RHODE ISLAND EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES

Notice of Public Hearing and Public Review of Rules

The Secretary of the Executive Office of Health & Human Services (EOHHS) has under consideration amendments to the Medicaid Code of Administrative Rules ("MCAR") Section #0399. EOHHS is proposing to amend pertinent sections of this section of the MCAR, currently entitled, "Global Consumer Choice Waiver", renumber it to section #1500, and re-title it: "Medicaid Long-Term Services and Supports: Interim Rule." These rules are being promulgated pursuant to the authority conferred under Chapters 40-6 and 40-8 of the General Laws of Rhode Island, as amended, and the federal Section 1115 Waiver approved by the federal Centers for Medicare and Medicaid Services (CMS).

The EOHHS has determined that the most effective way of updating the applicable rules is to create a new chapter in the MCAR that sets forth in plain language the rules governing LTSS and, as such, serves as companion to the MCAR chapters governing Medicaid Affordable Care Coverage (Section 1300 *et seq*.).

Toward this end, the purpose of this rule is to establish the provisions that implement the reforms beginning in 2016 and to provide a summary of changes that will take effect during calendar year 2016 and thereafter. To achieve the goal of rebalancing the long-term care system, Medicaid eligibility criteria have been reformed to enable beneficiaries to obtain long-term services and supports (LTSS) in the most appropriate and least restrictive setting.

The chief distinctions between the two types of LTSS are care setting and scope of Medicaid coverage. Beginning in 2016, the series of reforms for modernizing the system for organizing, financing and delivering Medicaid-funded LTSS will begin to take effect. While the modernization process is underway, many long-standing LTSS policies and procedures and the rules governing their implementation will become obsolete.

In the development of these proposed Regulations, consideration was given to the following: (1) alternative approaches; (2) overlap or duplication with other statutory and regulatory provisions; and (3) significant economic impact on small businesses in Rhode Island. No alternative approach, duplication or overlap, or impact upon small businesses was identified based upon available information. The regulations are adopted in the best interests of the health, safety, and welfare of the public.

In accordance with RIGL 42-35-3, an oral hearing has been requested on this matter. The Secretary will hold a Public Hearing on **Wednesday, January 13, 2016 at 10:00 a.m.** at which time and place all persons interested therein will be heard.

The Public Hearing will be convened as follows:

Wednesday, January 13, 2016 at 10:00 a.m.
Hewlett-Packard Enterprise Services
301 Metro Center Boulevard
Second Floor Conference Room
(Room 203)
Warwick, RI 02886
(Parking is adjacent to the building).

These proposed rules are accessible on the R.I. Secretary of State's website: http://www.sos.ri.gov/ProposedRules/ and the EOHHS website www.eohhs.ri.gov or available in hard copy upon request (401 462-1575 or RI Relay, dial 711). Interested persons should submit data, views, or written comments **by January 16, 2016** to: Elizabeth Shelov, Office of Policy and Innovation, RI Executive Office of Health & Human Services, Hazard Building, 74 West Road, Cranston, RI 02920 or Elizabeth.Shelov@ohhs.ri.gov.

The Rhode Island Executive Office of Health & Human Services in the Hazard Building is accessible to persons with disabilities. If communication assistance (readers /interpreters /captioners) is needed, or any other accommodation to ensure equal participation, please notify the Executive Office at (401) 462-1575 (hearing/speech impaired, dial 711) at least three (3) business days prior to the Public Hearing so arrangements can be made to provide such assistance at no cost to the person requesting.

Original signed by Jennifer Wood for:
Elizabeth H. Roberts, Secretary
Signed this 23rd day of December 2015

State of Rhode Island and Providence Plantations

Executive Office of Health & Human Services

Access to Medicaid Coverage under the Affordable Care Act

Section 1500:

MEDICAID LONG-TERM SERVICES AND SUPPORTS (LTSS)

December 2015 (Proposed)

Rhode Island Executive Office of Health and Human Services

Access to Medicaid Coverage under the Affordable Care Act

Rules and Regulations Section 1500:

Medicaid Long-Term Services & Supports

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Introduction

These rules entitled, **Section 1500 of the Medicaid Code of Administrative Rules entitled, "Medicaid Long-Term Services and Supports: Interim Rule",** are promulgated pursuant to the authority set forth in Rhode Island General Laws Chapter 40-8 (Medical Assistance); Title XIX of the Social Security Act; Patient Protection and Affordable Care Act (ACA) of 2010 (U.S. Public Law 111-148); and the Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-15).

Pursuant to the provisions of §42-35-3(a)(3) and §42-35.1-4 of the General Laws of Rhode Island, as amended, consideration was given to: (1) alternative approaches to the regulations; (2) duplication or overlap with other state regulations; and (3) significant economic impact on small business. Based on the available information, no known alternative approach, duplication or overlap was identified and these regulations are promulgated in the best interest of the health, safety, and welfare of the public.

These regulations shall supersede all sections of Section #0399 of the Medicaid Code of Administrative Rules entitled, "The Global Consumer Choice Waiver", that have been amended herein, and as promulgated by EOHHS and filed with the Rhode Island Secretary of State.

~~*0399 THE GLOBAL CONSUMER CHOICE WAIVER*~~

CHAPTER 1500

MEDICAID LONG-TERM SERVICES AND SUPPORTS-INTERIM RULE

~~0399.01~~ 1500.01 REDESIGN OF MEDICAID LONG-TERM SERVICES AND SUPPORTS (LTSS) IN RHODE ISLAND

A. Overview

~~REV:07/2009~~

In 2009, the State received approval for an innovative Medicaid Section 1115 Demonstration Waiver. Until 2013, the demonstration was known as the "Global Consumer Choice Compact Waiver (Global Waiver)" due to its unique financing arrangement in which the State and our federal partners mutually agreed to an aggregate cap on the bulk of Medicaid spending. One of the most important goals of the ~~Global Consumer Choice Compact Waiver~~ Global Waiver ~~is~~ was to reduce overutilization of high cost institutionally based care by ~~ensure that every beneficiary receives~~ ensuring that every Medicaid beneficiary was able to access the appropriate services, at the appropriate time, and in the appropriate and least restrictive setting. To achieve this goal for Medicaid-funded long-term ~~care (LTC~~) services and supports (LTSS), the waiver ~~provides~~ provided the State with the authority to collapse its existing section 1915 (c) home and community based service waivers (HCBS), ~~which have different eligibility criteria and services, into its newly approved section 1115 (a) Global Waiver.~~ to standardized eligibility requirements to the full extent feasible to both reduce the bias toward institutional care and promote less costly and restrictive alternatives. ~~Under the Global Waiver~~

In December of 2013, the State received approval for an extension of the Section 1115 waiver by the federal Centers for Medicare and Medicaid Services (CMS). As the extension eliminated the aggregate cap, references to the global compact were removed and the demonstration became known as Rhode Island's "Section 1115 waiver." Under the terms of the 2013, Section 1115 waiver agreement, the goal of rebalancing the LTSS system to promote HCBS was reaffirmed and strengthened. The State remains committed to ensuring that the scope of LTSS ~~services~~ available to a beneficiary is not based solely on a need for an institutional level of care, but is based on a comprehensive assessment that includes, but is not limited to, an evaluation of the medical, social, physical and behavioral health needs of each applicant.

Implementation of the federal Affordable Care Act (ACA) of 2010, began in January 2014, at the same time the Section 1115 waiver extension took effect. The State has endeavored to take every

opportunity available under the ACA to further the rebalancing goals of the waiver and on-going efforts to institute, Medicaid program-wide, an integrated system of coordinated services that covers acute and subacute care as well as LTSS. Implementation of the ACA has also provided the State with the technology to support improvements in every facet of the Medicaid LTSS system – from the point of application and the determination of eligibility through to service delivery. A statewide "Reinventing Medicaid Initiative", which began in 2015, has also added to this changing landscaping by authorizing the Executive Office of Health and Human Services (EOHHS) to:

- Establish incentive payment systems for nursing facilities and hospitals that improve quality and reduce unnecessary utilization;
- Streamline LTSS clinical and financial eligibility procedures to enhance the customer experience and access to and information about HCBS alternatives;
- Pursue implementation of LTSS managed care arrangements that integrate and coordinate services for Medicaid and dually eligible Medicaid and Medicare beneficiaries; and
- Promote the availability of LTSS options and alternatives with the capacity to address the unique and changing acuity needs of beneficiaries.

In 2016, these efforts will converge as LTSS determinations move to the State's new integrated eligibility system, which has both a web-based consumer and agency-staff portal, implementation of integrated care for Medicare-Medicaid dually eligible beneficiaries and the realignment of Medicaid LTSS clinical and financial eligibility criteria begins.

B. Scope and Purpose

Beginning on January 1, 2016, the series of reforms authorized by state policymakers for modernizing the system for organizing, financing and delivering Medicaid-funded LTSS will begin to take effect. While the modernization process is underway, many long-standing LTSS policies and procedures and the rules governing their implementation will become obsolete. The EOHHS has determined that the most effective way of updating the applicable rules is to create a new chapter in the Medicaid Code of Administrative Rules (MCAR) that sets forth in plain language the rules governing LTSS and, as such, serves as companion to the MCAR chapters governing Medicaid Affordable Care Coverage (Section 1300 *et seq.*). Toward this end, the purpose of this rule is to establish the provisions that implement the reforms beginning on January 1, 2016 and to provide a summary of changes that will take effect during calendar year 2016 and thereafter.

~~**0399.02 Transition to the Global Waiver**~~

~~REV:07/2009~~

C. Applicability

Under the terms of Title XIX of the U.S. Social Security Act of 1964, Medicaid LTSS in an institutional-setting is a State Plan service available to all otherwise eligible Medicaid beneficiaries and applicants with an eligibility related characteristic who meet the applicable clinical and financial criteria. "Institution" is the term used in the Act to refer to a hospital, an intermediate care facility for persons with intellectual disabilities (ICF/ID), and a nursing facility (NF), all of which are licensed by the Rhode Island Department of Health as health care facilities under Chapter 23-17 of the state's general laws. The clinical eligibility criteria for LTSS remain tied to these institutional settings and vary according to the level of care each provides and the needs of the population(s) they serve, even though the services are now available to beneficiaries in a home and community-based setting.

(1) **Scope.** Medicaid LTSS in a home and community-based setting is a service authorized by the state's Section 1115 waiver or, in a limited number of circumstances, the Medicaid State Plan. The authority for the State ~~of Rhode Island~~ to provide home and community-based services ~~transitions~~ was derived initially from ~~the authority found in~~ Section 1915(c) of the Social Security Act and transitioned to the State's ~~to that found in~~ Section 1115 demonstration waiver ~~of the Act~~ on July 1, 2009. The transition in authority ~~allows~~, which was continued in the waiver extension of 2013, allowed the State to implement new needs-based levels of care, expand the number of individuals that can access ~~long-term care services, and increase the availability of home and community- based services. On June 1, 2009 letters were sent to all Home and Community-based Waiver participants notifying them of the transition in authority. The agencies with authority to determine access for LTC prior to July 1, 2009, shall retain that authority subsequent to the transition date unless otherwise stated in this rule.~~ LTSS and standardize and streamline the eligibility criteria across programs and settings.

(2) **General Eligibility.** To be eligible for Medicaid LTSS, a person must meet a specific set of financial and clinical criteria that do not apply to other forms of coverage. This requirement applies to both new applicants and existing Medicaid beneficiaries and assures access to LTSS in an institutional setting. Under the terms and conditions of the Section 1115 waiver, home and

community-based LTSS are also available to Medicaid beneficiaries who meet the applicable clinical and financial criteria and are eligible on the basis of:

- Supplemental Security Income (SSI) receipt (MCAR, Section 0351.10) or an SSI characteristic related to age (65 and older), blindness, or a disabling condition and income up to 100 percent of the federal poverty level (FPL) (MCAR Section 0370);
- Special income state plan requirements for persons with a Medicaid characteristic and income from 100 percent of the FPL to 300 percent of the SSI limit (MCAR, Sections 0370 to 0372);
- Section 1915 (c) of Title XIX, home and community-based waiver criteria for persons who are aged or functionally disabled and have income up to 300 percent of the SSI level and would require the level of services provided in an institutional setting were it not for LTSS waiver services (MCAR, Section 0398);
- "Medically needy" state plan requirements for persons with income above 300 percent of the SSI level and medical and LTSS expenses at or below the cost of the applicable type of care in an institutional setting (i.e., nursing facility, hospital, intermediate care facility for persons with intellectual disabilities) (MCAR, Section 0390.05); and
- Medicaid Affordable Care Coverage (MACC) for adults ages nineteen (19) to sixty-four (64), who have income at or below 133 percent of the FPL and are not eligible or enrolled in Medicare or Medicaid under any other coverage group (MCAR Section, 1305.04).

In addition, the State has opted, through the "Katie Beckett" state plan provision, to make home and community-based LTSS accessible to children, living at home, who require the level of care typically provided in an institutional-setting. (See MCAR, Section 0370.20)

The provisions set forth herein apply to Medicaid-funded LTSS for persons eligible in any of these categories (above) whether authorized by the State's Medicaid state plan and/or Section 1115 waiver.

D. Definitions

For the purposes of Medicaid-funded long-term services and supports, the following terms are defined as follows:

Assisted Living Residence means a publicly or privately operated residence that provides directly or indirectly by means of contracts or arrangements personal assistance and may include the delivery of limited health services, as defined under subsection 23-17.4-2(12) of the Rhode Island General Laws, as amended (RIGL), to meet the resident's changing needs and preferences, lodging, and meals to six (6) or more adults who are unrelated to the licensee or administrator, excluding however, any privately operated establishment or facility licensed pursuant to chapter 17 of title 23 RIGL, and those facilities licensed by or under the jurisdiction of the department of behavioral healthcare developmental disabilities, and hospitals, the department of children, youth, and families, or any other state agency. The department of health shall develop levels of licensure for assisted living residences within this definition as provided in § 23-17.4-6 RIGL. Assisted living residences include sheltered care homes, and board and care residences or any other entity by any other name providing the services listed in this subsection that meet the definition of assisted living residences.

Characteristic means an eligibility group that is recognized by Medicaid federal and state law in order to determine eligibility for certain low-income individuals and families.

Community Supportive Living Program (CSLP) means alternatives to institutional care for low-income elders and persons with disabilities who are eligible for Medicaid long-term services and supports and participating in the State's Integrate Care Initiative (ICI).

Core Home and Community-Based Services (HCBS) means services provided to beneficiaries that ensure full access to the benefits of community living as well as the opportunity to receive services in the most integrated setting appropriate.

Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) means the state agency established under the provisions of Chapter 40.1-1 RIGL whose duty it is to serve as the state's mental health authority and establish and promulgate the overall plans, policies,

objectives, and priorities for State programs for adults with developmental disabilities as well substance abuse education, prevention and treatment.

Department of Human Services (DHS) means the State agency established under the provisions of Chapter 40-1 RIGL that is empowered to administer certain human services programs including: the Child Care Assistance Program (CCAP), RI Works, Supplemental Security Income (SSI), Supplemental Nutrition Program (SNAP), General Public Assistance (GPA) and various other services and programs under the jurisdiction of the Division of Elderly Affairs, Office of Rehabilitative Services, and Division of Veterans Affairs. The DHS has been delegated the authority through an interagency service agreement with the Executive Office of Health and Human Services, the Medicaid Single State Agency, to determine Medicaid eligibility in accordance with applicable State and federal laws, rules and regulations.

Developmental Disability means a group of conditions resulting from an impairment in physical, learning, language, or behavior areas. The BHDDH is responsible for administering programs for adults with developmental disabilities.

Executive Office of Health and Human Services (EOHHS) means the state agency established in 2006 under the provisions of Chapter 42-7.2 RIGL within the executive branch of state government and serves as the principal agency of the executive branch for the purposes of managing the departments of Children, Youth, and Families (DCYF); Health (DOH); Human Services (DHS); and Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH). The EOHHS is designated as the "single state agency," authorized under Title XIX of the U.S. Social Security Act (42 U.S.C. § 1396a *et seq*) and, as such, is legally responsible for the program / fiscal management and administration of the Medicaid Program.

Financial Eligibility means qualified or entitled to receive services based upon income and/or resource requirements.

Functional Disability means any long-term limitation in activity resulting from an illness, health condition, or impairment.

Habilitation Program means health care services that help a person acquire, keep or improve, partially or fully, and at different points in life, skills related to communication and activities of daily living. Habilitative services include physical therapy, occupational therapy, speech-language pathology, audiology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. These services address the competencies and abilities needed for optimal functioning in interaction with the environment. Habilitative and rehabilitative services and devices are mandated as essential health benefits ("EHB") in Section 1302 of the Patient Protection and Affordable Care Act (ACA).

Home and Community-Based Services means any services that are offered to Medicaid LTSS beneficiaries who have needs requiring and institutional level of care in the home or community-based setting that are authorized under the Medicaid State Plan or the State's demonstration waiver authorized under section 1115 of the Social Security Act (42 U.S.C. 1315).

Institution means a State licensed health facility where health and/or social services are delivered on an inpatient basis, such as hospitals, intermediate care facilities, or nursing facilities.

Integrated Care Initiative means EOHHS' two-phase strategy for implementing the Medicaid Integrated Care Program that uses various contractual arrangements to expand access to comprehensive care management and service. In Phase I efforts were focused on managing and integrating Medicaid covered services across the care continuum for Medicaid-only and Medicare and Medicaid "dually" eligible (MME) beneficiaries age twenty-one (21) or older. In Phase II, under the authority of a special federal waiver, full integration and management of all Medicare and Medicaid covered services for fully dual eligible participants will be provided. Service delivery in Phase II is governed by three-party contractual agreement involving the EOHHS, federal partners at CMS, and the participating managed entity.

Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) means a facility that provides care and services to persons with intellectual disabilities as an optional Medicaid benefit that enables states to provide comprehensive and individualized health care and rehabilitation services to individuals to promote their functional status and independence. This setting is an alternative to home and community-based services for individuals at the ICF/ID level of care.

Katie Beckett Eligibility means an eligibility category that allows certain children under age 19 who have long-term disabilities or complex medical needs who require an institutional level of care to obtain the Medicaid long-term services they need at home. With Katie Beckett eligibility, only the child's income and resources are considered when determining eligibility.

Level of care means the determination of an applicant/beneficiary's needs based on a comprehensive assessment that includes, but is not limited to, an evaluation of medical, social, functional and behavioral needs.

Long-term Services and Supports (LTSS) means a set of health care, personal care, and social services required by persons who have some degree of functional limitation that are provided in an institution, in the community, or at home on a long-term basis.

LTSS Managed Care Arrangement means long-term services that are provided by a health plan that utilizes selective contracting to channel beneficiaries to a limited number of providers and requires a utilization review component to control the unnecessary use of the long-term services and supports.

LTSS Specialist means a State agency representative responsible for determining eligibility for long-term services and supports, authorizing such services and supports and assisting applicants and beneficiaries in navigating the system. The term does not apply to EOHHS, Office of Medicaid Review (OMR) clinical staff, but does refer to agency representatives such as DHS eligibility personnel (including social workers) assigned to Medicaid LTSS and staff from the EOHHS and other agencies that administer programs associated with each respective institutional level of care.

Medicaid-Medicare Dually Eligible (MME) means and includes persons who meet the applicable Medicaid eligibility criteria related to income, age, disability status, and/or functional need and are also entitled to benefits under Medicare Parts "A" and are enrolled under Medicare Parts "B" and "D."

Medicaid Code of Administrative Rules (MCAR) means the compilation of rules governing the Rhode Island Medicaid program promulgated in accordance with the State's Administrative Procedures Act (R.I.G.L. §42-35).

Needs-Based Eligibility means the state Medicaid agency determines whether an individual or family is eligible for Medicaid benefits, based upon whether the individual or family meets the requirements set forth in statute, regulations, and other applicable legal authority.

Options Counseling means an interactive decision-support process whereby consumers, family members and/or significant others are supported in their deliberations to determine appropriate long-term care choices in the context of the consumer's needs, preferences, values, and individual life Circumstances.

Person-centered Planning means a process that strives to place the individual at the center of decision-making. It is based on the values of human rights, interdependence, choice and social inclusion, and can be designed to enable people to direct their own services and supports, in a personalized way. Person-centered planning is not one clearly defined process, but a range of processes sharing a general philosophical background, and aiming at similar outcomes. Person-centered planning is also a process directed by an individual, with impartial assistance when helpful, focusing on their desires, goals, needs, and concerns to develop supports to live a meaningful life maximizing independence and community participation.

Program of All Inclusive Care for the Elderly (PACE) means a service delivery option for beneficiaries who have Medicare and/or Medicaid coverage and meet a "high" or "highest" level of need for long-term services and supports. Beneficiaries must be 55 years or older to participate in this option.

Preventive Services means the limited range of LTSS available to Medicaid beneficiaries who are at risk for a nursing facility level of care. Includes homemaker, minor environmental modifications, physical therapy evaluation and services, respite and personal care.

RIte@Home means a program that provides personal care, homemaker, chore, attendant care and related services in a private home setting by a care provider who lives in the home. RIte @ Home is a service provided to Medicaid beneficiaries eligible for long-term care services who are elderly or adults with disabilities who are unable to live independently and who meet the "highest" or "high" level of care as determined through an evaluation.

Self-directed care means that beneficiaries, or their representatives if applicable, have the opportunity to exercise choice and control over a specified amount of the funds for and the providers who deliver the long-term services and supports they need as identified in an Individual Service and Spending Plan (ISSP) developed through the person-centered planning process. The EOHHS provides each beneficiary opting for this service delivery approach with a certified service counselor and advisement agency to provide decision-making assistance and support.

~~**0399.03**~~

E. ~~ACCESS TO LONG-TERM CARE~~ TYPES OF MEDICAID LTSS

~~REV:07/2009~~

~~For the purposes of this section, Medicaid-funded long-term care is defined as institutional services or home and community-based services and supports. Long-term care services~~ LTSS are designed to help people who have functional disabilities and/or chronic care needs to optimize their health and retain their independence. ~~Services may be episodic or ongoing and may be provided in a person's home, in the community (for example, shared living or assisted living), or in institutional settings (for example, intermediate care facilities, hospitals, or nursing homes).~~

~~**0399.04 TYPES OF LONG-TERM CARE**~~

~~REV:07/2009~~

To achieve the goal of rebalancing the long-term care system, ~~the Global Consumer Choice Compact Waiver allows~~ Medicaid eligibility criteria have been reformed to enable beneficiaries to obtain ~~the Medicaid~~ these services ~~they need~~ in the most appropriate and least restrictive setting. The types of ~~long-term care~~ LTSS available to beneficiaries are categorized as either institutional ~~and~~ or home and community-based. The chief distinctions between the two types of LTSS are care setting and scope of Medicaid coverage, as indicated below:

(1) Medicaid LTSS in an Institutional Setting. Beneficiaries that who meet the applicable financial and clinical eligibility criteria may access institutional long-term care services LTSS in the following State-licensed health care institutions/facilities:

a) (a) Nursing Facilities (NF). A beneficiary is eligible to access Medicaid-funded care LTSS in a nursing facility when it is determined on the basis of a comprehensive assessment (see Section 1500.3) as defined in Sections 0399.05.01.02 and 0399.11, that the beneficiary has the highest need for a NF level of care needs (See Section 0399.12.01).

b) (b) Intermediate Care Facility for the Mentally Retarded Intellectually Disabled (ICF/MRID). A beneficiary qualifies for an ICF/MR ID level of care if the beneficiary has been determined by the MHRH state Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) to meet the applicable institutional level of care. Rules governing such determinations are located in: "Rules and Regulations Relating to the Definition of Developmentally Disabled Adult and the Determination of Eligibility as a Developmentally Disabled Adult, by MHRH" and may be obtained at http://www.mhrh.ri.gov/ddd/pdf/MHRH_1746.pdf or by contacting the agency.

c) (c) Long-term Acute Care Hospital - Eleanor Slater Hospital (ESH). A beneficiary qualifies for a long-term acute care hospital stay if the beneficiary has been determined to meet an institutional level of care by the MHRH BHDDH (e.g., Eleanor Slater Hospital (ESH)) and/or by the DHS EOHHS. Medicaid LTSS may also be available to children in State custody or who have special health care needs that meet the hospital level of care.

Beneficiaries residing in an NF, ICF/MR ID and ESH hospital receive all of their Medicaid long-term services and supports through the facility with the exception of a limited set of covered equipment and supplies – e.g., eyeglasses, hearing aids, prosthetics, etc. are considered to be in an institution for the purposes of determining eligibility. Medicaid coverage in institutional settings includes room and board. Beneficiaries in these settings are subject to the post-eligibility treatment of income (PETI), which determines the amount they must contribute, sometimes referred to as “liability”, toward the cost of

LTSS. In the PETI calculation process, ~~The~~ the State's Medicaid payment for ~~institutional care~~ institutionally based LTSS is reduced by the amount of the beneficiary's income after certain allowable expenses are deducted. Other rules applicable to institutional care and services are located in ~~the~~ MCAR Sections ~~of~~ 0378.

~~0399.04.02 Home and Community Based Long-Term Care~~

~~REV:09/2013~~

(2) Medicaid Home and Community-based LTSS. --~~The Global Waiver~~ The State's Section 1115 demonstration waiver authorizes ~~the state to offer~~ an array of home and community-based services (HCBS) to ~~members~~ beneficiaries as an alternative to ~~institutionalization~~ institutionally based care. In general, ~~Home~~ home and community-based ~~long-term care services and supports (HCB/LTC Services) are in addition to the services otherwise provided under the Medicaid program~~ LTSS provide the type of services available in an institutional setting that are not covered by Medicare, commercial health plans or non-LTSS Medicaid coverage (e.g., assistance with the activities of daily living, such as personal care, preparing meals, toileting, and managing medications). Access to these services enables beneficiaries to optimize their health and retain their independences while delaying or diverting the need for care in more costly and restrictive institutionally based settings.

Room and board are NOT covered by Medicaid. Medicaid HCBS includes both core and preventive services as well as all other state plan and waiver services. Additional services may be available, depending on the type of a beneficiary's needs and the institutional level of care required. Beneficiaries receiving Medicaid LTSS in home and community-based settings are also subject to PETI and must contribute to the cost of their LTSS.

~~0399.04.02.01 Core and Preventive HCB/LTC Services~~

~~REV:09/2013~~

~~1) Core HCB/LTC services include the following broad categories of services:~~

- ~~Homemaker~~ ~~* Adult Companion Services~~
- ~~Environmental Modifications~~ ~~* Personal Care Assistance~~
- ~~Minor Environmental Modifications~~ ~~*Special Medical Equipment~~
- ~~Respite~~ ~~* Home Delivered Meals~~
- ~~Day Supports, including Adult Day Services~~
- ~~Personal Emergency Response~~ ~~* Supported Employment~~
- ~~Licensed Practical Nurse~~ ~~* RIte @ Home (Shared Living)~~
- ~~Services (Skilled Nursing)~~ ~~*Community Transition~~
- ~~Private Duty Nursing Services (including Registered Nurse)~~

- ~~Residential Supports~~
- ~~Supports for Consumer-Direction~~
- ~~Participant Directed Goods and Services~~
- ~~Case management~~
- ~~Assisted Living~~
- ~~PACE~~

~~Assisted Living, PACE and RIte @ Home are defined in greater detail in Sections 0399.20.01, 0399.21 and 0399.20.02.~~

~~**0399.05 ELIGIBILITY REQUIREMENTS**~~

~~REV:07/2009~~

F. ELIGIBILITY FOR MEDICAID LTSS

To qualify for Medicaid-funded long-term care services and supports under the ~~Global Waiver~~ State's Section 1115 demonstration, a person must meet the general and financial eligibility requirements as well as ~~meet~~ certain clinical/functional disability ~~eligibility~~ criteria. On January 1, 2016, reforms to the LTSS eligibility requirements will begin to be phased-in with the promulgation of a series of amended rules over a six (6) month period. This process begins with the provisions set forth in this rule revising the clinical/functional disability needs-based criteria for the nursing facility level of care and implementation of federal authority standardizing benefits and service options for Medicaid LTSS beneficiaries across categorically needy and medically needy eligibility categories.

This interim rule identifies the MCAR provisions applicable to financial eligibility until July 1, 2016 and sets forth the new clinical/functional disability criteria to take effect on January 1, 2016. In addition, the range of core HCBS will be expanded effective January 1, 2016. Section 1500.4 of this interim rule, describing core and preventive services, identifies and describes the new core HCBS available to beneficiaries as of that date.

(1) **General and Financial Eligibility Requirements.** The State's Section 1115 waiver establishes that all Medicaid LTSS applicants/beneficiaries must be subject to the general and financial eligibility requirements applicable to persons who are likely to be residents of an institution irrespective of whether that care is actually provided in an institution or the home and community-based setting. The EOHHS has delegated responsibility for evaluating the general and financial eligibility of Medicaid applicants and beneficiaries to the Rhode Island Department of Human Services (DHS).

(a) LTSS Eligibility Requirements (Effective until June 30, 2016). Except as indicated in paragraph (b) below, general and financial eligibility for Medicaid LTSS are determined in accordance with the following standing provisions:

- The general eligibility requirements -- Set forth in MCAR, Sections 0300.25 and 0300.25.20.05 respectively.
- Income and resource eligibility rules -- For Medicaid eligible persons who are: likely to be residents of an institution for a continuous period, have received LTSS for a minimum of thirty (30) days through a Medicaid managed care plan, or would have needs requiring the level of care in an institution if it were not for home and community-based waiver services, including for those ~~and~~ who have a spouse living in the community (see MCAR, Sections 0380.40-0380.40.35 and 0392.15.20- 0392.15.30). See also the applicable income and resource provisions in the ~~long-term care~~ for Medicaid LTSS in MCAR, Sections ~~from~~ 0376 to 0398.

~~Clinical eligibility is determined by an assessment of a beneficiary's level of care needs. Under the Global waiver, the income and eligibility rules in these Sections will apply to persons who are likely to receive home and community-based core services for a continuous period. That is, persons meeting the highest or high level of care who reside in the community.~~

- Evaluation of Income and Resources -- In Sections 0380.40-0380.40.35 and 0392.15.20-0392.15.30, all references to institutionalized spouses and continuous periods of institutionalization ~~will include those institutionalized spouses receiving home and community-based services in lieu of institutional services~~ apply to ALL beneficiaries eligible for Medicaid LTSS, irrespective of whether services are obtained in an institutional and home and community-based setting.

(b) LTSS Categorically versus Medically Needy (Effective January 1, 2016). The EOHHS requested and received approval from the CMS for a state plan amendment standardizing LTSS benefits and service options across the "categorically needy" and "medically needy" eligibility categories set forth in MCAR, Section 0370. Accordingly, all LTSS beneficiaries are eligible to receive the same core and preventive services.

~~**0399.05.01 Clinical Eligibility- Scope & Applicability**~~

~~REV:07/2009~~

(2) Clinical/Functional (CF) Eligibility Criteria. (Effective January 1, 2016).

The clinical/functional eligibility ~~level of care~~ criteria that must be met for each type of institution identified in subsection (E)(1) of this rule vary in accordance with the level of need of the beneficiaries they serve, the scope of services they are authorized to provide, and state and federal regulatory requirements.

(a) Intermediate care facilities for ~~the mentally retarded~~ persons with intellectual disabilities (ICF/ID)). The criteria used to evaluate clinical eligibility for the ICF/ID level of need are established by the BHDDH, in accordance with State law, and apply to Medicaid LTSS provided in the institutional-setting ~~and hospitals~~ and home and community-based service alternatives ~~to these institutions on June 30, 2009 shall remain in effect until such time as needs- based criteria~~ The criteria ~~have be~~en adopted by BHDDH in effect as of January 1, 2016, will continue to be used until such time as BHDDH establishes amended or new rules, regulations and/or procedures. ~~and applicable rules promulgated by the department(s) responsible for administering programs serving beneficiaries, as indicated below~~ . Further information on these criteria is located in Section 1500.02 (C) (b) (iii).

(b) Hospital – Each agency serving beneficiaries who may require Medicaid LTSS at the hospital level of care is authorized under the State's 1115 waiver to tailor the clinical/functional criteria to meet their population's general and unique needs within the parameters of applicable federal regulations and laws. This applies to individuals seeking services through the EOHHS Habilitation Program which were authorized prior to establishment of the Section 1115 demonstration in 2009 under the State's1915(c) Habilitation Waiver.

(c) Nursing Facility – Effective January 1, 2016, the EOHHS is revising the needs-based clinical/functional criteria for NF level of care established when the Section 1115 waiver demonstration was approved initially in 2009. The application of the previous and revised versions of the NF level of care criteria are as follows:

(i). Beneficiary entered NF prior to July 1, 2009. In accordance with the terms and conditions of the Section 1115 waiver approved in 2009, any Medicaid LTSS beneficiaries who were residing in a nursing facility on or before June 30, 2009, are subject to the NF level of criteria in effect prior to July 1, 2009. The revised needs-based criteria DO NOT apply to

beneficiaries eligible to receive Medicaid ~~-funded long-term care services~~ LTSS unless or until: ~~because he or she: (a) improves to a level of care that no longer meets the pre-waiver level of care criteria - that is, the beneficiary no longer qualifies for an institutional level of care under the criteria in effect on or before June 30, 2009; or (b) the beneficiary chooses home and community based services over the institution.~~ the needs of the beneficiary improve to such an extent that beneficiary no longer meets the criteria for Medicaid LTSS in effect prior to July 1, 2009 or the beneficiary chooses to transfer voluntarily to a home and community- based services setting;

(ii.) Beneficiary entered NF between July 1, 2009 and December 31, 2015. Any Medicaid LTSS beneficiaries who were determined eligible for a NF level of care during this period will continue to be subject to the criteria in effect at that time. Therefore, the revised needs-based criteria DO NOT apply to beneficiaries receiving Medicaid LTSS who were living in nursing facilities on or before December 31, 2015. The level of care criteria in effect between July1, 2009 and December 31, 2015 apply and will continue to apply unless or until the needs of the beneficiary improve to such an extent that beneficiary no longer meets the criteria for Medicaid LTSS or the beneficiary chooses to transfer voluntarily to a home and community-based services setting.

(iii) Applicant/Beneficiary for LTSS On/After January 1, 2016. The ~~new~~ revised needs-based levels of care DO apply to new applicants for Medicaid LTSS and existing beneficiaries ~~eligible to receive Medicaid-funded long-term care services~~ who ~~are~~ were living in the community on or before ~~June 30, 2009.~~ January 1, 2016.

The ~~new~~ revised ~~levels of care~~ criteria for assessing the highest need for a NF level of care will apply beginning with the beneficiary's annual re-assessment as part of the eligibility renewal process. If a ~~person~~ beneficiary ~~met the~~ has the highest or a high need for a NF institutional level of care ~~criteria~~ in the past, then the beneficiary ~~he or she~~ will continue to meet either the highest or a high need for an NF level of care in the future, and eligibility for ~~long-term care services~~ Medicaid LTSS will continue without interruption~~,~~ providing there have been no changes in all other general and financial eligibility requirements ~~continue to~~

~~be met~~. When assessing beneficiaries living in the community using the needs-based level of care criteria, a beneficiary is clinically eligible as highest need if the ~~department~~ EOHHS determines, as above, that the beneficiary meets at least one of the revised clinical/functional eligibility criteria for highest need~~;~~ or, absent that, the beneficiary has a critical need for ~~long-term care~~ NF care due to special circumstances as specified in MCAR, Section 1500.03(C)(2). ~~Accordingly, a~~

(iv) Criteria Applicable for Transition to HCBS – Current Beneficiaries. A Medicaid beneficiary ~~eligible for and~~ residing in a nursing facility whose eligibility was determined in accordance with subparagraph (i) or (ii) above ~~on or before June 30, 2009, who~~ and chooses to move to the community, ~~shall be~~ will be assessed using the ~~new~~ revised needs-based level of care at the time eligibility is ~~re-determined~~ renewed. A beneficiary who makes this choice is eligible for ~~long-term care~~ Medicaid LTSS as "highest need" if the ~~department~~ EOHHS determines at any time that the beneficiary:

- ~~meets~~ Meets at least one of the clinical/functional eligibility criteria for highest need; or
- ~~(2) the beneficiary does~~ Does not meet at least one of these criteria but nevertheless has a critical need for ~~long-term care~~ Medicaid LTSS due to special circumstances that may adversely affect the beneficiary's health and safety. Such special circumstances include a failed placement as well as other situations that may adversely affect a beneficiary's health and safety as specified in Section 1500.03(C)(2).

~~The needs-based levels of care will apply to all persons seeking Medicaid-funded long-term care services provided in a nursing facility or community alternative to that facility on or after July 1, 2009. Persons seeking Medicaid-funded long-term care services and supports administered by the Department of Mental Health, Retardation, and Hospitals (MHRH) will continue to meet the clinical eligibility standards in effect – that is, the level of care of intermediate facility for the mentally retarded/developmental disabled (ICFMR/DD) until such time as a needs-based set of criteria are developed in accordance with the terms and conditions established under the waiver. Rules governing such determinations are located in: "Rules and Regulations Relating to the Definition of Developmentally Disabled Adult and the Determination of Eligibility as a Developmentally Disabled Adult, by MHRH" and may be obtained at http://www.mhrh.ri.gov/ddd/pdf/MHRH_1746.pdf or by contacting the agency.~~

~~Persons seeking Medicaid-funded long-term care services provided in a long-term care hospital or in a community-based alternative to the hospital will continue to need to meet an institutional level of care. This applies to individuals who would have sought services under the 1915(c) Habilitation Waiver.~~

(d) Preventive Level of Need. Beneficiaries currently eligible for ~~community Medical Assistance~~ Medicaid via the provisions related to SSI, an SSI-characteristic (blind and low-income elderly or persons with disabilities), or as members of the MACC group for adults who are not clinically eligible for ~~long-term care~~ LTSS may be eligible for a limited range of home and community based services if they meet the criteria to qualify for preventive care (see "preventive need" in Section 1500.03(C)(4)). The availability of such services ~~shall be~~ is limited, depending upon funding.

~~***0399.05.01.02 Needs-based LTC Determinations***~~
~~REV:07/2009~~

1500.02 MEDICAID LTSS NEEDS-BASED DETERMINATIONS

A. OVERVIEW

The process~~es~~ for determining clinical eligibility ~~are based on~~ centers on a comprehensive assessment that includes an evaluation of the medical, social, physical and behavioral health needs of each beneficiary. The assessment ~~shall be~~ is tailored to the needs ~~of the beneficiaries services and,~~ of beneficiaries seeking the various types of LTSS (see Section 1500.01 (E) above) and ~~as such, may vary from one process to the next~~ tend to differ accordingly. For example, the clinical/functional needs based criteria for NF level of care are different than the criteria for the ICF/ID and hospital levels of care and may vary further by setting within each type of institution and the population served (i.e., hospital level of care for child in DCYF custody versus adult identified by BHDDH as a person with a serious and persistent behavioral health condition or illness). Based on this assessment, the needs of the beneficiary are classified as "highest" or "high" to reflect the scope and intensity of care required and the range of services available. Non-LTSS Medicaid ~~Beneficiaries already eligible for community MA~~ beneficiaries with chronic and disabling conditions who do not meet the highest or high level of care but are at risk for ~~institutionalization~~ the level of care typically provided in an institution may access certain short-term preventive services to optimize their health and promote independence.

Once the assessment is completed, a determination of Medicaid LTSS eligibility based on both general, financial and clinical/functional criteria is completed. Persons eligible for Medicaid LTSS then are engaged in the person-centered planning process in which the beneficiary is assisted in

establishing a care plan that uses his or her life goals as a focal point for organizing the delivery of the services authorized (core and preventive as indicated in Section, 1500.03(E), the options available based on level of need (see matrix below at subsection (B), and the service delivery alternatives available (LTSS managed long-term care arrangement, PACE, or community-based care coordination, see MCAR, Sections 0374 and 0375). Person-centered planning is a holistic approach for accessing Medicaid LTSS that involves the beneficiary, family members and providers. A description of the basic types of Medicaid LTSS is provided in Section 1500.01 (E).

~~There are two general types of services available to beneficiaries – core and preventive (see description in section 0399.10.20). An individual care plan is then developed that identifies the LTC core and preventive services and settings appropriate to meet the beneficiary's needs within the specified service classification.~~

B. LEVEL OF CARE AND NEEDS-BASED SERVICE OPTIONS

The scope of services accessible to a beneficiary varies in accordance with individual needs, preferences, availability, and the parameters established in the ~~Global Waiver~~ State's Section 1115 demonstration and/or federal and state regulations, rules or laws. For example, a beneficiary with the highest need for NF level of care may ~~be able to~~ obtain the full range of ~~services he or she needs~~ LTSS he or she requires at home or in a shared living arrangement, but may choose, instead, to access those services in a nursing facility. Community-based NF level of care options include PACE and accessing services through a self-directed model. A beneficiary determined to meet the NF high need may have access to care in the home and community based setting - including PACE -- and self-directed care, but does not have the option of nursing facility care. The matrix below outlines the service options based on level of need:

~~***0399.05.01.03 LTC Level of Care and Service Option Matrix***~~
~~REV:07/2009~~
~~LTC LEVEL OF CARE AND SERVICE OPTION MATRIX~~
~~HIGHEST HIGHEST HIGHEST~~
~~Nursing Home Hospital Level of ICF/MR Level of~~
~~Level of Care Care Care~~
~~(Access to (Access to (Access to ICF/MR Nursing Facilities Hospital, and all Community and all Residential Based Services) Community-Based Treatment Centers and all Services~~
~~Community-Based~~
~~Services)~~
~~HIGH HIGH HIGH~~
~~Nursing Home Hospital Level of ICF/MR Level of~~

~~Level of Care Care Care (Access to (Access to (Access to Community- Community- Community- Based Services) Based Services) Based Services) PREVENTIVE PREVENTIVE PREVENTIVE~~

Medicaid **LTSS Service Options Matrix** Needs-Based Level of Care Determinations		
Highest Need **NF Level of Care** (Access to Nursing Facilities and all Home and Community-based Services)	**Highest Need** **Hospital Level of Care** (Access to Hospital, Group Homes, Residential Treatment Centers and all other Home and Community-based Services)	**Highest Need** **ICF/ID Level of Care** (Access to ICF/ID Group Homes and all other Home and Community-based Services)
High Need **NF Level of Care** (Access to Core and Preventive Home and Community-based Services)	**High Need** **Hospital Level of Care** (Access to Core and Preventive Home and Community-based Services)	**High Need** **ICF/ID Level of Care** (Access to Core and Preventive Home and Community-based Services)
Preventive Need **NF Level of Care** (Access to Preventive Home and Community-based Services)	**Preventive Need** **Hospital Level of Care** (Access to Preventive Home and Community-based Services)	**Preventive Need** **ICF/ID Level of Care** (Access to Preventive Home and Community-based Services)

~~Nursing Home Hospital Level of ICF/MR Level of Level of Care Care Care (Access to (Access to (Access to Preventive Preventive Preventive Community- Community- Community-Based Based Services) Based Services) Services)~~

~~0399.06~~ C. MEDICAID LTSS ASSESSMENT & COORDINATION (A&C) ~~ORGANIZATION (ACO)~~

~~REV:07/2009~~

~~The Assessment and Coordination Organization (ACO)~~ Medicaid LTSS assessment and coordination (A&C) is a set of four (4) processes established across the health and human service departments that assist applicants/~~recipients~~ beneficiaries and their families in gaining access to and navigating the ~~LTC~~ LTSS system. ~~In this respect, the ACO is not a separate and distinct entity,~~ Although there is no one single, distinct entity that performs all these functions, the State's Section 1115 demonstration sets the direction for all Medicaid LTSS assessment and coordination activities ~~but a set of interrelated activities from across the departments~~ that serve the goal of rebalancing the long-term care system.

(1). A&C Processes. The four principal A&C processes ~~included in the ACO~~ are as follows:

~~a)~~ (a)Information and Referral -- The State provides information and referrals about publicly funded ~~LTC~~ LTSS to individuals and families through a variety of sources across agencies. The ~~ACO~~ EOHHS is responsible for enhancing and coordinating these resources to ensure that every person seeking Medicaid~~-funded LTC services~~ LTSS has access to the information they need to make reasoned choices about their care. The ~~Department of Human Services shall~~ EOHHS has entered into inter-agency agreements with each entity identified or designated as a primary source of information/referral source for LTSS beneficiaries, their family members and authorized representatives. ~~of long-term care~~. In addition, the Division of Elderly Affairs (DEA), within the RI Department of Human Services (DHS) administers the Aged and Disability Resource Center (ADRC) through "The POINT" at: 401-462-4444.

~~b.)~~ (b) Eligibility Determinations~~. Through the ACO~~, ~~the Department of Human Services~~ -- Under the terms of interagency agreement with the EOHHS, the Medicaid single state agency, the DHS has been delegated the responsibility to determine~~s~~ financial eligibility for ~~long-term care services~~ all Medicaid LTSS applicants and beneficiaries ~~provided across agencies~~. The EOHHS has delegated the authority to determine clinical/functional eligibility for Medicaid LTSS ~~is based on a comprehensive assessment of a person's medical, social, physical and behavioral health needs. Responsibilities for clinical eligibility are~~ across State agencies. The entities that conduct the assessments work in coordination with staff of the Medicaid agency, as appropriate, to ensure the eligibility determination process is coordinated and to preserve program integrity. Clinical/functional eligibility responsibilities are organized as follows:

~~*~~(i) NF Level of Care – Needs-based assessments for ~~Clinical eligibility to receive services in a nursing facility~~ a NF institutional level of care or community-based alternative ~~to that institution will be~~ is determined by ~~DHS,~~ the EOHHS, Office of Medical Review (OMR) utilizing ~~needs-based~~ the criteria set forth below in Section 1500.03.

~~*~~(ii) Hospital Level of Care – Needs-based assessments for ~~Clinical eligibility to receive services in~~ a long-term care hospital or community alternative ~~to the institution will be determined by DHS and MHRH~~, are tailored to the clinical requirements of the populations served in settings that meet the definition of "hospital" for Medicaid LTSS purposes. ~~as appropriate, utilizing an~~ institutional level of care. BHDDH and the RI Department of Children, Youth and Families (DCYF) have developed and apply specialized clinical criteria for adults and children, respectively, with various service needs at this institutional level; the EOHHS has established clinical criteria for beneficiaries requiring services through the Habilitation Program and similar settings.

~~*~~(iii) ~~Clinical eligibility to receive services in an intermediate care facility or community alternative to that institution will be determined by the Department of Mental Health Retardation and Hospitals, using an institutional level of care.~~ ICF/ID Level of Care – The BHDDH uses clinical criteria established in State law (R.I.G.L. § 40.1-1-8.1) and associated implementing rules (located at: (http://sos.ri.gov/documents/archives/regdocs/released/pdf/MHRH/MHRH_1746_.pdf) as well as the federal law and regulations when conducting needs-based eligibility determinations. The BHDDH also utilizes a population-specific services intensity scale to evaluate/authorize Medicaid LTSS required to meet assessed need.

~~*The entities that conduct the assessments work in coordination with staff of the Medicaid agency, as appropriate, to ensure the eligibility determination process is coordinated and to preserve program integrity.~~

~~c.)~~ (c) ~~Care Planning~~ Person-centered care planning. The comprehensive assessment completed with the beneficiary~~, in conjunction with other individuals chosen by the beneficiary,(which may include family/friendsor other providers);~~ that was used to determine clinical eligibility~~,~~ will also direct the development of a person-centered care plan. The person-centered plan will identify goals and objectives set by the beneficiary and may include the scope and amount of services required to meet the beneficiary's needs as well as the full array of service/care setting options. ~~ACO~~ A&C care planning

activities include establishing funding levels for the care for LTSS beneficiaries who have opted for self-direction (Personal Choice Program) or community-based coordination service delivery options. ~~and/or~~ This may include the development of a budget for self-directed services or the provision of vouchers for the purchasing of services. For Medicaid LTSS beneficiaries choosing to enroll in a manage long-term care arrangement, as defined in MCAR, Section 0375, the plan of choice assumes responsibility for ensuring the appropriate delivery of authorized services and on-going person-centered planning.

~~d.)~~ (d)Case management/evaluation~~.~~ --The activities of the various agencies and/or their contractual agents are designed to ensure beneficiaries are receiving the scope and amount of services identified in the person centered care plan . The broad range of services includes periodic review of person centered care plans, and may include coordination of services with the beneficiary's acute care management entity ~~(Rhody Health Partners, RIte Care,),~~ LTSS managed care plan or community health team and quality assurance. Depending on the agency and the population served, this may be performed by multiple entities working in collaboration or a single entity.

~~0399.06.01 Initiating Assessment & Coordination Process~~

~~REV:07/2009~~

(2) Initiating the Assessment & Coordination Process. ~~A screening tool developed by the DHS in collaboration with the health and human services~~ agencies is used to determine the most appropriate ~~placement and/or service referral for each applicant for LTC.~~ When applying for Medicaid LTSS, either through the on-line consumer portal at HealthSource RI or agency kiosk or on-paper (form known as "DHS-2") or in person with the assistance of a DHS agency specialist, applicants/beneficiaries must indicate the type of LTSS they are seeking. The State's integrated eligibility system, known as "RI Bridges", collects information related to the general and financial requirements for LTSS and conducts an initial screening to determine the appropriate entity for performing the comprehensive assessment of clinical/functional eligibility. Based on the results of this screen, referrals proceed as follows:

~~a)Beneficiaries determined to have a potential need for Medicaid funded long-term services and supports in a NF or the community alternative to a NF are referred to the DHS;~~
~~b) 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;~~

~~c) Beneficiaries determined to have a potential need for services for persons with developmental disabilities are referred to the MHRH;~~
~~d) Beneficiaries determined to have a potential need for long-term hospital services are referred to MHRH;~~
~~e)Beneficiaries determined to have a potential need for behavioral health services for a child or for an adult are referred to the DCYF or MHRH, respectively;~~

~~f) Beneficiaries who are not seeking information on long-term care services are referred to the appropriate agency, unit or entity. For example, information on acute managed care options is currently provided by the RI DHS Enrollment Hotline.~~

Medicaid LTSS A&C **Referral For Comprehensive Assessment**		
Beneficiary Has Potential Need For:	**Referral to:**	**Programs/Services Administered**
(a) Medicaid-funded NF care or an HCBS alternative. Includes adults and children.	EOHHS or its contractual designee (e.g., LTSS managed care plan)	LTSS Integrated Care (MCAR, Section 0375) LTSS Institutional Care (MCAR, Section 0378) SSI-related Coverage (MCAR, 0394) HCBS Programs (MCAR, Section 0396 Katie Beckett Eligibility (MCAR, Section 0370.20) Personal Choice (Self-directed Care) Program (MCAR, *Medicaid Personal Choice Program*) NF Transition Program (MCAR, Section 0378) PACE (MCAR, Section 1500.05(A))
(b) LTSS for elders or persons with disabilities, but who do not meet the financial eligibility criteria for full Medicaid due to excess income	DHS – Division of Elderly Affairs	Co-pay Programs (MCAR, Section 0398.20 and DEA *Rules, Regulations and Standards Governing the Home and Community Care Services to the Elderly Program*, Section II[1])
(c) Medicaid LTSS in an ICF/ID or HCBS alternative for persons age 19 and over with a developmental disability	BHDDH	Services for Adults with Developmental Disabilities (MCAR, 0398.10 and BHDDH implementing rules[2])
(d) LTSS for adults with serious behavioral health conditions	BHDDH	Services for persons with behavioral conditions, including adult psychiatric services and forensic

[1] See implementing rule located at: http://sos.ri.gov/documents/archives/regdocs/released/pdf/DELDA/5638.pdf
[2] See implementing rule located at: http://sos.ri.gov/documents/archives/regdocs/released/pdf/MHRH/MHRH_1746_.pdf

		services.[3] (BHDDH implementing rules, regulations and standards [4])
(e) LTSS for adults with traumatic brain injury	EOHHS	Habilitation Program (MCAR, Section
(f) LTSS for children currently in State custody or in foster care in RI at age 18 with developmental disabilities or behavioral health conditions	DCYF	Mental Health Evaluation (DCYF Policy: 700.0010) Transitioning Youth (DCYF Policy: 700.0185) Mental Health Services (DCYF Policy: 100.0155)
(g) LTSS for children with special health care needs up to age 21	EOHHS	

The agency receiving the referral is responsible for applying the appropriate needs-based criteria and determining the services options available as indicated in subsection (C) (1) (b) above.

~~0399.07 LTC~~

D. LTSS OPTIONS COUNSELING PROGRAM

~~REV:07/2009~~

A ~~long-term care~~ LTSS options counseling program is designed to provide beneficiaries and/or their representatives with information concerning the range of options that are available in Rhode Island to address a person's long-term care needs. The options discussed include the types of LTSS (institutional care ~~available,~~ and ~~the~~ home and community-based care), the range of available settings, ~~that is available~~ and how to access these services. The sources and methods of both public and private payment for ~~long-term care services~~ LTSS are also addressed. A person admitted to or seeking admission to a ~~long-term care~~ LTSS facility regardless of the payment source ~~shall be~~ must be informed by the facility of the availability of the long-term care options counseling program and ~~shall be provided with a long-term care options~~ provided with a consultation ~~if they so~~ upon request. Options counseling typically includes, but is not limited to, the following:

- An initial screening is conducted to determine how a person would be most appropriately served ~~is conducted~~. This screening is available to prospective and current residents of LTSS facilities and applicants/beneficiaries of Medicaid LTSS and other publicly funded LTSS

[3] See information on Eleanor Slater Hospital located at: http://www.bhddh.ri.gov/esh/description.php

[4] See Implementing rule located at: http://sos.ri.gov/documents/archives/regdocs/released/pdf/MHRH/MHRH_3088.pdf

programs, such as the DEA co-payment program. ~~This~~ The screening includes a determination of the need for crisis intervention, the available sources of funding for services, and the need for community services, Medicaid, or other publicly funded services.

- ~~A person who applies for Medicaid long-term care services shall be provided with a long-term care consultation~~. A consultation with an LTSS agency specialist for any applicant for Medicaid-funded LTSS that includes a discussion of service delivery options (managed care plan versus alternative), role of third-party payers (e.g., Medicare), and types of LTSS available based on level of need.

~~A person admitted to or seeking admission to a long-term care facility regardless of the payment source shall be informed by the facility of the availability of the long-term care options counseling program and shall be provided with a long-term care options consultation if they so request~~.

~~0399.08~~ E. COST NEUTRALITY FOR ~~HCB~~ HOME AND COMMUNITY- BASED SERVICES

~~REV:07/2009~~

As explained below, ~~The~~ the ~~DHS~~ EOHHS is responsible for setting ~~reviewing and approving~~ the aggregate cost neutrality of ~~the home and community based long-term care system~~ Medicaid home and community-based services on an annual basis. A core EOHHS function is to collaborate with agency partners through the A&C process to ensure that ~~To meet cost neutrality~~, the average per capita expenditures for home and community-based services ~~cannot~~ does not exceed one hundred percent (100%) of the average per capita expenditures ~~of the cost of institutional services if the individuals had been institutionalized~~ for the same set of Medicaid LTSS provided in an institutional setting – that is, NF, ICF/ID or long-term hospital. Accordingly, when comparing the cost of care in a HCBS versus institutional setting, the total average costs for all Medicaid LTSS core and preventive services must be considered, across providers, even if the beneficiary is residing in a specific HCBS setting (e.g., residing in a habilitation group home or assisted living and receiving limited skilled nursing or therapeutic day supports as separate services). The average monthly costs to Medicaid by institution are:

- Nursing Facilities ~~$ 5,531.00~~ $6,510.00
- ~~ICF-MR $18,758.34~~ ICF/ID $21,932.94
- Eleanor Slater Hospital $24,195.00

The ~~DHS~~ EOHHS uses these average monthly costs to Medicaid to identify and promote cost-effective community-based LTSS alternatives to institutional care ~~assist in determining whether home and community-based services are cost effective~~ as required under Title XIX of the Social Security Act.

~~0399.10~~ 1500.03 ~~OVERVIEW~~: NEEDS-BASED DETERMINATIONS OF NURSING FACILITY (NF) LEVEL OF CARE

~~REV:07/2009~~

A. OVERVIEW

~~The Global Waiver allows long-term care services to be provided~~ The State is authorized under the terms and conditions of the Section 1115 demonstration waiver to provide Medicaid LTSS in an institutional or home and community-based setting depending on the determination of the beneficiary's needs, individual plan of care, and the budget neutrality parameters established under ~~the Global Waiver~~ federal law and regulations. The purpose of this section is to set forth the process and criteria for evaluating the needs and service options of applicants/beneficiaries seeking a nursing facility level of care in either of these settings. Beneficiaries ~~with~~ determined to have ~~care~~ service needs in the NF category that meet the financial and clinical/functional eligibility criteria for a NF level of care also have an option for self-direction. As established in Section 1500.02(C)(1)(b), the responsibilities assessing the service option for the ICF/ID and hospital levels of care have been delegated to agencies across the EOHHS.

B. NF SERVICE OPTIONS CLASSIFICATIONS

The NF service classifications are designed to provide care options that reflect the scope and intensity of the beneficiary's needs ~~in this category are~~ and are as follows:

~~a)~~(1) **Highest need**. Beneficiaries with needs in this classification have access to all core services defined in Section ~~0399.04.02.01~~ 1500.04(A) as well as the choice of receiving services in an institutional/nursing facility, in their own home or the home of another, or one of the community-based settings identified below in Section 1500.05.

~~b)~~ (2) **High need.** Beneficiaries with needs in this classification have been determined to have needs that can safely and effectively be met at home or in the community with significant core services.

Accordingly, these beneficiaries have access to ~~an~~ the array of community-based core services required to meet their needs as specified in the person-centered individual plan of care.

~~c)~~ (3) **Preventive need.** Beneficiaries who do not yet need ~~LTC~~ Medicaid LTSS but are at risk for the NF level of care have access to services targeted at preventing admission, re-admissions or reducing lengths of stay in a skilled nursing facility. Core home and community- based services are not available to beneficiaries with this level of need. Medicaid beneficiaries~~, eligible under Section 0399.12.03,~~ who meet the preventive need criteria~~,~~ are not subject to the ~~LTC~~ Medicaid LTSS financial eligibility criteria established in MCAR, Sections 0380.40-0380.40.35 and 0392.15.20-0392.15.30.

~~**0399.10.01 Agency Respons for Determining Level of Care**~~

~~REV:07/2009~~

~~Beginning on July 1, 2009, beneficiaries determined to have a potential need for Medicaid-funded long-term services and supports in a nursing facility or in the community are referred to the Assessment and Coordination Organization (ACO) processes administered by the Department of Human Services (DHS). Those applying for state-only funded services and supports are referred to ACO processes administered by the Department of Elderly Affairs (DEA). The agency entities authorized to carry out these ACO processes are responsible for:~~

~~a) Coordinating related activities with the Medicaid financial eligibility staff; b) Conducting assessments that determine level of care needs; c) Developing service plans with the active involvement of beneficiaries and their families; d) Establishing funding levels associated with care plans developed for each beneficiary; e) Reviewing service plans on a periodic basis; and f) Working in collaboration with the beneficiary's care management plan or program (Connect Care Choice; PACE; Rhody Health Partners) to ensure services are coordinated in the most effective and efficient manner possible.~~

~~Financial eligibility for Medicaid-funded long-term care is conducted by the DHS field staff in accordance with Sections 0380.40-0380.40.35 and 0392.15.20-0392.15.30. Determinations of clinical level of care needs for nursing facilities are made by the DHS Office of Medical Review (OMR) nurses for both DHS and DEA beneficiaries.~~

~~**0399.11**~~ **B. NF CLINICAL ELIGIBILITY ASSESSMENT TOOL**

~~REV:07/2009~~

In determining clinical eligibility, the EOHHS Office of Medical Review (OMR) staff uses ~~an assessment instrument based on the~~ nationally recognized assessment instruments including, but not limited to, Minimum Data Set (MDS) ~~2.0~~ 3.0 Tool for NF care. To make the final determination of care needs, the results of this assessment are mapped against the needs-based and institutional level of care criteria. The ~~DHS shall make~~ EOHHS must make available to the public the procedural guidelines for use of the assessment as well as the instrument itself.

~~0399.12~~ C. APPLICATION OF NF NEEDS-BASED LEVEL OF CARE CRITERIA

~~REV:07/2009~~

Upon completing the assessment, the OMR staff determines whether a beneficiary's care needs qualify as highest, high or preventive based on a set of clinical and functional criteria that reflect both best practices across the states and the standards of prevailing care within the ~~LTC~~ LTSS community in Rhode Island. The functional disability criteria focus on the scope of a person's need for assistance with the Activities of Daily Living (ADLs) such as bathing, toileting, dressing, transferring, ambulation, eating, personal hygiene, medication management, and bed mobility. To determine the scope of need, OMR staff consider the extent to which the level of assistance a person requires falls into one of the following categories:

- **Total dependence (All Action by Caregiver):** Individual does not participate in any part of the activity.
- **Extensive Assistance (Talk, Touch, & Lift)**: Individual performs part of the activity, **but** caregiver provides physical assistance to lift, move, or shift individual.
- **Limited Assistance (Talk and Touch)**: Individual highly involved in the activity, **but** receives physical guided assistance and no lifting of any part of the individual.

The needs-based clinical criteria for a NF level of care deal with cognitive, behavioral and physical impairments and chronic conditions that require extensive personal care and/or skilled nursing assessment, monitoring and treatment on daily basis.

Clinical eligibility for beneficiaries who were receiving Medicaid LTSS in a NF setting prior to the January 1, 2016, are set forth in Section 1500.01(F)(2)(c) ~~based on these criteria is in the following Sections~~. The applicable criteria beginning on the date this rule takes effect are as follows:

~~**0399.12.01 Highest Need**~~

~~REV:07/2009~~

(1) **Highest Need.** Persons at this level of need have the choice of obtaining services in a NF or HCBS setting. ~~Beneficiaries shall be~~ Applicants/beneficiaries are deemed to have highest level of care need when they:

~~a)~~ (a) Require extensive assistance ~~or total dependence~~ with ~~at least one~~ three (3) of the following ~~Activities of Daily Living (ADLs) least one of the following Activities of Daily Living (ADL) - - toilet use, bed mobility, eating, or transferring~~ ADLs -- bathing, toileting, dressing, transferring, ambulation, eating, personal hygiene, medication management, and bed mobility; require total dependence with one (1) of these ADLs and limited assistance with two (2) additional ADLs; AND have one (1) or more unstable medical, behavioral, cognitive, psychiatric or chronic recurring conditions requiring nursing assistance, care and supervision on a daily basis; or

~~b)~~ (b) Lack awareness of needs or have moderate impairment with decision-making skills AND have one (1) of the following symptoms/conditions, which occurs frequently and is not easily altered: wandering, verbally aggressive behavior, ~~resists~~ resisting care, physically aggressive behavior, or behavioral symptoms requiring extensive supervision; or

~~c)~~ (c) Have at least one of the following conditions or treatments that require skilled nursing assessment, monitoring, and care on a daily basis: Stage 3 or 4 skin ulcers, ventilator, respirator, IV medications, naso-gastric tube feeding, end stage disease, parenteral feedings, 2nd or 3rd degree burns, suctioning, or gait evaluation and training; or

~~d)~~ (d)Have one or more unstable medical, behavioral or psychiatric conditions or chronic or reoccurring conditions requiring skilled nursing assessment, monitoring and care on a daily basis related but not limited to at least one of the following: dehydration, internal bleeding, aphasia, transfusions, vomiting, wound care, quadriplegia, aspirations, chemotherapy, oxygen, septicemia, pneumonia, cerebral palsy, dialysis, respiratory therapy, multiple sclerosis, open lesions, tracheotomy, radiation therapy, gastric tube feeding, behavioral or psychiatric conditions that prevent recovery.

~~*0399.12.01.01 Exceptions -- Highest Need*~~

~~REV:07/2009~~

(2) **Exceptions – Highest Need**. ~~Beneficiaries~~ Otherwise Medicaid LTSS eligible persons who do not meet the criteria ~~to establish highest need as indicated in the previous Section~~ established in subpart (1), paragraphs (a) to (d), may be deemed clinically eligible for ~~this~~ the NF level of care at the highest need ~~level of care~~ if the OMR determines that the beneficiary has a critical need for ~~long-term care services~~ Medicaid LTSS in an institutional setting due to special circumstances that, ~~if excluded from this level of care,~~ may adversely affect the ~~beneficiary's~~ health and safety. These special circumstances include but are not limited to:

~~1.~~ (a) Loss of primary caregiver (e.g. hospitalization of spouse, death of spouse);

~~2.~~ (b) Loss of living situation (e.g. fire, flood, foreclosure, sale of principal residence due to inability to maintain housing expenses);

~~3.~~ (c) The ~~individual's~~ health and welfare ~~shall be~~ of the applicant/beneficiary is 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.~~ (d) The beneficiary'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.)

~~5.~~ (e)The beneficiary met the criteria for a nursing facility level of care on or before June 30, 2009 and chose to receive Medicaid ~~LTC~~ LTSS at home or in a community setting ~~when,~~ and upon reassessment by the ~~department~~ EOHHS and, when appropriate, in consultation with the Rhode Island Long-term Care Ombudsman, the beneficiary is determined to have experienced a failed placement that, if continued, may pose risks to the beneficiary's health and safety; or

~~6.~~ (f) The beneficiary met the criteria for highest need ~~on or after~~ between July 1, 2009 and December 31, 2015 based on an assessment using the needs-based level of care and chose to receive Medicaid ~~LTC~~ LTSS at home or in the community setting when, and upon reassessment by the ~~department~~ EOHHS and, when appropriate, in consultation with the Rhode Island Long-term Care Ombudsman, the beneficiary is determined to have experienced a failed placement that, if continued, may pose risks to the beneficiary's health and safety.

~~0399.12.02 High Need~~

~~REV:07/2009~~

(3) **High Need.** Beneficiaries ~~shall be~~ are deemed to have ~~the~~ high ~~level of care~~ need for a NF level of care when they:

~~a)~~ (a) Require at least limited assistance on a daily basis with at least two of the following ADL's: bathing/personal hygiene, dressing, eating, toilet use, walking or transferring; or

~~b)~~ (b) Require skilled teaching or rehabilitation on a daily basis to regain functional ability in at least one of the following: gait training, speech, range of motion, bowel or bladder control; or

~~c)~~ (c) Have impaired decision-making skills requiring constant or frequent direction to perform at least one of the following: bathing, dressing, eating, toilet use, transferring or personal hygiene; or

~~d)~~ (d) Exhibit a need for a structured therapeutic environment, supportive interventions and/or medical management to maintain health and safety.

~~**0399.12.03 Preventive Need**~~

~~REV:09/2013~~

(4) **Preventive Need.** Beneficiaries who meet the needs-based criteria for the NF preventive ~~need criteria shall be~~ level of care are eligible for a limited range of home and community-based services and supports along with the full range of non-LTSS state plan and waiver health care benefits they are entitled to receive. ~~as recipients of Medicaid~~. Preventive care services optimize and promote beneficiary health, safety and independence through an array of care interventions that alleviate or minimize symptoms and functional limitations. Accordingly, the goal of preventive services is to delay or avert institutionalization or more extensive and intensive home and community-based care.

To qualify, the OMR must determine that one or more preventive services will improve or maintain the ability of a beneficiary to perform ~~ADL's~~ ADLs or Instrumental Activities of Daily Living ~~IADL's~~ (IADLs)[5] and/or delay or mitigate the need for intensive home and community-based or institutionally based care. Preventive services for beneficiaries ~~include~~ are described below in Section 1500.04(A).~~:~~

~~a) Homemaker Services- Services that consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the~~

[5] IADLs is an acronym that refers to skills required for independent living that include: using the telephone, traveling, shopping, preparing meals, doing housework, taking medications properly, and managing money.

~~home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.~~

~~b) Minor Environmental Modifications: Minor modifications to the home may include grab bars, versa frame (toilet safety frame), handheld shower and/or diverter valve, raised toilet seats and other simple devises or appliances such as eating utensils, transfer bath bench, shower chair, aids for personal care (e.g. reachers) and standing poles to improve home accessibility adaptation, health or safety.~~

~~c) Personal Care Assistance Services – Personal Care Services provide direct hands on support in the home or community to an individual in performing Activities of Daily Living (ADL) tasks that he/she is functionally unable to complete independently due to disability. Personal Care Services may be provided to an individual by:~~

~~1. A Certified Nursing Assistant who is employed under a State licensed home care/home health agency and meets such standards of education and training as are established by the State for the provision of these activities.~~

~~d) Physical Therapy Evaluation and Services - Physical therapy evaluation for home accessibility appliances or devices by an individual with a State approved licensing or certification. Preventive physical therapy services are available prior to surgery if evidence-based practice has demonstrated that the therapy will enhance recovery or reduce rehabilitation time.~~

~~e) Respite – Respite can be defined as a service provided to a participant unable to care for himself/herself that is furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Respite services will be recommended and approved by EOHHS, Office of Long Term Services and Supports.~~

~~0399.12.03.01 Limitations -- Preventive Need~~

~~REV:07/2009~~

(5) **Limitations – Prevent Need.** Access to and the scope of preventive services for qualified beneficiaries may be limited depending on the availability of funding. The ~~DHS~~ EOHHS may establish wait lists, in accordance with the provisions established in Section ~~0399.14~~ 1500.04(B), if such limitations become a necessity.

~~0399.13~~ D. REASSESSMENTS -- HIGH AND HIGHEST NEED

~~REV:07/2009~~

(1) **Change in Needs - High and Highest.** Beneficiaries determined to have high need at the time of a reassessment, or in the event of a change in health status~~, shall be determined~~ are deemed to have the highest need if they meet any of the clinical eligibility criteria established for that level of care in ~~section 0399.21.01~~ Section 1500.03(C)(1) .

~~**0399.13.01 Re-Eval of Beneficiaries with Highest Need**~~

~~REV:07/2009~~

(2) **Re-evaluation Highest Needs.** At the time ~~the OMR makes~~ a determination of highest need is made for a beneficiary who ~~resides in or is admitted to a nursing facility~~ opts to reside in a nursing facility, OMR evaluates ~~information indicating~~ whether there is a possibility that the beneficiary's ~~functional or health care~~ condition may improve ~~,~~ within the succeeding two month period. ~~is identified~~. ~~The~~ Based on this information, OMR notifies the beneficiary, his/her authorized representative and the nursing facility that NF ~~level of~~ care has been authorized and that the beneficiary's functional and medical status will be ~~reviewed~~ re-evaluated in thirty (30) to sixty (60) days.

At the time of ~~the review~~ re-evaluation, the OMR confirms that the beneficiary is still a resident of the nursing facility. ~~.Once this determination is made, the OMR~~ reviews the most recent Minimum Data Set, and requests any additional information necessary to make one of the following determinations:

~~a)~~ (a) Change Required -- The beneficiary no longer meets the criteria for highest level of need. In this instance, the OMR assesses whether the beneficiary has needs that meet the high or preventive needs-based criteria. Once the assessment is completed, the beneficiary~~,~~ and/or ~~his/her~~ authorized representative~~,~~ and the nursing facility are sent a ~~discontinuance~~ notice by the ~~Long Term Care Unit~~ EOHHS indicating that the beneficiary's needs no longer meet the criteria for highest NF level of care and, as a result, the current services classification and options may be discontinued or changed. ~~Prior to being sent a discontinuance notice, the beneficiary will be evaluated to determine whether or not the criteria for high need have been met.~~ Payment for care provided to a beneficiary determined to no longer have the highest need ~~shall continue until the DHS~~ is continued until all necessary agency procedures ~~has~~ are completed to successfully ~~the~~ transition to a more appropriate setting.

~~b)~~ (b) No Change. The beneficiary continues to meet the ~~appropriate level of care~~ applicable needs-based criteria, and no action is required.

(3) **Annual Reassessment and Renewal.** ~~Beneficiaries residing in the community~~ All Medicaid LTSS beneficiaries who are in the highest and high ~~groups will~~ service classifications have, at a minimum, an annual assessment.

1500.04 HCBS CORE AND PREVENTIVE SERVICES

The State's Section 1115 demonstration waiver and the Medicaid state plan identify and define the various core and preventive services available to beneficiaries living in home and community-based settings. The scope, amount and duration of these services a beneficiary is authorized to receive depends initially on the determination of needs conducted in the OMR comprehensive assessment process and the person-centered care planning process (PCP) that is developed thereafter in conjunction with the beneficiary, provider and family members or authorized representatives. Note: the RI Reinventing Medicaid Act of 2015 authorized the EOHHS to seek federal approval to expand the range of services to include: home stabilization, community health teams, peer specialists, and acuity-based adult day and assisted living services.

A. DEFINITIONS OF CORE AND PREVENTIVE HCBS

The listing below defines the available HCBS and identifies those that will become accessible effective January 1, 2016.

(1) **Core HCBS**. LTSS available based on need to any Medicaid eligible beneficiary:

(a) Adult Day Services -- a daytime community-based program for adults that provides a variety of social, recreational, health, nutrition, and related support services in a protective setting. May include a range of more intensive or specialized services such as medication administration, limited skilled nursing, and/or personal care for beneficiaries with higher level acuity needs.

(b) Adult Supportive Care Homes-- provides "directly or indirectly, by means of contracts or arrangements" personal assistance, lodging and meals to between two (2) and five (5) adults. Providers must be licensed as nursing facility, nursing care provider, assisted living residence or adult day services provider as well as an "adult supportive care home."

(c) Assisted living -- personal care and attendant services, homemaker, chore, companion services, meal preparation, medication oversight (i.e., cuing), and social and recreational programming in a home-like environment in the community. May also include a broader range of Medicaid LTSS for beneficiaries with higher acuity needs including, but not limited to, medication administration and management, dementia care, limited skilled nursing, intensive behavioral health service coordination, therapeutic day services, cognitive and behavioral health therapies and extended personal care and attendant services.

(d) Behavioral Services --- behavioral therapies designed to assist beneficiaries with chronic illnesses and conditions in managing their behavior and thinking functions, and to enhance their capacity for independent living.

(e) Case Management – assists beneficiaries in gaining access to necessary Medicaid services as well as non-Medicaid medical, social, educational and other services and supports without regard to payer. Case managers monitor access and utilization in accordance with the beneficiary's PCP process and initiate reassessments of level of need and review of services in conjunction with annual eligibility renewal.

(f) Community Health Teams – provide service coordination, care planning and oversight, and case management services (as defined in subparagraph (e) above) to Medicaid LTSS beneficiaries who are not enrolled in a managed long-term care plan.

(g) Day Supports (also includes day "habilitation") – provides assistance with acquisition, retention or improvement in self-help as well as socialization and adaptive skills. Day habilitation involves regularly scheduled provision in a non-residential setting, apart from the beneficiary's home or other residential living arrangement. As the beneficiary's plan dictates, physical, occupational and/speech therapy may also be provided. All services and supports are directed at enabling a Medicaid LTSS beneficiary to achieve and maintain maximum functional level in accordance with the POC.

(h) Environmental Modifications (also known as Home Accessibility Adaptations) -- physical modifications to a beneficiary's home or the home of a family member in which the beneficiary resides. The modifications must be identified in beneficiary's PCP process as necessary to support health, welfare, and safety and enable the beneficiary to function with greater independence at home. For services to be authorized, there must be evidence that without the modification(s) a beneficiary would require some type of institutionalized living arrangement, such a nursing facility or hospital. Adaptations that do not help the beneficiary's safety or independence are not included as part of this service, such as new carpeting, roof repair, central air, or home additions.

(i) Informal Supports – includes supports provided by family and friends as well other community resources that assist the beneficiary in achieving the goals identified in the person-centered plan of care.

(j) Home Stabilization (Available effective January 1, 2016) – provides services and supports for beneficiaries who are homeless or at risk of homelessness or transitioning to the community from an institutional settings. Range of LTSS includes intensive case management and community-

based care coordination as well as both more traditional home stabilization interventions (e.g., locating a home, managing a household, entitlement support and financial counseling, independent living skill training, safety training, homemaking, etc.) and critical health service supports (e.g., disease and medication management, peer mentoring, family therapy, substance abuse counseling, recovery readiness and relapse prevention, self-care, etc.).

(k) Home Delivered Meals -- prepared food brought to the beneficiary's home that may consist of a heated lunch meal and a dinner meal (or both), which can be refrigerated and eaten later. May also include shelf staples. This service is designed for the beneficiary who cannot self-prepare meals but is able to eat on his or her own. Meals must provide a minimum of one-third (1/3) of the current recommended dietary allowance. Other forms of assistance for meal preparation is limited for beneficiaries receiving this service.

(l) Home Health Aide -- a person who works under the supervision of a medical professional to assist the beneficiary with basic health services such as assistance with medication, nursing care, physical, occupational, and speech therapy. A home health aide is often a Certified Nursing Assistant (CNA) who provides both skilled personal care and homemaker services at a combined rate of payment.

(m) Homemaker -- in-home caregiver hired through an agency that consists of general household tasks. The caregiver helps with housekeeping items such as meal preparation, shopping, light housekeeping, and laundry. Homemaker services are typically authorized for a temporary period during which a beneficiary's caregiver is absent from the home for a limited period of time.

(n) Intermittent Skilled Nursing -- focuses on long-term needs rather than short-term acute healing needs, such as weekly insulin syringes or medi-set set up for beneficiaries unable to perform these tasks on their own. These services are provided when a need is established in a beneficiary's PCP by a licensed nursing professional under the supervision of an EOHHS Registered Nurse.

(o) LPN Services – provides time-limited skilled nursing services to a beneficiary by a Licensed Practical Nurses (LPN), practicing under the supervision of a Registered Nurse. Services typically exceed the scope of practice of a Certified Nursing Assistant (CNA) and are provided to a beneficiary in their home for short-term acute healing needs, with the goal of restoring and maintaining a beneficiary's maximal level of function and health. These services are for beneficiaries who have achieved some degree of stability despite the need for continuing chronic care nursing interventions that might otherwise require a hospitalization or a nursing facility stay. Service must be authorized by an EOHHS Registered Nurse.

(p) Minor Environmental Modifications -- provides minor changes to the home including grab bars, versa frame (toilet safety frame), handheld shower and/or diverter valve, raised toilet seats and other simple devises or appliances such as eating utensils, transfer bath bench, shower chair, aids for personal care (e.g., reachers) and standing poles to improve home accessibility adaptation, health or safety.

(q) PACE - Program for All-Inclusive Care for the Elderly -- includes LTSS and other health services for beneficiaries fifty-five (55) years or older who meet the criteria for high or highest level of need. PACE is responsible for providing all Medicare and Medicaid services.

(r) Participant Directed Goods and Services --includes services, equipment or supplies not otherwise provided under the Section 1115 waiver or state plan that address an identified need specified in a beneficiary's POC such as improving and maintaining full membership in the community. Access is contingent upon meeting the following requirements:

- Item or service would decrease the need for other Medicaid services; and/or promote inclusion in the community; or
- Item or service would increase the beneficiary's ability to perform ADLs or IADLs or increase the person's safety in the home environment; and
- Alternative funding sources are not available.

Individual goods and services are purchased from the beneficiary's self-directed budget through the fiscal intermediary when approved as part of the individual service plan (ISP). Examples include a laundry service for a person unable to launder and fold clothes or a microwave for a person unable to use a stove due to his/her disability. Does not include any good/service that would be restrictive to the individual or strictly experimental in nature.

(s) Personal Care – provides direct hands-on support to help with the day-to-day activities such as toileting, bathing, meal preparation and medication management which enable beneficiaries to be more independent in their own homes. Personal care services may be provided by a CNA who is employed by a State-licensed home care/home health agency and meets such standards of education and training as are established by the State or Personal Care Attendant (PCA) via employer authority under the self-directed care option. Does not include homemaker services, such as light housekeeping.

(t) Peer Supports (Available effective January 1, 2016) -- services provided by trained "peer specialists", working as part of a multi-disciplinary treatment team, who serve as mentors,

motivators, and role models for beneficiaries. Emphasis is on long-term recovery, wellness, self-advocacy, socialization and community connectedness.

(u) Personal Emergency Response System -- electronic equipment that allows beneficiaries 24-hour access to help in an emergency. The equipment is connected to your phone line and calls the response center and/or other forms of help once the help button is pressed.

(v) Physical Therapy Evaluation and Services - evaluation for home accessibility appliances or devices by an individual with a State-approved licensing or certification. Preventive physical therapy services are available prior to surgery if evidence-based practice has demonstrated that the therapy will enhance recovery or reduce rehabilitation time.

(w) Prevocational Services - for beneficiaries with intellectual disabilities or brain injuries, provides work experiences and training designed to assist individuals in developing skills needed for employment in the general workforce. Services include teaching concepts such as compliance, attendance, task completion, problem-solving, and safety.

(x) Private Duty Nursing – individual continuous care, rather than part-time or intermittent skilled nursing, provided by licensed nurses. Service must be authorized by an EOHHS Registered Nurse and is typically only available to beneficiaries requiring habilitative services.

(y) Rehabilitation Services -- designed to improve and or restore a person's functioning; includes physical therapy, occupational therapy, and/or speech therapy.

(z) Residential Supports (also known as habilitation services) – individually tailored supports that provide assistance with the acquisition, retention or improvement of skills related to the activities of daily living such as personal grooming, household chores, meal preparation and so forth. More intensive supports include adaptive skill development, community inclusion, transportation, adult educational supports and socialization. Personal care and protective oversight are included. Medicaid does not cover room and board, however. Goal of service is to provide the skills necessary for a beneficiary to reside in the most integrated setting appropriate to his or her need level in a HCBS, rather than an institutional setting.

(aa) Respite - provides relief for unpaid family or primary caregivers who are meeting all the needs of the beneficiary. The respite caregiver assists the beneficiary with all daily needs when the family or primary caregiver is absent. Respite can be provided by a homemaker, personal assistant, nurse, or in an adult day center.

(bb) Self-directed Care (also known as “Personal Choice”) --In-home caregiver hired and managed by the beneficiary. The beneficiary must be able to manage different parts of being an employer such

as hiring the caregiver, managing their time and timesheets, completing other employee paperwork. The caregiver helps with housekeeping items such as meal preparation, shopping, light housekeeping, and laundry. The caregiver can also help with hands-on personal care items such as personal hygiene, bathing, grooming, and feeding. Personal care assistants can include other independent direct care givers such as RNs, LPNs, and Home Health Aides.

(cc) Senior Companion (also known as "adult companion services") -- non-medical care, supervision, and socialization provide to a functionally impaired adult. Companions may assist or supervise the beneficiary with such tasks as meal preparation, household management, and shopping.

(dd) Special Medical Equipment (Minor Assistive Devices): Specialized Medical Equipment and supplies to include: devices, controls, or appliances, specified in the plan of care, which enable beneficiaries to increase their ability to perform activities of daily living; devices, controls, or appliances that enable the beneficiary to perceive, control, or communicate with the environment in which they live; and other durable and non-durable medical equipment not available under the State plan that is necessary to address a beneficiary's functional limitations. Items available under the Section 1115 waiver are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the beneficiary. All items shall meet applicable standards of manufacture, design and installation. Provision of Specialized Medical Equipment requires prior approved on an individual basis by the EOHHS.

(ee) Supports for Consumer Direction (also known as "facilitation") – focuses on empowering beneficiaries to define and direct their own personal assistance needs and services by providing guidance and support to facilitate successful personalized service planning and delivery. Service is designed to enable a beneficiary to identify and gain access to the full array of services, including non-Medicaid HCBS, necessary to optimize health and retain independence while living at home.

(ff) Supported Employment-- includes activities needed to maintain paid work by individuals receiving HCBS, including supervision, transportation, and training. Covers only the adaptations, supervision and training provided at a work-site for beneficiaries who are receiving the service as a result of the clinical/functional disability which is the basis for their Medicaid LTSS eligibility.

(gg) Supported Living Arrangements (also known as shared-living) – includes a bundle of core services ~~Personal care and services~~, (e.g., personal care, homemaker, chore, attendant care, companion services and medication oversight ~~(to the extent permitted under State law~~) provided in a private home by a principal care provider who lives in the home. ~~Supported Living Arrangements~~ The

supported living arrangements are furnished to adults who receive these services in conjunction with residing in the home. Separate payment ~~will~~ is not ~~be~~ made for homemaker or chore services furnished to an individual receiving Supported Living Arrangements, since these services are integral to and inherent in the provision of adult foster care-like services.

(hh) Transition Services – non-recurring payment of expenses for beneficiaries who are transitioning from an institutional or restrictive congregate service setting to a living arrangement in a private residence or a residence operated by a licensed provider. ~~non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses~~. Allowable expenses ~~are those necessary to~~ must enable a ~~person~~ beneficiary to establish a basic household, ~~that do not constitute~~ excluding room and board, and may include: security deposits ~~that are required~~ to obtain a lease on an apartment or home, essential household furnishings, and moving expenses, set-up fees or deposits for utility or service access, services necessary for the individual's health and safety not otherwise covered (e.g.,fumigation) and activities to assess need, arrange for and procure needed resources. ~~Community Transition Services~~ Such services are furnished only to the extent that they are reasonable and necessary as determined and identified clearly through the ~~service plan development~~ PCP development process~~, clearly identified in the service plan and the person~~ and only when the beneficiary is otherwise unable to ~~meet such expense or when the services cannot be obtained from other sources~~ to pay for or obtain the services from other sources. ~~They do not include~~ Excludes ongoing shelter expenses; food, regular utility charges, household appliances or items intended for recreational purposes~~.~~

(2) Preventive ~~Services~~ HCBS - Persons who are eligible for ~~Community Medical Assistance~~ non-LTSS Medicaid under MCAR section 0374 and who have been determined to meet a preventive level of care, have access to the following services as defined above: homemaker services, minor environmental modifications, personal care assistance services, physical therapy evaluation and services, and respite.

~~0399.14~~ B. LIMITATIONS ON THE AVAILABILITY OF ~~SERVICES~~ MEDICAID HCBS

~~REV:07/2009~~

Should the demand for home and community-based ~~long-term care services~~ Medicaid LTSS exceed supply or appropriations, access to core and/or preventive services may be limited for certain beneficiaries.

(1) Highest Need – NF and Hospital. Beneficiaries with the highest need ~~shall~~ have the option of seeking admission to a nursing facility while awaiting access to the full scope of home and community-based services. ~~Specifically, beneficiaries and applicants~~ Accordingly, applicants/beneficiaries deemed to be in the highest category for a nursing facility level of care or meet the requirement for a hospital level of care are *entitled* to services and ~~shall not be~~ must not be placed on a waiting list for ~~institutional services~~ Medicaid LTSS in an institutional setting. If a community placement is not initially available, beneficiaries with the highest need may be placed on a wait list for transition to the community while receiving services in a licensed health facility that provides the type of institutionally based LTSS that meets their needs. Different limitations apply for beneficiaries requiring an ICF/ID level of care as is determined by BHDDH under applicable federal and state laws and regulations.

(a) Priority Status -- In the event that a waiting list for any home and community- based service becomes necessary for any reason, the ~~DHS~~ EOHHS must provide services for beneficiaries determined to be NF or hospital highest need before providing services to beneficiaries that have a high need or preventive need. Beneficiaries with high need are given priority access to services over beneficiaries qualifying for preventive services.

(b) Continuation of Services -- ~~Additionally, beneficiaries receiving services~~ Services for beneficiaries with the highest need must continue ~~to have access to and receive~~ in the appropriate setting ~~such services~~ unless or until their condition improves ~~and~~ to such an extent that they no longer meet the same clinical/functional eligibility criteria.

(2) High Need – Beneficiaries with a high level of need may be subject to waiting lists for certain HCBS. However, for the NF level of care, beneficiaries with a high need are afforded priority status for any such services over beneficiaries who have a preventive level of need.

(3) Preventive Need – NF Only. Services for beneficiaries determine to have a need for a preventive level of care are subject to appropriations. Therefore, wait lists and/or limitations on the availability and the scope, amount and duration of preventive services are permissible, at the discretion of the EOHHS, to the full extent available resources dictate.

~~0399.15~~ 1500.05 LIMITATIONS ON ~~ENVIRONMENTAL MODIFICATIONS, MINOR ENVIROMENTAL MODIFICATIONS AND SPECIAL MEDICAL EQUIPMENT~~ THE SCOPE OF MEDICAID HCBS

~~REV:09/2013~~

The terms and conditions of the State's Section 1115 demonstration waiver authorize the EOHHS to set limits on the scope, amount and duration of certain Medicaid HCBS available to a beneficiary, based on needs and service classification – highest, high and preventive. The EOHHS has established such limits to ensure the cost neutrality provisions established under Title XIX, described in Section 1500.03(E) of this rule, are met.

A. ENVIRONMENTAL MODIFICATIONS, MINOR ENVIROMENTAL MODIFICATIONS AND SPECIAL MEDICAL EQUIPMENT. ~~Members who meet the Highest and High Level of Care (LOC) for core Home and Community Based services~~ Beneficiaries who have the highest and high needs for a NF level of care and have a functional necessity for environmental modifications, minor environmental changes, and special medical equipment are subject to limitations and special considerations~~, therein.~~ set forth below:

~~0399.15.01 Environmental Modifications~~

~~REV:09/2013~~

(1) Environmental Modifications. As defined in Section 1500.04(A) above, environmental modifications ~~are defined as those~~ physical adaptations to the home ~~of the member or the member's family~~ where a beneficiary resides that are ~~as~~ required by ~~the member's service plan,~~ in the POC ~~that are necessary~~ to ensure ~~the~~ his or her health, welfare and safety ~~of the member or that~~ and/or enable the ~~member~~ beneficiary ~~to attain or retain capability for independence or self care in the home and to avoid institutionalization, and are not covered or available under any other funding source~~ attain or retain independence and provide self-care. ~~A completed home assessment by a specially trained and certified rehabilitation professional is also~~ Acceptable adaptations may include the installation of modular ramps, grab-bars, vertical platform lifts and interior stair lifts.

~~Excluded are those adaptations that are of general utility, are not of direct medical or remedial benefit to the member. Excluded are any re-modeling, construction, or structural changes to the home, i.e. (changes in load bearing walls or structures) that would require a structural engineer, architect and /or certification by a building inspector. Adaptations that add to the total square footage of the home are excluded from this benefit.~~

~~All adaptations shall be provided in accordance with applicable State or local building codes and prior approval on an individual basis by EOHHS, Office of Long Term Services and Supports is required. Items should be of a nature that they are transferable if a member moves from his/her place of residence~~. The scope of the home modification(s) services available to Medicaid LTSS beneficiaries is as follows:

(a) All items require prior authorization and do not require a physician's order.

(b) All items must be recommended by an appropriately trained and certified rehabilitation professional.

(c) The ~~Home Modification~~ home modification must be documented as the most cost- effective to meet the ~~member's~~ beneficiary's needs for accessibility within the home.

(d) Items must be necessary to ensure the health, welfare and safety of the ~~individual~~ beneficiary, or to enable the ~~individual~~ beneficiary to attain or retain capability for independence or self-care in the home, and to avoid ~~institutionalization~~ a transition to a more restrictive institutional-setting.

(e) Home ~~Modifications shall~~ modifications must be made only to the ~~member's~~ beneficiary's primary residence~~,~~. A primary residence may be a free-standing house, condominium, or a rental unit owned or leased by the beneficiary, a family member or friend as long as it serves as the beneficiary's permanent living arrangement. Modifications to primary residence that is leased ~~.including rented apartments or houses~~ ~~(~~ may require the ~~with~~ written permission of the owner/landlord/lease-holder, when applicable~~)~~.

(f) Exterior access modifications are limited to one ingress/egress route into and out of the home.

(g) Repair, removal, construction or replacement of decks, patios, sidewalks and fences are not covered modifications.

(h) ~~Home Modifications~~ Home modifications under this section do not include ~~those~~ adaptations or improvements to the home that are considered to be standard housing obligations of the owner or tenant such as bringing the living area up to fire or electrical code.

(i) Other home modifications that are not covered include --

- Relocation of plumbing and/or bathroom fixtures ~~is not covered.~~

~~Repairs or modifications to equipment purchased under this definition are an allowable expense~~.

- ~~Examples of items not covered include~~ Repairs, addition, or purchase of driveways, decks, patios, hot tubs, central heating and air conditioning, raised garage doors, standard

home fixtures (~~i.e.,~~ e.g., sinks, tub, stove, refrigerator, etc.), raised counter tops, roll-in-showers or tub cuts.

- ~~Excluded are any re-modeling,~~ Any remodeling, construction, or structural changes to the home~~, i.e.~~ (e.g., changes in load bearing walls or structures) that would require a structural engineer, architect and /or certification by a building inspector.

(j) Requirements for ~~M~~modifications to rental property include~~:~~ --

- ~~Prior to any modification a~~ A determination ~~should~~ must be made as to ~~what, if anything, is the legal responsibility of~~ whether, and to what extent, the property owner, lessee or landlord has legal responsibility to make the modification or approve a modification authorized under this section.
- Written approval must be obtained from the property owner or landlord prior to the ~~service being approved~~ modification before approved by EOHHS and scheduled for delivery.

(k) Ramps may be covered modifications only if:

- ~~They meet ADA compliance~~ All American with Disabilities Act (ADA) compliance standards are met, and
- ~~Meet all~~ All applicable State and local building code requirements and permits ~~as~~ required are obtained with the necessary approvals; and
- ~~Ramp should be~~ The ramp is structured and built of materials that make it ~~of a nature that it is~~ readily transferable to another dwelling.

(l) Vertical platform lifts may be covered only if:

- There is not adequate acreage available to install a ramp that meets ~~state~~ State and local building codes; and/or
- The physical topography of the site precludes the installation of a ramp.

(m) Interior Stairway Lifts (stair glides) may be approved only if the first floor of the home does not have any toilet facilities.

(n) Repairs or modifications to equipment purchased under this definition are an allowable expense

~~B. Special Considerations:~~

(o) An Assessment for home modifications is required to determine the most appropriate and cost-effective ~~service requested~~ approach to address the beneficiary's service need. This assessment

must be completed by a specially trained and certified rehabilitation professional. Individuals ~~conducting~~ EOHHS has deemed qualified to conduct such assessments ~~may~~ include but are not limited to:

- Licensed Physical, and Occupational Therapists experienced in ~~Home and Community Based services~~ HCBS for persons with an LTSS level of need; and
- Assistive Technology Professionals (ATP), certified by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA). ~~-~~ An assistive technology ~~professional~~ is a service provider who analyzes the needs of individuals with disabilities, assists in the selection of the appropriate equipment, and trains the consumer on how to properly use the specific equipment. ~~)~~

~~C. Limitation on Service(s)~~

(p) ~~This~~ Home modification service is only available to Medicaid ~~members~~ who meet the clinical/functional criteria for and are authorized to receive other ~~on Core~~ core HCBS.

~~* This service is billable under HCPCS Code S5165.~~

~~0399.15.02 Special Medical Equipment~~

~~REV:09/2013~~

(2)Special Medical Equipment and ~~supplies to~~ Supplies. Supplies available in this area include ceiling or wall mounted patient lifts, track systems, tub slider systems, rolling shower chairs and/or automatic door openers and similar services, which ~~enable~~ ~~members~~ enhance or enable beneficiaries to increase their ability to perform activities of daily living~~,~~ ~~including such other~~ Such durable and non-durable medical equipment, which is designed specifically to address the functional limitations of beneficiaries, are authorized by the State's Section 1115 waiver and are not available as Medicaid state plan services under the Medicaid-funded primary and acute care system ~~that is necessary to address member functional limitations~~. Items ~~reimbursed with waiver funds~~ authorized for LTSS beneficiaries under the waiver are in addition to any other medical equipment and supplies ~~furnished under the Medicaid-funded primary and acute care system~~ provided to a beneficiary through Medicaid for their acute/subacute/primary care needs. ~~and exclude those items that are not of direct medical or remedial benefit to the member.~~ Medical equipment ~~funded under the primary and acute care system~~ includes ~~items~~ such as wheelchairs, prosthetics, and orthotics which are provided through a beneficiary's acute care coverage (e.g., Medicare, private insurance or Rhody Health Partners) are excluded. ~~These are services that were provided under the authority of the Rhode Island Medicaid State Plan prior to the~~

~~1115 Waiver approval. These items are still available under the 1115 Waiver and are described~~ at: ~~http://www.dhs.ri.gov/ForProvidersVendors/ServicesforProviders/Provider Manuals/DME/tabid/459/Default.aspx~~ The scope of special medical equipment and supplies available to Medicaid LTSS beneficiaries under this section is as follows:

(a) All items ~~shall~~ must ~~meet~~ comply with the applicable industry and/or government standards ~~of~~ pertaining to the manufacture, design and installation of the equipment or supplies requested.

(b) ~~Provision of Special Medical Equipment requires~~ All requests for special equipment and supplies must receive prior approval and authorization by the appropriate agency LTSS specialist before purchase and installation. ~~Prior approval on an individual basis by EOHHS, Office of Long Term Services and Supports and~~ Approval is based on a review of the beneficiary's needs as established in the PCP process and a home assessment completed by a specially trained and certified rehabilitation professional.

(c) Items ~~should be of a nature that they are~~ must be transferable if a ~~member~~ beneficiary ~~moves from his/her~~ changes place of residence.

(d) Remodeling construction, or structural changes to the home – Any changes~~, (i.e. changes in load bearing walls or structures)~~ that would require a structural engineer, architect and /or certification by a building inspector (i.e., changes in load bearing walls or structures) are excluded and, as such, are NOT covered.

(e) Limitations include –

~~A. Limitations:~~

- Ceiling or wall mounted patient lifts and track systems ~~o~~ – Approval contingent upon ~~Must be documented~~ ~~as~~ documentation indicating that the equipment is the most cost-effective method to meet the ~~member's~~ beneficiary's needs. A patient lift will be considered for use in one bedroom and/or one bathroom. A track system is limited to connecting one bedroom and one bathroom.

- Rolling shower chair -- ~~/ -- o~~ Item must have a functional expectancy of a minimum of five (5) years and ~~Must~~ be documented as the most cost-effective method to meet the ~~member's~~ beneficiary's needs in order to be approved.

- Electrical Adaptation -- Automatic Door Openers, adapted switches and buttons to operate equipment, and environmental controls, such as heat, air conditioning and lights may be approved for a member who lives alone or is without a caregiver for a major portion of the day.
- ~~All items require Prior Authorization by EOHHS, Office of Long Term Services and Supports and do not require a physician's order~~.

(f) ~~Items~~ Exceptions to the limitations set forth in (e) above may be acquired subject to Prior Authorization from EOHHS~~, Office of Long Term Services and Supports~~. Determinations will be based on the individual's unique circumstances as they apply to the current service definitions, policies and regulations. ~~Please refer to RI Global Consumer Choice Compact 1115 Waiver Demonstration Attachment B, Core and Preventive Home and Community Based Service definitions.~~

(g) Repairs or modifications to equipment purchased under this ~~definition~~ section are ~~an allowable expense~~ covered Medicaid expenses.

~~B. Special Considerations~~:

(h) An ~~A~~assessment for special medical equipment and supplies is required to determine the most appropriate and cost-effective ~~service requested~~ approach to address the beneficiary's service need. This assessment must be completed by a specially trained and certified rehabilitation professional. Individuals ~~conducting~~ EOHHS has deemed qualified to conduct such assessments ~~may~~ include but are not limited to:

- Licensed Physical, and Occupational Therapists experienced in ~~Home and Community Based services~~ HCBS for persons with an LTSS level of need; and
- Assistive Technology Professionals (ATP), certified by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA). ~~-~~ An assistive technology ~~professional~~ is a service provider who analyzes the needs of individuals with disabilities, assists in the selection of the appropriate equipment, and trains the consumer on how to properly use the specific equipment.

(i) Special medical equipment and supplies under this section are only available to Medicaid beneficiaries who meet the clinical/functional criteria for and are authorized to receive other core HCBS.

C. ~~Limitation on Service(s):~~

~~This is only available to Medicaid members on Core HCBS.~~

~~• This service is billable under HCPCS Code T2029.~~

~~0399.15.03 Minor Environmental Modifications~~

~~REV:09/2013~~

(3) Minor Environmental Modifications. Minor Environmental modifications may include grab bars, versa frame (toilet safety frame), handheld shower and/or diverter valve, raised toilet seats, and other simple devices or appliances such as eating utensils, transfer bath bench, shower chair, aids for personal care (e.g. reachers) and standing poles to improve home accessibility adaptation, health or safety. The scope of minor environmental modifications available to Medicaid LTSS beneficiaries under this section is as follows:

~~A. Limitations:~~

(a) All items require prior authorization by ~~EOHHS, Office of Long Term Services and Supports~~ an agency LTSS specialist; however, items on the EOHHS Approved List do not require a physician's order.

(b) All items must be recommended by an appropriately trained and certified health care professional or ~~DHS~~ LTSS social worker.

(c) Items must be necessary to ensure the health, welfare and safety of the ~~individual~~ beneficiary, or to enable the ~~individual~~ beneficiary to attain or retain capability for independence or self-care in the home, and to avoid ~~institutionalization~~ a transition to a more restrictive institutional-setting.

(d) Items for diversional or entertainment purposes are not covered.

(e) Items ~~should be of a nature that they are~~ must be transferable if a ~~member~~ beneficiary ~~moves from his/her~~ changes place of residence.

(f) Items cannot duplicate equipment provided under the Medicaid -funded primary and acute care system or through other sources of funding (i.~~e~~. e.g., Medicare, private insurance).

(g) Items not included on the EOHHS Approved List and priced greater than $500.00 ~~shall be~~ are considered special medical equipment and will be subject to the policies and procedures for that service ~~as described in the Core Services section of the Rhode Island 1115 Waiver.~~

- ~~This service is billable under HCPCS Code T2028, for Core HCBS and/or preventive services.~~

~~**0399.20 OVERVIEW: LTC RESIDENTIAL SERVICE OPTIONS**~~

~~REV:07/2009~~

1500.05 LTSS RESIDENTIAL SERVICE OPTIONS –NF LEVEL OF CARE

A. OVERVIEW

There are several community-based service options in residential settings, other than the home and nursing facilities, which may be available to beneficiaries who are determined ~~under Sections 0399.12.01 and 0399.12.02~~ to have the high or highest need for the ~~highest or high~~ NF level of care pursuant to Section ??????. Beneficiaries will be notified of whether they qualify for one of these residential options in conjunction with the comprehensive assessment ~~specified in Sections 0399.05.01.02 and 0399.11~~ and the development of the individualized plan of care. ~~Although~~ Medicaid coverage for room and board is typically not included for these options, though there are exceptions as is explained in the description of services provided below.

~~**0399.20.01 Assisted Living**~~

~~REV:07/2009~~

(1) Assisted Living Residential Service Options. Assisted living ~~services, are~~ is available to qualified ~~long-term care (LTC)~~ Medicaid LTSS beneficiaries who have ~~been determined to have a~~ the highest or a high ~~level of care~~ need for a nursing facility level of care and are determined, subsequent to the OMR comprehensive assessment, to be able to obtain the services they need ~~that can be~~ safely and effectively ~~met~~ in a ~~state~~ State licensed and Medicaid certified assisted living residence (ALR). The scope of HCBS that an ALR may be authorized to provide to a Medicaid LTSS beneficiary is determined by the residence's level of State licensure, compliance with varying Medicaid certification standards, and participation in the Community Supportive Living Program (CSLP). Upon the effective date of this rule, the EOHHS will make available two (2) assisted living residential service options.

(a) ALR Standard Option -- In this "Standard" option, the EOHHS or its designee, currently the Division of Elderly Affairs of the Department of Human Services (DHS), certifies ALRs based on two aspects of licensure status -- emergency egress and medication management –

and the capacity to provide a discrete set of HCBS (personal care and attendant services, homemaker, chore, companion services, meal preparation, medication oversight (i.e., cuing), and social and recreational programming) at a set per diem rate. Any additional services a beneficiary is authorized to receive under his or her personal-centered plan of care (e.g., physical therapy or limited skilled nursing), must be obtained from other Medicaid providers regardless of the ALR's level of licensure and capacity. Beneficiary assessments may be conducted by the Division of Elderly Affairs of LTSS specialists.

(b) Community Support Living Program (CSLP) Option – The CSLP Option was established in R.I.G.L. §40-8-13.2, as part of the Reinventing Medicaid Act of 2015, as a pilot to promote HCBS alternatives for beneficiaries with high acuity needs who are enrolled in LTSS managed care plans through the State's Integrated Care Initiative (ICI). The EOHHS administers the program through the ICI and has established multi-tiered Medicaid certification standards that correspond to State licensure levels that authorize ALR and adult and supportive care residences (ASCRs) to provide, based on a beneficiary's acuity needs, a range of enhanced and/or specialized services. Licensed residences that become certified and choose to participate in the CSLP must enter into contractual arrangements with the ICI managed care plans that tie payments to the scope of Medicaid LTSS they are certified to provide and a beneficiary's needs. All CLSP certified residences must provide the full scope of services available in the Standard Option, as indicated above, as well as therapeutic day services and more intensive personal care. Licensed residences that provide enhanced services (e.g., limited skilled nursing) and/or specialized services (e.g., dementia care) must have the appropriate level of State licensure and meet the appropriate tier of Medicaid certification.

~~that has also been certified as a Medicaid provider. The responsibility for certifying licensed assisted living residences as Medicaid providers is shared by the Executive Office of Health and Human Services, the Department of Human Services or the Department of Elderly Affairs. Certification standards adopted by these agencies in effect on June 30, 2009 shall remain in effect under the Global Consumer Compact Waiver until October 1, 2009, by which time the office and the departments shall develop and implement new certification standards that broaden the scope and availability of assisted living services to the full extent permitted by state law and appropriations~~.

~~For the purpose of this rule, assisted living services are defined as: personal care services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under state law), transportation to medically necessary appointments, therapeutic social and~~

~~recreational programming, when specified, provided in a home- like environment in a licensed community care facility in conjunction with residing in the facility. The services provided to beneficiaries by assisted living residences certified as Medicaid providers for the purposes of~~ ALRs participating in Medicaid under R.I.G.L. §42.66.8-3 ~~must also include those set forth in section 0300.20.20~~ are subject to the requirements of this section. Beneficiaries ~~opting for services in the~~ choosing to obtain Medicaid LTSS in one of the assisted living residences covered under this section of ~~state~~ Statelaw may be subject to waiting lists as ~~the number of beds certified for Medicaid purposes is capped~~ availability for beneficiaries may be limited. ~~Such beneficiaries shall have the option of seeking assisted living services in other Medicaid certified residences, depending on the scope of their needs as indicated in the individualized plan of care.~~ Note: beneficiaries subject to waiting lists may obtain the full scope of services authorized under their POC at home or in any other appropriately certified residential setting. Beneficiaries with the highest need for a NF level of care also have the option of choosing a nursing facility care setting.

~~Note: Medical equipment funded under the primary and acute care system includes items such as wheelchairs, prosthetics, and orthotics. These are services that were provided under the authority of the Rhode Island Medicaid State Plan prior to the 1115 Waiver approval. These items are still available under the 1115 Waiver and are described at:~~
~~http://www.dhs.ri.gov/ForProvidersVendors/ServicesforProviders/Provider Manuals/DME/tabid/459/Default.aspx~~

~~0399.20.02 RIte @ Home (Shared Living)~~

~~REV:09/2013~~

(2) RIte @ Home – Shared Living. Beneficiaries with a need for an NF or ICF/ID level of care have the option of entering into a shared-living arrangement that is similar to adult foster care. Shared-living is defined as personal care, homemaker, chore, attendant care and related services provided in a private home setting by a care provider who lives in the home. RIte @ Home is ~~a service~~ is the shared-living service ~~provided to~~ for Medicaid LTSS beneficiaries ~~eligible for long-term care services who are elderly or adults with disabilities~~ who are unable to live independently and who ~~meet~~ have the highest or a high need for a NF level of ~~care as determined through the evaluation conducted by the Assessment and Coordination Organization as specified in Section 0399.06~~. Each Medicaid beneficiaries opting

for RIte @ Home services will have a RIte @ Home Service and Safety Plan, developed to meet their own unique, individual needs.

RIte @ Home providers approved by EOHHS to serve Medicaid beneficiaries ~~shall be~~ are selected in accordance with the standards developed for such purposes ~~under the auspices of the Executive Office of Health and Human Services~~by the EOHHS. The BHDDH and DCYF also maintain shared-living programs that are certified and operate under standards geared toward the needs of the populations they serve.~~These program standards vary by population served so as to ensure services can be tailored to better meet the needs of beneficiaries.~~

~~***0399.20.02.01 Scope and Limitations***~~

~~REV:07/2009~~

~~Shared living certification standards and options developed and implemented by the Department of Mental Health, Retardation and Hospitals (MHRH) in effect on June 30, 2009 shall remain in effect under the Global Waiver unless or until such time as the MHRH determines otherwise.~~

~~**0399.21 PROG FOR ALL-INCLUSIVE CARE FOR THE ELDERLY**~~

~~REV:07/2009~~

(3) The Program for All-Inclusive Care for the Elderly (PACE). PACE is a ~~Medical Assistance program administered by the DHS~~ Medicaid LTSS program for beneficiaries who enrolled in Medicare that provides an integrated model of ~~medical and long-term care services~~ health care to qualified persons who are at least age fifty-five (55) ~~and above~~ and meet all the Medicaid LTSS financial requirement as well as the clinical/functional criteria for a high or the highest need for a NF level of care.

~~CMS and the Center for Adult Health approved PACE providers are responsible for providing the full scope of Medicaid State Plan categorical and medically needy services and the following additional services: o Multidisciplinary assessment and treatment planning; o Case Management services; o Personal Care; o Homemaking; o Rehabilitation; o Social Work; o Transportation; o Nutritional Counseling; o Recreational Therapy; o Minor Home Modifications; o Specialized Medical Equipment and Supplies.~~

~~The~~ Participation in the PACE program is voluntary ~~for any eligible person, but if an individual selects this program, he/she must get all medical and support services through the PACE organization~~. Beneficiaries opting to participate in PACE receive all Medicaid LTSS waiver and state plan services and supports through the program. There are no benefits outside of the PACE program. Information about eligibility, enrollment and disenrollment in the PACE program is located in Section 0374 and 0375, pertaining to managed care arrangements for adults with disabilities and elders.

~~DHS long term care/adult services staff is responsible for:~~
~~o All determinations and redeterminations of Medicaid Long Term Care categorical or medically needy eligibility and post-eligibility as described in Sections 0396.10 through 0396.10.20, and Sections 0396.15 through 0396.15.10.10;~~
~~o Determination of income to be allocated to cost of care (share);~~
~~o Maintenance of the DHS InRhodes and paper case file;~~
~~o Assisting disenrolled clients in application for alternate Medicaid Long Term Care programs, as needed.~~
~~The approved PACE provider is responsible for:~~
~~o Point of entry identification;~~
~~o Submitting all necessary documentation for level of care initial determinations and redeterminations and referral to DHS long term care/adult services offices for financial determinations;~~
~~o Checking Medicaid eligibility status and required share amount (if any) prior to enrolling the client in PACE as a Medicaid eligible individual, and at each reassessment;~~
~~o Providing and coordinating all needed services;~~
~~o Adhering to all PACE Provider requirements as outlined in the PACE Program Agreement between DHS and CMS, and to all credentialing standards required by the DHS Center for Adult Health including data submission.~~
~~The DHS Center for Adult Health is responsible for:~~
~~o Oversight and monitoring of all aspects of the PACE program;~~
~~o Conducting initial Level of Care Determinations and determining whether a permanent Level of Care should be assigned;~~
~~o Identifying clients for whom there is unlikely to be an improvement in functional/medical status.~~

~~0399.21.01 Involuntary Disenrollment~~

~~REV:07/2009~~

~~The PACE Organization may not request disenrollment because of a change in the enrollee's health status or because the enrollee's utilization of medical and/or social services, diminished mental capacity or uncooperative behavior is resulting from his or her special needs (except as specified below). Involuntary disenrollment conditions described in 42 CFR Section 460.164 will be used in Rhode Island. A person may be disenrolled for any of the following reasons:~~
~~o Non-payment of premiums on a timely basis: failure to pay or make satisfactory arrangements to pay any premium or co-payment due the PACE organization after a 30 day grace period.~~

o The participant moves out of the PACE program service area or is out of the service area for more than thirty (30) days unless the PACE organization agrees to a longer absence due to extenuating circumstances.
o The PACE organization is unable to offer health care services due to the loss of State licenses.
o The PACE organization's agreement with CMS and the State administering agency is not renewed or terminated.
o The participant is defined as a person who engages in disruptive or threatening behavior, including times when the participant physically attacked, verbally threatened, or exhibited harassing behavior toward a PACE program staff member, contractor, or other PACE program participant.
o A person whose behavior is jeopardizing his/her health or safety or that of others.
o A person with decision-making capacity who consistently refuses to comply with his/her individual plan of care or the terms of the Enrollment Agreement.
o A participant may lose eligibility for the PACE program and be disenrolled because they no longer meet level of care requirements.

0399.21.02 Dept Approval for Involuntary Disenrollment
REV:07/2009
Involuntary disenrollment from PACE requires the DHS Center for Adult Health approval. A proposed involuntary disenrollment for any of the above reasons shall be subject to timely review and prior authorization by the Department, pursuant to the Involuntary Disenrollment procedure below:
o Disenrollment request: The PACE Organization (PO) shall submit to the DHS Center for Adult Health a written request to process all involuntary disenrollments. With each request, the PACE Organization shall submit to DHS evidence attesting to the above situations.
Department's Approval: The Department will notify the PACE Organization about its decision to approve or disapprove the involuntary disenrollment request within fifteen (15) days from the date DHS has received all information needed for a decision.
Upon DHS approval of the disenrollment request, the PACE Organization must, within three (3) business days, forward copies of a completed Disenrollment Request Form to the DHS Long Term Care Office and to the Medicare enrollment agency (when appropriate).

0399.21.03 Notification of the Member
REV:07/2009
If and when the DHS approves the PACE Organization's request for disenrollment, the PACE Organization must send written notification to the member that includes:
o A statement that the PACE Organization intends to disenroll the member; o The reason(s) for the intended disenrollment; and o A statement about the member's right to challenge the decision to disenroll and how to grieve or appeal such decision.

0399.21.04 Disenrollment Appeal
REV:07/2009
If the member files a written appeal of the disenrollment within ten (10) days of the decision to disenroll, the disenrollment shall be delayed until the appeal is resolved.

0399.21.05 Loss Of PACE Enrollment

REV:07/2009

When a member loses PACE enrollment, the effective dates of disenrollment from the PACE Organization will be determined as follows:

- o Loss of Functional Level of Care: No longer requires the level of care provided in a nursing facility as defined in section 0399.12.01.
- o Out of Area Residence: The PACE Organization will notify the appropriate agencies, Medicare and/or Medicaid, if the member moves permanently out of the designated PACE catchment area. If the member moves permanently out of the catchment area, the date of disenrollment for Medicaid shall be the date when the move occurs. DHS will recoup Medicaid capitation payments made for any months after the month an out of area move occurs.
- o Death: If the participant dies, the date of disenrollment shall be the date of death. DHS will recoup any whole capitation payments for months subsequent to the month a participant dies.

0399.21.06 Notification to the Participant

REV:07/2009

When the PACE Organization notifies the Center for Adult Health and Medicare enrollment agencies of the loss of PACE enrollment, the PACE Organization shall also send written notification to the member. This written notification shall include:

- o A statement that the participant is no longer enrolled in the PACE program;
- o The reason(s) for the loss of PACE enrollment.

0399.21.07 Re-enrollment and Transition Out of PACE

REV:07/2009

All re-enrollments will be treated as new enrollees except when a participant re-enrolls within two months after losing Medicaid eligibility. In this situation, the participant's re- enrollment will not be treated as a new enrollment. The PACE Organization shall assist participants whose enrollment ceased for any reason in obtaining necessary transitional care through appropriate referrals, by making medical records available to the participant's new service providers; and (if applicable), by working with DHS to reinstate participant's benefits in the Medical Assistance Program.

0399.21.08 Voluntary Disenrollment

REV:07/2009

Participants in the PACE Program may voluntarily disenroll from the PACE Organization at any time. A voluntary disenrollment from the PACE Organization will become effective at midnight of the last day of the month in which the disenrollment is requested.

To qualify as a Medicaid eligible PACE participant, an individual must:

- O Meet the Medical Assistance requirement for disability and be at least fifty-five (55) years of age, or meet the Medical Assistance requirement for age (65 or older);
- O Meet the highest or high level of care;
- O Meet all other financial and non-financial requirements for Medical Assistance long-term care services, such as, but not limited to, citizenship, residency, resources, income, and transfer of assets.

1500.06 Severability

If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.

December 16, 2015
1500proposed12042015

Net Present Value: Section 1500, Medicaid Long-Term Services and Supports – Interim Rule

For each cost and benefit calculation, the following formula was used:

$$\mathrm{NPV}(i,N) = \sum_{t=0}^{N} \frac{R_t}{(1+i)^t}$$

Where "N" represents the total number of periods, "*t*" represents the period, and "*i*" represents the discount rate. Total Net Present Value estimates based on a series of assumptions outlined in this document. All NPV estimates are greater than 0 indicating that the rule should be adopted based on overall benefit.

Period	Savings to State
T_0	$2,188,500
T_1	$2,254,155
T_2	$2,321,780
T_3	$2,391,433
T_4	$2,463,176
T_5	$2,537,071
T_6	$2,613,183
T_7	$2,691,579
T_8	$2,772,326
T_9	$2,855,496
T_{10}	$2,941,161
NPV	$28,029,861

EOHHS is proposing to amend pertinent sections of the Medicaid Code of Administrative Rules, section 0399, currently entitled, "Global Consumer Choice Waiver", renumber it to section #1500, and re-title it: "Medicaid Long-Term Services and Supports: Interim Rule." These rules are being promulgated pursuant to the authority conferred under Chapters 40-6 and 40-8 of the General Laws of Rhode Island, as amended, and the federal Section 1115 Waiver approved by the federal Centers for Medicare and Medicaid Services (CMS).

The EOHHS has determined that the most effective way of updating the applicable rules is to create a new chapter in the Medicaid Code of Administrative Rules (MCAR) that sets forth in plain language the rules governing LTSS and, as such, serves as companion to the MCAR chapters governing Medicaid Affordable Care Coverage (Section 1300 *et seq*.). Toward this end, the purpose of this rule is to establish the provisions that implement the reforms beginning on or about January 1, 2016 and to provide a summary of changes that will take effect during calendar year 2016 and thereafter. The regulations are adopted in the best interests of the health, safety, and welfare of the public.

To achieve the goal of rebalancing the long-term care system, Medicaid eligibility criteria have been reformed to enable beneficiaries to obtain long-term services and supports (LTSS) in the most appropriate and least restrictive setting. The types of LTSS available to beneficiaries are categorized as either "institutional" or "home and community-based."

The chief distinctions between the two types of LTSS are care setting and scope of Medicaid coverage. Beginning on January 1, 2016, the series of reforms authorized by state policymakers for modernizing the system for organizing, financing and delivering Medicaid-funded LTSS will begin to take effect. While the modernization process is underway, many long-standing LTSS policies and procedures and the rules governing their implementation will become obsolete.

Below is a table that attempts to quantify the shift in LTSS care that will be permitted by this rule:

Facility Type (all licensed by the RI Department of Health)	Average Annual Cost Per Beneficiary	Total Medicaid Beneficiaries by Facility Type	Annual LTC Cost by Facility Type (Medicaid Beneficiaries)	$ Differential based upon shift in population to community-based care
Home Care	$18,396.	960	$17,660,160	
Increase in home care utilization		+25		+$459,900
Total Home Care			**$18,120,060**	
Adult Day Care	$8,508.	673	**$5,725,884**	
Assisted Living Residences	$13,920.	146	$2,032,320	
Increase in ALR bed use		+25		+$348,000
Total ALR			**$2,380,320**	
Nursing Facilities	$59,928	5209	$312,164,952	
Reduction in NF bed use		-50		-$2,996,400
Total Nursing Facilities			**$309,168,552**	
Totals		6,988	**$335,394,816**	Net Savings: $2,188,500

Q-2, SFY2014 data, *Report to the Rhode Island General Assembly, Senate Committee on Health & Human Services*, June 30, 2014. Available online at: www.eohhs.ri.gov

State Assumptions:

- Reduction in new Medicaid admissions to nursing facilities as a result in changes in the levels of care = 50 residents
- Half of the total of 50 LTSS clients (25) would access home care and 25 would access assisted living residences
- Increase in number of Medicaid home health agency clients = 25
- Increase in number of Medicaid assisted living residents = 25
- Total Periods: 10
- Discount Rate: 3% over each period
- Transitioning seniors back into community settings and coordinating their care will save the state money in LTSS costs

In addition to cost savings, persons will be enabled to remain where they want to be—at least until they need the intensive care that a nursing facility provides. By 2020, the Medicaid Program's goal is to spend 50 percent of long-term care expenditures on the elderly and disabled in home and community-based settings.