

## **Key Provisions of Second Article 17** (H-7390)

The following provides an overview of the Governor's proposed budget article that would make significant changes to Rhode Island's Medicaid program.

### **1. Authorizes the Executive Office of Health and Human Services (EOHHS), along with the RI Department of Human Services (DHS), to apply for an 1115a global demonstration waiver.**

EOHHS, with DHS, is authorized to apply for an 1115a global demonstration waiver that provides program flexibility in exchange for federal budgetary certainty and under which RI will operate all facets of the state's Medicaid program except as may be explicitly exempted under public or general laws.<sup>1</sup>

There would be a five year agreement to accept an aggregate annual allotment trended forward at an agreed upon rate, with protections to cover medical inflation and projected caseload growth in the event of a national emergency, a significant economic downturn, or such other circumstances that the state and the Centers for Medicare and Medicaid Services (CMS) may mutually deem appropriate

### **2. Allows cost-sharing for children and families at lower incomes and lifts 5% cap on cost-sharing.**

Allows cost-sharing at 133% the Federal Poverty Level (current level is 150% FPL)

Lifts the 5% cap on total cost-sharing and does not set an upper limit.

DHS is authorized to implement cost-sharing by regulation and shall consider co-payments, premium shares or other reasonable means to cost sharing.

Cost-sharing is not required for pregnant women or children under one.

### **3. Redefines "managed care" for children and families to include primary care case management model and makes managed care mandatory for all children**

Managed care is defined as systems that integrate an efficient financing mechanism with quality service delivery; provide a "medical home" to assure appropriate care and deter unnecessary services; and place emphasis on preventive and primary care. For the purposes of Medical Assistance, managed care systems are defined to include a primary care case management model in which ancillary services are provided under the direction of a physician in a practice that meets standards established by the department of human services, including standards pertaining to certification as an "advanced medical home".

---

<sup>1</sup> Waive: state-wideness; comparability of services; amount duration and scope; freedom of choice; retroactive coverage

Allow cost-sharing above 5% of income; establish health savings or power accounts; implement a tiered set of parameters to use as the basis for determining long-term care and setting needs; modify application of certain institutional income and resource rules

Waiver may request authority and funding for expenditures not otherwise included in Section 1903 including: home and community-based services for individuals ineligible for MA and not at immediate risk of institutionalization; compensation for caregiver spouses; services during presumptive eligibility; chore services provided by faith based organizations...

Authorization to establish an interagency assessment and coordination unit to determine level of care, develop service plans and a service budget, make referrals to appropriate settings...

Enrollment in managed care is mandatory for children and parents and for children in substitute care, children receiving Medical Assistance (MA) through an adoption subsidy and children eligible for MA based on disability.

Beneficiaries with third party medical coverage or insurance may be exempt from mandatory managed care.

#### **4. Cost-sharing required for all children**

Cost-sharing is required for beneficiaries with income at or above 133% FPL. DHS implements by regulation and shall consider co-payments, premium shares or other reasonable means.

All children and families receiving MA under Title 40 shall also be subject to co-payments for certain medical services as approved in the waiver.

#### **5. Cost-sharing for Katie Beckett (Section 15)**

Authorizes DHS to apply for a waiver requiring families of children with disabilities eligible through Katie Beckett to “take financial responsibility for a share of the cost of the medical assistance coverage based on the family’s ability to pay”. DHS authorized to establish a sliding scale cost sharing schedule based on a percentage of household income and to require that eligible children or families contribute to the cost of the care by premium sharing, cost sharing, participation in a consumer directed model based upon an individualized service budget or any combination of those methods.

#### **6. Change in benefit package for parents**

DHS may provide health benefits, similar to those available through commercial health plans, to parents or relative caretakers with income above 100% FPL who are not receiving FIP.

#### **7. Consumer directed health care accounts**

DHS is authorized to create consumer directed health care accounts, including but not limited to health opportunity accounts or health savings accounts to increase and encourage personal responsibility, wellness and health decision-making, disease management and to provide tangible incentives for beneficiaries who meet designated wellness initiatives.

#### **8. Mandatory managed care for individuals with disabilities and elders. Authority to redesign the benefit package for these MA recipients.**

Repeals current authorization for DHS to implement voluntary managed care system for people with disabilities (40-8.5-1).

Repeals current authorization for MHRH with the assistance of DHS to develop a system of service delivery through managed care for people with developmental disabilities. (Section 11)

Authorizes DHS to implement mandatory managed care for all individuals with disabilities and the elderly.

Managed care is defined as systems that integrate an efficient financing mechanism with quality service delivery; provide a “medical home” to assure appropriate care and deter unnecessary services; and place emphasis on preventive and primary care. For the purposes of Medical

Assistance, managed care systems are defined to include a primary care case management model in which ancillary services are provided under the direction of a physician in a practice that meets standards established by the department of human services.

Medical assistance recipients with third party medical coverage or insurance may be exempt from mandatory managed care.

The department is authorized to redesign benefit packages for medical assistance beneficiaries subject to appropriate federal approval.

## **9. Competitive value based purchasing**

DHS and/or EOHHS is authorized to obtain waivers to be able to use competitive value based purchasing to maximize the available service options and to promote accountability and transparency in the delivery of services for all Medical Assistance beneficiaries.

## **10. Long-Term Care reform for children, adolescents and adults: 50% of Medicaid Long-Term Care funding to home and community based care on/before December 31, 2012.**

Rebalance spending: DHS is directed to “adopt an affirmative plan of program design and implementation that addresses the goal of allocating a minimum of 50% of Medicaid long term care funding to home and community-based care on/before December 31, 2012”.

Maintain current long term care services during transition: DHS is directed to prioritize investments in home and community-based care and maintain the integrity and financial viability of all current long-term care services while pursuing this goal.

System change for all populations: Delivery of services and supports in less costly and less restrictive community settings will enable children, adolescents and adults to be able to curtail, delay or avoid lengthy stays in residential treatment facilities, juvenile detention centers, psychiatric facilities, and/or intermediate care or skilled nursing facilities.

Tiered set of criteria: DHS is directed to adopt a tiered set of criteria to be used to determine eligibility for services. Such criteria shall be developed in collaboration with the state’s health and human services departments and shall encompass eligibility determinations for services in nursing facilities, hospitals and ICF-MR as well as home and community based alternatives

Common standard of income eligibility for institutional and HCBS: Shall provide a common standard of income eligibility for both institutional and home and community based care.

Stricter admission standards for institutional care: DHS is authorized to adopt criteria for admission to a NF, hospital or ICF-MR that are more stringent than those employed for access to home and community based services. DHS defines the frequency of re-assessment.

Consolidation of all current 1915 waivers: DHS is directed to consolidate all home and community-based services currently provided through 1915 waivers into a single program of home and community-based services that include options for consumer direction and shared living.

Optional services can be limited to available funding: DHS is authorized to promulgate rules permitting certain optional services including but not limited to homemaker services, home modifications, respite and PT evaluations to be offered subject to availability of state-appropriated funding for these purposes.

Rate reform for homemaker, personal care and adult day services: DHS is directed to pursue rate reform:

Prospective base adjustment effective by July 1, 2008 across all department and programs of 10% of the existing standard or average rate, contingent upon a demonstrated increase in state-funded or Medicaid caseload by June 30, 2009.

By Sept. 30, 2008, development of certification standards supporting and defining targeted rate increments to encourage service specialization and scheduling accommodations including but not limited to medication and pain management, wound management, certified Alzheimer's Syndrome treatment and support programs and shift differentials for night and week-end services

By December 31, 2008 development of a proposed rate-setting methodology for home and community-based services to assure coverage of the based cost of service delivery as well as reasonable coverage of changes in cost caused by wage inflations.

Pay for certain non-Medicaid reimbursable expenses: Subject to availability of appropriation of funding, DHS is authorized to pay for non MA-reimbursable expenses necessary to transition residents back to the community.

Nursing Facility payment adjustments: By January 2010, DHS is required to develop a proposal for changes to NF rates to reflect the changes in cost and resident acuity that result from implementation of rebalancing.

**11. Transportation for Seniors and People with Disabilities: Directs DEA to include a passenger cost-sharing program for elderly/disabled transportation.**

**12. Home and Community Services for Elderly**

Adult day services program will be licensed by the Department of Health instead of the Department of Elderly Affairs.

Case management agencies provide care coordination instead of "case management".

Adds "shared living program" to definition section. A privately owned residence in which the family provides for or arranges for the needs of the client so that the client can remain in the community, a program that is designed to respect the unique character of each individual, promotes self-reliance and the freedom to make choices, and fosters dignity, autonomy and personal safety. Services may be provided in-home or a host home residence in which the family provides for or arranges for the needs of the client so that the client can remain in the community including but not limited to lodging and meals. This program is designed to provide the opportunity for the provision of an inter-generational multidisciplinary supports to preserve and strengthen families.

For the state-funded co-payment program services include care coordination, combination of homemaker/personal care services and other support services.

Eligibility: Must be in need of assistance with activities of daily living and/or meet a required level of care as defined by the department. Meet financial guidelines as determined by the department.

Eligibility is subject to annual appropriations.

**13. Anti-psychotics are added to the Preferred Drug List.**

**14. Implementation: The article takes place upon passage and regular rule-making would be required.** Except that DHS is authorized to implement 3 sections by emergency rule-making where no advance input from the public would be required:

Section 3: Cost-sharing for RIte Care/RIte Share families with income above 133% FPL. Cost-sharing can include co-payments, premium shares or other "reasonable means". The cap of 5% on cost-sharing is lifted.

Section 6: This section authorizes: mandatory managed care for elderly and individuals with disabilities; allows DHS to "redesign benefit packages for medical assistance beneficiaries subject to appropriate federal approval"; allows data sharing agreements with the Social Security Administration for people who become eligible for MA based on receipt of SSI or SSDI benefits; directs DHS to implement competitive value based purchasing.

Section 14: This section requires DHS to add antipsychotics to the preferred drug list.