

	<p align="center">Governor's Commission on Disabilities Legislation Committee Monday, January 4, 2016 3:00 PM - 4:30 PM John O. Pastore Center, 41 Cherry Dale Court, Cranston, RI 02920-3049 (voice) 401-462-0100 (fax) 462-0106 (tty) via RI Relay 711 (e-mail) gcd.disabilities@gcd.ri.gov (website) www.disabilities.ri.gov Follow us on twitter@ri_disabilities</p>
	<p>Attendees: Linda Ward (Chair.); Jack Ringland (Vice Chair.); Casey Gartland; Arthur M. Plitt; Angelina Stabile Absentees: Rosemary C. Carmody; Regina Connor; Linda Deschenes; Timothy Flynn; Kathleen Heren; William R. Inlow; Kathy Kushnir; Paula Parker; Msgr. Gerard O. Sabourin; Meredith Sheehan; & Dawn Wardyga Guests: Robert Marshall (DDC)</p>
	<p>Staff: Bob Cooper</p>
	<p>3:00 Call to Order and Acceptance of the Minutes, Linda Ward, Chair Vice Chair calls the meeting to order at 3:15 PM Introductions of Commissioners and guests</p>
	<p>MOTION: To accept the minutes of the previous meeting as presented Motion moved by CG, seconded by AP, passed unanimously</p>
<p align="center">Action Items:</p>	
	<p>3:05 Proposed Amendments to the State's Medicaid Regulations, Bob Cooper</p>
	<p>Purpose/Goal: To review and comment on proposed RI Medicaid State Plan amendments</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). 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</p>

calendar year 2016 and thereafter.
 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 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.

*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)

RI Legal Services is concerned with the more restricted highest eligibility for Home & Community Based Care

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

C. APPLICATION OF NF **NEEDS-BASED** LEVEL OF CARE CRITERIA

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

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

1500.04 HCBS CORE AND PREVENTIVE SERVICES

~~0399.14~~ **B.** LIMITATIONS ON THE AVAILABILITY OF ~~SERVICES~~
MEDICAID HCBS

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

(1) Highest Need – NF and Hospital. Beneficiaries with the highest need ~~shall~~ have the option of seeking admission to a nursing facility while awaiting access to the full scope of home and community-based services. ~~Specifically, beneficiaries and applicants~~ Accordingly, applicants/beneficiaries deemed to be in the highest category for a nursing facility level of care or meet the requirement for a hospital level of care are entitled to services and ~~shall not be~~ must not be placed on a waiting list for ~~institutional services~~ Medicaid LTSS in an institutional setting. If a community placement is not initially available, beneficiaries with the highest

need^{add} may be placed on a wait list for transition to the community ^{add}while receiving services in a licensed health facility that provides the type of institutionally based LTSS that meets their needs. Different limitations apply for beneficiaries requiring an ICF/ID level of care as is determined by BHDDH under applicable federal and state laws and regulations^{add}.

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

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

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

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

**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

1 ~~{delete}~~0399 – THE GLOBAL CONSUMER CHOICE WAIVER~~{delete}~~

2 ^{add}**CHAPTER 1500**

3 **MEDICAID LONG-TERM SERVICES AND SUPPORTS-INTERIM RULE**

4 **1500.01 REDESIGN OF MEDICAID LONG-TERM SERVICES AND SUPPORTS (LTSS) IN**
5 **RHODE ISLAND**

6 **A. Overview^{add}**

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

8 ~~(add)~~In 2009, the State received approval for an innovative Medicaid Section 1115 Demonstration Waiver. Until
9 2013, the demonstration was known as the “Global Consumer Choice Compact Waiver (Global Waiver)” due
10 to its unique financing arrangement in which the State and our federal partners mutually agreed to an aggregate
11 cap on the bulk of Medicaid spending.~~(add)~~ One of the most important goals of the ~~(delete)~~Global Consumer
12 Choice Compact Waiver~~(delete)~~ Global Waiver is~~(add)~~was to reduce overutilization of high cost institutionally
13 based care by~~(add)~~ ~~(delete)~~ensure that every beneficiary receives~~(delete)~~ ~~(add)~~ensuring that every Medicaid
14 beneficiary was able to access~~(add)~~ the appropriate services, at the appropriate time, and in the appropriate and
15 least restrictive setting. To achieve this goal for ~~(add)~~Medicaid-funded~~(add)~~ long-term ~~(delete)~~care~~(delete)~~ (LTC)
16 services ~~(add)~~and supports (LTSS~~(add)~~), the waiver ~~(delete)~~provides~~(delete)~~~~(add)~~provided~~(add)~~ the State with the
17 authority to collapse its existing section 1915 (c) home and community based service waivers (HCBS),
18 ~~(delete)~~which have different eligibility criteria and services, into its newly approved section 1115 (a) Global Waiver.
19 ~~(delete)~~to standardized eligibility requirements to the full extent feasible to both reduce the bias toward
20 institutional care and promote less costly and restrictive alternatives. ~~(add)~~ ~~(delete)~~Under the Global Waiver~~(delete)~~

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

Proposed Rules: 1

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

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
25 updating the applicable rules is to create a new chapter in the Medicaid Code of Administrative Rules
26 (MCAR) that sets forth in plain language the rules governing LTSS and, as such, serves as companion to
27 the MCAR chapters governing Medicaid Affordable Care Coverage (Section 1300 *et seq.*). Toward this end,

28 the purpose of this rule is to establish the provisions that implement the reforms beginning on January 1, 2016
29 and to provide a summary of changes that will take effect during calendar year 2016 and thereafter.^{add}

30 Proposed Rules: 2

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

13 (1) **Scope.** Medicaid LTSS in a home and community-based setting is a service authorized by the state’s
14 Section 1115 waiver or, in a limited number of circumstances, the Medicaid State Plan.^{add} The authority for the
15 State-~~{delete}~~ of Rhode Island~~{delete}~~ to provide home and community-based services ~~{delete}~~ transitions~~{delete}~~ ^{add} was
16 derived initially^{add} from ~~{delete}~~ the authority found in~~{delete}~~ ^{add} Section^{add} 1915(c) of the Social Security Act
17 ^{add} and transitioned to the State’s^{add} ~~{delete}~~ to that found in~~{delete}~~ Section 1115 ^{add} demonstration waiver^{add}
18 ~~{delete}~~ of the Act~~{delete}~~ on July 1, 2009. The transition in authority ~~{delete}~~ allows~~{delete}~~ ^{add}, which was continued in
19 the waiver extension of 2013, allowed^{add} the State to implement new needs-based levels of care, expand the
20 number of individuals that can access ~~{delete}~~ long term care services, and increase the availability of home and
21 community based services. On June 1, 2009 letters were sent to all Home and Community-based Waiver
22 participants notifying them of the transition in authority. The agencies with authority to determine access for
23 LTC prior to July 1, 2009, shall retain that authority subsequent to the transition date unless otherwise
24 stated in this rule.~~{delete}~~ ^{add} LTSS and standardize and streamline the eligibility criteria across programs and
25 settings.

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

30 Proposed Rules: 3

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
7 from 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
15 disabilities) (MCAR, Section 0390.05); and
- 16 • Medicaid Affordable Care Coverage (MACC) for adults ages nineteen (19) to sixty-four (64), who
17 have income at or below 133 percent of the FPL and are not eligible or enrolled in Medicare or
18 Medicaid 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
20 community-based LTSS accessible to children, living at home, who require the level of care typically
21 provided in an 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.

24 Proposed Rules: 4

1 **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
5 by means of contracts or arrangements personal assistance and may include the delivery of limited health
6 services, as defined under subsection 23-17.4-2(12) of the Rhode Island General Laws, as amended (RIGL), to
7 meet the resident's changing needs and preferences, lodging, and meals to six (6) or more adults who are
8 unrelated to the licensee or administrator, excluding however, any privately operated establishment or facility
9 licensed pursuant to chapter 17 of title 23 RIGL, and those facilities licensed by or under the jurisdiction
10 of the department of behavioral healthcare developmental disabilities, and hospitals, the department of
11 children, youth, and families, or any other state agency. The department of health shall develop levels of
12 licensure for assisted living residences within this definition as provided in § 23-17.4-6 RIGL. Assisted living
13 residences include sheltered care homes, and board and care residences or any other entity by any other name
14 providing the services 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
25 mental 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
6 (SNAP), General Public Assistance (GPA) and various other services and programs under the jurisdiction
7 of the Division of Elderly Affairs, Office of Rehabilitative Services, and Division of Veterans Affairs. The
8 DHS has been delegated the authority through an interagency service agreement with the Executive Office of
9 Health and Human Services, the Medicaid Single State Agency, to determine Medicaid eligibility in accordance
10 with 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
16 principal agency of the executive branch for the purposes of managing the departments of Children, Youth,
17 and Families (DCYF); Health (DOH); Human Services (DHS); and Behavioral Healthcare, Developmental
18 Disabilities, and Hospitals (BHDDH). The EOHHS is designated as the “single state agency,” authorized

19 under Title XIX of the U.S. Social Security Act (42 U.S.C. § 1396a et seq) and, as such, is legally responsible
20 for the program / fiscal 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,
24 or impairment.

25 **Proposed Rules: 6**

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
5 the competencies and abilities needed for optimal functioning in interaction with the environment. Habilitative
6 and rehabilitative services and devices are mandated as essential health benefits (“EHB”) in Section 1302 of
7 the Patient Protection and Affordable Care Act (ACA).

8 Home and Community-Based Services means any services that are offered to Medicaid LTSS
9 beneficiaries who have needs requiring and institutional level of care in the home or community- based
10 setting that are authorized under the Medicaid State Plan or the State’s demonstration waiver authorized under
11 section 1115 of 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-
18 one (21) or older. In Phase II, under the authority of a special federal waiver, full integration and management
19 of all Medicare and Medicaid covered services for fully dual eligible participants will be provided. Service
20 delivery in Phase II is governed by three-party contractual agreement involving the EOHHS, federal partners at
21 CMS, and 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
25 their functional status and independence. This setting is an alternative to home and community-based services
26 for 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
2 long-term disabilities or complex medical needs who require an institutional level of care to obtain the Medicaid
3 long-term services they need at home. With Katie Beckett eligibility, only the child’s income and resources
4 are considered when determining eligibility.

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

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

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

14 LTSS Specialist means a State agency representative responsible for determining eligibility for long- term
15 services and supports, authorizing such services and supports and assisting applicants and beneficiaries in
16 navigating the system. The term does not apply to EOHHS, Office of Medicaid Review (OMR) clinical staff,
17 but does refer to agency representatives such as DHS eligibility personnel (including social workers)

18 assigned to Medicaid LTSS and staff from the EOHHS and other agencies that administer programs associated
19 with each respective institutional level of care.
20 Medicaid-Medicare Dually Eligible (MME) means and includes persons who meet the applicable Medicaid
21 eligibility criteria related to income, age, disability status, and/or functional need and are also entitled to benefits
22 under Medicare Parts “A” and are enrolled under Medicare Parts “B” and “D.”

23 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
5 eligible for Medicaid benefits, based upon whether the individual or family meets the requirements set forth in
6 statute, 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
9 in 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.
11 It is based on the values of human rights, interdependence, choice and social inclusion, and can be designed
12 to enable people to direct their own services and supports, in a personalized way. Person-centered planning
13 is not one clearly defined process, but a range of processes sharing a general philosophical background, and
14 aiming at similar outcomes. Person-centered planning is also a process directed by an individual, with
15 impartial assistance when helpful, focusing on their desires, goals, needs, and concerns to develop supports
16 to live a meaningful 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
21 a 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
7 exercise choice and control over a specified amount of the funds for and the providers who deliver the long-
8 term services and supports they need as identified in an Individual Service and Spending Plan (ISSP) developed
9 through the person-centered planning process. The EOHHS provides each beneficiary opting for this service
10 delivery approach with a certified service counselor and advisement agency to provide decision-making
11 assistance and 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
16 who have functional disabilities and/or chronic care needs to optimize their health and retain their
17 independence. Services may be episodic or ongoing and may be provided in a person's home, in the
18 community (for example, shared living or assisted living), or in institutional settings (for example, intermediate
19 care facilities, hospitals, or nursing homes).

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

21 ~~REV:07/2009~~

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

29 Proposed Rules: 10

1 ~~0399.04.01 Institutional Long-Term Care~~

2 ~~REV:07/2009~~

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

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

11 (b) Intermediate Care Facility for the ~~Mentally Retarded~~ Intellectually Disabled
12 (ICF/~~MR~~ ID). A beneficiary qualifies for an ICF/~~MR~~ ID level of care if
13 the beneficiary has been determined by the ~~MHRH~~ state Department of Behavioral Healthcare,
14 Developmental Disabilities, and Hospitals (BHDDH) to meet the applicable institutional level of care.

15 ~~Rules governing such determinations are located in: "Rules and Regulations Relating to the Definition of~~
16 ~~Developmentally Disabled Adult and the Determination of Eligibility as a Developmentally Disabled Adult, by~~
17 ~~MHRH" and may be obtained at http://www.mhrh.ri.gov/ddd/pdf/MHRH_1746.pdf or by contacting the agency.~~
18

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

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

31 Proposed Rules: 11

1 LTSS. In the PETI calculation process, ~~The~~ the State’s Medicaid payment for
2 ~~institutional care~~ institutionally based LTSS 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~~ MCAR Sections ~~of~~ 0378.

5 ~~0399.04.02 Home and Community Based Long-Term Care~~

6 ~~REV:09/2013~~

7 (2) Medicaid Home and Community-based LTSS. ~~The Global Waiver~~ The State’s
8 Section 1115 demonstration waiver authorizes ~~the state to offer~~ an array of home and
9 community-based services (HCBS) to ~~members~~ beneficiaries as an alternative to
10 ~~institutionalization~~ institutionally based care. In general, ~~Home~~ home and

11 community-based ^{delete}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
19 as well as all other state plan and waiver services. Additional services may be available, depending on the
20 type of a beneficiary's needs and the institutional level of care required. Beneficiaries receiving Medicaid LTSS
21 in home and community-based settings are also subject to PETI and must contribute to the cost of their LTSS.
22 ^{add}

23 ^{delete}**0399.04.02.01 Core and Preventive HCB/LTC Services**

24 REV:09/2013

25 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)

Proposed Rules: 12

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

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

6 To qualify for Medicaid-funded long-term care services ^{add}and supports^{add} under the ^{delete}Global
7 Waiver^{delete} ^{add}State's Section 1115 demonstration,^{add} a person must meet the general and financial
8 eligibility requirements as well as ^{delete}meet^{delete}—certain clinical^{add}/functional
9 disability^{add}^{delete}eligibility^{delete} criteria. ^{add}On January 1, 2016 { Replace "January 1, 2016" with
10 "February 8, 2016"}, reforms to the LTSS eligibility requirements will begin to be phased-in with the
11 promulgation of a series of amended rules over a six (6) month period. This process begins with the provisions
12 set forth in this rule revising the clinical/functional disability needs-based criteria for the nursing facility level
13 of care and implementation of federal authority standardizing benefits and service options for Medicaid LTSS
14 beneficiaries across categorically needy and medically needy eligibility categories.

15 This interim rule identifies the MCAR provisions applicable to financial eligibility until July 1, 2016 and sets
16 forth the new clinical/functional disability criteria to take effect on January 1, 2016 { Replace "January 1,
17 2016" with "February 8, 2016"}. In addition, the range of core HCBS will be expanded effective January 1,
18 2016 { Replace "January 1, 2016" with "February 8, 2016"}. Section 1500.4 of this interim rule, describing
19 core and preventive services, identifies and describes the new core HCBS available to beneficiaries as of that
20 date.

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

27 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
9 not for home and community-based waiver services, including for those ^{add} ~~{delete}~~ and ~~{delete}~~ who have a
10 spouse living in the community (see MCAR, Sections 0380.40-0380.40.35 and 0392.15.20- 0392.15.30).
11 See also the applicable income and resource provisions in the ~~{delete}~~long-term-care~~{delete}~~ ^{add}for Medicaid
12 LTSS in 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
15 and community-based core services for a continuous period. That is, persons meeting the highest or high
16 level of 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
20 institutional services ~~{delete}~~—^{add}apply to ALL beneficiaries eligible for Medicaid LTSS, irrespective of
21 whether services are obtained in an institutional and home and community-based setting.

22 (b) LTSS Categorically versus Medically Needy (Effective ~~January 1, 2016~~ { Replace “January 1, 2016”
23 with “February 8, 2016”}). The EOHHS requested and received approval from the CMS for a state plan
24 amendment standardizing LTSS benefits and service options across the “categorically needy” and “medically
25 needy” eligibility categories set forth in MCAR, Section 0370. Accordingly, all LTSS beneficiaries are eligible
26 to receive the same core and preventive services. ^{add}

27 ~~{delete}~~0399.05.01 Clinical Eligibility Scope & Applicability

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

29 Proposed Rules: 14

1 ^{add}(2) Clinical/Functional (CF) Eligibility Criteria. (Effective ~~January 1, 2016~~ { Replace “January 1,
2 2016” with “February 8, 2016”}). ^{add}

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

7 (a) ^{add}Intermediate care facilities for ~~{delete}~~ the mentally retarded~~{delete}~~—^{add}persons with intellectual
8 disabilities (ICF/ID)). The criteria used to evaluate clinical {Insert “/functional”} eligibility for the ICF/ID level
9 of need are established by the BHDDH, in accordance with State law, and apply to Medicaid LTSS
10 provided in the institutional-setting ^{add} ~~{delete}~~ and hospitals~~{delete}~~ and ^{add}home and^{add} community-based
11 service alternatives ~~{delete}~~to these institutions on June 30, 2009 shall remain in effect until such time as needs-
12 based criteria ~~{delete}~~—^{add}The criteria have been adopted by BHDDH in effect as of ~~January 1, 2016~~ { Replace
13 “January 1, 2016” with “February 8, 2016”}., will continue to be used until such time as BHDDH
14 establishes amended or new rules, regulations and/or procedures. ^{add}~~{delete}~~ and applicable rules promulgated

15 by the department(s) responsible for administering programs serving beneficiaries, as indicated below^{delete}.
16 ^{add}Further information on these criteria is located in Section 1500.02 (C) (b) (iii).

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

23 (c) Nursing Facility – Effective ~~January 1, 2016~~ { Replace “January 1, 2016” with “February 8, 2016”}.
24 the EOHHS is revising the needs-based clinical/functional criteria for NF level of care established when the
25 Section 1115 waiver demonstration was approved initially in 2009. The application of the previous and revised
26 versions of the NF level of care criteria are as follows:

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

31 Proposed Rules: 15

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

8 (ii). Beneficiary entered NF between July 1, 2009 and ~~December 31, 2015~~ {Replace “December 31,
9 2015” with “February 7, 2016”}. Any Medicaid LTSS beneficiaries who were determined eligible
10 for a NF level of care during this period will continue to be subject to the criteria in effect at that time.
11 Therefore, the revised needs-based criteria DO NOT apply to beneficiaries receiving Medicaid LTSS
12 who were living in nursing facilities on or before December 31, 2015. The level of care criteria in effect
13 between July 1, 2009 and ~~December 31, 2015~~ {Replace “December 31, 2015” with “February 7,
14 2016”} apply and will continue to apply unless or until the needs of the beneficiary improve to such an
15 extent that beneficiary no longer meets the criteria for Medicaid LTSS or the beneficiary chooses to
16 transfer voluntarily to a home and community-based services setting.

17 (iii) Applicant/Beneficiary for LTSS On/After ~~January 1, 2016~~ { Replace “January 1, 2016” with
18 “February 8, 2016”}. ^{add}The ^{delete}new^{delete} ^{add}revised^{add} needs-based levels of care DO apply
19 to ^{add}new applicants for Medicaid LTSS and existing^{add} beneficiaries^{delete} eligible to receive
20 Medicaid-funded long term care services^{delete} who ^{delete}are^{delete} ^{add}were^{add} living in the community
21 on or before ^{delete}June 30, 2009.^{delete} ^{add}January 1, 2016 { Replace “January 1, 2016” with
22 “February 8, 2016”}. ^{add}

23 The ^{delete}new^{delete} ^{add}revised^{add} ^{delete}levels of care^{delete} ^{add}criteria for assessing the highest need
24 for a NF level of care^{add} will apply beginning with the beneficiary's annual re-assessment ^{add}as
25 part of the eligibility renewal process^{add}. If a ^{delete}person^{delete} ^{add}beneficiary^{add} ^{delete}met the^{delete}
26 ^{add}has the highest or a high need for a NF^{add} institutional level of care ^{delete}criteria^{delete} in the past,
27 ^{add}then the beneficiary^{add} ^{delete}he or she^{delete} ^{add}will ^{add}continue to^{add} meet either the highest or
28 ^{add}a^{add} high ^{add}need for an NF^{add} level of care in the future, and eligibility for ^{delete}long term care
29 services^{delete} ^{add}Medicaid LTSS^{add} will continue without interruption, providing ^{add}there have been
30 no changes in^{add} all other general and financial eligibility requirements ^{delete}continue

31 Proposed Rules: 16

1 to be met^{delete}. When assessing beneficiaries living in the community using the needs-based level of
2 care criteria, a beneficiary is clinically eligible as highest need if the ^{delete}department^{delete} EOHHS
3 determines, as above, that the beneficiary meets at least one of the ^{add}revised^{add}
4 clinical^{add}/functional^{add} eligibility criteria for highest need; or, absent that, the “beneficiary has a critical

5 need for ~~long term care~~ NF care due to special circumstances as specified in
6 MCAR Section 1500.03(C)(2). ~~Accordingly, a~~

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

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

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

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

Proposed Rules: 17

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
4 clinically eligible for ~~long term care~~ LTSS may be eligible for a limited range of home and
5 community based services if they meet the criteria to qualify for preventive care (see "preventive need" in
6 Section 1500.03(C)(4)). The availability of such services ~~shall be~~ is limited,
7 depending upon funding.

~~0399.05.01.02 Needs-based LTC Determinations~~

9 ~~REV:07/2009~~

1500.02 MEDICAID LTSS NEEDS-BASED DETERMINATIONS

A. OVERVIEW

12 The processes for determining clinical [Insert "/functional"] eligibility ~~are based on~~ centers on
13 a comprehensive assessment that includes an evaluation of the medical, social, physical and behavioral
14 health needs of each beneficiary. The assessment ~~shall be~~ is tailored to the needs ~~of~~
15 ~~the beneficiaries services and,~~ of beneficiaries seeking the various types of LTSS (see Section
16 1500.01 (E) above) and, ~~as such, may vary from one process to the next~~ tend to differ
17 accordingly. For example, the clinical/functional needs based criteria for NF level of care are different than
18 the criteria for the ICF/ID and hospital levels of care and may vary further by setting within each type of
19 institution and the population served (i.e., hospital level of care for child in DCYF custody versus adult
20 identified by BHDDH as a person with a serious and persistent behavioral health condition or

21 illness.^(add) Based on this assessment, the needs of the beneficiary are classified as "highest" or "high" to
 22 reflect the scope and intensity of care required and the range of services available. ^(add)Non-LTSS
 23 Medicaid^(add) ~~Beneficiaries already eligible for community MA~~^(delete) ^(add)beneficiaries with chronic and
 24 disabling conditions^(add) who do not meet the highest or high level of care but are at risk for
 25 ~~institutionalization~~^(delete) ^(add)the level of care typically provided in an institution^(add) may access certain
 26 short-term preventive services ^(add)to optimize their health and promote 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
 29 in 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
 5 0375). Person-centered planning is a holistic approach for accessing Medicaid LTSS that involves the
 6 beneficiary, family members and providers. A description of the basic types of Medicaid LTSS is provided in
 7 Section 1500.01 (E).^(add)

8 ~~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 ~~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
 16 highest need ^(add)for NF level of care^(add) may ~~be able to~~^(delete) obtain the full range of ~~services he or she~~^(delete)
 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
 21 care, but does not have the option of nursing facility care. ^(add)The matrix below outlines the service options
 22 based on level of need.^(add)

23 ~~0399.05.01.03~~ ^(delete) **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 LTSS Service Options Matrix Needs-Based Level of Care Determinations</u>		
<u>Highest Need</u> <u>NF Level of Care</u>	<u>Highest Need</u> <u>Hospital Level of Care</u>	<u>Highest Need</u> <u>ICF/ID Level of Care</u>
<u>(Access to Nursing Facilities and all Home and Community-based Services)</u>	<u>(Access to Hospital, Group Homes, Residential Treatment Centers and all other Home and Community-based Services)</u>	<u>(Access to ICF/ID Group Homes and all other Home and Community-based Services)</u>
<u>High Need</u> <u>NF Level of Care</u>	<u>High Need</u> <u>Hospital Level of Care</u>	<u>High Need</u> <u>ICF/ID Level of Care</u>
<u>(Access to Core and Preventive Home and Community-based Services)</u>	<u>(Access to Core and Preventive Home and Community-based Services)</u>	<u>(Access to Core and Preventive Home and Community-based Services)</u>
<u>Preventive Need NF Level of Care</u>	<u>Preventive Need Hospital Level of Care</u>	<u>Preventive Need ICF/ID Level of Care</u>
<u>(Access to Preventive Home and Community-based Services)</u>	<u>(Access to Preventive Home and Community-based Services)</u>	<u>(Access to Preventive Home and Community-based Services)^{add}</u>

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)~~ ^{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/~~recipients~~ ^{delete} ^{add}beneficiaries ^{add} and their families in gaining access to and
 4 navigating the LTC ^{add}LTSS ^{add} system. ~~In this respect, the ACO is not a separate and distinct~~
 5 ~~entity,~~ ^{delete} ^{add}Although there is no one single, distinct entity that performs all these functions, the State's
 6 Section 1115 demonstration sets the direction for all Medicaid LTSS assessment and coordination activities ^{add}
 7 ~~but a set of interrelated activities from across the departments~~ ^{delete} that serve the goal of rebalancing the
 8 long-term care system.

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

11 (a) Information and Referral -- The State provides information and referrals about publicly funded
 12 ~~LTC~~ ^{delete} ^{add}LTSS ^{add} to individuals and families through a variety of sources across agencies. The
 13 ~~ACO~~ ^{delete} ^{add}EOHHS ^{add} is responsible for enhancing and coordinating these resources to ensure that
 14 every person seeking Medicaid-~~funded LTC services~~ ^{delete} ^{add}LTSS ^{add} has access to the information
 15 they need to make reasoned choices about their care. The ~~Department of Human Services~~ ^{delete} shall
 16 ~~EOHHS has entered~~ ^{delete} ^{add} into inter-agency agreements with each entity identified or designated as
 17 a primary source of information/referral source for ^{add}LTSS ^{add} beneficiaries ^{add}, their family members
 18 and authorized representatives. ^{delete} ^{add} of long-term care ^{delete}. ^{add}In addition, the Division of Elderly Affairs
 19 (DEA), within the RI Department of Human Services (DHS) administers the Aged and Disability Resource
 20 Center (ADRC) through "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 ~~long-term care services~~ ^{delete} ^{add} all Medicaid
 24 LTSS applicants and beneficiaries. ^{add} ^{delete} provided across agencies ^{delete}. ^{add} The EOHHS has delegated the
 25 authority to determine clinical/functional ^{add} eligibility ^{add} for Medicaid LTSS ^{add} ^{delete} is based on a
 26 comprehensive assessment of a person's medical, social, physical and behavioral health needs.
 27 Responsibilities for clinical eligibility are ^{delete} ^{add} across State agencies. The entities that conduct the

28 assessments work in coordination with staff of the Medicaid agency, as appropriate, to ensure the eligibility
29 determination process is coordinated and to preserve program integrity. Clinical/functional eligibility
30 responsibilities are organized as follows:

31 Proposed Rules: 21

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

5 ~~§~~ (ii) Hospital Level of Care – Needs-based assessments for^{add} ~~Clinical eligibility to receive services~~
6 ~~in~~^{delete} a long-term care hospital or community alternative^{delete} to the institution will be determined by
7 DHS and MHRH^{delete} are tailored to the clinical requirements of the populations served in settings that
8 meet the definition of “hospital” for Medicaid LTSS purposes^{add} ~~as appropriate, utilizing an~~^{delete}
9 institutional level of care.^{add} BHDDH and the RI Department of Children, Youth and Families (DCYF) have
10 developed and apply specialized clinical criteria for adults and children, respectively, with various service
11 needs at this institutional level; the EOHHS has established clinical criteria for beneficiaries requiring services
12 through the 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} (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 [http://sos.ri.gov/documents/archives/regdocs/released/pdf/MHRH/MHRH_1746 .pdf](http://sos.ri.gov/documents/archives/regdocs/released/pdf/MHRH/MHRH_1746.pdf)) as well as the federal
18 law and regulations when conducting needs-based eligibility determinations. The BHDDH also utilizes a
19 population-specific services intensity scale to evaluate/authorize Medicaid LTSS required to meet assessed
20 need.^{add}

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

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

30 Proposed Rules: 22

1 activities include establishing funding levels for the care ^{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} 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} 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 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} 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 {Insert “(e) Nursing home diversion. Medicaid funded home modifications and personal care services that
16 are necessary to keep beneficiaries independent in their own homes thereby eliminating the need for
17 nursing facility care.”}

^{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>(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 **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
21 ^{add}also^{add} addressed. A person admitted to or seeking admission to a ~~{delete}~~ long term care ~~{delete}~~ ^{add}LTSS^{add}
22 facility regardless of the payment source ~~{delete}~~ shall be ~~{delete}~~ ^{add}must be^{add} informed by the facility of the
23 availability of the long-term care options counseling program and ~~{delete}~~ shall be provided with a long term care
24 options ~~{delete}~~ ^{add}provided with a^{add} consultation ~~{delete}~~ if they so ~~{delete}~~ ^{add}upon^{add} request. ^{add}Options
25 counseling typically 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

29 Proposed Rules: 26

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~~
9 ~~source shall be informed by the facility of the availability of the long term care options counseling program~~
10 ~~and shall be provided with a long term care options consultation if they so request.~~

11 ~~0399.08~~ E. COST NEUTRALITY FOR ~~HCB~~ 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~~
16 ~~community based long term care system~~ Medicaid home and community-based services on an
17 annual basis. A core EOHHS function is to collaborate with agency partners through the A&C process to
18 ensure that ~~meet cost neutrality~~, the average per capita expenditures for home and
19 community-based services ~~cannot~~ does not exceed one hundred percent (100%) of the
20 average per capita expenditures of the cost of institutional services if the individuals had been
21 institutionalized for the same set of Medicaid LTSS provided in an institutional setting – that is, NF,
22 ICF/ID or long-term hospital. Accordingly, when comparing the cost of care in a HCBS versus institutional
23 setting, the total average costs for all Medicaid LTSS core and preventive services must be considered, across
24 providers, even if the beneficiary is residing in a specific HCBS setting (e.g., residing in a habilitation
25 group home or assisted living and receiving limited skilled nursing or therapeutic day supports as
26 separate services) The average monthly costs to Medicaid by 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~~
3 ~~whether home and community based services are cost effective~~ as required under Title XIX of the Social
4 Security 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
10 the 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
12 needs, individual plan of care, and the budget neutrality parameters established under ~~the Global~~
13 ~~Waiver~~ federal law and regulations. The purpose of this section is to set forth the process and criteria
14 for evaluating the needs and service options of applicants/beneficiaries seeking a nursing facility level of care in
15 either of these settings. Beneficiaries ~~with~~ determined to have ~~care~~
16 service needs in the NF category that meet the financial and clinical/functional eligibility criteria
17 for a NF level of care also have an option for self-direction. As established in Section
18 1500.02(C)(1)(b), the responsibilities assessing the service option for the ICF/ID and hospital levels of care
19 have been delegated to agencies across the EOHHS.

20 B. NF SERVICE OPTIONS CLASSIFICATIONS

- 21 The ~~{add}~~NF~~{add}~~ service classifications ~~{add}~~are~~{add}~~ designed to ~~{add}~~provide care options that~~{add}~~ reflect the scope
 22 and intensity of the beneficiary's needs ~~{delete}~~in this category are~~{delete}~~ ~~{add}~~and are~~{add}~~ as follows:
- 23 a) ~~{add}~~(1)~~{add}~~ **Highest need.** Beneficiaries with needs in this classification have access to all core services
 24 defined in Section ~~{delete}~~0399.04.02.01~~{delete}~~ ~~{add}~~1500.04(A)~~{add}~~ as well as the choice of receiving
 25 services in an institutional/nursing facility, ~~{add}~~in their own~~{add}~~ home ~~{add}~~or the home of another~~{add}~~, or ~~{add}~~one
 26 of the~~{add}~~ community-based settings ~~{add}~~identified below in Section 1500.05~~{add}~~.
- 27 b) ~~{add}~~(2)~~{add}~~ **High need.** Beneficiaries with needs in this classification have been determined to have needs
 28 that can safely and effectively be met at home or in the community with significant core services.

29 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}~~
 7 who meet the preventive need criteria, are not subject to the ~~{delete}~~LTC~~{delete}~~ ~~{add}~~Medicaid LTSS~~{add}~~ financial
 8 eligibility 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
 14 applying for state only funded services and supports are referred to ACO processes administered by the
 15 Department of Elderly Affairs (DEA). The agency entities authorized to carry out these ACO processes are
 16 responsible for:

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

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

27 ~~{delete}~~0399.11~~{delete}~~ ~~{add}~~B. NF~~{add}~~ **CLINICAL** **{Replace "Clinical" with" COMPREHENSIVE"}**

28 **ELIGIBILITY ASSESSMENT TOOL**

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

30 Proposed Rules: 29

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

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

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

11 Upon completing the assessment, the OMR staff determines whether a beneficiary's care needs qualify as
12 highest, high or preventive based on a set of clinical and functional criteria that reflect both best practices
13 across the states and the standards of prevailing care within the ~~LTC~~ ^(add)LTSS^(add) community in
14 Rhode Island. ^(add)The functional disability criteria focus on the scope of a person's need for assistance with
15 the Activities of Daily Living (ADLs) such as bathing, toileting, dressing, transferring, ambulation, eating,
16 personal hygiene, medication management, and bed mobility. To determine the scope of need, OMR staff
17 consider the extent to which the level of assistance a person requires falls into one of the following categories:

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

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

26 Clinical {Insert “/functional”}eligibility ^(add)for beneficiaries who were receiving Medicaid LTSS in a NF
27 setting prior to the ~~January 1, 2016~~ { Replace “January 1, 2016” with “February 8, 2016”}, are set forth in
28 Section 1500.01(F)(2)(c)^(add) ~~based on these criteria is in the following Sections~~^(add). The applicable
29 criteria beginning on the date this rule takes effect are as follows:^(add)

30 Proposed Rules: 30

1 ~~0399.12.01 Highest Need~~

2 REV:07/2009

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

6 (a) Require extensive assistance ~~or total dependence~~ with at least one ~~of the following~~ ^(add)three ~~(3)~~ ^(add) of the
7 following ~~Activities of Daily Living (ADLs)~~ least one of the following Activities of Daily Living (ADL) —
8 toilet use, bed mobility, eating, or transferring ~~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
12 assistance, care and supervision on a daily basis; or^(add)

13 (b) {Retain existing description for HCBS) “Require extensive assistance or total dependence with at
14 least one of the following Activities of Daily Living (ADL) toilet use, bed mobility, eating, or
15 transferring, for whom the provision of home and community based services would divert from nursing
16 facility services.”}

17 (c) Lack awareness of needs or have moderate impairment with decision-making skills AND have one ^(add)(1)
18 ^(add) of the following symptoms/conditions, which occurs frequently and is not easily altered: wandering,
19 verbally aggressive behavior, ~~resists~~ ^(add)resisting^(add) care, physically aggressive behavior, or
20 behavioral symptoms requiring extensive supervision; or

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

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

11 ~~{add}~~**(4) Preventive Need.** ~~{add}~~ Beneficiaries who meet the ~~{add}~~**needs-based criteria for the NF**~~{add}~~ preventive
12 ~~{delete}~~ need criteria shall be ~~{delete}~~ ~~{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 ~~{delete}~~ as recipients of Medicaid~~{delete}~~. 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 ~~{delete}~~ADL's~~{delete}~~ ~~{add}~~**ADLs**~~{add}~~ or ~~{add}~~**Instrumental Activities of Daily**
20 **Living**~~{add}~~ ~~{delete}~~IADL's~~{delete}~~ ~~{add}~~**(IADLs)** ~~{add}~~ and/or delay or mitigate the need for intensive home and
21 community-based or institutionally based care. Preventive services for beneficiaries ~~{delete}~~include~~{delete}~~
22 ~~{add}~~**are described below in Section 1500.04(A).**~~{add}~~~~{delete}~~.

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

Proposed Rules: 3

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

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

8 c) ~~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
10 he/she is functionally unable to complete independently due to disability. Personal Care Services may be
11 provided 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
21 those persons who normally provide care for the participant. Respite services will be
22 recommended and approved by EOHHS, Office of Long Term Services and Supports.

0399.12.03.01 ~~Limitations~~—Preventive Need

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

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 ~~{delete}~~DHS~~{delete}~~ ~~{add}~~**EOHHS**~~{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.

~~{delete}~~0399.13~~{delete}~~ ~~{add}~~**D.** ~~{add}~~**REASSESSMENTS -- HIGH AND HIGHEST NEED**

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

31 ~~{add}~~**(1)** ~~{add}~~**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, ~~{delete}~~shall be determined~~{delete}~~ ~~{add}~~**are deemed**~~{add}~~ to
33 have the highest need if they meet any of the **clinical** ~~{insert}“/functional”~~ eligibility criteria established for
34 that level of care in ~~section~~~~{delete}~~0399.21.01~~{delete}~~ ~~{add}~~**Section 1500.03(C)(1)**~~{add}~~.

35

1 ~~{(delete)}~~ **0399.13.01 Re-Eval of Beneficiaries with Highest Need**

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

3 ~~{(delete)}~~ **(2) Re-evaluation Highest Needs.** ~~{(delete)}~~ At the time ~~{(delete)}~~ the OMR makes ~~{(delete)}~~ a determination of highest
 4 need ~~{(delete)}~~ **is made** ~~{(delete)}~~ for a beneficiary who ~~{(delete)}~~ resides in or is admitted to a nursing facility ~~{(delete)}~~ **opts**
 5 **to reside in a nursing facility, OMR evaluates** ~~{(delete)}~~ information indicating ~~{(delete)}~~ whether there is a
 6 possibility that the beneficiary's ~~{(delete)}~~ functional or health care condition may improve, within ~~{(delete)}~~ **the succeeding** ~~{(delete)}~~
 7 two month period ~~{(delete)}~~ **is identified.** ~~{(delete)}~~ **Based on this information,** ~~{(delete)}~~ OMR notifies the beneficiary,
 8 his/her authorized representative and the nursing facility that NF ~~{(delete)}~~ level of ~~{(delete)}~~ care has been authorized
 9 and that the beneficiary's functional and medical status will be ~~{(delete)}~~ reviewed ~~{(delete)}~~ **re-evaluated** ~~{(delete)}~~ in
 10 thirty (30) to sixty (60) days.

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

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

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

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

1 ~~{(delete)}~~ **1500.04 HCBS CORE AND PREVENTIVE SERVICES**

2 ~~{(delete)}~~ **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**
 4 **scope, amount and duration of these services a beneficiary is authorized to receive depends initially on the**
 5 **determination of needs conducted in the OMR comprehensive assessment process and the person-centered**
 6 **care planning process (PCP) that is developed thereafter in conjunction with the beneficiary, provider and**
 7 **family members or authorized representatives. Note: the RI Reinventing Medicaid Act of 2015 authorized**
 8 **the EOHHS to seek federal approval to expand the range of services to include: home stabilization, community**
 9 **health teams, peer specialists, and acuity-based adult day and assisted living services.**

10 **A. DEFINITIONS OF CORE AND PREVENTIVE HCBS**

11 ~~{(delete)}~~ **The listing below defines the available HCBS and identifies those that will become accessible effective**
 12 **January 1, 2016 { Replace "January 1, 2016" with "February 8, 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
20 licensed as nursing facility, nursing care provider, assisted living residence or adult day services provider
21 as well as 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
3 independent 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
15 also be provided. All services and supports are directed at enabling a Medicaid LTSS beneficiary to
16 achieve 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
19 modifications must be identified in beneficiary’s PCP process as necessary to support health, welfare, and
20 safety and enable the beneficiary to function with greater independence at home. For services to be
21 authorized, there must be evidence that without the modification(s) a beneficiary would require some type
22 of institutionalized living arrangement, such a nursing facility or hospital. Adaptations that do not help the
23 beneficiary’s safety or independence are not included as part of this service, ~~such as new carpeting, roof~~
24 ~~repair, central air, or home additions.~~ **{deleted “,such as new carpeting, roof repair, central air, or home**
25 **additions”**
- 26 (i) Informal Supports – includes supports provided by family and friends as well other community
27 resources that assist the beneficiary in achieving the goals identified in the person-centered plan of care.
- 28 (j) Home Stabilization (Available effective ~~January 1, 2016~~ **{Replace “January 1, 2016” with “February 8,**
29 **2016”}**) – provides services and supports for beneficiaries who are homeless or at risk of homelessness or
30 transitioning to the community from an institutional settings. Range of LTSS includes intensive case
31 management and community-

32 Proposed Rules: 37

- 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

9 or her own. Meals must provide a minimum of one-third (1/3) of the current recommended dietary
10 allowance. Other forms of assistance for meal preparation is limited for beneficiaries receiving this
11 service.

12 (l) Home Health Aide -- a person who works under the supervision of a medical professional to assist the
13 beneficiary with basic health services such as assistance with medication, nursing care, physical,
14 occupational, and speech therapy. A home health aide is often a Certified Nursing Assistant (CNA)
15 who provides both skilled personal care and homemaker services at a combined rate of payment.

16 (m) Homemaker -- in-home caregiver hired through an agency that consists of general household tasks. The
17 caregiver helps with housekeeping items such as meal preparation, shopping, light housekeeping, and
18 laundry. Homemaker services are typically authorized for a temporary period during which a beneficiary's
19 caregiver is absent from the home for a limited period of time.

20 (n) Intermittent Skilled Nursing -- focuses on long-term needs rather than short-term acute healing needs,
21 such as weekly insulin syringes or medi-set set up for beneficiaries unable to perform these tasks on their
22 own. These services are provided when a need is established in a beneficiary's PCP by a licensed nursing
23 professional under the supervision of an EOHHS Registered Nurse.

24 (o) LPN Services – provides time-limited skilled nursing services to a beneficiary by a Licensed Practical
25 Nurses (LPN), practicing under the supervision of a Registered Nurse. Services typically exceed the scope
26 of practice of a Certified Nursing Assistant (CNA) and are provided to a beneficiary in their home
27 for short-term acute healing needs, with the goal of restoring and maintaining a beneficiary's maximal
28 level of function and health. These services are for beneficiaries who have achieved some degree of
29 stability despite the need for continuing chronic care nursing interventions that might otherwise require a
30 hospitalization or a nursing facility stay. Service must be authorized by an EOHHS Registered Nurse.

31 **Proposed Rules: 38**

1 (p) Minor Environmental Modifications -- provides minor changes to the home including grab bars, versa
2 frame (toilet safety frame), handheld shower and/or diverter valve, raised toilet seats and other simple
3 devises or appliances such as eating utensils, transfer bath bench, shower chair, aids for personal care (e.g.,
4 reachers) and standing poles to improve home accessibility adaptation, health or safety {Replace with
5 “provides minor changes to the home to prevent nursing home admission, including grab bars, hand
6 rails, tub cuts, widening doorways, offset hinges, removal of glass shower doors and modifying
7 threshold transition”}.

8 (q) PACE - Program for All-Inclusive Care for the Elderly -- includes LTSS and other health services for
9 beneficiaries fifty-five (55) years or older who meet the criteria for high or highest level of need. PACE
10 is responsible for providing all Medicare and Medicaid services.

11 (r) Participant Directed Goods and Services --includes services, equipment or supplies not otherwise provided
12 under the Section 1115 waiver or state plan that address an identified need specified in a beneficiary's
13 POC such as improving and maintaining full membership in the community. Access is contingent
14 upon meeting the following requirements:

- 15 • Item or service would decrease the need for other Medicaid services; and/or promote inclusion in the
16 community; or
- 17 • Item or service would increase the beneficiary's ability to perform ADLs or IADLs or increase the
18 person's safety in the home environment; and
- 19 • Alternative funding sources are not available.

20 Individual goods and services are purchased from the beneficiary's self-directed budget through the fiscal
21 intermediary when approved as part of the individual service plan (ISP). Examples include a laundry
22 service for a person unable to launder and fold clothes or a microwave for a person unable to use a stove
23 due to his/her disability. Does not include any good/service that would be restrictive to the individual or
24 strictly experimental in nature.

25 (s) Personal Care – provides direct hands-on support to help with the day-to-day activities such as toileting,
26 bathing, meal preparation and medication management which enable beneficiaries to be more independent
27 in their own homes. Personal care services may be provided by a CNA who is employed by a State-licensed
28 home care/home health agency and meets such standards of education and training as are established by

29 the State or Personal Care Attendant (PCA) via employer authority under the self-directed care option.
30 Does not include homemaker services, such as light housekeeping.

31 (t) Peer Supports (Available effective ~~January 1, 2016~~ [Replace “January 1, 2016” with “February 8,
32 2016”]) -- services provided by trained “peer specialists”, working as part of a multi-disciplinary
33 treatment team, who serve as mentors.

34 Proposed Rules: 39

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
5 and/or 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
13 completion, 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
16 only 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
21 such as personal grooming, household chores, meal preparation and so forth. More intensive supports
22 include 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
25 most 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
3 laundry. The caregiver can also help with hands-on personal care items such as personal hygiene, bathing,
4 grooming, and feeding. Personal care assistants can include other independent direct care givers such as
5 RNs, LPNs, 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
10 supplies to include: devices, controls, or appliances, specified in the plan of care, which enable
11 beneficiaries to increase their ability to perform activities of daily living; devices, controls, or
12 appliances that enable the beneficiary to perceive, control, or communicate with the environment in which

13 they live; and other durable and non-durable medical equipment not available under the State plan that is
14 necessary to address a beneficiary’s functional limitations. Items available under the Section 1115 waiver
15 are in addition to any medical equipment and supplies furnished under the State plan and exclude those
16 items that are not of direct medical or remedial benefit to the beneficiary. All items shall meet
17 applicable standards of manufacture, design and installation. Provision of Specialized Medical Equipment
18 requires prior approved 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
26 training provided at a work-site for beneficiaries who are receiving the service as a result of the
27 clinical/functional 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 ~~Personal care and services~~, ^{add}(e.g., personal care, ^{add}homemaker, chore, attendant care,
30 companion services and medication oversight ~~(to the extent permitted under State law)~~ provided
31 in a private home by a principal care provider who lives in the home. ~~Supported Living~~
32 Arrangements^{add}The

33 Proposed Rules: 41

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

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

28 ~~0399.14~~ ^{add}B. ^{add}LIMITATIONS ON THE AVAILABILITY OF ~~SERVICES~~^{add}
29 ^{add}MEDICAID HCBS^{add}

30 ~~REV:07/2009~~

31 Proposed Rules: 42

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

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

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

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

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

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1 ~~0399.15~~ ^{delete} ^{add} 1500.05 ^{add} **LIMITATIONS ON** ~~ENVIRONMENTAL MODIFICATIONS,~~ ^{delete}
2 ~~MINOR ENVIROMENTAL MODIFICATIONS AND SPECIAL MEDICAL EQUIPMENT~~ ^{delete}
3 ^{add} **THE SCOPE OF MEDICAID HCBS** ^{add}

4 ~~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
7 needs and service classification – highest, high and preventive. The EOHHS has established such limits to
8 ensure the cost neutrality provisions established under Title XIX, described in Section 1500.03(E) of this rule,
9 are met.

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

16 ~~0399.15.01 Environmental Modifications~~ ^{delete}

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

18 ^{add} (1) ^{add} Environmental Modifications ^{add}. As defined in Section 1500.04(A) above, environmental
19 modifications ^{add} ~~are defined as those~~ ^{delete} physical adaptations to the home ^{delete} ~~of the member or the~~

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

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

33 Proposed Rules: 44

1 All adaptations shall be provided in accordance with applicable State or local building codes and prior
2 approval on an individual basis by EOHHS, Office of Long Term Services and Supports is required. Items
3 should be of a nature that they are transferable if a member moves from his/her place of residence. ~~(delete)~~ ^(add) The
4 scope of the 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, ^(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
18 primary residence that is leased ^(add) ~~(delete)~~ including rented apartments or houses ~~(delete)~~ ^(add) may
19 require the ^(add) ~~(delete)~~ with ~~(delete)~~ written permission of the owner/landlord ^(add) /lease-holder ^(add), when
20 applicable).
- 21 (f) Exterior access modifications are limited to one ingress/egress route into and out of the home.
- 22 (g) Repair, removal, construction or replacement of decks, patios, sidewalks and fences are not
23 covered ^(add) modifications ^(add).
- 24 (h) ~~(delete)~~ Home Modifications ~~(delete)~~ ^(add) Home modifications under this section ^(add) do not include
25 ~~(delete)~~ those ~~(delete)~~ adaptations or improvements to the home that are considered to be standard housing
26 obligations of the owner or tenant ^(add) such as bringing the living area up to fire or electrical code.
- 27 (i) Other home modifications that are not covered include -- ^(add)
 - 28 • Relocation of plumbing and/or bathroom fixtures ~~(delete)~~ is not covered.
- 29 Repairs or modifications to equipment purchased under this definition are an allowable expense.
 - 30 • Examples of items not covered include ~~(delete)~~ ^(add) Repairs, addition, or purchase of ^(add) driveways,
31 decks, patios, hot tubs, central heating and air conditioning, raised garage doors, standard
32

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

- 3 • ~~Excluded are any re-modeling,~~ ~~(~~ ~~i.e.~~ ~~)~~ ~~(~~ ~~e.g.~~ ~~)~~ ~~changes in load bearing walls or structures)~~ that would require a structural engineer, architect and /or certification by a building inspector.
- 4
- 5
- 6 (j) Requirements for ~~modifications~~ ~~to rental property include: --~~
- 7 • ~~Prior to any modification a~~ ~~determination~~ ~~should~~ ~~be made~~ ~~as to what, if anything, is the legal responsibility of~~ ~~the~~ ~~property owner,~~ ~~lessee~~ ~~or landlord~~ ~~has legal responsibility to make the modification or~~ ~~approve a modification authorized under this section~~.
- 8
- 9
- 10
- 11 • Written approval must be obtained from the property owner or landlord prior to the ~~service~~ ~~being approved~~ ~~modification before approved by EOHHS and scheduled for delivery~~.
- 12
- 13 (k) Ramps may be covered ~~modifications~~ only if:
- 14 • ~~They meet ADA compliance~~ ~~All~~ ~~American with Disabilities Act (ADA) compliance~~ ~~standards~~ ~~{Replace “Americans with Disabilities Act (ADA) compliance standards” with “Uniform~~ ~~Federal Accessibility Standards (UFAS)”}~~ ~~are met~~, and
- 15
- 16
- 17 • ~~Meet all~~ ~~Applicable~~ ~~State and local building code requirements and permits as~~ ~~required~~ ~~are obtained with the necessary approvals; and~~
- 18
- 19 • ~~Ramp should be~~ ~~The ramp is structured and built of materials that make it~~ ~~of a~~ ~~nature that it is~~ readily transferable to another dwelling.
- 20
- 21 (l) Vertical platform lifts may be covered only if:
- 22 • There is not adequate acreage available to install a ramp that meets ~~state~~ ~~State~~ and
- 23
- 24 • The physical topography of the site precludes the installation of a ramp.
- 25
- 26 (m) Interior Stairway Lifts (stair glides) may be approved only if the first floor of the home does not have any toilet facilities.
- 27
- 28 (n) Repairs or modifications to equipment purchased under this definition are an allowable expense

~~B. Special Considerations:~~

- 29 (o) An Assessment for home modifications is required to determine the most appropriate and cost-effective ~~service requested~~ ~~approach to address the beneficiary’s service need~~. This
- 30
- 31
- 32

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

2 ~~conducting~~ ~~EOHHS has deemed qualified to conduct~~ such assessments

3 ~~may~~ ~~include~~ ~~but are not limited to~~:

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

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

- 10
- 11 (p) This ~~Home modification service~~ is only available to Medicaid ~~members~~
- 12 ~~who meet the clinical/functional criteria for and are authorized to receive other~~ ~~on~~
- 13 ~~Core~~ ~~core~~ HCBS.

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

0399.15.02 Special Medical Equipment

REV:09/2013

17 ~~(2)~~ ~~Special Medical Equipment and supplies to~~ ~~Supplies. Supplies available in this area~~
18 include ceiling or wall mounted patient lifts, track systems, tub slider systems, rolling shower chairs and/or
19 automatic door openers ~~and similar services~~, which ~~enable members~~ ~~enhance or enable~~
20 ~~beneficiaries~~ to increase their ability to perform activities of daily living, ~~including such other~~
21 ~~Such~~ durable and non-durable medical equipment ~~, which is designed specifically to address the~~
22 ~~functional limitations of beneficiaries, are authorized by the State's Section 1115 waiver and are~~ not
23 available ~~as Medicaid state plan services~~ under the Medicaid-funded primary and acute care system
24 ~~that is necessary to address member functional limitations~~. Items ~~reimbursed with waiver~~
25 ~~funds~~ ~~authorized for LTSS beneficiaries under the waiver~~ are in addition to any ~~other~~
26 medical equipment and supplies ~~furnished under the Medicaid-funded primary and acute care~~
27 ~~system~~ ~~provided to a beneficiary through Medicaid for their acute/subacute/primary care needs,~~
28 ~~and exclude those items that are not of direct medical or remedial benefit to the member.~~ Medical
29 equipment ~~funded under the primary and acute care system includes items~~ such as wheelchairs,
30 prosthetics, and orthotics ~~which are provided through a beneficiary's acute care coverage (e.g., Medicare,~~
31 ~~private insurance or Rhody Health Partners) are excluded~~. ~~These are services that were provided~~
32 under the authority of the Rhode Island 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) ~~All items shall~~ ~~must~~ ~~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~~ ~~must be~~ transferable if a
15 ~~member~~ ~~beneficiary~~ moves from his/her ~~changes~~ place of
16 residence.
- 17 (d) ~~Remodeling~~ construction, or structural changes to the home ~~Any changes~~, (i.e.
18 ~~changes in load bearing walls or structures~~) that would require a structural engineer, architect and
19 /or certification by a building inspector ~~(i.e., changes in load bearing walls or structures) are~~
20 ~~excluded and, as such, are NOT covered~~.

21 (e) ~~Limitations include~~

22 ~~A. Limitations:~~

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

31 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.

~~All items require Prior Authorization by EOHHS, Office of Long Term Services and Supports and do not require a physician's order.~~

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

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

~~B. Special Considerations:~~

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

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

Proposed Rules: 49

- ^(add) Special medical equipment and supplies under this section are only available to Medicaid beneficiaries who meet the clinical/functional criteria for and are authorized to receive other core HCBS. ^(add)

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

~~This is only available to Medicaid members on Core HCBS.
This service is billable under HCPCS Code T2029.~~

0399.15.03 Environmental Modifications

~~REV:09/2013~~

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

~~A. Limitations:~~

- (a) All items require prior authorization by ~~EOHHS, Office of Long Term Services and Supports~~ ^(add) an agency LTSS specialist ^(add); however, items on the EOHHS Approved List do not require a physician's order.
- (b) All items must be recommended by an appropriately trained and certified health care professional or ~~DHS~~ ^(add) LTSS ^(add) social worker.
- (c) Items must be necessary to ensure the health, welfare and safety of the ~~individual~~ ^(add) beneficiary ^(add), or to enable the ~~individual~~ ^(add) beneficiary ^(add) to attain or retain capability for independence or self-care in the home, and to avoid ~~institutionalization~~ ^(add) a transition to a more restrictive institutional-setting ^(add).
- (d) Items for diversional or entertainment purposes are not covered.
- (e) Items ~~should be of a nature that they are~~ ^(add) must be ^(add) transferable if a ~~member~~ ^(add) beneficiary ^(add) ~~moves from his/her~~ ^(add) changes ^(add) place of residence.

- 27 (f) Items cannot duplicate equipment provided under the Medicaid -funded primary and acute care system or
28 through other sources of funding (i.e. ^{add}e.g., ^{add} Medicare, private insurance).
- 29 (g) Items not included on the EOHHS Approved List and priced greater than \$500.00 ^{delete}shall be ^{delete}
30 ^{add}are ^{add} considered special medical equipment and will be subject to the policies and procedures for that
31 service ^{delete}as described in the Core Services section of the Rhode Island 1115 Waiver.

32 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 A. OVERVIEW^{add}

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~~
8 ~~and 0399.12.02~~^{delete} to have ^{add}the high or highest need^{add} for the ^{delete}highest or high ^{delete} ^{add}NF^{add} level
9 of care ^{add}pursuant to Section ~~?????~~^{add}. Beneficiaries will be notified of whether they qualify for one of
10 these residential options in conjunction with the comprehensive assessment ^{delete}specified in Sections
11 ~~0399.05.01.02 and 0399.11~~^{delete} and the development of the individualized plan of care.
12 ~~Although~~^{delete} Medicaid coverage for room and board is typically not included for these options,
13 ^{add}though^{add} there are exceptions as is explained in the description of services provided below.

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

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

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

29 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
4 under his or her personal-centered plan of care (e.g., physical therapy or limited skilled nursing), must be
5 obtained from other Medicaid providers regardless of the ALR’s level of licensure and capacity.
6 Beneficiary 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.
8 §40-8-13.2, 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
13 range of enhanced and/or specialized services. Licensed residences that become certified and choose to
14 participate in the CSLP must enter into contractual arrangements with the ICI managed care plans
15 that tie payments to the scope of Medicaid LTSS they are certified to provide and a beneficiary’s needs. All
16 CLSP certified residences must provide the full scope of services available in the Standard Option, as

17 indicated above, as well as therapeutic day services and more intensive personal care. Licensed residences
18 that provide enhanced services (e.g., limited skilled nursing) and/or specialized services (e.g., dementia
19 care) must have the appropriate level of State licensure and meet the appropriate tier of Medicaid
20 certification.^{add}

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

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

31 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}~~ must also include those set forth in section 0300.20.20~~{delete}~~ ^{add} are
5 subject to the requirements of this section^{add}. Beneficiaries ~~{delete}~~ opting for services in the ~~{delete}~~ ^{add} choosing
6 to obtain 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
11 scope 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
15 wheelchairs, prosthetics, and orthotics. These are services that were provided under the authority of the Rhode
16 Island Medicaid State Plan prior to the 1115 Waiver approval. These items are still available under the
17 1115 Waiver and are 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~~ **{Delete the phrase “that is**
24 **similar to adult foster care”}**. Shared-living^{add} is defined as personal care, homemaker, chore, attendant care
25 and related services provided in a private home setting by a care provider who lives in the home. RItE @ Home
26 ~~{delete}~~ is a service~~{delete}~~ ^{add} is the shared-living service^{add} ~~{delete}~~ provided to ~~{delete}~~ ^{add} for^{add} Medicaid
27 ^{add} LTSS^{add} beneficiaries ~~{delete}~~ eligible for long-term care services who are elderly or adults with
28 disabilities~~{delete}~~ who are unable to live independently and who meet ~~{delete}~~ ^{add} have^{add} the highest or ^{add} a^{add}
29 high ^{add} need for a NF^{add} level of ~~{delete}~~ ^{add} care **{ Restore the word “care”}** as determined through the evaluation
30 conducted by the Assessment and Coordination Organization as specified in Section 0399.06.~~{delete}~~ Each
31 Medicaid beneficiaries opting

32 Proposed Rules: 53

1 for RItE @ Home services will have a RItE @ Home Service and Safety Plan, developed to meet their own
2 unique, 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 **0399.21PROG 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
17 Assistance 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
21 highest 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
23 scope of Medicaid State Plan categorical and medically needy services and the following additional
24 services: o Multidisciplinary assessment and treatment planning; o Case Management services; o Personal
25 Care; o Homemaking; o Rehabilitation; o Social Work; o Transportation; o Nutritional Counseling;
26 o 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
4 state plan services and supports through the program.^{add} There are no benefits outside of the PACE
5 program. ^{add} Information about eligibility, enrollment and disenrollment in the PACE program is located in
6 Section 0374 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 • ~~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 • ~~Determination of income to be allocated to cost of care~~ (share);
- 12 • ~~Maintenance of the DHS InRhodes and paper case file;~~
- 13 • ~~Assisting disenrolled clients in application for alternate Medicaid Long Term Care programs, as needed.~~

14 The approved PACE provider is responsible for:

- 15 • ~~Point of entry identification;~~
- 16 • ~~Submitting all necessary documentation for level of care~~ initial determinations and redeterminations
17 and referral to DHS long term care/adult services offices for financial determinations;
- 18 • ~~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 • ~~Providing and coordinating all needed services;~~
- 21 • ~~Adhering to all PACE Provider requirements as outlined~~ in the PACE Program Agreement between
22 DHS and CMS, and to all credentialing standards required by the DHS Center for Adult Health
23 including data submission.

24 The DHS Center for Adult Health is responsible for:

- 25 • ~~Oversight and monitoring of all aspects of the PACE program;~~
- 26 • ~~Conducting initial Level of Care Determinations~~ and determining whether a permanent Level of Care
27 should be assigned;
- 28 • ~~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 ~~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 • ~~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 • ~~The participant moves out of the PACE program service area or is out of the service area for more than~~
2 ~~thirty (30) days unless the PACE organization agrees to a longer absence due to extenuating circumstances.~~
3 • ~~The PACE organization is unable to offer health care services due to the loss of State licenses.~~
4 • ~~The PACE organization's agreement with CMS and the State administering agency is not renewed or~~
5 ~~terminated.~~
6 • ~~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~~
8 ~~PACE program staff member, contractor, or other PACE program participant.~~
9 • ~~A person whose behavior is jeopardizing his/her health or safety or that of others.~~
10 • ~~A person with decision making capacity who consistently refuses to comply with his/her individual plan~~
11 ~~of 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~~
13 ~~level 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~~
23 ~~or disapprove the involuntary disenrollment request within fifteen (15) days from the date DHS has~~
24 ~~received all information needed for a decision.~~

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

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~~0399.21.05 Loss Of PACE Enrollment~~

~~REV:07/2009~~

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

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

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

~~0399.21.06 Notification to the Participant~~

~~REV:07/2009~~

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

- ~~• A statement that the participant is no longer enrolled in the PACE program;~~
- ~~• The reason(s) for the loss of PACE enrollment.~~

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

~~REV:07/2009~~

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

~~0399.21.08 Voluntary Disenrollment~~

~~REV:07/2009~~

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

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

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

^(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)



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

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

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

5
6 Where “N” represents the total number of periods, “t” represents the period, and “i” represents the discount
7 rate. Total Net Present Value estimates based on a series of assumptions outlined in this document. All NPV
8 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

9 EOHHS is proposing to amend pertinent sections of the Medicaid Code of Administrative Rules, section
10 0399, currently entitled, “Global Consumer Choice Waiver”, renumber it to section #1500, and re-title it:
11 “Medicaid Long-Term Services and Supports: Interim Rule.” These rules are being promulgated
12 pursuant to the authority conferred under Chapters 40- 6 and 40-8 of the General Laws of Rhode Island, as
13 amended, and the federal Section 1115 Waiver approved by the federal Centers for Medicare and Medicaid
14 Services (CMS).

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

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

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

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

27 **Proposed Rules: 59**

1 The chief distinctions between the two types of LTSS are care setting and scope of Medicaid coverage.
2 Beginning on ~~January 1, 2016~~ [Replace “January 1, 2016” with “February 8, 2016”], the series of
3 reforms authorized by state policymakers for modernizing the system for organizing, financing and
4 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.



MOTION: To support the change from the “Care Planning” to “Person-centered care planning of the proposed 1500 Redesign Of Medicaid Long-Term Services And Supports (LTSS) In Rhode Island Amendment to the State Medicaid Code of Administrative Rules are beneficial if amended as follows:

1. **Delay** the effective date from Jan. 1, 2016 until at least February 8, 2016 (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”) in:

- a. Subsection 1500.01 (B) page 02 about line 28;
 - b. Subsection 1500.01 (F) page 13 lines 09, 16, 17, & 18;
 - c. Subsection 1500.01 (F)(1) page 14 line 22
 - d. Subsection 1500.01 F(2) page 15 lines 01, 11, & 21; page 16 lines 17, & 21;
 - e. Subsection 1500.03 C pag3 40 line 36, page 32 line 24;
 - f. Subsection 1500.04 page 36 line 12, page 37 line 27, page 39 line 28;
 - g. Subsection 1500.04 (A)(1)(j) page 37 line 30;
 - h. Subsection 1500.04 (A)(1)(t) page 39 line 31;
 - i. Net Present Value: Section 1500, Medicaid Long-Term Services and Supports - Interim Rule page 60 line 02;
2. **Delay** the expiration date from “December 31, 2015 “until at least “February 7, 2016” in:
- a. Subsection 1500.01 F(2) page 16 lines 08 & 13;
 - b. Subsection 1500.03 (C) page 32 line 24;
3. **Insert** “/functional” between “clinical” AND “eligibility” in:
- a. Subsection 1500.01 (C) page 03 line 09;
 - b. Subsection 1500.01 (D) page 11 line 04;
 - c. Subsection 1500.01 (F)(2) page 15 line 06 & page 18 line 04;
 - d. Subsection 1500.02 (A) page 18 line 12
 - e. Subsection 1500.02 (C) page 22 line 24;
 - f. Subsection 1500.03 (B) page 30 line 25;
 - g. & page 34 line 32;
 - h. Subsection 1500.03 (D) page 34 line 33;
4. **Replace** “CLINICAL” with COMPREHENSIVE” in the title of Subsection 1500.03 (B) in page 29 line 26;
5. **Insert** “/functional” between “clinical” AND “criteria” in:
- a. Subsection 1500.03 (C) page 30 line 22;
6. **Insert** “person centered” before “care planning” in Subsection 1500.03 (C) page 22 line 28.
7. **Insert** a new paragraph “(e) Nursing home diversion. Medicaid funded home modifications and personal care services that are necessary to keep beneficiaries independent in their own homes thereby eliminating the need for nursing facility care.” at the end of Subsection 1500.02 (B)(1) in page 23 after line 14;
8. **Delete** in the last sentence in paragraph (h) of Subsection 1500.04 (A)(1) “such as... additions” Page 37 lines 17 to 28;
9. **Retain** the current Home and Community Based “Highest” level of need definition “, for whom the provision of home and community based services would divert from nursing facility services.” Page

	<p>31 lines 6-13 ;</p> <p>10. Replace in paragraph (p) of Subsection 1500.04 (A)(1) the words starting with “provides” and ending with “safety” with “provides minor changes to the home to prevent nursing home admission, including grab bars, hand rails, tub cuts, widening doorways, offset hinges, removal of glass shower doors and modifying threshold transition.” Page 39 lines 01 to 04.</p> <p>11. Replace “Americans with Disabilities Act (ADA) compliance standards” with “Uniform Federal Accessibility Standards (UFAS)” in Subsection 1500.05(A)(1)(k) page 46 line 14;</p> <p>12. Delete the phrase “that is similar to adult foster care” in the second Subsection 1500.05 (A)(2) on page 53 line 23</p> <p>13. Retain the struck word “care” in the second Subsection 1500.05 (A)(2) page 53 line 28.</p> <p>14. Concern regarding Subsection 1500.04 (A)(a) & (c) about which entity will be responsible for conducting quality monitoring of assisted livings facilities for non-elder residents with dementia? Page 36 line 22. - check with MHA.</p> <p>Motion moved by CG, seconded by AP, passed unanimously</p>
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	<p>RI SPA 15-016 Reinventing Medicaid 2015: Rhode Island Integrated Health Homes</p>
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	<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. 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.
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	<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>
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2 **Rhode Island Integrated Health Homes**

3 **Introduction:**

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

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

- 16 • Comprehensive Care Management;
- 17 • Care Coordination and Health Promotion;
- 18 • Comprehensive Transitional Care;
- 19 • Individual and Family Support Services; and
- 20 • Chronic Condition Management and Population Management.

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

29 Assertive Community Treatment (ACT) is a mental health program made up of a multidisciplinary staff who
30 work as a team to provide the psychiatric treatment, rehabilitation, and support services clients need to
31 achieve their goals. ACT services are tailored for each client to enable each to find and live in their own
32 residence, to find and maintain work, to better manage symptoms, to involve community supports, to achieve
33 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
4 as 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
12 needed services and supports. Learning activities will support providers of health home services in addressing
13 the following components: - Provide quality-driven, cost-effective, culturally appropriate, and person- and
14 family-centered health home services; - Coordinate and provide access to high- quality health care services
15 informed by evidence-based clinical practice guidelines; - Coordinate and provide access to preventive and
16 health promotion services, including prevention of mental illness and substance use disorders; - Coordinate
17 and provide access to mental health and substance abuse services; - Coordinate and provide access to
18 comprehensive care management, care coordination, and transitional care across settings (transitional care
19 includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and
20 facilitating transfer from a pediatric to an adult system of health care); - Coordinate and provide access to
21 chronic disease management, including self-management support to individuals and their families; -
22 Coordinate and provide access to individual and family supports, including referral to community, social
23 support, and recovery services; - Coordinate and provide access to long-term care supports and services; -
24 Develop a person-centered treatment plan for each individual that coordinates and integrates all of his or her
25 clinical and non-clinical health-care related needs and services; - Demonstrate a capacity to use health
26 information technology to link services, facilitate communication among team members and between the
27 health home team and individual and family caregivers, and provide feedback to practices, as feasible and
28 appropriate, and; - Establish a continuous quality improvement program to collect and report on data that
29 facilitates an evaluation of increased coordination of care and chronic disease management on individual-level
30 clinical outcomes, experience of care outcomes, and 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. **Insert “The multi-disciplinary teams for**
3 **individuals receiving both developmental disabilities and behavioral health care services**
4 **shall include personnel from the developmental disabilities service provider.”** The recipient of
5 comprehensive care management is an individual with complex physical and behavioral health needs.

6 Ways Health IT Will Link:

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

8 1. Program has structured information systems, policies, procedures, and practices to create, document,
9 implement, and update a treatment plan for every consumer.

10 2. Health Home provider has a systematic process/system to follow-up on tests, treatments,
11 services/referrals which is integrated into the consumer's treatment plan.

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

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

20 4. Programs are committed to work with Rhode Island's health information exchange system
21 (CurrentCare) and be in compliance with any future version of the Statewide Policy Guidance
22 regarding information, policies, standards, and technical approaches, governing health information
23 exchange.

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

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

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

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

35 **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,

- Assist clients in making behavioral changes leading to positive lifestyle improvement, and
- Help clients set and achieve a wellness or health goal using standardized programs such as Whole Health Action Maintenance (WHAM).

Ways Health IT Will Link:

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

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

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

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

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

5. Programs have the capability to share information with other providers and collect specific quality measures as required by EOHHS and CMS.
6. Program is able to use EOHHS and CMS quality measures as an accountability framework for assessing progress towards reducing avoidable health costs, specifically preventable hospital admissions/readmissions, avoidable emergency room visits, and providing timely post discharge follow-up care.

Integrated Health Home: 9

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

Chronic Condition Management and Population Management

Service Definition:

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

- ❖ Assisting in the development of symptom self-management, communication skills, and appropriate social networks to assist clients in gaining effective control over their psychiatric symptoms;
- ❖ Provide health education, counseling, and symptom management to enable client to be knowledgeable in the oversight of chronic medical illness as advised by the client's primary/specialty medical team;
- ❖ Maintaining up-to-date assessments and evaluations necessary to ensure the continuing availability of required services;
- ❖ Assisting the client in locating and effectively utilizing all necessary medical, social, and psychiatric community services;
- ❖ Assisting in the development and implementation of a plan for assuring client income maintenance, including the provision of both supportive counseling and problem-focused interventions in whatever setting is required, to enable the client to manage their psychiatric and medical symptoms to live in 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
- 21 benefits counseling;
- 22 • Teach money-management skills (e.g. budgeting and bill paying) and assist client assessing
- 23 financial services (e.g. payeeship 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:

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.

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 DLA⁵, 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.

⁵ Daily Living Activities assessment

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.
- 5 **10.** Evidence that the outcome and evaluation tools being used by the health care team uses quality
6 metrics, including assessment and survey results and utilization of services to monitor and evaluate
7 the impact of interventions.

8 **Care Coordination and Health Promotion**

9 The medical record shall provide evidence that:

- 10 **1.** Each consumer on the Program's team has a dedicated case manager who has overall responsibility
11 and accountability for coordinating all aspects of the consumer's care.
- 12 **2.** A Program has a relationship with the community agencies in its local area. To that end it can
13 provide evidence that the case managers can converse with these agencies on an as- needed basis
14 when there are changes in a consumer's condition.
- 15 **3.** A Program facilitates collaboration through the establishment of relationships with all members of
16 consumer's interdisciplinary health team.
- 17 **4.** Policies, procedures and accountabilities (contractual or memos of understanding agreements) have
18 been developed to support and define the roles and responsibilities for effective collaboration
19 between primary care, specialists, behavioral health, long-term services and supports and
20 community-based organizations.
- 21 **5.** A psychiatrist or APRN/Nurse Practitioner provides medical leadership to the implementation and
22 coordination of program's activities by developing and maintaining working relationships with
23 primary and specialty care providers including various inpatient and long-term care facilities.
- 24 **6.** Protocol has been developed for priority appointments for Program's consumers to behavioral health
25 providers and services, and within the Program's provider network to avoid unnecessary or
26 inappropriate utilization of emergency room, inpatient hospital and institutional services.
- 27 **7.** The Program's provider has a system to track and share consumer's patient care information and
28 care needs across providers and to monitor consumer's outcomes and initiate changes in care, as
29 necessary, to address consumer needs.
- 30 **8.** 24 hours/seven days a week availability to provide information/emergency consultation services to
31 the consumer.

1 **Integrated Health Home: 13**

2 **Comprehensive Transitional Care**

3 The consumer's medical record shall provide evidence that:

- 4 **1.** A Program's case manager is an active participant in all phases of care transition, including timely
5 access to follow-up care and post-hospital discharge (see metrics).
- 6 **2.** The Program's provider has policies and procedures in place with local practitioners, health facilities
7 including emergency rooms, hospitals, residential/rehabilitation settings, and community-based
8 services, to help ensure coordinated, safe transitions in care.
- 9 **3.** A notification system is in place with Managed Care Organizations to notify the Programs of a
10 consumer's admission and/or discharge from an emergency room, inpatient unit, nursing home or
11 residential/rehabilitation facility.
- 12 **4.** The Program collaborates with physicians, nurses, social workers, discharge planners, pharmacists,
13 and others to continue implementation of the treatment plan with a specific focus on increasing the
14 consumer's ability to self-mange care and live safely in the community.
- 15 **5.** Care coordination is used when transitioning an individual from jail/prison into the community.

16 **Individual and Family Support Services**

17 The consumer's medical record shall:

- 18 1. Incorporate, through the consumer's treatment plan, the consumer and family preferences, education,
19 support for self-management, self-help, recovery, and other resources as needed to implement the
20 consumer's health action goals.
- 21 2. Identify and refer to resources that support the consumer in attaining the highest level of health and
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: 4**

- 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.

	Numerator	Denominator	Definition
IHH Year 1 Performance Measures: quarter data collected			
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 preceding 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

	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 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

	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
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:

	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) ⁶ 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 observation; skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care	Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	Percentage of discharges from an inpatient facility to home or any other site of care which a transition record was transmitted to the facility, home health provider or primary

⁶ a measure of blood sugar control over the past 2 to 3 months.

	Numerator	Denominator	Definition
			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 AOD 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 ⁷ 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 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	Number of hospital admissions for chronic conditions per 100,000 member months for health home enrollee age 18 and older.

⁷ Foot note not included in regulation

	Numerator	Denominator	Definition
		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.

Integrated Health Home: 21

Payment Methodology:

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

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

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

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

4. Providers must agree to contract and accept the rates paid by the Managed Care Organization as established with the Executive Office of Health and Human Service (EOHHS) and BHDDH as the sole and 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.

1 **Integrated Health Home: 22**

- 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
 25 expectations that consists of one (1) Master's level coordinator, two (2) registered nurses, one (1) hospital
 26 liaison, five (5) 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)

1 **Integrated Health Home: 23**

	IHH			
	OCCUPANCY	100.0%		
	CLIENTS	200		

Program Staff:					
Qualifications:			FTE	Cost/FTE	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

Integrated Health Home: 25

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 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	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

IHH Year 1 Performance Measures: quarter data collected	Numerator	Denominator	Definition
	clinical advice.		
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
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
MOTION: To support the person-centered care & integration of physical, medical and behavioral health service model of the proposed RI Medicaid State Plan Amendment 15-016 Reinventing			

Medicaid 2015: Rhode Island Integrated Health Homes. Specific sections of the proposal would be beneficial if amended as follows:

1. **Delete** the listing of agencies in the subsection on Provider Infrastructure, page 02 lines 15 - 21;
2. In the subsection on Provider Standards, page **Insert** in the subsection on Comprehensive Care Management, “The multi-disciplinary teams for individuals receiving both developmental disabilities and behavioral health care services shall include personnel from the developmental disabilities service provider.” In page 04 line 02;
3. **Spell out** acronyms (BMI, DLA, ED, HEDIS, SUD) first time used, especially in the Subsection on Monitoring;
4. **Footnote 8** in the Monitoring “IHH Year 1 Monitoring Measures” table regarding “metropolitan area” in “Prevention Quality Indicator (PQI 92: Numerator” is missing in page 20;
5. **In** Subsection on Payment Methodology -
 - a. Is the “12. Basis for IHH Methodology for IHH” staffing model a required minimum or maximum FTE’s, on pages 22 and 23?
 - b. The payment rate “Total” column mirrors the “Cost/FT” column, even when the “FTE” column is greater than 1 on page 23.
 - c. Is the “13. Basis of Methodology for ACT” staffing model a required minimum or minimum FTE’s, on page 24?
 - d. Why a 40% administrative overhead?

Motion moved by AP, seconded by AS, passed unanimously
 MOTION: To request a hearing on IHH
 Moved by AP, seconded by CG, passed unanimously

4:10 Refiled 2015 legislation that impact people with disabilities, Bob Cooper



Purpose/Goal: To review refiled legislation the Committee took a position on during the 2015 session, determine the potential impact on people with disabilities, and adopt legislative impact statements.

Civil Rights

16 H 7059 AN ACT RELATING TO STATE AFFAIRS AND GOVERNMENT -- COMMISSION ON STANDARDS AND TRAINING

Rep. Lombardi Referred to House Health, Education, & Welfare Committee
 This act would require mandatory training standards for police officers and trainees, in identifying, responding, and handling all incidents involving any person with a developmental disability.
 This act would take effect upon passage.

Last year the Legislation Committee found this bill Beneficial if amended -merged with H 7060 and expanded to include persons who

	<p>are deaf/hard of hearing</p> <p>16 H 7060 AN ACT RELATING TO STATE AFFAIRS AND GOVERNMENT -- COMMISSION ON STANDARDS AND TRAINING</p> <p>Rep. Lombardi Referred to House Health, Education, & Welfare Committee This act would require for police officer commission on standards and training to establish mandatory training standards for police officers and trainees in all incidents involving mental health literacy. This act would take effect upon passage. Last year the Legislation Committee found this bill Beneficial if amended - merged with H 7059 and expanded to include persons who are deaf/hard of hearing</p>
	<p>MOTION: To find beneficial if amended to merge both and add deaf, hard of hearing and traumatic brain injury on 16 H 7059 & H 7060 Acts Relating To State Affairs And Government -- Commission On Standards And Training.</p> <p>Motion moved by AS, seconded by CG, passed unanimously</p>
	<p style="text-align: center;"><u>Housing</u></p> <p>16 H 7076 AN ACT RELATING TO STATE AFFAIRS AND GOVERNMENT -- HOUSING RESOURCES -- HOMELESS SHELTERS</p> <p>Rep. Lombardi Referred to House Finance Committee This act would create a committee to establish homeless shelter standards. The committee would include: One homeless or formerly homeless person; Two (2) representatives of the Rhode Island homeless advocacy project; One representative of the Rhode Island coalition for the homeless; Two (2) homeless shelter providers operating a shelter for individuals; Two (2) homeless shelter providers operating a shelter for families; One representative from the Rhode Island office of housing and community development; One domestic violence shelter provider; and One resident or former resident of a domestic violence shelter. This act would take effect upon passage. Last year the Legislation Committee found this bill Beneficial if amended to add a representative from either the Executive Office of Health and Human Services or the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals and a rep of a consumer organization</p>
	<p>MOTION: To find beneficial if amended to add one (1) representative of EOHHS/BHDDH and one (1) representative of disability consumer organization. 16 H 7076 An Act Relating To State Affairs And Government -- Housing Resources -- Homeless Shelters.</p> <p>Motion moved by CG, seconded by AP, passed unanimously</p>
	<p style="text-align: center;"><u>Transportation</u></p> <p>16 S 2005 & H 7008 ACTS RELATING TO HIGHWAYS - SIDEWALKS</p> <p>Sen. Goodwin Referred to Senate Housing and Municipal Government Committee Rep. Blasejewski Referred to House Finance Committee This act would require the director of the department of transportation to organize and complete snow removal on all sidewalks located on state highway</p>

	<p>overpasses and on all pedestrian overhead walkways under the control of the state, that have significant pedestrian traffic, within twenty-four (24) hours after the end of a snowstorm. This act would take effect upon passage. Last year the Legislation Committee found these bills Beneficial</p>
	<p>MOTION: To find beneficial on 16 S 2005 & H 7008 Acts Relating To Highways - Sidewalks. Motion moved by AP, seconded by CG, passed unanimously</p>
	<p style="text-align: center;"><u>Special Education</u> This year's legislative package includes</p> <p>“Enactment of the 2016 versions of H 5383⁸ and S 299 SUB A act would direct all school superintendents to review discipline data for their school district, to decide whether there is a disparate impact on students based on race, ethnicity, or disability status.” The Commission did not endorse the 2nd half of this year's bills to “also, student suspensions would not be served out of school unless the student's conduct meets certain standards or the student represents a demonstrable threat to students, teachers or administrators.”</p> <p>16 H 7056 & H 7057 ACTS RELATING TO EDUCATION - SCHOOL COMMITTEES AND SUPERINTENDENTS</p> <p>Rep. Diaz Referred to House Health, Education, & Welfare Committee Rep. Lombardi Referred to House Health, Education, & Welfare Committee This act would direct all school superintendents to review discipline data for their school district, to decide whether there is an unequal impact on students based on race, ethnicity, or disability status, and to respond to any disparity. Every school district would submit a report to the council on elementary and secondary education describing any action taken on the disparity. All such reports shall be public records. Also, student suspensions would not be served out of school unless the student's conduct meets certain standards or the student represents a demonstrable threat to students, teachers or administrators. This act would take effect upon passage. Last year the Legislation Committee found these bills Beneficial if amended to add a definition of discipline</p>
	<p>MOTION: To support if amended to include a definition of discipline 16 H 7056 & H 7057 Acts Relating To Education - School Committees And Superintendents Motion moved by CG, seconded by AP, passed unanimously</p>
	<p><i>4:25 Agenda for the Next Meeting, Linda Ward</i></p> <p>Purpose/Goal: To set the agenda for the next meeting.</p> <p>Discussion: The Legislation Committee meetings in 2015 will be on the 1st Monday 3 - 4:30 PM: 02/01, 03/07,</p>

⁸ H 5383 <http://webserver.rilin.state.ri.us/BillText/BillText15/HouseText15/H5383.pdf> and S 299 SUB A
<http://webserver.rilin.state.ri.us/BillText/BillText15/SenateText15/S0299A.pdf>



4:30 Adjournment, Linda Ward

MOTION: To adjourn at 4:39 PM

Motion moved by CG, seconded by AP, passed unanimously