

Recommendations Re: Individuals with Developmental Disabilities

Note – The “Developmental Disabilities” subcommittee is an extension of the Long Term Care Committee of the Medicaid Global Waiver Task Force. Our charge, as we understand it, is to make recommendations that would increase the efficiency and effectiveness of the Global Waiver. The subcommittee met twice – the first meeting focused on addressing a core set of questions (what works, what needs to be modified, what is missing, etc.) – meeting minutes are attached; the second meeting focused on developing recommendations to be presented to Director Stenning and to EOHHS.

Further note – The subcommittee continues to strongly believe that the system of community supports for adults with developmental disabilities is working and should be sustained. The system of providing a continuum of community supports could be a model for other Medicaid populations.

Recommendation 1 – Maximize third party liability

Subcommittee members recommend that EOHHS staff be tasked with the following:

- Insure that expenses that should be charged to Medicare for individuals who are dual eligible are actually charged to Medicare;
- Insure that allowable expenses for adults with developmental disabilities who live with their families are accessing commercial insurance through their families when eligible;
- Insure that individuals eligible for employer coverage, use that coverage;
- Insure that all consumers are educated about Medicare eligibility;
- Insure that providers (and consumers) understand that, even while they are waiting for Medicare payment of service decisions, that allowable services can be provided and billed by Medicaid.

Recommendation 2 – Refine the process for determining eligibility for services/supports from the Division of Developmental Disabilities and for applying for those services.

Subcommittee members identified key issues and obstacles:

- Limited personnel in Division of Developmental Disabilities
- Need for interagency collaboration

Subcommittee members recommend:

- Beginning at age 14, there should be increased integration of Division of Developmental Disabilities and Office of Rehabilitation Services and Local Educational Agencies using the secondary Individualized Education Plan process.
- The age at which an individual can apply for eligibility for supports from the Division of Developmental Disabilities should be specified.
- Given the context of limited Division of Developmental Disabilities personnel, the Division should maximize the use of “point of contact” resources (e.g., adult provider organizations, transition IEP teams, CEDARR Centers, other organizations, etc.) for (1) information gathering and (2) assessment.

- The “point of contact” organization should assemble an interagency, interdisciplinary team to receive applications, collect information, conduct assessments.
- The information and assessment data would be sent to the Division of Developmental Disabilities for final decisions about eligibility and funding levels.
- Assessment modules could be developed to assess personal capacity and level of need. These modules could include (1) a general assessment of areas of need and an assessment of level of support (i.e., using a validated tool such as the *Supports Intensity Scale*); and (2) specific assessments in areas of need indicated by the general assessment – such as (a) employment, (b) residential, (c) independent living, (d) medical, (e) behavioral, etc.
- A timeline should be defined for completing (1) information gathering and assessment, (2) determination of eligibility, (3) determination of funding, and (4) initiation of service.
- Information should be “fed back” to the point of contact team.
- The Division of Developmental Disabilities should adopt the “State Assigned Student Identification” (SASID) system used by the Department of Education. This would facilitate the application process and eliminate duplication of paperwork.
- A criteria for “presumptive eligibility” should be established and implemented for students with developmental disabilities entering the adult Division of Developmental Disabilities system from Local Education Agencies and/or CEDARR Centers.

Recommendation 3 – Coordinate and expand the system(s) of Peer/Family Navigators and Coaches to assist individuals and families as they apply and enter the system.

Subcommittee members recommend:

- Provide support to individuals and families as they navigate the system. E.g., Health has a Peer Navigator network; Sherlock Center has several family navigators that support families in transition; Sherlock Center (with RIPIN and PAL) is training additional family navigators. Public citizens can also be navigators. In times of crises, families need to talk to “a person”;
- Specifically, promote and provide guidance in how to access and use the self-directed supports model.

Recommendation 4 – Maximize efforts to educate all pertinent constituencies.

Subcommittee members recommend (Note – these recommendations come from the first brainstorming session on October 6):

- Develop materials that are family friendly. Avoid “Medicaidese”. Families should be involved in the development of these materials. Materials should provide clear, concise information on (a) eligibility, (b) application process, (c) available services, (d) accessing services, self directed supports, etc.
- Educate people who work on the front lines – expect that they have “broad knowledge” of resources, services, systems, including self directed models. This would include transition coordinators in high schools, others.
- Increase the information and support capacity of all organizations that “touch people” – CEDARR centers, nursing homes, senior centers, hospitals, others.
- Seek pro bono support from RI Association of Advertisers to develop public relations campaign, PSAs, brochures, etc.

- Upgrade public information resources – DHS Medicaid web site, 211, Ask Rhody, etc.

Recommendation 5 – Develop a data collection and reporting system that tracks (a) demographic data, (b) new applications, (c) fiscal data, and (d) a limited (newly established) set of outcome data; and that increases transparency.

Subcommittee members recommend collecting and reporting the following:

- Population demographic data
- The number of new applicants, the time from application to eligibility determination to funding determination to initiation of service;
- Fiscal data by service type;
- Fiscal data by individual budget service and support needs;
- A limited number of outcome domains – e.g., employment, independent living, etc.

Subcommittee members realize the complexity in setting up such a data system and recommend initiating the new data components with new applicants.

Recommendation 6 – Develop a “planful” approach to providing specialized supports and services.

Subcommittee members recognize the high cost of low incident services, but also recognize the importance of providing services and supports in individual’s homes.

Recommendation 7 – Maximize use of cost effective transportation options

Subcommittee members recommend reviewing existing transportation studies (e.g., RIPTA’s state plan, DEA Coordinated Transportation Plan, Intersurface Transportation Act, others). Subcommittee members also endorse travel training supports.

Recommendation 8 – Competitively fund pilot programs that are inter-agency and allow for the creation of efficient and effective Medicaid services.