Rhode Island Executive Office of Health and Human Services
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Medicaid Code of Administrative Rules, Section 210-RICR-50-00-5, "Medicaid Long-Term Services and Supports: Functional/Clinical Eligibility"
Posted for Public Comment on June 27, 2018
Comment Period Ended on July 27, 2018
Summary Response to Comments September 5, 2018

	Respondent	Nature of the Comments	EOHHS' Response
1.	Jennifer Crosbie, Director of Government Relations, Seniorlink July 27, 2018	Specifically, the new rule proposes language that requires an individual to have "*one (1) or more unstable medical, behavioral, cognitive, psychiatric or chronic recurring conditions requiring nursing assistance, care and supervision daily.*" **The revised language has a significant impact on seniors and adults with disabilities (consumers) receiving RIte @ Home services and the caregivers who provide those consumers with daily care and support.**	The State corrected a typographical error, changing "and" to "or" and made structural changes in the organization of the section to address commenter's concerns. Provision not restored to exact language previously in effect. Follow-up with commenter indicates satisfaction with changes.
2.		The RIte @ Home Program Standards currently tie payment levels for consumers receiving RIte @ Home services to the State's **current** definition of "Highest" and "High." RIte @ Home is the **only** Medicaid-funded community LTSS for which the payment level is based on a level of care determination. The RIte @ Home service pays for daily care and support provided by a live-in caregiver and does not include nursing assistance, care and supervision as part of the service design. In revising the definition of the Highest LOC to require that an individual have chronic or unstable conditions that require *"nursing assistance, care and supervision daily"*, **the proposed rule would make current consumers of RIte @ Home services ineligible for their current level of service, resulting in decreased stipend payments to full-time caregivers, a reduction in the level of professional support provided to those caregivers and, potentially, discharges from this essential community service to more restrictive institutional services.**	The State corrected a typographical error, changing "and" to "or" and made structural changes in the organization of the section to address commenter's concerns. Provision not restored to exact language previously in effect. Follow-up with commenter indicates satisfaction with changes.
3.		We recommend that the State remove the additional clause added to the proposed new definition of Highest Level of Care as follows: "…*one (1) or more unstable medical, behavioral, cognitive, psychiatric or chronic recurring conditions ~~requiring nursing assistance, care and supervision daily".~~* Additionally, we recommend that the State consider revising RIte @ Home Program Standards to decouple the RIte @ Home payment level from the level of care determination. This recommendation removes the ongoing risk of inadvertent impact on consumers and caregivers served through the RIte @ Home program whenever the State revises the referenced rule. This practice would also align the payment practices of RIte @ Home services with those established for every other community-based service offered under the 1115 Waiver.	The State corrected a typographical error, changing "and" to "or" and made structural changes in the organization of the section to address commenter's concerns. Provision not restored to exact language previously in effect. Follow-up with commenter indicates satisfaction with changes.
4.	Carole Graves, Area Director, Seven Hills Rhode Island July 27, 2018	The additional language requires that an individual receiving care have, "one or more unstable medical, behavioral, cognitive, psychiatric or chronic recurring condition - **requiring nursing assistance, care and supervision daily."** We propose the deletion of the bolded clause due to the following factors: The proposed language, as it exists currently, would adversely affect our current consumers enrolled within our program by making many existing recipients ineligible for their current level of service and payment. The individuals and caregivers would experience significant	Same as above.

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		and undue fiscal burden due to the reduction of their stipend levels. The result may also include complete discharge from our program which may result in dire circumstances for our families.	
5.		We would like to recommend the removal of level of care determinations which set Rite@Home payment levels. In this way, our programs would match in fiscal procedure to other similar community-based services in the state.	Not appropriate
6.	Anne Mulready, Esq. R.I. Disability Law Center July 25, 2018	We appreciate the state's inclusion of the federal HCBS rule "conflict-free case management." Federal law allows states to only provide an exemption from apparent conflicts, when it has made a determination that "the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS." *See for e.g.* 42 C.F.R. § 441.301(c)(l)(vi). In such instances some kind of "firewall" arrangement may be appropriate. We ask the state to publicize its list of case management agencies, so that individuals will be able to know for what agencies the state has made this determination.	EOHHS takes this comment under advisement.
7.		**Section 5.6.7: PASRR:** The provisions of this section violate federal law. We are very concerned that the minimal process outlined in this section will result in individuals with intellectual disabilities and/or mental illness being inappropriately and illegally institutionalized in nursing facilities. By federal law, the state mental health authority and intellectual disability authority (BHDDH) must make PASSAR determinations of "whether an individual requires the level of services provided in a nursing facility and whether specialized services are needed." These determinations cannot be countermanded by the State Medicaid agency. **Subsection B.1** indicates PASSAR Level I reviews will be conducted by nursing facilities, which violates the federal delegation authority.	Please see reg revisions. Clarified the text.
8.		**Section B** also seems to blur the distinction between the two levels of PASSAR determinations. Level I is typically considered the determination of whether placement is appropriate, and Level II is the determination for those found appropriate, of whether specialized services are needed. For this reason, the purpose of the Level I determination appears to be incorrectly stated in Subsection (B)(1). It is not to determine whether a Level II screen is warranted, but to determine whether nursing facility placement is appropriate at all.	Clarified in the text of the regulation.
9.		**Subsection B.1** also indicates that authority to conduct Level I determinations will be exercised by hospitals and community authorities and that EOHHS agency representatives review these determinations. While it may be permissible for BHDDH to delegate some review functions to others, it is not clear that entities described in this section have been delegated such authority by BHDDH, and that these entities have the appropriately credentialed staff to conduct reviews. For persons with mental illness, initial Level I determinations must be based on an independent physical and mental evaluation.	Clarified in the text of the regulation.
10.		Presumably Level I determinations for individuals with intellectual disabilities should be made by persons who are qualified by knowledge and/or experience in working with this population. It is also not clear what qualifications are required for the EOHHS agency representatives are reviewing Level I	Done

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		determinations. At a minimum, these regulations should specify qualifications in order to assure that anyone who has delegated authority to conduct the Level I determinations, has the requisite skills and knowledge.	
11.		Also missing are important provisions about the federally required written notice, which BHDDH is required to give to the individual and others regarding the PASSAR determinations.	Done
12.		Section E also blurs the distinction of individuals who are "exempt" from PASSAR *(see* 42 C.F.R 483.106(b)(2), and individuals whose conditions meet a BHDDH-defined "advance group determination" for whom there is sufficient data for BHDDH to conclude after a Level I review that due to certain diagnoses, levels of severity of illness, or need for a particular services, admission to a nursing facility is normally needed *(see* 42 C.F.R. § 483.130 (c)). There is no blanket 30-day exemption in federal law as stated in Section E. This section needs to be redrafted to distinguish exempt individuals from any advance group determination made by BHDDH.	Done
13.		The current rule #0378 on Institutional Care contains a description of "specialized services" for each PASSAR population. It would be helpful to include that description here, as well as the state's responsibility for assuring that if needed, specialized services are made available.	Done
14.		**Section 5.7.4:** If the state lacks sufficient ICF/I-DD capacity to serve the needs of individuals in Tier E, under *Olmstead v. L.C.,* 527 U.S. 581 (1999), appropriate community settings should be developed. Absent a PASSAR determination that NF placement is appropriate, an individual meeting Tier E level of services should not be institutionalized in an NF, as indicated in Subsection A.	Noted
15.		"Community Support Residence" is listed several times. This term has not been defined and we could not find any existing licensure for a residence by that name.	Done; inserted federal definition for "community supported living services." In general, refers to services and supports provided to Medicaid beneficiaries through BHDDH, including at-home and community-based settings.
16.		On page 19, there are two references to § 5.7.3 D which appear to be a typo, and should read § 5.7.4 D.	Done
17.		**Section 5.8:** Subsection A.3 includes Behavioral Health Services for individuals with serious and persistent mental illness (SPMI), as within the scope of HCBS services. It has never been clear from the state's HCBS transition plan or from its §1115 waiver that EOHHS considers individuals with SPMI to be HCBS beneficiaries. If so, their needs should be addressed with the HCBS transition plan and in the proposed rule on HCBS services.	Noted, thank you