STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

10/16/2015 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:
Home Stabilization Initiative

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 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 implement a set of tenancy support services. These services are designed to encourage independence among Medicaid beneficiaries and provide them with the skills to be successful tenants. The goal is to improve health outcomes, reduce costs, and promote stability among vulnerable populations.

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 November 15, 2015 to Darren J. McDonald, Executive Office of Health and Human Services, Hazard Building, 74 West Road, 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: Home Stabilization Initiative
Change Number: 15-06-CII

Date of Request	November 16, 2015
Proposed Implementation Date:	January 1, 2016

Fiscal Impact:

	FFY 2016	**FFY 2017**
State:	**$649,689**	**$866,250**
Federal:	**$649,689**	**$866,250**
Total:	**$1,299,379**	**$1,732,500**

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Attachment A: Description of Change

There is a growing body of empirical evidence showing that the loss or absence of a "home" has adverse health effects that are far reaching, particularly for vulnerable populations who are at risk for or coping with serious physical and/or behavioral health conditions. The lack of a sense of permanence is also a relevant factor. As such, we are also referring here to individuals who stay intermittently in the homes of various family members and/or friends (so called "couch surfing") and/or who have lost their home setting when transitioning from residential treatment, institutional care-settings, military service, or incarceration. The available data indicate that there are significant subsets of high-cost Medicaid beneficiaries of all ages who cannot access or afford such a stable living arrangement. The purpose of the state's Home Stabilization Initiative (HSI) is to make an organized set of Medicaid-funded tenancy supports services available to Medicaid beneficiaries.

Toward this end, Rhode Island's Executive Office of Health and Human Services (EOHHS) will use the authorities requested under the Section 1115 waiver to implement a set of tenancy support services, in conjunction with its partner state and community agencies. This innovative HSI targets Medicaid beneficiaries who require support in maintaining their tenancy. The state intends to engage community providers certified as Home Stabilization providers (HSP) to conduct the provision of high quality, flexible, home-based services. The Certification process assures that successful providers have the capacity to develop and implement tenancy support services and the expertise and access to see them through.

To maximize the effectiveness of the HSI, the state intends to integrate the mix of existing State Plan, waiver, HUD Continuum of Care, and other publicly funded services and interventions that enhance home and health stability (e.g., home-based therapy, day services, employment supports, core home and community based services, home modifications, etc.).

The State believes that the HSI will demonstrate that tenancy support services provided through Section 1115 waiver authorities are an effective intervention that will improve health outcomes, reduces costs, and promote responsibility and independence among vulnerable populations.

HSI Target Groups

Tenancy support services will be made available to Medicaid beneficiaries based on an assessed need.

Tenancy Support Services

The State proposes to provide a wide range of narrowly focused services to HSI participants. These services will be evidence based and provided on an individualized basis to correspond to a beneficiary's needs. Tenancy support services are designed to supplement and enhance, rather than substitute for or supplant, existing federally funded services available. The HSP will provide support to teach a time-limited set of tenancy support services that promotes independence and ensures that an individual is able to meet the obligations of their tenancy. These services include: early identification and intervention for behaviors that may jeopardize

housing, such as late rental payment and other lease violations; education and training on the role, rights, and responsibilities of the landlord and tenant; coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy; assistance in resolving disputes with landlords/neighbors to reduce the risk of eviction or other adverse action; advocacy and linkage with community resources to prevent eviction when housing is, or may be jeopardized; assistance with the housing recertification process; coordinating with the tenant to review, update, and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers; continued training in being a good tenant and lease compliance, including on-going support with activities related to household management

Service Delivery and Payment

Tenancy support services will be provided by HSP who are certified to conduct tenancy support services.

The state proposes to develop a payment methodology that encourages tenancy support services that enhance the independence of beneficiaries. As such, the state plans to use its waiver authority to limit the duration of tenancy support services based on desired outcome for beneficiaries, which can be defined as a level of health and home stability in which tenancy support services are no longer required.

Rationale

The Informational Bulletin dated June 26, 2015, the Centers for Medicare and Medicaid Services made a "commitment to help state's expand home and community-based living opportunities…based on evidence demonstrating that providing housing-related activities and services facilitates community integration and is cost-effective."

Underlying the selection of the diverse set of tenancy support interventions, and of the HSI itself, is evidence-based research on housing first programs, nursing home transitions efforts, child welfare systems of care, and health homes initiatives serving beneficiaries with chronic diseases (e.g., diabetes) or serious behavioral health issues (e.g., addiction).

On the Housing First side, there is convincing data indicating that chronic health conditions and homelessness are more effectively addressed once people have been provided with a stable living environment – health outcomes improve, use of ED services drop, and beneficiaries are more likely to comply with plans of care. For example, a study of a housing-first program in Denver found 50% of tenants placed into supportive housing experienced improved health status, 43% had improved mental health outcomes, and 15% reduced substance use.[1] The evidence from a recent study conducted in Rhode Island is consistent with these findings. The study found that between 2010 and 2012:

- Over 38% (2,308/5,986) of the persons utilizing the homeless shelter system in Rhode Island received Medicaid funded services;

[1] www.denversroadhome.org/files/FinalDHFCCostStudy_1.pd

- The total cost of the Medicaid services for the 2,308 homeless individuals-- federal and state -- was $58,136,486;
- The top 67 utilizers -- or just above 3% -- cost a total of $9,325,375, or $139,185 per year;
- The average per person per month cost to Medicaid for the remaining homeless people included in the study was $4,971, which is 37% higher than the per person per month average expenditure for adults with disabilities in Medicaid who did not utilize the shelter system.[2]

Lending further credence to these findings, a Philadelphia, PA, health home for the homeless reported a 72% decrease in Medicaid costs for at risk youth and adult beneficiaries receiving both health supports and home stabilization services.[3]

There is equally compelling data related to MFP activities showing differences in the health and cost of providing community-based services for Medicaid-eligible elders versus adults with chronic disabilities. Elders transition to more stable home-like settings and, at least partially as a result, experience greater health benefits and need less costly care than more transient adults with similar intensive care needs. Moreover, the findings of this research make it clear that when these adults, most of whom have both physical and behavioral health disorders, are provided with the home stabilization services available to elders through the MFP, use of primary and preventive services goes up while, at the same time, utilization of high cost Medicaid services like the ED begin to drop.[4] Data looking more narrowly at Medicaid and/or Medicare beneficiaries who are at risk for long-term care indicate that the lack of integrated home and health stabilization services has greatly hindered efforts to divert/transition them institutional care-settings. Additionally, health outcomes and utilization for members of this subpopulation living in the community vary significantly depending on whether they are provided with stabilization services: a review of the relevant data found that those who received home and health stabilization services – typically through HUD supportive housing – tended to have fewer hospitalizations and acute, but serious conditions like pneumonia and were generally likely to comply with and benefit from disease self-management regimes.[5]

Similarly, research on children's health shows that there is a strong correlation between home stability and a host of health care problems ranging from substance use disorders, to serious mental illnesses and on to acute trauma, and asthma.[6] Evaluations of child welfare high fidelity wrap programs has found that integrated home and health stabilization services are mutually reinforcing; severely emotionally disturbed children who are transitioned from residential or

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[2]Materials for the Housing First and Medicaid Costs of Home Instability studies may be obtained by contacting Professor Eric Hirsch at: ehirsch@providence.edu. Information cited was provided in documents distributed at the Governor's Interagency Council on Homelessness, in April of 2013. Data derived from Rhode Island Homeless Management Information System- All people who used an emergency shelter from January 1, 2010 to April 30, 2012. Total number = **5,986**

[3] Wilkins, et al., Medicaid Financing for Services in Supportive Housing for Chronically Homeless People: Current Practices and Opportunities. Available at: http://aspe.hhs.gov/daltcp/reports/2012/chrhomls2.shtml

[4] Irvin, et. al., Money Follows the Person 2012 Annual Evaluation Report: Final Report (October 2013). Available at: http://www.mathematica-mpr.com/~/media/publications/PDFs/health/MFP_2012_Annual.pdf

[5] Lewin Group, "Picture of Housing and Health: Medicare and Medicaid Use Among Older Adults in HUD-Assisted Housing". Available at: http://aspe.hhs.gov/daltcp/reports/2014/HUDpic.shtml.

[6] See: http://www.gatesfoundation.org/What-We-Do/US-Program/Washington-State/Homelessness-and-Family-Stability and http://aspe.hhs.gov/hsp/10/homelesschildrenroundtable/index.shtml

congregate care to the community have fewer high cost health episodes when health and home stability is a service focus both prior to and after placement.[7] Additionally, the integration of these stabilization services has proven to be critical nation-wide in building and maintaining the family support systems children with serious behavioral health care conditions need to thrive in the community-setting. For example, the multi-disciplinary teams that anchor the high fidelity wraparound in Milwaukee identify integrated health and home stabilization services as a critical facet of the program's success.

It is the state's expectation that waiver of comparability to implement the HSI will yield cost savings and health improvements that meet or exceed the results of these initiatives and similar national trends. Note, however, that though the HSI contains elements of all these care models, it does not fall neatly in to just any one. The State plans instead to establish a care model with the capacity to deliver coordinated health and tenancy suport services at the crucial points where they intersect for Medicaid beneficiaries with high cost intensive care needs who might otherwise not thrive in the community

In sum, by implementing the HSI, the state hopes to realize reductions in costly institutionally-based care and medical interventions as well as improvements in health and well-being and in several ways. First, once living in a home, ongoing tenancy support services can be provided to beneficiaries that help prevent future health and home crisis's and ensure thoughtful management of ongoing care. The coordination and management of these secondary interventions over the short-term is expected to optimize wellness and facilitate the transition to independence and stability by gradually reducing intensive care management and ensuring supports for success are in place. Second, tenancy support services will also enhance beneficiary education, training and employment opportunities and family stability, and in ways that should reduce reliance on all publicly-funded services not just health care. From a Medicaid perspective, tenancy support services offer significant cost-savings opportunities. The available data show that tenancy support services reduce health care expenditures on emergency room care and hospitalizations and prevent the need for treatment in higher cost settings. And third, the HSI model aligns both the triple aim the state's long-standing commitment to ensure that Medicaid-financed services are responsive and appropriate given a person's medical, functional and social needs.

Waiver Authority Sought

EOHHS is requesting a waiver of comparability and expenditure authority in order to provide tenancy support services to members that have the required level of need.

EOHHS also seeks a waiver of Section 1902(a)(10)(B), amount, duration, and scope in order to:
(1) offer alternative services to members of the target groups and in the most cost-effective setting, (e.g. a person's residence),
(2) set limits on the scope and duration of these alternative services – in accordance with evidence-based practices; and
(3) develop and implement payment strategies that promote quality outcomes.

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[7] Bruns, E. J., & Suter, J. C. (2010). Summary of the wraparound evidence base. In E. J. Bruns & J. S. Walker (Eds.), The resource guide to wraparound. Portland, OR: NationalWraparound Initiative.

The State of Rhode Island also requests the authority to waive Section 1902(a) (23), requiring freedom of choice, and any willing provider requirements to ensure access to expert care and enable the state, under Section 1115, to obtain federal matching funds for expenditures for tenancy support services provided.

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 are 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.