



# **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**

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**February 1, 2022**

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## Letter from the Rhode Island State Medicaid Director

I am pleased to submit this February quarterly spending plan and narrative to the Centers of Medicare and Medicaid 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 Services (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 and 1115 Global Waiver: (1) LTSS HCBS directed at individuals age 65 and over; (2) LTSS HCBS directed at individuals with intellectual or developmental disabilities and physical disabilities age 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.

Per CMS' instructions, we have kept the initial spending plan intact, and added updates within each section clearly marked. In this way, CMS and other stakeholders can see the original plan, progress made against that plan, and any changes to the original plan based on CMS feedback or further State work. We have closely reviewed the CMS Partial Approval Letter received on January 26, 2022 and incorporated initiative updates and clarifications as requested within this quarterly report. A copy of the State's responses to the questions found within the CMS Partial Approval Letter received on August 9, 2021 are included as an addendum to this report.

Since our initial spending plan, we have focused on making progress in three key project areas that we have deemed most critical: (1) workforce recruitment and retention; (2) No Wrong Door (NWD) enhancements; and (3) intellectual and development disabilities (I/DD) provider capacity enhancements. As part of this work, we have submitted four State Plan Amendments (SPAs) for temporary fee-for-service rate increases for eligible providers and one pre-print to temporarily increase managed care rates for substance use treatment providers. Additionally, we continued planning to strengthen children's mobile crisis supports and to expand the children's behavioral health service array. We look forward to receiving final approval from CMS to implement these changes.

As we continue in this process, we aim to implement work in the above areas with claimed enhanced FMAP, and to begin prioritizing development of other initiatives including expansion of self-directed programs, dissemination of equity and quality challenge grants, oral health programs and children's behavioral health system reform as funding allows. We have also identified alternative sources of funding for components of several key initiatives, including developmental disabilities (DD) assistive technology and remote supports, mobile crisis supports, and certified community behavioral health clinics (CCBHCs) infrastructure development.

For many of our behavioral health investments, we are eager to hear from CMS on whether these uses are deemed approved based on the additional information provided in our letter dated September 13,

2021. For those programs that CMS did not specifically ask questions about, we assume that they are approved.

Beyond approval as an applicable use of funds, our program design must take into consideration the potential to receive additional federal financial participation (FFP) from CMS. This will maximize funding and help us do more in Rhode Island. We anticipate asking CMS more questions in the next quarter specifically related to rules around administrative match.

We continued to 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 continue to 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, Kristin Sousa, as the Interim 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,



Kristin Sousa  
Interim State 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 how we can build back a better and 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 Home and Community Based Services (HCBS) FMAP funding to address what we have learned from the public health emergency (PHE), address system inequities, and meet the complete needs of Rhode Island Medicaid members needing HCBS.

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, and access to HCBS, leveraging an updated interagency governance structure for Long Term Services and Supports (LTSS).
- Launched innovative HCBS programs such as the Independent Provider (IP) program to bring new levels of choice and self-direction to Medicaid members.
- Distributed over \$20M in supports for congregate care and home care workers during the PHE to ensure that no one working in these areas during the COVID surge of Fall 2020 was making less than \$15 per hour.
- 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 (OHA) 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 developmental disabilities (DD) provider rates, moving to acuity-based payment for assisted living residences, rewarding home care workers and agencies who achieve training in behavioral health, increasing shared living rates, and increasing the HCBS maintenance of need allowance.

From this foundation and vision, we can both build on the momentum of redesigning our LTSS program, expanding HCBS access, and our programmatic successes with Coronavirus Aid, Relief, and Economic Security (CARES) Act supported initiatives and learn from our administration of these funds.

In addition to our own policy work and analyses, 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?			

**1) Improving Rhode Island's "No Wrong Door" (NWD) System (\$9.3M)** – How can we continue progress to ensure that no matter what “door” a Rhode Islander comes through to seek 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 accelerate our progress by using the enhanced HCBS FMAP 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. Certified nursing assistant (CNA) turnover is high, and there are more licensed CNAs in the state than there 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. 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 the recruitment of new workers by the end of 2021, building off of our successful workforce stabilization program during the PHE that provided 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. We will 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 adequately meet consumer need 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 moves to adopt a \$15 per hour 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 that 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 care in rural areas.

To do this, we propose investing in advanced certifications for CNAs, personal care attendants (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 the race and gender disparities in this field, 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 service delivery pathways. This is particularly true as telehealth has become 25-35% of Rhode Island’s 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?*

Investing in provider infrastructure and capacity is critical to ensure we have the necessary resources to take care of individuals across the continuum of care. As we work on our LTSS rebalancing efforts, we have determined that part of our challenge is an undersupply of capacity in key areas such as assisted living. According to the Kaiser Family Foundation, Rhode Island has 10.9 Medicaid nursing facility residents per 1 Medicaid assisted living resident, compared to a national rate of 5.5 to 1. Conversely, Rhode Island has a large supply of nursing facility beds; we have 48 nursing facility beds per 1,000 people age 65 and older, the 9<sup>th</sup> highest rate in the country.<sup>1</sup> The same challenges hold true in our intellectual and developmental disabilities (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 (NHTP) to work with nursing facilities to change their models to promote single occupancy, green house models, behavioral health, ~~bed buybacks~~, supportive housing, or HCBS models such as assisted living. Similarly, we want to develop an expansion grant program to provide capital to assisted living residences (ALRs) ready to expand to take advantage of our new acuity-based rate structure. We want to build capacity in service advisory (SA) agencies and

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



fiscal intermediaries (FIs) to assist members going through self-directed programs. We need to build increased traumatic brain injury (TBI) service capacity in-state. We will launch a I/DD provider capacity building initiative to continue supporting 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 (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, especially home-based therapeutic services (HBTS) and personal assistance services and supports (PASS). We will seek new models related to transitioning youth to adult services, expand our Certified Community Behavioral Health Centers (CCBHCs) network, and fund integrated behavioral health activities with primary care.

**6) *Updating Technology to Better Serve our Members (\$7M)*** - *What technological improvements are needed 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 improving application processing by adopting new technologies. With our current 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 high 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 or removed from this plan as we continue to 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 this 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

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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 and enhance access to HCBS alternatives 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 ensure these NWD initiatives advance and to 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, the State pursued an array of initiatives 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 outreach strategy to expand awareness of HCBS options. The goals of NWD Phase II have been to streamline and standardize critical eligibility functions to reduce the bias toward institutional care and expedite access to services, eliminate inequities in access to HCBS, and implement a robust system for person-centered planning (PCP) and conflict-free case management (CFCM) across populations. NWD Phase III will focus on service delivery, service coordination, and quality assurance from the point of the initial eligibility determination through renewal, particularly for HCBS beneficiaries who choose non-regulated settings.

The State will use HCBS enhanced funds to supplement these NWD redesign initiatives across 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) broadening the reach of our PCOC initiative; and (4) financing the technical and program management assistance required to update business processes and ensure policy and practice alignment.

##### Spending and Project Planning Update for LTSS No Wrong Door as of February 1, 2022

1. *Modernization and integration of IT to support core eligibility functions to improve system navigation and ease of access*

No funds have been encumbered or spent for this project as of February 1, 2022, however the project planning continues. The State LTSS Governance Committee has received detailed system requirements, reviewed demonstrations on alternative approaches to the required system updates,

and approved expanding an existing IT contract. We were unable to finalize the contract this past quarter due to procurement delays, but are expecting to do so within the next month. Corresponding IT enhancements for our State eligibility system and Medicaid Management Information System (MMIS) are in the process of being scheduled towards the end of this calendar year.

2. *Recalibration and expansion of HCBS information and awareness activities to further extend outreach to underserved racial and ethnic communities*

No new work was initiated using enhanced HCBS FMAP funding during this quarter. The State is currently finalizing LTSS program brochures and updating the LTSS content on the Rhode Island EOHHS website utilizing other funding streams and existing resources.

3. *Broaden the reach of our Person-Centered Options Counseling (PCOC) initiative*

No new work was initiated with enhanced HCBS FMAP funding during this quarter. The following update from our October 18, 2021 report remains relevant: \$80,000 was encumbered to pay for forty additional Wellsky licenses and associated training to increase the number of State and contractual workers to provide PCOC. Additionally, \$50,000 was encumbered to build and maintain a comprehensive resource directory in the PCOC system. This allows PCOC counselors to seamlessly look for and refer consumers to a wide variety of programs and community-based organizations for products and services that meet their needs and preferences.

## 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 therefore crucial for us to make the investments in system modernization that are needed to remove the obstacles that we know exist, now, 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 enhanced funds to implement changes in both the integrated eligibility system and Medicaid Management Information System (MMIS) to address obstacles to HCBS flexibility. These changes will eliminate the need for 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 one of 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, e.g., 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 BRM tool for person-centered options counseling that has the capacity to support other ancillary eligibility functions. HCBS enhanced funding offers Rhode Island the unique opportunity to transition from the current fragmented network of CRMs and IT tools to this new BRM tool and to establish a unified cloud-based system capable of interfacing with the existing eligibility and payment systems IT infrastructure. The 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 importantly, this new tool ensures easier access to HCBS programs by providing the technical support necessary to eliminate program silos, promote person-centered practices, and create more streamlined business processes that are essential for achieving system rebalancing.

### **Enhanced HCBS Information, Awareness, and Outreach**

The State proposes to use HCBS enhanced 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 feedback from 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 work. The feedback has consistently shown that many of the Rhode Islanders in-need of, or at-risk for Medicaid LTSS are unaware of many of the currently available HCBS options. 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 (to MyOptionsRI), the addition of a new micro website, and production of an array of paper and electronic brochures that provide easy to understand information in multiple languages.

HCBS enhanced funds will be used to purchase the necessary expertise and assistance to extend the reach of this work, and to implement other planned and in-flight initiatives, 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 consistent information about HCBS options and the intensive training in person-centered practices that is required for this type of outreach.

### **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 that is 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 PCOC providers offering in-person services to underserved and minority populations.

### **NWD Implementation Assistance**

Rhode Island also plans to make a one-time investment in the technical assistance and human resources needed to manage the transition to the new BRM system and to build the business processes and financing streams necessary to sustain the NWD person-centered initiatives that are now underway. These resources include at least two full-time employees or contractual equivalents to assist in NWD general project management and to ensure the State's newly developed PCOC Network and the conflict-free case management system that is 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 performance, 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 choices
- Reduction in time between point of HCBS application submission and service delivery

## **Children's Behavioral Health Single Point of Access**

### **Opportunity Statement**

Children's behavioral health needs, which have been growing prior to the PHE, 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 for children’s behavioral health supports, increased 22% in 2020 during the PHE.<sup>2</sup>

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 underlying reason 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 settings than necessary. This makes it difficult for the system to deliver effective behavioral healthcare to Rhode Island children. For children and families of color, structural racism makes the challenge of getting appropriate services and supports even more difficult.

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

### **Spending and Project Planning Update for Single Point of Access as of February 1, 2022**

Please see the [Children’s Behavioral Health section](#) below for updates on this area of work.

### **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 all 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, e.g., 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.

To support this single point of access, resources are required for training and to implement standardized screening and assessment tools, such as the Child and Adolescent Needs and Strengths (CANS), and tools that measure Adverse Childhood Experiences (ACEs). These investments will help to ensure that consumer needs are accurately identified, and services are matched appropriately and effectively.

Successful implementation of the single point of access will also require a comprehensive communications component, to ensure all are well-informed about the availability and intended purpose of this service.

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<sup>2</sup> [6783 LCACT 1st Mailer \(rikidscount.org\)](#)

## Community Referral Platform

The single point of access will also require person-centered coordination and electronic referral management software to support a coordinated care network of health and social service providers in Rhode Island. EOHHS has competitively procured a Community Referral Platform (CRP) for its Accountable Entity program under the Health System Transformation Project (HSTP) supported by CMS. This funding will go towards building 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 access to children's behavioral health services in Rhode Island.

### Success Metrics

- Expanded referrals to community partners
- Improved provider capability to connect children 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 system rebalancing initiative. The majority of stakeholder survey respondents cited worker wages and training as priorities and highlighted many direct care workers (DCWs) are tempted to leave the HCBS workforce due to better paying positions in retail or food service. 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 insufficient respect and recognition have created chronic HCBS 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 to turn this care economy work into a valued part of our labor market and human infrastructure.

Learning from our investment of CARES Act dollars, Rhode Island will invest in a DCW outreach campaign, recruitment, and retention programs to incentivize the workforce growth necessary to support Rhode Island's rebalancing efforts. We will also invest in expanding training opportunities to improve service quality and support career growth.



## Spending and Project Planning Update for HCBS Workforce and Retention as of February 1, 2022

### 1. Workforce Hiring and Retention Incentives

Supporting provider efforts to recruit and retain direct care workers (DCWs) remains the State's top priority for this funding. Early in the project planning process, it became clear that scaling our model for CARES Act funding (which awarded grants to providers) was not operationally efficient and jeopardized additional federal match to fund the program. Providing direct grants to providers was administratively burdensome and time-consuming for both the State and the providers. This administrative burden meant that less funding would go to the direct care workforce.

After researching alternative options and learning from the experience of other states, we determined that targeted, temporary rate increases would allow Rhode Island to distribute the funding more quickly and equitably allowing eligible HCBS providers to implement recruitment and retention programs to stabilize their direct care workforce over the next year. Due to this change in approach, the state has removed the original spending plan language regarding recruitment and hiring incentives. The temporary rate increases will be implemented for providers who attest to passing through 85% of the funds to hiring and retention initiatives for direct care workers. The guidance, which can be found on the State's [HCBS Enhancement webpage](#), also requires providers to report financial and workforce data quarterly to ensure program fidelity. The State does not intend to sustain these rate increases because they are designed to support a one-time program. However, the State remains committed to utilizing the data coming out of this program to justify sustained rate increases in future years.

Several provider types have a mix of Managed Care and Fee for Service claims that make it difficult to equitably pursue just a Fee for Service increase or a state directed payment through managed care organizations (MCOs). These providers include personal care aids (PCAs) in the Independent Provider (IP) and Personal Choice (PC) programs, and home-based therapeutic services (HBTS) and personal assistance services and supports (PASS) providers. The State plans to utilize direct provider grants in these specific instances to ensure equitable funding distribution. We look forward to working closely with CMS in the month of February to identify whether administrative match can be claimed on these programs.

Over the past quarter, the State worked with Milliman and Day Health Strategies to accomplish the following:

- Designed and developed ARPA HCBS Recruitment and Retention program funding mechanisms for each eligible provider type based on their specific funding mix (fee for service vs. managed care) and their funding authority.
- Defined applicable service codes and calculated corresponding Fee for Service reimbursement increases to distribute program funding.
- Developed managed care state directed payment preprint to enable distribution of managed care program funding.
- Determined eligibility criteria, allowable activities, and required reporting requirements to ensure providers appropriately spend program dollars to increase the direct care workforce capacity.

- Conducted stakeholder discussions (i.e., with adult behavioral health, children’s behavioral health, LTSS, and self-directed service providers) to solicit feedback and iterate on the program design.
- Disseminated letters to inform Self Directed program participants about the worker retention and recruitment program and to explain the additional payments being made.
- Developed a web-based form to securely and efficiently collect data from providers on a quarterly basis. This data will provide us with helpful information, e.g., the number of part-time and full-time DCWs and licensed health professionals at each provider agency, average length of employment, and how racially and ethnically diverse the workforce is.
- Developed a quarterly reporting structure to monitor changes in DCW recruitment and retention over the next two years.
- Created program implementation and evaluation plans.
- Updated the draft budget (see table below) based on stakeholder conversations and additional claims analyses:

Provider Type Code	Provider Description	Funding Mechanism	Federal Authority	Estimated Funding Temporary – All Funds
<b>LTSS</b>				
072, 0	Home Care Agencies	FFS Rate Increase	SPA submitted 12/10/21	\$24,123,000
010 & 065	Skilled Nursing Homecare	FFS Rate Increase	SPA submitted 12/10/21	\$1,766,000
050	Adult Day Care	FFS Rate Increase	SPA submitted 12/10/21	\$2,129,000
055	Habilitation Group Homes	FFS Rate Increase	1115 Waiver	\$902,000
071 FI	Fogarty Center Fiscal Intermediary	FFS Rate Increase	1115 Waiver	\$20,000
116 FI	Independent Provider Fiscal Intermediary	FFS Rate Increase	1115 Waiver	\$1,000
071 PC	Personal Choice Recruitment & Retention Bonuses	Direct Grant	N/A (not a rate increase)	\$3,738,000
116 PC	Independent Provider Recruitment & Retention Bonuses	Direct Grant	N/A (not a rate increase)	\$187,000
089	PACE	Capitation Rate Increase	Pre-print to be submitted by 3/1/22	\$3,897,000
044	LTSS Case Management	FFS Rate Increase	To Be Determined	\$330,000
<b>Subtotal</b>				<b>\$ 37,093,000</b>
<b>Behavioral Health</b>				
060	Substance Rehab	MCO Direct Payment	Pre-Print submitted 12/28/21	\$ 3,055,000
061	CMHCs	FFS Rate Increase	12/23/21 and 12/29/21	\$11,580,000
080	HBTS/PASS	To Be Determined		\$6,973,000
109	Peer Recovery Programs	To Be Determined		\$73,000
<b>Subtotal</b>				<b>\$ 21,681,000</b>

The state carefully reviewed the behavioral health providers included in the Workforce Recruitment and Retention program to ensure compliance with [SMD #21-003](#). Each provider delivers state plan or 1115 waiver benefits that are either directly listed in Appendix B or could be listed. Community Mental Health Centers (CMHC), run programs that are included under the Rehabilitative Section of Rhode Island's Medicaid State Plan. Specifically, Psychiatric Rehabilitation Services (including Adult Behavioral Health Group Homes), Crisis Intervention Services, Substance Abuse Assessment Services, Outpatient Counseling Services, Detoxification Services and Substance Abuse Residential Services, Day/Evening Treatment, and Mental Health Emergency Service Interventions. To provide the workforce recruitment and retention funding increases, the State will increase three service codes most highly utilized by CMHCs for the Rehab services listed above. These include Assertive Community Treatment and Adult Behavioral Health service codes. Peer Recovery Programs are authorized as Peer Supports within the HCBS Services that are listed in Rhode Island's 1115 Demonstration Waiver.

### **Career Awareness and Outreach**

The State developed a project plan in partnership with Milliman and Day Health Strategies to implement the proposed investments in these areas. Over the past quarter, we:

- Met with State communications staff who released a campaign with similar goals for Child Care Workers to learn from their experiences and leverage existing knowledge and resources.
- No enhanced HCBS FMAP funding has been spent on this initiative yet, but we plan to launch a marketing campaign after recruitment and retention program funding is distributed.

### **Proposed Intervention & Theory of Change**

#### **Recruitment**

HCBS direct care workers (DCWs) are a category of paraprofessionals who typically provide direct personal care and support to older adults 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 certified nursing assistants (CNAs), home health aides (HHAs), personal care aides (PCAs), and social and human services assistants (S&HSAs). It is important to note the actual job titles are not standardized and may vary widely across settings. 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. The COVID-19 pandemic has exacerbated this challenge due to health and safety concerns, childcare difficulties, job loss, unemployment benefits, and other issues.

#### **Career Awareness & Outreach**

EOHHS will engage in and support partnerships with the State's Department of Labor and Training (DLT), the Governor's Workforce Board (GWB), the Rhode Island Department of Education (RIDE), the Department of Human Services (DHS), the 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, mentorship programs, worksite visits, social media campaigns, paid advertising, dissemination of educational materials, and other initiatives to raise awareness of job and career opportunities in home and community-based services, with the goal of increasing employment in this field over time.

### **Hiring Incentives**

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

~~DCWs hired between July 1, 2021 and March 31, 2024 will be eligible to receive a hiring bonus, based on total hours worked in the first six months of employment supporting older adults, individuals 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, insufficient respect and recognition, and limited advancement opportunities. High turnover rates reduce access to services, disrupt continuity of care, and result in insufficient workforce knowledge, skills, and experience to adequately care for HCBS consumers with increasingly complex needs.~~

~~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 a fiscal intermediary to administer the hiring and retention payments. Dedicated administrative capacity is required to maintain an accurate record of all distributed funds and to administer the program with fidelity to policy goals.~~

### **Sustainability**

All workforce incentives are designed as short-term strategies to help Rhode Island recover from the devastating impacts of the COVID-19 pandemic on the HCBS workforce. We understand ongoing investments are required to ensure the State has sufficient capacity to adequately support an aging population over time, in addition to our I/DD community and children and adults with behavioral health needs. We intend to use lessons learned from each HCBS workforce 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 State 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 longer term policy changes to sustain our workforce development efforts.

#### Success Metrics

- 10,000 job seekers reached through recruitment campaign
- 4,500 new DCWs hired over the next 3 years
- Reduced DCW turnover rates, as reported by provider agencies
- Timely payment of 100% of incentives

## Developing Rhode Island's HCBS Workforce

*Proposed Total Investment: \$6.1M*

### HCBS Workforce Training

#### Opportunity Statement

In addition to the HCBS workforce recruitment and retention initiatives described above, investments in workforce training are required to build the skills of our workers, support career laddering, and to increase the quality of services that are delivered.

#### Spending and Project Planning Update for HCBS Workforce Training as of February 1, 2022

Milliman and Day Health Strategies have been retained to support this work, along with the above workforce recruitment and retention program, and the career awareness and outreach initiative. Over the past quarter, we:

- Conducted five stakeholder focus groups with representatives from direct care workforce associations to solicit input on current workforce training programs, gaps in training, and where additional funding supports are needed.
- Engaged higher education partners in Rhode Island, the Department of Labor and Training, and the Postsecondary Commission for input on the most prevalent training needs for both HCBS paraprofessionals and licensed health professionals across the career continuum, as well as to partner on program implementation.
- Designed a program to address linguistic, racial, and ethnic disparities in licensed health professional roles, with a focus on offering career advancement supports to underrepresented groups within the DCW workforce.

#### 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 faced by their clients. Nor do they receive counseling or help to deal with the emotional challenges they face as a result of their work. To expand skills and advancement opportunities for workers, and enhance the 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 advancement and/or professional development. This includes, but is not limited to support for continued training in behavioral health care, Alzheimer's and dementia care, chronic disease care, and social determinants of health. It also includes funding for other consumer-centered training and employment supports.

### **Health Professional Equity Initiative**

Black, indigenous, and other workers of color (BIPOC) are significantly overrepresented in low wage HCBS direct care positions, but significantly underrepresented in higher-paid licensed health professional roles. The need for culturally and linguistically competent providers 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 to 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 pathway 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 in-State institution of higher education for courses and credits leading to a health professional degree and/or license, as well as paid educational leave time (i.e. 2 hours of leave per academic credit while enrolled in classes, not to exceed 20 hours of paid leave per 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**

- Additional certification for 6,000 workers
- Enrollment of 200 direct care workers in a 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 HCBS FMAP funding 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 2020 LTSS State Scorecard produced by AARP, the AARP Foundation, The Commonwealth Fund, and the SCAN Foundation, Rhode Island is ranked 37<sup>th</sup> in Quality of Life and Quality of Care, and 28<sup>th</sup> in Effective Transitions. Within those categories, our rate of employment for adults with ADL disabilities ages 18-64

relative to the rate of adults without disabilities is ranked 35<sup>th</sup> and our percentage of home health patients with a hospital admission ranked 47<sup>th</sup> in the country. Critically, our HCBS quality cross-state benchmarking capability is also low, ranking 36<sup>th</sup> among states.<sup>3</sup>

Quality measures on adult and children’s 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 100,000 children when compared to neighboring states. We see that a lack of home and community-based services for behavioral health across the age spectrum drives medical spending elsewhere – 10% of emergency department (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 that additional prevention and new care models are needed, less than a quarter of individuals received a follow up within 30 days of an ED visit for substance use disorder (SUD) related issues.

### **Spending and Project Planning Update for Quality and Equity as of February 1, 2022.**

Work in this program area has not yet been initiated.

### **Proposed Intervention & Theory of Change**

#### **Quality and Equity Challenge Grants**

Regardless of which specific quality measure we 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 we do not know if they are going to be successful. However, from our stakeholder engagement survey and conversations, we know 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-funded 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 a Request for Proposals (RFP) process with careful attention to outreach beyond typical vendors and providers, we expect to evaluate proposals to fund program costs above and beyond what might be currently claimable under existing authorities. Proposals will need to include an evaluation plan, and 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 entities to complete the evaluation.

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<sup>3</sup> <http://www.longtermscorecard.org/databystate/state?state=RI>

Finally, all proposals must include strategies to address racial and ethnic disparities in the quality measures to be achieved.

While we encourage our stakeholders 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 behavioral health (BH) and substance use disorders (SUD) services, housing stabilization, children’s behavioral health wraparound services with child welfare providers, and identifying opportunities to assist citizens returning from Rhode Island’s Adult Correctional Institutions (ACI).

### **Enhancing State Quality Strategy**

Rhode Island is currently receiving technical assistance from CMS and ADvancing States to develop and implement cross-agency data collection, analysis, and reporting processes to support oversight of HCBS services and standardized reporting of required sub-assurances under our Comprehensive 1115 Waiver. We believe this technical assistance should be supplemented by additional work under this opportunity to expand data collection in line with the CMS Request for Information (RFI) on the Recommended Measure Set for Medicaid-Funded Home and Community Based Services.<sup>4</sup> Included in that RFI are a long list of potential measures. We intend to use this funding to secure additional technical assistance to expand data collection and to make 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
- Reduced number of preventable ED visits and inpatient visits among members served in new pilot models
- Implementation of personal safety and respect measures
- Implementation of life decision measures

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<sup>4</sup> <https://www.medicaid.gov/medicaid/quality-of-care/downloads/rfi-hcbs-recommended-measure-set.pdf>



## Assistive Technology and Remote Supports

### Opportunity Statement

Technology can be leveraged to help support individuals with intellectual and development disabilities (I/DD), traumatic brain injuries, dementia, or physical disabilities, e.g. by keeping them safe, 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 activities, 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 providers 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 who choose this option, we free up Direct Support Professionals (DSP) who can work with individuals with more significant needs who require more direct hands-on care.

During the PHE, many people learned how to use new technologies 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.

### Spending and Project Planning Update for Assistive Technology as of February 1, 2022

#### Assistive Technology

This work remains a priority for the State. However, an alternative source of funding has been identified through the State budget process. Enhanced HCBS FMAP funding will no longer be dedicated to this project.

#### Remote Supports Pilot Project

Work on this initiative has not begun yet. Utilizing Remote Supports as a service option in the State remains a priority.

As a component of this project, we will help to fund internet connectivity for the pilot participants in need of this support. Internet connectivity is a vital component of this project because remote supports cannot be delivered without it. These investments will help to directly enhance, expand, and strengthen the HCBS services we are able to deliver to Rhode Islanders. For example, Remote Supports allow people to live their lives more independently by providing them with assistance whenever needed and regardless of the setting (e.g., rural or urban, residential, community-based, or within their place of employment). This type of support also helps with HCBS workforce shortage issues. Allowing individuals who want more independence and are capable of managing this independence, the ability to choose

Remote Supports in lieu of in-person supports, allows existing HCBS workers to be deployed where they are most needed and desired.

We intend to use this enhanced FMAP to fund a one-time pilot of remote supports. Additional funds will be needed to sustain this initiative over time. We will pursue State budget funds and other braided funding to accomplish this. There may also be opportunities to align and sustain this effort with the federal Affordable Connectivity program to bring broadband services to more households nationwide.

## Proposed Intervention & Theory of Change

### Access to Technology

To ensure equitable access to these technologies and build on the success of DigiAge<sup>5</sup>, 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 the areas of the State 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 technological 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 funding in a 3-year pilot project to develop a 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.

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<sup>5</sup> <https://oha.ri.gov/digiAGE>

## Sustainability

Experience from other states proves that expanding access to technology and 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

- Number of individuals utilizing remote supports for independent living and employment
- Greater independence evidenced by individuals doing things for themselves without direct staff involvement
- Increased request for technological supports
- 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 ongoing stakeholder engagement work is the need to increase the number of workers providing HCBS services. Only 60% of licensed nursing assistants are currently employed as Certified Nursing Assistants (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 older adults 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 the 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.

### Spending and Project Planning Update for Self-Directed Expansion as of February 1, 2022

No spending occurred this quarter in this program area, although the self-directed workforce will benefit from the workforce recruitment and retention program through the Personal Choice and Independent Provider programs.

Since CMS spending plan approval, state partners developed a draft workplan for regulatory reform to support self-directed program expansion. Additionally, state self-directed program managers met with Jeff Keilson of Advocates, a national expert on self-directed program development, to discuss recommendations for regulatory reform. Finally, a new team member was hired through existing state funds in September, 2021, which increases EOHHS' capacity to support program development. Our team is currently working on finalizing compliance and quality metrics for self-directed programs. This baseline data will allow us to measure our progress as we work towards reform. Over the next quarter we expect to draft regulatory reform options and identify improvements for our PCA referral platform.

In the Division of Developmental Disabilities, there have been stakeholder meetings to discuss how to increase capacity in the self-direct support model. These meetings are providing us with valuable information as to the areas we need to look at when looking expand this service model. Topics such as staffing pools and registries were discussed, and we have heard they would be beneficial because it can be difficult for individuals and their families to find staff, and this can be a barrier to program expansion. Discussion regarding additional resources like Support Brokage, Service Advisory, and/or Peer Supports would also help to expand self-directed supports for those individuals who may find it challenging to navigate some of the complexities that come with managing their own services and supports.

Work in this program area is expected to accelerate over the next two quarters.

### 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 conducting a policy and rate review for the current array of self-directed programs with the intention of enhancing the self-directed model of care, including Personal Choice, Independent Provider, Shared Living, DD Self-Directed Programs, and the Office of Healthy Aging (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 across programs, ensuring rates are set appropriately to support services, and ensuring service advisory agencies are compensated in some way for clients who receive advisory or application assistance services, even if they ultimately decide not to participate in a self-directed program.

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

These investments will also include alignment with our No Wrong Door and broader workforce outreach initiatives to conduct a public information campaign on self-directed model of care. Such a public information campaign will make special emphasis on equity and target communities of color. We also

aim to focus our outreach and recruitment efforts on areas of the State where home health care services are the least accessible and conduct targeted outreach to the community to inform them of PCA registry opportunities.

### Sustainability

We will use enhanced HCBS FMAP funds to support the development and implementation of these proposed initiatives, while pursuing policy and rate changes to sustain these programs over the longer-term.

### Success Metrics

- Increased number of service advisory agencies and fiscal intermediaries available to support the self-directed programs
- Increased number of PCAs enrolled in the Registry to be accessible by enrollees of our Independent Provider or Personal Choice self-directed programs
- Increased percentage of overall HCBS clients receiving self-directed services
- Increased number of HCBS BIPOC clients receiving self-directed services
- Rhode Islanders are able to quickly and easily access clear information on the array of self-directed services available to them, and how to access these services
- Greater support to empower individuals to manage self-directed services

## 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. The current service infrastructure for self-directed programs and provider agency programs needs to be transformed to better meet the desires, preferences, and needs of the individuals who rely on these supports.

With enhanced HCBS FMAP funding, we have an opportunity to help providers establish high quality employment supports, expand integrated community-based supports, support community mapping, and enhance program access and quality through the use of technology. We will solicit transformation ideas from DDO providers through a proposal process and disseminate funds to support the implementation of these ideas through a grants approach.

### Spending and Project Planning Update for I/DD Provider Capacity as of February 1, 2022

#### Transformative Change Models

The application for transformative change model proposals was released on December 3, 2021. The Developmental Disability Organizations (DDOs) were given until December 17, 2021, to submit their applications to The Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH). Twenty-nine applications were received by BHDDH from our licensed DDOs, reflecting a total of \$6.3 million in requested funding. With the goals of supporting as many providers as possible in an

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equitable way, while honoring the \$4 million established budget for this initiative, the maximum request amount was set at \$250,000, costs that were not allowable were removed from the budgets, and all submitted proposals were funded at 76% of the requested amount.

Current licensed DDOs will use this funding to build capacity within their organizations. The funding will be used for retention efforts through different types of professional development and recruitment efforts. Several of these activities and trainings will focus on person-centered programming, customized employment, community navigation, equity and diversity, implicit bias training, and technology use. Increased training and professional development opportunities will help providers acquire the knowledge and skills they need to be successful in their positions. This will lead to better service delivery to those receiving supports from these agencies.

The providers are now awaiting the disbursement of funds, contingent upon release by the General Assembly, so they can begin the work outlined in their submissions.

### **Technical Assistance**

This work remains a priority for the State. However, an alternative source of funding has been identified through the State budget process.

### **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 increase 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 high quality 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 within 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, set of 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 (TA). As we recover from the COVID-19 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.

The Supported Employment Leadership Network (SELN), a national organization which the State is receiving TA from, recommends an approach that incorporates an investment in both organization level TA, 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. We may be able to obtain some supplemental funding from other sources.

### Success Metrics

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

## Nursing Facility Transformation

### Opportunity Statement

~~Rhode Island invests over \$329 million annually to provide LTSS to approximately 11,000 beneficiaries over the age of 65. Currently, 75% of that spending supports services 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 State Fiscal Year (SFY) 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.<sup>6</sup> 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 settings, and to refocus institutions on the individuals who~~

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<sup>6</sup> Murray, Caitlin, Alena Tourtellotte, Debra Lipson, and Andrea Wysocki. "Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Years 2017 and 2018." Chicago, IL: Mathematica, January 7, 2021 (Note: Data unavailable for CA, NY, VA, IL, & NC)

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 injuries, 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 surveyed individuals and families 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 a home and community-based 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). The initiative will help nursing facilities who have been confronting declining occupancy due to the pandemic to remain on solid financial footing.

### Spending and Project Planning Update for Nursing Facility Transformation as of February 1, 2022

The State is not working on developing this initiative. In our letter to CMS dated September 14, 2021 we acknowledged that: “Payments solely for the purpose of reducing nursing facility bed size and/or capacity are not approvable under ARPA section 9817”. As such we have purposefully struck out any references to a bed buyback program from the above and below sections from this document. We are seeking alternative funding sources to pursue the policy goals laid out in this area.

### 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 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 behavioral health needs.

EOHHS proposes to both expand and refine this successful program by extending funding to additional participants and offering 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 to 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:



- ~~**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.~~
- ~~**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 Rhode Island 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 care, e.g., traumatic brain injury, behavioral health, 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.

### **Spending and Project Planning Update for Assisted Living Expansion as of February 1, 2022**

Work in this program area has not yet been initiated. The State has prioritized implementation of a state budget initiative to implement a tiered rate reimbursement structure for Assisted Living Residences. Since November 1, 2021, all Assisted Living providers received an increase in baseline funding. Effective February 1, 2022, Medicaid-enrolled Assisted Living Providers can apply for a higher

tier certification, which will allow them to get additional payments for more clinically complex Medicaid residents.

We anticipate picking up this initiative after the reimbursement structure is fully implemented in the Summer of 2022, as funding allows.

### Proposed Intervention & Theory of Change

#### Assisted Living Expansion Grants

The Assisted Living Expansion initiative will provide funding to Assisted Living Residences (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) Assisted Living (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

- Increased number of Medicaid LTSS certified ALRs
- Increased number of Medicaid beneficiaries in ALRs
- Decreased 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 traumatic brain injury (TBI) or acquired brain injury (ABI) to reside in one of three homes that provide residential support and ongoing habilitative services (HAB), 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 rehabilitation 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.

### Spending and Project Planning Update for Traumatic Brain Injury Capacity as of February 1, 2022

No HCBS enhanced FMAP funding has been accrued for this work to date. In February, a state workgroup will be initiated to update program metrics, quantify the coverage gap, and develop a series of short and long term solutions to be prioritized based on available funding. The State is striking the potential intervention of Specialized LTSS Residences because enhanced FMAP funding will not be utilized to incentive specialized nursing facility beds. This is still a strategy the State is interested in pursuing if alternative funding sources become available.

### 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 nursing homes 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 offset by savings from maintaining individuals in lower cost community-based settings in Rhode Island. Additionally, providing intense therapies in a timely manner to individuals with TBI/ABI increases 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 return to work or employment with supports
- For those needing continued supports, increased number of individuals 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

Please see updates for all Children's Behavioral Health Services below.

### 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 PHE.

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

siloes, 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. For children and families of color, structural racism makes the challenge of getting appropriate services for their needs 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 state agencies (i.e., BHDDH, DCYF, RIDE, and RIDOH), community members, 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 due to 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; expanding access to services to support children's mental health is critical.

### Spending and Project Planning Update for Children's Behavioral Health Services as of February 1, 2022

As of February 1, 2021, no funds have been encumbered for this project. However, EOHHS has continued to move forward significantly with the planning for this project, including soliciting and analyzing community comment on the Rhode Island Behavioral Health System of Care for Children and Youth. The State continues to work on exactly what funding is necessary from this enhanced HCBS FMAP opportunity to support the Children's System of Care. The plan still prioritizes the program proposals in this way:

1. Mobile Response and Stabilization Services/Single Point of Access, to be included within the statewide Mobile Crisis planning taking place for the Certified Community Behavioral Health Clinics (CCBHCs) and aligned with our 988 Planning Process. We are committed to having one mobile crisis system for the state, so as not to confuse parents who are seeking services for their children about how to receive help.
  - **Mobile Crisis - Aligning with CCBHC Planning:** Throughout the development of mobile crisis services with the CCBHC model (described below in this document), EOHHS will ensure that the specific needs for children and youth will be represented in the planning – for instance, alignment with the educational system's behavioral health components (including guidance counselors and school social workers) and the need to take the whole

family into account when serving children and youth. Mobile Crisis remains the first program for which enhanced HCBS FMAP funds will be encumbered.

- **Single Point of Access - Aligning with 988 Planning:** As Rhode Island plans for the new 988 Behavioral Health Crisis three-digit phone number, we are working together to ensure that 988 can be the main way that families pursue services. Given the June 2022 federal implementation for 988, Rhode Island will wait until SY23 to implement the Single Point of Access. This gives us the opportunity to fund and strengthen capacity in Mobile Response, Intensive Home and Community-Based Services, and Care Coordination programs in the current state fiscal year.
2. Expanding the Intensive Home and Community-Based Service Array to fill treatment gaps, so that children and youth who are referred for services through Mobile Response have a place for ongoing treatment and are not kept on waiting lists.
    - We plan to expand current contracts for Intensive Home and Community-Based Services to expand slots. We are aligning this planning with the enhanced HCBS FMAP workforce investments, so that the children’s services agencies can hire the staff they need to serve these additional patients. We have aligned this with potential investments of State Fiscal Recovery Funding in Department of Children, Youth, and Families (DCYF) providers as introduced by Governor McKee’s supplemental budget request on October 7, 2021.
  2. Expanding Care Coordination, as a key part of the System of Care. The role of care coordination helps turn these separate programs into a **system** – with care teams able to connect families to services that work together.
    - Care coordination is carried out today by agencies in the Family Care Community Partnership (FCCP) program, overseen by DCYF. If funding is allocated, we can expand current contracts for these services to cover an additional 300 families (above the 700 served now).
  3. Community Referral Platform (CRP): Rhode Island has procured Unite Us as our CRP, helping physical and behavioral health providers make referrals for Social Determinants of Health services. We are preparing to expand the platform to be available to providers throughout the System of Care. Unite Us is excited to be working with EOHHS to implement; we do not anticipate this happening until SFY23.
  4. Prevention Programs: Our final mid-term priority for funding is Prevention Services. If funding is allocated, we will be preparing an RFP to fund additional prevention services in SFY23.

## 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 because 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 wraparound 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 FCCPs 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 utilize 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 Home-Based Therapeutic Services (HBTS), Personal Assistance Services and Supports (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 the State 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 age 16 to 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 (ED) 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 over time and work 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 Community Referral Platform (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, 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 changes 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.

#### **Spending and Project Planning Update for Adult Behavioral Health Services as of February 1, 2022**



As of February 1, 2022, no funds have been encumbered for this project.

EOHHS remains committed to addressing the gaps in the Rhode Island behavioral health (BH) system identified in the 2021 BH Report. Following the completion of the 2021 BH Report, EOHHS completed a national scan of potential initiatives to identify policy options responsive to the system gaps and challenges identified. While no single policy initiative will comprehensively address all the gaps and challenges identified, the federally defined Certified Community Behavioral Health Clinic (CCBHC) model offers the greatest potential to improve critical shortcomings in Rhode Island’s BH system. EOHHS intends to develop and implement a state-specific model design for a statewide CCBHC program, inclusive of a single, coordinated, 24/7/365 statewide mobile mental health crisis system.

CCBHC Expansion and Other Practice Transformation services that are provided under this initiative are included in the Rehabilitative Section of Rhode Island’s Medicaid State Plan. Specifically, Community Psychiatric Supportive Treatment, Psychiatric Rehabilitation Services, Crisis Intervention Services, Substance Abuse Assessment Services, Outpatient Counseling Services, Detoxification Services and Substance Abuse Residential Services, Day/Evening Treatment, Child and Adolescent Intensive Treatment Services, Mental Health Emergency Service Interventions, Comprehensive Emergency Services.

This model in Rhode Island currently includes the creation of a CCBHC attribution model across the continuum of behavioral health complexity, anchored by the following population cohorts:

- Highest Acuity Adult
- High Acuity Adult
- SUD High Acuity Adult
- Mild-Moderate Acuity Adult
- High Need Kids
- Mild-Moderate Acuity Kids

At this time, the State’s interagency Adult Behavioral Health System of Care Transformation Service Team—in partnership with Faulkner Consulting Group and Health Management Associates—is continuing the development of implementation plans for 2023 and is now gathering provider and community partner feedback on the Rhode Island CCBHC model that is comprised of four key spending components:

1. Base Rate Payment
2. Quality Incentive Payment
3. Infrastructure Payment
4. Administrative and Programmatic Support Costs

State certified CCBHC providers will be eligible to receive a two-part payment for each Medicaid CCBHC attributed member served. The two-part payment includes both a base rate and a quality incentive payment. The CCBHC base rate is a population-adjusted capitation rate that reimburses providers for the provision of a state-defined set of CCBHC required services. The second part of the CCBHC payment is a quality incentive payment that CCBHCs will be eligible to earn based on performance. The quality incentive is expected to start with engagement measures and transition to performance measures over time.

At this time, funding from other sources has been identified for the latter two parts of this initiative. Enhanced HCBS FMAP funding may be leveraged in the future for the other parts of the model should a funding source be needed.

### 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 Centers (CCBHCs) 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 lifecycle 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: (1) crisis mental health services, including 24-hour, mobile response teams, emergency intervention, and crisis stabilization; (2) screening assessment and diagnosis, including risk management; (3) patient-centered treatment planning within the least-restrictive and appropriate setting; (4) peer support, counseling, and family support services; and (5) 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 the RI HCBS Medicaid behavioral health care system by adding 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 these investments may not all directly go to a CCBHC or an organization becoming a CCBHC, all will 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 average number of days before all identified support services are initiated)
- Number of preventive screenings/referred interventions for tobacco use and unhealthy alcohol use
- Initiation of substance use disorder (SUD) treatment in indicated cases
- Physical healthcare screenings for CCBHC patients, with focus on blood pressure and diabetes risk

- Decrease in emergency department (ED) admissions/hospitalizations for CCBHC patients, i.e., Plan All-Cause Readmission Rate (PCR-AD) using [Medicaid Adult Core Set](#)
- Improved core physical healthcare metrics, i.e., blood pressure; diabetes incidence
- Improved housing status, i.e., residential status at admission to CCBHC after defined period of time
- Improved employment status, i.e., 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 heightened 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 2021 by the Rhode Island General Assembly; this effort will focus on supporting individuals and families experiencing homelessness.

### **Spending and Project Planning Update for Housing Insecurity as of February 1, 2022**

As of February 2022, no funds have been encumbered for this project.

The enhanced, more intensive case management services that this initiative would provide are included as Home Stabilization Services within the HCBS Services that are listed in Rhode Island's 1115 Demonstration Waiver. We await CMS' confirmation that these are allowable uses of funds.

At this time, the state has prioritized Homeless Response Teams for implementation planning. HCBS funds dedicated to this project will be leveraged to support teams across the State who have strong histories in engaging individuals and families experiencing homelessness. Current planning includes the following potential activities:

- 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 Medicaid members in the setting where they are living: hotel/motel, community encampments, shelters or in their homes as individuals experiencing homelessness are housed.
- The geographic areas of focus will likely be Pawtucket, Providence, Washington County, West Warwick, and Woonsocket.

- Each Homeless Response team would be anchored in the community through a multi-purpose center that would act as a hub for individuals experiencing homelessness to access showers, laundry machine, food, and services through community partners.
- At this time, one implementation mechanism being explored for feasibility is the provision of a time-limited and enhanced, intensive home stabilization rate for homelessness to existing home stabilization providers for these services.

This initiative is being evaluated across various funding streams to maximize alignment with other initiatives and proposed resource allocations. Should this initiative be funded elsewhere, Medical Respite would be the next priority within this space for implementation planning. Pursuant to CMS guidance, HCBS enhanced FMAP funding will not be used to pay for clients' room and board in either the Medical Respite program or the Community-Based SUD Treatment Pilot. As such we have purposefully struck out any references to payment for room and board below.

### **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.

#### **Medical 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 ends 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**

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This one-time pilot initiative would provide incentive payments to Managed Care Organizations (MCOs) 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. These payments will help MCOs build capacity within the state and reduce reliance on out-of-state placements. Adding the incentive and disincentivizing out of state placement could help improve the continuum of care in Rhode Island.

### **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 was extended through July 31, 2021 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 Rhode Island.

### **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

- Increased number of individuals who get housed
- Increased Medicaid utilization by individuals served
- Decreased number of hospital re-admissions
- Decreased number of households evicted
- Increased number of households provided housing navigation services
- Increased stability of housed homeless and disabled participating in the programs
- Increased 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 oral 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. These activities are 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, Certified Nursing Assistants (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.

### Spending and Project Planning Update for Oral Health as of February 1, 2022

As of February 1, 2022, no funds have been encumbered for this project.

At this time, the State continues planning for the implementation of a training that will be developed for home health professionals (which is described in greater detail in the section below).

This training will likely be given twice in-person at a one-day training (contingent upon COVID safety protocols), and then an online version may be developed with the assistance of the New England Public Health Training Center (NEPHTC) and/or equivalent training partner. A coordinator will oversee the

development of the training, coordination, and promotion of the in-person training events. General oversight of the project is being considered as well.

This initiative, among others, is being reviewed by the Oral Health System Transformation Interagency Team to advise on implementation plans.

### 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

- Reduced hospital admissions for aspiration pneumonia among older adults
- Two in-person trainings hosted 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 Better 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 enhanced HCBS FMAP to address these challenges through technology investments to streamline eligibility by building interfaces to link systems in a person-centered way, and improving data quality and analytics capacity.

### Spending and Project Planning Update for Technology as of February 1, 2022

As of February 1, 2022, no funds have been encumbered on this initiative.

System requirements have been drafted and submitted via our existing state process for technology enhancements. State leadership has also viewed multiple demonstrations on eligibility enhancement opportunities, Network Adequacy programs, and data dashboard expansions. The State will not be pursuing the Network Adequacy build due to the complexity of this project and the competing priorities for enhanced HCBS FMAP funding. This work is closely tied with the No Wrong Door developments and may ultimately be combined. The system changes to expedite access and optimize eligibility workflow are being scheduled for State Fiscal Year 2023. As the No Wrong Door work procurement continues, the state will finalize requirements for the data dashboard through the development of a long term LTSS data strategy.

### 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:

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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. Particular 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

- Improved 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 worked with the Rhode Island Office of Management and Budget, the Governor's Office, and the Rhode Island General Assembly to establish new restricted revenue accounts and budget authority to ensure that enhanced funding from this ARPA direct award is appropriately accounted for in the State Fiscal Year (SFY) 22, 23 and 24 budgets. A new restricted account(s) will serve as clearing account to track all claimed funds and, subsequently, their use to finance the state share of the new HCBS investments. The federal costs associated with the new investments will be budgeted to a federal account within EOHHS to capture the federal costs of any eligible investments across agencies.

## Spending Plan Projection

Rhode Island estimates receiving enhanced FMAP equaling approximately \$66.4 M (as shown in Table 1 in the second column and bottom row and repeated in the second column bottom row of Table 2).

This will give the State approximately \$158.5 M All Funds in new HCBS investments (as shown in bottom row of Table 2). Actual All Funds investments may vary based on, for example, proportion of investments benefiting Expansion-eligible members, an administrative match of 50%, 0% match, and 90% match for IT investments.

The increase in expected claiming compared to the last Quarterly Spending Plan (submitted October 18, 2021) is driven by the fact that the prior estimate was based on CY2020 expenses, and these revised estimates are based on actual spending through September 2021 and expected claiming available to Rhode Island through March 2022.

**Table 1** shows the amount of spending that is eligible for enhanced FMAP, as well as the amount of enhanced FMAP the State expects to claim. **Table 2** shows the timing of our planned expenditures using the new state (equal to the amount of enhanced FMAP claimed). The estimates may be refined based on Rhode Island's actual spending in future quarters.

**Table 1. Spending Eligible for enhanced FMAP, and estimated enhanced FMAP claiming.**

Service <sup>7</sup>	10/1/21 estimate of annual spending/claiming <sup>8</sup>	2/1/2022 estimate of annual spending/claiming <sup>9</sup> A + B	Actual spending/claiming <sup>10</sup> A	Projected remaining spending/claiming <sup>11</sup> B
Home Health	12.8 <sup>12</sup>	422.5	186.9	235.6
1115 Waiver	363			
PACE	16.2	16.6	8.3	8.3
Case Management	3.0	3.4	1.7	1.7
Rehab Services	50.4 <sup>13</sup>	62.8	31.4	31.4
Managed Care	152	184.4	90.7	93.7
<b>Total spend eligible for</b>	597 <sup>15</sup>	689.3	337.4	351.9

<sup>7</sup> 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.

<sup>8</sup> These estimates were based on CY2020.

<sup>9</sup> By quarter the amounts claimed or projected to be claimed are:

Eligible Spending March-June 2021: \$166.7 million

Claimed: \$16.4 million

Eligible Spending July-September 2021: \$170.7 million

Claimed: \$16.7 million

Projected Eligible Spending for October-Dec 2021: \$168.7 million per quarter

Projected Claiming: \$16.6 million

Projected Eligible Spending for January – March 2022: \$168.7 million per quarter

Projected Claiming: \$16.6 million

<sup>10</sup> RI has claimed the eFMAP for March-June 2021 and July-September 2021

<sup>11</sup> Actuals for these quarters will likely increase based on investments in Table 2 made prior to March 31, 2022 which are eligible for eFMAP, which are not included here.

<sup>12</sup> Includes new investments adopted by legislature for SFY22

<sup>13</sup> This does not include \$3.5M of early intervention spending which RI confirmed is not eligible as it is not in our Rehab pages and therefore not eligible for HCBS eFMAP

<sup>15</sup> This does not include \$26.7M of school-based spending which RIs later estimates incorporate as eligible based on CMS guidance

<b>Enhanced FMAP<sup>14</sup></b>				
<b>Enhanced FMAP / state share of new HCBS investments<sup>16</sup></b>	<b>57</b>	<b>66.4</b>	<b>33.2</b>	<b>33.2</b>

**Table 2. New HCBS investment budget projections and actuals. Estimates are in millions.**

Item and Timing	February Submission, budget		Actuals	
	All Funds	State Share <sup>17</sup>	All Funds	State Share after Enhanced FMAP claimed
Workforce Provider Payments, before March 31, 2022 (page 18)	\$59.5	\$21.5	0	0
Workforce Administration, before March 31, 2022 (page 18)	\$1	\$0.5	\$0.466	\$0.233
<b>Workforce Subtotal</b>	<b>\$60.5</b>	<b>\$22</b>	<b>\$0.466</b>	<b>\$0.233</b>
Transformation Grants for Development Disability, FY22 admin matching (page 28)	\$4	\$2	0	0
Other Items Timing TBD, assumed FY22 at 54.88% benefits FMAP (no 10% eFMAP for HCBS)	\$47.4	\$21.4	0	0
Other Items Timing TBD, assumed FY23 or later at 54.19% benefits FMAP (no eFMAP for HCBS)	\$46.6	\$21.4	0	0
<b>Total</b>	<b>\$158.5</b>	<b>\$66.4<sup>18</sup></b>	<b>\$0.466</b>	<b>\$0.233</b>

<sup>14</sup> This does NOT include spending on new HCBS investments made prior to March 31, 2022; instead spending on those items in Table 2 is reflected as the benefits FMAP plus the 10% enhanced HCBS FMAP where applicable.

<sup>16</sup> This is not equal to 10% of "Total w/ Round 1 Investment" because Expansion spending is only eligible for 5% increase

<sup>17</sup> This is state share that assumes benefits FMAP plus enhanced HCBS FMAP where applicable; it is only applicable to eligible workforce investments

<sup>18</sup> This is not equal to 10% of "Total w/ Round 1 Investment" because Expansion spending is only eligible for 5% increase

## Stakeholder Engagement

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](#).

### Spending and Project Planning Update as of February 1, 2022

- The Long-Term Care Coordinating Council (LTCCC) received a written and verbal update on the workforce recruitment and retention planning at its September 2021 meeting.

- Stakeholder meetings with home health care agencies, adult day care, self-directed providers, HAB Group Home providers, Community Mental Health Centers, Peer Navigators, Substance Use Treatment Providers and HBTS/ PASS providers have been held from late October 2021 through January 2022 to discuss the Workforce Recruitment and Retention guidance. Many of these groups met multiple times as feedback was incorporated into updated guidance. We anticipate meeting with each of these provider groups at least one more time before April 2022 to provide support as the temporary rate increases are approved and implemented.
- EOHHS carried out stakeholder review of the Draft Behavioral Health System of Care Plan for Children and Youth by distributing the draft plan widely for written comment from October through December 2021, and by holding two virtual meetings to take verbal comment. More than 500 people received the plan and were encouraged to comment.
- EOHHS continued to hold Children’s System of Care Work Group meetings through the last quarter for assistance in crafting the plan.
- EOHHS continues to lead the Governor’s Overdose Intervention and Prevention Task Force, which held a large Community Engagement meeting in December 2021, taking public comment on what the Task Force’s priorities should be in the coming year. Housing access, substance use disorder treatment, and expanded behavioral health services were top listed priorities from our stakeholders.
- Stakeholder meetings focused on Certified Community Behavioral Health Clinics continued through the last quarter and will continue as implementation planning continues. Other stakeholder engagement for behavioral health projects includes 988 implementation planning and mobile crisis.
- An internal interagency team focused on Adult Behavioral Health and Oral Health have been convening to advise project prioritization and will soon include a new team focused on Housing Supports.
- BHDDH held a forum for the DD Transformation Fund in December 2021 to allow space for final questions before the applications were due.

## **Addendum. Rhode Island Response to CMS Questions in HCBS FMAP Partial Approval Letter Received August 9, 2021**

September 13, 2021

Jennifer Bowdoin  
Director  
Division of Community Systems Transformation  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, Maryland 21244-1850

Dear Ms. Bowdoin:

Please accept this letter as the Rhode Island Executive Office of Health and Human Service's (EOHHS) response to the request for additional information regarding EOHHS' HCBS spending plan received August 9, 2021, addressed to the RI Medicaid Program Director, Benjamin Shaffer, (hereafter referred to as "CMS Letter"). In the CMS Letter, CMS stated that EOHHS' plan met the requirements set forth in the May 13, 2021, CMS, State Medicaid Director Letter (SMDL) #21-003 and that EOHHS received partial approval. EOHHS is grateful for CMS' comprehensive review and feedback and is appreciative of the support and the opportunity to invest home and community-based services (HCBS) under section 9817 of the American Rescue Plan Act of 2021 (ARPA).

For those sections of Rhode Island's proposed spending plan for which CMS did not ask any follow up questions in the CMS Letter, Rhode Island assumes that we are approved to proceed to implementation and will update CMS through the quarterly spending plan process.

Depending on CMS approval, and on whether expenses are eligible for additional federal match as well as being eligible expenses, Rhode Island may alter proposals in the spending plan. We continue to refine and specify programs and will provide updates through the quarterly spending plan. Reductions in scope are likely necessary given available funding and varying uses of Medicaid match. Clarity from CMS on what is approved for spending and what is approved as Medicaid matchable would be helpful for implementation planning.

Below are the responses to the questions listed under the "Additional Information Requested" section of the CMS Letter. We hope that following your review, we can proceed to full approval and implementation of these programs to strengthen Rhode Island's home and community-based services.

## Responses to CMS Questions

### *No Wrong Door (NWD) Redesign Initiatives*

Q: “Confirm that the pre-eligibility, eligibility, and post-eligibility functions of the NWD redesign initiatives will not impose stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021.”

**EOHHS Response: The Rhode Island No Wrong Door system is designed to clarify, standardize and improve the current steps in the LTSS pre-eligibility and eligibility process and will not impose stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021.**

### *HCBS Workforce Recruitment and Retention*

Q: “Clearly indicate whether HBTS/PASS providers are delivering any of the services that are listed in Appendix B or could be listed in Appendix B (e.g., behavioral health services that are covered under another benefit but could be covered under the rehabilitative services benefit). If the providers are not delivering any of the services listed in Appendix B or that could be listed in Appendix B, explain how the hiring incentives will expand, enhance, or strengthen HCBS under Medicaid.”

**EOHHS Response: HBTS and PASS providers are delivering services listed in Appendix B. The services listed as Home and Community-Based Therapeutic Services in Attachment B of the RI Comprehensive 1115 Waiver Demonstration are inclusive of the following 1915(c) services: Consultative Clinical and Therapeutic Services, Psychosocial Rehabilitation Services, and Day Treatment and Supports.**

**Per Budget Services #4, EOHHS has the authority to provide the above HBTS service in the 1115 waiver to eligible youth who are at risk for out-of-home care or hospitalization. Therefore, it is EOHHS' interpretation that HBTS and PASS services are listed in Appendix B under the "Section 1115" category which states "Any of the Medicaid-covered HCBS services described above are eligible for the enhanced match when authorized under an approved 1115 demonstration."**

### *Nursing Facility Transformation*

Q: “Clearly describe how the Nursing Facility Transformation grants and the grants for Targeted, Specialized Nursing Facility Service Capacity Building will expand, enhance, or strengthen HCBS under Medicaid and will result in settings that are fully compliant with the home and community-based settings criteria. Payments solely for the purpose of building specialized nursing facility capacity are not approvable under ARP section 9817.”

**EOHHS Response: Based on CMS input, this Nursing Facility Transformation grant program would be structured in a way that enables the facilities to diversify their sources of revenue to offset losses from business interruption due to the public health emergency and ensure ongoing financial viability. Based on CMS guidance, EOHHS would restrict the use of funds to growing Assisted Living or other**



**HCBS services, and providing a pathway for these organizations to enter other HCBS markets, including but not limited to home care, supportive housing, or adult day.**

Q: “Describe how the nursing facility bed-buybacks will result in expanded HCBS capacity in settings that are fully compliant with the home and community-based settings criteria, and indicate whether any of the payments are intended solely to reduce nursing facility bed size and/or capacity. Payments solely for the purpose of reducing nursing facility bed size and/or capacity are not approvable under ARP section 9817.”

**EOHHS Response: Bed-buybacks that reduce the supply of non-HCBS settings help create the market conditions necessary for an increase in HCBS supply. However, if CMS holds that funding solely for bed-buybacks to reduce nursing facility bed size are not allowable, Rhode Island will not proceed with that element of the program, and instead focus on nursing facility transformation to settings that are compliance with HCBS criteria. EOHHS requests that CMS clarify whether bed-buyback uses are allowable, but not Medicaid matchable, or whether they are prohibited as a use under the SHO.**

*Assisted Living Expansion to Serve Medicaid Members*

Q: “Estimate the number of additional Medicaid-certified assisted living residences and the anticipated number of additional assisted living beds for Medicaid beneficiaries that will result from the Assisted Living Expansion to Serve Medicaid Members, as well as the percentage of residents in the facilities receiving funds that are expected to be Medicaid eligible.”

**EOHHS Response: EOHHS anticipates finalizing the total allocation for this initiative after additional financial analysis and partnership with Assisted Living Residences in Rhode Island. The amount of funding that EOHHS dedicates to this grant program will impact EOHHS’ ultimate goals for this initiative, which is largely dependent on uses of funds that are Medicaid matchable. However, the Assisted Living Expansion is designed to build off of our new tiered-rate system for Assisted Living that was approved in the Enacted State Fiscal Year 2022 Rhode Island State Budget. This tiered reimbursement system, combined with the grants funded through enhanced FMAP is estimated to increase the number of Medicaid certified facilities from 37 to 45 out of 65 total licensed assisted living residences in the state. We also plan to increase our number of Medicaid assisted living beds by at least 50.**

*Building Traumatic Brain Injury Capacity In-State*

Q: “Clearly describe how the “specialized LTSS residences” activity will expand, enhance, or strengthen HCBS under Medicaid and will result in settings that are fully compliant with the home and community-based settings criteria.”

**EOHHS Response: By "specialized LTSS residences," EOHHS is we are referring to the HCBS service known as Residential Habilitation. These home-like settings meet all of the requirements of the HCBS final rule.**

*Expanding Preventative and Community Children's Behavioral Health Services*

Q: "Clearly indicate if any of the activities under Expanding Preventative and Community Children's Behavioral Health Services are focused on: services other than those listed in Appendix B or that could be listed in Appendix B; or individuals who are not receiving any of the services listed in Appendix B or that could be listed in Appendix B. If any activities are not directly related to the services that are listed in Appendix B or that could be listed in Appendix B, explain how those activities expand, enhance, or strengthen HCBS under Medicaid."

**EOHHS Response: All of the services that EOHHS is investing in through this initiative are listed in Appendix B. These include:**

- **Care Coordination – This initiative increases rates for our Family Care Community Partnership (FCCP) program, which provide wraparound service to Medicaid children and their families to strengthen the family unit and keep kids in their home. These services are covered under budget services 4 in the RI 1115 Waiver. We consider them a HCBS service that is covered by Appendix B because Budget Service 4 expenditures are “for core and preventive services and home and community based therapeutic services as identified in Attachment B for Medicaid eligible youth who are at risk youth for out-of-home care or hospitalization and adults with a behavioral health diagnosis and/or developmental disability”(RI 1115 Waiver, page 7)**
- **Mobile Response and Stabilization Services – This scope of work falls under Case Management, Consultative Clinical and Therapeutic Services, Psycho-Social Rehabilitative Services, and Peer Supports, which are all services within Attachment B of the RI 1115 Waiver Demonstration.**
- **Intensive Home and Community Bases Services – This scope of work is in the Rehabilitation Services section of our State Plan. Section 13 D. describes Child and Adolescent Intensive Treatment Services (CAIT).**
- **Transition –Age Youth and Young Adult Services (2 one-stop multi-service Hubs) - This work falls under Case Management and potentially Career Planning, which are both services within Attachment B of the RI 1115 Waiver Demonstration.**
- **Infant Mental Health Certification – This scope falls under workforce readiness, in Consultative and Clinical Therapeutic Services, which is a covered HCBS service within Attachment B of the RI 1115 Waiver Demonstration.**
- **Pediatric Integrated Behavioral Health Practice Transformation – This scope falls under Consultative Clinical and Therapeutic Services, Case Management, and, as it includes working with parents, Training and Counseling Services for Unpaid Care Givers, which are a covered HCBS services within Attachment B of the RI 1115 Waiver Demonstration.**
- **Suicide Prevention Programming – This falls under Consultative Clinical and Therapeutic Services, which is a covered HCBS service within Attachment B of the RI 1115 Waiver Demonstration.**

- **Alignment of Community Health Teams and Family Home Visiting teams (DULCE program) - This falls under Case Management, which is a covered HCBS service within Attachment B of the RI 1115 Waiver Demonstration.**

*Expanding Preventative and Community Adult Behavioral Health Services*

Q: “Clearly indicate if any of the activities under Expanding Preventative and Community Adult Behavioral Health Services are focused on: services other than those listed in Appendix B or that could be listed in Appendix B; or individuals who are not receiving any of the services listed in Appendix B or that could be listed in Appendix B. If any activities are not directly related to the services that are listed in Appendix B or that could be listed in Appendix B, explain how those activities expand, enhance, or strengthen HCBS under Medicaid.”

**EOHHS Response: Many of these services align with Appendix B as: Rehabilitative Services, Section 1115. Additionally, other services provide significant HCBS benefits as justified below.**

- **Certified Community Behavioral Health Clinics (CCBHC) Expansion and Other Practice Transformation services that are provided under this initiative are included in the Rehabilitative Section of Rhode Island’s Medicaid State Plan. Specifically, Community Psychiatric Supportive Treatment, Psychiatric Rehabilitation Services, Crisis Intervention Services, Substance Abuse Assessment Services, Outpatient Counseling Services, Detoxification Services and Substance Abuse Residential Services , Day/Evening Treatment, Child and Adolescent Intensive Treatment Services, Mental Health Emergency Service Interventions, Comprehensive Emergency Services**
- **Single, statewide mobile mental health crisis system—including 988 integration, satellite emergency department alternatives, and related supports; The services that are provided under this initiative are included in the Rehabilitative Section of Rhode Island’s Medicaid State Plan. Specifically, this initiative would deliver the following Adult Behavioral Health Services that are defined within this section of the Medicaid State Plan: Crisis Intervention Services**
- **Centralized harm reduction system, naloxone, and supportive services with no-wrong door and affiliated street outreach activities—including a hotspot pilot of a community drop-in center; The services that are provided under this initiative are included in the Rehabilitative Section of Rhode Island’s Medicaid State Plan. Specifically, this initiative would deliver the following Adult Behavioral Health Services that are defined within this section of the Medicaid State Plan: Crisis Intervention Services**
- **Adult Psychiatry Resource Network (PRN) for telephonic behavioral health consultation; We believe this would have the following benefits to HCBS: Providing this telephonic service (already contained within Rhode Island’s 1115 Demonstration Waiver) to providers allows for quality, real-time, and person-centric behavioral health treatment services to be provided early in the care management process, which increases the likelihood of individuals living and**

**thriving within home and community settings for longer periods of time and prevents/delays long-term care services.**

- **Peer Community Health Workers with experience navigating youth, adult, and family behavioral health crises to assist parents in discharge planning, discharge planning adherence, transition, and community supports navigation; the services that are provided under this initiative are included as Peer Supports within the HCBS Services that are listed in Rhode Island’s 1115 Demonstration Waiver.**
- **Provider capacity building and equity-focused enrichment activities—such as culturally-and linguistically-appropriate services and multi-lingual trainings; We believe this would have the following benefits to HCBS Providing access to a more culturally competent workforce increases the likelihood of participation and retention in necessary care that promotes home and community-based living and delays/prevents/avoids long term care services. In addition, this initiative seeks to make multi-lingual training, education, and supports available to Medicaid eligible patients to reinforce health literacy.**
- **Develop care coordination and step-down transition plans for substance-exposed newborn system of care—focused on transitions into home and community settings; The services that are provided under this initiative are included in the Rehabilitative Section of Rhode Island’s Medicaid State Plan. Specifically, this initiative would deliver the following Adult Behavioral Health Services that are defined within this section of the Medicaid State Plan: Substance Abuse Assessment Services**
- **Add Primary Care Nurse embedded in the IHH Team to function as the team’s primary care liaison and would work intimately with all primary care offices within the service catchment area. We believe this would have the following benefits to HCSB. By providing the clinical resources to address the physical health needs of individuals within Health Homes, the likelihood of management and control of physical health conditions increases and promotes home and community-based living that prevents/delays/avoids the onset of debilitating conditions, long-term disabilities, and special healthcare needs that require long-term care services.**

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

Q: “Provide more information about the populations served and the services that would be paid for under the Homeless Response Teams, Respite, and community-based residential treatment pilot activities, including: whether the activities are focused on services other than those listed in Appendix B or that could be listed in Appendix B, or individuals who are not receiving any of the services listed in Appendix B or that could be listed in Appendix B; and the percentage of individuals served who are expected to be Medicaid eligible. If those activities are not directly related to the services that are listed in Appendix B or that could be listed in Appendix B and/or are not expected to target Medicaid beneficiaries, explain how those activities expand, enhance, or strengthen HCBS under Medicaid. In addition, indicate whether the Respite services would be provided in an institutional or home and community-based setting. If provided in an institutional setting, explain how the state will prevent long-term institutionalization for these individuals.”

**EOHHS Response: These services align with Appendix B as: Rehabilitative Services, Section 1115. Additionally, other services provide significant HCBS benefits as justified below.**

- **Homeless Response Teams - The enhanced, more intensive case management services that this initiative would provide are included as Home Stabilization Services within the HCBS Services that are listed in Rhode Island’s 1115 Demonstration Waiver.**
- **Medical Respite/Recuperative Care - The services that this initiative would provide expand those included within the Rehabilitative Section of Rhode Island’s Medicaid State Plan. Specifically, this initiative would deliver the following Adult Day Health Services and/or Traumatic Brain Injury Services that are defined within this section of the Medicaid State Plan to new community settings to allow for medical respite and recuperative care: Medication Administration, On-Going Monitoring of Health Status , Maintenance Therapy, Skilled Services, Personal Care Services, Care Coordination, Provision of Healthcare, Healthcare Coordination, Counseling, Care Plan Development, Team Coordination, and Advocacy, Direct Care. This HCBS benefit addresses Budget Population 15 [Adults with disabilities at risk for long-term care] within Rhode Island’s 1115 Waiver.**
- **Eviction Moratorium Stabilization - This initiative aims to expand home stabilization eligibility criteria for Home Stabilization Services to any Medicaid eligible individual at-risk of being and/or who as been evicted within the non-HCBS Home Stabilization Service section of Rhode Island’s 1115 Waiver. We believe that this will have HCBS benefit By implementing the Housing First Approach and providing these services for individuals living in the community who are at-risk of being and/or recently evicted, the likelihood of developing severe behavioral health (e.g., overdose, substance use, trauma, deteriorating mental health) and physical health (e.g., injury, assault, violence) conditions decreases and avoids/prevents the need for long-term care services.**
- **Community Based SUD Residential Treatment Pilot -The services that are provided under this initiative are included in the Rehabilitative Section of Rhode Island’s Medicaid State Plan. Specifically, this initiative would deliver the following Adult Behavioral Health Services that are defined within this section of the Medicaid State Plan: Substance Abuse Assessment Services, Substance Abuse Residential Services**

Q “Clearly indicate if the MCO Incentives Pilot is focused on expanding access to any services other than those listed in Appendix B or that could be listed in Appendix B, including to any institutional services. If this activity is expanding access to institutional services and/or to services other than those listed in Appendix B or that could be listed in Appendix B, explain how this activity expands, enhances, or strengthens HCBS under Medicaid.”

**EOHHS Response: The focus of this initiative would be on the provision of comprehensive Case Management, Rehabilitation--Adult Behavioral Health Services within Medicaid's State Plan and Home Stabilization Services within the list of HCBS Services in Rhode Island's 1115 Demonstration Waiver.**

If there are any additional questions, or if it would be helpful to schedule a discussion, please contact Benjamin Shaffer at [Benjamin.Shaffer@ohhs.ri.gov](mailto:Benjamin.Shaffer@ohhs.ri.gov). EOHHS appreciates all of CMS' support and looks forward to working with CMS further throughout the implementation of ARP section 9817.

Sincerely,



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