

**STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES**

**3/27/2020 PUBLIC NOTICE OF RHODE ISLAND COVID-19 1115 DEMONSTRATION
WAIVER REQUEST**

In accordance with Rhode Island General Laws 42-35, notice is hereby given that the Rhode Island Executive Office of Health and Human Services (EOHHS) has submitted to the Centers for Medicare and Medicaid Services (CMS) its request to amend the Coronavirus Disease (COVID-19) 1115 Waiver Demonstration, effective March 1, 2020.

COVID-19 1115 Demonstration Waiver Amendment Request

Ensuring access to care for Rhode Island Medicaid members is critical in responding to COVID-19. Due to the need for social distancing, EOHHS anticipates operating its Medicaid program with reduced staffing levels. Additionally, visitors to nursing homes are no longer being allowed in Rhode Island, meaning that elderly individuals do not have family assistance.

Public Comment Process

Given that this request is intended to address an emergency, as declared by the President on March 13, 2020, EOHHS has sought an exemption from the public notice process pursuant to 42 CFR 431.416(g). However, written public comments will be accepted.

The waiver request is accessible on the EOHHS website (<http://www.eohhs.ri.gov/ReferenceCenter/MedicaidStatePlanand1115Waiver.aspx>) or available in hard copy upon request (401-462-6348 or RI Relay, dial 711). Interested persons should submit data, views, or written comments by **April 24, 2020** to Melody Lawrence, Executive Office of Health and Human Services, 3 West Rd, Cranston, RI, 02920, or Melody.Lawrence@ohhs.ri.gov.

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Background and Program Description

Ensuring access to care for our population is critical as we respond to COVID-19. The goal of the waiver request is to ensure that Medicaid members continue to receive medically necessary Medicaid-covered services while minimizing exposure to the virus. Further, due to the need for social distancing, EOHHS anticipates operating its Medicaid program with reduced staffing levels. Additionally, visitors to nursing homes are no longer being allowed in Rhode Island, meaning that elderly individuals do not have family assistance.

Goals and Objectives of Requests

Goal 1: Prevent transmission of the novel coronavirus to workers and, in particular, to vulnerable Medicaid members. This goal will be achieved by:

- a) Limiting in-person meetings for person-centered care (3/16/20 request);
- b) Extending level of care authorizations (3/16/20 request);

- c) Modifying level of care determination assessment procedures (3/16/20 request);
- d) Not complying with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic;
- e) Adding an electronic method of service delivery allowing services to continue to be provided remotely in the home setting for: case management, personal care services that only require verbal cueing, in-home habilitation, and monthly monitoring (i.e., in order to meet the reasonable indication of need for services requirement in 1915(c) waivers);
- f) Adding medical supplies, equipment and appliances (over and above that which is in the state plan); and
- g) Adding coverage of home-delivered meals and other critical supplies for any person 60 years old or older who needs transportation assistance to medical appointments, meal sites, and other included sites.

Goal 2: Utilize limited staff resources to focus on preventing the most medically fragile members from experiencing adverse health outcomes. This goal will be achieved by:

- a) Extending the time for 12-month reviews of person-centered plans (3/16/20 request); and
- b) Limiting NEMT to only those appointments that are critical to the member's health (3/16/20 request).

Goal 3: Maintain statewide provider capacity even when services are temporarily disrupted. This goal will be achieved by:

- a) Paying retainer fees to certain habilitation and personal care providers, adult day program providers, hospitals, and providers of rehabilitation services (including substance use disorder and community mental health center services);
- b) Increasing reimbursement rates to home and community-based services providers; and
- c) Providing coverage of childcare for healthcare workers.

Goal 4: Minimize Medicaid coverage disruptions and utilize limited staff resources to facilitate enrollment. This goal will be achieved by:

- a) Excusing the mandate to reduce payment to nursing facilities and home and community-based service providers by the patient share amount for newly-eligible individuals and postponing asset re-evaluation for current beneficiaries;
- b) Allowing for self-attestation or alternative verification of individuals' eligibility (income/assets) and level of care to qualify for long-term care services and supports;
- c) Accepting self-attestation and conduct post-enrollment verification for Medicaid and CHIP applicants; and
- d) Allowing for self-attestation or alternative verification of eligibility for all eligibility criteria except citizenship and immigration.

Goal 5: Ensure that beneficiaries continue to receive services. This goal will be achieved by:

- a) Permitting payment to all HCBS providers and providers of home-based services for children with special needs in alternative settings where the setting otherwise authorized is not available due to the COVID-19 emergency;
- b) Permitting service definition limitations on the number of people served in each licensed or unlicensed home to be exceeded;

- c) Permitting shift nursing to be provided as a discrete service during the provision of residential habilitation, life sharing and supported living services to ensure participant health and safety needs can be met;
- d) Permitting Supplemental Habilitation to be provided, without requesting a variance, during the provision of licensed residential habilitation, licensed life sharing and supported living services to address the increased needs of individuals affected by the epidemic/pandemic or increased number of individuals served in a service location;
- e) Removing all respite limits to meet the immediate health and safety needs of participants;
- f) Permitting staff qualified under any HCBS service definition to be used for provision of any non-professional service under another service definition;
- g) Permitting shared living caretakers to provide all HCBS services, including, but not limited to, homecare and homemaker services;
- h) For HCBS residential or community-based day habilitation or shared/independent living locations, permitting the maximum number of individuals served in a location to be exceeded to address staffing shortages or accommodate use of other sites as quarantine sites; removing staffing ratios, due to staffing shortages, and suspending the requirement to provide services in community locations;
- i) Permitting payment for parents and legal guardians to provide HCBS and all home-based services for children with special needs when the non-family caregiver is not able to provide the service, either due to safety concerns (on the part of the non-family caregiver or the HCBS recipient) or other direct impacts of the emergency, such as his or her own dependent care obligations related to the state of emergency;
- j) Permitting the State's transportation broker to *not* use the least-costly method of transportation, to ensure that beneficiaries continue to access NEMT given limits created by social distancing and possible limitations on lower-cost transportation services.

Waiver and Expenditure Authorities Sought

EOHHS seeks a waiver of the following requirement of the Code of Federal Regulations:

- Patient Share Changes 42 CFR 435.725 – To permit the State to suspend the reduction of payments to nursing facilities by the amount of the patient share of the payment.
- Patient Share Changes 42 CFR 435.726 – To permit the State to suspend the reduction of payments to providers of home and community-based services by the amount of the patient share of the payment.
- Direct Payments 42 CFR 438.60 – To permit the State to make additional payments for services covered under managed care organization contracts so that EOHHS can directly pay to providers the retainers and rate increases described above.
- Pass Through Payments 42 CFR 438.6 – To permit the State to make “pass through” payments to managed care organizations so that EOHHS can leverage existing payment relationships between MCOs and providers to effectuate payment of the retainers and rate increases described above.

EOHHS also seeks to waive provisions of the State’s 1915(c) waiver, which was subsumed under the 1115 Demonstration Waiver, to implement requests related to HCBS settings and personnel.

EOHHS requests expenditure authority, under the authority of section 1115(a)(2) of the Social Security Act (the Act), that expenditures made by EOHHS for medical supplies, equipment and appliances (over and above that which is in the state plan), coverage of home-delivered meals and other critical supplies for people aged 60 and older, retainer payments for select State Plan services, and coverage of childcare for healthcare workers, which are not otherwise included as matchable expenditures under section 1903 of the Act shall, for the period of the State of Emergency, be regarded as expenditures under the state’s title XIX plan.

EOHHS previously sought a waiver of the following requirements/expectations of CMS on 3/16/20:

- Person-Centered Planning Process 42 CFR 441.725(a)(3) – To the extent necessary to permit the planning process to take place in writing, by telephone, and/or by video conference rather than in person.
- Person-Centered Plan Review 42 CFR 441.725(c) – To postpone for six months any service plan reviews for which the twelve (12) month review period occurs during the novel coronavirus emergency.
- Limitation of NEMT 42 CFR 431.53 – To permit EOHHS to limit transportation of Medicaid members in a way that ensures essential visits are maintained if a shortage of transportation providers occur.
- Extension of level of care authorizations - suspension of CMS’s expectation, stated in the Special Terms and Conditions for the State’s current 1115 waiver, Project No. 11-W-00242/1, that the State must conduct at least annually reevaluations of level of care or as specified in the approved waiver.
- Modifications to the level of care determinations - EOHHS requests suspension of CMS’s expectation that the State must conduct in-person level of care determinations for applicants or members that need institutional, home-and community-based services, and Katie Beckett.

Expenditure Estimates

In light of the novel coronavirus emergency, EOHHS has requested that it not be required to provide or demonstrate budget neutrality through “without waiver” and “with waiver” expenditure data.

Demonstration Eligibility

EOHHS does not anticipate that this waiver will affect enrollment in Medicaid. All current populations under the existing Rhode Island Comprehensive 1115 Waiver Demonstration will continue to be covered. Rhode Island’s Medicaid program provides an essential safety net for many Rhode Islanders. The program ensures low income and vulnerable populations have access to high quality healthcare services, mostly through Medicaid MCOs that are consistently ranked in the top ten in national NCQA rankings for Medicaid MCOs. EOHHS will continue to cover all of these

eligibility groups, including categorically eligible groups (mandatory and optional), medically needy (mandatory and optional), groups that could be covered under the Medicaid State Plan but are covered under the Demonstration, and groups that are covered under the Demonstration authority.

Benefits

All current State Plan and Waiver services will remain in-force.

Cost Sharing

There will be no cost sharing requirements for Rhode Island Medicaid members under this waiver.

Delivery System

This COVID-19 emergency waiver does not include any changes to the delivery system structure that is currently in place under the existing 1115 Demonstration. All services provided through the existing Demonstration are administered through one of the following delivery systems based on their payment mechanism-capitated managed care or fee-for-service and source of case/care management.

Managed Care Organizations

- RItE Care: Program for Families and Children administered by the MCOs. In addition, RItE Care includes all CHIP children as well as 90% of children in Substitute Care and 75% of Children with Special Health Care Needs (CSN). This population also includes the Extended Family Planning Program and the Pregnant Expansion Population both of which are very small populations representing less than 1% of the Medicaid population.
- Rhody Health Partners (RHP): Program for Aged, Blind and Disabled Adults (ABD) with no third-party liability (TPL) who are not eligible for long-term services and supports (LTSS). The program also enrolls adults in the new Medicaid Expansion population. The program is administered through the MCOs.
- Rhody Health Options (RHO): Program for ABD adults eligible for LTSS who may or may not have TPL. Beneficiaries will have access to home and community-based services either as an alternative to institutionalization or otherwise based on medical need. RHO is the responsible managed care entity for both institutional and HCBS services.
- RItE Smiles: Managed dental benefit program for children and young adults born on or after May 1, 2000. The program is administered through a pre-paid ambulatory health plan contract.

Other Care Management Programs

- Program for All-Inclusive Care for the Elderly (PACE): PACE is subsumed under the existing section 1115 Demonstration program and will remain an option for qualifying Demonstration eligible, that is, those that meet the High and Highest level of care determinations. EOHHS assures that Demonstration participants who may be eligible for the PACE program are furnished sufficient information about the PACE program to make an informed decision about whether to elect this option for receipt of services. EOHHS 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 the Code of Federal Regulations.)

Fee-for-Service (FFS)

- For those populations of beneficiaries that do not qualify for enrollment in managed care, they may receive services through the traditional Fee-For Service (FFS) arrangements with providers. Some populations may ‘opt-out’ of managed care programs and are also eligible to receive services through FFS. Self-direction beneficiaries (or, as they authorize, their families) have the option to purchase HCBS waiver like services through a self-direction service delivery system. Under this option, beneficiaries will work with the agency 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 EOHHS’s 1915(c) Cash and Counseling Waiver (RI Personal Choice), 1915(c) Developmental Disabilities Waiver, and Personal Assistance Service and Supports program. Self-Direction is fully described in the Self-Direction Operations Section of the STCs.

Marketplace Subsidies/Expansion Populations

- Alternative Benefit Plan (ABP): Effective January 1, 2014, the New Adult Group receive benefits through the state’s approved alternative benefit plan (ABP) state plan amendment (SPA), which are effective as of the date in the approved ABP SPA. Individuals in the New Adult group may receive, as a part of their ABP under this Demonstration, Expenditure Authority services such as Managed Care Demonstration Only Benefits and will be referred to as enrolled in a Qualified Health Plan (QHP).