

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

**9/10/2015 PUBLIC NOTICE OF PROPOSED CATEGORY II CHANGE TO
RHODE ISLAND'S COMPREHENSIVE 1115 WAIVER DEMONSTRATION**

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

**Reinventing Medicaid 2015:
Rate Reduction for Personal Choice Program**

As part of Governor Gina Raimondo's effort to reform Medicaid, the Working Group to Reinvent Medicaid issued an April report that recommended numerous initiatives to achieve financial savings in State Fiscal Year (SFY) 2016. The Governor introduced those recommendations in a budget article entitled, "The Reinventing Medicaid Act of 2015." The Rhode Island General Assembly passed the Reinventing Medicaid Act in June.

As a result of the Act's passage, EOHHS is seeking federal authority to implement several changes to the Medicaid program. This Category II request will reduce rates for the personal choice program. This change will yield an estimated \$200,000 in annual savings to the state.

This proposed Category II change is accessible on the EOHHS website (www.eohhs.ri.gov) or available in hard copy upon request (401-462-1965 or RI Relay, dial 711). Interested persons should submit data, views, or written comments by October 12, 2015 to Darren J. McDonald, Office of Policy and Innovation, Executive Office of Health and Human Services, 57 Howard Avenue, Cranston, RI, 02920, or darren.mcdonald@ohhs.ri.gov.

In accordance with the Rhode Island General Laws 42-35-3, a hearing will be conducted to receive public testimony on the proposed Category II change if requested by twenty-five (25) persons, or by an agency or association having at least twenty-five (25) members. A request for a hearing must be made within thirty (30) days of this notice.

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

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

**Category II Change
Change Name: Personal Choice Program
Change Number: 15-02-CII**

Date of Request	October 13, 2015
Proposed Implementation Date:	January 1, 2016

Fiscal Impact:

	FFY 2016	FFY 2017
State:	-\$79,348	-\$105,800
Federal:	-\$79,348	-\$105,800
Total:	-\$158,700	-\$211,600

**Description of Change:
Attachment A**

**Assurances:
Attachment B**

**Standard funding questions:
Attachment C**

Attachment A : Description of Change

Rhode Island is submitting a change of request to the Rhode Island Comprehensive Section 1115 Demonstration, with an effective date of January 1, 2016, to reduce the rates paid to Service Advisement Agencies who provide Case Management services through the Personal Choice Program. This change is part of the Budget Initiative for State Fiscal Year 2016.

This change is submitted as a Category II submission.

Background

Through the Personal Choice Program, the State reimburses Service Advisement agencies at a rate of \$125.00 per member per month for services provided. Initial assessments and preparation are billed at a rate of \$250.00 as a one-time fee. Required monthly services provided by the Service Advisement agencies include, a monthly check in with participant on issues related to social service needs, hospitalizations, overall health needs and issues with employees. Additionally, the agencies are responsible for quarterly home visits both planned and unannounced. Nursing and Mobility assessments are also required on a yearly basis. The State expects no change in the delivery of services as a result of the proposed rate cut.

The proposed change to Personal Choice Program will bring those rates into alignment with other Case Management rates throughout the State.

The proposed reimbursement would be as follows for a current enrollment of 294 participants

PROPOSED RATES:

Initial Assessment—\$250.00
 4 Quarterly visits—\$75.00
 Monthly phone contact in months
 without face to face contact (8 times
 per year)—\$60.00

CURRENT RATES:

Initial Assessment—\$250.00
 4 Quarterly visits—\$125.00
 Monthly phone contacts in months
 without face to face contact (8 times
 per year)—\$125.00

Projected Total Savings= \$211,600.00

Attachment B : Assurances

The State assures the following:

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

Attachment C: Standard Funding Questions

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

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

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

The State share is funded through general revenue funds appropriated by the legislature for this purpose.

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

No supplemental or enhanced payments were made.

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

N/A

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

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