Senior Agenda Coalition of RI

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Delivered via email

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Elizabeth Shelov
Office of Policy and Innovation
RI Executive Office of Health and Human Services
Hazard Building, 74 West Road
Cranston, RI 02920

Dear Ms. Shelov:

I am submitting these comments regarding Amending the Medicaid Code of Administrative Rules Section # 399 to a new section titled, MEDICAID LONG-TERM SERVICES AND SUPPORTS Proposed Section 1500 (December 2016).

The effort to update Medicaid rules for what is now titled "Global Consumer Choice Waiver", to retitle them as "Medicaid Long-term Services and Supports", to incorporate 2016 legislative changes and to put them in plain language is needed. However, we believe that putting the rules in plain language requires additional effort as there are many areas in the proposed rules which require clarification in order for them to be understandable to the reader. In addition, we remain concerned with the proposed changes to the Highest Need criteria for Nursing Facility Care.

Below are comments and questions on specific sections of the proposed rules.

Page 5 & 8. Section D. Definitions.
"Core Home and Community-Based Services (HCBS) means services provided to beneficiaries that ensure full access to the benefits of community living as well as an opportunity to receive services in the most appropriate setting.

Comment: This definition is very vague. What constitutes "the benefits of community living"? At the very least the definition should refer to the list of Core HCBS found in 1500.4

"LTSS Specialist".

Comments: What type of standardized assessments are being used and what training do these persons receive to ensure process is reliable. Does this definition apply to and include staff in non-governmental agencies under contract with EOHHS departments?

Page 7.
"Home and Community-Based Services means any services that are offered to Medicaid LTSS beneficiaries who have needs requiring and institutional level of care in the home or community-based setting that are authorized under the Medicaid State Plan or the State's demonstration waiver authorized under section 1115 of the Social Security Act (42 U.S.C. 1315)"

Comment: Use of the language “requiring an(d) institutional level of care in the home or community-based setting” is confusing. It is difficult for the reader to discern what is meant by an(d) *institutional level of care*? It is noted that on page 10, the term Institutional Long Term Care is deleted as a section title. The new language refers to “Institutional setting.”

Page 12.
Section F.

Comment: Section contains language indicating there will be changes to financial eligibility to take place after July 1. 2016. It is important for readers to know more about what the changes would look like prior to implementation.

Page 14
Section F. (b)

Comment: Note-There appear to be two subsections (b) under Section D.
The last sentence under (b) at end of page 14 states, “Accordingly, all LTSS beneficiaries are eligible to receive the same core and preventive services.” It is not clear if persons receiving Preventive Services are LTSS beneficiaries. They are listed in the Grid on page 20. Does this mean they have to go through the LTSS financial/clinical eligibility process? It was our understanding that persons who only need Preventive Services do not need to meet the LTSS financial eligibility criteria. Also, on page 42 there is a reference to non-LTSS Medicaid under MCAR 0374 who have been determined to meet a preventive level of care. Who makes this determination of the need for non-LTSS Preventive services?

Page 15
Section 2. Clincial/Functional Eligibility. Effective Date

Comment: Question of Effective Date – Reference is made in this and some of the following sections which appear that some provisions would be become effective as of January 1, 2016 although the regulations proposed have not been promulgated. The applicability of an effective date needs to be addressed.

Section F. (2)) **Clinical/Functional (CF) Eligibility Criteria. (Effective January 1, 2016).**
Subsection (b) Hospital

Comment: It is not clear which agencies would be included. It would be useful to list the agencies responsible for determining Hospital Level of Care

Page 16.
Subsection (ii)

Comment: Should the phrase “in effect between July 1 between July 1, 2009 and December 31, 2015” be repeated after the words, “no longer meets the criteria for Medicaid LTSS” in last sentence.

Page 24.
Section 1500.02. C. MEDICAID LTSS ASSESSMENT & COORDINATION (A&C)
Subsection (1).

Comments: Current funding to support the state ADRC which currently receives no dedicated state funds is inadequate. Resources are also needed to fully implement the Options Counseling Program referred to in Section D (page 26). Without adequate funding and fully

trained and knowledgeable staff performing these screening and LTSS counseling functions consumers and families will not be able to make the most appropriate person-centered and directed choices. There also needs to be consumer information provided about how to request the Options Counseling service.

Page 22.
Section (1) (i). NF Level of Care.

Comment: States the OMR determines the need for NF institutional level of care. Is this done through individual face-to-face assessment of the applicant? If not, what other agencies do the assessments and are they "paper-based" assessments as opposed to face-to-face assessments with applicant or designated family member. What is the role of DHS eligibility staff in the clinical assessment process?

Page 23.
Section (2) Initiating the Assessment & Coordination Process.

Comment: The language states the Medicaid LTSS applicant must indicate the type of LTSS they are seeking. It is unrealistic to expect the applicant would know enough about choices absent any counseling as to what type of LTSS they would need or could be eligible for. It also refers to the RI Bridges program which would direct persons to the appropriate entity for screening. Is the Bridges program operative and is it entirely computer-based without direct telephone contact with applicant? Are the inputs provided to the Bridges program sufficiently detailed enough to determine if applicant does not meet financial criteria given the complexity of Medicaid LTSS financial eligibility rules?

Page 23.
Section (d) refers to case management/evaluation activities.

Comment: A definition of Case management is not included in the Definition section in Section . Is the intent that the definition in Core HCBS apply here?

Page 27.
COST NEUTRALITY FOR HOME AND COMMUNITY-BASED SERVICES.

Comment: Is the projected cost for HCBS compared to average aggregate costs across all institutional settings or each individual institutional setting? For example, could a person at Highest need for NF institutional care receive 24/7 services in the home and what would be the point at which it would not be budget neutral using the cost figures noted?

Page 30.
Section (1) (a) Highest Need.

Comment: The new language states, "The needs-based clinical criteria for a NF level of care deal with cognitive, behavioral and physical impairments and chronic conditions that require extensive personal care and/or assessment, monitoring and treatment on daily basis." We are pleased to see the prior proposal to change "daily" to "24/7" has been eliminated. However, as proposed, the "highest need" level of care requires a combination of total dependence, extensive assistance and limited assistance with ADLs AND a need for nursing assistance, care and supervision on a daily basis. This appears to go beyond the criteria in MA and CT. For example, the MA criteria call for either the person having a daily need for a skilled service from a set of skilled services OR a medical or mental condition requiring a combination of at least

three services from a list of ADL needs which includes "direct care or attendance or constant supervision" in both the bathing and dressing category and nursing services at least three times a week from a set list of services. In CT, a person may qualify if they have a chronic condition and require "hands-on assistance with 3 ADLs. (Hands-on assistance means that physical assistance from another person is needed to *initiate or complete* the task in a way that assures health and safety. Both states have criteria less restrictive than what is being proposed for RI. Implementing the changes as proposed may make it more difficult for individuals with very extensive ADL needs such as two-person assists for transfers to access nursing facility care and it is questionable if the state has sufficient alternatives in place at this time to provide alternative residential care for those no longer able to safely live alone yet do not need daily skilled nursing care on a continuous basis. We are also concerned about the workforce capacity of the home care industry to accommodate those persons with very high ADLs need in home care settings during evening, nighttime and weekend hours. This lack of alternatives may be exacerbated when the final CMS rules for home and community-based services are fully implemented. Prior to making the changes as proposed in the draft, it is important that capacity issues for non-institutional care be addressed.

We note that Section 40.8.9-9 (c) of RIGL required the state to develop a tiered set of criteria for long term care services in collaboration with any consumer group, advisory board or other entity designated for such purpose. When the initial tiered criteria were developed for the Global Waiver it was done in collaboration with a group organized by the state that included relevant stakeholders and state staff. The result was a set of criteria that all could agree were fair and workable. We suggest that such a group be convened for purposes of making recommendations for any needed changes to the existing criteria before revising them.

Page 36. **A. DEFINITIONS OF CORE AND PREVENTIVE SERVICES**

(1) Core HCBS. LTSS available based on need to any Medicaid eligible beneficiary.
Comment: This language indicates that all of the listed services would be available to any Medicaid eligible beneficiary. Does this mean, for example, that if an elder who is clinically eligible at High Need level, could receive Rehabilitative Services, respite or intermittent skilled nursing services if they were not being provided under Medicare?

Respectfully Submitted,
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Senior Agenda Coalition of RI