

RESPONSES TO PUBLIC COMMENTS

**MEDICAL ASSISTANCE PROGRAM:
RULES RELATING TO THE LONG-TERM CARE PROGRAM
GLOBAL CONSUMER CHOICE WAIVER**

**PUBLIC HEARING HELD ON:
MAY 21, 2009**

August 1, 2009

Dear Interested Parties and Public Hearing Commenters,

Thank you for your comments with regard to DHS proposed changes to the Medical Assistance Long-Term Care Program. The Department takes into consideration all comments received. We have received all of the comments and are now responding in accordance with RIGL Sec. 42-35-1 et al.

1) **Issue: Transition Planning**

Concerns expressed that there is little guidance in the regulations devoted to the process of transition planning:

a. Question: If someone in a nursing facility is no longer deemed highest level of care need, as referred to in 0399.13.01 (b), is the OMR responsible for assisting in the transition of these individuals back into the community?

Response: *The Office of Community Programs (OCP), currently located in DHS, is responsible for assisting beneficiaries who choose to live in the community. The OCP is staffed by four nurses and two social workers.*

b. Question: Will these individuals continue to have long-term care medical assistance while they are in the process of obtaining appropriate community services?

Response: *Yes.*

c. Concerns expressed that there should be assurance that these individuals are transitioning to the community safely and appropriately without incurring increased financial hardships.

Response: *Although not addressed in the rule, each of the departments has developed protocols for ensuring the safety and security of beneficiary's transitioning to the community. Additionally, under the Global Consumer Choice Waiver, certain services associated with the transition to community may be Medicaid covered.*

e. Suggestion: DHS and DEA capacity will need to be immediately "ramped up" and a

process to “map” services expertise, service delivery, and geographic capacity needs to be developed and continuously monitored.

Response: *The department appreciates such suggestions and continues to make every effort to ensure there is adequate capacity in the community as well as a sufficient number of well-trained staff to implement the Global Waiver.*

f. Question: If the plan is to move and increase the amount of individuals being cared for in the home, how will the Department ensure that there is an adequate amount of CNA’s?

Response: *The Executive Office of Health and Human Services (EOHHS) is leading an interagency effort to ensure there are adequate community based providers to achieve the goals of the waiver. The Department of Health rules related to CNAs are under review as part of this process.*

2) **Issue: Rules relating to ICF/MR**

Concerns expressed that the rules contain little information regarding the process for those with mental illness and developmental disabilities.

a. Concern expressed that it is pre-mature to include Sections 0399.05.01.02 (Needs-Based LTC Determinations) and Section 0399.05.01.03 (LTC Level of Care Service Option Matrix) in the regulations since the levels of care/determination of eligibility for “highest”, “high” and “preventive” for ICF-MR and for Hospitals has not yet been defined.

Response: *The section of the final rule noted was revised to indicate that pre-July 1, 2009, process for determining the ICF/MR level of care was to remain in effect until changed by the Department of Mental Health, Retardation and Hospitals (MHRH). Amendments to the rule now under preparation clarify the scope of the rule in this regard further.*

b. Concern expressed that the state will not create more ICF/MR’s, and therefore only 18 individuals can be eligible for the highest level of services at any given time.

Question: Does the Department have a process in mind by which they can find more than 18 individuals with developmental disabilities eligible for the highest level of care?

Response: *Under current Medicaid law, an individual with developmental disabilities must meet the ICF/MR “institutional” level of care to obtain community based – e.g., at home or in a group home – services. MHRH currently uses needs-based criteria in making these determinations. The rule did not establish “new” needs-based levels of care for individuals with development disabilities that change the current criteria or process for determining access to the ICF/MR level of care.*

c. Suggestion: For individuals eligible for home and community based services as an alternative to ICF/MR or long-term hospitalization, the rule should include a description of “institutional level of care criteria” that will continue to apply to individuals in institutions on or before 6/30/09 or reference the section of Medicaid regulations that defines this.

Response: *The rule has been amended to state specifically that these provisions are not applicable to the ICF/MR or long-term care hospitals. The amendment will be promulgated on an emergency basis on July 28, 2009, subsequent to review by the Global Waiver External Task Force.*

d. Question: Will there be a needs-based set of criteria for individuals with behavioral health needs, including serious mental illness, and will it be based on a long term care hospital level of care? Will these individuals have access to the set of core and preventive services described within the proposed rule?

Response: *The needs-based criteria related to the hospital level of care have not been developed. However, in accordance with the terms of the Global Waiver, once these needs-based levels of care have been implemented, only those beneficiaries who meet the criteria as “highest” need will have access to the institutions classified under the “hospital level” in section 0399.05.01.03*

e. Question: How are ICF-MR waiver group homes and residential treatment centers classified?

Response: *As indicated above, section 0300.05.01.03 shows the LTC level of care and service option matrix. Also, see response to D above.*

f. Suggestion: The rule pertaining to ICF-MR refers to ‘Rules governing determination of eligibility for ICF-MR level of care and references MHRH regulations. But the referenced regulations do not specify a level of care for ICF-MR. The proposed regulations state that “the agencies with authority to determine eligibility for LTC prior to July 1, 2009, shall retain that authority subsequent to the transition date unless otherwise stated in this rule” (0399.02). These proposed regulations should either include the current levels of care for ICF-MR (and hospital care) or provide a citation to other rules that provide the eligibility standards for eligibility for “long term care” – whether in the institution or the community.

Response: *In the final adopted rule a citation to the ICF/MR levels of care is provided in sections 0399.04.01 and 0399.05.0. Further clarification of the scope and applicability of the rule is provided in the amendments to the rule noted above.*

g. Concern expressed that Section 0399.05.01’s reference to the future use of new “needs based criteria” for ICF/MR level of care is inconsistent with the reference in Section 0399.06 to the continuing use of “institutional levels of care” to determine eligibility for services related to long term care hospitalization or ICF/MR eligibility. Individuals

currently eligible for services through the Division of Developmental Disabilities need to know whether and when any new “needs based criteria” will be developed and what these criteria will be.

Response: *The MHRH has been informed of this concern. Requests for further clarification on this matter should be directed to the MHRH.*

h. Question: What is the time frame for determining the “needs-based set of criteria” for individuals with developmental disabilities? If there is no plan to change from the current clinical eligibility standards, then references to developing new criteria should be stricken from the regulations.

Response: *See responses to this issue questions A through G above.*

3) **Issue: Services**

Concerns expressed that the rule should specify who has access to the services, there needs to be a more specific/clearer description and definition of services, and certain additional services should be included in the rule.

a. Suggestion: The rules should be rewritten to include comprehensive descriptions of the services. Each of the core services should be defined. The definitions provided in the RI Global Consumer Choice Compact Demonstration (“Waiver”) in Attachment B, should be incorporated into the regulations.

Response: *The department has no plans to include such definitions in its rule at this time as they are defined in other sections of the DHS Code of Rules as well as the Special Terms and Conditions of the Waiver. Materials for providers, and consumers and their families are being developed which explain each of the available services in simple language.*

b. Suggestion: The post-eligibility treatment of income should be included with the description of the service, e.g., assisted living description followed by post-eligibility treatment of income.

Response: *The department is planning to issue proposed amendments to the financial eligibility rules pertaining to long-term care in the near future. Citations to the rules on post-eligibility treatment for each service will be clarified at that time. The pre-waiver requirements for assisted living remain in effect.*

c. Concern expressed that Section 0399.12.03 only includes four services and does not mention opportunity for using any core services as referred to in Section 0399.04.02.01.

Response: *In accordance with the waiver, persons eligible for preventive services are Community MA beneficiaries who have access to the full range of state*

plan services as well as the preventive services listed. Note: the DHS is filing an amendment to the rule that clarifies which preventive services are available at present.

d. Question: How many preventive services group does the Department think they will be able to serve?

Response: *No estimates are available at this time.*

e. Suggestion: HEALTH should be involved in the discussion for certification standards and the existing assisted living licensing law should be reviewed to determine if, in fact, persons in the Highest Need category are appropriate for assisted living under existing law.

Response: *The EOHHS is working on this issue. The Department of Health will be engaged before any certification standards with respect to an entity licensed by this agency are issued.*

f. Suggestion: Section 0399.20.02.01 refers to certification standards for sharing living, which may vary by population. Public input should be considered in the development of these standards.

Response: *The standards will be available for public review through the RFP process.*

g. Suggestion: The description of core services should include adult companion service, adult day care, Assistive Technology, Medical Transportation and physical therapy evaluation and services.

Response: *These services are listed as a core services in Section 0399.04.02.01 of the final rule.*

h. Suggestion: The rules list “Shared Living” and “Sharing Living/Supported Living Arrangements.” One of these should be deleted.

Response: *Supported Living Arrangements has been deleted from the final rule.*

i. Question: Will the full scope of “home health aid” services as defined in 42 CFR 440.70 be available under the state plan, including the optional physical therapy, occupational therapy, speech pathology and audiology services?

Response: *State plan services will be available. The availability of optional services will depend on resources for beneficiaries at the preventive level of care.*

j. Question: Subsection (2) “Preventive Services” states that a person would “have access to the following services; or other core services.” Yet 0399.10 “Overview: Determination of NF Level of Care,” only refers to the four preventive services. Is it the intent that persons would also be able to access any of the core services when needed?

Response: *No. For, a person to access the full array of core services, the person would need to meet the high or highest level of care.*

k. Suggestion: The rule should specify that spouses and/or other family members can be compensated for providing personal care services and the rate of compensation.

Response: *This determination is made on a case by case basis and, as such, will be explained in the eligibility determination, options counseling and service plan development processes.*

4) **Issue: Financial Eligibility**

Concerns expressed that the rules contain minimal information regarding financial eligibility and post eligibility treatment of income.

a. Suggestion: Section 0399.04 should be clarified regarding how financial eligibility rules are applied for individuals seeking home and community based services, including specifying how much of the person’s income must be applied to the cost of the community based services.

Response: *Under the Global Waiver, the institutional rules for financial eligibility apply to home and community based services as is noted throughout the final rule. As indicated earlier, the department is planning to issue proposed amendments to the financial eligibility rules pertaining to long-term care in the near future. Reorganizing the rules in line with your suggestion is under consideration.*

b. Suggestion: The Waiver at Paragraph 25 provides that for individuals receiving 1915(c) like services, the state will apply the medically needy income standard plus \$400 and otherwise use institutional eligibility including the application of spousal impoverishment eligibility rules for Medically Needy individuals at the high and highest level of care. This provision should be included in this section.

Response: *The department does not have the resources at present to implement this provision of the waiver. The Centers for Medicare & Medicaid Services (CMS) has been advised of the delay.*

c. Concern expressed that the references to other sections within the financial eligibility section of the regulations are confusing, vague and incorrect.

Response: *References were corrected in the final rule. Further clarifications are made in the proposed amendments to the rule to be adopted on July 28, 2009.*

d. Suggestion: Clarify whether or not there is a distinction between “categorically needy” and “medically needy” in regard to availability of services and whether or not there is an income cap (federal cap) for obtaining home and community based services or assisted living services.

Response: *A second round of amendments to the rule clarifying this issue will be noticed in conjunction with the amendments defining failed placement. Pre-Global Waiver caps related to home and community based services will continue to apply –i.e. assisted living -- unless indicated otherwise until further notice.*

e. Suggestion: For couples, when one spouse is attempting to access non-nursing home services, a POCI must be established to determine the joint resources. There is no provision for this in the rules. The rules should state that a POCI is established when one spouse applies for LTC services and meets a level of care, even if ineligible for excess assets. The Department can issue a denial if financially ineligible for excess assets, but the amount of the joint assets will be determined and the couple will know the level to which assets must be spent down. This would be the case for in-home services. For assisted living, PACE, and shared living, the determination of the POCI could be similar to what is suggested for in-home services, or it could be the first day of the month the spouse began receiving such services, even if no Medicaid application is filed. The joint resources could be determined at the time an application is filed, going back to the first day of the month services began. DHS needs to make a decision as to what will be required to establish a POCI in non-nursing home cases.

Response: *The department is reviewing this suggestion and will provide a final determination in the second round of proposed amendments to the rule.*

f. Suggestion: The language of this section should be clarified by explaining that the income and resource eligibility rules for institutional care will also be applied to persons who are likely to receive home and community based core services for a continuous period.

Response: *The final rule clarified this distinction*

g. Question: Section 0399.05.01 describes plans to provide prevention services for a group of individuals who will not need to meet the financial eligibility criteria of those eligible for an institutional level of care. What will these broader financial eligibility rules be?

Response: *Preventive services will be available to Community Medicaid beneficiaries who meet the appropriate clinical eligibility criteria.*

h. Suggestion: Post eligibility treatment of income is not explained in the proposed rules. There needs to be information about the drug coverage and costs in the regulations to enable individuals to make appropriate decisions if they choose not to go to a nursing home (if in the highest need group) or which community based service to choose. The regulations should include, as to each service, how income is treated post-eligibility, including how much income the applicant can retain.

Response: The second phase of proposed amendments to the rule will clarify the post eligibility treatment of income. Until such time, current policy applies and is explained at length in the eligibility determination and choice/options counseling processes.

5) **Issue: Grandfathering**

Concerns expressed that the grandfathered group, if voluntarily transitioned from a nursing facility, will be able to re-enter a facility if placement in the home or community is unsuccessful and that the existing level of care criteria for this group be clearly defined in the rules.

a. Suggestion: Section 0399.05.01 needs to be modified to ensure future eligibility based on current eligibility criteria for the grandfathered group. The rules should grandfather the existing institutional level of care eligibility for persons who transition out of institutions on a voluntary basis.

Response: Provisions in the Global Waiver Special Terms and Conditions and federal Medicaid law prohibit application of the suggested change. However, in view of the comments and concerns raised by the people and communities we serve, the rule has been modified to correspond to changes in state law enacted to address this issue. (See HB 5112 C.) The relevant amendments to the final rule are to be adopted on emergency and filed regular on July 28, 2009, and are posted on the EOHHS and DHS websites.

b. Suggestion: Full grandfathering should apply to individuals who have been in the institution for at least 60 days – and thus would be considered to be “residing” vs. individuals who may have entered the facility for rehabilitation. This would be consistent with section 0399.13.01, which requires review for an individual entering a NF after 30 – 60 days.

Response: The state does not have the discretion to implement this suggestion under the Global Waiver Special Terms and conditions.

c. Suggestion: The rules should provide a “grandfathering protection” for individuals residing in ICR-MR/DD waiver group homes on/before June 30, 2009. This protection will be necessary if “needs based levels of care” are developed for this population, as this section of the regulations indicates will happen.

Response: *See responses above.*

d. Question: Section 0399.05.01 provides that the new level of care criteria apply to persons currently in home and community based services starting with their annual reassessment and that they will be placed in either the highest or high need group and that eligibility will be continued without interruption. Is the intent that they will be placed in the high need group even if they do not meet the new LOC criteria at the high need?

Response: *That is not the intent; the assessment will determine a beneficiary's clinical eligibility. The Department will ensure that there is a safe and appropriate transition to other available services if a person does not meet the clinical level of care required for Medicaid-funded long-term care services.*

e. Suggestion: The rules should specify that any individual receiving home and community based services or residing in an institution on/before June 30, 2009 who is subsequently determined to be in need of the "high" level of care will not be placed on a waiting list for services.

Response: *The amended rule – adopted emergency on July 28, 2009 -- establishes the department's policy in this area in accordance with the special terms and conditions of the Global Waiver.*

f. Suggestion: The regulation should describe the "institutional level of care criteria" that will continue to apply to individuals in institutions on/before June 30, 2009 or reference the section(s) of the Medicaid regulations that defines this. If there are policies/procedures used to determine "institutional level of care criteria" which are not currently in the regulations, these should be added to the rules so that in the future it is clear how the "institutional level of care" was determined.

Response: *The final rule cites the sections of the DHS Code of Administrative Rules that apply to beneficiaries in this category.*

g. Question: The rules state that beneficiaries who are in nursing homes will be grandfathered in. Do we know how many current beneficiaries receiving HCBS waiver services will be negatively impacted by this waiver?

Response: *The department expects implementation of the Global Consumer Choice Waiver to ensure that every beneficiary has access to the services they need in the most appropriate setting. Accordingly, we do not anticipate that beneficiaries will be adversely affected. However, beneficiaries who disagree with Medicaid decisions will continue to have the right to an appeal and in a fair hearing.*

h. Concern expressed that those who want to leave a nursing facility and were there prior to July 1, 2009, should be able to leave the facility and be eligible for home and community based services.

Response: *The issue was addressed in the amendments to the emergency rule filed on July 28, 2009 as well as second set of proposed amendments under development in conjunction with the community that define failed placements.*

6) **Issue: Eligibility for LTC Services for Children**

Concerns expressed that there is little detail in the rules about children with special needs and the determination of level of care for this population.

a. Question: Will DCYF be responsible for developing clinical levels of care for children needing long term care services and their families?

Response: *At this time, no changes are proposed to the services or delivery systems in place for children with special health care needs.*

b. Question: Will there be facilities (other than a nursing facility, an ICF-MR, or Eleanor Slater Hospital) that will be relevant for the purposes of determining the long-term care needs of children?

Response: *At this time, no changes are proposed to the services or delivery systems in place for children with special health care needs.*

c. Question: Will existing organizations (e.g., Family Care Community Partnerships, CEDARRs) be responsible for any ACO functions including clinical care assessments, care planning or case management evaluation?

Response: *The ACO's principal responsibilities include the determination of clinical eligibility, establishing service budgets and management/evaluation of high risk cases in the community. The organizations noted will continue to play a role in the development of an individual care plan, case management, etc.*

d. Question: Will there be a set of core and preventative services specifically for children and their families?

Response: *At this time, no changes are proposed to the services or delivery systems in place for children with special health care needs.*

7) **Issue: Clinical Eligibility**

Concerns expressed about the screening tool/assessment instrument, lack of clear definitions, and lack of clear information regarding the preventive level of care.

a. Suggestion: In Section 0399.12.01.01: define “special circumstances” as it relates to an exception for the highest need group as follows:

1. Loss of primary caregiver (e.g. hospitalization of spouse, death of spouse);
2. Loss of living situation (e.g. fire, flood);
3. The individual’s health and welfare shall be at imminent risk if services are not provided or if services are discontinued (e.g. circumstances such as natural catastrophe, effects of abuse or neglect, etc.); or
4. The individual’s health condition would be at imminent risk or worsen if services are not provided or if services are discontinued (e.g. circumstances such as natural catastrophe, effects of abuse or neglect, etc.)

Response: *This language has been added to the final rule.*

b. Suggestion: The clinical eligibility assessment tool must include appropriate screens for determining need for home and community based care including IADLs, safety issues and quality of life concerns that may not be captured in a tool specifically developed for nursing facility care.

Response: *We believe the tool that has been developed captures these areas.*

c. Suggestion: The regulations should include the assessment instrument that will be used to determine clinical eligibility so that applicants can understand how the terms in the regulations are applied.

Response: *The DHS shall make available to the public the procedural guidelines for use of the assessment instrument as well as the instrument itself.*

d. Suggestion: In Section 0399.12.01.01, provide some examples of what might be considered “special circumstances”.

Response: *The final rule includes examples of special circumstances (see response to question 7 part b).*

e. Suggestion: Provide a clear definition of the exceptions in Section 0399.12.01.01.

Response: *The department elected to use broad language to ensure that the exceptions apply to beneficiaries with unique or special circumstances – as determined on a case-by-case basis relative to need.*

f. Suggestion: Section 0399.05.01 reads, “Beneficiaries who are not clinically eligible for long-term care may be eligible for a limited range of home and community based services if they meet the criteria to qualify for preventive care.” However, the matrix for LTC Level of Care and Service Options includes the Preventive Level of Care indicating that preventive services are part of the LTC mix. The sentence also states that long term care financial eligibility criteria will not need to be met in order to access preventive services but does not make a reference to what the financial criteria will be. It appears

that the department may be carving out the preventive LOC from the uniform treatment of income and resources proposed in Section 0399.05—Eligibility Requirements for those in institutions and home and community care. The language regarding financial eligibility for those in preventive LOC is ambiguous as the rule states that those meeting the preventive LOC “may be eligible for a limited range of home and community based services,” thus inferring that the preventive services are, in fact, home and community services. Clarify this language and intent and if the language is intended to be the population of elders below 200% of the FPL referred to in the Global Waiver as Population 10.

Response: *Preventive services are services that also exist in the core long-term care services. Preventive services are for persons who meet the financial eligibility criteria outlined in Sections 0351-0368 and 0370. These sections define how aged, blind, and disabled individuals can access Medicaid. Sections 0376 – 0396 determine eligibility for Medicaid long-term care; they do not apply to individuals seeking preventive services only.*

h. Suggestion/Question: The rule should describe how eligibility for long-term care services in a hospital or a community-based alternative to the hospital is determined or reference the Medicaid rules that describe eligibility for institutional level of care. While section 0399.05.01.03 indicates that there will be “needs based levels of care” for hospital level of care, this section of the rules does not mention this (in contrast to the rules regarding ICF-MR level of care). Is there a plan to develop new criteria? If not then the rules should not be included this in the matrix.

Response: *There is a plan to develop needs-based criteria for all three institutional levels of care.*

i. Question: What is meant by the sentence: “The long-term care financial eligibility criteria will not need to be met in order to access preventive home and community-based services?”

Response: *Preventive services are for persons who meet the financial eligibility criteria outlined in Sections 0351-0368 and 0370. These sections define how aged, blind, and disabled individuals can access Medicaid. Sections 0376 – 0396 determine eligibility for Medicaid long-term care; they do not apply to individuals seeking preventive services only.*

j. Question: Is there one screening tool that is used for all populations, or are there different screening tools? This should be clarified in the rules.

Response: There are three settings for which a determination of clinical eligibility for Medicaid-funded long-term care services is necessary: long-term nursing facility; intermediate care facilities for the mentally retarded (ICF/MR); and long-term hospitals. Assessment tools exist to determine clinical eligibility for all three setting and for the community alternatives to these settings. The State has recently revised the assessment tools that apply to persons seeking Medicaid-funded services in a nursing facility or community alternative. The assessment tools that apply to ICF/MRs, hospitals and the community alternatives to those institutions are not impacted by the new rules and have not changed.

8) **Issue: Terms Need to be Clearly Defined**

Concerns expressed that certain terms need to be clearly defined in order to ascertain the intent of the rule.

a. Question/Concern: In Section 0399.12.01, the terms “extensive assistance”, “total dependence” and “limited assistance” are not defined. The terms “moderate impairment with decision-making skills” and “frequently” are not defined. In Section 0399.12.02, the terms “limited assistance” and “constant and frequent” are not defined. Will these terms in the assessment tool be based on observation over a period of time, on self-reporting, or some other measurement? Lack of these definitions make it difficult for applicants or their representatives to anticipate level of care decisions and plan appropriately.

Response: *These terms are defined in the assessment tools themselves. These tools are available to the public via the DHS and EOHHS website.*

b. Suggestion: Define “medical institution,” “licensed health care facility,” “institutional long-term care” and “institutional services.” The definition of “institution” needs to be clear and used consistently throughout the rule.

Response: *The term “licensed health care facility” has been removed from the final rule. In general, the term “institution” refers to nursing facilities, intermediate care facilities for the mentally retarded, and long-term care hospitals. This definition is based on federal terminology.*

c. Suggestion: Define or reference other regulations for the following terms: “state-only funded long term care services and supports” in Section 0399.06.01 and “residential treatment centers” in Section 0399.05.01.03.

Response: *The following language has been added to the rule: “Beneficiaries determined to have a potential need for State-only funded long-term services and supports including transportation and the DEA co-pay program are referred to the DEA. We will remove the term residential treatment centers from the rule in a later version.*

d. Suggestion: The regulations must provide applicants and recipients with clear guidance regarding eligibility, services, etc. The provisions of the waiver, or other federal/state laws that are intended to be applied should be specified.

Response: *We will include this information in future issuances of the rules.*

e. Question: In the first paragraph following the Service Option Matrix, what is meant by “budget neutrality”? Are there caps on individual budgets? Does this mean “cost neutrality” as described in 0399.08?

Response: *Budget neutrality is defined in the same way as cost neutrality. There will be no hard limits on individual budgets. Cost neutrality will be monitored on an aggregate basis, taking into account the average cost of an institutional stay.*

9) **Issue: Assessment and Coordination Organization**

Concerns expressed about divided responsibility between DHS and DEA, and the need for clarification regarding “state-only funded long term care services and supports.”

a. Suggestion: The rules should define the “state only funded long term care services and supports”. Are these different from the Medicaid funded LTC services and supports?

Response: *The following language has been added to the rule: “Beneficiaries determined to have a potential need for State-only funded long-term services and supports including transportation and the DEA co-pay program are referred to the DEA.”*

b. Suggestion: Given that one of the goals of the waiver is to streamline the eligibility process and create easier access for individuals, it seems inconsistent to split the assessment process for NF-LTC services and supports between DEA and DHS based on the source of the funding for those services. Rather, applicants should be able to have the assessment at either agency.

Response: *All clinical eligibility determinations for Medicaid-funded long-term care services in a nursing facility or community alternative must be determined by the Office of Medical Review in DHS. DEA has the responsibility for determining eligibility for access to non-Medicaid funded long term care services.*

c. Suggestion: Subsection (b) states that eligibility for LTC hospital will be determined by DHS. This should be done in concert with MHRH.

Response: *The rule has been modified to include this language.*

d. Question: Subsection c) Care Planning provides that ACO care planning activities include establishing funding levels for the care. What guidance will be used in setting the funding level? Will they be based purely on the institution cost-neutrality figures set forth in 0399.08?

Response: *The determination of the budget will be based on a beneficiary's broad range of needs. The cost-neutrality figures are, as noted, guidelines.*

e. Question: Subsection (b) states that beneficiaries determined to have a potential need for State-only funded LTC services and supports will be referred to DEA. Does this mean that DEA will no longer have responsibility for the Medicaid waiver programs it currently administers? Are there any other state-only funded LTC services that should be included? Also, maintaining split responsibility between DHS and DEA for accessing services for elders and adults with disabilities continues the current system fragmentation and consumer confusion regarding how to access service.

Response: *The agencies are working together in collaboration. See also the response to "b" above.*

f. Question: What does access to Residential Treatment Center for the highest level of care include?

Response: *The term residential treatment center will be removed from the rules.*

10) **Issue: Long Term Care Options Counseling Program**

Concerns expressed that the rule does not include information regarding who conducts the LTC Options Counseling and where, and that individuals involved in LTC programs should have access to this service.

a. Question: Who provides the LTC option counseling services and where the initial screening is conducted?

Response: *Initially, counseling will provided by the DHS field staff, The Point, the DEA Case Management agencies and the Office of Medical Review for elders and adults with disabilities. MHRH and DCYF will continue to provide choice counseling through existing processes. EOHHS agencies are in the process of improving and expanding the choice counseling processes.*

b. Suggestion: This Section states that individuals who seek admission to LTC facilities must be made aware of the LTC Care Options Counseling Program. This should not be limited to persons admitted to facilities, but should also be required for admission to other LTC programs, such as adult day care, assisted living, and home care programs.

Response: *Options counseling will be available to anyone seeking long-term care.*

11) **Issue: Cost Neutrality**

Concerns/questions relating to payment limits, aggregate vs. individual, how will these limits be set and monitored/controlled and what costs are counted.

Question: Is there an “aggregate cost-neutrality amount for home and community based services” that DHS intends to apply as implied by the proposed regulation? Is this for all populations or specific to each population?

Response: *The aggregate cost neutrality amount for home and community based services is equivalent to the cost of services provided in an institution. Different cost-neutrality amounts will apply according to the institution in which the person might have been residing but for the provision of the community-based care.*

Question: Will there be cost neutrality targets set by population category and funded within separate departments?

Response: *Yes; to the extent that separate departments administer separate long-term care systems. For example, MHRH administers long-term care services for individuals with developmental disabilities, the aggregate cost neutrality for that program is based on the average cost of an ICF/MR.*

e. Question: If projections show home and community services costs exceeding the pre-determined annual cap, what will the mechanism be for cost controls?

Response: *The same mechanisms that are in place now to control costs. The Departments will need to review areas including, but not limited to, scope of benefits and rates paid to providers.*

f. Question: Will the regulations be reviewed and adjusted on a regular basis to adjust for changes in the average cost of institutional care?

Response: *These numbers are updated in the regulations on an annual basis.*

g. Suggestion: Identify in detail the costs that will be counted in Section 0399.07 (i.e. housing subsidies, food stamps, Meals on Wheels, etc.).

Response: *The department appreciates your suggestion, but does not plan to provide such a list at this time.*

h. Question: Does the \$5,531.00 that is listed as the monthly cost for a nursing facility include medicine and equipment?

Response: *Yes.*

12) **Issue: Limitations on the Availability of Services/Waiting Lists**

Concerns expressed about waiting lists and capacity of services.

a. Suggestion: The rules should provide an entitlement to home and community based services for individuals in the highest level of care. There should not be waiting lists for HCBS for these individuals. The rule should be changed to, “Beneficiaries in the highest need group will be entitled to either nursing home care or HCBS.”

Response: *The statute authorizing the DHS and EOHHS to seek the Global Waiver did not direct the agency to seek such an entitlement. Accordingly, the Global Waiver does not authorize the department to do so in the special terms and conditions established in conjunction with our federal partners.*

b. Question: Should this section be broadened to include all institutional care and not just nursing facilities?

Response: *No. The section applies to nursing facilities as state. Rules for the other institutions will be developed as appropriate..*

c. Question: Are there estimates of how many Medicaid beneficiaries will receive services under this waiver and how many will be placed on waiting lists?

Response: *There are no such estimates at this time.*

d. Question: Beneficiaries who opt for assisted living could be placed on a waiting list because the number of beds certified for Medicaid is capped. What is the cap? How can we make sure that the demand for and the supply of Medicaid assisted living units are in sync?

Response: *There is no longer a cap on the total number of beneficiaries who can be served in assisted living. The State is working closely with the assisted living industry and other stakeholders to ensure increased access to assisted living for Medicaid beneficiaries..*

Issue: Retroactive Denials

Concerns expressed about retroactive denial of payment for nursing homes if an individual no longer meets the highest level of care.

a. Suggestion: Additional language should be added to ensure that nursing homes or other institutional providers are not denied payment for services rendered to a Medicaid recipient should they no longer meet the highest need until the recipient goes through the appeals process and /or is appropriately transitioned to the community.

Response: *The following language has been added to Section 0399.13.01 of the rule: “Payment for care provided to a beneficiary determined to no longer have the highest need shall continue until the DHS has completed the transition to a more appropriate setting.”*

b. Suggestion: Suggested language for Section 0399.06: Prohibition Against Retroactive Denials. No nursing home shall be denied payment for services rendered to a Medicaid recipient on the grounds that the recipient does not meet clinical criteria unless and until the Department of Human Services or its designee has (i) performed an individual assessment of the recipient at issue and provided written notice to the nursing home that the recipient does not meet level of care criteria; (ii) the recipient declines the right to appeal that determination, or makes an appeal that is unsuccessful; and (iii) the resident is discharged in accordance with a safe placement arranged by the Department of Human Services or its designee.

Response: *Applicable language was incorporated into the final rule.*

c. Suggestion: When ACO has not determined the level of care, and a nursing home accepts a new resident in accordance with a discharge planner’s judgment that “highest” level of care criteria have been met, any determination contrary by the ACO should not have a retroactive effect. Similarly, if the ACO has approved nursing home placement, but a decision is made on reassessment that “highest need” criteria are no longer met, that decision should not have a retroactive effect.

Response: *Discharge planners from hospitals no longer have the ability to authorize Medicaid-funded nursing home stays. The ACO is working closely with hospitals to implement this change. Persons who are Medicaid eligible only will be assessed for clinical eligibility prior to their discharge from the hospital by the ACO/Office of Medical Review.*

We agree that if the ACO/Office of Medical Review has made a determination that a person meets the highest need, payment to a nursing facility will be available for the period in which the person met the highest need. If upon reassessment, the person no longer meets the highest need, retroactive payment adjustments will not be made.

13) **Issue: Appeals/Hearing Process**

Concerns regarding due process and the right to appeal and participate in a hearing.

a. Question: Will there be an appeals process?

Response: *The existing appeals process applies.*

b. Suggestion: The regulations should specify the due process rights of individuals who apply for long term care services (including preventive services), spelling out time frames for decision-making, written notice, opportunity for hearing and right to continued benefits when a reassessment of level of care results in a determination of ineligibility for the current level of care.

Response: *This information is contained in Section 0110 General Provisions of the in the DHS Administrative Code of Rules .*

14) **Issue: Agency Rule-Making**

Concerns and questions regarding prior rules/waivers, a fiscal note, use of public input from the hearings, and textual revisions to the rule.

a. Question: Are the current rules pertaining to the individual waivers still effective or are those rules repealed?

Response: *Portions of those rules have been revised as a result of new Section 0399 and are in effect. Sections 0398.10 pertaining to the home and community based system of care for individuals with developmental disabilities and 0398.35.05 pertaining to the Habilitative Waiver have not been impacted by new Section 0399.*

b. Suggestion: Provide a fiscal note as is indicated to be available in the notice of rule-making.

Response: *Fiscal notes related to the implementation of the Global Waiver were prepared for the legislature and are available upon request.*

c. Suggestion: Typo in Section 0399.14 reads, “Should the demand for home and community-based long-term care services exceed the demand or appropriations...” The second mention of “demand” should read “supply.”

Response: *This has been corrected in the final rule.*