Spending Plan Narrative 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

FY2023 Q3

January 17, 2023

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Letter from the Rhode Island State Medicaid Director

I am pleased to submit this FY2023 Q3 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.

Our 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 our initial spending plan intact, and added updates for each activity under the header of 'Spending and Project Planning Update as of [Quarterly Report Date]'. All updates and/or substantive modifications are highlighted in yellow for ease of CMS review. 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.

Since our initial spending plan, we have focused on making progress in three key project areas that we have deemed most critical: HCBS workforce recruitment and retention; LTSS No Wrong Door (NWD) enhancements; and children's behavioral health system capacity enhancements. In the past six months, the State has achieved several milestones, such as: (1) distributing all budgeted HCBS E-FMAP funds for recruitment and retention incentives for HCBS direct care workers (DCWs); (2) developing an advanced certification program for DCWs to increase workforce skills, credentials, and advancement opportunities; (3) Enrolling 127 employees of HCBS provider agencies into the State's new Health Professional Equity Initiative (HPEI) program which supports paraprofessionals of color and others to pursue higher education leading to health professional credentials, degrees, and/or licensure; (4) Made significant headway in implementing an electronic client management information system (CIMS) to automate, standardize, and streamline many LTSS eligibility and post eligibility functions to more efficiently deliver quality services to Rhode Islanders; (5) Contracting with two children's service providers to kick off the State's Mobile Response and Stabilization Service (MRSS), which will help provide relief to school districts with significant needs for children's behavioral health and hospital Emergency Departments struggling with overcrowding because of the confluence of RSV, the flu, COVID, and behavioral health challenges; and (6) Increasing capacity in serving children and families across Rhode Island by expanding service rates and available slots for the HCBS service array and Family Care Community Partnerships (FCCPs). Additional details regarding these initiatives and others can be found in the subsequent pages of this report.

We have made no substantive modifications to our spending plan since our last quarterly report submission (in July 2022). We are however requesting CMS' consideration of, and feedback on a new

proposed activity. The State would like to explore using HCBS E-FMAP funds to plan, build, and implement an oral health emergency department (ED) diversion initiative. If approved by CMS, these funds would be leveraged to help: 1) recruit, hire, and train public health dental hygienists (PHDHs) to function as ED dental care coordinators, evaluate patients, provide onsite-care, and make a determination for admission; 2) recruit dentists to be on-call for phone or telehealth consults; and 3) incentivize and facilitate getting patient care the next day by having a community-based system for emergency care, e.g., enhancing health centers' ability to manage emergencies by sharing an oral surgeon across health centers in the state, or providing supplements outside of the Medicaid to participating providers to manage last-minute, after-hours emergencies. Additional details can be found on page 52 of this report. We welcome all questions and look forward to further discussion with CMS regarding this proposal.

Last, we continue 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 State Medicaid Program Director is the designated point of contact for the narrative submissions, and that Kimberly Pelland, Rhode Island Medicaid Chief Financial Officer, is the designated state point of contact for the quarterly spending plan.

Sincerely,

Kristin Sousa
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?*			

RHODE ISLAND

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 9th highest rate in the country.[1] 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

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

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

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 entering the final phases of the NWD project which focuses on modernizing and integrating eligibility and post-eligibility functions as part of a broader effort to make the LTSS system more person-centered, quality-driven, and resilient.

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 priority 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 January 17, 2023

Priority Area 1. LTSS IT system modernization. Over the past two quarters, the State made significant progress by implementing the interRAI Home Care (HC-10) standardized assessment to replace multiple home-grown tools that were administered differently across agencies. The State also entered into a contract with Wellsky Health and Human Services, Inc for a consumer information management system (CIMS) to automate and streamline the assessment process.

The State is cognizant of the requirements associated with the use of enhanced HCBS FMAP for system changes/reforms with the potential to affect eligibility and/or the scope of services. To ensure compliance with ARP section 9817 Maintenance of Effort (MOE) requirements as described in SMDL #21-003 and SMDL # 22-002, the State has taken the following steps:

1. EOHHS engaged a national contractor highly experienced in assessment transitions – HCBS Strategies Inc. – to assist in ensuring that implementation of the interRAI HC–10 for home care meets all applicable MOE requirements. The contract with HCBS Strategies Inc. for this work is expected to amount to approximately $300,000; about a third was paid out in the last two quarters.
2. With the contractor's assistance, the State modified the interRAI HC-10 to incorporate all the items and response sets from the retired assessments that were previously scored when determining HCBS functional needs. Thus, the modified interRAI HC-10 is a composite instrument that consists of the common elements of the retired assessments as well as those unique to the interRAI HC-10;
3. The modified interRAI HC-10 was built into, and automated in the Wellsky HHS CIMS.
4. The system applies the same scoring tool that was used for the retired assessments as an algorithm for evaluating functional needs. Only the items and responses on the modified interRAI HC-10 that were scored on the retired assessment instruments are considered when authorizing the scope, amount, and duration of HCBS.
5. For a month, the State used the modified interRAI HC-10 and the retired instruments in tandem to assess a sample of applicants to gauge whether there were differences in outcomes. No differences were identified.
6. HCBS Strategies Inc. is collecting data on the responses to all the items on the modified interRAI HC-10. This data is being collected for a period of six months to a year to develop a new algorithm that is more reliable and consistent with prevailing standards of care. The State does not expect there to be sufficient data and testing to deploy this new algorithm before 2024.
7. Once fully tested, the new algorithm and the scoring tool used for the retired assessments will both be applied during the MOE period. The system default is to only authorize HCBS in an amount that meets or exceeds the level determined using the scoring tool from the retired assessment instruments until the MOE period expires.

While these activities have been underway, the State requested and received approval for an Advanced Planning Document (APD) from CMS for supplemental funds to support subsequent phases of the LTSS Modernization Project. The State is currently working with Wellsky under the auspices of this APD to accomplish key tasks.

The LTSS IT Modernization Project also focuses on implementation of conflict-free case management (CFCM) on a statewide basis across populations. Aside from the payments to HCBS Strategies Inc., the bulk of spending over the last two quarters has been for the configuration of the Wellsky CIMS to support to implementation of CFCM – about $1.08 million. The State's goal is to begin implementation of CFCM in January 2024. There is a budget initiative to pay for these services under review in the RI General Assembly.

Priority Area 2. Information, awareness, and outreach. In the past two quarters, the State spent minimal funds in this area, primarily for the publication and translation of public materials about HCBS.

Our expectation is that additional funds will be expended for awareness and outreach over the next two quarters as the CFCM initiative moves forward.

Priority Area 3. Person-Centered Options Counseling (PCOC) Network expansion. A portion of our HCBS E-FMAP funding will be spent on translation services for this program. Other funding sources have allowed the State to provide two week-long training sessions to 45 counselors and to expand the network to two additional organizations.

Priority Area 4. Change management. We are in the final stages of completing the procurement process for a change management vendor through the State's RFP process for Priority Area 4, which directly complements the ongoing activities in Priority Area 1. The vendor will assist with: i) the realignment of State business practices; ii) the design and implementation of new staff workflows within the system; iii) the development and implementation of a comprehensive strategy for coordinating the attendant changes to existing State IT systems and databases to ensure data interoperability, portability, and access, and minimize disruptions to service delivery; and iv) the build and execution of an effective communications and stakeholder engagement strategy to ensure all technological and process changes are successfully adopted and sustained.

Additional updates will be provided in the FFY Q1 2024 Spending Plan Narrative Update to be submitted to CMS on July 18, 2023.

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 client information management system (CIMS) 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 CIMS 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 CIMS tool and to establish a unified cloud-based system capable of interfacing with the existing eligibility and payment systems IT infrastructure. This CIMS has 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 can help to ensure 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 former 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 invest 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 CIMS 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 majority of the LTSS IT system modernization work requires a one-time investment of funds. These investments 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. Finally, the State is including these the ongoing maintenance costs into its long-term capital budget planning to secure the resources necessary for ongoing maintenance.

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.[2]

Navigating the children's behavioral healthcare system in Rhode Island can be daunting. Particularly when a child experiences a behavioral health crisis, parents may not know what to do, or who is available to help meet their child's needs. One 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 January 17, 2023

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.

[2] 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, as well as 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 January 17, 2023

Workforce Hiring and Retention Incentives

The State has completed the distribution of all budgeted enhanced HCBS E-FMAP funds for recruitment and retention incentives for HCBS DCWs. See table below for all disbursed funds per HCBS provider type.

Provider Type Code	Provider Description	Funding Mechanism	Federal Authority	Estimated Funding Temporary – All Funds
LTSS				
072, 0	Home Care Agencies	FFS Rate Increase	SPA submitted 12/10/21; approved 3/10/22	~~$24,123,000~~ 24,550,000
010 & 065	Skilled Nursing Homecare	FFS Rate Increase	SPA submitted 12/10/21; approved 3/10/22	~~$1,766,000~~ $1,575,000
050	Adult Day Care	FFS Rate Increase	SPA submitted 12/10/21; approved 3/9/22	~~$2,129,000~~ $1,296,000
055	Habilitation Group Homes	FFS Rate Increase	1115 Waiver	~~$1,022,000~~ $1,166,000
071 FI	Fogarty Center Fiscal Intermediary	FFS Rate Increase	1115 Waiver	~~$20,000~~ $24,000
116 FI	Independent Provider Fiscal Intermediary	FFS Rate Increase	1115 Waiver	~~$1,000~~ $3,000
071 PC	Personal Choice Recruitment & Retention Bonuses	Direct Grant	N/A (not a rate increase)	~~$3,738,000~~ $3,522,436
116 PC	Independent Provider Recruitment & Retention Bonuses	Direct Grant	N/A (not a rate increase)	~~$187,000~~ $402,564
089	PACE	Capitation Rate Increase	N/A (SPA determined to be unnecessary)	~~$2,800,000~~ $3,414,419
044	LTSS Case Management	FFS Rate Increase	1115 Waiver	~~$407,000~~ $349,000
			Subtotal	**~~$36,193,000~~ $36,302,419**
Behavioral Health				
MCO	Substance Use Disorder (SUD) Rehab	MCO Direct Payment	Pre-Print submitted 12/28/21; approved 4/27/22	~~$3,055,000~~ $8,094,000
061	CMHCs	FFS Rate Increase	SPAs submitted 12/23/21 and 12/29/21 Adult BH SPA approved 3/18/21; ACT SPA approved 7/29/22	$11,580,000
080	HBTS/ PASS	FFS Rate Increase	1115 Waiver	~~$5,734,332~~ $5,713,000
080	HBTS/PASS	Direct Grant	1115 Waiver	$2,020,416
109	Peer Recovery Programs	FFS Rate Increase	1115 Waiver	~~$73,000~~ $29,000
MCO	Emergency Outpatient Services (EOS)	MCO Direct Payment	Pre-Print submitted 4/12/22; approved 4/27/22	$314,000

Subtotal	**~~$27,815,748~~ $27,750,416**

CMS approved the rate increases in the Attachment K on September 16, 2022. Our SPA to increase rates for ACT services was approved on July 29, 2022. For the rate increases that use 1115 waiver authority, the State submitted and worked with CMS to finalize an Attachment K request.

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 increased 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. Children's Emergency Outpatient services are included in Section 13(d) of our State Plan under Rehabilitative Services.

Career Awareness and Outreach

In early February 2023, the State will launch a direct care workers (DCW) outreach campaign strategy to promote this career pathway, develop a strong in-state pipeline of DCWs, and promote workforce diversity. Print and digital materials were developed in partnership with Day Health in FY23 Q1. In FY23 Q2, the State procured the services of RDW Group to develop and execute the media buy strategy, and some modifications in content and media strategy are likely to be adopted based on the recommendations and expertise of RDW. The campaign theme is "Rhode Island is Where You Can Make Caring a Career". The ads will drive people to the State's newly launched Caring Careers website, which contains information about continuing education, professional development, and advanced certification opportunities for current HCBS DCWs, as well as information about job openings and related training for those looking for a job in HCBS.

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

Hiring incentives remain a core component of our workforce recruitment and retention program. This section of the spending plan narrative is crossed out because we have adjusted our methodology for distributing funding to eligible direct care workers. Our updated approach is described above.

~~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

Direct care worker retention payments remain a core component of our workforce recruitment and retention program. This section of the spending plan narrative is crossed out because we have adjusted our methodology for distributing funding to eligible direct care workers. Our updated approach is described above.

~~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 with a wage passthrough requirement to those nursing assistants with the certification. In the SFY23 budget (beginning July 1, 2022), we received authority to: i) increase home health provider rates to establish a minimum wage of $15 an hour; ii) increase the wages for personal-care attendants in self-directed program to $15 an hour; and iii) increase the starting salary for the Developmentally Disabled direct care workforce to $18/hr. All these legislative mandates are effective July 1, 2022. 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 January 17, 2023

Over the past two quarters, the State finalized an advanced certification program plan for direct care workers (DCWs) to increase workforce skills, credentials, and advancement opportunities. We have executed contracts with local higher education partners to operationalize this plan in the near future. We have also contracted with the RI Certification Board and have begun paying costs associated with certain professional certifications required or available to HCBS DCWs.

EOHHS entered into contracts with its three public institutions of higher education in June 2022 to provide various advanced certification, continuing education, and professional development opportunities for HCBS direct care workers. The schools have been slow to launch these programs; however, efforts are now underway at all three schools to survey HCBS providers, conduct direct outreach to workers, and develop curriculum to meet the ongoing education and training needs of HCBS DCWs. All programs will be offered at no cost to workers, and, in the case of lower wage paraprofessionals, may include stipends upon completion of training. Finally, as noted above, the various educational opportunities offered by the schools for HCBS direct care workers are listed on EOHHS' new Caring Careers website.

Last, in partnership with the Office of the Postsecondary Commissioner, we did extensive outreach for our new Health Professional Equity Initiative (HPEI), which resulted in expressions of interest from more than 250 HCBS DCWs. After conducting individual interviews to determine eligibility and suitability, over 160 employees of HCBS provider agencies were provisionally accepted into the program, which will support paraprofessionals of color and others to pursue higher education leading to health professional credentials, degrees, and/or licensure. As of December 31, 2022, there were approximately 127 individuals enrolled in the HPEI program and pursuing pathways towards higher education degrees and licensure in behavioral health and nursing. In addition, recruitment to fill another 5 to 10 slots will be completed in January 2023.

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 37th in Quality of Life and Quality of Care, and 28th in Effective Transitions. Within those categories, our rate of employment for adults with ADL disabilities ages 18-64 relative to the rate of adults without disabilities is ranked 35th and our percentage of home health

patients with a hospital admission ranked 47th in the country. Critically, our HCBS quality cross-state benchmarking capability is also low, ranking 36th among states.[3]

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 January 17, 2023.

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~~ March 31, 2025. 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. Finally, all proposals must include strategies to address racial and ethnic disparities in the quality measures to be achieved.

[3] http://www.longtermscorecard.org/databystate/state?state=RI

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.[4] 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

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

[4] https://www.medicaid.gov/medicaid/quality-of-care/downloads/rfi-hcbs-recommended-measure-set.pdf

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 January 17, 2023

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.

Proposed Intervention & Theory of Change

Assistive Technology Fund

As originally communicated in the FFY Q3 2022 Spending Plan Narrative Update: 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. As such the section below has been crossed out.

~~To ensure equitable access to these technologies and build on the success of DigiAge[5], 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~~

[5] https://oha.ri.gov/digiAGE

~~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

As originally communicated in the FFY Q3 2022 Spending Plan Narrative Update: 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. As such the section below has been crossed out.

~~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.

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.

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 January 17, 2023

No funds were encumbered or spent for this project in the past two quarters. The State has discussed design options with Applied Self Direction (a national learning and advocacy collaborative, of which RI is a member of) and had exploratory conversations with State teams in Oregon, Minnesota, and New Jersey. The State continues to engage with interagency partners and stakeholders to more fully scope

this project. Additional updates will be provided in the FFY Q1 2024 Spending Plan Narrative Update to be submitted to CMS on July 18, 2023.

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 pursing 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

Version: January 2023

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 January 17, 2023

Transformative Change Models

In FFY 2022 Q4, $4 million was dispersed to 29 Developmental Disability Organizations (DDOs) selected through an application-based grant process. These funds will enable currently licensed DDOs to build capacity within their organizations by investing in recruitment, retention, and professional development efforts such as trainings focused on person-centered programming, employment trainings, community navigation and mapping, leadership development, mentoring, and use of technology. These activities will help providers acquire Direct Support Professionals (DSP) who will have the knowledge and skills they need to be successful in their positions, resulting in better service for those served by these provider agencies.

The DDO grantees are currently in different stages of implementation in their recruitment, retention, and professional development efforts.

Recruitment & Retention. Over the past year, many providers have invested their funding directly into DSP recruitment and retention efforts. Agencies have seen some level of success in offering referral incentives to identify new DSPs candidates and offering retention bonuses to existing DSPs. Although providers have seen an increase in hiring, most are still not at sufficient staffing levels. They have continued to encounter challenges due to a competitive market for a limited workforce. To further assist providers, the Division of Developmental Disabilities has contracted with a vendor to help providers strategize and implement solutions to stabilize the workforce, leveraging $900,000 in All Funds (non-ARPA dollars).

Professional Development. Over the past two quarters, most providers have started to purchase training materials and/or software licenses, set up online training opportunities, and some have engaged with a Subject Matter Expert to assist with training. At least 636 employees from across agencies have attended some type of professional development training, i.e., community navigation and community mapping, and person-centered programming. More activities are planned with staff for the year ahead. In surveys conducted to-date to assess the efficacy of implemented trainings, many respondents cited an improved ability to meaningful engage with the individuals they serve, and to

better help these individuals connect with their community. For example, one agency reported the continued training helped their staff to not only assist one individual in connecting with a community organization aligned with her interests, but also to secure employment with the organization. Another agency shared the training helped their staff to assist an individual with complex behaviors begin martial arts classes which had a positive impact upon his level of communication, his behaviors, and his willingness to be around others.

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

Update as of FFY Q3 2022: 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.

~~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

The State is leveraging braided funding to advance this crucial I/DD system transformation work. In addition to the HCBS E-FMAP investment described above, the Legislature has approved a rate increase for SFY22 ($39.7M) and SFY23 ($35.6M) to assist with recruiting and retaining a qualified workforce. There was $12M allocated for Transformation activities (of this, $4M is from ARPA funding and disbursed in SFY22; $6M is All Funds and will be disbursed in SFY23; and $2M is General Revenue), with an additional $2M in All Funds for Technology appropriated (of this, $1M was disbursed in SFY22 and another $1M will be disbursed in SFY23). Funding was also allocated for vendor contracts in SFY22/23 including $102,200 for a technology expert/training, $900,000 for assistance with the Statewide Workforce Initiative, and $490,875 for Rate Methodology review and development work.

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~~

As originally communicated in the FFY Q3 2022 Spending Plan Narrative Update: The State is no longer 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.

~~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.[6] 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 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.

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:

[6] 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)

- **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 January 17, 2023

No funds have been encumbered or spent for this project to date. We continue to engage with stakeholders to scope this project more fully and to prepare for implementation. Additional updates will be provided in the FFY Q1 2024 Spending Plan Narrative to be submitted to CMS on July 18, 2023.

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.

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. The SFY22 Assisted Living Tiered Rates initiative maintained or increased provider rates, as compared to April 1,

2022. This was budgeted and paid for outside of HCBS E-FMAP funding and there will be no efforts to decrease these rates.

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 January 17, 2023

No funds have been encumbered or spent for this project to date. We continue to engage with stakeholders to scope this project more fully and to prepare for implementation. Additional updates will be provided in the FFY Q1 2024 Spending Plan Narrative to be submitted to CMS on July 18, 2023.

Proposed Intervention & Theory of Change

As originally communicated in the FFY Q3 2022 Spending Plan Narrative Update: The State has struck the potential intervention of Specialized LTSS Residences because enhanced HCBS 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.

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 Preventive and Community Children's Behavioral Health Services

Opportunity Statement

Children's behavioral health needs, while growing prior to the public health emergency, have been exacerbated in Rhode Island by the stresses of COVID-19. Recent data from Rhode Island Kids Count found that calls to RI Kids Link, a Rhode Island hotline on children's behavioral health, increased 22% in 2020 during the 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 siloed, with responsibility for children's behavioral health services fragmented across different state agencies and too often carried out in more restrictive programs than necessary. This makes it difficult for the system to deliver effective behavioral healthcare to all Rhode Island children. 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.

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 prioritizes the below program proposals as follows. All initiatives have been approved by CMS as eligible for enhanced HCBS FMAP.

1) Establishing statewide Mobile Response and Stabilization Services (MRSS) to ensure children and youth are able to quickly access help when needed.
2) Ensuring alignment of this MRSS system with the new statewide 988 behavioral health hotline, as a single point of access for care – and ensuring that there is also No Wrong Door for accessing treatment.

3) Expanding the home and community-based service array, to fill treatment gaps, to ensure children and youth who are referred for services through Mobile Response have a place for ongoing treatment and receive these supports in a timely manner.
4) Expanding care coordination to turn separate programs into a comprehensive system of support.
5) Implementing a temporary rate increase for First Connections providers to reflect current operating cost needs and to ensure program strength. This First Connections investment was added to the State Spending Plan in FFY2022 Q4 after a critical and urgent need for additional provider funding was identified to keep this vital home-visiting prevention program afloat beyond June 30, 2022. It is the State's desire to fund additional preventive services, if possible, at a later time.
6) Expanding use of the State's community referral platform (CRP), Unite Us, to providers throughout the Children's Behavioral Health System of Care. This platform helps physical and behavioral health providers make referrals for Social Determinants of Health (SDoH) services.

Spending and Project Planning Update for Children's Behavioral Health Services as of January 17, 2023

In the past six months, the State has continued to move forward significantly with implementation of many of the projects above, via an interagency and stakeholder-engaged approach. This has been critical, given the rising numbers of hospitalizations due to RSV, flu, COVID, as well as behavioral health challenges.

Mobile Response and Stabilization Services (MRSS) and Single Point of Access

After a competitive Request for Proposals process, the State has contracted with two children's service providers to kick off our Mobile Response and Stabilization Service (MRSS) project. Family Service of Rhode Island and Tides Family Services became eligible to provide mobile crisis services on November 17, 2022. The providers are receiving referrals from a set of school districts with significant needs for children's behavioral health and from hospital Emergency Departments struggling with overcrowding because of the confluence of RSV, the flu, COVID, and behavioral health challenges.

The organizations' clinicians meet with the youth and a caregiver to assess for safety and collaborate with their school and other providers to create a comprehensive plan to reduce the risk for hospitalization. Their clinicians can meet with the youth and their caregiver in their home, school, or office within two hours of referral, 24/7. At least one caregiver/guardian must be present and consent to evaluation. The evaluation process helps determine the appropriate level of care and directly links the youth to services. The providers offer short-term stabilization and case management for up to 30 days. Services are provided by experienced staff in both English and Spanish. Additional language support is available, as needed.

As we have noted previously, we are working with the federally mandated 988 crisis line in the State to have them help with mobile crisis dispatch. BHDDH has received a grant that will allow the State to procure a dispatch system and we are beginning that procurement.

Expanding the Intensive Home and Community-Based Service Array

In partnership with Medicaid, DCYF has implemented $5.1M in All Funds to support a full-year provider rate increase and slot expansion to expand the HCBS service array, effective July 1, 2022. The State anticipates sustaining these changes for two years with HCBS E-FMAP, for a total investment of $10.1M. In tandem, the State has completed the contract amendments with providers to formalize their provision of expanded services and they are providing the expanded services now. Overall, DCYF-funded, home-based service providers have used the rate increases to offer more competitive salaries to fill high numbers of vacancies and then add additional slots to further expand the number of children and families served. Since July 1, 2022, the number of operational slots has increased by 12 percent and the number of children and families served on a given day has increased by 14 percent. Going back further, the number of operational slots has increased by 26 percent since February 2022.

Expanding Care Coordination

Through this funding, we aim to expand our family-driven wraparound approaches to service planning and delivery through Family Care Community Partnerships (FCCPs) to ensure that services meet the family's and youth's identified strengths and needs.

DCYF has just expanded the current FCCP service rate to begin to address their workforce issues. EOHHS is investing $750,000 in FY23 and another $750,000 in FY24 to expand the FCCPs' available slots. This additional expansion of the State's contracts with FCCPs is enabling them to increase their capacity in serving families by up to 300 additional point-in-time slots. As of the most recent available statistics from November 2022, daily FCCP utilization had increased by 107 families, or 22% overall, since July 1, 2022.

One critical piece of this expansion is supporting the hiring process and workforce development. These dollars are also being used to pay for high-fidelity wraparound training for the FCCPs.

Expanding Preventive Services and First Connections

There is currently a critical and urgent need for additional First Connections provider funding. We expanded our collaboration with Medicaid to mobilize HCBS E-MAP swiftly to support a one-time, temporary infusion of funds to keep this vital home-visiting program afloat beyond SFY22, while the State works to identify and secure alternative funding sources to ensure its longer-term sustainability. We secured an additional $0.4M in All Funds thereby bringing the total allocated budget for this project from $1.1M to $1.5M, to reflect a full-year (as opposed to 9 months) provider rate increase to adequately support First Connections providers. As of this report allocated funding has made available to First Connections providers and they are spending funding as expected.

Community Referral Platform

No funds were encumbered or spent for this project in the past two quarters. We continue to engage with stakeholders to determine scope this project, ongoing funding needs, and our full sustainability plan. Additional updates will be provided in the FFY Q1 2024 Spending Plan Narrative Update to be submitted to CMS on July 18, 2023.

Proposed Intervention & Theory of Change

Version: January 2023

Mobile Response and Stabilization Services (MRSS) and Single Point of Access

See 'Children's Behavioral Health Single Point of Access' section above (pg. 15 & 16) for additional information.

Expanding the Intensive Home and Community-Based Service Array

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.

Expanding 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 wraproud approach works to reduce racial and ethnic disparities in the system.

We propose to expand our family-driven wraparound approaches to service planning and delivery through the 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 utilizing funding to show continued engagement with community-based organizations of color.

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

Expanding Preventive Services

Our stakeholder engagement 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.

One such program is First Connections, an optional state plan benefit. The service is a voluntary, short-term risk assessment and response Home Visiting program, implemented statewide by five community agencies. The majority of families are identified through a universal developmental screening done at birth. If a child/family is determined to be facing significant risk, they are offered a home visit that, if accepted, is provided by a multi-disciplinary team. Based on family need, any combination of a nurse, community health worker (CHW), and social worker may complete this visit. During the visit, the nurse screens the infant for development, provides health education and coaching, screens for maternal depression, and conducts a home assessment. The CHW may address basic family needs and a social worker may address mental health needs. Based on the results of the assessment, the team develops a plan for long-term services that have been shown to enhance child and family wellbeing. Families may be connected to food assistance, childcare, health care, parental mental health services, Early Intervention, and long-term home visiting services. First Connections visits are associated with on-schedule well child visits, better compliance with up-to-date immunizations, better compliance with lead screening, increased linkage to Early Intervention, and better engagement in the long-term family visiting programs. All of these prevention activities will help keep Rhode Island's children in better physical and behavioral health, contributing to a better quality of life and lower costs of care over time.

Community Referral Platform

See 'Children's Behavioral Health Single Point of Access' section above (pg. 15-16) for additional information.

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.

The State has been successful in the past six months with our pursuit of additional funding. We intend to sustain the program via a braiding of the following funds:

- EOHHS received the SAMHSA Children's Mental Health Initiative funding for MRSS and a new Community-Based Intensive Care program, with $10M in funding over four years. This funding will allow us to expand the number of children served – and will provide a new program that MRSS can refer to when children need more intensive home-based services.
- EOHHS has also successfully pursued $850,000 in Congressional Directed Funding for our MRSS program, thanks to the work of both Senator Jack Reed and Senator Sheldon Whitehouse.
- EOHHS and RI Medicaid continue to work with BHDDH and DCYF to implement the $30 million Certified Community Behavioral Health Centers (CCBHCs) Infrastructure Grants passed by the Rhode Island General Assembly in June 2022. We are creating Cost Report guidance, Certification Standards, and a Certification Application, and preparing for when the Assembly considers a rate proposal for CCBHCs in the FY24 budget. BHDDH and EOHHS also applied for the SAMHSA CCBHC Planning Grant, which we hope will lead to Rhode Island's ability to participate in the CMS CCBHC Demonstration Program and to receive expanded FMAP. The CCBHC program will include a statewide Mobile Crisis component, for which we will apply for an 85/15 FMAP for three years.

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 January 17, 2023

The State will invest HCBS E-FMAP dollars to catalyze behavioral health service system changes to accelerate recovery from the pandemic and address exacerbated behavioral health issues. To this end, the State has allocated $2M to-date to support the implementation of 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, as described above.

No funds were encumbered or spent for this project in the past two quarters. We continue to engage with stakeholders to more fully scope this project and to prepare for implementation and align with our State's budget and any changes on the Federal level regarding CCBHCs. Additional updates will be provided in the FFY Q1 2024 Spending Plan Narrative to be submitted to CMS on July 18, 2023.

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

The State has been developing and pursuing a braided funding strategy to build and sustain a robust and quality statewide CCBHCs network. In the event Rhode Island benefits in the short-term from the passage of Federal legislation that expands E-FMAP beyond the existing 10 demonstration States, Rhode Island's model can be shifted to align with this new opportunity. Until then, the Rhode Island CCBHC programmatic model is being funded through braided funds (i.e., SFRF for infrastructure and capacity building and HCBS E-FMAP for initial rate sustainability). Long-term, the State will seek any Federal demonstration expansion opportunities or changes to Medicaid with a State Plan Amendment to sustain this initiative.

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 heighted the awareness of homelessness as a public health issue. The State's shelter system, already at capacity, was mandated to reduce beds by 146 to reduce shelter density. Consequently, non-HCBS E-FMAP funded interim non-congregate shelter programs opened but these only provided temporary respite for the hundreds of Rhode Islanders experiencing homelessness. By the end of December 2022, these interim programs reduced capacity. Consolidated operations have sent many clients back to unsuitable congregate shelters and the streets. The need for additional supportive services and creative shelter support for persons experiencing homelessness persists into a new season, both literally as Rhode Islanders struggle through the freezing winter temperatures, and figuratively as temporary housing/shelter program access and availability ebb and flow to address the changing needs of Rhode Islanders experiencing homelessness.

Providing immediate resources to assist with the acquisition of housing capital, support housing operating expenses, and expand the housing stabilization wraparound services needed to successfully keep individuals housed is critical to a comprehensive housing solution for the State. The State is addressing and preventing homelessness through the creation of permanent supportive housing and initiatives in the budget passed in June 2021 by the Rhode Island General Assembly. The State's HCBS E-FMAP investment is focused on the third component—wraparound services and community-based settings—to ensure wraparound service delivery for substance use and other medical services are made available for clients within the least restrictive and most appropriate community-based setting, in addition to capital and operating. Taking this approach has demonstrated housing retention, homelessness prevention, decreased substance use, reduced longer stays in treatment, improved quality of life, lowered health costs, and decreased justice system involvement.

Spending and Project Planning Update for Housing Insecurity as of January 17, 2023

The State has continued to scope the following projects and prepare for implementation using an interagency and stakeholder-engaged approach—including through the Health is Housing Collaborative led by the Rhode Island Coalition to End Homelessness (RICEH), the Rhode Island Continuum of Care (RICoC), and the newly formed Department of Housing. Planning is being done across the following five key areas related to housing wraparound supports to align with and enhance, but not duplicate efforts of the Department of Housing, COVID Long-Term Planning for Quarantine/Isolation (Q/I), Non-Congregate Settings, and Pay for Success:

1) ~~Home Stabilization Services Expansion (Fall/Winter 2022)~~
   Home Stabilization services expansion is no longer being pursued as a component of HCBS E-FMAP. We are retracting this funding/spending request for several reasons. Initially, this expenditure was included in the Spending Plan to ensure state legislative authority for a waiver amendment to change the education requirement for providing home stabilization services. However, the State is no longer pursuing a waiver *amendment*. Instead, the education requirement will be amended in the waiver *extension*. The waiver extension will go into effect January 1, 2024. Between now and 2024, we will continue to leverage the emergency case management benefit, which was authorized as a disaster relief State Plan Amendment. This benefit is very similar to home stabilization but does not include the strict education requirement that home stabilization currently has. We intend to reallocate the initially budgeted $100,000 for this project to the others described in further detail below. As such, we have struck the project from this list and additional references to it below.
2) Homeless Service Provider Workforce Recruitment and Retention [including homeless response teams] (*Summer 2023*) – Anticipated $100,000
3) Medical Respite (including Q/I) Pilot (*Winter 2023*) - Anticipated $920,000
4) Managed Care Organizations (MCO) Incentives (*Under Evaluation*)
5) Public Housing or Resident Service Coordinators (*Summer 2023*)

Final budget allocations and timelines per project is contingent – in part – upon what passes in the SYF23, 24, and 25 budgets to avoid duplication and determine final priority ranking of initiatives.

Learnings from other ongoing statewide housing initiatives, such as Pay for Success, Q/I Facility Operations, Lifespan's Medical Respite pilot, the HEZ Housing Learning Collaborative, and the MCO Engagement in Rapid Rehousing of Non-Congregate Shelter (Hotel) Program, are also being used to inform finalization of these initiatives.

Homeless Service Provider Workforce Recruitment and Retention

For workforce recruitment and retention for homeless service providers, the State will partner with the Department of Housing—inclusive of the Office of Housing and Community Development – and supplement funding to grow the workforce, specifically focusing on Rhode Island's home stabilization service providers while the Department of Housing focuses on workforce incentives and capacity for providing related services through the Consolidated Homeless Fund, such as homeless service providers.

No funds were encumbered or spent for this project in the past two quarters. This project was delayed due to competing priorities but is scheduled to begin in 2023. Planning efforts are still underway to launch this work and maintain an estimated spending of $100,000.

Medical Respite (including Q/I) Pilot

Medical respite care (MRC) is acute and post-acute care for persons experiencing homelessness who are too ill or frail to recover from illness or injury on the streets but are not ill enough to be in a hospital. "Medical respite" is short-term community-based care that allows individuals experiencing homelessness the opportunity to rest in a safe environment while accessing medical care and other supportive services. Medical respite care is offered in a variety of settings including freestanding facilities, homeless shelters, nursing homes, and transitional housing (National Health Care for the Homeless Council, 2021). This pilot will leverage existing, non-Medicaid funds for room and board by co-locating with the State's Quarantine and Isolation Facility and leverage HCBS E-FMAP to support the wrap-around services and capacity-building costs for medical respite. This pilot has been developed in alignment with the National Standards for Medical Respite Programs. Projected HCBS E-FMAP spending will support required components of MRC programs such as providing a safe, secure, and trauma-informed environment, client clinical care, and case management. Alternative sources of funding have been secured to support costs associated with rental of the MRC facility and associated utility/ operational costs. The 6-month pilot budget is projected to be ~$920,000. Program evaluation is planned, and if successful outcomes are demonstrated, EOHHS may issue a request to extend MRC programming. No funds were encumbered or spent for this project in the past two quarters. Spending on this project is scheduled to begin in January 2023.

MCO Incentives Pilot

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. No funds were encumbered or spent for this project in the past two quarters. Reevaluation of this project for continued feasibility is ongoing.

Public Housing or Resident Service Coordinators (RSC)

Funds directed for this initiative are intended to support existing and newly developed public and private subsidized housing in supporting residents achieve better health outcomes through on-site service coordination. RSCs are instrumental in connecting residents to community-based programs that are proven to impact health outcomes. This initiative is planned to address issues identified when the public health crisis and housing providers came together to address the COVID-19 emergency, including a lack of access to the basic social determinants of health resources. Strengthening the public/private housing programs through expanding the number of RSCs will create enhanced opportunities for existing residents to retain their housing, prevent homelessness, and will offer property management agencies an additional tool to support clients who are moving from shelter to housing by ensuring individuals matched to units have the support to facilitate entry and maintain safe and appropriate housing. Additional information on implementation and budget will be included in a future submission.

Proposed Intervention & Theory of Change

As originally communicated in the FFY Q3 2022 Spending Plan Narrative Update: In compliance with CMS guidance, the State will no longer pursue the use of HCBS enhanced FMAP funds 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.

~~**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.~~

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 piloted an MRC program in the summer of 2021 and later established a permanent five-bed program that has started to demonstrate successful outcomes. However, the need for this type of program and support exceeds the existing capacity. Medical respite and recuperative care has been included in Rhode Island's 1115 Medicaid Waiver. This initial pilot funded by the HCBS E-FMAP funds could inform future MRC under the 1115 waiver. ~~This program would be piloted as part of a LTSS program that replicates the Office of Healthy Aging Respite program with assisted living facilities and nursing homes. The reimbursement cost would be enhanced to meet the needs of the population and facility and the stay would be limited to up to one month, however, it is anticipated that a Respite would need a capacity of up to 20 beds.~~

~~**MCO Incentives Pilot**~~

~~This one-time pilot initiative would provide incentive payments to Managed Care Organizations (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~~. (described above)

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. The feasibility of this planned program is being evaluated

due to existing shortages of SUD beds in the State amongst the opioid epidemic and post COVID-19 emergency. If this pilot is rolled out as anticipated, the State may need to put contingency plans in place if people with SUD have prolonged stays in SUD treatment resulting from this pilot and individualized treatment needs.

Sustainability

Sustainability planning remains top of mind during scoping and planning of these sub-initiatives. ~~For (1) Home Stabilization Services Expansion, we intend to align this with our 1115 Waiver Renewal submission to Medicaid for sustainability.~~ For (2) Homeless Service Provider Workforce Recruitment and Retention, the intention is to align this with the Consolidated Homeless Fund moving forward beyond HCBS E-FMAP funded period. For (3) Medical Respite, this is being aligned with SFRF for capital and OHCD funding for operating with service provision through the MCO Program, Accountable Entities, and Commercial insurers for sustainability. For (4) MCO Incentives, sustainability of successes or lessons learned from existing collaborations may be pursued in future contracts and/or directives. For (5) Resident Service Coordinators, sustainability plans are still being developed but are proposed to align with additional funding sources from the Department of Housing, as they are dedicated to developing the homeless and housing service provider workforce. The State will continue to research and explore additional opportunities to grow and strengthen the service provider workforce in RI, as well as funding opportunities to continue this work beyond the HCBS E-FMAP funding period.

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. The program proposed below offers a chance to put Rhode Island in a better place than before the COVID-19 pandemic, specifically with adult 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 daily mouth care is an included service.

Individuals with functional deficits, either physical or cognitive, rely on others to provide supportive services such as hygiene and toileting. These individuals may also need help performing basic oral hygiene, regular inspection of their mouths, and scheduling for dental care. These activities are critical 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 January 17, 2023

The State has allocated $0.9M to support the following oral health initiatives: 1) A dental care in home health setting pilot and 2) Recruit, retain, and pilot the use of community-based public health dental hygienists through dental practice collaborative agreements to provide oral health services to Medicaid populations outside of the clinic setting. The following will identify the planned and approved activities, and the progress the State has made towards distributing funds allocated for these oral health investments.

Dental Care in Home Health Settings Pilot

The State allocated $0.5M to support this initiative. The following activities were approved to support the pilot: 1) developing an oral care training for home health professionals (including personal care aides, home health aides, visiting nurses, etc.) to provide them with the knowledge and skills needed to provide clients with general oral health information, routine mouth care and oral screenings, and to make referrals to dental treatments, 2) ensure the proper pay-for-reporting by participating home health providers, training participation stipends, printing and postage for the training and related materials, 3) essential technology supports such as mobile dental equipment for public health dental hygienists, and 4) provide incentives for community-based safety net dental clinics and oral surgery sites for patients using home and community-based services with dental needs beyond the scope of services a Home Health Assessment and/or Public Health Dental Hygienists (PHDH) can provide.

The State has made progress towards distributing the funds allocated for this initiative. The Community College of Rhode Island (CCRI) was identified as a state partner to plan, develop, and film the oral care training video for home health professionals. This partnership was finalized in December 2022 and funds for the development of this training will be distributed beginning in January 2023. The State anticipates implementing the Home Health Training in the spring of 2023. Additionally, RI anticipates identifying organizational partners (across home health, public health dental hygienist, and community-based dentistry providers) for the dental care in home health settings pilot in SFY 2023 Q3 with an anticipated pilot start in SFY 2023 Q4.

Use of Public Health Dental Hygienists (PHDHs) to Increase Dental Care Access

The State allocated $0.4M to support this initiative. The approved activities were to support the training of community-based public health dental hygienists (PHDH) to provide oral health services outside of the clinic setting and increase access to dental care to Medicaid populations.

The State has made progress towards distributing funds allocated for approved oral health investments. The partnership with Community College of Rhode Island (CCRI) was finalized in December 2022 and funds for tuition support will be distributed after the first cohort of applicants are identified. This cohort will begin courses in February 2023, with an anticipated completion date of June 2023.

Community-Based Care Alternatives for Dental Emergencies

The planning of the above initiatives has brought forth the need for a third initiative, to address the overutilization of emergency department (EDs) for non-traumatic dental conditions. EDs have historically treated patient's complaints of mouth pain with an opioid prescription. Unfortunately, this course of treatment has helped fuel Rhode Island's opioid addiction and overdose crisis. Conversations with community partners and dental professionals have helped the State to identify an alternative system for emergency dental care with follow up community-based care will help prevent opioid addiction, misuse, and overdose.

The State would like to explore using HCBS E-FMAP funds to plan, build, and implement the ED diversion initiative. The funds to support this initiative would be used to: 1) recruit, hire, and train public health dental hygienists (PHDHs) to function as ED dental care coordinators, evaluate patients, provide onsite-care, and make a determination for admission; 2) recruit dentists to be on-call for phone or telehealth consults; and 3) incentivize and facilitate getting patient care the next day by having a community-based system for emergency care, e.g., enhancing health centers' ability to manage emergencies by sharing an oral surgeon across health centers in the state, or providing supplements outside of the Medicaid to participating providers to manage last-minute, after-hours emergencies. We welcome CMS' guidance on if this would be an allowable use of HCBS E-FMAP funding.

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 HCBS 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 or oral surgical treatment (possibly connect with Initiative 3 for a home visit from a PHDH)

This training will be available online. A coordinator will be hired to oversee the development of the training, coordination, and promotion of the 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.

Use of Public Health Dental Hygienists (PHDHs) to Increase Dental Care Access

In tandem, the State will invest enhanced HCBS FMAP to leverage PHDHs to expand access to dental care in low-income senior housing or other HCBS-equivalent setting. This initiative will focus on

recruiting trained PHDHs through the Community College of Rhode Island. The State will work with dental practices through the provision of technical assistance to understand and rectify barriers to creating collaborative agreements with PHDHs (including concerns related to malpractice dental insurance) to facilitate an increase in PHDHs practicing outside of a practice and instead in the community. A collaborative agreement is needed with a dentist for a PHDH to practice and receive reimbursement in Rhode Island. To do this, the State will invest in a shareable resource for portable dental equipment to make it easier for dentists and PHDHs who wish to expand services to priority Medicaid populations with access and functional needs, and provide services to those who are homebound. This type of investment includes a portable x-ray machine, delivery unit with compressor, laptop with capability to host a HIPAA-compliant dental record system and digital radiography, basic limited instruments and supplies—as well as ongoing maintenance.

The benefits to Medicaid members are numerous: i) Initial settings for this pilot will be senior housing, senior centers, and related HCBS-settings, as appropriate, that house a large proportion of Medicaid beneficiaries not receiving oral health and dental services. This initiative is needed, and supports moving away from institutional-based care; ii) Community-based beneficiaries have poor access to dental care as well as low uptake of preventive dental services. These can be homebound individuals and/or those for whom receiving care close to home creates greater opportunities for success. Using PHDHs, dentists can expand services in a novel way to reach these Rhode Islanders without needing to change practice hours, schedules, or obtain additional space; iii) This shared resource opportunity, paired with the benefits of operating outside the clinic walls with a new workforce allows for the prevention of severe oral health disease, unnecessary visits to the emergency department, over-prescription of opioids for pain management, and potential facility-based care. The COVID-19 pandemic has shown us that populations can be reached successfully where they live for preventive health care services.

Sustainability

Sustainability remains key for these initiatives. As such, (1) the Home Health Training will be created through a Dental and Home Health partnership to provide direct care to homebound individuals and is a one-time ask for funding as the training would be recorded and available for continued use. For (2) Enhanced Public Health Hygienist Provision of Community-Based Care, lessons learned from the development of collaborative practice agreements between dentists and public health dental hygienists will be documented and used for as the standard for expanding community-based oral health care moving forward. The future of adult dental care remains a continued priority for EOHHS and Medicaid.

Success Metrics

- Reduced hospital admissions for aspiration pneumonia among older adults
- Virtual trainings hosted for Home Health Professionals and dentist-led academic detailing visits at home health agency partners
- 75% of attendees of the in-person training and those who take the online modules, and their employer is a participant in the Dental Care in Home Health Settings Pilot, 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 January 17, 2023

No funds were encumbered or spent for this project in the past two quarters. We continue to engage with stakeholders to more fully scope these projects and to prepare for implementation. Additional updates will be provided in the FFY Q1 2024 Spending Plan Narrative to be submitted to CMS on July 18, 2023.

Proposed Intervention & Theory of Change

Streamline HCBS Eligibility – Expedite Access and Optimize Workflow

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

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

1. Complete a comprehensive analysis of the existing workflow process – this process will include stakeholders, staff and all associated third parties.
2. Develop and implement eligibility system design changes to expedited LTSS eligibility and update dual channel interfaces to improve communications between systems. 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

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.

Additional updates will be provided in the FFY Q1 2024 Spending Plan Narrative to be submitted to CMS on July 18, 2023.