RI EOHHS Response to Comments: 1115 Waiver Extension Stakeholder Input Sessions

Summary of Comment	EOHHS Response
Commenter asked whether we would need waiver authority for Community Health Workers. Commenters raised concerns that peer specialists would be subsumed into the community health worker category, and that changes to standards and training for peer specialists would threaten progress to date to institute a career ladder and ensure consistency. Requested assurances that the uniqueness of peer recovery will be addressed and that current standards and training would continue.	EOHHS advised that other states are typically granted the authority to allow paraprofessionals (including peers and community health workers) to provide Medicaid-covered services through the State Plan. No waiver will be requested for community health workers. Any future work conducted by EOHHS would seek to leverage the work that has already been done to strengthen the preparation/training of this workforce.
Commenters suggested that evidenced-based practices that aren't currently available prior to involvement with DCYF be available, and receive federal matching funds, to prevent the need to become involved with DCYF.	EOHHS has the authority to cover these services, if medically necessary, under EPSDT, so a waiver request is not needed. EOHHS & DCYF are in conversation regarding this.
Commenters questioned whether additional authority is needed to include foster parents in the Maternal, Infant, and Early Childhood Family Home Visiting Program and suggested that they be eligible for Family Home Visiting Services.	RIDOH clarified that a home visitor may work directly with foster families in conjunction with DCYF and the biological family as part of the larger case plan. The home visiting program will provide technical assistance to the local implementing agency. No additional authority is needed.
Commenter requested that the agency implement an expedited eligibility process. While waiting for their long-term care eligibility determination, home care services are not being provided because the home care providers will not set up services until the client has been approved for the service (which is assurance that the home care agency will be appropriately reimbursed). Nursing facilities take the risk and admit without Medicaid approvals.	The current 1115 Waiver grants EOHHS the authority for an expedited eligibility process. EOHHS will be requesting that those services covered under expedited eligibility be inclusive of all Preventive Services, as defined in the Waiver, instead of just personal care and Adult Day. Internal discussions are under way to improve the clinical determination processes of LTSS applications, also.
Expand Expedited Eligibility adult day benefit from 3 days per week to 4 days per week and the personal care benefit to 20 hours per week.	EOHHS will request waiver authority to increase the number of days of adult day from 3 to 5, and the option to provide additional hours of personal care/homemaker services, above the twenty (20) now allowed, for beneficiaries with the highest clinical/functional need for an institutional level of care.

Commenter suggested that EOHHS implement the Support and Services at Home (SASH) model in Rhode Island. Saint Elizabeth Community received grant funding from Tufts to begin the program in their facilities.	EOHHS has the authority to cover the core services offered through the SASH model. Additional waiver authority would only be needed if certain providers (e.g., those participating in this model) would be reimbursed differently. EOHHS does not have plans to implement the SASH model for two reasons: 1) due to small population sizes, this model would not be viable and 2) there would be many areas of duplication with care coordination (e.g., bundled rate or PMPM instead of encounter based).
Commenters advised on the cost of care issues. Providers are expected to collect the beneficiary's cost of care, but are not always informed of each of their beneficiary's cost of care amounts. Additionally, these amounts often change retroactively and patients are unable to pay such high expenses.	EOHHS will request waiver authority to collect beneficiary cost of care directly from the Medicaid eligible individuals. If implemented, payments to providers would no longer be adjusted for an individual's cost of care.
Commenter had concerns that the Medically Needy Income Maintenance Level that is identified in the current Special Terms and Conditions (STCs) of the current 1115 Waiver is too narrowly construed, and is written for a specific population and does not allow enough money for people to remain in the community. There is economic benefit for the state-economic multiplier effect.	EOHHS reviewed the STC language and believes that this may have been written into the STCs in error. Because this is a minor technical correction, EOHHS will discuss with CMS to ensure it is corrected in the next waiver extension period.
Commenter suggested EOHHS request the authority to pay for remote support devices such as video cameras, vital signs monitors, and fall monitors that are typically used by the IDD population in other states. These technologies help people remain safely at home, avoiding unnecessary hospital and nursing facility admissions.	EOHHS will request this in the upcoming waiver extension as a covered Home and Community Based Service (HCBS).
Commenter requested that RI take advantage of the 1915(c) option to pay relatives/guardians as caregivers. Additionally, it was requested that EOHHS seek authority to pay for enhanced supports for family caregivers.	EOHHS will be requesting a waiver of 42 CFR 441.360 and 440.167 to pay relatives and/or legal guardians, including spouses, as caregivers. Additionally, EOHHS is requesting that Training and Counseling Services for Unpaid Caregivers, and Consultative Clinical and Therapeutic Services be a covered Preventive Service.
Commenter suggested that enhanced supports for family caregivers, whether paid or unpaid, are needed.	EOHHS will request that Clinical and Therapeutic Services that assist unpaid caregivers and/or paid support staff in carrying out individual treatment/support plans, and that are not covered by the Medicaid State Plan, and are necessary to improve the individual's independence and inclusion in their community, be added to the list of Preventive services.
Commenter asked whether EOHHS could add primary providers for persons in a nursing home on to the current waiver, and allow the specialized Accountable Entity (AE) to integrate this provider. Advised that EOHHS should consider measuring it by instituting a measure specific to discharges into the community.	These suggested changes do not require 1115 waiver authority and can be achieved through operational modifications.

Commenter suggested that the state should define some parameters for the federal government around memory care as it is not always defined as skilled care and additional support is needed for facilities that provide this enhanced level of service.	After further discussion with the commenter, it was evident that commenter was suggesting that EOHHS seek authority to increase payment rates for those facilities that offer memory care. Such authority would be granted through a SPA, so there is no 1115 Waiver authority needed at this time. EOHHS is discussing this more internally.
Commenter suggested that an integrated model be used in Supportive Care Homes that includes individuals with intellectual or developmental disabilities. Other states have successfully used such integrated models.	In the waiver extension request, the definition of Community-Based Supported Living Arrangements does not specify a particular population and therefore will allow the authority to use an integrated model.
Commenter raised the concern that there are no opportunities for the adult DD population to practice living skills (such as activities of daily living (ADLs), accessing transportation, and skills to live independently in an apartment) in the community. Suggested that programs be developed to foster partnerships between community agencies and public and private facilities to help agencies deliver these services in community settings that replicate real-life situations.	EOHHS will be pursuing authority to establish programs that address acquisition of life skills. It will be requested that these programs be offered to Medicaid eligible individuals over the age of 21 years who have chronic and moderate to severe cognitive, developmental, medical/neurological, and/or psychiatric conditions whose level of functioning may be significantly compromised, those who may be ready to transition to a lower level of care or those who are at-risk for a more restrictive placement or hospitalization.
Commenter advised on an access issue for pregnant women with intellectual and developmental disabilities that are in need of family home visiting services.	These suggested changes do not require 1115 waiver authority and can be achieved through operational modifications. Efforts to improve these issues will be coordinated across the Rhode Island Department of Health, EOHHS (Early Intervention staff), and the Department of Behavioral Health, Developmental Disabilities, and Hospitals.
Commenter suggested a waiver service for telephonic behavioral health services similar to Arizona Medicaid's coverage of telephonic crisis interventions.	EOHHS has determined that this would require a SPA, not a waiver authority.
Commenter proposed that by eliminating the Communities of Care ER diversion program, administrative dollars would be saved and increased flexibility would be granted for MCO care management programs.	EOHHS has determined that no additional federal authority would be needed if the state decided to eliminate this program. Therefore, no waiver request will be submitted.
Commenter asked that a waiver be pursued to expand the ability to provide alternative treatment modalities for pain management outside of the current Ease the Pain initiative, as an expansion could alleviate opioid concerns.	EOHHS has determined that this would require authority through the State Plan and does not require a waiver. No waiver will be submitted for this.
Commenter requested that EOHHS expand the in-plan skilled nursing home benefit from 30 days to 90 days, which is applied to Rhody Health Partners and the expansion population, as this would allow plans to improve coordination during critical transitions of care.	EOHHS has determined that this does not require a waiver. This is state policy due to current rate setting methodologies.

Commenter suggested that EOHHS establish legislative authority allowing Medicaid to pay for specialty consults with primary care through video/electronic communication.	EOHHS will request waiver authority to cover child, adolescent, and adult telephonic psychiatric consultation services for primary care practitioners.
Commenter suggested EOHHS seek authority to change the current reimbursement requirement to allow MCOs and FFS to directly reimburse the nursing home for hospice room and board payments. This would be an alternative to the current "pass through" payments, allowing the MCOs to have flexibility in setting the actual rate paid to the nursing home for hospice room and board. Currently, they receive 95% of their current per diem rate.	This change would require EOHHS to receive additional waiver authority. However, to implement this change, significant operational changes are required, and EOHHS has not been made aware of access concerns due to the current arrangement. No waiver authority for this will be pursued.
Commenter requested that EOHHS cover transportation with regard to accessing services/supports related to social determinants of health, as it would enable access to nutrition, socialization and other supports for individuals outside of other resources. No-fare bus passes was mentioned as a specific example.	EOHHS will be requesting waiver authority to cover Non-Medical Transportation as a Preventive HCBS. Additionally, there is a state-wide no-fare bus pass program that most Medicaid eligible individuals would qualify for.
Commenter suggested removing any references to "vehicles" from the environmental modification benefit or provide greater restrictions on what would be covered.	Environmental Modifications is now a State Plan benefit under Home Health, so the entire definition will be removed from the 1115 waiver.
Commenter suggested EOHHS seek Costs Not Otherwise Matchable (CNOM) waiver authority to add a new population; low-income Medicare Eligibles at risk for Medicaid long-term care (sometimes referred to as "Pre-Medicaid").	EOHHS intends to integrate performance incentives within the comprehensive AE program that will focus on Medicaid enrollees that are at risk for LTSS; achieving the same goals and intent without needing to seek new federal authority or create a new program. No waiver authority is needed.