

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

**10/23/2015 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):

Peer Specialist

Peer specialists are credentialed health care professionals who provide an array of interventions that promote socialization, long-term recovery, wellness, self-advocacy, and connections to the community. The peer specialist does not serve as a substitute for other practitioners, but as part of a multi-disciplinary team—the peer is not a sponsor, case manager, or a therapist, but rather a role model, mentor, advocate, and motivator.

By emphasizing long-term recovery, wellness, self-advocacy, socialization, development of natural supports, preventing relapse, and connectedness to one's community this benefit seeks to improve beneficiaries' health and reduce overall health care costs by minimizing emergency department visits and hospital readmissions, and delaying or preventing the onset of other chronic illnesses and conditions requiring Medicaid-funded long-term care.

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 23, 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: Peer Specialist
Change Number: 15-07-CII

Date of Request	November 24, 2015
Proposed Implementation Date:	February 1, 2016

Fiscal Impact:

	FFY 2016	FFY 2017
State:	\$407,340	\$543,120
Federal:	\$407,340	\$543,120
Total:	\$814,680	\$1,086,240

Description of Change:
Attachment A

Assurances:
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Attachment A: Description of Change

Overview

The State of Rhode Island requests the authority provide the services of highly qualified peer specialists to Medicaid beneficiaries with certain chronic diseases and conditions. A peer specialist is a credentialed health care professional who provides an array of interventions that promote socialization, long-term recovery, wellness, self-advocacy, and connections to the community. When providing these services and supports, the peer specialist does not serve as a substitute for other practitioners, but as part of a multi-disciplinary team. The role of the peer specialist is to bring to the beneficiary the unique vantage point and skills of someone who has succeeded in managing a serious behavioral health condition or developmental disability or has lived experience with addiction and recovery or bouts of homelessness. A peer specialist also can be a loved one, family member or friend who has shared in these experiences with a person directly affected.

The use of peer specialists has occurred most frequently in the behavioral health arena and specifically for persons with substance use disorders or serious mental illnesses. These peer specialists (peer recovery specialist or PRS) typically work under the direction of a licensed health care practitioner or care manager or coordinator. In addition to providing wellness supports, the peer specialist utilizes his or her own experiences to act as a role model, teacher, and guide who both encourages and empowers the beneficiary to succeed. The PRS assists the beneficiary in a variety of unique ways ranging from articulating service preferences and needs to identifying and evaluating affordable housing options, and on to teaching coping and self-advocacy skills.

Specific other examples of PRS work include, but are not limited to, the following:

- Supporting individuals in accessing community-based resources, recovery, health and wellness support, and employment services;
- Guiding individuals in developing and implementing recovery, health and wellness, and employment plans;
- Serving as a role model for the integration of recovery, health and wellness, and employment;
- Educating individuals regarding services and benefits available to assist in transitioning into and staying in the workforce;
- Navigating state and local systems (including addiction and mental health treatment systems);
- Mentoring individuals as they develop strong foundations in recovery and wellness;
- Promoting empowerment and a sense of hope through self-advocacy by sharing personal recovery experiences;
- Serving as an integral member of an individual's recovery and wellness team

Peer Recovery Specialists may be employed as part-time or full-time staff depending on agency capacity and community needs. Providers often employ more than one PRS within an agency and use peers to build agency service capacity. To ensure PRS provide culturally relevant

services, agencies try to match beneficiaries with peers who share their lived experience, culture, ethnicity, health and behavioral health service experiences.

PRS services are a critical component of the continuum of care and, as such, play an important role in optimizing health and delaying the need for high cost acute and long-term institutional-based care for Medicaid beneficiaries. For this reason, Rhode Island plans to incorporate a PRS model into the Medicaid program as part of a broader effort to provide beneficiaries better and more person-centered services.

The State will require PRS participating in Medicaid to obtain certification to ensure they are properly qualified. To be a certified in the State, a prospective peer specialist must meet the following criteria:

- Diagnosed with mental illness, addiction, chronic illness, or intellectual/developmental disability (I/DD), and have received treatment for that diagnosis or is currently receiving mental health, addiction, physical health or I/DD services or have lived experience with a family member or loved one with one of these experiences. Individuals who have undergone periods of homelessness may also apply for this credential. Further, they must be willing and able to share their lived experience with those who have similar life issues
- Credentialed by the Rhode Island Certification Board (RICB) as a Peer Recovery Specialist. RICB credentialing standards meet minimum standards of the International Certification and Reciprocity Consortium (IC&RC).

Peer Recovery Specialists certified through this process will be qualified to provide non-clinical, person-centered, recovery-focused support. The service levels provided will be determined on an individual basis taking into account the intensity of the beneficiary's situation and the experience of the Peer Recovery Specialist. Peer Recovery Specialist services include a range of activities that are delivered in community settings. The location where peer services are provided will be flexible based on the need.

Target Populations

Medicaid beneficiaries with behavioral health, physical and/or developmental disabilities without regard for service delivery mechanism.

Waiver Authority Sought

EOHHS seeks a waiver of Section 1902(a)(10)(B), amount, duration, and scope, in order to offer a peer specialist benefit to only certain individuals and to offer these services in the most cost-effective setting.

Rationale

Behavioral health professionals have identified peers as a means to reconnect addiction, mental health treatment, and wellness with the recovery/health process. The peer is not a sponsor, case

manager, or a therapist, but rather a role model, mentor, advocate, and motivator. By emphasizing long-term recovery, wellness, self-advocacy, socialization, development of natural supports, preventing relapse, and connectedness to one's community this benefit seeks to improve beneficiaries' health and reduce overall health care costs by minimizing ED visits and hospital readmissions, and delaying or preventing the onset of other chronic illnesses and conditions requiring Medicaid-funded long-term care.

This request aligns with the waiver extension's guiding principle of ensuring Medicaid-financed services are responsive and appropriate to a person's medical, functional, and social needs.

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.