6 (continued)	and f) are covered using title XIX funds if title XXI funds are exhausted. Budget Population 6b [Pregnant Expansion]. Individuals who, at the time of initial application: (a) are pregnant women; (b) have other coverage; (c) have net family incomes between 185 and 250 percent of the FPL; (d) receive benefits only by virtue of the Comprehensive demonstration; and (e) meet the citizenship and identity requirements specified in the Deficit Reduction Act of 2005.	Title XIX	Pregnant Expansion
Budget Population 8	Parents pursuing behavioral health treatment with children temporarily in State custody with income up to 200 percent of the FPL.	Title XIX	Substitute care
Budget Population 9	CSHCN (as an eligibility factor) who are 21 and under who would otherwise be placed in voluntary State custody below 300 percent SSI.	Title XIX	CSHCN alt
Budget Population 10	Effective through December 31, 2013, those at risk for LTC with income at or below 200 percent of the FPL.	Title XIX	Elders 65 and over

Table 3. Demonstration Expansion Groups			
Demonstration population number	***Population description***	***Funding Stream***	***CMS-64 Eligibility Group Reporting***
Budget Population 10 (continued)	Effective January 1, 2014, those at risk for LTC with income at or below 250 percent of the FPL who are in need of home and community-based services (state only group).	Title XIX	Elders 65 and over
Budget Population 11	217-like Categorically Needy Individuals receiving HCBW-like services & PACE-like participants Highest need group.	Title XIX	217-like group
Budget Population 12	217-like Categorically Needy Individuals receiving HCBW-like services and PACE-like participants in the High need group	Title XIX	217-like group
Budget Population 13	217-like Medically Needy receiving HCBW-like services in the community (High and Highest group). Medically Needy PACE-like participants in the community.	Title XIX	217-like group
Budget Population 15	HCBS waiver like services for adults living with disabilities with incomes at or below 300 percent of the SSI with income and resource lists above the Medicaid limits.	Title XIX	AD Risk for LTC

Table 3. Demonstration Expansion Groups			
Demonstration population number	***Population description***	***Funding Stream***	***CMS-64 Eligibility Group Reporting***
Budget Population 16	Effective through December 31, 2013, services for uninsured adults with mental illness and or substance abuse problems with incomes below 200 percent of the FPL not eligible for Medicaid.	Title XIX	Adult Mental Unins
Budget Population 17	Coverage of detection and intervention services for at-risk young children not eligible for Medicaid up to 300 percent of SSI.	Title XIX	Youth Risk Medic
Budget Population 18	Effective through December 31, 2013, services for persons living with HIV with incomes below 200 percent of the FPL who are ineligible for Medicaid.	Title XIX	HIV
Budget Population 19	Effective through December 31, 2013, services for non-working disabled adults ages 19-64 eligible for the General Public cash assistance program, but who do not qualify for disability benefits.	Title XIX	AD Non-working
Budget Population 20	Effective January 1, 2014, 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,	Title XIX	Alzheimer adults

Table 3. Demonstration Expansion Groups			
Demonstration population number	***Population description***	***Funding Stream***	***CMS-64 Eligibility Group Reporting***
Budget Population 20	are in need of home and community care services, and whose income is at or below 250 percent of the FPL.	Title XIX	Alzheimer adults
Budget Population 21	Effective January 1, 2014, young adults aged 19-21 aging out of the Katie Beckett eligibility group with incomes below 250 percent of the FPL, who are otherwise ineligible for Medical Assistance, and are in need of services and/or treatment for behavioral health, medical or developmental diagnoses.	Title XIX	Beckett aged out

21. **AFDC-Related Eligibility Determinations.** Effective through December 31, 2013, to reflect a policy of family responsibility, in determining the eligibility of individuals reported in Budget Groups 3, 4, and 7-9, the state considers the income of the applicant based on the entire family unit, including the applicant as well as that of the following family members who reside in the household: (1) individuals for whom the applicant has financial responsibility; (2) individuals who have financial responsibility for the applicant; and (3) any other individual for whom such individual in (2) above has financial responsibility. Note: the income of a step-parent who has financial responsibility is also included when determining eligibility for an applicant child. Effective January 1, 2014, the state will use modified adjusted gross income (MAGI) methodologies for determining income for these populations, consistent with the state plan.

22. **Resource Test.** Effective through December 31, 2013, the state may elect to impose a resource test so that, notwithstanding the general financial standards described above, the state may elect to limit eligibility for individuals eligible under groups referenced above for parents and caretaker relatives, if they have liquid resources (cash, marketable securities and similar assets) at or above the amount of $10,000. Pregnant women and children are exempt from this resource test. Effective January 1, 2014, the state will use modified adjusted gross income (MAGI) methodologies for determining income for non-ABD populations and will not impose a resource test.

23. **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.

24. **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.

25. **Individuals Receiving section 1915(c)-Like Services.**

    a. 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, 435.726, and 435.236 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.

    b. 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, 435.726, and 435.236 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.

    c. Medically Needy at the High and Highest Level of Care. The state will apply the medically needy income standard plus $400. 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.

    d. 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, 435.726 and 435.236 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, 435.726 and 435.236 and section 1924 of the Act, if the state had section 1915(c) waiver programs.

26. **Maintenance of Current Optional Populations.** The State must maintain eligibility of all optional populations that are covered under the Rhode Island Medicaid State Plan as of November 1, 2008, except to the extent that this demonstration expressly permits changes in eligibility methods and standards. Any changes affecting these populations will be considered a Category III Change as specified in paragraph 18 of these STCs. In making any such changes, the State must give priority to extension or continuation of eligibility for

optional populations prior to extension or continuation of eligibility for groups not otherwise eligible under the State Plan.

27. **Extended Eligibility for Persons Transitioning between Medicaid/CHIP and Qualified Health Plans in the Marketplace.** Effective January 1, 2014, the state will extend Medicaid or CHIP eligibility for persons who are transitioning from Medicaid or CHIP to a Qualified Health Plan (QHP) through the Marketplace to the end of the month before QHP coverage may feasibly become effective. If the termination otherwise would have been effective on or before the 15th of a given month, then coverage will be extended to the end of that month. If the termination otherwise would have been effective on or after the 16th of a given month, then coverage will be extended to the end of the following month.

28. **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.

29. **Referral for More Comprehensive Coverage.** Effective January 1, 2014, in order to ensure that vulnerable populations who are not currently covered by a comprehensive health insurance plan, but receive only services through expenditure authority as described in Budget Populations 16, 18, and 19, have the opportunity to access more comprehensive care, the providers that serve these individuals must refer and educate them on how to apply for more comprehensive insurance. All individuals included in the demonstration, including the new adult group, are eligible to receive services in Attachment A.

30. **Efficient Transition to Coverage in the New Adult Group.** Individuals enrolled in Budget Populations 16, 18, and 19 prior to December 31, 2013, who have incomes up to and including 133 percent of the FPL will be eligible in the new adult group under the state plan. The state must engage in extensive outreach efforts to assure that individuals with incomes up to 133 percent of the FPL are enrolled into comprehensive Medicaid coverage.

    a. The state must attempt to contact every individual expected to lose limited benefit coverage through the demonstration and move to full Medicaid coverage;

    b. The state must assure that there is no duplication of federal funding when individuals in Budget Populations 16, 18, and 19 are enrolled to the New Adult Group.

c. No later than January 31, 2014, the state must collect data to determine whether individuals have lost demonstration coverage but have not enrolled in full Medicaid coverage. The state must share these data with CMS in writing on a monthly basis.

31. Efficient Transition to Marketplace Coverage. Effective January 1, 2014, the state reduce eligibility for parents caretaker relatives from 175 percent to 133 percent of the FPL. The state must engage in extensive outreach efforts to assure that individuals with incomes above 133 through 175 percent are seamlessly enrolled into Marketplace coverage. This may include, but is not limited to, the following actions:

a. The state must attempt to contact every individual expected to lose Medicaid coverage and move to Marketplace coverage;

b. The state must conduct community events, which will include information sessions dedicated to sharing information to assist individuals moving from Medicaid coverage to Marketplace coverage;

c. The state must conduct significant outreach and communication strategies to Marketplace Subsidy Program enrollees to ensure that they are able to remain in a QHP after January 31, 2014, when they will no longer be eligible for a premium holiday.

d. No later than January 31, 2014, the state must collect data to determine whether individuals have lost Medicaid coverage but have not enrolled in Marketplace coverage. The state must share these data with CMS on a monthly basis through March 31, 2014.

VI. BENEFITS

32. 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 as of November 1, 2008, unless specified in this document. 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. Benefits that are available to RIte Care enrollees under this demonstration include all benefits listed in Attachment A and under the Medicaid State Plan. To the extent that the state complies with the provisions of section IV to make changes in the benefit package, the state has the flexibility to provide customized benefit packages to beneficiaries based on medical need. All changes in benefits (whether reductions or additions) provided through the approved alternative benefit plan SPA, for the new adult group described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act must be submitted as an amendment to the state plan.

b. Alternative Benefit Plan. Effective January 1, 2014, the New Adult Group will receive 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 New Adult Group may receive, as part of their ABP under this

demonstration, Expenditure Authority services such as Managed Care Demonstration Only 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 250 percent of the FPL who lose Medicaid eligibility at the conclusion of their 60-day postpartum period. See Section X for more detailed requirements.

d. Long-Term Care and HCBS. Long term care services are provided when medically necessary to certain individuals eligible under the Medicaid state plan. As indicated above, the New 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 plan of care. Benefit packages for all individuals who meet the highest, high, or preventive level of care criteria will include access to core and preventive HCBS, as described in paragraph 33, subject to any waiting list as described in paragraph 34. The core and preventive service HCBS definitions are included in Attachment B of this document. The state will assure compliance with the characteristics of HCBS settings as described in 1915(c) and 1915(i) regulations in accordance with implementation/effective dates published in the Federal Register. More detailed requirements are provided in this section.

e. Limited Benefit Packages. Individuals in Budget Populations 10, 16, 18, 19, 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.

33. 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 will be provided through mandatory care management programs, which include Connect Care Choice, and Rhody Health Partners. Based on a level of care determination, individuals eligible as ABD under the Medicaid state Plan can fall into the following groups: 1) highest, 2) high, and 3) preventive.

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 core and preventive services as defined in Attachment D.

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 community based core and preventive services as defined in Attachment D.

c. Preventive level of care. Individuals who do not presently need an institutional level of care will have access to services targeted at preventing admission, re-admissions or

reducing lengths of stay in an institution. These beneficiaries will receive preventive services as defined in Attachment D.

d. Long term care services under this demonstration will include coverage of HCBS-like services that are equivalent to the services previously furnished under section 1915(c) HCBS waivers, including waiver numbers 0040.90.R5 (Aged and Disabled), 0176.90.R3 (Elderly), 0335.90.R1 (Assisted Living), 0379.90.03 (Habilitation), 0041-IP.03 (Personal Choice), 0462 (Respite for Children-Hospital), 0463 (Respite for Children-ICF/MR), 0466 (Children with Mental Illness), 0162.90.R3 (MR/DD).

e. Primary and acute care services for Medicaid ABD eligible individuals meeting the highest, high or preventive level of care may be provided through Primary Care Case Management or Rhody Health Partners or Connect Care Choice plans or other 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, managed care delivery systems of Rhody Health Options or Connect Care Choice Community Partners or through the Program of All Inclusive Care for the Elderly (PACE). This STC does not preclude the state from entering into other contract arrangements with entities that can provide these services.

34. Waiting List for HCBS. Should a waiting list for long-term care services 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.) Finally, applicants for the High group must receive services prior to applicants in the Preventive category.

35. Long-Term Care Enrollment. For those participants residing in an institution at the point of implementation of the demonstration, 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.

36. 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.

37. **Long-Term Care Insurance Partnership.** The state may 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.

VII. COST SHARING

38. 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 below.

Premium Limits for Budget Populations 3, 6, and 8

Family Income Level	children under 1*	children 1 to 19th birthday*	adults	pregnant women	extended family planning
150-185 percent FPL	None	Up to 5 percent of family income	Up to 5 percent of family income	None	None
185-200 percent FPL	None	Up to 5 percent of family income	Up to 5 percent of family income	None	None
200-250 percent FPL	None	Up to 5 percent of family income	Up to 5 percent of family income	None	None

*no cost sharing or premiums for children in foster care or adoption subsidy

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

- Cost-sharing for BBA working disabled adults defined in section 1902(a)(10)(A)(ii)(XIII) will follow the Medicaid state plan
  - All unearned income over the Medically Needy Income Limit (MNIL) will be owed as a monthly premium;
- Cost-sharing for Budget Population 10 is to be treated like post-eligibility treatment of income or spend-down requirements.
- In order to prevent families from being burdened by two sets of premium payments, for households with incomes between 150 percent FPL and 250 percent FPL in which children are Medicaid eligible and enrolled in RIte Care, and parent/caretaker relatives are enrolled in commercial coverage, will no longer be required to pay the Medicaid premium, only the premium associated with the commercial coverage.

VIII. DELIVERY SYSTEM

39. Assessment and Coordination Organization Process. Access to institutional and community-based supports and services will be through the Assessment and Coordination Organization (ACO) process. The purpose of the ACO is to streamline the intake and assessment processes and provide beneficiaries and their families with clear, concise, and accurate information about their care options. The ACO process will involve the beneficiary and involved family members, and treating practitioners and providers to ensure comprehensive assessments and care planning. The ACO is described more fully in Attachment C.

40. Long-Term Care Services. Institutional and community-based long-term care services will be 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 Rhody Health Options or Connect Care Choice Community Partners

b. Fee-for-service. Beneficiaries will be able to access long-term care services in the same way that services are accessed today, 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 by the ACO and/or the health plan or PCCM network.

c. Self-direction. Beneficiaries (or, as they authorize, their families) will also have the option to purchase HCBS waiver like services through a self-direction service delivery system. Under this option, beneficiaries will work with the ACO to develop a budget amount for services needed. The beneficiary, with the support of a fiscal intermediary, will then be able to purchase services directly. This option is based on experience from Rhode Island's section 1915(c) Cash and Counseling Waiver (*RI Personal Choice*), section 1915(c) Developmental Disabilities Waiver, and Personal Assistance Service and Supports program. Self-direction is fully described in the Self-direction Operations Section.

41. Primary and Acute Care Services. Primary and acute care services will be delivered through the following systems:

a. Managed Care Organizations: RIte Care, Rhody Health Partners, Rhody Health Options or Connect Care Choice Community Partners

b. Primary Care Case Management Program: Connect Care Choice

c. Pre-paid Dental Ambulatory Health Plans: RIte Smiles

d. PACE: PACE Organization of Rhode Island

e. Premium Assistance: Rite Share

f. Fee-for-service

42. 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).

The state will continue to maintain a contract with a health care management consulting firm experienced in health plan management, which will be responsible for managing the operational and administrative aspects of the program under the State's direction.

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

44. Selective Contracting. The state may pursue selective contracting in order to restrict the provider from (or through) whom an individual can obtain services. Emergency services and family planning services will not be covered by this provision. Providers with whom the state contracts will meet, accept, and comply with the reimbursement, quality, and utilization standards under the state plan, which standards shall be consistent with section 1923 of the Act. These standards are consistent with access, quality, and efficient and economic provision of covered care and services. Restrictions on providers will not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing those services.

If the state pursues selective contracting for nursing facilities, the state must submit, for CMS review and approval, a description of the process for selecting providers of nursing facility services and allocating nursing facility beds. The state must demonstrate that the process used to select providers of nursing facility services and to allocate Medicaid reimbursed nursing facility beds is consistent with access, quality, and efficient and economic provision of care and services for all participants needing nursing facility services including special regard to access to services for individuals with complex long-term care needs.

45. Process for the Review and Approval of Contracts. The following process applies to contracts between the state and managed care organizations, pre-paid ambulatory health plans; primary care case management providers, and contracts pursuant to the selective contracting process.

All contracts listed above and modifications of existing contracts must be approved by CMS prior to the effective date of the contract or modification of an existing contract. The state will submit to CMS copies of the contracts or modifications and documentation supporting compliance with state and Federal statutes, regulations, special terms and conditions, and waiver and expenditure authority 45 days prior to implementation.

IX. SELF-DIRECTION

46. Required Elements of Self-Direction. The state must meet the following requirements to operate its self-direction program for core and preventive services including through a High-Fidelity Wraparound process for children in residential treatment who are transitioning back to a home-based setting.

47. Voluntary Program. The program is voluntary for demonstration eligibles who are eligible for and receiving home and community based long-term care services and supports.

48. Paid Providers of Services. Except for legally liable relatives, such as spouses and parents, any individual capable of providing the assigned tasks and freely chosen by a participant to be a paid provider of self-directed services and supports may be hired by the participant. Participants retain the right to: 1) train their workers 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 workers so that their workers can meet any additional qualifications required or desired by the participants.

49. Information Furnished to Participants. The following information must be provided to participants: principles and benefits of participant direction; participants' rights, roles and responsibilities; self-direction election form; description of other feasible alternatives; fiscal/employer agent contact information; counseling/service advising agency contact information; grievance and appeal process and forms; roles and responsibilities of the fiscal/employer agent and the counseling/advising agency; and participant-directed planning. Trained advisers from the service advisement agency will provide the information to participants.

50. Assessment. An assessment 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, will be completed. The assessment includes 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. The assessment information supports the development of the person-centered service plan and individual budget.

51. 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. An Individual Service and Spending Plan (ISSP) is developed with the assistance of the service advisor team and those individuals the participant chooses to include. The ISSP includes the services and supports that the participant needs to live independently in the community. A back-up plan must be developed and incorporated into the ISSP to assure that the needed assistance will be provided in the event that the regular services and supports identified in the ISSP are temporarily unavailable. The back-up plan may include other individual assistants or agency services. 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 ISSP will be reviewed and

updated at least annually. Entities or individuals that have responsibility for service plan development may not provide other direct demonstration services to the participant.

52. **Employer Authority.** Participants have the opportunity to exercise choice and control (i.e., hire, fire, supervise, manage) over individuals who furnish their long term care demonstration services authorized in the person-centered service plan. In this demonstration, the participant functions as the employer of record of workers who furnish direct services and supports to the participant.

53. **Budget Authority.** Participants also have the opportunity to exercise choice and control over a specified amount of funds in a 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 long term care demonstration services and supports that are authorized in the person-centered service plan.

54. **Individual Budget.** An individual budget is the amount of funds available to the participant to self-direct. It 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 to calculate the resources available to each participant that is open to public inspection; and reviewed according to a specified method and frequency. A change in the budget must also result in a change to the person-centered plan.

55. **Information and Assistance in Support of Participant Direction.** The state shall have a support system that provides participants with information, training, counseling, and assistance, as needed or desired by each participant, to assist the participant to effectively direct and manage his or her self-directed services and budgets. Participants shall be informed about self-directed care, including feasible alternatives, before electing the self-direction option. Participants shall also have access to the support system throughout the time that they are self-directing their care. Support activities include, but are not limited to, advisement agency services and financial management services.

56. **Counseling/Advisement Agencies.** The state shall provide each participant with a Service Advisor from a counseling/advisement agency that conducts participant screening, assessment and reassessment; 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. Counseling/advisement agencies shall meet state established certification standards to provide supports to participants.

57. **Financial Management Services.** The state shall provide financial management services (FMS) that: provide payroll services for program participants and/or designated representatives; are responsible for all taxes, fees, and insurances required for the program participant to act as an employer of record; manage all non-labor related payments for goods and services authorized in the participant's approved spending plan; assure that all payments made under the demonstration comply with the participant's approved spending plan; and conduct criminal background and abuse registry screens of all participant employees at the

State's expense. FMS entities shall meet IRS requirements of being a fiscal/employer agent and state established certification standards to provide supports to participants. FMS shall be reimbursed as an administrative activity at the 50 percent administrative rate.

58. **Services to be Self-Directed.** Participants who elect the self-direction opportunity will have the option to self-direct all or some of the long-term care core and preventive services and supports under the demonstration. The services, goods, and supports that participants will self-direct are limited to the core and preventive services, listed in Attachment B. Services, goods, and supports that are not subject to employer and budget authority, i.e., participants do not have hiring authority and do not become the employer of record over these services, goods or items, will still be included in the calculations of participants' budgets. Participants' budget plans will reflect the plan for purchasing these needed services, goods and supports.

59. **Individual Directed Goods and Services.** 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 service 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 will 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 Core and Preventive Services.

60. **Participant Direction by Representative.** The state provides for the direction of services by a representative. The representative may be a legal representative of the participant or a non-legal representative freely chosen by an adult participant. The representative shall not be paid and must pass a screen indicating ability to perform the functions in the best interest 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, will be required to select a representative to assist him or her with the responsibilities of self-direction. If a participant refuses to select a representative, or if a participant loses a representative (if already required for participation) and cannot locate a replacement, he or she will be required to transfer to a non-self-directed traditional service delivery system. Service advisors will assist the participant in the transition to the traditionally delivered service system to ensure continuity of care.

61. **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.

62. **Service Plan Monitoring.** The Service Advisor shall, at a minimum, make quarterly in-person visits to the participant and monthly telephone contact in the first year, then semi-annual in-person and quarterly phone contact thereafter or more when requested or indicated by concern. Additionally, the RN and Mobility Specialist assess for needs at least annually.

The entire Service Advisor Team is available to the participant upon request and/or Advisor identification of a potential health/safety concern.

63. **Expenditure Safeguards.** The FMS reports monthly to the participant and the Service Advisor, and quarterly to the state, on the budget disbursements and balances. If more than 20 percent underutilization of authorized services is discovered, the Service advisor will work with the participant in assessing the reason and crafting a solution, such as a new worker or a reassessment of needs.

64. **Disenrollment.** 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, such as a continuous demonstrated 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. A participant who has demonstrated an inability to self-direct his or her services and supports will be required to select a representative to assist the participant with the responsibilities of self-direction. If a participant voluntarily or involuntarily disenrolls from the self-directed service delivery option, the state must have safeguards in place to ensure continuity of services.

65. **Fair Hearing.** Participants may request a fair hearing when a reduction in services occurs or when a requested adjustment to the budget is denied or the amount of the budget is reduced.

66. **Cash Option.** At such time as the state elects, a participant may elect to receive the amount of the funds in his or her individual budget in a prospective cash disbursement. Prior to the election of the cash option, the state will notify CMS of this election according to the Process for Category II changes. Prior to implementation of the cash option, the state will secure a waiver of the income and asset requirements from the Social Security Administration.

67. **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 according to the Process for Category II changes. 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 Category III changes.

68. **Personal Needs Allowance.** Effective January 1, 2014, the state will 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.

X. EXTENDED FAMILY PLANNING PROGRAM

69. 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 women, meeting the eligibility criteria below into the demonstration who have a family income at or below 200 percent of the FPL (through December 31, 2013) and at or below 250 percent of the FPL (beginning January 1, 2014) and who are not otherwise enrolled in Medicaid or Children's Health Insurance Plan (CHIP). Women losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum and who have a family income at or below 200 percent of the FPL (through December 31, 2013) and at or below 250 percent of the FPL (beginning January 1, 2014) at the time of annual redetermination are auto enrolled in the Extended Family Planning group.

70. 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.

71. Eligibility Redeterminations. The state must ensure that redeterminations of eligibility for this component of the demonstration are conducted, at a minimum, once every 12 months. At the State's option, redeterminations may be administrative in nature.

72. Disenrollment from the Extended Family Planning Program. If a woman becomes pregnant while enrolled in the Extended Family Planning Program, she may be determined eligible for Medicaid under the State plan. The State must not submit claims under the demonstration for any woman who is found to be eligible under the Medicaid State plan. In addition, women who receive a sterilization procedure and complete all necessary follow-up procedures will be disenrolled from the Extended Family Planning Program.

73. Extended Family Planning Program Benefits. Benefits for the family planning expansion group are limited to family planning and family planning-related services. 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 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. Sexually transmitted infection (STI) testing, 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.

74. 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 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. 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. Drugs for the treatment of STIs/STDs, except for HIV/AIDS and hepatitis, when the STI/STD is identified/ diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/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. 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.

d. Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.

e. 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.

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

XI. RITE SMILES

76. 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 born on or after May 1, 2000. The managed care delivery system is continuing under this demonstration. 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.

XII. DESIGNATED STATE HEALTH PROGRAMS (DSHP)

77. Marketplace Subsidy Program. Effective January 1, 2014, the state may claim as allowable expenditures under the demonstration the payments made through its state-funded program to provide premium subsidies for parents and caretaker relatives with incomes above 133 percent of the FPL through 175 percent of the FPL who purchase health insurance through the Marketplace. For the month of January 2014, the payments made by the Marketplace Subsidy Program may serve to create a premium holiday for beneficiaries. During the month of January 2014, the payments made by the Marketplace Subsidy Program may equal up to 100 percent of the QHP premium amount, where the premium has been reduced by any federal tax credits for which a beneficiary is eligible. Effective February 1, 2014, 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 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)*

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 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.

a. Funding Limit. Expenditures for the subsidies are limited on an annual basis as follows (total computable). Expenditures for DYs 9 and 10 are contingent upon CMS approval of the evaluation report required in STC 94.

	DY 6	DY 7	DY 8	DY 9	DY 10
DSHP - State-Funded Marketplace Subsidy Limit	$3,298,154	$3,021,190	$3,270,462	$3,540,302	$3,540,302

b. Reporting. The state must provide data regarding the operation of this subsidy program in the quarterly report required per STC 94. This data must, at a minimum, include:

   i. The number of individuals served by the program each month;
   ii. The size of the subsidies; and
   iii. A comparison of projected costs with actual costs.

c. Evaluation. In DY 7 as part of the annual report, the state must evaluate the effect of the Marketplace Subsidy Program for enrollment in a QHP, using childless adults who are not eligible to receive a subsidy as a comparison group, as required per STC 94. The state must submit this report no later than May 1, 2016. CMS will evaluate the report and determine whether the state has met the requirements 60 days after receipt of the report. If the report does not meet CMS approval, federal funding for the Marketplace Subsidy Program for DYs 9 and 10 may be denied.

d. Budget Neutrality. This subsidy program will be subject to the budget neutrality limit specified in STC 113.

78. Expenditures for Limited Benefit Budget Populations. Effective January 1, 2014, the state may claim as allowable expenditures under the demonstration the payments made through its state-funded program to provide for a limited benefit package of supplemental services as follows:

   a. **Uninsured Adults with Mental Illness.** Effective January 1, 2014 through April 30, 2014, expenditures for a state-funded program that provides a limited benefit package of supplemental services for uninsured adults with mental illness and or substance abuse problems with incomes below 200 percent of the FPL. Effective May 1, 2014, expenditures for a state-funded program that provides a limited benefit package of supplemental services for uninsured adults with mental illness and or substance abuse problems with incomes above 133 percent of the FPL and below 200 percent of the FPL who are ineligible for Medicaid.

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

persons living with HIV with incomes above 133 percent of the FPL and below 200 percent of the FPL who are ineligible for Medicaid.

c. **Non-working disabled adults.** Effective January 1, 2014 through April 30, 2014, expenditures for a state-funded program that provides a limited benefit package of supplemental services for non-working disabled adults ages 19-64 eligible for the General Public cash assistance program. Effective May 1, 2014, expenditures for a state-funded program that provides a limited benefit package of supplemental services for non-working disabled adults ages 19-64 eligible for the General Public cash assistance program with incomes above 133 percent of the FPL, but who do not qualify for disability benefits.

XIII. HEALTHY BEHAVIORS INCENTIVES PROGRAM

79. Healthy Behaviors Incentives. Subject to federal approval, the state may establish a program based on incentives: individuals who adopt healthy behaviors may be eligible for rewards, ranging from a gift card for health-related goods to a premium holiday. Such program may be a part of state's efforts to reduce emergency room utilization, such as through the Communities of Care program.

80. Healthy Behaviors Incentives Protocols. The state is required to submit protocols pertaining to the program no later than 60 days after the date of this approval (Attachment H). Protocols must include, at a minimum, descriptions of the following:

a. Populations impacted

b. Incentives offered to beneficiaries

c. Any penalties to disincentivize unhealthy behaviors

d. Payment and financing methodologies, explaining which entities receive and administer funding, how incentive amounts are determined, and an explanation of any quality controls used to ensure proper use of funds**.**

XIV. PAYMENTS TO FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs) FOR UNINSURED POPULATIONS

81. Overview. Since this demonstration was approved in 2009, federal financial participation (FFP) has been authorized for payments to FQHCs for uninsured populations (Budget Services 5).

82. Available FFP. Annually, FFP is authorized to pay for limited benefits for uninsured populations in FQHCs until December 31, 2015 up to $1.3 million total computable. Payments made by the state are limited to no more than the total of actual costs incurred in any given year. Expenditures may be made to the list of providers found in Attachment J for care to the uninsured. There shall be no FFP available for treatment of unqualified aliens. In

the overall calculation of uninsured costs, the state must reduce the calculation by one percent to account for unallowable costs of services for unqualified aliens.

83. **Category III Request.** CMS may only consider a request to continue payments to FQHCs for uninsured populations past December 31, 2015 if the state has submitted a category III request in conformity with STC 19 and the state has submitted the required information on the need for uncompensated care in their annual report, discussed in STC 94.

84. **Eligible Providers.** The state may pay for uninsured care to FQHCs listed in Attachment J. Any changes to Attachment J must be approved by CMS. The state must report to CMS any changes to the operational status of any FQHC listed in Attachment J.

85. **Reporting Payments to FQHCs.** The state will report all expenditures for uninsured care payments to FQHCs under this demonstration on the Forms CMS-64.9 Waiver and/or 64.9P Waiver under the appropriate waiver name.

86. **Aggregate Annual Limit of Payments.** Each FQHC's uninsured care cost is net of the waiver payments received under this section. Any excess waiver payments made to an individual FQHC above its uninsured care costs will be recouped and redistributed to other FQHCs, using the same methodology as the original FQHC uninsured care payments, which are distributed proportionately based on the FQHC's uninsured care costs. The redistribution will only be made to the extent that such redistribution does not result in any FQHC receiving payments for uninsured care in excess of its uninsured care costs. Any excess waiver payments will be redistributed to other qualifying FQHCs.

XV. GENERAL REPORTING REQUIREMENTS

87. **General Financial Requirements.** The state must comply with all general financial requirements under title XIX and title XXI set forth in sections XVI and XVII, respectively.

88. **Compliance with Managed Care Reporting Requirements.** The state must comply with all managed care reporting regulations at 42 CFR 438 *et. seq*. except as expressly waived or identified as not applicable in the expenditure authorities incorporated into these STCs.

89. **Reporting Requirements Relating to Budget Neutrality.** The state shall comply with all reporting requirements for monitoring budget neutrality as set forth in section XVIII.

90. **Title XXI Reporting Requirements.** The state will provide to CMS on a quarterly basis, an enrollment report for the title XXI populations showing end of quarter actual and unduplicated ever enrolled figures. This data will be entered into the Statistical Enrollment Data System within 30 days after the end of each quarter.

91. **Confirmation of CHIP Allotment with the Submission of CHIP State Plan Amendments.** Should the state seek an amendment under the CHIP state plan that has a budgetary impact on allotment neutrality, the state shall submit an updated allotment neutrality budget with the CHIP state plan amendment for CMS review and approval.

92. **Quarterly Calls.** CMS shall schedule quarterly conference calls with the state for the duration of the demonstration. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, quality of care, access, benefits, audits, lawsuits, financial reporting and budget neutrality issues, health plan financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers, or state plan amendments the state is considering submitting. The state and CMS shall discuss quarterly expenditure reports submitted by the state for purposes of monitoring budget neutrality. CMS shall update the state on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the demonstration. The state must inform CMS of any changes it anticipates making to the demonstration as a Category I, II, or III change. The state and CMS shall jointly develop the agenda for the calls.

93. **Quarterly Operational Reports.** The state must submit quarterly progress reports in the format specified in Attachment E no later than 60 days following the end of each quarter.

    The intent of these reports is to present the State's analysis and the status of the various operational areas under the demonstration. These quarterly reports must include, but are not limited to:

    a. Updated budget neutrality and allotment neutrality monitoring spreadsheets;

    b. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery including approval and contracting with new plans; benefits; cost-sharing, enrollment; grievances; quality of care; access; health plan financial performance that is relevant to the demonstration; pertinent legislative activity; and other operational issues;

    c. Action plans for addressing any policy and administrative issues identified;

    d. Any changes the state made or plans to make to the demonstration as a Category I or II change;

    e. The number of individuals enrolled in each major program of the Comprehensive demonstration; including, but not limited to TANF and related programs, the extended family planning program; each of the limited benefit programs; and ABD with breakouts for the LTC reform community and institutional programs;

    f. The number of individuals served by and costs of the Marketplace Subsidy program; and

    g. Evaluation and Quality Assurance and Monitoring activities and interim findings.

94. **Annual Report.** The state must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the demonstration. This report must also

contain a discussion of the items that must be included in the quarterly operational reports required under paragraph 93. The state shall submit the draft annual report no later than 120 days following the end of the demonstration year (May 1st). Within 30 days of receipt of comments from CMS, a final annual report shall be submitted.

The annual report for year 3 of the demonstration shall include an evidence package that CMS can use to conduct a quality review of the State's Home and Community-Based Services system operated under the demonstration. This review will be similar to the quality review currently conducted on all section 1915(c) waivers and will be used to evaluate the overall performance of the HCBS program and to identify the need for any modifications or technical assistance necessary to continue successful operation of the program. Attachment G is a listing of the types of evidence-based information CMS must review in order to determine the State's implementation of its quality management and improvement strategy – that is discovery, remediation, and improvement activities with regard to HCBS waiver assurances. After reviewing the evidence package, the CMS Regional Office will contact the state staff to discuss necessary follow-up activities.

For DY 7, the state must present an evaluation of the impact of the Marketplace Subsidy Program on QHP enrollment trends. The evaluation must address the following questions:

- How many parents/caretaker adults with incomes between 133 and 175 percent of the FPL have taken up QHP coverage with the assistance of the Marketplace Subsidy Program?
- How many childless adults with incomes between 133 and 175 percent of the FPL have taken up QHP coverage?
- Do enrollment trends in QHPs differ significantly between parents and childless adults with incomes between 133 and 175 percent of the FPL?
- Based on the findings of this evaluation, please explain the state's recommendations for the future of the Marketplace Subsidy Program.

Beginning in 2014, as part of each annual report, the state must collect and report data on the use of the payments for uninsured populations to FQHCs, (payments described in STC 81). The state must report on the costs associated with these individuals by provider, as outlined in Attachment J. In the report, the state must include information about the uninsured people being served by FQHCs including, but not limited to the following:

- The number of FQHC uninsured encounters
- Costs of FQHC uninsured encounters
- Number of uninsured people in the state
- General description of who the uninsured are, such as individuals who are difficult to enroll due to homelessness, individuals who report finding coverage cost prohibitive as the reason for lack of coverage, etc.

XVI. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

95. Quarterly Expenditure Reports. The state shall provide quarterly expenditure reports using the form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority.

This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in section XVIII.

96. **Reporting Expenditures Under the Demonstration.** In order to track expenditures under this demonstration, Rhode Island must report demonstration expenditures through the Medicaid and state Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 and Section 2115 of the state Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). Expenditures for optional targeted low income children (CHIP Children) claimed under the authority of title XXI shall be reported each quarter on forms CMS-64.21U Waiver and/or CMS 64.21UP Waiver.

    a. For the extended family planning component of the demonstration, the state should report demonstration expenditures on Forms CMS-64.9 Waiver and/or 64.9P Waiver as follows:

        i. Allowable family planning expenditures eligible for reimbursement at the State's Federal medical assistance percentage rate (FMAP) should be entered in Column (B) on the appropriate waiver sheets.
        ii. Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate should be entered in Column (D) on the appropriate waiver sheets.

    b. Premiums and other applicable cost sharing contributions from enrollees that are collected by the state under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns (A) and (B). Additionally, the total amounts that are attributable to the demonstration must be separately reported on the CMS-64 Narrative by demonstration year.

    c. For each demonstration year, twenty eight (28) separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed to report expenditures for the following demonstration populations and demonstration services. The waiver names to be used to identify these separate Forms CMS-64.9 Waiver and/or 64.9P Waiver appear in the second column of the tables below, labeled "CMS-64 Eligibility Group Reporting." Expenditures should be allocated to these forms based on the guidance found below.

Demonstration population number	***CMS-64 Eligibility Group Reporting***	***PMPM Grouping for Without Waiver Budget Neutrality Worksheets***
Budget Population 1	ABD no TPL	ABD no TPL
Budget Population 2	ABD TPL	ABD TPL
Budget Population 3	RIte Care	RIte Care
Budget Population 4	CSHCN	CSHCN
Budget Population 14	BCCTP	ABD no TPL, ABD TPL
Budget Population 22	New Adult Group	Low-Income Adult Group

Demonstration population number	***CMS-64 Eligibility Group Reporting***	***PMPM Grouping for Without Waiver Budget Neutrality Worksheets***
Budget Population 7	CHIP Children	RIte Care

Demonstration population number	***CMS-64 Eligibility Group Reporting***	***PMPM Grouping for Without Waiver Budget Neutrality Worksheets***
Budget Population 5	EFP	Family Planning Group
Budget Population 6	Pregnant Expansion	RIte Care
Budget Population 8	Substitute care	CSHCN
Budget Population 9	CSHCN Alt	CNOM
Budget Population 10	Elders 65 and over	CNOM
Budget Population 11	217-like group	217-like Group

Demonstration population number	***CMS-64 Eligibility Group Reporting***	***PMPM Grouping for Without Waiver Budget Neutrality Worksheets***
Budget Population 12	217-like group	217-like Group
Budget Population 13	217-like group	217-like Group
Budget Population 15	AD Risk for LTC	CNOM
Budget Population 16	Adult Mental Unins	CNOM
Budget Population 17	Youth Risk Medic	CNOM
Budget Population 18	HIV	CNOM
Budget Population 19	AD Non-working	CNOM
Budget Population 20	Alzheimer adults	CNOM
Budget Population 21	Beckett aged out	CNOM

Demonstration services number	***CMS-64 Eligibility Group Reporting***	***PMPM Grouping for Without Waiver Budget Neutrality Worksheets***
Budget Services 1	Windows	CNOM
Budget Services 2	RIteShare & Colltns	RIte Care
Budget Services 3	Other Payments	RIte Care
Budget Services 4	Core Preventive Services	CNOM
Budget Services 5	FQHCs	CNOM

d. Specific Reporting Requirements for Budget Population 7.

i. The state is eligible to receive title XXI funds for expenditures for this demonstration population, up to the amount of its title XXI allotment (including

any reallocations or redistributions). Expenditures for these children under title XXI must be reported on separate Forms CMS-64.21U Waiver and/or 64.21UP Waiver in accordance with the instructions in section 2115 of the state Medicaid Manual.

ii. Title XIX funds are available under this demonstration if the state exhausts its title XXI allotment (including any reallocations or redistributions). If the state exhausts its available title XXI funds prior to the end of a Federal fiscal year, title XIX Federal matching funds are available for these children. During the period when title XIX funds are used, expenditures related to this demonstration population must be reported as waiver expenditures on the Forms CMS 64.9 Waiver and/or CMS 64.9P Waiver and will be considered expenditures subject to the budget neutrality agreement as defined in paragraph 97.

e. Description of Budget Services.

i. Budget Services 1 [Windows]. Cost of replacement windows in residences of lead poisoned eligibles.

ii. Budget Services 2 [RIteShare & Colltns]. Premiums paid by state for ESI coverage and premiums paid by RIte Care enrollees.

iii. Budget Services 3 [Other Payments]. Payments to health plans for performance incentives; risk sharing; and stop loss, as well as FQHC supplemental payments.

iv. Budget Services 4 [Core Preventive Services]. Core and preventive services for Medicaid-eligible at-risk youth.

v. Budget Services 5 [FQHCs]. Services billed to the Rhode Island Office of Health and Human Services by the FQHCs for providing a limited benefit package for uninsured individuals.

97. Expenditures Subject to the Budget Neutrality Agreement. For purposes of this section, the term "expenditures subject to the budget neutrality agreement" means expenditures for all medical assistance payments except DSH, the phased-down Part D contributions and LEA payments. Such expenditures include all expenditures that are described in paragraph 96. Payments for medical assistance for emergency services for non-qualified aliens are subject to the budget neutrality agreement. All expenditures that are subject to the budget neutrality agreement are considered demonstration expenditures and must be reported on Forms 64.9 Waiver and/or 64.9P Waiver.

98. Premium Collection Adjustment. The state must include demonstration premium collections as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis on the budget neutrality monitoring spreadsheet.

99. Administrative Costs. Administrative costs will not be included in the budget neutrality agreement, but the state must 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.

100. Claiming Period. All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 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 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must 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.

101. Reporting Member Months. The following describes the reporting of member months for demonstration populations:

a. For the purpose of monitoring the budget neutrality agreement and for other purposes, the state must provide to CMS, as part of the quarterly report required under paragraph 93, the actual number of eligible member months for all Budget Populations defined in paragraph 96. The state must submit a statement certifying the accuracy of this information accompanying the quarterly report.

   To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

b. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member months.

102. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. Rhode Island must estimate matchable demonstration expenditures (total computable and Federal share) subject to the budget neutrality agreement 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 must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the 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.

103. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the demonstration as a whole as outlined below, subject to the limits described in section XVIII:

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

b. Net medical assistance expenditures made under section 1115 demonstration authority with dates of service during the demonstration period.

104. Extent of Federal Financial Participation for the Extended Family Planning Program. CMS shall provide Federal Financial Participation (FFP) for CMS-approved services (including prescriptions) provided to women under the extended family planning program at the following rates and as described in Section X of these STCs.

a. For procedures or services clearly provided or performed for the primary purpose of family planning (contraceptives and sterilizations) and which are provided in a family planning setting, FFP will be available at the 90 percent Federal matching rate. Procedure codes for office visits, laboratory tests, and certain other procedures must carry a diagnosis that specifically identifies them as a family planning service.

b. Family planning-related services reimbursable at the Federal Medical Assistance Percentage (FMAP) rate are defined as those services generally performed as part of, or as follow-up to, a family planning service for contraception. Such services are provided because a "family planning-related" problem was identified/ diagnosed during a routine/periodic family planning visit. Services/surgery, which are generally provided in an ambulatory surgery center/facility, a special procedure room/suite, an emergency room, an urgent care center, or a hospital for family planning-related services, are not considered family planning-related services and are not covered under the demonstration.

c. FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. For example, in the instance of testing for sexually transmitted infections as part of a family planning visit, FFP will be available at the 90 percent Federal matching rate. Subsequent treatment would be paid for at the applicable federal matching rate for the state. For testing or treatment not associated with a family planning visit, no FFP will be available.

d. CMS will provide FFP at the appropriate 50 percent administrative match rate for general administration costs, such as, but not limited to, claims processing, eligibility assistance and determinations, outreach, program development, and program monitoring and reporting.

105. Sources of Non-Federal Share. Rhode Island certifies that the matching non-federal share of funds for the demonstration is state/local monies. Rhode Island further certifies that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. Premiums paid by enrollees and collected by the state shall not be used as a source of non-federal share for the demonstration. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. Rhode Island agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
b. Any amendments that impact the financial status of the program shall require Rhode Island to provide information to CMS regarding all sources of the non-Federal share of funding.

Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state government to return and/or redirect any portion of the Medicaid payments. 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, and 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**.**

106. Monitoring the Demonstration. The state will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame

107. Mandated Increase in Physician Payment Rates in 2013 and 2014. Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law110-152) requires state Medicaid programs to pay physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014. The federal government provides a Federal medical assistance percentage of 100 percent for the claimed amount by which the minimum payment exceeds the rates that would have been paid for those services as of July 1, 2009. The state must exclude from the budget neutrality test for this demonstration the portion of the mandated increase for which the federal government pays 100 percent. Should the state elect this, these amounts must be reported on the base forms CMS-64.9, 64.21, or 64.21U (or their "P" counterparts), and not on any waiver form.

XVII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

108. Quarterly Expenditure Reports. In order to track title XXI expenditures under this demonstration, the state must report quarterly demonstration expenditures through the MBES/CBES, following routine CMS-64.21 reporting instructions as outlined in sections 2115 and 2500 of the state Medicaid Manual. Eligible title XXI demonstration expenditures are expenditures for services provided to title XXI children who are eligible with FPL levels within the approved CHIP state plan. CMS will provide enhanced FFP only for allowable expenditures that do not exceed the State's available title XXI funding.

Title XXI expenditures must be reported on separate Forms CMS-64.21U Waiver and/or CMS-64.21UP Waiver, identified by the Demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made).

109. Claiming Period. All claims for expenditures related to the demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately on the Form CMS-21 net expenditures related to dates of service during the operation of the section 1115 demonstration.

110. Standard CHIP Funding Process. The standard CHIP funding process will be used during the demonstration. Rhode Island must estimate matchable expenditures for CHIP Children and Pregnant Women between 185 percent and 250 percent of the FPL on the quarterly Form CMS-37.12 (Narrative) for both Medicaid Assistance Payments (MAP) and state and local Administrative costs (ADM). CMS will 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 must submit the Form CMS-64.21U Waiver and/or CMS-64.21UP Waiver. CMS will reconcile expenditures reported on the Form CMS-64.21 waiver forms with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

111. Limit on Title XXI Funding. Rhode Island will be subject to a limit on the amount of Federal title XXI funding that the state may receive on demonstration expenditures during the demonstration period. Federal title XXI funding available for demonstration expenditures is limited to the State's available allotment, including any redistributed funds. Should the state expend its available allotment and redistribution, no further enhanced Federal matching funds will be available for the expenditures for demonstration Populations 6 and 7 until the next allotment becomes available. Once all available title XXI funds are exhausted, the state will continue to provide coverage to Demonstration Population 6 and 7 and is authorized to claim Federal funding under title XIX funds (title XIX funds are not available for the separate program) until further title XXI Federal funds become available. The state must request a Category II change per the process outlined in STC 18 and notify CMS of its intent to exercise its authority to cover Population 7 using title XIX funds. When title XXI funds are exhausted Population 7 derives its eligibility through the costs not otherwise matchable authority under the demonstration and will be considered a title XIX expenditure.

112. Limit on Administrative Costs. Total expenditures for outreach and other reasonable costs to administer the title XXI state plan and for the demonstration that are applied against the State's title XXI allotment may not exceed 10 percent of total expenditures.

XVIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

113. Limit on Title XIX Funding. The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. For the first five years of the demonstration, the limit was set at an aggregate amount of $12.075 billion (total computable), and beginning January 1, 2014, the limit is determined by using a per capita cost method. Budget neutrality

expenditure limits are set on a yearly basis based on calculated member months with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

114. Risk. Effective January 1, 2014, the state will be at risk for the per capita cost for demonstration populations as defined in STC 20, but not at risk for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the state at risk for changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

115. Calculation of the Budget Neutrality Limit. For the purpose of calculating the overall budget neutrality limit for the demonstration beginning January 1, 2014, separate annual budget limits will be calculated for each DY on a total computable basis, as described in STC 116.a. below. The annual limits will then be added together with the prior aggregate cap amount ($12.075 billion) 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 of this limit will be calculated by multiplying the total computable budget neutrality limit by Composite Federal Share 1, which is defined in STC 119 below. The demonstration expenditures subject to the budget neutrality limit are those reported under the following Waiver Names (ABD Adults No TPL, ABD Adults TPL, RIte Care, CSHCN), plus any excess spending from the Supplemental Tests described in STCs 117 and 118.

116. Per Capita Budget Neutrality Limit and Aggregate Adjustment. For each DY, separate annual budget limits of demonstration service expenditures will be calculated. Each annual budget limit will have per capita and aggregate components.

a. Per capita limits. The per capita component is determined as the sum of the products of the trended monthly per person cost times the actual number of eligible/member months, as reported to CMS by the state under the guidelines set forth in STC 101. The trend rates and per capita cost estimates for each MEG for each year of the demonstration are listed in the table below.

MEG	Trend Rate	DY 6 (CY 2014)	DY 7 (CY 2015)	DY 8 (CY 2016)	DY 9 (CY 2017)	DY 10 (CY 2018)
ABD Adults No TPL	4.3%	$2,667	$2,781	$2,899	$3,023	$3,152
ABD Adults TPL	4.3%	$3,016	$3,144	$3,278	$3,417	$3,563
RIte Care	5.2%	$455	$479	$504	$530	$558
CSHCN	5.0%	$2,689	$2,825	$2,967	$3,116	$3,273

b. Aggregate adjustments. The difference between actual demonstration expenditures for DY 1 – 5 and the demonstration's aggregate cap for DY 1-5 ($12.075 billion) will be added to the per capita limits to determine the cumulative budget neutrality limit for the demonstration.

117. Supplemental Budget Neutrality Test 1: Hypothetical Groups. Effective January 1, 2014, the budget neutrality test for this demonstration includes an allowance for hypothetical populations, which are optional populations that could have been added to the Medicaid program through the state plan, but instead will be covered in the demonstration only. The expected costs of hypothetical populations are reflected in the "without-waiver" budget neutrality expenditure limit. The state must not accrue budget neutrality "savings" from hypothetical populations. To accomplish these goals, a separate expenditure cap is established for the hypothetical groups, to be known as Supplemental Budget Neutrality Test 1.

a. The MEGs listed in the table below are for the Supplemental Budget Neutrality Test 1.

MEG	Trend Rate	DY 6 (CY 2014)	DY 7 (CY 2015)	DY 8 (CY 2016)	DY 9 (CY 2017)	DY 10 (CY 2018)
217-like Group	3.1%	$3,629	$3,735	$3,848	$3,968	$4,095
Family Planning Group	5.3%	$19	$20	$21	$22	$23

b. The Supplemental Cap 1 is calculated by taking the PMPM cost projection for each group in the above table in each DY, times the number of eligible member months for that group and DY, and adding the products together across groups and DYs. The Federal share of Supplemental Cap 1 is obtained by multiplying the total computable Supplemental Cap 1 by Composite Federal Share 2.

c. Supplemental Budget Neutrality Test 1 is a comparison between the Federal share of Supplemental Cap 1 and total FFP reported by the State for hypothetical groups under the MEG "217-like group" described in STC 96.

d. If total FFP for hypothetical groups should exceed the Federal share of Supplemental Cap 1, the difference must be reported as a cost against the budget neutrality limit described in paragraph 102.

118. Monitoring of New Adult Group Spending and Opportunity to Adjust Projections. For each DY, a separate annual budget limit for the new adult group will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the state under the guidelines set forth in STC 101**.** The trend rates and per capita cost estimates for the new adult group are listed in the table below.

MEG	Trend Rate	DY 6 – PMPM	DY 7 - PMPM	DY 8 - PMPM	DY 9 - PMPM	DY 10 - PMPM
New Adult Group	5.1%	$773	$813	$855	$899	$945

a. If the state's experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the new adult group PMPM limit described above may underestimate the actual costs of medical assistance for the new adult group, the state has the opportunity to submit an adjustment the PMPM limit, along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to STC 6. In order to ensure timely adjustments to the PMPM limit for a demonstration year, the revised projection must be submitted to CMS by no later than the end of the third quarter of the demonstration year for which the adjustment would take effect.

b. The budget limit for the new adult group is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across DYs. The federal share of the budget neutrality cap is obtained by multiplying total computable budget neutrality cap by the federal share.

c. The state will not be allowed to obtain budget neutrality "savings" from this population.

d. If total FFP reported by the state for the new adult group should exceed the federal share of FFP for the budget limit for the new adult group by more than 3 percent following each demonstration year, the state must submit a corrective action plan to CMS for approval.

119. Composite Federal Share Ratios. The Composite Federal Share is the ratio calculated by dividing the sum total of Federal financial participation (FFP) received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. There are three Composite Federal Share Ratios for this demonstration: Composite Federal Share 1, based on the expenditures reported under the MEGs listed in STC 116 (which are further defined by demonstration group in STC116); Composite Federal Share 2, based on the expenditures reported under the "217-like group" MEG, defined in STC 117; and Composite Federal Share 3, based on the expenditures reported under the "New Adult Group" MEG, defined in STC 118. Should the demonstration be terminated prior to the end of the extension approval period (see STC 10), the Composite Federal Share will be determined based on actual

expenditures for the period in which the demonstration was active. 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 upon method.

120. **Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

121. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, if the state's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

Demonstration Year	Cumulative Target Definition	Percentage
DY 6	Cumulative budget neutrality limit plus:	2.0 percent
DY 7	Cumulative budget neutrality limit plus:	1.5 percent
DY 8	Cumulative budget neutrality limit plus:	1.0 percent
DY 9	Cumulative budget neutrality limit plus:	0.5 percent
DY 10	Cumulative budget neutrality limit plus:	0 percent

122. **Exceeding Budget Neutrality.** If the cumulative budget neutrality expenditure limit has been exceeded at the end of the demonstration period, the excess Federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.

XIX. EVALUATION OF THE DEMONSTRATION/ QUALITY ASSURANCE AND QUALITY IMPROVEMENT

123. **State Must Separately Evaluate Components of the Demonstration.** As outlined in subparagraphs (a) and (b), the outcomes from each evaluation component must be integrated into one programmatic summary that describes whether the state met the demonstration goal, with recommendations for future efforts regarding both components. The state must submit to CMS for approval a draft evaluation design no later than 120 days after award of the

demonstration. The evaluation must outline and address evaluation questions for both of the following components:

a. Rhode Island Comprehensive Demonstration. At a minimum, the draft design must include a discussion of the goals, objectives, and evaluation questions specific to the entire demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. The evaluation must address the adequacy and appropriateness of the benefit coverage, safety and outcome of the LTC reform and expansion groups, especially the extended Family Planning, HIV Services, Elders 65 and Over and Parents pursuing behavioral health services expansion groups. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The draft design must identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.

b. Focused Evaluations. The separate components of the demonstration that must be evaluated include, but are not limited to, the following:

   i. LTC Reform, including the HCBS-like and PACE-like programs;
   ii. RIte Care;
   iii. Rite Share;
   iv. The section 1115 Expansion Programs (Limited Benefit Programs), including but not limited to:
      (1) Children and Families in Managed Care and Continued eligibility for Rite Care parents when kids are in temporary state custody;
      (2) Children with Special Health Care Needs;
      (3) Elders 65 and Over;
      (4) HCBS for Frail Elders, HCBS for adults with disabilities, HCBS for Kids in residential diversion and HCBS for at risk/Medicaid eligible youth;
      (5) Uninsured adults with mental illness/substance abuse problems;
      (6) Coverage of detection and intervention services for at risk young children;
      (7) HIV Services;
   v. The Marketplace Subsidy Program

124. Interim Evaluation of the Marketplace Subsidy Program. The state must submit an interim evaluation of the Marketplace subsidy program to CMS by September 1, 2014 that meets the requirements of the CMS-approved evaluation design. The state must evaluate the number of individuals who participate in the program compared against the number of individuals who were enrolled in RIte Care and RIte Share in December 31, 2013. The state must evaluate whether and how the change in the premium subsidy affected enrollment.

125. Interim Evaluation Reports. In the event the state requests an extension of the demonstration beyond the current approval period under the authority of section 1115(a), (e),

or (f) of the Act, the state must submit an interim evaluation report as part of the State's request for each subsequent renewal.

126. Final Evaluation Design and Implementation.

a. CMS must provide comments on the draft evaluation design within 60 days of receipt, and the state shall submit a final design within 60 days after receipt of CMS comments.

b. The state must implement the evaluation design and submit its progress in each quarterly operational and annual report.

c. The state must submit to CMS a draft of the evaluation report within 120 days after expiration of the demonstration. CMS must provide comments within 60 days after receipt of the report. The state must submit the final evaluation report within 60 days after receipt of CMS comments.

127. Cooperation with Federal Evaluators. Should CMS undertake an evaluation of the demonstration, the state must fully cooperate with Federal evaluators and their contractors' efforts to conduct an independent federally funded evaluation of the demonstration.

XX. MEASUREMENT OF QUALITY OF CARE AND ACCESS TO CARE IMPROVEMENT

128. Comprehensive Quality Strategy (CQS). The state shall adopt and implement a comprehensive and dynamic continuous quality improvement strategy that integrates all aspects of quality improvement programs, processes, and requirements across the state's Medicaid program. This CQS must include all components of the Medicaid state plan, including but not limited to: the Comprehensive demonstration (Rite Care, Rhody Health, Connect Care Choice, Rite Smiles, and the HCBS programs).

a) The CQS must also address the following elements:
   i. The state's goals for improvement, identified through claims and encounter data, quality metrics and expenditure data. The goals should align with the three part aim but should be more specific in identifying specific pathways for the state to achieve these goals.
   ii. The associated interventions for improvement in the goals. All programmatic performance improvement plans (PIPs) must be included in the comprehensive quality strategy.
   iii. The specific quality metrics for measuring improvement in the goals. The metrics should be aligned with the Medicaid and CHIP adult and child core measures, and should also align with other existing Medicare and Medicaid federal measure sets where possible. The metrics should go beyond HEDIS and CAHPS data, and should reflect cost of care.
   iv. Metrics should be measured at the following levels of aggregation: the state Medicaid agency, each health plan or program, if applicable, and potentially at each direct health services provider. The state will work with CMS to further define metrics as appropriate for the plan.

v. The specific methodology for determining benchmark and target performance on these metrics for each aggregated level as planned.
vi. Specific metrics related to each population covered by the Medicaid program. HCBS performance measures, consistent with the corrective action plan, in the areas of: level of care determinations, person-centered service planning process, outcome of person-centered goals, health and welfare, and assuring there are qualified providers and appropriate HCBS settings.
vii. Monitoring and evaluation. This should include specific plans for continuous quality improvement, which includes transparency of performance on metrics and structured learning, and also a rigorous and independent evaluation of the demonstration, as described in STC 123. The evaluation should reflect all the programs covered by the CQS as mentioned above.

b) The CQS should include a timeline that considers metric development and specification, contract amendments, data submission and review, incentive disbursement (if available), and the potential re-basing of performance data.

c) The CQS must include state Medicaid agency and any contracted service providers' responsibilities, including managed care entities, and providers enrolled in the state's FFS program. The state Medicaid agency must retain ultimate authority and accountability for ensuring the quality of and overseeing the operations of the program. The CQS must include distinctive components for discovery, remediation, and improvement.

d) The first draft of this CQS is due to CMS no later than 120 days following the approval of this new demonstration/amendment/renewal. CMS will review this draft and provide feedback to the state. The state must revise and resubmit the CQS to CMS for approval within 45 days of receipt of CMS comment. The state must revise (and submit to CMS for review and approval) their CQS whenever significant changes are made to the associated Medicaid programs and the content of the CQS. Revisions to the CQS must be submitted to CMS for review and approval within 90 days of approval.

   Any further revisions must be submitted accordingly:
   i. Modifications to the CQS due to changes in the Medicaid operating authorities must be submitted concurrent with the proposed changes to the operating authority (e.g., state plan or waiver amendments or waiver renewals); and/or
   ii. Changes to an existing, approved CQS due to fundamental changes to the CQS must be submitted for review and approval to CMS no later than 60 days prior to the contractual implementation of such changes. If the changes to the CQS do not impact any provider contracts, the revisions to the CQS may be submitted to CMS no later than 60 days following the changes.

e) The state must solicit for and obtain the input of beneficiaries, the Medical Care Advisory Committee (MCAC), and other stakeholders in the development of its CQS and make the initial CQS, as well as any significant revisions, available for public

comment prior to implementation. Pursuant to STC 94, Annual Report, the state must also provide CMS with annual reports on the implementation and effectiveness of their CQS as it impacts the demonstration.

f) As required by 42 C.F.R. §438.360(b)(4), the state must identify in the CQS any standards for which the EQRO will use information from private accreditation reviews to complete the compliance review portion of EQR for participating MCOs or PIHPs. The state must, by means of a crosswalk included in the CQS, set forth each standard that the state deems as duplicative to those addressed under accreditation and explain its rationale for why the standards are duplicative.

g) Upon approval by CMS, this document will be found as Attachment C to these STCs.

XXI. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

Date - Specific	Deliverable	STC Reference
120 days after award of the demonstration	Submit Draft Evaluation Plan, including the Extended Family Planning program	Section XIX, paragraph 123
September 1, 2014	Interim Evaluation of Marketplace Subsidy Program	Section XIX, paragraph 124

	Deliverable	STC Reference
Annual	By May 1st - Draft Annual Report	Section XV, paragraph 94
Quarterly	CHIP Enrollment Reports	Section XIII, paragraph 90
	Operational Reports	Section XV, paragraph 93
	Title XIX Expenditure Reports	Section XVI, paragraph 96
	Title XXI Expenditure Reports	Section XVII, paragraph 108
	Eligible Member Months	Section XVI, paragraph 101

ATTACHMENT A – Managed Care Demonstration Only Benefits

These benefits are not provided under the Rhode Island Medicaid State Plan, but only under the demonstration and for persons enrolled in managed care delivery systems, including risk based managed care (e.g. RIte Care) and PCCM programs (e.g. ConnectCare Choice).

Nutrition services
Individual/group education, parenting and childbirth education classes
Tobacco cessation services for non-pregnant beneficiaries
Window replacement for lead-poisoned children
Complementary alternative medicine services to a subset of enrollees with chronic pain diagnoses

ATTACHMENT B - Core and Preventive Home and Community-based Service Definitions

CORE SERVICES

Homemaker: 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. Homemakers shall meet such standards of education and training as are established by the state for the provision of these activities.

Environmental Modifications (Home Accessibility Adaptations): Those physical adaptations to the home of the member or the member's family as required by the member's service plan, that are necessary to ensure the health, welfare, and safety of the member or that enable the member to attain or retain capability for independence or self care in the home and to avoid institutionalization, and are not covered or available under any other funding source. A completed home assessment by a specially trained and certified rehabilitation professional is also required. Such adaptations may include the installation of modular ramps, grab-bars, vertical platform lifts and interior stair lifts. Excluded are those adaptations that are of general utility, and are not of direct medical or remedial benefit to the membert. Excluded are any re-modeling, construction, or structural changes to the home, i.e. (changes in load bearing walls or structures) that would require a structural engineer, architect and/or certification by a building inspector. Adaptations that add to the total square footage of the home are excluded from this benefit. All adaptations shall be provided in accordance with applicable state or local building codes and prior approved on an individual basis by the EOHHS Office of Long Term Services and Supports is required. Items should be of a nature that they are transferable if a member moves from his/her place of residence.

Special Medical Equipment : Specialized Medical Equipment and supplies to include Ceiling or Wall Mounted Patient Lift, Track System, tub slider system, rolling shower chair and/or Automatic Door Opener, which enable a member to increase his/her ability to perform activities of daily living , including such other durable and non-durable medical equipment not available under the Medicaid-funded primary and acute care system that is necessary to address participant functional limitations. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the Medicaid-funded primary and acute care system and exclude those items that are not of direct medical or remedial benefit to the member. Medical equipment funded under the primary and acute care system includes items such as wheel chairs, prosthetics, and orthotics. These services that were provided under the authority of the Rhode Island State Plan prior to the 1115 Waiver approval. These items are still available under the 11115 Waiver and are described on the EOHHS website. All items shall meet applicable standards of manufacture, design and installation. Provision of Special Medical Equipment requires prior approval on an individual basis by the EOHHS, Office of Long Term Services and Supports and a home assessment completed by a specially trained and certified rehabilitation professional. Items should be of a nature that they are trnsferable if a member moves from his/her place of residence. Excluded are any re-modeling, construction, or structural changes to

the home, (i.e. changes in load bearing walls or structures) that would require a structural engineer, architect and/or certification by a building inspector.

Minor Environmental Modifications: Minor modifications to the home may include grab bars, versa frame (toilet safety frame), handheld shower and/or diverter valve, raised toilet seats, and other simple devices or appliances, such as eating utensils, transfer bath bench, shower chair, aids for personal care (e.g., reachers), and standing poles to improve home accessibility adaption, health, or safety.

Meals on Wheels (Home Delivered Meals): The delivery of hot meals and shelf staples to the waiver recipient's residence. Meals are available to an individual who is unable to care for his/her nutritional needs because of a functional dependency/disability and who requires this assistance to live in the community. Meals provided under this service will not constitute a full daily nutritional requirement. Meals must provide a minimum of one-third of the current recommended dietary allowance. Provision of home delivered meals will result in less assistance being authorized for meal preparation for individual participants, if applicable.

Personal Emergency Response (PERS): PERS is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the individual's phone and programmed to signal a response center once a "help" button is activated. Trained professionals staff the response center, as specified by Center for Adult Health contract standards. This service includes coverage for installation and a monthly service fee. Providers are responsible to insure the upkeep and maintenance of the devices/systems.

LPN Services (Skilled Nursing): Licensed Practical Nurse services provided under the supervision of a Registered Nurse. Licensed Practical Nurse Services are available to participants who require interventions beyond the scope of Certified Nursing Assistant (C.N.A.) duties. LPN services are provided in accordance with the Nurse Practice Act under the supervision of a registered nurse. This service is aimed at individuals who have achieved a measure of medical stability despite the need for chronic care nursing interventions. Individuals are assessed by a Registered Nurse (RN) in the EOHHS, Office of Community Programs.

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 individual is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable an individual to establish a basic household; these expenses do not constitute room and board and may include: security deposits that are required to obtain a lease on an apartment or home, essential household furnishings, and moving expense, set-up fees or deposits for utility or service access, services necessary for the individual's health and safety and activities to assess need, arrange for, and procure needed resources. Community Transition Services are furnished only to the extent that the services are reasonable and necessary as determined through the service plan development process, the services are clearly identified in the service plan, and the individual is unable to meet such expense or the services cannot be obtained from other sources.

The services do not include ongoing shelter expenses, food, regular utility charges, household appliances or items intended for recreational purposes.

Residential Supports: Assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in his/her own home and a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance (where applicable), or upkeep and improvement.

Day Supports: Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Day supports focus on enabling the individual to attain or maintain his/her maximum functioning level, and are coordinated with any other services identified in the person's individual plan.

Supported Employment: Includes activities needed to sustain paid work by individuals receiving waiver services, including supervision, transportation and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision, and training required by an individual receiving waiver services as a result of his/her disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported Living Arrangements: Personal care and services, homemaker, chore, attendant care, companion services, and medication oversight (to the extent permitted under state law) provided in a private home by a principal care provider who lives in the home. Supported Living Arrangements are furnished to adults who receive these services in conjunction with residing in the home. Separate payment will not be made for homemaker or chore services furnished to an individual receiving Supported Living Arrangements, since these services are integral to and inherent in the provision of adult foster care services.

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 and as identified in the Individual Service Plan (ISP). These services are provided to an individual at home and require an assessment to be completed by a Registered Nurse (RN) from the Office of Community Programs.

Supports for Consumer Direction (Supports Facilitation): Focuses on empowering participants to define and direct their own personal assistance needs and services; guides and supports, rather than directs and manages, the participant through the service planning and delivery process. The Facilitator counsels, facilitates, and assists in development of an ISP which includes both paid and unpaid services and supports designed to allow the participant to live in the home and participate in the community. A back-up plan is also developed to assure that the needed assistance will be provided in the event that regular services identified in the Individual Service Plan are temporarily unavailable.

Participant Directed Goods and Services: Participant Directed Goods and Services are services, equipment, or supplies not otherwise provided through this waiver or through the Medicaid state plan that address an identified need, that are in the approved ISP (including improving and maintaining the individual'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 the item or service would promote inclusion in the community; AND/OR the item or service would increase the individual's ability to perform ADLs or IADLs; AND/OR the item or service would increase the person's safety in the home environment; AND alternative funding sources are not available. Individual Goods and Services are purchased from the individual's self-directed budget through the fiscal intermediary when approved as part of the ISP. Examples include a laundry service for a person unable to launder and fold clothes, or a microwave for a person unable to use a stove due to his/her disability. This will not include any good/service that would be restrictive to the individual or strictly experimental in nature.

Case Management: Services that assist participants in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Case managers are responsible for ongoing monitoring of the provision of services included in the individual's plan of care. Case managers initiate and oversee the process of assessment and reassessment of the individual's level of care and review of plans of care on an annual basis and when there are significant changes in client circumstances.

Senior Companion (Adult Companion Services): Non-medical care, supervision, and socialization provided to a functionally impaired adult. Companions may assist or supervise the participant with such tasks as meal preparation, laundry, and shopping. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks, which are incidental to the care and supervision of the participant. This service is provided in accordance with a therapeutic goal in the service plan of care.

Assisted Living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under state law), therapeutic social and recreational programming, provided in a home-like environment in a licensed community care facility in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility; but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to an individual who resides in his/her own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms, and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the

opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other unit. The facility must have a central dining room, living room, or parlor, and common activity center(s) (which may also serve as living room or dining room). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each individual to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and must treat each person with dignity and respect. Costs of room and board are excluded from payments for assisted living services.

Personal Care Services: Personal Care Services provide direct support in the home or community to an individual in performing Activities of Daily Living (ADL) tasks that he/she is functionally unable to complete independently due to disability. Personal Care Services may be provided by:

1. A Certified Nursing Assistant which is employed under a State licensed home care/home health agency and meets such standards of education and training as are established by the State for the provision of these activities.

2. A Personal Care Attendant via Employer Authority under the Self Direction option.

Respite: Respite can be defined as a service provided to a participant unable to care for himself/herself that is 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 services will be recommended and approved by EOHHS, Office of Long Term Services and Supports.

PREVENTIVE SERVICES:

Homemaker: 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/herself or others in the home. Homemakers shall meet such standards of education and training as are established by the state for the provision of these activities.

Minor Environmental Modifications: Minor modifications to the home may include grab bars, versa frame (toilet safety frame), handheld shower and/or diverter valve, raised toilet seats, and other simple devices or appliances, such as eating utensils, transfer bath bench, shower chair, aids for personal care (e.g., reachers), and standing poles to improve home accessibility adaption, health, or safety.

Physical Therapy Evaluation and Services: Physical therapy evaluation for home accessibility appliances or devices by an individual with a state-approved licensing or certification. Preventive physical therapy services are available prior to surgery if evidence-based practice has demonstrated that the therapy will enhance recovery or reduce rehabilitation time.

Respite Services: Temporary caregiving services given to an individual unable to care for himself/herself that is furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care for the participant. Respite services will be recommended and approved by EOHHS, Office of Long Term Services and Supports.

Personal Care Services: Personal Care Services provide direct hands on support in the home or community to an individual in performing Activity of Daily Living (ADL) tasks that he/she is functionally unable to complete independently due to disability. Personal Care Services may be provided to an individual by:

1. A Certified Nursing Assistant which is employed under a State licensed home care agency and meets such standards of education and training as are established by the State for the provision of these activities.

HABILITATIVE SERVICES:

Residential habilitation is 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 his/her needs. Residential habilitation also includes personal care and protective oversight and supervision.

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

Day habilitation is 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).

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

ATTACHMENT C - Assessment and Coordination Organization

Rhode Island Long-Term Services and Supports
Assessment and Coordination Organization

Summary:
The Assessment and Coordination Organization is not an actual organization. It is, instead, the organization of several current disparate *processes* that individuals and families use when seeking long-term services and supports. Today, if an individual needs institutional or community-based long-term care services, information about those services and ways to access the services is available from many different sources. These sources include: *The Point,* 211, community agencies, discharge planners, etc. Despite the well-meaning efforts of these entities, the complexity of Rhode Island's long-term care system does not always ensure the information is consistent, valid, or current.

The first goal of the Assessment and Coordination Organization is to ensure that the information about Rhode Island's publicly funded long-term services and supports system provided by all sources is accurate and timely. In order to achieve this goal, the state will seek to enter into interagency agreements with each entity identified as a primary information source.

Different agreements will be developed to reflect the unique relationship each primary information source has with the publicly-funded long-term services and supports system. For example, the State's Aging and Disability Resource Center, *The Point,* was created for the sole purpose of providing information, referrals, and general assistance for seniors, adults with disabilities, and their caregivers. The interagency agreement with *The Point* will reflect that role and will differ from the agreement that the state might enter with community agencies who view information and referral as secondary to their primary missions. Entities such as physician practices will be included in this primary information source group to the extent it is reasonable. For example, primary care practices that participate in the Connect Care Choice program will be given training on the existing programs so that they may better serve their Connect Care Choice members who have long-term services and supports needs.

The interagency agreements will delineate the various ways the primary information source entity will receive information about the publicly funded long-term care systems and other health care programs, including electronic transmissions, written information, trainings, and workshops. The agreements will indicate ways to access state agency representatives if more information is needed. The agreements will also provide guidance on the second function of primary information source entities, appropriate referral of individuals to the next step.

Appropriate referral is the second goal of the Assessment and Coordination Organization. The state will ensure those primary information sources can direct persons to the appropriate next step – whether that next step is assessment for long-term care services; counseling for enrollment into an acute care managed care program; or referral to a specific state agency for more information. In order to achieve this goal, the will develop a universal screening tool. This tool will be developed to capture information quickly that is necessary for the primary information source to determine the most appropriate placement and/or service referral.

Depending on the results of the initial screen, an individual may be referred to the following areas:

- Individuals determined to have a potential need for Medicaid funded long-term services and supports in a nursing facility or in the community will be referred to the Rhode Island Executive Office of Health and Human Services (EOHHS);
- Individuals determined to have a potential need for state-only funded long-term services and supports will be referred to the Rhode Island Department of Elderly Affairs (RI-DEA);
- Individuals determined to have a potential need for services for the developmentally disabled or mentally retarded will be referred to the Rhode Island Department of Mental Health, Retardation, and Hospitals (RI-MHRH);
- Individuals determined to have a potential need for long-term hospital services will be referred to Eleanor Slater Hospital, a state hospital that treats patients with acute and long term medical illnesses, as well as patients with psychiatric disorders;
- Individuals determined to have a potential need for behavioral health services for a child or for an adult will be referred to the Rhode Island Department of Children, Youth, and Families (RI-DCYF) or the RI-MHRH, respectively;
- Individuals who are seeking information for services other than long-term care will be referred to the appropriate place. For example, information on acute care managed care options is currently provided by the EOHHS Enrollment Hotline.

The assessment entities will be responsible for:

- Coordinating with the Medicaid eligibility staff;
- Conducting assessments;
- Determining levels of care;
- Developing service plans with the active involvement of individuals and their families;
- Developing funding levels associated with care plans;
- Conducting periodic reviews of service plans;
- Coordinating services with care management entities (Connect Care Choice; PACE; Rhody Health Partners);

Assessments and related functions are currently conducted by the state agencies (or their contracted entities) listed above. The development of care plans is one of the most important functions conducted by these entities or their contractors. The Assessment and Coordination Organization will ensure that these care plans are developed with the active participation of individuals and families. Full consumer participation will require information about the cost of services, utilization, and quality. One of the goals of the Waiver will be to provide the individual and his/her family with health reports that will indicate the amount that has been spent on the individual's services. This information will allow an individual to make more-informed choices about where his/her service plan dollars should be spent. These health reports will be generated through the CHOICES MMIS Module.

The Assessment and Coordination Organization's third goal is to ensure improved and increased communication between these assessment entities. For example, if an individual assessed by RI-DHS for long-term community-based care is also found to have behavioral health needs, the

individual's service plan will be developed in coordination with RI-MHRH. Communication between the assessment entities will occur through regular meetings and training sessions.

RI-DHS, in close coordination with the other EOHHS agencies, will provide the administrative functions of the Assessment and Coordination Organization. These functions include: ensuring that the primary information entities and the assessment entities coordinate functions and communicate amongst each other and with each other; establishing training sessions and workshops; regularly tracking utilization; and monitoring outcomes to ensure that the Assessment and Coordination Organization's goals are met. On-going monitoring will enable the state to conduct interdisciplinary high-cost case reviews that could ultimately result in improvements to the system.

ATTACHMENT D - Level of Care Criteria

Long-term Care Level of Care Determination Process

Attached are: (1) A chart comparing the level of care determination process as determined by the section 1115a Comprehensive demonstration; and (2) A document describing the criteria for the highest level of care – with the waiver – developed by a workgroup that included members from the nursing home industry, consumer advocates, and health professionals. The state is in the process of developing similar criteria for the other two levels of care proposed in the Comprehensive demonstration.

Level of Care Determination Process: With the Comprehensive Waiver		
LTC Level of Care and Service Option Matrix		
Highest Nursing Home Level of Care (Access to Nursing Facilities and all Community-based Services)	**Highest Hospital Level of Care** (Access to Hospital, Group Homes, Residential Treatment Centers and all Community-based Services)	**Highest ICF/IDD Level of Care** (Access to ICFMR, Group Homes and all Community-based Services)
High Nursing Home Level of Care (Access to Core and Preventive Community-based Services)	**High Hospital Level of Care** (Access to Core and Preventive Community-based Services)	**High ICF/IDD Level of Care** (Access to Core and Preventive Community-based Services)
Preventive Nursing Home Level of Care (Access to Preventive Community-based Services)	**Preventive Hospital Level of Care** (Access to Preventive Community-based Services)	**Preventive ICF/IDD Level of Care** (Access to Preventive Community-based Services)

Institutional Level of Care Determination Policy: Nursing Facility

Highest Need Group

In order to qualify for admission to a nursing home, an individual must be enrolled in the Highest Needs 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* with three (3) Activities of Daily Living (ADL), total dependence* with one (1) ADL, and limited assistance* with two (2) additional ADLs:
    - Toilet Use
    - Eating
    - Bed Mobility
    - Bathing
    - Dressing
    - Personal Hygiene
    - Transferring
    - Ambulation
    - Medical Management

    AND the individual has one (1) or more unstable, medical, behavioral, cognitive, psychiatric, or chronic reoccurring conditions requiring nursing assistance, care, and supervision on a daily basis;

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.

*** Definitions:**

1. Extensive Assistance (Talk, Touch, and Lift): Individual performs part of the activity, but caregiver provides physical assistance to lift, move, or shift individual.
2. Total Dependence (All Action by Caregiver): Individual does not participate in any part of the activity.
3. 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.

High Need Group

An individual who meets any of the following eligibility criteria shall be eligible and enrolled in the High Needs 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.

Preventive Need Group

An individual who meets the preventive service criteria shall be eligible for enrollment in the preventive needs group. Preventive care services are designed to promote and preserve health and safety or to alleviate symptoms to address functional limitations. Preventive services may avert or avoid institutionalization. An individual in need of the following services, and who can demonstrate that these services will improve or maintain abilities and/or prevent the need for more intensive services, will be enrolled in the preventive need group.

1. Homemaker Services: General household tasks including basic home and household assistance for a health condition or to address functional limitations. The services include meal preparation, essential shopping, laundry, and cleaning for an individual without a social support system able to perform these services for him/her. These services may be performed and covered on a short term basis after an individual is discharged from an institution and is not capable of performing these activities himself/herself.

2. Minor Environmental Modifications: Minor modifications to the home may include grab bars, versa frame (toilet safety frame), handheld shower and/or diverter valve, raised toilet seats, and other simple devices or appliances such as eating utensils, transfer bath bench, shower chair, aids for personal care (e.g., reachers) and standing poles to improve home accessibility adaption, health, or safety.

3. Physical Therapy Evaluation and Services: Physical therapy evaluation for home accessibility appliances or devices by an individual with a state-approved licensing or certification. Preventive physical therapy services are available prior to surgery if evidence-based practice has demonstrated that the therapy will enhance recovery or reduce rehabilitation time.

4. Respite Services: Temporary caregiving services given to an individual unable to care for himself/herself that is furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care for the participant. Respite services will be recommended and approved by EOHHS, Office of Long Term Services and Supports.

5. Personal Care Services: Personal Care Services provide direct hands on support in the home or community to an individual in performing Activity of Daily Living (ADL) tasks that he/she is functionally unable to complete independently due to disability. Personal Care Services may be provided to an individual by:

a. A Certified Nursing Assistant which is employed under a State licensed home care agency and meets such standards of education and training as are established by the State for the provision of these activities.

Assessments and Reassessments

1. An individual enrolled in the High Needs 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.

2. 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:

   a. 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.

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

3. An individual residing in the community who is in the Highest and High groups will have, at a minimum, an annual assessment.

ATTACHMENT E - Quarterly Progress Report Template and Instructions

As stated in Special Terms and Conditions paragraph93, the state must submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report template is intended as a framework, and can be modified when CMS and the state agree to the modification. A complete quarterly progress report must include the budget neutrality monitoring workbook.

I. Narrative Report Format

Title Line One -_____(*Name of Individual State Program*)

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:
Demonstration Year: year # and dates

II. Introduction

Describe the goal of the demonstration, what service it provides, and key dates of approval/operation. ***(This should be the same for each report.)***

III. Enrollment Information

Complete the following table that outlines all enrollment activity under the demonstration. Indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by placing "0" in the appropriate cell.

Note: *Enrollment counts should be participant counts, not participant months.*

Population Groups (as hard coded in the CMS-64)	Number of Current Enrollees (to date)	Number of Voluntary Disenrollments in Current Quarter*	Number of Involuntary Disenrollments in Current Quarter**
Budget Population 1: ABD no TPL			
Budget Population 2: ABD TPL			
Budget Population 3: RIte Care			
Budget Population 4: CSHCN			
Budget Population 5: EFP			
Budget Population 6: Pregnant Expansion			
Budget Population 7: CHIP Children			
Budget Population 8: Substitute care			
Budget Population 9: CSHCN Alt			
Budget Population 10: Elders 65 and over			
Budget Population 11: 217-like group			
Budget Population 12: 217-like group			
Budget Population 13: 217-like group			
Budget Population 14: BCCTP			
Budget Population 15: AD Risk for LTC			
Budget Population 16: Adult Mental Unins			
Budget Population 17: Youth Risk Medic			
Budget Population 18: HIV			
Budget Population 19: AD Non-working			
Budget Population 20: Alzheimer adults			
Budget Population 21: Beckett aged out			

*Voluntary Disenrollments:
Cumulative Number of Voluntary Disenrollments Within Current Demonstration Year:
Reasons for Voluntary Disenrollments.

**Involuntary Disenrollments:
Cumulative Number of Involuntary Disenrollments Within Current Demonstration Year:
Reasons for Involuntary Disenrollments:

If the demonstration design includes a self-direction component, complete the following two sections:

IV. "New"-to-"Continuing" Ratio

Report the ratio of new-to-continuing Medicaid personal care service clients at the close of the quarter.

V. Special Purchases

Identify special purchases approved during this quarter (by category or by type).
Examples of "special purchases" have been provided below.

# of Units/ Items	Item or Service	**129. Description of Item/Service** (if not self-explanatory)	**Total Cost**
10	Microwaves		$1,000.89
1	Water Therapy	Aqua massage therapy that will assist individual with motor function.	$369.00
CUMULATIVE TOTAL			$1,369.89

VI. Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for the current quarter.

VII. Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in the current quarter.

VIII. Financial/Budget Neutrality Developments/Allotment Neutrality Developments/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, CMS-64 reporting for the current quarter, and, if appropriate, allotment neutrality and CMS-21 reporting for the current quarter. Identify the State's actions to address these issues.

IX. Consumer Issues

Summarize the types of complaints or problems enrollees identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

X. Marketplace Subsidy Program Participation

Complete the following table that displays enrollment and cost information pertaining to the Marketplace Subsidy Program. Include a summary and explanation of any trends discovered.

Month	Number of Marketplace Subsidy Program Enrollees	Change in Marketplace Subsidy Program Enrollment from Prior Month	Average Size of Marketplace Subsidy Received by Enrollee	Projected Costs	Actual Costs
January					
February					
March					
April					
May					
June					
July					
August					
September					
October					
November					
December					

XI. Evaluation/Quality Assurance/Monitoring Activity

Identify, describe, and report the outcome of all major evaluation/quality assurance/monitoring activities in current quarter.

XII. Enclosures/Attachments

Identify by title any attachments along with a brief description of the information contained in the document.

XIII. State Contact(s)

Identify individuals by name, title, telephone, fax, and address so that CMS may contact individuals directly with any questions.

XIV. Date Submitted to CMS

Enter the date submitted to CMS in the following format: (mm/dd/yyyy).

The state may add additional program headings as applicable.

ATTACHMENT F – HCBS Evidentiary Review Guidance

HCBS Quality Review Worksheet

I. Level of Care (LOC) Determination	
The state demonstrates that it implements the processes and instrument(s) in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's LOC consistent with care provided in a hospital, nursing facility, or intermediate care facility for individuals with intellectual disability.	
Sub Assurances	**CMS Expectations**
An evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future.	State submits evidence that it has reviewed applicant files to verify that individual level of care evaluations are conducted.
The level of care of enrolled participants is reevaluated at least annually or as specified in its approved waiver.	State submits evidence that it regularly reviews participant files to verify that reevaluations of level of care are conducted at least annually or as specified in the approved waiver.
The process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.	State submits that it regularly reviews participant files to verify that the instrument described in approved waive is used in all level of care redeterminations, the person(s) who implement level of care determinations are those specified in approved waiver, and the process/instruments are applied appropriately.

II. Service Plans	
The state demonstrates it has designed and implemented an effective system of reviewing the adequacy of service plans for waiver participants.	
Sub Assurances	**CMS Expectations**
Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.	State demonstrates that service plans are reviewed periodically to assure that all of participant needs are addressed and preferences considered.
The state monitors service plan development in accordance with its policies and procedures.	State submits evidence of its monitoring process for service plan development and any corrective action taken when service plans were not developed according to policies and procedures.

II. Service Plans	
The state demonstrates it has designed and implemented an effective system of reviewing the adequacy of service plans for waiver participants.	
Sub Assurances	**CMS Expectations**
Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.	State submits evidence of its monitoring process for service plan update/revision including service plan updates taken when service plans were not updated/revised according to policies and procedures.
Services are delivered in accordance with the service plan, including the type, scope, amount, and frequency specified in the service plan.	State submits evidence of the results of its monitoring process for ensuring the services identified in the service plan are implemented.
Participants are afforded choice: (1) Between waiver services and institutional care; and, (2) Between/among waiver services and providers.	State submits evidence of the results its monitoring process for ensuring the services identified in the service plan are implemented.

III. Qualified Providers	
The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.	
Sub Assurances	**CMS Expectations**
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 waiver service.	State provides documentation of periodic review by licensing/certification entity.
The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.	State provides documentation that non-licensed/non-certified providers are monitored on a periodic basis sufficient to provide protections to waiver participants.
The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.	State provides documentation of monitoring of training and actions it has taken when providers have not met requirements (e.g., technical assistance, training)

IV. Health and Welfare	
The state demonstrates, on an ongoing basis, that it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.	
Sub Assurances	**CMS Expectations**
The state, on an ongoing basis, identifies, address, and seeks to prevent the occurrence of abuse, neglect and exploitation.	State demonstrates that, on an ongoing basis, abuse, neglect and exploitation are identified, appropriate actions have been taken when the health or welfare of a participant has not been safeguarded, and an analysis is conducted of abuse, neglect and exploitation trends and strategies it has implemented for prevention.

V. Administrative Authority	
The state demonstrates that it retains ultimate administrative authority over the waiver program and that its administration of the waiver program is consistent with the approved waiver application.	
Sub Assurances	**CMS Expectations**
The state Medicaid agency retains the ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.	State submits evidence of its monitoring of all delegated functions, and implementation of policies/procedures related to its administrative authority over the waiver program, including: memoranda of agreements, description of roles and responsibilities relative to program operations, monitoring, and remediation or system improvements instituted when problems are identified in the operation of the waiver program.

VI. Financial Accountability	
The state demonstrates that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.	
Sub Assurance	**CMS Expectations**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.	• State submits results of its financial monitoring process for verifying maintenance of appropriate financial records as specified in the approved waiver. • State submits results of its review of waiver participant claims to verify that they are coded and paid in accordance with the waiver reimbursement methodology. • State demonstrates that interviews with state staff and providers are periodically conducted to verify that any identified financial irregularities are addressed.

VI. Financial Accountability	
The state demonstrates that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.	
Sub Assurance	**CMS Expectations**
	• State demonstrates that site visits are conducted with providers to verify that they maintain financial records according to provider agreement/contracts.

The state may submit summary reports for each HCBS sub assurance outline above based on a significant sample of any single or combined method or source of evidence as follows:

- Record reviews, on-site
- Record reviews, off-site
- Training verification records
- On-site observations, interviews, monitoring
- Analyzed collected data (including surveys, focus group, interviews, etc.)
- Trends, remediation actions proposed/taken
- Provider performance monitoring
- Operating agency performance monitoring
- Staff observation/opinion
- Participant/family observation/opinion
- Critical events and incident reports
- Mortality reviews
- Program logs
- Medication administration data reports, logs
- Financial records (including expenditures)
- Financial audits
- Meeting minutes
- Presentation of policies or procedures
- Reports to state Medicaid agency or delegated administrative functions
- Other

Attachment G: Reserved for Comprehensive Quality Strategy

Attachment H: Reserved for Description of Healthy Behaviors Incentives Program

Attachment I: Reserved for Evaluation Plan

Attachment J: List of FQHCs

As indicated in section XIV of the STCs, the state assures that the payments made to FQHCs do not exceed the cost of delivering services to the uninsured. The state must report annually data associated with the services and costs delivered by the FQHCs to any uninsured individuals following the chart below. The methodology for the encounter rate is defined in the Medicaid State plan.

FQHC	**Medical Encounter Rate**[1]	**Uninsured Encounters**	**Overall Uninsured Cost**
Blackstone Valley Community Health Care Inc.	$194.56		
Comprehensive Community Action Program	$190.69		
East Bay Community Action Program	$175.57		
Northwest Community Health Care	$152.61		
Providence Community Health Centers	$184.61		
Thundermist Health Center	$153.30		
Tri-Town Community Action Agency	$153.25		
Wood River Health Services	$152.91		

[1] The figures are for illustrative purposes and come from calendar year 2013.