

**STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES**

**7/10/2019 PUBLIC NOTICE OF PROPOSED CHANGE TO
RHODE ISLAND'S COMPREHENSIVE 1115 WAIVER DEMONSTRATION**

In accordance Rhode Island General Laws 42-35, notice is hereby given that the Executive Office of Health and Human Services (EOHHS) will seek federal authority to implement the following changes to Rhode Island's Comprehensive 1115 Waiver Demonstration (project no. 11-W-00242/1):

Independent Provider Program Rates

The FY 2019 Appropriations Act, enacted in July 2018, directed EOHHS to establish a new Self-Directed program, known as the Independent Provider (IP) model, to provide individuals with disabilities who are over the age of eighteen (18) or elders aged sixty-five (65) or over, and who meet either a high or highest level of care, the option to self-direct their Personal Care and Homemaker services. The IP program will allow consumers to hire and manage caregivers of their choice, while EOHHS manages certain aspects of the program, such as setting wages, qualification standards, and authorized service hours. As part of the establishment of this program, EOHHS is submitting a rate for Personal Care Aids (PCAs), and a monthly rate for Fiscal Intermediary and Service Advisory Agency services to the Centers for Medicare and Medicaid (CMS) for review and approval. The proposed rates for the IP program are as follows:

- Personal Care Aid Services: T1019; \$3.83 per 15 minute unit
- Fiscal Intermediary: \$170.00 per member per month
- Service Advisory Agency: \$125.00 per member per month

This proposed amendment is accessible on the EOHHS website (www.eohhs.ri.gov) or available in hard copy upon request (401-462-6348 or RI Relay, dial 711). Interested persons should submit data, views, or written comments by August 12, 2019 to Maria Petrillo, Executive Office of Health and Human Services, 3 West Rd, Cranston, RI, 02920, or maria.petrillo@ohhs.ri.gov.

Notice is hereby given in accordance with the provisions of Chapter 42-35 of the Rhode Island General Laws, as amended, that the Secretary will hold two (2) Public Hearings on the above-mentioned matter, at which time and place all persons interested therein will be heard. Public Hearings will be held on:

Public Hearing #1	Public Hearing #2
Wednesday July 24 th , 2019 1:00-2:00 pm 2 nd Fl Conf Rm 301 Metro Centre Blvd Warwick, RI 02886	Wednesday August 7 th , 2019 4:15-5:15 pm Woonsocket Public Library 303 Clinton Street Woonsocket, RI 02895

The Executive Office of Health and Human Services does not discriminate against individuals based on race, color, national origin, sex, gender identity or expression, sexual orientation, religious belief, political belief, or handicap in acceptance for or provision of services or employment in its programs or activities.

**Rhode Island Comprehensive Section 1115 Demonstration
Project Number: 11-W-00242/1**

Waiver Amendment

Change Name: Independent Provider Program Rates

Change Number: 19-01

Date of Request	August 12, 2019
Proposed Implementation Date:	October 1, 2019

Fiscal Impact:

	FFY 2019	FFY 2020
State:	\$ 0	\$ 0
Federal:	\$ 0	\$ 0
Total:	\$ 0	\$ 0

Description of Change:

Attachment A

Assurances:

Attachment B

Standard funding questions:

Attachment C

Attachment A: Description of Change

Overview

The FY 2019 Appropriations Act, enacted in July 2018, directed EOHHS to establish a new Self-Directed program, known as the Independent Provider (IP) model. The IP program is a self-directed pathway available to all adult LTSS consumers choosing services in an at-home setting who are seeking to self-direct only nonmedical personal care and homemaker services. The IP program is available to individuals with disabilities who are over the age of eighteen (18) or elders aged sixty-five (65) or over who meet either a high or highest level of care. The LTSS consumer has the flexibility to select a Personal Care Aid (PCA) of their choice and self-direct the schedule and way the IP authorized services are provided by the PCA.

As part of the establishment of this program, EOHHS is submitting a rate for Personal Care Aids, and a monthly rate for Fiscal Intermediary and Service Advisory Agency services to the Centers for Medicare and Medicaid for review and approval.

The direct services of the PCA will be billed on a 15-minute unit basis under the T1019 code at \$3.83 per unit.

EOHHS will pay the Fiscal Intermediary on a per member per month basis to manage hiring and payroll for the Personal Care Aids who participate in the IP program. The Fiscal Intermediary rate will be set to \$170.00 per member per month: equivalent to the \$125 paid for operating Personal Choice with an additional load included for the actual cost of Worker's Compensation incurred by the Fiscal Intermediary.

EOHHS will pay the Service Advisory Agency on a per member per month basis to assess service needs, assist consumers with planning needed services, and to act as an additional resource to the consumer, representative, and/or family to promote safety and quality of care. The Service Advisory Agency rate will be set at \$125.00 per member per month equivalent to the rate paid for Service Advisory in Personal Choice.

Attachment B: Assurances

The State assures the following:

- This change is consistent with the protections to health and welfare as appropriate to Title XIX of the Social Security Act (the Act)
- The change results in appropriate, efficient, and effective operation of the program, including Justification and Response to Funding Questions
- This change would be permissible as a State Plan or Section 1915 Waiver Amendment and is otherwise consistent with sections 1902, 1903, 1905, and 1906, current federal regulations, and CMS policy

Attachment C: Standard Funding Questions

1. Section 1903(a)(I) provides that Federal matching funds are available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local government entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of the providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

Providers receive and retain the total Medicaid expenditures claimed by the State. No portion of the payments is returned to the State, local governmental entity, or any other intermediary organization

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation were not used by the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditures and State share amounts for each Medicaid payment. If any of the nonfederal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify the total expenditures being certified are eligible for Federal matching funds in accordance with 42CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:
 - (i) A complete list of the names of entities transferring or certifying funds;
 - (ii) the operational nature of the entity (state, county, city, other);
 - (iii) the total amounts transferred or certified by each entity;
 - (iv) clarify whether the certifying or transferring entity has general taxing authority: and ,
 - (v) whether the certifying or transferring entity received appropriations (identify level of appropriations.)

The state share is funded through general revenue funds appropriated by the legislature for this purpose. Revenue generated from the state's hospital license fee

is deposited directly into the state's General Revenue Fund. Other revenue sources—such as income tax, sales tax, corporate tax, and lottery receipts—are likewise deposited directly into the General Revenue Fund. When the legislature appropriates monies from this fund, it does not identify the source that brought that money to the state. As a result, it is not possible to identify the specific revenue source used to fund the state's share of Medicaid payments beyond the General Revenue Fund.

3. Section 1902(a) (30) requires that the payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

N/A

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

N/A

5. Does the governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable cost of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

No governmental providers receive payments that, in the aggregate, exceed their reasonable costs of providing services.