



## The Long-Term Care Proposals In Rhode Island's Global Consumer Compact Waiver

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On August 8, 2008, Rhode Island submitted for approval to the Centers for Medicare & Medicaid Services (CMS) the Rhode Island Global Consumer Choice Compact Waiver, under which the state proposes to accept a capped allotment of Medicaid funds from the federal government in exchange for much broader discretion in the operation of its Medicaid program.

The proposal has received a great deal of attention due to the departure the state would make from the standard operation of a state Medicaid program if the waiver is approved. Generally, there is no limit on federal assistance for a state Medicaid program; every participating state is guaranteed a federal match for every dollar it chooses to spend, provided that the state offers a statutorily mandated package of benefits to certain segments of its Medicaid population. The guaranteed match is critical for states when they experience enrollment increases in economic downturns.

Rhode Island, however, decided that having more power to choose who may be eligible and the services for which to provide coverage is worth the capped federal allotment that would accompany such expanded discretion. It has proposed to CMS to be the first state “to request the demonstration authority under Section 1115(a) of Title XIX to use global budgeting as a financing mechanism for all Medicaid populations and services.”<sup>1</sup>

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<sup>1</sup> Rhode Island Global Consumer Choice Compact Waiver at 7 (hereafter “Waiver”).

The danger posed to beneficiaries and the state by the proposed financing arrangement has been ably explained by others.<sup>2</sup> What is specifically noteworthy for seniors and persons with disabilities is that the “most significant changes proposed [by the waiver] are on the long-term care side...”<sup>3</sup> Concerned, among other things, about how to deliver services “as the majority of the baby boomers enter old age,”<sup>4</sup> the state has determined that a “fundamental” restructuring of its Medicaid LTC program within the fixed confines of a capped allotment of federal financing is the primary solution for addressing the state’s Medicaid woes.

What follows is an overview of the waiver’s long-term care proposals. Included in the discussion are the factors the state has identified as its motivation for its LTC changes, an overview of the state’s current LTC delivery system, and the specific elements of its proposed plan. Issues that are raised include the fact that Rhode Island has not availed itself of important LTC opportunities that do not require waivers, has only recently implemented other programs that may produce favorable results, and, most importantly, does not appear to be fully embracing the *purpose* of the Vermont LTC program, the central feature of which Rhode Island has borrowed for its own proposal.

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<sup>2</sup> JUDY SOLOMON, CENTER ON BUDGET AND POLICY PRIORITIES, RHODE ISLAND’S MEDICAID PROPOSAL WOULD PUT BENEFICIARIES AT RISK AND UNDERMINE THE FEDERAL-STATE PARTNERSHIP (2008), [http://www.cbpp.org/9-4-08health.htm#\\_ftn2](http://www.cbpp.org/9-4-08health.htm#_ftn2).

<sup>3</sup> Waiver at 11.

<sup>4</sup> Id. at 14

The waiver has not yet been approved, and is still missing some critical details. For now, the information below will hopefully provide sufficient background to advocates concerned about how the proposal may impact the continued availability of coverage for LTC.

## Why Rhode Island is Targeting its Medicaid LTC Program

The primary goal of Rhode Island’s waiver is to keep its Medicaid costs down. The waiver says that “Rhode Island’s fiscal crisis was a key factor” behind its proposal to block-grant its Medicaid program,<sup>5</sup> and the agency alleges that things will be even worse for the state by 2011.<sup>6</sup> Compounding this forecast is the surge in costs the agency expects aging boomers to generate,<sup>7</sup> leaving little doubt that the state’s decision to make “fundamental” LTC changes to achieve “reform” is a reflection of its belief that its LTC program is a major part of its Medicaid financial problem.

What is it about Rhode Island’s Medicaid LTC program that is creating the problem? The department says that, for starters, the “institutional bias” foisted upon it by “federal Medicaid guidelines” needs to be addressed.<sup>8</sup> That such a bias exists in the Medicaid program cannot be disputed; however, Rhode Island is behind other states in the effort to reduce this bias. According to a report issued by the AARP Public Policy Institute, Rhode Island ranks 38<sup>th</sup> among states in the percentage of its Medicaid expenditures going toward home and community-based services (HCBS) for older people and adults with physical disabilities.<sup>9</sup> Indeed, the department concedes in

the waiver that Rhode Island has the third highest nursing facility occupancy rate in the nation.<sup>10</sup>

“Historically low” provider reimbursement rates for community providers is also identified as a problem.<sup>11</sup> This claim is supported by research of the Center for Health Program Development and Management at the University of Maryland, Baltimore, which Rhode Island commissioned in 2005. The research revealed that “Rhode Island’s rate setting methodologies tilt in favor of institutional care, making it difficult for community-based providers to compete with nursing facilities for workers.”<sup>12</sup>

Other issues are identified, but the central reason for the state’s focus on LTC, “as stated throughout [the] proposal,” is that too many people are receiving coverage for nursing facility services.<sup>13</sup> The state therefore asserts that focusing on providing more HCBS is “one of the integral components of the Global Compact.”<sup>14</sup>

Rhode Island is hardly alone in its effort to deliver more HCBS coverage through its Medicaid program; the “rebalancing” of Medicaid’s LTC delivery from facilities to the community has become a nationwide priority. However, as noted above, Rhode Island is currently behind other states in the delivery of HCBS, so a review of what Rhode Island is and is not doing should be useful in evaluating the utility of the waiver to accomplish rebalancing.

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5 Id. at 7.

6 Id. at 13.

7 Id. at 14.

8 Id. at 19.

9 ENID KASSNER ET AL., AARP PUBLIC POLICY INSTITUTE, A BALANCING ACT: STATE LONG-TERM CARE REFORM (2008), [http://assets.aarp.org/rgcenter/il/2008\\_10\\_ltc.pdf](http://assets.aarp.org/rgcenter/il/2008_10_ltc.pdf).

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10 Waiver at 20.

11 Id. at 31.

12 CENTER FOR HEALTH PROGRAM DEVELOPMENT AND MANAGEMENT, COMMUNITY-BASED LONG-TERM CARE SERVICES IN RHODE ISLAND: A REPORT ISSUED PURSUANT TO JOINT RESOLUTION 05-R 384 1 (2005), [http://www.dhs.state.ri.us/dhs/reports/ltc\\_services.pdf](http://www.dhs.state.ri.us/dhs/reports/ltc_services.pdf).

13 Waiver at 61.

14 Id.

## Rhode Island's Current HCBS System

The state is operating nine HCBS waivers under the authority of 42 U.S.C. §1396n(c).<sup>15</sup> These waivers include an “Elders” waiver, an “Aged and Disabled Waiver,” an “Assisted Living” waiver and a “Consumer-Directed Personal Choice” waiver supported by a grant from the Robert Wood Johnson Foundation.<sup>16</sup> Rhode Island also has a Program of All Inclusive Care for the Elderly (PACE).<sup>17</sup> In 2004, Rhode Island served 2,705 older people and adults with physical disabilities through 1915(c) waivers (not including those served in Rhode Island’s MR/DD waiver), compared with 11,754 in nursing facilities.<sup>18</sup>

Rhode Island also operates an Aging and Disability Resource Center (ADRC) program, called “The Point,”<sup>19</sup> and received a Real Choice Systems Transformation Grant from the U.S. Department of Health and Human Services (HHS)

in 2006 to improve access to HCBS.<sup>20</sup> Rhode Island has received other Real Choice grants, including one in 2003 for a Respite Care for Adults Feasibility Study and a Nursing Facility Transition Grant in 2002. Rhode Island was also an original grantee of the Nursing Home Transition Demonstration Program sponsored by CMS and the Office of the Assistant Secretary for Planning and Evaluation (ASPE).<sup>21</sup>

As mentioned above, there is also the research Rhode Island commissioned the Center for Health Program Development and Management to do on expanding HCBS. Based on the review, the researchers recommended that Rhode Island increase their provider reimbursement rates, improve consumers’ access to information about community-based options, and “develop more systemic approaches to coordinate services across program and payers.”<sup>22</sup> The authors also recommended that Rhode Island combine their Medicaid NF and HCBS expenditures into one budget line, so that savings in NF expenditures realized from HCBS delivery could be “reinvested in expanded community-based services.”<sup>23</sup>

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15 HCBS waiver programs authorized under 42 U.S.C. §1396n(c) are specifically designed to provide packages of HCBS to individuals who would otherwise need institutional care in the absence of the services. They are commonly referred to as “1915(c)” programs, because 42 U.S.C. §1396n(c) is §1915 of the Social Security Act. Because of the expansive scope of the Global Compact waiver, Rhode Island is seeking federal approval for it under 42 U.S.C. §1315 (§1115 of the Social Security Act), which provides broader power to CMS to waive state compliance with Medicaid statutory provisions than §1915 does.

16 See Model Program that Improves Quality of Life for Elderly Medicaid Beneficiaries and Those with Disabilities Expands to 11 States, Robert Wood Johnson Foundation (2004), <http://www.rwjf.org/pr/product.jsp?id=21466>.

17 See PACE Organization of Rhode Island, <http://www.pace-ri.org/>.

18 KASNER, *supra* note 9.

19 ADRCs are supported through a “partnership” between the Administration on Aging (AoA) and CMS to help states develop single points of entry, or “one-stop shops,” for consumer information on long-term care. See Dina Elani & Greg Case, *Aging and Disability Resource Centers: One Contact for Easy Access to Long-Term Care Supports*, 30 TASH Connections 1 (Sept.—Oct. 2004).

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20 Real Choice Systems Change Grants are “intended to assist states in developing the infrastructure necessary to support people of any age with a disability or long-term illness to live and participate in their communities.” CYNTHIA SHIRK, NATIONAL HEALTH POLICY FORUM, TRADING PLACES: REAL CHOICE SYSTEMS CHANGE GRANTS AND THE MOVEMENT TO COMMUNITY-BASED LONG-TERM CARE SUPPORTS 1 (2007), [http://www.nhpf.org/pdfs\\_ib/IB822\\_SystemsChange\\_05-30-07.pdf](http://www.nhpf.org/pdfs_ib/IB822_SystemsChange_05-30-07.pdf). Since 2001, the federal government has awarded more than \$270 million through 332 grants to every state, the District of Columbia, and two U.S. territories. Centers for Medicare & Medicaid Services, Real Choice Overview, [www.cms.hhs.gov/RealChoice/](http://www.cms.hhs.gov/RealChoice/).

21 See generally, JUDY KASPER & MOLLY O’MALLEY, NURSING HOME TRANSITION PROGRAMS: PERSPECTIVES OF STATE OFFICIALS (Kaiser Commission on Medicaid and the Uninsured, 2006), <http://www.kff.org/medicaid/upload/7484.pdf>.

22 CENTER FOR HEALTH PROGRAM DEVELOPMENT AND MANAGEMENT, *supra* note 12, at 2.

23 Id.

These recommendations became state mandates in the Long Term Care Service and Finance Reform Act of 2006, sponsored by state Senator Rhoda E. Perry and state Representative Raymond J. Sullivan, Jr. (the “Perry-Sullivan Act”), which was enacted to, among other things, expand “the capacity of the long-term care system as a whole to support consumer choice and independence...”<sup>24</sup>

But putting aside these active efforts to divert more service delivery in the community, there are several things Rhode Island has *not* done to advance this goal. First, Rhode Island has generally not provided coverage for personal care services as a state plan benefit.<sup>25</sup> Second, though Rhode Island has previously received transition grants, it was not one of the 31 states to receive a Money Follows the Person grant. The difference in federal support is substantial. Whereas the ASPE transition grants did not exceed \$500,000 and the Real Choice grants generally did not exceed \$800,000,<sup>26</sup> 11 MFP states

received more than \$50 million.<sup>27</sup> The District of Columbia, which has nearly half the population of Rhode Island, received \$26 million.<sup>28</sup>

Rhode Island also did not receive a Nursing Home Diversion grant from the Administration on Aging, nor has it submitted state plan amendments to adopt the new Medicaid HCBS state plan option or the self-directed personal care option. Rhode Island also has not developed an Olmstead plan.<sup>29</sup>

These missed opportunities should at least be considered in evaluating whether Rhode Island’s plan to bring fundamental changes to its LTC program through a capped waiver is the most practical remedy for what ails its current system. The pure youth of the opportunities it *has* taken advantage of should also be considered. The Real Choice LTC transformation grant was awarded, and the original Perry-Sullivan Act mandates were enacted, only two years ago. Similarly, Rhode Island’s Cash & Counseling program was implemented in 2006, its PACE program in December 2005, and its ADRC program in 2003.

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24 2006 R.I. Pub. Laws Chs. 263, §1, and 286, §1 (codified at R.I. Gen. Laws §§40-8.9-1—8), <http://www.rilin.state.ri.us/PublicLaws/law06/law06263.htm>.

25 See KAISER COMMISSION ON MEDICAID AND THE UNINSURED, MEDICAID HOME AND COMMUNITY-BASED SERVICES PROGRAMS: DATA UPDATE 2 (2007), <http://www.kff.org/medicaid/upload/7575.pdf>; SENIOR AGENDA COALITION, REFORMING LONG-TERM CARE FOR RHODE ISLAND 10 (2007), <http://www.senioragendari.org/publications/ltc.pdf>.

26 See FEDERAL SYSTEMS CHANGE GRANTS TO STATES AND TERRITORIES: 2001-2005, UCSF NATIONAL CENTER FOR PERSONAL ASSISTANCE SERVICES (2006), <http://www.pascenter.org/systemschange/>

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27 Money Follows the Person Rebalancing Demonstration, Centers for Medicare & Medicaid Services, [http://www.cms.hhs.gov/DeficitReductionAct/Downloads/MFP\\_FactSheet.pdf](http://www.cms.hhs.gov/DeficitReductionAct/Downloads/MFP_FactSheet.pdf). For more information about the Money Follows the Person program, SEE THE NATIONAL SENIOR CITIZENS LAW CENTER’S MONEY FOLLOWS THE PERSON 101, [http://www.nslc.org/areas/medicaid/article.2008-01-23.2399931224/at\\_download/attachment](http://www.nslc.org/areas/medicaid/article.2008-01-23.2399931224/at_download/attachment).

28 *Id.*

29 SEE MARTIN KITCHENER ET AL., STATE OLMSTEAD PLANS AND ALTERNATIVE STRATEGIES (2006), UCSF NATIONAL CENTER FOR PERSONAL ASSISTANCE SERVICES (2006), <http://www.pascenter.org/olmstead/olmsteadplans.php>, and SENIOR AGENDA COALITION, *supra* note 25, at 6.

It seems reasonable to question whether this collection of new initiatives is falling so short of the state's rebalancing goal that an entirely different direction should be taken so quickly.

## The State Proposes Changes

Despite having left some opportunities on the table and providing little time to gauge the effectiveness of those it has adopted, the state legislature amended the original Perry-Sullivan Act in 2008 to mandate that the Rhode Island Department of Human Services seek approval from the federal government to apply a three-tiered clinical eligibility standard for Medicaid LTC coverage,<sup>30</sup> a radical departure from the most common method employed by states to test eligibility. The law also directed that the state consolidate its nine HCBS waivers, and that reimbursement rate adjustments be made to community-based providers. The ultimate goal of these changes is to allocate “a minimum of fifty percent (50%) of Medicaid long-term care funding to [HCBS] on or before December 31, 2012.”<sup>31</sup>

These mandates became the major elements of the LTC changes proposed in the Global Compact waiver. Others are drawn from the original Perry-Sullivan Act mandates, and the rest are independent options the state has the authority to adopt.

Without question, though, the most critical element is the three-tiered level of care scheme. The review of the Global Compact's LTC changes, which, again, are central to the state Medicaid “reform” effort, must begin with this feature of the proposal.

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30 The Rhode Island Medicaid Reform Act of 2008, 2008 R.I. Pub. Laws Ch. 100, Art. 17, §8 (codified at R.I. Gen. Laws §40-8.9-9), <http://www.rilin.state.ri.us/PublicLaws/law08/law08100-17.htm>.

31 *Id.*

## Three-tiered Level of Care

Medicaid LTC applicants in all states have to demonstrate a clinical need for LTC services in order to qualify for coverage. States vary in the stringency of their LTC standards, but what they generally have in common is that they each apply a *single* standard. For example, if a state requires LTC applicants to exhibit a need for assistance in three activities of daily living (ADLs),<sup>32</sup> then a Medicaid LTC applicant who meets this standard is *entitled* to Medicaid coverage of NF services, and may receive HCBS if a slot is available in a 1915(c) waiver. If the individual does not meet the standard, s/he may not receive NF or HCBS waiver services.

In 2003, however, Vermont proposed its Choices for Care waiver, a “bold new approach” to expanding HCBS through the splitting of its single LTC clinical standard into three standards: highest need, high need and moderate need.<sup>33</sup> *Highest need* individuals would be entitled to nursing facility care *or* HCBS, depending on their choice, rendering HCBS an entitlement for a portion of Vermont's LTC population. *High need* individuals would be offered the same choice between NF services and HCBS, but coverage for either would be contingent on funding availability. *Moderate need* individuals would be offered “preventive and supportive services,” also depending on funding availability.

Vermont's theory was that highest need individuals, given the guaranteed option, would choose HCBS more frequently than NF care,

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32 Examples include feeding, bathing, dressing, and toileting.

33 Vt. Dep't of Aging and Disabilities, The Vermont Long-Term Care Plan: A Demonstration Waiver Proposal to the Centers for Medicare and Medicaid Services (2003), <http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/downloads/VTLTC1115-Proposal.pdf>.

which would reduce the state's LTC expenditures at the same time it would improve beneficiary satisfaction. The savings the state would realize would ensure that funding would always be available for the high need population, which would similarly make the consistent choice for HCBS over NF care with the same results. States have been operating HCBS programs for years, but through Choices for Care, Vermont was seeking to bring HCBS to an entirely new level to demonstrate the superiority of a LTC system that makes HCBS the *primary* method of service delivery.

The catch for Medicaid applicants and beneficiaries, however, was that Vermont's proposed highest need standard was a stricter standard than its then-single LTC standard, meaning that Vermont was essentially *narrowing* the entitlement to Medicaid LTC coverage through Choices for Care.<sup>34</sup> The high need standard was the one comparable to the state's single LTC standard, meaning that high need individuals under Choices for Care would not get *any* services if funding was not available, whereas they would be *entitled* to at least NF services if Choices for Care was not approved. The state stressed, however, its belief that guaranteeing the choice of HCBS to a portion of its Medicaid population would produce savings necessary to ensure that funding would always be available for individuals meeting the high need standard.<sup>35</sup>

At the time it submitted its proposal to CMS, Vermont was already well ahead of other states in delivering Medicaid coverage for HCBS.<sup>36</sup> As early as 2001, nearly 40 percent of Vermont's LTC spending for older people and adults with physical disabilities was going toward HCBS, significantly

above national average. This was in part the result of the commitment the state legislature had made several years before to spend more Medicaid LTC dollars on HCBS.<sup>37</sup> But despite this commitment and the relative success it produced, CMS critiqued Choices for Care for two years before it finally approved it in 2005. A central issue for CMS during deliberations was Vermont's highest need clinical eligibility standard, the first iteration of which CMS found too restrictive.<sup>38</sup>

The unique nature of Choices for Care has made it, as one prominent newspaper noted, "an effort being watched around the nation."<sup>39</sup> But given its youth, it remains exactly that—an effort being *watched*. Indeed, the 2007 Senior Agenda report, while speaking somewhat favorably about Vermont's approach, cautioned that it is "too new to study outcomes."<sup>40</sup> Initial reports actually reveal that Choices for Care is experiencing a host of problems.<sup>41</sup>

In spite of this, Rhode Island has decided to adopt Choices for Care's most salient characteristic, the three-tiered standard, despite not being able to point to the same level of success in delivering HCBS as Vermont was able to at the time it submitted its proposal to CMS. Additionally, as

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34 *Id.* at Apps. B and C.

35 *Id.* at 3-4.

36 KASNER, *supra* note 9.

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37 An Act Relating to the Coordination, Financing, and Distribution of Long-Term Care Services, 1996 Vt. Acts & Resolves 160.

38 Vt. Dep't of Aging and Disabilities, Supplemental Questions: Vermont Long-Term Care Plan Responses from Vermont 11 (2003), <http://www.dad.state.vt.us/1115waiver/FinalResponseCMS31704.pdf>.

39 Lucette Lagnado, *Olden Days, Seniors in Vermont are Finding They Can Go Home Again: In Shift from Nursing Homes, State has Family Members Care for Elderly Relatives, Helping Gram at \$9.25 an Hour*, Wall St. J., Oct. 23, 2006, at A1.

40 SENIOR AGENDA, *supra* note 25, at 24.

41 Steve Peoples, *A Lesson from Vermont on Medicaid*, Providence Journal, October 5, 2008.

can be seen below, Rhode Island’s plan is not as generous as Vermont’s.

### Rhode Island’s Three Tiers

Rhode Island proposes to create a highest level of care, high level of care, and “preventive” level of care. Individuals meeting the highest or high levels of care will be offered “core” and “preventive” services, which will include, among others, personal care services, home modifications, assisted living services, adult day care, and homemaker services.<sup>42</sup> Individuals meeting the preventive level of care will be offered only preventive services: homemaker services; minor home modifications; respite care; physical therapy evaluations; and home-based treatment services.<sup>43</sup> Services will be available at all times to highest level individuals, while high and preventive need individuals will only receive services if funding is available.

This framework is identical to Vermont’s program, but it not clear that the goals are the same. While HCBS will be available under Rhode Island’s plan at all times to highest level individuals, it is not clear that the state actually expects them to utilize the services. Highest level of care is identified in the waiver as being “reserved for nursing home and residential treatment facilities.”<sup>44</sup> Additionally, the waiver increases the HCBS personal maintenance allowance *only for*

*high need individuals*.<sup>45</sup> Finally, while Vermont’s “high need” individuals are offered *either* HCBS or NF services, high level individuals in Rhode Island’s plan are *not* offered NF services. This seems to mean that Rhode Island will use the highest and high level categories strictly as a method by which to separate those who will be in nursing homes and those who will not.

Why is this troubling? Because it possibly reflects that Rhode Island is using Vermont’s framework not for the purpose of implementing a “bold new approach” to dramatically expand the use of HCBS over institutional services but rather to simply cut eligibility. Vermont literally banked on highest need individuals choosing HCBS over NF and committed itself to facilitating the choice. From the *choices for care* the highest need individuals made, the state expected to realize savings that would ensure *choices* for the high need population, as opposed to savings being realized through fewer people receiving coverage.

But if Rhode Island is expecting highest level individuals predominantly, if not exclusively, to use NF, then any savings it expects the three-tiered framework to produce would theoretically only come from *fewer* individuals receiving coverage. That Rhode Island is not similarly expecting, as Vermont did, to produce savings through highest level use of HCBS may be further reflected from its statement that “due to resource constraints in the first few years of the demonstration, the number of

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42 Waiver at 27.

43 Id.

44 Id. at 25.

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45 Id. at 60. Generally, a Medicaid HCBS enrollee must use his income to pay providers in order to defray Medicaid’s costs. However, Medicaid allows the enrollee to keep a portion of his income to meet his expenses in the community, which is referred to as the “personal maintenance allowance.” The waiver says that the “enhanced” allowance will only be available to individuals in need of a *high level of care*” (emphasis added). Throughout the document, “high” and “highest” level are defined separately, so it appears that the enhanced personal needs allowance is strictly for the high level population.

elders eligible for [high need] coverage... will be limited...<sup>46</sup>

Simply put, Rhode Island's waiver seems to imply that its aim is not to deliver *more* HCBS coverage, but rather to simply deliver *less* NF coverage. What would provide further insight would be the state's plans for its clinical eligibility standards. For example, if its highest level standard turns out to be identical to its current single standard, then the high level individuals would truly be an *expansion* group, because they would be individuals who would not qualify under the state's current program but would have the chance under the Global Compact waiver to receive HCBS services. Even if that chance were dependent on funding availability, it would be something more than they currently have. In this way, the state *would* ultimately be delivering more HCBS, as opposed to merely reducing NF coverage.

If, however, Rhode Island makes its highest level standard stricter than its current standard, then some individuals who are guaranteed some form of Medicaid LTC coverage in the state's current program would only get services under the waiver if funding is available. One of the many questions such a scenario would raise is what will happen to those who have already been enrolled but do not have needs that will meet the highest level standard. CMS forced Vermont to guarantee that those individuals would be grandfathered.<sup>47</sup>

Rhode Island, however, does not address this possibility, because it has not provided information on its proposed three tiers in the waiver. This is a glaring omission given the central role the tiers

play. In the absence of information on the three tiers is a description of a program that differs substantially from the program it is modeled on.

#### *Other Features:*

While the three-tiered standard proposal is the most important part of Rhode Island's proposed LTC changes, it is not the only one. Below are the other elements of Rhode Island's plan.

### **Assessment and Coordination Organization**

In order to reduce fragmentation through its LTC program, the state will establish the Assessment and Coordination Organization (ACO), the purpose of which is to "streamline the intake and assessment processes and provide beneficiaries and their families with clear, concise and accurate information about their care options."<sup>48</sup> The ACO will serve as the access point for people in need of or receiving LTC, and will conduct clinical assessments, develop services plans, make referrals, train and educate consumers and discharge planners, and track utilization and monitor outcomes.<sup>49</sup>

The Point, Rhode Island's ADRC, will be an "integral component" of the ACO.

### **Improving HCBS Service Delivery**

Per its statutory mandate, Rhode Island will combine its nine HCBS waivers and make services equally available to all. "The Global Compact will consolidate services currently provided under the nine 1915(c) waivers and group them as core or preventive services."<sup>50</sup>

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46 Id. at 59.

47 Vt. Dep't of Disabilities, Aging and Independent Living, Choices for Care Vermont Long-Term Care Medicaid Program Manual Highest and High Need Groups II.-4 (2005), <http://www.ddas.vermont.gov/ddas-policies/policies-cfc/policies-cfc-highest/policies-cfc-highest-manual>.

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48 Waiver at 27.

49 Id. 27-28.

50 Id. at 61.

The state also will attempt to help nursing facility residents transition back to the community by utilizing “all of the Medicaid options other states have used to cover... transition expenses.”<sup>51</sup> These options have been available for states for several years now, dating back to 2002 when CMS informed them that they could receive reimbursement for services provided to Medicaid-enrolled nursing facility residents transitioning to the community (where they would be enrolled in HCBS waiver programs).<sup>52</sup> These include security deposits for leases, essential household furnishings, moving expenses, “set up” fees for utilities, and health and safety assurances, such as pest eradication and a one-time cleaning.

Rhode Island now plans to incorporate these services to help transition and divert “hundreds” of state residents from nursing facilities over the next few years. According to the waiver, the state has transitioned more than 100 individuals from nursing facilities in the last year alone.<sup>53</sup>

The state also proposes to allow for presumptive eligibility for individuals seeking HCBS so that some may receive services while their financial eligibility is being screened.<sup>54</sup>

## Supporting Self-Direction

The state also “intends to fully support and pursue the concept of self-directed care for as many beneficiaries and services as may be

appropriate.”<sup>55</sup> For several years now, states have allowed recipients of personal care services greater control over their services, such as providing them the ability to hire their own service providers, including family members.<sup>56</sup> States have needed specific permission (i.e., waivers) to operate these “cash and counseling” programs, and Rhode Island is running one.

The *Deficit Reduction Act of 2005* provided states the authority to make self-directed personal care a state plan benefit, meaning that states do not have to receive the special approval that comes with a waiver in order to allow for self-direction.<sup>57</sup> States choosing this option simply amend their state plans to include it, and they may cap the number of individuals who are allowed to self-direct their care and limit the self-direction program to certain areas of the state. States also may allow recipients to hire family members.

Rhode Island seems to indicate that it wants to incorporate the rules and allowances of the DRA benefit through the waiver approval process instead of an amendment to the state plan. “[T]he State intends to enable beneficiaries and their families to take advantage of self-directed Personal Assistance Services. The State will comply with the program requirements listed in Section 1915(j) of the SSA, but will not seek federal approval prior to implementation.”<sup>58</sup>

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51 Id.at 31.

52 Centers for Medicare & Medicaid Services, Dear State Medicaid Director Letter, May 9, 2002, SMDL #02-008, <http://www.cms.hhs.gov/smdl/downloads/smdl050902a.pdf>.

53 Waiver at 33.

54 Id. at 60.

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55 Id. at 64.

56 See <http://www.cashandcounseling.org/about>.

57 Pub. L. No. 109-171, §6087 (codified at 42 U.S.C. §1396n(j)).

58 Waiver at 64.

## Increasing Rates

Given that its “rate setting methodologies tilt in favor of institutional care,”<sup>59</sup> Rhode Island also proposes an immediate increase in its provider rates. Specifically, the plan calls for an immediate prospective base adjustment to rates paid to providers of homemaker, adult day and personal care services between five and ten percent of the existing standard or average rate, contingent on the providers showing an increase in their state-funded caseload.<sup>60</sup> The state also proposes to expand the flexibility of community providers to provide home delivered meals and adult day services on weekends and holidays, and to expand services for which reimbursement may be made.

## Long-Term Care Insurance and Reverse Mortgage Partnerships

The DRA provided an incentive to individuals who have a prospective need for LTC to purchase long-term care insurance.<sup>61</sup> The program is called the Long-Term Care Partnership Program (the partnership program), and it allows Medicaid LTC applicants who have purchased policies to keep more of their assets when they need Medicaid (provided that their states have adopted the program). For example, if an individual in a state operating a partnership program purchases LTC insurance that provides \$50,000 in coverage, the individual will be allowed to keep \$50,000 in resources *above* the Medicaid resource limit (which is generally \$2,000 to \$4,000 for a single individual) and still qualify for Medicaid once

his policy runs out and he applies for coverage. As of August 15, 2008, 18 states were operating Medicaid LTC Partnership Programs.<sup>62</sup>

Rhode Island is not one of these states, but it proposes now to become one. Interestingly, the state also proposes a *reverse mortgage* partnership program, which will offer “individuals who purchase reverse mortgages the same set of incentives available to those participating in the Long-Term Care Partnership Program.”<sup>63</sup> It is not entirely clear how this program would work, and the Medicaid statute does not provide authority for such a program as it expressly does for partnership programs.

## Is it the Right Approach?

What is noteworthy about the reverse mortgage partnership program proposal is that it is essentially the only item in Rhode Island’s menu of LTC changes that requires a waiver. Consider its companion, the insurance partnership program, which the DRA expressly allows states to operate. No waiver is required. Increasing community provider rates is also something federal law provides states the express authority to do. In fact, given Rhode Island’s concerns about how its rates relate to the sufficiency of the community-based provider population, the state may actually be *required* by the Medicaid statute to raise them.<sup>64</sup>

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59 CENTER FOR HEALTH PROGRAM DEVELOPMENT AND MANAGEMENT, *supra* note 12, at 2.

60 Waiver at 32.

61 Pub. L. No. 109-171, §6021 (codified at 42 U.S.C. §1396p(b)(1) and (5)).

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62 See National Clearinghouse for Long-Term Care Information, U.S. Dept. of Health and Human Services, [http://www.longtermcare.gov/LTC/Main\\_Site/Paying\\_LTC/Private\\_Programs/LTC\\_Insurance/index.aspx#SPLTCIP](http://www.longtermcare.gov/LTC/Main_Site/Paying_LTC/Private_Programs/LTC_Insurance/index.aspx#SPLTCIP).

63 Waiver at 60.

64 See 42 U.S.C. §1396a(a)(30)(A), which requires that reimbursement rates be “sufficient to enlist enough providers so that care and services are available” to the state’s Medicaid population.

The state itself notes that the establishment of the ACO does not require a waiver.<sup>65</sup> It also points to its existing authority to offer self-direction for personal care services, and, as noted, it has been several years since CMS advised states of their authority to receive reimbursement for the transition-related services Rhode Island proposes to now expand through its waiver.

Even a multi-tiered clinical eligibility standard for NF/HCBS services is now allowed outside of a waiver. Before enactment of the DRA, states generally only had been allowed to offer a package of HCBS to individuals who met the state's single Medicaid LTC clinical standard. In order to help states expand HCBS opportunities, the DRA provided states the authority to offer HCBS to individuals who do *not* meet the state's NF standard.<sup>66</sup> In fact, states opting to offer HBCS as a state plan option have to ensure that its NF clinical standard is separate and distinct from its HCBS state option standard.

Rhode Island insists, however, on adopting Vermont's three-tiered approach, as well as forcing upon itself the approval process and spending cap that come with a waiver for initiatives that do not require either. Unfortunately, the state does not sufficiently explain in its proposal how

straightjacketing itself in this way is the best way to achieve its LTC goals.

## Will it Be Approved?

When Vermont submitted its proposal, it was able to laud its success in making HCBS available to its LTC population and point to a ten-year legislatively mandated effort to do so. Still, it took two years for Vermont to receive approval. Vermont also submitted its proposal before the DRA authorized the Money Follows the Person program and gave states the authority to add self-directed personal care services and HCBS as state plan options.

Rhode Island is not similarly situated. It cannot point to the same success in providing HCBS, and should be held to account for why it is choosing the waiver over other opportunities it has yet to take advantage of. And given that part of the reason why CMS took two years to approve Vermont's plan was because of the agency's concerns over the substance of Vermont's clinical eligibility standards, the failure of Rhode Island to include *any* of that substance will probably not work to the state's advantage. If Rhode Island does receive approval, it should only come after an exhausting and time-consuming review.

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65 Waiver at 29.

66 Pub. L. No. 109-171, §6086 (codified at 42 U.S.C. §1396n(i)).

## Summary

States are expected to spend \$50 billion on Medicaid LTC coverage in 2008.<sup>67</sup> Obviously, this coverage is extremely expensive for states, and the demographic changes on the horizon clearly make it imperative that they reshape their programs now in order to continue to support demand.

Because, however, of the complexity of the LTC system and the needs of the population, proposals aimed at fundamentally changing a state's delivery system should be carefully constructed, have a transparent design, and strive to ensure that individuals without necessary supports have access to services.

Rhode Island's proposal currently does not meet this criterion. The waiver is missing critical details, and the state concedes that individuals in need of services at least initially will be denied services. Furthermore, given that the state proposes to be the first to use global budgeting, it should clearly explain why such a radical option is the only option, which Rhode Island would certainly have some troubling doing. As currently written, this waiver should not be approved.

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67 DANIEL I. SHOSTAK, STRATEGIC AFFAIRS FORECASTING & PAUL A. LONDON, PAUL A. LONDON ASSOCIATES, STATE MEDICAID EXPENDITURES FOR LONG-TERM CARE 2008-2027 3 (2008), <http://www.ahip.org/content/default.aspx?docid=24597>.