

210-RICR-50-10-1

TITLE 210 – Executive Office of Health and Human Services

Chapter 50 - Medicaid Long-Term Services and Supports (LTSS)

Subchapter – 10 Home and Community-Based Services

Part 1 - LTSS Home and Community Based Services (HCBS)

1.1 Overview and Purpose

- A. Medicaid LTSS was only available to beneficiaries in institutional settings until 1983 when Congress amended Title XIX of the Social Security Act to add Section 1915 (c) which established the authority for home and community-based service (HCBS) waivers. Rhode Island was among the first states to pursue this authority and, in that first year alone, received approval for four (4) Section 1915 (c) waivers. By the time Rhode Island sought approval for its program-wide Medicaid Section 1115 waiver demonstration, the State was administering eleven, separate Section 1915 (c) waivers, many of which had distinct eligibility requirements. The State consolidated these separate HCBS waivers in 2009 when the federal government approved Rhode Island's innovative Section 1115 demonstration waiver.
- B. Under the broad authority of the State's Section 1115 waiver, Rhode Island has established a core set of home and community-based services which are available to LTSS beneficiaries in multiple living arrangements. The scope of HCBS available to a beneficiary varies somewhat depending on the type of institutional eligibility a person is seeking (i.e., nursing facility (NF), intermediate care facility for persons with intellectual or developmental disabilities (ICF/I-DD), or long-term care hospital (LTH)), level of need as measured by the applicable evaluation instrument (e.g., high or highest need for the NF services or service intensity scale for ICF/I-DD), and the person-centered planning process. The purpose of this Part is to identify the full range of Medicaid HCBS options available to LTSS beneficiaries, depending on their level of need, as determined in Part 50-00-1 of this Title.

1.2 Legal Authority

- A. This Chapter is promulgated pursuant to the following federal and state authorities:
 - 1. Federal Law -- Title XIX of the U.S. Social Security Act 42 U.S.C. §§ 1396a, 1115, 1902, 1903, 1905, 1915, 1919, 1929, and 1934 (a).

2. Federal Regulations -- 42 C.F.R. Part 441 including §§ 441.180, 441.300 to 310, 441.350 to 365 and 42 C.F.R. §§ 430.25, 435.217, 440.180, 441.700, and 460.92(b).
 3. The RI Medicaid State Plan and the Title XIX, Section 1115 (a) Demonstration Waiver (11-W-00242/1), effective through December 31, 2018.
- B. State Authority R.I. Gen. Laws -- §§ 40-8.9.9; 40-8.10; 40-8.13, 42-66; and 40.1-22.

1.3 Definitions

- A. For the purposes of this Part, the terms below are defined as follows:
1. “HCBS living arrangement” means a private home in which a beneficiary lives, or a community-based supportive care residence as defined in R.I. Gen. Laws § 40-8.13-12 and § 1.6(4) of this Part that has been certified by Medicaid and authorized by the State, by licensure or certification standards, to provide long-term care services and supports to one or more persons. This category includes assisted living residences, State and provider operated groups homes, shared living arrangements, the home of the beneficiary and other private residences.
 2. “Programs of All-Inclusive Care for the Elderly” or “PACE” means the Medicaid State Plan service delivery option for beneficiaries who are dually eligible for Medicare and Medicaid. PACE is available for beneficiaries opting for HCBS who meet the NF level of care at the “high” or “highest” level.
 3. “RIte@Home” means the shared living, supportive care living arrangement administered by the Executive Office of Health and Human Services (EOHHS) for persons who have LTSS needs that meet the NF level of care.

1.4 Accessing Medicaid Home and Community Based Services

- A. Medicaid LTSS is available to applicants and beneficiaries who meet the non-financial, financial and functional/clinical eligibility criteria for eligibility set forth in this Chapter. Under the terms of the State's Section 1115 demonstration waiver, a person seeking Medicaid LTSS must have an established need as set forth in Part 50-00-1 of this Title but is not required to be receiving long-term care at the time an application is made. In addition, it is not necessary for an applicant to make a choice of the type of LTSS -- HCBS or health institution -- when requesting Medicaid coverage. As indicated in Part 5 of this Chapter, a person's

level of need in the functional/clinical eligibility determination process affects the range of Medicaid LTSS options and settings that may be available.

- B. Persons seeking Medicaid HCBS are subject to a functional assessment that includes a standard set of evaluation criteria that consider the full range of the person's physical, medical, behavioral health and social needs. This assessment takes a variety of forms and may be performed by an agency representative or a contractual entity. The assessment is a component of the person-centered planning process, when feasible, and is one of several factors reviewed when determining whether and to what extent a person has the need for an institutional level of care and the scope of HCBS authorized for payment.
- C. The Medicaid State Plan and Rhode Island's Section 1115 demonstration waiver authorize the State to implement certain conditions affecting access to Medicaid HCBS including:
 - 1. No room and board coverage -- Medicaid does not provide coverage for room and board costs when LTSS is provided in a home or a community-based setting. The post-eligibility treatment of income process, set forth in Part 50-00-8 of this Title, provides various allowances that protect -- that is, treat as unavailable -- a portion of beneficiary's income for room and board costs. Other forms of public assistance are also available to help pay shelter and food costs including the federal Supplemental Security Income (SSI) and Supplemental Nutrition Assistance (SNAP) programs and the State's optional Supplemental Payment (SSP) program, as well as a variety of publicly funded housing and meal support programs. Agency representatives are available to assist applicants and beneficiaries seeking these additional forms of assistance.
 - 2. Needs-based -- The scope, amount and duration of authorized HCBS a beneficiary receives is determined by needs level, as specified in Part 50-00-5 of this Title, and within these parameters the goals and outcomes the beneficiary establishes in the person-centered planning process. Only the HCBS that have been authorized by the Medicaid State Plan and Section 1115 demonstration are covered and, therein, only the service array associated with a beneficiary's LTSS level of need -- high or highest -- may be accessed unless the exceptions established in Part 50-00-5 of this Title apply.
 - 3. Expedited eligibility -- Expedited eligibility for persons seeking Medicaid LTSS in a home and community-based setting is available in certain circumstances. The provisions governing expedited eligibility for Medicaid LTSS are located in Parts 50-00-1 and 50-00-5 of this Title.

1.5 Person-Centered Planning

- A. Federal regulations require states providing HCBS through Section 1915 and Section 1115 Medicaid waiver authorities to implement a person-centered planning process (PCPP) that is driven by the Medicaid beneficiary. The PCPP serves as the basis for the authorization of the Medicaid HCBS.
- B. The person-centered planning process is directed by a Medicaid LTSS applicant/beneficiary (or family members) for the purposes of identifying the strengths, capacities, preferences, needs and desired outcomes that become the core of an individualized plan of LTSS care. The applicant/beneficiary will lead the person-centered planning process where possible. The applicant's/beneficiary's representative should have a participatory role, as needed and as defined by the applicant/beneficiary, unless State law confers decision-making authority to the legal representative.
- C. The LTSS applicant/beneficiary may invite others to participate in the PCPP who may enable or assist in identifying and accessing a personalized mix of paid and unpaid services and supports that will assist him or her in achieving personally defined outcomes in the most inclusive community setting. The applicant/beneficiary sets the planning goals for achieving these outcomes in collaboration with the other PCPP participants he or she has selected. The plan of care incorporates both the personally defined outcomes of the applicant/beneficiary and the training supports, therapies, treatments, and or other services the individual is to receive to achieve those outcomes.

1.5.1 Principles of Person-Centered Planning

- A. State agencies that administer programs that provide Medicaid LTSS in the home and community-based settings adhere to the principles of the PCPP to the full extent feasible pending full implementation of the process EOHHS-wide.
 - 1. General principles -- The PCPP must be led by applicant/beneficiary and include participants chosen by the applicant/beneficiary. The PCPP strives to:
 - a. Inform and support. Provide the information and support necessary for the applicant/beneficiary to direct the process to the maximum extent possible;
 - b. Avert service delays. at times and locations of convenience to the applicant/beneficiary;
 - c. Reflect personal values and preferences. Be conducted in a manner that respects the values and prioritizes the preferences of the applicant/beneficiary and in plain language;

- d. Facilitate person-centered consensus-building. Includes strategies for solving disagreements in a manner that supports the interests and informed choices of the applicant/beneficiary;
 - e. Offer informed choice. Describes the full range of HCBS service options within the applicable level of care tier or classification;
 - f. Promote community participation and integration. Identifies how the outcomes and goals of the applicant/beneficiary are strengthened and supported by social relationships, community participation, employment, income and savings, healthcare and wellness, education and others.
 - g. Encourage independence. Identifies what services are self-directed.
 - h. Manage risks. Potential risks and strategies for mitigating them, including back-up plans and providers.
2. Person-centered plan (PCP) -- The principles of the PCPP inform the determination of functional/clinical eligibility and therefore the scope of service options available based on level of need. The PCP must be written in plain language and in a manner that is understandable to persons with disabilities or limited English proficiency and incorporates the goals and desired outcomes of the beneficiary within this context and the agreed upon roadmap for achieving them including, but not limited to: choice of setting; clinical and support needs; caregivers and service providers, both paid and unpaid and their respective roles and responsibilities for meeting those needs; self-directed care, if any; and integrated employment opportunities and requirements. The applicant/beneficiary must indicate agreement with the plan and shares the plan of care, as appropriate, with other participants in the PCPP process and responsible providers.
- B. The PCPP is ongoing and continues after Medicaid HCBS is initially authorized and Medicaid payment begins. The State is required to support the continued engagement of a Medicaid beneficiary and/or his or her family during the period in which services are authorized and, in particular, when conducting reassessments and/or redeterminations of LTSS functional/clinical eligibility that may precipitate or necessitate changes in a plan of care and/or the available service options.

1.6 Medicaid Home and Community-based Long-term Services and Supports

- A. The HCBS options a LTSS beneficiary is authorized to receive depends on the determination of needs level and the person-centered care planning process

(PCPP) involving the beneficiary, provider and family members or authorized representatives. The following are the Medicaid HCBS authorized under the Medicaid State Plan and Section 1115 demonstration waiver available based on need to beneficiaries:

1. Adult Companion Services -- Non-medical care, supervision, and socialization, provided to a functionally impaired adult. Companions may assist or supervise the beneficiary with such tasks as meal preparation, laundry and shopping. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the beneficiary. This service is provided in accordance with a therapeutic goal in the service plan.
2. Assisted Living Services -- Personal care and supportive services (homemaker, chore, attendant services, meal preparation) that are furnished to HCBS beneficiaries who reside in a setting that meets the HCBS setting requirements and includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Medicaid covered assisted living services also include social and recreational programming, and medication assistance. In addition, the assisted living residence must be Medicaid certified provider and, as such, adhere to the following:
 - a. Medicaid covered services that are provided by third parties must be coordinated with the assisted living provider.
 - b. Services must be furnished in a manner that meets a beneficiary's LTSS needs in a manner that promotes self-reliance, dignity and independence. The beneficiary has a right to privacy and has the freedom to move about unless a health practitioner has certified in writing that the beneficiary has a cognitive impairment or similar condition as to be a danger to self or others if given the opportunity to lock the door.
 - c. Assisted living residences with the appropriate State licensure and Medicaid certification may provide an enhanced or specialized package of services, such as dementia care, when necessary to meet a beneficiary's acuity needs. Prior authorization by the State or a Medicaid managed care plan is required.
 - d. Personalized services must be provided to a beneficiary residing in a single or double living unit, when both occupants consent to the arrangement, that contains sleeping and toilet facilities. Each living unit is separate and distinct from each other unit. The residence

must have a central dining room, living room, or parlor, and common activity center(s) (which may also serve as living room or dining room).

- e. The beneficiary must retain the right to assume risk, tempered only by his or her ability to assume responsibility for that risk.
- 3. Case Management -- Medicaid coverage is available for case management services that assist beneficiaries in gaining access to needed HCBS and other State plan services, as well as medical, social, educational and other services, regardless of the funding source for those services.
 - 4. Community-Based Supported Living Arrangements (CSLA) -- Enhanced and specialized HCBS for persons with more intensive LTSS needs provided through Medicaid certified community-based providers – including certain assisted living residences, group homes for persons with developmental or behavioral health disabilities, and other adult supportive care homes. These providers are authorized by the State to address high level functional/clinical needs that otherwise would require care in an institutional- setting. To participate in the program, HCBS providers must meet standards set by the State related to minimum licensure and certification and establish and maintain an acuity-based, tiered service and payment system that ties reimbursements to: beneficiary's clinical/functional level of need; the scope of HCBS authorized and provided; and specific quality and outcome measures. Occupancy limits on the number of residents allowed in such arrangements may apply in accordance with State licensure and/or certification requirements.
 - 5. Community Transition Services - Community transitions services are non-recurring set-up expenses for applicants and beneficiaries who are transitioning from an institutional or another provider-operated setting 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 enable a person to establish a basic household that do not constitute room and board.
 - a. Allowable expenses include, but are not limited to: security deposits that are required to obtain a lease on an apartment or home; essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; services necessary for the person's health and safety such as pest eradication and one-time cleaning prior to occupancy; moving expenses; necessary home accessibility adaptations; and activities to assess need, arrange for

and procure needed resources; storage fees; weather appropriate clothing; assistance with obtaining needed documentations for housing agreements.

- b. Allowable expenses for community transitions are only covered to the extent that they are reasonable and necessary as determined through the PCPP, are clearly identified in the person-centered service plan, and the person is unable to afford paying for the transition services, or the services cannot be obtained from other sources.
6. Day treatment and supports -- Services that are necessary for the diagnosis or treatment of a beneficiary's behavior health condition, mental illness, or disability. The purpose of this service is to maintain the beneficiary's condition and functional level and to prevent relapse or hospitalization. Range of services available includes the following:
- a. Individual and group therapy with physicians or psychologists (or other health professionals to the extent authorized under State law);
 - b. Occupational therapy, requiring the skills of a qualified occupational therapist;
 - c. The services of trained psychiatric nurses, social workers, and other professionals and paraprofessionals trained to work with individuals with psychiatric illness;
 - d. Drugs and biologicals furnished for therapeutic purposes, that are otherwise not covered by Medicaid or Medicare;
 - e. Individual activity therapies that are not primarily recreational or diversionary;
 - f. Family counseling (the primary purpose of which is treatment of the beneficiary's condition);
 - g. Training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment); and
 - h. Diagnostic services.
7. Habilitation services – Services designed to assist beneficiaries in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully in a home or community-based setting. May be included as part of integrated day services or residential habilitation services, as indicated below:

- a. Day habilitation. Regularly scheduled habilitative services and related activities in a setting apart from the beneficiary's private residence. These day services focus on enabling a beneficiary to attain or maintain his or her maximum potential and are coordinated with any needed therapies in the PCP, such as physical, occupational or speech therapy.
 - b. Residential habilitation. Individually tailored habilitation services and supports targeted at improving skills related to living in the community. Includes adaptive skill development, assistance with the activities of daily living, community inclusion, transportation, adult education, employment supports, and the development of social and leisure skills that assist the beneficiary in living in the most integrated setting appropriate. In addition, the service covers personal care and protective oversight and supervision.
- 8. Homemaker services – The performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the beneficiary or caretaker regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.
- 9. Home delivered meals -- The delivery of hot meals and shelf staples to the beneficiary's residence. These services are available to a beneficiary who has a functional dependency/disability that limits the ability to prepare meals and who requires food preparation and delivery to live in the community. Home delivered meals must provide a minimum of one-third of the current recommended dietary allowance and generally do not meet the full daily nutritional requirement.
- 10. Individual directed goods and services – The services, equipment, or supplies not otherwise covered by Medicaid that address an identified need in the beneficiary's service plan, including improving and maintaining the beneficiary's opportunities for full membership in the community. Individual directed goods and services are purchased from the beneficiary-directed budget. To be covered, the beneficiary must not have the funds to purchase the item or service or the item or service must not be available through another source and the item or service must:
 - a. Decrease the need for other Medicaid services; AND/OR
 - b. Promote inclusion in the community; AND/OR
 - c. Increase the beneficiary's safety in the home environment; AND,
 - d. Not be an experimental or prohibited treatment.

11. Integrated supported employment -- Integrated employment supports are services and training activities provided in regular business and industry settings for beneficiaries who have disabilities. The outcome of this service is sustained paid employment and work experience leading to further career development and integrated community-based employment for which the beneficiary is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.
 - a. Supports may include any combination of the following services: vocational/job-related discovery or assessment, person- centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefits management, transportation and career advancement services. Other workplace support services may include services not specifically related to job skill training that enable the HCBS beneficiary to be successful in integrating into the job setting.
 - b. Supported employment must be provided in a manner that promotes integration into the workplace and interaction between beneficiaries and people without disabilities in those workplaces.
12. Medication management/administration – Pharmacologic management including review of medication use, both current and historical, if indicated; evaluation of symptoms being treated, side effects and effectiveness of current medication(s), adjustment of medications if indicated, and prescription, provided by a medical professional practicing within the scope of his or her licensure.
13. Personal care -- A range of services and supports that enables HCBS beneficiaries to accomplish tasks that they would normally do for themselves if they did not have functional and/or clinical limitations. Personal care may take the form of hands-on assistance or cuing to prompt the beneficiary to perform a task. The services may be provided on an episodic or on a continuing basis and may be provided by a home health aide, personal care attendant, or direct service worker.
14. Personal Emergency Response System (PERS) -- PERS is an electronic device that enables HCBS beneficiaries to secure help in an emergency. The system is connected to the beneficiary's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein.
15. Prevocational Services – Services intended to develop and teach general skills that lead to competitive and integrated employment including, but not

limited to the ability to: communicate effectively with supervisors, co-workers and customers; follow directions; attend to tasks; solve workplace problems; engage in appropriate work conduct and meet applicable norms related to grooming and dress; and adhere to health and safety standards.

- a. Participation in prevocational services is not a required pre-requisite for HCBS individual or small group supported employment services.
 - b. Includes volunteer work and other non-paid work that facilitate the development of general, non-job-task-specific strengths and skills that enhance a beneficiary's employability.
 - c. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as determined by the beneficiary in the PCPP with the assistance of the health professionals and other participants in that process. Beneficiaries receiving prevocational services must have employment-related goals in their person-centered service plan and their general habilitation activities must be designed to support such employment goals.
- 16. Private duty nursing -Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within their scope of practice under State law. These services are provided to a beneficiary at home.
 - 17. Respite care -- Services provided to beneficiaries, within parameters established by the State, who are unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the beneficiary.
 - 18. Shared-living – A supported living arrangement in which necessary core HCBSs (e.g., personal care, homemaker, chore, companion services and medication oversight) are bundled and provided in a private residence to a beneficiary by a principal caregiver who shares the home. The scope of HCBS available in share living arrangements, and service agencies, varies depending whether a beneficiary requires a NF or ICF/I-DD level of care and the extent of his or her acuity needs. The State pays the principal caregiver through the service agency for the HCBS provided to the beneficiary and for assisting in coordinating access to other needed services. Separate payment is not made for homemaker or chore services furnished to the beneficiary as these services are integral to and inherent in the provision of the shared living arrangement.
 - 19. Skilled nursing -- Services listed in the PCP plan that are within the scope of a nurse's area of practice under State law. HCBS skilled nursing is

distinguished from private duty nursing in that it is part time or intermittent and provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse in either the beneficiary's home or Medicaid certified community living arrangement.

20. Specialized medical equipment and supplies -- Specialized medical equipment and supplies are devices, controls, or appliances, specified in the plan of care, that enable beneficiaries to: increase their ability to perform activities of daily living; perceive, control, or communicate with the environment in which they live; ensure life support; or address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items. Also includes:
 - a. Other durable and non-durable medical equipment and medical supplies not covered under the State Plan that are necessary to address a beneficiary's functional limitations.
 - b. Remote devices that enable appropriately licensed health care professionals to monitor certain aspects of a beneficiary's health at home or in other residential living arrangements.
 - c. Items covered under HCBS funds 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.
 - d. All items must meet applicable standards of manufacture, design and installation.
 21. Supports for consumer direction – The services and supports provided by a facilitator – referred to as the service advisement agency -- that empowers beneficiaries participating in self-directed “personal choice” service delivery options under Part 2, subchapter 10 of this Chapter to define and direct their own personal assistance needs and services; guides and supports, rather than directs and manages, the beneficiary through the service planning and delivery process. The facilitator counsels and assists in development of the PCP which includes both paid and unpaid services and supports designed to enable the beneficiary to live at home and participate in the community. A back-up plan is also developed to assure that the needed assistance will be provided in the event that regular services identified in the PCP are temporarily unavailable.
- B. Medicaid LTSS beneficiaries receiving core HCBS are entitled to all primary care essential benefits authorized under the Medicaid State Plan including home care and home modifications. Unless self-directed, HCBS are delivered by Medicaid certified providers through PACE, a Medicaid managed care plan, or on a fee-for-

service basis, in accordance with the provisions set forth in Part 40-10-1 of this Title.

1.7 Limitations on the Availability of Medicaid HCBS

- A. The State may establish waiting lists for an HCBS service option, including a specific setting, when demand exceeds the availability of services and/or appropriated funds.
 - 1. Prioritized access -- During a period in which a waiting list is in effect, access to HCBS is based on level of need. Persons determined to have the highest needs levels, including those with imminent health and safety risks, are therefore given priority access over those with lower needs levels.
 - 2. Limits -- The State may not extend waiting lists for HCBS determined to be medically necessary by a treating health care practitioner to prevent an imminent risk to a beneficiary's health or safety.
 - 3. Notice -- Prior to the establishment of HCBS waiting lists, the State provides a full implementation plan indicating the date the waiting list takes effect, the process for notifying beneficiaries of their status and the procedures in place to ensure compliance with applicable federal and state laws and address the needs of beneficiaries at risk.

1.7.1 Limitations on Nursing Facility (NF) and Long-Term Hospital (LTH) Levels of Care

- A. The limitations that apply for when waiting lists or other limitations on HCBS occur for beneficiaries who need a NF or LTH level of care are set forth in State law.
 - 1. Highest level -- Beneficiaries with the highest need have the option of seeking admission to a NF or LTH while awaiting access to the full scope of home and community-based services. Accordingly, applicants/beneficiaries deemed to be in the highest category for a NF level of care or meet the requirement for a LTH level of care are *entitled* to services and must not be placed on a waiting list for Medicaid LTSS in an institutional setting. If a community placement is not initially available, beneficiaries with the highest need may be placed on a waiting 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.
 - a. Priority Status. In the event that a waiting list for any home and community- based service becomes necessary, the EOHHS must provide services for beneficiaries determined to be NF or LTH

highest need before providing services to beneficiaries that have a high need. Beneficiaries with high need are given priority access to services over beneficiaries qualifying for LTSS preventive services.

- b. Continuation of Services. Services for beneficiaries with the highest need must continue in the appropriate setting unless or until their condition improves 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 under R.I. Gen. Laws § 40-8.10-3. Beneficiaries who meet the functional/clinical eligibility criteria for the high level of long-term hospital (LTH) care must be provided with required services in an institutional setting until HCBS become available. Rules pertaining to the LTSS preventive level of need are located in Part 40-05-1 of this Title.

1.7.2 Limitations ICF/I-DD Level of Care for Persons with Developmental Disabilities

- A. The State must adhere to the requirements set forth in the Section 1115 demonstration waiver if waiting lists or other restrictions are established for HCBS for persons with developmental disabilities. The goal is two-fold: 1) Ensure care is available for those whose medical needs cannot otherwise be addressed; and 2) Limit the availability when any community-based alternative is available.
 1. Highest need -- As placement in an ICF/I-DD is not generally available, the State must give beneficiaries with the highest needs levels in Tiers D and E, as specified in Part 50-00-5 of this Title, priority access for any home and community-based services that are restricted over beneficiaries with a high need. Placement in an alternative living arrangement that provides the same or a more robust service array, including a NF or LTH, may be provided on an interim basis for any applicant or beneficiary who has clinical or functional needs requiring medical care.
 2. High need -- Beneficiaries with high needs levels in Tier C are given priority access over beneficiaries with needs levels in Tiers B and A. Accordingly, beneficiaries with needs levels in Tier A have limited access to any restricted HCBS until beneficiaries with greater needs have been served.
 3. Exceptions – The State may make exceptions to the priority access standards set forth herein in accordance with the provisions in Part 50-00-5 of this Title, as appropriate, or rules, regulations and procedures

promulgated specifically for that purpose by the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH).

1.8 HCBS Setting Requirements

- A. The federal government regulations beginning at 42 C.F.R. § 441.700 establish standards and criteria that states must follow when determining whether Medicaid coverage is available for certain HCBS services and settings. This section incorporates the federal standards and establishes the core HCBS for long-term services and supports. The federal standards and requirements for HCBS are designed to: provide states with more flexibility when using federal funds to pay for Medicaid in non-institutional-settings; and establish a set of standards for HCBS that ensures Medicaid LTSS beneficiaries will have full access to advantages of community life and health services in integrated settings. The EOHHS is committed to implementing a federally approved, stakeholder-driven transition plan that assures the State is in compliance with these requirements by the deadline for adoption in 2022. These regulations hereby adopt and incorporate 42 C.F.R. § 441.700 et seq. (2014) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these regulations.

- B. HCBS setting requirements include the following characteristics:
 - 1. The setting is integrated in and supports full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as applicants/beneficiaries not receiving Medicaid HCBS.
 - 2. The setting is selected by the applicant/beneficiary from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the applicant's/beneficiary's needs, preferences, and, for residential settings, resources available for room and board.
 - 3. Ensures an applicant's/beneficiary's rights of privacy, dignity and respect, and freedom from coercion and restraint.
 - 4. Optimizes, but does not regiment, applicant/beneficiary initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

5. Facilitates applicant/beneficiary choice regarding services and supports, and who provides them.
6. In a provider-owned or controlled residential setting, in addition to the above qualities at paragraphs (a)(I)(i) through (v) of this section, the following additional conditions must be met:
 - a. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the applicant/beneficiary receiving services, and the applicant/beneficiary has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law;
 - b. Each applicant/beneficiary has privacy in their sleeping or living unit:
 - (1) Units have entrance doors lockable by the applicant/beneficiary, with only appropriate staff having keys to doors;
 - (2) Applicants/beneficiaries sharing units have a choice of roommates in that setting; and
 - (3) Applicants/beneficiaries have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
 - c. Applicants/beneficiaries have the freedom and support to control their own schedules and activities, and have access to food at any time;
 - d. Applicants/beneficiaries are able to have visitors of their choosing at any time;
 - e. The setting is physically accessible to the applicant/beneficiary; and
 - f. Any modification of the additional conditions, under paragraphs (a)(I)(vi)(A) through (D) of this section, must be supported by a

specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

- (1) Identify a specific and individualized assessed need.
- (2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
- (3) Document less intrusive methods of meeting the need that have been tried but did not work.
- (4) Include a clear description of the condition that is directly proportionate to the specific assessed need.
- (5) Include regular collection and review of data to measure the ongoing effectiveness of the modification.
- (6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- (7) Include the informed consent of the applicant/beneficiary.
- (8) Include an assurance that interventions and supports will cause no harm to the applicant/beneficiary.