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Elizabeth Shelov
Office of Policy and Innovation
RI Executive Office of Health and Human Services
Hazard Bldg
74 West Rd., Cranston, RI
Via e-mail

Dear Ms. Shelov:

The following are comments regarding the proposed "Section 1500 of the Medicaid Code of Administrative Rules, entitled 'Medicaid Long-Term Services and Supports: Interim Rule".

Eligibility for and access to long-term services and supports (LTSS) have long been an area of confusion for consumers, so the effort to provide simpler and clearer rules is very welcome. While the proposed rules are step in the right direction, we have a number of suggestions and comments to ensure that consumers know the LTSS to which they may be entitled and how to access those services.

1. Be specific about the time that an eligibility or procedural rule is effective. The proposed rule is described as "Medicaid Long-Term Services and Supports: Interim Rule", and for the most part sets-forth rules that are effective January 1, 2016 (e.g., new Level of Care criteria and new home and community based services), but also purports to describe criteria and procedures that will not be effective until some future date (e.g., application through the Bridges system which is not scheduled to go into effect until at least July, 2016). The rules should be limited to current policies and criteria, and references to future policies and procedures should be removed. Once EOHHS is ready to put those rules into effect, it will need to comply with the rule-making process. The Administrative Procedures Act (RIGL 42-35-1 et seq) does not provide for "interim rules".

2. Streamline and Clarify. Under Rhode Island's 1115 waiver, all previous waivers, which were either service or population specific, were ended. Yet existing regulations still refer to the "old" waivers (see MCAR, Section 0398) and the proposed rule refers to sections of Section 0398 – e.g., services for adults with developmental disabilities and the DEA co-pay program (see chart at p. 25). The proposed rule also refers to the "habilitation program", which seems to be a reference to the "habilitation waiver" instead of "habilitative services" which should be available to any Medicaid-eligible LTSS applicant/beneficiary. The rules at 0398 must be revised.

   Under the 1115 waiver, core and preventive services are not linked to populations or the type of institutional care an individual may need. Appreciating that different state agencies may have expertise in performing assessments, developing service plans, providing case management for specific populations (e.g., BHDDH for people with SPMI and IDD; DCYF for children with SED),

the proposed Section 1500 LTSS rules should be consistent in explaining that core and preventive services are available to all and if there are population-specific LTSS, the rule should explain those services.

The rule also needs to be clearer concerning whether provisions apply just to LTSS accessed through EOHHS or through all agencies. For example, there is a definition of LTSS specialist, but it is not clear what the role of this individual is and whether there are such individuals at all the agencies that assess and plan for LTSS.

3. Assessment and Coordination (1500.02C). The purpose of the assessment and coordination process is not to "serve the goal of rebalancing the long-term care system", but to ensure that all applicants/beneficiaries have access to the long-term care services they need in the least restrictive environment. The rule should be amended to reflect that purpose. The rule should also incorporate the CMS requirements and Olmstead requirements pertaining to person-centered services, least restrictive environment, etc.

   A long time problem that needs to be addressed is coordination of services across the different populations that may need LTSS. The 1115 Waiver Extension Request, (March, 2013) acknowledges this problem and promises a solution: "coordination of information and eligibility programs across populations and state agencies needs to be improved. For the consumer, our systems remain fragmented and difficult to understand. Customer service needs to be improved. Rhode Island is committed to consumer empowerment as an importance force for improved health outcomes. We will have a robust Consumer Assistance Program housed at EOHHS that will support and help to coordinate all of the information and referral, options counseling, eligibility assistance and case management that occurs across the EOHHS agencies (p 6-7).

   Understanding the challenges inherent in achieving this fully integrated system, there are processes that can be put in place to make progress toward this end. For example, the rules should require that any entity that performs I&R services – whether at BHDDH, DHS, DEA, in the community, must understand the full range of LTSS, which agencies perform assessment and plan development for which populations and how to make referrals. There needs to be an "any/all door" system.

   Similarly, the LTSS Options Counseling Program needs to be an "any/all door" system. It is not clear from the proposed rule (1500.02D) whether the rule is describing an options counseling program just for individuals served through OHHS/DEA or for all populations. If the latter, there should be reference to the individuals that perform this function at those agencies.

In addition, the rules refer to how the Assessment and Coordination Process is initiated in July, 2016 when the Bridges program is in effect. But how is the process initiated now?

4. Clarify eligibility for and access to "preventive" services. The rules sometimes describe "preventive" services as LTSS, requiring the person to be assessed through the OMR, and sometimes as non-LTSS and able to be accessed without a level of care determination. There are also several different definitions of eligibility for preventive services: For example, at 1500.03A, preventive services are for individuals who do not yet need Medicaid LTSS but are at risk for NF level of care and need services targeted at preventing admission, re-admission, reducing length of stay in a skilled nursing facility. And at 1500.03C, preventive services are a range of home and community-based services and supports that delay or avert institutionalization or more extensive and intensive home and community based care. At 1500.02 the rule states "non-LTSS Medicaid beneficiaries with chronic and disabling conditions who do not meet the highest or high level of care but at risk for the level of care typically provided in an institution may access certain short-term preventive services to optimize their health and promote independence. The latter two definitions are broader that the first, allowing a person to qualify for preventive services to either "optimize health and promote independence" or to avoid more intensive home and community based care – these are more appropriate than the "at risk of NF level of care". But the "short term" limitation should be removed: a person with a chronic health problem may need on-going home maker services to retain independence, for example.

   The rule also needs to explain how an individual who is currently receiving Medicaid (sometimes referred to as "community MA") and needs preventive services can access those services – including what might be different paths for a people in fee for service coverage and those enrolled in a managed care organization. For example, it should be clear in the rules how a Medicaid expansion adult or a Rite Care parent who is injured in a car accident and requires the services characterized as "preventive" are assessed for eligibility and has services put in place.

   The rule also needs to be amended to reflect that all Medicaid-enrolled individuals are eligible for LTSS. AT 1500.01(C)(2), there is a list of Medicaid categories, that includes the Medicaid Expansion population. Is it the intention that this population would be eligible for preventive services only or that the person could be assessed through the OMR and be found eligible for high or highest level of care, without being subject to the financial eligibility rules for a person eligible for Medicaid based on disability?

   And why would there be a distinction between the expansion population and the RIte Care parent? A RIte Care parent should be eligible for preventive services to the same extent and through the same process as the "expansion population" individual.

5. Cost Neutrality. 1500.02E. All of the Medicaid program (with limited exception, e.g. DSH and LEA) is operated under the 1115 waiver and cost-neutrality is relative to all Medicaid

expenditures. There should not be a separate limit on expenditures for HCBS (as implied in the rule). It is also not clear in this section whether an individual who is eligible for LTSS in an institution, but wants to live in the community and for whom the cost would exceed the listed institutional cost would be entitled to do so.

Thank you for your consideration of these comments. I look forward to the response.

Sincerely,

Linda Katz
Policy Director

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