Spending Plan for Implementation of American Rescue Plan Act of 2021, Section 9817

Additional Support for Medicaid Home and Community-Based Services during the COVID-19 Emergency

State of Rhode Island

July 9, 2021

Version: July 2021

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Letter from the Rhode Island State Medicaid Director

I am pleased to submit this initial quarterly spending plan to the Centers of Medicaid and Medicare Services (CMS) for review regarding the implementation of the American Rescue Plan Act (ARPA) Section 9817 for the provision of enhanced Home and Community Based (HCBS) FMAP.

Working across the departments and divisions of our Executive Office of Health and Human Services (EOHHS), and having received significant stakeholder feedback, we believe that the investments laid out in this plan will make a material impact in the lives of Rhode Islanders, and in the stability, reach and quality of our HCBS programs.

This initial plan incorporates programs in four main service areas covered under Rhode Island's HCBS Services and 1115 Global Waiver: 1) LTSS HCBS Services directed at individuals 65 and over; 2) LTSS HCBS Services directed at individuals with intellectual or developmental disabilities and physical disabilities 18 and over; 3) Adult behavioral health services; and 4) Children's behavioral health and child welfare services. Enhancements across this service array recognize the connected nature of our healthcare system, and the integrated way in which our beneficiaries receive care in the community.

This proposal groups spending programs across six functional areas and in each program narrative, we make connections across service areas and populations. This reflects our understanding and stakeholder feedback suggesting that despite the differing nature of services provided, needs across HBCS services and populations are similar.

You will note in the spending plan footnotes to clarify what is included, as well as any additional guidance we are hoping for from CMS as you review the plan.

This proposal is over-inclusive of ideas. We have deliberately included more potential programs than we may have full capacity to fund depending on timing of funding and allowable uses of funds. We have also included programs that CMS may consider outside the allowable scope of the guidance. We aimed to provide this full range of potential investments so that CMS could provide guidance on those items that might be impermissible.

While we believe that these proposals are strong and represent good investments opportunities to enhance our HCBS system, we also recognize that programmatic details may changes based on CMS guidance, the ability to claim additional federal match on these items, and continued work with stakeholders. Given that, we look forward to the chance to update this plan as we move forward and provide additional guidance on specific programs as we work towards implementation. To the extent that program design impacts our ability to claim additional match, particularly around workforce recruitment, retention and development, we would appreciate CMS providing additional guidance on what program design is permissible.

Finally, as with all programs launched at Rhode Island EOHHS, we ground our decision making in our core values of choice, community engagement, and race equity.

In accordance with SMD# 21-003, as part of Rhode Island's application I assure that…

- The state is using the federal funds attributable to the increased FMAP to supplement and not supplant existing state funds expended for Medicaid HCBS in effect as of April 1, 2021;
- The state is using the state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program;
- The state is not imposing stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021;
- The state is preserving covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021; and
- The state is maintaining HCBS provider payments at a rate no less than those in place as of April 1, 2021; and
- That I, Benjamin Shaffer, as the State Medicaid Program Director is the designated point of contact for the narrative submissions, and that Katie Alijewicz, Rhode Island Medicaid Chief Financial Officer, is the designated state point of contact for the quarterly spending plan.

Sincerely,

Benjamin Shaffer
Medicaid Program Director
Executive Office of Health and Human Services
State of Rhode Island

Executive Summary

The greatest challenge we face in health and human services today is to think about how we can build back a better, more equitable, healthcare system after the COVID-19 pandemic and be prepared for the changing needs and desires of Rhode Islanders. It is our collective challenge and opportunity to direct the maximum potential amount of $144M one-time, enhanced HCBS FMAP funding to address what we learned from the public health emergency (PHE), address system inequities and meet the complete needs of Rhode Island Medicaid members needing HCBS services.

We build these proposed investments on a strong foundation of previous work. Over the last three years, before and during the PHE, the Rhode Island General Assembly, Governor's Office, the Executive Office of Health and Human Services (EOHHS), its sister agencies and partners have:

- Designed and began building an updated No Wrong Door (NWD) system to increase awareness of HCBS services, leveraging an update interagency governance structure for Long Term Services and Supports.
- Launched innovative HCBS programs such as the Independent Provider program to bring new levels of choice and self-direction to Medicaid members.
- Distributed over $20M in workers supports for congregate care and home care workers during COVID-19 to ensure that no one working in these areas during the height of COVID was making less than $15/hr.
- Passed and signed new safe-staffing legislation for nursing facilities.
- Implemented a $20M LTSS Resiliency initiative with funding across 10 different programs to support LTSS providers, workers and expand HCBS options during the PHE, including a $9M nursing facility change and transformation program.
- Launched the DigiAge initiative through the Office of Healthy Aging to provide devices, connectivity, and training for older Rhode Islanders.
- Created a community-based emergency department alternative for residents experiencing a behavioral health crisis.
- Increased behavioral health and substance use provider capacity in cultural competency and telehealth.
- Passed additional state budget investments in HCBS, including increases in shift-differentials for home care workers, raises in DD worker rates, moving to acuity-based payment for assisted living residences, rewarding home care workers and agencies who achieve training in behavioral health, increase shared living rates, and increase the HCBS maintenance of need allowance.

From this foundation and vision, we can both build on the momentum of redesigning our Long-Term Services and Supports (LTSS) program, expanding HCBS access, and our programmatic successes with CARES Act supported initiatives and learn from our administration of these funds.

In addition to our own policy work and analysis, which we will highlight throughout this plan, we sought broad-based stakeholder feedback during this process. We administered a survey that received over

600 total responses, 30% of whom identified as direct care workers. More information is provided in the "Stakeholder Feedback" section of this submission and available on the EOHHS website.

Through this planning process and building off the CMS Rebalancing Toolkit, we have developed six key areas of investment across four services areas:

Enhanced HCBS FMAP: Proposed Investment Areas

State will be organizing its initial CMS plan to spend within the following investment areas, across all service categories (LTSS, I/DD, Children's Behavioral Health, Adult Behavioral Health).

Area	LTSS	I/DD	CBH/Child Welfare	Adult BH
No Wrong Door	*How can we continue progress to ensure that no matter what "door" through which a Rhode Islander seeks information on LTSS or behavioral health services, they receive consistent, person-centered and conflict free information?*			
Stabilizing the Direct Care Workforce to Increase Access to HCBS	*How can we increase availability of services to ensure that Rhode Island Medicaid members receive the right service at the right time*			
Workforce Development	*How can we make direct care work and family caregiving work, expert, valued, supported and encouraged?*			
Quality Improvement / Promoting Equity	*How do we ensure that the access we provide improves the quality of the lives of our residents? How do we tackle racial disparities in access and outcomes? How do we encourage and experiment with new care models for complex beneficiaries ?*			
Infrastructure Investment to Expand Provider Capacity	*What infrastructure needs do we need to buy with larger funding amounts to advance the continuum of care? How do we transform our services?*			
Updating Technology	*What technology needs to change to better administer services, accelerate eligibility determinations, improve customer service and utilize data?*			

RHODE ISLAND

1) ***Improving Rhode Island's "No Wrong Door" System ($9.3M)***– How can we continue progress to ensure that no matter what "door" through which a Rhode Islander seeks information on LTSS or behavioral health services, they receive consistent, person-centered and conflict free information?

Having already begun work on our NWD system, we can utilize enhanced funding to accelerate our progress by using the HCBS enhanced funds to supplement these NWD redesign initiatives in four critical areas: (1) modernization and integration of IT to support core eligibility functions to improve system navigation and ease of access; (2) recalibration and expansion of HCBS information and awareness activities to further extend outreach to underserved racial and ethnic communities; (3) expansion of person-centered options counseling and (4) finance the technical and program management assistance required to update business processes and ensure policy and practice alignment.

Additionally, we propose a single point of access system within Children's Behavioral Health that can apply NWD principles to child welfare and children's behavioral health.

2) ***Stabilizing the Direct Care Workforce to Increase Access to HCBS (56.375M)*** – How can we increase availability of services to ensure that Rhode Island Medicaid members receive the right service at the right time?

The most common thing we heard in our stakeholder engagement was the need to increase the number of workers providing HCBS services. CNA turnover is high, and there are more licensed CNAs in the state than are working, indicating that many are leaving the healthcare industry. Children's services providers and Developmental Disability Organizations (DDOs) must rebuild their workforces after losing many talented staff during the PHE. Providers across the HCBS spectrum face a tight, post-pandemic labor market. And self-directed workers need access to the same rewards as those that may work in a more traditional program, so that we can grow self-direction, self-determination, and choice in Rhode Island.

The most immediate need we have to address with this funding is to find ways to recruit new workers by the end of the 2021, building off of our successful workforce stabilization program during the PHE that sent over $30M in CARES funding to Rhode Island direct care workers. It is our intention to quickly implement a workforce recruitment and retention program, along with career awareness and outreach across HCBS before March 31, 2022 to work with HCBS providers to provide recruitment bonuses and other rewards to increase access and strengthen our core of health and human service workers.

As we continue this program, we will need to work with providers to reward and retain workers throughout the life of this available funding and determine strategies to differentiate the HCBS workforce from a minimum wage workforce, including the development of career ladders, apprenticeships, mentorship, benefits and other retention strategies. In this way, we hope to show that providers can meet the access needs with increased funding, evaluate the temporary funding's effectiveness, and develop sustainability strategies through the State's budget process. This is particularly necessary as Rhode Island adopts a $15 minimum wage by 2024.

3) ***Developing Rhode Island's HCBS Workforce ($6.1M)*** – How can we make direct care work and family caregiving work valued and encouraged?

In addition to the above investments in recruitment, rewards and retention, we must also increase the training of our workforce to provide the quality care the Rhode Islanders need and to help direct-care workers find a well-paying, well-valued career.

We need an expanded and strengthened HCBS workforce supporting vulnerable populations in the community, with a focus on providing behavioral healthcare, dementia care, night/weekend care, care for complex populations, and in rural areas.

To do this, we propose investing in advancing certifications for CNAs, PCAs and other HCBS workers to achieve recognized training in the above areas. We also recognize that direct care work is often a gateway into the healthcare profession, particularly for women of color. Recognizing these disparities, we also propose a Health Professional Equity Initiative to provide support to those longer-term direct care workers who may want to seek professional degrees to advance their careers.

4) ***Achieving Quality Improvement and Race Equity ($10M)***– How do we ensure that the access we provide improves the lives of our residents? How do we tackle racial disparities in access and outcomes? How do we encourage and experiment with new care models for complex beneficiaries?

After workforce, the second highest priority cited by our stakeholder survey was quality of services provided. In behavioral health, we need additional care coordination and wraparound services to meet

the needs of struggling youth and adults with behavioral health diagnoses. We need new models of home care that help keep people out of inpatient settings. We need culturally competent interventions.

The state does not have a monopoly on good ideas when it comes to quality improvement and race equity. Recognizing this, we plan to launch a "Challenge Grant Opportunity" to all stakeholders to propose programs and funding uses to help develop care models and tackle specific quality outcome measures.

We also recognize that technology has the potential to increase quality of care, while developing new models. This is particularly true as telehealth has become 25%-35% of Rhode Island Medicaid claims during the PHE. To ensure equitable access to these technologies and building on the success of DigiAge, Rhode Island will establish an assistive technology fund to assist clients with a one-time purchase of these devices, and provide outreach, training and support to develop appropriate use models for connected devices in the home.

5) ***Building Infrastructure to Expand Our Care Continuum and Provider Capacity ($55M)*** – How do we invest to add to our continuum of care and transform/improve services?

Provider infrastructure and capacity is critical to making sure we have the supply necessary to take care of individuals across our continuum of care. As we have worked on our LTSS rebalancing efforts, we determined that part of our challenge is an undersupply of capacity in key areas: assisted living being a good example. According to the Kaiser Family Foundation, Rhode Island has 10.9 Medicaid nursing facility residents for 1 Medicaid assisted living resident, compared to 5.5 nationally. Conversely, Rhode Island has a large supply of nursing facility beds; we have 48 nursing facility beds per 1,000 people aged 65+, the 9th highest rate in the country.[1] The same challenges hold true in our I/DD space where we need to increase provider capacity to service members in the community rather than more restrictive settings.

To address these capacity challenges, we want to target the expansion of our care continuum by extending our Nursing Facility Transformation program to work with nursing facilities to change their models to promote single occupancy, green house models, behavioral health, bed-buybacks and supportive housing, or home and community based services or models, such as assisted living. Similarly, we want to develop an expansion grant program to provide capital to assisted livings ready to expand to take advantage of our new, acuity-based, rate structure. We want to build capacity in service advisory agencies and fiscal intermediaries to assist members going through self-directed programs. We need to build increased traumatic brain injury service capacity in-state. We will launch a I/DD provider capacity building initiative to continue to support transition of care from facility-based programs, and to build stronger integrated community-based day and employment supports and services.

Outside our LTSS system but within our HCBS offerings, we will support the development of better care coordination for Children's Behavioral Health services using Family Community Care Partnerships

[1] KFF, 2019 Nursing Home State Health Facts data, https://www.kff.org/state-category/providers-service-use/nursing-facilities/ KFF. Total Number if Residents in Certified Nursing Facilities. 2019. https://www.kff.org/other/state-indicator/number-of-nursing-facility-residents.

(FCCPs). Recognizing the impact of the PHE on children with special needs and their families, we will focus capacity building attention on Medicaid members needing intensive HCBS services, especially HBTS and PASS services. And we will seek new models related to transitioning youth to adult services, Certified Community Behavioral Health Centers (CCBHCs) and fund integrated behavioral health activities with primary care.

6) ***Updating Technology to Serve our Members ($7M)*** - What technology needs to change to better administer services, accelerate eligibility determinations, improve customer service, and utilize data?

Technology and data can make the difference between a good idea and sound implementation. Making our systems easy for all Rhode Islanders to use to access services, to show a unified picture of a Medicaid client and to facilitate workload across EOHHS is paramount to our success. Rhode Island has shown significant success in technology changes that facilitate process improvements. With this integrated approach, we have improved the timeliness of LTSS applications to 92% determined within 90 days and decreased our backlog of overdue LTSS Medicaid applications to 40, from a previous height of 1,554.

Application timeliness is just one part of the puzzle. The CMS Rebalancing Toolkit highlights person-centered planning services, no wrong door systems, community transition support and data-based decision making as key elements of rebalancing. Through this enhanced FMAP, we will make technology and data improvements to 1) further improve the timeliness of HCBS LTSS applications; 2) Modify current systems to allow for more flexible program design and program choice; 3) Modify current systems to improve the speed and consistency of HCBS assessments across programs, including integration with person centered planning, 4) develop new data systems to track our progress and 5) build new measures of HCBS network adequacy across managed care and fee-for-service.

We recognize that all the investments listed above are a significant undertaking and expect projects to be added and fall off this plan as we work through implementation details with stakeholders, assess capacity and finalize the budget and federal match based on additional guidance from CMS.

Conclusion

EOHHS is eager to receive feedback from CMS on the content of our proposed plan. As we wait for that feedback, EOHHS and its constituent agencies will continue to further develop each of the proposed initiatives. Upon receipt of CMS' comments and guidance, we will formulate a finalized plan for review by stakeholders and ultimately, take our plan through the overall Rhode Island governance structure set up for agency direct awards under ARPA through the Rhode Island Office of Management and Budget (OMB). As part of this process, and knowing that the Rhode Island General Assembly is expected to review and appropriate ARPA funds pursuant to Section 9901 of the Act, we may find that funding from other sources reduces the need to fund many of the proposed programs listed in this plan. Again, given the various potential funding sources, EOHHS has over-included potential spending in this plan to receive CMS feedback and to continue stakeholder conversations; as such, we do not expect to fully fund all programs listed below.

EOHHS commits to notifying CMS when any changes occur and appreciates the flexibility provided to successfully and impactfully implement programs with this enhanced HCBS FMAP.

Spending Plan Narrative

Improving Rhode Island's "No Wrong Door" System

Proposed Total Investment: $9.3M

LTSS No Wrong Door Enhancement Initiative

Opportunity Statement

One of the core components of Rhode Island's plan to promote HCBS alternatives and enhance access is the ongoing effort to redesign our LTSS system to incorporate the principles of No Wrong Door (NWD) advanced by the U.S. Administration of Community Living. Rhode Island plans to use the HCBS enhanced match to make a one-time investment to assure these NWD initiatives advance and sustain the State's rebalancing goals.

Rhode Island is currently mid-way through a three-phased NWD project, which focuses on modernizing and better integrating critical pre-eligibility, eligibility, and post-eligibility functions to improve ease of access, expand choice, and assure quality.

In NWD Phase I, that State has pursued an array of initiatives that are designed to improve system navigation and provide decision support, including the launch of a Person-Centered Options Counseling (PCOC) network and the development of an information marketing and out-reach strategy to expand awareness of HCBS options. The goal of NWD Phase II has been to streamline and standardize critical eligibility functions to reduce the bias toward institutional care, expedite and eliminate inequities in access to HCBS, and implement a robust system for person-centered planning and conflict-free case management across populations. NWD Phase III, focuses on service delivery and coordination and quality assurance from the point of the initial eligibility determination through to renewal, and particularly for HCBS beneficiaries who choose non-regulated settings.

The State will use HCBS enhanced funds supplement these NWD redesign initiatives in four critical areas: (1) modernization and integration of IT to support core eligibility functions to improve system navigation and ease of access; (2) recalibration and expansion of HCBS information and awareness activities to further extend outreach to underserved racial and ethnic communities; (3) broaden the reach of our person-centered options counseling initiative and (4) finance the technical and program management assistance required to update business processes and ensure policy and practice alignment.

Proposed Intervention & Theory of Change

System Modernization – Improved Access, Choice and Navigation

Investments in expanding and sustaining LTSS service options, and in promoting new ways of thinking about and understanding consumer choices, must be matched with system functionality that leverages IT to support these same goals. HCBS enhanced funding offers the opportunity to make the changes in system functionality that are necessary to move ongoing LTSS resiliency and NWD redesign reforms

forward. It is crucial, therefore, that we make the investments in systems modernization now that are necessary to remove the obstacles we know exist so that Rhode Island and the eligibility and financing systems we rely on are better prepared for tomorrow. Overcoming these technological limitations is, in this sense, an essential component of modernization and a giant leap toward recovery.

First, The State plans to use HCBS funds to implement changes in both the integrated eligibility system and MMIS that pose obstacles to HCBS flexibility without a series of time-consuming manual workarounds. These systems issues are the technical artifacts of the various 1915(c) waivers that existed before Rhode Island established a single HCBS program designed to maximize service access and choice under its Section 1115 demonstration waiver authority. Similar technical issues have impeded efforts to implement HCBS expedited eligibility to the full extent authorized under Rhode Island's Section 1115 demonstration waiver. Rhode Island will use HCBS enhanced funding to finance the system changes required to ensure that policy and practice related to access and choice are fully aligned as we intensify and expand our rebalancing efforts going forward.

Second, due to both its size and comprehensive HCBS waiver program, Rhode Island is uniquely situated to become among the first states in the nation to implement a single beneficiary relationship management (BRM) for Medicaid HCBS in which "information follows the person". At present, the State maintains multiple client relationship management (CRM) tools that support the core ancillary eligibility functions performed outside the integrated eligibility system and MMIS – HCBS assessments, level of care determinations, service planning, case management, etc. These CRMs were all purchased independently over a decade ago to assist in managing specific HCBS programs and/or Section 1915(c) waivers and, despite investments in upgrades, have limited functionality and interoperability. As a result, Rhode Island has a fragmented and complex system for conducting and managing HCBS ancillary functions that lacks the structural capacity to advance the core, person-centered principles of No Wrong Door.

As part of NWD reform Phase I, EOHHS has purchased a beneficiary relations management tool for person-centered options counseling that has the capacity to support these and other ancillary eligibility functions. HCBS enhancement funds offer Rhode Island the unique opportunity to transition from the current fragmented network of CRMs and IT tools to this new tool and establish a unified cloud-based system capable of interfacing with the existing eligibility and payment systems IT infrastructure. The HCBS BRM will also have the functionality required to support NWD initiatives that strengthen and expand person-centered planning and conflict free case management statewide. More important, this new tool ensure easier access to HCBS programs by providing the technical support necessary to eliminate program silos, promote person centered practices, and create the more streamlined business processes so essential for achieving rebalancing.

Enhanced HCBS Information, Awareness, and Outreach

The State proposes to use HCBS enhancement funds to broaden ongoing NWD outreach and awareness activities and expand efforts to provide culturally appropriate information to underserved communities. This work began in response to stakeholder forums and focus groups, including the Equity Council chaired by Lieutenant Governor Sabina Matos and Secretary Womazetta Jones, held as part of the NWD redesign that have consistently shown that many of the Rhode Islanders in-need of and at-risk for Medicaid LTSS are unaware of many of the HCBS options currently available. A significant number of the

health providers these consumers rely on have also indicated that they are also not particularly well-informed about HCBS and that accurate, easy to follow information is not generally readily available. Investments the State has made thus far in increasing outreach and awareness include the development of a marketing strategy that emphasizes HCBS choices, a complementary rebranding of the LTSS gateway and the addition of a new micro website, and production of an array of paper and e- brochures that provide easy to understand information in multiple languages.

HCBS enhancement funds will be used to purchase the expertise and assistance necessary to extend the reach of this work, and other initiatives planned and/or underway, across mediums and in the languages, words, and images that have meaning to the diverse populations we serve. Rhode Island also plans to allocate a portion of the funds allocated in this area to provide our workforce and community partners with both the consistent information about HCBS options and the intensive training in person-centered practices that effective outreach of this kind requires.

Person-Centered Options Counseling Network Expansion

The centerpiece of Phase I of the State's NWD initiative has been the establishment of a person-centered options counseling (PCOC) network. The State plans on making a one-time investment in strengthening the PCOC network to meet the increase in demand anticipated as a result of efforts to expand awareness about and access to HCBS options. The funds will be used for technical assistance to bolster network capacity and refine certification standards, provide broader access to training on person-centered practices both in-house and across the network, and offset some of the initial start-up costs for new providers in the network (e.g., licensing fees, network communications, etc.). In addition, Rhode Island plans to purchase additional IT functionality to support to PCOC providers offering in-person services to underserved and minority populations.

NWD Implementation Assistance

Rhode Island the State also plans to make a one-time investment in the technical assistance and human resources to manage the transition to the new HCBS BRM system and build the business processes and financing streams necessary to sustain the NWD person-centered initiatives now underway. These resources include at least two full-time employees/contractual equivalents to assist in NWD general project management and assure the State's newly developed Person-Centered Options Counseling Network and the Conflict-Free Case Management System under construction are sustainable and have the capacity to respond to changes in demand during the next 36 months. In addition, the State plans to invest in the technical assistance required to develop a plan to improve LTSS navigation that includes business process and IT reforms and a proposal for standing-up a self-financing corps of culturally diverse HCBS application assisters.

Sustainability

The one-time investments associated with each component of this initiative cover the costs of developing a plan for ensuring the sustainability of the interventions proposed, as appropriate. In general, the State expects that savings derived from rebalancing, improving efficiency and performances, and promoting better access and outcomes will offset most of the costs associated with this initiative.

Success Metrics

- Statewide access to PCOC
- Increased awareness of HCBS alternatives
- Reduction in time between point HCBS application submitted and service delivery

Children's Behavioral Health Single Point of Access

Opportunity Statement

Children's behavioral health needs, while growing prior to the public health emergency, have been exacerbated by the stresses of COVID-19. For example, recent data from Rhode Island Kids Count found that calls to RI Kids Link, a Rhode Island hotline on children's behavioral health, increased 22% in 2020 during the public health emergency.[2]

Navigating the children's behavioral healthcare system in Rhode Island can be daunting. Particularly when a child experiences a behavioral health crisis, parents may not know what to do, or who is available to help meet their child's needs. One reason for these challenges is that our current system is siloed, with responsibility for children's behavioral health services fragmented across different state agencies and too often carried out in more restrictive programs than necessary. This makes it difficult for the system to deliver effective behavioral healthcare to Rhode Island children. And for children and families of color, structural racism makes the challenges getting appropriate services for the needs that they have even more difficult.

Rhode Island will utilize HCBS enhanced FMAP funding to strengthen and expand our existing pediatric behavioral health hotline so that it can serve as a central access point for the entire state.

Proposed Intervention & Theory of Change

Strengthening the System with a Single Point of Access.

A primary goal of the Children's Behavioral Health system is to make coordinated services more accessible for families. Creating a single point of access streamlines the process and removes barriers to obtaining timely, necessary services and supports for children and youth, particularly for those experiencing a behavioral health crisis. Rhode Island will use enhanced HCBS FMAP funding to expand an already-existing 24/7 pediatric behavioral health triage and referral hotline into a central referral hub for children's behavioral health referrals for the state**.** Rhode Island's central goal is to ensure that families can enter the system through any point - schools, primary care physicians, or community programs that will all know how to identify and refer a child or family. Once the family reaches the system, there will be a unified process for receiving the care they need to thrive.

The single point of access will need resources for training and supports to implement standardized screening and assessment tools, such as the Child and Adolescent Strength and Needs (CANS) and tools that measure Adverse Childhood Experiences (ACEs) can help to ensure that needs are accurately identified, and services are matched appropriately and effectively.

[2] 6783 LCACT 1st Mailer (rikidscount.org)

The Single Point of Access will also need a comprehensive communications component, to publicize the availability of the services to organizations that refer for services and for parents and youth.

Community Referral Platform

The Single Point of Access will also require patient-centered coordination and electronic referral management software to build a coordinated care network of health and social service providers in Rhode Island. EOHHS has just competitively procured the Community Referral Platform (CRP) for its Accountable Entity program under the Health System Transformation Project (HSTP) supported by CMS. This funding will go to build out the CRP to integrate with the single point of access to allow for referrals to social service partners.

Sustainability

Building a coordinated access point and developing a referral platform that will support it are onetime costs that will yield long term improvements in assess to children's behavioral health services in Rhode Island.

Success Metrics

- Expanded referrals to community partners
- Improved provider satisfaction in connecting kids with the behavioral health treatment they need
- Reduced wait time in accessing pediatric behavioral health services

Increasing Access to HCBS

Proposed Total Investment: $56.375M

HCBS Workforce Recruitment and Retention

Opportunity Statement

Supporting and building the HCBS direct care workforce is a cornerstone of Rhode Island's Covid-19 recovery strategy as well as our LTSS re-balancing initiative. The majority of stakeholder survey respondents cited worker wages and training as a priority and highlighted the fact that many direct care workers are tempted to leave the workforce due to better paying positions in retail or foodservice. Historically, approximately 22% of approved HCBS service plans for LTSS Home Health agencies may go unfilled. Low wages and challenging working conditions, limited advancement opportunities, and little respect and recognition have created chronic HCBS direct care worker (DCW) shortages that diminish access and quality of services. Workforce shortages have been exacerbated by COVID-19 and may be further challenged by a tight post-pandemic labor market, statutory increases in the minimum wage without current statutory rate increases, and growing demand for HCBS services. Major investments in workforce recruitment, retention, and training will be needed to reverse labor shortages and begin to turn this care economy work in to a valued part of our labor market and human infrastructure.

Learning from our investment of CARES Act dollars, Rhode Island will invest in a direct care workers outreach campaign, recruitment and retention programs to incentivize the workforce growth necessary to support Rhode Island's rebalancing efforts, and expand successful training opportunities to improve quality and support career growth.

Proposed Intervention & Theory of Change

Workforce Recruitment

HCBS direct care workers (DCW) are a category of paraprofessional workers who typically provide direct personal care and support to elderly individuals and individuals with physical, intellectual, and developmental disabilities or mental health and substance use disorders. In HCBS settings, DCWs are most commonly categorized by the Bureau of Labor Statistics as Nursing Assistant, Home Health & Personal Care Aide, and Social & Human Services Assistant. (Actual job titles are not standardized and vary widely.) Other than Nursing Assistants, DCWs are typically unlicensed, and require little, if any, pre-employment training or certification. DCWs are among the fastest growing occupations in Rhode Island and are projected to have the highest number of job openings (largely due to turnover) between 2018-2028[1]. The pandemic has exacerbated these challenges due to health & safety concerns, childcare difficulties, job loss, unemployment benefits, and other issues.

Career Awareness & Outreach

EOHHS will engage in and support partnerships with Department of Labor and Training (DLT), Governor's Workforce Board (GWB), RI Department of Education (RIDE), Department of Human Services (DHS), Department of Behavioral Healthcare, Development Disabilities, and Hospitals (BHDDH), higher education and/or other public and community-based workforce partners to promote HCBS training, education, jobs, and careers to unemployed and underemployed adults and in-school and out-of-school youth. Activities shall include career days, job fairs, guest speakers, internships, mentors, worksite visits, social media, paid advertising, educational materials, and other initiatives to raise awareness of job and career opportunities – and increase employment -- in home and community-based services

Hiring Incentives

Recruitment efforts will include hiring incentives that will be paid after six months of employment as an incentive to new hires and to enable HCBS employers, including but not limited to Medicaid Certified Home Health Agencies, Assisted Living Facilities, PCAs in Self-Directed programs, Developmental Disability Organizations and HBTS/PASS providers to compete in a tight labor market.

DCWs hired between July 1, 2021 – March 31, 2024 will be eligible to receive hiring bonus, based on total hours worked in the first six months of employment supporting seniors, people with physical, intellectual, or developmental disabilities, children with special needs, individuals with mental health and substance abuse disorders, and young people in Rhode Island's Department of Children, Youth, and Families. Specific bonus amounts will be outlined in administrative guidance and will be determined in consultation with stakeholders.

Workforce Retention

DCW turnover rates are extremely high due to low wages, a competitive labor market, difficult working conditions, little respect and recognition, and limited advancement opportunities. High turnover rates reduce access to services, continuity of care, and workforce knowledge, skills, and experience to care for increasingly complex HCBS consumers.

To help reduce turnover rates and improve workforce retention, the state will support retention bonuses for DCWs. Specific bonus amounts will be outlined in administrative guidance and will be determined in consultation with stakeholders.

Funding under this initiative will also be used to contract with a fiscal intermediary to administer the hiring and retention payments, recognizing that to keep accurate records of funding and to administer according to policy goals requires dedicated administrative capacity.

Sustainability

All workforce incentives are designed as short-term programs to help Rhode Island recover from the devastating impacts of Covid-19 on the HCBS workforces. However, we understand that Rhode Island requires ongoing investments in HCBS workforce development to ensure that the state has the capacity requires to support an aging population in addition to our I/DD community and children and adults with behavioral health needs. We intend to use the lessons learned from each HCBS work force initiative to inform our ongoing policy work, including our annual budget development. For example, using CARES Act dollars, we provided Behavioral Health training to 200 HCBS Nursing Assistants. Based on the success of that program, we incorporated a new rate structure into our Fiscal Year 2022 budget bill that provided an increase in payments to agencies who had at least 30% of their workers complete the training. In this way, we maximized the one-time nature of the funds to advocate for long term policy changes to support workforce development.

Success Metrics

- Recruitment Campaign will reach 10,000 job seekers
- 4,500 new Direct care workers will be hired over 3 years
- Reduction in turnover rate as reported by provider agencies
- 100% of incentive payments will be made timely

Developing Rhode Island's HCBS Workforce

Proposed Total Investment: $6.1M

HCBS Workforce Training

Opportunity Statement

In addition to the initiatives in the above section on expanding HCBS access through workforce recruitment and retention, workforce training to increase the skill of our workforce, continue building a career ladder and increasing quality, is paramount. While retention funding described above is necessary, we believe that investing in our workforce requires more training.

Proposed Intervention and Theory of Change

Advanced Certifications for CNAs, PCAs, and S&HSAs

HCBS DCWs often receive little, if any, formal training in how to identify and address the complex physical, emotional, and social challenges that are faced by their patients and clients. Nor do they receive counseling or help on how to deal with the emotional challenges themselves of working with such a population. In order to expand skills and advancement opportunities for workers while enhancing quality and continuity of care for consumers, the state will support workforce training opportunities and/ or incentives for DCWs to obtain approved, advanced certifications and other trainings that are industry-validated and linked to career pathways and/ or professional development, including but not limited to: behavioral health, Alzheimer's and dementia, chronic diseases, social determinants of health, employment supports, evidence-based behavioral health practices, and other consumer-centered training.

Health professional equity initiative

Black, Indigenous and People of Color are significantly overrepresented in low wage HCBS direct care worker jobs but are significantly underrepresented in higher-paid licensed health professional roles. The need for culturally and linguistically competent clinicians is particularly critical in behavioral health settings. This long-standing equity issue adversely impacts workers, families, consumers, and provider agencies. Barriers to higher education and licensed occupations can be formidable, and a substantial investment is needed to address historic race-based inequities and prepare a more diverse, culturally and linguistically competent workforce.

To help address racial and ethnic inequities in the health professional workforce and to expand career pathways opportunities for DCWs who have been employed for at least two years, the state will support a full tuition waiver (in conjunction with other available tuition assistance programs) at any public institution of higher education in RI for courses and credits leading to a health professional degree and/or license, as well as paid educational leave time (2 hours leave per academic credit while enrolled in classes, not to exceed 20 hours paid leave/week). Marketing and outreach for this initiative will focus on marginalized communities and communities of color with the specific goal of increasing diversity in the direct care workforce.

Success Metrics

- 6,000 workers will achieve an additional certification
- 200 Direct Care Workers will enroll in health professional degree program

Improving Quality and Race Equity

Proposed Total Investment: $10M

Quality and Race Equity Challenge Grants

Opportunity Statement

In addition to investing in workforce development and access to services, the enhanced FMAP provides an opportunity to build new quality models of service delivery and to encourage providers and community organizations to participate in quality improvement programs. Access to services is important, but so too is the quality of those services. According to the Long-Term Services and Supports 2020 State Scorecard produced by AARP, the AARP Foundation, The Commonwealth Fund, and the SCAN Foundation, Rhode Island is ranked 37th in Quality of Life and Quality of Care, and 28th in Effective Transitions. Within those categories, our rate of employment for adults with ADL disabilities ages 18-64 relative to rate of adults without disabilities is ranked 35th and our percentage of home health patients with a hospital admission ranks 47th in the country. Critically, our HCBS quality cross-state benchmarking capability is also low, ranking 36th among states.[1]

Quality measures on adult and children's behavioral health and adult behavioral health also need improvement. Rhode Island's rates for substance abuse are above the national average for all drugs surveyed except for cigarettes. Rhode Island has the highest rate of juvenile delinquency cases per 100K children when compared to neighboring states. And we see that a lack of home and community based services for behavioral health across the age spectrum drives medical spending elsewhere: 10 percent of ED visits in 2018 had a primary diagnosis related to behavioral health and over a quarter of the mental health visits were children, according to RI Department of Health data. Medicaid claims data suggests that counseling services are more often provided after a hospitalization, rather than before as preventative care. Finally, as an indicator needed prevention and new care models, less than one-quarter of individuals received a follow up within 30 days after an emergency department visit for SUD-related issues.

Proposed Intervention & Theory of Change

Quality and Equity Challenge Grants

Regardless of the specific quality measure to point to, we know that expanding access to existing programs will not be enough to have a full population health impact. We also know that with temporary funding, it is not advisable to propose only one or two programs to fund if you do not know if they are going to be successful. However, from our stakeholder engagement survey and conversations, we know that there are organizations that if they received one-time funding for pilot programs, could show increases in quality attainment that could serve as the basis for future state investments, either through Medicaid-funding pay for performance programs or through other value-based payment arrangements with our Managed Care Programs and Accountable Entities.

EOHHS proposes a "Challenge Grant" opportunity to fund quality improvement programs that can be implemented and evaluated by March 31, 2024. Through an RFP process with careful attention to outreach beyond typical vendors and providers, we expect to evaluate proposals fund program costs above and beyond what might be currently claimable under existing authorities. The application will also need to include a plan for an evaluation including the administrative costs and Medicaid authorities required to sustain any future program expansion, should it be shown to be effective. The RFP process will explicitly seek culturally-competent providers with either minority-ownership or governance, and will encourage partnerships among deeply-rooted community organizations to meet

the grant requirements. For example, grass roots, minority-led organizations may partner with educational institutions or other research-based entity to complete the evaluation. Finally, all grants submitted must show an impact to address racial and ethnic disparities in the quality measures to be achieved.

While we encourage our stakeholder to promote their own programs, EOHHS will encourage applicants to consider quality measures that prioritize reducing emergency department and inpatient use, safety at home, preventative BH and SUD services, housing stabilization, children's behavioral health wraparound services with child welfare providers, and identifying opportunities to assist returning citizens from the Rhode Island Adult Correctional Institutions (ACI).

Enhancing State Quality Strategy

RI is currently receiving technical assistance from CMS and Advancing States to develop and implement cross-agency operational, data collection methods and oversight of HCBS services that will allow for standardized reporting of required sub-assurances under our Comprehensive 1115 Waiver. We feel that this technical assistance should be supplemented by additional work under this opportunity to expand data collection in line with the CMS Request for Information on the Recommended Measure Set for Medicaid-Funded Home and Community Based Services.[2] Included in that RFI are a long list of potential measures. We intend to use this funding for addition technical assistance to expand data collection and necessary system modifications to support that collection, enhance our quality strategy and develop public facing quality scorecards.

Sustainability

"Challenge Grant" recipients will have the opportunity through funded evaluations to show efficacy of programs that could be used to appropriate additional funding or Medicaid rate changes to support the continuation of programs with other grant dollars. Such evaluation could also be used for additional grant funding to support programs as required. Technical assistance under the quality strategy initiative will be designed to ensure that existing state program administrators and data analysts can keep data up to date following the completion of the funded project.

Success Metrics

- Number of Medicaid members served in new pilot models
- ED visits and inpatient visits among members served in new pilot models
- Personal safety and respect measures
- Life decision measures

Assistive Technology and Remote Supports

Opportunity Statement

The use of technology can help support individuals (I/DD, Traumatic Brain Injury, Dementia, Physical Disabilities) by helping keep them safe, reminding them about medications, or helping them stay connected to the community at large. Technology can help people live on their own or age in place,

have greater access to transportation, provide needed reminders for daily living skills, assist with medication management, and many other tasks and/or activities. Overall, the use of technology promotes independence and self-sufficiency.

Additionally, we can leverage technology to help aid individuals without the need for in-person staffing. Remote support uses two-way communication in real time, so the individual receiving the support can communicate with their provider when they need them. Remote supports services decrease the need for in person staffing and have been successfully implemented in several states including Ohio, Minnesota, Indiana, South Dakota, Tennessee, and Wisconsin. By alleviating the need for in person staffing for individuals who are able to benefit from remote supports, and choose this option, we free up Direct Support Professionals (DSP) who can work with individuals who have more significant needs and require more direct hands on care.

During the Public Health emergency, many people learned how to use new technology to stay connected with work, family, friends, and support services. The use of technology has allowed individuals to stay connected. In some cases, it has expanded their communities. This is a gain that cannot be lost post pandemic.

Proposed Intervention & Theory of Change

Access to Technology

To ensure equitable access to these technologies and building on the success of DigiAge, Rhode Island will establish an assistive technology fund to assist clients with a one-time purchase of these devices. Recognizing disparities in technology ownership and usage, this program will make specific use of community in-reach to those areas of Rhode Island hardest hit by COVID-19. Technology can assist individuals with support needs to address impairments in memory, abstract thinking, executive functioning, task sequencing, motor, and/or adaptive behavior. It allows for increased independence and the potential for a broader community.

There are all types of tech devices individuals can purchase to improve the quality of their life including laptops, smartphones, and tablets. Additionally, specialized smart devices can assist/alert when an individual has something burning on the stove, forgets to shut off the stove, needs automatic home temperature controls, or struggles with medication management. Technology also offers new ways of connecting individuals. People can engage in all types of activities such as skill building classes, exercise classes, cooking classes, as well as many others that are all online.

Technology Training

Training in new technology is essential for individuals to fully benefit from any new service or device. There is a need to have trained staff assist individuals in learning how to use their devices, whatever they may be. Provider agencies and individuals who self-direct their support services should have access to training dollars, so they can get the most use out of their technology.

Remote Support Services Pilot Project

Rhode Island will invest Enhanced HCBS FMAP funding in a 3-year pilot project to develop remote staffing model. The project will use a competitive process to acquire technical assistance, solicit proposals from stakeholders, and design, implement and evaluate two to three project proposals. As part of project evaluation, we will conduct a Medicaid rate review and identify legislative, regulatory and system requirements that would need to change to support sustained implementation of successful programs.

Sustainability

Experience from other states proves that expanding access to technology and use remote supports is cost effective. When these supports are used to assist individuals there is a decreased need for in-person staffing. There is a cost associated with acquiring the technology that will be used by individuals, but the technology can last for several years. The use of these one-time funds will allow us to learn more about what works so we can further define an effective strategy for the use of technology as it continues to evolve along with individual preferences and ability to utilize technology.

Success Metrics

- # Individuals utilizing remote supports for independent living and employment
- Greater independence evidenced by individuals doing things for themselves w/out staff involvement
- Increase request for technology
- Increased online community memberships

Building Infrastructure to Expand Provider Capacity and Care Continuum

Proposed Total Investment: $55M

Self-Directed Program Expansion

Opportunity Statement

A common theme in our regular stakeholder engagement work is the need to increase the number of workers providing HCBS services. Only 60% of our licensed Nursing Assistance are currently employed as CNAs, indicating that many are leaving the healthcare industry. While our workforce proposals are inclusive of CNAs, we have an opportunity to grow our self-directed programs and support a different type of consumer and worker. Self-directed workers, known as Personal Care Aides (PCAs) or Independent Providers (IPs), need access to the same rewards as those that may work in a more traditional program, so that we can grow self-direction and self-determination in Rhode Island.

The service advisory agencies who help case manage and otherwise assist seniors and clients with developmental or physical disabilities in self-directed programs also need to be incentivized to keep up with increased demand and to support the growth of these programs more completely. During the PHE, many DD families shifted support services to a Self-Directed model. EOHHS also saw an increase of more than 150 workers in LTSS self-directed model. We need to reevaluate how and what we pay the provider agencies with whom we contract to oversee these programs.

Finally, Rhode Island has built up its self-directed programs over time. With additional one-time support, we can review our overlapping programs and build consistency in them to make them more attractive to workers and more understandable to Rhode Islanders.

Proposed Intervention & Theory of Change

We propose investing in our self-directed programs to expand the workforce and increase utilization of these programs. This should include propose conducting a policy and rate review of the current array of self-directed programs with the intention of enhancing the self-directed model of care, including Personal Choice, IP, Shared Living, DD self-directed programs, and the OHA case management program. This review should include an analysis of how service advisory agencies (SAs) and fiscal intermediaries (FIs) are paid across programs with the intent of creating consistency amongst programs; to ensure that rates are set appropriately to support services; and to ensure that service advisory agencies are compensated in some way for clients who ultimately do not participate in self-directed programs.

To act as a bridge to new rates, we will also invest enhanced FMAP with service advisory to expand services and support self-directed programs. Additionally, enhanced FMAP funds will be used to incentivize additional agencies to certify with Medicaid to be Service Advisement Agencies.

These investments will also include working with the No-Wrong Door program and our broader workforce outreach initiative to conduct a public information campaign on self-directed model of care. Such a public information campaign will make special emphasis on equity and targeting communities of color. We also aim to target outreach and recruitment efforts at areas of the state where home health care is least accessible and conduct targeted outreach to the community to inform them of PCA registry opportunities.

Sustainability

By utilizing FMAP funding, we hope to both craft a plan for sustainability through the policy and rate review, while providing funding for three years to wait for passage and implementation of proposed changes.

Success Metrics

- Increase the number of service advisory agencies and fiscal intermediaries available for the self-directed programs.
- Increase the number of PCAs enrolled in the Registry to be accessible by enrollees of IP or Personal Choice.
- Increase percentage of overall clients receiving self-directed services as their HCBS service.
- Increase number of clients of color receiving self-directed services as their HCBS service.
- Clear information on website and available to community explaining array of self-directed services and clear steps on how to access these services.
- Greater support in empowering individuals to manage services for Self Directed

I/DD Provider Capacity Enhancements

Opportunity Statement

Individuals in the Adult I/DD service system want to have access to more service model options to meet their goals. Current service infrastructure between self-directed programs and provider agency programs needs to transform to better meet the desires, preferences, and needs of the individuals who rely on these supports.

There is a need to identify models for supporting provider transformation initiative, including establishment of a transition fund. The goal of the initiative is to establish high quality Employment Supports, Integrated Community Based Supports, Community Mapping, and the Use of Technology. There is also the need to expand the use and capacity of the Self-Directed support model.

Proposed Intervention & Theory of Change

Transformative Change Models

This grant program aims to incentivize providers to improve their practice models by providing access to tools and technology designed to improve access to, and quality of, integrated community day and employment support programs. This proposal will be in parallel to a significant rate enacted by the Rhode Island General Assembly in our recently passed budget for the current state fiscal year. Through provider transformation we aim to:

- Improve access to and the quality of integrated community day and employment support programs;
- Enhance service delivery models to focus on person-centeredness and the supports consumers need to live meaningful lives of their choosing in the community of their choosing;
- Strengthen provider infrastructure and practice models to ensure an efficient, sustainable service-delivery network; and
- Improve the system's ability to prepare for improved outcomes through value-based payments and other contractual structures.

Effective integrated day and employment practices can only thrive in organizations where a clear focus, values, and infrastructure are present. A comprehensive transformation initiative must address the development of new business models that focus on priorities such as organization goals, culture, job placement process, communications, fiscal and staff resources, professional development, customer engagement, quality assurance, and community partnerships.

Technical Assistance

These grants will provide Developmental Disabilities Organizations (DDOs) one-time financial support to promote organizational change and capacity building to improve quality through technical assistance. As we recover from the pandemic, we need to innovate on service models and practices to better support consumers in the community and meet their needs, goals, and preferences, with a focus on community and employment first.

Through our TA from the Supported Employment Leadership Network (SELN), this nation leading organization recommends an approach that incorporates an investment in both organization level

technical assistance, employment support professional training, and implementation support in the form of coaching and mentoring.

Sustainability

These resources will be one time and we aim to use what we learn from the grant and the TA to develop future year budget proposals to sustain the positive change. Some of the funding may be able to be obtained from other funding sources.

Success Metrics

- Increased percentage of consumers engaging in person centered services
- Individuals receiving, I/DD services indicate they had choice
- Individuals receiving, I/DD services indicated they are meaningfully engaged
- Individuals receiving, I/DD services will indicate they are supported in activities that support employment, leisure, spiritual, social, educational goals.
- Employment that is customized
- Providers diversity revenue streams to promote flexibility
- Increase in inclusion, equity, and diversity in seen in programming and hiring practices

Nursing Facility Transformation

Opportunity Statement

The State of Rhode Island invests over $329 million annually to provide long-term services and supports (LTSS) to approximately 11,000 beneficiaries over age 65. Currently, 75% of those services are delivered through high-cost nursing facilities. Importantly, the average cost of care for nursing facilities for individuals over 65 is ~$30,000 greater than for home and community-based services (HCBS). As of FY 2018, Rhode Island had the lowest share of Medicaid LTSS spending on HCBS in the nation, creating an unsustainable financial situation given our aging population.[1] Under Rhode Island General Laws section 40-8.9, our goal is 50%.

We have a significant opportunity to rebalance Medicaid LTSS utilization away from institutional settings and towards home and community based (HCBS) settings, and to refocus institutions on the individuals who most need that level of care. Rhode Island does not have sufficient specialized nursing facility capacity to care for more needy Medicaid members, such as individuals with complex behavioral health needs, traumatic brain injury (TBI), or patients in need of a ventilator. Instead, we have more "generalized" nursing facilities that serve the general population and have become the de-facto choice for many Rhode Islanders, even though individuals and families surveyed typically express a desire to remain at home or in their community.

The goals of the Nursing Facility Transformation and Bed Buyback Extension are to 1) reduce utilization of nursing facilities for Medicaid members who can be appropriately served in an HCBS setting and choose such a setting, and 2) support high quality Nursing Facilities to adjust their business models and develop targeted capacity to serve specific Medicaid populations in need (e.g., those with complex

behavioral health needs). This initiative will help nursing facilities who have been confronting declining occupancy due to the pandemic to remain on solid financial footing.

Proposed Intervention & Theory of Change

Nursing Facility Transformation and Bed Buyback Extension:

Under the CARES Act, EOHHS established a Grant program that provided $9 million in funding to 11 nursing facilities to transform and diversify their business models, resulting in 286 licensed nursing facility beds being taken offline or repurposed to build service capacity and meet specific RI needs. Of those, 27 beds were taken out of service, another 102 were repurposed to non-institutional use, and the rest were reserved for specialized capacity for memory care, patients needing ventilators, and patients with BH needs.

EOHHS proposes to both expand and refine this successful program to extend funding to additional participants and offer extensions to existing participants. We also plan to refine the program requirements to more specifically target the types of specialized capacity most needed by Medicaid beneficiaries – namely brain injury support, complex behavioral health, supportive housing models, and Department of Corrections geriatric discharges. If successful, this expanded program will include an additional 5-10 facilities over two years.

EOHHS plans to distribute funding via a competitive grant process to nursing facilities in Rhode Island, some of which are small businesses and non-profits. Consistent with the CARES Act funded 2020 program, nursing facilities will be awarded grants to accomplish one of the following transformations:

1. **Nursing Facility Transformation** that enables the facilities to diversify their sources of revenue to counter losses from business interruption due to the public health emergency and ensure ongoing financial viability.
2. **Targeted, Specialized Nursing Facility Service Capacity Building** to develop a specialized unit under current licensure with the structural capacity and approved clinical care models to support at specific, targeted at-risk populations with specialized needs where service provision by a nursing facility to these populations can stabilize occupancy and free up hospital capacity.

Sustainability

This one-time funding will support nursing facilities in transforming their practice models to specifically target populations and services that will better meet the needs of the RI Medicaid long term care continuum. This investment in diversification of nursing facilities will allow Medicaid to maintain lower nursing facility utilization rates and continue to realize savings over time.

Success Metrics

- Total number of licensed nursing facility beds
    - Number of licensed nursing facility beds repurposed for specialized use by the type of specialized use – TBI, BH, dementia, supportive housing, etc.
    - Number of licensed nursing facility beds taken out of service

Assisted Living Expansion to Serve Medicaid Members

Opportunity Statement

Assisted living residences (ALRs) offer a community-based 24/7 supportive living option for people who do not require the level of skilled care provided by nursing facilities. However, access to assisted living for low-income Rhode Islanders is substantially limited, as many providers either do not participate in the Medicaid program or severely restrict the number of placements available for Medicaid LTSS beneficiaries.

There are a growing number of Rhode Islanders who could be safely served in an ALR but are unable to gain admission to these types of LTSS settings and therefore remain in higher cost institutional settings. According to Kaiser Family Foundation, only 15% of Rhode Island's assisted living residents are on Medicaid; whereas well performing states on LTSS rebalancing measures have more than 25% of assisted living residents on Medicaid. Further, according to the American Health Care Association, Rhode Island's ratio of Medicaid nursing facility residents to assisted living residents is 10.9. The national average is 5.53.

Proposed Intervention & Theory of Change

Assisted Living Expansion Grants

The Assisted Living Expansion initiative will provide funding to ALRs to expand capacity subject to the condition that they reserve beds for Medicaid eligible residents and more generally take a meaningful step toward making ALR options more accessible and more affordable for all Rhode Islanders. EOHHS will make grant funding available as an incentive to ALRs to attain initial Medicaid LTSS certification, and to those ALRs already certified who make a commitment to serve a certain number of Medicaid beneficiaries on an ongoing basis.

EOHHS attempted a similar ALR expansion program using Coronavirus Relief Funds (CRF) in 2020, but the program was ultimately unsuccessful, and no grants were distributed. The three primary reasons for lack of interest from RI ALR providers in the prior program were: (1) AL Medicaid rates were not sufficient; (2) the incentive program was insufficiently funded; and (3) given the tight timelines under CARES act for the use of the funds, there was limited provider engagement. Based on these learnings, we propose to redesign this important program by drawing on the lessons of the last year. As a starting point, the General Assembly recently adopted EOHHS-proposed ALR rate reform that ties rates to tiered acuity. We will also begin by actively engaging providers in the design/development of the program details and requirements to get them on board earlier in the process. In addition, we plan to have opportunities for a more substantive funding commitment.

Funding will be distributed to eligible ALRs who agree to increase access for low-income Rhode Islanders who need LTSS in a safe, supportive environment but without the level of skilled care provided by an institution. Grant funding will be awarded upon proof of Medicaid certification for newly certified ALRs. Additional grant funding will be made available to facilities who commit to increasing the number of Medicaid beneficiaries served. Grant funding will also be used to incentivize certain outcomes, to be developed in conjunction with industry stakeholders, such as supporting underserved populations or adopting cultural sensitivity training.

ALRs may use grant funding to defray costs of obtaining certification and setting up new programs, processes, and outreach for Medicaid beneficiaries. ALRs will be encouraged to establish processes for timely and frequent connection to local nursing facilities and hospitals to encourage transitions of care that either avoid or minimize nursing facility stays. Providers will also need to establish new processes for classification of Medicaid eligible AL residents in accordance with the new Medicaid tiered rate structure to enable facilities to accept and support populations with higher acuity.

Sustainability

This initiative will provide one-time funding to incentivize initial Medicaid LTSS certification of ALRs and increased ALR participation in the Medicaid program and promotes public health and safety in our post pandemic environment as it promotes independent living. Ongoing payments for Medicaid beneficiaries in ALRs will be part of the regular Medicaid program and will not require ongoing additional initiative funding. In addition, having ALR placements available to Medicaid beneficiaries as an alternative to congregate settings and more expensive nursing facility settings will result in long term savings for the Medicaid program.

Success Metrics

- Increase in the number of Medicaid LTSS certified ALRs
- Increase in the number of Medicaid beneficiaries in ALRs
- Ratio of Medicaid nursing facility residents to assisted living residents

Building Traumatic Brain Injury Capacity In-State

Opportunity Statement

Currently, the State has a Traumatic Brain Injury program that provides services through two different pathways. One allows for individuals with a TBI (traumatic brain injury) or ABI (acquired brain injury) to reside in one of three homes that provide residential support and ongoing habilitative services, the other allows for personal care type services to be provided in a home or community setting by either a nursing agency or one of the DDO's which provides a direct service worker. Pre-pandemic, the community resident was also able to receive day HAB through a licensed community rehab facility which has since stopped its day program for adults. The current design of the program does not address a continuum of care for individuals with a TBI/ ABI and relies heavily on placements in residential settings. Due to the limited number of in-state beds, Rhode Island must sometimes rely on out of state placements to meet the needs of its members. Another challenge of the current program design is that eligibility is limited by the need to have a "Hospital Level of Care" which may prevent individuals from accessing services which are beneficial to them.

Rhode Island will utilize enhanced HCBS FMAP dollars to increase and diversify the services to individuals with TBI/ABI within their community of choice. Creating a program that provides community based rehabilitative services and supports, at increasing acuity levels, the state may lessen the need for long term residential placements in state and out of state (at a cost of $1000 per day minimum.) Out of state placements create a problem for case management and oversight of the provision of services.

Proposed Intervention & Theory of Change

Utilizing enhanced HCBS FMAP dollars, we conduct the interagency planning, rate review, and system enhancements required to expand the Habilitation program to include the following services:

- **Cognitive Rehabilitation Services**: services provided in a home or community setting where the skills will be used to maximize the functioning and success of the individual.
- **Outpatient clinic/Day program:** specializing in rehabilitation therapy and additional services such as counseling, behavioral supports, activities.
- **Specialized LTSS Residences:** Identifying NHs through nursing home transformation for specialization in TBI /ABI patients, or a higher level of residential living that supports individuals with behavioral needs that are currently in out of state placements.
- **Support to the TBI Association of Rhode Island:** For increased accessibility to support groups and resources for Individuals with TBI/ABI and their families.
- **Funding for a Project Manager/ Consultant:** Consultant will lead interagency project management and will research other state programs to recommend best practices

Sustainability

This initiative would need to have funding in future budgets, but we anticipate that costs will be off set by savings from maintaining individuals in lower cost community-based settings which in Rhode Island. Additionally, by providing intense therapies in a timely to individuals with TBI/ABIs the possibility for a more successful recovery with hopefully less dependence on services.

Success Metrics

- Decreased number of individuals who are seeking out of state placements
- Increased number of individuals able to return to a pre-injury level of functioning or a return to work or employment with supports
- For those needing continued supports, receiving those services in the least restrictive settings
- Increased numbers of individuals moving from most restrictive to least restrictive service provisions

Expanding Preventative and Community Children's Behavioral Health Services

Opportunity Statement

Children's behavioral health needs, while growing prior to the public health emergency, have been exacerbated in Rhode Island by the stresses of COVID-19. Recent data from Rhode Island Kids Count found that calls to RI Kids Link, a Rhode Island hotline on children's behavioral health, increased 22% in 2020 during the public health emergency.

Navigating the children's behavioral healthcare system in Rhode Island can be daunting. Particularly when a child experiences a behavioral health crisis, parents may not know what to do, or who is available to help meet their child's needs. One reason for these challenges is that our current system is siloed, with responsibility for children's behavioral health services fragmented across different state agencies and too often carried out in more restrictive programs than necessary. This makes it difficult for the system to deliver effective behavioral healthcare to all Rhode Island children. And for

children and families of color, structural racism makes the challenges getting appropriate services for the needs that they have even more difficult.

Rhode Island's system, like many others, also faces workforce deficits. These deficits predate the COVID-19 pandemic and have only grown more acute since its onset. Systems related gaps include critical workforce shortages in key areas of behavioral health including among psychiatrists, mid-level practitioners, and entry level workforce resulting in widespread, high levels of turnover or position vacancies among the network of behavioral healthcare providers. In addition, immigrants and people of color (particularly Latinx Rhode Islanders) are significantly under-represented among clinicians, which diminishes capacity to provide culturally and linguistically competent care.

EOHHS, our partner agencies (BHDDH, DCYF, RIDE, and RIDOH), and community member and stakeholders have been working to create a newly updated Children's Behavioral Health System of Care for children and adolescents since the summer of 2020. The System of Care proposal is united here with interventions for transition-age youth especially for the populations at highest risk through illness and structural racism. Our overarching goal is to develop a culturally and linguistically competent aligned system, with the immediate focus on developing a crisis continuum of care for children experiencing a behavioral health crisis, focused on care at home and in the community rather than in more restrictive settings. There is a pressing need to address the psychosocial and mental health needs of vulnerable children and adolescents and to remove racial and ethnic disparities in children's mental health services. The COVID-19 crisis has led to short term as well as long term psychosocial and mental health implications for children and adolescents and expanding access to services to support children's mental health will be critical.

Proposed Intervention & Theory of Change

Care Coordination

Within systems of care, children and youth with significant need/high risk behavioral health conditions require intensive coordination of services and supports. Many states use high fidelity wraparound as their care management model as traditional case management, MCO care coordination, or health home approaches are not sufficient for children and youth with significant behavioral health challenges. In Rhode Island, the Family Care Community Partnerships (FCCPs) have employed the wraparound model since their inception in 2009. This has allowed for a care-planning approach that is individualized, comprehensive, coordinated across child-serving systems, culturally appropriate, focused on home and community-based care, and carried out in partnership with children and their families. Additionally, the wraproud approach works to reduce racial and ethnic disparities in the system.

We propose to expand our family-driven wraparound approaches to service planning and delivery through the Family Care Community Partnerships (FCCP) to ensure that services meet the family and youth's identified strengths and needs. Currently, state-contracted FCCPs provide wraparound services to approximately 700 families at a given point in time – and this proposal will expand that to serve the 1,000 families currently in need. FCCPs will also need to utilizing funding to show continued engagement with community-based organizations of color.

It is important to note that while DCYF holds the contract with the FCCPs, the services are offered to all Rhode Island children and are not specifically part of our child welfare system since this is a prevention initiative. In fact, only 3% of children who were discharged from the FCCP formerly enter the child welfare system within 6 months of discharge.

Intensive Home and Community Based Services (e.g. HBTS/PASS)

Our proposal for the System of Care is to expand Intensive Home and Community Based Services to remove wait lists for DCYF families and increase support to Medicaid families receiving HBTS, PASS or Respite Services, and open services to all families served by the FCCPs. Investing in more appropriate care sooner can lead to a quicker recovery and cut down on longer hospital stays and help recover from reductions in staff due to the PHE, particularly for HBTS/PASS providers.

Transition-Age Youth and Young Adults Services

The period between adolescence to young adulthood can be difficult for many young people. Those with behavioral health conditions experience additional challenges, particularly when it comes to navigating several complex systems of services and supports. Further, individuals of transition age engage differently and require services that fit with the developmental and cultural needs of their age group. Services need to be holistic, prevention focused and provided in a youth-friendly environment, with specifically addressing the fear, bias, and discrimination felt by people with behavioral health conditions, with staff competent to work with this age group. To maximize access to and engagement in appropriate services, we propose to pilot two "one-stop, multi-service hubs" dedicated to youth and young adults 16-26.

Prevention Services

The stakeholder engagement described above has focused significantly on the importance of adding a much stronger prevention component to our children's behavioral health System of Care. This could include expanding Pediatric Integrated Behavioral Health Practice Transformation, among others.

Sustainability

The primary sustainability strategy for the Children's Behavioral Health System of Care in general and this HCBS in particular is that instead of spending money on more expensive hospitalizations, Emergency Department visits, and other more restrictive care, we will focus on prevention, mobile crisis, and care coordination, with referrals to high quality and lower cost home and community-based care. We will track the reductions in spending for hospitalizations and residential care and work over time with the General Assembly to apply those to ongoing spending for enhanced services and necessary Medicaid or DCYF rate changes adjustments. Many of these programs above include one-time start-up costs to be funded by HCBS dollars, that may require rate adjustments in the future.

Success Metrics

- Results of standardized assessments for Rhode Island children and youth – provided through mobile crisis services and other home and community-based services and tracked through the CRP- will improve.

- Rhode Island will see fewer psychiatric and medical hospital admissions and ED visits, and less need for residential placement services.
- The balance of behavioral health spending will shift away from higher-cost restrictive services and toward home and community-based expenditures.
- Waitlists for in-patient services and children boarding at medical settings waiting for psychiatric care will reduce.

Expanding Preventative and Community Adult Behavioral Health Services

Opportunity Statement

EOHHS and our partner agencies propose to use the opportunity of HCBS investment as a catalyst for behavioral health service system change to accelerate recovery from the pandemic and address exacerbated behavioral health issues. The onset of the COVID-19 pandemic further burdened the over-strained behavioral healthcare system. Emerging evidence strongly suggests that the pandemic has resulted in significantly increased behavioral health service needs. Increased rates of overdose fatalities, higher rates of reported substance use, increased feelings of anxiety and depression, COVID-19 related loss, and increased rates of behavioral health crisis and subsequent hospitalizations underscore this demand increase. Further, demand for behavioral health services is expected to increase substantially in the coming months as the "aftershocks" of the pandemic reverberate through Rhode Island communities, affecting many vulnerable populations disproportionately, including the State's Medicaid population.

For adults, the most critical needs right now to be addressed through various American Rescue Plan Act funding streams are the development of community-based behavioral health crisis services to avoid unnecessary hospital use and the targeted creation of additional treatment services. This proposal specifically addresses behavioral health system gaps, by incentivizing service providers' uptake of outcomes-based models and home and community-based services. In addition, BIPOC communities (particularly Latinx Rhode Islanders) are significantly under-represented among clinicians, which diminishes capacity to provide culturally and linguistically competent care.

Proposed Intervention & Theory of Change

Certified Community Behavioral Health Centers and HCBS-Supportive Adult Behavioral Health

Funding will be utilized to implement a statewide network of Rhode Island Certified Community Behavioral Health Center (CCBHC) program based on the Federal definitions within the Excellence in Mental Health Act. The CCBHC program is designed to provide de-institutionalized, comprehensive behavioral health (i.e., mental health, substance use) and social services to vulnerable populations with complex needs across the life cycle, and will also host programs that support adults with less intensive service needs. CCBHCs are required to offer an array of services including but not limited to Crisis mental health services, including 24-hour, mobile response teams, emergency intervention, and crisis stabilization; Screening assessment and diagnosis, including risk management; Patient-centered treatment planning within the least-restrictive and appropriate setting; Peer support, counseling, and family support services; and Inter-system coordination and connections (e.g., other providers, criminal

justice, developmentally disabled, foster care, child welfare, education, primary care, community-based, etc.).

This investment will strengthen RI HCBS Medicaid behavioral health care system by two additional CCBHCs and increasing the number of providers utilizing measurement-based care. It also provides us the opportunity to expand our knowledge about best practices in adult behavioral health system reform by creating two system transformation pilots and up to 10 Enhanced Service Pilots (such as primary care integration.

While the investments below may not all directly go to a CCBHC or an organization becoming a CCBHC, all support behavioral health system goals aligned with creation of CCBHCs by strengthening the services that work alongside CCBHCs to efficiently place clients in the appropriate, least-restrictive setting and/or will be integrated into CCBHCs as part of sustainability plans.

Sustainability

This funding will be used as a combination of one-time funding, braided funding with other resources, and start-up funding requiring sustainability. Future state budget funds will be needed to sustain initiatives over time. The State is already using grant funding to determine rate funding models for CCBHCs.

Success Metrics

- Number and percent of new clients with initial evaluation provided within 10 business days (and/or mean number of days before all identified support services are initiated)
- Number of preventive screenings/referred interventions for tobacco use & unhealthy alcohol use
- Initiation of SUD treatment in indicated cases
- Physical healthcare screenings for CCBHC patients (focus on blood pressure and diabetes risk)
- Decrease in ED admissions/hospitalizations for CCBHC patients (Plan All-Cause Readmission Rate (PCR-AD) using Medicaid Adult Core Set)
- Improved core physical healthcare metrics (blood pressure; diabetes incidence)
- Improved housing status (residential status at admission to CCBHC after defined period of time)
- Improved employment status (employment status at admission to CCBHC after defined period of time)
- Improved treatment experience as determined by patient/family experience of care survey

Providing HCBS Services to Help Rhode Islanders Experiencing Homelessness or Housing Insecurity

Opportunity Statement

Rhode Island has seen a four-fold increase in street homelessness since the 2019 Point in Time Count. The COVID-19 pandemic has heighted the awareness of homelessness as a public health issue and the state's shelter system, already at capacity, was mandated to reduce beds by 146. Consequently, there are approximately 500 individuals and families living in a hotel through a state-funded program that is slated to end September 30, 2021 or sleeping in reconfigured places not originally meant for human

habitation. The State is committed to addressing homelessness through the creation of permanent supportive housing and initiatives in the budget passed in June by the Rhode Island General Assembly, this effort will focus on supporting individuals and families experiencing homelessness.

Proposed Intervention & Theory of Change

Homeless Response Teams

The homeless response team is based on the evidence-based practice of an ACCESS team and will consist of Outreach-based intensive case managers with a client to staff ratio of 10:1 coupled with peer recovery specialists, access to psychiatrists/psychiatric nurses and primary care doctors who will engage people in the setting where they are living: hotel/motel, community encampments, shelters or in their homes as individuals experiencing homelessness are housed.

The funding will support teams across the State who have strong histories in engaging individuals and families experiencing homelessness. The areas of focus will be Pawtucket, Providence, Washington County, West Warwick, and Woonsocket. BHDDH applied for a Cooperative Agreement to Benefit Homeless Individuals in 2015, the grant was for 3 years and we successfully housed over 150 individuals by using a similar model.

Respite

There is an immediate need for respite to allow individuals experiencing homelessness who have been discharged to the streets after being treated for health conditions such as burns, head trauma, sexual assault or who are in need of assistance recovering from an operation or other medical conditions. A major Rhode Island hospital is currently collaborating with the Rhode Island Coalition to End Homelessness to pilot a respite program in the existing hotel program that will end September 30, 2021. However, this type of program is needed beyond this timeframe and for individuals living in places not meant for human habitation who are not part of the hospital's system and who may just need health respite without intensive medical supervision. This program would be piloted as part of a LTSS program that replicates the Office of Healthy Aging Respite program with assisted living facilities and nursing homes. The reimbursement cost would be enhanced to meet the needs of the population and facility and the stay would be limited to up to one month, however, it is anticipated that a Respite would need a capacity of up to 20 beds.

MCO Incentives Pilot

This one-time pilot initiative would provide incentive payments to Managed Care Organizations to take responsibility for addressing gaps and barriers for individuals experiencing homelessness, including real time local/in-state access to services that have traditionally been unavailable to this population when they are at the point of contemplation – detox, short- and long-term substance use treatment and mental health psychiatric inpatient and outpatient treatment. If they are able to build capacity within the state and reduce reliance on out-of-state placements, thereby increasing capacity in RI. Adding the incentive and disincentivizing out of state placement could help improve the continuum of care.

Eviction Moratorium Stabilization

Housing Navigation and Home Stabilization for individuals who have lost housing due to the ending of the eviction moratorium will required targeted intervention. The moratorium for eviction has been extended through 7/31/21 and the State would like to provide the Home Find and Home Stabilization services that are currently available through Medicaid to individuals who are homeless or at risk of homelessness with a primary diagnosis of mental health or physical health conditions to an expanded population of individuals with primary substance use disorder or developmental disabilities. Our partners in the housing field are unable to predict the numbers in this population who may be impacted, however, we will target 250 households. This program could target individuals' impact by the eviction moratorium in year 1 and continue to offer these services for individuals living with I/DD and substance use disorder who are interested in moving to the community to least restrictive settings or the target population for the existing Home Stabilization Program could be expanded. Exact amounts will be contingent upon the moratorium and volume of evictions.

Community-Based SUD Housing

Develop a community-based residential treatment pilot program for individuals with primary substance use conditions or co-occurring mental health and substance use conditions that is modelled after one of the State's most successful programs, SSTARBIRTH, that allows for 6-month stays for mothers with young children. Similarly this program would allow selected clients to move within the three levels of residential Substance Use Treatment (3.1, 3.3 and 3.5) based on clinically determined lengths of stay that are not subject to continuous authorizations for up to 6 months to determine if this is beneficial to clients' overall recovery. This program would also pay for client's room and board who could not pay for it themselves, which is national model to cover costs to providers not paid through Medicaid. This could help determine if it would incentivize providers to increase residential treatment capacity for substance use conditions, particularly alcohol which, along with opioids is the most prevalent substance that people seek treatment for in RI.

Sustainability

The funding would be on-going for three years. The sustainability plan for the major initiative, Initiative 1 would be the implementation of CCBHC with the Behavioral Healthcare System and/or the transition of individuals who need on-going case management to the community mental health system's IHH/ACT program. The Respite Program could become a hybrid of an existing OHA Respite program but would not be critical once individuals are housed or have access to shelters with personal care/home health assistance. MCO Incentives would be replaced by systems cost savings. The Resident Service Coordinator Program could be sustained through elevating the percentage of funds allowable in the properties operating reserves or through a Medicaid-funded program. The long-term community-based levels of care would be sustained through Medicaid policy changes on lengths of stay based on cost saving identified through this pilot (reducing cycling through emergency services.

Success Metrics

- Number of individuals who get housed
- Medicaid utilization by individuals served
- Hospital re-admissions
- Number of households evicted and provided housing navigation services
- Increased stability of housed homeless and disabled participating in the programs

- Number of households diverted from the homeless system

Investing in Oral Health

Opportunity Statement

The past year has shed a bright light on the health inequalities that exist in our state, and oral health was not exempt. These proposed programs offer a chance to put Rhode Island in a better place than before the COVID-19 Pandemic, specifically with Medicaid populations living in home or community-based settings, such as those in senior housing, homebound and/or receiving home health services, and those transitioning out from skilled facilities where mouth care is an included service.

Individuals with functional deficits, either physical or cognitive, rely on others to provide supportive services such as hygiene and toileting. These individuals may also need help performing basic oral hygiene, regular inspection of their mouths, and scheduling for dental care. This is critical for this population because vulnerable populations are often at greater risk for dental disease due to medications and diet changes. Additionally, poor oral hygiene among functionally dependent older adults is a key cause of aspiration pneumonia. If these individuals were in nursing homes, CNAs would be responsible to provide daily mouth care per state and federal regulations along with assuring that routine dental care is available. For those living in the community, the same standards must be met, but this will require training and resources.

Proposed Intervention & Theory of Change

Dental Care in Home Health Settings Pilot

To address the disparities in Oral Health Care access and improve health outcomes, Rhode Island will invest enhanced FMAP funding to formalize a Dental Provider and Home Health Partnership to increase dental care for homebound individuals. A training will be developed for home health professionals (including personal care aides, IPs, home health aides, visiting nurses, and others licensed in RI) that will include the following topic areas:

- General oral health information (i.e.why good oral health is important for these individuals)
- Mouth care and best practices for oral hygiene with different populations
- Oral Screening (how to identify any issues that may be developing)
- Referral to dental treatment (possibly connect with Initiative 3 for a home visit from a PHDH)

This training will be available both in person and online. A coordinator will be hired to oversee the development of the training, coordination, and promotion of the in person training events and general oversight of the project and an evaluation will be completed to allow RI Medicaid to determine the benefit of sustaining the program. Program planning and implementation will be informed by a stakeholder advisory group. This group will assist with promoting the educational events and continued oral health prevention activities.

Sustainability

Dental and Home Health Partnership to Provide Direct Care to Homebound Individuals is a one-time ask for education. The training would be recorded and available for later use.

Success Metrics

- Reduce hospital admissions for aspiration pneumonia among older adults
- Host 2 in person trainings for Home Health Professionals
- 75% of attendees of the in person training and those who take the online modules report using mouthcare techniques taught and making referrals to dental care when necessary when provided a follow-up evaluation at 3 months, 6 months, and 12 months post training.

Updating Technology to Serve Our Members

Proposed Total Investment: $7M

Eligibility System, Network Adequacy and Data Analytics Expansion

Opportunity Statement

The effective implementation of activities to strengthen and enhance Rhode Island's HCBS systems of care requires investment in technology infrastructure. Currently, the technology that supports these activities are siloed by agency and program, and many systems are antiquated, some dating back to 1997. Since our customers individual needs cross multiple programs and agencies, this infrastructure can lead to a customer providing the same information to multiple agencies. It also contributes to delayed eligibility determinations and limit our ability to develop meaningful dashboards and other analytic tools.

Rhode Island plans to leverage one-time HCBS enhanced FMAP to address these challenges through technology investments to streamline eligibility, building interfaces to link systems in a person-centered way, and improving data quality and analytics capacity.

Proposed Intervention & Theory of Change

Streamline HCBS Eligibility – Expedite Access and Optimize Workflow

Determining LTSS eligibility and providing adequate and accurate coverage has been and is a multi-step process that involves a variety of parties including eligibility technicians, social case worker and clinical determination staff. A process of this complexity requires that each step of the way is completed by the responsible parties in a timely and accurate manner. A smooth transition without delays is critical in ensuring that clients in a home or community-based setting receive the care they need when they need it. Managing the nuances of this can be a challenging process. Without significant oversight and attention to detail, HCBS clients pose the risk of a delayed determination of their eligibility and access to the services they need.

We aim to update and streamline the overall workflow such that it is not only quicker to benefits for HCBS clients, but also simpler to manage with reduced overhead and long-term technology costs. This will be achieved through:

1. Complete a comprehensive analysis of the existing workflow process – This process will include stakeholders, staff and all associated third parties.
2. Develop and implement eligibility system design changes to expedited LTSS eligibility and update dual channel interfaces to improve communications between systems. Particularly attention will be paid to how needs assessments are conducted and flow through the various systems (integrated eligibility, MMIS, case management etc.) currently required in the eligibility and post eligibility process.

This work will supplement and add to the technology enhancements discussed in the No Wrong Door section of this proposal.

Network Adequacy of Providers

The State of Rhode Island is looking to collaborate with the MCOs to determine, implement and validate innovative HCBS network adequacy standards in addition to the traditional time and distance standards to ensure sufficient network access for their HCBS population.

Our approach to determining this is a multi-step process where we plan to:

- Create workgroups with multiple stakeholders where the different typical HCBS approaches to network adequacy will be reviewed to be deemed in sufficient to meet stakeholder concern
- Using an approach that uses the number of actual direct care workers available to participants would provide a more precise way to measure HCBS network adequacy and support the oversight needed
- Developing an approach of using a ratio of participants to Full Time Equivalents available as a means of measurement
- Develop a robust network adequacy solution with data integration across HCBS providers
- Seek to adopt HCBS standards, data sources, new processes, making tweaks to the standards based on data availability between LTSS providers and State

Data Analytics Expansion

Enhanced FMAP funding will be leveraged to expand EOHHS Integrated Data Ecosystem and Medicaid analytic capability. This includes one-time investments in a data contractor to build out our Medicaid data warehouse with a specific eye towards incorporating new LTSS data; expansion of dashboard capabilities, and system changes to improve the quality of demographic data, including race and ethnicity data. More specifically, with current data warehouse functionality we have limited ability developing dashboards and monitor trends in real time. This investment will allow the state to purchase an enhanced Power BI product to improve our analytic capability. Additionally, the moderate enhancements to the integrated eligibility system are required to improve the quantity and quality of race, ethnicity and other demographic data. These enhancements will yield long term improvements in the quality of our data and will enable the Medicaid program to gain additional insights into the health of our members.

Sustainability

The majority of this investment in Medicaid technology is a one-time investment that will yield long term improvements for our HCBS programs. The cost of upgrading our Power BI tool will be an ongoing expense, however the State expects that the savings achieved through the retirement of duplicative legacy systems will offset the costs of this enhancement.

Success Metrics

- Ability to track and process expedited LTSS applications in under 10 days
- Completion of a dashboard to track HCBS network adequacy
- Improved quality and quantity of demographic data, including race and ethnicity data

Rhode Island Legislative Appropriation

EOHHS will work with the Rhode Island Office of Management and Budget, Governor's Office and Rhode Island General Assembly to ensure that funding from this ARPA direct award is appropriately accounted for in the State FY 22, FY 23 and FY 24 budgets. We anticipate following a process similar to appropriation of CARES Act funding in agency budgets.

Spending Plan Projection

Rhode Island estimates receiving enhanced FMAP equaling approximately $57 M. This will give the state between $115 million and $144 million all funds depending on federal match rate and rate of spending to allow Rhode Island to execute on the above priorities:

Service[3]	Est. annual spend ($M)
Home Health Services[4]	12.8
1115 Waiver Services meeting other definitions	363
PACE	16.2
Case Management	3.0
Rehabilitative Services[5]	50.4
Managed Care Expenses meeting other definitions	152

[3] As interpreted by Rhode Island EOHHS per definitions in Appendix B of SMD 21-003 issued by CMS on May 13, 2021. Note that where appendix B listed a line on the CMS-64, EOHHS assigned that spending to the service heading listed in appendix B, however, there is considerable spending eligible that does not yet have a CMS-64 line indicated.

[4] Includes new investments adopted by legislature for SFY22

[5] This does not include $3.5M of early intervention spending which RI believes should be eligible; we are awaiting CMS guidance

Total annual spend based on historical[6]	597
Investments made before March 31, 2022	TBD
Total w/ investments made before March 31, 2022	
Value of HCBS enhanced FMAP bump (amount available for us as state share of new HCBS investments)[7]	57
Value of All Funds total available for new HCBS investments	115-144

[6] This does not include $26.7M of school-based spending which RI believes should be eligible; we are awaiting CMS guidance on how to handle given it is a certified public expenditure.

[7] This is not equal to 10% of "Total w/ Round 1 Investment" because Expansion spending is only eligible for 5% increase

Stakeholder Feedback

EOHHS sought public comment on the types of activities that could be funded to enhance, expand, or strengthen Medicaid HCBS, as well as ways this funding could be used to address disparities and equity issues in the provision of HCBS. EOHHS is interested in distributing funding in line with our core values of choice, equity, and community engagement.

To gather opinions from all interested parties quickly and efficiently, EOHHS created and issued a survey to collect information that would lead to Rhode Island's proposal. EOHHS issued the survey on May 20, 2021 through June 2, 2021. The survey was circulated to the EOHHS Interested Parties list usually used for public comments on regulations and state plan amendments. We asked that recipients share the survey with others to get the widest range of input in a short period time.

The survey asked respondent to rate by level of importance each item in Appendix C and D of the CMS SMD on this funding opportunity, as well as provide free form comments.

Based on this survey, we received over 600 responses and comments from a wide range of stakeholders including direct care workers, family members, and staff from all type of organizations. For details on the type of respondent and the survey results, please refer to the link below on the EOHHS website. Based on the rating scale and the associated comments we pulled out four main themes:

1. Respondents outlined the need for increased training, salary, and supports (i.e. respite care) for caregivers and direct support workers.
2. Respondents requested additional community engagement opportunities for individuals with disabilities, including employment opportunities, and increased day service programs.
3. Respondents discussed the workforce shortage, difficulty hiring staff due to low wages, and long wait lists for home services.
4. Respondents also provided ideas related to new potential programs to be funded to improve the quality of HCBS services and develop innovative models of care to Rhode Islanders.

Based on these responses, and additional input from members and participants of the Long-Term Care Coordinating Council, the Equity Council, our Long-Term Services and Supports interagency team, the Children Behavioral Health System of Care workgroup, and other groups, we are pleased to submit this proposal for review and approval. Based on CMS feedback and approval, our planning and community engagement will continue, as we hope to ensure we are continuously reflecting the HCBS needs of our consumers while we focus on the long-term vision of our LTSS system. Our proposal, a summary of survey responses and future updates will be posted on the EOHHS webpage here.