Volume I: Narrative

MONEY FOLLOWS THE PERSON

OPERATIONAL PROTOCOL

FOR THE

RHODE ISLAND

THE RHODE TO HOME DEMONSTRATION PROJECT

Submitted to: Department of Health and Human Services,

Centers for Medicare and Medicaid Services (CMS)

September 2011 Final

- *May 28, 2014: Revised Operational Protocol, to include MLTSS, waiting CMS final approval. Final "revised"Operation Protocol will be posted on line: http://www.eohhs.ri.gov/RhodetoHome.aspx*

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PROJECT ABSTRACT

The Rhode Island ***Rhode to Home*** Money Follows the Person (MFP) demonstration will provide the State with an additional opportunity to achieve its goal of rebalancing its long-term care system. Rhode Island will transition eligible individuals who are in a qualified institutional setting for 90 days or more into a qualified community-based residence. Specifically, the *Rhode to Home* MFP demonstration will transition the target populations in two phases. Phase I will include transitioning elders and persons with disabilities in nursing home care. At the end of the demonstration period in CY 2016, a total of 640 Phase I Medicaid beneficiaries will be transitioned into the community. The total budget for the Phase I target population through CY 2016 is $30.9 million. Phase II will include: adults with disabilities from acute and long-term acute care facilities (LTAC); adult patients with medical and behavioral health conditions from the Eleanor Slater Hospital and; children and youth in psychiatric hospitals and in state and out-of state Institutions of Mental Diseases (IMDs).

The demonstration will use a coordinated system of care to assist a participant transition into and to successfully remain in the community, with the appropriate supports, so that they can experience more independence and a better quality of life. Participation in the demonstration will be strictly voluntary and participants will receive information about long-term care options so that they can make an informed decision. The *Rhode to Home* is designed as a person-centered system, where the participant and his/her family/guardian are involved in all stages of the assessment, plan development and care delivery processes. Every measure will be taken to ensure the health, safety, welfare, and well being of participants in the program.

OPERATIONAL PROTOCOL OVERVIEW

Over the past decade, Rhode Island (RI) has made significant strides in enhancing the availability of Home and Community Based Services (HCBS) for Rhode Island residents. The RI Global Consumer Choice Waiver (Global Waiver) approved by the federal Department of Health and Human Services, Centers for Medicare and Medicaid and Services (CMS), provides flexibility to transform the State's Medicaid program and the long-term care (LTC) system. The Money Follows the Person (MFP) grant will help the State meet one of the primary goals of the Global Waiver which is to rebalance State expenditures from institutional settings to a home and community based setting.

The Rhode Island MFP demonstration project entitled ***Rhode to Home*** is consistent with the CMS goal of creating a balanced Long-Term Care (LTC) system in which people with chronic conditions and disabilities have choice, control and access to a full array of quality services to improve health outcomes, independence and a high quality of life.

The MFP demonstration enables the State to provide the necessary HCBS resources to promote the transition of eligible individuals who have been in qualified inpatient facilities for at least 90 days into qualified residences. Community settings are more often preferred by Rhode Islanders and are less costly than institutional placements. The savings realized from transitioning individuals from an institutional to a community-based setting will be "reinvested" into the State's LTC system.

The *Rhode to Home* demonstration will transition target populations in two phases. Phase I will include transitioning elders and individuals with disabilities in nursing home care. This Operational Protocol only applies to Phase I of the demonstration. The state recognizes that the CMS approval received in July 2011 applies only to the Phase I population. Phase II will

include transitioning the following populations: adults with disabilities from acute and long-term acute care facilities (LTAC); adult patients with medical and behavioral health conditions from the Eleanor Slater Hospital; and children and youth in psychiatric hospitals and in-state and out-of-state Institutions of Mental Disease (IMDs). This Operational Protocol (OP) describes the implementation policies and procedures for the targeted Phase I populations. Please note that Rhode Island's planning for MFP has focused initially on the Phase I populations. The State remains keenly interested in MFP for the Phase II populations. In particular, preliminary work on MFP for children and youth in psychiatric hospitals and in-state and out-of-state IMDs, though not integrated in the budget text, is included in Appendix K of this submission. If there is favorable review of RI's proposal, the State would respectfully request the opportunity to submit a material modification based on a more fully developed and approved Operational Protocol for Phase II populations.

Specifically, the RI demonstration will address the key elements cited by CMS to achieve a balanced system that are discussed throughout this document and highlighted below:

- **A Trusted, Visible, and Reliable System for Accessing Care:** The RI demonstration will build on the existing capacity of the Aging and Disability Resources Center (ADRC), called the POINT, to provide access to information and assistance that supports consumer choice. In addition, the State plans to implement an aggressive campaign directed to all stakeholders to promote the demonstration and to educate all Medicaid beneficiaries about LTC options.
- **Standardized Assessment Tool:** the RI Department of Humana Services (DHS) currently uses a standardized tool to evaluate a beneficiary's needs. The tool has been expanded to include key MFP elements such as risk assessment. The comprehensive

medical, social service and risk assessments will be conducted by the MFP project Transition Nurses. An on-site housing assessment will be conducted to ensure that the transitioning residence meets CMS's qualified definition and to ensure that the residence is safe and meets the participants' needs.

- **Available and Accessible Support Services:** The RI demonstration contains a significant array of formal and informal support services for participants and caregivers. The demonstration will enable the State to provide robust transition service benefits, respite care, and non-medical transportation. The MFP demonstration includes a structured system to link participants with, and coordinate care for; health and social services, meals on wheels, food assistance programs, recreational and cultural events, support group activities, and other available community resources that enhance the lives of participants and promotes a sense of community
- **Community Workforce:** DHS will continue its efforts to develop enhanced reimbursement that promote the use of community-based services as well as increase the community workforce, where appropriate. DHS has developed a modified acuity-based reimbursement system for selected HCBS services.
- **Self-Directed Services:** RI offers HCBS with a self-directed option for people with disabilities, elders, and families of Children with Special Health Care Needs. The self-directed option will be extended to all MFP participants who would like and are capable of managing their own care and services, with the proper assistance.
- **Transition Coordinator:** The *Rhode to Home* demonstration will have Transition Coordinators assist elders transition to a community setting and provide care management throughout the demonstration period so that they may successfully remain

in the community. A Peer Mentor will assist people with disabilities transition to a community setting and provide care management throughout the demonstration period and thereafter, if required by the Medicaid beneficiary to successfully remain in the community.

- **Quality Management:** The RI MFP demonstration will operate under the same Quality Assurance Standards of the Global Waiver for HCBS. The demonstration will implement and monitor the effectiveness of: the 24-hour back-up system, risk assessment and mitigation process, and the incident management system. The Transition Coordinator and Peer Mentor will be in constant communication with participants regularly to identify problems and provider agencies will be required to report critical incidences. The MFP Program/Quality Specialist will collect all information, analyze the causes of the problem, and develop improvement strategies, when required.
- **Health Information Technology (HIT):** Several initiatives are identified in the administrative budget to improve the collection, processing, analysis and reporting of information. HIT is critical to the Medicaid program and MFP demonstration.
- **Interagency and Public Collaboration:** The Medicaid Program was in the Department of Human Services (DHS), and DHS is administratively under the jurisdiction of the Executive Offices of Health and Human Services (EOHHS). As of July 1, 2011, the Medicaid program was made a separate unit within EOHHS and is no longer a part of DHS. EOHHS is the umbrella agency responsible for the planning and coordination of services and care to multiple populations covered by the MFP demonstration (e.g. adults and youth with behavioral health/mental illnesses and developmental disabilities). The policy-makers and staff of EOHHS departments consistently work together to improve

services that cut across different population groups. In addition, the demonstration will implement a robust and multi-dimensional approach to ensure that stakeholders are involved in the planning, implementation, and operation of the *Rhode to Home* demonstration.

- **Access to Affordable Housing:** To facilitate the availability of accessible and affordable housing, the RI demonstration will establish a full-time Housing Coordinator position. The Housing Coordinator will identify existing affordable housing opportunities and work with companies to build and renovate housing.

The RI grant application is based on the following service delivery model and processes:

- Provide Community Outreach and Education
- Identify the Target Population
- Conduct a Comprehensive Assessment
- Develop a Care Plan
- Arrange for Housing and LTC Services and Make Referrals
- Provide Oversight and Monitoring of Care and Services
- Implement Metrics that Evaluate the Effectiveness and Cost of Care

The following Exhibit highlights the major steps in the *Rhodes to Home* programmatic process for the Phase I populations.

Rhode to Home **Phase I Programmatic Process**

- **Provide Community Outreach & Education**
  - Stakeholders and Advisory Committee Members
  - Consumer & Provider Focus Groups
  - Multi-media campaign
  - Educational materials
  - ADRC *"The Point"*
  - Public Service Announcements
  - Outreach/Marketing/Education Staff Specialist
  - Assessment Nurses
  - Transition Coordinators & Peer Mentor/Coaches
- **Identify the Target Populations**
  - Analysis of MMIS claims data
  - Use of MDS Section "Q"
  - DHS nursing home transition staff
  - Referrals from patients, family, and providers
  - DHS Long Term Care Field Staff
  - DEA Home and Community Care staff
- **Conduct a Comprehensive Assessment**

  Assessment Test
  - Registered Nurses from DHS Transition Program
  - Clinical Social Worker from DHS Transition Program
  - Patient/ Family
  - Other involved medical providers and therapists

  Process
  - Determine desire to participate in MFP
  - Explain MFP and options
  - Conduct a risk assessment
  - Assess housing and shelter environment
  - Assess care giver and support system
  - Assess medical and behavioral health status including: clinical history, ADLs, complex medical and chronic conditions, medical equipment needs and medications
  - Use standard assessment tool
- **Develop A Care Plan**
  - MFP Team includes: nurse, transition coordinator/peer mentor, providers (e.g. physicians, therapists, facility nurses, other involved in the case), and the patient/family/care giver
  - Develop goals and objectives
  - Indicate level, scope, intensity and duration of services
  - Indicate providers to meet medical, behavioral health, other clinical and medical equipment needs, human/social service needs, shelter and housing modification needs, and other needs required to remain in the community.
  - Determine disease and self-management programs needs
  - Determine responsibility for referral and follow-up among MFP Team
  - Develop a mitigation plan based on risk assessment
  - Develop a 24 hour back-up plan
- **Arrange for Housing and LTC Services and Make Referrals**
  - Arrange for and/or refer for medical care and treatment by Transition team nurses
  - Assist elderly members arrange for non-medical human service needs by Transition Coordinators
  - Assist disabled individuals arrange for non-medical transition services by Peer Mentor
  - Assist participants and/or arrange for special transition services
  - Conduct "readiness review" of housing and support services
  - Conduct an initial home visit
- **Provide Oversight and Monitoring of Care and Services**
  - Follow-up with participants or with community providers about the provision of transition services, including monthly home visits (Transition Nurses, Transition Coordinators, Peer Mentor)
  - Provide support and coaching through the demonstration period (Transition Coordinators and Peer Mentor)
  - Monitor planned versus actual service provision of Qualified HBCS, Demonstration and Supplemental services (Transition Coordinators and Peer Mentor)
  - Revise and monitor effectiveness of 24 hour back-up plan once transitioned in the community
  - Identify, respond to and report critical incidences of abuse, neglect, exploitation, or other critical occurrences such as hospitalizations or deaths
  - Arrange for/refer for new required services
  - Provide training, mentoring and coaching to promote self-management
  - Revise care plan, if necessary
- **Implement Metrics to Evaluate Effectiveness and Costs of Care**
  - Establish performance measures
  - Establish documentation standards
  - Monitor care and member results continuously and determine outcome on members
  - Determine cost of member care
  - Provide member data to monitor program performance, assess program impact, and evaluate cost-effectiveness

The following describes our Draft Operational Protocol for the MFP grant that follows the requirements presented in the CMS grant announcement.

A. PROJECT INTRODUCTION

The Rhode Island Medicaid program has expanded over the years beyond the role of being a safety net to becoming a principal source of health care coverage and services, having served approximately one-third of the State's population within the last five years. It is now an integral part of the State's health care delivery system, serving over 176,000 individuals last year, at a cost of approximately $1.7 billion dollars. Medicaid expenditures make up approximately 25 percent of the State's budget.

When Medicaid began in the mid-1960s, the RI Medicaid program was modeled as a traditional indemnity fee-for-service (FFS) health insurance program. Though out the years, the State has implemented special programs to better manage the quality and cost of care. The State's initial Medicaid managed care program RIte Care, began in 1994, with the Aid to Families with Dependent Children (AFDC), now the Temporary Assistance to Needy Families (TANF) program, and has expanded over the years to cover other special related populations including pregnant women and children with special health care needs. Today, all Medicaid eligible children and families without other third-party coverage are required to enroll in a Managed Care Organization (MCO). In the past, Rhode Island's adult aged, blind and disabled (ABD) populations were provided services through the Medicaid fee-for-service (FFS) system. Today, all Medicaid eligible adults without third-party coverage in the ABD program are required to either enroll in a MCO through our Rhody Health Partners program, or in the State's FFS Primary Care Case Management (PCCM) model, the Connect Care Choice (CCC) program. The CCC program offers extensive care management services for adults who have multiple and complex medical and behavioral health conditions.

In recent years, the State has been confronted with difficult choices about how to contain Medicaid costs, while preserving health care coverage and medical services for its residents. RI implemented an innovative approach that shifts the focus, financing and operation of the State's Medicaid program. In 2008, the RI Medicaid Reform Act directed the State to apply for a global demonstration project under the authority of Section 1115(a) of Title XIX of the Social Security Act. The goal of the State legislation is to restructure the State's Medicaid program to establish a sustainable cost-effective, person-centered and opportunity driven program utilizing competitive and value-based purchasing to maximize available service options" and a "results-oriented" coordinated care system. Under the leadership of EOHHS, RI developed and CMS approved the waiver in January 2009.

The overriding purpose of the Global Waiver is to provide RI with the flexibility to get the right services, to the right people, at the right time and in the right setting. The Waiver contains three fundamental goals: (1) rebalance RI's long-term care system, (2) integrate care management and provide a medical home to all Medicaid population groups, and (3) complete the transition from a payer to a purchaser of care. The MFP demonstration provides RI with the opportunity to ensure that we meet a primary goal of the Global Waiver and rebalance the long-term care delivery system by focusing on transitioning institutional populations into a community-based setting.

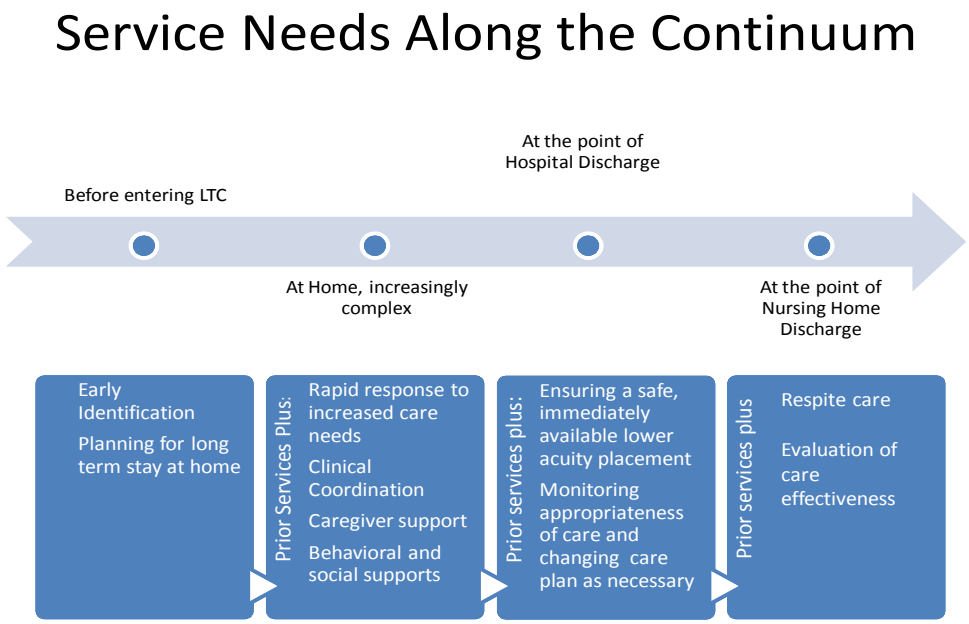
The Global Waiver establishes a new State-Federal agreement that provides RI with substantially greater flexibility than was available under existing program guidelines. RI is using the additional flexibility to redesign the Medicaid program to provide more cost-effective services and care, in the least restrictive and most appropriate setting possible.

The State now operates the Medicaid program under this single Global Waiver compact based on an aggregate budget ceiling for Federal reimbursement, with the exception of disproportionate share hospital payments, administrative expenses, phased Part-D contributions, and payments to local education agencies.

The goals of the RI Global Waiver align with the intended outcome of the MFP Demonstration project. They both focus on providing supports and services that an individual needs to live successfully in the community for extended periods of time. Both programs seek to deliver care in non-institutional settings, and to offer beneficiaries an increased opportunity for self-management. Finally, both seek more cost-effective uses of state and federal resources through care delivery in the right setting at the right time.

In November 2010, RI issued a Request for Information (RFI) that solicited guidance from stakeholders, providers, community organizations and consumers about emerging program strategies that have the potential to prevent or defer nursing home care through increased use of community-based services. DHS anticipates that responses to the RFI will offer additional insight into effective strategies for extending duration of community-based residency.

DHS has identified the needs of the long-term care populations along a continuum of care and the associated opportunities to provide less costly and intensive services in lieu of institutional care. These needs were grouped for discussion purposes into the following points: (1) Initial Access to Care; (2) Increasingly in Need of Care While Living at Home; (3) At Hospital Discharge; and (4) at Nursing Home Discharge. DHS identified particular needs for Medicaid beneficiaries, noting that the needs identified at one point is likely to include those needed at the earlier points.



At Points 1 and 2, individuals may become eligible for Medicaid services at some point in the future. At Point 3, individuals may be Medicare beneficiaries when admitted to the hospital, but not yet Medicaid eligible. When a patient is ready for discharge from an inpatient stay, discharge planners find a safe, immediately available placement. Many patients need a rehabilitation stay in a nursing home. By the time a patient reaches Point 4: Nursing Home Discharge, previous living and caregiver arrangements may no longer be in place. Support for patients transitioning back to the home include ensuring that all elements of the Care Plan are in place and that services are adequate to meet the patient's needs. The RFI describes the specific elements of a care coordination capability to support extended community-based residency. They include:

- Ability to resolve problems or eliminate barriers to successful community based cares
- Periodic "customer service" check-ins after the transition timeframe ends

- Assistance with accessing services that do not require authorization (Adult Day, meal delivery, transportation)
- Links among clinical caregivers, including primary care and therapists, and home care providers
- Reporting of any service delivery problems to State LTC staff

Care coordination services represent an opportunity to ensure that Medicaid beneficiaries, both the elderly and persons with disabilities, have similar access to home-based care and related support services. The State expects that the responses to the RFI will provide invaluable information to use in developing initiatives and programs that meet the needs of elders and individual's with disabilities. Suggestions from the RFI process will be incorporated into the MFP demonstration.

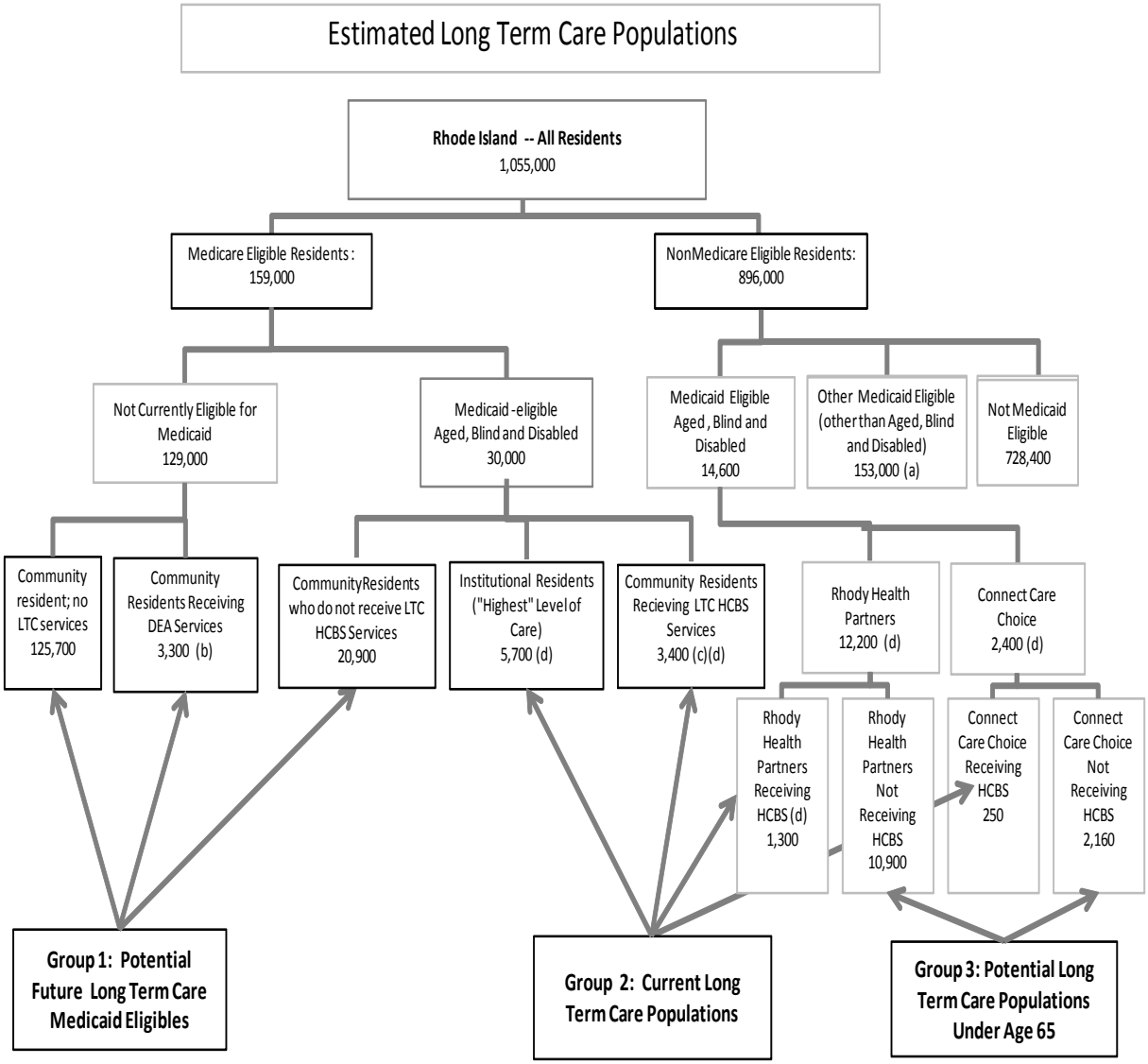
1. Organization and Administration

Overview of Need

While Rhode Island is the smallest state in the country from a geographic perspective, it is the second most urban state, exceeded only by New Jersey. RI has over one million residents, with over 1,000 individuals per square mile. With 14 percent of its population 65 years old or over, it has the fifteenth largest proportion of elder residents in the nation. The current elder population is expected to increase by 21 percent from the current 157,000 to 247,000 individuals by 2030.

Medicare and Medicaid provide essential medical resources for Rhode Islanders. Over 159,000 individuals are eligible for Medicare services, including 30,000 who are dual eligible. The Exhibit following this page provides a picture of individuals requiring long-term care.

In State Fiscal Year (SFY) 2010, Medicaid long-term care expenditures for Phase I populations were $395 million. Institutional care expenditures were $344.7 million or 84.7 percent and HCBS were $60.3 million or 15.3 percent. In addition, the Department of Elderly Affairs provided services to individuals who were not eligible for Medicaid at a cost of approximately $11.5 million.



Notes

All numbers are estimates. Numbers less than 1,000 are rounded to the nearest 10; numbers greater than 1,000 are rounded to the nearest 100.
Numbers are estimates of the average number of people per day in each group.
State Total Population and Medicare data source: Kaiser State Health Facts listing data for 2007-2008
DHS and DEA data represents averages for SFY 2010.
HCBS: Home and Community Based Services.
(a) includes Children and Families (Rite Care/Rite Share) and partial eligibility categories.
(b) includes DEA Community Waiver,Co-Pay populations ("CNOM") and Assisted Living.
(c) Includes PACE (average 180 individuals).
(d) includes MR/DD community residents (average of 3500 individuals across all programs)

RI has a significantly higher use of nursing homes than the national average, with 56 nursing home residents per 1,000 individuals, as compared to 38 nursing home residents per 1,000 individuals nationally. RI ranked fourth in the nation in the proportion of overall population that spent ninety days or more in a nursing home. In addition, RI nursing home residents are less impaired and have a lower severity of need than the national average. Nursing facility residents in the RUG Group "Reduced Physical Function" comprised 42% (2,378 individuals) of the September 2009 nursing facility census. This average score for the individuals in the "Reduced Physical Function" category was .74. As a group, the 5667 nursing facility residents in September 2009 had an average RUG score of .99. A higher acuity number indicates a need for more nursing time.

The high use of nursing homes, longer stays and the lower acuity levels of need provides RI with a significant opportunity to provide long-term services in a community-based setting, which is less costly and often more desirable to consumers. The MFP demonstration will enable the State to focus its resources on transitioning those residents who have been in an institutional setting for more than 90 days.

Access to and the availability of long-term care services and supports is a critical issue in Rhode Island. Long-term care services are particularly critical for the frail elderly, children and youth who are involved in the child protective and criminal justice systems, and adults with disabilities, including developmental disabilities. All too often, these individuals are served in an institutional rather than in a community-based setting. RI has been committed to and working on improving availability of options for those requiring long-term care for a number of years now. Some of the most salient initiatives include:

- The creation of a Governor's Cabinet on Chronic and Long Term Care. In 2004, the Acting Director of the Center for Gerontology and Health Research at Brown University conducted a special study entitled *A Vision for the Present and Future: Rethinking Chronic and Long Term Care in RI.*
- In 2006, the RI Department of Human Services, pursuant to a joint resolution of the RI General Assembly commissioned the University of Maryland, Baltimore County, to conduct a study about existing efforts and recommendations to improve the delivery of community-based LTC services in the State.
- The Long-Term Care Service and Finance Reform Act (Perry/Sullivan) legislation included: provisions for nursing home savings reinvested in home and community-based services, uniform long term care provider cost reports, improved information and referral, streamlined identification and assessments, and increases for specific home and community-based providers.
- In 2006, RI was awarded the Real Choice System Transformation Grant to improve information and referral, a Long-Term Care Services and Supports Quality Management System and Finance and Payment reforms.
- In January 2009, the Global Consumer Choice 1115 Demonstration Waiver was approved by CMS. One of the main goals to rebalance LTC State expenditures from institutional settings to home and community based settings.
- The Medical Assistance Reform Act passed by the General Assembly in June 2009, provided the Legislative authority to implement the Global Waiver and provided for a cross-section of stakeholders to be convened on a monthly basis to provide input on the implementation of the provisions of the Global Waiver changes.

- Former Governor Carcieri's State-of-the-State address, stressed the need to rethink RIs long-term care system and committed to providing residents with options to meet their needs and preferences
- Affordable Care Act (ACA) of 2010 provides additional opportunities to rebalance the Long-Term Care delivery system in RI.
- Lt. Governor Elizabeth Robert's lead a larger Task Force group made up of diverse stakeholders to make recommendations for the implementation of the opportunities created under the ACA. The Healthy RI Task Force recommended that the long-term care stakeholder activities be convened under the auspices of Lt. Governors' Long-Term Care Coordinating Counsel.

Over the past several years, the State has convened on-going workgroups with stakeholders who have worked diligently to develop consensus recommendations for reform. The following describes our LTC system and efforts to rebalance LTC resources.

Gaps in the Long Term Care System and How MFP Will Address the Gaps

Like many states, Rhode Island (RI) has an over-reliance on institutional care. Under the Global Waiver, RI has made a number of systems reform improvements to rebalance the delivery of long term care services from the institutional setting to a home and community based setting. RI has developed and implemented a standardized long-term care assessment tool and created level of care criteria for long-term care services. In addition, RI has implemented a Nursing Home Transition Program to assist an individual to transition from a nursing facility to the community. The cross department planning and implementation for these initiatives has included development of options counseling materials in print and in web-based medium, hiring of new state staff, training of staff, training of discharge planners, training of stakeholders and

implementation of system modifications. To compliment the rebalancing long term care initiatives, RI is implementing a multi payer Advanced Primary Care Practice demonstration, the Chronic Care Sustainability Initiative (CSI) and patient centered medical home initiatives. These efforts to strengthen primary care and the medical home concept will provide a strong medical safety net for individuals as they transition into the community. We believe the initiatives underway will continue to position RI to achieve the goal of 50/50 balance. The *Rhode to Home* demonstration will provide the opportunity to RI residents that are in a qualified setting for 90 days or more to transition to a "qualified" community based setting. It is envisioned that these individuals would require more intensive transition services to ensure a successful community placement. The MFP demonstration offers RI the opportunity to advance the necessary supports to facilitate a person-centered transition and to ensure successful transition is achieved and maintained. The Quality of Life survey process will garner valuable participant experience and offer insight to program design modifications or improvements.

In February 2011, legislation was introduced to change the payment methodology for Nursing Facilities. The proposal seeks to eliminate the cost basis principles of reimbursement and replace it with a base payment structure that reimburses Nursing Facilities appropriately based on the needs of the Medicaid beneficiary. Additional acuity payment adjustments would be factored into the payment methodology. The state also has proposed a selective contracting initiative for Home Health services. The selective contracting initiative would leverage purchasing strategies with performance outcomes and quality oversight and monitoring. It is anticipated that these rebalancing initiatives would be implemented in State Fiscal Year 2012.

The State has approved legislation for Adult Supportive Care that would allow Assisted Living Facilities to serve new residents with short-term skilled needs, such as medication teaching or monitoring a medical condition. The RI Department of Health has not yet promulgated the rules for Adult Supportive Care. Currently, Assisted Living Facilities are not allowed to serve beneficiaries with these short-term skilled needs. The State may consider future strategies such as Nursing Facility bed reductions/buy back opportunities.

The *Rhode to Home* demonstration will enable RI to fund both Transitional Services and Respite services, which were not provided heretofore because of a lack of funds. The State is currently authorized to provide these services under the Global Waiver. Transition Coordinators will be introduced to provide the intensive case management services required by elders during the demonstration period when the participants needs are greatest to ensure that participants have access to a comprehensive array of home and community based services and support so that they successfully remain in the community. Peer Mentoring Services will also be introduced to provide the necessary case management and supports required by the disabled population during the demonstration period and thereafter, if necessary. The Peer Mentor will be a person with disabilities who successfully lives in a community-based setting.

A barrier to transitioning individuals into the community is adequate and affordable housing resource. The *Rhode to Home* proposal includes a full-time Housing Coordinator position solely dedicated to the MFP project. The Housing Coordinator will have overall responsibility to assure there is accessible, suitable, and affordable safe housing to meet the needs of transitioning MFP participants. Specifically, the Housing Coordinator will have two major areas of responsibility: (1) to work with and serve as the project liaison to federal, state and local housing organizations to identify opportunities within established programs that

facilitate access to affordable housing, and (2) to work with housing developers and builders to tell them about federal, state and local opportunities and financial assistance for building and or renovating housing to meet the needs of the MFP population. The efforts of the Housing Coordinator will enable MFP staff to work with MFP participants to identify and secure available and affordable housing that meets their transition needs.

Over the past eighteen-months, RI has successfully transitioned 216 individuals under the Nursing Home Transition program. The individuals transitioned had established "roots" in the community, which helped to facilitate the ability to achieve the successful transitions. As envisioned under the *Rhode to Home* demonstration, the target population will require a higher level of coordination of the services and supports necessary to ensure a successful transition. Since July 2010, DHS has received 309 referrals for information related to transitioning to the community.

Part # 1: System Assessment and Gap Analysis

Description of LTC System and Legislative/Regulatory Initiatives

Like most states, the primary source of long-term care funding is provided through the State Medicaid program. Throughout the years, RI has taken advantage of opportunities to rebalance the LTC system by using alternative methods for determining eligibility and in providing a comprehensive array of Section 1915 (c) home and community based services including: assisted living services, homemaker, personal care assistance services, environmental modification services, home delivered meals, home skilled nursing services, adult day services, shared living services and self-directed services. These services and others are more fully discussed in the Benefit and Services Section of this Operational Protocol (OP).

The Long-Term Care system in RI consists of 93 nursing homes, 48 home nursing care agencies, 7 home care agencies, 15 adult day care centers and 59 assisted living facilities, operating in different locations throughout the State. In addition, RI has a PACE program administered by CareLink, which is a not-for-profit network of long-term care providers. The PACE program provides a comprehensive array of services for elders throughout the State.

RI has also funded a number of long-term care initiatives with State-only funds under the direction of the Department of Elderly Affairs (DEA): $3.6 million for the Co-Pay Program for home care, homemaker services and adult day care services; over $600,000 for respite care; and $750,000 for individual adult day centers and assistive technology and personal care for adults with disabilities, all administered through the DEA. In addition, the State funded a $600,000 annual grant to the Visiting Nurse Association through the DHS. The federal Administration on Aging (AoA) has designated DEA as the Area Agency on Aging (AAA) in RI. AoA under the

Older Americans Act is a significant source of funding for long-term care services for elder RI residents. These funds support senior nutrition programs; protective services; the Long-Term Care Ombudsman; and information, referral and assistance activities through the Aging and Disability Resource Center (The POINT). The POINT is often the first place beneficiaries and their families call for information about the publicly funded long-term care system. The POINT maintains a call-in center that provides information about how to contact local service providers such as home care providers, meals on wheels and transportation, as well as a walk-in center for those who need assistance with application completion and other services. The POINT's website (http://adrc.ohhs.ri.gov/) offers a wide range of links to other State and federal programs such as home heating subsidies, food stamps and senior center locations, as well as information on accessible arts, recreation and other cultural opportunities. THE POINT is available during business hours and callers have access to a "live" benefits specialist. The *Rhode to Home* MFP demonstration will build on the POINT's capacity to serve the MFP demonstration.

Assessment of Medicaid Program and Services

In recent years, the State has implemented a variety of initiatives across population groups to rebalance the long-term care system designed to:

- **Reduce reliance on institutional based care** through the Real Choices Systems Transformation grants; restructured HCBS payments for home care, adult day care, assisted living and PACE; and analyzed the needs of special populations to improve access, assure quality, and improve funding for LTC system improvements.
- **Expand capacity of home and community-based providers** that reduced the reliance on institutional care and promote the use of HCBS such as: shared living options for individuals with developmental disabilities as well as aged, blind and disabled Medicaid

beneficiaries; self-directed services under the Personal Choice Program; provided wrap-around services to children with behavioral health needs; and developed alternatives to hospitalization for children and adults with psychiatric conditions.

Although these efforts moved the State in the right direction, there continued to be an over reliance on institutional care.

The Global Waiver provides RI with greater flexibility to address both the consequences of the institutional bias in Medicaid and to improve access to and the provision of home and community-based care. Since the implementation of the Global Waiver, the Medicaid program has Consolidated Section 1915 (c) Home and Community-Based Waivers to improve the efficiency and accountability as well as to achieve higher utilization of HCBS. The consolidation enabled the State to: integrate and coordinate services for high need populations, facilitate the exchange of health information across venues and providers and, provide latitude to identify and invest in new long-term care alternatives. More importantly, it expanded access to the array of services for all Medicaid beneficiaries that were previously limited to only designated populations.

Specifically, the State has accomplished the following initiatives since the Global Waiver to **ensure appropriate utilization** of institutional services and facilitate access to community-based services and supports:

- **Nursing Home Placements** have been changed : (1) new Level-of-Care (LOC) criteria were developed, (2) an integrated assessment and determination process was developed, (3) the assessment tool was revised to ensure that nursing home placements are limited to beneficiaries requiring the highest level of need, and (4) a LTC assessment and referral system was implemented using a web-based tool ("OMAR"). Approximately, 6,300

individuals were assessed using these new processes resulting in approximately 4,450 who were eligible for the highest level-of-care.

- **Options Counseling** is available to provide beneficiaries and their families with information necessary to make educated choices about the care they receive and available community resources.
- **Hospital Discharge Planners Delegated Authority for Nursing Home Placements** has been relinquished and now State staff conducts expedited reviews using a new uniform assessment tool to determine LOC.
- **A Nursing Home Diversion Initiative for Hospital Discharges** has been implemented through the Connect Care Choice (CCC) program to identify Medicaid FFS beneficiaries that could be discharged from the hospital to a community-based setting**.** Nurse Case Managers work closely with the hospital discharge planners and the State clinical staff to facilitate appropriate discharge placement in community-based settings.
- **A Nursing Home Transition Project** has been implemented to identify Medicaid beneficiaries that may be transitioned from the nursing home to a community based setting. A State staffed Assessment Team (composed of registered nurse and a licensed clinical social worker) in collaboration with all nursing homes state- wide: (1) identify potential Medicaid beneficiaries that may be transitioned to a home or community-based setting, (2) conduct an assessment to determine whether the beneficiary is appropriate for a home and community setting, (3) provide information about options so beneficiaries and their families can make an informed decision, (4) ensure that needed supports and services are in place prior to the nursing home discharge, and (5) work with the beneficiaries with medically complex conditions throughout the transition period.

These initiatives have resulted in more than 1,000 individuals being diverted from institutional care or transitioned into community-based care.

The State has also implemented the following initiatives under the Global Waiver to **expand access** to community based services and supports:

- **A Preventive Level of Care** was created for Medicaid beneficiaries who are at risk of needing institutional LTC services, but are currently not at that level. The State has developed a benefit package for those beneficiaries to prevent or at least delay their institutional care.
- **Shared Living** was expanded to other population groups. Prior to the Global Waiver, Shared Living was available to Medicaid beneficiaries with Developmental Disabilities. Now Shared Living is available to elders and adults with disabilities. Two Shared Living agencies were selected to develop and administer the Share Living benefit for eligible Rhode Islanders.
- **Home Health Care Agencies** are now required to have a formal relationship with a skilled nursing facility to provide skilled nursing services; received a 10 percent reimbursement increase; and are eligible for enhanced reimbursement if they achieve higher care standards.
- **Additional Assisted Living** options are being explored with an interagency work group to address unmet needs for Medicaid beneficiaries; and the per diem reimbursement rate was increased from $36.32 to $42.16 in July 2010.
- **Adult Day Services** providers received a 10 percent increase with funds available as a result of the Long Term Care Services and Finance Reform Act and DHS initiated statewide training of Adult Day Services. The State is also exploring acuity-based

payment reimbursement methodologies to address increased beneficiary needs in certain sub-populations (e.g. Alzheimer's, wound care, medication management).

RI has successfully implemented the following initiatives to **improve the coordination** of all publicly funded long-term care services and supports.

- **An Assessment and Coordination Organization (ACO)** has been established for the EOHHS departments to streamline the intake and assessment processes and to provide beneficiaries and their families with clear, concise, and accurate information about their care options.
- **Needs of High-Cost Users** are being addressed by an Inter-agency High-Cost Case Review Work Group to identify high cost cases (e.g. vent cases in nursing homes, neonatal intensive care cases, SPMI cases) and to provide alternative less costly care through care management, selective contracting and/or change in setting.
- **The Sherlock Plan** is RI's Medicaid Buy-In program for adults with disabilities who seek to gain or maintain employment while still maintaining health coverage. The Sherlock Plan is being reassessed and revised to ensure that it is more responsive and cost-effective.

In addition to these initiatives, the State has developed a nursing home acuity based payment system. The Rhode Island Legislature has directed the state to implement acuity based rates for nursing facilities. EOHHS staffs are meeting with stakeholders to finalize the reimbursement system.

The initiatives developed and implemented under the Global Waiver have made a significant difference, but there is still much work ahead for RI to achieve a more balanced LTC system. There has been some change in the balance of expenditures for long-term care services.

Expenditures for institutional care have declined from 90 percent to 84.7 percent of total Medicaid dollars spent. The Nursing Home Transition Project has resulted in significant transition to community based care, but it lacks the resources required to achieve our goal of a 50/50 balance of LTC expenditures. MFP will enable RI to transition beneficiaries with longer-term institutional stays; to provide additional resources to increase the number of beneficiaries served; to increase access to community-based services; and to supports; and to achieve a higher success rate of beneficiaries staying in a home and community setting through the use of Transition Coordinators for elders and Peer Mentors for the adults with disabilities. As important, transition into the community requires suitable and affordable residences. The *Rhode to Home* demonstration will employ a Housing Coordinator to identify affordable housing opportunities, educate builders and contractor of financial assistance and tax credits available to them to build or renovate residences to meet the needs of the MFP population, and to work with State Housing staff. The MFP demonstration will provide RI with an opportunity to develop improved IT systems and other infrastructure that facilitates transitioning into, and safely maintaining community living. In addition, the POINT (ADRC) will be enhanced to serve as a focal point for information about LTC options available to consumers. The MFP demonstration will also enable the State to develop additional enhanced reimbursement and payment systems, as well as training and recruitment to increase the community workforce pool. RI will seek to leverage the federal funding opportunities for rental assistance for non-elderly persons with disabilities being discharged from an institutional setting for elders as well.

Potential MFP Participants

The *Rhode to Home* MFP demonstration will transition target populations in two phases. Phase I will include transitioning elders and persons with disabilities in nursing home care. A

total of 640 individuals from qualified institutions will be transitioned into qualified residential settings in Phase I. The number of participants who will be transitioned each year is presented in the Demonstration Implementation Policies and Procedures Section 2: Benchmarks. The *Rhode to Home* staff will identify specific individuals who desire to be transitioned from institutional care to home/community care through the multiple referral sources and by referrals from positive responses to the MDS 3.0 Part Q. This is more fully discussed in the Demonstration Implementation Policies and Procedures Section 1: Participant Recruitment and Enrollment.

Phase II will include transitioning the following populations: adults with disabilities from acute and long-term acute care facilities (LTAC); adult patients with medical and behavioral health conditions from the Eleanor Slater Hospital; and children and youth in psychiatric hospitals and in-state and out-of-state Institutions of Mental Diseases (IMDs). In Phase II, the initial focus will be on MFP for children and youth in psychiatric hospitals and in-state and out-of-state IMDs. Appendix K provides additional background.

Current Efforts to Provide Self-Directed Services

RI has provided individuals with opportunities to self-direct their services and supports since 1986, when it launched a 1915 (c) waiver that allowed individuals with severe disabilities the opportunity to hire personal care attendants with the assistance of PARI Independent Living Center (PARI waiver). In 2004, RI was one of ten states that were awarded a Robert Wood Johnson Foundation grant under the Cash and Counseling Expansion Program. The program was designed to give Medicaid eligible elders and adults with disabilities who require assistance with their Activities of Daily Livings (ADLs) and Instrumental Activities of Daily Living (I-ADLs), greater control in the provision of their care. Though out the years, RI took advantage of the

opportunities presented by the 1915 (c) waivers that enable Medicaid beneficiaries to live independently in the community through self-directed care. These waivers are highlighted below:

- **Cash and Counseling Waiver: *The PersonalChoice Program*** has operated since 2006. Participants in this waiver are adults with disabilities and elders who want and are capable of directing their own services or who have a designated representative able to perform this function. The Medicaid program contracts with Tri-Town Community Action Agency, a Department of Elderly Affairs certified case management agency and People Actively Reaching Independence (PARI) a federally funded Center for Independent Living, to assist beneficiaries to direct, managed and evaluate their care. In addition, the State contracts with Ocean State Community Resources (OSCR) Options program and PARI to serve as Fiscal Intermediaries for the Personal Choice Program. The program currently serves approximately 380 individuals.
- **Developmental Disabilities Waiver: *OPTIONS*** is for Medicaid beneficiaries with developmental disabilities as an alternative to the traditional service delivery system so that the individuals may self-direct their care and support that is required to live independently in the community. Ocean State Community Resources administers and serves as the fiscal intermediary for the program for the last fifteen years. Under *OPTIONS*, Medicaid beneficiaries are considered a legal *employer* in the State of Rhode Island and considered a "sole proprietor" by the Internal Revenue Service. Currently, there are approximately 200 people with developmental disabilities statewide who participate in this program.
- **Personal Assistance Services and Supports (PASS) Program** is available to Medicaid eligible children with chronic and moderate to severe cognitive, physical, developmental

and/or psychiatric conditions. Under this program, the worker is employed by a certified PASS Agency that is responsible for the background checks, payroll, orientation and basic training. It is the child's family, however, who is responsible for the recruitment, specific training, management, and supervision of the PASS workers. (This program is funded as an EPSDT service).

- **Respite for Children Program** is available to families of children with special health care needs who meet an institutional level of care. It allows caregivers time off from their care giving responsibilities. Similar to the PASS program, the worker is employed by a certified Respite Agency that is responsible for the background checks, payroll functions, and general orientation/training of workers.

Under the Global Waiver, RI has authority to expand the self-directed services to other populations, including: (1) Children eligible under the "Katie Beckett" provision of the Social Security Act, (2) Individuals with Behavioral Health Needs, and (3) Children and Youth under the guardianship of DCYF.

RI intends to offer any MFP participant an opportunity to receive services and supports through a self-directed option, if they desire and are capable of self-managing their care, with appropriate assistance.

Stakeholder Involvement in LTC System

RI has always been committed to involving stakeholders in the Medicaid program. Meaningful stakeholder involvement is essential to design programs that are responsive to consumer needs, to implement initiatives in an efficient and effective manner, and to respond to critical issues confronting the State. The Medicaid Program has numerous standing task forces and committees that provide input to DHS, including the following:

- **Global Waiver Task Force** and its operating committees that represent a myriad of Medicaid stakeholders that provide the State with recommendations related to issues, policies and operational requirements.
- **Medicaid Medical Care Advisory Committee** composed of physicians statewide who meet monthly with the Medical Director and the Medicaid Director to discuss medical issues and clinical policies.
- **Consumer Advisory Committee** composed of advocates and consumers who meet monthly with the state DHS representatives to discuss issues, policies and reports.

RI will establish a MFP Stakeholder Steering Committee composed of Medicaid beneficiaries, advocacy groups, LTC providers, community health and human services organizations and state officials to help guide the development, implementation and administration of the MFP project. RI is also proposing to conduct consumer and provider focus groups for each target population to obtain additional insights about the needs, concerns, and effective services and supports required to maintain an independent life in the community. The proposed effort to involve stakeholders in the MFP Demonstration is more fully described in Demonstration Policies and Procedures, Section 4: Stakeholder.

Part # 2: Description of the Demonstrations Administrative Structure

Beginning July 1, 2011, the Executive Office of Health and Human Services (EOHHS) administers the RI Medicaid program. The Medicaid program has agreements with other State agencies to maximize the utilization and coordination of services for the Medicaid population. These other agencies include: Local Education Agencies (LEAs); Department of Human Services (DHS): Department of Health (DOH): Department of Children, Youth and Families (DCYF); Department of Elderly Affairs (DEA), and the Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH). The EOHHS has overriding responsibility for the Medicaid program and its expenditures, although the other departments within EOHHS have legislative authority for the populations they serve.

EOHHS will serve as the lead agency for the MFP demonstration grant. The MFP Demonstration Project will report directly to the Administrator of the Office of Institutional/Community Services and Supports (OICSS)**,** who in turn reports directly to the Medicaid Director.

Within EOHHS, the following two organizational units have vital roles in the long-term care system.

- **Long Term Care Field Offices,** within DHS, are located in four locations statewide. The field offices are responsible for determining whether or not a beneficiary meets the financial eligibility requirements for the Long Term Care Medicaid Program. If a beneficiary is found to be eligible for Long-term Care Medicaid, the field offices determine if the beneficiary needs to share in the cost of his or her care. Financial eligibility is re-determined on an annual basis. Field office staff complete case management assessment forms for home and community-based services. The field

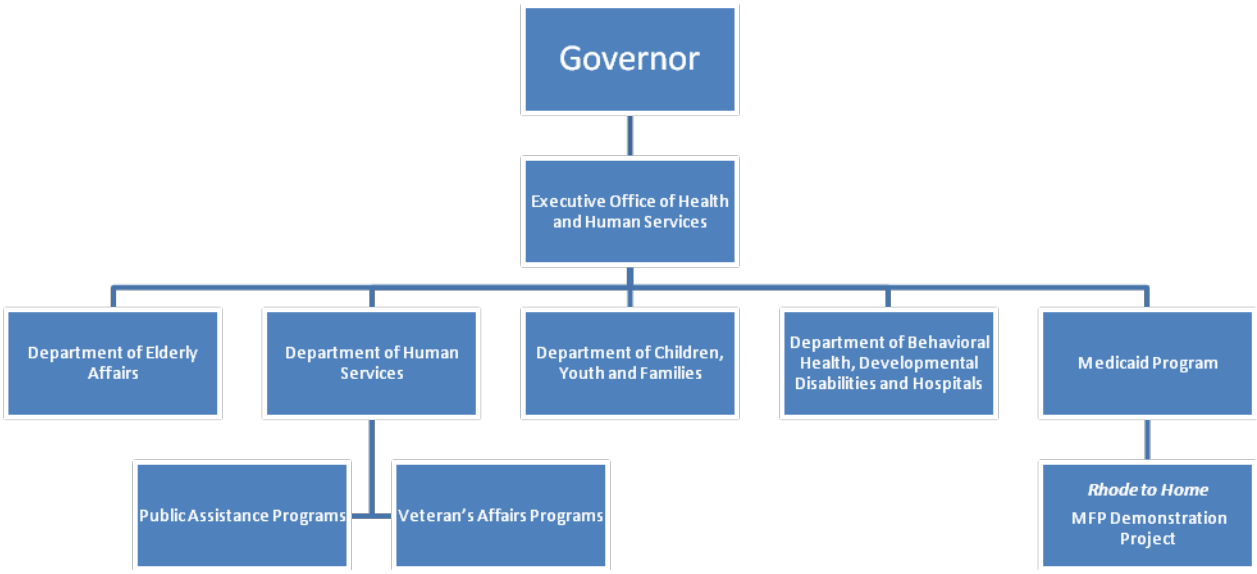
offices also ensure that individuals who receive Supplemental Security Income (SSI) and who meet the Preventive Level of Care (see summary of Office of Medical Review below) are receiving appropriate services. The Office of Community Programs assists individuals who meet the Preventive LOC, but who do not receive SSI (see below). In addition, the field offices authorize and provide oversight of certain long-term care services and supports. For example, the field offices authorize nursing home stays, assess the need for the number of service hours for a beneficiary receiving home and community-based services, and help arrange for the provision of such services. These field offices are often the initial contact or entry point for consumers requiring Medicaid funded long-term care services.

- **Office of Institutional/Community Services and Supports (OICSS**), within the Medicaid program, consists of the following two organizational units:
    - **The Office of Medical Review (OMR)** determines the clinical eligibility and determines the appropriate level-of-care (LOC) for beneficiaries applying for Medicaid-funded long-term care. OMR works in conjunction with the field offices to ensure that applications for Medicaid-funded long-term care are determined on a timely basis**.** OMR determines clinical eligibility for Medicaid-funded Long-term Care using a comprehensive functional needs assessment tool. The LOC assessment examines an individual's functional status through a standardized questionnaire completed by trained clinicians. The assessment examines medical condition, capacity for self-care, medication regimen, specialized medical needs, and a behavioral health assessment. The results of this

evaluation are used to determine whether an applicant's needs meet the Highest, High, or Preventive LOC criteria.

- **The Office of Community Programs (OCP)** is responsible for managing the health and long-term care needs of some medically complex individuals. Some of these are individuals have needs for long-term community-based services and supports due to their chronic conditions. These high-risk individuals are referred to the OCP from the LTC field offices, the OMR, or the community. The OCP works closely with the Connect Care Choice Program and with Rhody Health Partners program. The OCP is responsible for the State's Nursing Home Transition Project that is discussed in this Operational Protocol.

The Medicaid program has agreements with all the State departments within the EOHHS. Upon grant award, these agreements will be amended to include the MFP demonstration, where appropriate. Each department has the capability and capacity to provide the full range of program design and planning, clinical intervention, program monitoring and support functions (e.g. accounting, IT, contracting, finance and accounting) required to administer their programs. EOHHS, as the lead Medicaid agency, has the full-range of technical and programmatic expertise and systems in place to administer the Medicaid program, either by using State or contractor staff. The Staffing Plan and Budget Section of this Operational Protocol (OP) describe the additional programmatic and administrative/support staff resources required to administer the MFP demonstration. The following is an organization chart of the MFP demonstration that depicts the relationship of EOHHS, and the other departments within EOHHS.



2. Benchmarks

Rhode Island has taken significant steps to reduce its over reliance on institutional care, including, but not limited to: (1) passing legislation to foster re-balancing efforts including flexible financing for LTC and increased reimbursement for HCBS providers, (2) expanding the capacity and enhanced the reimburse for selected home and community based services, (3) expanding access to home and community based services, (4) re-defined eligibility criteria bases for LTC services based on level of care required by Medicaid beneficiaries, (5) developing standardized process and tools to determine the specific individual needs, and (6) administering a Nursing Home Transition program to provide an opportunity of beneficiaries to transition from nursing home to community-based care. These efforts have made a significant difference as expenditures for institutional long-term care services have declined from 90 percent to 84.7 percent. However, much work remains to achieve a re-balancing of LTC services to achieve the

goal of a 50/50 balance. The MFP Demonstration provides RI with an opportunity to improve transition beneficiaries into the community and reach the goal of a 50/50 balance.

Rhode Island intends to reinvest its re-balancing funds to continuously improve its capability to serve Medicaid beneficiaries. For example, funds may be used to conduct timely home modification assessments, to fund Respite Care and Community Transition Services, and to provide Peer Mentor services as a Qualified HCBS after the MFP eligibility period.

Benchmarks will be used that establish empirical measures to assess Rhode Island's progress in transitioning individuals from an institutional to community-based setting and in rebalancing its long-term care system. This section describes the benchmarks for the *Rhode to Home* demonstration project for Phase I target populations. The first two benchmarks are those required by CMS and the remaining three benchmarks were selected by the State from the CMS list.

Benchmark 1: The Projected Number of Eligible Individuals Transitioned to Each Population Group from an Inpatient Facility to a Qualified Residence during Each Calendar Year

The following indicates how many individuals the *Rhode to Home* demonstration will transition each year for the Phase I target population. (The elders are those individuals 65 years and older in nursing homes, whereas, the disabled population is those individuals under 65 years old in nursing homes).

POPULATIONS	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	TOTAL
Elders: Nursing Home	36	108	108	108	108	108	576
Disabled: Nursing Home	4	12	12	12	12	12	64
TOTAL	40	120	120	120	120	120	640

Benchmark 2: Increase in State Medicaid Expenditures for HCBS During Each Calendar Year of the Demonstration Project

The total authorized expenditures for HCBS for SFY 2010 period for our target population were $60.3 million. Under the current array of HCBS services, RI proposes to make available and to include in this benchmark all qualified HCBS for Medicaid beneficiaries and Transition Coordinator Demonstration Services to MFP Participants during the time period 2011- 2016. These categories of spending are included in the projected annual HCBS expenditure targets that include Federal and State funds. The process by which RI will capture the expenditure data to report on the benchmark is via a query of the claims paid for HCBS services from the MMIS. Separate flags will be used to identify Medicaid beneficiaries and MFP participants and the expenditures associated with each individual.

HCBS program monitoring is currently being done as a component our oversight and monitoring activities under the Global Waiver. The early HCBS increases RI has experienced under our rebalancing efforts under the Global Waiver lead to our projected eight percent increase for this benchmark. However, based on the technical assistance offered by CMS, RI has revised the *Rhode to Home* program increase the percentage of HCBS expenditures by five percent each in demonstration year. The following presents HCBS expenditures in millions for each demonstration year.

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
HCBS EXPENDITURES	$63.3	$66.5	$69.8	$73.3	$77.0	$80.8

Benchmark 3: Percentage Increase in HCBS versus Institutional Long-Term Care Expenditures Under Medicaid for Each Year of the Demonstration Program

In SFY 2010, Medicaid long-term care expenditures were $395 million for the Phase I population. Institutional Nursing Home and Hospice expenditures were $ 334.7 million or 84.7 percent and HCBS expenditures were $60.3 million or 15.3 percent of total long-term care expenditures. The following presents the percent increase in HCBS versus Nursing Home and Hospice institutional care for each demonstration year. Under the current array of HCBS services, RI proposes to make available and to include in this benchmark all qualified HCBS for

Medicaid beneficiaries and Transition Coordinator Demonstration Services to MFP Participants during the time period 2011- 2016. These categories of spending are included in the projected annual HCBS expenditure targets.

The process by which RI will capture the expenditure data to report on the benchmark is via a query of the claims paid for HCBS services and Nursing Home and Hospice Institutional services from the MMIS. Separate flags will be used to identify the type of services and the associated expenditures for Medicaid beneficiaries. Nursing Home and Hospice Institutional and HCBS program monitoring is currently being conducted.

Percent of LTC Expenditures	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
HCBS	15.8%	16.3%	16.8%	17.3%	17.8%	18.3%
Institutional	84.2%	83.7%	83.2%	82.7%	82.2%	81.7%

Benchmark 4: Increases in the Use of Self-Directed Services

As an empirical measure for the benchmark, RI will monitor the increase in the number of individuals participating in a self-directed option. In SFY 2010, 380 individual's participated in the PersonalChoice program. RI's objective is to increase the number of participants in the PersonalChoice program by 5 percent each year; and to have 10 percent of the MFP participants operating under a self-directed model. The following describes the number of participants who will receive care under a self-directed model for each demonstration year

Using Self-Directed Option	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
MFP Participants	6	12	12	12	12	12
Other Individuals	399	419	440	462	485	509
TOTAL	405	431	452	474	497	521

The former MFP participants enrolled in a self-directed model have not been counted in the numbers for the Other Individuals after they are no longer in the MFP demonstration. The Other Individuals category is comprised of individuals who have selected a self-directed model who are not and did not participate in the MFP program.

Benchmark 5: Increase the Number of Referrals Received by DHS of those Individuals Interested in Receiving Care in a Community-Based Setting.

RI is proposing an aggressive marketing and outreach effort to inform consumers about long-term care options. The marketing and outreach campaign will consist of: multi-media campaign, collaboration with community and State organizations, distribution of written and visual materials in key locations throughout the State, meetings and presentation to consumers and other stakeholders, and an enhancement of The POINT (ADRC). As a result of these efforts and the receipt of Section Q of the MDS form, RI expects to increase the referrals received of those individuals who are interested in home and community-base setting. It is anticipated that referrals may come from: consumers and Medicaid beneficiaries, his/her family or guardian,

caregivers, physicians and other providers caring for the individual, health and human service agencies and from The POINT (ADRC).

For the past year, DHS has received a total of 400 referrals of individuals interested in receiving home and community-based services. RI objective is to increase the number of individuals interested in community-based services by 5 percent each Calendar Year of the Demonstration. The following presents the number of referral for each demonstration year.

REFERRALS	CY 2011*	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
Number of Referrals Received of Individuals Interest in Home & Community-Based Care	410	431	453	476	500	525

* The number of referrals reflect in 2011 is 2.5 percent because MFP will be implemented for only six months. DHS will monitor the referral sources continuously to target indicate where additional outreach and marketing is necessary and to develop targeted improvement strategies

DEMONSTRATION IMPLEMENTATION POLICIES AND PROCEDURES

This section describes the operational policies and procedures that will govern Rhode Island's *Rhodes to Home* MFP demonstration. The description follows the format prescribed in the CMS Program Announcement guidelines. Responses from RI Long-Term Care Request for Information (RFI) may provide additional improvement strategies and specific recommendations that the State could incorporate into the MFP demonstration. This Operational Protocol (OP) describes the implementation policies and procedures for the targeted Phase I populations.

1. Participant Recruitment and Enrollment

The *Rhode to Home* MFP demonstration will transition target populations in two phases. Phase I will include:

- Transitioning elders in nursing home care, and
- Transitioning persons with disabilities in nursing home care.

Phase II may include the following populations: transitioning adults with disabilities from acute and long-term acute care facilities (LTAC); adult patients with medical and behavioral health conditions from the Eleanor Slater Hospital; and children and youth in psychiatric hospitals and in-state and out-of-state Institutions for Mental Disease (IMDs).

The recruitment and enrollment methods used for each target population may vary; however, the following principles will apply to all target populations.

- Participant enrollment in the demonstration is strictly voluntary.
- Participants will be advised of LTC options available.
- Participants will be eligible for Medicaid for at least one day.

- Participants will have resided in a qualified facility for a period of at least ninety days prior to enrolling in the *Rhode to Home.*
- Participants will be transitioned into a qualified residence.

In addition, institutional eligibility and post eligibility treatment of income rules will apply for all eligible participants.

Focal Point for Receiving, Assigning and Tracking Referrals

RI is proposing to have a Referral Coordinator/Administrative Assistant located in the Office of Institutional/Community Services and Supports (OICSS) within the Department of Human Services (DHS) the designated Medicaid agency, who will receive all referrals to the MFP Program. The Referral Coordinator/Administrative Assistant will review the case and determine the assignment to the Transitional Assessment Nurse for subsequent comprehensive assessment and care plan development. The Referral Coordinator will be a full-time position, solely dedicated to the MFP project. The Referral Coordinator will enter data about each referral in the MFP database and track the disposition of each referral.

RI will conduct a comprehensive outreach and marketing campaign to garner support for the MFP project and to enhance referrals. These activities include: (1) distribution of outreach materials throughout the State, (2) speaking engagements and attendance at conferences, (3) press releases and public service announcements, (4) holding a MFP State Forum, (5) sending letters to potential participants and their families, and (5) enhancing the current capacity of the Aging and Disability Resource Center (ARDC), called The POINT in RI, to identify potential participants and to provide information and assistance that support consumer choice.

As a result of these efforts, it is anticipated that referrals will come from multiple sources including the: beneficiary, his/her family or care givers, current beneficiary providers, ARDC (The POINT), and other parties familiar with the potential applicant. In addition, the Referral Coordinator will review all MDS 3.0 Section Q received to identify potential candidates for the MFP project. The OICSS is identified as the State Local Contact Agency for the MDS Section Q forms.

Service Providers and Use of Centers for Independent Living

As previously noted, the RI long term care system consists of a network of LTC providers that includes 93 nursing facilities, 48 home nursing agencies, 7 home care agencies, 15 adult day care centers, 43 home health care providers and 59 assisted living facilities operating in different locations throughout the State. In addition, the State has a PACE program. The list of Nursing Homes is contained in Appendix B. The list of community-based providers is contained in Appendix C. In addition, the State has a self-directed Personal Choice program that is administered by a contracted Center for Independent Living and case management entities.

The State has a rigorous process to ensure that quality providers are enrolled in the Medicaid program. All facilities must be approved/certified by a designated State Agency based on the type of facility. Clinicians must be licensed by the Department of Health and a background check is performed on all clinical staff. Facilities and providers must be in “good standing” with Medicare and Medicaid; and facilities and providers must be in “good standing” with their approval and licensure agency.

Criteria and Process to Identify Individuals for Transitioning

The RI *Rhode to Home* demonstration will conduct a statewide outreach and marketing campaign to promote the program, to garner community support, and to enhance referrals. This campaign will include: (1) the distribution of *Rhode to Home* materials at sites throughout the State, (2) speaking engagements and attendance at conferences, (3) press releases, public services announcements, and other media venues, 4) holding a *Rhode to Home* State Forum, (5) sending letters to potential participants or their families, and (6) building on the current capacity of the ARDC (the POINT) to provide access to information and assistance that support consumer choice. This outreach/marketing effort is more fully described latter in Section 3 Outreach/Marketing/Education. As a result of the effort, the MFP demonstration will obtain referrals from multiple sources including: the Medicaid beneficiary, his/her family or care givers, current beneficiary medical care providers, and other parties familiar with a potential applicant. In addition, OICSS is identified as the State Local Contact Agency for the new MDS 3.0 Section Q. All referrals for potential discharge statewide come through OCISS. Non-Medicaid eligible individuals are triaged to appropriate entities for options counseling.

In Phase I, the Transition Assessment Nurse will contact all potential *Rhode to Home* participants and their families/guardians to explore the potential for transitioning to a community based setting. The Assessment Nurse will meet with the potential participant in the nursing home. During the meeting, the Assessment Nurse will explore with the nursing home resident the following topics:

- **Nursing Home Stay** including the reasons why they were admitted, where they were living before, how the decision was made to move into the nursing home, who made the decision, and why this particular nursing home was selected.

- **Services and Benefits** available in the nursing home, additional supports provided by family and friends, likes and dislikes about the nursing home, and what social and recreational activities do they participate in, and their interest in moving out of the nursing home.
- **Potential Participants Vision of Community Residences** such as where they would live, prior experience working with care givers and personal care/home health providers, needed assistance for transitioning, their major concerns or fears about transitioning into the community, real or perceived barriers to living in the community.
- **Issues Related to Successful Transition** including eligibility for Medicaid/MFP, available and affordable housing, existing financial resources and their ability to manage them, legal or criminal issues, ability to access primary and specialty medical care, existing support system, medical and behavioral health conditions, consumer awareness and skills, consumer connection to the community, factors that may endanger the health and safety of the consumer and engaging guardians, when assigned.

The Transition Assessment Nurse will further explore with the patient's family/guardian the appropriateness and desirability of transitioning to a community setting. This meeting will also be used to: discuss LTC options; to present beneficiary rights and responsibilities; to reinforce that participation in MFP is strictly voluntary and will not affect eligibility to any public or medical assistance program and; to discuss potential cost sharing responsibilities. The Transition Assessment Nurse will have additional conversations with the beneficiary and his/her representative so that they may make an informed decision, as necessary.

ADRC Referral Capacity

The RI Department of Elderly Affairs (DEA) is the designated Area Agency on Aging (AAA) for the State. DEA is the recipient of the ARDC grant and is responsible for administering The POINT. The POINT currently maintains a call-in center that provides information about services available for elders and persons with disabilities and how to access those services. The POINT's web site offers a wide range of links to community, State and Federal programs that benefit elders and persons with disabilities. The POINT is available during normal business hours and callers have "live" access to a benefits specialist. In addition, The POINT staff provides assistance in completing applications for needed services, during normal business hours.

The RI MFP project, *the Rhode to Home,* plans to expand the capacity and capability of The POINT to be an integral part of the MFP demonstration project. The POINT will play a pivotal role in providing information and referral services as well as providing Options Counseling to elders and persons with disabilities requiring assistance. The POINT will refer interested and appropriate potential MFP members to the MFP Referral Coordinator for assignment and scheduling of subsequent Assessment and Care Planning activities. DHS staff will continue to work with DEA staff to update the information in the DEA data base about the availability of existing services, improve the capacity of The POINT to provide Options Counseling, expand the working hours of The POINT staff telephone center beyond working hours, and expand the capacity of The POINT staff to provide face to face assistance. The Administrative Budget provides the resources required improving the capacity and capability of The POINT to be an integral part of the *Rhodes to Home* project, as the focal point of

informational and referral services as well as providing Options Counseling to potential MFP participants.

Qualified Institutional Setting Transitioned From

Phase I *Rhode to Home* participants will be Medicaid beneficiaries who are residents in Medicaid enrolled nursing homes, statewide. All of the nursing homes meet the definition of a qualified resident for the MFP program.

Assuring Minimum Residency Requirements of 90 Consecutive Days

All MFP participants will be required to be in a qualified inpatient institutional facility for a period of not less than 90 consecutive days. (Nursing home days not counted toward meeting this 90 day requirement include: (1) days associated with admissions solely for receiving short term rehabilitative services, and (2) patients admitted to a Skilled Nursing Facility for post hospital extended care rehabilitative services covered by Medicare.) Under DHS's current Nursing Home Transition Project, Transition Assessment Nurses and Social Workers are currently working with, and at times present in, all Medicaid enrolled nursing homes statewide. The *Rhode to Home* Transition Assessment Nurses will also be in these same facilities serving MFP participants.

The MFP Transition Nurses will review all referrals and candidates for the program. Nursing home records will be checked and the MDS 3.0 will be reviewed to determine the date and reason for admission as well as any lapses/breaks in nursing home residency to determine if a beneficiary was in the nursing home for 90 consecutive days. The Transition will check the InRhodes Medicaid Eligibility System to determine if the potential participant is Medicaid

eligible and check the MMIS Claims System to determine that claims were paid for the individual during the 90-day period.

Process to Ensure that Participants Eligible for Medicaid for at Least One Day Prior to Transition

As previously noted, the Transition Assessment Nurse will receive and review all referrals for the demonstration and positive responses to Section Q of the MDS 3.0 to identify those residents who may be eligible for Medicaid for at least one day. For those residents who are currently not a Medicaid beneficiary and express an interest in participating in the *Rhode to Home* program, the MFP Transition Assessment Nurse will facilitate the completion of the Long Term Care Medicaid Eligibility Application. The Long Term Care Medicaid Application is contained in Appendix D.

The applications will be sent to the LTC Field Offices to determine financial eligibility for LTC, and subsequently sent to the Office of Medical Review to determine clinical eligibility, including the appropriate LOC. An applicant will receive a letter indicating the results of the eligibility determination within 30 days, whenever possible. The MFP Transition Nurse will be notified about the results of the financial and clinical eligibility process. If eligible, the applicant would then be entered into the In Rhodes Eligibility system. After one day of receiving Medicaid services the beneficiary will be eligible for the MFP demonstration. The Assessment Transition Team will begin the assessment and care planning process once eligibility is confirmed.

Discussion with MFP Candidates About Options

Consumers will be presented with options available to them to meet their long-term care needs throughout their Medicaid eligibility period. Long-term care options will be provided at key points including:

- Options Counseling by the ARDC "The POINT" prior to referral to the MFP program
- During the Assessment and Care Planning process by the Assessment and Care Plan Team
- Throughout the MFP demonstration period by the Transition Coordinator, Peer Mentor or Self-Directed Care Manager

These discussions with the consumer will reinforce the voluntary nature of the program, institutional and community based options, provider versus self-managed services, the process for enrolling in the MFP program, supports and services provided in the MFP program to facilitate a successful transition, consumer responsibilities and appeals rights, and key requisites for remaining in the community.

At the conclusion of the MFP demonstration period, the Transition Coordinator or Peer Mentor will consult with the beneficiaries, their family, and caregivers about options available to them after the demonstration period. The Transition Coordinator or Peer Mentor will refer to and work with providers and service/support agencies, including the care managers, to ensure that there is continuity of care for the MFP member after the demonstration period.

Process for Determining Required Services and Supports as well as Participant Readiness for Transition

The Transition Assessment Nurse will conduct a comprehensive assessment of those eligible MFP candidates who desire transitioning to a community setting. The Comprehensive Assessment Tool that will be used is included in Appendix E. It consists of the following components:

- **Comprehensive Transitional Assessment:** is conducted by the MFP Transition Assessment Nurse. It includes the following information, including, but is not limited to: referral source, client identifying data, informal support systems, residence and living arrangements, home based services receiving, functional abilities/ADL assessment, behavioral health assessment, fall risk, hearing and vision assessment, diet, dental problems, height/weight, health care providers, medical issues, skin integrity, pain, diabetes, labs and immunizations received, transition recommendations including HCBS and medical equipment needs.
- **Transition Challenges and Risk Assessment:** will be conducted by the MFP Transition Assessment Nurse based on the Connecticut Transition Challenges checklist. This assessment includes a review of many factors including: physical health, mental health, financial or insurance benefits, consumer engagement, services and support, housing, legal matters, facility related issues, and provider issues that may adversely affect the welfare and safety of the participant.

The Transition Assessment Nurse, Medicaid beneficiary, family/guardians, nursing home clinical staff, the beneficiary's primary care provider and other medical specialists involved in the case, will determine whether or not the beneficiary is appropriate for transitioning.

The designated Transition Coordinator for elders or by the designated Peer Mentor for individuals with disabilities will conduct a Housing Assessment. The housing assessment will be conducted: (1) to assess whether the transitioning residence complies with CMS's definition of a qualified residence, and (2) to conduct a safety inspection of the residence. The Housing Coordinator will be available to consult with the Assessment and Care Plans Teams to provide additional expertise, as required. A copy of the housing assessment tool and safety checklist is included as Appendix F.

A Care Plan will be developed for all MFP Participants. Care Plan Development Team members include: the Transition Assessment Nurse, Medicaid beneficiary and his/her family or guardian, the beneficiary's primary care provider and other medical specialists involved in the case, and the designated Transition Coordinator (elders) or Peer Mentor (adults with disabilities). A copy of the Care Plan Format is included in Appendix G. The Care Plan includes three sections:

- **Service Plan** that indicates: goals, frequency and duration of services; primary care plans; residential and modifications; human service plans, formal and informal supports required; recreational and cultural activities; special need plan; and responsibility for referrals and linkages.
- **Risk Mitigation Plan** that includes a description of the risk factors and specific interventions to address each risk.
- **Emergency Back-Up Plan** that includes the participant's back-up for the supports required in the Service Plan including: a list of the services required for the participant's health, safety and well being; the type of services/supports and the name and telephone number of who to call; the name and contact of the *Rhode to Home* third level 24 hour

contract agency; the emergency numbers of other community agencies to call in case the participant's backup system does not work; and agencies to call if the participant requires transportation or home medical equipment.

At a minimum, a Comprehensive Assessment is conducted and a Care Plan is revised, annually or, whenever, the participants needs change or are not being met.

MFP participants will be encouraged to place themselves on the Rhode Island Special Needs Emergency Registry developed by the RI Department of Health and the RI Emergency Management Agency. This on-line registry was developed to serve the needs of RI residents with disabilities, chronic conditions, and special needs. Information is shared with State and local responders (such as police and fire departments) so that they may better meet caller's needs. The registry contains: basic ID information, ambulatory status, physical support devices used, medical support systems used and physical disabilities.

The designated Transition Coordinator or Peer Mentor will conduct a "readiness review" prior to all discharges from the nursing home. This includes reaffirming transportation services, caregivers, medical services, human and support services required for transitioning. In addition, the Transition Coordinator or Peer Mentor will make a home visit to assure that all modifications were made and that medical equipment and devices are in place.

The Transition Coordinator of Peer Mentor will arrange the services and supports required for transition under the payer-managed system, except for arranging for the required medical services. It is Rhode Island's experience that arranging for medical care, an individual with a medical background best accomplishes service. Under RI's current Nursing Home Transition project, arranging for medical care is done by RNs. Likewise the Transition Assessment Nurses will arrange for the medical services and care in the MFP project.

The Transition Coordinator or the Peer Mentor serves as the point person and care manager for the participant during the demonstration period to ensure a successful and lasting transition. Each will: (1) contact the participant by telephone within the first 24 hours of discharge, (2) conduct home visits within 10 days of transition, 30 days after transition, every 60 days thereafter, or more frequently as needed to assure that the participant's medical, human service and support needs are met, (3) contact the participant or his representative at least monthly by telephone to assess current conditions and needs, (4) contact the participant or his/her representative within 24 hours after receiving a request or phone call, (5) consult with Care Team members about changes in the participant's status or needs to revise the Care Plan, (6) ensure that the participant has access to a primary care provider and that the provider receives medical information about the patient, (7) arrange for additional medical, human and support services, as required, (8) identify appropriate social and community opportunities for the participant including adult day programs, cultural opportunities and social groups for elders and individuals with disabilities, (9) educate the participant and care giver about the 24 back-up plan, (10) assess on an on-going basis the adequacy of the back-up safety plan and make improvements to ensure the participant's health and safety are met, and (11) report critical incidents, such as abuse, neglect and exploitation, to the Program/Quality Specialist in OICSS and to the proper authorities for investigation and resolution.

The current State case managers are not sufficient to provide the intensive services required by MFP participants. It is our experience that the level of case management oversight, monitoring and intervention is very high during the initial transition phases for elders. Therefore, the Transition Coordinators will provide the intensive care management services for the elder population and during the initial MFP phases. Current state staff can begin case management

activities after the 365-day eligibility period. It is the State's experience that the level of case management required for disabled adults are high during and after the transition period and that is why Rhode Island is proposing Peer Mentors as a Qualified HCBS.

Re-enrollment of Beneficiaries After Completed MFP and Re-institutionalized

A *Rhode to Home* participant, who has been institutionalized for less than 30 days consecutive days during the twelve-month period, may simply re-enter the demonstration program. The Transition Coordinator or Peer mentor will review the Care Plan upon the participant's return home to ensure that needs continue to be adequately met.

The participant will be disenrolled from the MFP demonstration if he/she is institutionalized for more than 30 days during the twelve-month period. These Medicaid beneficiaries, however, may re-enroll in the program without meeting the 90-day residency requirement. For those beneficiaries, the Care Plan will be reviewed and modified, if necessary, to assure that the appropriate services and support are provided.

It is RI's understanding that regardless of when a Medicaid beneficiary is re-institutionalized or the reason for re-institutionalization, a participant is only eligible for 365 days in the MFP demonstration and that the State is only eligible for a total of 365 days of enhanced match for each participant.

Until further CMS guidance, RI will not reenroll an individual back into the MFP demonstration that has received the 365 days of eligible MFP services and is then subsequently re-institutionalized.

Approval of the Plan of Care

A multidisciplinary team will develop the MFP Care Plan. The Care Plan will be developed by the Transition Assessment Nurse; the Medicaid beneficiary and his/her family, guardian or care giver, the beneficiaries primary care provider and other medical specialists involved in the case, and the designated Transitional Coordinator (elders) or Peer Mentor (adults with disabilities). The Care Plan will be based on the Comprehensive Assessment that is conducted and that is person-centered and focused on the specific health, human service and community based needs. The Service Plan consists of three sections: (1) Service Plan that identifies the frequency and duration of services, (2) Risk Mitigation Plan that includes a description of risk factors and intervention to address each risk factor, and (3) Risk Back-Up Plan identifying the necessary backups for supports and services identified in the Care Plan. The MFP participant or their representative will be required to sign the Care Plan as well as the designated Transition Coordinator or Peer Mentor. As part of the Care Development process the participant is informed of their rights to appeals and decision regarding the provision of care.

A copy of the Care Plan will be sent to the appropriate Long-Term Care Field Office (LTCFO) to enter the Service Plan information into the In-Rhodes Eligibility System, which is tied to the MMIS system, in effect authorizing the services for claims payment. The Long-Term Care field office will notify the designated Transition Coordinator or Peer Mentor if there are any problems with authorizing the proposed amount, scope or duration of services. A formal notification will be sent to the recipient notifying them of their rights to appeal the decision, including the appeals process. The designated Transition Coordinator or Peer Mentor will again inform the participant of their rights to appeals after an adverse decision related to the authorized services.

Procedures and Processes to Ensure Patients/Families Received Information to Make Informed Decisions

The Transitional Assessment Nurse will meet with the Medicaid beneficiary and his/her family/guardian before beginning the Assessment Process. The meeting in the nursing home will be exploratory in nature to determine beneficiary needs and desires as well as to obtain family members/guardians perspective about the appropriateness and desirability of transitioning to a community setting. During this meeting, the Transition Assessment Nurse will reinforce the voluntary nature of the demonstration and provide information to enable them to make an informed decision. The Assessment Nurse will review with the beneficiary and his/her family/guardian a brochure about MFP, fact sheets that describe the key elements of the demonstration (e.g. enrollees rights and responsibilities, voluntary nature of the demonstration, the process for enrolling in the demonstration, supports and services provided to ensure a successful transition, key requisites for remaining in a community setting). The Assessment Nurse will respond to all questions and converse with the beneficiary and his/her family/guardian to ensure that they have sufficient information to make an informed decision before beginning the Comprehensive Assessment Process. The results of the MFP Comprehensive Assessment will be reviewed with the beneficiary and his/her family/guardian. If the beneficiary is an appropriate MFP candidate, the Assessment Nurse will have further conversations with the beneficiary and his/her family/guardian to ensure that they have sufficient knowledge about options available to them and an understanding of the MFP demonstration. The Medicaid beneficiary and his/her family/guardian will be integral members of the Assessment and Care Plan Team.

The Assessment Nurse, the beneficiary's primary care providers and other medical specialists involved in the care of the beneficiary will be involved in the Assessment and Care Planning process. In addition, the beneficiary; his/her family, guardian, and caregivers; and the designated Transition Coordinator or Peer Mentor will be involved in the Assessment and Care Planning processes. RI will welcome involving other individuals in the Assessment and Care Planning processes at the consumer's request.

Once the Medicaid beneficiary has been enrolled in the program and successfully transitioned, the designated Transition Coordinator or Peer Mentor will become the primary contact and care manager for the MFP participant to ensure a successful and lasting transition. As previously noted, Transition Coordinators (for elders) and Peer Mentors (for individuals with disabilities) will conduct a home visit within 10 days of the transition. The participant's family/guardian and caregivers will be invited to attend this meeting. This visit will serve two purposes: to ensure that the initial phase of the transition is proceeding as planned, and to determine if any changes need to be made in the Care Plan or if additional services/supports are required; and to provide a more in depth education about key MFP demonstration elements and how to access them. Key topics that will be addressed at this visit include: (1) the proper use of the 24 hour back-up system, (2) the identification and reporting of critical incidents related to abuse, neglect and exploitation, and (3) service or care issues that are not being met.

The Transition Coordinator or the Peer Mentor will provide and review with the beneficiary a 24 hour Back-Up System Fact Sheet describing the three tiered approach described in Section 6 of this document (i.e. contact participant's own back-up, contact the service provider, and contact the 24/7 contracted organization after business hours and on holidays). If these steps do not work, then the beneficiary will be instructed to contact their designated

Transition Coordinator or Peer Mentor who will follow-up to determine why the system failed and what appropriate changes should be made in the back-up system or in the Care Plan. The Transition Coordinator or Peer Mentor will report these instances to the MFP Program/Quality Specialist so that all failures are accounted for and to determine if system-wide changes are necessary.

The Transition Coordinator or the Peer Mentor will provide and review with the beneficiary a Critical Incident Reporting Fact Sheet that describes how to recognize and report incidences of abuse, neglect and exploitation. The participant will be instructed to notify their Transition Coordinator, who in turn will notify the proper State Authorities for investigation as well as the telephone of the State Authority to report such incidents directly themselves. Appendix H provides an illustrative flow chart on how DHS will handle critical incidences, when reported to them.

RI law requires any person who has reasonable cause to believe that an elderly person has been abused to report it to the Department of Elderly Affairs, Abuse and Protective Services Unit Intake line at (401) 462-0555. The DEA Protective Services Unit is responsible for investigating complaints of elderly abuse of Rhode Islanders 60 and older by a family member, caregiver or person with duty of care. Abuse may include physical, emotional, sexual, financial exploitation or abandonment. The Unit assesses the elder's needs and develops a plan of care to prevent additional abuse and to provide the necessary social services. The average turn-around time for investigating a complaint is based on the need or severity of the circumstances surrounding a case. A DEA Unit Supervisor establishes priorities for all cases. Priority I cases are investigated and completed within 1-2 working days. Priority II cases are investigated and completed within 3-4 working days. Priority II cases are investigated and completed within 3-5 days.

DEA offer up to three days of emergency respite placements and protective services for clients who agree to the placements, should this be necessary to protect the client.

DEA Unit also contracts with the regional case management agencies to coordinate care and services based on the outcome of assessments. For example, DEA contracts with The Alliance for Better Long Term-Care to provide Ombudsman Services. DEA refers cases for Ombudsman Services as soon as the need is determined based on the investigated assessments. The Ombudsman serves as an advocate, mediator and problem solver for persons receiving services from licensed home health care agencies and/or hospice services. The Ombudsman also investigates complaints of abuse or inadequate or poor services in the areas of care that the client or their family has not been able to resolve with the provider agency.

The Transition Coordinator or Peer Mentor will notify the MFP Program/Quality Specialist of all critical incidences to assess whether there are patterns that require system-wide changes in the demonstration. Both the 24-hour backup system and critical incidences will be described in the MFP Participant Handbook.

2. Informed Consent and Guardianship

The Rhode to Home MFP Demonstration Project will incorporate informed consent procedures and guardianship participation consistent with current State law and policies. The procedures for obtaining informed consent and guardianship requirements vary by target population and the following are the requirements related to the adult populations.

Informed Consent

Providing information about informed consent will occur throughout the care delivery process beginning with outreach efforts. The Care Plan Team will explain the reasons for informed consent and ask the participant or guardian to sign an informed consent form. The Transition Coordinator or Peer Mentor continue the education process throughout the clinical process and obtain revised informed consent forms, when necessary. Topics covered by the informed consent form include:

- General information about the program, including purpose, voluntary nature and impact on the participant's Medicaid eligibility status.
- Benefits of participating in the program.
- Information about services available to the participant at the conclusion of the demonstration year.
- Responsibilities of the participant while enrolled in the program.
- Confidentiality of MFP participant information**.**
- The participant's ability to withdraw from the program at any time.
- Specific contact information for reporting incidents of abuse, neglect, theft or financial exploitation.
- Specific contact information for reporting complaints or appealing decisions regarding the type or delivery of services.
- Specific contact information for complex questions regarding benefits or services.

- The option to formally decline participation in the program.

The Informed Consent Form also indicates:

- That the beneficiary may have to make a monthly contribution towards the cost of my services. The case manager will review that with the beneficiary before they have to make a decision to participate in the program.

- The program lasts for 365 days. At the end of the year, the participant may continue to receive qualified home and community based services as long as they remain eligible for Rhode Island Long Term Care. If they do not meet the eligibility requirements for Long Term Care, the beneficiary may be eligible for other services that the case manager will describe for me and assist me.

A draft of the proposed Informed Consent Form is included in Appendix I.

Guardianship

As in many other states, Rhode Island statutes presume that an adult eighteen years of age or older is capable of handling his or her own affairs. In 1992, Rhode Island established a Limited Guardianship process that "least interferes with the legal capacity of a person to act in his or her own behalf." (Rhode Island General Laws, § 33-15-1). The process seeks to ensure that an individual's ability to make care decisions is fully exercised, and requires guardianship only in areas where capacity is not sufficient. The law also establishes a principle of "least restrictive alternatives" that are reviewed through the petition process. Such options may include social supports through government programs as well as more formal arrangements such as powers of attorney and trusts.

In keeping with these requirements, The *Rhode to Home* Assessment Team will initially ensure that candidates and guardians have appropriate education and opportunity for questions during the care planning process. The Transition Coordinator or Peer Mentor will continue that education process throughout the MFP demonstration period. The *Rhode to Home* Assessment Team staff will assess each individual's guardianship status, including whether the individual has a guardian, whether the individual does or does not need a guardian, and whether the individual has been referred for guardianship documentation.

The Transition Assessment Nurse will identify the guardian for each potential participant, will discuss the MFP program with the guardian, and will create a contact plan for the guardian, including how frequently the guardian should be contacted by the Transition Coordinator or Peer Mentor during the transition process. Expectations for guardians' participation will be clearly identified and included in the Care Plan. The Care Plan will support the statutory requirements for limited guardians including, but not limited to, annual reports to the probate court. The Transition Coordinator or Peer Mentor will document the guardian contact information, nature of the relationship between guardian and participant, and contact preferences throughout the MFP demonstration period.

3. Outreach/Marketing/Education

RI plans to develop and conduct a multi-dimensional outreach, marketing and education campaign to: (1) inform the public and stakeholders about the MFP project, (2) educate participants about the MFP program, and (3) train MFP staff and its contractors to conduct the essential tasks and provide the vital MFP services.

The Rhode Island MFP project will submit all outreach, education and training materials that will be used in the demonstration program to the CMS Project Officer for her approval prior to using them.

General Outreach and Marketing Efforts

RI will implement a multi-media campaign to: (1) promote the benefits and the value of the MFP demonstration, (2) provide information about who is eligible for the project, (3) describe how to enroll in the program, (4) describe LTC options, (5) describe what services and supports are available, and (6) identify who to contact to learn more about the program. Specifically, this section describes the types of media, forums to be used, dissemination locations, and the availability of bilingual materials and interpretation services outlined in the CMS MFP announcement guidelines.

The *Rhode to Home* demonstration's general outreach and marketing efforts will include the following:

- **Print Materials** such as brochures/pamphlets, fact sheets and posters that will be displayed and/or distributed statewide in community agencies, or though LTC providers, civic organizations, advocacy groups or governmental organizations, statewide.
- **Power Point Slides** will be developed and used in presentations.

- **Videos** will be used in general outreach and marketing efforts, discussions with Medicaid beneficiaries, and in educational efforts with MFP participants and their families/representatives.
- **Presentations** will be conducted by *Rhode to Home* project staff and members of the MFP Steering Committee to: key community groups; at health care meetings and conferences; to physicians, nurses and therapists; and at professional association meetings.
- **Web Sites** for EOHHS and its departments (including the POINT web site) will be up dated to include the MFP demonstration and to describe how to enroll in the demonstration.
- **A Press Release and Event** will be conducted to announce the MFP project.
- **Newspaper Articles/Stories** will be drafted for publishing in key newspaper throughout the State.
- **Radio and/or Television** coverage will be obtained through Public Services Announcements or by having State and DHS policy makers appear on community/public service programs.
- **A *Rhode to Home* State Forum** will be conducted in Providence to promote the demonstration and to enhance referrals. The State Forum will be designed for potential families/representatives of potential participants, advocacy groups, community leaders, LTC providers and other stakeholders. The forum will include presentations by State and MFP staff, members of the MFP Steering Committee, and State Leaders. Breakout sessions will be conducted to encourage exchanges between presenters and attendees and to increase referral to the project.

DHS produces bilingual materials in Spanish and has interpretative services available, when needed.

Information Communicated to Participant

Specific and focused education efforts will be implemented to assure that Medicaid beneficiaries and their families/representatives have sufficient information to make an informed decision about their participation. The following specific measures will be conducted to inform participants about the MFP demonstration.

- **Letters** will be sent to all potential participants and/or their family/representative living in nursing homes to inform them about the demonstration and the opportunities that they may have to live in the community.
- **A Brochure** will be developed for potential MFP participants that describes: (1) eligibility requirements, (2) the programmatic/clinical assessment, care plan development and transitioning processes.(3) services and supports available to assist in transitioning, (4) other LTC options, (5) continuation of other Medicaid benefits, (6) beneficiary responsibilities including the importance of beneficiary involvement throughout the process, (7) beneficiary rights including the voluntary nature of the demonstration, (8) next steps and who from the MFP project will contact them, (9) what happens after the 365 demonstration period, and (10) key requisites for successful transition and remaining in the community.
- **MFP Transition Assessment Team** will conduct consultations in nursing homes enrolled in the Medicaid program, throughout the State. The Transition Assessment Team can meet with the nursing home patient or his/her family member/representative to

review the MFP fact sheet and brochure with them; show them a video of a successfully transitioned persons; and answer any questions they may have about the demonstration. These meetings provide the Transition Team with an opportunity to begin determining the needs, current support system, LTC options, potential housing options available to the beneficiary, and critical requisites for successful transition and living in the community. These meetings provide consumers and families with vital information so that they make an informed choice.

In all instances, RI will only include in the *Rhode to Home* demonstration those Medicaid beneficiaries who want to transition into the community and have the capability to safely transition into a community-based setting.

Staff Training Plans

All MFP staff with direct contact with participants will receive both classroom and practical training. The staff will be required to review the MFP Operational Protocol and all project materials and tools. The training sessions will be conducted over a two to three day period. The training sessions will include: (1) presentation about the goals of the MFP program, (2) Rhode Island's need to rebalance its LTC system, (3) the State's Rhode *to Home* project, (4) a detailed presentation of each elements and tool that will be used by staff in administering the program, (5) Medicaid beneficiary rights and responsibilities, and (6) State Medicaid policies, procedures and benefits package available to all beneficiaries. Breakout sessions will also be conducted for the staff that represents the various functions within the program. A separate break-out session will be conducted for the Assessment Team Nurses, Transition Coordinators and Peer Mentor to review in detail the operational protocols and tools that will be used in the

process (e.g. LTC Medicaid Eligibility Form, Comprehensive Assessment Tool, Care Treatment Plan including the 24 hour back-up system and critical incident identification and reporting. These staff will be required to go through the programmatic process and complete each instrument that will be used. The staff will also receive special training on how to enhance participant and family/guardian engagement in all phases of the MFP project and ways to foster a cooperative relationship.

A break-out session will be conducted for the Housing Coordinator to review (1) what federal, State and local resources are available to identify and to access affordable housing, (2) State builders and contractors and how to best interface with them, and (3) how to assist participants in finding and transitioning to qualified residences.

This training will be conducted during the first month staff begin employment prior to serving participants. The first training will be this August 2011. The Administrator of OICSS, current staff in RI's Nursing Home Transition Project and the MFP Project Director/Deputy Project Director, will conduct the training. The Administrator of OICSS, the Project Director/Deputy Project Director, will train all new hires immediately upon employment.

MFP contractors will be required to supplement State training, to share their experiences and key practices for the specific MFP target populations and to conduct on-going training to addresses critical issues or operational problems. These training events will be approved and attended by RI MFP staff.

All new Transition Assessment Nurses, Transition Coordinators, and Peer Mentor will work with DHS's current Transition Nurses and Social Workers before they will provide services on their own.

The MFP Program Development/Quality Specialist will monitor the progress of work performed by the clinical/treatment operational staff. DHS is committed to providing on-going training to all staff throughout the project that responds to emerging needs or new operational requirements.

How Participants are Informed of Cost Sharing Responsibilities

All participants and/or their responsible representative, such as a guardian or power-of-attorney will be advised by the MFP Transition Assessment Team the expected cost share that the participant must pay to the provider for their Home and Community- Based Services. Subsequent to the actual discharge from the institution, the participant or the other responsible party will be sent an InRhodes notice detailing the exact cost share that the participant is responsible to pay towards the services received from the authorized provider.

All participants and/or their responsible representative, such as a guardian or power-of-attorney will be advised by the MFP Transition Assessment Nurse the expected cost share that the participant must pay to the provider for their home and community based services. Subsequent to the actual discharge from the institution, the participant or the other responsible party will be sent an In Rhodes notice detailing the exact cost share that the participant is responsible to pay towards the services received from the authorized provider. This process will not take more than 30 days and it will be completed prior to transition.

4. Stakeholder Involvement

RI has a rich tradition of including stakeholders in the planning of programs and will seek to build on stakeholder involvement under the Global Waiver and the Real Choice System

Transformation grant. The following describes how consumers and home and community based providers will be involved in the MFP Demonstration.

EOHHS has developed a strong working relationship with the broad based stakeholder community in RI. The stakeholders' input to program development is considered a valuable resource to implementing program initiatives in RI. RI has developed the MFP Operational Protocols in accordance with the priorities identified by the stakeholders that have been providing input on the RI efforts to rebalance long-term care services and supports under the Real Choice Systems Transformation Grant and the RI Medicaid Global Waiver planning and implementation activities.

The DHS program initiatives enjoy strong support from our stakeholder partners, which include the institutional providers. The Nursing Facility trade associations, Leading Age RI and RI Health Care Association, have worked closely with the state to implement many of the rebalancing activities under the Global Waiver. The institutional providers participated in the training for the new levels of care, the Nursing Home Transition Program and the MDS Section Q initiative. RI will be hosting a discharge planner training conference at the end of April to provide additional discharge training on community resources and tools available to discharge planners. In addition, the Executive Director of Leading Age RI serves as the chairman of the Global Waiver Taskforce Housing subcommittee. This subcommittee has helped to foster strategies to identify affordable housing capacity for adults with disabilities and elderly Medicaid beneficiaries. Letters of support for the *Rhode to Home* demonstration are attached.

RI will form a *Rhode to Home* Stakeholder Steering Committee (Steering Committee) to collaborate with DHS and MFP staff throughout the demonstration period. The goals of the Steering Committee are to obtain valuable input that helps guide the development,

implementation and operations of the project as well as to obtain specific recommendations that foster rebalancing of LTC services. It is also expected that MFP Steering Committee members will be invaluable in promoting the benefits of the MFP demonstration statewide.

The Steering Committee will consist of 15-20 members representing Medicaid beneficiaries, advocacy groups, long-term care providers, community health and human services organizations, housing agencies and authorities, and state agencies. Specifically, we intend to invite specific individuals who represent:

- Alliance for Better Long-Term Care
- A consumer from each population groups served by the MFP demonstration
- State Nursing Home Association
- Behavioral Health Facility Associations/Groups (e.g. ICF/MRs, Psychiatric Hospitals)
- Housing Agencies and Authorities (e.g. Rhode Island Housing; local Public Housing Agencies, Community Development Agencies)
- Rhode Island Associations of Builders and Contractors
- State LTC community-based service associations/organizations (e.g. Rhode Island Assisted Living Association (RIALA); Rhode Island Association of Facilities and Services for the Aging (RIAFSA); Rhode Island Health Care Association (RIHCA); Rhode Island Partnership for Home Care (RIPHC); Community Provider Network of Rhode (CPNRI).
- Community Health and Human Services providers such as the PARI Center for Independent Living.
- State Agency Partners (including DEA, DCYF, BHDDH, DHS as well as the Rhode Island Department of Health).

- The Advocacy Groups that will be on the MFP Steering Committee that represent the Phase I population (i.e. elders and persons with disabilities) include: PARI Center for Independent Living, Ocean State Center for Independent Living, Governor's Commission for Disabilities, Alliance for Better Long-Term care, Senior Agenda Collation, AARP, Brian Injury Association of \Rhode Island, Rhodes to Independence, the Poverty Institute, Lt. Governor's LTCCC, and Rhode Island Parent Information network.

Steering Committee members who are participants (or family of participants) will be offered a $50 stipend per meeting to cover expenses associated with their participation. It is Rhode Island intent to ensure that consumer's have sufficient representation on the Steering Committee to ensure that their perspective is appropriately addressed in all Steering Committee deliberations.

The MFP Steering Committee will be headed by the Medicaid Director and Co-Chaired by the OICSS Administrator. The MFP Project Manager will prepare the Steering Committee agenda in consultation with MFP Steering Committee members. The MFP Steering Committee will meet monthly during the early phases of the project and bi-monthly thereafter.

DHS will invite a representative from the MFP Steering Committee to be a member of our on-going Global Waiver Task Force, Medical Care Advisory Committee, and Consumer Advisory Committee.

Consumer engagement is a challenge but is absolutely critical to the ultimate project success. The *Rhodes to Home* demonstration will also conduct consumer and provider focus groups in the MFP demonstration. These focus groups will provide unique insight into the needs, requirements, and key variables of success from a consumer and provider perspective. Critical areas that will be pursued in these focus groups include: (1) key factors in preventing transition, (2) key factors in decision-making to transition to a community setting, (3) critical services and

supports that maintain community-based living, (4) an assessment of the current available community supports (i.e. real or perceived access problems as well as the quality of care), and (5) desired improvement in the current system. DHS will develop the questions to be addressed in the focus groups in consultation with the MFP Work Groups established within the Steering Committee. The Focus Group sessions will be taped and a report will be prepared describing the results of the focus group. DHS will consider qualified companies, such as MCH Evaluations Inc., a Minority Business Enterprise with over 20 years of experience conducting focus groups with Medicaid beneficiaries. The focus groups will consist of participants who have already successfully transitioned into the community. Separate focus groups will be conducted for each target population (i.e. up to a total of three consumer focus group sessions). Each focus group will consist of 8-10 participants. Consumer focus group participants will be provided with lunch and a $50 stipend to cover transportation.

Separate provider focus groups will be conducted with providers that serve each of the different MFP target populations (up to three focus group sessions). Each focus group will consist of 8-10 participants. Provider focus group participants will be provided with lunch.

Most importantly, the MFP demonstration will draw on the local and nationally recognized academic resources of Brown University Center of Gerontology at key points during the demonstration as well as the University of Rhode Island School of Pharmacy.

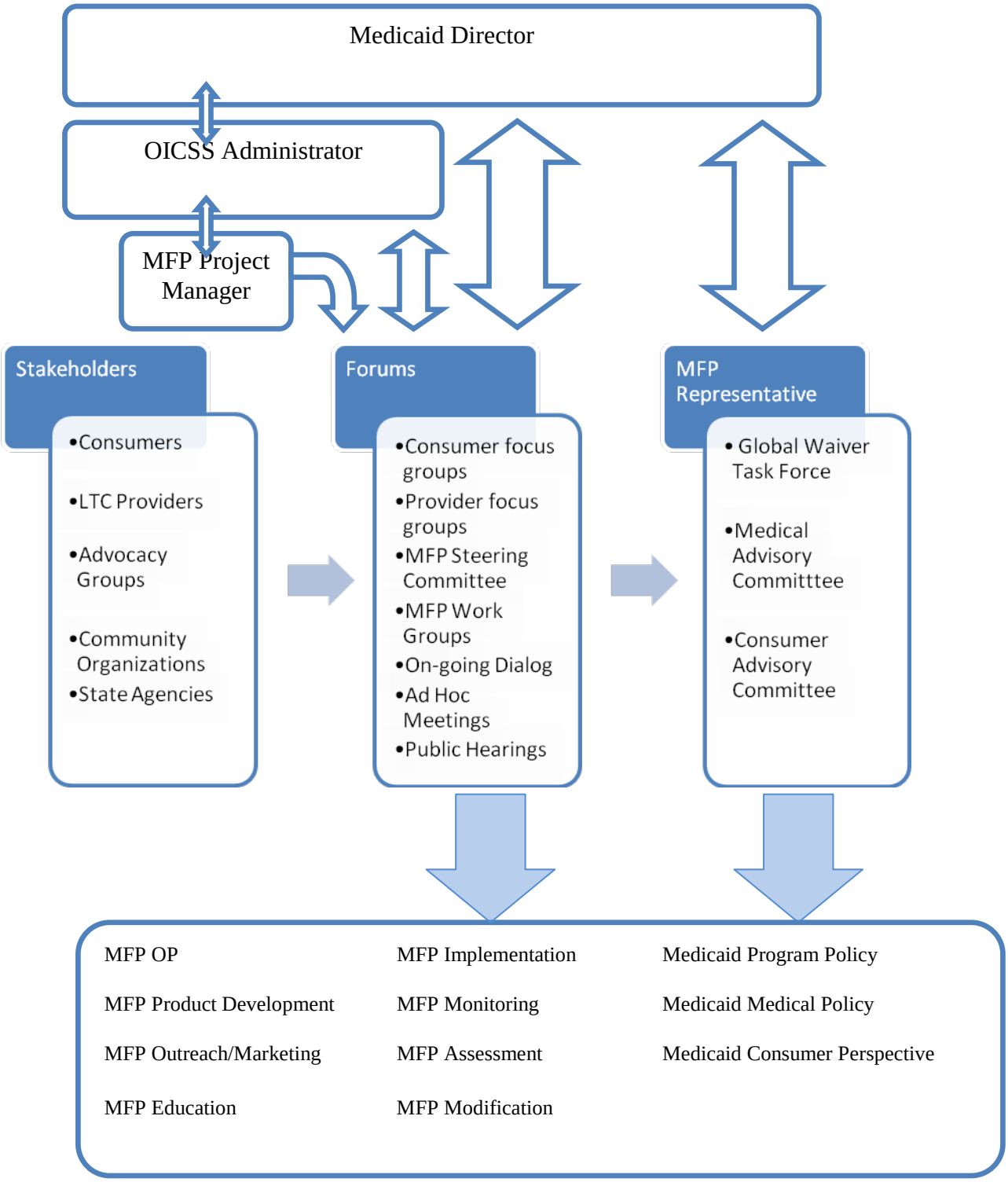
Throughout the MFP demonstration, DHS and the other EOHHS departments will continue to work collaboratively with other state agencies to rebalance the LTC system. EOHHS has scheduled monthly policy meetings and department staff will work together, on a daily basis.

Public Hearings are held by DHS to receive stakeholder input into major changes in Medicaid policy or when proposing a new program. Most importantly, the Medicaid Director

and the Administrator of Office of Institutional/Community Services and Supports (OICSS) have maintained an “open door” policy to meet with and to discuss critical issues with consumers and providers. That practice will remain during the MFP demonstration period.

The following exhibit reflects how stakeholders will influence the MFP Demonstration. Consumers and other stakeholders will have an input into the operation components of the MFP demonstration through various forums. Consumers and providers will: (1) participate in separate focus groups, (2) be represented on the MFP Steering Committee, (3) work on MFP work groups to develop and/or review MFP operational components, and (4) encouraged to testify in a Public Hearing that may be held. In addition, the Medicaid Director, OICSS Administrator and the MFP Project Director will maintain an “open-door” policy to speak with or meet with consumers or other stakeholders individually or with a group to discuss MFP related issues and to maintain an on-going dialogue with these individuals/groups.

Stakeholder Involvement



5. Benefits and Services

The Global Waiver consolidated the services provided under the nine 1915 (c) waivers and categorized them as either a core or preventive service. The covered core and preventive services are available to all Medicaid population groups, depending on individual need. These services are described as the Qualified HCBS Services.

The chart below provides an overview of the revised benefits and services that is proposed by Rhode Island and the status of each benefit. The chart is followed by the responses to each of the questions noted in the specific terms and conditions.

Overview of MFP Benefits and Services

BENEFITS/SERVICES	STATUS
QUALIFIED HCBS	
Core	
Homemaker	**Global Waiver Approved**
Environmental Modifications	**Global Waiver Approved**
Special Medical Equipment (Minor Assistive Devices)	**Global Waiver Approved**
Meals on Wheels	**Global Waiver Approved**
Personal Emergency Response	**Global Waiver Approved**
LPN Services	**Global Waiver Approved**
Residential Supports	**Global Waiver Approved**
Day Supports	**Global Waiver Approved**
Supported Employment	**Global Waiver Approved**
Supported Living Arrangements	**Global Waiver Approved**

Private Duty Nurse	**Global Waiver Approved**
Participant Directed Goods & Services	**Global Waiver Approved**
Case Management	**Global Waiver Approved**
Senior Companion	**Global Waiver Approved**
Assisted Living	**Global Waiver Approved**
Personal Care Assistance	**Global Waiver Approved**
Respite	**Global Waiver Approved**
Community Transition Services	**Global Waiver Approved**
Preventive	
Homemaker	**Global Waiver Approved**
Minor Environmental Modifications	**Global Waiver Approved**
Physical Therapy Evaluations & Services	**Global Waiver Approved**
New Service	
Peer Mentor (Persons with Disabilities)	**Provide under MFP & then under Global Waiver**
DEMONSTRATION SERVICES*	
Transition Coordinator (Elders)	**Provide under MFP**
SUPPLEMENTAL SERVICES	
	None requested under Part I MFP Implementation

***Non-Emergency Transportation: identified in initial MFP OP has been eliminated as a Demonstration Service because HCBS providers have capacity to provide non-medical transportation.**

Qualified HCBS

The following describes the qualified HCBS that RI currently provides and will provide under the *Rhodes to Home* MFP demonstration. All of the Qualified HCBS services under the MFP grant during the 365-day demonstration period are at the enhanced match and after the 365-day period at the standard FMAP.

Core Services

The following are the core services Rhode Island currently provides to Medicaid beneficiaries under the Global Waiver.

- **Homemaker Services**: that consists of the performance of general household tasks (e.g. meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the state for the provision of these activities.
- **Environmental Modifications (Home Accessibility Adaptations):** Those physical adaptations to the private residence and/or vehicle of the participant or the participant's family, required by the participant's service plan, are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g. in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheel chair). All services shall be provided in

accordance with applicable State or local building codes and are prior approved on an individual basis by the DHS CAH.

- **Special Medical Equipment (Minor Assistive Devices):** Specialized Medical Equipment and supplies to include (a) devices, controls, or appliances, specified in the plan of care, which enable participants to increase their ability to perform activities of daily living; (b) Devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; including such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. Provision of Specialized Medical Equipment requires prior approval on an individual basis by the DHS.
- **Meals on Wheels (Home Delivered Meals):** The delivery of hot meals and shelf staples to the waiver recipient's residence. Meals are available to individuals unable to care for their nutritional needs because of a functional dependency/disability and who require this assistance to live in the community. Meals provided under this service will not constitute a full daily nutritional requirement. Meals must provide a minimum of one-third of the current recommended dietary allowance. Provision of home delivered meals will result in less assistance being authorized for meal preparation for individual participants, if applicable.

- **Personal Emergency Response (PERS):** PERS is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. Trained professionals staff the response center, as specified by DHS. This service includes coverage for installation and a monthly service fee. Providers are responsible to insure the upkeep and maintenance of the devices/systems.
- **LPN Services (Skilled Nursing):** Licensed Practical Nurse services provided under the supervision of a Registered Nurse. Licensed Practical Nurse Services are available to participants who require interventions beyond the scope of Certified Nursing Assistant (C.N.A.) duties. LPN services are provided in accordance with the nurse practice act under the supervision of a registered nurse. This service is aimed at individuals who have achieved a measure of medical stability despite the need for chronic care nursing interventions.
- **Residential Supports**: Assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in their own home and a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance (where applicable), or upkeep and improvement.
- **Day Supports**: Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Day supports focus on enabling the individual to attain

or maintain his/her maximum functioning level and are coordinated with any other services identified in the person's individual plan.

- **Supported Employment**: Includes activities needed to sustain paid work by individuals receiving waiver services, including supervision, transportation and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.
- **Supported Living Arrangements**: Includes personal care and services, homemaker and chore services, attendant care, companion services and medication oversight (to the extent permitted under State law) provided in a private home by a principal care provider who lives in the home. Supported Living Arrangements are furnished to adults who receive these services in conjunction with residing in the home. Separate payment will not be made for homemaker or chore services furnished to an individual receiving Supported Living Arrangements, since these services are integral to and inherent in the provision of adult foster care services.
- **Private Duty Nursing:** Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law and as identified in the Individual Service Plan. These services are provided to an individual at home.
- **Supports for Consumer Direction (Supports Facilitation):** Focuses on empowering participants to define and direct their own personal assistance needs and services; guides

and supports, rather than directs and manages, the participant through the service planning and delivery process. The Facilitator counsels, facilitates and assists in development of an Individual Service Plan which includes both paid and unpaid services and supports designed to allow the participant to live in the home and participate in the community. A back-up plan is also developed to assure that the needed assistance will be provided in the event that regular services identified in the Individual Service Plan are temporarily unavailable.

- **Participant Directed Goods and Services:** Participant Directed Goods and Services are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need and are in the approved Individual Service Plan (including improving and maintaining the individual's opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; and/or promote inclusion in the community; and/or the item or service would increase the individual's ability to perform ADLs or IADLs; and/or increase the person's safety in the home environment; and, alternative funding sources are not available. Individual Goods and Services are purchased from the individual's self-directed budget through the fiscal intermediary when approved as part of the ISP. Examples include a laundry service for a person unable to launder and fold clothes or a microwave for a person unable to use a stove due to his/her disability. This will not include any good/service that would be restrictive to the individual or strictly experimental in nature.
- **Case Management:** Services that assist participants in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other

services, regardless of the funding source for the services to which access is gained. Case managers are responsible for ongoing monitoring of the provision of services included in the individual's plan of care. Case managers initiate and oversee the process of assessment and reassessment of the individual's level of care and review of plans of care on an annual basis and when there are significant changes in client circumstances.

- **Senior Companion (Adult Companion Services):** Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the participant with such tasks as meal preparation, laundry and shopping. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks, which are incidental to the care and supervision of the participant. This service is provided in accordance with a therapeutic goal in the service plan of care.
- **Assisted Living:** Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed community care facility in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility but the care provided by these other entities supplements that provided by the community care facility and does not supplant it. Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the

arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room, or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way that fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect. Costs of room and board are excluded from payments for assisted living services.

- **Personal Care Assistance Services:** Personal Care Assistance (PCA) Services provide direct support in the home or community to individuals in performing tasks they are functionally unable to complete independently due to disability, based on the Individual Service and Spending Plan. Personal Assistance Services include:
    - Participant assistance with activities of daily living, such as grooming, personal hygiene, toileting bathing, and dressing
    - Assistance with monitoring health status and physical condition
    - Assistance with preparation and eating of meals (not the cost of the meals itself)

- Assistance with housekeeping activities (bed making, dusting, vacuuming, laundry, grocery shopping, cleaning)
- Assistance with transferring, ambulation; use of special mobility devices
- Assisting the participant by directly providing or arranging transportation (If providing transportation, the PCA must have a valid driver's license and liability coverage as verified by the Fiscal Intermediary.

- **Respite** is defined as a service provided to participants unable to care for themselves that is furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Federal Financial Participation is not claimed for the cost of room and board as all respite services under this waiver are provided in a private home setting, which may be in the participant's home or occasionally in the respite provider's private residence, depending on family preference and case-specific circumstances. When an individual is referred to a DHS-certified respite agency, a respite agency staff person works with the family to assure they have the requisite information and/or tools to participate and manage respite services. The individual/family will already have an allocation of hours that has been recommended and approved by DHS. These hours will be released in six-month increments. The individual/family will determine how they wish to use these hours. Patterns of potential usage might include: intermittent or occasional use; routine use of a few hours each week; planned weekends away; a single block of hours that might allow the rest of the family to spend a few days together, or some combination of the above. The individual's/family's plan will be incorporated into a written document that will also outline whether the individual/family wants help with recruitment, the training needed by

the respite worker, the expectations of the individual/family relative to specific training and orientation to the home, and expectations relative to documenting the respite worker's time. Each participant in the waiver may receive up to 100 hours of respite services in a year. Additional hours may be available for urgent situations, at the discretion of DHS. (Under the Global Waiver, RI is already authorized to provide respite services but has not had the funding to provide the services)

- **Community Transition Services**: Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from a qualified institution to a qualified residence in the community. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: security deposits that are required to obtain a lease on an apartment or home, essential household furnishings, and moving expense, set-up fees or deposits for utility or service access, services necessary for the individual's health and safety, and activities to assess need, arrange for and procure needed resources. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan, and the person is unable to meet such expense or when the services cannot be obtained from other sources. They do not include ongoing shelter expenses; food, regular utility charges, household appliances or items intended for recreational purposes. (Under the Global Waiver, Rhode Island is authorized to provide Community Transition Services but has been unable to fund the services).
- **Peer Mentoring Services** which will be offered to eligible disabled MFP participants residing in nursing homes for at least 90 + days and throughout their transitioning period

as long as they remain in a community-based setting. The Peer Mentor will be a person with disabilities who successfully lives in a community-based setting. The Peer Mentor serves as the point person and care manager during the demonstration period and thereafter, if required by the participant to successfully remain in the community. The Peer Mentor will: participate in the development of the Care Plan; assist in referring to or arranging for the required services and supports; conduct a home "readiness review"; keep in constant contact with participants to assess service provision and needs; link participant to required services and supports; identify and report critical incidents, break-downs in 24 hour back-up system and other problems to the MFP project and to proper State authorities; and to serve as an educator, mentor, and coach throughout the demonstration period and thereafter, as required.

Preventive Services

The following are the preventive services RI provides under the Global Waiver.

- **Homemaker Services**: consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him/herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.
- **Minor Environmental Modifications:** Minor modifications to the home may include grab bars, versa frame (toilet safety frame), handheld shower and/or diverter valve, raised toilet seats, and other simple devices or appliances, such as eating utensils, transfer bath bench,

shower chair, aids for personal care (e.g., reachers), and standing poles to improve home accessibility adaption, health, or safety.

- **Physical Therapy Evaluation and Services:** Physical therapy evaluation for home accessibility appliances or devices by an individual with a State-approved licensing or certification. Preventive physical therapy services are available prior to surgery if evidence-based practice has demonstrated that the therapy will enhance recovery or reduce rehabilitation time.

Demonstration Services

The following service will be provided to MFP participants during the 365-demonstration period, but will not be available after the 365-day demonstration period to Medicaid beneficiaries.

Community Transition Services-- $1,000 per participant for costs associated with establishing a safe, appropriate community residence

- **Transition Coordinators** will provide the transition services for the elder nursing home population transitioning into a community setting. They serve as the point person and care manager for the elder participant during the 365-demonstration period to ensure a successful and lasting transition. The Transition Coordinators will: participate in the development of the Care Plan; assist in referring to or arranging for the required services and supports; conduct a home "readiness review"; keep in constant contact with participants to assess service provision and needs; link participants to required services and supports; identify and report critical incidents, break-downs in the 24 hour back-up system and other problems to the MFP project and to proper State authorities; and will serve as an educator, mentor, and coach throughout the demonstration period. Transition

coordinators provide services to only transitioning or transitioned participants 100 percent of their time. From a reimbursement perspective, Transition Coordinators are considered an administrative expense and reimbursed by CMS 100 percent during the 365-demonstration period.

Supplemental Services

Rhode Island is not proposing to provide any Supplemental Services for the two populations that will be covered under Phase I of the demonstration project. The State recognizes that it will have to submit an amendment to the MFP OP to provide Supplemental Services in the future for the existing or any new populations groups participating in the MFP demonstration program.

6. Consumer Supports

RI's approach is based on a coordinated model of care management to assist MFP participants and their families/representatives transition to and successfully remain in the community. As described in the previous section, RI will provide a full range of HCBS services and supports to all MFP participants in addition to the enriched benefits available through the Medicaid program.

Participants and their families/representatives will be involved in all key MFP processes including assessment, care planning, transitioning, supervising and determining the effectiveness of existing services and supports, and revising of Care Plans. Transition Assessment Nurses in conjunction with the Medicaid beneficiary will determine needs. A Care Plan Team with beneficiary participation will develop an operational Care Plan that meets the specific needs of

participant. Transition Coordinators for elders and/or the Peer Mentors for individuals with disabilities will assist the participant in transitioning into and remain in a community setting. The Transition Coordinators and Peer Mentors will assist participants in arranging for required supports and conduct a "readiness review" to ensure that residents meet the qualified definitions and that the housing meets safety requirements. The Transition Coordinator and Peer Mentor will work with the participant throughout the demonstration period to: assure that the services and support needs are met, ensure that the back-up system is properly functioning, report critical incidences to the proper authorities and, participate in modifying the participants Care Plan.

In addition, a special gerontology physician and therapists are available to assure that the participant's medical needs are met. Policies and procedures will be in place to receive and resolve participant complaints and grievances. It is within this system, that participant needs are met and that their welfare and safety are ensured.

Describe Educational Materials

RI will use the following educational tools to explain the demonstration to enrolled MFP participants and that will be useful to the participant as a future reference guide. These include:

- **Fact Sheets** will be used to describe key elements of the MFP program, including, but not limited to: who is eligible for the program, what services and benefits are available to participants, supports and services to assist in transitioning to a community setting, long term care options available to Medicaid beneficiaries, appropriate use of the 24 hour backup system, and reporting of Critical Incidents.
- **A Member Handbook** will be prepared and distributed to all new participants. The Member Handbook will be used during orientation sessions and as an on-going reference

source. The member handbook will describe: (1) the MFP demonstration goals and objectives and value of the demonstration, (2) the benefit package that is available under the demonstration and through Medicaid for the participants, (3) the services and supports that are available to assist participants transition and maintain an independent community based living, (4) the roles and responsibilities of services providers and agencies, Transition Assessment Nurses, Transition Coordinators and Peer Mentors, Housing Coordinator and other *Rhode to Home* specialists available to support the participant, (5) the participant's role and responsibilities, (6) how to access services, (7) what to do in emergent or urgent situations or when a participant's ongoing supports are either temporarily not available or not working appropriately, (8) what to do when the participant has a question, a complaint or a grievance, (9) who to report critical instances to that involve fraud, abuse or neglect, (10) Quality of Life Surveys, and (11) other key demonstration components.

Describe 24-Hour Back-Up System

A 24-hour back-up system is essential for MFP participants to ensure that services and supports are available on an as needed basis. The Rhode Island project proposes three levels of back up for all MFP participants:

- **Participants' Own Back-Up:** As part of the Care Plan, participants will be asked to designate an individual or individuals who may provide back-up services and supports to them. This designated individual(s) may be a family member or friend who is trustworthy, responsible and is knowledgeable about the participant's needs. The ideal individual(s) must live near the participant's residence so that they can provide assistance

in a timely fashion. A member of the State's Care Plan Development staff (e.g. Transition Assessment Nurse, Transition Coordinator, or the Peer Mentor) will contact the participant's designated back-up to assure that the individual is able and willing to serve as a first line back-up.

- **Service agencies** providing the services/supports will be a second back-up level. The agreement with the agencies will require them to serve as a back-up when individual service providers are either temporarily or permanently not able to provide the necessary services and supports to participants. The service providers will be required to submit monthly call logs detailing participant's requests for back-up assistance to the OICSS listing caller and the date and time of the call, the reason for the call, and the provider's action taken. DHS also requires service agencies to have written policies and procedures to handle inquiries and complaints from Medicaid beneficiaries that will be extended to cover MFP participants.
- ***Rhode to Home*** **After Business Hours or Holidays Live Back-up** available through a contracted transition coordination entity will provide the third level backup. The contractor will be required to: (1) maintain and staff a toll-free telephone and have a "live" person answering the phone, (2) maintain current inventory of a cadre of services providers that may be required by participants (e.g. transportation services; direct service workers such as homemakers, personal care workers, home aides; repair or replacement of durable medical equipment and supplies; medical service such as ambulance or appointment to physicians, therapists, and other health care providers; and other support needs such as meals or human services), (3) provide service or refer/arrange for the needed service/support, (4) follow-up that the service was provided, and (5) report

utilization on a monthly basis including call wait times, nature of request, categorization of urgency and types of responses. RI will contract out this service with an existing organization that provides triage and crisis intervention services.

MFP participants will be instructed on these back-up support systems as part of the Care Development process and during the initial home visit conducted by the Transition Coordinator or Peer Mentor. The MFP Participant Handbook will describe the 24-hour back-up system as well as a separate Fact Sheet on what to do when the 24- hour back-up system fails.

Frequent use of or need to use the back-up systems may indicate that the participant's service providers and supports are not functioning properly and that the Care Plan may need to be modified. A major responsibility of the Transition Coordinators and Peer Mentors will be to monitor the use of back-up systems by their assigned participants and to determine whether changes need to be made in the Care Plan.

Copy of Complaint and Resolution Process When Back-Up System Does Not Work

All participants will be instructed to contact their designated Transition Coordinator or Peer Mentor when the 24-hour back up system described above does not work. The Transition Coordinator or Peer Mentor will determine the reason for the problem and develop, along with the participant, improvement strategies to resolve the problem. The Transition Coordinator and Peer Mentor will be required to return telephone calls from participants within 24 business hours. MFP participants will also be instructed on how to use the existing Medicaid complaint and resolution system, telephone hotline, and the DHS's OCP staff of nurses and social workers to provide assistance in care coordination and case management.

The *Rhode to Home* program will build on the experience and resources of other State agencies. For example, DEA has an After Hours Program for Elders in Crisis, where they contact Family Services of RI to provide crisis intervention services, after 4 pm Mondays-Friday, and 24 hours on Saturdays, Sundays and State holidays. The Family Services clinician triages the call and determines if the elder is in immediate need of face-to-face intervention or if the issue can be handled by referral. Family Services notifies the DEA the following business day of the incident and the DEA determines whether further intervention is needed. Examples of problems may include that a caregiver has been hospitalized and the elder at home cannot be left alone, the elder has no food or electricity, or report of abuse or neglect. The United Way RI has a Safety Net Program to address an elder's needs in a crisis situation such as: homelessness and lack of a shelter; in need of food, clothing, shelter; medical emergencies; transportation services; and lack of heating or utilities. In addition, United Way 211 is a 24 hour help line that connects callers to essential services, such as: food, shelter, medical services, child care, transportation, counseling, and crisis intervention. These organizations may be able to enhance their programs and be able to serve as the *Rhode to Home's* third level "live" back-up system. The Office of Community Programs also has a staff of nurses who provide nurse case management for those clients living in the community, who are on RI Medicaid and who are medically complex. They assist in care coordination as well as monitoring health and safety in the home setting. These services are provided during working hours.

The Transition Coordinator or Peer Mentor will receive reports about use of back-up services to use in monitoring the adequacy of Care Plans in meeting the participant's needs. Reports will also be used by the *Rhode to Home* Program/Quality Specialist to monitor provider performance and identify program improvement strategies, when necessary.

7. Self-Direction

Rhode Island has always been committed to enabling Medicaid beneficiaries to self-direct and manages their own care. The MFP demonstration provides the State with another opportunity to offer individuals who are capable and desire a self-directed option. The opportunities for elders and persons with disabilities through a self-directed model are discussed below.

The Medicaid beneficiaries and his/her family/guardians will be presented with two options to receive care: (1) self-direct their own services, or (2) receive services through the provider managed system. (Medicaid beneficiaries in nursing homes beyond 30 days are not eligible under the RIte Care and Rhody Health Partners programs to enroll in a Managed Care Organization-MCO). During the initial assessment, the Transition Team will explore the potential participant's capacity and desire to arrange and managed his/her own services, including whether or not the beneficiary has a surrogate or care giver that may assist them. The Transition Assessment Team will refer those cases to a Self-Directed Contractor. (DHS now contracts with Tri-Town Community Action Agency, which is a certified case management entity and People Actively Reaching Independence (PARI), a federally funded Center for Independent Living). A Service Advisor will be assigned to assist the beneficiary: (1) conduct a comprehensive assessment, (2) develop a Care and Back-Up Plan, (3) develop a budget, (4) arrange for services, and (5) manage the services throughout the care process. The MFP participant will have a great deal of freedom in selecting their providers/care givers; determining working hours, staffing levels and wages; and in directing and managing the delivery of care. A separate Fiscal Intermediary (FI) agency is responsible is for all required financial, human

resource, and accounting tasks associated with the participant's enrollment in the self-directed model. Ocean State Community Resources and PARI currently are certified by RI DHS as FIs. This model has proven to be very successful for adults with disabilities and elder populations in our RI Personal Choice Program and will be adopted for the MFP demonstration. Self-directed participants will be responsible for locating, hiring and managing caregivers. The *Rhode to Home* self-directed participants will have access to an online regional work force database (Rewarding Work. org.) to facilitate the participant's access to a pool of Direct Care workers.

Appendix J contains the CMS Self-Directed Template for the adult and disabled nursing home populations.

Voluntary Termination in a Self-Directed Model

DHS has developed an effective approach to handling voluntary terminations of self-direction that assures the continuity of care. We plan to use this same approach for the MFP self-directed participants that are described below. All MFP participants may voluntarily terminate their self-directed program at any time.

There are several reasons why a beneficiary may want to terminate a self-directed program including: difficulty finding care givers and support staff, difficulty managing the workers and care, and changes in the beneficiary's conditions including health conditions and support network. Regardless of the reason, the MFP participant simply will have to advise their Service Advisor or their Care Manager from the contracted agency that they want to terminate self-direction. The service advisor will discuss the desired termination with their supervisor.

How Continuity of Care will be Assured

The contracted self-direction agency will notify the MFP program in DHS OICCS. The contract agency and self-directed participant will be asked to provide DHS with a copy of all

records related to the beneficiary's self-directed services. The case will be assigned to an Assessment Team Nurse who will conduct an assessment and develop a new Care Plan. The contracted agency staff, the MFP participant, and self-directed care givers and providers will participate in the assessment and care plan development processes to ensure the continuity of care. A Transition Coordinator (elders) or a Peer Mentor (disabled) will be assigned to the self-directed participant to assist in the transition process and to serve as a point person throughout the demonstration period.

Anticipated Goals for Self –Direction

Rhode Island currently serves approximately 380 individuals in its Personal Choice self-directed program. (This excludes persons with developmentally disabilities because they are not a targeted population for the Rhode Island MFP demonstration). However, not all of the 380 individuals meet the MFP eligibility requirements. As indicated in Benchmark 4: Increase the Use of Self-Directed Services, it is RI's goal to increase the use of self-directed services for those individuals eligible for the Personal Choice program by 5 percent each year. At the end of CY 2016, there will be 509 individuals enrolled in the Personal Choice program. In addition, it is RI's goal to have 10 percent of *Rhode to Home* MFP participants operating under a self-directed option, each demonstration year.

Documenting MFP Participants

All participants in the current self-directed program (Personal Choice) have a unique identifier in the In Rhodes Eligibility System and in the MMIS. This same system will be used for any MFP

participant who elects to self-direct their services. Note that this unique identifier would be in ADDITION to the unique identifier that will identify MFP participants.

Involuntary Termination in a Self-Directed Model

Participants who demonstrate the inability to self-direct waiver services whether due to misuse of funds, consistent non-adherence to program rules or an ongoing health and safety risk, will be required to select a representative to assist them with the responsibilities of self-direction. If a participant refuses to select a representative, or if participant loses a representative (if already required for program participation) and cannot locate a replacement, they will be required to transfer to another waiver program that has traditional agency oversight. Service advisors will assist the participant in the transition to the traditional agency to ensure continuity of care.

Issues may be identified by any entity contracted to provide support to the participant, (i.e. Peer Mentor, Fiscal Agent, Service Advisor) all concerns would be directed to the Advisement Agency which would attempt to address the situation through appropriate actions designed to obtain compliance (except in the instance of Medicaid Fraud or risk of imminent harm), such as additional training, increased support and oversight or behavior contracting. In the event that these interventions are not successful the contracted self-direction agency will notify the MFP program in DHS OICCS. The contract agency and self-directed participant will be asked to provide DHS with a copy of all records related to the beneficiary's self-directed services. The case will be assigned to an Assessment Team Nurse who will conduct an assessment and develop a new Care Plan. The contracted agency staff, the MFP participant, and self-directed care givers and providers will participate in the assessment and care plan development processes to ensure the continuity of care.

8. Quality

Quality Overview and Assurances

The State ensures CMS that the MFP demonstration will incorporate the same level of quality assurance and improvement activities required under the 1915 (c) waiver program during the individual's transition process and for all LTC services received, thereafter. The State has procedures in place to provide the assurance.

Rhode Island provides HCBS through the Global Consumer Choice Waiver. As part of the Global Waivers Standard Terms and Conditions (STC), Rhode Island prepared an Evaluation of the Demonstration Quality Assurance and Quality Improvement Plan to meet CMSs Standard Terms and Conditions (STC) for the Global Waiver. The STC requires the State to: (1) conduct an evaluation of the three Global Waiver goals, and (2) conduct special focused evaluations. One of the goals of the Global Waiver is to reform the long-term care system. As previously noted, RI administers all services including HCBS through the Global Waiver. As part of the Evaluation Plan, Rhode Island provided the following assurance:

> "The State shall keep in place the existing quality systems for the waivers, demonstrations, and programs that currently exist and will remain intact under the Global 1115 (RIte Care, Rhody Health, Connect Care Choice, RIte Smiles, and PACE). For its Home and Community Based Services System under the Global 1115, the State will utilize a QA/QI plan consistent with the Quality rubric utilized in the CMS 1915 (c) waiver program that will assure the health and welfare of program participants."

RI provides CMS assurance that the QA/QI for the MFP demonstration will meet the requirement of HCBS and the STC of the Global Waiver. The Global Waiver Goal to reform the LTC system included three sub-goals as described below:

- To undertake measurable reform of Rhode Island's long term care programs including the following objectives: (1) to rebalance the State's existing long-term care system with home and community based services, (2) to increase the utilization of home and community based services, and (3) to modify the State's income and resource eligibility requirements for Medicaid funded services.
- To establish objective, a needs based LOC determination process for Medicaid LTC applicants with an objective to develop LOC systems focused on identifying medical, behavioral health and social needs so that a beneficiary may remain safely in a home and community based setting.
- To limit the rate of growth in the State's Medicaid expenditures including the following objectives: (1) reduce expenditures by implementing the two above sub-goals, (2) conduct selective contracting, (3) prevent or delay full Medicaid benefits by implementing cost not otherwise match able (CNOM) measures, and (4) promote the delivery of case management services through organized systems of care.

Specific indicators/metrics have been adopted to monitor and measure achievement of these long-term care objectives. As part of the Global Waiver process, RI provided assurances that the HCBS provided under the Waiver will meet 1915 (c) HCBS QI/QA requirements related to: level of care determination, services plan description, identification of qualified HCBS providers for participants being transferred, health and welfare, administrative authority and financial accountability. This assurance is extended to the *Rhode to Home* MFP demonstration.

Who Monitors, Measures, and Develops Reports

Under the Global Waiver Special Terms and Conditions (STCs), RI is required to maintain the existing quality systems for the waiver/demonstrations/programs that currently exist and will remain intact under the Global Waiver. The State staff with program responsibility for managing the specific home and community-based programs are responsible for maintain the existing quality systems. These staff is members of the Global Waiver Quality and Evaluation Workgroup. The Global Waiver Quality and Evaluation Workgroup meet monthly and review the quality oversight and monitoring reports presented by the various staff. Program redesign, evaluation design, HCBS quality indicators, Prevention Quality Indicators, Updates from the national HCBS Quality Enterprise are discussed by the Global Waiver Evaluation and Quality Workgroup. The proposed *Rhode to Home* Quality Specialist would be a member of the Global Waiver Quality and Evaluation Workgroup.

The Critical Incidences will be monitored by the Transition Coordinator or Peer Mentor and reported to the proper authorities. The Transition Coordinator or Peer Mentor will educate participants about how to: (1) recognize conditions of abuse, neglect and exploitation and who to report it to, and (2) how to deal with emergent and urgent care situation. A Critical Incident Fact sheet will be distributed to each participant to use as a reference guide with the names and telephone numbers vital to handling critical incidences. The Transition Coordinator and Peer Mentor will be required to contact participants monthly and to conduct home visits within 10 days of transition, 30 days

after transition, and every 60 days thereafter, or as frequently as required to ensure the participant's health and safety. In addition, the Critical Incidences will be reported to the *Rhode to Home* Quality Specialist. The Quality Specialist will be a full-time position dedicated to the MFP demonstration. This individual will have overall responsibility for program development and quality assurance activities. This position ensures that care planning standards are uniformly applied, that Continuous Quality Improvement (CQI) activities are integrated into program design, and monitor service delivery through care plans and by after-hours vendors. This position supports achievement of all five benchmarks through ensuring adherence to program design and established standards. These reports will be shared with the *Rhode to Home* Program leadership and to the MFP Steering Committee on a regular basis.

Specific *Rhode to Home* Quality Parameters

Critical principles governing the MFP demonstration are that participation in the demonstration is strictly voluntary and that the Medicaid beneficiary and his/her family have sufficient information to make an informed decision. In addition, the participant and his/her family are involved in all phases of the treatment process from outreach, assessment and care planning, service/care provision, and transitioning after the demonstration period. RI has designed the *Rhode to Home* demonstration with the operational policies and procedures needed to ensure that those critical principles are met. In Phase I, the *Rhode to Home* demonstration Transition Assessment Nurse, Transition Coordinator or Peer Mentor and the Housing Coordinator will work together as a Project Team with the participant and his/her representative during the assessment, care planning and transitioning processes. The designated Transition

Coordinator or Peer Mentor will assist the participant throughout the demonstration period and will take whatever measures are necessary and appropriate to ensure the health, safety and welfare of the participant. The Transitional Coordinator or Peer Mentor will report all incidences or problems sighted to the MFP Program/Quality Specialist, who will be responsible for recording, assessing and developing system-wide improvement strategies, where necessary. A Participant Handbook will be developed that describes the Policies and Procedures, including participant rights and responsibilities, for the *Rhodes to Home* demonstration. RI provides the following other assurances for the *Rhode to Home* demonstration:

- **A Care Plan** will be developed that meets the needs and preferences of each participant and assures that the services received are consistent with the Care Plans. The Care Plans will be revised to meet changes in the participants needs at any time throughout the demonstration period. All participants will be reassessed and a revised care plan developed before the demonstration period ends to ensure continuity of care. Medicaid beneficiaries will be reassessed and a revised Care Plan will be developed annually, thereafter. Care Plans will safeguard the participant's health and welfare.
- **24 Hour Back-Up System** will be developed based on a three-tiered approach as described in Section 6: Consumer Supports; (1) the participant's own back-up system will be part of the Care Plan, (2) the participant will be instructed to contact the provider agency, if the their own back-up is unavailable, and (3) DHS will contract with a community organization to provide "live" back-up support, for after business hours and on weekends and holidays. A Fact Sheet will be distributed to and reviewed with each participant describing when and how to use the 24-hour back-up system by the Transition Coordinator or Peer Mentor.

- **Risk Assessment and Mitigation Plan** is one of the components of the Comprehensive Assessment that will be conducted for each participant that covers: health and medical conditions, care giver and support needs, financial situation, legal issues, availability of housing, linkages with medical and health care providers, identification with the transitioning community, and other factors that may adversely affect the welfare and safety of the participant. The Care Plan will contain a section devoted to measures that address risk factors and a Mitigation Plan for each participant. The Transition Coordinator or Peer Mentor will conduct an on-site "home readiness" assessment and will monitor these factors throughout the demonstration and convene the Care Development Team to revise the Care Plan, if required.
- **Critical Incidences** that may include abuse, neglect and exploitation as well as unexpected hospitalizations, injuries, medication errors will be monitored by the Transition Coordinator or Peer Mentor and reported to the proper authorities. The Transition Coordinator or Peer Mentor will educate participants about how to: (1) recognize conditions of abuse, neglect and exploitation and who to report it to, and (2) how to deal with emergent and urgent care situation. A Critical Incident Fact sheet will be distributed to each participant to use as a reference guide with the names and telephone numbers vital to handling critical incidences. The Transition Coordinator and Peer Mentor will be required to contact participants monthly and to conduct home visits within 10 days of transition, 30 days after transition, and every 60 days thereafter, or as frequently as required to ensure the participant's health and safety. In addition, participants will be instructed to contact the Transition Coordinator or Peer Mentor whenever they have a question or a problem arises that the participant cannot handle.

Transition Coordinators and the Peer Mentor will be required to respond to participant inquires within 24 business hours.

Other systems and procedures will be developed to ensure the health, safety and welfare of *Rhode to Home* participants throughout the demonstration, when necessary.

The *Rhode to Home* Program Development/Quality Specialist will monitor: critical incidences reported, 24 hour back-up system failures, participants inquiries and complaints as well as the operational compliance with MFP requirements, such as conducting comprehensive assessments when participants begin and complete the demonstration, developing Care Plans when participants begin and complete the demonstration, and providing the ongoing support services throughout the demonstration period. The Program/Quality Specialist will develop and implement strategies to improve program operations.

In addition, the *Rhode to Home* Deputy Project Director and Project Director will monitor project status through the use of an enhanced data reporting and analytic system, including but not limited to: development and implementation status of project components/milestones; marketing/education/outreach efforts; assessments conducted; care plans developed; participant enrollment by target population; critical incidences reported; 24 hour back–up system failures, care plans revised; self-directed participants including the number who voluntarily terminate self-direction; the number of participant grievances and comments; planned versus actual expenditures; and the number and status of participants completing the demonstration (including the number of and reasons why participants leave the program before the demonstration period ends); and the rebalancing of LTC expenditures by institutional and community based settings. Monthly reports will be developed and shared with project and State staff, the Stakeholder Steering Committee, and other interested parties.

RI does not have wait times for personal care attendants to serve Medicaid beneficiaries. RI does not anticipate a problem with maintaining a sufficient supply of personal care attendants for the MFP program and for other Medicaid beneficiaries.

9. **Housing**

The lack of access to affordable housing is often the major barrier to successful transition into the community. It is essential that MFP participants have access to affordable housing. This is particularly challenging for RI, since the State has the fourth oldest housing stock in the nation. RI has taken significant steps throughout the years to ensure that special needs populations (e.g. elders and individuals with disabilities) have access to appropriate housing, as indicated below. The lack of affordable housing is so critical to Medicaid beneficiaries that a Housing Work Group has been established as part of the Medicaid Global Waiver Task Force.

The MFP demonstration provides RI with an opportunity to coalesce existing resources to provide affordable housing for the MFP populations. The *Rhode to Home* MFP demonstration will employ a Housing Coordinator who will be pivotal in securing affordable housing for MFP participants.

The MFP Housing Coordinator will be invited to participate on the Global Waiver Taskforce Housing subcommittee. This committee is composed of community representatives and state partners knowledgeable about housing capacity challenges, waiting lists requirements, advances in program initiatives by state and federal authorities and the need to improve access to affordable, quality housing resources. The Housing subcommittee reports monthly to the Global Waiver Taskforce on strategies to improve housing resources to support the rebalancing initiatives outlined in the Global Waiver. The subcommittee is interested in exploring renovation

projects that could directly support available housing capacity and innovative models to support individuals with disabilities and elderly beneficiaries. As RI has new leadership in the Executive Branch, the Housing subcommittee is awaiting direction from the new leadership.

The following describes Rhode Island's efforts to meet the housing needs of MFP participants.

Process for Documenting the Participants Transitioning Residence

During the MFP Assessment Process, the Transition Coordinator or Peer Mentor will conduct an on-site review of the participant's residence to ensure that it meets MFP definition of a qualified residence and to conduct a safety inspection. Appendix F contains the Housing Assessment Tool. In accordance with the CMS policy guidance addendum dated July 30, 2009 and CMS policy guidance dated February 2008, the *Rhode to Home* will transition participants to a "qualified residence that meet the following requirements:

- A home owned or leased by the individual or the individual's family member, or
- An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas which the individual or the individual's family representative has domain and control and include the following provisions:
    - The dwelling must have a lease that is considered a legal document by all parties signing or referenced in the lease. The lease may be signed by someone other than the individual or the individual's family representative.

- The lease must not name anyone other than the MFP participant or a family representative as having domain and control over living, sleeping, bathing, and cooking areas of the dwelling.
- The building must give access to the community. For example, in order to assure security, safety or privacy many apartment complexes have gates, multiple doors, or security guard checkpoints leading to an exit on the street outside of the complex. Each tenant or their family representative must be provided a key, identification card, or keypunch number to easily get in or out of a complex or facility 24 hours a day.
- The apartment in which the MFP participant resides must have lockable entrance or egress to the unit not just the building.
- The apartment in which the MFP participant resides must comport with federal fair housing guidelines.

To be a qualified residence under MFP, leases should not:

- Include rules and/or regulations from a service agency *as conditions of tenancy* or include a requirement to receive services from a specific company;
- Require notification of periods of absence, e.g. a person who is absent from a facility for more that 15 consecutive days, or discuss transfer to a nursing facility or hospital;
- Include provisions for being admitted, discharged, or transferred out of or into a facility; or

- Reserve the right to assign apartments and change apartment assignments, or
- A residence, in a community residential setting, in which no more than four unrelated individual resides.

CMS Policy Guidance indicates the conditions that must be met in these housing types to be a qualified residence as covered in the Housing Assessment Tool. Similar to the conditions in the CMS Policy Guidelines, Assisted Living may qualify as an appropriate Housing unit.

In accordance with the CMS Policy Guidance dated July 30, 2009 Assisted Living Facilities may be considered a "qualified residence" under the following conditions:

- **Must have a lease:** A lease is a contract in which the legal right to use and occupy property is conveyed in exchange for payment or some other form of consideration. It is generally for a fixed period of time, although it may be a term for life, or may be terminable at any time. States need to evaluate if the following mandatory elements of a lease exist in the Assisted Living Facilities resident agreement or contract.
  - A provision that specifies that the Assisted Living Facility provider (possessor of real property) convey the right to use and occupy the property. The Assisted Living Facilities may also offer and provide a set of healthcare services and supports in exchange for rent or a fee.

- A provision that specifies the period of time that is governed by the agreement/contract agreed to by the resident and the Assisted Living Facilities, including rights of termination by the resident and the provider and document a formal appeal process for resident terminations.
- A written instrument with a conveyance and covenants detailing the services and residence that will be provided in the Assisted Living agreement or Assisted Living contract.
- Provisions that the residents tenancy rights can be terminated only for violations including non-payment of rent, posing a direct threat to others, and property damage.
- The resident is provided sufficient information and opportunity to consider the possession of the Assisted Living Facilities residence and related services and supports to be provided.
- The lease/agreement must state that the Assisted Living Facilities will meet all Federal and State Fair Housing Laws.

- **Must be an apartment with living, sleeping, bathing and cooking areas:** If apartments are not required by the State's Assisted Living Facilities licensing regulations, MFP may only contract with Assisted Living Facilities that offer apartment units.
- **Unit must have lockable access and egress.** Assisted Living Facilities that serve participants with cognitive impairments must include design features that maximize the participants' capacity to live as independently as possible. Conditions that limit a person's activities must be addressed in the plan of care, be

related to risks to the individual's health and welfare, and agreed to by the individual or caregiver in writing.

The Assisted Living Facilities must provide the resident with lockable access and egress to and from the resident's apartment, and means to access or leave the facility. This may include key, ID card, keypad number, electronic scanner, or watchman made available to the participant, family member or guardian based on a person-centered plan of care. Participants who are not cognitively impaired and have a plan of care that indicates the capacity to live independently with supports must have full access and egress from their residence.

- **A qualified residence cannot require that services must be provided as a condition of tenancy or from a specific company for services available in addition to those included in the rate.** Participants have the right to choose their living arrangements, and one residential option is an Assisted Living Facilities that meets the requirements of a qualified setting under MFP. While one of the defining characteristics of an Assisted Living Facilities is that the landlord is also the provider of services either directly or through contract, participants who choose to live in an Assisted Living Facilities have a choice of providers of Medicaid services that are available in addition to the services that are included in the service rate paid to the Assisted Living Facilities. Traditional Assisted Living Facilities services usually include, depending on the needs of the individual, housekeeping, meal preparation, transportation, personal care, and assistance with medication administration.

For an Assisted Living Facilities to be eligible as a MFP qualified residence, the tenant (or responsible party) must participate in the care planning process, and there must be a formal process for resolving care plan differences between the Assisted Living Facilities and the tenant. Regulations that provide for managed or negotiated risk meet this requirement. If the regulations do not provide a process for resolving care plan differences between the Assisted Living Facilities and the tenant, the agreement/contract must define a process.

The agreement/contract should indicate that when the tenant chooses to pay room and board for a unit, they also choose the Assisted Living Facilities as their provider for services that are included in the Medicaid rate. Assisted living must be a voluntary choice made by the consumer. Participants cannot be denied services or Assisted Living Facilities due to physical, sensory and/or mental health conditions. Before choosing an Assisted Living Facilities, the individual should be provided with a choice of potential residences and service providers appropriate to their needs. Assisted Living Facilities should not be the only option available to a transitioning individual.

- **Assisted Living Facilities may not require notification of absences from the facility**. Notice of absences cannot be a condition of the agreement/contract but can be part of the Assisted Living Facilities operating practices as long as the

expectation is reasonable, noted in the plan of care, and related to one of the following criteria.

- Notice of absence may be required based on an individual assessment, risk to the tenant and the need to assure health and welfare.
- Notification of absence may be required in order to ensure that Medicaid is not billed for days on which services were not delivered.
- Absences for less than 30 days cannot result in termination/discharge.
- To assure health and welfare requirements, the tenant may have to inform the Assisted Living Facilities when the tenant leaves the building. The length of the absence that needs to be communicated to the Assisted Living Facilities can vary by the predetermined risk as noted in the care plan.

- **Aging in place must be a common practice of the Assisted Living Facilities.** An Assisted Living Facilities can participate as a qualified residence only if it allows aging in place. This means that a resident contract may not be terminated due to declining health or increased care needs. The state may contract for MFP reimbursed services with Assisted Living Facilities that include aging in place opportunities as provided for in State licensing regulations.

Residents whose service needs cannot be met under the resident agreement or contract may bring in an outside service provider to meet the additional needs if allowed by state regulation; or if able, the Assisted Living Facilities may provide the additional services. Additional Medicaid payments to an outside provider

would only be made for services that are not included in the rate paid to the Assisted Living Facilities.

- **Leases may not reserve the right to assign apartments or change apartment assignments.** Agreements/contracts may not reserve the right to assign apartments or change apartment assignments beyond the normal provisions of landlord tenant law. However, changes based on the plan of care developed with the resident may be made. In such cases, the written agreement should be modified to reflect the new agreement with the tenant.

CMS Policy Guidance indicates the conditions that must be met in these housing types to be a qualified residence as covered in the Housing Assessment Tool. The Housing Coordinator will speak with the property manager or landlord and review pertinent documents (e.g. leases, occupancy certificates/approvals, facility licenses, etc.) to ensure that the residence meets MFP requirements.

The purpose of the housing inspection is to ensure that the residence is safe and to determine if modifications are necessary to meet the participant's special needs. The Safety Checklist requires the MFP staff to: assess the overall housing structure including entry and egress points, kitchen appliances, living rooms and bedrooms, stairways, bathroom facilities, hallways and passageways. The Transition Coordinator or Peer Mentor will conduct on-site assessments, when the participant has special needs, to determine the specific modification(s) required to make the residence accessible to the participants and to estimate the costs. The decision to proceed with home modification will be made in consultation with the Assessment

Team and approved by OICSS staff that has responsibility to oversee and approve all specific home modifications.

Process to Assure Sufficient Supply of Qualified Residences for MFP Participants

Access to affordable housing requires a public and private partnership. The Housing Coordinator will facilitate this partnership through three major roles: (1) work with federal, state and local housing organizations to identify opportunities within established programs that facilitate access to affordable housing, (2) work with housing developers and builders to tell them about federal, state and local opportunities and financial assistance for building and/or renovating housing to meet the needs of the MFP population, and (3) work with State staff who link MFP participants to available and affordable housing that meets their needs. Each of these critical roles is discussed below.

Identifying Housing Opportunities

The Housing Coordinator will be responsible for identifying a broad range of options that promote the construction, acquisition, conversion, or identification of existing housing for MFP participants. These options may include: (1) pre-construction and bridge loans, (2) interest free or deferred payment loans, (3) tax credits, (4) direct funds or cash assistance, (5) housing vouchers, (6) rent/home subsidies, and (7) other measures that increase affordable and accessible housing. To this end, the Housing Coordinator will work with the federal, State and local authorities. For example, the Federal Department of Housing and Urban Development (HUD) provides funding to local Public Housing Authorities (PHA) to provide public housing units and voucher programs to supplement the cost of housing. The Housing Coordinator will work with

the HUD field office to identify existing housing opportunities for Rhode Island under the HUD 202 program for the elderly and 811 programs for the disabled. The Housing Coordinator also will work with federal Department of Agriculture that administers home ownership and rental programs.

At the State level for the Phase I target population, the Housing Coordinator will build on DHS' relationship with Rhode Island Housing (RIH) to identify specific opportunities, such as the Low Income Housing Tax Credit Program and others, that provide financial or tax credits to builders for construction of new or renovation of existing houses as well as to identify voucher and direct financial programs for consumers. Over the past five years, the RIH has expanded the housing supply through major initiatives to renovate existing structures. EOHHS has a Memorandum of Understanding with RIH that enables low-income individuals with disabilities to receive Housing Choice Vouchers so that they may transition into a community setting. The Housing Coordinator will continue to work with RIH to expand affordable housing opportunities, voucher programs and set-asides particularly for elders. The Housing Coordinator will work with the Rhode Island Office of Economic Recovery and Reinvestment to access new and expanded funds that are available through The American Reinvestment and Recovery Act. In addition, the Housing Coordinator will build on the current work with other state agencies to increase access to affordable housing. For example, DEA has a waiver program for elderly individuals in assisted living facilities. DEA also has an Assisted Living Program that has created criteria to evaluate the appropriateness of residences that will be used by the Housing Coordinator in linking MFP participants to the existing housing supply. The Housing Coordinator will work with other state agencies to: develop rates that promote alternative residences (such as assisted living arrangements); coordinate and integrate the wealth of

available information about housing on many different web sites; and implement strategies identified in the Real Choices Systems Transformation grant.

Under the Global Waiver Taskforce Housing subcommittee, the Housing Coordinator will engage the major housing planning processes at the state and local levels that determine the allocation of federal and state housing resources for persons with disabilities and chronic conditions. The Housing Coordinator will develop and provide the necessary needs assessment data on accessible and affordable community housing for persons with disabilities and chronic conditions from a variety of sources including the Global Waiver Housing Subcommittee, the housing authorities, and state partners and the Global Waiver Evaluation and Monitoring Workgroup. The Housing Coordinator will solicit best practices identified under the RCST grants. In addition, the Housing Coordinator will seek to identify housing resources that need legislative/regulatory changes.

The RI ALFs are very supportive of the MFP demonstration on a state and national level. RI's relationship with the ALFs has been a cooperative effort to secure and/or maintain housing for individuals that would benefit from an ALF under the MFP demonstration. The industry trade association has offered a letter of endorsement of the RI's *Rhode to Home* proposal. RI has shared with the industry trade association the CMS Assisted Living Housing guidance issued on July 30, 2009. The industry trade association conducted an environmental scan to identify the ALFs that would meet the CMS guidance issue on July 30, 2009 and has provided that report to the state. The industry has supported changes to the state regulations for the Adult Supportive Care Act that was pasted during the SFY 2010 legislative session and is awaiting rules to be promulgated by the RI Department of Health.

The Housing Coordinator will also work closely with the Public Housing Authorities in Rhode Island to identify housing and rental assistance programs. The EOHHS has an agreement with the Pawtucket Housing Authority to assist persons with disabilities to receive federally funded housing vouchers, which is similar to the agreement with RIH. The Housing Coordinator will work the PHA in other cities to increase the availability of affordable housing. The MFP demonstration will pursue every avenue possible to promote the use of housing set-asides for elders and individuals with disabilities.

The state executed a Memorandum of Understanding with the Rhode Island Housing Authority and the Pawtucket Housing Authority required for the CMS/HUD housing voucher solicitation. RI anticipated identifying fifty individual that would be eligible under each of these voucher initiatives, should either of the housing authorities be awarded the vouchers. RI anticipated that MFP participants would benefit from this initiative. Unfortunately, the RI proposals were not awarded the CMS/HUD vouchers. Without the flexibility offered to prioritize waiting list voucher assignments for individuals transitioning from qualified institutions under the CMS/HUD voucher program, the housing authorities must maintain their current waiting lists for vouchers. As the DHS has developed a positive working relationship with the housing authorities, DHS anticipates exploring future opportunities to position MFP participants to secure housing vouchers in "qualified residences." Valuable information has been shared during the MFP-TA Housing sessions. RI will seek to implement these strategies to foster securing housing vouchers for MFP participants.

As a result of these efforts, the Housing Coordinator will develop a list of opportunities for builders that may assist them directly or through tax credit programs to build or renovate housing for the MFP population. In addition, the Housing Coordinator will identify existing

housing inventories as well as develop his/her own supplemental inventory that will be used in meeting MFP participants housing needs.

Work With Builders and Construction Companies

A major role of the Housing Coordinator is to make builders and construction companies aware of the assistance that is available to build new or renovate existing housing so that they meet the needs of MFP's special populations. The Housing Coordinator will collect materials about federal, state and local levels that are available to them. The Housing Coordinator will meet with executives of these companies and attend trade conferences to educate builders across the State about existing opportunities including tax credit, financial assistance or priority permit programs for increasing the supply of housing for special needs populations. The Housing Coordinator will also introduce builders to representatives of housing assistance organizations and to assist the builders in securing the assistance required to increase access to affordable housing. A representative of the building/housing industry will serve on the MFP Steering Committee.

Work With State Staff

The Housing Coordinator will work with State staff who will link MFP percipients to accessible and affordable housing. The purpose of this collaboration is to ensure state staff are knowledgeable about qualified suitable housing available for transition. The State staff will provide MFP participants with information about the types of housing options that is qualified under the MFP program, the availability of suitable housing, and the availability of financial assistance or voucher programs. Using existing inventories and his/her own supplemented inventory list and community knowledge, the State staff will identify specific residences that are

currently available to them in the community they desire to live and will assist the participant or his/her representative: visit and inspect the residence, review leases, arrange for movers and transportation, complete applications for housing assistance or vouchers, and provide other assistance to facilitate securing the residence.

This multi-prong approach will enhance a MFP participant's ability to locate suitable housing to meet their needs.

10. Continuity of Care Post the Demonstration

As previously noted, RI's entire Medicaid program is now operating under the Global Consumer Choice Waiver, approved by CMS in January 2009. The individual 1915 (c) waivers have been consolidated under the Global Waiver. All services that were directed to specific target populations under each individual 1115 (c) waiver are now available to all eligible Medicaid beneficiaries. This has enabled the State to provide an enriched benefit that fosters both the continuity and coordination of care, as well as provides beneficiaries with greater options to choose from to promote independent community living. By definition, the enriched benefits of all the services proposed as Qualified HCBS will be available to eligible beneficiaries after the 365-day period.

Rhode Island will request a modification in our Global Waiver to add Peer Mentor services.

All MFP participants will be reassessed and a new Care Plan developed at the end of the demonstration period, and annually thereafter. The purpose of the reassessment and Care Plan is to assure that current needs are addressed and to ensure the continuity of care and treatment after the demonstration period. The Transition Coordinator or Peer Mentor will assist elders and persons with disabilities transition back into the Medicaid system program. The Transition

Coordinator/Peer Mentor will review the options available to participants and their families/guardians.

State staff will assess participants receiving Transition Coordinators as a Demonstration Service before the transitioning period to assure that they continue to meet the High Level of care required to receive core services under the Global Waiver. If eligible, they will be monitored by nurses and worker from DHS' Long Term Care Unit and the Office of Community Programs to assure the continuity of care for HCBS. Individuals who do not meet the eligibility criteria will be referred to the DEA Co-Pay program or to other community programs and services.

11. Communication with CMS

The State's Project Director will serve as chief liaison to CMS. Specifically, RI will keep the CMS Project Officer informed of progress regarding, changes in nursing home payment methodology selective contracting for home health services, promulgated rules for adult supportive services and addition of identifiers in the InRhodes eligibility and MMIS claims processing systems. The State will inform CMS how much of the rebalancing funds the have expended and on what by December 31, 2011, and reflect this commitment in the semi-annual report for the period July – December 2011.

The States' Deputy Project Director will serve as the liaison with CMS regarding the evaluation activities.

* * *

Appendix K provides an overview of the Department of Children Youth and Families and a description of the Phase II MFP population for children and youth in psychiatric hospitals and in-

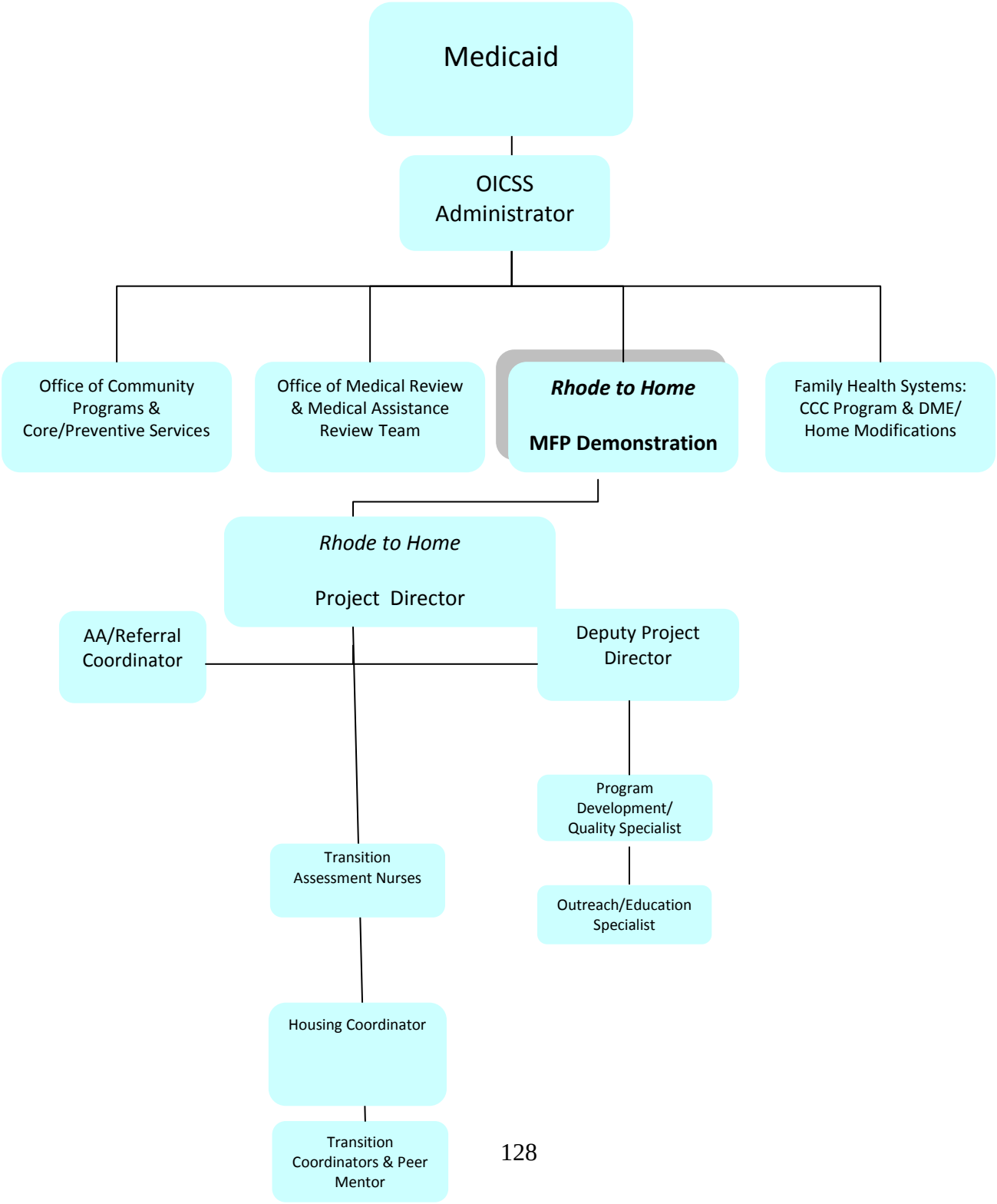
state and out-of-state Institutions of Mental Disease (IMDs). The final OP will contain the policies and procedures for the targeted Phase II populations including the DCYF population.

C. PROJECT ADMINISTRATION

This section describes the project administration for Phase I of the MFP Demonstration project. As indicated in the Demonstration Announcement, this section contains an Organization Chart and a Staffing Plan.

1. Organization Chart

The following is the organization chart for the *Rhode to Home demonstration.*



. Staffing Plan

The following are the dedicated positions proposed to conduct the *Rhodes to Home* project including a brief description of the level of effort, roles and responsibilities, and staff position qualifications. The staff positions are described within the following categories: positions required to transition MFP participants that cut across all population groups and positions required for the elder and disabled nursing home target population group. The proposed positions will either be filled by State staff or contracted out (through community-based organizations or a professional services contractor) which will be decided in consultation with the new State administration.

MFP Project Positions The following are project positions that are necessary to administer this grant. By its very nature, these positions transcend target populations and comprise the vital support functions required by the MFP demonstration. RI believes that the positions described below are all critical to ensure that participants successfully transition to and remain in the community as well as being essential to the State in meeting its benchmarks. Therefore, the cost associated with the following staff positions will be reimbursed at 100 percent administrative expense throughout the demonstration project.

- **Project Director** will be a full-time position solely dedicated to the MFP demonstration. The Project Director will report to the Director of Office of Institutional/Community Services and Supports (OICSSS), who in turn reports to the Medicaid Director. The Project Director will have overall responsibility for the design, implementation and operation of the MFP demonstration project. Specifically, the Project Director has responsibility to: (1) finalize the Operational Protocol, (2) develop project materials, (3) conduct readiness reviews and implement MFP project, (4) monitor project performance,

expenditures, and meet re-balancing LTC goals, (5) work with stakeholders throughout the demonstration (6) serve as chief liaison to CMS and its evaluation and technical assistance contractors, (7) assist the State design strategies and programs to re-balance the long term care delivery and financing systems compatible with Medicaid, and (8) prepare MFP and other LTC reports for CMS, the State or other interested parties. At a minimum, the Project Director will have seven to ten years experience with the Medicaid program and in the LTC industry working to rebalance the LTC delivery and financing system. The ideal candidate will have extensive experience with LTC systems designed to serve individuals with complex medical, behavioral health and co-morbid conditions; and have expertise and experience conducting health care analytic tasks. The Project Director will have a Master Degree in health care or a degree related to this demonstration. Although DHS has identified several individuals for the Project Director position, the person has not been selected. RI understands that CMS has authority to approve the individual who will be the Project Director.

- **Deputy Project Director** will be a full-time position solely dedicated to the MFP demonstration. The Deputy Project Director will report to the Project Director. The Deputy will assist the Project Director conduct each of the eight responsibilities noted above. The Deputy Project Director will step in for and serve as the Project Director, when the Project Director is not available or able to perform his/her duties. At a minimum, the Deputy Project Director will have four to seven years experience with the Medicaid program and in the LTC industry working to re-balance the LTC delivery and financing system. The ideal candidate also will have extensive experience with LTC systems designed to serve individuals with complex medical, behavioral health and co-

morbid conditions; and has expertise and solid experience conducting health care analytics tasks. The Deputy Project Director will have a Master Degree in Health Care or a related field to the MFP project. The person to fill this position has not been hired. RI understands that CMS has the authority to approve the individual selected to be the Deputy Project Director.

- **Program Development/Quality Specialis**t will be a full-time position solely dedicated to the MFP demonstration. This individual will have overall responsibility for program development and quality assurance activities. Specifically, the individual will: (1) assist the Project Manager and Deputy Project Manager finalize the Operational Protocol, (2) work with stakeholders in developing MFP required improvement interventions and project products, (3) monitor that procedures remain in place comparable to those required under the HCBS waivers for MFP participants, (4) assure/monitor that participants have a service plan based on individual needs, (5) assure/monitor that participants health and welfare are safeguarded, (6) assure/monitor that recipients have an adequate back-up plan, a risk assessment has been conducted and appropriate mitigation process works and that there are functional incident management system in place, (7) assure/monitor that adequate services and system are in place and provided to participants completing the 365 day MFP eligibility period, (8) monitor and assess the effects of State LTC re-balancing efforts, (9) interface with CMS and DHS on all quality assurance, and (10) work with State staff to develop improvement strategies and program/service intervention to further re-balancing the long term care system, (11) serve as the central repository for Critical Incident reporting by receiving and following-up on all critical incidences reported including reporting it to the proper authorities, and (12) serve as the

central point of information regarding the use of the 24 hour back-up system and ameliorative actions taken. The individual will have a Master Degree in Health Care or a related field for this demonstration. At a minimum, the individual must have three to five years experience in the health care industry related to the long-term care system. The individual must possess strong analytic, program design and writing skills.

- **Outreach/Marketing/Education Specialist** will be a full-time position solely dedicated to the MFP project for the first two and one-half years. This individual will have overall responsibility to assure that the vital outreach; marketing and education activities are developed and implemented. Specifically the individual will: (1) work with stakeholders to finalize the Operational Protocol, (2) work with stakeholders to develop required outreach and marketing materials including, brochures, pamphlets, letters, presentations; and posters for the project, (3) conduct seminars and speak at conferences to promote the values of the MFP project, (4) meet with community leaders, providers, health and human services organizations and advocacy groups to educate them about how to access the system, the services and supports available, and the participants rights and responsibilities, (5) assess the effectiveness of outreach and marketing materials, and revise them when necessary, and (6) develop presentation materials and reports, as needed. The individual must have a Bachelors degree. At a minimum, the individual must have three to five years communication experience in the health care industry; preferably in long term care services. The individual must possess strong verbal and writing skills, be creative and artistic, and able to use an array of software products including Word, Power Point, Excel and other communication/design and presentation packages.

- **Housing Coordinator** will be a full-time position solely dedicated to the MFP project. The Housing Coordinator will have overall responsibility to assure there is accessible, suitable, and affordable safe housing to meet the needs of transitioning MFP participants. Specifically, the Housing Coordinator will have three major areas of responsibility: (1) to work with and serve as the project liaison to federal, state and local housing organizations to identify opportunities within established programs that facilitate access to affordable housing, (2) to work with housing developers and builders to tell them about federal, state and local opportunities and financial assistance for building and or renovating housing to meet the needs of the MFP population, and (3) to work with MFP participants to identify and secure available and affordable housing that meets their transition needs. At a minimum, the Housing Coordinator will have five years experience serving as a housing coordinator for special need population groups (e.g. elders, disabled, developmentally disabled, mentally ill or other individuals with complex housing needs) or a similar position that enabled the candidate to obtain the required knowledge and experience of a Housing Coordinator for special need populations. Experience in Rhode Island or in the contiguous states as well as experience working with contractors who build affordable accessible housing is preferred.
- **Referral Coordinator/Administrative Assistant** will be a full-time position solely dedicated to the MFP Demonstration Project. The Referral Coordinator/Administration Assistant will provide administrative support for the entire MFP staff team. Specifically, the Administrative Assistant will assist project staff: (1) maintain calendars and schedule meeting, (2) take notes and prepare minutes of project and stakeholder meetings, (3) prepare presentations and reports, (4) maintain a central MFP project library, (5) receive

all MDS-Q forms from the nursing homes statewide and refer them to the appropriate MFP project staff for review and follow-up, and (6) conduct other administrative activities as they arise throughout the demonstration period. At a minimum, the individual will have three to five years experience and have knowledge of Word, Power Point and Excel software packages.

Additional state resources will be used to support IT and financial requirements related to the project. There will be a contract with a vendor, such as MCH Evaluations, Inc., to conduct the consumer and provider focus groups.

Finally, there will be a contract with a vendor to conduct the Quality of Life Surveys that measure how the MFP participant is living in a community versus the institutional setting. The contractor will be required to conduct three surveys of each participant: (1) prior to transitioning, (2) approximately 11 months after transitioning, and (3) about two years after transitioning. Specifically, the contractor will be required to: (1) use the Mathematica, Inc. survey instrument: (2) obtain online training and technical assistance and read the training manual, (3) conduct these surveys in person with the participant or with a knowledgeable representative for the participant, (4) enter survey results online using an Access database, (5) track participant resident locations or status so that subsequent surveys may be conducted or reasoning provided for not being able to conduct the surveys are known and are reasonable, and (6) assure that the participant receives the $100 for each survey conducted. At a minimum, the staff selected for this position or the contractor will have three to five years experience conducting surveys of the MFP special population groups.

Nursing Home Population

The following positions are associated with transitioning the elder and persons with disability nursing home populations. RI believes that the positions described below are all critical to ensure that participant successfully transition to and remain in the community; and are essential to the State in meeting its benchmarks. Therefore, the cost associated with the following staff positions will be reimbursed at 100 percent administrative expense throughout the demonstration project.

- **Transition Assessment Registered Nurses** will be two full-time positions solely dedicated to the MFP project. The Registered Nurses will be a part of the Assessment Team providing the clinical medical perspective and will: (1) review referrals for transition including the MDS forms submitted by nursing homes, (2) conduct on-site assessments including a risk assessment for transition, (3) consult with patient's health care providers and MFP project's medical consultants (i.e. Gerontologist, Physical Therapist, Occupational Therapist) about the patient, (4) refer potentially eligible MFP participants to the appropriate DHS Long Term Care unit to determine financial eligibility and to the Office of Medical review to determine clinical eligibility, (5) determine medical needs required for transition, (6) explain MFP and other options to the patient/family and determine the desire to participate, (7) develop a Care Plan including Back-up Safety Plan with patient, family and other Care Team members, (8) participate in nursing home discharge planning meetings, (9) arrange for (or confirm that) required transition medical services are in place, and (10) follow-up with the patient and providers within 30 days to assure that medical services are provided and needs are being met.

- **Transition Coordinators** will be four full-time positions solely dedicated to the MFP project. These positions will be contracted through a certified community organization, such as the Centers for Independent Living or Area Agencies on Aging. The Transition Coordinators will work closely with nursing home elders throughout the 365-demonstration period. They serve as the point person and care manager for the participant during the demonstration period to ensure a successful and lasting transition. The Transition Coordinators will: (1) develop the Care Plan and Back-up Safety Plan with other Care Team members, (2) assist Transition Assessment Registered Nurse arrange for (or confirm) required medical, human service and support needs, (3) conduct a home "readiness review" to assess housing (i.e. meets qualified residential definition and meets safety requirements based on a checklist) and to assure that all services and supports are in place prior to transition, (4) contact a participant by telephone within the first 24 hours of discharge, (5) conduct home visits within 10 days of transition, 30 days after transition, every 60 days thereafter, or more frequently as needed to assure that the participant's medical, human service and support needs are met, (6) contact the participant or his representative at least monthly by telephone to assess current conditions and needs, (7) contact the participant or his/her representative within 24 hours after receiving a request or telephone, (8) consult with Care Team members about the participants status or needs, (9) link participants to primary care and other medical, human and support services required, (10) identify appropriate social and community opportunities for the participant including adult day programs, cultural opportunities and social groups for elders, (11) educate the participant and care giver about the 24 back-up plan, assess on an on-going basis the adequacy of the back-up safety plan, and make

improvements to ensure the participant's health and safety are met, and (12) report critical incidents, such as abuse, neglect and exploitation, to the Program/Quality Specialist in OICSS and to the proper authorities for investigation and resolution. Transition Coordinators will carry a caseload of up to 35 transitioned elder participants. The Qualifications for Transition Coordinators include a Bachelor's degree in human services (e.g. social work, psychology, gerontology, nursing) and three years of related experience. Transition Coordinators will be considered an administrative expense. Transition Coordinators only provide services to successfully transitioning or transitioned participants during the demonstration period 100 percent of their time. The Transition Coordinators are considered a Demonstration service and will be reimbursed at the enhanced FMAP rate during the Demonstration period.

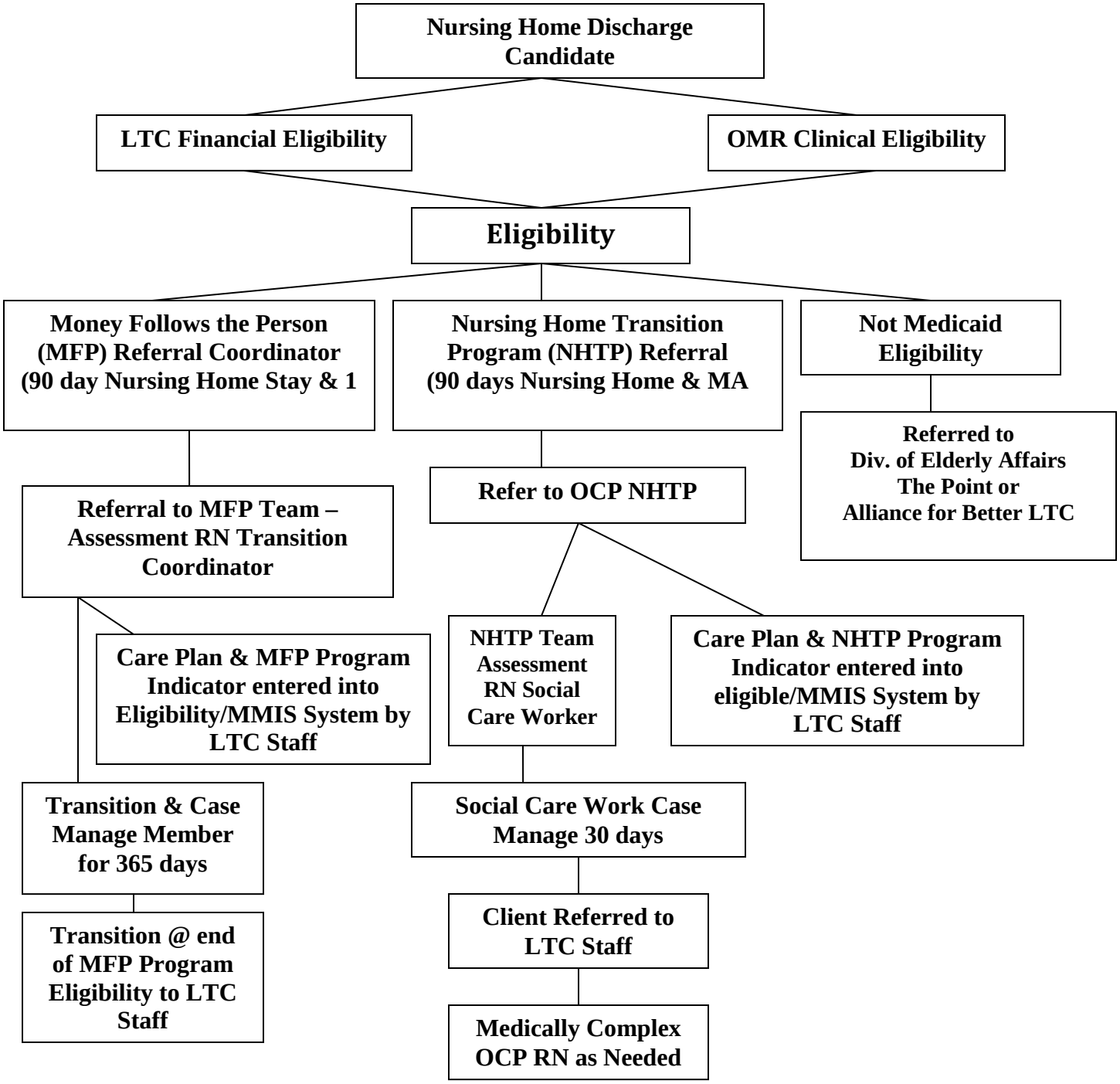
- **Peer Mentor** will be a full-time position solely dedicated to the MFP project. These positions will be contracted through a certified community organization such as the PARI Centers for Independent Living. The Peer Mentor will assist individuals with disabilities into the community and provide care management throughout the demonstration period and thereafter, if required by the participant. The Peer Mentor will be an individual with a disability who is successfully living in the community. The Peer Mentor will be ideal for providing the mentoring, encouragement and coaching required by MFP participants with disabilities. Like the Transition Coordinators, the Peer Mentor will: (1) develop the Care Plan and Back-up Safety Plan with other Care Team members, (2) assist Transition Assessment Registered Nurse arrange for (or confirm) required medical, human service and support needs, (3) conduct a home "readiness review" to assess housing (e.g. meets qualified residential definition and meet safety requirements based on a checklist) and to

assure that all services and supports are in place prior to transition, (4) contact by telephone a participant within the first 24 hours of discharge, (5) conduct home visits within 10 days of transition, 30 days after transition, every 60 days thereafter, or more frequently as needed to assure that the participant's medical, human service and support needs are met, (5) contact the participant or his representative at least monthly by telephone to assess current conditions and needs, (6) contact the participant or his/her representative within 24 hours after receiving a request or telephone, (7) consult with Care Team members about the participants status or needs, (8) link participants to primary care and other medical, human and support services required, (9) identify appropriate social and community opportunities for the participant including adult day programs, cultural opportunities and social groups for individuals with disabilities, (10) educate the participant and care giver about the appropriate use of the 24-hour back up plan, assess the adequacy of the back-up safety plan, and make improvements to ensure the participant's health and safety are met, and (11) report critical incidents, such as abuse, neglect and exploitation, to the Program/Quality Specialist in OICSS and to the proper authorities for investigation and resolution. The Peer Mentor will carry a caseload of 15 transitioned individuals with disabilities. (The Peer Mentor position is considered a Qualified Service and will be reimbursed at the enhanced FMAP rate during the 365-day demonstration period, and at the standard FMAP rate after the demonstration period.)

A background check will be required of all candidates prior to employment in the MFP demonstration.

The staff support required by the LTC Field Office staff to determine financial eligibility and the Office of Medical Review (OMR) staff required to determine clinical eligibility and

establish an appropriate level-of-care will be provided by DHS as part of their ongoing Medicaid responsibilities. The Table below reflects the LTC field offices, and OMR will relate to the MFP program.


Nursing Home Discharge Candidate
LTC Financial Eligibility
OMR Clinical Eligibility
Eligibility
Money Follows the Person (MFP) Referral Coordinator (90 day Nursing Home Stay & 1
Nursing Home Transition Program (NHTP) Referral (90 days Nursing Home & MA
Not Medicaid Eligibility
Referred to Div. of Elderly Affairs The Point or Alliance for Better LTC
Referral to MFP Team – Assessment RN Transition Coordinator
Refer to OCP NHTP
Care Plan & MFP Program Indicator entered into Eligibility/MMIS System by LTC Staff
NHTP Team Assessment RN Social Care Worker
Care Plan & NHTP Program Indicator entered into eligible/MMIS System by LTC Staff
Transition & Case Manage Member for 365 days
Social Care Work Case Manage 30 days
Transition @ end of MFP Program Eligibility to LTC Staff
Client Referred to LTC Staff
Medically Complex OCP RN as Needed

In addition to these staff positions and consultant agreements, DHS will contract for the administration of the MFP self-directed services with a properly licensed organization in good standing with State regulators (e.g. the PARI Independent Living Center or Tri-Town Community Action Agency). DHS also will contract with an organization that currently can offer a 24-hour Back-up Support Capability/System (such as United Way).

All contracting efforts will meet acceptable Federal and State procurement practices, guidelines and requirements.

The table below indicates the timeline for bringing on staff for each position. DHS is assuming that the demonstration will begin on September 1, 2011. The first six months after grant award will be devoted to finalizing the Operational Protocol and for developing the required systems and procedures for the MFP grant. The MFP Demonstration will be implemented and "go live" in Project Month , Six, September1, 2011. The employment of staff will be adjusted to reflect any changes in the development or implementation schedule.

Employee Positions*	Start Date
Project Director	July 2011
Deputy Project Director	July 2011
Program Development/Quality Specialist	August2011
Outreach/Marketing/Education Specialist	August 2011
Housing Coordinator	August 2011

Employee Positions*	Start Date
Referral Coordinator/Administrative Assistant	August 2011
Transition Assessment RN-1	August 2011
Transition Assessment RN-2	January 2012
Transition Coordinator-1*	September~~August~~ 2011
Transition Coordinator-2*	September 2011
Transition Coordinator-3*	January 2012
Transition Coordinator-4*	April 2012
Peer Mentor*	April 2011

*Transition Coordinators and Peer Mentors will be funded as a service at a level equivalent to the full time positions listed in this table.

3. Billing and Reimbursement Procedures

An identifier will be placed in the State's InRhodes Eligibility System to identify MFP participants. In addition, the MFP eligibility flag will be linked to those services qualified for enhances match in the State's Medicaid Management Information System (MMIS). System edits will be established and tested to ensure that claims are properly adjudicated. Separate files will be established to segregate the costs associated with the MFP demonstration project from Medicaid cost and to produce Claims Reports that will serve as the basis for "drawing down" federal funds.

The current Medicaid program to prevent and detect fraud and abuse will be applied to the MFP demonstration. Audits will be conducted in accordance with generally accepted government standards as issued by the federal government's Accountability Office.

D. EVALUATION

Rhode Island will not conduct a separate evaluation in addition to the CMS national evaluation that is being conducted by Mathematica Inc. We assure CMS that EOHHS will fully comply with all requirements associated with the MFP Demonstration national evaluation. Rhode Island will monitor and assess the progress of our project, however, to assure that we meet all the terms and conditions of our grant and the program as described in this Final Operational Protocol.

The Deputy Project Director will serve as liaison to the national evaluator and to CMS and Mathematica Inc. for evaluation activities.

E. BUDGET

The budget presented below is for the Phase I elder and disabled populations in nursing homes only. The budget complies with the CMS requirement that that administrative portion of the budget does not exceed 20% of the total MFP budget through 2016. The five year budget reflects total federal dollars of $24,570,450, of which $19,656,360 (80%) are services dollars and $4,914,090 (20%) are administrative dollars. (The SF-424a form reflects the partial year budget for CY 2011 from 4/1/211-12/31/2011 and estimates for subsequent years based on guidance from the RI CMS Project Officer.) Rhode Island recognizes that if must expend all of the funds under the MFP Planning Grant before using the MFP Demonstration Grant funds.

1. Administrative Presentation

Budget Summary for Phase I of the *Rhode to Home* Money Follows the Person Demonstration Project

RI is requesting the following total amounts for each year of Phase I of the *Rhode to Home* MFP demonstration project. Please note that numbers may not add due to rounding.

	2011	2012	2013	2014	2015	2016	Total
Services	$ 490,178	$ 3,231,673	$4,387,668	$5,364,025	$6,146,137	$6,227,346	$ 25,847,027
Service PMPM	$ 4,902	$ 3,078	$ 3,047	$ 3,725	$ 4,268	$ 4,325	$ 3,741
Administration	$ 490,571	$ 963,249	$ 940,019	$874,767	$900,849	$889,070	$ 5,058,525
Administrative PMPM	$ 4,906	$ 917	$ 653	$ 607	$ 626	$ 617	$ 732
Total	$980,748	$ 4,194,922	$5,327,687	$6,238,791	$7,046,986	$7,116,416	$30,905,552
Total PMPM	$9,807	$ 3,995	$3,700	$ 4,332	$ 4,894	$ 4,942	$ 4,473

Note that the project begins in CY2011 and the number of member months reaches a total of 60 by the end of the year. During CY2012, the program reaches full capacity. An inflation factor of 2% per year was included to indicate normal program cost increases.

Enrollment Summary

This table summarizes the expected enrollment into the program and shows the number of member months for the year. These numbers were used in calculating the PMPMs in the budget summary.

Projected Member Months and Average Number of Members per Month

	2011	2012	2013	2014	2015	2016
Member Months per year						
Total	100	1,050	1,440	1,440	1,440	1,440
Over 65	90	945	1,296	1,296	1,296	1,296
Under 65	10	105	144	144	144	144
Average members per month						
Total	17	88	120	120	120	120
Over 65	15	79	108	108	108	108
Under 65	2	9	12	12	12	12

Per Member Per Month (PMPM)

The steps used in calculating the PMPM for the Qualified HCBS services and demonstration services were as follows:

Step 1. Obtain Actual Spending and Eligibility Information

DHS obtained actual spending, utilization and eligibility information for the Rhode Island individuals who were determined eligible for Home and Community Based Services (HCBS) for the period July 2010 through March 31, 2011. This information was obtained from the MMIS system as of September 30, 2011.

Step 2. Analysis

DHS analyzed the data to obtain the following numbers for the nine-month period:

a. Total number of individuals eligible for HCBS

b. Service-specific total expenditures

The PMPM was calculated by dividing "(b) service specific total expenditures" by "(a) Total number of individuals eligible for HCBS." The unit cost for these services is shown in Table 1.

Table 1: Baseline Unit Costs for Qualified HCBS

MFP Service	Qualified HCBS Service	Units Used	Cost per Unit
Special Medical Equipment Minor Assistive Devices	Assessment of Home and Family	Per month	$ 20.00
Assisted Living	Assisted Living	Per Day	$59.00
Day Supports	Attendant care	per 15 min	$6.00
Respite Care (100 hours per year limit)	Attendant care	per month	$ 60.83
Peer Mentors (only for participants under age 65)	Case Management, per 15 minutes	per 15 min	$9.00
Supports for Consumer Direction	Case Management, per month	per month	$125.00
Person Emergency Response (PERS) start up cost	Emergency device set up	One time per person	$49.00
Person Emergency Response (PERS) monthly cost	Emergency device monthly fee	Per month	$ 34.00
Meals on wheels	Meals on wheels	Per meal	$ 4.00
Minor Environmental Modifications	Home modifications, per service	One time	$ 1,226.00
Homemaker services	Homemaker	Per 15 min	$ 4.00
Environmental modifications Home Accessibility Adaptations	Special Medical Equipment Minor Assistive Devices	One time	$ 176.00
Targeted Case Management	Targeted Case Management	per 15 min	$15.00
Personal Care Services	Personal Care	15 min	$ 1,880.00
LPN Services (Skilled Nursing)	Private Duty/indep nursing	per hour	$ 8.00
Participant Directed Goods and Services	Specialized Supply NOS	Per month	$134.00

Summary of Benchmarks

The following summary of selected benchmarks is included here as a reference when reviewing the position descriptions.

Benchmark 1 Number of individuals transitioned from a qualified institution to the community

Benchmark 2 Increase HCBS Expenditures

Benchmark 3 Percentage increase in HCBS expenditures relative to Nursing Facility (qualified institution) expenditures

Benchmark 4 Increase use of self directed services

Benchmark 5 Number of Referrals received from those individuals interested in obtaining care in a community-based setting

Personnel and Fringe Benefits:

This budget proposal provides staffing resources through contracted positions. However, the state may opt to create some or all of these as state positions based on input from the incoming administration.

Functions such as executive oversight, claims processing, contract monitoring, legal review and budgeting will be provided by the Department of Human Services and the Executive Office of Health and Human Services.

Contracted Costs

Personnel: *The Rhode to Home* MFP Demonstration Project expects to contract for all positions described in this project. This section describes the positions to be filled, the MFP Service Category, the applicable FFP category, and a brief description of how the positions will help the

state meet the proposed benchmarks in the OP. The proposed positions will be either filled by State staff or contracted our through community-based organizations, which will be decided in consultation with the new State administration.

The project-staffing model is based upon programs and functions already in operation by the EOHHS and other state agencies. Staffing levels are directly informed by experience in the following areas:

- Global Waiver Level of Care Assessment Process: Under the Global Waiver, the Office of Institutional and Community Support Services conducts a structure, multi-dimensional assessment of every individual who is eligible for long term care services. The MFP Demonstration intake design is based upon lessons learned after more than a year of full-scale operation.
- Home and Community-based Care: In establishing a proposed level of service for MFP Demonstration participants, EOHHS reviewed actual utilization rates for selected in-home support services. EOHHS examined the actual utilization rates and estimated the level of services that would be needed to successfully maintain an individual safely and comfortably at home.
- Collaboration with state housing authority: The state provides support for certain populations in-group living situations. In a recent Request for Information pertaining to strengthening community based supports, the state identified availability of appropriate housing as a major barrier to returning to the community. EOHHS has already secured an agreement with Rhode Island Housing (state public housing authority) to prioritize the applications of individuals seeking to return to the community from an institution.

- Care coordination models in Medicaid Managed Care programs: Medicaid beneficiaries under the age of 65 are enrolled in either contracted managed care or in a strong, state operated primary care clinician plan. Both options offer robust care coordination strategies that inform the design and staffing of this Demonstration Project.

These positions are needed to ensure that MFP participants can successfully transition into and remain in the community, thus ensuring that the State meets its OP benchmarks. Therefore, Rhode Island is requesting reimbursement at 100 percent federal match throughout the term of the demonstration project.

Administrative Positions

- **Project Director** will be a full-time position solely dedicated to the MFP demonstration. The Project Director will have overall responsibility for the design, implementation and operation of the *Rhode to Home* MFP Demonstration Project. The Project Director will have overall responsibility for ensuring that all MFP participants are able to live safely and securely in the community while guiding project staff to meet all five OP benchmarks. The Project Director will supervise Care Coordination services such as Transition Assessment, Housing, Transition Coordinators and Peer Mentors. Other responsibilities include stakeholder communications; CMS liaison; report submission; strategic planning; and developing project materials.

Project Director				
Proposed Salary		$72,749		
Requested Match		100% FMAP as an MFP Demonstration Administrative Expense		
Basis of Request:		Directs and leads program		
Benchmark 1	**Benchmark 2**	**Benchmark 3**	**Benchmark 4**	**Benchmark 5**
✓	✓	✓	✓	✓

- **Deputy Project Director** will be a full-time position solely dedicated to the MFP demonstration. The Deputy Project Director will report to the Project Director. The Deputy Project Director will oversee Program Support functions such as Program Development/Quality, Outreach/Marketing/Education, Financial Reporting, Information Technology reports and modifications, and liaison with CMS and it' Evaluation contractor. The Deputy Project Director supports the program's achievement of all five benchmarks by providing oversight of information resources, quality improvement and outreach efforts.

Deputy Project Director				
Proposed Base Salary		$65,307		
Requested Match		100% FMAP as an MFP Demonstration Administrative Expense		
Basis of Request:		Provides oversight of program support functions		
Benchmark 1	**Benchmark 2**	**Benchmark 3**	**Benchmark 4**	**Benchmark 5**
✓	✓	✓	✓	✓

- **Program Development/Quality Specialist** will be a full-time position dedicated to the MFP demonstration. This individual will have overall responsibility for program development and quality assurance activities. This position ensures that care planning standards are uniformly applied, that Continuous Quality Improvement (CQI) activities are integrated into program design, and monitor service delivery through care plans and by after hours vendors. This position supports achievement of all five benchmarks through ensuring adherence to program design and established standards.

Program Development/ Quality Specialist				
Proposed Base Salary		$65,307		
Requested FFP Match		100% FMAP as an MFP Demonstration Administrative Expense		
Basis of Request:		Monitors program quality; develops reporting mechanisms		
Benchmark 1	**Benchmark 2**	**Benchmark 3**	**Benchmark 4**	**Benchmark 5**
✓	✓	✓	✓	✓

- **Outreach/Marketing/Education Specialist** will be a full-time position solely dedicated to the MFP project or contracted out on a consultant basis, for the first two and one-half years of the demonstration. This individual will have overall responsibility to assure that the vital outreach, marketing and education activities are developed and implemented, including stakeholder relations; develop program-marketing materials; attend community meetings. This position ensures that care providers, families and community organizations are aware of the *Rhode to Home* MFP Demonstration and therefore will support the program's efforts to achieve Benchmarks 1, 2, and 3. However, the services are not directly provided to successfully transitioned participants. The state therefore requests a federal matching amount equal to the FMAP in effect for the quarter.

Outreach/Marketing/Education Specialist				
Proposed Base Salary		$43,563		
Requested Match		100% FMAP as an MFP Demonstration Administrative Expense		
Basis of Request:		Supports general program awareness; not limited to transitioned beneficiaries		
Benchmark 1	**Benchmark 2**	**Benchmark 3**	**Benchmark 4**	**Benchmark 5**
✓	✓	✓	✓	✓

- **Housing Coordinator** will be a full-time position solely dedicated to the MFP project. The Housing Coordinator will have overall responsibility to assure there is accessible, suitable, and affordable safe housing to meet the needs of transitioning MFP participants. Specifically, the Housing Coordinator have three major areas of responsibility: (1) to work with and serve as the project liaison to federal, state and local housing organizations to identify opportunities within established programs that facilitate access to affordable housing, (2) to work with housing developers and builders to tell them about federal, state and local opportunities and financial assistance for building and or renovating housing to meet the needs of the MFP population, and (3) to work with State staff who assist MFP participants identify and secure available and affordable housing that meets their transition needs. The estimated service level anticipates that housing in desirable areas is difficult for clients to locate independently. In helping MFP Demonstration participants make a successful transition into stable housing, this position addresses a critical need in community based services and supports the program's achievement of all benchmarks.

Housing Coordinator				
Proposed Salary:		$53,894		
Requested Match		100% FMAP as an MFP Demonstration Administrative Expense		
Basis of Request:		Ensures successful community residence		
Benchmark 1	**Benchmark 2**	**Benchmark 3**	**Benchmark 4**	**Benchmark 5**
✓	✓	✓	✓	✓

- **Referral Coordinator/Administration Assistant** will be a full-time position solely dedicated to the *Rhode to Home* MFP Demonstration Project. The Administration Assistant/Referral Coordinator will provide administrative support for the entire MFP staff team. Specifically, the Administrative Assistant will assist project staff: (1) maintain calendars and schedule meeting, (2) take notes and prepare minutes of project and stakeholder meetings, (3) prepare presentations and reports, (4) maintain a central MFP project library, (5) receive all MDS-Q forms from the nursing homes statewide and refer them to the appropriate MFP project staff for review and follow-up, and (6) conduct other administrative activities throughout the demonstration period. This position provides continuing assistance to the program and supports efforts to meet all benchmarks.

Referral Coordinator/Administrative Assistant/				
Proposed Salary:		$36,567		
Requested Match		100% FMAP as an MFP Demonstration Administrative Expense		
Basis of Request:		Supports all administrative staff		
Benchmark 1	**Benchmark 2**	**Benchmark 3**	**Benchmark 4**	**Benchmark 5**
✓	✓	✓	✓	✓

- **Transition Assessment Nurses** will be two full-time positions dedicated to the MFP project. The Register Nurses will be a part of our Assessment Team providing the clinical medical perspective. Based on the state's experience to date with conducting level of care assessments, these individuals will screen candidates for participation in the *Rhode to Home* MFP Demonstration Project as well as care plan development and implantation services for those who transition into the community. These staff members will assist the *Rhode to Home* MFP Demonstration Project in achieving all five benchmarks. The state is requesting federal matching funds as follows:
    - Screening of potential candidates: Based on current participation rates, DHS estimates that one in three candidates will successfully transition from a qualified institution to a community setting. DHS also expects that screening and interviewing each candidate will require one workday per week (20%). The total time dedicated to candidates who do not transition is estimated one day each, for a total of two days per week, or 40% of each staff member's time. For this portion of the Transition Assessment Nurses' costs, DHS is requesting federal financial participation of 75% as allowed for clinical medical personnel who are providing care in a Medicaid program.
    - Care planning and implementation for individuals who successfully transition to the community: The Transition Assessment Registered Nurses will spend the balance of their time screening the estimated one candidate per week who transitions to the community as well as providing care plan implementation services. These individuals directly support Benchmarks 1,2,3,4 and 5 through

their efforts to identify appropriate candidates and to ensure that the approved service array is consistent with the care plan.

The rematch rate for the Transition Assessment Nurses is based on the following assumptions: Transition Assessment Nurses will screen candidates for MFP and will also provide assistance in establishing contact with required medical services for MFP participants. Based on experience with the state's Nursing Home Transition Program, EOHHS expects that the Transition Assessment Nurses will spend approximately 60% of their time screening candidates who ultimately choose not to enroll in the program. The remaining 40% of their time will be used to screen and support MFP enrollees.

Estimated Proportion of FTE Time for Screening MFP Candidates

			Notes on Calculations
1	Work weeks per year	50	
2	Screening yield	33%	DHS experience
3	Target per month	10	
4	Number needing to be screened per month	30.30	1 out of 3 screened ultimately participate
5	Total number of screens for year	364	(4) time 12 months
6	Hours per screening	10.00	DHS experience
7	Total hours needed	3,636	(5) times (6)
8	Number of Transition Assessment Nurses	2	
9	Hours per Nurse to be spent screening	1,818	(7) divided by number of nurses
10	Hours per FTE per week	36	(9) divided by (1)
11	Hours in work week	40	
12	Percentage of time on screening	91%	(10) divided by (11)
13	Percentage of screened individuals who not enroll	66%	2 of 3 do not enroll
14	Time spent on NonMFP Participants	60%	Portion of time used for those individuals who ultimately do not enroll

Transition Assessment Nurse				
Proposed Salary:		$68,919		
Requested Match		40% of FTEs at FMAP rate for clinical services; 60% of FTEs at 100% FMAP under MFP Demonstration Administrative Expense		
Basis of Request:		Performs screening and delivers care planning		
Benchmark 1	**Benchmark 2**	**Benchmark 3**	**Benchmark 4**	**Benchmark 5**
✓	✓	✓	✓	✓

- **Transitional Coordinators** will be 4 full-time staff, based on a caseload ratio of 1 to 35 community residing elderly beneficiaries. These positions will be contracted through a certified community organization, such as the Centers for Independent Living or Area Agencies on Aging. The Transition Coordinators will work exclusively with individuals who are transitioning to the community and serve as the point person and care manager for the participant during the demonstration period to ensure a successful and lasting transition. Transition Coordinators will support the achievement of all benchmarks, especially Benchmark 5 and will provide services only to transitioned participants during the demonstration period 100 percent of their time.

Transitional Coordinators				
Proposed Salary:		Contracted via a community organization		
Requested Match		Enhanced FMAP MFP Demonstration Service		
Basis of Request:		Serves only transitioned beneficiaries		
Benchmark 1	**Benchmark 2**	**Benchmark 3**	**Benchmark 4**	**Benchmark 5**
✓	✓	✓	✓	✓

- **Peer Mentor** will be one full-time position supporting individuals under age 65 to successfully transition and maintain a community residence. The staffing ratio of one FTE to 15 participants is based on estimated utilization of care management services. These positions will be contracted through a certified community organization such as the PARI Centers for Independent Living. The Peer Mentor will assist the person with a disability transition into the community and provide care management throughout the demonstration period and thereafter, if required by the participant. The Peer Mentor will

be a person with a disability (or a representative of persons with disabilities) who is successful living in a home and community setting. The Peer Mentor will support all five benchmarks, especially benchmarks 4 and 5. This service is considered a HCBS Qualified Service.

Peer Mentor				
Proposed Salary:		Contracted via a community organization		
Requested Match		Enhanced MFP Demonstration Qualified HCBS Service Expense		
Basis of Request:		Serves only transitioned beneficiaries		
Benchmark 1	**Benchmark 2**	**Benchmark 3**	**Benchmark 4**	**Benchmark 5**
✓	✓	✓	✓	✓

Overhead Rate

The state has calculated an overhead rate for contracted positions based on premiums and rates as a percentage of the average salary as follows:

Health Care Benefits	26%
Payroll taxes (FICA, FUTA, UI, Workmen's Comp)	16%
Equipment and Facilities	8%
Administrative overhead	10%
Total overhead rate as percentage of contracted salary	60%

- Health care Benefits include medical, dental, vision and long term disability with an employer share of premium at 75 percent
- Payroll taxes are based on established state and federal rates
- Equipment and facilities include the contracting entity's cost of renting and furnishing office space and providing telephone, desktop computers, copiers, etc.

- Administrative overhead supports the contracting entity's infrastructure costs for payroll, benefits administration, recruitment, taxes and other compliance responsibilities and a 2 percent margin.

Travel

The *Rhode to Home* MFP Demonstration Project Administrative Budget includes the following annual travel reimbursements, for which the state is requesting 100 percent FMAP as a cost of administering the program.

- In-state mileage reimbursement for staff: The annual amount requested for instate travel is based on 7 FTEs traveling 75 miles per week for 50 weeks per year at the current IRS rate of $.51 per mile.
- Out of state travel to attend CMS MFP Conferences: The request of $15,000 per year is based on two trips per year for the Project Director and the Deputy Director (4 trips) at an estimated cost of $2,500 for airfare, hotel and expenses to locations to be determined.

Supplies

- The *Rhode to Home* MFP Demonstration Project Administrative Budget includes an annual expense of $9,360 for office supplies used in the course of the project. The state is requesting 100 percent FMAP as a cost of administering the program.
- The *Rhode to Home* MFP Demonstration Project Administration Budget includes graphic design and printing costs for marketing and outreach materials. The state is requesting FMAP at the Standard Rate since these materials reach a population that is broader than transitioned individuals.

Equipment

The MFP program staff (i.e. Transition Assessment Nurses, Transition Coordinators and Peer Mentor) will be supplied with cell phones and laptop computers to securely collect and transmit participant information while in face-to-face meetings in the field during the program year. Providing this equipment is intended to allow staff to:

- maintain connectivity with evolving secure data exchange systems;
- securely collect and share information with other members of the MFP team;
- facilitate prompt resolution of emerging concerns before the MFP participant's health status or residential situation are impaired.

The intent of upgrading or replacing equipment is to ensure that program staff does not need to return to paper forms requiring data entry. Please note that the annual amount has been reduced to reflect the elimination of the transition coordination social workers. To reflect the later than anticipated start date, the replacement cost estimate has been moved to Calendar Year 2015. This represents the midpoint between a three year lifecycle for laptops and desktops at universities and the five year depreciation schedule used by the IRS for computer equipment in general. Note that cell phones are usually replaced on a faster lifecycle; it is assumed that this cost will be built into the telecommunications contract plan.

Other Administrative Budget Items

The *Rhode to Home* MFP Demonstration Project includes funding for items that are critical to the efficient and effective operation of the program; the state is requesting 100 percent FMAP for these costs, as follows:

- **Information Technology Services**: The state is requesting the following one time and ongoing support for services related to data management and reporting:
    - Development and implementation of a web-based data collection tool: Programming, testing and deployment: $39,000 one time cost

      Annual cost of $9,750 to maintain

      The web-based data collection tool will support the efforts of staff to collect and record information about program participants during the care planning process and subsequently while in the community. The goal of the system is to provide a single source of information about the individual's needs, backup plan, and care instructions. Industry security standards will be used to grant function-specific permissions to data.
    - Modifications to the state MMIS system to flag and track program participants: System changes are needed to add new codes and fields to accurately track expenditures for the program. Based on prior experience, the state estimates that approximately 930 hours at $150 per hour (standard system vendor rate) will be required to develop and implement the coding at a cost of $139,500, of which $115,000 will be supported by the planning grant, followed by annual maintenance and changes at $10,500 per year (70 hours).
- **Focus Groups, Surveys and Participation Incentives:** The state is requesting 100 percent FMAP as part of the MFP Administrative Budget for the following activities:
    - Consumer/Provider focus groups to be conducted in the first 12 months of the project to ensure that community and clinical concerns are appropriately addressed. The estimated cost in both CY 2011 and CY2012 is $40,950 per year.

This analysis is based on information from a marketing company with expertise in contacting and working with low-income populations.

- Quality of Life Surveys: The state will make best effort to contract for the administration and collection of quality of life surveys at the established rate of $100 each (12,000 per year). Rhode Island recognizes that the $100 associated with conducting the Quality of Life Surveys is for paying the party conducting the surveys and not to the participants. Nevertheless, Rhode Island continues to be concerned that the $100 allotted for conducting the Surveys may not cover the actual costs.
- Participation Incentives: The state expects to engage consumers and family caregivers in a number of advisory groups. Past experience with community based stakeholder groups suggests that a small stipend significantly increases participation for the duration of the project. The budget includes $6,000 for this purpose.

- **Enhanced Self-Directed Worker Registry:** The State is requesting 100 percent FMAP to support the update of the existing directory of workers available to self-directed participants and to provide free access to the registry for MFP participants. The budget includes a one time cost of $10,000 to collect and review the registry services, with first year cost of $9,126 and an annual cost of $ 9,360 to ensure that qualified workers are accurately listed and provide support to the State and MFP participants. The estimates for the Self Directed Worker Registry work were based upon proposals received by EOHHS last year from a private contractor that operates the existing Self-Directed Worker Registry. The project includes one time website enhancements and worker

outreach activities. On an annual basis, the work includes ongoing maintenance, access for consumers and customer support. The enhanced ADRC referral capacity proposed costs were based on cost associated with the current ADRC expenses. It is anticipated that the ADRC contractor would perform the enhanced ADRC referral capacity activities.

- **Enhance the ADRC referral capacity:** The state is requesting 100 percent Administrative FMAP to support at an annual cost of $16,692to ensure that the ADRC collects and maintains accurate information specific to the needs of transitioned individuals.
- **Back up 24/7 system**: The state is requesting 100 percent Administrative FMAP for the annual cost of $39,000 to enable a community based agency to provide 24/7 back up services to transitioned participants who are unable to obtain urgently needed care from either their personal back up or the responsible provider. The estimated cost includes the nights, weekend and holiday cost of providing access to a "live" person with knowledge of the Rhode Island service provider array and the *Rhode to Home* MFP Demonstration Project in particular.

Services

- **Qualified Home and Community Based Services:** The *Rhode to Home* MFP Demonstration Project expects to provide the following Qualified Home and Community Based Services. Estimated service utilization is based on actual utilization for long term care beneficiaries who reside in the community, adjusted for service intensity. The estimated PMPM cost per transitioned individual is $ $2,732 in FY11, with 2 percent inflation added per year. The state is requesting reimbursement at the standard FMAP rate in effect

beginning July 1, 2011 (FFY12Q1). The list of Qualified Home and Community Based Services is:

Assisted Living

Case Management

Day Supports

Environments modifications /Home Accessibility Adaptations

Homemaker

LPN Services (Skilled Nursing)

Meal on Wheels

Minor Environment Modifications

Participant Directed Goods and Services

Peer Mentoring Services

Person Care Assistance Services

Person Emergency Response (PERS)

Physical Therapy Evaluation and Services

Private Duty Nursing

Residential Supports

Respite

Senior Companion

Special Medical Equipment Minor Assistive Devices

Supported Employment

Supported Living Arrangements

Supports for Consumer Direction

Community Transition Services

- **Demonstration Services:** The budget includes the following services that will be offered to transitioned individuals during the 365 day period:
    - **Transition Coordinators:** The transition coordinators, described above, will be available during the term of the *Rhode to Home* MFP Demonstration Project.
- **Supplemental Services:** The budget does not include a request for funding to support supplemental services.

2. Administrative Budget

The following is the Administrative Budget for the *Rhode to Home* project is displayed on the SF 424 and SF 424A Forms. In addition, the *Rhode to Home* contracted Personnel Summary can be found in the budget narrative additional documents section.

3. Evaluation Budget

Rhode Island does not require a separate Evaluation Project budget because the State is not proposing to conduct an Evaluation in addition to the Federal MFP Evaluation conducted by Mathematica, Inc. A staff person has been included in our staffing to work with and provide information to the national evaluator. The cost associated with that staff position is treated as an essential administrative cost at 100 percent FMAP.