



Governor's Commission on Disabilities
Legislation Committee
Monday, January 4, 2016 3:00 PM - 4:30 PM
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Attendees: Linda Ward (Chair.); Jack Ringland (Vice Chair.); Rosemary C. Carmody; Regina Connor; Timothy Flynn; Kathleen Heren; William R. Inlow; **Kathy Kushnir**; Arthur M. Plitt; & Angelina Stabile

Absentees: Linda Deschenes; Casey Gartland; Paula Parker; ; Msgr. Gerard O. Sabourin; Meredith Sheehan; & Dawn Wardyga

Guests: Michael Cronan (EOHHS); Andrew McQuaide (BHDDH); Colleen Polselli (DoH); (BHDDH), **Robert Marshall (DDC)**; Lorna Ricci & Beth Pinkham (OSCIL)

Staff: Bob Cooper, Hannah Vitello (Legislative Fellow)



3:00 Call to Order and Acceptance of the Minutes, Linda Ward, Chair

Chair calls the meeting to order at 3 PM
 Introductions of Commissioners and guests



MOTION: To accept the minutes of the previous meeting as presented
 Motion moved by RCa, seconded by JR, passed unanimously

Action Items:



3:05 Proposed Amendments to the State's Medicaid Regulations, Bob Cooper

Purpose/Goal: To review and comment on proposed amendments to the RI Medicaid State Plan

Medicaid State Plan Section 15-017 "Reinventing Medicaid 2015: Cedar Family Center Redesign"

Letter sent to Secretary Roberts: 12/30/15
 The Governor's Commission on Disabilities requests a public hearing relating to SPA 15-017.

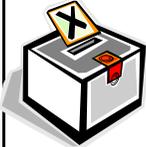
- Questions:
- Where in the Medicaid State Plan will the proposed Amendment be located? It appears to start with iii. Provider Infrastructure. Without knowing how the proposed amendment fits in the context of i. and ii it is difficult to understand the broader impact of the proposed amendment to the SECTION 0322 Early Childhood Intervention regulation.

- Should the numbering of the Measure Specification for Goals 1 and 2 be sequential, or should the numbering start again at 1, in both of Goal 2's measure specifications, Clinical Outcomes & Quality of Care?
- Is the name change from CEDARR (comprehensive evaluation, diagnosis, assessment, referral and re-evaluation) to Cedar, reflective of a change in responsibilities? Will they no long conduct re-evaluations?
- What entity will be taking over the CEDARR Centers' role in the PASS program? How long will the transition period be?

The Commission found harmful unless amended the proposed RI SPA 15-017 Reinventing Medicaid 2015 Amendments: Cedar Family Center Redesign:

- **General comment:**
 - The transition period seems very rushed, there needs to be at least a month to ensure no child is left behind/dropped in the handoff from CEDARR Centers' to the managed care provider. During the transition period, the CEDARR Center's need to retain enough staff to handle these critical services.
- **iv. Service Definitions - Comprehensive Care Management - Cedar HEALTH HOME SPECIFIC DEFINITION:** "The Family Care Plan is based on assessment information, the strengths and needs of the child and family and on clinical protocols which indicate the types and intensity of care considered medically necessary."
 - Rather than Cedar Centers conducting clinical assessments, a more holistic "needs assessment" should be required. Treat the whole child/family, don't create more silos. The loss of a "whole child" manager could decreased effectiveness. The Family Care Plan should spell out the responsibilities of the comprehensive care management services provider connecting/assisting the family with transportation, transition to school, SNAP, and other social services that CEDARR Centers traditionally provided.
- **Care Coordination - Service Definitions - Cedar HEALTH HOME SPECIFIC DEFINITION:** "Provide information to families about specific disorders, treatment and provider options, systems of support, services, assistance and legal rights available to Children with Special Health Care Needs and their families, resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, funding options, school based services, faith based organizations, etc."
 - Family of children with special health care needs will often need more than just "information ..." but assistance arranging for transportation, transition to school, SNAP, and other social services that CEDARR Centers traditionally provided. Many families are overwhelmed by the level of care and involvement needed during the earliest period of their child. The initial level of stress on the family can be tremendous.

- **Comprehensive Transitional Care (including appropriate follow up, from Inpatient to other settings) - Service Definition - Cedar HEALTH HOME SPECIFIC DEFINITION:** “The Cedar Team will collaborate with all parties involved including the facility, primary care physician, Health Plan (if enrolled) and community providers to ensure a smooth discharge into the community and prevent subsequent re-admission(s).”
 - Coordination should extend beyond the health plan to include connecting/assisting the family with transportation, transition to school, SNAP, and other social services.
- **Individual and Family Support Services (including authorized representatives) - Cedar HEALTH HOME SPECIFIC DEFINITION:** “The Cedar Team is responsible for providing assistance to the family in accessing and coordinating services. These services include the full range of services that impact on Children with Special Health Care Needs and include, but are not limited to, health, behavioral health, education, substance abuse, juvenile justice and social and family support services. The Cedar Team will actively integrate the full range of services into a comprehensive program of care. At the family's request, the Cedar Team can play the principal role as organizer, information source, guide, advocate, and facilitator for the family by helping the family to assess strengths and needs, identify treatment goals and services, and navigate agency and system boundaries.”
 - This comprehensive approach should be mirrored in the other definitions of the Cedar HEALTH HOME SPECIFIC DEFINITIONS.
- **Referral to Community and Social Support Services - Service Definition - Cedar HEALTH HOME SPECIFIC DEFINITION:** “Referral to Community and Social Support Services will be provided by members of the Cedar Team and will include information about formal and informal resources beyond the scope of services covered by Medicaid, such as those which may be available from other parents, family members, community-based organizations, service providers, grants, social programs, funding options including the family's health coverage, school-based services, faith based organizations, etc.”
 - Family of children with special health care needs will often need more than just “information ...” but assistance arranging for transportation, transition to school, SNAP, and other social services.
- **viii. Quality Measures: Goal Based Quality Measures - Goal 1: Improve Care coordination - Quality of Care - Measure Specification - 3. Family Care Plan Goals Met.** “c. 100% of goals completed within 12 months”; **Goal 2: Improve Health Outcomes of Children and Youth with Special Health Care Needs (CYSHCN) - Clinical Outcomes - Measure Specification - 3. Family Care Plan Goals Met.** “c. 100% of goals completed within 12 months”; and **Goal 2: Improve Health Outcomes of Children and Youth with Special Health Care Needs (CYSHCN) - Quality of Care - Measure Specification - 3. Family Care Plan Goals Met.** “c. 100% of goals completed within 12 months”.

	<ul style="list-style-type: none"> ○ The focus on short-term service plans (up to 1 year) for children with significant health care needs, could result in gaps in service each year and set-backs. Multi-year service plans are more realistic for this population, while retaining the goal of “building on the strengths of the child, family, extended family and community supports to support long-term empowerment.” <p>The Commission is also very concerned that the Secretariat’s website posting of proposed State Plan Amendments does not comply with the accessible communication standards for Websites issued by the US Department of Health and Human Services’ Section 504 Regulation or the US Department of Justice’s ADA Title II regulation, nor does it comply with RIGL 42-87 and the RI.Gov accessibility standard. The Secretariat was advised by the Commission in November 5, 2015 of the potential legal challenge to any State Plan Amendment so posted (see attached US DoJ Website Guidelines).</p>
	<p>MOTION: To revise the comments on Medicaid State Plan Section 15-017 “Reinventing Medicaid 2015: Cedar Family Center Redesign” to include Cedar Centers or care coordinator responsible for scheduling transportation including non-medical transportation. Center/coordinator should also continue scheduling appointments.</p> <p>Motion moved by RCa_, seconded by AP passed unanimously</p>
	<p>Section #0399 “Global Consumer Choice Waiver /Section 1500: Medicaid Long-Term Services & Supports</p>
	<p>The Secretary of the Executive Office of Health & Human Services (EOHHS) has under consideration amendments to the Medicaid Code of Administrative Rules (“MCAR”) Section #0399. EOHHS is proposing to amend pertinent sections of this section of the MCAR, currently entitled, “Global Consumer Choice Waiver”, renumber it to section #1500, and re-title it: “Medicaid Long-Term Services and Supports: Interim Rule.” These rules are being promulgated pursuant to the authority conferred under Chapters 40-6 and 40-8 of the General Laws of Rhode Island, as amended, and the federal Section 1115 Waiver approved by the federal Centers for Medicare and Medicaid Services (CMS).</p> <p>The EOHHS has determined that the most effective way of updating the applicable rules is to create a new chapter in the MCAR that sets forth in plain language the rules governing LTSS and, as such, serves as companion to the MCAR chapters governing Medicaid Affordable Care Coverage (Section 1300 <i>et seq.</i>). Toward this end, the purpose of this rule is to establish the provisions that implement the reforms beginning in 2016 and to provide a summary of changes that will take effect during calendar year 2016 and thereafter.</p> <p>To achieve the goal of rebalancing the long-term care system, Medicaid eligibility criteria have been reformed to enable beneficiaries to obtain long-term services and supports (LTSS) in the most appropriate and least restrictive setting.</p> <p>The chief distinctions between the two types of LTSS are care setting and scope of Medicaid coverage. Beginning in 2016, the series of reforms for modernizing the system for organizing, financing and delivering Medicaid-funded LTSS will begin to take effect. While the modernization process is underway, many longstanding LTSS policies and procedures and the rules governing their implementation will become obsolete.</p>

Interested persons should submit data, views, written comments, or a request for a hearing **by January 16, 2016**

Public Hearing on Wednesday, January 13, 2016 at 10:00 a.m.
Hewlett-Packard Enterprise Services
301 Metro Center Boulevard, Second Floor Conference Room (Room 203)
Warwick, RI 02886 (Parking is adjacent to the building)

Rhode Island Executive Office of Health and Human Services
Access to Medicaid Coverage under the Affordable Care Act Rules and Regulations Section 1500:
Medicaid Long-Term Services & Supports

Introduction

These rules entitled, Section 1500 of the Medicaid Code of Administrative Rules entitled, “Medicaid Long-Term Services and Supports: Interim Rule”, are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 (Medical Assistance); Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111- 148); and the Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15).

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication or overlap was identified and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

These regulations shall supersede all sections of Section #0399 of the Medicaid Code of Administrative Rules entitled, “The Global Consumer Choice Waiver”, that have been amended herein, and as promulgated by EOHHS and filed with the Rhode Island Secretary of State.

Proposed Rules: ii

~~{delete}~~ **0399 THE GLOBAL CONSUMER CHOICE WAIVER** ~~{delete}~~

{add} CHAPTER 1500

MEDICAID LONG-TERM SERVICES AND SUPPORTS-INTERIM RULE

1500.01 REDESIGN OF MEDICAID LONG-TERM SERVICES AND SUPPORTS (LTSS) IN RHODE ISLAND

A. Overview ^{add}

~~{delete}~~ REV:07/2009 ~~{delete}~~

^{add} In 2009, the State received approval for an innovative Medicaid Section 1115 Demonstration Waiver. Until 2013, the demonstration was known as the “Global Consumer Choice Compact Waiver (Global Waiver)” due to its unique financing arrangement in which the State and our federal partners mutually agreed to an aggregate cap on the bulk of Medicaid spending. ^{add} One of the most important goals of the ~~{delete}~~ Global Consumer Choice Compact Waiver ~~{delete}~~ Global Waiver is ^{add} was to reduce overutilization of high cost institutionally based care by ^{add} ~~{delete}~~ ensure that every beneficiary receives ~~{delete}~~ ^{add} ensuring that every Medicaid beneficiary was able to access ^{add} the appropriate services, at the appropriate time, and in the appropriate and least restrictive setting. To achieve this goal for ^{add} Medicaid-funded ^{add} long-term ~~{delete}~~ care ~~{delete}~~ (LTC) services ^{add} and supports (LTSS) ^{add}, the waiver ~~{delete}~~ provides ~~{delete}~~ ^{add} provided ^{add} the State with the authority to collapse its existing section 1915 (c) home and community based service waivers (HCBS), ~~{delete}~~ which have different eligibility criteria and services, into its newly approved section 1115 (a) Global Waiver. ~~{delete}~~ ^{add} to standardized eligibility requirements to the full extent feasible to both reduce the bias toward institutional care and promote less costly and restrictive alternatives. ^{add} ~~{delete}~~ Under the Global Waiver ~~{delete}~~

^{add} In December of 2013, the State received approval for an extension of the Section 1115 waiver by the federal Centers for Medicare and Medicaid Services (CMS). As the extension eliminated the aggregate cap, references to the global compact were removed and the demonstration became known as Rhode Island’s “Section 1115 waiver.” Under the terms of the 2013, Section 1115 waiver agreement, the goal of rebalancing the LTSS system to promote HCBS was reaffirmed and strengthened. The State remains committed to ensuring that ^{add} the scope of ^{add} LTSS ^{add} ~~{delete}~~ services ~~{delete}~~ available to a beneficiary is not based solely on a need for

27 ^{add}an^{add} institutional ^{add}level of^{add} care, but is based on a comprehensive assessment that includes, but is
28 not limited to, an evaluation of the medical, social, physical and behavioral health needs of each applicant.

29 ^{add}Implementation of the federal Affordable Care Act (ACA) of 2010, began in January 2014, at the
30 same time the Section 1115 waiver extension took effect. The State has endeavored to take every

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1 opportunity available under the ACA to further the rebalancing goals of the waiver and on-going efforts to institute,
2 Medicaid program-wide, an integrated system of coordinated services that covers acute and subacute care as well
3 as LTSS. Implementation of the ACA has also provided the State with the technology to support
4 improvements in every facet of the Medicaid LTSS system – from the point of application and the determination
5 of eligibility through to service delivery. A statewide “Reinventing Medicaid Initiative”, which began in 2015,
6 has also added to this changing landscaping by authorizing the Executive Office of Health and Human Services
7 (EOHHS) to:

- 8 • Establish incentive payment systems for nursing facilities and hospitals that improve quality and reduce
9 unnecessary utilization;
- 10 • Streamline LTSS clinical and financial eligibility procedures to enhance the customer experience and
11 access to and information about HCBS alternatives;
- 12 • Pursue implementation of LTSS managed care arrangements that integrate and coordinate services
13 for Medicaid and dually eligible Medicaid and Medicare beneficiaries; and
- 14 • Promote the availability of LTSS options and alternatives with the capacity to address the unique and
15 changing acuity needs of beneficiaries.

16 In 2016, these efforts will converge as LTSS determinations move to the State’s new integrated eligibility
17 system, which has both a web-based consumer and agency-staff portal, implementation of integrated care for
18 Medicare-Medicaid dually eligible beneficiaries and the realignment of Medicaid LTSS clinical and financial
19 eligibility criteria begins.

20 **B. Scope and Purpose**

21 Beginning on January 1, 2016, the series of reforms authorized by state policymakers for modernizing the
22 system for organizing, financing and delivering Medicaid-funded LTSS will begin to take effect. While the
23 modernization process is underway, many long-standing LTSS policies and procedures and the rules governing
24 their implementation will become obsolete. The EOHHS has determined that the most effective way of updating
25 the applicable rules is to create a new chapter in the Medicaid Code of Administrative Rules (MCAR) that sets
26 forth in plain language the rules governing LTSS and, as such, serves as companion to the MCAR chapters
27 governing Medicaid Affordable Care Coverage (Section 1300 *et seq.*). Toward this end, the purpose of this
28 rule is to establish the provisions that implement the reforms beginning on January 1, 2016 and to provide a
29 summary of changes that will take effect during calendar year 2016 and thereafter.^{add}

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1 ~~{delete}~~ **0399.02 Transition to the Global Waiver**

2 REV:07/2009~~{delete}~~

3 ^{add}**C. Applicability**

4 Under the terms of Title XIX of the U.S. Social Security Act of 1964, Medicaid LTSS in an institutional-
5 setting is a State Plan service available to all otherwise eligible Medicaid beneficiaries and applicants with an
6 eligibility related characteristic who meet the applicable clinical and financial criteria. “Institution” is the term
7 used in the Act to refer to a hospital, an intermediate care facility for persons with intellectual disabilities
8 (ICF/ID), and a nursing facility (NF), all of which are licensed by the Rhode Island Department of Health as
9 health care facilities under Chapter 23-17 of the state’s general laws. The clinical eligibility criteria for LTSS
10 remain tied to these institutional settings and vary according to the level of care each provides and the needs of
11 the population(s) they serve, even though the services are now available to beneficiaries in a home and
12 community-based setting.

13 (1) **Scope.** Medicaid LTSS in a home and community-based setting is a service authorized by the state’s Section
14 1115 waiver or, in a limited number of circumstances, the Medicaid State Plan.^{add} The authority for the State
15 ~~{delete}~~ of Rhode Island ~~{delete}~~ to provide home and community-based services ~~{delete}~~ transitions ~~{delete}~~ ^{add} was derived
16 initially^{add} from ~~{delete}~~ the authority found in ~~{delete}~~ ^{add} Section^{add} 1915(c) of the Social Security Act ^{add} and

17 ~~transitions to the State's~~^{add} ~~to that found in~~^{delete} Section 1115 ^{add} demonstration waiver^{add} ~~of the~~^{delete}
18 ~~Act~~^{delete} on July 1, 2009. The transition in authority ~~allows~~^{delete} ^{add} , which was continued in the waiver
19 extension of 2013, allowed^{add} the State to implement new needs-based levels of care, expand the number of
20 individuals that can access ~~long-term care services, and increase the availability of home and community-~~^{delete}
21 ~~based services. On June 1, 2009 letters were sent to all Home and Community-based Waiver participants notifying~~
22 ~~them of the transition in authority. The agencies with authority to determine access for LTC prior to July 1,~~
23 ~~2009, shall retain that authority subsequent to the transition date unless otherwise stated in this rule.~~^{delete}
24 ^{add} LTSS and standardize and streamline the eligibility criteria across programs and settings.

25 (2) General Eligibility. To be eligible for Medicaid LTSS, a person must meet a specific set of financial and
26 clinical criteria that do not apply to other forms of coverage. This requirement applies to both new applicants and
27 existing Medicaid beneficiaries and assures access to LTSS in an institutional setting. Under the terms and
28 conditions of the Section 1115 waiver, home and

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1 community-based LTSS are also available to Medicaid beneficiaries who meet the applicable clinical and
2 financial criteria and are eligible on the basis of:

- 3 • Supplemental Security Income (SSI) receipt (MCAR, Section 0351.10) or an SSI characteristic related
4 to age (65 and older), blindness, or a disabling condition and income up to 100 percent of the federal
5 poverty level (FPL) (MCAR Section 0370);
- 6 • Special income state plan requirements for persons with a Medicaid characteristic and income from
7 100 percent of the FPL to 300 percent of the SSI limit (MCAR, Sections 0370 to 0372);
- 8 • Section 1915 (c) of Title XIX, home and community-based waiver criteria for persons who are aged or
9 functionally disabled and have income up to 300 percent of the SSI level and would require the level
10 of services provided in an institutional setting were it not for LTSS waiver services (MCAR, Section
11 0398);
- 12 • “Medically needy” state plan requirements for persons with income above 300 percent of the SSI level
13 and medical and LTSS expenses at or below the cost of the applicable type of care in an institutional
14 setting (i.e., nursing facility, hospital, intermediate care facility for persons with intellectual disabilities)
15 (MCAR, Section 0390.05); and
- 16 • Medicaid Affordable Care Coverage (MACC) for adults ages nineteen (19) to sixty-four (64), who have
17 income at or below 133 percent of the FPL and are not eligible or enrolled in Medicare or Medicaid
18 under any other coverage group (MCAR Section, 1305.04).

19 In addition, the State has opted, through the “Katie Beckett” state plan provision, to make home and community-
20 based LTSS accessible to children, living at home, who require the level of care typically provided in an
21 institutional-setting. (See MCAR, Section 0370.20)

22 The provisions set forth herein apply to Medicaid-funded LTSS for persons eligible in any of these categories
23 (above) whether authorized by the State’s Medicaid state plan and/or Section 1115 waiver.

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D. Definitions

2 For the purposes of Medicaid-funded long-term services and supports, the following terms are defined as
3 follows:

4 Assisted Living Residence means a publicly or privately operated residence that provides directly or indirectly by
5 means of contracts or arrangements personal assistance and may include the delivery of limited health services,
6 as defined under subsection 23-17.4-2(12) of the Rhode Island General Laws, as amended (RIGL), to meet the
7 resident's changing needs and preferences, lodging, and meals to six (6) or more adults who are unrelated to the
8 licensee or administrator, excluding however, any privately operated establishment or facility licensed pursuant
9 to chapter 17 of title 23 RIGL, and those facilities licensed by or under the jurisdiction of the department
10 of behavioral healthcare developmental disabilities, and hospitals, the department of children, youth, and
11 families, or any other state agency. The department of health shall develop levels of licensure for assisted
12 living residences within this definition as provided in § 23-17.4-6 RIGL. Assisted living residences include
13 sheltered care homes, and board and care residences or any other entity by any other name providing the services
14 listed in this subsection that meet the definition of assisted living residences.

15 Characteristic means an eligibility group that is recognized by Medicaid federal and state law in order to
16 determine eligibility for certain low-income individuals and families.

17 Community Supportive Living Program (CSLP) means alternatives to institutional care for low- income
18 elders and persons with disabilities who are eligible for Medicaid long-term services and supports and
19 participating in the State’s Integrate Care Initiative (ICI).

20 Core Home and Community-Based Services (HCBS) means services provided to beneficiaries that ensure full
21 access to the benefits of community living as well as the opportunity to receive services in the most integrated
22 setting appropriate.

23 Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) means the state
24 agency established under the provisions of Chapter 40.1-1 RIGL whose duty it is to serve as the state’s mental
25 health authority and establish and promulgate the overall plans, policies,

26 Proposed Rules: 5

1 objectives, and priorities for State programs for adults with developmental disabilities as well substance
2 abuse education, prevention and treatment.

3 Department of Human Services (DHS) means the State agency established under the provisions of Chapter 40-
4 1 RIGL that is empowered to administer certain human services programs including: the Child Care Assistance
5 Program (CCAP), RI Works, Supplemental Security Income (SSI), Supplemental Nutrition Program (SNAP),
6 General Public Assistance (GPA) and various other services and programs under the jurisdiction of the
7 Division of Elderly Affairs, Office of Rehabilitative Services, and Division of Veterans Affairs. The DHS has
8 been delegated the authority through an interagency service agreement with the Executive Office of Health and
9 Human Services, the Medicaid Single State Agency, to determine Medicaid eligibility in accordance with
10 applicable State and federal laws, rules and regulations.

11 Developmental Disability means a group of conditions resulting from an impairment in physical, learning,
12 language, or behavior areas. The BHDDH is responsible for administering programs for adults with
13 developmental disabilities.

14 Executive Office of Health and Human Services (EOHHS) means the state agency established in 2006 under the
15 provisions of Chapter 42-7.2 RIGL within the executive branch of state government and serves as the principal
16 agency of the executive branch for the purposes of managing the departments of Children, Youth, and Families
17 (DCYF); Health (DOH); Human Services (DHS); and Behavioral Healthcare, Developmental Disabilities, and
18 Hospitals (BHDDH). The EOHHS is designated as the “single state agency,” authorized under Title XIX of the
19 U.S. Social Security Act (42 U.S.C. § 1396a et seq) and, as such, is legally responsible for the program / fiscal
20 management and administration of the Medicaid Program.

21 Financial Eligibility means qualified or entitled to receive services based upon income and/or resource
22 requirements.

23 Functional Disability means any long-term limitation in activity resulting from an illness, health condition, or
24 impairment.

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1 Habilitation Program means health care services that help a person acquire, keep or improve, partially or
2 fully, and at different points in life, skills related to communication and activities of daily living. Habilitative
3 services include physical therapy, occupational therapy, speech-language pathology, audiology and other
4 services for people with disabilities in a variety of inpatient and/or outpatient settings. These services address the
5 competencies and abilities needed for optimal functioning in interaction with the environment. Habilitative and
6 rehabilitative services and devices are mandated as essential health benefits (“EHB”) in Section 1302 of the
7 Patient Protection and Affordable Care Act (ACA).

8 Home and Community-Based Services means any services that are offered to Medicaid LTSS beneficiaries
9 who have needs requiring and institutional level of care in the home or community- based setting that are
10 authorized under the Medicaid State Plan or the State’s demonstration waiver authorized under section 1115 of
11 the Social Security Act (42 U.S.C. 1315).

12 Institution means a State licensed health facility where health and/or social services are delivered on an inpatient
13 basis, such as hospitals, intermediate care facilities, or nursing facilities.

14 Integrated Care Initiative means EOHHS’ two-phase strategy for implementing the Medicaid Integrated Care
15 Program that uses various contractual arrangements to expand access to comprehensive care management and
16 service. In Phase I efforts were focused on managing and integrating Medicaid covered services across the care
17 continuum for Medicaid-only and Medicare and Medicaid “dually” eligible (MME) beneficiaries age twenty-one
18 (21) or older. In Phase II, under the authority of a special federal waiver, full integration and management of all
19 Medicare and Medicaid covered services for fully dual eligible participants will be provided. Service delivery in
20 Phase II is governed by three-party contractual agreement involving the EOHHS, federal partners at CMS, and
21 the participating managed entity.

22 Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) means a facility that provides
23 care and services to persons with intellectual disabilities as an optional Medicaid benefit that enables states to
24 provide comprehensive and individualized health care and rehabilitation services to individuals to promote their
25 functional status and independence. This setting is an alternative to home and community-based services for
26 individuals at the ICF/ID level of care.

27 Proposed Rules: 7

1 Katie Beckett Eligibility means an eligibility category that allows certain children under age 19 who have long-
2 term disabilities or complex medical needs who require an institutional level of care to obtain the Medicaid long-
3 term services they need at home. With Katie Beckett eligibility, only the child’s income and resources are
4 considered when determining eligibility.

5 Level of care means the determination of an applicant/beneficiary’s needs based on a comprehensive assessment
6 that includes, but is not limited to, an evaluation of medical, social, functional and behavioral needs.

7 Long-term Services and Supports (LTSS) means a set of health care, personal care, and social services required
8 by persons who have some degree of functional limitation that are provided in an institution, in the community,
9 or at home on a long-term basis.

10 LTSS Managed Care Arrangement means long-term services that are provided by a health plan that utilizes
11 selective contracting to channel beneficiaries to a limited number of providers and requires a utilization review
12 component to control the unnecessary use of the long-term services and supports.

13 LTSS Specialist means a State agency representative responsible for determining eligibility for long- term
14 services and supports, authorizing such services and supports and assisting applicants and beneficiaries in
15 navigating the system. The term does not apply to EOHHS, Office of Medicaid Review (OMR) clinical staff, but
16 does refer to agency representatives such as DHS eligibility personnel (including social workers) assigned
17 to Medicaid LTSS and staff from the EOHHS and other agencies that administer programs associated with each
18 respective institutional level of care.

19 Medicaid-Medicare Dually Eligible (MME) means and includes persons who meet the applicable Medicaid
20 eligibility criteria related to income, age, disability status, and/or functional need and are also entitled to benefits
21 under Medicare Parts “A” and are enrolled under Medicare Parts “B” and “D.”

22 Proposed Rules: 8

1 Medicaid Code of Administrative Rules (MCAR) means the compilation of rules governing the Rhode Island
2 Medicaid program promulgated in accordance with the State’s Administrative Procedures Act (R.I.G.L. §42-
3 35).

4 Needs-Based Eligibility means the state Medicaid agency determines whether an individual or family is eligible
5 for Medicaid benefits, based upon whether the individual or family meets the requirements set forth in statute,
6 regulations, and other applicable legal authority.

7 Options Counseling means an interactive decision-support process whereby consumers, family members
8 and/or significant others are supported in their deliberations to determine appropriate long- term care choices in
9 the context of the consumer’s needs, preferences, values, and individual life Circumstances.

10 Person-centered Planning means a process that strives to place the individual at the center of decision- making. It
11 is based on the values of human rights, interdependence, choice and social inclusion, and can be designed to
12 enable people to direct their own services and supports, in a personalized way. Person-centered planning is not
13 one clearly defined process, but a range of processes sharing a general philosophical background, and aiming at
14 similar outcomes. Person-centered planning is also a process directed by an individual, with impartial assistance

15 when helpful, focusing on their desires, goals, needs, and concerns to develop supports to live a meaningful
16 life maximizing independence and community participation.

17 Program of All Inclusive Care for the Elderly (PACE) means a service delivery option for beneficiaries who have
18 Medicare and/or Medicaid coverage and meet a “high” or “highest” level of need for long-term services and
19 supports. Beneficiaries must be 55 years or older to participate in this option.

20 Preventive Services means the limited range of LTSS available to Medicaid beneficiaries who are at risk for a
21 nursing facility level of care. Includes homemaker, minor environmental modifications, physical therapy
22 evaluation and services, respite and personal care.

23 Proposed Rules: 9

1 RIt@Home means a program that provides personal care, homemaker, chore, attendant care and related
2 services in a private home setting by a care provider who lives in the home. RIt@ome is a service provided to
3 Medicaid beneficiaries eligible for long-term care services who are elderly or adults with disabilities who are
4 unable to live independently and who meet the “highest” or “high” level of care as determined through an
5 evaluation.

6 Self-directed care means that beneficiaries, or their representatives if applicable, have the opportunity to exercise
7 choice and control over a specified amount of the funds for and the providers who deliver the long-term services
8 and supports they need as identified in an Individual Service and Spending Plan (ISSP) developed through the
9 person-centered planning process. The EOHHS provides each beneficiary opting for this service delivery
10 approach with a certified service counselor and advisement agency to provide decision-making assistance and
11 support. ^{add}

12 ~~{delete}~~ 0399.03 ACCESS TO LONG-TERM CARE ~~{delete}~~ ^{add} E. **TYPES OF MEDICAID LTSS** ^{add}

13 ~~{delete}~~ REV:07/2009

14 For the purposes of this section, Medicaid-funded long-term care is defined as institutional services or home and
15 community-based services and supports. Long-term care services ^{add} **LTSS** ^{add} are designed to help people who
16 have functional disabilities and/or chronic care needs to optimize their health and retain their independence.
17 Services may be episodic or ongoing and may be provided in a person's home, in the community (for example,
18 shared living or assisted living), or in institutional settings (for example, intermediate care facilities, hospitals, or
19 nursing homes).

20 ~~0399.04 TYPES OF LONG-TERM CARE~~

21 ~~REV:07/2009~~ ^{delete}

22 To achieve the goal of rebalancing the long-term care system, ~~{delete}~~ the Global Consumer Choice Compact
23 Waiver allows ~~{delete}~~ ^{add} Medicaid eligibility criteria have been reformed to enable ^{add} beneficiaries to obtain
24 ~~{delete}~~ the Medicaid ~~{delete}~~ ^{add} these ^{add} services ~~{delete}~~ they need ~~{delete}~~ in the most appropriate ^{add} and ^{add} least
25 restrictive ^{add} setting ^{add}. The types of ~~{delete}~~ long-term care ~~{delete}~~ ^{add} **LTSS** ^{add} available to beneficiaries are
26 categorized as ^{add} either ^{add} institutional ~~{delete}~~ and ~~{delete}~~ ^{add} or ^{add} home and community-based. ^{add} The chief
27 distinctions between the two types of LTSS are care setting and scope of Medicaid coverage, as indicated below:
28 ^{add}

29 Proposed Rules: 10

1 ~~{delete}~~ **0399.04.01 Institutional Long-Term Care**

2 ~~REV:07/2009~~ ^{delete}

3 ^{add} (1) Medicaid LTSS in an Institutional Setting. ^{add} Beneficiaries ~~{delete}~~ that ~~{delete}~~ ^{add} who ^{add} meet the applicable
4 ^{add} financial and ^{add} clinical eligibility criteria may access institutional ~~{delete}~~ long-term care services ~~{delete}~~
5 ^{add} **LTSS** ^{add} in the following ^{add} State-licensed health care institutions/ ^{add} facilities:

6 (a) Nursing Facilities (NF). A beneficiary is eligible to access Medicaid-funded ~~{delete}~~ care ~~{delete}~~ ^{add} **LTSS** ^{add}
7 in a nursing facility when it is determined on the basis of a comprehensive assessment ^{add} (see Section 1500.3)
8 ^{add} ~~{delete}~~ as defined in Sections 0399.05.01.02 and 0399.11, ~~{delete}~~ that the beneficiary has the highest ^{add} need
9 for a NF ^{add} level of care ~~{delete}~~ needs (See Section ~~0399.12.01~~) ~~{delete}~~.

10 (b) Intermediate Care Facility for the ~~{delete}~~ Mentally Retarded ~~{delete}~~ ^{add} Intellectually Disabled ^{add}
11 (ICF/~~MR~~ ^{add} **ID** ^{add}). A beneficiary qualifies for an ICF/~~MR~~ ^{add} **ID** ^{add} level of care if

12 the beneficiary has been determined by the ~~MHRH~~^{add} state Department of Behavioral Healthcare,
13 Developmental Disabilities, and Hospitals (BHDDH)^{add} to meet the applicable institutional level of care.

14 ~~Rules governing such determinations are located in: "Rules and Regulations Relating to the Definition of~~
15 ~~Developmentally Disabled Adult and the Determination of Eligibility as a Developmentally Disabled Adult, by~~
16 ~~MHRH" and may be obtained at http://www.mhrh.ri.gov/dcd/pdf/MHRH_1746.pdf or by contacting the agency.~~
17 ~~{delete}~~

18 (c) Long-term Acute Care Hospital - ~~Eleanor Slater Hospital (ESH)~~^{delete}. A beneficiary qualifies for a
19 long-term acute care hospital stay if the beneficiary has been determined to meet an institutional level of care
20 by ~~the MHRH~~^{delete}^{add} BHDDH (e.g., Eleanor Slater Hospital (ESH))^{add} and ^{add}/or^{add} by the DHS
21 EOHHS. Medicaid LTSS may also be available to children in State custody or who have special health care needs
22 that meet the hospital level of care.^{add}

23 Beneficiaries residing in an NF, ICF/~~MR~~^{delete}^{add} ID^{add} and ~~ESH~~^{delete} ^{add}hospital receive all of their
24 Medicaid long-term services and supports through the facility with the exception of a limited set of covered
25 equipment and supplies – e.g., eyeglasses, hearing aids, prosthetics, etc.^{add} ~~are considered to be in an~~
26 ~~institution for the purposes of determining eligibility~~^{delete}^{add}. Medicaid coverage in institutional settings includes
27 room and board. Beneficiaries in these settings are subject to the post-eligibility treatment of income (PETI),
28 which determines the amount they must contribute, sometimes referred to as “liability”, toward the cost of

Proposed Rules: 11

1 LTSS. In the PETI calculation process, ~~The~~^{delete}^{add} the State’s^{add} Medicaid payment for
2 ~~institutional care~~^{delete} ^{add}institutionally based LTSS^{add} is reduced by the amount of the beneficiary's
3 income after certain allowable expenses are deducted. Other rules applicable to institutional care and services are
4 located in ~~the~~^{delete} ~~MCAR~~^{delete}^{add} Sections ~~of~~^{delete} 0378.

~~0399.04.02 Home and Community Based Long-Term Care~~

6 ~~REV:09/2013~~^{delete}

7 ^{add}(2) Medicaid Home and Community-based LTSS. ~~The Global Waiver~~^{delete} ^{add}The State’s
8 Section 1115 demonstration waiver^{add} authorizes ~~the state to offer~~^{delete} an array of home and
9 community-based services ^{add}(HCBS)^{add} to ~~members~~^{delete} ^{add}beneficiaries^{add} as an alternative to
10 ~~institutionalization~~^{delete} ^{add}institutionally based care. In general, ~~Home~~^{delete} ^{add}home^{add} and
11 community-based ~~long-term care services and supports (HCB/LTC Services) are in addition to the services~~
12 ~~otherwise provided under the Medicaid program~~^{delete} ^{add}LTSS provide the type of services available in an
13 institutional setting that are not covered by Medicare, commercial health plans or non-LTSS Medicaid
14 coverage (e.g., assistance with the activities of daily living, such as personal care, preparing meals, toileting,
15 and managing medications). Access to these services enables beneficiaries to optimize their health and retain
16 their independences while delaying or diverting the need for care in more costly and restrictive institutionally
17 based settings.

18 Room and board are NOT covered by Medicaid. Medicaid HCBS includes both core and preventive services as
19 well as all other state plan and waiver services. Additional services may be available, depending on the type
20 of a beneficiary’s needs and the institutional level of care required. Beneficiaries receiving Medicaid LTSS in
21 home and community-based settings are also subject to PETI and must contribute to the cost of their LTSS.^{add}

~~0399.04.02.01 Core and Preventive HCB/LTC Services~~

23 ~~REV:09/2013~~

24 1) Core HCB/LTC services include the following broad categories of services:

- | | |
|--|-------------------------------|
| Homemaker | * Adult Companion Services |
| ● Environmental Modifications | * Personal Care Assistance |
| ● Minor Environmental Modifications | * Special Medical Equipment |
| ● Respite | * Home-Delivered Meals |
| ● Day Supports, including Adult Day Services | |
| ● Personal Emergency Response | * Supported Employment |
| ● Licensed Practical Nurse | * Rite @ Home (Shared Living) |
| ● Services (Skilled Nursing) | * Community Transition |
| Private Duty Nursing Services (including Registered Nurse) | |

- Residential Supports
- Supports for Consumer Direction
- Participant Directed Goods and Services
- Case management
- Assisted Living
- PACE

25

1 Assisted Living, PACE and Rite @ Home are defined in greater detail in Sections 0399.20.01, 0399.21
2 and 0399.20.02.

3 **0399.05 ELIGIBILITY REQUIREMENTS**

4 REV:07/2009^{delete}

5 **F. ELIGIBILITY FOR MEDICAID LTSS**^{add}

6 To qualify for Medicaid-funded long-term care services ^{add}and ^{add}supports under the ^{delete}Global
7 Waiver ^{delete} ^{add}State's Section 1115 demonstration, ^{add}a person must meet the general and financial eligibility
8 requirements as well as ^{delete}meet ^{delete}certain clinical ^{add}/functional disability ^{add}^{delete}eligibility ^{delete}criteria.

9 ^{add}On January 1, 2016, reforms to the LTSS eligibility requirements will begin to be phased-in with the
10 promulgation of a series of amended rules over a six (6) month period. This process begins with the provisions
11 set forth in this rule revising the clinical/functional disability needs-based criteria for the nursing facility level of
12 care and implementation of federal authority standardizing benefits and service options for Medicaid LTSS
13 beneficiaries across categorically needy and medically needy eligibility categories.

14 This interim rule identifies the MCAR provisions applicable to financial eligibility until July 1, 2016 and sets
15 forth the new clinical/functional disability criteria to take effect on January 1, 2016. In addition, the range of
16 core HCBS will be expanded effective January 1, 2016. Section 1500.4 of this interim rule, describing core and
17 preventive services, identifies and describes the new core HCBS available to beneficiaries as of that date.

18 (1) General and Financial Eligibility Requirements. The State's Section 1115 waiver establishes that all
19 Medicaid LTSS applicants/beneficiaries must be subject to the general and financial eligibility requirements
20 applicable to persons who are likely to be residents of an institution irrespective of whether that care is
21 actually provided in an institution or the home and community-based setting. The EOHHS has delegated
22 responsibility for evaluating the general and financial eligibility of Medicaid applicants and beneficiaries to
23 the Rhode Island Department of Human Services (DHS).

24 Proposed Rules: 13

1 (a) LTSS Eligibility Requirements (Effective until June 30, 2016). Except as indicated in paragraph (b) below,
2 general and financial eligibility for Medicaid LTSS are determined in accordance with the following standing
3 provisions:^{add}

- 4 • The general eligibility requirements -- Set forth in ^{add}MCAR, ^{add}Sections 0300.25 and 0300.25.20.05
5 respectively.
- 6 • Income and resource eligibility rules -- For Medicaid eligible persons who are: likely to be residents of an
7 institution for a continuous period, ^{add}have received LTSS for a minimum of thirty (30) days through a
8 Medicaid managed care plan, or would have needs requiring the level of care in an institution if it were not
9 for home and community-based waiver services, including for those^{add} ^{delete}and ^{delete} who have a spouse
10 living in the community (see MCAR, Sections 0380.40-0380.40.35 and 0392.15.20- 0392.15.30). See also
11 the applicable income and resource provisions in the ^{delete}long-term care ^{delete}^{add}for Medicaid LTSS in
12 MCAR,^{add} Sections ^{delete}from ^{delete}0376 to 0398.

13 ^{delete}Clinical eligibility is determined by an assessment of a beneficiary's level of care needs. Under the Global
14 waiver, the income and eligibility rules in these Sections will apply to persons who are likely to receive home and
15 community-based core services for a continuous period. That is, persons meeting the highest or high level of
16 care who reside in the community. ^{delete}

- 17 • ^{add}Evaluation of Income and Resources -- ^{add}In Sections 0380.40-0380.40.35 and 0392.15.20-
18 0392.15.30, all references to institutionalized spouses and continuous periods of institutionalization
19 ^{delete}will include those institutionalized spouses receiving home and community based services in lieu of

institutional services^{delete}_{add} apply to ALL beneficiaries eligible for Medicaid LTSS, irrespective of whether services are obtained in an institutional and home and community-based setting.

(b) LTSS Categorically versus Medically Needy (Effective January 1, 2016). The EOHHS requested and received approval from the CMS for a state plan amendment standardizing LTSS benefits and service options across the “categorically needy” and “medically needy” eligibility categories set forth in MCAR, Section 0370. Accordingly, all LTSS beneficiaries are eligible to receive the same core and preventive services.^{add}

~~0399.05.01 Clinical Eligibility Scope & Applicability~~

REV:07/2009^{delete}

Proposed Rules: 14

^{add}(2) Clinical/Functional (CF) Eligibility Criteria. (Effective January 1, 2016).^{add}

The ^{add}clinical/functional eligibility^{add} level of care criteria that must be met for ^{add}each type of institution identified in subsection (E)(1) of this rule vary in accordance with the level of need of the beneficiaries they serve, the scope of services they are authorized to provide, and state and federal regulatory requirements.

(a)^{add} Intermediate care facilities for^{delete} the mentally retarded^{delete}—^{add}persons with intellectual disabilities (ICF/ID)). The criteria used to evaluate clinical eligibility for the ICF/ID level of need are established by the BHDDH, in accordance with State law, and apply to Medicaid LTSS provided in the institutional-setting^{add} ~~and hospitals~~^{delete} and ^{add}home and^{add} community-based service alternatives ^{delete}to these institutions on June 30, 2009 shall remain in effect until such time as needs-based criteria^{delete}.^{add} The criteria have been adopted by BHDDH in effect as of January 1, 2016, will continue to be used until such time as BHDDH establishes amended or new rules, regulations and/or procedures.^{add}~~and applicable rules promulgated by the department(s) responsible for administering programs serving beneficiaries, as indicated below~~^{delete}.^{add} Further information on these criteria is located in Section 1500.02 (C) (b) (iii).

(b) Hospital – Each agency serving beneficiaries who may require Medicaid LTSS at the hospital level of care is authorized under the State’s 1115 waiver to tailor the clinical/functional criteria to meet their population’s general and unique needs within the parameters of applicable federal regulations and laws. This applies to individuals seeking services through the EOHHS Habilitation Program which were authorized prior to establishment of the Section 1115 demonstration in 2009 under the State’s 1915(c) Habilitation Waiver.

(c) Nursing Facility – Effective January 1, 2016, the EOHHS is revising the needs-based clinical/functional criteria for NF level of care established when the Section 1115 waiver demonstration was approved initially in 2009. The application of the previous and revised versions of the NF level of care criteria are as follows:

(i). Beneficiary entered NF prior to July 1, 2009^{add}. In accordance with the terms and conditions of the Section 1115 waiver approved in 2009, any Medicaid LTSS beneficiaries who were residing in a nursing facility on or before June 30, 2009, are subject to the NF level of criteria in effect prior to July 1, 2009. The ^{add}revised^{add} needs-based criteria DO NOT apply to

Proposed Rules: 15

beneficiaries eligible to receive Medicaid-funded ^{delete}long term care services^{add} LTSS^{add} unless or until: because he or she: (a) improves to a level of care that no longer meets the pre-waiver level of care criteria—that is, the beneficiary no longer qualifies for an institutional level of care under the criteria in effect on or before June 30, 2009; or (b) the beneficiary chooses home and community based services over the institution.^{delete} ^{add}the needs of the beneficiary improve to such an extent that beneficiary no longer meets the criteria for Medicaid LTSS in effect prior to July 1, 2009 or the beneficiary chooses to transfer voluntarily to a home and community-based services setting;

(ii.) Beneficiary entered NF between July 1, 2009 and December 31, 2015. Any Medicaid LTSS beneficiaries who were determined eligible for a NF level of care during this period will continue to be subject to the criteria in effect at that time. Therefore, the revised needs-based criteria DO NOT apply to beneficiaries receiving Medicaid LTSS who were living in nursing facilities on or before December 31, 2015. The level of care criteria in effect between July 1, 2009 and December 31, 2015 apply and will continue to apply unless or until the needs of the beneficiary improve to such an extent that beneficiary no longer meets the criteria for Medicaid LTSS or the beneficiary chooses to transfer voluntarily to a home and community- based services setting.

16 (iii) Applicant/Beneficiary for LTSS On/After January 1, 2016. The ~~new~~ revised
17 needs-based levels of care DO apply to new applicants for Medicaid LTSS and existing
18 beneficiaries ~~eligible to receive Medicaid funded long term care services~~ who ~~are~~
19 were living in the community on or before ~~June 30, 2009.~~ January 1, 2016.
20 The ~~new~~ revised levels of care ~~criteria for assessing the highest need for~~
21 a NF level of care will apply beginning with the beneficiary's annual re-assessment as part of
22 the eligibility renewal process. If a ~~person~~ beneficiary ~~met the~~ has
23 the highest or a high need for a NF institutional level of care ~~criteria~~ in the past, then
24 the beneficiary ~~he or she~~ will continue to meet either the highest or a high
25 need for an NF level of care in the future, and eligibility for ~~long term care services~~
26 Medicaid LTSS will continue without interruption, providing there have been no
27 changes in all other general and financial eligibility requirements ~~continue~~

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1 ~~to be met~~. When assessing beneficiaries living in the community using the needs-based level of care
2 criteria, a beneficiary is clinically eligible as highest need if the ~~department~~ EOHHS determines,
3 as above, that the beneficiary meets at least one of the revised clinical /functional eligibility
4 criteria for highest need; or, absent that, the beneficiary has a critical need for ~~long term care~~
5 NF care due to special circumstances as specified in MCAR, Section 1500.03(C)(2).
6 ~~Accordingly, a~~

7 (iv) Criteria Applicable for Transition to HCBS – Current Beneficiaries. A Medicaid beneficiary
8 ~~eligible for and~~ residing in a nursing facility whose eligibility was determined in
9 accordance with subparagraph (i) or (ii) above ~~on or before June 30, 2009, who~~ and
10 chooses to move to the community, ~~shall be~~ will be assessed using the ~~new~~
11 revised needs-based level of care at the time eligibility is ~~re-determined~~ renewed.
12 A beneficiary who makes this choice is eligible for ~~long term care~~ Medicaid LTSS as
13 "highest need" if the ~~department~~ EOHHS determines at any time that the beneficiary:
14

- 15 ~~meets~~ Meets at least one of the clinical /functional eligibility criteria for
highest need; or
- 16 ~~(2) the beneficiary does~~ Does not meet at least one of these criteria but nevertheless
17 has a critical need for ~~long term care~~ Medicaid LTSS due to special circumstances
18 that may adversely affect the beneficiary's health and safety. Such special circumstances include
19 a failed placement as well as other situations that may adversely affect a beneficiary's health and
20 safety as specified in Section 1500.03(C)(2).

21 ~~The needs based levels of care will apply to all persons seeking Medicaid funded long term care services~~
22 ~~provided in a nursing facility or community alternative to that facility on or after July 1, 2009. Persons seeking~~
23 ~~Medicaid funded long term care services and supports administered by the Department of Mental Health,~~
24 ~~Retardation, and Hospitals (MHRH) will continue to meet the clinical eligibility standards in effect – that is,~~
25 ~~the level of care of intermediate facility for the mentally retarded/developmental disabled (ICFMR/DD) until~~
26 ~~such time as a needs based set of criteria are developed in accordance with the terms and conditions established~~
27 ~~under the waiver. Rules governing such determinations are located in: "Rules and Regulations Relating to~~
28 ~~the Definition of Developmentally Disabled Adult and the Determination of Eligibility as a Developmentally~~
29 ~~Disabled Adult, by MHRH" and may be obtained at http://www.mhrh.ri.gov/ddd/pdf/MHRH_1746.pdf or by~~
30 ~~contacting the agency.~~

31 ~~Persons seeking Medicaid funded long term care services provided in a long term care hospital or in a community~~
32 ~~based alternative to the hospital will continue to need to meet an institutional level of care. This applies to individuals~~
33 ~~who would have sought services under the 1915(c) Habilitation Waiver.~~

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1 (d) Preventive Level of Need. Beneficiaries currently eligible for ~~community Medical~~
2 ~~Assistance~~ Medicaid via the provisions related to SSI, an SSI-characteristic (blind and low-income
3 elderly or persons with disabilities), or as members of the MACC group for adults who are not clinically
4 eligible for ~~long term care~~ LTSS may be eligible for a limited range of home and community
5 based services if they meet the criteria to qualify for preventive care (see "preventive need" in Section

6 ~~{add}~~1500.03(C)(4)~~{add}~~. The availability of such services ~~{delete}~~shall be ~~{delete}~~~~{add}~~is~~{add}~~ limited, depending upon
7 funding.

8 ~~{delete}~~0399.05.01.02 ~~Needs-based LTC Determinations~~

9 REV:07/2009~~{delete}~~

10 ~~{add}~~**1500.02 MEDICAID LTSS NEEDS-BASED DETERMINATIONS**

11 **A. OVERVIEW**~~{add}~~

12 The processes for determining clinical eligibility ~~{delete}~~ are based on ~~{delete}~~~~{add}~~ centers on~~{add}~~ a comprehensive
13 assessment that includes an evaluation of the medical, social, physical and behavioral health needs of each
14 beneficiary. The assessment ~~{delete}~~shall be ~~{delete}~~~~{add}~~is~~{add}~~ tailored to the needs~~{delete}~~ of the beneficiaries services
15 and, ~~{delete}~~~~{add}~~ of beneficiaries seeking the various types of LTSS (see Section 1500.01 (E) above) and~~{add}~~ ~~{delete}~~as
16 such, may vary from one process to the next ~~{delete}~~ ~~{add}~~tend to differ accordingly. For example, the
17 clinical/functional needs based criteria for NF level of care are different than the criteria for the ICF/ID and
18 hospital levels of care and may vary further by setting within each type of institution and the population
19 served (i.e., hospital level of care for child in DCYF custody versus adult identified by BHDDH as a person
20 with a serious and persistent behavioral health condition or illness).~~{add}~~ Based on this assessment, the
21 needs of the beneficiary are classified as "highest" or "high" to reflect the scope and intensity of care required
22 and the range of services available. ~~{add}~~Non-LTSS Medicaid~~{add}~~ ~~{delete}~~Beneficiaries already eligible for
23 community MA ~~{delete}~~~~{add}~~beneficiaries with chronic and disabling conditions~~{add}~~ who do not meet the highest or
24 high level of care but are at risk for ~~{delete}~~institutionalization~~{delete}~~ ~~{add}~~the level of care typically provided in an
25 institution~~{add}~~ may access certain short-term preventive services ~~{add}~~to optimize their health and promote
26 independence.

27 Once the assessment is completed, a determination of Medicaid LTSS eligibility based on both general,
28 financial and clinical/functional criteria is completed. Persons eligible for Medicaid LTSS then are engaged in
29 the person-centered planning process in which the beneficiary is assisted in

30 Proposed Rules: 18

1 establishing a care plan that uses his or her life goals as a focal point for organizing the delivery of the services
2 authorized (core and preventive as indicated in Section, 1500.03(E), the options available based on level of
3 need (see matrix below at subsection (B), and the service delivery alternatives available (LTSS managed
4 long-term care arrangement, PACE, or community-based care coordination, see MCAR, Sections 0374 and 0375).
5 Person-centered planning is a holistic approach for accessing Medicaid LTSS that involves the beneficiary,
6 family members and providers. A description of the basic types of Medicaid LTSS is provided in Section
7 1500.01 (E).~~{add}~~

8 ~~{delete}~~There are two general types of services available to beneficiaries — core and preventive (see
9 description in section 0399.10.20). An individual care plan is then developed that identifies the LTC core and
10 preventive services and settings appropriate to meet the beneficiary's needs within the specified service
11 classification.~~{delete}~~

12 ~~{add}~~**B. LEVEL OF CARE AND NEEDS-BASED SERVICE OPTIONS**~~{add}~~

13 The scope of services accessible to a beneficiary varies in accordance with individual needs, preferences,
14 availability, and the parameters established in the ~~{delete}~~Global Waiver ~~{delete}~~~~{add}~~State's Section 1115
15 demonstration~~{add}~~ and/or federal and state regulations, rules or laws. For example, a beneficiary with the highest
16 need ~~{add}~~for NF level of care~~{add}~~ may ~~{delete}~~be able to ~~{delete}~~obtain the full range of ~~{delete}~~services he or she
17 needs~~{delete}~~ ~~{add}~~LTSS he or she requires~~{add}~~ at home or in a shared living arrangement, but may choose, instead,
18 to access those services in a nursing facility. Community-based NF level of care options include PACE and
19 accessing services through a self-directed model. A beneficiary determined to meet the ~~{add}~~NF~~{add}~~ high need
20 may have access to care in the home and community based setting - including PACE -- and self-directed care,
21 but does not have the option of nursing facility care. ~~{add}~~The matrix below outlines the service options based
22 on level of need:~~{add}~~

23 ~~{delete}~~0399.05.01.03 ~~LTC Level of Care and Service Option Matrix~~

24 REV:07/2009

25 LTC LEVEL OF CARE AND SERVICE OPTION MATRIX

HIGHEST	HIGHEST	HIGHEST
Nursing Home Level of Care (Access to Nursing Facilities and all Community Based)	Hospital Level of Care (Access to Hospital, Residential Treatment Centers and all Services Community Based Services)	ICF/MR Level of Care (Access to ICF/MR and all Community Based Services)
HIGH	HIGH	HIGH
Nursing Home Level of Care (Access to Community Based Services)	Hospital Level of Care (Access to Community Based Services)	ICF/MR Level of Care (Access to Community Based Services)
PREVENTIVE	PREVENTIVE	PREVENTIVE
Nursing Home Level of Care (Access to Preventive Community Based Services)	Hospital Level of Care (Access to Preventive Community Based Services)	ICF/MR Level of Care (Access to Preventive Community Based Services) ^{delete}

26

Proposed Rules: 19

<u>^{add}Medicaid</u> LTSS Service Options Matrix Needs-Based Level of Care Determinations		
<u>Highest Need NF Level of Care</u> (Access to Nursing Facilities and all Home and Community-based Services)	<u>Highest Need Hospital Level of Care</u> (Access to Hospital, Group Homes, Residential Treatment Centers and all other Home and Community-based Services)	<u>Highest Need ICF/ID Level of Care</u> (Access to ICF/ID Group Homes and all other Home and Community-based Services)
<u>High Need NF Level of Care</u> (Access to Core and Preventive Home and Community-based Services)	<u>High Need Hospital Level of Care</u> (Access to Core and Preventive Home and Community-based Services)	<u>High Need ICF/ID Level of Care</u> (Access to Core and Preventive Home and Community-based Services)
<u>Preventive Need NF Level of Care</u> (Access to Preventive Home and Community-based Services)	<u>Preventive Need Hospital Level of Care</u> (Access to Preventive Home and Community-based Services)	<u>Preventive Need ICF/ID Level of Care</u> (Access to Preventive Home and Community-based Services) ^{add}

27 ~~{delete}~~0399.06~~{delete}~~ ^{add}**C. MEDICAID LTSS**^{add} **ASSESSMENT & COORDINATION** ^{add} **(A&C)** ^{add}

28 ~~{delete}~~ **ORGANIZATION (ACO)**

29 REV:07/2009

30

Proposed Rules: 20

1 The Assessment and Coordination Organization (ACO)^{delete} ^{add} **Medicaid LTSS assessment and coordination**
2 **(A&C)** ^{add} is a set of four (4) processes established across the health and human service departments that
3 assist applicants/^{delete}recipients^{delete} ^{add} **beneficiaries**^{add} and their families in gaining access to and navigating
4 the LTC ^{add} **LTSS**^{add} system. ^{delete} In this respect, the ACO is not a separate and distinct entity,^{delete}
5 ^{add} **Although there is no one single, distinct entity that performs all these functions, the State's Section 1115**
6 **demonstration sets the direction for all Medicaid LTSS assessment and coordination activities** ^{add} ^{delete} **but a set**
7 **of interrelated activities from across the departments** ^{delete} that serve the goal of rebalancing the long-term care
8 system.

9 ^{add} **(1). A&C Processes.** ^{add} **The four** ^{add} **principal A&C**^{add} processes ^{delete} **included in the ACO**^{delete} are as
10 follows:

11 **(a) Information and Referral --** The State provides information and referrals about publicly funded ^{delete} **LTC**^{delete}
12 ^{add} **LTSS**^{add} to individuals and families through a variety of sources across agencies. The ^{delete} **ACO**^{delete}

13 ~~{add}EOHHS{add}~~ is responsible for enhancing and coordinating these resources to ensure that every person
14 seeking Medicaid-funded LTC services ~~{add}LTSS{add}~~ has access to the information they need to
15 make reasoned choices about their care. The ~~{delete}~~Department of Human Services shall ~~{delete}~~~~{add}EOHHS has~~
16 ~~{add}entered{add}~~ into inter-agency agreements with each entity identified or designated as a primary source of
17 information/referral source for ~~{add}LTSS{add}~~ beneficiaries ~~{add}~~, ~~{add}their family members and authorized~~
18 ~~{add}representatives{add}~~ of long-term care ~~{delete}~~. ~~{add}~~~~{add}~~In addition, the Division of Elderly Affairs (DEA), within the RI
19 Department of Human Services (DHS) administers the Aged and Disability Resource Center (ADRC) through
20 “The POINT” at: 401-462-4444. ~~{add}~~

21 (b) Eligibility Determinations ~~{delete}~~. Through the ACO, the Department of Human Services ~~{delete}~~ ~~{add}~~--Under the
22 terms of interagency agreement with the EOHHS, the Medicaid single state agency, the DHS has been delegated
23 the responsibility to ~~{add}~~ determines financial eligibility for ~~{delete}~~long-term care services ~~{delete}~~ ~~{add}~~~~{add}~~
24 ~~{add}all Medicaid~~
25 ~~{add}LTSS applicants and beneficiaries{add}~~ ~~{delete}~~ provided across agencies ~~{delete}~~. ~~{add}~~~~{add}~~The EOHHS has delegated the
26 authority to determine clinical/functional ~~{add}~~ eligibility ~~{add}~~ for Medicaid LTSS ~~{add}~~ ~~{delete}~~is based on a
27 comprehensive assessment of a person’s medical, social, physical and behavioral health needs.
28 Responsibilities for clinical eligibility are ~~{delete}~~ ~~{add}~~across State agencies. The entities that conduct the
29 assessments work in coordination with staff of the Medicaid agency, as appropriate, to ensure the eligibility
30 determination process is coordinated and to preserve program integrity. Clinical/functional eligibility
31 responsibilities are organized as follows:

Proposed Rules: 21

1 * ~~{add}~~ ~~{add}~~(i) NF Level of Care – Needs-based assessments for ~~{add}~~ ~~{delete}~~Clinical eligibility to receive services in a
2 nursing facility ~~{delete}~~ ~~{add}~~a NF institutional level of care ~~{add}~~ or community ~~{add}~~-based ~~{add}~~ alternative ~~{delete}~~ to that
3 institution will be ~~{delete}~~ ~~{add}~~ is ~~{add}~~ determined by ~~{delete}~~DHS, ~~{delete}~~ ~~{add}~~ ~~{add}~~the EOHHS, Office of Medical Review
4 ~~{add}~~(OMR) utilizing ~~{delete}~~needs-based ~~{delete}~~ ~~{add}~~the criteria set forth below in Section 1500.03.

5 * ~~{add}~~ ~~{add}~~(ii) Hospital Level of Care – Needs-based assessments for ~~{add}~~ ~~{delete}~~Clinical eligibility to receive services
6 in ~~{delete}~~a long-term care hospital or community alternative ~~{delete}~~ to the institution will be determined by DHS
7 and MHRH ~~{delete}~~, ~~{add}~~are tailored to the clinical requirements of the populations served in settings that meet
8 the definition of “hospital” for Medicaid LTSS purposes. ~~{add}~~ ~~{delete}~~as appropriate, utilizing an ~~{delete}~~ **institutional**
9 level of care. ~~{add}~~BHDDH and the RI Department of Children, Youth and Families (DCYF) have developed and
10 apply specialized clinical criteria for adults and children, respectively, with various service needs at this
11 institutional level; the EOHHS has established clinical criteria for beneficiaries requiring services through the
12 ~~{add}~~Habilitation Program and similar settings. ~~{add}~~

13 ~~{delete}~~* Clinical eligibility to receive services in an intermediate care facility or community alternative to that
14 institution will be determined by the Department of Mental Health Retardation and Hospitals, using an
15 institutional level of care. ~~{delete}~~ ~~{add}~~(iii) ICF/ID Level of Care – The BHDDH uses clinical criteria established in
16 State law (R.I.G.L. § 40.1-1-8.1) and associated implementing rules (located at:

17 ~~{add}~~(http://sos.ri.gov/documents/archives/regdocs/released/pdf/MHRH/MHRH_1746_.pdf) as well as the federal law
18 and regulations when conducting needs-based eligibility determinations. The BHDDH also utilizes a population-
19 specific services intensity scale to evaluate/authorize Medicaid LTSS required to meet assessed need. ~~{add}~~

20 ~~{delete}~~* The entities that conduct the assessments work in coordination with staff of the Medicaid agency, as
21 appropriate, to ensure the eligibility determination process is coordinated and to preserve program integrity.

22 (c) ~~{delete}~~ Care Planning ~~{delete}~~ ~~{add}~~ ~~{add}~~Person-centered care planning ~~{add}~~. The comprehensive assessment completed
23 with the beneficiary, ~~{delete}~~ in conjunction with other individuals chosen by the beneficiary, (which may include
24 family/friends or other providers); ~~{delete}~~ ~~{add}~~ that was ~~{add}~~ used to determine clinical eligibility, will also direct
25 the development of ~~{add}~~ a person-centered ~~{add}~~ care plan. The person-centered plan will identify goals and
26 objectives set by the beneficiary and may include the scope and amount of services required to meet the
27 beneficiary's needs as well as the full array of service/care setting options. ~~{delete}~~ ACO ~~{delete}~~ ~~{add}~~ ~~{add}~~A&C ~~{add}~~ care
28 planning

Proposed Rules: 22

1 activities include establishing funding levels for the care ~~{add}~~ ~~{add}~~for LTSS beneficiaries who have opted for self-
2 direction (Personal Choice Program) or community-based coordination service delivery options. ~~{add}~~ ~~{delete}~~
3 and/or ~~{delete}~~ ~~{add}~~ ~~{add}~~This may include ~~{add}~~ the development of a budget for self-directed services or the provision
4 of vouchers for the purchasing of services. ~~{add}~~ ~~{add}~~For Medicaid LTSS beneficiaries choosing to enroll in a

5 manage long-term care arrangement, as defined in MCAR, Section 0375, the plan of choice assumes
 6 responsibility for ensuring the appropriate delivery of authorized services and on-going person-centered
 7 planning. ^{add}

8 (d) Case management/evaluation- ~~--~~The activities of the various agencies and/or their contractual agents
 9 ^{add} are ^{add} designed to ensure beneficiaries are receiving ^{add} the ^{add} scope and amount of services identified in
 10 the person centered care plan. The broad range of services includes periodic review of person centered care
 11 plans, and may include coordination of services with the beneficiary's acute care management entity ^{delete}
 12 ~~(Rhody Health Partners, RIte Care,)~~ ^{delete} ^{add} LTSS managed care plan or community health team ^{add} and
 13 quality assurance. Depending on the agency and the population served, this may be performed by multiple
 14 entities working in collaboration or a single entity.

15 ~~{delete}~~ **0399.06.01 Initiating Assessment & Coordination Process**

16 ~~REV:07/2009~~ ^{delete}

17 ^{add} (2) Initiating the Assessment & Coordination Process. ^{add} ~~{delete}~~ A screening tool developed by the DHS
 18 in collaboration with the health and human services agencies is used to determine the most appropriate
 19 placement and/or service referral for each applicant for LTC ^{delete} ^{add} When applying for Medicaid LTSS, either
 20 through the on-line consumer portal at HealthSource RI or agency kiosk or on-paper (form known as "DHS-2")
 21 or in person with the assistance of a DHS agency specialist, applicants/beneficiaries must indicate the type of
 22 LTSS they are seeking. The State's integrated eligibility system, known as "RI Bridges", collects information
 23 related to the general and financial requirements for LTSS and conducts an initial screening to determine the
 24 appropriate entity for performing the comprehensive assessment of clinical/functional eligibility ^{add}. Based on
 25 the results of this screen, referrals proceed as follows:

26 ~~{delete}~~ a) Beneficiaries determined to have a potential need for Medicaid-funded long-term services and supports
 27 in a NF or the community alternative to a NF are referred to the DHS;

28 b) Beneficiaries determined to have a potential need for State only funded long-term services and supports,
 29 including transportation and the DEA Co-Pay Program, are referred to the DEA;

30 **Proposed Rules: 23**

1 c) Beneficiaries determined to have a potential need for services for persons with developmental disabilities
 2 are referred to the MHRH;

3 d) Beneficiaries determined to have a potential need for long-term hospital services are referred to MHRH;

4 e) Beneficiaries determined to have a potential need for behavioral health services for a child or for an adult are
 5 referred to the DCYF or MHRH, respectively;

6 f) Beneficiaries who are not seeking information on long-term care services are referred to the appropriate
 7 agency, unit or entity. For example, information on acute managed care options is currently provided by the RI
 8 DHS Enrollment Hotline. ^{delete}

9 **Proposed Rules: 24**

^{add} Medicaid LTSS A&C Referral For Comprehensive Assessment		
Beneficiary Has Potential Need For:	Referral to:	Programs/Services Administered
<u>(a) Medicaid-funded NF care or an HCBS alternative. Includes adults and children.</u>	<u>EOHHS or its contractual designee (e.g., LTSS managed care plan)</u>	<u>LTSS Integrated Care (MCAR, Section 0375) LTSS Institutional Care (MCAR, Section 0378) SSI-related Coverage (MCAR, 0394) HCBS Programs (MCAR, Section 0396 Katie Beckett Eligibility (MCAR, Section 0370.20) Personal Choice (Self-directed Care) Program (MCAR, Medicaid Personal Choice Program) NF Transition Program (MCAR, Section 0378) PACE (MCAR, Section 1500.05(A))</u>

^{add}Medicaid LTSS A&C
Referral For Comprehensive Assessment

<u>Beneficiary Has Potential Need For:</u>	<u>Referral to:</u>	<u>Programs/Services Administered</u>
<u>(b) LTSS for elders or persons with disabilities, but who do not meet the financial eligibility criteria for full Medicaid due to excess income</u>	<u>DHS – Division of Elderly Affairs</u>	<u>Co-pay Programs (MCAR, Section 0398.20 and DEA Rules, Regulations and Standards Governing the Home and Community Care Services to the Elderly Program, Section II¹)</u>
<u>(c) Medicaid LTSS in an ICF/ID or HCBS alternative for persons age 19 and over with a developmental disability</u>	<u>BHDDH</u>	<u>Services for Adults with Developmental Disabilities (MCAR, 0398.10 and BHDDH implementing rules²)</u>
<u>(d) LTSS for adults with serious behavioral health conditions</u>	<u>BHDDH</u>	<u>Services for persons with behavioral conditions, including adult psychiatric services and forensic services.³ (BHDDH implementing rules, regulations and standards⁴)</u>
<u>(e) LTSS for adults with traumatic brain injury</u>	<u>EOHHS</u>	<u>Habilitation Program (MCAR, Section</u>
<u>(f) LTSS for children currently in State custody or in foster care in RI at age 18 with developmental disabilities or behavioral health conditions</u>	<u>DCYF</u>	<u>Mental Health Evaluation (DCYF Policy: 700.0010) Transitioning Youth (DCYF Policy: 700.0185) Mental Health Services (DCYF Policy: 100.0155)</u>
<u>(g) LTSS for children with special health care needs up to age 21^{add}</u>	<u>EOHHS</u>	

10 The agency receiving the referral is responsible for applying the appropriate needs-based criteria and
11 determining the services options available as indicated in subsection (C) (1) (b) above. ^{add}

12 ~~{delete}~~0399.07 LTC~~{delete}~~

13 ^{add}**D. LTSS^{add} OPTIONS COUNSELING PROGRAM**

14 ~~{delete}~~REV:07/2009~~{delete}~~

15 A ~~{delete}~~ long term care ~~{delete}~~ ^{add}LTSS^{add} options counseling program is designed to provide beneficiaries and/or
16 their representatives ^{add}with^{add} information concerning the range of options that are available in Rhode Island
17 to address a person's long-term care needs. The options discussed include the ^{add}types of LTSS^{add}
18 (institutional care ~~{delete}~~ available, ~~{delete}~~ ^{add}and^{add} ~~{delete}~~ the ~~{delete}~~ home and community-based care ^{add}), the
19 range of available settings, ^{add} ~~{delete}~~ that is available~~{delete}~~ and how to access these services. The sources and
20 methods of both public and private payment for ~~{delete}~~ long term care services~~{delete}~~ ^{add}LTSS^{add} are ^{add}also^{add}
21 addressed. A person admitted to or seeking admission to a ~~{delete}~~ long term care ~~{delete}~~ ^{add}LTSS^{add} facility
22 regardless of the payment source ~~{delete}~~ shall be~~{delete}~~ ^{add}must be^{add} informed by the facility of the availability
23 of the long-term care options counseling program and ~~{delete}~~ shall be provided with a long term care options~~{delete}~~
24 ^{add}provided with a^{add} consultation ~~{delete}~~ if they so~~{delete}~~ ^{add}upon^{add} request. ^{add}Options counseling typically
25 includes, but is not limited to, the following: ^{add}

26 An initial screening ^{add}is conducted^{add} to determine how a person would be most appropriately served is
27 eonducted. ^{add}This screening is available to prospective and current residents of LTSS facilities and
28 applicants/beneficiaries of Medicaid LTSS and other publicly funded LTSS

Proposed Rules: 26

¹ See implementing rule located at: <http://sos.ri.gov/documents/archives/regdocs/released/pdf/DELDA/5638.pdf>

² See implementing rule located at: http://sos.ri.gov/documents/archives/regdocs/released/pdf/MHRH/MHRH_1746_.pdf

³ See information on Eleanor Slater Hospital located at: <http://www.bhddh.ri.gov/esh/description.php>

⁴ See Implementing rule located at: http://sos.ri.gov/documents/archives/regdocs/released/pdf/MHRH/MHRH_3088.pdf

1 programs, such as the DEA co-payment program. ~~This~~ ~~The~~ screening includes a
2 determination of the need for crisis intervention, the available sources of funding for services, and the need for
3 community services, Medicaid, or other publicly funded services.

4 ~~A person who applies for Medicaid long term care services shall be provided with a long term care~~
5 ~~consultation.~~ A consultation with an LTSS agency specialist for any applicant for Medicaid-funded
6 LTSS that includes a discussion of service delivery options (managed care plan versus alternative), role of
7 third-party payers (e.g., Medicare), and types of LTSS available based on level of need.

8 ~~A person admitted to or seeking admission to a long term care facility regardless of the payment source~~
9 ~~shall be informed by the facility of the availability of the long term care options counseling program and shall~~
10 ~~be provided with a long term care options consultation if they so request.~~

11 **0399.08 E. COST NEUTRALITY FOR ~~HCBS~~ HOME AND COMMUNITY- BASED**
12 **SERVICES**

13 ~~REV:07/2009~~

14 As explained below, ~~The~~ ~~the~~ ~~DHS~~ ~~EOHHS~~ is responsible for
15 setting ~~reviewing and approving~~ the aggregate cost neutrality of ~~the home and community~~
16 based long term care system Medicaid home and community-based services on an annual basis.
17 A core EOHHS function is to collaborate with agency partners through the A&C process to ensure that
18 meet cost neutrality, the average per capita expenditures for home and community-based services
19 cannot does not exceed one hundred percent (100%) of the average per capita expenditures of
20 the cost of institutional services if the individuals had been institutionalized for the same set of Medicaid
21 LTSS provided in an institutional setting – that is, NF, ICF/ID or long-term hospital. Accordingly, when
22 comparing the cost of care in a HCBS versus institutional setting, the total average costs for all Medicaid LTSS
23 core and preventive services must be considered, across providers, even if the beneficiary is residing in a
24 specific HCBS setting (e.g., residing in a habilitation group home or assisted living and receiving limited
25 skilled nursing or therapeutic day supports as separate services) The average monthly costs to Medicaid by
26 institution are:

- Nursing Facilities ~~\$ 5,531.00~~ \$6,510.00
- ~~ICF MR~~ ICF/ID ~~\$18,758.34~~ \$21,932.94
- Eleanor Slater Hospital \$24,195.00

27 **Proposed Rules: 27**

1 The ~~DHS~~ ~~EOHHS~~ uses these average monthly costs to Medicaid to identify and promote
2 cost-effective community-based LTSS alternatives to institutional care ~~assist in determining whether~~
3 ~~home and community-based services are cost effective~~ as required under Title XIX of the Social Security
4 Act.

5 ~~0366.10~~ 1500.03 ~~OVERVIEW~~ NEEDS-BASED **DETERMINATIONS**
6 **OF NURSING FACILITY (NF) LEVEL OF CARE**

7 ~~REV:07/2009~~

8 **A. OVERVIEW**

9 ~~The Global Waiver allows long term care services to be provided~~ The State is authorized under the
10 terms and conditions of the Section 1115 demonstration waiver to provide Medicaid LTSS in an
11 institutional or home and community-based setting depending on the determination of the beneficiary's needs,
12 individual plan of care, and the budget neutrality parameters established under ~~the Global Waiver~~
13 federal law and regulations. The purpose of this section is to set forth the process and criteria for evaluating
14 the needs and service options of applicants/beneficiaries seeking a nursing facility level of care in either of these
15 settings. Beneficiaries ~~with~~ determined to have ~~care~~ service needs in the
16 NF category that meet the financial and clinical/functional eligibility criteria for a NF level of care also
17 have an option for self-direction. As established in Section 1500.02(C)(1)(b), the responsibilities assessing
18 the service option for the ICF/ID and hospital levels of care have been delegated to agencies across the EOHHS.

19 **B. NF SERVICE OPTIONS CLASSIFICATIONS**

20 The NF service classifications are designed to provide care options that reflect the scope and
21 intensity of the beneficiary's needs ~~in this category are~~ and are as follows:

- 22 a) ~~{add}~~(1)~~{add}~~ **Highest need.** Beneficiaries with needs in this classification have access to all core services
 23 defined in Section ~~{delete}~~0399.04.02.01~~{delete}~~ ~~{add}~~1500.04(A)~~{add}~~ as well as the choice of receiving services
 24 in an institutional/nursing facility, ~~{add}~~in their own~~{add}~~ home ~~{add}~~or the home of another~~{add}~~, or ~~{add}~~one of the~~{add}~~
 25 community-based settings ~~{add}~~identified below in Section 1500.05~~{add}~~.
- 26 b) ~~{add}~~(2)~~{add}~~ **High need.** Beneficiaries with needs in this classification have been determined to have needs that
 27 can safely and effectively be met at home or in the community with significant core services.

28 **Proposed Rules: 28**

1 Accordingly, these beneficiaries have access to ~~{delete}~~an~~{delete}~~ ~~{add}~~the~~{add}~~ array of community-based core services
 2 required to meet their needs ~~{add}~~as~~{add}~~ specified in the ~~{add}~~person-centered~~{add}~~ individual plan of care.

3 e) ~~{add}~~(3)~~{add}~~ **Preventive need.** Beneficiaries who do not yet need ~~{delete}~~LTC~~{delete}~~ ~~{add}~~Medicaid LTSS~~{add}~~ but
 4 are at risk for the NF level of care have access to services targeted at preventing admission, re-admissions or
 5 reducing lengths of stay in a skilled nursing facility. Core home and community-based services are not available
 6 to beneficiaries with this level of need. Medicaid beneficiaries, ~~{delete}~~eligible under Section 0399.12.03,~~{delete}~~ who
 7 meet the preventive need criteria, are not subject to the ~~{delete}~~LTC~~{delete}~~ ~~{add}~~Medicaid LTSS~~{add}~~ financial eligibility
 8 criteria established in ~~{add}~~MCAR~~{add}~~ Sections 0380.40-0380.40.35 and 0392.15.20-0392.15.30.

9 ~~{delete}~~0399.10.01 Agency Respons for Determining Level of Care

10 ~~REV:07/2009~~ -

11 ~~Beginning on July 1, 2009, beneficiaries determined to have a potential need for Medicaid funded long-term~~
 12 ~~services and supports in a nursing facility or in the community are referred to the Assessment and Coordination~~
 13 ~~Organization (ACO) processes administered by the Department of Human Services (DHS). Those applying~~
 14 ~~for state only funded services and supports are referred to ACO processes administered by the Department of~~
 15 ~~Elderly Affairs (DEA). The agency entities authorized to carry out these ACO processes are responsible for:~~

- 16 -a) ~~Coordinating related activities with the Medicaid financial eligibility staff; b) Conducting assessments that~~
 17 ~~determine level of care needs; c) Developing service plans with the active involvement of beneficiaries and their~~
 18 ~~families; d) Establishing funding levels associated with care plans developed for each beneficiary; e) Reviewing~~
 19 ~~service plans on a periodic basis; and f) Working in collaboration with the beneficiary's care management plan or~~
 20 ~~program (Connect Care Choice; PACE; Rhody Health Partners) to ensure services are coordinated in the most~~
 21 ~~effective and efficient manner possible.~~

22 ~~Financial eligibility for Medicaid funded long term care is conducted by the DHS field staff in accordance~~
 23 ~~with Sections 0380.40-0380.40.35 and 0392.15.20-0392.15.30. Determinations of clinical level of care needs for~~
 24 ~~nursing facilities are made by the DHS Office of Medical Review (OMR) nurses for both DHS and DEA~~
 25 ~~beneficiaries~~~~{delete}~~.

26 ~~{delete}~~0399.11~~{delete}~~ ~~{add}~~B. NF~~{add}~~ **CLINICAL ELIGIBILITY ASSESSMENT TOOL**

27 ~~{delete}~~REV:07/2009~~{delete}~~

28 **Proposed Rules: 29**

1 In determining clinical eligibility, the ~~{add}~~EOHHS Office of Medical Review (OMR)~~{add}~~ staff uses ~~{delete}~~an
 2 ~~assessment instrument based on the~~~~{delete}~~ nationally recognized ~~{add}~~assessment instruments including, but not
 3 ~~limited to,~~ ~~{add}~~ Minimum Data Set (MDS) ~~{delete}~~2.0~~{delete}~~ ~~{add}~~3.0~~{add}~~ Tool for NF care. To make the final
 4 determination of care needs, the results of this assessment are mapped against the needs-based and institutional
 5 level of care criteria. The ~~{delete}~~DHS shall make~~{delete}~~ ~~{add}~~EOHHS must make~~{add}~~ available to the public the
 6 procedural guidelines for use of the assessment as well as the instrument itself.

7 ~~{delete}~~0399.12~~{delete}~~ ~~{add}~~C.~~{add}~~ **APPLICATION OF NF ~~{add}~~NEEDS-BASED~~{add}~~ LEVEL OF CARE**
 8 **CRITERIA**

9 ~~{delete}~~REV:07/2009~~{delete}~~

10 Upon completing the assessment, the OMR staff determines whether a beneficiary's care needs qualify as highest,
 11 high or preventive based on a set of clinical and functional criteria that reflect both best practices across the
 12 states and the standards of prevailing care within the ~~{delete}~~LTC~~{delete}~~ ~~{add}~~LTSS~~{add}~~ community in Rhode Island.
 13 ~~{add}~~The functional disability criteria focus on the scope of a person's need for assistance with the Activities of
 14 ~~{add}~~Daily Living (ADLs) such as bathing, toileting, dressing, transferring, ambulation, eating, personal hygiene,

15 medication management, and bed mobility. To determine the scope of need, OMR staff consider the extent
16 to which the level of assistance a person requires falls into one of the following categories:

- 17 • **Total dependence (All Action by Caregiver):** Individual does not participate in any part of the activity.
- 18 • **Extensive Assistance (Talk, Touch, & Lift):** Individual performs part of the activity, but caregiver
19 provides physical assistance to lift, move, or shift individual.
- 20 • **Limited Assistance (Talk and Touch):** Individual highly involved in the activity, but receives
21 physical guided assistance and no lifting of any part of the individual.

22 The needs-based clinical criteria for a NF level of care deal with cognitive, behavioral and physical impairments
23 and chronic conditions that require extensive personal care and/or skilled nursing assessment, monitoring
24 and treatment on daily basis.^{add}

25 Clinical eligibility ^{add}for beneficiaries who were receiving Medicaid LTSS in a NF setting prior to the January
26 1, 2016, are set forth in Section 1500.01(F)(2)(c)^{add} ~~{delete}~~ based on these criteria is in the following
27 Sections^{delete}^{add}. The applicable criteria beginning on the date this rule takes effect are as follows:^{add}

28 Proposed Rules: 30

1 ~~{delete}~~**0399.12.01 Highest Need**

2 REV:07/2009^{delete}

3 ^{add}**(1) Highest Need.** Persons at this level of need have the choice of obtaining services in a NF or HCBS setting.
4 ^{add} ~~{delete}~~ Beneficiaries shall be ~~{delete}~~^{add} Applicants/beneficiaries are^{add} deemed to have highest level of care
5 need when they:

6 (a) Require extensive assistance ~~{delete}~~ or total dependence^{delete} with at least one^{delete} ^{add}three (3)^{add} of the
7 following ~~{delete}~~ Activities of Daily Living (ADLs) least one of the following Activities of Daily Living (ADL) —
8 toilet use, bed mobility, eating, or transferring^{delete} ^{add}ADLs -- bathing, toileting, dressing, transferring,
9 ambulation, eating, personal hygiene, medication management, and bed mobility; require total dependence with
10 one (1) of these ADLs and limited assistance with two (2) additional ADLs; AND have one (1) or more
11 unstable medical, behavioral, cognitive, psychiatric or chronic recurring conditions requiring nursing assistance,
12 care and supervision on a daily basis; or^{add}

13 (b) Lack awareness of needs or have moderate impairment with decision-making skills AND have one ^{add}(1)
14 ^{add} of the following symptoms/conditions, which occurs frequently and is not easily altered: wandering,
15 verbally aggressive behavior, ~~{delete}~~ resists^{delete} ^{add}resisting^{add} care, physically aggressive behavior, or
16 behavioral symptoms requiring extensive supervision; or

17 (c) Have at least one of the following conditions or treatments that require skilled nursing assessment,
18 monitoring, and care on a daily basis: Stage 3 or 4 skin ulcers, ventilator, respirator, IV medications, naso-gastric
19 tube feeding, end stage disease, parenteral feedings, 2nd or 3rd degree burns, suctioning, or gait evaluation and
20 training; or

21 (d) Have one or more unstable medical, behavioral or psychiatric conditions or chronic or reoccurring
22 conditions requiring skilled nursing assessment, monitoring and care on a daily basis related but not limited
23 to at least one of the following: dehydration, internal bleeding, aphasia, transfusions, vomiting, wound
24 care, quadriplegia, aspirations, chemotherapy, oxygen, septicemia, pneumonia, cerebral palsy, dialysis,
25 respiratory therapy, multiple sclerosis, open lesions, tracheotomy, radiation therapy, gastric tube feeding,
26 behavioral or psychiatric conditions that prevent recovery.

27 ~~{delete}~~0399.12.01.01 Exceptions — Highest Need

28 REV:07/2009^{delete}

29 Proposed Rules: 31

1 ^{add}**(2) Exceptions – Highest Need.** ^{add} ~~{delete}~~ Beneficiaries^{delete} ^{add} Otherwise Medicaid LTSS eligible
2 persons^{add} who do not meet the criteria ~~{delete}~~ to establish highest need as indicated in the previous Section^{delete}
3 ^{add} established in subpart (1), paragraphs (a) to (d),^{add} may be deemed clinically eligible for ~~{delete}~~ this^{delete}
4 ^{add} the NF level of care at the highest need^{add} ~~{delete}~~ level of care^{delete} if the OMR determines that the
5 beneficiary has a special need for ~~{delete}~~ long term care services^{delete} ^{add} Medicaid LTSS in an institutional
6 setting^{add} due to special circumstances that ~~{delete}~~ if excluded from this level of care,^{delete} may adversely affect
7 the ~~{delete}~~ beneficiary's^{delete} health and safety. These special circumstances include but are not limited to:

8 ~~1.~~ ~~(a)~~ ^(a) Loss of primary caregiver (e.g. hospitalization of spouse, death of spouse);

9 ~~2.~~ ~~(b)~~ ^(b) Loss of living situation (e.g. fire, flood, foreclosure, sale of principal residence

10 due to inability ~~to~~ maintain housing expenses);

11 ~~3.~~ ~~(c)~~ ^(c) The ~~individual's~~ health and welfare ~~shall be~~ ^(add) of the

12 applicant/beneficiary is ^(add) at imminent risk if services are not provided or if services are discontinued

13 (e.g., circumstances such as natural catastrophe, effects of abuse or neglect, etc.); or

14 ~~4.~~ ~~(d)~~ ^(d) The beneficiary's health condition would be at imminent risk or worsen if

15 services are not provided or if services are discontinued (e.g. circumstances such as natural catastrophe,

16 effects of abuse or neglect, etc.)

17 ~~5.~~ ~~(e)~~ ^(e) The beneficiary met the criteria for a nursing facility level of care on or before June

18 30, 2009 and chose to receive Medicaid ~~LTC~~ ^(add) LTSS ^(add) at home or in a community setting

19 ~~when,~~ ~~(add)~~ ^(add) and ^(add) upon reassessment by the ~~department~~ ^(add) EOHHS ^(add) and, when

20 appropriate, in consultation with the Rhode Island Long-term Care Ombudsman, the beneficiary is

21 determined to have experienced a failed placement that, if continued, may pose risks to the beneficiary's

22 health and safety; or

23 ~~6.~~ ~~(f)~~ ^(f) The beneficiary met the criteria for highest need ~~on or after~~ ^(add) between ^(add) July 1, 2009 ^(add) and December 31, 2015 ^(add) based on an assessment using the needs-

24 based level of care and chose to receive Medicaid ~~LTC~~ ^(add) LTSS ^(add) at home or in the

25 community setting when, ~~(add)~~ ^(add) and ^(add) upon reassessment by the ~~department~~ ^(add) EOHHS ^(add)

26 and, when appropriate, in consultation with the Rhode Island Long- term Care Ombudsman, the

27 beneficiary is determined to have experienced a failed placement that, if continued, may pose risks to

28 the beneficiary's health and safety.

29

30 ~~0399.12.02 High Need~~

31 ~~REV:07/2009~~

32 ^(add) (3) High Need, ^(add) Beneficiaries ~~shall be~~ ^(add) are ^(add) deemed to have ~~the high level of care need~~

33 ^(add) for a NF level of care ^(add) when they:

34 Proposed Rules: 32

- 1 ^(a) Require at least limited assistance on a daily basis with at least two of the following ADL's:
- 2 bathing/personal hygiene, dressing, eating, toilet use, walking or transferring; or
- 3 ^(b) Require skilled teaching or rehabilitation on a daily basis to regain functional ability in at least one of
- 4 the following: gait training, speech, range of motion, bowel or bladder control; or
- 5 ^(c) Have impaired decision-making skills requiring constant or frequent direction to perform at least
- 6 one of the following: bathing, dressing, eating, toilet use, transferring or personal hygiene; or
- 7 ^(d) Exhibit a need for a structured therapeutic environment, supportive interventions and/or medical
- 8 management to maintain health and safety.

9 ~~0399.12.03 Preventive Need~~

10 ~~REV:09/2013~~

11 ^(add) (4) Preventive Need, ^(add) Beneficiaries who meet the ^(add) needs-based criteria for the NF ^(add) preventive

12 ~~need criteria shall be~~ ^(add) level of care are ^(add) eligible for a limited range of home and community-

13 based services and supports along with the ^(add) full range of non-LTSS state plan and waiver ^(add) health care

14 benefits they are entitled to receive ~~as recipients of Medicaid~~ ^(add) as recipients of Medicaid ^(add). Preventive care services optimize and

15 promote beneficiary health, safety and independence through an array of care interventions that alleviate or

16 minimize symptoms and functional limitations. Accordingly, the goal of preventive services is to delay or avert

17 institutionalization or more extensive and intensive home and community-based care.

18 To qualify, the OMR must determine that one or more preventive services will improve or maintain the ability

19 of a beneficiary to perform ~~ADLs~~ ^(add) ADLs ^(add) or ^(add) Instrumental Activities of Daily Living ^(add)

20 ~~IADLs~~^(add) (IADLs)^{5 (add)} and/or delay or mitigate the need for intensive home and community-
21 based or institutionally based care. Preventive services for beneficiaries ~~include~~^(add) are described
22 below in Section 1500.04(A)^(add).

23 a) ~~Homemaker Services~~—Services that consist of the performance of general household tasks (e.g., meal
24 preparation and routine household care) provided by a qualified homemaker, when the individual
25 regularly responsible for these activities is temporarily absent or unable to manage the

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1

2 home and care for him or herself or others in the home. Homemakers shall meet such standards of
3 education and training as are established by the State for the provision of these activities.

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

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

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

15 d) ~~Physical Therapy Evaluation and Services~~—Physical therapy evaluation for home accessibility
16 appliances or devices by an individual with a State approved licensing or certification. Preventive
17 physical therapy services are available prior to surgery if evidence based practice has demonstrated that
18 the therapy will enhance recovery or reduce rehabilitation time.

19 e) ~~Respite~~—Respite can be defined as a service provided to a participant unable to care for
20 himself/herself that is furnished on a short term basis because of the absence or need for relief of those
21 persons who normally provide care for the participant. Respite services will be recommended and
22 approved by EOHHHS, Office of Long Term Services and Supports.

23 **~~0399.12.03.01~~ Limitations -- Preventive Need**

24 ~~REV:07/2009~~

25 ^(add)**(5) Limitations – Prevent Need**^(add) Access to and the scope of preventive services for qualified
26 beneficiaries may be limited depending on the availability of funding. The ~~DHS~~^(add) ~~EOHHHS~~^(add) may
27 establish wait lists, in accordance with the provisions established in Section 0399.14 ^(add)**1500.04(B)**^(add),
28 if such limitations become a necessity.

29 ~~0399.13~~^(add) **D**^(add) **REASSESSMENTS -- HIGH AND HIGHEST NEED**

30 ~~REV:07/2009~~

31 ^(add)**(1) Change in Needs - High and Highest**. Beneficiaries determined to have high need at the time of a
32 reassessment, or in the event of a change in health status, ~~shall be determined~~^(add) are deemed^(add) to
33 have the highest need if they meet any of the clinical eligibility criteria established for that level of care in
34 section ~~0399.21.01~~^(add) **Section 1500.03(C)(1)**^(add).

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1 ~~0399.13.01~~ **Re-Eval of Beneficiaries with Highest Need**

2 ~~REV:07/2009~~

3 ^(add)**(2) Re-evaluation Highest Needs**^(add) At the time ~~the OMR makes~~^(add) a determination of highest
4 need ^(add)is made^(add) for a beneficiary who ~~resides in or is admitted to a nursing facility~~^(add) opts to

⁵ IADLs is an acronym that refers to skills required for independent living that include: using the telephone, traveling, shopping, preparing meals, doing housework, taking medications properly, and managing money.

5 ~~reside in a nursing facility, OMR evaluates~~^{add} ~~information indicating~~^{delete} whether there is a possibility
6 that the beneficiary's functional or health care condition may improve, within ^{add} the succeeding^{add} two month
7 period ~~is identified. The~~^{delete} ^{add} Based on this information,^{add} OMR notifies the beneficiary, his/her
8 authorized representative and the nursing facility that NF ~~level of~~^{delete} care has been authorized and that
9 the beneficiary's functional and medical status will be ~~reviewed~~^{delete} ^{add} re-evaluated^{add} in thirty (30) to
10 sixty (60) days.

11 At the time of ~~the review~~^{delete} ^{add} re-evaluation^{add}, the OMR confirms that the beneficiary is still a resident
12 of the nursing facility. ~~Once this determination is made, the OMR~~^{delete} reviews the most recent Minimum
13 Data Set, and requests any additional information necessary to make one of the following determinations:

14 ^{add} (a) Change Required ~~--~~^{add} The beneficiary no longer meets the criteria for highest level of need.
15 In this instance, the ^{add} OMR assesses whether the beneficiary has needs that meet the high or preventive
16 needs-based criteria. Once the assessment is completed, the^{add} beneficiary, and/or ~~his/her~~^{delete}
17 authorized representative, and the nursing facility are sent a ~~discontinuance~~^{delete} notice by the
18 ~~Long Term Care Unit~~^{delete} ^{add} EOHHS indicating that the beneficiary's needs no longer meet the
19 criteria for highest NF level of care and, as a result, the current services classification and options may be
20 discontinued or changed. ^{add} ~~Prior to being sent a discontinuance notice, the beneficiary will be~~^{delete}
21 evaluated to determine whether or not the criteria for high need have been met. ~~Payment for care~~^{delete}
22 provided to a beneficiary determined to no longer have the highest need ~~shall continue until the~~^{delete}
23 ~~DHS~~^{delete} ^{add} is continued until all necessary agency procedures^{add} ~~has~~^{delete} ^{add} are^{add}
24 completed ^{add} to successfully^{add} ~~the~~^{delete} transition to a more appropriate setting.

25 ^{add} (b) No Change.^{add} The beneficiary continues to meet the ~~appropriate level of care~~^{delete} ^{add}
26 applicable needs-based criteria^{add}, and no action is required.

27 ^{add} (3) Annual Reassessment and Renewal.^{add} ~~Beneficiaries residing in the community~~^{delete} ^{add} All
28 Medicaid LTSS beneficiaries^{add} who are in the highest and high ~~groups will~~^{delete} ^{add} service
29 classifications^{add} have, at a minimum, an annual assessment.

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1 ^{add} 1500.04 HCBS CORE AND PREVENTIVE SERVICES

2 The State's Section 1115 demonstration waiver and the Medicaid state plan identify and define the various
3 core and preventive services available to beneficiaries living in home and community-based settings. The scope,
4 amount and duration of these services a beneficiary is authorized to receive depends initially on the determination
5 of needs conducted in the OMR comprehensive assessment process and the person-centered care planning
6 process (PCP) that is developed thereafter in conjunction with the beneficiary, provider and family members
7 or authorized representatives. Note: the RI Reinventing Medicaid Act of 2015 authorized the EOHHS to seek
8 federal approval to expand the range of services to include: home stabilization, community health teams, peer
9 specialists, and acuity-based adult day and assisted living services.

10 A. DEFINITIONS OF CORE AND PREVENTIVE HCBS

11 The listing below defines the available HCBS and identifies those that will become accessible effective
12 January 1, 2016.

13 (1) Core HCBS. LTSS available based on need to any Medicaid eligible beneficiary:

14 (a) Adult Day Services -- a daytime community-based program for adults that provides a variety of social,
15 recreational, health, nutrition, and related support services in a protective setting. May include a range
16 of more intensive or specialized services such as medication administration, limited skilled nursing,
17 and/or personal care for beneficiaries with higher level acuity needs.

18 (b) Adult Supportive Care Homes-- provides "directly or indirectly, by means of contracts or arrangements"
19 personal assistance, lodging and meals to between two (2) and five (5) adults. Providers must be licensed
20 as nursing facility, nursing care provider, assisted living residence or adult day services provider as well as
21 an "adult supportive care home."

22 (c) Assisted living -- personal care and attendant services, homemaker, chore, companion services, meal
23 preparation, medication oversight (i.e., cuing), and social and recreational programming in a home-like
24 environment in the community. May also include a broader range of Medicaid LTSS for beneficiaries with
25 higher acuity needs including, but not limited to, medication administration and management, dementia

26 care, limited skilled nursing, intensive behavioral health service coordination, therapeutic day services,
27 cognitive and behavioral health therapies and extended personal care and attendant services.

28 **Proposed Rules: 36**

- 1 (d) Behavioral Services --- behavioral therapies designed to assist beneficiaries with chronic illnesses and
2 conditions in managing their behavior and thinking functions, and to enhance their capacity for independent
3 living.
- 4 (e) Case Management – assists beneficiaries in gaining access to necessary Medicaid services as well as non-
5 Medicaid medical, social, educational and other services and supports without regard to payer. Case
6 managers monitor access and utilization in accordance with the beneficiary’s PCP process and initiate
7 reassessments of level of need and review of services in conjunction with annual eligibility renewal.
- 8 (f) Community Health Teams – provide service coordination, care planning and oversight, and case
9 management services (as defined in subparagraph (e) above) to Medicaid LTSS beneficiaries who are not
10 enrolled in a managed long-term care plan.
- 11 (g) Day Supports (also includes day “habilitation”) – provides assistance with acquisition, retention or
12 improvement in self-help as well as socialization and adaptive skills. Day habilitation involves regularly
13 scheduled provision in a non-residential setting, apart from the beneficiary’s home or other residential
14 living arrangement. As the beneficiary’s plan dictates, physical, occupational and/speech therapy may also
15 be provided. All services and supports are directed at enabling a Medicaid LTSS beneficiary to achieve
16 and maintain maximum functional level in accordance with the POC.
- 17 (h) Environmental Modifications (also known as Home Accessibility Adaptations) -- physical modifications
18 to a beneficiary’s home or the home of a family member in which the beneficiary resides. The modifications
19 must be identified in beneficiary’s PCP process as necessary to support health, welfare, and safety and enable
20 the beneficiary to function with greater independence at home. For services to be authorized, there must
21 be evidence that without the modification(s) a beneficiary would require some type of institutionalized living
22 arrangement, such a nursing facility or hospital. Adaptations that do not help the beneficiary’s safety or
23 independence are not included as part of this service, such as new carpeting, roof repair, central air, or home
24 additions.
- 25 (i) Informal Supports – includes supports provided by family and friends as well other community resources
26 that assist the beneficiary in achieving the goals identified in the person-centered plan of care.
- 27 (j) Home Stabilization (Available effective January 1, 2016) – provides services and supports for beneficiaries
28 who are homeless or at risk of homelessness or transitioning to the community from an institutional settings.
29 Range of LTSS includes intensive case management and community-

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- 1 based care coordination as well as both more traditional home stabilization interventions (e.g., locating a
2 home, managing a household, entitlement support and financial counseling, independent living skill training,
3 safety training, homemaking, etc.) and critical health service supports (e.g., disease and medication
4 management, peer mentoring, family therapy, substance abuse counseling, recovery readiness and relapse
5 prevention, self-care, etc.).
- 6 (k) Home Delivered Meals -- prepared food brought to the beneficiary’s home that may consist of a heated
7 lunch meal and a dinner meal (or both), which can be refrigerated and eaten later. May also include shelf
8 staples. This service is designed for the beneficiary who cannot self-prepare meals but is able to eat on his or
9 her own. Meals must provide a minimum of one-third (1/3) of the current recommended dietary allowance.
10 Other forms of assistance for meal preparation is limited for beneficiaries receiving this service.
- 11 (l) Home Health Aide -- a person who works under the supervision of a medical professional to assist the
12 beneficiary with basic health services such as assistance with medication, nursing care, physical,
13 occupational, and speech therapy. A home health aide is often a Certified Nursing Assistant (CNA) who
14 provides both skilled personal care and homemaker services at a combined rate of payment.
- 15 (m) Homemaker -- in-home caregiver hired through an agency that consists of general household tasks. The
16 caregiver helps with housekeeping items such as meal preparation, shopping, light housekeeping, and
17 laundry. Homemaker services are typically authorized for a temporary period during which a beneficiary’s
18 caregiver is absent from the home for a limited period of time.

- 19 (n) Intermittent Skilled Nursing -- focuses on long-term needs rather than short-term acute healing needs,
20 such as weekly insulin syringes or medi-set set up for beneficiaries unable to perform these tasks on their own.
21 These services are provided when a need is established in a beneficiary's PCP by a licensed nursing
22 professional under the supervision of an EOHHS Registered Nurse.
- 23 (o) LPN Services – provides time-limited skilled nursing services to a beneficiary by a Licensed Practical
24 Nurses (LPN), practicing under the supervision of a Registered Nurse. Services typically exceed the scope
25 of practice of a Certified Nursing Assistant (CNA) and are provided to a beneficiary in their home
26 for short-term acute healing needs, with the goal of restoring and maintaining a beneficiary's maximal
27 level of function and health. These services are for beneficiaries who have achieved some degree of stability
28 despite the need for continuing chronic care nursing interventions that might otherwise require a
29 hospitalization or a nursing facility stay. Service must be authorized by an EOHHS Registered Nurse.

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- 1 (p) Minor Environmental Modifications -- provides minor changes to the home including grab bars, versa frame
2 (toilet safety frame), handheld shower and/or diverter valve, raised toilet seats and other simple devises or
3 appliances such as eating utensils, transfer bath bench, shower chair, aids for personal care (e.g., reachers)
4 and standing poles to improve home accessibility adaptation, health or safety.
- 5 (q) PACE - Program for All-Inclusive Care for the Elderly -- includes LTSS and other health services for
6 beneficiaries fifty-five (55) years or older who meet the criteria for high or highest level of need. PACE is
7 responsible for providing all Medicare and Medicaid services.
- 8 (r) Participant Directed Goods and Services --includes services, equipment or supplies not otherwise provided
9 under the Section 1115 waiver or state plan that address an identified need specified in a beneficiary's POC
10 such as improving and maintaining full membership in the community. Access is contingent upon meeting
11 the following requirements:
- 12 • Item or service would decrease the need for other Medicaid services; and/or promote inclusion in the
13 community; or
 - 14 • Item or service would increase the beneficiary's ability to perform ADLs or IADLs or increase the
15 person's safety in the home environment; and
 - 16 • Alternative funding sources are not available.
- 17 Individual goods and services are purchased from the beneficiary's self-directed budget through the fiscal
18 intermediary when approved as part of the individual service plan (ISP). Examples include a laundry
19 service for a person unable to launder and fold clothes or a microwave for a person unable to use a stove
20 due to his/her disability. Does not include any good/service that would be restrictive to the individual or strictly
21 experimental in nature.
- 22 (s) Personal Care – provides direct hands-on support to help with the day-to-day activities such as toileting,
23 bathing, meal preparation and medication management which enable beneficiaries to be more independent in
24 their own homes. Personal care services may be provided by a CNA who is employed by a State-licensed
25 home care/home health agency and meets such standards of education and training as are established by
26 the State or Personal Care Attendant (PCA) via employer authority under the self-directed care option. Does
27 not include homemaker services, such as light housekeeping.
- 28 (t) Peer Supports (Available effective January 1, 2016) -- services provided by trained "peer specialists",
29 working as part of a multi-disciplinary treatment team, who serve as mentors,

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- 1 motivators, and role models for beneficiaries. Emphasis is on long-term recovery, wellness, self- advocacy,
2 socialization and community connectedness.
- 3 (u) Personal Emergency Response System -- electronic equipment that allows beneficiaries 24-hour access to
4 help in an emergency. The equipment is connected to your phone line and calls the response center and/or
5 other forms of help once the help button is pressed.
- 6 (v) Physical Therapy Evaluation and Services - evaluation for home accessibility appliances or devices by an
7 individual with a State-approved licensing or certification. Preventive physical therapy services are

8 available prior to surgery if evidence-based practice has demonstrated that the therapy will enhance recovery
9 or reduce rehabilitation time.

10 (w) Prevocational Services - for beneficiaries with intellectual disabilities or brain injuries, provides work
11 experiences and training designed to assist individuals in developing skills needed for employment in
12 the general workforce. Services include teaching concepts such as compliance, attendance, task completion,
13 problem-solving, and safety.

14 (x) Private Duty Nursing – individual continuous care, rather than part-time or intermittent skilled nursing,
15 provided by licensed nurses. Service must be authorized by an EOHHS Registered Nurse and is typically only
16 available to beneficiaries requiring habilitative services.

17 (y) Rehabilitation Services -- designed to improve and or restore a person's functioning; includes physical
18 therapy, occupational therapy, and/or speech therapy.

19 (z) Residential Supports (also known as habilitation services) – individually tailored supports that provide
20 assistance with the acquisition, retention or improvement of skills related to the activities of daily living such
21 as personal grooming, household chores, meal preparation and so forth. More intensive supports include
22 adaptive skill development, community inclusion, transportation, adult educational supports and
23 socialization. Personal care and protective oversight are included. Medicaid does not cover room and
24 board, however. Goal of service is to provide the skills necessary for a beneficiary to reside in the most
25 integrated setting appropriate to his or her need level in a HCBS, rather than an institutional setting.

26 (aa) Respite - provides relief for unpaid family or primary caregivers who are meeting all the needs of the
27 beneficiary. The respite caregiver assists the beneficiary with all daily needs when the family or primary
28 caregiver is absent. Respite can be provided by a homemaker, personal assistant, nurse, or in an adult day
29 center.

30 (bb) Self-directed Care (also known as “Personal Choice”) --In-home caregiver hired and managed by the
31 beneficiary. The beneficiary must be able to manage different parts of being an employer such

32 **Proposed Rules: 40**

1 as hiring the caregiver, managing their time and timesheets, completing other employee paperwork. The
2 caregiver helps with housekeeping items such as meal preparation, shopping, light housekeeping, and laundry.
3 The caregiver can also help with hands-on personal care items such as personal hygiene, bathing, grooming,
4 and feeding. Personal care assistants can include other independent direct care givers such as RNs, LPNs,
5 and Home Health Aides. .

6 (cc) Senior Companion (also known as “adult companion services”) -- non-medical care, supervision, and
7 socialization provide to a functionally impaired adult. Companions may assist or supervise the beneficiary
8 with such tasks as meal preparation, household management, and shopping.

9 (dd) Special Medical Equipment (Minor Assistive Devices): Specialized Medical Equipment and supplies
10 to include: devices, controls, or appliances, specified in the plan of care, which enable beneficiaries to
11 increase their ability to perform activities of daily living; devices, controls, or appliances that enable the
12 beneficiary to perceive, control, or communicate with the environment in which they live; and other durable
13 and non-durable medical equipment not available under the State plan that is necessary to address a
14 beneficiary’s functional limitations. Items available under the Section 1115 waiver are in addition to any
15 medical equipment and supplies furnished under the State plan and exclude those items that are not of
16 direct medical or remedial benefit to the beneficiary. All items shall meet applicable standards of
17 manufacture, design and installation. Provision of Specialized Medical Equipment requires prior approved
18 on an individual basis by the EOHHS.

19 (ee) Supports for Consumer Direction (also known as “facilitation”) – focuses on empowering beneficiaries to
20 define and direct their own personal assistance needs and services by providing guidance and support to
21 facilitate successful personalized service planning and delivery. Service is designed to enable a beneficiary
22 to identify and gain access to the full array of services, including non-Medicaid HCBS, necessary to optimize
23 health and retain independence while living at home.

24 (ff) Supported Employment-- includes activities needed to maintain paid work by individuals receiving HCBS,
25 including supervision, transportation, and training. Covers only the adaptations, supervision and training

26 provided at a work-site for beneficiaries who are receiving the service as a result of the clinical/functional
27 disability which is the basis for their Medicaid LTSS eligibility.

28 (gg) Supported Living Arrangements (also known as shared-living) – includes a bundle of core services^{add}
29 ~~{delete}~~ Personal care and services^{delete}, ^{add}(e.g., personal care,^{add} homemaker, chore, attendant care,
30 companion services and medication oversight ^{delete}(to the extent permitted under State law)^{delete} provided
31 in a private home by a principal care provider who lives in the home. ^{delete}Supported Living
32 Arrangements^{delete} ^{add}The

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1 supported living arrangements^{add} are furnished to adults who receive these services in conjunction with
2 residing in the home. Separate payment ~~{delete}~~ will ~~{delete}~~ ^{add}is^{add} not be made for homemaker or chore services
3 furnished to an individual receiving Supported Living Arrangements, since these services are integral to
4 and inherent in the provision of adult foster care-like services.

5 (hh) ^{add}Transition Services – non-recurring payment of expenses for beneficiaries who are transitioning
6 from an institutional or restrictive congregate service setting to a living arrangement in a private residence
7 or a residence operated by a licensed provider.^{add} ~~{delete}~~non-recurring set up expenses for individuals
8 who are transitioning from an institutional or another provider operated living arrangement to a living
9 arrangement in a private residence where the person is directly responsible for his or her own living
10 expenses. ~~{delete}~~ Allowable expenses are those necessary to ~~{delete}~~ ^{add}must^{add} enable a ~~{delete}~~ person^{delete}
11 ^{add}beneficiary^{add} to establish a basic household, ~~{delete}~~ that do not constitute ~~{delete}~~ ^{add}excluding^{add} room
12 and board, and may include: security deposits ~~{delete}~~ that are required to obtain a lease on an apartment
13 or home, essential household furnishings, and moving expenses, set-up fees or deposits for utility or
14 service access, services necessary for the individual's health and safety ^{add}not otherwise covered
15 (e.g., fumigation)^{add} and activities to assess need, arrange for and procure needed resources.
16 ~~{delete}~~ Community Transition Services^{delete} ^{add}Such services^{add} are furnished only to the extent that they
17 are reasonable and necessary as determined ^{add}and identified clearly^{add} through the ~~{delete}~~ service plan
18 development^{delete} ^{add}PCP development^{add} process, clearly identified in the service plan and the person
19 ^{add}and only when the beneficiary^{add} is ^{add}otherwise^{add} unable to meet such expense or when the
20 services cannot be obtained from other sources ^{add}to pay for or obtain the services from other sources^{add}.
21 ~~{delete}~~ They do not include ~~{delete}~~ ^{add}Excludes^{add} ongoing shelter expenses; food, regular utility charges,
22 household appliances or items intended for recreational purposes.

23 ^{add}(2)^{add} Preventive ~~{delete}~~ Services^{delete} ^{add}HCBS^{add} Persons who are eligible for ~~{delete}~~ Community Medical
24 Assistance ~~{delete}~~ ^{add}non-LTSS Medicaid under MCAR section 0374^{add} and who have been determined to meet
25 a preventive level of care, have access to the following services ^{add}as defined above^{add}: homemaker services,
26 minor environmental modifications, personal care assistance services, physical therapy evaluation and services,
27 and respite.

28 ~~{delete}~~ 0399.14^{delete} ^{add}B.^{add} LIMITATIONS ON THE AVAILABILITY OF ~~{delete}~~ SERVICES^{delete}
29 ^{add}MEDICAID HCBS^{add}
30 ~~{delete}~~ REV:07/2009^{delete}

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1 Should the demand for home and community-based ~~{delete}~~ long-term care services^{delete} ^{add}Medicaid LTSS^{add}
2 exceed supply or appropriations, ^{add}access to core and/or preventive services may be limited for certain^{add}
3 beneficiaries.

4 ^{add}(1) Highest Need – NF and Hospital.^{add} Beneficiaries with the highest need ~~{delete}~~ shall^{delete} have the option
5 of seeking admission to a nursing facility while awaiting access to the full scope of home and community-
6 based services. ~~{delete}~~ Specifically, beneficiaries and applicants^{delete} ^{add}Accordingly, applicants/beneficiaries
7 deemed to be^{add} in the highest category ^{add}for a nursing facility level of care or meet the requirement for a
8 hospital level of care^{add} are ^{add}entitled^{add} to services and ~~{delete}~~ shall not be^{delete} ^{add}must not be^{add} placed on
9 a waiting list for ~~{delete}~~ institutional services^{delete} ^{add}Medicaid LTSS in an institutional setting. If a community
10 placement is not initially available, ^{add}beneficiaries with the highest need^{add} may be placed on a wait list for
11 transition to the community ^{add}while receiving services in a licensed health facility that provides the type of
12 institutionally based LTSS that meets their needs. Different limitations apply for beneficiaries requiring an
13 ICF/ID level of care as is determined by BHDDH under applicable federal and state laws and regulations^{add}.

14 ^(add)(a) Priority Status --^(add) In the event that a waiting list for any home and community- based service
15 becomes necessary for any reason, the ~~{delete}~~DHS~~{delete}~~ ^(add)EOHHS^(add) must provide services for
16 beneficiaries determined to be ^(add)NF or hospital^(add) highest need before providing services to beneficiaries that
17 have a high need or preventive need. Beneficiaries with high need are given priority access to services over
18 beneficiaries qualifying for preventive services.

19 ^(add)(b) Continuation of Services --^(add) ~~Additionally, beneficiaries receiving services~~{delete}~~~~ ^(add)Services
20 for beneficiaries with the highest need^(add) must continue~~{delete}~~ to have access to and receive~~{delete}~~ ^(add)in the
21 appropriate setting^(add) ~~such services~~{delete}~~~~ unless ^(add)or until^(add) their condition improves ~~{delete}~~ and ~~{delete}~~ ^(add)
22 to such an extent that^(add) they no longer meet the same clinical ^(add)/functional^(add) eligibility criteria.

23 ^(add)(2) High Need – Beneficiaries with a high level of need may be subject to waiting lists for certain HCBS.
24 However, for the NF level of care, beneficiaries with a high need are afforded priority status for any such services
25 over beneficiaries who have a preventive level of need.

26 ^(add)(3) Preventive Need – NF Only. Services for beneficiaries determine to have a need for a preventive level of care
27 are subject to appropriations. Therefore, wait lists and/or limitations on the availability and the scope, amount
28 and duration of preventive services are permissible, at the discretion of the EOHHS, to the full extent available
29 resources dictate.^(add)

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1 ~~{delete}~~0399.15~~{delete}~~ ^(add)1500.05^(add) LIMITATIONS ON ~~{delete}~~ENVIRONMENTAL MODIFICATIONS,
2 MINOR ENVIROMENTAL MODIFICATIONS AND SPECIAL MEDICAL EQUIPMENT~~{delete}~~

3 ^(add)THE SCOPE OF MEDICAID HCBS^(add)

4 ~~{delete}~~REV:09/2013~~{delete}~~

5 ^(add)The terms and conditions of the State’s Section 1115 demonstration waiver authorize the EOHHS to set
6 limits on the scope, amount and duration of certain Medicaid HCBS available to a beneficiary, based on needs
7 and service classification – highest, high and preventive. The EOHHS has established such limits to ensure the
8 cost neutrality provisions established under Title XIX, described in Section 1500.03(E) of this rule, are met.

9 A. ^(add)ENVIRONMENTAL MODIFICATIONS, MINOR ENVIROMENTAL
10 MODIFICATIONS AND SPECIAL MEDICAL ^(add)EQUIPMENT^(add) ~~{delete}~~Members who meet the Highest
11 and High Level of Care (LOC) for core Home and Community Based services~~{delete}~~ ^(add)Beneficiaries who have
12 the highest and high needs for a NF level of care^(add) and have a functional necessity for environmental
13 modifications, minor environmental ^(add)changes,^(add) and special medical equipment are subject to limitations
14 and special considerations ~~{delete}~~, therein~~{delete}~~ ^(add)set forth below:^(add)

15 ~~{delete}~~0399.15.01 Environmental Modifications

16 ~~{delete}~~REV:09/2013~~{delete}~~

17 ^(add)(1) ^(add)Environmental Modifications^(add). As defined in Section 1500.04(A) above, environmental
18 modifications^(add) ~~{delete}~~are defined as those~~{delete}~~ physical adaptations to the home ~~{delete}~~of the member or the
19 member’s family~~{delete}~~ ^(add)where a beneficiary resides that are^(add) ~~{delete}~~as~~{delete}~~ required by ~~{delete}~~the member’s
20 service plan,~~{delete}~~ ^(add)in the POC^(add) ~~{delete}~~that are necessary~~{delete}~~ to ensure ~~{delete}~~the~~{delete}~~ ^(add)his or her^(add) health,
21 welfare and safety ~~{delete}~~of the member or that~~{delete}~~ ^(add)and/or^(add) enable the ~~{delete}~~member~~{delete}~~
22 ^(add)beneficiary^(add) ~~{delete}~~to attain or retain capability for independence or self-care in the home and to avoid
23 institutionalization, and are not covered or available under any other funding source~~{delete}~~ ^(add)attain or retain
24 independence and provide self-care^(add). ~~{delete}~~A completed home assessment by a specially trained and certified
25 rehabilitation professional is also~~{delete}~~ ^(add)Acceptable^(add) adaptations may include the installation of modular
26 ramps, grab-bars, vertical platform lifts and interior stair lifts.

27 ~~{delete}~~Excluded are those adaptations that are of general utility, are not of direct medical or remedial benefit
28 to the member. Excluded are any re modeling, construction, or structural changes to the home, i.e. (changes
29 in load-bearing walls or structures) that would require a structural engineer, architect and /or certification by
30 a building inspector. Adaptations that add to the total square footage of the home are excluded from this benefit.

31 Proposed Rules: 44

1 All adaptations shall be provided in accordance with applicable State or local building codes and prior approval
2 on an individual basis by EOHHS, Office of Long Term Services and Supports is required. Items should be of

3 a nature that they are transferable if a member moves from his/her place of residence. ~~(delete)~~ ^(add) The scope of the
4 home modification(s) services available to Medicaid LTSS beneficiaries is as follows:

- 5 (a) ^(add) All items require prior authorization and do not require a physician's order.
- 6 (b) All items must be recommended by an appropriately trained and certified rehabilitation
7 professional.
- 8 (c) The ~~(delete)~~ Home Modification ~~(delete)~~ ^(add) home modification ^(add) must be documented as the most cost-
9 effective to meet the ~~(delete)~~ member's ~~(delete)~~ ^(add) beneficiary's ^(add) needs for accessibility within the home.
- 10 (d) Items must be necessary to ensure the health, welfare and safety of the ~~(delete)~~ individual ~~(delete)~~ ^(add)
11 beneficiary ^(add), or to enable the ~~(delete)~~ individual ~~(delete)~~ ^(add) beneficiary ^(add) to attain or retain capability for
12 independence or self-care in the home, and to avoid ~~(delete)~~ institutionalization ~~(delete)~~ ^(add) a transition to a
13 more restrictive institutional-setting ^(add).
- 14 (e) Home ~~(delete)~~ Modifications ~~(delete)~~ shall ~~(delete)~~ ^(add) modifications must ^(add) be made only to the
15 ~~(delete)~~ member's ~~(delete)~~ ^(add) beneficiary's ^(add) primary residence, ~~(delete)~~ ^(add) A primary residence may be a free-
16 standing house, condominium, or a rental unit owned or leased by the beneficiary, a family member or
17 friend as long as it serves as the beneficiary's permanent living arrangement. Modifications to primary
18 residence that is leased ^(add) ~~(delete)~~ including rented apartments or houses ~~(delete)~~ ^(add) may require the ^(add)
19 ~~(delete)~~ with ~~(delete)~~ written permission of the owner/landlord ^(add) /lease-holder ^(add), when applicable).
- 20 (f) Exterior access modifications are limited to one ingress/egress route into and out of the home.
- 21 (g) Repair, removal, construction or replacement of decks, patios, sidewalks and fences are not covered
22 ^(add) modifications ^(add).
- 23 (h) ~~(delete)~~ Home Modifications ~~(delete)~~ ^(add) Home modifications under this section ^(add) do not include
24 ~~(delete)~~ those ~~(delete)~~ adaptations or improvements to the home that are considered to be standard housing
25 obligations of the owner or tenant ^(add) such as bringing the living area up to fire or electrical code.
- 26 (i) Other home modifications that are not covered include -- ^(add)
- 27 • Relocation of plumbing and/or bathroom fixtures ~~(delete)~~ is not covered.

28 Repairs or modifications to equipment purchased under this definition are an allowable expense.

- 29 • Examples of items not covered include ~~(delete)~~ ^(add) Repairs, addition, or purchase of ^(add) driveways,
30 decks, patios, hot tubs, central heating and air conditioning, raised garage doors, standard

Proposed Rules: 45

1 home fixtures (i.e., ^(add) e.g., ^(add) sinks, tub, stove, refrigerator, etc.), raised counter tops, roll-in- showers
2 or tub cuts.

- 3 • ~~(delete)~~ Excluded are any re-modeling, ~~(delete)~~ ^(add) Any remodeling, ^(add) construction, or structural changes to
4 the home ~~(delete)~~, i.e., ~~(delete)~~ ^(add) e.g., ^(add) changes in load bearing walls or structures) that would require a
5 structural engineer, architect and /or certification by a building inspector.
- 6 (j) Requirements for ^(add) modifications ^(add) to rental property include: --
- 7 • ~~(delete)~~ Prior to any modification a ~~(delete)~~ ^(add) A ^(add) determination ~~(delete)~~ should ~~(delete)~~ ^(add) must ^(add) be made
8 ~~(delete)~~ as to what, if anything, is the legal responsibility of ~~(delete)~~ ^(add) whether, and to what extent, ^(add) the
9 property owner ^(add), lessee ^(add) or landlord ^(add) has legal responsibility to make the modification or
10 approve a modification authorized under this section ^(add).
- 11 • Written approval must be obtained from the property owner or landlord prior to the ~~(delete)~~ service
12 being approved ~~(delete)~~ ^(add) modification before approved by EOHHS and scheduled for delivery ^(add).
- 13 (k) Ramps may be covered ^(add) modifications ^(add) only if:
- 14 • ~~(delete)~~ They meet ADA compliance ~~(delete)~~ ^(add) All American with Disabilities Act (ADA) compliance
15 standards are met ^(add), and
- 16 • ~~(delete)~~ Meet all ~~(delete)~~ ^(add) All ^(add) applicable State and local building code requirements and permits as
17 required ^(add) are obtained with the necessary approvals; and ^(add)
- 18 • ~~(delete)~~ Ramp should be ~~(delete)~~ ^(add) The ramp is structured and built of materials that make it ^(add) ~~(delete)~~ of a
19 nature that it is ~~(delete)~~ readily transferable to another dwelling.

- 20 (l) Vertical platform lifts may be covered only if:
- 21 • There is not adequate acreage available to install a ramp that meets ~~state~~ ^(add) State ^(add) and local
 - 22 building codes; ^(add) and/or ^(add)
 - 23 • The physical topography of the site precludes the installation of a ramp.

24 (m) Interior Stairway Lifts (stair glides) may be approved only if the first floor of the home does not have

25 any toilet facilities.

26 (n) Repairs or modifications to equipment purchased under this definition are an allowable expense

27 ~~B. Special Considerations:~~

28 (o) An Assessment for home modifications is required to determine the most appropriate and cost-

29 effective ~~service requested~~ ^(add) approach to address the beneficiary's service need ^(add). This

30 assessment

31 Proposed Rules: 46

1 must be completed by a specially trained and certified rehabilitation professional. Individuals

2 ~~conducting~~ ^(add) EOHHS has deemed qualified to conduct ^(add) such assessments ~~may~~ ^(add)

3 include ^(add) but are not limited to ^(add):

- 4 • Licensed Physical, and Occupational Therapists experienced in ~~Home and Community Based~~
- 5 ~~services~~ ^(add) HCBS for persons with an LTSS level of need; and ^(add)
- 6 • Assistive Technology Professionals (ATP), certified by the Rehabilitation Engineering and Assistive
- 7 Technology Society of North America (RESNA). ~~—An assistive technology professional~~ ^(add) is a
- 8 service provider who analyzes the needs of individuals with disabilities, assists in the selection of the
- 9 appropriate equipment, and trains the consumer on how to properly use the specific equipment. ~~.)~~

10 ~~C. Limitation on Service(s)~~

11 (p) This ~~Home modification service~~ ^(add) Home modification service ^(add) is only available to Medicaid ~~members~~ ^(add) members ^(add)

12 ^(add) who meet the clinical/functional criteria for and are authorized to receive other ^(add) ~~on~~

13 ~~Core~~ ^(add) core ^(add) HCBS.

14 ~~This service is billable under HCPCS Code S5165.~~

15 **0399.15.02 Special Medical Equipment**

16 REV:09/2013

17 ^(add) (2) ^(add) Special Medical Equipment and ~~supplies to~~ ^(add) Supplies. Supplies available in this area ^(add)

18 include ceiling or wall mounted patient lifts, track systems, tub slider systems, rolling shower chairs and/or

19 automatic door openers ^(add) and similar services ^(add), which ~~enable members~~ ^(add) enhance or enable

20 beneficiaries ^(add) to increase their ability to perform activities of daily living, ~~including such other~~ ^(add)

21 ^(add) Such ^(add) durable and non-durable medical equipment ^(add), which is designed specifically to address the

22 functional limitations of beneficiaries, are authorized by the State's Section 1115 waiver and are ^(add) not available

23 ^(add) as Medicaid state plan services ^(add) under the Medicaid-funded primary and acute care system ~~that~~

24 ~~is necessary to address member functional limitations~~ ^(add). Items ~~reimbursed with waiver funds~~ ^(add)

25 ^(add) authorized for LTSS beneficiaries under the waiver ^(add) are in addition to any ~~other~~ ^(add) other ^(add) medical equipment

26 and supplies ~~furnished under the Medicaid-funded primary and acute care system~~ ^(add) provided to a

27 beneficiary through Medicaid for their acute/subacute/primary care needs. ^(add) ~~and exclude those items that~~

28 ~~are not of direct medical or remedial benefit to the member.~~ ^(add) Medical equipment ~~funded under the~~

29 ~~primary and acute care system includes items~~ ^(add) such as wheelchairs, prosthetics, and orthotics ^(add) which are

30 provided through a beneficiary's acute care coverage (e.g., Medicare, private insurance or Rhody Health

31 Partners) are excluded ^(add). ~~These are services that were provided under the authority of the Rhode Island~~

32 ~~Medicaid State Plan prior to the~~

33 Proposed Rules: 47

1 1115 Waiver approval. These items are still available under the 1115 Waiver and are described at:

2 <http://www.dhs.ri.gov/ForProvidersVendors/ServicesforProviders/ProviderManuals/DME/tabid/459/Default.aspx>

3 ~~The scope of special medical equipment and supplies available to Medicaid LTSS beneficiaries under~~

4 this section is as follows:

5 (a) ~~shall~~ ~~meet~~ ~~comply with the~~ applicable
6 ~~industry and/or government~~ standards of ~~pertaining to the~~ manufacture, design and
7 installation ~~of the equipment or supplies requested.~~

8 (b) ~~Provision of Special Medical Equipment requires~~ ~~All requests for special~~
9 ~~equipment and supplies must receive prior approval and authorization by the appropriate agency LTSS~~
10 ~~specialist before purchase and installation.~~ ~~Prior approval on an individual basis by EOHHS,~~
11 ~~Office of Long Term Services and Supports and~~ ~~Approval is based on a review of the~~
12 ~~beneficiary's needs as established in the PCP process and~~ a home assessment completed by a
13 specially trained and certified rehabilitation professional.

14 (c) Items ~~should be of a nature that they are~~ ~~transferable if a~~ ~~member~~
15 ~~beneficiary~~ ~~moves from his/her~~ ~~changes~~ place of residence.

16 (d) ~~Remodeling~~ construction, or structural changes to the home ~~Any changes~~, (i.e.
17 ~~changes in load bearing walls or structures~~) that would require a structural engineer, architect and/or
18 certification by a building inspector ~~(i.e., changes in load bearing walls or structures) are excluded~~
19 ~~and, as such, are NOT covered~~.

20 (e) ~~Limitations include~~

21 ~~A. Limitations:~~

- 22 • ~~Ceiling or wall mounted patient lifts and track systems~~ ~~Approval contingent upon~~
23 ~~Must be documented as~~ ~~documentation indicating that the equipment is~~ the most
24 cost-effective method to meet the ~~member's~~ ~~beneficiary's~~ needs. A patient lift will be
25 considered for use in one bedroom and/or one bathroom. A track system is limited to connecting
26 one bedroom and one bathroom.
- 27 • ~~Rolling shower chair~~ ~~Item must have a functional expectancy of a minimum~~
28 of five (5) years and ~~Must~~ be documented as the most cost-effective method to meet
29 the ~~member's~~ ~~beneficiary's~~ needs ~~in order to be approved.~~

Proposed Rules: 48

- 1 • ~~Electrical Adaptation~~ ~~Automatic Door Openers, adapted switches and buttons to operate~~
2 equipment, and environmental controls, such as heat, air conditioning and lights may be approved
3 for a member who lives alone or is without a caregiver for a major portion of the day.
- 4 • ~~All items require Prior Authorization by EOHHS, Office of Long Term Services and Supports~~
5 ~~and do not require a physician's order.~~

6 (f) ~~Items~~ ~~Exceptions to the limitations set forth in (e)~~ above may be acquired subject to
7 Prior Authorization from ~~EOHHS, Office of Long Term Services and Supports~~.
8 Determinations will be based on the individual's unique circumstances as they apply to the current service
9 definitions, policies and regulations. ~~Please refer to RI Global Consumer Choice Compact 1115~~
10 ~~Waiver Demonstration Attachment B, Core and Preventive Home and Community Based Service~~
11 ~~definitions.~~

12 (g) Repairs or modifications to equipment purchased under this ~~definition~~ ~~section~~ are
13 an allowable expense ~~covered Medicaid expenses~~.

14 ~~B. Special Considerations:~~

15 (h) An ~~assessment~~ for special medical equipment and supplies is required to determine the most
16 appropriate and cost-effective ~~service requested~~ ~~approach to address the beneficiary's~~
17 ~~service need~~. This assessment must be completed by a specially trained and certified rehabilitation
18 professional. Individuals ~~conducting~~ ~~EOHHS has deemed qualified to conduct~~ such
19 assessments ~~may~~ include ~~but are not limited to~~:

- 20 • ~~Licensed Physical, and Occupational Therapists experienced in~~ ~~Home and Community Based~~
21 ~~services~~ ~~HCBS for persons with an LTSS level of need; and~~
- 22 • ~~Assistive Technology Professionals (ATP), certified by the Rehabilitation Engineering and~~
23 ~~Assistive Technology Society of North America (RESNA).~~ - An assistive technology
24 ~~professional~~ is a service provider who analyzes the needs of individuals with disabilities,

25 assists in the selection of the appropriate equipment, and trains the consumer on how to properly use
26 the specific equipment.

27 Proposed Rules: 49

- 1 • ^{add}Special medical equipment and supplies under this section are only available to Medicaid
2 ^{add}beneficiaries who meet the clinical/functional criteria for and are authorized to receive other core
3 ^{add}HCBS.

4 ~~{delete}~~ C. Limitation on Service(s):

5 This is only available to Medicaid members on Core HCBS.

6 This service is billable under HCPCS Code T2029.

7 **0399.15.03 Environmental Modifications**

8 ~~REV:09/2013~~^{delete}

9 ^{add}(3) Minor Environmental Modifications. Minor Environmental modifications may include grab bars, versa frame
10 (toilet safety frame), handheld shower and/or diverter valve, raised toilet seats, and other simple devices or
11 appliances such as eating utensils, transfer bath bench, shower chair, aids for personal care (e.g. reachers) and
12 standing poles to improve home accessibility adaptation, health or safety. ^{add}The scope of minor environmental
13 ^{add}modifications available to Medicaid LTSS beneficiaries under this section is as follows:

14 ~~{delete}~~ A. Limitations: ~~{delete}~~

- 15 ^{add}(a) All items require prior authorization by ~~{delete}~~ EOHHS, Office of Long Term Services and Supports ~~{delete}~~ ^{add}an
16 ^{add}agency LTSS specialist; however, items on the EOHHS Approved List do not require a physician's order.
- 17 ^{add}(b) All items must be recommended by an appropriately trained and certified health care professional or ~~DHS~~
18 ^{add}LTSS social worker.
- 19 ^{add}(c) Items must be necessary to ensure the health, welfare and safety of the ~~{delete}~~ individual ~~{delete}~~
20 ^{add}beneficiary, or to enable the ~~{delete}~~ individual ~~{delete}~~ ^{add}beneficiary ~~{delete}~~ to attain or retain capability for
21 independence or self-care in the home, and to avoid ~~{delete}~~ institutionalization ~~{delete}~~ ^{add}a transition to a more
22 ^{add}restrictive institutional-setting.
- 23 ^{add}(d) Items for diversional or entertainment purposes are not covered.
- 24 ^{add}(e) Items ~~{delete}~~ should be of a nature that they are ~~{delete}~~ ^{add}must be transferable if a ~~{delete}~~ member ~~{delete}~~
25 ^{add}beneficiary ~~{delete}~~ moves from his/her ~~{delete}~~ ^{add}changes place of residence.
- 26 ^{add}(f) Items cannot duplicate equipment provided under the Medicaid -funded primary and acute care system or
27 through other sources of funding (i.e. ^{add}e.g., Medicare, private insurance).
- 28 ^{add}(g) Items not included on the EOHHS Approved List and priced greater than \$500.00 ~~{delete}~~ shall be ~~{delete}~~
29 ^{add}are considered special medical equipment and will be subject to the policies and procedures for that
30 service ~~{delete}~~ as described in the Core Services section of the Rhode Island 1115 Waiver.

31 Proposed Rules: 50

- 1 • This service is billable under HCPCS Code T2028, for Core HCBS and/or preventive services.

2 **0399.20 OVERVIEW: LTC RESIDENTIAL SERVICE OPTIONS**

3 ~~REV:07/2009~~^{delete}

4 ^{add}1500.05 LTSS RESIDENTIAL SERVICE OPTIONS –NF LEVEL OF CARE

5 ^{add}A. OVERVIEW

6 There are several community-based service options in residential settings, other than the home and nursing
7 facilities, which may be available to beneficiaries who are determined ~~{delete}~~ under Sections ~~0399.12.01 and~~
8 ~~0399.12.02~~ to have ^{add}the high or highest need for the ~~{delete}~~ highest or high ~~{delete}~~ ^{add}NF level of care
9 ^{add}pursuant to Section ??????. Beneficiaries will be notified of whether they qualify for one of these
10 residential options in conjunction with the comprehensive assessment ~~{delete}~~ specified in Sections ~~0399.05.01.02~~
11 and ~~0399.11~~ and the development of the individualized plan of care. ~~{delete}~~ Although ~~{delete}~~ Medicaid
12 coverage for room and board is typically not included for these options, ^{add}though there are exceptions as is
13 explained in the description of services provided below.

14 ~~{delete}~~ **0399.20.01 Assisted Living**

15 ~~REV:07/2009~~^{delete}

16 ~~{add}~~(1) Assisted Living Residential Service Options. ~~{add}~~ Assisted living ~~{delete}~~ services are ~~{delete}~~ ~~{add}~~ is ~~{add}~~ available
17 to qualified ~~{delete}~~ long-term care (LTC) ~~{delete}~~ ~~{add}~~ Medicaid LTSS ~~{add}~~ beneficiaries who have ~~{delete}~~ been determined
18 to have a ~~{delete}~~ ~~{add}~~ the ~~{add}~~ highest or ~~{add}~~ ~~{add}~~ a ~~{delete}~~ high ~~{delete}~~ level of care ~~{delete}~~ need ~~{add}~~ for a nursing facility level of
19 care and are determined, subsequent to the OMR comprehensive assessment, to be able to obtain the services they
20 need ~~{add}~~ ~~{delete}~~ that can be ~~{delete}~~ safely and effectively ~~{delete}~~ ~~{delete}~~ met ~~{delete}~~ in a ~~{delete}~~ state ~~{delete}~~ ~~{add}~~ State ~~{add}~~ licensed
21 ~~{add}~~ and Medicaid certified ~~{add}~~ assisted living residence ~~{add}~~ (ALR). The scope of HCBS that an ALR may be
22 authorized to provide to a Medicaid LTSS beneficiary is determined by the residence's level of State
23 licensure, compliance with varying Medicaid certification standards, and participation in the Community
24 Supportive Living Program (CSLP). Upon the effective date of this rule, the EOHHS will make available two (2)
25 assisted living residential service options.

26 (a) ALR Standard Option -- In this "Standard" option, the EOHHS or its designee, currently the Division of
27 Elderly Affairs of the Department of Human Services (DHS), certifies ALRs based on two aspects of
28 licensure status -- emergency egress and medication management --

Proposed Rules: 51

1 and the capacity to provide a discrete set of HCBS (personal care and attendant services, homemaker,
2 chore, companion services, meal preparation, medication oversight (i.e., cuing), and social and recreational
3 programming) at a set per diem rate. Any additional services a beneficiary is authorized to receive under
4 his or her personal-centered plan of care (e.g., physical therapy or limited skilled nursing), must be obtained
5 from other Medicaid providers regardless of the ALR's level of licensure and capacity. Beneficiary
6 assessments may be conducted by the Division of Elderly Affairs of LTSS specialists.

7 (b) Community Support Living Program (CSLP) Option -- The CSLP Option was established in R.I.G.L. §40-
8 8-13.2, as part of the Reinventing Medicaid Act of 2015, as a pilot to promote HCBS alternatives for
9 beneficiaries with high acuity needs who are enrolled in LTSS managed care plans through the State's
10 Integrated Care Initiative (ICI). The EOHHS administers the program through the ICI and has established
11 multi-tiered Medicaid certification standards that correspond to State licensure levels that authorize ALR and
12 adult and supportive care residences (ASCRs) to provide, based on a beneficiary's acuity needs, a range
13 of enhanced and/or specialized services. Licensed residences that become certified and choose to participate
14 in the CSLP must enter into contractual arrangements with the ICI managed care plans that tie payments
15 to the scope of Medicaid LTSS they are certified to provide and a beneficiary's needs. All CLSP certified
16 residences must provide the full scope of services available in the Standard Option, as indicated above, as well
17 as therapeutic day services and more intensive personal care. Licensed residences that provide enhanced
18 services (e.g., limited skilled nursing) and/or specialized services (e.g., dementia care) must have the
19 appropriate level of State licensure and meet the appropriate tier of Medicaid certification. ~~{add}~~

20 ~~{delete}~~ that has also been certified as a Medicaid provider. The responsibility for certifying licensed assisted living
21 residences as Medicaid providers is shared by the Executive Office of Health and Human Services, the
22 Department of Human Services or the Department of Elderly Affairs. Certification standards adopted by these
23 agencies in effect on June 30, 2009 shall remain in effect under the Global Consumer Compact Waiver until
24 October 1, 2009, by which time the office and the departments shall develop and implement new certification
25 standards that broaden the scope and availability of assisted living services to the full extent permitted by state
26 law and appropriations.

27 For the purpose of this rule, assisted living services are defined as: personal care services, homemaker,
28 chore, attendant care, companion services, medication oversight (to the extent permitted under state law),
29 transportation to medically necessary appointments, therapeutic social and

Proposed Rules: 52

1 recreational programming, when specified, provided in a home-like environment in a licensed community
2 care facility in conjunction with residing in the facility. The services provided to beneficiaries by assisted
3 living residences certified as Medicaid providers for the purposes of ~~{delete}~~ ~~{add}~~ ALRs participating in Medicaid
4 under ~~{add}~~ R.I.G.L. §42.66.8-3 ~~{delete}~~ ~~{add}~~ must also include those set forth in section 0300.20.20 ~~{delete}~~ ~~{add}~~ are subject
5 to the requirements of this section ~~{add}~~. Beneficiaries ~~{delete}~~ ~~{add}~~ opting for services in the ~~{delete}~~ ~~{add}~~ choosing to obtain
6 Medicaid LTSS in one of the ~~{add}~~ assisted living residences covered under this section of ~~{delete}~~ state ~~{delete}~~
7 ~~{add}~~ State ~~{add}~~ law may be subject to waiting lists as ~~{delete}~~ the number of beds certified for Medicaid purposes is
8 capped ~~{delete}~~ ~~{add}~~ availability for beneficiaries may be limited ~~{add}~~. ~~{delete}~~ Such beneficiaries shall have the option
9 of seeking assisted living services in other Medicaid certified residences, depending on the scope of their needs

10 as indicated in the individualized plan of care. Note: beneficiaries subject to waiting lists may obtain the full scope
11 of services authorized under their POC at home or in any other appropriately certified residential setting.
12 Beneficiaries with the highest need for a NF level of care also have the option of choosing a nursing facility care
13 setting.

14 Note: Medical equipment funded under the primary and acute care system includes items such as wheelchairs,
15 prosthetics, and orthotics. These are services that were provided under the authority of the Rhode Island Medicaid
16 State Plan prior to the 1115 Waiver approval. These items are still available under the 1115 Waiver and are
17 described at:

18 <http://www.dhs.ri.gov/ForProvidersVendors/ServicesforProviders/ProviderManuals/DME/tabid/459/Default.asp>
19 *

20 ~~0399.20.02~~ **RItE @ Home (Shared Living)**

21 REV:09/2013^{delete}

22 (2) RItE @ Home ^{add} Shared Living. Beneficiaries with a need for an NF or ICF/ID level of care have the
23 option of entering into a shared-living arrangement that is similar to adult foster care. Shared-living^{add} is defined
24 as personal care, homemaker, chore, attendant care and related services provided in a private home setting by a
25 care provider who lives in the home. RItE @ Home ^{delete}s a service^{delete} ^{add}is the shared-living service^{add}
26 ^{delete} provided to ^{delete}^{add}for^{add} Medicaid ^{add}LTSS^{add} beneficiaries ^{delete}eligible for long-term care
27 services who are elderly or adults with disabilities^{delete} who are unable to live independently and who meet
28 ^{delete}^{add}have^{add} the highest or ^{add}a^{add} high ^{add}need for a NF^{add} level of ^{delete}care as determined through the
29 evaluation conducted by the Assessment and Coordination Organization as specified in Section 0399.06.^{delete}
30 Each Medicaid beneficiaries opting

31 Proposed Rules: 53

1 for RItE @ Home services will have a RItE @ Home Service and Safety Plan, developed to meet their own unique,
2 individual needs.

3 RItE @ Home providers approved by EOHHS to serve Medicaid beneficiaries^{delete} shall be ^{add}are^{add} selected
4 in accordance with the standards developed for such purposes ^{delete}under the auspices of the Executive Office
5 of Health and Human Services^{delete} ^{add}by the EOHHS. The BHDDH and DCYF also maintain shared-living
6 programs that are certified and operate under standards geared toward the needs of the populations they
7 serve.^{add} ^{delete}These program standards vary by population served so as to ensure services can be tailored to
8 better meet the needs of beneficiaries.

9 ~~0399.20.02.01~~ **Scope and Limitations**

10 REV:07/2009

11 Shared living certification standards and options developed and implemented by the Department of Mental
12 Health, Retardation and Hospitals (MHRH) in effect on June 30, 2009 shall remain in effect under the Global
13 Waiver unless or until such time as the MHRH determines otherwise.

14 ~~0399.21~~ **PROG FOR ALL-INCLUSIVE CARE FOR THE ELDERLY**

15 REV:07/2009^{delete}

16 (3) The Program for All-Inclusive Care for the Elderly (PACE)^{add}. PACE^{add} is a ^{delete}Medical Assistance
17 program administered by the DHS^{delete} ^{add}Medicaid LTSS program for beneficiaries who enrolled in
18 Medicare^{add} that provides an integrated model of ^{delete}medical and long-term care services^{delete} ^{add}health
19 care^{add} to qualified persons ^{add}who are at least^{add} age fifty-five (55) ^{delete}and above^{delete} ^{add}and meet
20 all the Medicaid LTSS financial requirement as well as the clinical/functional criteria for a high or the highest
21 need for a NF level of care.^{add}

22 ^{delete}CMS and the Center for Adult Health approved PACE providers are responsible for providing the full scope
23 of Medicaid State Plan categorical and medically needy services and the following additional services: o
24 Multidisciplinary assessment and treatment planning; o Case Management services; o Personal Care; o
25 Homemaking; o Rehabilitation; o Social Work; o Transportation; o Nutritional Counseling; o
26 Recreational Therapy; o Minor Home Modifications; o Specialized Medical Equipment and Supplies.

27 Proposed Rules: 54

1 The ~~(delete)~~ ^(add) Participation in the ^(add) PACE program is voluntary ~~(delete)~~ for any eligible person, but if an
2 individual selects this program, he/she must get all medical and support services through the PACE
3 organization ~~(delete)~~. ^(add) Beneficiaries opting to participate in PACE receive all Medicaid LTSS waiver and state
4 plan services and supports through the program. ^(add) There are no benefits outside of the PACE program.
5 ^(add) Information about eligibility, enrollment and disenrollment in the PACE program is located in Section 0374
6 and 0375, pertaining to managed care arrangements for adults with disabilities and elders. ^(add)

7 ~~(delete)~~ DHS long term care/adult services staff is responsible for:

- 8 ● ~~(delete)~~ All determinations and redeterminations of Medicaid Long Term Care categorical or medically needy
9 eligibility and post-eligibility as described in Sections through 0396.10.20, and Sections 0396.15 through
10 0396.15.10.10;
- 11 ● ~~(delete)~~ Determination of income to be allocated to cost of care (share);
- 12 ● ~~(delete)~~ Maintenance of the DHS InRhodes and paper ease file;
- 13 ● ~~(delete)~~ Assisting disenrolled clients in application for alternate Medicaid Long Term Care programs, as needed.

14 The approved PACE provider is responsible for:

- 15 ● ~~(delete)~~ Point of entry identification;
- 16 ● ~~(delete)~~ Submitting all necessary documentation for level of care initial determinations and redeterminations and
17 referral to DHS long term care/adult services offices for financial determinations;
- 18 ● ~~(delete)~~ Checking Medicaid eligibility status and required share amount (if any) prior to enrolling the client in
19 PACE as a Medicaid eligible individual, and at each reassessment;
- 20 ● ~~(delete)~~ Providing and coordinating all needed services;
- 21 ● ~~(delete)~~ Adhering to all PACE Provider requirements as outlined in the PACE Program Agreement between DHS
22 and CMS, and to all credentialing standards required by the DHS Center for Adult Health including data
23 submission.

24 The DHS Center for Adult Health is responsible for:

- 25 ● ~~(delete)~~ Oversight and monitoring of all aspects of the PACE program;
- 26 ● ~~(delete)~~ Conducting initial Level of Care Determinations and determining whether a permanent Level of Care
27 should be assigned;
- 28 ● ~~(delete)~~ Identifying clients for whom there is unlikely to be an improvement in functional/medical status.

29 **0399.21.01 Involuntary Disenrollment**

30 REV:07/2009

31 ~~(delete)~~ The PACE Organization may not request disenrollment because of a change in the enrollee's health status or
32 because the enrollee's utilization of medical and/or social services, diminished mental capacity or uncooperative
33 behavior is resulting from his or her special needs (except as specified below). Involuntary disenrollment
34 conditions described in 42 CFR Section 460.164 will be used in Rhode Island. A person may be disenrolled for
35 any of the following reasons:

- 36 ● ~~(delete)~~ Non-payment of premiums on a timely basis: failure to pay or make satisfactory arrangements to pay any
37 premium or co-payment due the PACE organization after a 30 day grace period.

38 **Proposed Rules: 55**

- 1 ● ~~(delete)~~ The participant moves out of the PACE program service area or is out of the service area for more than thirty
2 (30) days unless the PACE organization agrees to a longer absence due to extenuating circumstances.
- 3 ● ~~(delete)~~ The PACE organization is unable to offer health care services due to the loss of State licenses.
- 4 ● ~~(delete)~~ The PACE organization's agreement with CMS and the State administering agency is not renewed or
5 terminated.
- 6 ● ~~(delete)~~ The participant is defined as a person who engages in disruptive or threatening behavior, including times
7 when the participant physically attacked, verbally threatened, or exhibited harassing behavior toward a PACE
8 program staff member, contractor, or other PACE program participant.
- 9 ● ~~(delete)~~ A person whose behavior is jeopardizing his/her health or safety or that of others.
- 10 ● ~~(delete)~~ A person with decision-making capacity who consistently refuses to comply with his/her individual plan of
11 care or the terms of the Enrollment Agreement.

- 12 • A participant may lose eligibility for the PACE program and be disenrolled because they no longer meet level
13 of care requirements.

14 **0399.21.02 Dept Approval for Involuntary Disenrollment**

15 REV:07/2009

16 ~~Involuntary disenrollment from PACE requires the DHS Center for Adult Health approval. A proposed~~
17 ~~involuntary disenrollment for any of the above reasons shall be subject to timely review and prior authorization~~
18 ~~by the Department, pursuant to the Involuntary Disenrollment procedure below:~~

- 19 • ~~Disenrollment request: The PACE Organization (PO) shall submit to the DHS Center for Adult Health a~~
20 ~~written request to process all involuntary disenrollments. With each request, the PACE Organization shall~~
21 ~~submit to DHS evidence attesting to the above situations.~~
22 • ~~Department's Approval: The Department will notify the PACE Organization about its decision to approve or~~
23 ~~disapprove the involuntary disenrollment request within fifteen (15) days from the date DHS has received all~~
24 ~~information needed for a decision.~~

25 ~~Upon DHS approval of the disenrollment request, the PACE Organization must, within three (3) business days,~~
26 ~~forward copies of a completed Disenrollment Request Form to the DHS Long Term Care Office and to the~~
27 ~~Medicare enrollment agency (when appropriate).~~

28 **0399.21.03 Notification of the Member**

29 REV:07/2009

30 ~~If and when the DHS approves the PACE Organization's request for disenrollment, the PACE Organization must~~
31 ~~send written notification to the member that includes:~~

- 32 • ~~A statement that the PACE Organization intends to disenroll the member;~~
33 • ~~The reason(s) for the intended disenrollment; and~~
34 • ~~A statement about the member's right to challenge the decision to disenroll and how to grieve or appeal such~~
35 ~~decision.~~

36 **0399.21.04 Disenrollment Appeal**

37 REV:07/2009

38 ~~If the member files a written appeal of the disenrollment within ten (10) days of the decision to disenroll, the~~
39 ~~disenrollment shall be delayed until the appeal is resolved.~~

40 [Proposed Rules: 56](#)

1 **0399.21.05 Loss Of PACE Enrollment**

2 REV:07/2009

3 ~~When a member loses PACE enrollment, the effective dates of disenrollment from the PACE Organization~~
4 ~~will be determined as follows:~~

- 5 • ~~Loss of Functional Level of Care: No longer requires the level of care provided in a nursing facility as defined~~
6 ~~in section 0399.12.01.~~
7 • ~~Out of Area Residence: The PACE Organization will notify the appropriate agencies, Medicare and/or~~
8 ~~Medicaid, if the member moves permanently out of the designated PACE catchment area. If the member~~
9 ~~moves permanently out of the catchment area, the date of disenrollment for Medicaid shall be the date when~~
10 ~~the move occurs. DHS will recoup Medicaid capitation payments made for any months after the month an~~
11 ~~out of area move occurs.~~

12 ~~Death: If the participant dies, the date of disenrollment shall be the date of death. DHS will recoup any whole~~
13 ~~capitation payments for months subsequent to the month a participant dies.~~

14 **0399.21.06 Notification to the Participant**

15 REV:07/2009

16 ~~When the PACE Organization notifies the Center for Adult Health and Medicare enrollment agencies of the loss~~
17 ~~of PACE enrollment, the PACE Organization shall also send written notification to the member. This written~~
18 ~~notification shall include:~~

- 19 • ~~A statement that the participant is no longer enrolled in the PACE program;~~

- 20 • The reason(s) for the loss of PACE enrollment.

21 ~~0399.21.07 Re-enrollment and Transition Out of PACE~~

22 REV:07/2009

23 ~~All re-enrollments will be treated as new enrollees except when a participant re-enrolls within two months~~
24 ~~after losing Medicaid eligibility. In this situation, the participant's re-enrollment will not be treated as a new~~
25 ~~enrollment. The PACE Organization shall assist participants whose enrollment ceased for any reason in obtaining~~
26 ~~necessary transitional care through appropriate referrals, by making medical records available to the participant's~~
27 ~~new service providers; and (if applicable), by working with DHS to reinstate participant's benefits in the Medical~~
28 ~~Assistance Program.~~

29 ~~0399.21.08 Voluntary Disenrollment~~

30 REV:07/2009

31 ~~Participants in the PACE Program may voluntarily disenroll from the PACE Organization at any time. A~~
32 ~~voluntary disenrollment from the PACE Organization will become effective at midnight of the last day of the~~
33 ~~month in which the disenrollment is requested.~~

34 ~~To qualify as a Medicaid eligible PACE participant, an individual must:~~

- 35 • ~~Meet the Medical Assistance requirement for disability and be at least fifty five (55) years of age, or meet the~~
36 ~~Medical Assistance requirement for age (65 or older);~~
37 • ~~Meet the highest or high level of care;~~
38 • ~~Meet all other financial and non-financial requirements for Medical Assistance long-term care services, such~~
39 ~~as, but not limited to, citizenship, residency, resources, income, and transfer of assets.^{delete}~~

40 Proposed Rules: 57

^{add}1500.06 Severability

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable^{add}



Net Present Value: Section 1500, Medicaid Long-Term Services and Supports – Interim Rule

For each cost and benefit calculation, the following formula was used:

$$NPV(i, N) = \sum_{t=0}^N \frac{R_t}{(1+i)^t}$$

Where “N” represents the total number of periods, “t” represents the period, and “i” represents the discount rate. Total Net Present Value estimates based on a series of assumptions outlined in this document. All NPV estimates are greater than 0 indicating that the rule should be adopted based on overall benefit.

Period	Savings to State
T ₀	\$2,188,500
T ₁	\$2,254,155
T ₂	\$2,321,780
T ₃	\$2,391,433
T ₄	\$2,463,176
T ₅	\$2,537,071
T ₆	\$2,613,183
T ₇	\$2,691,579
T ₈	\$2,772,326
T ₉	\$2,855,496
T ₁₀	\$2,941,161
NPV	\$28,029,861

EOHHS is proposing to amend pertinent sections of the Medicaid Code of Administrative Rules, section 0399, currently entitled, “Global Consumer Choice Waiver”, renumber it to section #1500, and re-title it: “Medicaid Long-Term Services and Supports: Interim Rule.” These rules are being promulgated pursuant to the authority conferred under Chapters 40- 6 and 40-8 of the General Laws of Rhode Island, as amended, and the federal Section 1115 Waiver approved by the federal Centers for Medicare and Medicaid Services (CMS).

The EOHHS has determined that the most effective way of updating the applicable rules is to create a new chapter in the Medicaid Code of Administrative Rules (MCAR) that sets forth in plain language the rules governing LTSS and, as such, serves as companion to the MCAR chapters governing Medicaid Affordable Care Coverage (Section 1300 *et seq.*).

Toward this end, the purpose of this rule is to establish the provisions that implement the reforms beginning on or about January 1, 2016 and to provide a summary of changes that will take effect during calendar year 2016 and thereafter.

The regulations are adopted in the best interests of the health, safety, and welfare of the public.

To achieve the goal of rebalancing the long-term care system, Medicaid eligibility criteria have been reformed to enable beneficiaries to obtain long-term services and supports (LTSS) in the most appropriate and least restrictive setting. The types of LTSS available to beneficiaries are categorized as either “institutional” or “home and community-based.”

The chief distinctions between the two types of LTSS are care setting and scope of Medicaid coverage. Beginning on January 1, 2016, the series of reforms authorized by state policymakers for modernizing the system for organizing, financing and delivering Medicaid-funded LTSS will begin to take effect. While the modernization process is underway, many long-standing LTSS policies and procedures and the rules governing their implementation will become obsolete.

Below is a table that attempts to quantify the shift in LTSS care that will be permitted by this rule:

Facility Type (all licensed by the RI Department of Health)	Average Annual Cost Per Beneficiary	Total Medicaid Beneficiaries by Facility Type	Annual LTC Cost by Facility Type (Medicaid Beneficiaries)	\$ Differential based upon shift in population to community-based care
Home Care	\$18,396.	960	\$17,660,160	
Increase in home care utilization		+25		+\$459,900
Total Home Care			\$18,120,060	
Adult Day Care	\$8,508.	673	\$5,725,884	
Assisted Living	\$13,920.	146	\$2,032,320	
Increase in ALR bed		+25		+\$348,000
Total ALR			\$2,380,320	
Nursing Facilities	\$59,928	5209	\$312,164,952	
Reduction in NF bed		-50		-\$2,996,400
Total Nursing			\$309,168,552	
Totals		6,988	\$335,394,816	Net Savings: \$2,188,500

Q-2, SFY2014 data, *Report to the Rhode Island General Assembly, Senate Committee on Health & Human Services*, June 30, 2014.

Available online at: www.eohhs.ri.gov

State Assumptions:

- Reduction in new Medicaid admissions to nursing facilities as a result in changes in the levels of care = 50 residents
- Half of the total of 50 LTSS clients (25) would access home care and 25 would access assisted living residences
- Increase in number of Medicaid home health agency clients = 25
- Increase in number of Medicaid assisted living residents = 25
- Total Periods: 10
- Discount Rate: 3% over each period
- Transitioning seniors back into community settings and coordinating their care will save the state money in LTSS costs

In addition to cost savings, persons will be enabled to remain where they want to be—at least until they need the intensive care that a nursing facility provides. By 2020, the Medicaid Program’s goal is to spend 50 percent of long-term care expenditures on the elderly and disabled in home and community-based settings.

	Section/Description	Potential Actions	Page/Line
	1500.01 Redesign Of Medicaid Long-Term Services And Supports (LTSS) In Rhode Island Renames and replaces Chapter 0399 “Global Consumer Choice Compact Waiver” Regulations the “Medicaid Long-Term Services And Supports-Interim Rule”		
	A. Overview Adds the Affordable Care Act implementation, the Reinventing Medicaid Initiative and the new integrated eligibility system.		Page 01 Line 01 - P02 L20
	B. Scope and Purpose Create a new Section to take effect on 01/01/16	Delay the effective date (P02 L28)to Section § 42-35-4 of the Administrative Procedures Act “Each rule hereafter adopted is effective twenty (20) days after filing with the secretary of state”	P02 L20 - P2 L29
	C. Applicability Replaces Section 0399.02 “Transition to the Global Waiver”	Insert “/functional” between “clinical” AND “eligibility” ⁶ (P03 L09)	P03 L01 - P03 L12
	1. Scope Updates section		P03 L13 - P03 L24
	2. General Eligibility Creates new section		P03 L25 - P04 L24
	D. Definitions Creates new section - defining: Assisted Living Residence Characteristics Community Supportive Living Program (CSLP)	Insert “/functional” between “clinical” AND “eligibility” (P11 L04)	P05 L01 - P10 L11

⁶⁶ Change from clinical/functional to comprehensive assessment throughout.

	Section/Description	Potential Actions	Page/Line
	Core Home and Community-Based Services (HCBS) Developmental Disabilities Financial Eligibility Functional Disability Habilitation Program Home and Community Based Services Institution Integrated Care Initiative Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) Katie Beckett Eligibility Level of care Long-term Services and Supports (LTSS) LTSS Managed Care Arrangement LTSS Specialist Medicaid-Medicare Dually Eligible (MME) Medicaid Code of Administrative Rules (MCAR) Needs-Based Eligibility Options Counseling Person-centered Planning Program of All Inclusive Care for the Elderly (PACE) Preventive Services Rlte@Home Self-directed care		
	E. Types of Medicaid LTSS Renames & merges Sections 0399.03 Access To Long-Term Care, 0399.04 Types Of Long-Term Care, 0399.04.01 Institutional Long-Term Care , 0399.04.02 Home and Community Based Long-Term Care LTSS ae grouped into 2 categories:		P10 L12 - P12 L21

	Section/Description	Potential Actions	Page/Line
	<p>1. “in an Institutional Setting”, which include: Nursing Facilities (NF); Intermediate Care Facility for the Intellectually Disabled (ICF/ID); Long-term Acute Care Hospital (expanded to include “children in state custody or who have special health care needs that meet the hospital level of care”). Beneficiaries are subject to a co-pay.</p> <p>2. “Medicaid Home and Community-based LTSS”. Beneficiaries are subject to a co-pay.</p>		
	Deleted is Section 0399.04.02.01 Core and Preventive HCB/LTC Services, that lists the services		P12 L22 - P13 L02
	F. Eligibility For Medicaid LTSS - (1) General and Financial Eligibility Requirements Replaces Section 0399.05 Eligibility Requirements	Delay the effective dates (P13 L09, P13 L15, P13 L16, P13 L22) to Section § 42-35-4 of the Administrative Procedures Act “Each rule hereafter adopted is effective twenty (20) days after filing with the secretary of state”	P13 L03 - P14 L25
	(2) Clinical/Functional (CF) Eligibility Criteria. (Effective January 1, 2016) Replaces 0399.05.01 Clinical Eligibility- Scope & Applicability Adds “functional eligibility” criteria to the existing “clinical eligibility” standard	Delay the effective dates (P15 L06, P15 L10, P15 L19, P16 L08, P16 L12 [2x], P16 L16, P16 L19) to Section § 42-35-4 of the Administrative Procedures Act “Each rule hereafter	P14 L26 - P18 L07

	Section/Description	Potential Actions	Page/Line
		<p>adopted is effective twenty (20) days after filing with the secretary of state”</p> <p>Support use of functional criteria</p> <p>Insert “/functional” between “clinical” AND “eligibility” (P15 L06, P18 L04)</p>	
	<p>1500.02 Medicaid LTSS Needs-Based Determinations Replaces 0399.05.01.02 Needs-based LTC Determinations, 0399.05.01.03 LTC Level of Care and Service Option Matrix</p>	<p>Insert “/functional” between “clinical” AND “eligibility” (P18 L12,</p>	<p>P18 L10 - P20 L26</p>
	<p>C. Medicaid LTSS Assessment & Coordination (A&C) Replaces 0399.06 Assessment & Coordination Organization (ACO)</p>	<p>Support the change from “Care Planning” to “Person-centered care planning”</p> <p>Insert “person centered” before “care planning” P22 L27.</p> <p>Insert “/functional” between “clinical” AND “eligibility” (P22 L25)</p> <p><i>Comment nursing home diversion - in assessment & reassessment after home mods.</i></p>	<p>P20 L27 - P26 L09</p>
	<p>D. LTSS Options Counseling Program Replaces 0399.07 LTC Options Counseling Program</p>		<p>P26 L10 - P27 L10</p>
	<p>E. Cost Neutrality For Home And Community- Based Services</p>		<p>P27 L11 - P28 L07</p>

	Section/Description	Potential Actions	Page/Line
	<p>Replaces 0399.08 Cost Neutrality For HBC Services</p> <p>Updates the average monthly costs for institutional settings.</p>		
	<p>1500.03 Determinations of Nursing Facility (NF) Level of Care Replaces 0366.10 Overview Determinations of NF Level Of Care & 0399.10.01 Agency Response for Determining Level of Care</p>		P28 L05 - P29 L25
	<p>B. NF Clinical Eligibility Assessment Tool</p> <p>Replaces 0399.11-Clinical Eligibility Assessment Tool</p>	<p>Insert “/functional” between “clinical” AND “eligibility” (P29 L26, P30 L01)</p>	P29 L26 - P30 L06
	<p>C. Application Of NF Needs-Based Level Of Care Criteria Replaces 0399.12 Application Of NF Level Of Care Criteria, 0399.12.01 Highest Need, 0399.12.01.01 Exceptions -- Highest Need, 0399.12.02 High Need, 0399.12.03 Preventive Need, 0399.12.03.01 Limitations - - Preventive Need</p> <p>Creates categories of assistance: Total dependence, Extensive Assistance, & Limited Assistance</p> <p>Deletes definitions of: Homemaker Services, Minor Environmental Modifications, Personal Care Assistance Services, Physical Therapy Evaluation and Services, & Respite (Revised definitions are in 1500.04)</p>	<p>Insert “/functional” between “clinical” AND “criteria” (P30 L22)</p> <p>Insert “/functional” between “clinical” AND “eligibility” (P30 L25, P34 L32)</p> <p>Delay the effective dates (P32 L24) to Section § 42-35-4 of the Administrative Procedures Act</p> <p>“Each rule hereafter adopted is effective twenty (20) days after filing with the secretary of state”</p>	P30 L07 - P34 L27
	<p>D. Reassessments -- High And Highest Need</p>	<p>Insert “/functional” between “clinical”</p>	P34 L28 - P35 L30

	Section/Description	Potential Actions	Page/Line
	Replaces 0399.13 Reassessments -- High And Highest Need, 0399.13.01 Re-Eval of Beneficiaries with Highest Need	AND "eligibility" (P34 L32)	
	<p>1500.04 HCBS Core And Preventive Services</p> <p>New Section Creates list of services in 2 categories:</p> <p>Core HCBS: Adult Day Services; Adult Supportive Care Homes, Assisted Living; Behavioral Services; Case Management; Community Health Teams; Day Supports (also includes day "habilitation"); Environmental Modifications (also known as Home Accessibility Adaptations); Informal Supports; Home Stabilization; Home Delivered Meals; Home Health Aide; Homemaker; Intermittent Skilled Nursing; LPN Services; Minor Environmental Modifications; PACE - Program for All-Inclusive Care for the Elderly; Participant Directed Goods and Services; Personal Care; Peer Supports; Personal Emergency Response System; Physical Therapy Evaluation and Services; Prevocational Services; Private Duty Nursing; Rehabilitation Services; Residential Supports (also known as habilitation services); Respite; Self-directed Care (also known as "Personal Choice"); Senior Companion (also known as "adult companion services"); Special Medical Equipment (Minor Assistive Devices); Supports for Consumer</p>	<p>Delay the effective dates (P36 L12, P37 L 27, P39 L28) to Section § 42-35-4 of the Administrative Procedures Act "Each rule hereafter adopted is effective twenty (20) days after filing with the secretary of state"</p> <p>Who conducts quality monitoring at assisted livings facilities for non-elders, (demensia)</p> <p>Adult day care populations concern about merging behavioral healthcare clients and elders.</p>	P36 L01 - P42 L27

	Section/Description	Potential Actions	Page/Line
	<p>Direction (also known as “facilitation”); Supported Employment; Supported Living Arrangements (also known as shared-living); & Transition Services.</p> <p>Preventive HCBS: homemaker services; minor environmental modifications; personal care “assistance services; physical therapy evaluation and services; and respite.</p>		
	<p>B. Limitations on The Availability of Medicaid HCBS Replaces 0399.14 Limitations on The Availability of Services</p> <p>Clarifies the policies for waiting lists, priority for limited services and option for highest need to return/admission to nursing facilities until home and community based services are available.</p>		P42 L28 - P43 L29
	<p>1500.05 Limitations on The Scope of Medicaid HCBS Replaces 0399.15 Limitations On Environmental Modifications, Minor Environmental Modifications And Special Medical Equipment, 0399.15.01 Environmental Modifications, 0399.15.02 Special Medical Equipment, 0399.15.03 Environmental Modifications</p>	<p>Replace “Americans with Disabilities Act (ADA) compliance standards” with “Federal Fair Housing Amendments Act Standards” or “Uniform Federal Accessibility Standards (UFAS)” (P46 L14). Residential (single & multi-family) dwelling are exempt from the ADA.</p>	P44 L01 - P51 L01

	Section/Description	Potential Actions	Page/Line
	<p>1500.05 LTSS Residential Service Options -NF Level of Care</p> <p>Replaces 0399.20</p> <p>Overview: LTC Residential Service Options, 0399.20.01 Assisted Living, 0399.20.02 Rlte @ Home (Shared Living), 0399.20.02.01 Scope and Limitations, 0399.21 Progr For All-Inclusive Care For The Elderly,</p> <p>Deletes Sections: 0399.21.01 Involuntary Disenrollment, 0399.21.02 Dept. Approval for Involuntary Disenrollment, 0399.21.03 Notification of the Member, 0399.21.05 Loss Of PACE Enrollment, 0399.21.06 Notification to the Participant, 0399.21.07 Re-enrollment and Transition Out of PACE, & 0399.21.08 Voluntary Disenrollment.</p> <p>Creates 2 options: Assisted Living Residence (ALR) & Community Support Living Program (CSLP).</p>	<p>Retain the word "care" (P53 L28)</p> <p><i>Why use of "adult foster care" language</i></p>	<p>P51 L02 - P57 L39</p>
	<p>1500.06 Severability</p>		<p>P58 L01 - P58 L04</p>
	<p>RI SPA 15-016 Reinventing Medicaid 2015: Rhode Island Integrated Health Homes</p>		
	<p>As part of Governor Gina Raimondo's effort to reform Medicaid, the Working Group to Reinvent Medicaid issued an April report that recommended numerous initiatives to achieve financial savings in State Fiscal Year (SFY) 2016. The Governor introduced those recommendations in a budget article entitled, "The Reinventing Medicaid Act of 2015." The Rhode Island General Assembly passed the Reinventing Medicaid Act in June.</p> <p>As a result of the Act's passage, EOHHS is seeking federal authority to implement several changes to the Medicaid program. This state plan amendment will substantially redesign the state's behavioral health homes to improve treatment and outcomes.</p> <p>Changes included the following:</p>		

	<ul style="list-style-type: none"> • Re-creation of Assertive Community Treatment (ACT). This redesign proposes an ACT for those identified to be in need as established in a standardized level of care/functionality assessment. • Use of a standardized tool to identify functionality and guide level of care planning. • Use of performance metrics tied to quality withholds and incentives. • Unbundling of clinical services leading to greater efficiencies. • Removing minimum contacts for IHH so that resources can be distributed to meet clients need • Increased fee for services rates to increase provision of services which have been largely underutilized in the current structure. • Movement in-plan enhances opportunities for state, plans and programs to establish alternative programming which will improve outcomes • Integrating IHH and treatment services into the full MCO continuum of care will encourage effective system redesign with clinical and financial goals shared across State agencies, MCOs and CMHOs.
	<p><i>Interested persons should submit data, views, or written comments by January 18, 2016 to Darren J. McDonald, Executive Office of Health and Human Services, Hazard Building, 74 West Road, Cranston, RI, 02920, or darren.mcdonald@ohhs.ri.gov.</i></p>

Integrated Health Home: 1

Rhode Island Integrated Health Homes

Introduction:

The full integration of clients' medical and behavioral benefits into managed care creates new opportunities for further clinical integration across the continuum of care. This integration will allow integrated health homes (IHH) greater capacity to work with clients across all levels of care in order to achieve substantial clinical improvement. Services provided through IHHs and Assertive Community Treatment (ACT) are the fixed points of responsibility to coordinate and ensure the delivery of person-centered care, provide timely post-discharge follow-up, and improve patient health outcomes by addressing primary medical, specialist, and behavioral health care. Emphasis is placed on the monitoring of chronic conditions, as well as preventative and educational services focused on self-care, wellness, and recovery.

This program is accountable for reducing health care costs, specifically preventable hospital admissions / readmissions and avoidable emergency room visits. These outcomes are achieved by adopting a whole-person approach to the consumer's needs and addressing the consumer's primary medical, specialist, and behavioral health care needs; and by providing the following timely and comprehensive services:

- Comprehensive Care Management;
- Care Coordination and Health Promotion;
- Comprehensive Transitional Care;
- Individual and Family Support Services; and
- Chronic Condition Management and Population Management.

IHH is built upon the evidence-based practices of the patient-centered medical home model. IHH builds linkages to other community social supports and enhances coordination of medical and behavioral healthcare in keeping with the needs of persons with multiple chronic illnesses. IHH is a service provided to community-based clients by professional mental health staff in accordance with an approved treatment plan for the purpose of ensuring the client's stability and continued community tenure. IHH teams monitor and provide medically necessary interventions to assist in the management of symptoms of illness as well as overall life situations, including accessing needed medical, social, educational, and other services necessary to meeting basic human needs.

Assertive Community Treatment (ACT) is a mental health program made up of a multidisciplinary staff who work as a team to provide the psychiatric treatment, rehabilitation, and support services clients need to achieve their goals. ACT services are tailored for each client to enable each to find and live in their own residence, to find and maintain work, to better manage symptoms, to involve community supports, to achieve individual goals, and to maintain optimism and recover. Unlike other community-based programs, ACT is

34 not a linkage or brokerage case-management program that connects individuals to mental health, housing, or
35 rehabilitation programs or services. Rather, the ACT team is mobile and delivers services in community
36 locations. Seventy-five percent or more of the services are provided outside of program offices in locations
37 that are comfortable and convenient for clients. The clients served have severe and persistent mental illnesses
38 that significantly impact functioning. The ACT teams are available to provide these necessary services 24
39 hours a day, seven days a week, 365 days a year.

1 Integrated Health Home: 2

2 Clients eligible for IHH services will meet diagnostic and functional criteria established by the Department
3 of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH). The required diagnoses are as
4 follows:

- 5 Schizophrenia Schizoaffective Disorder
- 6 Schizoid Personality Disorder Bipolar Disorder
- 7 Major Depressive Disorder, recurrent Obsessive-Compulsive Disorder Borderline Personality Disorder
- 8 Delusional Disorder
- 9 Psychotic Disorder

10 Individuals will also be assessed for eligibility using the Daily Living Activities-Adult Mental Health-a
11 standardized functional assessment of appropriateness for this level of intervention.

12 Provider Infrastructure:

13 Rhode Island has six CMHOs, which along with two other providers of specialty mental health services form
14 a statewide, fully integrated, mental health delivery system, providing a comprehensive range of services to
15 clients. All CMHOs and two specialty providers (Fellowship Health Resources, Inc. and Riverwood Mental
16 Health Services) are licensed by the state under the authority of Rhode Island General Laws and operate in
17 accordance with Rules and Regulations for the Licensing of Behavioral Healthcare Organizations. The six
18 CMHOs, Fellowship Health Resources, Inc. and Riverwood Mental Health Services, will serve as designated
19 providers of CMHO health home services. The six CMHOS, Fellowship Health Resources, Inc. and
20 Riverwood Mental Health Services, represent the only entities that would meet eligibility requirements as a
21 CMHO health home. Each CMHO health home is responsible for establishing an integrated service network
22 statewide for coordinating service provision.

23 CMHO health homes will have agreements, memorandums of understanding, and linkages with other health
24 care providers, in-patient settings and long-term care settings that specify requirements for the establishment
25 of coordinating comprehensive care.

26 The health home teams consist of individuals with expertise in several areas, any team member operating
27 within his or her scope of practice, area of expertise and role or function on a health home team, may be
28 called upon to coordinate care as necessary for an individual,

29 (i.e., the bio-psychosocial assessment can only be conducted as described under Care Management; however,
30 a community support professional operating in the role of a hospital liaison may provide transitional care,
31 health promotion and individual and family support services, as an example).

32 Standards for CMHO health home providers specify that each health home indicate

1 Integrated Health Home: 3

2 how each provider will: structure team composition and member roles in CMHOs to achieve health home
3 objectives and outcomes; coordinate with primary care (which could include co-location, embedded services,
4 or the implementation of referral and follow-up procedures outlined in memoranda of understanding);
5 formalize referral agreements with hospitals for comprehensive transitional care, and carry out health
6 promotion activities.

7 CMHOs will be supported in transferring service delivery by participating in statewide learning activities.
8 Given CMHOs' varying levels of experience with practice transformation approaches, the State will assess
9 providers to determine learning needs. CMHOs will therefore participate in a variety of learning supports, up
10 to and including learning collaboratives, specifically designed to instruct CMHOs to operate as health homes
11 and provide care using a whole-person approach that integrates behavioral health, primary care and other needed
12 services and supports. Learning activities will support providers of health home services in addressing the

13 following components: - Provide quality-driven, cost-effective, culturally appropriate, and person- and family-
14 centered health home services; - Coordinate and provide access to high- quality health care services informed
15 by evidence-based clinical practice guidelines; - Coordinate and provide access to preventive and health
16 promotion services, including prevention of mental illness and substance use disorders; - Coordinate and provide
17 access to mental health and substance abuse services; - Coordinate and provide access to comprehensive care
18 management, care coordination, and transitional care across settings (transitional care includes appropriate
19 follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer
20 from a pediatric to an adult system of health care); - Coordinate and provide access to chronic disease
21 management, including self-management support to individuals and their families; - Coordinate and provide
22 access to individual and family supports, including referral to community, social support, and recovery services;
23 - Coordinate and provide access to long-term care supports and services; - Develop a person-centered treatment
24 plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care
25 related needs and services; - Demonstrate a capacity to use health information technology to link services,
26 facilitate communication among team members and between the health home team and individual and family
27 caregivers, and provide feedback to practices, as feasible and appropriate, and; - Establish a continuous quality
28 improvement program to collect and report on data that facilitates an evaluation of increased coordination of
29 care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and
30 quality of care outcomes at the population level.

31 Service Definitions:

32 **Comprehensive Care Management**

33 Service Definition:

34 Comprehensive care management services are conducted with an individual and involve the identification,
35 development and implementation of treatment plans that address the needs of the whole person. Family/Peer
36 Supports can also be included in the process. The service involves the development of a treatment plan based
37 on the completion of an assessment. A particular emphasis is the use of the multi-disciplinary teams including
38 medical personnel who may or may

1 **Integrated Health Home: 4**

2 not be directly employed by the provider of the health home. The recipient of comprehensive care
3 management is an individual with complex physical and behavioral health needs.

4 Ways Health IT Will Link:

5 CMHO will be required to achieve the following preliminary standards:

- 6 1. Program has structured information systems, policies, procedures, and practices to create, document,
7 implement, and update a treatment plan for every consumer.
- 8 2. Health Home provider has a systematic process/system to follow-up on tests, treatments,
9 services/referrals which is integrated into the consumer's treatment plan.

10 Guidance: Programs have a system/process to identify, track, and proactively manage the care needs
11 of consumers using up-to-date information. In order to coordinate and manage care, the program
12 practice has a system in place to produce and track basic information about its consumer population,
13 including a system to proactively coordinate/manage care of a consumer population with specific
14 disease/health care needs.

- 15 3. The Program has a developed process and/or system which allows the consumer's health information
16 and treatment plan to be accessible to the interdisciplinary provider team, and which allows for
17 population management/identification of gaps in care including preventative services.
- 18 4. Programs are committed to work with Rhode Island's health information exchange system
19 (CurrentCare) and be in compliance with any future version of the Statewide Policy Guidance
20 regarding information, policies, standards, and technical approaches, governing health information
21 exchange.

22 Guidance: Provider is committed to promote, populate, use, and access data through the statewide
23 health information exchange system. Provider is to implement the following tasks: Provider works
24 with RI's Health Information Exchange to ensure they receive the technical assistance in regards to
25 any of the above requirements.

- 26 5. Programs have the capability to share information with other providers and collect specific quality
27 measures as required by EOHHS and CMS.
- 28 6. Program is able to use EOHHS and CMS quality measures as an accountability framework for
29 assessing progress towards reducing avoidable health costs, specifically preventable hospital
30 admissions/readmissions, avoidable emergency room visits, and providing timely post discharge
31 follow-up care.
- 32 Guidance: Provider is committed to and is engaged in utilizing quality measures to improve services.

33 **Care Coordination and Health Promotion**

1 **Integrated Health Home: 5**

2 Service Definition:

- 3 Each client will be assigned a primary case manager who coordinates and monitors the activities of the
4 individual treatment team and has primary responsibility to write the person-centered treatment/care
5 coordination plan, ensure plans are revised as necessary, and advocate for client rights and preferences. The
6 case manager will collaborate with primary and specialty care providers as required. Additionally, the case
7 manager will provide medical education to the client (e.g. educating through written materials, etc.).
- 8 The IHH team is responsible for managing clients' access to other healthcare providers and to act as a partner
9 in encouraging compliance with treatment plans established by these providers.
- 10 Health promotion activities are delivered by the team to engage clients in addressing healthy lifestyles and
11 include services such as smoking cessation, nutrition, and stress management. The MCO and Community
12 Mental Health Organization (CMHO) will meet regularly to review performance metrics and to collaborate
13 on improvement plans. The IHH will coordinate with the client's Primary Care Physician (PCP). These
14 additional plans will be incorporated into the patient's overall treatment plan.

15 Ways Health IT Will Link:

16 CMHO will be required to achieve the following preliminary standards:

- 17 1. Program has structured information systems, policies, procedures, and practices to create, document,
18 implement, and update a treatment plan for every consumer.
- 19 2. Health Home provider has a systematic process/system to follow-up on tests, treatments,
20 services/referrals which is integrated into the consumer's treatment plan.
- 21 Guidance: Programs have a system/process to identify, track, and proactively manage the care needs
22 of consumers using up-to-date information. In order to coordinate and manage care, the program
23 practice has a system in place to produce and track basic information about its consumer population,
24 including a system to proactively coordinate/manage care of a consumer population with specific
25 disease/health care needs.
- 26 3. The Program has a developed process and/or system which allows the consumer's health information
27 and treatment plan to be accessible to the interdisciplinary provider team, and which allows for
28 population management/identification of gaps in care including preventative services.
- 29 4. Programs are committed to work with Rhode Island's health information exchange system and be in
30 compliance with any future version of the Statewide Policy Guidance regarding information, policies,
31 standards, and technical approaches, governing health information exchange.

32 Guidance: Provider is committed to promote, populate, use, and access data through the statewide
33 health information exchange system. Provider is to implement the following

1 **Integrated Health Home: 6**

- 2 tasks: Provider works with RI's Health Information Exchange to ensure they receive the technical
3 assistance in regards to any of the above requirements.
- 4 5. Programs have the capability to share information with other providers and collect specific quality
5 measures as required by EOHHS and CMS.
- 6 6. Program is able to use EOHHS and CMS quality measures as an accountability framework for
7 assessing progress towards reducing avoidable health costs, specifically preventable hospital
8 admissions/readmissions, avoidable emergency room visits, and providing timely post discharge

9 follow-up care.
10 Guidance: Provider is committed to and is engaged in utilizing quality measures to improve services.

11 **Comprehensive Transitional Care**

12 Service Definition:

13 The IHH team will ensure consumers are engaged by assuming an active role in discharge planning. The IHH
14 team will ensure collaboration between consumers and medical professionals to reduce missed appointments
15 and dissatisfaction with care. Specific functions include:

- 16 ❖ Engage with the client upon admission to the hospital and ensure that the discharge plan addresses
17 physical and behavioral health needs. For all medical and behavioral health inpatient stays, the IHH
18 team conducts an on-site visit with client early in the hospital stay, participates in discharge planning,
19 and leads the care transition until the client is stabilized.
- 20 ❖ Upon hospital discharge (phone calls or home visit):
 - 21 • Ensure that reconciliation of pre- and post-hospitalization medication lists is completed.
 - 22 • Assist consumer to identify and obtain answers to key questions or concerns.
 - 23 • Ensure the consumer understands their medications, can identify if their condition is worsening
24 and how to respond, knows how to prevent a health problem from becoming worse, and has
25 scheduled all follow-up appointments.
 - 26 • Prepare the consumer for what to expect if another care site is required (i.e. how to seek immediate
27 care in the setting to which they have transitioned).
- 28 ❖ Identify linkages between long-term care and home and community-based services.

29 Ways Health IT Will Link:

30 The CMHO will be required to achieve the following preliminary standards:

- 31 1. Program has structured information systems, policies, procedures, and practices to create, document,
32 implement, and update a treatment plan for every consumer.
- 33 2. Health Home provider has a systematic process/system to follow-up on tests, treatments,
34 services/referrals which is integrated into the consumer's treatment plan.

1 **Integrated Health Home: 7**

2 Guidance: Programs have a system/process to identify, track, and proactively manage the consumers'
3 care needs using up-to-date information. In order to coordinate and manage care, the program
4 practice has a system in place to produce and track basic information about its consumer population,
5 including a system to proactively coordinate/manage care of a consumer population with specific
6 disease/health care needs.

7 3. The program has a developed process and/or system which allows the consumer's health information
8 and treatment plan to be accessible to the interdisciplinary provider team of providers, and which
9 allows for population management/identification of gaps in care including preventative services.

10 4. Programs are committed to work with Rhode Island's health information exchange system
11 (CurrentCare) and be in compliance with any future version of the Statewide Policy Guidance
12 regarding information, polices, standards, and technical approaches, governing health information
13 exchange.

14 Guidance: Provider is committed to promote, populate, use, and access data through the statewide
15 health information exchange system. Provider is to work with RI's Health Information Exchange to
16 ensure they receive the technical assistance in regards to any of the above requirements.

17 5. Programs have the capability to share information with other providers and collect specific quality
18 measures as required by EOHHS and CMS.

19 6. Program is able to use EOHHS and CMS quality measures as an accountability framework for
20 assessing progress towards reducing avoidable health costs, specifically preventable hospital
21 admissions/readmissions, avoidable emergency room visits, and providing timely post discharge
22 follow-up care.

23 Guidance: Provider is committed to and is engaged in utilizing quality measures to improve services.

24 **Individual and Family Support Services**

25 Service Definition:

26 IHH team will provide practical help and support, advocacy, coordination, and direct assistance in helping
27 clients to obtain medical and dental health care. Services include individualized education about the client's
28 illness and service coordination for clients with children (e.g. services to help client fulfill parenting
29 responsibilities, services to help client restore relationship with children, etc.).

30 IHH peer specialists will help consumers utilize support services in the community and encourage them in
31 their recovery efforts by sharing their lived experience and perspective. Peer support validates clients'
32 experiences, guides and encourages clients to take responsibility for their own recovery. In addition, peer
33 supplies will:

1 **Integrated Health Home: 8**

- 2 • Help clients establish a link to primary health care and health promotion activities,
- 3 • Assist clients in reducing high-risk behaviors and health-risk factors such as smoking, poor illness
4 self-management, inadequate nutrition, and infrequent exercise,
- 5 • Assist clients in making behavioral changes leading to positive lifestyle improvement, and
- 6 • Help clients set and achieve a wellness or health goal using standardized programs such as Whole
7 Health Action Maintenance (WHAM).

8 Ways Health IT Will Link:

9 The CMHO will be required to achieve the following preliminary standards:

- 10 1. Program has structured information systems, policies, procedures, and practices to create, document,
11 implement, and update a treatment plan for every consumer.
- 12 2. Health Home provider has a systematic process/system to follow-up on tests, treatments, and
13 services/referrals which is integrated into the consumer's treatment plan.
14 Guidance: Programs have a system/process to identify, track, and manage the consumers' care needs
15 by using up-to-date information. In order to coordinate and manage care, the program practice has a
16 system in place to produce and track basic information about its consumer population, including a
17 system to proactively coordinate/manage care of a consumer population with specific disease/health
18 care needs.
- 19 3. The program has a developed process and/or system which allows the consumer's health information
20 and treatment plan to be accessible to the interdisciplinary provider team, and which allows for
21 population management/identification of gaps in care including preventative services.
- 22 4. Programs are committed to work with Rhode Island's health information exchange system
23 (CurrentCare) and be in compliance with any future version of the Statewide Policy Guidance
24 regarding information, policies, standards, and technical approaches, governing health information
25 exchange.
26 Guidance: Provider is committed to promote, populate, use, and access data through the statewide
27 health information exchange system. Provider is to work with RI's Health Information Exchange to
28 ensure they receive the technical assistance in regards to any of the above requirements.
- 29 5. Programs have the capability to share information with other providers and collect specific quality
30 measures as required by EOHHS and CMS.
- 31 6. Program is able to use EOHHS and CMS quality measures as an accountability framework for
32 assessing progress towards reducing avoidable health costs, specifically preventable hospital
33 admissions/readmissions, avoidable emergency room visits, and providing timely post discharge
34 follow-up care.

1 **Integrated Health Home: 9**

2 Guidance: Provider is committed to and is engaged in utilizing quality measures to improve services.

3 **Chronic Condition Management and Population Management**

4 Service Definition:

5 The IHH team supports its consumers as they participate in managing the care they receive. Interventions
6 provided under IHH may include, but are not limited to:

- 7 ❖ Assisting in the development of symptom self-management, communication skills, and appropriate
8 social networks to assist clients in gaining effective control over their psychiatric symptoms;
- 9 ❖ Provide health education, counseling, and symptom management to enable client to be knowledgeable
10 in the oversight of chronic medical illness as advised by the client's primary/specialty medical team;
- 11 ❖ Maintaining up-to-date assessments and evaluations necessary to ensure the continuing availability of
12 required services;
- 13 ❖ Assisting the client in locating and effectively utilizing all necessary medical, social, and psychiatric
14 community services;
- 15 ❖ Assisting in the development and implementation of a plan for assuring client income maintenance,
16 including the provision of both supportive counseling and problem-focused interventions in whatever
17 setting is required, to enable the client to manage their psychiatric and medical symptoms to live in
18 the community. This includes:
 - 19 • Provide a range of support services or direct assistance to ensure that clients obtain the basic
20 necessities of daily life, including but not necessarily limited to: financial support and/or benefits
21 counseling;
 - 22 • Teach money-management skills (e.g. budgeting and bill paying) and assist client assessing
23 financial services (e.g. payeehip etc.).
 - 24 • Develop skills related to reliable transportation (help obtain driver's license, arrange for cabs,
25 finds rides).
 - 26 • Provide individual supportive therapy (e.g. problem solving, role playing, modeling and
27 support), social skill development, and assertive training to increase client social and
28 interpersonal activities in community settings) e.g. plan, structure, and prompt social and leisure
29 activities on evenings, weekends, and holidays, including direct support and coaching.
- 30 ❖ Assistance with other activities necessary to maintain personal and medical stability in a community
31 setting and to assist the client to gain mastery over their psychiatric symptoms or medical conditions
32 and disabilities in the context of daily living. For example:

1 Integrated Health Home: 10

- 2 • Support the client to consistently adhere to their medication regimens, especially for clients
3 who are unable to engage due to symptom impairment issues.
- 4 • Accompanying clients to and assisting them at pharmacies to obtain medications.
- 5 • Accompany consumers to medical appointments, facilitate medical follow up.
- 6 • Provide direct support and coaching to help clients socialize - structure clients' time, increase
7 social experiences, and provide opportunities to practice social skills and receive feedback
8 and support.

9 The IHH team will conduct the necessary analysis related to how well they are managing entire
10 populations, based on measurable health outcomes and utilization. This information helps IHHs improve
11 their care delivery system, to the benefit of each IHH clients receiving care.

12 Ways Health IT Will Link:

13 The CMHO will be required to achieve the following preliminary standards:

- 14 1. Program has structured information systems, policies, procedures, and practices to create, document,
15 implement, and update a treatment plan for every consumer.
- 16 2. Health Home provider has a systematic process/system to follow-up on tests, treatments, and
17 services/referrals which is integrated into the consumer's treatment plan.

18 Guidance: Programs have a system/process to identify, track, and manage the consumers' care needs
19 by using up-to-date information. In order to coordinate and manage care, the program practice has a
20 system in place to produce and track basic information about its consumer population, including a
21 system to proactively coordinate/manage care of a consumer population with specific disease/health
22 care needs.

- 23 3. The program has a developed process and/or system which allows the consumer's health information
 24 and treatment plan to be accessible to the interdisciplinary provider team, and which allows for
 25 population management/identification of gaps in care including preventative services.
- 26 4. Programs are committed to work with Rhode Island's health information exchange system
 27 (CurrentCare) and be in compliance with any future version of the Statewide Policy Guidance
 28 regarding information, policies, standards, and technical approaches, governing health information
 29 exchange.
- 30 Guidance: Provider is committed to promote, populate, use, and access data through the statewide
 31 health information exchange system. Provider is to work with RI's Health Information Exchange to
 32 ensure they receive the technical assistance in regards to any of the above requirements.
- 33 5. Programs have the capability to share information with other providers and collect specific quality
 34 measures as required by EOHHS and CMS.

1 **Integrated Health Home: 11**

- 2 6. Program is able to use EOHHS and CMS quality measures as an accountability framework for
 3 assessing progress towards reducing avoidable health costs, specifically preventable hospital
 4 admissions/readmissions, avoidable emergency room visits, and providing timely post discharge
 5 follow-up care.

6 Guidance: Provider is committed to and is engaged in utilizing quality measures to improve services.

7 **Provider Standards:**

8 *Comprehensive Care Management*

9 The IHH and ACT shall provide evidence of compliance with the following:

- 10 1. Service capacity and team composition; roles and responsibilities meet staffing requirements.
- 11 2. A comprehensive and culturally appropriate health assessment is used that yields both subjective and
 12 objective findings regarding the consumer's health needs.
- 13 3. The consumer's treatment plan clearly identifies primary, specialty, community networks and
 14 supports to address identified needs; along with family members and other supports involved in the
 15 consumer's care.
- 16 4. A consumer's treatment plan reflects the consumer's engagement level in goal setting, issue
 17 identification, self-management action, and the interventions to support self-management efforts to
 18 maintain health and wellness.
- 19 5. Service coordination activities use treatment guidelines that establish integrated clinical care
 20 pathways for health teams to provide organized and efficient care coordination across risk levels or
 21 health conditions.
- 22 6. The Program functions as the fixed point of responsibility for engaging and retaining consumers in
 23 care and monitoring individual and population health status to determine adherence or variance from
 24 recommended treatment guidelines.
- 25 7. Routine/periodic reassessment, using the DLA⁷, conducted every 6 months at a minimum, to include
 26 reassessment of the care management process and the consumer's progress towards meeting clinical
 27 and person-centered health action plan goals.
- 28 8. The Program assumes primary responsibility for psychotropic medications, including administration;
 29 documentation of non-psychotropic medications prescribed by physicians and any medication
 30 adherence, side effects, issues etc.

1 **Integrated Health Home: 12**

- 2 9. The Program uses peer supports (certified Peer Recovery Specialists) and self-care programs to
 3 increase the consumer's knowledge about their health care conditions and to improve adherence to
 4 prevention and treatment activities.

⁷ Daily Living Activities assessment

- 22 functioning in their families and in the community, including ensuring transportation to and from
 23 medically necessary services.
- 24 3. Demonstrate communication and information shared with consumers and their families and other
 25 caregivers with appropriate consideration of language, activation level, literacy and cultural
 26 preferences.

27 ***Chronic Condition Management and Population Management***

28 The consumer's medical record shall:

- 29 1. Identify available community-based resources discussed with consumers and evidence of actively
 30 managed appropriate referrals, demonstrate advocating for access to care and

1 **Integrated Health Home: 14**

2 services, and include evidence of the provision of coaching for consumers to engage in self-care and
 3 follow-up with required services.

- 4 2. Reflect policies, procedures, and accountabilities (through contractual or memos of understanding,
 5 affiliation agreements or quality service agreements) to support effective collaboration with
 6 community-based resources, which clearly define roles and responsibilities.

7 **Monitoring:**

8 To assess quality improvements and clinical outcomes, the State will collect clinical and quality of care data
 9 for the CMS Core Set of Measures and state-specific performance measures. These measures may include a
 10 combination of claims, administrative, and qualitative data. Data for each measure will be collected through
 11 defined quality processes aligned to state and provider benchmarks.

12 Attached are the IHH performance measures for each quarter followed by the CMS Core set of Measures.

IHH Year 1 Performance Measures: quarter data collected	Numerator	Denominator	Definition
Quarter 1 Incentive			
Complete DLA	# IHH eligible members during the measurement quarter who have had a completed DLA-20 within the last 6 months	# IHH eligible members during the measurement quarter	% of IHH eligible members who have a completed DLA-20
Quarter 2 Incentive			
BMI	# IHH eligible members during the measurement quarter who have a documented BMI in the proceeding 12 month period	# IHH eligible members during measurement year (Note follow-up documentation to be included in Y2)	Percentage of patients age 18 and older with documented BMI during the current encounter or previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter. Normal Parameters Age 65

IHH Year 1 Performance Measures: quarter data collected	Numerator	Denominator	Definition
			years and older BMI > or = 23 and < 30 Age 18 64 years BMI > or = 18.5 an < 25
Employment Rate	# IHH eligible members during the measurement quarter who are employed (full or part time or in the armed forces as of 06/30/2016	# IHH eligible members during measurement quarter (excluding IHH eligible members whose employment status is “retired” or “unknown”	% of IHH population that report full or part time employment
Discharge for Non-Treatment Adherence	# IHH eligible members during the measurement quarter discharged for non-compliance or who terminate service prior to completion against clinical advice	# IHH eligible members during measurement quarter (unknown data excluded from both)	% IHH eligible members during the measurement quarter discharged for non-treatment adherence
3 Quarter Incentive			
Annual Physical Exam or Well Visit with PCP	# IHH eligible adults with a claim for an annual physical or well visit during the measurement year	# IHH eligible adults during measurement year	85% of population has Annual Physical Exam with PCP
Adults per 1000 for MH and SUD acute inpatient	# IHH eligible members during the measurement quarter with a psychiatric or substance use inpatient hospital admission (Not ASU/CDU)	Total number of adults in RI X 1000	Need to establish Baseline Measurement and Target for Year 1
Patient Satisfaction Survey	Number of estimated attributed members who Strongly Agree or Agree with questions 7 – 12 of the OEI.	All estimated attributed members responding to the OEI (unknown number excluded from both when 1/3 or more of measures are missing)	Questions 7-12 % Responses Strongly Agree or Agree
4 Quarter Incentive			
Mental Health Inpatient After Care Follow Up 3 Days	# IHH eligible adults who have a face to face visit with any member of the IHH team within 3 business days of a psychiatric hospital discharge (not including the discharge day)	# of IHH eligible adults with a psychiatric hospitalization during measurement year	90% of members who have a MH Inpatient Admission will receive 1 face to face contact by a IHH member within 3 business days of discharge
Mental Health Inpatient After Care	Number of adults receiving inpatient care	Number of adults who had an encounter with	Follow HEDIS specs for members who received an

IHH Year 1 Performance Measures: quarter data collected	Numerator	Denominator	Definition
Follow Up 7 Days		MH Practitioner or Prescriber within 7 business days of discharge	appointment by an MH Practitioner or Prescriber within 7 business days of discharge
Hospital 30-Day Readmission All Cause Med, Surg. BH	Number of adults admitted to a hospital for any reason	Number of adults readmitted to a hospital 30 days after discharge from a hospital admission	The percentage of acute inpatient stays that were followed by a readmission within 30 days for any reason in adults ages 18 or older.
Total Cost of Care	Total cost of care for all adults itemized by plan and unenrolled		Identify decrease in total cost of care from SFY 15 to SFY 16
IHH Year 1 Monitoring Measures			
Stable Housing	Number of estimated attributed member who are living in private, public or residential settings.	All estimated attributed members (unknown data excluded from both.)	% of population who report stable housing (Private/Subsidized)
Smoking Cessation	Rate 1: Screening for tobacco use in patients with serious mental illness during the measurement year or prior to the measurement year and received follow-up care if identified as a current tobacco user.	Rate 1: All patients 18 years of age or older as of December 31 of the measurement year with at least one inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year.	75% of members referred smoking cessation counseling/medication evaluation (NQF Specs)
Acuity Level Transition	1.) # ACT clients in prior month in IHH of FFS in current month 2.) # IHH clients in prior month in ACT or FFS in current month 3.) # FFS clients in prior month in IHH or ACT current month	Admits and discharges not included	% of members who Transition from High to Moderate or Low Acuity & % of members who Transition from Low or Moderate Acuity to High
ED Visits/1000	Number of ED visits	Number of enrollee months	Rate of ED visits per 1,000 enrollee months among HH Enrollees. A total rate as well as rates for the following age cohorts should be reported:

IHH Year 1 Performance Measures: quarter data collected	Numerator	Denominator	Definition
			0-17, 18-64 and 65+.
Inpatient Average Length of Stay	UHC & NHP please provide numerator methodology	UHC & NHP please provide denominator methodology	Average Length of Stay for Inpatient (by Medical, MH, & SUD)
Comprehensive Diabetes Care Hemoglobin Alc (HbAlc) ⁸ Poor Control (>9.0%)	# IHH eligible clients whose most recent HbAlc level is greater than 9.0% (poor control) during the measurement year.	# IHH eligible clients with a diagnosis of diabetes (excluding gestational or steroid induced diabetes)	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbAlc level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbAlc test was not done during the measurement year.
Screening for Clinical Depression and Follow Up	All patients age 12 and older	# of patients screened for clinical depression on the date of encounter using an age-appropriate standardized depression screening tool, and if positive, a follow up plan is documented on the date of the positive screen.	Percentage of Health Home enrollee age 12 and older screened for clinical depression using an age appropriate standardized depression screening tool, and if positive, a follow up plan is documented on the date of the positive screen.
Controlling High Blood Pressure	Patients 18 to 85 years of age by the end of the measurement year who had at least one outpatient encounter with a diagnosis of hypertension (HTN) during the first six months of the measurement year.	The number of patients in the denominator where recent BP is adequately controlled during the measurement year. For a patient's BP to be controlled, both the systolic and diastolic BP must be <140/90 (adequate control). To determine if a patient's BP is adequately controlled, the representative BP must be identified.	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year. Single rate is reported.
Care Transition-Timely Transmission of Transition Record	All patients, regardless of age, discharged from an inpatient facility (e.g, hospital inpatient or	Patients for whom a transition record was transmitted to the facility or primary physician or	Percentage of discharges from an inpatient facility to home or any other site

⁸ a measure of blood sugar control over the past 2 to 3 months.

IHH Year 1 Performance Measures: quarter data collected	Numerator	Denominator	Definition
	observation; skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care	other health care professional designated for follow-up care within 24 hours of discharge	of care which a transition record was .transmitted to the facility, home health provider or primary physician/other health professional designated for follow up care within 24 hours of discharge among health home enrollees
Initiation & Engagement of Alcohol and other Drug Dependency Treatment	Patients age 13 years of age and older who were diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and ½ months of the measurement year (e.g. January 1 – November 15).	Initiation of AOD treatment through an inpatient admission, outpatient encounter or partial hospitalization within 14 days of diagnosis. Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOOD diagnosis within 30 days after the date of the Initiation encounter (inclusive).	Percentage of health home enrollees age 13 or older with a new episode of alcohol or other drug dependence who: initiated treatment through an inpatient admission, outpatient visit, IOP, or PHP within 14 days of diagnosis. Initiated treatment and who had 2+ services within a diagnosis of AOD within 30 days of initiation visit.
Prevention Quality Indicator (PQI 92: Chronic Conditions Composite	Population ages 18 years and older in metropolitan area ⁹ or county. Discharges in the numerator are denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.	Discharges, for patients ages 18 years and older, that meet the inclusion and exclusion rules for the numerator in any of the following PQIs: PQI #1 Diabetes Short-Term Complications Admission Rate PQI#3 Diabetes Long-Term Complications Admissions Rate PQI#5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate PQI#7 Hypertension Admission Rate	Number of hospital admissions for chronic conditions per 100,000 member months for health home enrollee age 18 and older.

⁹ Foot note not included in regulation

IHH Year 1 Performance Measures: quarter data collected	Numerator	Denominator	Definition
		PQI#8 Heart Failure Admission Rate PQI#13 Angina Without Procedure Admission Rate PQI#14 Uncontrolled Diabetes Admission Rate PQI#16 Lower-Extremity Amputation among Patients with Diabetes Rate Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator.	
Inpatient Utilization	Inpatient utilization by discharge date, rather than by admission date and include all discharge that occurred during the measurement year.	Number of enrollee months	Rate of acute inpatient care and services (total, maternity, mental and BH, surgery and medicine) per 1,000 enrollee months among HH enrollees. A total rate as well as rates for the following age cohorts should be reported: 0-17, 18-64, 65+.
Nursing Facility Utilization			The number of admissions to a nursing facility from the community that results in a short term (less than 101 days) or long term stay (greater than or equal to 101 days) during the measurement year per 1,000 enrollment months. A total rate as well as rate for the 18-64 age cohort and 65 and older age cohort should be reported.

1 [Integrated Health Home: 21](#)

2 **Payment Methodology:**

3 **Per Diem Rate to CMHO for Integrated Health Home (IHH) and Assertive Community Treatment**
4 **(ACT)**

5 1. The State will establish a fee structure designed to enlist participation of a sufficient number of providers
6 in the IHH and ACT program so that eligible persons can receive the services included in the plan, at least to
7 the extent that these are available to the general population.

8 2. Providers must be Community Mental Health Centers or other private, not-for-profit providers of mental
9 health services who are licensed by the Rhode Island Department of Behavioral Healthcare, Developmental
10 Disabilities and Hospitals (BHDDH).

11 3. All providers must conform to the requirements of the current Rules and Regulations for the Licensing of
12 Behavioral Healthcare Organizations, and all other applicable state and local fire and safety codes and
13 ordinances.

14 4. Providers must agree to contract and accept the rates paid by the Managed Care Organization as
15 established with the Executive Office of Health and Human Service (EOHHS) and BHDDH as the sole and
16 complete payment in full for services delivered to beneficiaries, except for any potential payments made from
17 the beneficiary's applied income, authorized co-payments, or cost sharing spend down liability.

18 5. Providers must be enrolled in the RI Medicaid Program, have a contract with the Managed Care
19 Organizations and agree to meet all requirements, such as, timely access to care and matching beneficiaries
20 service needs.

21 6. The State will not include the cost of room and board or for non-Medicaid services as a component of the
22 rate for services authorized by this section of the state plan.

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2 7. The State will pay for services under this section on the basis of the methodology described in 12-14 of
3 this document.

4 8. The amount of time allocated to IHH and ACT for any individual staff member is reflective of the actual
5 time that staff member is expected to spend providing reimbursable IHH and ACT services to Medicaid
6 recipients.

7 9. Providers will be required to collect and submit complete encounter data for all IHH/ACT claims on a
8 monthly basis utilizing standard Medicaid coding and units in an electronic format to be determined by
9 EOHHS, BHDDH and Managed Care Organizations. Six months after the effective date of this SPA and
10 following the receipt of encounter data, the state will conduct an analysis of the data to develop recipient
11 profiles, study service patterns, and analyze program costs vs. services received by recipients, for potential
12 adjustments to the case rate as well as for consideration of alternative payment methodologies.

13 Analysis will be conducted annually after the first six month review.

14 10. The State assures that IHH and ACT services under this submission will be separate and distinct and that
15 duplicate payment will not be made for similar services available under other program authorities.

16 11. The rates were set as of January 1, 2016 and are effective through the state fiscal year, pending
17 additional analysis for services. All rates are published on the RI EOHHS website at
18 <http://www.dhs.ri.gov/forProvidersVendors/MedicalAssistanceProviders/FeeSchedules/tabid/170/Default.aspx>.

19 **12. Basis for IHH Methodology for IHH:**

20 The process is based on a CMS approved methodology that utilizes reliable estimates of the actual costs to the
21 provider agencies for staff and operating/support and then feeding those costs into a fee model. The process
22 also included the development of a standard core IHH team composition and suggested caseload based on
23 estimates of available staff hours and client need.

24 Flexibility is given to the providers for the costs of the entire team. Ten positions are noted as core expectations
25 that consists of one (1) Master's level coordinator, two (2) registered nurses, one (1) hospital liaison, five (5)
26 CPST specialists and one (1) peer specialist.

27 Agencies will also be able to flex staff by need to certain teams. Agencies are still accountable to the entire
28 number of staff, cost and salaries for all positions for Health Homes of the agency.

29 Any deviation from the model must have clinical and financial justification that is approved by BHDDH, the
 30 state Mental Health Authority. The goal is to give providers flexibility so that providers are able to manage
 31 the team to obtain the outcomes.

32 **Staffing Model (per 200 clients):**

<u>Title</u>	<u>FTE</u>
Master's Level Program Director	1
Registered Nurse	2
Hospital Liaison	1
CPST Specialist	5-6
Peer Specialist	1
Medical Assistant	1 (optional)

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	IHH				
	OCCUPANCY	100.0%			
	CLIENTS	200			
Program Staff:					
Qualifications:			FTE	Cost/FT	Total
Master's Level Coordinator			1.0	\$78,817	\$78,817
Registered Nurse			2.0	\$81,500	\$81,500
Hospital Liaison			1.0	\$44,200	\$44,200
CPST Specialist BA			6.0	\$44,200	\$44,200
Peer Specialist			1.0	\$43,711	\$43,711
Medical Assistant			1.0	\$39,738	\$39,738
					\$634,666
			12.0		
	Fringe (Included in base cost)				0
Total base staff cost					\$634,666
Total all staff cost					\$634,666
Total administration and operating at state average				40%	\$253,866
Total all costs					\$888,532
Per diem:			\$12.17		
PMPM			\$370.22		

2 **13. Basis of Methodology for ACT:**

3 The State has reviewed ACT rates across the country and we have done a cost base review with our providers
 4 to determine the rate. Providers report that due to the intensity and the extended hours of the program; and
 5 the additional responsibility of providing an integrated health home

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2 service to our most vulnerable population; salaries and wages that are typical for these positions are increased.
 3 State and Managed Care oversight for model fidelity will be implemented to assure outcomes.
 4 Rhode Island has compared our ACT rates to other states providing just ACT services. For example, New
 5 York has rates between \$1482-1716 per month, Nebraska is \$1311-\$1396 per month, North Carolina is the
 6 lowest at \$1181.28 per month and Maryland is \$1183.34 per month. Rhode Island's rate is \$1267 per month
 7 and was reviewed with providers of 12.75 staff per 100 clients. The per diem will be \$41.65.

8 **Required Staffing Model per 100 clients:**

<u>Title</u>	<u>FTE</u>
Program Director (LICSW, LMHC, LMFT, RN)	1
Registered Nurse	2
Master's Level Clinician	1
Vocational Specialist (BA level)	1
Substance Use Disorder Specialist (BA level)	2
CPST Specialist	4
Peer Specialist	1
Psychiatrist	.75

9 **14. Payment Methodology Withhold:**

10 All CMHOs will be required to report to the MCOs and RI Medicaid on a quarterly basis on a set of Year
 11 1 required metrics. EOHHS and BHDDH support the importance of standardized reporting on outcome
 12 measures to ensure providers are increasing quality so clients make gains in overall health.

13 CMHO's will receive 90% of IHH and 90% of the health home services imbedded in the ACT rate. If the
 14 CMHO is able to demonstrate meeting the minimum quarterly reporting requirements and identified quality
 15 thresholds, the CMHC will receive the additional 10% payment from the MCOs. The 10% payment will be
 16 reconciled after all reports are received and approved by BHDDH and the Managed Care Organizations.

17 Attached are the performance metrics for the withhold

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IHH Year 1 Performance Measures: quarter data collected	Numerator	Denominator	Definition
Quarter 1 Incentive			
Completed DLA	# IHH eligible members during the measurement quarter who have had a complete DLA-20 within the last 6 months	# IHH eligible members during measurement quarter	% of IHH eligible members who have a completed DLA-20
Quarter 2 Incentive			
BMI	#IHH eligible members during the measurement quarter who have a documented BMI in the preceding 12 month period	# IHH eligible adults during measurement year (Note: Follow-up documentation to be included in Y2)	Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six

IHH Year 1 Performance Measures: quarter data collected	Numerator	Denominator	Definition
			months of the encounter. Normal Parameters: Age 65 years and older BMI > or= 23 and < 30 Age 18 - 64 years BMI > or= 18.5 and < 25
Employment Rate	# IHH eligible members during the measurement quarter who are employed (full or part time) or in the armed forces as of 06/30/2016	# IHH eligible members during the measurement quarter (excluding IHH eligible members whose employment status is "retired" or "unknown")	% of IHH population that report part or full time employment
Discharge for Non-Treatment Adherence	Number of IHH eligible members during measurement quarter discharged for non-compliance or who terminated service prior to completion against clinical advice.	Number of IHH eligible members during measurement quarter (unknown data excluded from both)	% of IHH members during the measurement period discharged for non-treatment adherence
Quarter 3 Incentive			
Annual Physical Exam or Well Visit with PCP	# IHH eligible adults with a claim for an annual physical or well visit during the measurement year	# IHH eligible adults during measurement year	85% of population has Annual Physical Exam with PCP
Adults per 1000 for MH and SUD acute inpatient	# IHH eligible members during the measurement quarter with a psychiatric or substance use inpatient hospital admission (Not ASU/CDU)	Total number of adults in RI X 1000	Need to establish Baseline Measurement and Target for Year 1
Patient Satisfaction Survey	Number of estimated attributed members who Strongly Agree or Agree with questions 7 – 12 of the OEI.	All estimated attributed members responding to the OEI (unknown number excluded from both when 1/3 or more of measures are missing)	Questions 7-12 % Responses Strongly Agree or Agree
4 Quarter Incentive			
Mental Health Inpatient After Care Follow Up 3 Days	# IHH eligible adults who have a face to face visit with any member of the IHH team within 3 business days of a psychiatric hospital discharge (not including the discharge day)	# of IHH eligible adults with a psychiatric hospitalization during measurement year	90% of members who have a MH Inpatient Admission will receive 1 face to face contact by a IHH member within 3 business days of discharge

IHH Year 1 Performance Measures: quarter data collected	Numerator	Denominator	Definition
Mental Health Inpatient After Care Follow Up 7 Days	Number of adults receiving inpatient care	Number of adults who had an encounter with MH Practitioner or Prescriber within 7 business days of discharge	Follow HEDIS specs for members who received an appointment by an MH Practitioner or Prescriber within 7 business days of discharge
Hospital 30-Day Readmission All Cause Med, Surg. BH	Number of adults admitted to a hospital for any reason	Number of adults readmitted to a hospital 30 days after discharge from a hospital admission	The percentage of acute inpatient stays that were followed by a readmission within 30 days for any reason in adults ages 18 or older.
Total Cost of Care	Total cost of care for all adults itemized by plan and unenrolled		Identify decrease in total cost of care from SFY 15 to SFY 16

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	Section/Description	Potential Actions	Page/Line
	<p>RI Integrated Health Homes (IHH) Introduction: “Services provided through IHHs and Assertive Community Treatment¹⁰ (ACT) are the fixed points of responsibility to coordinate and ensure the delivery of person-centered care, provide timely post-discharge follow-up, and improve patient health outcomes by addressing primary medical, specialist, and behavioral health care.”</p>	<p>Support the person-centered care & integration of physical, medical and behavioral health service model</p>	<p>P01 L01 - P02 L11</p>
	<p>Provider Infrastructure: Identifies the providers: The six CMHOs, Fellowship Health Resources, Inc. and Riverwood Mental Health Services, and two specialty providers Fellowship Health Resources, Inc. and Riverwood Mental Health Services.</p>	<p>Question does identifying the providers in a state plan amendment, prohibit other entities? What happens with duals DD +</p>	<p>P02 L12 - P03 L30</p>

¹⁰ ACT mental health program made up of a multidisciplinary staff

	Section/Description	Potential Actions	Page/Line
		BH receive primary from DD provider	
	<p>Service Definitions: Describes “Service Definitions” and “Ways Health IT Will Link: “ for: Comprehensive care management services, Care Coordination and Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services, & Chronic Condition Management and Population Management</p>		P03 L31 - P11 L06
	<p>Provider Standards: Creates standards for: Comprehensive care management services, Care Coordination and Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services, & Chronic Condition Management and Population Management</p>	<p>Use comprehensive in LLTSS regs in place of clinical/functional</p> <p>Care team needs to include for duals both DD & BH.</p> <p>In LTSS home mod to specific.</p>	P11 L07 - P14 L06
	<p>Monitoring Sets clinical and quality of care data standards, outlined in tables, Measuring: Daily Living Activities (DLA); Body Mass Index (BMI); Employment Rate; Discharge for Non-Treatment Adherence; Annual Physical Exam or Well Visit with PCP; MH and SUD acute inpatient admissions; Patient Satisfaction; Mental Health Inpatient After Care Follow Up 3 Days & 7 Days; Hospital 30-Day Readmission All Cause Med, Surg. BH; Total Cost of Care; Stable Housing; Smoking Cessation; Acuity Level Transition; Emergency Department (ED) Visits;</p>	<p>Footnote 8 regarding “metropolitan area” in “Prevention Quality Indicator (PQI 92: Numerator” is missing. Spell out acronyms (BMI, DLA, ED, HEDIS, SUD) first time used.</p>	P14 L07 - P20 L31

	Section/Description	Potential Actions	Page/Line
	Inpatient Average Length of Stay; Comprehensive Diabetes Care Hemoglobin Alc (HbAlc) Poor Control; Screening for Clinical Depression and Follow Up; Controlling High Blood Pressure; Care Transition-Timely Transmission of Transition Record; Initiation & Engagement of Alcohol and other Drug Dependency Treatment; Prevention Quality Indicator (PQI 92: Chronic Conditions Composite; Inpatient Utilization; and Nursing Facility Utilization		
	12. Payment Methodology: Describes payment rates for Community Mental Health Organizations (CMHO) and IHH Staffing Model	Section numbers begin with 12. Is the staffing model a required or caped rate?	P21 L01 - P22 L33
	13. Basis of Methodology for ACT: Required Staffing Model		P23 L02 - P24 L07
	14. Payment Methodology Withhold: Performance metrics for the withhold, from monitoring criteria		P24 L09 - P25 L02
	Motion moved by __, seconded by __, <i>passed/unanimous/ opposed by_/ abstained_ / defeated/ supported by__</i>		
	<i>4:25 Agenda for the Next Meeting, Linda Ward</i>		
	Purpose/Goal: To set the agenda for the next meeting.		
	Discussion: The Legislation Committee meetings in 2015 will be on the 1 st Monday 3 - 4:30 PM: 01/05 th ; 02/02 nd ; 03/02 nd ; 04/06 th ; 05/4 th ; 06/01 st ; 07/06 th ; 08/10 th ; 09/21 st ; 11/02 nd ; and 12/07 th .		
	MOTION: Meeting on Monday 01-11-16 to consider both regulations Motion moved by TF, seconded by AP, passed unanimously		
	<i>4:30 Adjournment, Linda Ward</i> Potential MOTION: To adjourn at 4:17 Motion moved by AP, seconded by JR, passed unanimously		