



# Governor's Commission on Disabilities' Special Joint Legislation & Executive Committees

**Monday January 5, 2009 5 – 7 PM**

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<b>Legislation Attendees:</b>	Timothy Flynn (Chair.); Kate McCarthy-Barnett (Vice Chair.); Jeanne Behie; Sharon Brinkworth; Rosemary C. Carmody; Elaina Goldstein; William R. Inlow; Katherine Lowe; Arthur M. Plitt; Rev. Gerard O. Sabourin; Janet Spinelli; & Linda Ward	
<b>Absent:</b>	Raymond Bandusky; Linda Deschenes; Liberty Goodwin; Susan Hurd; Paula Parker; & Gwendolyn Reeve	
<b>Executive Attendees:</b>	Timothy Flynn (Vice Chair.); Rosemary Carmody; Kate McCarthy-Barnett; Lorna Ricci; & Patricia Ryherd	
<b>Absent:</b>	John MacDonald (Chair.); Judi Drew; Ronald McMinn; Bill Nieranowski; & John Treat	
<b>----- Minutes -----</b>		
<b>Call to Order</b>	<b>Tim Flynn Legislation Cmte. Chairperson &amp; John J. MacDonald, Executive Cmte. Chairperson</b>	<b>5 min.</b>
<p>The meeting was called to order by Tim Flynn, Commission Vice Chairperson and Legislation Committee Chairperson.</p> <p>Introductions: Members and guests introducing themselves.</p>		
<b>The Federal Offer RI Global (Medicaid) Compact – Discussion and Vote on its Impact on People with Disabilities and their Families</b>	<b>Tim Flynn, Vice Chair, Commission</b>	<b>110 Min.</b>
<p>Discussion: Members review the Federal Offer sections on:</p> <ul style="list-style-type: none"> <li>II. Program Description And Objectives</li> <li>IV. Title XIX Program Flexibility</li> <li>V. Eligibility, Benefits and Enrollment</li> <li>VII. Delivery System – Subsection 34. Assessment and Coordination Organization</li> <li>VII. Delivery System – Subsection 35. Institutional and community based long-term care services ... and VIII. Self-Direction</li> <li>XV. Monitoring Budget Neutrality for the Demonstration</li> </ul>		
<b>Comparison of RI's August Proposal and Centers for Medicaid &amp; Medicare's December Offer</b>		
<b>August 2008 RI Medicaid Proposal</b>	<b>December 2008 Federal Medicaid Offer</b>	
<b>5:15 – 5:30</b>		

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<p><b>Statement of Purpose: The Principles of Medicaid Reform</b> (pg 5)</p> <p><b>1. Guiding Principles of Reform</b>  The design of the Global Compact waiver was guided by Medicaid reform principles, each of which has either been influenced by or integrated into the demonstration. This core set of principles is as follows.</p> <p><b>Consumer Empowerment and Choice.</b> If consumers have more information about and control over their health care and community support options, they will make more reasoned and cost-effective choices about their health, often enhanced when their good decision-making is rewarded.</p> <p><b>Personal Responsibility.</b> Consumers will become better health care purchasers for themselves and their families when they have easy to understand and accurate information and timely access to a continuum of needed services. Health Savings Accounts and the wraparound planning process are two methods that demonstrate the effectiveness of consumer choice and personal responsibility.</p> <p>* <b>Community-based care solutions.</b> Rhode Island is committed to offering consumers care in the “least restrictive settings” and to assisting more beneficiaries who require long-term care to remain in the community. The State’s Medicaid redesign is based on the assumptions, articulated most clearly in the Olmstead law case and the New Freedom Initiative that an expanded continuum of care that includes community-based services will result in improved health, quality of life and more cost-effective care.</p> <p>* <b>Prevention, Wellness and Independence.</b> The Medicaid program will strive to better enable consumers to receive individualized health care that is outcomes-oriented and focused on prevention, recovery and retaining/maintaining independence.</p> <p>* <b>Competition.</b> Competition among health care providers is necessary to ensure best value purchasing, leverage resources and create opportunities for improving service quality and performance.</p> <p>* <b>Pay for Performance.</b> Medicaid purchasing and payment methods will encourage and reward service quality and cost-effectiveness by tying reimbursements to physicians, dentists, hospitals, and other major health care providers to common, evidence-based quality performance measures, including patient satisfaction.</p> <p>* <b>Improved Technology.</b> Current technology must be leveraged to take advantage of recent innovations and advances that assist decision makers, consumers and providers to make informed and cost-effective decisions</p>	<p><b>II. PROGRAM DESCRIPTION AND OBJECTIVES</b> (pg 2)</p> <p>The Special Terms and Conditions set forth herein define the scope of the Demonstration and, as such, will serve as the compact between the federal government and the State governing operations of the Medicaid program with respect to:</p> <p><b>Program Flexibility:</b> The State’s authority and the type of administrative processes for making changes in the Medicaid program during the Demonstration that further the goals of the Demonstration and program reform more generally. The State is awarded this flexibility to demonstrate that it can provide Medicaid beneficiaries access to the most appropriate services without eliminating populations;</p> <p><b>Aggregate Budget Ceiling:</b> Federal financial responsibilities will be subject to an aggregate budget ceiling. While the State will be at risk for caseload and unforeseen cost trends, the State will have tools under the demonstration to adjust demonstration operations so that State financial responsibilities are within its budget targets.</p> <p><b>Savings Reinvestment:</b> The authority of the State to utilize savings achieved in conjunction with implementation of the Demonstration to promote the following core principles of reform:</p> <ul style="list-style-type: none"> <li>o <b>Consumer Empowerment and Choice:</b> To provide consumers more information and control over their health care and community support options.</li> <li>o <b>Personal Responsibility:</b> To allow consumers to become better health care purchasers for themselves and their families.</li> <li>o <b>Community-based care solutions:</b> To offer community-based health care solutions and alternatives to institutional care for individuals who can appropriately remain in their community.</li> <li>o <b>Prevention and Wellness:</b> To strive to better enable consumers to receive individualized health care that is outcomes-oriented and focused on prevention, wellness, recovery and maintaining independence.</li> <li>o <b>Competition and Value:</b> To allow for greater competition between health care providers and ensure cost-effective purchasing strategies that promote value to taxpayers.</li> <li>o <b>Pay for Performance:</b> To employ Medicaid purchasing and payment methods that encourage and reward service quality and cost-effectiveness by linking reimbursements to common, evidence-based quality performance measures, including patient satisfaction.</li> </ul>

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<p>regarding health care. Timely feedback to consumers on the quality and outcome of the services helps them to be directly involved in the service delivery to adjust to their individualized needs, often resulting in reduced cost of the episode of care.</p>	
<p>MOTION: To support the Federal Medicaid Offer’s Program Description and Objectives Section, subject to assurance that any stimulus increase to Federal Medicaid funding does not reduce the state’s actual Medicaid appropriation. SB/EG, passed, Nay BI</p>	
<p>5:40 – 5:55</p>	
<p><b>4. State Flexibility</b> (pg 46)  Under the proposed demonstration, the State will have the program flexibility to optimize program efficiency and effectiveness. The State commits to continued coverage of all mandatory Medicaid populations and mandatory services. In the event that total available federal and state funds within the Global Waiver are not sufficient to maintain all current populations and benefits, the State requires the flexibility to make some adjustments to eligibility and services covered based on fiscal limits. Alternatively, if there are savings realized within the waiver budget, the State is committed to reinvesting funds into the State’s Medicaid or other state-administered health care programs, including support services that can have impact on health care costs (e.g. assisted living, meals on wheels, accessible housing), wellness and prevention initiatives.</p>	<p><b>IV. TITLE XIX PROGRAM FLEXIBILITY</b> (pg 7)  Rhode Island has flexibility to make changes to its demonstration based on how the changes align with the categories defined below and the corresponding process in this Section paragraph 18 Process for Changes to the Demonstration. The category of changes described below are for changes to the program as described in the STCs. Initiatives described in the STCs are approved upon approval of the demonstration.</p> <p><b>17. Categories of Changes and General Requirements for Each Category.</b> When making changes, the State must characterize the change in one of the three following categories. CMS has 15 calendar days after receiving notification of the change (either informally for Category I or formally for Categories II and III) to notify the State of an incorrect characterization of a programmatic change. The CMS characterization shall be binding and non-appealable as to the procedure to be followed.</p> <p>a) <b>Category I Change:</b> Is a change which is administrative in nature for which the State has current authority under the State plan or demonstration, and which does not affect beneficiary eligibility, benefits, overall healthcare delivery systems, payment methodologies or cost sharing. The State must notify CMS of such changes either in writing or orally in the periodic review calls and update reports as specified in the General Reporting Section paragraphs 71 through 73. Implementation of these changes does not require approval by CMS and can not be effective prior to notification to CMS.</p> <p>Examples of Category I changes include, but are not limited to:</p> <ul style="list-style-type: none"> <li>o Changes to the instruments used to determine the level of care</li> <li>o Changes to the Assessment and Coordination Organization Structure</li> <li>o Changes to general operating procedures</li> <li>o Changes to provider network methodologies (provider enrollment procedures, but not delivery system changes)</li> </ul>

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	<ul style="list-style-type: none"> <li>o Changes to prior authorization procedures</li> <li>o Adding any HCBS service that has a core definition in the 1915(c) Instructions/Technical Guidance if the State intends to use the core definition.</li> <li>o Modifying an HCBS service definition to adopt the core definition.</li> </ul> <p>b) <b>Category II Change:</b> Is a change that could be made as a State Plan Amendment or through authority in sections 1915(b), 1915(c), 1915(i) or 1915(j) without any change in either the STCs, or the section 1115 waiver and expenditure authorities. These changes may affect benefit packages, overall healthcare delivery systems, cost sharing levels, and post-eligibility contributions to the cost of care. Such changes do not, however, include changes that affect beneficiary eligibility (including changes to the level of spenddown eligibility). The State must comply with its existing public notice process prior to implementation, and must comply with the section 1115 demonstration public notice process as described in paragraph 14 of these STCs. The State must notify CMS in writing of Category II changes, and must furnish CMS with appropriate assurances and justification, that include but are not limited to the following:</p> <ul style="list-style-type: none"> <li>i) That the change is consistent with the protections to health and welfare as appropriate to title XIX of the Act, including justification;</li> <li>ii) That the change result in appropriate efficient and effective operation of the program, including justification and response to funding questions;</li> <li>iii) That the changes would be permissible as a State Plan or section 1915 waiver amendment; and that the change is otherwise consistent with sections 1902, 1903, 1905, and 1906, current Federal regulations, and CMS policy interpretive issuances; and</li> <li>iv) Assessment of the cost of the change.</li> </ul> <p>The State must not implement these changes until CMS approves these assurances. CMS will not provide Federal matching funds for activities affected by unapproved but implemented Category II changes. Examples of Category II changes include, but are not limited to:</p> <ul style="list-style-type: none"> <li>o Changes to the ICF/MR, hospital or nursing home level of care criteria that are applied prospectively (not to existing long term care or HCBS recipients);</li> <li>o Adding any HCBS service for which the State intends to use a definition other than the core definition. (The service definition must be included with the assurances.)</li> <li>o Modifying any HCBS service definition unless it is to adopt the core definition.</li> </ul>

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	<ul style="list-style-type: none"> <li>o Adding an “other” HCBS service that does not have a core definition. (The service definition must be included with the assurances.)</li> <li>o Removing any HCBS service that is at that time being used by any participants.</li> <li>o Change/modify or end RIte Share premium assistance options for otherwise eligible individuals;</li> <li>o Changes to payment methodologies for Medicaid covered services including, but not limited to DRG payments to hospitals or acuity based payments to nursing homes;</li> <li>o Healthy Choice Accounts Initiatives;</li> <li>o Changes to State plan benefits;</li> <li>o Benefit changes up to the DRA Benchmark flexibility limits; and</li> <li>o Cost-Sharing Changes up to the DRA limits unless otherwise defined in the STCs or currently waived.</li> </ul> <p>c) <b>Category III Change:</b> Is a change requiring modifications to the current waiver or expenditure authorities including descriptive language within those authorities and the STCs, and any other change that is not clearly described within Categories I and II. In addition, a programmatic change may be categorized as a Category III change by the State to obtain reconsideration after unsuccessfully pursuing approval of the change under Category II. The State must comply with its existing public notice process prior to implementation, and must comply with the section 1115 demonstration public notice process as described in paragraph 14 of these STCs. The State must notify CMS in writing of Category III changes, and submit an amendment to the demonstration as described in paragraph 18: Process for Changes to the Demonstration. Category III changes shall not be implemented until after approval of the amendment by CMS.</p> <p>Examples of Category III changes:</p> <ul style="list-style-type: none"> <li>o All Eligibility Changes</li> <li>o Changes in Mandatory Benefit Package or EPSDT</li> <li>o Spend down level changes</li> <li>o Aggregate cost-sharing changes that would exceed 5 percent of family income unless, otherwise specified in these STCs;</li> <li>o Benefit changes that exceed DRA benchmark flexibility;</li> <li>o Post-eligibility treatment of income; and</li> <li>o Amendments requesting changes to the budget neutrality cap.</li> </ul> <p>18. <b>Process for Changes to the Demonstration.</b> The State must submit the corresponding notification to</p>

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	<p>CMS for any changes it makes to the demonstration as characterized in the Category I, II or III definitions section depending on the level of change. CMS will inform the State within 15 calendar days of any correction to the State's characterization of a programmatic change, which shall be binding and non-appealable as to the procedure for the change. The State must also have a public notice process as described in paragraph 14 of these STCs for Category II and III changes to the demonstration.</p> <p>a) <b>Process for Category I Changes:</b> The State must notify CMS of any changes to the demonstration defined as a Category I change 30 calendar days before implementing the change. The State must also report these changes in the quarterly and annual reports for purposes of monitoring the demonstration. The State does not need CMS approval for changes to the demonstration that are Category I changes.</p> <p>i) If CMS determines at any time subsequent to State implementation of a Category I change that it is not consistent with State assurances, or is contrary to Federal statutes, regulations or CMS policy then CMS reserves the right to take action to request prompt State corrective action as a condition of continued operation of the demonstration. If the State does not take appropriate action CMS reserves the right to end the demonstration per Paragraph 10 of these STCs.</p> <p>b) <b>Process for Category II Changes:</b> The State will notify CMS of any changes to the demonstration defined as a Category II change. This notification will include assurances that the change is consistent with Federal statutes, regulations and CMS policy. The State shall not implement Category II changes until CMS approves the sufficiency of those assurances. No federal funding shall be available for unapproved demonstration activities affected by a Category II change.</p> <p>The State must submit the notification and assurances 45 calendar days prior to the date set by the State for implementing the change. CMS will not provide Federal matching funds for unapproved Category II changes. After receipt of the State's written notification, CMS will notify the State:</p> <p>i) within 45 calendar days of receipt if the assurances supporting the change are approved; or</p> <p>ii) within 45 calendar days of receipt if the assurances do not establish that the change is consistent with Federal statutes, regulations and CMS policy. As part of the notification CMS will describe the missing information, necessary corrective actions and/or additional assurances the State must pursue to make the</p>

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	<p>change consistent.</p> <p>iii) During days 46 and beyond CMS will be available to work with the State. During this time period the State can provide to CMS additional justification or assurance in order to clarify the appropriateness of the change.</p> <p>iv) During days 46 through 75 the State upon taking appropriate action, must submit a written statement to CMS indicating how the State has addressed CMS concerns on the assurances. Within 15 calendar days of the date of the additional submission CMS will notify the State if the assurances are approved.</p> <p>v) By day 90 if the assurances have not been approved by CMS, then the State may obtain reconsideration by pursuing the change as a Category III change.</p> <p>vi) If CMS determines at any time subsequent to State implementation of an approved Category II change that the assurances are no longer valid, CMS shall request prompt State corrective action as a condition of continued operation of the demonstration.</p> <p>c) <b>Process for Category III Changes.</b> The State must submit an amendment to the demonstration as defined in paragraphs below.</p> <p>i) All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 18 c) ii) below. The State will notify CMS of proposed Demonstration changes at the monthly monitoring call, as well as in the written quarterly report, to determine if a formal amendment is necessary.</p> <p>ii) Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must be reviewed by the Federal Review Team and must include, but are not limited to, the following:</p> <p>(1) An explanation of the public process used by the State consistent with the requirements of paragraph 14 to reach a decision regarding the requested amendment;</p> <p>(2) A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality expenditure cap. Such analysis must include current “with waiver” and “without waiver” status on both a summary and detailed level through the current extension approval period using the</p>

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	<p>most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment;</p> <p>(3) An up-to-date SCHIP Allotment Neutrality worksheet;</p> <p>(4) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation including a conforming title XIX and/or title XXI State plan amendment if necessary; and</p> <p>(5) If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.</p>

**MOTION:** To oppose the Federal Medicaid Offer’s IV. Title XIX Program Flexibility Section, unless state law requires public hearings prior to the submission of category II or III changes to the Centers for Medicare and Medicaid. AP/LW passed unanimously

<p><b>A. COMPONENT I --Rebalancing the Long Term Care System and De-Institutionalization across the Spectrum</b> (pg 25)</p> <p>Rhode Island’s long-term care system is heavily based on nursing home care, residential care and high-end services in restrictive and costly venues. Through this Global Compact change initiative, the State proposes to rebalance the system in favor of community-based care by diverting prospective admissions, transitioning beneficiaries whenever appropriate and feasible and developing care setting and service alternatives. The goal of this facet of reform is to move towards a 50/50 split in the total dollars spent for beneficiaries receiving services in institutional and residential high-end placements versus less restrictive, but care appropriate settings in the community by 2013.</p> <p>The component of the demonstration reflects the State’s commitment to implement a service delivery system that encourages individual self-determination, family direction/involvement, interagency collaboration, and individual choice through the provision of highly specialized and individually tailored home-based services. As such, the State’s goal is to encourage the self-determination of all individuals receiving services, and draw on natural support systems wherever possible. Through formal and structured interagency collaboration in determining the needs for and scope of services, the entire community-based service delivery system for all individuals will improve, and ultimately, ensure that each person receives the best possible combination of age-appropriate services and supports.</p> <p><b>1. Restructuring the Long Term Care (LTC) System</b></p>	<p><b>V. ELIGIBILITY, BENEFITS AND ENROLLMENT</b> (pg 12)</p> <p>19. <b>Overview.</b> The Global Consumer Choice Compact includes several distinct components including.</p> <p>a) The RIte Care program provides Medicaid State Plan benefits through comprehensive mandatory managed care delivery systems to most recipients under the State plan the amount, duration and scope of these services may vary are subject to Section IV Program Flexibility.</p> <p>b) The Extended Family Planning program provides access to services to women whose income is at or below 200 percent of the FPL, and who lose Medicaid eligibility under RIte Care at the conclusion of their 60-day postpartum period. See Section IX for more detailed requirements.</p> <p>c) RIte Share, the State’s premium assistance program, enrolls individuals who are eligible for Medicaid/SCHIP and are an employee or dependent of an employee of an employer that offers a “qualified” plan into the ESI coverage.</p> <p>d) Rhody Health Partners provides Medicaid State Plan benefits to aged, blind, and disabled beneficiaries who have no other health insurance through a managed care delivery system. The amount, duration, and scope of these services may vary.</p> <p>e) Connect Care Choice provides Medicaid State Plan benefits to aged, blind, and disabled beneficiaries who have no other health insurance through a primary care case management system, The amount, duration, and scope of these services may vary.</p> <p>f) Home and Community Based Service Programs Authorized under Sections 1915(c), referenced in</p>
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<p>To achieve balance in Rhode Island’s long-term care system, the paradigm must shift to eliminate the existing institutional bias in long-term care and create the infrastructure for a person-centered system that provides a broad array of community-based care choices. The Global Compact Waiver will achieve this shift by enabling the State to use its flexibility to reduce reliance on high-end institutional placements, expand available and effective community-based services, and empower beneficiaries and their families to determine the most appropriate setting for their care.</p> <p><b>Level of Care and Service Determinations</b></p> <p>Two of the most significant changes to be implemented with the additional flexibility provided to the State under this proposed demonstration are: (1) the consolidation of the State’s various Section 1915 (c) Home and Community Based Service (HCBS) waivers; and (2) the development and implementation of a new three-tier level of care determination process. Both the consolidation of the State’s HCBS waivers and the further refinement of level of care determinations are essential for assuring that every beneficiary requiring long-term care is able to access the right services in the most appropriate setting regardless of the basis of eligibility for services. Access to primary and acute health care is not impacted by these levels of care determinations.</p> <p>To replace the current single level of care determination, Rhode Island will draw on elements from the successful long-term care initiatives of other states that utilize a system for determining the scope of necessary services through an assessment of the need for an institutional level of care -- i.e., nursing facility, Intermediate Care Facility for Mental Retardation (ICFMR), and hospital. The service tiers developed through an interagency collaboration are as follows:</p> <ul style="list-style-type: none"> <li>* The <b>highest level of care</b> will be reserved for nursing home and residential treatment facilities. Beneficiaries meeting this level of care will also have the option to choose community-based care, including an extensive menu of services and supports.</li> <li>* A <b>high level of care</b> will allow the beneficiary access to an array of community-based core services, including but not limited to shared living, assisted living and home care services and supports.</li> <li>* A <b>preventive level of care</b> will enable beneficiaries to receive services targeted at preventing re-admissions or reducing lengths of stay. Funding will be established for a service package that will include such items as homemaker services, home modifications or physical</li> </ul>	<p>Paragraph 28 d) and 1915(i) of the Act enroll and serve individuals who need home and community based services either as an alternative to institutionalization or otherwise based on medical need.</p> <p><b>20. Specific Eligibility Criteria.</b> Mandatory and optional Medicaid and/or SCHIP State Plan groups described below are subject to all applicable Medicaid laws and regulations except as expressly waived under authority granted by this Demonstration. Those groups made eligible by virtue of the expenditure authorities expressly granted in this Demonstration are subject to Medicaid and/or SCHIP laws, regulations and policies except as expressly identified as not applicable under expenditure authority granted by this Demonstration. Below is a chart that provides an overview of the eligibility groups. Eligibility will be determined by the Rhode Island Medicaid State Plan, the Rhode Island SCHIP State Plan, or the definition(s) of demonstration eligible expansion populations.</p> <p><b>21. AFDC-Related Eligibility Determinations .</b> To reflect a policy of family responsibility, in determining the eligibility of individuals reported in Budget Groups 3, 4, and 7-9, the State considers the income of the applicant based on the entire family unit, including the applicant as well as that the following family members who reside in the household: (1) individuals for whom the applicant has financial responsibility; (2) individuals who have financial responsibility for the applicant; and (3) any other individual for whom such individual in (2) above has financial responsibility. Note: the income of a step-parent who has financial responsibility is also included when determining eligibility for an applicant child.</p> <p><b>22. Resource Test:</b> Notwithstanding the general financial standards described above, individuals who would not qualify as eligible under the approved State plan as in effect on November 1, 2008 cannot be eligible under this demonstration if they have liquid resources (cash, marketable securities and similar assets) at or above the amount of \$10,000. Pregnant women are exempt from this resource test.</p> <p><b>23. Eligibility Determinations – ABD Related.</b> Eligibility determinations for ABD related populations in the community must follow the income and resource methodologies of the SSI program and the current Medicaid State Plan.</p> <p><b>24. Eligibility/Post-Eligibility Treatment of Income and Resources for Institutionalized Individuals.</b> In determining eligibility for institutionalized individuals, the State must use the rules specified in the currently</p>

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<p>therapy services.  <b>Core services</b> will be available to beneficiaries that meet the criteria for the <b>highest level</b> of care at all times and to those qualifying at the <b>high level of care</b> group, but only to the extent <b>funding is available</b>.  <b>Preventive services</b> will be available to the <b>highest level of care</b> group at all times and to the <b>high and preventive level of care</b> group, but again only as long as <b>adequate funding</b> is available.  <b>[Core Services:</b>  Personal Care Services  Home Health Services  Home Modifications  Companion Services  Supportive Employment  Personal Emergency Response Systems  Adult Day Programs  Service Coordination  Assisted Living  Medication Management  Meal on Wheels  Adult Day Care  Shared Living  Assistive Devices  Family Support  Behavior Management  Case Management]  <b>[Preventive Services:</b> Homemaker Services  Minor Home Modifications  Respite  Physical Therapy Evaluations  Home-Based Treatment Services]</p>	<p>approved Medicaid State plan.  All individuals receiving institutional services must be subject to post-eligibility treatment of income rules set forth in section 1924 of the Act and 42 CFR section 435.733.  <b>25. Individuals Receiving 1915(c) Like Services.</b>  i) <b>Categorically Needy individuals at the Highest Level of Care.</b> The State will use institutional eligibility and post eligibility rules for individual who would only be eligible in the institution in the same manner as specified under 42 CFR 435.217, 435.726 and 435.236 of the federal regulations and section 1924 of the Social Security Act, to the extent that the State operates a program under the demonstration using authority under section 1915(c) of the Act.  ii) <b>Categorically needy individuals at the High Level of Care.</b> The State will use institutional eligibility and post eligibility rules for individuals who would not be eligible in the community because of community deeming rules in the same manner as specified under 42 CFR 435.217, 435.726, and 435.236 of the federal regulations and 1924 of the Social Security Act, to the extent that the State operates a program under the demonstration using authority under section 1915(c) of the Act.  <b>26. Maintenance of Current Optional Populations.</b> The State must maintain eligibility of all optional populations that would be eligible under the approved Medicaid State Plan as of November 1, 2008, except to the extent that this demonstration expressly permits changes in eligibility methods and standards. Any changes affecting these populations will be considered a Category III Change as specified in paragraph 17 of these STCs. In making any such changes the State must give priority to extension or continuation of eligibility for optional populations prior to extension or continuation of eligibility for expansion groups unless it has been determined by the State that the extension or continuation of eligibility for the expansion groups is essential for achieving the purposes of the demonstration.  <b>27. Benefits.</b> Benefits provided through this demonstration programs are as follows:  a) <b>RIte Care.</b> Benefits are the full scope of benefits set forth in the approved State plan as of November 1, 2008, unless specified in this document. Benefits are delivered through managed care organizations or managed care delivery systems, with the exception of certain services paid by the State on a fee-for-service basis. All benefits that are available to RIte Care</p>

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	<p>enrollees under this Demonstration are listed in Attachment A. The State has the flexibility to provide customized benefit packages to beneficiaries based on medical need, and the amount duration and scope of all covered services may vary to reflect the needs of the populations served.</p> <p>b) <b>Extended Family Planning Program.</b> Family planning services are provided for a maximum period of 24 months to eligible recipients at or below 200 percent of the FPL who lose Medicaid eligibility at the conclusion of their 60-day postpartum period. See Section IX for more detailed requirements.</p> <p>c) <b>Long-Term Care and HCBS.</b> The State has the flexibility to provide customized benefit packages to beneficiaries that include long-term care and home and community based services based on medical necessity and an individual's plan of care. In addition the State will provide all individuals who meet the highest, high or preventive level of care criteria with access to HCBS, as described in paragraph 28, subject to any waiting list as described in paragraph 29. The service definitions are included in Attachment B of this document. The amount, duration and scope of all covered services may vary to reflect the needs of the individual in accordance with his or her plan of care. More detailed requirements are provided in this section in paragraphs 28-30.</p> <p>28. <b>Long-Term Care and HCBS.</b> The long-term care component of the demonstration will provide institutional and home and community-based long term care services including an option for self direction to individuals eligible as aged, blind or disabled (ABD) under the Medicaid State Plan. Primary care for this population will be provided through mandatory care management programs, which include Connect Care Choice, and Rhody Health Partners. Based on a level of care determination individuals eligible as ABD under the Medicaid State Plan will fall into the following groups 1) Highest, 2) high and 3) preventive.</p> <p>a) <i>Highest level of care.</i> Individuals who are determined based on medical need to require the institutional level of care will receive services through nursing homes, long term care hospitals or intermediate care facilities for the mentally retarded (ICF/MR). Beneficiaries meeting this level of care will have the option to choose community-based care including core and preventive services as defined in Attachment B.</p> <p>b) <i>High level of care.</i> Individuals who are determined based on medical need to benefit from either the institutional level of care or a significant level of home and community-based services will have access to</p>

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	<p>community based core and preventive services as defined in Attachment B.</p> <p>c) Preventive level of care. Individuals who do not presently need an institutional level of care will have access to services targeted at preventing admission, re-admissions or reducing lengths of stay in an institution. These beneficiaries will receive preventive services as defined in Attachment B.</p> <p>d) The State will include the services of up to nine of Rhode Island's pre-demonstrational 1915(c) HCBS waivers into the Demonstration. The existing waivers include 0040.90.R5 (Aged and Disabled), 0176.90.R3 (Elderly), 0335.90.R1 (Assisted Living), 0379.90.03 (Habilitation), 0041-IP.03 (Personal Choice), 0462 (Respite for Children-Hospital), 0463 (Respite for Children-ICF/MR), 0466 (Children with Mental Illness), 0162.90.R3 (MR/DD).</p> <p>e) Primary and acute care services for Medicaid ABD eligible individuals meeting the highest, high or preventive level of care may be provided through Primary Care Case Management or Rhody Health Partners or Connect Care Choice plans or other managed fee-for-service (FFS). Individuals who are dually eligible for Medicare and Medicaid will receive primary and acute care services through Medicare FFS, a Medicare Advantage Plan or through the Program of All Inclusive Care for the Elderly (PACE). This STC does not preclude the State from entering into other contract arrangements with entities that can provide these services.</p> <p>29. <b>Waiting List for HCBS.</b> Should a waiting list for long-term care services develop, the State must provide services for individuals classified in higher levels of care categories before providing services to individuals classified in lower categories. Specifically, participants receiving services must continue to receive services unless their condition improves and they move to a lower level of care category. Also, participants and applicants in the highest category are entitled to services and must not be put on a waiting list for institutional services. (If a community placement is not initially available, they may be put on a wait list for transition to the community.) Finally, applicants for the High group must receive services prior to applicants in the Preventive category.</p> <p>30. <b>Long-Term Care Enrollment.</b> For those participants residing in an institution at the point of implementation of the Demonstration, the State must apply pre-demonstration level of care criteria to those individuals unless the participant transitions to the</p>

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	<p>community because he or she (a) improves to a level where they would no longer meet the pre-demonstration institutional level or care, or (b) the individual chooses community care over institutional care. Once that participant is residing in the community, all future level of care redeterminations will be based on the new level of care criteria established for the purposes of this Demonstration.</p> <p><b>31. Program for All-inclusive Care for the Elderly (PACE).</b> PACE is subsumed under this 1115 demonstration program and will remain an option for qualifying demonstration eligibles, i.e., those that meet the High or Highest level of care determinations. The State assures that demonstration eligibles who may be eligible for the PACE program are furnished sufficient information about the PACE program in order to make an informed decision about whether to elect this option for receipt of services. The State will comply with all federal requirements governing its current PACE program, and any future expansion or new PACE program, in accordance with section 1934 of the Social Security Act and regulations at Part 460 of Title 42 of the Code of Federal Regulations.</p> <p><b>32. Long-Term Care Insurance Partnership.</b> The State may implement a Long-Term Care Insurance Partnership Program as described in the Rhode Island State Plan. Under the Long-Term Care Insurance Partnership Program, an individual who is a beneficiary under a qualified long-term care insurance policy is given a resource disregard equal to the amount of insurance benefit payments made to or on behalf of the individual. The State does not seek adjustment or recovery from the individual's estate for the amount of assets or resources disregarded.</p>
<p><b>MOTION:</b> To support the Federal Medicaid Offer's V. Eligibility, Benefits, and Enrollment Section, but the Commission has concerns about the capacity of the system to conduct the assessments and provide community based services. EG/PR passed Nay BI</p>	
<p><b>6:00 – 6:15</b></p>	
<p><b>Assessment and Coordination Organization</b> (pg 27) To ensure beneficiaries served under the Global Compact have access to the appropriate services in the appropriate setting, the State is establishing an interagency long-term care Assessment and Coordination Organization (ACO), under the umbrella of the Executive Office of Health and Human Services. The purpose of this centralized assessment organization is to streamline the intake and assessment processes and provide beneficiaries and their families with clear, concise and accurate information about their care</p>	<p><b>VII. DELIVERY SYSTEM</b> (pg 27) 34. <u>Assessment and Coordination Organization:</u> Access to institutional and community-based supports and services will be through the Assessment and Coordination Organization (ACO). The purpose of the ACO is to streamline the intake and assessment processes and provide beneficiaries and their families with clear, concise, and accurate information about their care options. The ACO is described more fully in Attachment D. <b>Attachment D: Assessment and Coordination</b></p>

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<p>options.</p> <p>The ACO’s chief function will be to serve as the service access point for beneficiaries and their families who are in need of or already receiving long-term care. As such, beneficiaries requiring acute care services through RItE Care and RItE Share or one of the care management systems for adults (Rhody Partners or Connect Care Choice) will not be required to participate in the ACO. Specifically, the Assessment and Coordination Organization will be responsible for providing the following to prospective and current long-term care beneficiaries:</p> <ul style="list-style-type: none"> <li>Conducting assessments for determining level of care needs;</li> <li>Determining level of care;</li> <li>Developing service plans with beneficiaries and their families;</li> <li>Pricing a service budget, authorizing services, and developing a voucher when appropriate;</li> <li>Making referrals to appropriate settings;</li> <li>Reviewing progress and re-authorizing, modifying or focusing access to services based on the client’s feedback and changing needs;</li> <li>Coordinating services with care management entities;</li> <li>Training and educating consumers, discharge planners and providers in coordination with other on-going efforts in this area;</li> <li>Tracking utilization and monitoring outcomes;</li> <li>Conducting interdisciplinary high cost case reviews; and</li> <li>Offering choice counseling to beneficiaries and their families.</li> </ul> <p>As part of the eligibility determination process for long-term care or community support services, Medicaid beneficiaries will receive through the ACO both a targeted assessment and individualized “choice” counseling to assist them in making reasoned decisions about their care options. Current Medicaid beneficiaries who are at risk or develop the need for either intensive residential services (nursing home/ group homes/ child residential) or community support services will also be assessed by the ACO.</p> <p>The ACO’s Choice Counseling program is designed to provide beneficiaries with the information necessary to make educated choices about their care. The ACO will include choice counselors who have experience with special populations. The choice counselors will explain the nature of the global waiver to beneficiaries, as well as their rights around participation, access to service and appeal, and help them choose a plan of care. Accurate information about prices, utilization and quality will be</p>	<p><b>Organization</b> (pg 87)</p> <p><b>Rhode Island Long-Term Services and Supports Assessment and Coordination Organization</b></p> <p><b>Summary:</b></p> <p>The Assessment and Coordination Organization is not an actual organization. It is, instead, the organization of several current disparate <i>processes</i> that individuals and families use when seeking long-term services and supports. Today, if an individual needs institutional or community-based long-term care services, information about those services and how to access them is available from many different sources. These sources include: <i>The Point</i>; 211; community agencies, discharge planners, etc. Despite the well-meaning efforts of these entities, the complexity of Rhode Island’s long-term care system does not always ensure the information is consistent, valid, or current.</p> <p>The first goal of the Assessment and Coordination Organization is to ensure that the information about Rhode Island’s publicly funded long-term services and supports system provided by all sources is accurate and timely. In order to achieve this goal, the State will seek to enter into inter-agency agreements with each entity identified as a primary information source.</p> <p>Different agreements will be developed to reflect the unique relationship each primary information source has with the publicly-funded long-term services and supports system. For example, the State’s Aging and Disability Resource Center, <i>The Point</i>, was created for the sole purpose of providing information, referrals, and general assistance for seniors, adults with disabilities, and their caregivers. The inter-agency agreement with <i>The Point</i> will reflect that role and will differ from the agreement that the State might enter into with community agencies who view information and referral as secondary to their primary missions. Entities such as physician practices will be included in this primary information source group to the extent it is reasonable. For example, primary care practices that participate in the Connect Care Choice program will be given trainings on the existing programs so that they may better serve their Connect Care Choice members who have long-term services and supports needs.</p> <p>The inter-agency agreements will delineate the various ways the primary information source entity will receive information about the publicly funded long-term care systems and other health care programs, including electronic transmissions, written information, trainings, and workshops. The agreements will indicate how to access State agency representatives if more information</p>

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<p>available routinely through the ACO to ensure transparency and ease of access. To both enhance choice and promote personal responsibility, beneficiaries also will be provided with health reports that indicate how much they have spent on their health care and where so they can self-evaluate whether their dollars have been spent well.</p> <p>It is important to note that the State’s <i>Aging and Disability Resource Center (ADRC)</i> – The Point -- will be an integral component of the ACO. The Point will continue to play a crucial role in providing information and referrals and take the lead in implementing the new Choice Counseling program. As The Point serves all elders and adults with the disabilities, Choice Counseling will also be available to members of this population requiring services on the acute care side. For example, such counseling will be provided to assist adult beneficiaries when choosing a care management system – health plan or PCCM. As the role of The Point expands, so too will its capacity to work in collaboration with the ACO staff responsible for processing eligibility, developing service plans, and tracking service demand and utilization. Additionally, the State is currently pursuing a Real Choices Systems Change grant focusing on broadening the capacity of The Point for beneficiaries requiring behavioral health services. The State plans to develop an algorithm to assist the ACO in making determinations of care and service needs that is tied into information provided through the CHOICES MMIS Module now under development as well as to the State’s health information exchange system. Both of these efforts are being financed in whole or in part with Medicaid grants and will be integrated, as appropriate, into the Global Compact Waiver.</p> <p>Centralizing responsibility for determining the scope of care and service level through a single interagency process is designed specifically to shift the loci of decision-making away from providers and to beneficiaries and their families. As such, the ACO will not only assist in drawing a clearer delineation between the payers and providers in the design and implementation of a service plan, but it will also further the long-range objective of reform to break the stronghold providers have over the scope and setting of beneficiary services.</p> <p>Universal functions of the ACO such as training, staff meetings, stakeholder education, assessment tool reviews, and outreach initiatives will be coordinated by EOHHS. Contracted community-based providers will</p>	<p>is needed. The agreements will also provide guidance on the second function of primary information source entities – to appropriately refer individuals to the next step.</p> <p>Appropriate referral is the second goal of the Assessment and Coordination Organization. The State will ensure those primary information sources can direct persons to the appropriate next steps – whether that next step is assessment for long-term care services; counseling for enrollment into an acute care managed care program; or referral to a specific state agency for more information. In order to achieve this goal, the State will develop a universal screening tool.</p> <p>This tool will be developed to quickly capture information necessary for the primary information source to determine the most appropriate placement and/or service referral.</p> <p>Depending on the results of the initial screen, an individual may be referred to the following areas:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Individuals determined to have a potential need for Medicaid funded long-term services and supports in a nursing facility or in the community will be referred to the Rhode Island Department of Human Services (RI-DHS);</li> <li><input type="checkbox"/> Individuals determined to have a potential need for State-only funded long-term services and supports will be referred to the Rhode Island Department of Elderly Affairs (RI-DEA);</li> <li><input type="checkbox"/> Individuals determined to have a potential need for services for the developmentally disabled or mentally retarded will be referred to the Rhode Island Department of Mental Health, Retardation, and Hospitals (RI-MHRH);</li> <li><input type="checkbox"/> Individuals determined to have a potential need for long-term hospital services will be referred to Eleanor Slater Hospital, a state hospital that treats patients with acute and long term medical illnesses as well as patients with psychiatric disorders;</li> <li><input type="checkbox"/> Individuals determined to have a potential need for behavioral health services for a child or for an adult will be referred to the Rhode Island Department of Children, Youth, and Families (RI-DCYF) or the RI-MHRH, respectively;</li> <li><input type="checkbox"/> Individuals who are not seeking information on long-term care services will be referred to the appropriate place. For example, information on acute care managed care options are currently provided by the RI-DHS Enrollment Hotline.</li> </ul> <p>The assessment entities will be responsible for:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> coordinating with the Medicaid eligibility staff;</li> </ul>

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<p>continue to provide ongoing case management for beneficiaries with periodic reviews by the Assessment and Coordination Organization. EOHHS will have the option to issue an RFP to solicit vendors to support the training of community – based providers and to assist in the monitoring of service plans.</p> <p>The establishment of the ACO does not require federal waiver authority. However, the State is proposing to use the flexibility under the demonstration to enable the ACO to use the assessments as the basis for establishing individual budgets, power accounts, and determining access to certain services. The latitude to implement this innovative aspect of the ACO is not only critical for achieving the goals of reform, but for the overall success of the demonstration as well.</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> conducting assessments;</li> <li><input type="checkbox"/> determining levels of care;</li> <li><input type="checkbox"/> developing service plans with the active involvement of individuals and their families;</li> <li><input type="checkbox"/> developing funding levels associated with care plans;</li> <li><input type="checkbox"/> conducting periodic reviews of service plans;</li> <li><input type="checkbox"/> coordinating services with care management entities (Connect Care Choice; PACE; Rhody Health Partners);</li> </ul> <p>Assessments and related functions are currently conducted by the State agencies (or their contracted entities) listed above. One of the most important functions that these entities or their contractors conduct is the development of care plans. The Assessment and Coordination Organization will ensure that these care plans are developed with the active participation of individuals and families. Full consumer participation will require information about the cost of services; utilization; and quality. One of the goals of the Waiver will be to provide consumers and their families with health reports that will indicate how much has been spent on their services. This information will allow individuals to make more-informed choices about where their service plan dollars should be spent. These health reports will be generated through the CHOICES MMIS Module.</p> <p>The Assessment and Coordination Organization’s third goal is to ensure improved and increased communication between these assessment entities. For example, if an individual assessed by RI-DHS for long-term community-based care is also found to have behavioral health needs; the individual’s service plan will be developed in coordination with RI-MHRH. Communication between the assessment entities will occur through regular meetings and trainings.</p> <p>RI-DHS in close coordination with the other EOHHS agencies will provide the administrative functions of the Assessment and Coordination Organization. These functions include ensuring that the primary information entities and the assessment entities coordinate functions and communicate amongst each other and with each other; establishing trainings and workshops; regularly tracking utilization; and monitoring outcomes to ensure the Assessment and Coordination Organization’s goals are met. On-going monitoring will enable the State to conduct interdisciplinary high-cost case reviews that could ultimately result in improvements to the system.</p>
<p><b>MOTION:</b> To oppose the Federal Medicaid Offer’s VI. Delivery System – 34. Assessment and Coordinator Organization Subsection &amp; Attachment D, unless the development of the Assessment and Coordination system includes input from representatives of consumers</p>	

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<p>(i.e. including but not limited to the Developmental Disabilities Council, Governor’s Commission on Disabilities, Governor's Council on Behavioral Health, and Statewide Independent Living Council) and provider organizations and utilizes existing expertise and resources RC/AP passed, Nay BI, PR, JS.</p>	
<p>6:20 – 6:35</p>	
<p><b>c. Service Delivery System</b> (pg 29)  <b>Institutional and community-based long-term care services will be delivered in three ways:</b>  <u>Fee-for-service:</u> Beneficiaries will be able to access long-term care services in the same way that services are accessed today, through a fee-for-service system. Under this system, a beneficiary can choose the agency or provider to deliver the service(s). In turn for those services requiring authorization or that is “out-of-plan”, the agency/provider bills the Medicaid agency for services authorized by the ACO and/or the health plan or PCCM network.  <u>Self-direction:</u> Beneficiaries and their families will also have the option to purchase personal assistance services (including, but not limited to aid in daily living tasks such as bathing, dressing, toileting, meal preparation) through a self-direction option. Under this option, beneficiaries will work with the ACO to develop a budget amount for services needed. The beneficiary, with the support of a fiscal intermediary, will then be able to purchase services directly. This option is based on experience from Rhode Island’s 1915(c) Cash and Counseling Waiver (<i>RI Personal Choice</i>), 1915(c) Developmental Disabilities Waiver, and Personal Assistance Service and Supports program. Self-direction will also be implemented through a High-Fidelity Wraparound process for children in residential treatment who are transitioning back to a home-based setting. Families will play a leading role in service design by selecting from a menu of options that address the child’s behavioral health issues and support system.  <u>Limited Funding:</u> <i>Beneficiaries assessed to be at the high level of care will have access to core and preventive community-based services (homemaker services; moderate home modifications; respite; and physical therapy evaluations) on a limited basis. Beneficiaries assessed at the preventive level of care will have access to preventive community-based services on a limited basis. These services will be available to individuals at these levels of care based on available funding. The State will determine if the limits will be set on a service basis or an individual basis.</i></p>	<p><b>VII. DELIVERY SYSTEM</b> (pg 27)  <b>35. Institutional and community-based long-term care services will be delivered in two through the following delivery systems:</b>  <u>Fee-for-service:</u> Beneficiaries will be able to access long-term care services in the same way that services are accessed today, through a fee-for-service system. Under this system, a beneficiary can choose the Medicaid participating agency or provider to who will deliver the service(s). In turn for those services requiring authorization or that are “out-of-plan”, the agency/provider bills the Medicaid agency for services authorized by the ACO and/or the health plan or PCCM network.  <u>Self-direction:</u> Beneficiaries and their families will also have the option to purchase HCBS waiver like services through a self-direction service delivery system. Under this option, beneficiaries will work with the ACO to develop a budget amount for services needed. The beneficiary, with the support of a fiscal intermediary, will then be able to purchase services directly. This option is based on experience from Rhode Island’s 1915(c) Cash and Counseling Waiver (<i>RI Personal Choice</i>), 1915(c) Developmental Disabilities Waiver, and Personal Assistance Service and Supports program. Self-Direction is fully described in the Self-Direction Operations Section.  <b>VIII. SELF-DIRECTION</b> (pg 28)  <b>41. Required Elements of Self-Direction.</b> The State must meet the following requirements to operate its self-direction program for core and preventive services including through a High-Fidelity Wraparound process for children in residential treatment who are transitioning back to a home-based setting.  <b>42. Voluntary Program.</b> The program is voluntary for demonstration eligibles that are eligible for and receiving home and community based long-term care services and supports.  <b>43. Paid Providers of Services.</b> Except for legally liable relatives, such as spouses and parents, any individual capable of providing the assigned tasks and freely chosen by a participant to be a paid provider of self-directed services and supports may be hired by the participant. Participants retain the right to: 1) train their</p>

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	<p>workers in the specific areas of services and supports needed; 2) have those services and supports furnished in a manner that comports with the participants' personal, cultural, and/or religious preferences; and 3) access other training provided by or through the State for their workers so that their workers can meet any additional qualifications required or desired by the participants.</p> <p>44. <b>Information Furnished to Participants.</b> The following information must be provided to participants: principles and benefits of participant direction; participants' rights, roles and responsibilities; self-direction election form; description of other feasible alternatives; fiscal/employer agent contact information; counseling/service advising agency contact information; grievance and appeal process and forms; roles and responsibilities of the fiscal/employer agent and the counseling/advising agency; and participant-directed planning. Trained advisers from the service advisement agency will provide the information to participants.</p> <p>45. <b>Assessment.</b> An assessment of an individual's needs, strengths, and preferences for services, as well as any risks that may pose a threat of harm to the individual, will be completed. The assessment includes information about the individual's health condition, personal goals and preferences, functional limitations, age, school, employment, household and other factors that are relevant to the authorization and provision of services. The assessment information supports the development of the person-centered service plan and individual budget.</p> <p>46. <b>Person-Centered Planning.</b> The State must utilize a person-centered and directed planning process, intended to identify the strengths, capacities, preferences, needs, and desired outcomes of the participant. An Individual Service and Spending Plan (ISSP) is developed with the assistance of the service advisor team and those individuals the participant chooses to include. The ISSP includes the services and supports that the participant needs to live independently in the community. A back-up plan must be developed and incorporated into the ISSP to assure that the needed assistance will be provided in the event that the regular services and supports identified in the ISSP are temporarily unavailable. The back-up plan may include other individual assistants or agency services. The State shall have a process that permits participants to request a change to the person-centered plan, if the participant's health circumstances necessitate a change, but in any event, the ISSP will be reviewed and updated at least annually. Entities or individuals that have responsibility</p>

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	<p>for service plan development may not provide other direct demonstration services to the participant.</p> <p>47. <b>Employer Authority.</b> Participants have the opportunity to exercise choice and control (i.e., hire, fire, supervise, manage) over individuals who furnish their long term care demonstration services authorized in the person-centered service plan. In this demonstration, the participant functions as the employer of record of workers who furnish direct services and supports to the participant.</p> <p>48. <b>Budget Authority.</b> Participants also have the opportunity to exercise choice and control over a specified amount of funds in a participant-directed budget. Under the budget authority, the participant has decision-making authority and management responsibility for the participant-directed budget from which the participant authorizes the purchase of long term care demonstration services and supports that are authorized in the person-centered service plan.</p> <p>49. <b>Individual Budget.</b> An individual budget is the amount of funds available to the participant to self-direct. It is developed using a person-centered planning process; based on actual service utilization and cost data and derived from reliable sources; developed using a consistent methodology to calculate the resources available to each participant that is open to public inspection; and reviewed according to a specified method and frequency. Modifications to the budget must be preceded by a change in the service plan.</p> <p>50. <b>Information and Assistance in Support of Participant Direction.</b> The State shall have a support system that provides participants with information, training, counseling and assistance, as needed or desired by each participant, to assist the participant to effectively direct and manage their self-directed services and budgets. Participants shall be informed about self-directed care, including feasible alternatives, before electing the self-direction option. Participants shall also have access to the support system throughout the time that they are self-directing their care. Support activities include, but are not limited to, advisement agency services and financial management services.</p> <p>51. <b>Counseling/Advisement Agencies.</b> The State shall provide each participant with a Service Advisor from a counseling/advisement agency that conducts participant screening, assessment and reassessment; participant orientation, training, preparation and support of all participant functions; participant assistance in spending plan development and monitoring; and ongoing monitoring of participant satisfaction, health and safety.</p>

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	<p>Counseling/advisement agencies shall meet State established certification standards to provide supports to participants.</p> <p><b>52. Financial Management Services.</b> The State shall provide financial management services (FMS) that: provide payroll services for program participants and/or designated representatives; are responsible for all taxes, fees and insurances required for the program participant to act as an employer of record; manage all non-labor related payments for goods and services authorized in the participant’s approved spending plan; assure that all payments made under the demonstration comply with the participant’s approved spending plan; and conduct criminal background and abuse registry screens of all participant employees at the State’s expense. FMS entities shall meet IRS requirements of being a fiscal/employer agent and State established certification standards to provide supports to participants. FMS shall be reimbursed as an administrative activity at the 50 percent administrative rate.</p> <p><b>53. Services to be Self-Directed.</b> Participants who elect the self-direction opportunity will have the option to self-direct all or some of the long-term care core and preventive services and supports under the demonstration. The services, goods and supports that participants will self-direct are limited to the core and preventive services, listed in Attachment B. Services, goods and supports that are not subject to employer and budget authority, i.e., participants do not have hiring authority and do not become the employer of record over these services, goods or items, will still be included in the calculations of participants’ budgets. Participants’ spending plans will reflect the plan for purchasing these needed services, goods and supports.</p> <p><b>54. Individual Directed Goods and Services.</b> Individual directed goods and services may be purchased from accumulated funds (“savings”) as approved in the individual budget plan. Goods and services must relate to a need or goal identified in the person-centered service plan. Accumulated funds or savings may be carried over from month to month, and year to year, only if designated for a specific good or service. If the goods or services are not purchased at the time indicated in the budget plan, then the State will recoup any unspent and un-earmarked funds at designated intervals and according to procedures established by the State. These long-term care core and preventive services and supports are defined in Attachment B Service Definitions</p> <p><b>55. Participant Direction by Representative.</b> The</p>

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	<p>State provides for the direction of services by a representative. The representative may be a legal representative of the participant or a non-legal representative freely chosen by an adult participant. The representative shall not be paid and must pass a screen indicating ability to perform the functions in the best interest of the participant and must pass a criminal background check. Participants who demonstrate the inability to self-direct their services and supports whether due to misuse of funds, consistent non-adherence to program rules or an ongoing health and safety risk, will be required to select a representative to assist them with the responsibilities of self-direction. If a participant refuses to select a representative, or if a participant loses a representative (if already required for participation) and cannot locate a replacement, they will be required to transfer to a non-self-directed traditional service delivery system. Service advisors will assist the participant in the transition to the traditionally delivered service system to ensure continuity of care.</p> <p>56. <b>Independent Advocacy.</b> All participants shall have access to an independent advocate or advocacy system in the State. This function is performed by individuals or entities that do not provide direct services, perform assessments, or have monitoring, oversight or fiscal responsibilities for the demonstration.</p> <p>57. <b>Service Plan Monitoring.</b> The Service Advisor shall, at a minimum, make quarterly in-person visits to the participant and monthly telephone contact in the first year, then semi-annual in-person and quarterly phone contact thereafter or more when requested or indicated by concern. Additionally, the RN and Mobility Specialist assess for needs at least annually. The entire Service Advisor Team is available to the participant upon request and/or Advisor identification of a potential health/safety concern.</p> <p>58. <b>Expenditure Safeguards.</b> The FMS reports monthly to the participant and the Service Advisor, and quarterly to the State, on the budget disbursements and balances. If more than 20 percent underutilization of authorized services is discovered, the Service advisor will work with the participant in assessing the reason and crafting a solution, such as a new worker or a reassessment of needs.</p> <p>59. <b>Disenrollment.</b> Participants may voluntarily disenroll from the self-directed option at any time and return to a traditional service delivery system. Participants may also be involuntarily disenrolled from the self-directed option for cause, such as a continuous demonstrated inability to self-direct their services and</p>

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	<p>supports whether due to misuse of funds, consistent non-adherence to program rules or an ongoing health and safety risk. Participants who have demonstrated an inability to self-direct their services and supports will be required to select a representative to assist them with the responsibilities of self-direction. If a participant voluntarily or involuntarily disenrolls from the self-directed service delivery option, the State must have safeguards in place to ensure continuity of services.</p> <p>60. <b>Fair Hearing.</b> Participants may request a fair hearing when a reduction in services occurs or when a requested adjustment to the budget is denied or the amount of the budget is reduced.</p> <p>61. <b>Cash Option.</b> At such time as the State elects, participants may elect to receive the amount of the funds in their individual budget in a prospective cash disbursement. Prior to the election of the cash option, the State will notify CMS of this election according to the Process for Category II changes. Prior to implementation of the cash option, the State will secure a waiver of the income and asset requirements from the Social Security Administration.</p> <p>62. <b>Additional Populations and Services.</b> At such time as the State elects to add additional populations or services to the self-direction option, the State will notify CMS of this election according to the Process for Category II changes. If, however, the State’s proposal to add populations or services exceeds or changes the expenditure authorities of section 1915(c), 1915(i) or 1915(j), then the State will follow the Process for Category III changes.</p>
<p>MOTION: To support the Federal Medicaid Offer’s VI. Delivery System – 35. Institutional and community-based long-term care services will be delivered in two through the following delivery systems Subsection &amp; VIII. Self-Direction Section. The General Assembly should request clarification regarding provision 52. Financial Management Services “The State shall provide financial management services (FMS) that:” Could the state contract/delegated out these services as it current does or must the state provide these services? PR/AP Passed, Nay BI.</p>	
<p><b>6:40 – 6:55</b></p>	
<p><b>A. SUPPORTING FINANCIAL ARRANGEMENTS FOR THE GLOBAL COMPACT</b> (pg 44)</p> <p><b>3. Maintenance of Effort</b></p> <p>In Rhode Island, as in many other states, Medicaid has steadily consumed an increasing proportion of the state budget. In SFY 2007, Medicaid program costs – excluding administrative expenditures and disproportionate share and LEA payments -- represented approximately 23 percent of the overall general revenue</p>	<p><b>XV. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION</b> (pg 44)</p> <p>The following describes the method by which budget neutrality will be assured under the Demonstration. The Demonstration will be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period. The STCs specify the aggregate financial cap on the amount of Federal title XIX funding</p>

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<p>budget. (As indicated in Chapter Two, this figure reaches nearly 25% if these other expenditures are factored in to the total.). Under this compact, the State will commit to maintenance of effort based on the percent of the State budget committed to the Medicaid program for the base year (SFY 2007). That is, for each year of the waiver period, Rhode Island commits to a minimum Medicaid expenditure based on a fixed percentage of the general revenue budget. The methodology for determining this dollar amount will be delineated as review of this waiver proposal moves forward.</p> <p style="text-align: center;">*****</p> <p><b>5. Total Rhode Island Medicaid Forecasted Expenditures</b></p> <p>The State's forecasts for the full five-year period are presented below. Table I provides projected expenditures for a waiver period FFY 2009 through 2013 based on historical trends in the base period. The total annual amount of projected expenditures for the program is based on all federally matched Medicaid services, at the current Federal match participation rate of 52.51 percent.</p> <p>Cumulative Target</p> <p>FFY 08 \$ 1.886 billion  FFY 09 \$ 3.950 billion  FFY 10 \$ 6.199 billion  FFY 11 \$ 8.649 billion  FFY 12 \$ 11.324 billion  FFY 13 \$ 14.246 billion  With a 5 Yr Cap of <b>\$12.359 billion</b></p>	<p>that the State may receive on expenditures subject to the budget neutrality cap as specified in paragraph 77 of Section XIII. The budget neutrality cap will be for the Federal share of the total computable cost of \$12.075 billion for the five-year demonstration period. The cap places the State at risk for enrollment and for per participant month cost trends.</p> <p>92. <b>Limit on Title XIX Funding.</b> The limit defined above will apply to actual expenditures for the Demonstration period, as reported by the State under section XIII. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the State using the procedures described in Section XIII, paragraph 76. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the CMS-64.</p> <p>93. <b>Enforcement of Budget Neutrality.</b> CMS shall enforce budget neutrality over the life of the Demonstration, rather than on an annual basis. However, if the State exceeds the calculated cumulative budget neutrality expenditure limit by the percentage identified below for any of the Demonstration years, the State must submit a corrective action plan to CMS for approval.</p> <p>Cumulative Target</p> <p>Year 1 \$ 2.600 billion  Year 2 \$ 5.000 billion  Year 3 \$ 7.300 billion  Year 4 \$ 9.700 billion  Year 5 <b>\$12.075 billion</b></p>	
<p>MOTION: To oppose the entire Federal Medicaid Offer AP/LW. Defeated: Aye: BI &amp; LW, Nay AP, GS, JS, SB, PR, JB, EG, KMcCB, &amp; LR, abstain RC.</p>		
<p>MOTION To not take a position on XV. Monitoring Budget Neutrality For The Demonstration PR/LR</p> <p>Executive Cmte members: passed, Aye PR &amp; LR, Nay KMcCB, Abstain RC  Legislation Cmte. members: Aye EG, SB, GS, Nay AP, LW, JB, BI Abstain JS</p>		
<p>Motion to reconsider the previous motion on XV. Monitoring Budget Neutrality For The Demonstration LR/PR passed Nay AP</p>		
<p>MOTION: The House Finance Committee needs to know the impact of the reduction from \$12,359 to \$12.075 billion.</p> <p>In the event of the FMAP increase at the federal share Commission recommends the state's allocation, not be reduced. LR/AP passed Nay RC &amp; SB, Abstain JS &amp; EG.</p>		
<p><b>Announcements and Scheduling of Meetings</b></p>	<p><b>Chairperson</b></p>	<p><b>1 min.</b></p>
<p>Next Legislation Cmte. meeting will be on:</p>	<p>Tuesday January 13<sup>th</sup></p>	<p>Starting at: 3 PM</p>

Next Executive Cmte. meeting will be on:	Tuesday March 3 <sup>rd</sup>	Starting at: 4 PM
<b>Adjournment:</b>	Vice Chairperson adjourned the meeting at 7:30 PM	
<b>Observers:</b>	Mary Wambach, Kathleen Samways	
<b>Resource persons:</b>	Bob Cooper, Committee Staff	