CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

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

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). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. The STCs are effective October 1, 2008 unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This Demonstration extension is approved through September 30, 2011.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility and Benefits; Cost Sharing; Delivery Systems; Extended Family Planning Program; General Reporting Requirements; General Financial Requirements under Title XIX; General Financial Requirements under Title XXI; Monitoring Budget Neutrality for the Demonstration; Evaluation of the Demonstration; and Schedule of Deliverables for the Demonstration Extension Period.

Additionally, four attachments have been included to provide supplemental information and guidance for specific STCs.

II. PROGRAM DESCRIPTION AND OBJECTIVES

The RIte Care demonstration is a statewide program that provides State plan benefits to pregnant women, as well as children and their parents through a mandatory managed care delivery system. Eligibility for children and pregnant women is up to 250 percent of the Federal poverty level (FPL), while for parents eligibility is limited to 175 percent of the FPL. These groups are eligible through the Medicaid State plan and the demonstration itself.

Higher income children age 8 through 18, considered optional targeted low-income children, are funded through title XXI funds. Once title XXI funding is exhausted for these children, expenditures can be claimed under title XIX. The State also has the authority to cover expenditures for window replacement for homes with children who have tested positive for lead levels above the normal limit. Finally, women up to 200 percent of the FPL who would

otherwise lose eligibility at the end of the 60-day post partum period are eligible for family planning related services only.

RIte Share is the State's mandatory family premium assistance program which helps low-income families obtain health insurance coverage through their employer, rather than direct public coverage, by paying the employee's share of monthly premiums for family coverage. If an applicant is eligible for RIte Share, the applicant will be enrolled in that program, rather than direct coverage under RIte Care.

In order for an applicant to be enrolled in RIte Share:

- The parents and/or their children are determined eligible for Medicaid/SCHIP (RIte Care), and
- One of the parents has access to employer-sponsored insurance (ESI) and works for an employer that offers an approved plan.

RIte Share members are eligible for "wrap around" services, which are Medicaid-covered services not included in the employer's health plan, as well as for coverage of commercial insurance deductibles, coinsurance or co-payments.

The State's goals in implementing the Demonstration are to:

- Increase access to and improve the quality of care for Medicaid families;
- Expand access to health coverage to all eligible pregnant women and all eligible uninsured children; and
- Control the rate of growth in the Medicaid budget for the eligible population.

III. GENERAL PROGRAM REQUIREMENTS

1. **Concurrent Operation**: The State's title XIX State plan, as approved; its title XXI State plan, as approved; and its Medicaid section 1115 demonstration entitled "RIteCare," for the demonstration extension period 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 SCHIP and 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 waiver and expenditure authority documents of which these terms and conditions are part, must apply to the Demonstration.

4. **Changes in SCHIP and Medicaid Law, Regulation, and Policy**. The State must, within the time frames specified in the applicable law, regulation, or policy directive, come into compliance with any changes in Federal law, regulation, or policy that occur

during this Demonstration approval period, unless the provision being changed is expressly waived.

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

   a) To the extent that a change in Federal law, regulation or policy requires either a reduction or an increase in the Federal financial participation (FFP) for expenditures made under the Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement and allotment neutrality agreement for the Demonstration as necessary to comply with such change. The modified agreements would be effective upon implementation of the change.

   b) If mandated changes in the Federal law require State legislation, the changes must 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 will not be required to submit title XIX or title XXI State plan amendments for changes to Demonstration 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 except as otherwise noted in these STCs.

7. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, cost sharing, family planning services covered under this Demonstration, sources of the non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 8 below.

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

   a) An explanation of the public process used by the State, consistent with the requirements of paragraph 16 to reach a decision regarding the requested amendment;

   b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period

using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment;

c) An updated SCHIP allotment neutrality spreadsheet, if necessary;

d) A detailed description of the amendment, with sufficient supporting documentation; and

e) A description of how the evaluation design will be modified to incorporate the amendment provisions, if necessary.

9. **Extension of the Demonstration.** States that intend to request a demonstration extension under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the Demonstration, the chief executive officer of the State must submit to CMS either a Demonstration extension request or a phase-out plan, consistent with the requirements of paragraph 10.

   The State must also provide an interim evaluation report for the current extension period with the extension request, pursuant to Section XII, paragraph 58.

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 must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. 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, which shall cover a period of time not less than 6 months, is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP will be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.

11. **Enrollment Limitation During Demonstration Phase-Out.** If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 10, during the last 6 months of the Demonstration, individuals who would not be eligible for Medicaid under the current Medicaid State plan must not be enrolled unless the Demonstration is extended by CMS. Enrollment may be suspended if CMS notifies the State in writing that the waiver Demonstration will not be renewed.

12. **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.

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

14. **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 or promote the objectives of title XIX or XXI. CMS must promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and must afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.

15. **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 requirements; and reporting on financial and other Demonstration components.

16. **Public Notice and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) when any program changes to the Demonstration, including but not limited to those referenced in paragraph seven, are proposed by the State.

17. **FFP.** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

18. **Crowd-out Strategies for Higher Income Populations and Maintaining Focus on Core Populations.** Rhode Island has implemented procedures to ensure that public coverage under the SCHIP and Medicaid programs does not substitute for private coverage, consistent with and equivalent to the procedures described in the CMS State Health Official letter dated August 17, 2007. Rhode Island provided assurances and supporting documentation to demonstrate effective and efficient operation focusing on enrollment of low-income children and protecting private coverage options, as described in that letter. Confirmation of CMS's acceptance of these assurances was provided in a letter to the State dated May 9, 2008. Rhode Island will continue to use these procedures and maintain these assurances throughout the Demonstration extension period.

IV. ELIGIBILITY AND BENEFITS

19. **Eligibility.** The RIte Care Demonstration includes three distinct components.

    a) The RIte Care program provides Medicaid State Plan benefits through comprehensive

mandatory managed care delivery systems to most recipients under the State plan.

b) The Extended Family Planning program provides access to services to women whose income is at or below 200 percent of the FPL, and who lose Medicaid eligibility under RIte Care at the conclusion of their 60-day postpartum period.

c) RIte Share, the State's premium assistance program, enrolls individuals who are eligible for Medicaid/SCHIP and are an employee or dependent of an employee of an employer that offers a "qualified" plan into the ESI coverage.

The mandatory and optional Medicaid State plan populations described below derive their eligibility through the Medicaid State plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State plan, except as expressly waived and as described in these STCs. State plan eligibles are included in the Demonstration to generate savings to provide only family planning benefits to women as specified in the eligibility chart below, to mandate enrollment in managed care by waiving the freedom of choice requirement, and to waive other specific programmatic requirements.

Groups which are made Demonstration-eligible by virtue of the expenditure authorities expressly granted in this Demonstration are subject to all applicable Medicaid laws or regulations in accordance with the Medicaid State Plan, except as specified as not applicable in the expenditure authorities for this Demonstration.

The criteria for RIte Care eligibility are outlined below in a chart that shows each specific group of individuals; under what authority they are made eligible for the demonstration; and the name of the eligibility and expenditure group under which expenditures are reported to CMS and the budget neutrality expenditure agreement is constructed.

Medicaid Mandatory State Plan Groups (Categorical Eligibility)	**Federal Poverty Level (FPL) or other Qualifying Criteria**	**Expenditure and Eligibility Group Name**
• Pregnant women, including those 60-days postpartum • Children under age 1 • Children ages 1 through 5	Up to 133% of the FPL	TANF/ Demonstration Population 1
• Children ages 6 through 18 • Custodial parents or caretaker relatives of Medicaid/SCHIP children	Up to 100% of the FPL	
Children receiving Supplemental Security Income (SSI); "Katie Beckett" children; and children receiving subsidized adoption assistance	Non-income criteria	CSHCN/ Demonstration Population 5

Medicaid Optional State Plan Groups (Categorical Eligibility)	FPL	Expenditure and Eligibility Group Name
• Pregnant women, including those 60-days postpartum • Children under age 1	Above 133 to 185% FPL	TANF/ Demonstration Population 1
Custodial parents or caretaker relatives of Medicaid/SCHIP children	Above 100 to 175% FPL	1931 Parents/ Demonstration Population 3
SCHIP State Plan Group	**FPL**	**Expenditure and Eligibility Group Name**
Children ages 8 through 18 who meet the definition of "optional targeted low income child"	Above 100 to 250% FPL	SCHIP Children/ Demonstration Population 7

Groups with Categorical Link Made Eligible through the Demonstration	FPL	Expenditure and Eligibility Group Name
• Children under age 1 • Children ages 1 through 5 • Children ages 6 through 7 • Children ages 8 through 18 with access to private health insurance	Above 185 to 250% FPL Above 133 to 250% FPL } Above 100 to 250% FPL	1902(r)(2) Children/ Demonstration Population 2
Pregnant women, including those 60-days postpartum	Above 185 to 250% FPL	Pregnant Expansion/ Demonstration Population 6

Groups with No Categorical Link Made Eligible through Demonstration	FPL	Expenditure and Eligibility Group Name
Women who lose Medicaid eligibility 60 days postpartum	Up to 200% FPL	EFP/ Demonstration Population 4

20. **Eligibility Exemptions.** Notwithstanding the eligibility criteria in paragraph 19, the following persons may not be required but may voluntarily enroll in RIte Care:

    a) Children in substitute care placement; and
    b) Young adults under 21 who were in state custody as of their 18th birthday ("Chafee option").

21. **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.

22. **Benefits.** Benefits provided through this Demonstration for the RIte Care and extended family planning programs are as follows:

    a) **RIte Care.** Medicaid benefits are State plan benefits 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. All benefits that RIte Care enrollees may receive under this Demonstration are listed in Attachment A.

    b) **Extended Family Planning Program.** Family planning services are provided for a maximum period of 24 months to eligible recipients at or below 200 percent of the FPL who lose Medicaid eligibility at the conclusion of their 60-day postpartum period.

V. COST SHARING

23. The following premiums and co-payments limits apply to the Demonstration populations as noted below. Any change to these limits is subject to the amendment process outlined in Section III, paragraph eight.

Population	Premiums Per Month	Co-Payments
Demonstration Populations 1, 2, 3, 5, 6 and 7 above 133 percent of the FPL	Up to 5% of income NOTE: Premiums are not charged to pregnant women and children under 1 below 185% FPL	• Prescription Drugs: ▪ $5 Generic ▪ $10 Brand-name • Non-emergent Use of the ER: $25
Demonstration Population 4	None	• $2 Health care provider visits • $1 30-day supply of contraceptives • $15 voluntary sterilization procedures

The specific monthly premium amounts charged to Demonstration Populations 1, 2, 3, 5,

6 and 7 above 133 percent of the FPL shall be reported by the State annually and each quarter as required in Section VIII, paragraphs 32 and 33.

VI. DELIVERY SYSTEMS

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

    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 expenditure 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 approval prior to implementation.

VII. EXTENDED FAMILY PLANNING PROGRAM

25. **Extended Family Planning Program.** Family planning services are provided to uninsured women who lose Medicaid eligibility at 60 days postpartum with family income at or below 200 percent of the FPL for a maximum period of 24 months. During the extension period, new participants will only be considered eligible if their income is no higher than 200 percent of the FPL. The State will have 12 months from the beginning of the extension period to disenroll current enrollees whose income exceeds 200 percent of the FPL at their annual eligibility redetermination.

    a) **Duplicate Payments.** The State must not use title XIX funds to pay for individuals enrolled in Medicare, Medicaid, SCHIP, any other Federally funded program (i.e., title X), or component of this section 1115 Demonstration who seek services under the extended family planning program. The State shall only enroll or reenroll individuals into the extended family planning program that are uninsured (defined as not having creditable coverage) and have incomes up to and including 200 percent of the FPL. During this one-year period, the State shall pursue third party liability reimbursement for any currently enrolled individual who has other insurance and ensure that Medicaid will be the payer of last resort.

    b) **Primary Care Referral.** The State shall facilitate access to primary care services for enrollees in the extended family planning program. The State shall submit to CMS a

c) **Eligibility Redeterminations.** The State will ensure that redeterminations of eligibility for this component of the Demonstration are conducted, at a minimum, once every 12 months.

i. **Process.** The State shall submit for CMS approval its process for eligibility re-determinations no later than August 1, 2008. The process for eligibility redeterminations shall not be passive in nature, but will require that an action be taken by the extended family planning program recipient in order to continue eligibility for this program. The State may satisfy this requirement by having the recipient sign and return a renewal form to verify the current accuracy of the information previously reported to the State.

ii. **Integrity.** No later than August 1, 2008, the State will provide to CMS for approval, an appropriate methodology for ensuring the integrity of annual eligibility determinations of individuals covered under the extended family planning program. The State will use this methodology to conduct reviews of the eligibility determination process on an annual basis. As part of the submission, the State will also develop an eligibility determination error rate methodology. If annual reviews of the eligibility determination process suggest error rates beyond a State established threshold, the State will develop a corrective action plan for CMS approval.

iii. **Extended Family Planning Program Income Limit.** Effective October 1, 2008, new participants will only be considered eligible if their income is no higher than 200 percent of the FPL. The State will have 12 months from the beginning of the extension period to disenroll current enrollees whose income exceeds 200 percent of the FPL at their annual eligibility redetermination. The State shall only enroll or reenroll individuals into the extended family planning program that are uninsured (defined as not having creditable coverage) and have incomes up to and including 200 percent of the FPL

VIII. GENERAL REPORTING REQUIREMENTS

26. **General Financial Requirements.** The State must comply with all general financial requirements under title XIX and title XXI set forth in Sections IX and X, respectively.

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

28. **Reporting Requirements Relating to Budget Neutrality.** The State shall comply with all reporting requirements for monitoring budget neutrality as set forth in Section XI.

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

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

31. **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, benefits, audits, lawsuits, financial reporting and budget neutrality issues, health plan financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or State plan amendments the State is considering submitting. The State and CMS shall discuss quarterly expenditure reports submitted by the State for purposes of monitoring budget neutrality. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.

32. **Quarterly Operational Reports.** The State must submit progress reports in the format specified in Attachment B no later than 60 days following the end of each quarter.

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

    a) Updated budget neutrality and allotment neutrality monitoring spreadsheets;

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

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

    d) The number of individuals enrolled in the extended family planning program; and

e) Evaluation activities and interim findings.

33. **Annual Report.** The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. This report must also contain a discussion of the items that must be included in the quarterly operational reports required under paragraph 32. The State shall submit the draft annual report no later than February 1st of each year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted.

34. **Reporting Requirements Related to the Extended Family Planning Program.**

a) In each annual report required by paragraph 33, the State shall report the average total Medicaid expenditures for a Medicaid-funded birth each year. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth up to age 1. (The services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants.)

b) In each annual report required by paragraph 33, the State shall report the number of actual births that occur to extended family planning demonstration participants. (Participants include all individuals who obtain one or more covered medical family planning services through the extended family planning program each year.)

c) The State will submit to CMS base-year fertility rates and a methodology for calculating the fertility rates no later than August 1, 2008. For purposes of this section, "fertility rate" means birth rate. These rates must:
   i. Reflect fertility rates during Base Year 1994 for women, age 15-44 years, with family incomes at or below 200 percent FPL and ineligible for Medicaid except for pregnancy; and
   ii. Include births paid for by Medicaid.

d) At the end of each Demonstration year (DY), a DY fertility rate will be determined for Demonstration participants during that DY.

   The base-year fertility rate and the Demonstration year fertility rate will be used to calculate a measure of births averted through the Demonstration using the following formula:

   Births Averted = (base-year fertility rate) – (fertility rate of Demonstration participants during DY) X (number of Demonstration participants during DY)

   The intent of the extended family planning program is to avert unintended pregnancies in order to offset the cost of family planning services for Demonstration participants.

IX. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

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

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

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

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

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

    c) For each Demonstration year, 10 separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed to report expenditures for the following Demonstration populations and Demonstration services. The waiver names to be used to identify these separate Forms CMS-64.9 Waiver and/or 64.9P Waiver appear in brackets. Expenditures should be allocated to these forms based on the guidance found below.

        i. **Demonstration Population 1** [TANF]**:** Mandatory children; pregnant women up to 185% FPL; and caretaker relatives up to 100% FPL

ii. **Demonstration Population 2** [1902(r)(2) Children]**:** Children through age 18 from mandatory FPL levels to 250% FPL

iii. **Demonstration Population 3** [1931 Parents]**:** Caretaker relatives above 100% to 175% FPL

iv. **Demonstration Population 4** [EFP]**:** Postpartum Medicaid eligibles receiving family planning only services

v. **Demonstration Population 5** [CSHCN]**:** Children with special health care needs only when required to enroll in mandatory managed care

vi. **Demonstration Population 6** [Pregnant expansion]**:** Pregnant women from 185% to 250% FPL

vii. **Demonstration Population 7** [SCHIP Children]**:** Optional targeted low-income children aged 8 through 18 above 100% to 250% of the FPL

viii. **Demonstration Services 1** [Windows]**:** Cost of replacement windows in residences of lead-poisoned eligibles

ix. **Demonstration Services 2** [RIteShar & Collctns]**:** Premiums paid by State for ESI coverage and premiums paid by RIteCare enrollees

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

d) Notification Requirement for Demonstration Population 5.

i. The State must notify CMS in writing at least 60 days in advance of the implementation of mandatory managed care enrollment for this population.

ii. Upon implementation, the State will be required to begin reporting expenditures for the population as specified in subparagraph (c), as well as member months as required under paragraph 41. Additionally, the expenditures attributable to this Demonstration population will:

1. Count toward the budget neutrality expenditure limit calculated under Section XI, paragraph 54, using the per member per month (PMPM) amounts for Demonstration Population 5 described in that paragraph; and
2. Be considered expenditures subject to the budget neutrality agreement as defined in paragraph 37.

e) Specific Reporting Requirements for Demonstration Population 7.

i. The State is eligible to receive title XXI funds for expenditures for this Demonstration population, up to the amount of its title XXI allotment (including any reallocations or redistributions). Expenditures for these children under title XXI must be reported on separate Forms CMS-64.21U Waiver and/or 64.21UP Waiver in accordance with the instructions in section 2115 of the State Medicaid Manual.

ii. Title XIX funds are available under this Demonstration if the State exhausts its title XXI allotment (including any reallocations or redistributions). If the State exhausts its available title XXI funds prior to the end of a Federal fiscal year, title XIX Federal matching funds are available for these children. During the period when title XIX funds are used, expenditures related to this Demonstration Population must be reported as waiver expenditures on the Forms CMS 64.9 Waiver and/or CMS 64.9P Waiver.

iii. If the State chooses to claim expenditures for Demonstration Population 7 under title XIX, the expenditures attributable to this Demonstration population will:

1. Count toward the budget neutrality expenditure limit calculated under Section XI, paragraph 54, using the per member per month (PMPM) amounts for Demonstration Population 7 described in that paragraph; and
2. Be considered expenditures subject to the budget neutrality agreement as defined in paragraph 37, so that the State is not at risk for claiming title XIX Federal matching funds when title XXI funds are exhausted.

37. **Expenditures Subject to the Budget Neutrality Agreement.** For purposes of this section, the term "expenditures subject to the budget neutrality agreement" means expenditures for those benefits and services outlined in Section I of Attachment A, as well as those services specified in Attachment C. All expenditures that are subject to the budget neutrality agreement are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.

38. **Premium Collection Adjustment.** The State must include Demonstration premium collections as a manual adjustment (decrease) to the Demonstration's actual expenditures on a quarterly basis on the CMS-64 Summary Sheet.

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

40. **Claiming Period.** All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. All claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must

continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

41. **Reporting Member Months.** The following describes the reporting of member months for Demonstration populations:

    a) For the purpose of calculating the budget neutrality agreement and for other purposes, the State must provide to CMS, as part of the quarterly report required under paragraph 32, the actual number of eligible member months for the Demonstration Populations defined in paragraph 36(c)(i-vii). The State must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

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

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

    c) For the purposes of this Demonstration, the term "Demonstration eligibles" excludes unqualified aliens and refers to the Demonstration Populations described in paragraph 36(c)(i-vii).

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

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

a) Administrative costs, including those associated with the administration of the Demonstration;

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

c) Net medical assistance expenditures made under section 1115 Demonstration authority with dates of service during the Demonstration extension period; and

d) Net premium and cost-sharing payments paid by RIte Care enrollees during the Demonstration extension period.

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

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

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

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

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

e) Rhode Island will provide to CMS an updated list of Current Procedural Terminology (CPT) and Healthcare Common Procedural Coding Systems (HCPCS) codes covered under the Demonstration on January 31 of each Demonstration year. The revised code list should reflect only changes due to updates in service codes for those services for which the State has already received approval.

f) Changes to services listed in Attachment C will require an amendment to the Demonstration in accordance with Section III, paragraph eight of these STCs.

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

    a) CMS may review the sources of the non-Federal share of funding for the Demonstration at any time. Rhode Island agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

    b) Any amendments that impact the financial status of the program shall require Rhode Island to provide information to CMS regarding all sources of the non-Federal share of funding.

    Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as Demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the District government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

46. **Monitoring the Demonstration.** The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

X. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

47. **Quarterly Expenditure Reports.** In order to track title XXI expenditures under this Demonstration, the State must report quarterly Demonstration expenditures through the MBES/CBES, following routine CMS-64.21 reporting instructions as outlined in sections 2115 and 2500 of the State Medicaid Manual. Eligible title XXI Demonstration

expenditures are expenditures for services provided to title XXI children who are eligible with FPL levels within the approved SCHIP State Plan. CMS will provide enhanced FFP only for allowable expenditures that do not exceed the State's available title XXI funding.

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

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

49. **Standard SCHIP Funding Process.** The standard SCHIP funding process will be used during the demonstration. Rhode Island must estimate matchable expenditures for SCHIP Children on the quarterly Form CMS-37.12 (Narrative) for both Medicaid Assistance Payments (MAP) and State and local Administrative costs (ADM). CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64.21U Waiver and/or CMS-64.21UP Waiver. CMS will reconcile expenditures reported on the Form CMS-64.21 waiver forms with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

50. **Limit on Title XXI Funding**. Rhode Island will be subject to a limit on the amount of Federal title XXI funding that the State may receive on demonstration expenditures during the Demonstration extension period. Federal title XXI funding available for demonstration expenditures is limited to the State's available allotment, including any redistributed funds. Should the State expend its available allotment and redistribution, no further enhanced Federal matching funds will be available for the expenditures for Demonstration Population 7 until the next allotment becomes available. Once all available title XXI funds are exhausted, the State will continue to provide coverage to Demonstration Population 7 and is authorized 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.

51. **Limit on Administrative Costs.** 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.

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

52. **Limit on Title XIX Funding**. 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. The limit is determined by using a per capita cost method. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the State using the procedures described in Section IX, paragraph 38. The data supplied by the State to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

53. **Risk.** Rhode Island shall be at risk for the per capita cost for Demonstration enrollees under this budget neutrality agreement, but not for the number of Demonstration enrollees in each of the groups. By providing FFP for all Demonstration enrollees, Rhode Island will not be at risk for changing economic conditions which impact enrollment levels. However, by placing Rhode Island at risk for the per capita costs for Demonstration enrollees, CMS assures that the Federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

54. **Eligibility Groups (EGs) Used to Calculate the Budget Neutrality Expenditure Limit.** The following describes the method for calculating the budget neutrality expenditure limit for the Demonstration:

    a) For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for each EG described as follows:

        i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the State under section IX, paragraph 41 for each EG, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (ii) below. Historical PMPM costs used to calculate the budget neutrality expenditure limit in prior Demonstration periods are provided in Attachment D.

        ii. The PMPM costs for the EGs used to calculate the annual budget neutrality expenditure limit for this Demonstration are specified below.

Eligibility Group	Trend Rate	DY 15 PMPM	DY 16 PMPM	DY 17 PMPM
TANF	6%	$286.62	$303.81	$322.04
CSHCN *	7.62%	$1,345.10	$1,447.60	$1,557.90
1931 Parents	6%	$457.38	$484.82	$513.91
SCHIP Children **	6%	$279.21	$295.96	$313.72
1902(r)(2) Children	6%	$279.21	$295.96	$313.72
Pregnant Expansion	6%	$457.38	$484.82	$513.91

* When these children are required to enroll in an MCO, the PMPM costs for this population will be used to calculate the budget neutrality expenditure limit.

** When the State has exercised its authority to claim Title XIX funds as outlined in Section IX, paragraph 36(e), the PMPM costs for this population will be used to calculate the budget neutrality expenditure limit.

iii. The annual budget neutrality expenditure limit for the Demonstration as a whole is the sum of the projected annual expenditure limits for each EG calculated in subparagraph (ii) above.

b) The overall budget neutrality expenditure limit for the Demonstration is the sum of the annual budget neutrality expenditure limits calculated in subparagraph (a)(iii). The Federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that the State may receive for expenditures on behalf of Demonstration populations as well as Demonstration services described in section IX, paragraph 36(c) during the Demonstration period.

c) The Federal share of the budget neutrality expenditure limit is calculated by multiplying the limit times the Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the State on actual demonstration expenditures during the approval period, as reported through MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections and pharmacy rebates) by total computable Demonstration expenditures for the same period as reported on the same forms. FFP and expenditures for the extended family planning program must be subtracted from numerator and denominator, respectively, prior to calculation of this ratio. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed-upon method.

55. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration, rather than on an annual basis. However, if the State exceeds the calculated cumulative budget neutrality expenditure limit by the percentage identified below for any of the Demonstration years, the State must submit a corrective action plan

to CMS for approval.

Demonstration Year	Cumulative Target Definition	Percentage
Years 1 through 15	Cumulative budget neutrality cap plus:	1.0 percent
Years 1 through 16	Cumulative budget neutrality cap plus:	0.5 percent
Years 1 through 17	Cumulative budget neutrality cap plus:	0 percent

In addition, the State may be required to submit a corrective action plan if an analysis of the expenditure data in relationship to the budget neutrality expenditure cap indicates a possibility that the Demonstration will exceed the cap during this extension.

56. **Exceeding Budget Neutrality**. If the budget neutrality expenditure limit has been exceeded at the end of the demonstration period, the excess Federal funds must be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

XII. EVALUATION OF THE DEMONSTRATION

57. **State Must Separately Evaluate Components of the Demonstration.** As outlined in subparagraphs (a) and (b), the outcomes from each evaluation component must be integrated into one programmatic summary that describes whether the State met the Demonstration goal, with recommendations for future efforts regarding both components**.** The State must submit to CMS for approval a draft evaluation design no later than September 1, 2008. The evaluation must outline and address evaluation questions for both of the following components:

    a) **RIte Care.** At a minimum, the draft design must include a discussion of the goals, objectives, and evaluation questions specific to the entire Demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

    b) **Extended Family Planning Program**. The draft design must include a discussion of the goals, objectives and evaluation questions specific to this component of the Demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the extended family planning program, particularly among the target family planning population, during the period of approval. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the extended family planning program shall be isolated from other initiatives occurring in the State. The draft design must identify whether the State

will conduct the evaluation, or select an outside contractor for the evaluation. The report should also include an integrated presentation and discussion of the specific evaluation questions (including those that focus specifically on the target population for the family planning program) that are being tested. At a minimum, the following data elements will be included in the measurement methodology:

Measure	Number	Percentage Change
Enrollment		
Averted Births		
Inter-birth Spacing		
Family Planning Patients Receiving a Clinical Referral for Primary Care	(estimate may be based on a sample)	

58. **Interim Evaluation Reports.** In the event the State requests to extend the Demonstration beyond the current approval period under the authority of §1115(a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.

59. **Final Evaluation Design and Implementation.**

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

    b) The State must implement the evaluation design and submit its progress in each quarterly operational and annual reports.

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

60. **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.

XIII. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

Date - Specific	Deliverable	STC Reference
8/1/2008	Submit Primary Care Referral Materials Distributed to Extended Family Planning Recipients	Section VII, paragraph 25

Date - Specific	Deliverable	STC Reference
8/1/2008	Submit Process for Eligibility Redeterminations for Extended Family Planning Program	Section VII, paragraph 25
8/1/2008	Submit Methodology for Monitoring Family Planning Annual Determinations	Section VII, paragraph 25
8/1/2008	Submit Base-year Fertility Rates for Extended Family Planning Program	Section VIII, paragraph 34
9/1/2008	Submit Draft Evaluation Plan, including Evaluation Designs for RIte Care and the Extended Family Planning program	Section XII, paragraph 57
9/30/2010	Submit Demonstration Extension Request	Section III, paragraph 9
9/30/2010	Submit Interim Evaluation Report	Section XII, paragraph 58

	Deliverable	STC Reference
Annual	By January 31st – Updated Family Planning Codes	Section IX, paragraph 44
	By February 1st - Draft Annual Report	Section VIII, paragraph 33
Quarterly	SCHIP Enrollment Reports	Section VIII, paragraph 29
	Operational Reports	Section VIII, paragraph 32
	Title XIX Expenditure Reports	Section IX, paragraph 35
	Title XXI Expenditure Reports	Section X, paragraph 47
	Eligible Member Months	Section IX, paragraph 41

ATTACHMENT A
COMPREHENSIVE BENEFITS FOR WHICH
RITE CARE POPULATIONS ARE ELIGIBLE

Section I – Demonstration Benefits Subject to the Budget Neutrality Agreement
Clinic services including Rural Health Clinics, Federally Qualified Health Centers, and School-Based Health Center services
Diagnostic services
Durable medical equipment, including surgical appliances, prosthetic devices, orthotic devices, assistive technology, and medical supplies
Early Intervention services
Emergency medical services, including emergency transportation
Family planning services and supplies
Group education programs
Home health services including private duty and other skilled nursing and personal care/homemaker service
Inpatient and outpatient hospital services
Insurance premium assistance payments
Interpreter services including translation
Laboratory and X-ray services
Nutrition services #
Optometry services including refractions and eyeglasses
Parenting and childbirth education classes #
Physician services including nurse practitioners and nurse midwife services
Physical and occupational therapy
Podiatry services
Prescription drugs, over-the-counter drugs, and medical supplies
Services of other practitioners
Skilled nursing facility services
Speech, hearing, and language therapy
Tobacco cessation services #
Transplant services
Window replacement for lead-poisoned children #

These benefits are not provided under the Rhode Island Medicaid State Plan, but only under the Demonstration.

ATTACHMENT A
COMPREHENSIVE BENEFITS FOR WHICH
RITE CARE POPULATIONS ARE ELIGIBLE

Section II – Demonstration Benefits Not Subject to the Budget Neutrality Agreement
Comprehensive Evaluation, Diagnostic, Assessment, Referral and Reevaluation (CEDARR) services and CEDARR Direct Services (for individuals under age 21 only)
Court-ordered services to a non-network provider
Dental services
Early Periodic Screening, Diagnosis, and Treatment services (for individuals under age 21 only). The following services are not covered by the Rhode Island State Medicaid Plan but are Medicaid covered services as defined by the Social Security Act. They are covered if medically necessary for RIte Care eligible children under the age of 21 and subject to prior approval by the State and include: • Chiropractic services • Other medically necessary (as determined and prior authorized by the State) to treat or ameliorate a condition that is identified during an EPSDT screen
Family outreach home visits to high-risk infants
Inpatient and outpatient behavioral health services (mental health and chemical dependency services) for individuals under age 21 only: • Children's Intensive Services (CIS) • Child Sexual Abuse Comprehensive Evaluation, including child/parent evaluation and emergency room evaluations prior approved by the State • Comprehensive Emergency Services (CES) • Project Connect • Administratively necessary inpatient days as prior approved by the State • Intensive community based services prior approved by the State • Residential treatment for children prior approved by the State
Residential Substance Abuse Treatment Services for adolescents aged 13-17
Early Start/Therapeutic Remedial Treatment Program (for individuals up to age 3)
Intensive community-based behavioral health services for individuals classified as seriously and persistently mentally ill (SPMI)
Lead program home assessment and case management services
Non-emergency medical transportation
Special Education services
Targeted case management services

ATTACHMENT B
QUARTERLY OPERATIONAL REPORT CONTENT AND FORMAT

Under Section VIII, paragraph 32, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook is provided.

NARRATIVE REPORT FORMAT:

Title Line One – Rite Care
Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:
Example:
Demonstration Year: 15 (10/1/2008 – 9/30/2009)
Federal Fiscal Quarter: 1/2009 (10/08 - 12/08)

Introduction

Information describing the goal of the demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

Enrollment Information

Please complete the following table that outlines all enrollment activity under the demonstration. The State should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by "0".

Note: Enrollment counts should be person counts, not member months.

Demonstration Populations (as hard coded in the CMS 64)	**Current Enrollees** (to date)	**Disenrolled in Current Quarter**
DP 1: Mandatory children; pregnant women up to 185% FPL; and caretaker relatives up to 100% FPL [TANF]		
DP 2: Children under age 18 from mandatory FPL levels to 250% FPL [1902(r)(2) Children]		
DP 3: Caretaker relatives above 100% to 175% FPL [1931 Parents]		
DP 4: Postpartum Medicaid eligibles receiving family planning only services [EFP]		
DP 5: Children with special health care needs [CSHCN]		
DP 6: Pregnant women from 185% to 250% FPL [Pregnant expansion]		
DP 7: Optional targeted low-income children aged 8 through18 [SCHIP Children]		

ATTACHMENT B
QUARTERLY OPERATIONAL REPORT CONTENT AND FORMAT

Outreach/Innovative Activities

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

Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in the current quarter, including but not limited to approval and contracting with new plans, benefit changes, and legislative activity. This section should also include a discussion of the operation of RIte Share.

Included in this section should be the monthly premium amounts charged to enrollees in the Demonstration with income levels at or above 133% of the FPL, stratified as follows:

- Incomes 133% - 150%
- Incomes 151% - 200%
- Incomes 201% - 250%

Financial/Budget Neutrality Development/Issues

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

Member Month Reporting
Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
TANF				
1931 Parents				
1902(r)(2) Children				
Pregnant Expansion				
SCHIP Children (Title XIX match)				

B. For Informational Purposes Only

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
SCHIP Children (Title XXI match)				
CSHCN *				
EFP				

* Only until this group is required to enroll in an MCO

ATTACHMENT B
QUARTERLY OPERATIONAL REPORT CONTENT AND FORMAT

Consumer Issues

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences. Also discuss feedback received from other consumer groups.

Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity in current quarter.

Extended Family Planning Program

Identify all significant program developments/issues/problems that have occurred in the current quarter, including the required data and information under Section VII, paragraph 19, including enrollment data requested that is not represented in the formatted tables.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Enclosures/Attachments

Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s)

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

ATTACHMENT C
EXTENDED FAMILY PLANNING PROGRAM COVERED SERVICES

Amendments to this Attachment may be made consistent with Section III, paragraph 7.

The following procedure codes are considered family planning services as noted below:

Code	Description	90% FFP	90% FFP with V25 or FP	FMAP
00851	Tubal ligation / transection	✓		
11975	Insertion, implantable contraceptive capsules	✓		
11976	Removal, implantable contraceptive capsules		✓	
11977	Removal w/ reinsertion, implantable contraceptive capsules	✓		
57170	Diaphragm or cervical cap fitting w/ instructions	✓		
58300	Insertion of intrauterine device (IUD)	✓		
58301	Removal of intrauterine device (IUD)		✓	
58600	Ligation or transection of fallopian tubes	✓		
58611	Ligation or transection of fallopian tubes	✓		
58615	Occlusion of fallopian tubes by device	✓		
58670	Laparoscopy, surgical; w/fulguration of oviducts (w/ or w/out transection)	✓		
58671	Laparoscopy, surgical; w/occlusion of oviducts by device (eg: band, clip, etc.)	✓		
81000	Urinalysis, by dipstick or reagent for bilirubin, glucose, hemoglobin, etc.		✓	
81002	Urinalysis, non-automated without microscopy		✓	
81003	Urinalysis, automated, without microscopy		✓	
81005	Urinalysis; qualitative or semiqualitative, except immunoassays		✓	
81007	Urinalysis, bacteriuria screen, except by culture or dipstick		✓	
81015	Urinalysis, microscopic only		✓	
81020	Urinalysis, two or three glass test		✓	
81025	Urine pregnancy test, by visual color comparison methods		✓	
85013	Blood count; spun microhematocrit		✓	
85014	Blood count; other than spun microhematocrit		✓	
85018	Blood count; hemoglobin		✓	
86255	Fluorescent antibody; screen, each antibody		✓	
86592	Syphilis test; qualitative (.g., VDRL, RPR, ART)		✓	
85693	Syphilis test; quantitative		✓	
86631	Antibody; Chlamydia		✓	
86632	Antibody; Chlamydia, IgM		✓	
86689	Antibody; HTLV or HIV antibody, confirmatory test (e.g., Western Blot)		✓	
86694	Antibody; herpes simplex, non-specific type test		✓	
86695	Antibody, herpes simplex, type 1		✓	
86701	Antibody; HIV-1		✓	
86702	Antibody; HIV-2		✓	
86703	Antibody; HIV-1 and HIV-2, single assay		✓	

ATTACHMENT C
EXTENDED FAMILY PLANNING PROGRAM COVERED SERVICES

Code	Description	90% FFP	90% FFP with V25 or FP	FMAP
86781	Antibody; Treponema Pallidum, confirmatory test (e.g., FTA-abs)		✓	
87081	Culture, bacterial, screening only, for single organisms		✓	
87110	Culture, chlamydia		✓	
87206	Smear, primary source, w/ interpretation; fluorescent &/or fast stain		✓	
87207	Smear, primary source, w/ interpretation; special stain (e.g., malaria, herpes)		✓	
88141	Cytopathology, cervical or vaginal (any reporting system) physician interp.		✓	
88142	Cytopathology, cervical or vaginal (any reporting system) thin prep		✓	
88143	Cytopathology, with manual screening and rescreening under physician supervision		✓	
88147	Cytopathology smears, cervical or vaginal; screening in automated system		✓	
88148	Cytopathology, ccreening by automated system with manual rescreening - phys. supervis.		✓	
88150	Cytopathology, slides, cervical or vaginal; manual screening - phys. supervis.		✓	
88155	Cytopathology, slides, cervical or vaginal; definitive hormonal evaluation		✓	
88164	Cytopathology, slides, cervical or vaginal; (Bethesday System)		✓	
88165	Cytopathology, with manual screening and rescreening - phys supervis.		✓	
88166	Cytopathology, with manual screening and computer-assisted rescreening - phys supervis.		✓	
88167	Cytopathology, with manual screening and computer-assisted rescreening - cell selection		✓	
88302	Level II Surgical Pathology		✓	
99201	New Patient - Office or other outpatient visit		✓	
99202	New Patient - Office or other outpatient visit		✓	
99203	New Patient - Office or other outpatient visit		✓	
99204	New Patient - Office or other outpatient visit		✓	
99205	New Patient - Office or other outpatient visit		✓	
99211	Established Patient - Office or other outpatient visit		✓	
99212	Established Patient - Office or other outpatient visit		✓	
99213	Established Patient - Office or other outpatient visit		✓	
99214	Established Patient - Office or other outpatient visit		✓	
99215	Established Patient - Office or other outpatient visit		✓	
J0530	Injection, penicillin G benzathine and penicillin G procaine, up to 600,000 units			✓
J0540	Injection, penicillin G benzathine and penicillin G procaine, up to 1,200,000 units			✓
J0550	Injection, penicillin G benzathine and penicillin G procaine, up to 2,400,000 units			✓
J0560	Injection, penicillin G benzathine, up to 600,000 units			✓
J0570	Injection, penicillin G benzathine, up to 1,200,000 units			✓
J0580	Injection, penicillin G benzathine, up to 2,400,000 units			✓
J0690	Injection, cefazolin sodium, 500 mg			✓

ATTACHMENT C
EXTENDED FAMILY PLANNING PROGRAM COVERED SERVICES

Code	Description	90% FFP	90% FFP with V25 or FP	FMAP
J0694	Injection, cefoxitin sodium, 1 g			✓
J0696	Injection, ceftriaxone sodium, per 250 mg			✓
J0697	Injection, sterile cefuroximr sodium, per 750 mg			✓
J0698	Cefotaxime sodium, per g			✓
J0710	Injection, cephapirin sodium, up to 1 g			✓
J0715	Injection, ceftizoxime sodium, per 500 mg			✓
J1055	Injection, medroxyprogesterone acetate for contraceptive use, 150 mg	✓		
J1850	Injection, kanamycin sulfate, up to 75 mg			✓
J1890	Injection, cephalothin sodium, up to 1 g			✓
J3000	Injection, streptomycin, up to 1 g			✓
J3260	Injection, tobramycin sulfate, up to 80 mg			✓
J3320	Injection, spectinomycin dihydrochloride, up to 2 g			✓
J3370	Injection, vancomycin HC1, 500 mg			✓
S0610	Annual GYN - new patient		✓	
S0612	Annual GYN - established patient		✓	
99395	Comprehensive Preventive Medicine Reevaluation		✓	
00008257602	Alesse-28	✓		
00555904358	Apri	✓		
51285057628	Apri	✓		
00555906658	Aranelle	✓		
00555906667	Aranelle	✓		
00555904558	Aviane	✓		
51285001728	Aviane	✓		
00555071558	Camila	✓		
00062325002	Conceptrol	✓		
00536999512	Condoms	✓		
00555904958	Cryselle	✓		
00052028306	Cyclessa	✓		
00009074630	Depo-Provera	✓		
00009737604	Depo-Provera	✓		
00009470901	Depo-Subq Provera 104	✓		
00052026106	Desogen	✓		
11926022112	Encare	✓		
50486022112	Encare	✓		
00555904758	Enpresse	✓		
00555034458	Errin	✓		
00071092815	Estrostep FE	✓		
00071092847	Estrostep FE	✓		
00430057014	Estrostep FE	✓		

ATTACHMENT C
EXTENDED FAMILY PLANNING PROGRAM COVERED SERVICES

Code	Description	90% FFP	90% FFP with V25 or FP	FMAP
02340012800	Extra Sensitive	✓		
00062318012	Gynol II	✓		
00062318501	Gynol II Extra Strength	✓		
52544089228	Jolivette	✓		
00555902557	Junel	✓		
00555902742	Junel	✓		
00555902757	Junel	✓		
00555902658	Junel FE	✓		
00555902858	Junel FE	✓		
00555905058	Kariva	✓		
00555906467	Kelnor 1/35	✓		
08137008908	K-Y Plus	✓		
00555901458	Lessina	✓		
00555901467	Lessina	✓		
52544027928	Levora-28	✓		
70907001312	Lifestyles	✓		
00008251402	Lo/Ovral -28	✓		
51285007997	Loestrin	✓		
00430053014	Loestrin 24 FE	✓		
51285008370	Loestrin FE	✓		
52544084728	Low-Ogestrel	✓		
52544094928	Lutera	✓		
00703680101	Medroxyprogesterone Acetate	✓		
00703681121	Medroxyprogesterone Acetate	✓		
59762453701	Medroxyprogesterone Acetate	✓		
52544095021	Microgestin	✓		
52544095121	Microgestin	✓		
52544063028	Microgestin FE	✓		
52544063128	Microgestin FE	✓		
00052028106	Mircette	✓		
51285011458	Mircette	✓		
52544052628	Mononessa	✓		
52544055028	Necon	✓		
52544055228	Necon	✓		
52544055428	Necon	✓		
52544055628	Necon	✓		
52544093628	Necon	✓		
52544062928	Nora-Be	✓		
51285009158	Nordette-28	✓		

ATTACHMENT C
EXTENDED FAMILY PLANNING PROGRAM COVERED SERVICES

Code	Description	90% FFP	90% FFP with V25 or FP	FMAP
00555900858	Nortrel	✓		
00555900867	Nortrel	✓		
00555900942	Nortrel	✓		
00555901058	Nortrel	✓		
00555901258	Nortrel	✓		
00052027301	Nuvaring	✓		
52544084828	Ogestrel	✓		
00062192001	Ortho-evra	✓		
00062192015	Ortho-evra	✓		
00062141116	Ortho Micronor	✓		
00062190315	Ortho Tricyclen	✓		
00062125115	Ortho Tricyclen LO	✓		
00062190115	Ortho-Cyclen	✓		
00062330400	Ortho-Diaphragm	✓		
00062330500	Ortho-Diaphragm	✓		
00062330600	Ortho-Diaphragm	✓		
00062334500	Ortho-Diaphragm	✓		
00062176115	Ortho-Novum	✓		
00062178115	Ortho-Novum	✓		
00430058014	Ovcon-35	✓		
00430058114	Ovcon-35	✓		
00430058214	Ovcon-35	✓		
00430058514	Ovcon-50	✓		
51285003893	Plan B	✓		
64836000001	Plan B	✓		
00555902058	Portia	✓		
00093531628	Previfem	✓		
00093531681	Previfem	✓		
52544095428	Reclipsen	✓		
51285005866	Seasonale	✓		
66993061128	Solia	✓		
00555901658	Sprintec	✓		
50419043303	Tri-Levlen 28	✓		
52544093528	Trinessa	✓		
00008253601	Triphasil-28	✓		
00093531528	Tri-Previfem	✓		
00093531581	Tri-Previfem	✓		
00555901858	Tri-Sprintec	✓		
52544029128	Trivora-28	✓		

ATTACHMENT C
EXTENDED FAMILY PLANNING PROGRAM COVERED SERVICES

Code	Description	90% FFP	90% FFP with V25 or FP	FMAP
22600064712	Trojan	✓		
22600090750	Trojan	✓		
22600090950	Trojan	✓		
22600092050	Trojan	✓		
22600093850	Trojan	✓		
22600095000	Trojan	✓		
22600095250	Trojan	✓		
22600095850	Trojan	✓		
22600097250	Trojan	✓		
22600091750	Trogan Enz	✓		
22600093050	Trogan Enz	✓		
22600093150	Trogan Enz	✓		
22600093250	Trogan Enz	✓		
22600093270	Trogan Enz	✓		
22600093350	Trogan Enz	✓		
22600093750	Trogan Enz	✓		
22600093770	Trogan Enz	✓		
22600093950	Trogan Enz	✓		
22600064212	Trojan Magnum	✓		
22600064512	Trojan Magnum	✓		
22600098050	Trojan Natural Lamb	✓		
22600098750	Trojan Natural Lamb	✓		
22600094550	Trojan Ribbed	✓		
22600094750	Trojan Ribbed	✓		
22600094950	Trojan Ribbed	✓		
22600092240	Trojan Very Sensitive	✓		
22600092340	Trojan Very Sensitive	✓		
22600092640	Trojan Very Thin	✓		
22600092740	Trojan Very Thin	✓		
48723000111	VCF	✓		
52925011201	VCF	✓		
52925031214	VCF	✓		
00555905158	Velivet	✓		
00555905167	Velivet	✓		
50419040203	Yasmin 28	✓		
50419040503	Yaz	✓		
52544038328	Zovia 1/50E	✓		
52544038428	Zovia 1/50E	✓		

ATTACHMENT D
RITE CARE HISTORICAL PER MEMBER/PER MONTH LIMITS

The table below lists the calculated per-member per-month (PMPM) figures by eligibility group used to develop the Demonstration budget neutrality expenditure limits for the first 14 years of the Rite Care Demonstration. All Demonstration years began on August 1 of each year and ended July 31 of the following year, except as noted below.

- Group 1 includes mandatory children, pregnant women and custodial parents/caretaker relatives
- Group 2 includes higher income mandatory and optional children
- Group 3 includes higher income custodial parents/caretaker relatives and pregnant women, which were added to the Demonstration and budget neutrality in Demonstration Year 7.
- Group 5 includes children with special health care needs which were added to the Demonstration and budget neutrality in Demonstration Year 7. However, because these children were never enrolled in Rite Care on a mandatory basis, the figures below have not been included in the budget neutrality expenditure limit calculations.

DY	Time Period	Group 1		Group 2		Group 3		Group 5	
		PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate
1	1994-1995	$126.17	4%	$122.94	4%				
2	1995-1996	$130.80	4%	$127.01	4%				
3	1996-1997	$136.02	4%	$132.17	4%				
4	1997-1998	$141.45	4%	$137.09	4%				
5	1998-1999	$147.16	4%	$142.94	4%				
6	1999-2000	$153.03	4%	$148.64	4%				
7	2000-2001	$159.15	4%	$154.41	4%	$168.00	4%	$627.29	10%
8	2001-2002	$165.78	6%	$161.07	6%	$174.72	6%	$686.08	10%
9	2002-2003	$175.73	6%	$170.54	6%	$185.20	6%	$754.69	10%
10	2003-2004	$185.53	6%	$179.78	6%	$196.31	6%	$830.16	10%
11 †	8/1/2004-12/31/2004	$196.45	6%	$190.57	6%	$208.09	6%	$913.17	10%
	1/12005-7/31/2005	$224.83	6%	$219.02	6%	$358.79	6%	$943.54	10%
12	2005-2006	$238.32	6%	$232.16	6%	$380.32	6%	$1032.89	9.47%
13	2006-2007	$252.62	6%	$246.09	6%	$403.14	6%	$1130.70	9.47%
14 *	2007-2008	$267.78	6%	$260.86	6%	$472.32	6%	$1237.78	9.47%

† PMPMs were recalculated on 1/1/2005 based on the actuarially sound monthly capitation rates the State had to establish to be compliant with BBA regulations.

* DY 14 was extended 2 additional months (from 8/1/08 through 9/30/08) in order to align Demonstration years with Federal fiscal years.