OMB #: 0938-0707

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

Form CMS-R-211

APPLICATION FOR
STATE CHILD HEALTH PLAN UNDER TITLE XXI
OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory:_____Rhode Island_____
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act,
(42 CFR 457.40(b))

_____
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight
(42 CFR 457.40(c)):

Name: Deborah J. Florio, Program Administration
Position/Title: Administrator, Center for Child and Family Health
Rhode Island Department of Human Services

Name: Tim McCormick, Financial Oversight
Position/Title: Associate Director of Management Services
Rhode Island Department of Human Services

SECTION 1. GENERAL DESCRIPTION AND PURPOSE OF THE STATE CHILD HEALTH PLANS AND STATE CHILD HEALTH PLAN REQUIREMENTS (SECTION 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) **(42 CFR 457.70)**:

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program **(Section 2103)**; **OR**

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan **(Title XIX)**; **OR**

1.1.3. ☒ A combination of both of the above.

1.2 ☒ Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. **(42 CFR 457.40(d))**

1.3 ☒ Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. **(42CFR 457.130)**

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment **(42 CFR 457.65)**:

Effective date: October 1, 1997, although the effective date for the Section 1115 waiver was January 18, 2001.

Effective date for Amendment #1 expansion of eligibility up to 300 percent FPL is January 5, 1999.

Effective/Approval date for Amendment #2, Rhode Island's compliance SPA is September 19, 2002.

Effective date for Amendment #3, Rhode Island's separate child health program is November 1, 2002.

Effective date for Amendment #4, adding a $10,000 liquid asset limit for

eligibility, is October 1, 2006.

Effective date for Amendment #5, removing a $10,000 liquid asset limit for eligibility is July 1, 2007.

Effective date for Amendment #6, provide pregnancy-related services for targeted low-income pregnant women with family incomes up to including 250 percent of the Federal poverty level is December 9, 2009.

Effective date for Amendment #7, to an eligibility group of children who are otherwise eligible aliens lawfully residing in the United States as authorized by section 214 of the Children's Health Insurance Reauthorization Act of 2009 is July 1, 2009.

Implementation date: October 1, 1997, although the various components of the program, including applicable amendment provisions, have been implemented since then.

Implementation date: Amendment #1 was not implemented.

Implementation date for Amendment #2, compliance SPA was per CMS regulation.

Implementation date for Amendment #3, Rhode Island's separate child health program is November 1, 2002.

Implementation date for Amendment #4, adding a $10,000 liquid asset limit for eligibility is October 1, 2006. However, this amendment was not implemented.

Implementation date: for Amendment #5, removing a $10,000 liquid asset limit for eligibility is July 1, 2007.

Implementation date: for Amendment #6, provide pregnancy-related services for targeted low-income pregnant women with family incomes up to including 250 percent of the Federal poverty level is December 9, 2009.

Implementation date: for Amendment #7, to an eligibility group of children who are otherwise eligible aliens lawfully residing in the United States as authorized by section 214 of the Children's Health Insurance Reauthorization Act of 2009 is July 1, 2009.

SECTION 2. GENERAL BACKGROUND AND DESCRIPTION OF STATE APPROACH TO CHILD HEALTH COVERAGE AND COORDINATION (SECTION 2102 (A)(1)-(3)) AND (SECTION 2105)(C)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (42 CFR 457.80(a))

In November of 1993, the State of Rhode Island was granted a Section 1115 Waiver (11-W-00004/1) to develop and implement a mandatory Medicaid managed care demonstration program called RIte Care. RIte Care, implemented in August 1994, has the following general goals:

- To assure care as well as coverage to all eligible Medicaid families and children, all eligible pregnant women and all eligible uninsured children
- To control the rate of growth in the Medicaid budget for the eligible population

RIte Care was designed for the following groups to be enrolled in licensed health maintenance organizations (HMOs, or Health Plans):

- Family Independence Program (FIP)[1] families
- Pregnant women up to 250 percent of the Federal poverty level (FPL)
- Children up to age 6 in households with incomes up to 250 percent of the FPL who are uninsured

RIte Care has been expanded five times, with Federal approval, as follows:

- Effective March 1, 1996, to expand to children up to age 8 in households with incomes up to 250 percent of the FPL who are uninsured
- Effective May 1, 1997, to expand to children up to age 18 in households with incomes up to 250 percent of the FPL who are uninsured

[1]Originally Aid to Families with Dependent Children (AFDC)

- Effective November 1, 1998, to expand to families with children under age 18 including parents with incomes up to 185 to FPL (expansion under Section 1931)

- Effective July 1, 1999, to expand to children up to age 19 in households with incomes up to 250 percent of the FPL

- Effective December 1, 2000, to maximize children in foster care placements from fee for service Medicaid to RIte Care

The May 1997 and July 1, 1999 expansions, because they were implemented after March 15, 1997, qualify as eligible Medicaid expansions under Title XXI of the Social Security Act. By Section 1115 waiver approval, effective January 18, 2001, Section 1931 parents and relative caretakers and pregnant women between 185 and 250 percent of the FPL were covered under Title XXI. On December 20, 2002, the State submitted a draft amendment to provide prenatal care to unborn children, if other applicable State eligibility requirements are met, as a separate child health program. Thus, everywhere else in this State Child Health Insurance Program (SCHIP) Plan (Plan) where a *separate child health program* is referenced, it is only for this population. Otherwise, all other aspects of the State's approved Plan are a Medicaid expansion. It should be noted that the State received approval on January 5, 1999 to expand to children under age 19 in households with income up to 300% of the FPL. The State has not yet implemented the approved amendment and has no immediate plans to do so due to budgetary constraints.

In addition to these covered populations, the RIte Care Health Plans must make coverage available to certain State funded or "buy-in" groups who pay 100 percent of the applicable premium; the first group's premiums are supplemented by State-only funds:

- Pregnant women who are uninsured whose household income is between 250 and 350 percent of the FPL

- Children who are uninsured whose household income is in excess of 250 percent of the FPL

- Licensed family child care providers and their children under age 18

RIte Care has proved to be extremely successful as the following information indicates:

- Member Choice of Health Plan

    — Enrolled approximately 118,000 members into one of three Health

Plans

— Ninety-three percent of enrollees chose their own Health Plan in the first year

— Only 4 percent changed Health Plans when given the opportunity to do so during the first open enrollment period; only 1 percent during the second open enrollment period; and only 3 percent during the third open enrollment period. Plans changes have remained low.

- Covered Uninsured Families

  — Made comprehensive health coverage available to previously uninsured children up to age 19, up to 250 percent of the Federal poverty level and previously uninsured pregnant/postpartum women

  — Made coverage available to parents and adult caretakers up to 185 percent of the FPL

- Improved Access to Primary Care

  — Increased primary care physician participation from 350 to over 900 physicians

  — Increased average per enrollee physician visits from two per year pre-RIte Care (1993) to five per year in RIte Care

  — Decreased emergency room visits and hospital utilization each by more than one-third from 1993 to RIte Care

- Positive Impact on Maternal Health

  — Increased the number of women on Medicaid waiting at least 18 months between births from 60 percent pre-RIte Care (1993-94) to 79 percent in 1999 completely closing the gap between Medicaid and commercially-insured women

  — The percentage of pregnant women on Medicaid who smoked during pregnancy decreased significantly from 32 percent in 1993-94 to 24 percent in 2000

- Improved Prenatal Care

— The number of women on Medicaid who began prenatal care in the first trimester increased from 78 percent in 1993-94 to 84 percent in 2000

— The number of women on Medicaid receiving adequate prenatal care increased significantly from 57 percent in 1993-94 to 73 percent in 2000

- Improved Infant Health Outcomes

  — In inner city areas of the State:

    - The low birth weight infants born decreased from 10 percent in 1993 to 5 percent in 1995.

    - The percentage of infants who had their first physician visit before two weeks increased significantly from 54.4 percent in 1993 to 70 percent in 1995.

    - The percentage of infants who waited less than two weeks for specialty care increased significantly from 43.5 percent in 1993 to 71.4 percent in 1995.

- Improved Child Health

  — Children in RIte Care have higher well-child visit rates than children enrolled in commercial insurance as well as children enrolled in Medicaid nationally

  — In a study of 2-year-olds in RIte Care, 79 percent were screened for lead poisoning compared to only 19 percent in Medicaid nationally

- Excellent Member Satisfaction

  — Overall, 98 percent of the respondents to the 2001 RIte Care Member Satisfaction Survey were ”very satisfied” or “satisfied” with RIte Care. This percentage has remained relatively constant since the State began enrolling individuals in RIte Care

  — Survey responses stratified by Health Plans ranged from 96 to 98 percent who reported that overall they were “very satisfied” or “satisfied” with RIte Care

The State has built upon these successes by making RIte Care available to

expanded populations. Incrementally, as noted above and where permissible, including these expansion populations in the State Child Health Insurance Program (SCHIP).

According to the U.S. Bureau of the Census[2], the number of persons covered and not covered by health insurance in the State of Rhode Island in 1996 was 940,000. Of this total, 93,000 (with a standard error of 13,000), or 9.9 percent (with a standard error of 1.3 percent), were not covered by insurance. Preliminary estimates[3], not adjusted for the uninsured or sample design, of the uninsured children in Rhode Island as if July 1, 1996, were as follows:

Percent with No Health Coverage, Ages 0 to 17, Rhode Island, 1996

Income Group	Percent Uninsured
<100% FPL	19.2%
100 to 199% FPL	13.1
200 to 299% FPL	7.5
300 to 399% FPL	1.6
>=400% FPL	1.0
Don't Know	19.1
Refused	14.1
Total	**9.5%**

With an estimate of 235,283 children in Rhode Island as of July 1, 1996, this means that there were an estimated 22,352 without health insurance coverage as of July 1, 1996.

Although these estimates have not been adjusted, we believe that the number of uninsured children targeted under this Title XXI Program Plan would have been less than 14,000[4] as of July 1, 1996.

The State's efforts have had a remarkable impact on the children uninsurance rate in the State. More recent CPS data show that in 2000, 6.2 percent of the overall population in Rhode Island lacked health insurance and 2.4 percent (this

[2]Bennefield, R.L. "Health Insurance Coverage: 1996", *Current Population Reports: Consumer Income*

[3]U.S. Bureau of the Census. "Estimates of the Population of the U.S., Region, and States by Selected Age Groups and Sex: Annual Time Series, July 1, 1990. to July 1, 1996," St-96-10

[4]22,352 x 61.4% = 13,724

is a three-year average) of children lacked health insurance – both the lowest in the nation.[5]

As described in Section 5 of this Plan, the State has undertaken a well-defined outreach effort to identify and enroll uninsured children in RIte Care Health Plans. The State also implemented activities made possible by other changes in the Balanced Budget Act of 1997, to simplify the application and enrollment process. This was done to remove barriers associated with applying and enrolling through a "welfare" environment. An example of some of the outreach strategies implemented include:

- Accessing the National Governor's Association sponsored "Insure Kids Now" hotline
- Providing funding for outreach workers to 32 community-based organizations to enroll new children each month
- Targeted mailings to community organizations and school-based personnel
- Distributing information to every school-aged child Kindergarten through 6th grade in the State
- Media coverage in professional newsletters and Rhode Island newspapers
- Using the Department of Human Services Web-site to disseminate information
- Providing public service announcements and radio and television interviews through the media
- Streamlining the mail-in application in both English and Spanish
- Supporting a bi-lingual information line.

2.2 Describe the current State efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2)

2.2.1. The steps the State is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance).

5 Griffin, J. *Profiles and Trends of the Uninsured in Rhode Island: Characteristics of Uninsured Working-Age Adults in Rhode Island 1996-2000*, MCH Evaluation, Inc. April 2002.

As noted earlier, the State has had an ongoing, active outreach program to enroll uninsured eligible children in RIte Care. This outreach effort is described in Section 5 of the Plan.

The State's contracts with RIte Care Health Plans require that the Health Plans work to identify uninsured children for potential enrollment. Specifically, Section 2.05.01 of the Health Plan contract requires: "The Contractor, through members of its provider network, is encouraged to identify uninsured patients who may be RIte Care eligible and to make referrals to the State for eligibility determination." The contract also contains important coordination requirements. Specifically, Section 2.07 requires coordination with out-of-plan services and other health/social services available to members including:

- Special education
- Mental health services for seriously and persistently mentally ill adults (SPMI) and severely emotionally disturbed children (SED)—these are out-of-plan benefits
- Newborn Metabolic Screening Program
- Comprehensive Emergency Services Program
- Children's Intensive Services Program
- Early Start Program
- Lead Program
- Adolescent Pregnancy and Parenting Service Network
- Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

In addition, Health Plans are required under Section 2.08.10 of the contract, to contract with the currently operating school-based clinics in the State and to contract with future school-based clinics that might be developed. Health Plans are also encouraged to contract with Title X providers and Federally qualified health centers (FQHCs).

With respect to the FQHCs, it is important to understand that Rhode Island does not have a service delivery system within its public health structure. Thus, the FQHCs, primarily, and hospitals, secondarily, have served as the historical safety net for the uninsured in the State. When RIte Care was being implemented, the FQHCs elected to form their own Health Plan—Neighborhood Health Plan of Rhode Island. However, all other RIte Care participating Health Plans have elected to include some of the FQHCs in their provider networks. In addition, FQHCs operate the

existing school-based clinics in the State. Thus, FQHCs are an integral component of RIte Care, without a mandate for their inclusion within networks.

Another important coordination feature of RIte Care is that Health Plans are responsible for certain Early Intervention (EI) services, subject to a stop-loss provision. Section 2.07.04.01 of the Health Plan contract stipulates that the Health Plan is responsible for the first $3,000 for medically necessary, appropriate speech, hearing, language, physical and occupational therapies under EI. The State covers any additional services on a fee-for-service basis, as billed by the Health Plans as stop-loss claims.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

RIte Share, Rhode Island's new Premium Assistance Program, helps low- and middle-income families obtain health insurance coverage through their employer by paying the employee's share of monthly premiums for family coverage.

Under RIte Share, individuals who are eligible for Medicaid/SCHIP and are employed by an employer that offers a "qualified" plan, enrolls in the ESI through their employer. 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 ESI and works for an employer that offers an approved plan

The employer contribution to the cost of coverage remains unchanged. The State pays for the employee's share of the health insurance premium either by paying the employer or by paying the employee. 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 co-payments.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to

increase the number of children with creditable health coverage.
(Previously 4.4.5.) **(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)); (42CFR 457.80(c))**

The State has had an ongoing, active outreach program to identify and enroll uninsured eligibles in RIte Care. This outreach effort is described in detail in Section 5 of this document.

The State's contracts with RIte care Health Plans require that the Health Plans work to identify uninsured individuals for potential enrollment. Specifically, Section 2.05.01 of the Health Plan contract requires: "The Contractor, through members of its provider network, is encouraged to identify uninsured patients who may be RIte Care eligible and to make referrals to the State for eligibility determination." The contract also contains important coordination requirements. Specifically, Section 2.07 requires coordination with out-of-plan services and other health/social services available to members:

- Special education
- Mental health services for seriously mentally ill adults and seriously emotionally disturbed children
- Newborn Metabolic Screening Program
- Comprehensive Emergency Services Program
- Children's Intensive Services Program
- Early Start Program
- Lead Program
- Adolescent Pregnancy and Parenting Service Network
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Family Outreach Program

In addition, Health Plans are required under Section 2.08.10 of the contract to contract with school-based health clinics. Health Plans are also encouraged to contract with Title X providers and Federally qualified health centers (FQHCs).

With respect to FQHCs, it is important to understand that Rhode Island does not have a service delivery system within its public health structure. Thus, the FQHCs, primarily, and hospitals, secondarily, have served as the historical safety

net for the uninsured in the State. When RIte Care was being implemented, the FQHCs elected to form their own Health Plan – Neighborhood Health Plan of Rhode Island (NHPRI). However, all other RIte Care participating Health Plans have elected to include some of the FQHCs in their provider networks. In addition, the FQHCs operate the existing school-based health clinics in the State. Thus, the FQHCs are an integral component of RIte Care.

Another important coordination feature of RIte Care is that Health Plans are responsible for certain Early Intervention (EI) services, subject to a stop-loss provision. Section 2.07.04.01 of the Health Plan contract stipulates that the

Health Plan is responsible for the first $3,000 for medically necessary, appropriate speech, hearing, language, physical and occupational therapies under EI. The State covers any additional services on a fee-for-service basis, as billed by the Health Plan as stop-loss claims.

SECTION 3. METHODS OF DELIVERY AND UTILIZATION CONTROLS (SECTION 2102)(A)(4))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. **(Section 2102)(a)(4); (42CFR 457.490(a))**

The State will contract with licensed health maintenance organizations (HMOs, or Health Plans) for a comprehensive benefit package for the targeted low-income children and other populations (i.e., parents and adult caretakers and pregnant women). In Rhode Island, this also means that the HMOs are accredited by the National Committee for Quality Assurance (NCQA) as a requirement of State law. The licensed HMOs will be Health Plans participating in RIte Care and the comprehensive benefit package will be a Secretary-approved plan – the RIte Care benefit package.

The Health Plans are paid a monthly capitation rate to provide the comprehensive benefit package. Health Plans can earn payments over and above capitation payments, under a Performance Incentive Program that was put into place in July 1998, for the attainment of certain administrative, access, and clinical goals. In addition, there are several other nuances concerning the financing methods:

- **Risk-Share Payments** – The Rhode Island Department of Human Services (DHS) has entered into risk-share arrangements with two Health Plans – Coordinated Health Partners (CHP) and Neighborhood Health Plan of Rhode Island (NHPRI). The purpose of these arrangements is to assure RIte Care-eligible individuals have a choice of Health Plans in which to enrollee. Under the risk-sharing methodology, risk is shared according to whether the actual Medical Loss Ratio in any quarter is within agreed-upon ranges or "risk corridors."

- **Stop-Loss Payments --** Some services have been covered by the Health Plans on a partial-risk basis from the beginning. Currently, transplants (where Health Plans must cover all costs up to the actual transplant of a bodily organ), Early Intervention (EI, where Health Plans must cover the first $3,000 in benefits), mental health care (where Health Plans must cover the first 30 days of inpatient care and the first 30 outpatient visits), substance abuse treatment (where Health Plans must cover the first 30 days of inpatient rehabilitation and the first 30 outpatient visits), and nursing home care (where

Health Plans must cover the first 30 days of care) are the only services operating under RIte Care on a partial-risk basis. After these thresholds are reached, DHS reimburses the Health Plans for the cost of services above the threshold at 90 percent of the regular Medicaid fee-for-service rate or cost, whichever is less.

- **Transportation** – DHS has had an agreement with the Rhode Island Public Transportation Authority (RIPTA) since the beginning of RIte Care for RIPTA to provide bus passes and non-emergency paratransit services (e.g., taxis) to RIte Care-eligible individuals. DHS has had this arrangement with RIPTA because of the importance of transportation in assuring access to needed health care services by low-income individuals.

- **Out-of-Plan Payments[6] for Neonatal Intensive Care Unit (NICU)** – When the RIte Care Health Plan Contracts were renegotiated in July 1998, Health Plans were given the option of DHS assuming the risk of NICU services rendered at Women's & Infants Hospital versus the Health Plans retaining the risk for these services. This was done because of the historic, relatively high cost for these services for RIte Care-eligible individuals. Health Plans that elected to shift the risk for NICU services have a lower capitation rate for the under one age group.

In addition, enrollees in RIte Care are eligible to receive out-of-plan services, covered under the Medicaid fee-for-service system. See Section 6.2 in this regard.

Besides paying a portion of employee-sponsored insurance (ESI) coverage, RIte Share covers co-payments and Medicaid benefits not covered by an enrollee's ESI coverage once he or she is enrolled in RIte Share.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. **(Section 2102)(a)(4); (42CFR 457.490(b))**

The Health Plans will be at risk for the services provided to targeted low-income children and other populations. The Health Plans will use their own mechanisms to manage utilization. As noted above, the Health Plans are State-licensed HMOs and are NCQA-accredited.

[6] The State provides other out-of-plan benefits to RIte Care eligible individuals that are not reflected in Table 2-5.

SECTION 4. ELIGIBILITY STANDARDS AND METHODOLOGY. (SECTION 2102(B))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)); (42CFR 457.305(a) and 457.320(a))**

4.1.1. ☒ Geographic area served by the Plan: Statewide

4.1.2. ☒ Age: Conception to birth for unborn children

4.1.3. ☒ Income: Up to 250% of the FPL

4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources):

4.1.5. ☒ Residency (so long as residency requirement is not based on length of time in state): Applicants living in the State with the intent to stay; this includes children under 19 as provided for in Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) who are otherwise eligible aliens lawfully residing in the United States: such aliens consist of qualified aliens subject to the 5-year bar, aliens described in 8CFR 103.12(a)(4), and legal non-immigrants whose admission to the U.S. is not conditioned on having a permanent residence in a foreign country (such non-immigrants include citizens of the Compact of Free Association States who are considered permanent non-immigrants but does not include visitors for business or pleasure or students). The State assures that it will continue to verify the immigration status of this group of children to ensure they meet the eligibility requirements.

4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility): Not applicable

4.1.7. ☒ Access to or coverage under other health coverage: Effective January 1, 2002, enrollment in RIte Share, the State's premium assistance program, became mandatory for Medicaid-eligible individuals whose employers offered an approved health plan. For the separate child health program, applicants cannot be enrolled under a group health plan or health insurance coverage (including access to a State health benefits plan).

4.1.8. ☒ Duration of eligibility: Same as Medicaid.

4.1.9. ☒ Other standards (identify and describe): A Social Security Number (SSN) is required for Medicaid-eligible individuals. This does not apply to the separate child health program. At redetermination, proof of current immigration status will be required just as it is required for the initial eligibility determination.

4.1-P The following standards may be used to determine eligibility of targeted low-income pregnant women for health assistance under the plan. Please note whether any of the following standards apply. If applicable, describe the criteria that will be used to apply the standard (Section 2112).

4.1.1-P ☒ Geographic area served by the Plan: Statewide

4.1.2-P ☒ Age: the minimum age for targeted low-income pregnant women is 19 years old.

4.1.3-P ☒ Income: above 185% up to and including 250% of the FPL

4.1.4-P ☐ Resources: Not applicable

4.1.5-P ☒ Residency: Applicant living in the State with the intent to stay.

4.1.6-P ☐ Disability; Not applicable

4.1.7-P ☒ Access to or coverage under other health coverage: Enrollment in RIte Share, the State's premium assistance program, is mandatory for Medicaid-eligible individuals whose employers offered an approved health plan. For the separate child health program, applicants cannot be enrolled under a group health plan or health insurance coverage (including access to a State health benefits plan) at the time of application.

4.1.8-P ☒ Duration of eligibility: For targeted low-income pregnant women, eligibility is during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends.

4.1.9-P ☒ Other standards (identify and describe): For a pregnant woman, the pregnancy must be medically verified and there is no presumptive eligibility. These standards provide that if a child is born to a targeted low-income pregnant women who was receiving pregnancy-related assistance under this plan on the date of the child's birth, the child shall be deemed to have applied for medical assistance under title XIX and to have been found eligible for such assistance under such title, as appropriate, on the date of such birth and to remain eligible for such assistance until the child attains 1 year of

age. (Section 2112(e))

4.1.10 ☒ **Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to provide coverage to the following otherwise eligible individuals lawfully residing in the United States:**

(1) "Qualified aliens" otherwise subject to the 5-year waiting period per section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996;

(2) Citizens of a Compact of Free Association State (i.e., Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau) who have been admitted to the United States (U.S.) as non-immigrants and are permitted by the Department of Homeland Security to reside permanently or indefinitely in the U.S.;

(3) Individuals described in 8 CFR 103.12(a)(4) who do not have a permanent residence in the country of their nationality and are in statuses that permit them to remain in the U.S. for an indefinite period of time pending adjustment of status. These individuals include:

- (a) Individuals currently in temporary resident status as Amnesty beneficiaries pursuant to section 210 or 245A of the Immigration and Nationality Act (INA);
- (b) Individuals currently under Temporary Protected Status pursuant to section 244 of the INA;
- (c) Family Unity beneficiaries pursuant to section 301 of Public Law 101-649 as amended, as well as pursuant to section 1504 of Pub. L. 106-554;
- (d) Individuals currently under Deferred Enforced Departure pursuant to a decision made by the President; and
- (e) Individuals who are the spouse or child of a U.S. citizen whose visa petition has been approved and who has a pending application for adjustment of status; and

(4) Individuals in non-immigrant classifications under the INA who are permitted to remain in the U.S. for an indefinite period, including the following who are

specified in section 101(a)(15) of the INA:

- Parents or children of individuals with special immigrant status under section 101(a)(27) of the INA as permitted under section 101(a)(15)(N) of the INA;
- Fiancées of a citizen as permitted under section 101(a)(15)(K) of the INA;
- Religious workers under section 101(a)(15)(R);
- Individuals assisting the Department of Justice in a criminal investigation as permitted under section 101(a)(15)(U) of the INA;
- Battered aliens; and
- Individuals with a petition pending for 3 years or more as permitted under section 101(a)(15)(V) of the INA.

☒ The State elects the CHIPRA section 214 option for children up to age 19

☐ The State elects the CHIPRA section 214 option for pregnant women through the 60-day postpartum period

4.1.10.1 ☒ The State provides assurance that for individuals whom it enrolls in CHIP under the CHIPRA section 214 option that it has verified, both at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)); (42CFR 457.320(b))**

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.

4.2.2. ☒ Within a defined group of covered targeted low-income

children, these standards do not cover children of higher income families without covering children with a lower family income. These standards do not provide for a CHIP income eligibility level for pregnant women lower than the State's Medicaid level. **(Section 2112(b)(2))** These standards do not provide coverage for higher-income pregnant women without covering lower-income pregnant women. **(Section 2112(b)(3))** These standards provide pregnancy-related assistance for targeted low-income pregnant women in the same manner, and subject to the same requirements, as they provide child health assistance for targeted low-income children under this plan and in addition to providing child health assistance to such women. **(Section 2112(b)(4))**

4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2)); (42CFR 457.350)**

Any person may request information about either RIte Care or RIte Share, either by telephone, mail, or in person. A request for information may be followed by an application for RIte Care, RIte Share, or another form of assistance. Authorized DHS staff must furnish information to the inquiring person in accordance with DHS policy and procedures. The DHS InfoLine staff also furnishes information upon request regarding RIte Care and RIte Share, and how to apply.

A formal application procedure is required to ensure a person's right to apply without delay. It affords an opportunity to state her/his needs and to learn what DHS can do to assist her/him. It also affords DHS the opportunity to apprise the person of her/his responsibilities in relation to DHS and the programs, both as an applicant, and, should eligibility be established, as a recipient.

An applicant may be assisted in the application process, including completion of the application form, by one or more individuals of her/his choice, and when accompanied by such individual(s), may be represented by them.

DHS streamlined the RIte Care application process effective November 1, 1998 by introducing a shortened, mail-in application and by eliminating most verification requirements. This application is in English/Spanish and is widely available at community agencies or by contacting DHS.

Family Assistance Program (formerly AFDC) cash recipients access RIte Care by virtue of their cash eligibility as determined through the Family Independence Program application process. Medical Assistance Only (MAO) cases and non-MA unborn children access RIte Care and RIte Share through the mail-in application. No separate screening or application process is required.

Applicants for RIte Care and RIte Share may mail in applications to DHS or submit applications at any DHS district office or any site designated by DHS. Under Medicaid law, DHS is required to outstation eligibility workers in community settings. DHS, along with the Department of Health, provides funding to the RI Health Center Association (RIHCA) to meet this requirement. Each health center employs a Family Resource Counselor on its premises. These FRCs are of the culture and/or speak the language of the community in which they serve. The FRCs are trained to screen families/pregnant women for RIte Care/RIte Share; assist potentially eligible families in the completion and filing of the mail-in application; provide follow-up to applicants as appropriate; check the Recipient Eligibility Verification System (REVS) to determine the outcome of the application; and assist recipients with the annual renewal process. They are also responsible for screening and referring families for the cash assistance, Food Stamps, WIC and childcare services. DHS is an active participant in the regular training sessions in which all FRCs are mandated to participate. This ensures that the FRCs are aware of any changes to the State's assistance programs.

Applications are acted upon promptly. A decision on eligibility or ineligibility must be made within 30 days of an application filing date. This standard is not used as a waiting period nor as a basis for denial of an application. The applicant must be informed of the reason for any delay in a decision and her/his right to a hearing, if delay is beyond 30 days.

When the applicant is found to be eligible, the acceptance date for medical coverage is the first day of the month of application. When the applicant is found ineligible or the applicant makes the decision after signing the application the she/he does not want assistance, DHS notifies the applicant in writing of the rejection. This letter informs the applicant at the same time of her/his right to appeal the decision and the method by which the applicant can request a hearing.

The program provides for 12 months continuous coverage for infants, regardless of income changes, except for death, voluntary withdrawal from the program, removal from the State, or failure to pay the applicable premium share. For an unborn child, upon birth the child will be automatically eligible as a Medicaid expansion case until the child's first

birthday. At that point, the child's continuing eligibility will be re-determined just like any other Medicaid expansion case. For other than infants, eligibility is re-determined every 12 months. If there is a change of income in the interim and DHS becomes aware of it, re-determination will occur at that time.

These standards assure that the State shall verify that eligible children under 19 as provided for in Section 214 of CHIPRA who are otherwise eligible aliens lawfully residing in the United States continue to lawfully reside in the United States using the documentation presented to the State by the individual on initial enrollment. If the State cannot successfully verify that the individual is lawfully residing in the United States in this manner, it shall require that the individual provide the State with further documentation or other evidence to verify that the individual is lawfully residing in the United States. (Section 1903(v)(a)(4)(c) of the Act).

The State assures that by choosing to provide for the optional coverage of children under 19 as provided for by Section 214 of CHIPRA who are otherwise eligible aliens lawfully residing in the United State: The State has elected the option to apply such coverage with respect to such category of children under Title XIX (Section 2107(e)(1)(E))

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). **(Section 2106(b)(7)); (Section 2112(b)(7)); (42CFR 457.305(b))**

☒ Check here if this section does not apply to your state.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. **(Sections 2102(b)(3)(A) and 2110(b)(2)(B)); (42 CFR 457.310(b), 42CFR 457.350(a)(1), 457.80(c)(3))**

At eligibility determination and redetermination, all applications are reviewed for coverage under a group health plan, or health insurance coverage, for access to a State health benefits plan, and for Medicaid eligibility prior to enrollment in a Title XXI separate child health program.

These standards do not apply any exclusion of benefits for

pregnancy-related assistance based on any preexisting condition or any waiting period, including any waiting period imposed to carry out section 2102(b)(3)(C) for receipt of such assistance. **(Section 2112(b)(5))**

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. **(Section 2102)(b)(3)(B)); (42CFR 457.350(a)(2))**

Screening procedures identify any applicant or enrollee who would be potentially eligible for Medicaid eligibility based on his or her mother under one of the poverty level groups described in Section 1902(1) of the Social Security Act, Section 1931 of the Act, or Medicaid demonstration project under Section 1115 of the Act.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)); (42CFR 431.636(b)(4))**

Any applicant who is found ineligible for Medicaid and appears to be eligible for the separate child health program is automatically reviewed for separate child health program eligibility.

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. **(Section 2102)(b)(3)(C)); (42CFR 457.805, 42 CFR 457.810(a)-(c))**

4.4.4.1. ☒ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

The principal method is to monitor the availability of private health insurance at the time of initial application (and at re-determination). This ties to RIte Share now being mandatory. In addition, the State established a Business Advisory Committee. Finally, the two commercial Health Plans participating in RIte Care monitor their commercial enrollment levels carefully.

4.4.4.2. ☒ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

See Section 4.4.4.1.

4.4.4.3. ☐ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution. The State has not yet implemented its approved amendment to cover targeted low-income children up to 300% of the FPL.

4.4.4.4. ☒ If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period. Qualification does not require that a family be without coverage for a defined waiting period. This is because families cannot drop coverage to enroll in RIte Care due to Rhode Island's requirement that any applicant or enrollee with access to qualifying coverage must maintain or enroll in that coverage, and the State will reimburse the family for their monthly premium share, as a condition of Medicaid (separate child health program) eligibility.

The minimum employer contribution. There is no minimum employer contribution.

The cost-effectiveness determination. Cost-effectiveness is determined on an employer plan-specific basis, as opposed to an individual- or family-specific basis. This method ensures that the cost to the State for those enrolled in the premium assistance program (RIte Share) is less than enrolling those same individuals or families in RIte Care.

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native.
(Section 2102)(b)(3)(D)); (42 CFR 457.125(a))

RIte Care and RIte Share are available to targeted low-income individuals in the State who are American Indians and Alaskan Natives, except as noted in Section 8.6, cost-sharing does not apply to American Indians and Alaskan natives. Otherwise, the programs

are identical in all respects. Also see Section 9.9.1 for involvement of the Narragansett Tribe, the only Federally recognized tribe in the State of Rhode Island.

SECTION 5. OUTREACH (SECTION 2102(C))

Describe the procedures used by the state to accomplish:

5.1 Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: (Section 2102(c)(1)); (42CFR 457.90)

When RIte Care expanded eligibility to include uninsured children aged 8 to 18 up to 250 percent of the FPL, the State embarked on a multifaceted outreach plan to enroll these children. The purpose of this outreach plan was to build upon prior efforts to enroll the targeted low-income child populations in RIte Care. To effectively reach target populations, multiple outreach methods took place with a total investment of $1.8M by the Department of Human Services (DHS), a considerable investment given the size of the State. Outreach was coordinated very closely with Rhode Island's Covering Kids grant. The first phase of the outreach campaign began early in 1999, when DHS established performance-based contracts with 32 community-based agencies and community health centers to fund outreach workers to find and enroll eligible children. These contracts were in place until June 2000. The second major phase of the outreach campaign was a comprehensive school-based initiative over the 1999-2000 academic year.

TYPES OF OUTREACH

The following outreach activities have occurred as part of the public information campaign.

Targeted mailings
Print material, such as brochures, flyers, and inserts, have been developed and mailed or distributed to the groups that have contact with the targeted low-income child population. RIte Care Info Line telephone numbers are included on all print materials.

The targeted mailings included:

- Community Organizations
  - State/government agencies and programs
  - Non-profit community organizations
  - Hospitals, health center organizations, Health Plans
- School superintendents, principals, parent teacher organizations

- School nurses, school social workers, school psychologists, special education directors

- Head Start Directors, licensed preschools and nursery schools

Distribution of Materials to Every School-Age Child in Rhode Island
Similar to South Carolina's efforts for Partners for Health Children program, a RIte Care brochure was distributed to every (K through 6th grade) child in the State. This was undertaken in cooperation with the 347 schools in the State, with the schools actually handling the distribution of materials to each child.

Print Media
Media coverage on this expanded eligibility was promoted in professional newsletters and Rhode Island newspapers during the public information campaign.

Internet
Information on the eligibility expansion of RIte Care was be added to the Department of Human Services (DHS) Website.

Piggyback mailings
When possible, information on the eligibility expansion has been inserted and mailed with other State or local mailings when appropriate, e.g., unemployment checks.

Public Service Announcements
Announcements for radio that were developed by HCFA have been used for this public information campaign. Airtime was purchased rather than relying on PSAs.

Press Conference
A kick-off press conference has announced the beginning of each eligibility expansion and initiation of the Covering Kids Project in Rhode Island.

Television and Radio Interviews
Interviews on television and radio shows were set up for DHS and Center for Child and Family Health (CCFH) staff.

OUTREACH TO NON-ENGLISH SPEAKING POPULATIONS

Hispanic Outreach
All print materials for the general public have been translated into Spanish and distributed to known Hispanic organizations throughout the State. Newspaper advertisements (in Spanish) were developed and placed in Hispanic

newspapers. A Hispanic outreach subcommittee was formed and provided recommendations to DHS. This group has also been working closely with one of the Covering Kids' groups on immigrants. The RIte Care Application has been translated into Spanish.

Other Non-English Speaking Outreach
Contact has been made with community leaders in minority groups other than Spanish. Information was be distributed in English and then translated by community representatives into their language.

OUTREACH TO THE NARRAGANSETT TRIBE

DHS staff has met with tribal leaders as well as representatives of the Narragansett Indian Health Center.

COMMUNITY-BASED OUTREACH

In addition to the above activities, the State contracted with 32 community-based organizations (CBOs) to help find and enroll eligible children and families. These contracts combined base staffing of outreach workers plus incentive funds for successfully enrolled children. In addition, DHS contracted with the Rhode Island community health centers to also help enroll children. These activities were **not**, however, funded with Title XXI funds.

SIMPLIFICATION OF ELIGIBILITY/ENROLLMENT PROCEDURES

Efforts were made to simplify the eligibility and enrollment process for RIte Care, in order to de-stigmatize the program. Under these revised processes, potential enrollees sign up for RIte Care by mail and do not need to make a visit to the local welfare offices. The 32 contracted CBOs also served as sites where potential enrollees can receive an application and also receive help in completing it. In addition, 14 community-based health centers and 3 hospitals are helping to enroll potential members.

SECTION 6. COVERAGE REQUIREMENTS FOR CHILDREN'S HEALTH INSURANCE (SECTION 2103)

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) **(42CFR 457.410(a))**

6.1.1. ☐ Benchmark coverage; **(Section 2103(a)(1) and 42 CFR 457.420)**

6.1.1.1. ☐ FEHBP-equivalent coverage; **(Section 2103(b)(1))** (If checked, attach copy of the plan.)

6.1.1.2. ☐ State employee coverage; **(Section 2103(b)(2))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. ☐ HMO with largest insured commercial enrollment; **(Section 2103(b)(3))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☐ Benchmark-equivalent coverage; **(Section 2103(a)(2) and 42 CFR 457.430)** Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431**. See instructions.**

6.1.3. ☐ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for ☐existing comprehensive state-based coverage.

6.1.4. ☒ Secretary-Approved Coverage. **(Section 2103(a)(4)) (42 CFR 457.450)**

6.1.4.1. ☐ Coverage the same as Medicaid State plan

6.1.4.2. ☒ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project

6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. ☐ Other (Describe)

6.2. The state elects to provide the following forms of coverage to children (including unborn children) and targeted low-income pregnant women: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a)); (42CFR 457.490) --** Most services are covered without limits, except as medically necessary. See the enclosed Attachments A and B from the *RIte Care Health Plan Contract*, for a delineation of the amount, duration and scope of in- and out-of-plan benefits for the Secretary-approved coverage.

6.2.1. ☒ Inpatient services **(Section 2110(a)(1))**

6.2.2. ☒ Outpatient services **(Section 2110(a)(2))**

6.2.3. ☒ Physician services **(Section 2110(a)(3))**

6.2.4. ☒ Surgical services **(Section 2110(a)(4))**

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services **(Section 2110(a)(5))**

6.2.6. ☒ Prescription drugs **(Section 2110(a)(6))**

6.2.7. ☒ Over-the-counter medications **(Section 2110(a)(7))**

6.2.8. ☒ Laboratory and radiological services **(Section 2110(a)(8))**

6.2.9. ☒ Prenatal care and prepregnancy family services and supplies **(Section 2110(a)(9))** For the optional group of pregnant women covered under this plan, services include postpartum services through the end of the month in which the 60-day period (beginning on the last day of the pregnancy) ends. **(Section 2112(f)(2)**

6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services **(Section 2110(a)(10))**

6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11)**

6.2.12. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**

6.2.13. ☒ Disposable medical supplies **(Section 2110(a)(13))**

6.2.14. ☒ Home and community-based health care services (See instructions) **(Section 2110(a)(14))**

6.2.15. ☒ Nursing care services (See instructions) **(Section 2110(a)(15))**

6.2.16. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16)**

6.2.17. ☒ Dental services **(Section 2110(a)(17))** These services are covered to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions. **(Section 2103(c)(5)**

6.2.18. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**

6.2.19. ☒ Outpatient substance abuse treatment services **(Section 2110(a)(19))**

6.2.20. ☒ Case management services **(Section 2110(a)(20))**

6.2.21. ☒ Care coordination services **(Section 2110(a)(21))**

6.2.22. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**

6.2.23. ☒ Hospice care **(Section 2110(a)(23))**

6.2.24. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**

6.2.25. ☒ Premiums for private health care insurance coverage **(Section 2110(a)(25)) –** Premium share for RIte Share; see Section 8.1

6.2.26. ☒ Medical transportation **(Section 2110(a)(26))**

6.2.27. ☒ Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**

6.2.28. ☒ Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: **(42CFR 457.480)**

6.3.1. ☒ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b)(1)(B)(ii))**; **OR**

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2103(f))**. Please describe: *Previously 8.6*

6.4 **Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: **(Section 2105(c)(2) and(3)); (42 CFR 457.1005 and 457.1010)**

6.4.1. ☐ **Cost Effective Coverage.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following **(42CFR 457.1005(a))**:

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system**. **The state may cross reference section 6.2.1 - 6.2.28.** **(Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))**

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage

that would otherwise be provided for the coverage described above.; **Describe the cost of such coverage on an average per child basis**.
(Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system.** **(Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))**

6.4.2. ☐ **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3)) (42CFR 457.1010)**

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** **(Section 2105(c)(3)(A)); (42CFR 457.1010(a))**

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B)); (42CFR 457.1010(b))**

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. **(42CFR 457.1010(c))**

SECTION 7. QUALITY AND APPROPRIATENESS OF CARE

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (**Section 2102(a)(7)(A));(42CFR 457.495(a))**

The methods used for quality and appropriateness of care are the same as RIte Care. From the very beginning of RIte Care, the State has taken to heart the fact that it is a *demonstration* initiative. DHS developed a plan for monitoring[7] RIte Care Health Plans early on. The plan included the following mechanisms for monitoring 12 areas of Health Plan operations:

- Annual Site Visit Protocol
- Disenrollment Grievance Log
- Informal Complaints and Grievance and Appeals Log
- Primary Care Provider (PCP) Survey
- Enhanced Services Report
- MMIS Special "Runs"
- Member Satisfaction Survey
- Self-Assessment Tool For Health Plan Internal Quality Assurance Plan Compliance With HCQIS
- Access Study Format
- PCP Open Practice Report
- Other Provider Report
- Financial Reporting Requirements
- Third-Party Liability Report

The State also crafted and has implemented an extensive research and evaluation program to determine how well RIte Care has done in accomplishing its goals. In fact, research began before RIte Care was actually implemented in order to have some baseline data for comparison with *demonstration* results.

The Components of the State's Quality Strategy

The following constitute the various components of the State's strategy for quality

7 The latest version is: Birch & Davis Health Management Corporation. *Plan For Monitoring RIte Care Health Plans*, August 1996.

assessment and performance improvement.

1 Performance Incentive Program

In the RIte Care Health Plan Contracts effective July 1, 1998, the State established a performance incentive program, under which Health Plans can earn payments over and above capitation and SOBRA payments for the attainment of certain administrative, access, and clinical goals. The State did so "to improve care by using available health plan data on access and outcomes" and "to improve the quality of health plan performance data."[8] This was part of an ongoing strategy of partnership with the Health Plans, with both the State and the Health Plans committed to continuous quality improvement for RIte Care. The "approach leverages a comparatively small amount of money in spotlight areas that DHS considers important."[9]

The program began with 21 measures in three areas of focus: 9 for the administrative are, 5 for the access to care area, and 7 for the clinical care area. Five "pilot measures" were added in 2000 and include the following areas:

- Postpartum visit after delivery
- First outpatient pediatric visit for infants born into RIte Care
- Emergency room visits by child enrollees with asthma
- Outpatient visit after discharge for a mental health diagnosis
- Translation assistance

Each measure is clearly defined, has a numeric "standard" to be achieved, and has "scoring guidelines."

Data on the *administrative* measures are collected during on-site reviews of each Health Plan. The Encounter Data System provides the information for the *access* and *clinical* measures. Data from 1998 established the baseline against which later performance is compared. DHS offers each Health Plan monetary incentives[10] as a reward for improvements in performance, information accuracy, and the completeness of data submitted.

In 2001, DHS received a Purchaser Award from the National Health Care Purchasing Institute for the program to recognize DHS' "value purchasing" management philosophy.

2 Encounter Data System

8 Dyer, M.B., M. Bailit, and C. Kokenyesi. *Working Paper: Are Incentives Effective in Improving the Performance of Managed Care Plans?*, Center for Health Care Strategies, March 2002.

9 Rhode Island Department of Human Services. *Rhode Island Medicaid Program: Annual Report Fiscal Year 2001*, 42.

10 The total incentive pool equals approximately one percent of total capitation payments made to the Health Plans.

The RIte Care Health Plans have worked diligently to implement an encounter data reporting system. Such a reporting system is one of the Special Terms and Conditions imposed by the Federal Government in granting the State the waivers necessary to implement RIte Care. An encounter data system is designed to identify services provided to an individual and track utilization over time and across service categories, provider types, and treatment facilities. Unique features and functional components of encounter data include:

- **Episode-specific**: services associated with a particular episode of care are grouped together
- **Person-level**: able to track individuals though the system
- **Standardized**: all Health Plans are reporting using the same definition
- **Longitudinal**: able to track people across reporting period
- **Comprehensive**: able to track people across service and treatment categories

Tracking medical encounters from a point of service (e.g., a physician's office) through claim processing by the Health Plans to a data processing component to functional analytical files presents many operational challenges. As the Federal Government, Rhode Island, and the other waiver States have learned, it takes at least three years to achieve a level of consistency in reporting by Heath Plans in order to have usable encounter data.

Information from the Rhode Island Encounter Data System has been reported since 1998, when a level of reporting consistency was reached and data were verified. Besides supporting the performance incentive program, the Encounter data System is also used to monitor utilization. Monitoring utilization is important in assuring that enrollees have access to needed services. Since June 2001, encounter data have been used to prepare *RIte Stats* – a bimonthly publication of the DHS Center for Child and Family Health (which administers RIte Care and RIte Share) to provide information to the public on the health care provided under RIte Care.

Whenever possible, encounter data analyses are compared to comparable national benchmarks such as from:

- National Ambulatory Medical Survey
- National Health Interview Survey
- National Hospital Ambulatory Medical Care Survey
- National Medicaid HEDIS Database/Benchmark Project
- Treatment Episode Data Set

3 Risk-Share Reporting

As noted in Section 3.1, DHS has entered into risk-share arrangements with two Health Plans – CHP and NHPRI. The purpose of these arrangements is to assure RIte Care-eligible individuals have a choice of Health Plans in which to enroll[11]. Under the risk-sharing methodology, risk is shared according to whether the actual Medical Loss Ratio[12] in any quarter is within agreed-upon ranges or "risk corridors."

The risk-share arrangements require that the Health Plans report monthly to DHS on the following:

- Utilization data, including hospital admissions, length of stay, days per 1,000 enrollees, and maternity stays
- Claims payable and claims statistics, including claims received, claims processed, and average processing time in days
- Financial information

These reporting requirements are currently being renegotiated with the Health Plans to partition the utilization data into the following categories: (1) institutional services (behavioral health and medical services by admissions, total days, and length of stay, emergency visits, ambulatory surgery, and other outpatient services reported as visits); (2) professional services (primary care, specialty services, emergency room physician visits, and behavioral health visits; (3) pharmacy (number of prescriptions); and (4) all other services used.

4 RIte Care Annual Member Satisfaction Survey

Each year, since 1996, ACS/Birch & Davis, under contract to DHS, has conducted an Annual Member Satisfaction Survey. Satisfaction data provide a commentary by enrollees on the services they receive. Each annual survey is comprised of a random sample of RIte Care members, who are selected as representative of the RIte Care enrolled population. The samples are designed to be effective at a 25 percent response rate (plus or minus 5 percent) in measuring member satisfaction at the RIte Care program level at a 95 percent confidence**.**

Each survey sample is mailed a survey questionnaire. The questionnaire is developed, in collaboration with the RIte Care Consumer Advisory Council, for this survey to reflect RIte care-specific program concerns. Questionnaires are pre-tested and modified accordingly. There are adult and child versions of the questionnaire. Adults answer on

11 Federal regulations require that enrollees have a choice of plans in which to enroll.
12 Medical Loss Ratio means Medical Expenses divided by Premium.

behalf of child members. Both versions are in English and Spanish. Sample members who did not respond to the initial mailing are sent a replacement mailing of the questionnaire. Responses received after a specified date each year are not included in the data analysis.

Each Annual Member Satisfaction Survey collects information on the following dimensions[13]:

- Regular doctor – other than whether the member has a regular doctor, information about:
  - Doctor's location
  - How long it has been since last seen
  - Ability to talk to or see when sick
  - Waiting time for appointment when sick
  - Waiting time for appointment to begin
  - Ability to reach after hours and on holidays and weekends
  - Overall satisfaction
- Prevention services – information about areas discussed by regular doctor, such as the following for adults:
  - Tobacco, alcohol, or drug use
  - Diet, exercise, or seat belt use
  - Stress, depression, or anxiety
  - Family planning
- Pharmacy services – problems getting prescriptions filled
- Specialty services
  - Satisfaction with getting a referral
  - Problems experienced if dissatisfied
- Emergency services
  - Satisfaction, if ER services were used
  - Problems experienced, if dissatisfied
- Member services – helpfulness of plan staff, if a problem arose
- Member rights

13 It should be noted that dimensions, or questions, may change somewhat from year to year

  - Been denied services
  - Know how to appeal coverage decisions
  - Know about RIte Care Consumer Advisory Committee

- Transportation services

  - Satisfaction with RIte Care transportation benefits, if used
  - Availability of car seat for child under 3, if taxi or van used

- Interpreter services – needed one for a visit, but one not offered

- Overall satisfaction

Data from the survey are item-analyzed separately for adult and child versions of the questionnaire. Responses are analyzed by Health Plan and for English-speaking versus Spanish-speaking respondents. Where possible, responses are compared over time to examine trends.

5 Complaint, Grievance, and Appeals Reporting by the Health Plans

Enrollees may file a complaint, grievance, or appeal with their Health Plan[14] at any time. Health Plans have, since RIte Care enrollment began, submitted quarterly reports to DHS summarizing the types of complaints made and whether or not they were resolved. Health Plans have also submitted a Grievance and Appeal Log quarterly from the beginning that itemizes, by enrollee, the nature of the grievance or appeal, how long it took to resolve, how it was resolved, and how long it took to notify the enrollee of the resolution. Data are summarized periodically.

In addition to reporting by the Health Plans, complaints from enrollees (or their representatives, providers, advocates, other State agencies, and others can come to DHS directly through the bilingual DHS InfoLine or to DHS staff. Complaints may also go the RIte Care Consumer Advisory Committee. In addition, enrollees may avail themselves of the DHS Fair Hearing process at any time

6. Provider Network Data

Access to care has multiple dimensions. One dimension, for example, is providing access to care for individuals who had no or limited access due to being uninsured. Another dimension, for example, is improving access for those who had coverage but nonetheless had difficulty obtaining the services they needed.

14 Enrollees may also register complaints with the State at any time including availing themselves of the DHS Fair Hearing process.

The State monitors the adequacy of the service delivery system on a continuous basis. Provider network listings are updated monthly, from information submitted by the Health Plans. Among the items of information submitted is whether or not a provider's practice is open to new members. Another item, for example, is language(s) spoken. The listings are matched, as necessary, with enrollee/ applicant listings to assess any network gaps in primary care provider (PCP) availability, for example. Geo-access analyses have also been performed periodically.

Provider network data analysis is also considered in light Annual Member Satisfaction Survey and complaint, grievance, and appeals analyses, to present a broader picture of the adequacy and appropriateness of the provider networks.

7. NCQA Information

As noted in Section 3.1, RIte Care-participating Health Plans must be State-licensed HMOs and must be, by State law, accredited by NCQA. Accreditation information is provided to the State by the Health Plans. Health Plan Employer Data and Information Set (HEDIS) are also provided to the State by the Health Plans. HEDIS data encompasses the following domains:

- Effectiveness of Care
- Access/Availability of Care
- Satisfaction with the Experience of Care[15]
- Health Plan Stability
- Use of Services
- Cost of Care
- Informed Health Care Choice
- Health Plan Descriptive Information

The Effectiveness of Care domain includes, for example:

- Childhood immunization status
- Adolescent immunization status
- Breast cancer screening
- Cervical cancer screening
- Chlamydia screening in women
- Prenatal care in the first trimester
- Check-ups after delivery
- Controlling high blood pressure
- Comprehensive diabetes care
- Use of appropriate medications for people with asthma

15 This is actually the Consumer Assessment of Health Plans Survey (CAHPS).

The Access/Availability of Care domain includes:

- Adult's access to preventive/ambulatory health services
- Children's access to primary care practitioners

It should be noted that NCQA may rotate some of the measures from one year to the next, to reduce the burden on the Health Plans. NCQA requires an audit of HEDIS results by an independent agency (certified by NCQA) to ensure that HEDIS specifications have been met.

The similarity between some of the HEDIS measures and the RIte Care performance incentive program is not coincidental. Where possible, the performance incentive program used HEDIS specifications for a given measure since the Health Plans were already collecting information in this manner. It is important to note, however, that except for NHPRI, the HEDIS data reported by the Health Plans are not RIte Care-, or more precisely, Medicaid-specific.

The HEDIS results reported back to the Health Plans by NCQA (and, in turn, submitted to the State) show the results not for the Health Plan itself, but in comparison to "HEDIS national percentiles" at the 90^{th}, 75^{th}, 50^{th}, and 25^{th} levels, where available. The results are also shown for the Health Plan for prior years and in comparison to pre-set Health Plan goals, where applicable.

8. External Quality Review Organization (EQRO) Studies

One of the Special Terms and Conditions for the RIte Care waiver is that the State must contract with an EQRO. The State has used its EQRO to validate encounter data as well as to perform clinical focused studies. The clinical focused studies, which are based on detailed review of a sample of medical and other records, have included the following clinical areas:

- Neonatal intensive care unit (NICU) utilization
- Emergency room (ER) utilization
- Behavioral health care

The State is in the process of procuring a new EQRO contract. In addition to the conduct of clinical focused studies, the State expects the EQRO will be used to perform analytical studies using already available data.

9. Medicaid Management Information System (MMIS) Data

Because RIte Care enrollees are covered by the Medicaid fee-for-service system (FFS) for out-of-plan services (i.e., services not covered by the capitation payments to the Health Plans), *ad hoc* reports from the MMIS are prepared to analyze utilization of these

services. In addition, the MMIS provides the basic demographic information on enrollees (e.g., age, gender, and race). This latter information is actually imported into the MMIS from the State's eligibility system.

10. Transportation Data

As noted in Section 3.1, DHS has had an agreement with the Rhode Island Public Transportation Authority (RIPTA) since the beginning of RIte Care for RIPTA to provide bus passes and non-emergency paratransit services (e.g., taxis) to RIte Care-eligible individuals. DHS has had this arrangement with RIPTA because of the importance of transportation in assuring access to needed health care services by low-income individuals. RIPTA submits reports to DHS quarterly on the number of bus passes issued and on the utilization of paratransit services. These data are analyzed periodically.

11. Special Studies

As noted above, the State has implemented an extensive research and evaluation (R&E) program for RIte Care. This program has included a variety of special studies, undertaken as a particular need has arisen or part of the "planned" R&E effort. Among the studies performed have been:

- Behavioral Health Care Access Study – This study[16] was completed and submitted to CMS in 1998 and included intensive, on-site review of Health Plan compliance with behavioral health contract provisions established to address concerns related to provider specialization and the multiethnic, multilingual nature of the enrolled RIte Care population.

- **Prenatal Care and Birth Outcome Study –** This study[17], originally based on data through 1995 and reported in *RIte Care Program Quarterly Report: October 1996 through December 1996*, was updated using Calendar Year 1999 birth certificate date from the Office of Vital Statistics of the Rhode Island Department of Health. Study results, using the 1995 data, were also published in the *American Journal of Public Health*[18]*.*

- **Infant Health Survey** – This survey[19] was conducted to assess the impact of RIte Care on access to and the quality of pediatric primary care in an inner city high-risk population. The study was initiated prior to individuals enrolling

16 Birch & Davis Health Management Corporation. *RIte care Behavioral Health Access Study*, 1998.
17 Griffin, J. The *Impact of RIte Care on Adequacy of Prenatal Care and the Health of Newborns*, MCH Evaluation, Inc., March 2001.
18 Griffin, J. F., *et. al.* "the Effect of a Medicaid Managed Care Program on the Adequacy of Prenatal Care Utilization in Rhode Island," *American Journal of Public Health*, 89(4), April 1999, 497 – 501.
19 Griffin, J. *Changes in Access and Quality of Pediatric Health Care in Inner City Providence from 1993 to 1995: Results of the RIte Care Infant Health Survey*, MCH Evaluation, Inc., April 28, 1998.

in RIte Care Health Plans, so that the effects of RIte Care could be clearly discerned. Specifically, the sample for this study involved two inner city birth cohorts. The first, 1993 Cohort (i.e., pre-RIte Care), consisted of all resident births for Providence inner city census tracts 1 through 7, 12 through 14, 19 and 26 that occurred from March 1, 1993 through July 30, 1993. The second, 1995 Cohort (i.e., post-RIte Care), consisted of all inner city births from the same census tracts and born from March 1, 1995 through July 30, 1995.

In 1998, Rhode Island received a demonstration grant from the Robert Wood Johnson Foundation's Center on Health Care Strategies to develop a *Health Indication System for Rhode Islanders on Medicaid*[20]. This project brought fundamental change through the establishment of the Evaluation Studies Workgroup and the emergence of a partnership between program staff and the Workgroup. The Workgroup includes researchers from Brown University, DOH, DHS, and contracted evaluation services (with MCH Evaluation, Inc.) This project produces health outcome measures from existing databases and surveys, and through special studies. The existing databases and surveys include:

- MMIS
- Linked Infant Birth/Death File
- Birth File
- Hospital Discharge File
- Health Interview Survey
- Behavioral Risk Factor Surveillance Survey

Among some of the special studies have been:

- A study[21] of immunization status of 19- to 35-month-old children who had been continuously enrolled in RIte Care for at least one year, based upon medical record reviews

- A study[22] of a documented blood lead screen test of children aged 19 to 35 months who had been continuously enrolled in RIte Care for at least one year had, also based on medical record reviews

Special studies will continue to be performed as part of the State's quality strategy.

12 Contract Requirements

20 For more information on Rhode Islanders indicators, please see: http://dhs.state.ri.us/dhs/reports/dhcresys.htm.
21 Vivier, P. M., *et.al.* "An Analysis of the immunization status of preschool children enrolled in a statewide Medicaid managed care program," *The Journal of Pediatrics*, 139(5), November 2001, 624-629.
22 Vivier, P.M., *et.al.* "A Statewide Assessment of Lead Screening Histories of Preschool Children Managed in a Medicaid Managed care Program," *Pediatrics*, 108(2), 2001.

One of the guiding principles for the State's quality strategy is having properly aligned contract requirements for the Health Plans, obligating them to be active participants in quality assessment and performance improvement. Some of these obligations have been described above (e.g., encounter data reporting and complaints, grievances, and appeals reporting). Two other long-standing contractual obligations have been for each Health Plan to perform at least three quality improvement studies each year and for each Health Plan to conduct its own member satisfaction survey.

DHS has amended the RIte Care Health Plan Contract multiple times to ensure the Federal requirements and STCs, at least those that can be contractually based, were met. In June 2001, the RIte Care Health Plan Contract were amended to conform to what the State believed were the managed care provisions of the Balanced Budget Act of 1997 (BBA). Thus, 16 changes were made to the contracts with the Health Plans at that time.

In reviewing the details of the June 14, 2002 *Final Rule* implementing the managed care provisions of the BBA, the State finds that it will need to make additional changes to the RIte Care Health Plan Contract. These changes are due mostly to the *Final Rule*'s language differing somewhat from the actual language in the statute. Thus, one component of the State's quality strategy is to amend the RIte Care Health Plan Contracts prior to June 16, 2003 to bring them into compliance with the provisions of the *Final Rule*.

Will the state utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☒ Quality standards
7.1.2. ☒ Performance measurement
7.1.3. ☒ Information strategies
7.1.4. ☒ Quality improvement strategies

7.2. Describe the methods used, including monitoring, to assure: (**Section 2102(a)(7)(B)); (42CFR 57.495)**

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. **(Section 2102(a)(7)); (42CFR 457.495(a))**

Same as RIte Care.

7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. **(Section 2102(a)(7)); 42CFR 457.495(b))**

Same as RIte Care.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. **(Section 2102(a)(7)); (42CFR 457.495(c))**

Same as RIte Care.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law **or,** in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. **(Section 2102(a)(7)); (42CFR 457.495(d))**

Same as RIte Care.

SECTION 8. COST SHARING AND PAYMENT (SECTION 2103(E))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? **(42CFR 457.505)**

8.1.1. ☒ YES

8.1.2. ☐ NO**, skip to question 8.8.**

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)); (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums: Effective January 1, 2002, all families in the RIte Care (and RIte Share) have been required to pay a portion of the cost of premiums for their health insurance coverage if their income is above 150 percent of the FPL as follows:

Income Level	Monthly Family Premium (as of 8/1/02)
150-185% of FPL	$61
185-200% of FPL	$77
200-250% of FPL	$92

8.2.2. Deductibles:

8.2.3. Coinsurance or copayments:

8.2.4. Other: These standards provide pregnancy-related assistance to a targeted low-income women consistent with the cost-sharing protections under secition 2103(e) and apply the limitation on total annual aggregate cost-sharing. **(Section 2112(b)(6))** Enrollee cost-sharing is not required for preventative or pregnancy-related services.

8.3. Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. **(Section 2103(e)((1)(B)); (42CFR 457.505(b))**

The public is notified about cost-sharing and changes in cost-sharing in

the same manner as RIte Care. The public is notified of any changes in cost-sharing through the State's Administrative Procedures Act process. In addition, individuals directly affected by any change (i.e., those currently paying a premium share) are notified in writing prior to any proposed change in premium share amounts.

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: **(Section 2103(e))**

8.4.1. ☒ Cost-sharing does not favor children from higher income families over lower income families. **(Section 2103(e)(1)(B)); (42CFR 457.530)**

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. **(Section 2103(e)(2)); (42CFR 457.520)**

8.4.3 ☒ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. **(Section 2103(e)(1)(A)); (42CFR 457.515(f))**

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: **(Section 2103(e)(3)(B)); (42CFR 457.560(b) and 457.505(e))**

The premium share amount is set well below 5 percent of family income. There is no variable cost-sharing (e.g., point-of-service co-pays) that could increase family contribution to over 5 percent of income.

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. **(Section 2103(b)(3)(D)); (42CFR 457.535)**

Anyone identifying herself or himself as American Indian (or Alaskan Native) during the eligibility determination process is "flagged" for non-liability for any otherwise applicable premium share amount based upon income.

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. **(42CFR 457.570 and 457.505(c))**

An enrollee/family who does not pay the premium share amount for a period of two months will be disenrolled from Medical Assistance or the

separate child health program. The member is notified of this action through a closure notice, which is generated in the middle of the second month of arrears. The notice identifies the amount and months for which payment is owed, the dates of the disenrollment period, and the members affected. The notice also informs the family that they can prevent this action from taking place by making payment in full on or before the last day of the month.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

- ☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR 457.570(a))**
- ☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non payment of cost-sharing charges. **(42CFR 457.570(b))**
- ☒ In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. **(42CFR 457.570(b))**
- ☒ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR 457.570(c))**

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: **(Section 2103(e))**

8.8.1. ☒ No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4)); (42CFR 457.220)**

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. **(Section 2105(c)(5); (42CFR 457.224)** (*Previously 8.4.5)*

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. **(Section 2105(c)(6)(A)); (42CFR 457.626(a)(1))**

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1)); (42CFR 457.622(b)(5))**

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B)) (42CFR 457.475)**

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A)); (42CFR 457.475)**

SECTION 9. STRATEGIC OBJECTIVES AND PERFORMANCE GOALS AND PLAN ADMINISTRATION (SECTION 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: **(Section 2107(a)(2)); (42CFR 457.710(b))**

Increasing creditable health care coverage among targeted low-income children and other low-income children through RIte Care will be accomplished through four (4) key strategic objectives:

- Outreach and enrollment of eligible low-income children
- Increasing access to health care coverage and use of health care services
- Improving continuity and quality of care
- Containing medical costs

Each of these strategic objectives will be achieved by reaching a series of performance goals (See Section 9.2).

9.2. Specify one or more performance goals for each strategic objective identified: **(Section 2107(a)(3)); (42CFR 457.710(c))**

The performance goals for each one of the objectives delineated in Section 9.1 are shown in Tables 2 through 5 below:

Table 2
Outreach Performance Goals

Improve Outreach Efforts as Measured By:

- Increase the number of Medicaid-eligibles enrolled in RIte Care
- Reduce the percentage of uninsured children
- Reduce the percentage of uninsured adults

Table 3
Access Performance Goals

Increase Continuity and Quality of Care as Measured by:

- Increase the number of enrollees who report that they have improved access to the health care
- Facilitate access to specialty resources through PCP referrals
- Improve access to health care by removing barriers including:

- Location
- Transportation
- Appointment waiting time
- Language

- Enhance the benefit package and coverage available to eligible children

Table 4
Continuity and Quality Performance Goals
Improve Continuity and Quality of Care as Measured by:

- Improve use of age-appropriate prevention care
- Increase the number of primary care visits
- Reduce the number of lead poisoned children
- Increase preventive dental care

Table 5
Cost Containment Performance Goals
Contain Medical Costs as Measured by:

- Constrain the rate of increase in Medicaid expenditures per capita
- Decrease the inappropriate use of hospital emergency rooms
- Decrease inappropriate or preventable hospitalization (e.g., PID, asthma, otitis media, pneumonia, dehydration)

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state□s performance, taking into account suggested performance indicators as specified below or other indicators the state develops: (Section 2107(a)(4)(A),(B)); (42CFR 457.710(d))

Program evaluation, the final component of the quality monitoring strategy for RIte Care, is important for assessing whether RIte Care has achieved the performance goals it has established for RIte Care as written in Section 9.2. Progress or lack of progress toward these performance goals would dictate a need for any one or more of the following:

- Change in the Health Plan's or the Center for Child and Family Health's operational processes or priorities

- Reassessment and refinement of quality review methodologies

- Increase Health Plan accountability for noncompliance

- Revision or addenda to RIte Care Health Plan contracts or policies

- Revision of the program goals and objectives

Ninety days before the end of each fiscal year, CCFH staff will begin compiling information on the attainment of the performance goals specified in Tables 2 through 5. This will be done as an amalgam of the quality improvement and other monitoring activities to be undertaken.

Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107(a)(4))

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. ☒ The reduction in the percentage of uninsured children.

9.3.3. ☒ The increase in the percentage of children with a usual source of care.

9.3.4. ☒ The extent to which outcome measures show progress on one or more of the health problems identified by the state.

9.3.5. ☐ HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.

9.3.7. ☐ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

- 9.3.7.1. ☒ Immunizations
- 9.3.7.2. ☒ Well childcare
- 9.3.7.3. ☐ Adolescent well visits
- 9.3.7.4. ☒ Satisfaction with care
- 9.3.7.5. ☒ Mental health
- 9.3.7.6. ☒ Dental care
- 9.3.7.7. ☒ Other, please list: *Pap smears, mammograms*

9.3.8. ☐ Performance measures for special targeted populations.

9.4. ☒ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. **(Section 2107(b)(1)); (42CFR 457.720)**

9.5. ☒ The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state☐s plan for these annual assessments and reports. **(Section 2107(b)(2));**

(42CFR 457.750)

The State will compile the *Framework for Annual Report of the Child's Health Insurance Plans Under Title XXI of the Social Security Act* for each Federal fiscal year and submit it to CMS by January 1st of each year.

9.6. ☒ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3)); (42CFR 457.720)**

9.7. ☒ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. **(42CFR 457.710(e))**

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)); (42CFR 457.135)

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)
9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)
9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c)); (42CFR 457.120(a) and (b))

This process was co-led, under the overall aegis of the Director of the Department of Human Services, by the Administrator of the Center for Child and Family Health and the Co-Chair of the RIte Care Consumer Advisory Council. An initial public meeting was held on December 3, 1997, to explain to the public the opportunities and constraints provided for under Title XXI as well as to elicit public opinion on the directions the State's Title XXI program should take. It was the consensus of those in attendance at this meeting that the State should pursue the incremental approach to Title XXI reflected in the initial Plan submission, then to submit an amended Plan after conclusion of the public planning process. Subsequent public meetings were held on January 7 and 22, 1998. A Title XXI committee of the State's Federal Legislative Task Force was formed and met either monthly or bi-monthly through 1998 and 1999.

The Title XXI planning process has also entailed meetings with the other State

agencies having historic involvement with Medicaid:

- Department of Children, Youth and Families (DCYF)
- Department of Education (DOE)
- Department of Health (DOH)
- Department of Mental Health, Retardation and Hospitals (MHRH)

In addition, the Title XXI committee has included some 100 individuals representing an array of public and private interests including, for example:

- Governor's Office
- Legislative representatives
- State agencies
- RIte Care Consumer Advisory Council
- Office of Child Advocate
- RI ARC
- Urban League of Rhode Island
- RI KIDS COUNT
- Westbay Community Action
- Campaign to Eliminate Childhood Poverty
- RI Health Center Association
- United Way
- Family Voices
- RI Coalition for the Homeless
- Ocean State Action
- Health Plans

This is a similar group through which DHS worked in planning for welfare reform in the State. Thus, the Title XXI planning process had broad-based public input. The specific recommendations reflected in this Plan Amendment were adopted by the Title XXI Workgroup of the Federal Legislative Task Force, by consensus, at its September 1999 meeting.

During the Title XXI implementation phase, public involvement has been assured through the RIte Care Consumer Advisory Council which meets monthly. This is consistent with the State's approach to Title XXI by expanding RIte Care. The Consumer Advisory Council provides the public forum for addressing any aspect of RIte Care. In addition, the Consumer Advisory Council plays a critical role in reviewing State-developed materials to be sent to potential applicants/enrollees and in certain evaluation activities e.g., annual Member Satisfaction Survey.

DHS also established a Business Advisory Committee to provide advice and guidance or various aspects of the Section 1115 waiver.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. (Section 2107(c)); (42CFR 457.120(c))

In 1999, the Rhode Island Department of Human Services (DHS) and the Narragansett Native American Tribe (Tribe) signed a formal consultation agreement to encourage the free exchange of information to improve collaboration between the State and the Tribe with regard to health services.

The State has sought comments from the Tribe on its Section 1115 waiver (and amendments) and SCHIP plans through a SCHIP planning committee and continues to encourage participation from the Tribe in RIte Care's ongoing Consumer Advisory Committee.

DHS has also developed an ongoing partnership to:

- Streamline the payment claims system for RIte Care members
- Facilitate meeting meetings between NHPRI and the Indian Health Center to allow the center to participate in NHPRI's provider network
- Exempt Native Americans from cost-sharing

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in 457.65(b) through (d).

Coverage of pregnant women above 185 percent of the FPL up to and including 250 percent of the FPL has been established law in Rhode Island for many years under Section 42-12.3-3 of the General Laws of Rhode Island and provided the basis for the State's coverage of such women under its CHIP Section 1115 waiver that expired September 30, 2008. The amendment relating to benefits merely clarifies what has been existing coverage under CHIP since October 1, 1997.

Coverage of eligible children under 19 as provided for in Section 214 of the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA) who are otherwise eligible aliens lawfully residing in the United States was authorized by the Rhode Island General Assemble in approving the 2010 State Budget, thus the public was informed through the State's customary legislative process.

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: (Section 2107(d)); (42CFR 457.140)

Planned use of funds, including –

- Projected amount to be spent on health services;

- Projected amount to be spent on administrative costs; and

- Assumptions on which the budget is based, including cost per individual and expected enrollment.

Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees. Cost-sharing payments have been accounted for and the Net Benefit Costs are net of cost-sharing.

The non-Federal source of funding for the budget is State appropriations. The assumptions used for the budget the separate child health program for pregnant women component of the CHIP State plan are as follows:

- 100 pregnant women at an estimated cost of $886.80 per member per month; this includes payment for capitation, for labor and delivery, and for other pregnancy-related services.

Addition of SCHIP Coverage for Prenatal Care & Associated Health Care Services	PREGNANT WOMEN**	OTHER COVERED POPULATIONS	Total
	FFY2009	FFY2009	
State's enhanced FMAP rate	**66.84%**	**66.84%**	**66.84%**
Member Months	**600.00**	**98,415.27**	99,015.27
Benefit Costs			
Payments to Managed Care Plans	$167,712	$12,126,202	$12,293,914
Insurance Payments (RIteShare)			
per member/per month rate @ # of eligibles	*$279.52*	*$123.21*	*$124.16*
Fee for Service	$364,371	$19,545,716	$19,910,086
Total Benefit Costs	**$532,082**	**$31,671,918**	**$32,204,001**
Offsetting beneficiary cost sharing payments (Prem Coll'n)	0		
Net Benefit Costs	**$532,082**	**$31,671,918**	**$32,204,001**
per member/per month rate @ # of eligibles	$886.80	$321.82	
Administration Costs			
Personnel	$9,449	$562,465	$571,914
General administration	$7,689	$457,691	$465,380
Contractors/Brokers	$40,431	$2,406,580	$2,447,011
Claims Processing	$1,436	$85,504	$86,940
Outreach/marketing costs	$79	$4,698	$4,777
Other	$36	$2,168	$2,204
Total Administration Costs	**$59,120**	**$3,519,102**	**$3,578,222**
10% Administrative Cap	$59,120	$3,519,102	$3,578,222
Federal Share	$395,160	$23,521,678	$23,916,838
State Share	$196,043	$11,669,342	$11,865,385
TOTAL COSTS OF APPROVED SCHIP PLAN	**$591,203**	**$35,191,020**	**$35,782,223**

**Budget Projection for SFY09 includes expenses from April 2009 thru Sept 2009.

SECTION 10. ANNUAL REPORTS AND EVALUATIONS (SECTION 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)); (42CFR 457.750)

10.1.1. ☒ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.1.2. ☒ The state assures it will comply with future reporting requirements as they are developed. **(42CFR 457.710(e))**

10.1.3 ☒ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

SECTION 11. PROGRAM INTEGRITY (SECTION 2101(A))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue to Section 12.

11.1 ☒ The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. **(Section 2101(a)); (42CFR 457.940(b))**

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.935(b))**
The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)

11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)

11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)

11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)

11.2.4. ☒ Section 1128A (relating to civil monetary penalties)

11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)

11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

SECTION 12. APPLICANT AND ENROLLEE PROTECTIONS (SECTIONS 2101(A))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**.

Eligibility and Enrollment Matters

12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR 457.1120.

The review process for eligibility and enrollment matters is the Medicaid (DHS) Fair Hearing process. The DHS Fair Hearing process is available to any applicant or enrollee for review of denial of eligibility, failure to make timely determination of eligibility, and suspension or termination of enrollment including disenrollment for failure to pay cost-sharing. An expedited DHS Fair Hearing when there is an immediate need for health services. The procedures for review assure:

- Reviews are conducted by an impartial person in accordance with 42 CFR 457.1150
- Review decisions are timely in accordance 42 CFR 457.1160
- Applicants and enrollees have an opportunity to:
    - Represent themselves or have representatives of their choosing in the review
    - Timely review their files and other applicable information relevant to the review of the decision
    - Fully participate in the review process, whether the review is conducted in person or in writing, including presenting supplemental information during the review process
    - Receive continued enrollment in accordance with 42 CFR 457.1170

Health Services Matters

12.2 Please describe the review process for **health services matters** that complies with 42 CFR 457.1120.

There are multiple avenues for an enrollee for external review of a delay, denial, reduction, suspension, or termination of health services in whole or in part, including determination about the type and level of services, and failure to

approve, furnish, or provide payment for health services in a timely manner. The enrollee may avail herself or himself of the DHS Fair Hearing process described in Section 12.1. The enrollee may also avail herself or himself of the external review process through the Rhode Island Department of Health, provided for under State law.

These reviews are completed in accordance with the medical needs of the patient, and are completed within the timeframes specified in 42 CFR 457.1160.

Enrollees may also avail themselves of Health Plan internal review processes, although such reviews need not be conducted prior to enrollees availing themselves of DHS Fair Hearings or DOH external reviews.

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

All enrollees in RIte Share may avail themselves of the Medicaid (DHS) Fair Hearing process.

ATTACHMENT A

SCHEDULE OF IN-PLAN BENEFITS

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SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Inpatient Hospital Care	Up to 365 days per year based on medical necessity	Yes
Outpatient Hospital Services	Covered as needed, based on medical necessity. Includes physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, respiratory therapy, and other Medicaid covered services delivered in an outpatient hospital setting. (Health Plans have the option to deliver these types of services in other appropriate settings.)	Yes
Physician Services	Covered as needed, based on medical necessity; up to three GYN visits annually to a network provider is covered without a PCP referral	Yes
Family Planning Services	Women covered as described in Attachment F (non-extended family planning group receives same family planning benefit as extended family planning group)	Yes

ATTACHMENT A

Page 2 of 8

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Prescription Drugs	Covered when prescribed by a Health Plan physician/provider (or other physician for SED and SPMI) Generic substitution required unless specified otherwise by physician.	Yes
Non-Prescription Drugs	Covered when prescribed by a Health Plan physician/provider; limited to non-prescription drugs covered by the Rhode Island Medical Assistance Program	Yes
Laboratory Services	Covered when ordered by a Health Plan physician/provider (or other physician for SED and SPMI), including urine screens	Yes
Radiology Services	Covered when ordered by a Health Plan physician/provider	Yes
Diagnostic Services	Covered when ordered by a Health Plan physician/provider (or other physician for SED and SPMI)	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Mental Health and Substance Abuse Services-Outpatient	Both short- and long-term treatment covered as needed based on medical necessity, subject to stop-loss limitations in Definition Section 1.30 and groups/services out-of-plan in Attachment B. Includes methadone maintenance, outpatient methadone detoxification, collateral visits, and medically necessary court-ordered services subject to limitations described in Attachment B	Yes, except for groups screened-out as described in Attachment B and subject to stop-loss in Section 1.30
Mental Health and Substance Abuse Services-Inpatient	Both short- and long-term treatment covered as needed, based on medical necessity. (Butler Hospital may be used for services). Includes day treatment, partial hospitalization, and residential treatment, except for residential treatment for children ordered by DCYF, and except for residential substance abuse treatment for children age 13 to 17. Covered residential treatment includes therapeutic services but does not include room and board, except in a facility accredited by the Joint Commission on accreditation of Healthcare Organizations ("JCAHO"). Covered services subject to limitations described in Attachment B	Yes, except for groups screened-out, as described in Attachment B and subject to stop-loss provisions in Section 1.30

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
EPSDT Services	Provided to all children and young adults up to age 21, (described in greater detail in Section 2.06.02.02) Includes tracking, follow-up and outreach to children for initial visits, preventive visits, and follow-up visits. Includes interperiodic screens as medically indicated. Includes multi-disciplinary evaluation and treatment for children with significant developmental disabilities or developmental delays	Yes, for all EPSDT services except those described in Attachment 2.B

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Home Health Services	Covered if ordered by a Health Plan physician. Includes private duty nursing and homemaking/personal care services when medically necessary. Personal care/ homemaking services include such tasks as assisting the client with personal hygiene, dressing, feeding, transfer, ambulatory needs, and household tasks incidental to the client's health needs. These homemaking tasks might include making the client's bed, cleaning the client's living areas such as bedroom and bathroom, and doing the client's laundry and shopping. These services may be provided for RIte Care members and his/her children if the member is unable, because of illness or disability, to provide caretaking functions for herself/himself and her/his child(ren). Does not include respite care, relief care, or day care.	Yes
School-Based Clinic Services	Covered as medically necessary at four designated sites	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Emergency Room Services and Emergency Transportation Services	Covered, for emergency services (Section 2.09.03), or when authorized by a Health Plan Provider, or in order to assess whether a condition warrants treatment as an emergency service	Yes
Nursing Facility Care	Covered when ordered by a Health Plan physician	Yes, subject to stop-loss provisions in Section 1.30
***Services of Other Practitioners**	Covered if referred by a Health Plan physician	Yes
Podiatry Services	Covered as ordered by Health Plan physician	Yes
Optometry Services	For adults 21 and older, benefit is limited to examinations that include refractions and provision of eyeglasses if needed once every two years, and other medically necessary treatment visits for illness or injury to the eye. For children under 21, covered as medically necessary with no other limits	Yes

*Practitioners certified and licensed by the State of Rhode Island including nurse practitioners, physician assistants, social workers, licensed dieticians, psychologists, and licensed nurse midwives.

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Hospice Services	Up to 210 days lifetime maximum as ordered by a Health Plan physician. Services limited to those covered by Medicare	Yes
Durable Medical Equipment	Covered as ordered by a Health Plan physician. Includes surgical appliances, prosthetic devices, orthotic devices, and medical supplies. Includes hearing aids and molded shoes	Yes
Early Intervention	Covered as included within the IFSP as described in Section 2.07.04.01, subject to stop-loss limitations in Section 1.30	Yes, up to the first $3000 for speech, language, hearing, physical, and occupational therapies
Nutrition Services	Covered as delivered by a licensed dietitian for certain medical conditions as defined in Attachment E and as referred by a Health Plan physician	Yes
Group Education/Programs	Including childbirth education classes, parenting classes, and smoking cessation programs and services	Yes

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Transportation Services (Non-Emergency)	Covered non-emergency transportation services include bus passes, and also includes para-transit services, when authorized/arranged by the Health Plan through RIPTA Coordinator	Yes
Interpreter Services	Covered if a Health Plan has more than 100 members or 10 percent of its RIte Care membership, whichever is less, who speak a single language other than English as a primary language	Yes
Transplant Services	Covered when ordered by a Health Plan physician	Yes, subject to stop-loss limitations in Section 1.30

ATTACHMENT B

SCHEDULE OF OUT-OF-PLAN BENEFITS

Page 1 of 4

These benefits are not included in the capitated benefit and are not the responsibility of the Health Plan to provide or arrange. The Health Plan is expected to refer to and coordinate with these services as appropriate. These services will be provided by existing Medicaid-approved providers who will be reimbursed directly by the State on a fee-for-service or contractual basis

ELIGIBLE GROUP	*BENEFIT(S) PROVIDED OUT-OF-PLAN*
All RIte Care Enrollees	Dental services Court ordered mental health and substance abuse services in which the court order specifies a non-network provider AIDS non-medical case management
Children	All out-of-plan benefits listed above in "All RIte Care Enrollees" Early intervention in natural settings or center-based health and education programs for children at risk for being developmentally delayed, in excess of plan limits Special Education services as defined in the child's Individual Education Plan (IEP) for children with special health needs or developmental delays Lead Program home assessment and non-medical case management provided by Department of Health or Lead Centers for lead poisoned children Non-medical case management for Head Start children

ELIGIBLE GROUP	*BENEFIT(S) PROVIDED OUT-OF-PLAN*
Children (Continued)	Residential substance abuse treatment services for adolescents aged 13 to 17 Residential Treatment for children ordered by DCYF; covered benefits exclude room and board except in a JCAHO-accredited facility Children's Intensive Services (administered by DCYF) Comprehensive Emergency Services (administered by DCYF) Child sexual abuse evaluations, parent/child evaluations, and DCYF-ordered emergency room evaluations prior-approved by the State, (medically necessary follow up therapy is an in-plan benefit) DCYF ordered administratively necessary inpatient days prior-approved by the State Intensive community-based treatment prior approved by the State (administered by DCYF) Early Start Programs (administered by DCYF) 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 age 21, subject to prior approval from the State and will be paid on a fee-for-service basis, and include: • Chiropractic services

ELIGIBLE GROUP	*BENEFIT (S) PROVIDED OUT-OF-PLAN*
Women	All out-of-plan benefits listed above in "All RIte Care Enrollees" Adolescent Self-Sufficiency Collaborative
Seriously and Persistently Mentally Ill (SPMI) Adults and Seriously Emotionally Disturbed (SED) Children	In accordance with Sections 2.07.03.01 and 2.07.03.02, at such time that SPMI and SED individuals are identified , these individuals will have all out-of-plan benefits listed above in "All RIte Care Enrollees" and, in addition will receive the following mental health services out-of-plan: • Individual, group, and family therapy • Acute psychiatric inpatient hospitalization • Emergency room visits for psychiatric emergencies • Day treatment • Inpatient psychiatric facility services for individuals under age 21 or 22 if confined beyond 21st birthday • Community psychiatric supportive treatment

ATTACHMENT B

Page 4 of 4

ELIGIBLE GROUP	*BENEFIT (S) PROVIDED OUT-OF-PLAN*
Seriously and Persistently Mentally Ill (SPMI) Adults and Seriously Emotionally Disturbed (SED) Children (Continued)	• Multi-disciplinary psychiatric treatment planning • Mobile treatment team • Crisis intervention Seriously Emotionally Disturbed Children, in addition to receiving all above mental health benefits out-of-plan, will also receive all benefits listed in "Children" above
Postpartum Women Enrolled in Extended Family Planning Only	No out-of-plan benefits for this group
Pregnant Women Who Do Not Meet Current Medical Assistance Citizenship or Residency Requirements, or Who Are Greater than 250 Percent of the FPL	No out-of-plan benefits for this group