CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS
AMENDED JUNE 18, 2008

NUMBER: **11-W-00004/1**
21-W-00002/1

TITLE: **Rhode Island RIte Care Demonstration**

AWARDEE: **Rhode Island Department of Human Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Rhode Island RIte Care section 1115(a) Medicaid demonstration (hereinafter "Demonstration"). The parties to this agreement are the Rhode Island Department of Human Services (State) and the Centers for Medicare & Medicaid Services (CMS). These STCs set forth below and the lists of waivers and expenditure authorities, are incorporated in their entirety into the letter approving the Demonstration. The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration extension. This Demonstration is approved for the 3-year and 2-month period, from August 1, 2005 through September 30, 2008. The State Children's Health Program (SCHIP) components included are approved from August 1, 2005, through September 30, 2008.

The STCs have been arranged into the following subject areas: General Program Requirements; General Reporting Requirements; Eligibility and Enrollment; Benefits and Coverage; Cost Sharing; Delivery Systems; Evaluation; General Financial Requirements under Title XIX and Title XXI; Monitoring Budget Neutrality; and SCHIP Financial Requirements.

II. GENERAL PROGRAM REQUIREMENTS

1. **Concurrent Operation**: The State's Title XIX State plan, as approved; its Title XXI State plan, as approved; its Title XXI demonstration, as approved; and its Medicaid section 1115 demonstration entitled "RIteCare," for the time period as approved; will continue to operate concurrently.

2. **Compliance with Federal Non-Discrimination Statutes.** The State agrees that it shall comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

3. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid and SCHIP program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the award letter of which these terms

and conditions are part, shall apply to the Demonstration.

4. **Changes in Law**. The State shall, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid and SCHIP program that occur after the approval date of this Demonstration

5. **Impact on Demonstration of Changes in Federal Law, Regulation and Policy Statements.** To the extent that a change in Federal law impacts State Medicaid spending on program components included in the Demonstration, CMS shall incorporate these changes into a modified budget neutrality expenditure cap for the demonstration. The modified budget neutrality expenditure cap would be effective upon implementation of the change in the Federal law. The growth rates for the budget neutrality baseline are not subject to this STC. If mandated changes in the Federal law require State legislation, the changes shall take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

6. **State Plan Amendments.** The State shall not be required to submit Title XIX State plan amendments for changes to any populations covered solely through the Demonstration. If a population covered through the State plan is affected by a change to the Demonstration, a conforming amendment to the State plan may be required.

7. **Changes Subject to the Amendment Process.** Nothing herein shall be construed as precluding the State from submitting an amendment request for any program or budget elements. However, changes related to eligibility, enrollment, benefits, cost sharing, Federal financial participation (FFP), sources of the non-Federal share, budget neutrality, and other comparable program and budget elements must be submitted to CMS as amendments to the Demonstration. The State shall not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP may not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 8, below.

8. **Amendment Process.** Amendment requests must be submitted to CMS for approval no later than 120 days prior to the date of implementation and may not be implemented until approved. Utilizing the standard review process CMS will consult with the Federal review team. Should the budget plan as referenced in paragraph 27 below require the State submit an amendment then the amendment process described here shall apply. Amendment requests shall include but not be limited to the following:

   a) An explanation of the public process used by the State to reach a decision regarding the requested amendment;
   b) A current assessment of the impact the requested amendment shall have on budget neutrality;
   c) A detailed description of the amendment, with sufficient supporting documentation; and
   d) A description of how the evaluation design shall be modified to incorporate this amendment request.

e) Approval of an amendment is at the sole discretion of the Secretary.

9. **Extension of the Demonstration.** If the State intends to extend the Demonstration beyond the period of approval granted under section 1115(a), the requirements in section 1115(e) may apply. During the 6-month period ending 1 year before the date the Demonstration would otherwise expire, the Chief Executive Officer of the State that is operating the Demonstration may submit to the Secretary of the Department of Health and Human Services a written request to extend the Demonstration for up to 3 years. If the Secretary fails to respond to the request within 6 months after the date it is submitted, the request is deemed to have been granted. The extension of a Demonstration shall be on the same terms and conditions that applied to the Demonstration before it was extended. If an original condition of approval of a Demonstration was that it be budget neutral, the Secretary shall take such steps as may be necessary to ensure that in the extension of the Demonstration, such condition continues.

10. **Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase-out the Demonstration, the State and CMS will collaborate on the phase out plan. The State shall submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. The State may also submit an extension plan on a timely basis to prevent disenrollment of Demonstration enrollees. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan and extension plan are subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP shall be available for only normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

11. **Conversion to State Plan Authority:** The State retains its authority to convert populations covered under the section 1115 demonstration to the State plan. All State Plan amendment submission and approval procedures would apply and are not limited by these STCs.

12. **Enrollment Limitation.** During the last 6 months of the Demonstration, the enrollment of individuals who would not be eligible for Medicaid under the then current State plan shall not be permitted unless the waiver is extended by CMS.

13. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing at which it has been determined that the State has materially failed to comply with the terms of the project. CMS shall promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

14. **Finding of Non-Compliance.** The State waives none of its rights to challenge CMS' finding that the State materially failed to comply.

15. **Withdrawal of Waiver Authority**. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest. If a waiver or expenditure authority is withdrawn, FFP shall be available for only normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

16. **Adequacy of Infrastructure.** The State shall ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing; and reporting on financial and other Demonstration components.

17. **Public Notice and Consultation with Interested Parties.** The State shall continue to comply with the State Notice Procedures set forth in 59 *Fed. Reg*. 49249 (1994) when any program changes to the Demonstration are proposed by the State.

18. **Quality Assurance Strategy Plan**. The State must comply with the managed care regulations published at 42 CFR 438.

III. GENERAL REPORTING REQUIREMENTS AND MILESTONES

19. **General Financial Requirements.** The State shall comply with all general financial requirements under Title XIX set forth in Section IX, General Reporting Requirements under Title XIX.

20. **Reporting Requirements Relating to Budget Neutrality.** The State shall comply with all reporting requirements for monitoring budget neutrality set forth in Section X, Monitoring Budget Neutrality for the Rhode Island RIte Care demonstration.

21. **Encounter Data.** All managed care organizations (MCOs) contracted with the State under the Demonstration shall be responsible for the collection of all data on services furnished to enrollees through encounter data or other methods as specified by the State, and the maintenance of these data at the plan level. The State shall, in addition, develop mechanisms for the collection, reporting, and analysis of these data (which should at least include all inpatient hospital and physician services), as well as a process to validate that each plan's encounter data are timely, complete and accurate. The State shall have contractual provisions in place to impose financial penalties if accurate data are not submitted in a timely fashion.

22. **Encounter Data Validation Study for New MCOs or Prepaid Inpatient Health Plan.** If the State contracts with new MCOs or PIHPs under this Demonstration, the State shall conduct a validation study 6 months after the effective date of the contract to determine completeness and accuracy of encounter data. The initial study shall include validation

through a sample of medical records of Demonstration enrollees.

23. **Submission of Encounter Data.** The State shall submit encounter data for services provided under this Demonstration to the MSIS system as is consistent with Federal law and Section IX of this document. The State must assure that encounter data maintained at the MCO and provider level can be linked with eligibility files maintained at the State.

24. **Monthly Calls.** CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, health plan financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or State plan amendments the State is considering submitting. The State and CMS shall discuss quarterly expenditure reports submitted by the State for purposes of monitoring budget neutrality. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS (both the Project Officer and the Regional Office) shall jointly develop the agenda for the calls.

25. **Quarterly Reports.** The State shall submit progress reports 60 days following the end of each quarter as follows:

- Quarterly report for the quarter ending December 31 is due February 28
- Quarterly report for the quarter ending March 31 is due May 31
- Quarterly report for the quarter ending June 30 is due August 31

The intent of these reports is to present the State's analysis and the status of the various operational areas under the demonstration. These quarterly reports shall include:

a) A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, enrollment, quality of care, access, health plan financial performance that is relevant to the Demonstration, the benefit package, and other operational issues.
b) Action plans for addressing any policy and administrative issues identified.
c) A separate discussion of the State efforts related to the collection and verification of encounter data.
d) The quarterly reports will include enrollment data, member month data, budget neutrality monitoring tables in the attached format, as well as an update on the budget plan, etc.
e) The State shall report Demonstration program enrollment on a quarterly basis. The format of the report shall be specified by CMS. Average monthly enrollment will be reported for each of the eligibility groups.

The State can consolidate the quarterly reports for this waiver and the SCHIP waiver (# 21-W-00002/1).

26. **Annual Report.** The State shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The State shall submit the draft annual report no later than 120 days after the end of each operational year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted. The State can consolidate the annual reports for this waiver and the SCHIP waiver (# 21-W-00002/1).

27. **Milestone Requirement.** The parties acknowledge the projection that the expenditures under RIte Care, as currently configured programmatically, will be above the approved budget neutrality ceiling in demonstration year 14 (8/1/07 through 9/30/08). By March 1, 2006 the State shall submit a draft budget plan to CMS that describes the State's plan to achieve budget neutrality over the life of the demonstration; revisions are expected by the end of July 2006. CMS shall review and approve the budget plan including but not limited to the basis for calculation of budget neutrality. Subsequently the State shall implement the approved budget plan. Some examples of areas to explore in developing this plan include, but are not limited to, implementing existing authorities pertaining to co-payments and waiting lists, examining the adequacy of the current MCO rate structure to assure access, quality and Health Plan participation, or defining a preferred drug list.

    a) The State shall submit at the end of WY 13 (8/1/06 through 7/31/07), a budget neutrality assessment that reflects the budget plan and any proposed amendments at which time CMS will complete an interim review of all reported expenditures under the demonstration up to this date and projected expenditures for WY 14.

    b) Should CMS' review at the end of WY 13 (8/1/06 through 7/31/07) of the budget neutrality assessment indicate the State will not be budget neutral at the end of WY 14, CMS will not consider extending the demonstration, as currently structured at the end of WY 14.

    c) The State agrees in advance that it will return any FFP to the Federal Government determined by CMS to be over the approved budget neutrality ceiling.

    d) At the time CMS' determination is made, the State and CMS will develop an appropriate timeline and methodology for remittance.

IV. ELIGIBILITY AND ENROLLMENT

28. **Maintenance of Effort for SCHIP.** The State shall not close enrollment, institute waiting lists, or decrease eligibility standards with respect to the children covered under its Title XXI State plan while the demonstration is in effect.

29. The State shall throughout the course of the demonstration continue to show that it has

implemented procedures to enroll and retain eligible children for Medicaid under the State plan. The State also shall throughout the course of the demonstration continue to show that it adopted and effectively implemented at least three of the following policies and procedures in its child health programs:

- Use of a joint, mail-in application and common application procedures
- Procedures that simplify the redetermination/coverage renewal process by allowing families to establish their child's continuing eligibility by mail
- Elimination of assets test
- Twelve-month continuous eligibility
- Presumptive eligibility

The State may at any time submit to CMS a request for approval to change the particular policies or procedures used to meet this requirement.

30. The State will use Title XXI funds to cover services for children in the separate child health program and the SCHIP Medicaid expansion, and then will use remaining title XXI funds, to the extent available, to fund services for each of the demonstration populations in the priority order listed below. If the State estimates it will exhaust the available title XXI Federal funds for any claiming period, the State must first use available title XXI allotments for children. Once these title XXI funds are exhausted, the State will continue to provide coverage to the SCHIP demonstration populations identified below, and will claim Federal funding under Title XIX funds (title XIX funds are not available for the separate program) until further title XXI Federal funds become available.

    - Children covered under the separate program.

    - Children eligible under the title XXI State plan, including the Medicaid expansion children (children between the ages of 8 and 18 with family incomes between 100 and 250 percent of the FPL), covered under this demonstration.

    - **Demonstration Population 1:** Individuals who, at the time of initial application: (a) are custodial parents or relative caretakers of children who are eligible under the Title XIX State plan or the Title XXI State plan; (b) are uninsured, and at a time of a redetermination, are insured through RIte Share if at all; (c) have net family incomes between 100 percent and 185 percent of the FPL; and (d) receive benefits only by virtue of the RIte Care demonstration.

    - **Demonstration Population 2:** Individuals who, at the time of initial application: (a) are uninsured pregnant women; (b) are uninsured, and at a time of a redetermination, are insured through RIte Share if at all; (c) have net family incomes between 185 percent and 250 percent of the FPL; and (d) receive benefits only by virtue of the RIte Care demonstration.

Eligibility Determination

To reflect a policy of family responsibility, the State considers each member of the family unit (including any family members eligible under the approved State plan) for purposes of determining countable income. Countable income therefore includes the income of the applicant as well as that the following family members who reside in the household: (1) individuals for whom the applicant has financial responsibility; (2) individuals who have financial responsibility for the applicant; and (3) any other individual for whom such individual in (2) above has financial responsibility. **Note**: the income of a step-parent who has financial responsibility is also included when determining eligibility for an applicant child.

31. **Optional and Expansion Eligibility Groups Expenditure and Enrollment Cap**

The State may reduce eligibility to demonstration populations by amending the demonstration (with CMS approval) as described in number seven and eight of Section II General Program Reporting Requirements.

32. **Enrollment Process.** The State agrees to notify demonstration participants regarding eligibility changes. The notification to participants must meet the provisions of 42 CFR 431.210.

33. **Enrollment Data Requirements for SCHIP**. The State will provide CMS the following enrollment reports quarterly:

- Actual and unduplicated enrollment of the demonstration populations by income, gender race and ethnicity. This enrollment information shall be provided to CMS through the SCHIP Statistical Enrollment Data System (SEDS).
- Number of waiver enrollees whose eligibility for the SCHIP demonstration was up for recertification.
- Number of waiver enrollees who were recertified to be eligible for the SCHIP demonstration.
- Number of waiver enrollees who applied for the SCHIP demonstration but were denied for, at a minimum, the following reasons: income; failure to complete the application process; enrollment in other government programs; coverage by private insurance; or, residence in another State.
- Number of waiver enrollees who were disenrolled from the SCHIP demonstration for, at a minimum, the following reasons: increase or decrease in income; failure to complete the renewal process; failure to pay premiums; enrollment in other government programs; purchase of private coverage; or, residence in another State.

V. BENEFITS AND COVERAGE

34. **Demonstration Populations.** The following populations shall be covered under the demonstration. Changes to the following are pursuant to the amendment process as discussed in item seven and eight under Section II, General Program Requirements.

a) TANF and TANF-related parents, children and pregnant women eligible for Medicaid under Rhode Island's existing State plan (Group 1);
b) Children who are covered under 1115 demonstration authority who could be made eligible through a State plan amendment under section 1902(r)(2) and related provisions (Group 2);
c) Parents and relative caretakers with income up to 185 percent FPL; and pregnant women with income from 185 to 250 percent of the FPL who are covered under 1115 demonstration authority who could be made eligible through a State plan amendment under section 1931 and related provisions (Group 3);
d) Women who lose Medicaid eligibility 60 days post partum and are eligible for extended family planning services under 1115 waiver authority (Group 4); and
e) Children with special health care needs eligible for Medicaid under Rhode Island's existing Medicaid State plan and enrolled in RIte Care under this Demonstration on a mandatory basis (Group 5).

Benefits

Demonstration enrollees receive Medicaid State plan benefits as listed under the State's contract with health plans for the contract year effective January 1, 2005. In addition, demonstration enrollees receive window replacement benefits for lead-poisoned children.

Women up to 250 percent of FPL who would otherwise lose Medicaid eligibility at the end of the 60-day post partum period for up to 24 months receive family planning related services only.

VI. COST SHARING

35. The State agrees to maintain the State Plan co-payments and premium provisions for the mandatory population. Should premiums and co-payments be instituted and or modified for other State plan populations, the State will need to amend its approved State plan. Should premiums and copayments be instituted and/or modified for the demonstration populations, the State shall submit an amendment pursuant to item seven as outlined by the process in item eight in Section II General Program Requirements. Approved premiums and co-payments will be included in the annual report.

Listed below are the approved premium and co-payment limits for the demonstration populations.

Population	Premiums Per Month	Deductibles	Co-Payments
Families with eligible children:		None	$5 generic Rx $10 Brand Rx $25 for non-emergent ER use
110-250% FPL	Up to 5% of income		
Pregnant Women 110-250% FPL	Up to 5% of income	None	$5 generic Rx $10 Brand Rx $25 for non-emergent ER use
Extended Family Planning	None	None	$2 Health care provider visits $1 30-day supply of contraceptives $15 voluntary sterilization procedures

VII. DELIVERY SYSTEMS

36. **Limitation of Freedom of Choice.** Freedom of choice for provider shall be limited for the population covered under the demonstration.

37. **Contracts.** All contracts and modifications of existing contracts between the State and managed care organizations (MCOs) must be approved by CMS prior to the effective date of the contract or modification of an existing contract. The State will provide CMS with a minimum of 30 days to review and approve changes. The Rhode Island Department of Human Services will be responsible for ensuring MCO compliance with State and Federal statutes, regulations, special terms and conditions, and waiver and cost not otherwise matchable authority.

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

    Procurement and the subsequent final contracts developed to implement selective contracting by the State with any provider group shall be subject to CMS Regional Office approval prior to implementation.

VIII. EVALUATION

38. **Submission of Draft Evaluation Design.** The State shall submit to CMS for approval within 120 days from the award of the Demonstration a draft evaluation design. At a minimum, the draft design shall include a discussion of the goals, objectives and specific hypotheses that are being tested, including those that focus specifically on the target population for the Demonstration. The draft design shall discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design shall identify whether the State shall conduct the evaluation, or select an outside contractor for the evaluation.

39. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft design within 60 days of receipt, and the State shall submit a final design within 60 days of receipt of CMS comments. The State shall implement the evaluation design, and submit to CMS a draft of the evaluation report 90 days after the expiration of the current demonstration period. CMS shall provide comments within 60 days of receipt of the report. The State shall submit the final report no later than 60 days after receipt of the comments from CMS.

40. **Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the Demonstration, the State must fully cooperate with Federal evaluators and their contractors' efforts to conduct an independent federally funded evaluation of the Demonstration.

IX. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX AND XXI

41. The State shall provide quarterly expenditure reports using the form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section X (Monitoring Budget Neutrality for the Demonstration).

42. The following describes the reporting of expenditures subject to the budget neutrality cap:

    a) In order to track expenditures under this Demonstration, Rhode Island shall report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap shall be reported on

separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). Corrections for any incorrectly reported demonstration expenditures for previous demonstration years must be input within 3 months of the beginning of the Demonstration. For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to this Demonstration), the adjustments should be reported on lines 9 or 10.C, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 41c.

b) For each Demonstration year, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the Demonstration, subject to the budget neutrality cap. The State must complete separate forms for the following categories: TANF and TANF-related parents, children and pregnant women eligible for Medicaid under Rhode Island's existing State plan (Group 1); Children who are covered under 1115 demonstration authority who could be made eligible through a State plan amendment under section 1902(r)(2) and related provisions (Group 2); Parents and relative caretakers with income up to 185 percent FPL; and pregnant women with income from 185 to 250 percent of the FPL who are covered under 1115 demonstration authority who could be made eligible through a State plan amendment under section 1931 and related provisions (Group 3); Women who lose Medicaid eligibility 60 days post partum and are eligible for extended family planning services under 1115 waiver authority (Group 4); and Children with special health care needs eligible for Medicaid under Rhode Island’s existing Medicaid State plan and enrolled in RIte Care under this Demonstration on a mandatory basis (Group 5).

c) The sum of the quarterly expenditures for the five waiver name categories for all Demonstration years shall represent the expenditures subject to the budget neutrality cap (as defined in item 42.c.).

d) For purposes of this section, the term “expenditures subject to the budget neutrality cap” shall include all Medicaid expenditures on behalf of the individuals who are enrolled in this Demonstration (as described in item 42.c. of this section) and who are receiving the services subject to the budget neutrality cap. All expenditures that are subject to the budget neutrality cap are considered Demonstration expenditures and shall be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver. Specifically these expenditures are:

- Capitation payments to MCOs for Medicaid benefits covered under this Demonstration
- SOBRA “kick payments”
- Neonatal intensive care unit payments to Women’s and Infants’ Hospital
- FQHC supplemental payments

- Fee-for-service for services otherwise subject to budget neutrality, while eligible individuals in Groups 1, 2, and 3 are not enrolled in managed care
- Reinsurance/stop-loss payments
- Performance incentive payments to MCOs
- RIte Share
- Risk-share payments
- Window replacement

e) Premiums and other applicable cost-sharing contributions from enrollees that are collected by the State from enrollees under the Demonstration shall be reported to CMS on Form CMS-64.9 Waiver, Line 18.A. in order to assure that the Demonstration is properly credited with premium collections.

f) Administrative costs shall not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All administrative costs shall be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

g) All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

43. The following describes the reporting of member months subject to the budget neutrality cap:

a) For the purpose of calculating the budget neutrality expenditure cap described in Section X, the State shall provide to CMS on a quarterly basis the actual number of eligible member/months for all five of the Medicaid Eligibility Groups (MEGs) defined in 46. This information shall be provided to CMS 30 days after the end of each quarter as part of the CMS-64 submission, either under the narrative section of the MBES/CBES or as a stand-alone report. To permit full recognition of "in-process" eligibility, reported counts of member months shall be subject to minor revisions for an additional 180 days after the end of each quarter. For example, the counts for the quarter ending September 30, 1999, due to be reported by November 30, 1999, are permitted to be revised until June 30, 2000.

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

to the total, for a total of 4 eligible member/months.

c) The term "Demonstration eligibles" refers to the following categories of RIte Care demonstration enrollees**:** Children who are covered under 1115 demonstration authority who could be made eligible through a State plan amendment under section 1902(r)(2) and related provisions (Group 2); Parents and relative caretakers with income up to 185 percent FPL; and pregnant women with income from 185 to 250 percent of the FPL who are covered under 1115 demonstration authority who could be made eligible through a State plan amendment under section 1931 and related provisions (Group 3); Women who lose Medicaid eligibility 60 days post partum and are eligible for extended family planning services under 1115 waiver authority (Group 4); and Children with special health care needs eligible for Medicaid under Rhode Island's existing Medicaid State plan and enrolled in RIte Care under this Demonstration on a mandatory basis (Group 5).

d) The term "Demonstration eligibles" excludes unqualified aliens, including unqualified aliens from the Compact of Free Association countries.

e) The standard Medicaid funding process shall be used during the Demonstration. Rhode Island must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. In addition, the estimate of matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality cap must be separately reported by quarter for each Federal fiscal year on the Form CMS-37.12 for both the Medical Assistance Program and Administrative Costs. CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the following, subject to the limits described in Section X:

a) Administrative costs, including those associated with the administration of the Demonstration;
b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State plan;
c) Net medical assistance expenditures made with dates of service during the operation of the Demonstration.
d) Net premium and cost-sharing payments paid by RIte Care eligibles.

44. The State shall certify State/local monies used as matching funds for the Demonstration and shall further certify that such funds shall not be used as matching funds for any other Federal grant or contract, except as permitted by law. All sources of the non-Federal

share of funding and distribution of monies involving Federal match are subject to CMS approval. Upon review of the sources of the non-Federal share of funding and distribution methodologies of funds under the Demonstration, all funding sources and distribution methodologies deemed unacceptable by CMS shall be addressed within the time frames set by CMS. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

45. The State shall submit its MSIS data electronically to CMS in accordance with CMS requirements and timeliness standards. The State shall ensure, within 120 days of the approval of the Demonstration, that all prior reports are accurate and timely.

X. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

46. Rhode Island shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration including:

- Capitation payments to MCOs for Medicaid benefits covered under this Demonstration
- SOBRA "kick payments"
- Neonatal intensive care unit payments to Women's and Infants Hospital
- FQHC supplemental payments
- Fee-for-service for services otherwise subject to budget neutrality, while eligible individuals in Groups 1, 2, and 3 are not enrolled in managed care
- Reinsurance/stop-loss payments
- Performance incentive payments to MCOs
- RIte Share
- Risk-share payments
- Window replacement

The limit is determined by using a per capita cost method, and budget targets are set on a yearly basis with a cumulative budget limit for the length of the entire Demonstration.

47. Rhode Island shall be at risk for the per capita cost (as determined by the method described below) for Demonstration eligibles under this budget neutrality agreement, but not at risk for the number of current eligibles. By providing FFP for all current eligibles, Rhode Island will not be at risk for changing economic conditions. However, by placing Rhode Island at risk for the per capita costs for current eligibles, CMS assures that the Federal demonstration expenditures do not exceed the level of expenditures had there been no demonstration.

48. The five Enrolled Groups (EGs) under this budget neutrality agreement are:

- TANF and TANF-related parents, children and pregnant women eligible for Medicaid under Rhode Island's existing State plan (Group 1);
- Children who are covered under 1115 demonstration authority who could be made eligible through a State plan amendment under section 1902(r)(2) and related provisions (Group 2);
- Parents and relative caretakers with income up to 185 percent FPL; and pregnant women with income from 185 to 250 percent of the FPL who are covered under 1115 demonstration authority who could be made eligible through a State plan amendment under section 1931 and related provisions (Group 3);
- Women who lose Medicaid eligibility 60 days post partum and are eligible for extended family planning services under 1115 waiver authority (Group 4); and
- Children with special health care needs eligible for Medicaid under Rhode Island's existing Medicaid State plan and enrolled in RIte Care under this Demonstration on a mandatory basis (Group 5).

a) For each year of the budget neutrality agreement an annual limit is calculated for each of the five EGs. The annual limit for the Demonstration is the sum of the projected annual limits for Group 1, Group 2, Group 3 and Group 5 (to the degree that mandated enrollment of Group 5 under this Demonstration has occurred).

b) Each EG estimate shall be calculated as a product of the number of eligible member months for EGs reported by the State under item 42.b of Section IX for that EG, times the appropriate per member per month (PMPM) cost from the table below.

Waiver Year	Trend Rate	Group 1 PMPM	Group 2 PMPM	Group 3 PMPM	Group 5 PMPM	Trend Rate
1992 (Base)		$103.30	$100.20			
1993	8%	$111.56	$108.21			
1994	6%	$118.25	$114.70			
1995	6%	$125.35	$121.59			
1996	4%	$130.36	$126.45			
1997	4%	$135.57	$131.50			
1998	4%	$140.99	$136.76			
1999	4%	$146.63	$142.23			
2000	4%	$152.50	$147.93			
2001 (base group 3, 5)	4%	$158.60	$153.85	$168.00	$627.99	10%
2002	6%	$169.94	$160.00	$174.72	$686.08	10%
2003	6%	$174.84	$169.60	$185.20	$754.69	10%
2004	6%	$185.53	$179.78	$196.31	$830.16	10%

Waiver Year	Trend Rate	Group 1 PMPM		Group 2 PMPM		Group 3 PMPM		Group 5 PMPM		Trend Rate
2005	6%	$196.45	1-1-05 $224.83	$190.57	1-1-05 $219.02	$208.09	1-1-05 $358.79	$913.17	1-1-05 $943.54	10%
2006	6%	$238.32		$232.16		$380.32		$1032.89		9.47%
2007	6%	$252.62		$246.09		$403.14		$1130.70		9.47%
2008	6%	$267.78		$260.86		$472.32		$1237.78		9.47%

c) The budget neutrality limit is the sum of the annual estimates for the Demonstration period for all EGs, less the amount of premiums paid by the beneficiaries. The Federal share of the budget neutrality limit represents the maximum amount of FFP that the State may receive for expenditures on behalf of the EGs described in 43.c. of Section IX during the Demonstration period.

d) The following are the ceiling PMPM costs for the calculation of the budget neutrality expenditure ceiling for the Demonstration enrollees under this section 1115(a) Demonstration. The PMPM costs below should be net of premiums paid by RIte Care eligibles. The ceiling PMPM limits are effective January 1, 2005.

Group 1	$224.83
Group 2	$219.02
Group 3	$358.79
Group 5	$943.54

49. For the purpose of calculating the budget neutrality limit for this Demonstration the State shall provide to CMS, on a quarterly basis, the actual number of eligible member months for enrollees for each of the five EGs. This information should be provided to CMS within 30 days after the end of each quarter as part of the CMS-64 submission, either under the narrative section of the MBES/CBES or as a stand-alone report.

50. For the purpose of monitoring budget neutrality, within 60 days after the end of each quarter, the State shall provide a report to CMS, in the format provided by CMS, identifying the State's actual member months subject to budget neutrality as set forth in Paragraph 43 for each EG and corresponding actual expenditures for each EG, less the amount of premiums paid by beneficiaries.

51. If at the end of this Demonstration period the budget neutrality limit has been exceeded, the excess Federal funds shall be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

52. The State and CMS will develop a modified budget limit in preparation for the implementation of the Medicare Prescription Drug, Improvement and Modernization Act (MMA), effective January 1, 2006. By September 30, 2005, the State will develop a tracking and identification methodology for all persons under the Demonstration who are

eligible for Medicare Part D. After December 31, 2005, no duplication of coverage of the Part D benefits shall be provided under this Demonstration.

XI. SCHIP FINANCIAL REQUIREMENTS

53. The State shall provide quarterly expenditure reports using the Form CMS-21 to report total expenditures for services provided under the approved SCHIP plan and those provided through the Rhode Island Demonstration under section 1115 authority. CMS will provide FFP only for allowable Rhode Island Demonstration expenditures that do not exceed the State's individual allotment.

54. In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid Budget and Expenditure System (MBES), as part of the routine quarterly CMS-21 reporting process. Title XXI demonstration expenditures will be reported on separate Form CMS-21, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made).

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

    b) The standard SCHIP funding process will be used during the demonstration. Rhode Island must estimate matchable SCHIP expenditures on the quarterly Form CMS-21B. On a separate CMS 21B, the State shall provide updated estimates of expenditures for the waiver population. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 quarterly SCHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the State, and including the reconciling adjustment in the finalization of the grant award to the State.

    c) The State will certify State/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

55. Rhode Island will be subject to a limit on the amount of Federal title XXI funding that the State may receive on demonstration expenditures during the waiver period. Federal title XXI funding available for demonstration expenditures is limited to the State's available allotment, including any redistributed funds. Should the State expend its available allotment and redistribution, no further enhanced Federal matching funds will be

available for costs of the demonstration populations until the next allotment becomes available.

56. If title XXI allotment and redistribution are exhausted, then title XIX Federal matching funds will be provided for the eligible *demonstration populations* under the title XIX section 1115 demonstration. The State will be required to adhere to its title XIX section 1115 demonstration budget neutrality ceiling. If title XXI allotments are exhausted, the State must use State-only funds to support the separate SCHIP population (unborn children).

57. Total Federal title XXI funds for the State's SCHIP program (i.e., the approved title XXI State plan and the demonstration) are restricted to the State's available allotment and redistributed funds. Title XXI funds (i.e., the allotment or redistributed funds) must first be used to fully fund costs associated with the SCHIP State plan population. Demonstration expenditures are limited to the remaining funds.

58. Total expenditures for outreach and other reasonable costs to administer the title XXI State plan and the demonstration that are applied against the State's title XXI allotment may not exceed ten percent of total expenditures.