



# Governor's Commission on Disabilities Executive Committee Agenda Monday, February 18, 2013 4:00 - 5 PM

John O. Pastore Center, 41 Cherry Dale Court,  
Cranston, RI 02920-3049  
(voice) 401-462-0100 (fax) 462-0106 (tty) via RI Relay 711  
(e-mail) [disabilities@gcd.ri.gov](mailto:disabilities@gcd.ri.gov)  
(website) [www.disabilities.ri.gov](http://www.disabilities.ri.gov)



**Attendees:** Timothy Flynn (Chair.); Rosemary Carmody (Vice Chair), Joseph Cirillo, Sarah Everhart Skeels, Casey Gartland, Bill Inlow, Ronald McMinn, Linda Ward  
**Absent:** Andrew Argenbright, Meryl Berstein, Judi Drew, Jon Dupre,

**Guests:**

Anthony Robinson

**Staff:**

Bob Cooper (Executive Secretary)



Clock graphic

**4:00 Call to Order and Acceptance of the Minutes, Tim Flynn Chair**

Chair calls the meeting to order at 4:10  
Introductions of Commissioners and guests



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**MOTION:** To accept the minutes of the previous meeting as presented  
RC/LW passed unanimously

## Action Items:

**4:05 Appointments/Reappointments of Commissioners Tim Flynn, Chair**

**Purpose/Goal:** To decide whether to initiate an outreach and recruitment to fill the a vacancy (Marylouise Gamache) and recommendations for reappointment

**Discussion:**

The following members terms end on May 1, 2013: Initial Appointment

- |  |            |
|--|------------|
| 1. Rosemary Carmody of Coventry, Vice Chair, Election Chair        | 7/27/1998  |
| 2. Ronald C. McMinn of Cumberland Accessibility Chairperson        | 6/26/2001  |
| 3. Andrew Argenbright of East Providence D. B. E. Vice Chairperson | 5/6/2011   |
| 4. Jeanne Behie of South Kingstown*                                | 10/21/2005 |
| 5. Sharon Brinkworth of Barrington                                 | 10/14/2005 |
| 6. Marylouise Gamache of Barrington**                              | 5/6/2011   |
| 7. Arthur M. Plitt of Pawtucket                                    | 7/27/1998  |

\* Hasn't been able to attend meetings during the past 2 years

\*\* Resigned via email on 1/1/2013



people graphic



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**MOTION:** To recommend the reappointment of the following, if they will serve another term: Rosemary Carmody of Coventry, Ronald C. McMinn of Cumberland, Andrew Argenbright of East Providence, Sharon Brinkworth of Barrington, & Arthur M. Plitt of Pawtucket LW/JC passed  
RC & RMcM Abstained



Presentation graphic

**4:10 Taking a Position on Rhode Island Medicaid Section 1115 Research and Demonstration (Global Consumer Choice Compact) Waiver Extension Request, Bob Cooper, Executive Secretary**

Purpose/Goal: To comment on the State's Global Consumer Choice Compact Extension Request.

Excerpts from the waiver extension request

**SECTION I. PROGRAM DESCRIPTION**

**Purpose, Goals, and Objectives**

In June 2008, Rhode Island submitted to the Centers for Medicare and Medicaid Services (CMS) a proposal for an 1115 Waiver Demonstration entitled the "Global Consumer Choice Compact." The Demonstration is scheduled to end on December 31, 2013. This proposal reflects a request to extend the current Demonstration under Section 1115(e) of the Social Security Act (the Act). Rhode Island requests a five-year extension period, beginning January 1, 2014 and ending December 31, 2018. A five-year extension is requested as we believe the proposal meets the definition of a waiver under section 1915(h)(2)(A) of the Act in that it provides medical assistance for dual-eligible individuals.<sup>1</sup>

When Rhode Island first proposed the Demonstration, the State was experiencing significant economic distress. One of the explicit reasons the State pursued the original waiver was to attempt to rein in spending on the Medicaid program.

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The original proposal posited that the restrictions the federal government places on State Medicaid Programs are a direct driver of program costs. The State requested increased flexibility to administer the Program in exchange for federal funding certainty.

The federal funding certainty was designed as a cap or limit on the amount of spending the federal government would be expected to provide. Overall spending on the five-year demonstration was capped at \$12.075 billion. This budget neutrality arrangement was different than Rhode Island's budget neutrality agreements in previous 1115 Waivers in that it was not enforced on an annual basis and, more importantly, it placed the State at risk for enrollment or caseload as well as per participant per month cost trends.

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In addition to the federal funding cap, the other major component of the original Demonstration was the State's request for flexibility. In general, we sought to use the requested flexibility to build a Medicaid program that was guided by a core set of principles:

**Administrative Simplification**

- Combination of 11 waivers into one waiver authority
- Streamlined waiver amendment process

**Consumer Empowerment and Choice**

**Personal Responsibility**

- Development and implementation of an Assessment and Coordination Organization Process
- Development of the Office of Community Programs
- Application of spousal impoverishment rules equally across long-term care settings

**Community-based care solutions**

- Revise Medicaid Long-term Care clinical eligibility determinations
- Expand services such as Shared Living
- Development of Acute Stabilization Unit
- Expanded access to Assisted Living

**Prevention, Wellness and Independence**

- Nursing home Transition and Diversion
- Increased use of self-directed care
- Mandatory managed care enrollment

**Competition**

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<sup>1</sup>The State has submitted to CMS a Category II Waiver Change to implement an integrated managed care delivery system for Medicaid-eligible adults with disabilities and people eligible for both Medicaid and Medicare.

- Selective Contracting
- Hospital Rate Reform
- Acuity-based adjusted nursing home rates

**Pay for Performance**

- Managed Care Contracting Provisions

Since the Waiver was approved, these guiding principles have changed as a result of two major developments. The first is the experience and the lessons we have learned in the actual implementation of these activities:

1. *Selective contracting, in the way implemented by Rhode Island, has not been effective.*  
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2. *The ability to impact the long-term care system requires a broader, more comprehensive approach.*  
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3. *The effectiveness of managed care approaches is constrained if the scope of included services is narrow.*  
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4. *The effectiveness of managed care approaches is limited unless the system at the point of service delivery is impacted.*  
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5. *An effective health care system needs to include a broader definition of health*  
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6. *An increased effort to coordinate information and eligibility assistance across State agencies is still needed.*  
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The second development that causes us to assess our original guiding principles is the introduction of the Affordable Care Act. .... One of the major goals of the ACA is to ensure as many people as possible have access to and avail themselves of affordable coverage. EOHHS intends to seek General Assembly approval to submit a State Plan Amendment to implement the Medicaid expansion available in the ACA.

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As a result of these two developments, we have revised the original guiding principles into the following focus areas that are supported by both the 1115 Waiver Demonstration and the ACA:

**Ensure information about services and how to access them is readily available and consistent.**

We will have a robust **Consumer Assistance Program** housed at EOHHS that will support and help to coordinate all of the information and referral, options counseling, eligibility assistance, and case management that occurs across the EOHHS agencies.

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**Ensure Medicaid financed services are responsive and appropriate to a person’s medical, functional, and social needs.**

Services need to be coordinated across providers and systems. They need to be available and provided timely at the point when they will have the most impact. We need to develop more community-based service alternatives such as “Bridge” for person becoming more vulnerable in the community, Supportive Housing, Housing Retention Services, Emergency Room Diversions and high fidelity wraparound services for children and youth.

**Ensure the Medicaid program is coordinated and integrated with other publicly-financed health care**

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The 1115 Demonstration and the ACA provide enhanced opportunities for State agencies to increase interdepartmental cooperation and coordination so that we have more effective and responsive programs. This inter-agency cooperation has been evident in the way we have implemented the CNOM<sup>2</sup> Program.

**Ensure the Medicaid program is coordinated with other insurance systems**

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We will use managed care as a cost-effective tool to improve access and coordinate care. When we pay directly for services or contract with managed care organizations, we will implement reimbursement methodologies that deliver outcomes, not more services. ....

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<sup>2</sup> Costs Not Otherwise Matchable (CNOM)

**Utilize Information Technology Systems more efficiently**

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We will have a dedicated and active **Quality and Evaluation Office** that will ensure any budget initiative, grant, program, or medical benefit actually achieves the results we are seeking.

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This extension request seeks to **continue all existing Waiver and Expenditure Authorities** and outlines new initiatives we will be pursuing and the appropriate waiver or expenditure authority requested for implementation.

**SECTION II. DEMONSTRATION ELIGIBILITY**

**Question #1: Include a chart identifying any populations whose eligibility will be affected by the Demonstration**

**ELIGIBILITY GROUPS UNDER THE APPROVED STATE PLAN AS OF NOVEMBER 1, 2008**

**Categorically Needy<sup>3</sup> Medicaid Eligibility Groups**

<b>Mandatory Categorically Needy Coverage Groups</b>	
<b>Medicaid Eligibility Groups</b>	<b>Income and Resource Standards and/or Other Qualifying Criteria</b>
§1931 low income families with children §1902(a)(10)(A)(i)(I); §1931	Income: Up to 110 percent of FPL <sup>4</sup> Resource: No resource test
Children receiving IV-E payments (IV-E foster care or adoption assistance) §1902(a)(10)(A)(i)(I)	Income: Up to 100 percent of FPL Resource: No resource test
Individuals who lose eligibility under §1931 due to employment §1902(a)(10)(A)(i)(I); §402(a)(37); §1925	Income: Up to 110 percent of FPL Resource: No resource test
Individuals who lose eligibility under §1931 because of child or spousal support §1902(a)(10)(A)(i)(I); §406(h)	Income: Up to 110 percent of FPL Resource: No resource test
Individuals participating in a work supplementation program who would otherwise be eligible under §1931 §1902(a)(10)(A)(i)(I); §482(e)(6)	Income: Up to 110 percent of FPL Resource: No resource test
Individuals who would be eligible AFDC except for increased OASDI income under P.L. 92-336 (July 1, 1972) 42 CFR 435.114	Income: Up to 110 percent of FPL Resource: No resource test
<b>Disabled children no longer eligible for SSI<sup>5</sup> benefits because of a change in definition of disability §1902(a)(10)(A)(i)(II)(aa)</b>	Income: 100 % SSI Resource: \$2,000
Individuals under age 21 eligible for Medicaid in the month they apply for SSI §1902(a)(10)(A)(i)(II)(cc)	Income: 100 % SSI Resource: \$2,000
Qualified pregnant women §1902(a)(10)(A)(i)(III); §1905(n)(1)	Income: Up to 100 percent of FPL Resource: No resource test
Qualified children §1902(a)(10)(A)(i)(III); §1905(n)(2)	Income: Up to 100 percent of FPL Resource: No resource test
Poverty level pregnant women and infants §1902(a)(10)(A)(i)(IV)	Income: up to 185 percent of FPL Resource: No resource test
Qualified family members §1902(a)(10)(A)(i)(V)	Income: Up to 100 percent of FPL

<sup>3</sup> This refers to people who belong to any of the groups that Medicaid has to cover by law. This includes people with low incomes, elderly people, children, and people with disabilities. The difference between categorically eligible and categorically needy is that categorically needy people DO need Medicaid services, and they automatically qualify for them. These rules apply to Medicaid in every state. State plans must cover people who are categorically needy if they want to receive money from the federal government.

<sup>4</sup> Federal Poverty Level (FPL)

<sup>5</sup> Supplemental Security Income (SSI)

<b>Mandatory Categorically Needy Coverage Groups</b>	
<b>Medicaid Eligibility Groups</b>	<b>Income and Resource Standards and/or Other Qualifying Criteria</b>
	Resource: No resource test
Poverty level children under age 6 §1902(a)(10)(A)(i)(VI)	Income: Up to 133 percent of FPL Resource: No resource test
Poverty level children under age 19, born after September 30, 1983 (or, at State option, after any earlier date) §1902(a)(10)(A)(i)(VII)	Income: Up to 100 percent of FPL Resource: No resource test
Newborns deemed eligible for 1 year as long as mother remains eligible or would remain eligible if pregnant §1902(e)(4)	Income: up to 185 percent of FPL Resource: No resource test
Pregnant women who lose eligibility receive 60 days coverage for pregnancy related and post partum services §1902(e)(5)	Income: Resource: No resource test
Pregnant women who lose eligibility because of a change in income remain eligible 60 days post partum §1902(e)(6)	Income: up to 185 percent of FPL Resource: No resource test
Poverty level infants and children who while receiving services lose eligibility because of age must be covered through an inpatient stay §1902(e)(7)	Resource: No resource test
Individuals receiving SSI cash benefits §1902(a)(10)(A)(i)(II)	Income: 100 % SSI Resource: \$2,000 individual \$3,000 couple
<b>Disabled individuals whose earning exceed SSI substantial gainful activity level §1619(a)</b>	Income: 100 % SSI Resource: \$2,000 individual \$3,000 couple
<b>Disabled individuals whose earning are too high to receive SSI cash benefits §1902(a)(10)(A)(i)(II)(bb); §1905(q); 1619(b)</b>	Income: 100 % SSI Resource: \$2,000 individual \$3,000 couple
Pickle: individuals who would be eligible for SSI if Title II COLAs were deducted from income §503 of P.L. 94-566; §1939(a)(5)(E)	Income: 100 % SSI Resource: \$2,000 individual \$3,000 couple
<b>Disabled widows and widowers §1634(b); §1939(a)(2)(C)</b>	Income: 100 % SSI Resource: \$2,000 individual \$3,000 couple
<b>Disabled adult children who lose SSI due to OASDI §1634(c); §1939(a)(2)(D)</b>	Income: 100 % SSI Resource: \$2,000 individual \$3,000 couple
Early widows/widowers §1634(d); §1939(a)(2)(E)	Income: 100 % SSI Resource: \$2,000 individual \$3,000 couple
Individuals ineligible for SSI/SSP <sup>6</sup>	Income: 100 % SSI
because of requirements prohibited under Medicaid 42 CFR 435.122	Resource: \$2,000 individual \$3,000 couple
Qualified Medicare Beneficiaries §1902(a)(10)(E)(i); §1905(p)(1)	Income: 100 percent of FPL Resource: \$4,000 single \$6,000 couple
<b>Qualified disabled and working individuals (defined in §1905(s)); not otherwise eligible for Medicaid §1902(a)(10)(E)(ii)</b>	Income: 200 percent of FPL Resource: \$4,000 single \$6,000 couple
Specified Low-Income Medicare Beneficiaries §1902(a)(10)(E)(iii)	Income: >100 percent but =<120 percent of FPL Resource: \$4,000 single \$6,000 couple
Qualified Individuals; not otherwise eligible for Medicaid §1902(a)(10)(E)(iv)	Income: >120 percent but =<135 percent of FPL Resource: \$4,000 single \$6,000 couple

<b>Optional Categorically Needy<sup>7</sup> Coverage Groups</b>	
<b>Medicaid Eligibility Groups</b>	<b>Income and Resource Standards and/or Other Qualifying Criteria</b>
Individuals who are eligible for but not receiving IV-A §1902(a)(10)(A)(ii)(I)	Income: Up to 110 percent of FPL Resource: No resource test

<sup>6</sup> State Supplemental Program (SSP)

<sup>7</sup> States also have the option to provide Medicaid coverage for other "categorically needy" groups. These optional groups share characteristics of the mandatory groups, but the eligibility criteria are somewhat more liberally defined.

<b>Optional Categorically Needy<sup>7</sup> Coverage Groups</b>	
<b>Medicaid Eligibility Groups</b>	<b>Income and Resource Standards and/or Other Qualifying Criteria</b>
Individuals who are eligible for IV-A cash assistance if State did not subsidize child care §1902(a)(10)(A)(ii)(II)	Income: Up to 110 percent of FPL Resource: No resource test
Children under age 1	Income: Up to 250 percent of FPL Resource: No resource test
Children under 21, (or at State option, 20, 19, or 18) who are under State adoption agreements §1902(a)(10)(A)(ii)(VIII)	Income: Title IV-E (§1931 Standard; Up to 110 percent of FPL) Resource: Title IV-E (§1931 Standard; no resource test)
Independent foster care adolescents §1902(a)(10)(A)(ii)(XVII)	Income: 110 percent of FPL Resource: No resource test
Optional Targeted Low Income Children §1902(a)(10)(A)(ii)(XIV); §1905(u)(2)	Income: =< 250% Resource: No resource test
Individuals under 21 or at State option, 20, 19, 18, or reasonable classification 1 §1905(a)(i); 42 CFR 435.222	Income: Up to 110 percent of FPL Resource: No resource test
Individuals who are eligible for but not receiving SSI or State supplement cash assistance §1902(a)(10)(A)(ii)(I)	Income: 100 % SSI Resource: \$2,000 individual \$3,000 couple
<b>Individuals who would have been eligible for SSI or State supplement if not in a medical institution §1902(a)(10)(A)(ii)(IV)</b>	Income: 100 % SSI Resource: \$2,000 individual \$3,000 couple
<b>Special income level group: individuals who are in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of SSI income standard §1902(a)(10)(A)(ii)(V)</b>	Income: 300 percent of SSI Federal benefit level Resource: \$2,000 individual \$3,000 couple
<b>Aged or disabled individuals whose SSI income does not exceed 100% of FPL §1902(a)(10)(A)(ii)(X)</b>	Income: =< 100 percent FPL Resource: \$4,000 individual \$6,000 couple
Individuals receiving only an optional State supplement payment which may be more restrictive than the criteria for an optional State supplement under Title XVI §1902(a)(10)(A)(ii)(XI)	Income: based on living arrangement can not exceed 300% SSI Resource: \$2,000 individual \$3,000 couple
<b>BBA<sup>8</sup> working disabled group: Working disabled individuals who buy in to Medicaid §1902(a)(10)(A)(ii)(XIII)</b>	Income: Up to 250 percent FPL Resource: Up to \$10,000 individual Up to \$20,000 couple
<b>Uninsured women, under 65, who are screened for breast or cervical cancer under CDC program and not eligible for Medicaid §1902(a)(10)(A)(ii)(XVIII)</b>	
<b>TEFRA<sup>9</sup> section 134 children: disabled individuals age 18 or under who require an institutional level of care; care can be provided outside the institution; estimated amount for home care can be no more than estimated amount for institutional care §1902(e)(3)</b>	Income: 300 percent of SSI Federal benefit level Resource: \$2,000
<b>Presumptive eligibility for women who are screened for breast or cervical cancer under CDC program §1920B</b>	

### **Medically Needy<sup>10</sup> Medicaid Eligibility Groups**

<sup>8</sup> Balanced Budget Act of 1997 (BBA)

<sup>9</sup> Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

<sup>10</sup> The Medically Needy program can help pay for Medicaid-covered services. Individuals enrolled in the Medically Needy Program have income or assets that exceed the limits for regular Medicaid. A certain amount of medical bills must be incurred each month before Medicaid is approved. This is your “share of cost.”

<b>Optional Medically Needy Coverage Groups</b>	
<b>Medicaid Eligibility Groups</b>	<b>Income and Resource Standards and/or Other Qualifying Criteria</b>
Individuals under 18 who would be mandatorily categorically eligible except for income and resources §1902(a)(10)(C)(ii)(I)	Income: 1331/3 percent of §1931 income standard Resource: Family size 1: \$4,000 Family size 2: \$6,000 Each additional person: \$100
Pregnant women who would be categorically eligible except for income and resources §1902(a)(10)(C)(ii)(II)	Income: 1331/3 percent of §1931 income standard Resource: Family size 1: \$4,000 Family size 2: \$6,000 Each additional person: \$100
Newborns, who except for income and resources would be eligible as categorically needy, deemed eligible for 1 year as long as mother remains eligible or would remain eligible if pregnant §1902(a)(10)(C); §1902(e)(4)	Income: 1331/3 percent of §1931 income standard Resource: Family size 1: \$4,000 Family size 2: \$6,000 Each additional person: \$100
Pregnant women who lose eligibility received 60 days coverage for pregnancy-related and post partum services §1902(a)(10)(C); §1902(e)(5)	Income: 1331/3 percent of §1931 income standard Resource: Family size 1: \$4,000 Family size 2: \$6,000 Each additional person: \$100
All individuals under 21 or at State option, 20, 19, or 18 or reasonable classifications who would not be covered under mandatory medically needy group of individuals under 18 §1902(a)(10)(C); §1905(a)(i)1	Income: 1331/3 percent of §1931 income standard Resource: Family size 1: \$4,000 Family size 2: \$6,000 Each additional person: \$100
Specified relatives of dependent children who are ineligible as categorically needy §1902(a)(10)(C); §1905(a)(ii)	Income: 1331/3 percent of §1931 income standard Resource: Family size 1: \$4,000 Family size 2: \$6,000 Each additional person: \$100

<b>Optional Medically Needy Coverage Groups</b>	
<b>Medicaid Eligibility Groups</b>	<b>Income and Resource Standards and/or Other Qualifying Criteria</b>
Aged individuals who are ineligible as categorically needy §1902(a)(10)(C); §1905(a)(iii)	Income: 1331/3 percent of §1931 income standard Resource: Family size 1: \$4,000 Family size 2: \$6,000 Each additional person: \$100
<b>Blind individuals who are ineligible as categorically needy §1902(a)(10)(C); §1905(a)(iv)</b>	Income: 1331/3 percent of §1931 income standard Resource: Family size 1: \$4,000 Family size 2: \$6,000 Each additional person: \$100
<b>Disabled individuals who are ineligible as categorically needy §1902(a)(10)(C); §1902(v)</b>	Income: 1331/3 percent of §1931 income standard Resource: Family size 1: \$4,000 Family size 2: \$6,000 Each additional person: \$100
<b>TEFRA section 134 children: disabled individuals age 18 or under who require an institutional level of care; care can be provided outside the institution; estimated amount for home care can be no</b>	Income: 300 percent of SSI Federal benefit level Resource: \$4,000

<b>Optional Medically Needy Coverage Groups</b>	
<b>Medicaid Eligibility Groups</b>	<b>Income and Resource Standards and/or Other Qualifying Criteria</b>
more than estimated amount for institutional care §1902(e)(3)	

## ELIGIBILITY GROUPS UNDER THE DEMONSTRATION

### ***Groups That Could Be Covered Under the State Plan But Gain Eligibility Through §1115 Demonstration***

<b>Medicaid Eligibility Groups</b>	<b>Income and Resource Standards and/or Other Qualifying Criteria</b>
Parents/Caretakers with Children	Income: Above 110% to 175% FPL Resource: No resource test
Pregnant Women	Income: Above 185% to 250% FPL Resource: No resource test
Children Under 6	Income: Above 133% to 250% FPL Resource: No resource test
Children Under 19	Income: Above 100% to 250% FPL Resource: No resource test

### ***Expansion Groups Under §1115 Demonstration***

<b>Medicaid Eligibility Groups</b>	<b>Income and Resource Standards and/or Other Qualifying Criteria</b>
Women who lose Medicaid eligibility 60 days postpartum received 24 months of family planning services	Income: Up to 200% FPL Resource: No resource test
<b>Children and families in managed care enrolled in Rlte Care (children under 19 &amp; parents) when the parents have behavioral health conditions (substance abuse/mental illness) that result in their children being placed in temporary State custody.</b>	Income: up to 200% FPL Resource:
<b>Children with special health care needs (as an eligibility factor) who are 21 and under who would otherwise be placed in voluntary state custody—residential diversion</b>	Income: 300 percent of SSI Resource: no resource limit
<b>Individuals 65 and over At risk for LTC<sup>11</sup> who are in need of home and community-based services (state only group).</b>	Income: at or below 200% of the FPL Resource Test: No resource test
<b>Categorically Needy Individuals under the State Plan receiving HCBW<sup>12</sup> services &amp; PACE<sup>13</sup>-like participants highest need group</b>	Use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified under 42 CFR 435.217, 435.726 and 435.236 of the federal regulations and section 1924 of the Social Security Act, if the State had 1915(c) waiver programs.
<b>Categorically needy individuals under the State Plan receiving HCBW services &amp; PACE-like participants High need group</b>	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

<sup>11</sup> Long Term Care (LTC)

<sup>12</sup> Home-and-Community- Based Waiver (HCBW)

<sup>13</sup> Program of All-Inclusive Care for the Elderly (PACE)

<b>Expansion Groups Under §1115 Demonstration</b>	
<b>Medicaid Eligibility Groups</b>	<b>Income and Resource Standards and/or Other Qualifying Criteria</b>
	manner as specified under 42 CFR 435.217, 435.236, and 435.726 of the federal regulations and 1924 of the Social Security Act, if the State had 1915(c) waiver programs.
<b>Medically needy under the State Plan receiving HCBW services in the community (high and highest group) Medically needy PACE-like participants in the community</b>	Apply the medically needy income standard plus \$400 and use institutional eligibility rules, including the application of spousal impoverishment eligibility rules.
<b>Adults with disabilities served by the Office of Rehabilitation Services (ORS) who are not eligible for Medicaid, but may become so if these services are not provided</b>	Income: up to 300% of SSI
<b>Services for uninsured adults w/mental illness and/or substance abuse problems who are at risk for a hospital level of care</b>	Income: up to 200% of the FPL
<b>Medicaid eligible youth who are at risk for placement in residential treatment facilities and or in patient hospitalization</b>	Income: up to 250% FPL Resource
<b>Children under age 18 who are at risk for Medicaid or institutional care not eligible for Medicaid</b>	Income: up to 300% of SSI for child Resource:
<b>HIV Positive individuals who are otherwise ineligible for Medicaid</b>	Incomes: at or below 200% of the FPL
<b>Adults –ages 19-64 – who are unable to work due to a variety of health conditions, but do not qualify for disability benefits.</b>	Income: up to 200% FPL Resource:

**Question #2: Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan:**

The State will comply with the MAGI<sup>14</sup> standards and methodologies for MAGI populations as required under the Affordable Care Act. Eligibility standards and methodologies for non-MAGI populations will remain the same with the exception as noted in the response to question 6 below. Hospitals that elect to implement presumptive eligibility are required to become Navigators and use the online portal to apply for Medicaid eligibility on behalf of their patients.

**Question #3: Specify any enrollment limits that apply for expansion populations under the Demonstration:**

Not applicable

**Question #4: Provide the projected number of individual who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs:**

Enrollment projections are currently being developed.

<sup>14</sup> Modified Adjusted Gross Income (MAGI)

**Question #5: To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State):**

No change anticipated from current waiver.

The State utilizes spousal impoverishment rules under Section 1924. Spousal impoverishment rules apply to an individual who is in a medical institution or nursing facility or who would be in a medical institution or nursing facility but for the provision of home or community-based services and is married to a spouse who is not in a medical institution or nursing facility.

**Question #6: Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013):**

Existing eligibility procedures under the Waiver continue to apply. In addition, the State seeks the following waiver for expedited long-term care services.

**Expedited Long Term Care Services:** The State is seeking a waiver to accept self attestation of the financial eligibility criteria for new Long Term Care (LTC) applicants for a period of up to ninety (90) days. The individual would be required to complete the LTC Clinical and Financial Application for LTC services. The individual would need to meet the Clinical Eligibility criteria and provide a self-attestation of the LTC financial 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 would include a maximum of ten (10) hours weekly of person care/homemaker services and/or a maximum of three (3) days weekly of Adult Day Care Services. Upon determination of the approval of the full LTC financial application, the individual would receive the full LTC benefit package. The limited community-based LTSS services would be available for up to ninety (90) days or until the eligibility for LTC decision is rendered, which ever comes first. This will enable the individual to be maintained in the community and avoid costly institutional care.

**Continuity of Coverage Between Exchange and Medicaid:** Ensure continuity of coverage for persons who lose eligibility for Medicaid or CHIP and as a result become eligible for a Qualified Health Plan (QHP) through the Exchange by retaining Medicaid or CHIP eligibility until enrollment in a QHP begins. This will help ensure continuity of care for these individuals during this transition period.

**Question #7: If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014:**

The State has completed the draft MAGI conversion template and will adhere to MAGI conversion methodology guidance for all applicable populations as it is released from CMS. The State will work with CMS to implement the income conversion methodology as required. The State will follow its Verification Plan and Reasonable compatibility standards as approved by CMS in determining MAGI eligibility.

The State of Rhode Island intends to carry forward all existing eligibility groups from the previous waiver. In addition, through the State Plan, Rhode Island intends to:

- Expand Medicaid eligibility for “Independent Former Foster Children” from age 21 to age 26 as required by the Affordable Care Act,
- Expand Medicaid eligibility for adults with income less than 133% of the Federal Poverty Level, pending authorization from the Rhode Island General Assembly and<sup>15</sup>

### **SECTION III. DEMONSTRATION BENEFITS**

#### **INTRODUCTION**

The intent of this section is to outline the benefits provided under this demonstration extension.

The details provided are intended to carry over all the benefits outlined in the prior demonstration while describing additional benefits the State is contemplating. To the extent that the State complies with the provisions of this extension to make changes in the benefit package, the State has the flexibility to provide customized benefit packages to beneficiaries based on medical need. All State Plan amendments will continue to be applicable and remain in-force.

#### **Question #1: Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:**

Benefits are the full scope of benefits set forth in the approved State plan, unless specified in the Demonstration. Benefits are delivered through managed care organizations or managed care delivery systems, with the exception of certain services paid by the State on a fee-for-service basis.

#### **Question #3: If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration:**

The State intends to continue the benefits provided to the eligibility groups outlined in the prior demonstration as identified in the special terms and conditions, Attachment A.

#### **Question #4: If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:**

The state does not intend to use benchmark-equivalent coverage for a population.

#### **Question #5: In addition to the Benefit Specifications and Qualifications form, please complete the following chart if the Demonstration will provide benefits that differ from the Medicaid or CHIP State plan:**

Rhode Island will continue to use the additional flexibility afforded by the demonstration to further redesign the State’s Medicaid program to provide cost-effective services that will ensure beneficiaries receive the appropriate services in the least restrictive and most appropriate setting during the Demonstration period.

The State will continue to use Program Flexibility that provides the State authority and the type of administrative processes for making changes in the Medicaid program during the Demonstration period. The State was awarded flexibility to demonstrate that it can provide Medicaid beneficiaries access to the most appropriate services while attempting to preserve the overall scope of eligibility and coverage.

#### **POTENTIAL NEW SERVICES UNDER CONSIDERATION**

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<sup>15</sup> Sentence ends

## **Extended Family Planning<sup>i</sup>**

### **Waiver of Institutions for Mental Disease (IMD) Exclusion**

Residential substance abuse treatment is an evidence-based and clinically effective treatment milieu for members who are diagnosed with substance use disorders. In Rhode Island, there are five residential providers in six different locations statewide. During state fiscal year 2012, approximately 1300 people were served by these providers, with 1500 total stays. Of the 1500 stays approximately 400 stays were for Medicaid eligible clients. Because these treatment facilities have more than 16 beds, they are defined as Institutions for Mental Disease (IMDs), and therefore payment for these services cannot be rendered by Medicaid fee-for-service programs.

As defined in §1905 (i) of the Social Security Act, and Chapter 42 of the Code of Federal Regulations Section 435.1009, Institutions for Mental Disease (IMDs) are inpatient facilities of more than 16 beds whose patient roster is more than 51% people with severe mental illness. Federal Medicaid matching payments are prohibited for IMDs with a population between the ages of 22 and 64.

EOHHS requests a waiver of this section of the Act, in order to receive federal matching payments for substance abuse treatment services in facilities with greater than 16 beds.

### **Wellness Benefit<sup>ii</sup>**

#### **Peer Mentoring**

#### **Peer Specialist/Peer Navigator**

#### **Pain Management**

A pain management benefit, which was approved using a category II change, was incorporated into the Communities of Care Program in April 2012. This benefit enhancement is targeted to Communities of Care members who experience chronic pain and have been diagnosed with a limited set of conditions, including chronic back and/or neck pain, migraines and fibromyalgia. The program includes evidence-based clinical practice guidelines, an integrated treatment plan, and the integration of complementary therapies such as chiropractic, acupuncture, and massage therapy, when diagnostically appropriate. Ongoing collaboration and communication with the enrollee's Primary Care Provider and (when appropriate) behavioral health provider is a requirement. Preliminary results indicate this pain management approach has been successful in reducing emergency department utilization. Under this Waiver Extension, the State reserves the right to expand Pain Management to designated additional populations experiencing chronic pain.

#### **STOP – Sobering Treatment Opportunity Program**

A large driver of Emergency Room utilization is clients who are “chronic inebriates”. First responders (e.g. police, fire and rescue) are required to bring inebriated individuals to hospital emergency rooms, if they are not in police custody for committing a crime. EOHHS is requesting authority to provide services in an alternative treatment setting, which provides a combination of a short-term recovery program, detoxification services and/or referral arrangements. This program is called The Sobering Treatment Opportunity Program (STOP).<sup>iii</sup>

#### **Evidence Based Treatment for Children**

The State is working closely with the Department of Children, Youth and Families to ensure that children in or at risk of entering DCYF custody have access to a range of in home behavioral health programs that have been shown to be effective in decreasing problem behaviors, and increasing developmentally appropriate prosocial behavior.<sup>iv</sup>

#### **Intensive Care Management<sup>v</sup>**

#### **Community Based Support Services/Supportive Housing**

EOHHS requests a waiver of comparability to provide certain Medicaid eligible clients with a set of community support services. Provision of these services will result in a reduction in the need for medical interventions. These clients have health conditions (e.g., illnesses, behavioral health conditions or functional impediments) that require long term interventions that are restorative and optimize quality of life in community-based settings. In addition, these clients require support to maintain stable housing.<sup>vi</sup>

**Question #6: In addition, please complete the <http://Medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-LTSS-Benefits.pdf>, and the: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/ByTopics/Waivers/1115/Downloads/Long-Term-Services-Benefit-Specifications-and Provider-Qualifications.pdf>**

Long Term Services and Support will continue to be provided. The services to be provided during the extension period at reference in Attachment 2.

Heading from Attachment 2 (terms defined in endnote <sup>vii</sup>)

1. Homemaker;
2. Environmental Modifications (Home Accessibility Adaptations);
3. Special Medical Equipment (Minor Assistive Devices);
4. Meals on Wheels (Home Delivered Meals);
5. Personal Emergency Response (PERS);
6. LPN Services (Skilled Nursing);
7. Community Transition Services;
8. Residential Supports;
9. Day Supports;
10. Supported Employment;
11. Supported Living Arrangements;
12. Private Duty Nursing;
13. Supports for Consumer Direction (Supports Facilitation);
14. Participant Directed Goods and Services;
15. Case Management;
16. Senior Companion (Adult Companion Services);
17. Assisted Living;
18. Personal Care Assistance Services;
19. Respite;
20. Preventive Services;
21. Minor Environmental Modifications; and
22. Physical Therapy Evaluation and Services.

**Question #7: Indicate whether premium assistance for employer sponsored coverage will be available through the Demonstration:**

The State plans no changes to its authority regarding the Premium Assistance Program in this extension period.

**Special Terms and Conditions Attachment A: SERVICES<sup>16</sup>**

**State Plan Services as of 11/1/2008 – Any State Plan Services added after 11/1/2008 are also included in this extension.**

Service	Description
Inpatient Hospital Services	Mandatory 1905(a)(1)
Outpatient Hospital Services	Mandatory 1905(a)(2)

<sup>16</sup> These services can be modified through a Category II process up to Deficit Reduction Act (DRA) benchmark benefit flexibility levels and then the State must pursue a Category III change.

<b>Service</b>	<b>Description</b>
Rural health clinic services	Mandatory 1905(a)(2)
FQHC services <sup>17</sup>	Mandatory 1905(a)(2)
Laboratory and x-ray services	Mandatory 1905(a)(3)
Diagnostic Services	Optional 1905(a)(13)
Nursing Facility Services for 21 and over	Mandatory 1905(a)(4)
EPSDT <sup>18</sup>	Mandatory 1905(a)(4)
Family Planning	Mandatory 1905(a)(4)
Physicians' services	Mandatory 1905(a)(5)
Medical and Surgical services furnished by a dentist	Mandatory 1905(a)(5)
Podiatrists' services	Optional 1905(a)(6)
Optometrists' services	Optional 1905(a)(6)
Intermittent or part-time nursing provided by a home health agency services	Mandatory for individuals who, under the State Plan, are entitled to nursing facility services 1902(a)(10)(D)
Home health aide services provided by a home health agency	Mandatory for individuals who, under the State Plan, are entitled to nursing facility services 1902(a)(10)(D)
Medical supplies, equipment, and appliances	Mandatory for individuals who, under the State Plan, are entitled to nursing facility services 1902(a)(10)(D)
Physical therapy; occupational therapy; speech pathology; audiology provided by a home health	Optional 1902(a)(10)(D) 42 CFR 440.70
Clinic Services	Optional 1905(a)(9)
Dental Services	Optional 1905(a)(10)
Prescribed Drugs	Optional 1905(a)(12)
Non-Prescription Drugs	Optional 1927(d)
Dentures	Optional 1905(a)(12)
Prosthetic Devices	Optional 1905(a)(12)
Eyeglasses	Optional 1905(a)(12)
Preventive Services	Optional 1905(a)(13)
Rehabilitative Services	Optional 1905(a)(13)
Services for individuals over age 65 in IMDs <sup>19</sup>	Optional 1905(a)(14)
Intermediate Care Facility Services	Optional 1905(a)(15)
Inpatient psychiatric facility services for under 22	Optional 1905(a)(16)
Nurse-midwife services	Mandatory 1905(a)(17)
Hospice Care	Optional 1905(a)(18)
Case Management Services and TB <sup>20</sup> related services	Optional 1905(a)(19)
Extended services for pregnant women	Optional 1902(e)(5)
Certified pediatric or family nurse practitioners'	Mandatory 1905(a)(21) is a mandatory service
Nursing facility services for patients under 21	Optional 1905(a)(28) 42 CFR 440.170
Personal care services in recipient's home	Optional 1905(a)(28) 42 CFR 440.170
Transportation	Optional as a medical service 1905(a)(28)440.170 required as an administrative function 42 CFR 431.53
Primary care case management services	Optional 1905(a)(25)
PACE services <sup>21</sup>	Optional 1905(a)(26)
Emergency services for certain legalized aliens and undocumented aliens	Mandatory 1903(v)(2)(A)

<sup>17</sup> Federally Qualified Health Centers (FQHC)

<sup>18</sup> Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

<sup>19</sup> Institutions for Mental Disease (IMD)

<sup>20</sup> Tuberculosis (TB)

<sup>21</sup> Program of All-Inclusive Care for the Elderly (PACE)

## Special Terms and Conditions Attachment A1: Demonstration Only Benefits

These benefits are not provided under the Rhode Island Medicaid State Plan, but only under the Demonstration and apply to all delivery systems in this Demonstration extension. Any additional Demonstration Only Benefits added since the last Demonstration are also subject to inclusion in this renewal.

- Nutrition services
- Parenting and childbirth education classes
- Tobacco cessation services**
- Window replacement for lead-poisoned children**

### SECTION IV. COST SHARING REQUIREMENTS

#### Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

The cost sharing requirements requested in the Demonstration and the extension differ from those provided under the Medicaid State plan. As outlined in Attachment 3, “Cost Sharing”, the State reserves the right to set premiums to a maximum of 5% of family income. The State retains the right to adjust these premiums when it deems it appropriate and is not required to adjust premiums annually to maintain this right. The State will no longer seek to utilize co-pays in its cost sharing plan with the exception of EFP.

#### Indicate if there are any exemptions from the proposed cost sharing (if additional space is needed, please supplement your answer with a Word attachment.

Exemptions from cost sharing include: pregnant women, children under 1, children in foster care or adoption subsidy, post foster care coverage group (Chafee children), Alaskan Native/American Indian children and adults.

<b>ATTACHMENT 3: COST SHARING CHART</b>						
	<b>Children Under 1*</b>	<b>Children 1 to 19th birthday*</b>	<b>Adults</b>	<b>Pregnant Women</b>	<b>Extended Family Planning</b>	
<b>Family Income</b>	<b>Premiums</b>	<b>Premiums</b>	<b>Premiums</b>	<b>Premiums</b>	<b>Premiums</b>	<b>Co-pays</b>
Under 100% FPL <sup>22</sup>	None	None	None	None	None	\$2 health care provider visits \$1 for 30 day supply of contraceptives \$15 voluntary sterilization procedures
100-133% FPL	None	None	None	None	None	\$2 health care provider visits \$1 for 30 day supply of contraceptives \$15 voluntary sterilization procedures

<sup>22</sup> Federal Poverty Level (FPL)

### ATTACHMENT 3: COST SHARING CHART

	Children Under 1*	Children 1 to 19th birthday*	Adults	Pregnant Women	Extended Family Planning	
Family Income	Premiums	Premiums	Premiums	Premiums	Premiums	Co-pays
133-150% FPL	None	up to 5% of family income	up to 5% of family income	None	None	\$2 health care provider visits \$1 for 30 day supply of contraceptives \$15 voluntary sterilization procedures
150-185% FPL (150-175% FPL for adults)	None	up to 5% of family income	up to 5% of family income	None	None	\$2 health care provider visits \$1 for 30 day supply of contraceptives \$15 voluntary sterilization procedures
185-250% FPL	up to 5% of family income	up to 5% of family income	N/A	up to 5% of family income	None	\$2 health care provider visits \$1 for 30 day supply of contraceptives \$15 voluntary sterilization procedures
<ul style="list-style-type: none"> <li>• Cost Sharing exemptions: -children in foster care or adoption subsidy -Post foster care coverage group (Chafee children) -Alaskan Native/American Indian children and adults</li> <li>• <b>Cost-sharing for BBA<sup>23</sup> working disabled adults defined in section 1902(a)(10)(A)(ii)(XIII) will follow the Medicaid State Plan</b></li> <li>• <b>All unearned income over the Medically Needy Income Limit (MNIL) will be owed as a monthly premium;</b></li> <li>• <b>Cost-Sharing for [Elders 65 and over] At risk for LTC<sup>24</sup> with income at or below 200 percent of the FPL who are in need of home and community-based services (state only group) is to be treated like post-eligibility treatment of income or spend down requirements.</b></li> </ul>						

### SECTION V. DELIVERY SYSTEM AND PAYMENT RATES FOR SERVICES

**Question #1: Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:**

- Yes** – benefits for the Medicaid population are delivered through Managed Care delivery system; managed care organizations, Primary Care Case Management Program (PCCM), or Program for all Inclusive Care for the Elderly (PACE).
- No**

**Question #2: Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration's expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by**

<sup>23</sup> Balanced Budget Act of 1997 (BBA)

<sup>24</sup> Long Term Care (LTC)

**the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms.**

In its current Demonstration Waiver, Rhode Island oversees the operation of a series of successful programs which have been nationally recognized for their quality, including Rite Care, RItE Share, Rhody Health Partners, Connect Care Choice, PACE, and Extended Family Planning. The current Demonstration Waiver has afforded the State the ability to move away from discrete, capped enrollments for home and community-based services in order to make the right services available to Medicaid enrollees at the right time and in the right setting. Going forward, Rhode Island seeks to build on its successful experience in serving Medicaid enrollees who are enrolled in its capitated managed care (RItE Care and Rhody Health Partners) and primary care case management (Connect Care Choice) programs and enhance the integration of home and community-based services into these delivery systems for persons with disabilities.

Our goal is to improve quality and value by:

- Promoting members’ access to a full array of health and supportive services
- Using creative strategies (such as peer navigation) to engage members in their own care and self-management in partnership with their health and social service providers
- Offering care coordination and care management services for persons with chronic medical and behavioral health needs
- Providing resources to enhance the ability of institutionalized members to be safely transitioned to home and community-based settings

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1. Patient Centered Medical Home<sup>viii</sup>
2. Delivery System Reform Incentive Payment<sup>ix</sup>
3. Dental Services for Older Children and Adults<sup>x</sup>
4. Integrated Care Initiative<sup>xi</sup>

**Question #3: Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:**

- Managed care
  - ✓ Managed Care Organization (MCO)
  - Prepaid Inpatient Health Plans (PIHP)
  - ✓ Prepaid Ambulatory Health Plans (PAHP)
- Fee-for-service (including Integrated Care Models)
  - ✓ Primary Care Case Management (PCCM)
  - ✓ Health Homes
- Other (please describe)
  - ✓ PACE

**Question #4: If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration**

Eligibility Type	Delivery System
Families with Dependent Children	Enrolled in RItE Care with one of two participating MCOs for medical care. RItE Smiles PAHP for dental benefits
Women who receive Extended Family Planning Benefits	Enrolled in one of two participating MCOs
Children with Special Health Care Needs	Enrolled in RItE Care with one of two participating MCOs RItE Smiles PAHP for dental benefits
Children in Substitute Care Arrangements Youth aged out of foster care system eligible under the Affordable	Enrolled in RItE Care with MCO selected by the Department of Children, Youth and Families RItE Smiles

Eligibility Type	Delivery System
Care Act	PAHP for dental benefits
Families with Dependent Children who have access to employer sponsored insurance	Enrolled in RItE Share program. Commercial carrier is primary, and Medicaid fee-for-service wraps around that benefit.
Aged, Blind, and Disabled (ABD) Adults ;V Medicaid Only	Enrolled in: <ul style="list-style-type: none"> <li>• Rhody Health Partners with one of two MCOs</li> <li>• Connect Care Choice</li> <li>• PACE</li> <li>• RItE Smiles PAHP</li> </ul>
Aged, Blind, Disabled (ABD) Adults ;V Medicare and Medicaid Eligible (MME)	To be Enrolled in: <ul style="list-style-type: none"> <li>• Rhody Health Options with one of two MCOs</li> <li>• Connect Care Choice Community Partners</li> <li>• PACE</li> <li>• RItE Smiles PAHP</li> </ul>
Childless Adults eligible under the Affordable Care Act	To be enrolled in RItE Care participating managed care organization and RItE Smiles PAHP

## ATTACHMENTS

### CATEGORY CHANGES

The initial waiver period began in January, 2009. Pursuant to the program flexibility provisions of the waiver, several category changes have been submitted to CMS. The table above provides a list of Category Changes, approved and under review. Rhode Island intends that each of these be incorporated into and carried forward into the renewal period.

<b>ATTACHMENT 1: 1115 Waiver - Category Changes Since 2008</b>			
Number	Date Submitted	Effective Date	Title
<b>2013</b>			
13-01-CII	N/A		Integrated Care Initiative
<b>2012</b>			
<b>12-01-CII</b>	<b>2/23/2012</b>	<b>4/1/2012</b>	<b>Pain Management</b>
<b>12-02-CII</b>	<b>3/29/12 6/5/12</b>	<b>4/1/2012</b>	<b>Nursing Facility Rate Reduction</b>
<b>12-03-CII</b>	<b>5/21/2012</b>	<b>7/1/2012</b>	<b>Modify the rate paid for Durable Medical Equipment Services</b>
12-04-CII	5/16/12 8/24/12	7/1/2012	Nutrition Benefits to RHP <sup>25</sup>
12-05-CII	N/A	N/A	Draft not officially submitted
12-06-CII	12/7/2012	7/1/2013	License Fee Waiver
<b>12-07-CII</b>	<b>12/28/2012</b>	<b>10/1/2012</b>	<b>Nursing Home Payment</b>
<b>2011</b>			
<b>11-01-CII</b>	<b>6/4/2011</b>	<b>12/20/2011</b>	<b>HCBS<sup>26</sup> for Individuals with DD<sup>27</sup></b>
11-02-CI	8/22/2011	10/1/2011	Elimination of RItE Share Provider CoPayments
11-03-CI	8/22/2011	10/1/2011	RItE Care <sup>28</sup> /RItE Share <sup>29</sup> Co-Share Premiums to 5% of Family Income

<sup>25</sup> Regional Healthcare Plans (RHP)

<sup>26</sup> Home-and-Community- Based Services (HCBS)

<sup>27</sup> Developmental Disabilities (DD)

<sup>28</sup> RItE Care is Rhode Island's Medicaid managed care program for families on the RI Works Program and eligible uninsured pregnant women, children, and parents.

<sup>29</sup> RItE Share is Rhode Island's Premium Assistance Program that helps Rhode Island families afford health insurance through their employer by paying for some or all of the employee's cost.

## ATTACHMENT 1: 1115 Waiver - Category Changes Since 2008

Number	Date Submitted	Effective Date	Title
<b>11-04-CII</b>	<b>9/30/2011</b>	<b>10/1/2011</b>	<b>Elimination of Nursing Home Facility Rate Adjustment</b>
<b>2010</b>			
10-01-CII	2/15/2010	4/1/2010	Reimbursement Methodology for Inpatient Hospital Services
10-03-CI	12/17/2010	1/1/2010	Medicare Improvements for Patients and Providers Act of 2008
10-04-CI	12/17/2010	1/1/2010	Tribal Consultation
10-05-CI	12/17/2010	1/1/2010	PARIS <sup>30</sup> Data Match
10-06-CI	12/17/2010	1/1/2011	Screening, Brief Intervention, Referral and Treatment
<b>2009</b>			
09-01-CII	6/8/2009	7/22/2009	
09-02-CI	6/8/2009		Prescription Drugs CMAP <sup>31</sup> under Medicaid Drug Rebate Prog.
09-03-CII			WITHDRAWN
09-04-CII	8/13/2009	10/1/2009	Outpatient Hospital Services

Concerns	Likes	Dislikes
<p>Continuity of care, delivered by competent agencies, as moving into managed care/selective</p> <p>Emphasize continuation of dental services for older children and adults</p>	<p>Eliminating the caps</p> <p>Support moving into the community, pay the expenses</p> <p>Wellness Benefit<sup>xii</sup></p> <p>Peer navigators</p> <p>Peer Mentoring</p> <p>Peer Specialist/Peer Navigator</p> <p>Pain Management</p> <p>STOP - Sobering Treatment Opportunity Program (<i>what are the performance benchmark, startup costs</i>)</p> <p>Evidence Based Treatment for Children</p> <p>Intensive Care Management</p> <p>Community Based Support Services/Supportive Housing</p> <p>The Expansion Groups Under 1115</p> <p>Expedited long term care services</p> <p>Continuity coverage between exchange and Medicaid</p> <p>Expanded Long Term Services &amp; Supports</p> <p>Optional Services (no difference between homemaker and preventive services)</p>	<p>Vague descriptions</p>

<sup>30</sup> Public Assistance Reporting Information System (PARIS)

<sup>31</sup> Community Medical Assistance Program (CMAP)

Concerns	Likes	Dislikes
	Tobacco cessation Window replacement - lead prevention	
 <small>voting check off graphic</small>	<b>MOTION:</b> To recommend the Commission <i>support if amended</i> the Rhode Island Medicaid Section 1115 Research and Demonstration (Global Consumer Choice Compact) Waiver Extension Request CG/RC passed unanimously	
 <small>calendar graphic</small>	<b>4:55 Agenda and Scheduling the Next Meeting, Tim Flynn, Chair</b>	
	Items to be placed on the next meeting's agenda: 1. Interviewing and Selecting Summer and Fall Fellows 2.	
	Next meeting will be on: Monday May 6, 2013 3 - 5	
 <small>alarm clock graphic</small>	<b>5:00 Adjournment, Tim Flynn, Chair</b>	
 <small>voting check off graphic</small>	<b>MOTION:</b> To adjourn at 5:04 LW/RC passed unanimously	

<sup>i</sup> To better achieve the goals of the Extended Family Planning Program, which are to ensure optimal inter-birth intervals and optimal maternal and child health for Medicaid recipients, and reduce the complexity of administration the Extended Family Planning Benefit will include the following categories of service:

1. New patient or Established patient office visits
2. Screening, testing, counseling, and treatment (and, where applicable, vaccination) for sexually transmitted infections
3. Screening and treatment for urinary tract infection
4. Age appropriate preventive screening, not covered by Breast and Cervical Cancer screening program, as recommended by the US Preventive Services Task Force.
5. FDA approved contraceptive pharmaceuticals and devices, including condoms, and their associated insertion and removal procedure codes. Also including facility fees for outpatient surgical procedures.
6. Pre-conceptional counseling
7. Folic acid supplements
8. Tobacco cessation counseling and nicotine replacement therapy

<sup>ii</sup> Incentives to reward healthy behaviors and life style choices have been successful in motivating recipients to make choices that contribute to positive health and well being, thus reducing expenditures for services such as hospitalizations, emergency department visits and specialty care. The State included rewards for consumer behavior in its Communities of Care Program, developed as a part of the CMS Emergency Department Diversion grant awarded in April 2008. Preliminary evaluation results indicate the rewards initiative was instrumental in encouraging and reinforcing adherence to program goals, and led to significant reductions in utilization of emergency department visits. The State would like to reserve the right to include a wellness benefit to reward designated recipients for participation in programs such as weight loss, smoking cessation, stress management, etc.

<sup>iii</sup> A clinical and functional assessment is performed prior to admission to assure that the client is appropriate for STOP. A history and physical exam is administered by the RN team member, using a standardized assessment tool, as well as blood screen, to determine if other issues are contributing to the client's condition. Screening to identify potential mental health issues will be performed as well using evidence based suicide/mental health assessment tool, where appropriate.

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Licensed clinical staff will be available at the facility to monitor medical issues, prescribe medications, perform minor primary care services, and facilitate transfer to the hospital, whenever necessary. Peer specialists will be utilized to help engage clients and guide them through the steps of participation, recovery and ongoing support services in the program. Length of stay with STOP is typically 48 to 72 hours.

Once a member has completed detoxification, the peer specialist at the STOP center will refer the client for outpatient and/or residential treatment as appropriate. The peer specialist/sober coach will conduct the appropriate follow up to coordinate appointments for the client, and assist client in keeping appointments.

EOHHS is requesting authorization to use member incentives to encourage clients to engage in ongoing substance abuse treatment, upon discharge from STOP.

<sup>iv</sup> Examples of evidence based treatment programs include but are not limited to Brief Strategic Family Therapy, Functional Family Therapy and Multi Systemic Therapy. Specific interventions included in these programs are established behavioral health modalities such as child and family therapy, group therapy, parental training, and intensive care management and coordination. Services are provided by licensed clinicians with the exception of the clinical care coordination and treatment supportive services which are provided by a bachelor's level provider working under the supervision of a licensed clinician.

<sup>v</sup> The State is currently working to obtain CMS approval to develop an Integrated Care Initiative to integrate care and financing for individuals with both Medicare and Medicaid. The State reserves the right to seek approval for an expanded intensive care management benefit to be provided to these beneficiaries. The details of this benefit will be delineated in the Integrated Care Initiative Proposal to be submitted to CMS.

<sup>vi</sup> This target population includes individuals who are frequent users of or at risk of becoming frequent users of high-cost emergency or hospital care. Housing instability is one barrier to better health, and health outcomes will not meaningfully improve without support to maintain housing.

With expanded Medicaid eligibility under the Affordable Care Act, the landscape for supportive housing programs has changed as a majority of homeless persons are now eligible for Medical Assistance. Furthermore, Rhode Island identified obtaining and maintaining housing as a critical goal for Medicaid reform in our state.

The State will designate beneficiaries who it believes would most appropriately from this benefit.

EOHHS is requesting a waiver of comparability in order to provide a set of services, to be delivered in a home-like setting. These services are individualized based on client needs and includes health care coordination (including mental health and substance use), assistance navigating social service and benefit systems, and housing maintenance support. The list that follows details these services:

- Care Management or Service Coordination
  - o Assessment
    - Services intake
    - Assessment identifying client need
    - Gathering required documents for eligibility determination
    - Arranging for further testing and evaluation
    - Conducting reassessments
    - Documenting assessment activities
  - o Service Plan Development:
    - Service Plan Development with client/tenant
    - Writing service plan
    - Determining who should provide services
    - Obtaining signatures
    - Update and review service plan
    - Documenting service plan development
  - o Referral, Monitoring, Follow-up:
    - Referrals to other ancillary services
    - Referral and related activities
    - Assist in connecting to services
    - Coordination of services identified in service plan
    - Monitoring and evaluation
    - Documenting referral, monitoring and follow-up
    - Personal advocacy
- Medication management/monitoring
  - o Harm Reduction strategies

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- o Substance abuse counseling
  - o Peer counseling, mentoring
  - o Education about mental illness
  - o Psychotropic medication education
  - o Recovery readiness
  - o Relapse prevention
  - Routine medical care, medication management, vision, dental, HIV/AIDS services
    - o Medication set-up
    - o Medication coordination
    - o HIV/AIDS/STD education
    - o End of life planning
  - Entitlement assistance/benefits counseling
    - o Entitlement and benefits counseling
    - o Application for income assistance and the Supplemental Nutrition Assistance Program
    - o Application for health benefits, including Medical Assistance and specific programs funded through Medical Assistance
    - o Referral to legal advocacy and assistance with appeals when needed to appeal a denial of public benefits
    - o Budgeting and financial education
  - New tenant orientation/move-in assistance
    - o Finding housing
    - o Applying for housing
    - o Landlord advocacy
    - o Securing household supplies, furniture
    - o Tenancy supports
    - o Eviction prevention
  - Outreach and in-reach services
    - o Identifying and engaging with un-served, under-served individuals, and poorly-served individuals
    - o Connecting individuals with mainstream services
  - Independent living skills training
    - o Nutrition education
    - o Cooking/meal prep
    - o Personal hygiene and self-care
    - o Housekeeping
    - o Apartment safety
    - o Using public transportation
      - Job Skills training/education
    - o School connections
    - o Access to Social Support
    - o Truancy intervention
    - o Access to academic support
    - o Opportunities/access to GED, post-secondary training
    - o Supported employment
    - o Childcare (we do not provide but connect people to resources)
      - Domestic Violence intervention
  - o Domestic Abuse Services
    - o Crisis planning, intervention
    - o Child Protection assessment, follow-up
    - o Referral to Legal Advocacy
    - o Training in personal and household safety
    - o Crisis intervention-clinic based or mobile crisis
  - Support groups Self-determination/Life satisfaction
    - o Grief counseling
    - o Development of recovery plans
    - o Group therapy
    - o Recreation

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- o Social Support
  - o Community involvement/integration
  - o Parenting supports and mentoring
  - o Peer monitoring/support
  - o Conflict resolution/mediation training

- Respite Care
- Individual counseling
- Discharge planning
- Reengagement

vii **ATTACHMENT 2 – Core and Preventive Home and Community-based Service Definitions**

**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 private residence and/or vehicle of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare, and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheel chair). All services shall be provided in accordance with applicable State or local building codes and are prior approved on an individual basis by the EOHHS Office of Long Term Services and Supports.

**Special Medical Equipment (Minor Assistive Devices):** Specialized Medical Equipment and supplies including: (a) devices, controls, or appliances specified in the plan of care, which enable a participant to increase his/her ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which he/she lives, including such other durable and non-durable medical equipment that is necessary to address participant functional limitations and that is not available under the State plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. Provision of Specialized Medical Equipment requires prior approval on an individual basis by the EOHHS, Office of Long Term Services and Supports.

**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.

**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.

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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.

**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.

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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 Assistance Services:** Personal Care Assistance Services provide direct support in the home or community to an individual in performing tasks that he/she is functionally unable to complete independently due to disability. Personal Care Services may be provided by a Certified Nursing Assistant and meet such standards of education and training as are established by the State for the provision of these activities or via Employer Authority under Self Direction options.

Personal Care Services may provide:

- Assistance with activities of daily living, such as grooming, personal hygiene, toileting, bathing, and dressing
- Assistance with monitoring health status and physical condition
- Assistance with preparation and eating of meals (not the cost of the meals itself)
- Assistance with housekeeping activities (bed making, dusting, vacuuming, laundry, grocery shopping, cleaning)
- Assistance with transferring, ambulation, and use of special mobility devices

Assisting the participant by directly providing or arranging transportation. (If providing transportation, the PCA must have a valid driver's license and liability coverage as verified by the FI)

**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. Allocation of Respite hours will be recommended and approved by EOHS, 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.

<sup>viii</sup> Furthermore, RI Medicaid has participated in a multi-payer effort to pilot and spread the Patient Centered Medical Home (PCMH) model of primary care since 2008. These efforts will continue through the period of the waiver demonstration, with the goal of an officially recognized PCMH for every RI Medicaid beneficiary. The RI PCMH efforts became rooted in legislation in July of 2011 with the passage of the Rhode Island All Payer Patient Centered Medical Home Act. This Act requires a number of payment reform and evaluation initiatives aimed at spreading the

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model, with leadership from the Secretary of Health and Human Services and the Office of the Health Insurance Commissioner. In 2012, Medicaid signed agreements with all of the states Federally Qualified Health Centers to become designated as Patient Centered Medical Homes. Types of PCMH payments: Through our Managed Care Organizations and PCCM programs, Medicaid will make two types of payments to the RI All Payer Patient Centered Medical Home Program:

1. PMPM care coordination payments to designated PCMHs. These payments support practices in providing on-site care management services; required data collection and quality measurement activities, expanded evening and week-end access; enhanced care transitions activities; agreements with specialty providers; co-located behavioral health care; and development of team-based care strategies and evidence based interventions for chronic disease.

2. Payments to support the all-payer program infrastructure: As required by legislation, the All-payer PCMH program is directed by a multi-stakeholder coalition which is co-convened by the Office of the Health Insurance Commissioner and the Secretary of Health and Human Services. The coalition plays a critical role in the implementation of the PCMHs and is supported by all Rhode Island insurers (including fee-for-service Medicare under the Medicare Advanced Primary Care Practice Demonstration). Payments to the coalition support the following activities:

Data and Evaluation— definition and harmonization of quality and utilization measures to be collected and reported by the practices for payment and evaluation purposes. Development of an all-payer claims data set to track improvements in utilization of hospitals and emergency departments over time (until such time as a state-run all payer claims database is available).

Practice transformation support— regular meetings of practices to share best practices in the transformation to a medical home, care improvements, team based care strategies, data collection strategies, etc.

Convening stakeholders— stakeholders meet monthly with multiple intervening sub-committee and oversight meetings. Staffing for these functions is provided by the coalition.

Contract development – Rhode Island’s PCMH program is unique in that terms of the PCMH contract are developed publicly and all payers and practices comply with the same general contract terms.

Collaborative measurement portal— EHR-derived quality measures are submitted to the coalition quarterly and displayed through a collaborative, web-based measurement portal. This portal allows practices to track their performance and improvement over time, to compare their performance to other PCMH’s, and for the program as a whole to track improvements in population health as a result of the PCMH intervention.

Expected benefits: The PCMH program will form the foundation of support for the Integrated Care Initiative being pursued for Medicare and Medicaid Eligibles. As that program works to provide coordinated care between the multiple elements of the health care delivery and social systems for vulnerable individuals, a highly functioning PCMH is necessary to serve as a hub of care coordination and prevention strategies. Similarly, we anticipate that the Delivery System Reform Incentive Program Pilot will need to build on a strong base of community PCMHs in order to successfully achieve the care coordination, patient experience, clinical quality and utilization goals required for the program.

<sup>ix</sup> EOHHS requests demonstration authority to pilot a “Delivery System Reform Incentive Payment” (DSRIP) program with one or more hospitals and the aligned provider community during the period of the demonstration. This effort will build on and enhance a number of other efforts being pursued in the Medicaid program, including:

Patient centered medical homes and Health Homes for Medicaid beneficiaries

Integrated Care Initiative for Medicare and Medicaid Eligible (MME) individuals

Statewide Health Information Exchange (HIE)

Multi-payer payment and delivery system reform, including payments based on quality and a transition away from a fee-for-service only payment system

Medicaid Adult and Child core quality measurement program

Meaningful Use and Electronic Health Record Incentive Payments

Federally Qualified Health Center payment methodology

Communities of Care program for high Emergency Department utilizing members

Nursing Home Transitions and Money Follows the Person programs

<sup>x</sup> The State implemented RItE Smiles, its managed dental care benefit for Medicaid/CHIP children, in September 2006. The RItE Smiles Program currently serves Rhode Island children born on or after May 1 2000. This Program has been successful in increasing access to dental services, promoting development of good oral health behaviors, decreasing the need for emergency and restorative dental care, and decreasing Medicaid expenditures for oral health. The State requests demonstration authority to waive freedom of choice to establishing mandatory managed care enrollment for the delivery of oral health care for older children and adults, who currently receive dental care through the state’s fee for service delivery system.

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<sup>xi</sup> The State submitted a Category Change II Request January 2013. It is included in this extension request to highlight our focus on coordinated delivery systems. EOHHS's Integrated Care Initiative is for persons eligible for Medicaid only or Medicaid/ Medicare benefits. The Integrated Care Initiative is founded on a care philosophy to ensure that services are delivered in the most appropriate care setting for each member based on their medical, behavioral health and social service needs.

Initially, the State will procure vendors to integrate acute, primary and specialty care with long term care services and supports. This procurement will commence in early 2013 and enrollment will begin in September. In order to achieve full integration (primary care, acute care, specialty care, behavioral health care and long-term services and supports), the State is proposing to follow two primary pathways. A summary of the pathways is described below. This approach will allow for consumer choice and ensure accountability, access and improved outcomes for Medicare and Medicaid Eligible (MME) members and those members requiring long-term care services and supports. Each of the models is not exclusive of the other and the State will pursue both major pathways in parallel.

#### **Enhanced PCCM Model**

The Enhanced PCCM Model, **Connect Care Choice Community Partners (CCCCP)**, builds on the Connect Care Choice (CCC) Primary Care Case Management (PCCM) program's demonstrated capacity and experience to serve individuals with complex medical conditions. Currently, 17 CCC practice sites, meeting standards of performance adopted from the chronic care model of "best practices" serve approximately 1,800 Medicaid-only beneficiaries across Rhode Island. The CCC model encompasses primary care/nurse case management teams and co-located behavioral health to provide quality focused and holistic care to beneficiaries. CCC is designed to achieve and preserve access to primary, preventive, behavioral health and specialty care that allows the individual to remain well and independent in the community and decrease unnecessary acute episodes of care.

To address the needs for greater integration of primary care, acute care, specialty care, behavioral health and long-term care services and for high touch care coordination, a bundled service contract will seek to build **Coordinating Care Entity (CCE)** which would oversee and manage the performance data, quality assurance and quality improvement activities and build a **Community Health Team (CHT)** that would coordinate the social supports and services for the Medicaid-only and MME members. The CCE would coordinate the high touch care management with the existing CCC Nurse Care Managers integrated in the CCC Primary Care Practice sites and the EOHHS Office of Community Programs (OCP) Nurse Care Managers for the LTSS and CHT the to provide linkages to social supports for a coordinated, seamless delivery system. The LTSS services that are currently funded and managed through the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) will continue to be funded and managed through BHDDH. The CCCCCP team will coordinate these services with the BHDDH social caseworker and the BHDDH support coordinator.

#### **Managed Care Organizations**

The State will contract with two or more Health Plans to provide the comprehensive array of primary care, acute care, specialty care, behavioral health, and long-term care services and supports to Medicaid-only adults who receive LTSS as well as to MME individuals who are eligible for full Medicaid benefits, under a capitation arrangement. The target populations for this enrollment fall into four groups: (1) MMEs living in the community receiving no long-term care services or supports, (2) MMEs living in the community receiving long term care services and supports, (3) MMEs living in an institutional care setting, and (4) Medicaid-only adults who receive LTSS in a nursing home or in the community.

This model will be implemented in two phases:

**Phase I**, effective September 1, 2013, improves the Medicaid program by enhancing the integration of the full range of services (primary care, acute care, specialty care, behavioral health care and long-term services and supports) for all Medicaid eligible adults, importantly including persons who are dually eligible for Medicaid and Medicare. Additionally, as described below, certain services for individuals with developmental disabilities and individuals with severe and persistent mental illness will not be included in Phase I.

During Phase I all MME individuals in these groups will be enrolled in a Health Plan.

However, during this period services that are currently funded and managed through BHDDH will continue to be funded and managed through BHDDH. Attachment B of the Model Contract identifies those services that will remain "out-of-plan" during Phase I.

**Phase II** includes the provision of all Medicaid covered benefits to the Medicaid only adults who receive LTSS and to all full benefit MMEs population, except for those individuals who are specifically excluded from this initiative as described in the Model contract appended to this LOI. Phase II includes the provision

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of all Medicaid benefits and Medicare benefits to the Medicaid only and to dually eligible Medicaid and Medicare individuals.

<sup>xii</sup> Incentives to reward healthy behaviors and life style choices have been successful in motivating recipients to make choices that contribute to positive health and well being, thus reducing expenditures for services such as hospitalizations, emergency department visits and specialty care. The State included rewards for consumer behavior in its Communities of Care Program, developed as a part of the CMS Emergency Department Diversion grant awarded in April 2008. Preliminary evaluation results indicate the rewards initiative was instrumental in encouraging and reinforcing adherence to program goals, and led to significant reductions in utilization of emergency department visits. The State would like to reserve the right to include a wellness benefit to reward designated recipients for participation in programs such as weight loss, smoking cessation, stress management, etc.