

## **210-RICR-50-00-5**

# **TITLE 210 – Executive Office of Health and Human Services**

## **CHAPTER 50 - MEDICAID LONG-TERM SERVICES AND SUPPORTS (LTSS)**

### **Subchapter 00 - Long-Term Services**

#### **Part 5 - Medicaid Long-Term Services and Supports: Functional/Clinical Eligibility**

### **5.1 Overview**

The process for determining function/clinical eligibility for long-term services and supports (LTSS) centers on a comprehensive evaluation that includes a functional assessment and consideration of each applicant's unique medical, social, physical and behavioral health needs. The results of this evaluation process are used to determine whether, and to what extent, an applicant has the need for the level of care typically provided in a nursing facility (NF), intermediate care facility for persons with intellectual or developmental disabilities (ICF-I/DD), or long-term care hospital (LTH). Under the terms of the Medicaid State Plan and the State's Title XIX, Section 1115 demonstration waiver, a person must have this level of need and meet both the non-financial and financial eligibility requirements set forth in this Part to qualify for Medicaid LTSS coverage in one of these institutions, at home, or in a community-based service (HCBS) setting.

### **5.2 Legal Authority**

- A. This Part 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, Sections 1115, 1902, 1903, 1905, 1915, 1919.
  - 2. Federal Regulations -- 42 C.F.R. Part 440 including §§ 440.40, 440.70, 440.150, 440.155, 440.180, 440.181, 440.182.
  - 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 RI Gen. Laws §§ 40-8.9.9(c); 40-8.10-3; 40-8.13, 42-7.2-5(6)(v); 42-66.6, 40.1-22.

### **5.3 Definitions**

- A. For the purposes of this Part, the following definitions apply:

"Activities of daily living" or "ADLs" means the routine activities that people tend to do every day without needing assistance. There are six basic ADLs: eating, bathing, dressing, toileting, transferring, and mobility and ambulation. The need for assistance with medication management and personal hygiene is also considered an ADL.

2. "Community supported living services for I/DD" means one or more of the home and community-based Medicaid LTSS services and supports identified in §50-10-1 provided to assist an intellectually/ developmentally disabled person with the activities of daily living in a setting such as primary residence, the home of another, a BHDDH group home, or other community living setting arrangement where such services and supports are available.
3. "Department of Behavioral Healthcare, Hospitals, and Developmental Disabilities" or "BHDDH" means the entity within the executive branch of Rhode Island State government that serves as the mental health authority and administers LTSS programs funded in whole or in part by Medicaid for persons with intellectual or developmental disabilities and serious mental/behavioral health needs.
4. "Department of Children, Youth and Families" or "DCYF" means the State agency responsible for administering child protective and behavioral health services for children and youth, and their families, who are at-risk for or in the care and custody of the State, including several LTSS programs funded in part by Medicaid and CHIP.
5. "Department of Human Services" or "DHS" means the State agency that has been delegated responsibility for processing Medicaid LTSS eligibility through and providing functional assessments and case management services to certain applicants and beneficiaries in accordance with the terms and conditions of an interagency agreement with the EOHHS.
6. "Division of Elderly Affairs" or "DEA" means the unit within the DHS with responsibility for administering the State's HCBS co-pay program for persons who do not qualify for Medicaid LTSS as well as conducting assessments for certain Medicaid HCBS programs under RI General Laws and the terms and conditions of an interagency agreement with the EOHHS, the Medicaid Single State Agency in Rhode Island.
7. "Executive Office of Health and Human Services" or "EOHHS" means the entity within the executive branch of Rhode Island state government that is designated as the Medicaid Single State Agency in RI General Laws and the Medicaid State Plan and that, in this capacity, is responsible for overseeing the administration of all Medicaid-funded LTSS in collaboration

with the health and human services agencies under the office's jurisdiction.

8. "Functional disability" means a deficit or deficits in the capacity to perform the activities of daily living and/or the instrumental activities of daily living of sufficient magnitude that alone, or in conjunction with certain health conditions, constitutes a need for the level of care LTSS typically provided in an institutional setting.
9. "Instrumental activities of daily living" or "IADLs" means the skills a person needs to live safely and successfully in a residential setting of choice without outside supports. Such skills include, but are not limited to, using the telephone, traveling, shopping, preparing meals, doing housework, taking medications properly, and managing money.
10. "Level of care" means the amount of services and supports necessary to meet a person's needs. When associated with a licensed health care institution, the term refers to the set of services and supports the institution is authorized and typically provides to people with a specific range of needs.
11. "Minimum Data Set" or "MDS" means a component of the federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems.
12. "Needs-based criteria" means the health and functional status factors used in the determination of LTSS functional/clinical eligibility to assess a person's need for the level of care provided in a nursing facility, ICF/ID, or certain hospital settings.

## **5.4 Assessments for Needs-Based Level of Care Determinations**

- A. The scope of services accessible to a beneficiary varies in accordance with a person's needs, including his or her goals and preferences, the range of services and supports available under the State's Medicaid State Plan and Section 1115 demonstration waiver, as well as federal and State regulations, rules or laws. The range of available authorized service options varies with each type of health institution (NF, ICF/I-DD, LTH), as the populations they serve have a range of service and support needs that also vary. As indicated in the following sections, the service options available to a person who meets the functional/clinical eligibility requirements for LTSS associated with one of these institutions is tied to the scope of his or her service needs at the time of application and in subsequent reassessments of need.

- B. The functional/clinical eligibility determination process uses needs-based criteria drawn from a variety of sources. The process is initiated when the information necessary to evaluate an applicant's current health status and functional service needs become available to the State through one or more of the following sources:
1. Health care practitioner evaluation --The application includes a clinical evaluation form that must be completed by a treating, licensed health care practitioner with first-hand knowledge about the health status and functional needs of an applicant. The signed and completed form, and any required associated documentation, provide the baseline for determining an applicant's needs level.
  2. Health records and documentation -- Applicants must provide the State with the authorization to obtain health records and other forms of clinical documentation from health care providers and practitioners who have or are providing care to the applicant.
  3. Health institution care/service plans -- Agency representatives from across the EOHHS agencies obtain information from health providers who assess and/or develop care/service plans for applicants who have or are receiving services or are about to be discharged.
  4. HCBS functional assessment -- The State requires in-depth functional assessments of applicants seeking home and community-based services to ensure they can obtain the appropriate services safely and effectively in the setting of choice. The results of the assessments also assist in care planning and guide the authorization of services. As the State pursues a "no wrong door" approach, these assessments may be conducted by agency representative working for the State or various community entities using assessment tools that, although sometimes variable, focus on the same set of functional abilities and limitations.
    - a. NF level of care- HCBS. Responsibilities for HCBS functional assessments are shared across the EOHHS agencies.
    - b. ICF/I-DD level of care -HCBS -- Agency representatives in the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) conduct assessments of all applicants seeking the ICF/I-DD level of care without regard to setting.
    - c. LT Hospital level of care -HCBS. The EOHHS agency representative that determine the NF level of care assess applicants for the HCBS Habilitation Program that serves people with severe disabilities that occur in adulthood. BHDDH agency representatives conduct assessments of persons with serious and

persistent behavioral health needs seeking Medicaid LTSS in a community-based congregate setting.

## **5.5 Development of Plan of Care, Service Planning and Authorization, and Case Management**

- A. The development of a plan of care is a multifaceted and multilayered process that may start prior to making a request for Medicaid LTSS if a prospective applicant and his or her family are seeking LTSS information and referral or counseling on the available LTSS options. In instances in which an applicant bypasses these options, care planning typically starts at the point of application and continues after a determination of level of care has been completed and services have been authorized. The core elements of the care planning process include, but are not limited to:
1. Person-centered -- Irrespective of the type of Medicaid LTSS a person is seeking (health institution v. HCBS), the care planning process is driven by an applicant's health care goals, expectations and choices.
  2. Health institutions and service planning -- Federal regulations require that health institutions providing Medicaid funded LTSS conduct in-depth evaluations that consider a prospective resident's needs, values, and preferences when establishing a plan of care. Agency representatives consider the results of these evaluations when determining level of care, assisting in the development of the plan of care, and authorizing services. In addition:
    - a. NF and PASRR. In accordance with federal law, the State Preadmission Screening and Resident Review (PASRR) evaluation for all prospective NF residents focuses on cognitive, developmental and intellectual disabilities and behavioral health conditions that may require specialized services in a health institution. The results of this evaluation are used to incorporate specific services into the plan of care for applicants determined to have special needs as set forth in subsection § 5.7 of this Part below. The State must authorize payment for any such services included in the plan of care for Medicaid beneficiaries.
    - b. HCBS transitions. Health institutions must inform prospective residents and patients, as well anyone about to be discharged, who needs continuous LTSS about HCBS options. This information must be considered and recorded in any continuity of care service plans. NF and ICF/I-DD health institutions must also report to EOHHS any Medicaid applicant or beneficiary expressing a preference for HCBS options, as indicated subsection § 5.5 of this Part.

2. HCBS care planning -- HCBS person-centered planning supports an individual's right and ability to share his or her desires and goals, to consider different options for support, and to learn about the benefits and risks of each option. The essential elements of this process are set forth in in Subchapter 10 Part 1 of this Chapter.
- B. For Medicaid LTSS coverage to begin, services must be authorized. Both the needs assessment and care planning process provide the critical information Agency representatives require to develop and authorize a service plan that meets the individual needs of a beneficiary. The scope of service planning from this point may be broadened or targeted more narrowly depending on whether a beneficiary is currently receiving or has chosen the type of LTSS and/or a service option.
1. Type of LTSS and service setting and delivery options - The Medicaid LTSS authorization of services is a function of the level of care determination and the applicant/beneficiary choice of the available LTSS type (health institution and/or HCBS) and service options therein. LTSS type and options are: health institution (NF, ICF/I-DD, LTH) or HCBS (assisted living residence, PACE, home care, shared living, IDD group home, habilitation at home or in a congregate setting, personal choice self-directed care). Availability of service options is based on the extent of a person's need for a particular institutional level of care -- that is, whether that need meets the applicable criteria to qualify as high or highest or some level within these categories for persons with intellectual/developmental disabilities.
  2. Service plan -- An agency representative or community representative includes a service plan that incorporates the results of the care planning process into the plan authorizing LTSS type and service option. Accordingly, the service plan identifies the scope of authorized services in a health institution (such as skilled v. custodial in a NF) or in an HCBS setting (such as degree of supervision, number of homemaker v. skilled hours, and/or the availability of direct supports.)
- C. Case management is a set of inter-related activities that ensure access to coordinated Medicaid LTSS and the monitoring of service needs and outcomes. Case management is an LTSS covered service under the Medicaid State Plan and Section 1115 waiver and may be provided by agency representatives, Medicaid managed care plans, community-based providers and organizations, and/or other contractual case management entities authorized by the State. Depending on the agency and the population served, this may be performed by multiple entities working in collaboration or a single entity. In addition:
1. Conflict-free -- Case management must be conflict free to the full extent feasible. Accordingly, persons or entities providing LTSS case

management services should not have a fiduciary interest in or influence over the scope, amount, or duration of Medicaid LTSS that beneficiaries receive. In instances in which such conflicts appear or may exist, the State is bound by federal law to establish firewalls that ensure that care management activities are performed independently, in accordance with State standards, and under the direction of agency representatives. The State reserves the discretion to limit or terminate any arrangement for case management services that does not operate in compliance with these firewalls or that otherwise fails to serve the best interests of beneficiaries.

2. Scope of Services -- Case management services include, but are not limited to, assisting in or conducting screening and/or more in-depth assessments prior to and during the eligibility determination process, facilitating the person-centered planning process, aiding in the development of service plans, conducting periodic reviews and reassessments of functional/clinical needs, and coordinating services with the beneficiary's primary care and community service providers, LTSS program representatives, agency LTSS specialists, and family members when appropriate.

## **5.6 Nursing Facility (NF) Needs-based Level of Care Determinations**

### **5.6.1 Overview**

Under Rhode Island law, any health care institution licensed as a NF and certified for Medicare and Medicaid is authorized to provide skilled nursing and custodial care. Many facilities in the State also have the authority and capacity to offer subacute care, typically in the form of rehabilitation services, limited skilled nursing, and/or hospice care.

### **5.6.2 NF Service Classifications**

- A. The NF service classifications are designed to provide service options that reflect the scope and intensity of the beneficiary's need for the level of care typically provided in a nursing facility.
  1. Highest need -- Beneficiaries in this classification have access to all the Medicaid LTSS covered services they need at home, in the community, or in a nursing facility, in accordance with their plan of care.
  2. High need -- Beneficiaries in the high classification have needs that can be met safely and effectively at home or in a community-based Medicaid certified LTSS setting such as an assisted living or shared living residence. Accordingly, these beneficiaries have access to the full array of State Plan and Section 1115 demonstration waiver home and community

based services required to meet their needs as specified in the person-centered individual plan of care.

- B. To determine the level of care and appropriate service classification, agency representatives review the materials provided from the sources identified in § 5.4 of this Part and, as appropriate, the most current Minimum Data Set (MDS) Tool for NF care. To make the final determination of care needs, the results of this review are mapped against the needs-based and institutional level of care criteria.

### **5.6.3 Application of NF Needs-Based Criteria**

- A. The NF level of care determination focuses on health status and functional abilities as well as social and environmental factors and the availability of personal supports. The needs-based criteria reflect both best practices across the state and the prevailing standards of care within the LTSS community in Rhode Island.
  - 1. Functional criteria –The functional disability criteria focus on the scope of a person's need for assistance with 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, agency representatives consider the extent to which the level of assistance a person requires falls into one of the following categories:
    - a. Total dependence (All Action by Caregiver): The person does not participate in any part of the activity.
    - b. Extensive Assistance (Talk, Touch, & Lift): The person performs part of the activity, but caregiver provides physical assistance to lift, move, or shift individual.
    - c. Limited Assistance (Talk and Touch): The person is highly involved in the activity but receives physical guided assistance that does not require lifting of any part of him or her.
  - 2. Health Status Criteria –The needs-based health status 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.
- B. Persons with highest need for a NF level of care have the choice of obtaining services in a NF or HCBS setting.
  - 1. Needs-based criteria – A person is determined to have highest need when the results of the functional/clinical assessment indicate he or she:



- a. Requires extensive assistance or total dependence with at least one of four specific ADLs – toileting, bed mobility, eating, or transferring and limited assistance with at least one other ADL; or
  - b. Has one (1) or more unstable medical, behavioral, cognitive, psychiatric or chronic recurring conditions requiring nursing assistance, care and supervision daily; or
  - c. Lacks awareness of needs or has a moderate impairment with decision-making skills AND has one (1) of the following symptoms/conditions, which occurs frequently and is not easily altered: wandering, verbally aggressive behavior, resisting care, physically aggressive behavior, or behavioral symptoms requiring extensive supervision; or
  - d. Requires skilled nursing assessment, monitoring, and care daily for at least one of the following conditions or treatments: 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
  - e. Requires skilled nursing assessment, monitoring, and care on a daily basis for one or more unstable medical, behavioral or psychiatric conditions or chronic or reoccurring conditions 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.
2. Exceptions -- Otherwise Medicaid LTSS-eligible persons who do not meet the needs-based criteria may be deemed to have the highest need for a NF level of care if an agency representative determines there is a critical need for Medicaid LTSS in a nursing facility due to special circumstances. These special circumstances must adversely affect the person's health and safety and be related to one of the following:
- a. Loss of primary caregiver, due to hospitalization, debilitating illness, or death of a spouse, caretaker sibling, or adult child;
  - b. Loss of living situation, due to a fire, flood, foreclosure, or sale of principal residence as the result of the inability to afford to maintain housing;
  - c. A principal treating health care practitioner, or prior to ending an acute care hospital stay, a discharge planner indicates, based on a

functional/clinical assessment, that the health and welfare of the applicant/beneficiary is at imminent risk if services are not provided or if services are discontinued;

- d. The applicant/beneficiary met the highest NF level of care criteria on or before June 30, 2015 and chose to receive Medicaid LTSS at home or in a community-setting and the beneficiary reports he or she has experienced a failed placement that, if continued, may pose health or safety risks; or
- e. The beneficiary was admitted to a hospital from a NF and is being discharged to the same or another NF upon discharge within any given forty (40) day period.

C. Persons with a high level of need for the NF level of care have a choice of HCBS service options but are restricted from receiving Medicaid LTSS in a NF.

- 1. Needs-based criteria -- Beneficiaries are deemed to have a high need for a NF level of care when one of the following is met:
  - a. Require at least limited assistance daily with at least two of the following ADLs: bathing/personal hygiene, dressing, eating, toilet use, walking or transferring; or
  - b. Require skilled teaching or rehabilitation daily to regain functional ability in at least one of the following: gait training, speech, range of motion, bowel or bladder control; or
  - 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. Exhibit a need for a structured therapeutic environment, supportive interventions, and/or medical management to maintain health and safety.
- 2. Exceptions –
  - a. An LTSS applicant who is currently receiving non-LTSS Medicaid coverage may qualify for HCBS expedited eligibility as set forth in Part 50-00-1 of this Title pending completion of a full determination of level of care for a period of no more than ninety (90) days.
  - b. An applicant for Medicaid LTSS who is not a current beneficiary may qualify for HCBS expedited eligibility upon completion of a preliminary assessment by a treating health care practitioner

indicating that absent immediate access to this limited package of services, the applicant must be admitted to a health care institution.

- c. An LTSS applicant who is a current Medicaid beneficiary who has received expedited eligibility for a period of ninety (90) days may be deemed to meet the high level of care if:
  - (1) A full level of care of determination has not been completed by the end of the expedited eligibility period; and
  - (2) The applicant meets the financial eligibility requirements for an LTSS eligibility pathway identified in Subchapter 00 Part 1 of this Chapter; and
  - (3) The applicant's treating health care practitioner indicates that the discontinuation of HCBS will adversely affect the applicant's health and safety and/or require immediate admission into a NF or hospital.

#### **5.6.4 LTSS Preventive Services**

LTSS Preventive Need. Beneficiaries who meet the needs-based criteria for the LTSS preventive level of care are eligible for a limited range of home and community-based services and supports along with the full range of IHCC group benefits they are entitled to receive. The goal of preventive services is to optimize health to delay or avert institutionalization or more extensive and intensive home and community-based care. Rules pertaining to the LTSS preventive level of need are located in Part 40-05-1 of this Title.

#### **5.6.5 Transitions to HCBS**

Nursing facilities are required to refer to EOHHS any LTSS beneficiary who expresses a preference to obtain LTSS at home or in a community-based setting. Specifically, a Medicaid beneficiary is entitled to receive transition counseling if responding affirmatively to MDS Section Q, question 0500. This question asks whether the beneficiary wants to talk to someone about the possibility of leaving the facility and returning to live and receive services in the community. Agency representatives also pro-actively identify beneficiaries who may be interest in HCBS options. The team reviews functional and clinical data, including utilization, to identify possible candidates for a transition.

#### **5.6.6 Reassessment of NF Level of Care Needs**

- A. All Medicaid LTSS beneficiaries are re-assessed at set intervals after placement and at least annually to determine whether they are receiving the appropriate level of services in the most appropriate setting. A level of care re-evaluation is conducted when the findings of the reassessment indicate that the beneficiary's

needs have changed to such an extent that more intensive or specialized service options may be required.

- B. The reassessments for LTSS beneficiaries receiving the NF level of care proceed in accordance with the following:
  - 1. Change in scope of need -- Beneficiaries determined to have a high need for a NF level of care at the time of an annual reassessment or an assessment done in conjunction with a change in health status are deemed to have the highest need if they meet any of the needs-based criteria established for highest need in §§ 5.6.2 and 5.6.3 of this Part.
  - 2. Periodic reassessment of highest need – At the time a determination of highest need is made for a beneficiary who opts to reside in a nursing facility, agency representatives evaluate whether there is a possibility that the beneficiary's condition may improve within the succeeding two (2) month period. Based on this information, the agency representative notifies the beneficiary, any authorized representative(s) and the nursing facility, that NF care has been authorized and that the beneficiary's functional and health status will be re-evaluated in thirty (30) to sixty (60) days. At the time of reassessment, the LTSS eligibility specialist reviews all available information about clinical and functional status to determine whether a change in level of need and/or service options is required.

#### **5.6.7 Preadmission Screening/Resident Review (PASRR)**

- A. The PASRR is a federal requirement designed to: prevent the inappropriate placement of persons with serious mental or behavioral health conditions, intellectual disability or other developmental disability; and ensure that all NF applicants and residents regardless of payer source are identified, evaluated and determined to be appropriate for admission or continued stay and provided with specialized services (SS), if needed.
- B. There are two levels to the PASRR:
  - 1. Level I -- Completed prior to NF admission. The purpose is to identify: all NF applicants who possibly have developmental/ intellectual disabilities (DD/ID) and serious and persistent mental/behavioral health (MBH) conditions; and, on that basis, determine whether NF placement is appropriate and if Level II Preadmission Screening (PAS) (for specialized services) is warranted. An assessment to determine if NF placement is appropriate must be done in accordance with the criteria set forth in 42 C.F.R. 483.132(a).
    - a. In Rhode Island, BHDDH retains control and responsibility for PASRR, while certain PASRR responsibilities are delegated to EOHHS. For all persons seeking admission to a NF without regard

to payer, an EOHHS agency representative completes the PASRR Level I determination based upon information submitted by appropriately licensed or certified health care providers who are qualified by knowledge and/or experience in working with this population. BHDDH conducts all PASRR Level II evaluations, in consultation with EOHHS.

2. Level II -- The purpose of Level II is to comprehensively evaluate the need for specialized services persons found to be appropriate for NF placement. There are two types of level II evaluations -- one for new applicants and one for resident reviews conducted on an "as needed" basis or when a person receiving specialized services experiences a change in condition --

- a. Pre-Admission Screening Determination (PAS). The state agency responsible must determine if an applicant has a physical and/or behavioral health condition that requires the NF level of care and if the NF is required to provide any specialized services to meet needs identified on the PAS. PAS determinations must be made in writing within an annual average of seven (7) to nine (9) working days of referral. If the applicant is seeking readmission to the NF due to an exempt hospital discharge (convalescent stay) that subsequently requires more than thirty (30) days of a NF level of care, a PASRR resident review is used and the determination must be conducted within forty (40) days of admission.
- b. Resident Review (RR). The State agency with PASRR authority for each NF resident must determine whether he or she continues to have the highest need for the level of services provided by a NF and whether or not specialized services authorized during the PAS should continue. Resident reviews for persons with ID/DD are conducted periodically and upon significant change; and for persons with MBH conditions when there is a significant change unless it is an exempted hospital discharge or other categorical determination.

C. Under federal law, PASRR responsibilities are delegated as follows:

1. EOHHS -- The Medicaid single state agency is responsible for the following:
  - a. Ensures that all requirements of federal law are met;
  - b. Develops written agreements with the BHDDH, in its role as a PASRR authority;

- c. Assures that the PASRR authorities fulfill their statutory responsibilities;
  - d. Oversees NF compliance with any assigned PASRR functions established by the BHDDH in level II evaluations;
  - e. Requires that no person be admitted to a Medicaid certified NF without a PASRR level I PAS;
  - f. Ensures any specialized services determined necessary in the PASRR evaluation process are made available;
  - g. Notifies the NF resident related of the outcome of the PASRR determination and indicates whether specialized services are needed, the placement options available to the person, and appeal rights (See 42 C.F.R. §§ 483.130(k), 483.130(l)).
  - h. Provides a system of appeals for persons affected by any PASRR determination; and
  - i. Withholds Medicaid payment for any person who is living with a developmental disability or serious mental/behavioral health condition who is admitted to a NF without PASRR Level II or who remains in a NF contrary to PASRR rules.
2. BHDDH -- As the State's mental health authority, BHDDH retains control and responsibility for PASRR and must make timely level II evaluations. In addition, BHDDH ensures that all PASRR level II findings are issued in the form of a written evaluative report which is provided to the applicant/resident and their legal guardian, the admitting or retaining NF, the attending physician and where applicable the discharging hospital of the applicant or resident; and arranges for the provision of specialized services when appropriate in the NF setting or alternative placement option.
3. Nursing facilities -- NFs are responsible for the maintenance of all PASRR forms within a person's record. In addition, to ensure documentation compliance, nursing facilities are required to maintain an active list of anyone within the PASRR MBH and DD/ID services. NFs must also:
- a. Care planning. NFs must also consider the PASRR, other related assessments and treatment recommendations within the care planning process. During the resident's annual care planning process, the nursing facility must complete a full assessment and care plan update for anyone receiving PASRR-related services.

- b. Immediate need. When there is a significant change in a resident's condition, a NF is required to initiate treatment to meet immediate needs and then begin a comprehensive reassessment. Treatment is geared to improvements when possible and prevention of avoidable decline, pending additional review and action by the State PASRR authorities. A comprehensive assessment must be completed by the 14th day after noting a significant change and the care plan must be revised accordingly within seven (7) days after its completion. The NF must also assure that any new or additional specialized services are provided pending a determination of whether a RR by the State is warranted during this twenty-one (21) day period.
  - c. Notice for Resident Review. If, upon completing an assessment and associated care plan update, the NF determines that a resident review is or might be necessary due to a significant change or other situation, the nursing facility must promptly provide LTSS clinical specialist and/or the BHDDH PASRR authority with proper written notification.
  - d. Interfacility Transfers. In cases of inter-facility transfers, the transferring NF is responsible for ensuring that PASRR evaluations accompany the resident when moved.
- 4. Specialized services for the NF population include:
  - a. Specialized Services for Behavioral Health Conditions
    - (1) Specialized services do not have to be provided by NFs. The term "Specialized Services" is equated with the level of care provided in psychiatric hospitals, or other intensive programs staffed with trained mental health professionals on a 24-hour/7-day basis. The patient's care follows the aggressive implementation of a treatment plan developed by an interdisciplinary team including a physician and other qualified mental health professionals and incorporates therapies supervised by these professionals. Treatment is aimed at diagnosing and reducing behavioral symptoms to improve the patient's level of functioning to a point that permits a reduction in intensity of services. While some of these services may be the same as those required to be provided by the nursing facility, it is the intensive level that sets these specialized services apart.
  - b. Specialized Services for Persons with Intellectual/Developmental Disabilities are provided in accordance with the following:

- (1) Specialized services take the form of a continuous program of specialized and generic training, treatment, health care, and related services and supports that aggressively and consistently:
  - (AA) facilitates the acquisition of the behaviors necessary for the person to function with as much self-determination and independence as possible; and
  - (BB) promotes the prevention or deceleration of regression or loss of current optimal functional status.  
Specialized services do not include services to maintain generally independent beneficiaries who are able to function with little supervision or in the absence of a continuous specialized services program.
- (2) BHDDH is responsible for the provision of specialized services that enhance the quality of life for persons with intellectual/developmental disabilities and maximize their potential for inclusion and participation in community life. The role of PASRR within this framework is to ensure and enhance the quality of care for persons with an IDD who are residing in nursing facilities and to certify that a nursing facility is the most appropriate and least restrictive residential setting.

D. Exemptions to PASRR are identified in federal regulations at 42 C.F.R. §§ 483.100 through 483.138. In accordance with BHDDH's "advance group determination" wherein certain diagnoses and conditions that typically require NF admission are designated as exempt, the following classes are exempt from PASRR in Rhode Island: any person expected to be residing in a NF for less than thirty (30) days; any person in need of respite or emergency protective services; any person who has a terminal illness, severe or debilitating physical condition or illness, delirium, or dementia.

## **5.7 ICF/ID Needs-based Level of Care Determinations for Adults with Intellectual/Developmental Disabilities (IDD)**

### **5.7.1 Overview**

A. In Rhode Island, the Medicaid ICF/I-DD level of care is reserved for persons with developmental disabilities who meet the criteria established in Part 40-00-1 of this Title. Although there are licensed ICF/I-DD health institutions operating in Rhode Island, they are limited in number and open only to new applicants who require intensive and continuous skilled services in a highly restricted setting.



Since the 1980s, the State has implemented a "community first" approach for adults with developmental disabilities who, were it not for access to HCBS, would require the level of care typically provided in an ICF/I-DD.

- B. In accordance with the principles established in the Olmstead decision (Olmstead v. L.C., 527 U.S. 581), BHDDH has developed service options that encourage independence and self-direction, facilitate supportive employment, and provide the appropriate level of care. The service classifications established by BHDDH are designed to ensure that the service options available to beneficiaries meet their needs in the least restrictive setting.

### **5.7.2 Assessments and Application of Needs-based Criteria**

- A. The BHDDH Division of Developmental Disabilities (DDD) is responsible for determining whether an applicant for Medicaid LTSS meets the level of care for DD services under the terms of an interagency agreement with the EOHHS. In determining level of care, DDD eligibility specialists consider whether an applicant meets the criteria established in State law with respect to developmental/intellectual disabilities. The needs of applicants who meet this definition are then assessed using a Supports Intensity Scale – Adult Version (SIS-A), the nationally recognized instrument of choice for assessing the scope of ID/DD level of need. In addition, BHDDH uses the Situational Assessment of Need (SAN) tool to evaluate the scope of supervision a beneficiary requires as well as any other associated risk factors relevant in and across service settings.
- B. The SIS-A and SAN assessment instruments focus on different aspects of need:
  - 1. The Supports Intensity Scale -- Adult Version (SIS-A) -- The SIS measures support requirements in 57 life activities and 28 behavioral and medical areas including, but not limited to, home living, community living, lifelong learning, employment, health and safety, social activities, and protection and advocacy. The assessment is conducted through an interview with the applicant and other persons who know the applicant well.
    - a. Life activities. The SIS ranks each activity according to the frequency (refers to how often support is needed), amount (refers to how much time in one day another person is needed to provide support), and type of support (refers to what kind of support should be provided).
    - b. Behavioral and medical health. The behavioral and medical section of the SIS-A rates exceptional medical and behavioral support needs.
    - c. Supports Intensity Level (SIL). The SIL is determined based on the Total Support Needs Index, which is a standard score generated

from scores on all the items tested by the Scale. These results are organized into service classifications -- "tiers" -- that correspond to level of need and the available service options.

2. Situational Assessment of Need (SAN) -- The SAN is used to determine if a person with high needs levels requires the 24-hour supervision of a group home or shared living settings by evaluating behavioral health and legal risk factors. If the results of the SAN demonstrate that the person requires 24-hour supervision, then the beneficiary may be offered the option of placement in a community group home or shared living setting. The service options available do not change with the new placement, however.

### **5.7.3 Service Classifications**

- A. The service classifications for Medicaid for LTSS for adults with disabilities are the tiers generated by the SIS assessment of needs levels.
  1. Needs levels and associated tiers --The SIS assessment results are categorized as follows:
    - a. Tier A (High)- Qualifying Disability with mild support needs
    - b. Tier B (High)- Qualifying Disability with moderate support needs
    - c. Tier C (Highest)- Qualifying Disability with identified medical/behavioral needs requiring significant supports
    - d. Tier D (Highest)- Qualifying Disability with extraordinary medical issues requiring significant medical supports
    - e. Tier E (Highest)- Qualifying Disability with extraordinary behavioral issues requiring significant behavioral supports
  2. Service classifications -- The State has established service classifications based on the SIS tiers:
    - a. Highest level of need. Tiers E, D and C:
      - (1) Tier E (extraordinary needs) -- Adults at this tier have extraordinary behavioral issues requiring significant behavioral supports including one-to-one supervision for at least a significant portion of each day. Many persons at this tier have a mental health condition in addition to a developmental disability and may pose a safety risk to themselves and/or the community without continuous on-site support.

- (2) Tier D (extraordinary needs) -- Adults at this tier include persons with the most extensive/complex medical support needs that require nurse management to minimize medical risk factors. Maximum assistance with activities of daily living is required to meet their extensive physical support needs and personal hygiene; including lifting/transferring and positioning. Feeding tubes and other feeding supports (e.g., aspiration risk management), oxygen therapy or breathing treatments, suctioning, and seizure management are common as well. Persons at this needs level may be medically unstable or receiving hospice services.
- (3) Tier C (significant needs) -- Adults at this tier have profound medical/behavioral needs requiring significant supports. Some time may be spent alone, engaging independently in certain community activities and/or with natural supports.

b. High level of needs. Tiers B and A:

- (1) Tier B (moderate needs) -- Adults at this level require more hours of daily support than those with needs at Tier A. Even though members of this tier have a broader scope of personal needs than those in Tier A, 24/7 supports are not required as their needs are still considered minimal in a significant number of life areas.
- (2) Tier A (mild needs) -- Adults at this level are assessed as having mild support needs. Persons at this tier are capable of managing many aspects of their lives with limited supports and services. They do not require 24/7 paid supports as they are able to spend a significant amount of time on their own and/or engaging in the community with limited supports and services.

#### **5.7.4 Service Options**

- A. Services in an ICF/I-DD health institution are reserved for beneficiaries determined to have the highest level of "extraordinary need" (Tier E) on the SIS who require intensive 24/7 care and, due to extenuating circumstances, may only be served in a highly restricted setting. Generally, medical conditions requiring continuous on-site skilled, rather than custodial care, prohibit applicants at this level from obtaining care in an HCBS setting. Persons with this level of need are served in an NF or LTH offering the same or a more robust service array.
- B. The HCBS service options available to beneficiaries with the needs levels at each service classification provide the appropriate care and supports in the least

restrictive setting. A summary of the service options available at each tier is as follows:

DD/ID Needs-Based Service Tier Classifications and Options		
Tier	Service Options	Available Supports
<p>Tier D and E (Highest):</p> <p>Extraordinary Needs</p>	<p>Living with family/caregiver</p> <p>Independent Living</p> <p>Shared Living</p> <p>Group Home/Specialized Group Home</p> <p>Community Supported Living Services</p>	<p>Community Residential Support or access to overnight support services</p> <p>Integrated Employment Supports</p> <p>Integrated Community and/or Day supports</p> <p>Transportation</p>
<p>Tier C (Highest):</p> <p>Significant Needs</p>	<p>Living with family/caregiver</p> <p>Independent Living</p> <p>Shared Living</p> <p>Group Home</p> <p>Community Supported Living Services</p>	<p>Community Residential Support or Access to overnight support services</p> <p>Integrated Employment Supports</p> <p>Integrated Community and/or Day supports</p>

		Transportation
<p>Tier B (High):</p> <p>Moderate Needs</p>	<p>Living with family/caregiver</p> <p>Independent Living</p> <p>Shared Living</p> <p>Community Supported Living Services</p> <p>Group Home (Only an available service option when the conditions set forth below in § 5.7.4 D are met).</p>	<p>Integrated Employment supports</p> <p>Integrated Community and/or Day supports</p> <p>Access to overnight support services</p> <p>Transportation</p>
<p>Tier A (High):</p> <p>Mild Needs</p>	<p>Living with Family/Caregiver</p> <p>Independent Living</p> <p>Community Supported Living Services</p> <p>Group Home (Only an available service option when the conditions set forth below in § 5.7.4 D are met).</p> <p>Shared Living (Tier A will have access to Shared Living services if</p>	<p>Integrated Employment supports</p> <p>Integrated Community and/or Day Supports</p> <p>Access to overnight support services</p> <p>Transportation</p>

	they meet at least one defined exception).	
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- C. Otherwise eligible persons who do not meet the needs-based criteria set forth above for the highest tier -- D and E -- may be placed in an alternative, more intensive care setting if certain special circumstances apply. In these situations, the scope of authorized supports remains tied to the tier associated with needs even though the setting has changed. Such circumstances include:
1. Loss of primary caregiver, such as hospitalization, debilitating illness, or death of spouse, caretaker sibling or adult child;
  2. Loss of living situation, such as fire, flood, foreclosure, or sale of principal residence due to inability to maintain housing expenses;
  3. A principal treating health care provider, or prior to ending an acute care hospital stay, a discharge planner indicates, based on a functional/clinical assessment, that the health and welfare of the applicant/beneficiary is at imminent risk if services are not provided or if services are discontinued;
  4. The applicant/beneficiary met the highest level of care criteria on or before June 30, 2015 and chose to receive Medicaid LTSS at home or in a community-setting and the beneficiary reports he or she has experienced a failed placement that, if continued, may pose risks to the beneficiary's health and safety;
  5. The beneficiary was admitted to a hospital or NF and is being discharged back to the original setting within any given forty (40) day period; or
  6. There is a court order or other legal action requiring the provision of intensive supports or supervision that is only available in a residential supportive care setting.

#### **5.7.5 Reassessments of the ICF/I-DD Level of Need**

The BHDDH conducts reassessments of clinical and functional status at least annually and on an "as needed" basis. Unless these assessments warrant further review, redeterminations of clinical/functional eligibility and the level of need occur at five (5) year intervals.

### **5.8 Long-term Hospital Assessments and Level of Care Determinations**

- A. Long-term hospitals and the related HCBS alternatives serve people who may have one or more of a diverse set of clinical and/or functional needs. In addition,

the intervals for re-determining level of care may differ depending on a beneficiary's acuity needs. Accordingly, both the process and criteria for determining the LTH level of need vary across agencies and populations as follows:

1. HCB Habilitative Care – EOHHS LTSS specialists determine the level of need for applicants and beneficiaries seeking home and community based habilitative services. The NF needs-based criteria set forth in § 5.6.3 of this Part apply. Applicants and beneficiaries with the high and highest need have the choice of obtaining Medicaid HCBS services in a community residential care setting or at home.
  2. Under 21 psychiatric care – Medicaid applicants and beneficiaries up to age twenty-one (21) may obtain LTH services in a licensed psychiatric residential treatment center or a hospital under the authority of the Early, Periodic, Screening, Detection and Treatment (EPSDT) requirements of Title XIX and the Medicaid State Plan. Assessments center on “medical necessity” and clinical/functional need and are conducted by treating health practitioners, the Medicaid managed care plans, and/or the DCYF, if the child or young adult is participating in one of the department's programs.
  3. Behavioral health services – The BHDDH and the State's Community Mental Health Centers assess the clinical and functional needs of applicants/beneficiaries with serious and persistent behavioral health conditions and/or mental illnesses. This assessment is used to determine:
    - a. Level of care. Whether the person requires the services and supports typically provided in an LTH to meet their clinical and functional needs;
    - b. Service classification. What the scope and intensity of the person's need for the LTH level of care are; and
    - c. Service options. Whether the person's needs can be met safely and effectively in the available HCBS alternatives, or require the more intensive services, supports, and supervision that can be accessed in a more restrictive health institution setting.
- B. Reassessments are conducted annually or on a more frequent basis, depending on need. Redeterminations of functional/clinical eligibility occur no more than once annually, and less frequently for Medicaid LTSS beneficiaries who have clinical and/or functional limitations that are not expected to change.

**210-RICR-50-00-5**

**TITLE 210 - EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES**

**CHAPTER 50 - MEDICAID LONG-TERM SERVICES AND SUPPORTS**

**SUBCHAPTER 00 - LONG-TERM SERVICES**

**PART 5 - "MEDICAID LONG-TERM SERVICES AND SUPPORTS:  
FUNCTIONAL/CLINICAL ELIGIBILITY" (210-RICR-50-00-5)**

Type of Filing: Refile Capabilities

**Department of State**

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