

OFFICIAL

Revision: HCFA-Region I
SEPTEMBER 1990

ATTACHMENT 3.1-A
Page 9b

STATE RHODE ISLAND

24. Pediatric or family nurse practitioners' services as defined in Section 1905(a)(21) of the Act (added by Section 6405 of OBRA '89):

Provided: ☐ No Limitations ☒ With Limitations*

*Description provided on attachment.

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Attachment 3.1-A
Supplement to Page 9b

LIMITATIONS

24. Certified Pediatric or Family Nurse Practitioners

Limitations same as for physicians' services. See Supplement to page 2 of Attachment 3.1-A.

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PRIOR AUTHORIZATION PRACTICES UTILIZED IN THE ADMINISTRATION OF THE
RHODE ISLAND MEDICAL ASSISTANCE PROGRAM

1. Inpatient Hospital Services - Prior authorization is required for elective surgical procedures of a cosmetic nature which must be performed for functional purposes.

Prior authorization is required for Hospital Admissions for the following elective surgical procedures:

Tonsillectomy and adenoidectomy with or without Myringotomy;

Uterine Dialation and Curettage with or without cervical biopsy and/or cauterization; and

Ganglionectomy

Prior authorization is required for provision of Dental Services on an inpatient hospital basis.

Prior authorization is required for the assignment of more than 25 Administratively necessary days per hospitalization.

Prior authorization is required for hospitalization beyond the 15th day for non-Medicare patients treated primarily for a cerebrovascular accident, orthopedic problems, pneumonia or psychiatric disorders.

Prior authorization must be obtained from the Medical Assistance Program for the payment of all out-of-state medical and hospital services with the following exceptions:

- a. Emergency medical treatment and hospital services;
- b. Treatment provided by hospitals and practitioners located in close proximity to the Rhode Island state line (e.g., Attleboro, Seekonk, Fall River, New London, etc.); and
- c. Medical and hospital treatment provided children in Foster Care residing with families located outside the State of Rhode Island or in out-of-state residential treatment centers.

- 2.a. Outpatient Hospital Services - Physical, occupational and speech therapy services require prior authorization.

- 2.b. Rural Health Clinic - The prior authorization requirements which are applicable to ambulatory services when provided in other settings will apply to those ambulatory services other than Rural Health Clinic services when provided in a Rural Health Clinic.

3. Other Laboratory and X-ray Services - Special diagnostic and therapeutic x-rays and clinical laboratory tests not included in the x-ray and clinical laboratory fee schedule require prior authorization.

- 4.a. Skilled Nursing Facility Services - Prior authorization is required for all admissions.

PRIOR AUTHORIZATION PRACTICES UTILIZED IN THE ADMINISTRATION OF THE
RHODE ISLAND MEDICAL ASSISTANCE PROGRAM (cont'd.)

4.b. Early and Periodic Screening, Diagnosis and Treatment – The prior authorization requirements which are applicable to all other medical services and supplies provided in the Rhode Island Medical Assistance program apply for EPSDT services

5. Physicians' Services – Prior authorization is required for surgical procedures of a cosmetic nature which must be performed for functional purposes.

6.a. Podiatrists' Services – Prior authorization is required for x-rays performed for diagnostic evaluation purposes and molded shoes.

6.b. Optometrists' Services – Prior authorization is required for perceptual visual training.

Prior authorization is required for contact lenses when indicated for medical conditions.

7.a.-b.-d. Home Health Services – Home health services are provided in accordance with 42 CFR 440.70 and include nursing services, home health aide services, therapy visits and medical supplies, equipment and appliances. Home health services are provided to a recipient on his or her physician's orders as part of a written plan of care that the physician reviews every 60 days, except as specified in 42 CFR 440.70(b)(3). A face-to-face encounter, in accordance with 42 CFR 220.70(f), is required. Medicaid recipients do not have to be homebound in order to receive home health services. Home health services can be provided in any non-institutional setting in which normal life activities take place. Medical supplies, equipment and appliances suitable for use in any setting in which normal life activities take place are provided in accordance with physician review and other requirements as specified in 42 CFR 440.70(b)(3)

Home health agencies must meet the Medicare conditions of participation in 42 CFR Part 484.

Services cannot be provided in a hospital, nursing facility, or ICF-MR, except as allowed at 42 CFR 70.70(c).

9. Clinic Services - Ambulatory Surgical Centers must meet all the requirements of 42 CFR Part 416, Subpart C; and must be licensed as Freestanding Ambulatory Surgical Centers by the Rhode Island Department of Health.

10. Dental Services – Prior authorization is required for individuals to receive selected diagnostic, endodontic, periodontic, restorative, orthodontic, and surgical services performed in community-based and hospital settings as follows:

- Diagnostic- Extraoral radiography
- Restorative- Resin-based composite crown, Crown repair, Unspecified restorative procedure
- Endodontic: Unspecified endodontic procedure
- Periodontic: Scaling and Root Planing , Localized delivery of chemotherapeutic agents
- Surgical: Vestibuloplasty, Advanced maxillofacial surgery, TMJ Diagnosis and Surgery, Salivary gland surgery

- Orthodontic- all orthodontic procedures with D8000 codes require prior authorization.
- Adjunctive services: Drug delivery, Desensitization, Surgical complication management, Occlusal guard

11.a.-b.-c. Physical Therapy and Related Services – Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders are provided in accordance with 42 CFR 440.110. Prior authorization is required for all Physical Therapy, Occupational Therapy and Services for Individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

12.a. Prescribed Drugs – prior authorization is required for all injectables (excluding insulin and adrenalin), appetite depressant drugs, central nervous system stimulants, expensive vitamins, hematinics, and lipotropic preparations (selling for over \$10 per 100 tablets, capsules or pint of liquid), and new and/or expensive preparations.

12.b. Dentures – prior authorization is required for rebase, relines, interim dentures, and precision attachments for individuals under 21 years of age.

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PRIOR AUTHORIZATION PRACTICES UTILIZED IN THE ADMINISTRATION OF THE
RHODE ISLAND MEDICAL ASSISTANCE PROGRAM (Cont'd.)

- 12.c. Prosthetic Devices - Prior authorization is required for all prosthetic devices.
- 12.d. Eyeglasses - Prior authorization is required for corrective vision devices not specified in the Rhode Island Medical Assistance fee schedule.
- 14.a. Services for Individuals Age 65 or older in Institutions for Mental Diseases - Prior authorization is required for out-of-state inpatient hospital services.
- 15.a. Intermediate Care Facility Services - Prior authorization is required for all admissions.
- 15.b. Intermediate Care Facility Services for the Mentally Retarded - Prior authorization is required for all admissions.
16. Inpatient Psychiatric Facility Services for Individuals under 22 Years of Age - Prior authorization is required for all admissions.
18. Hospice Care Services - Prior authorization required for all services.
- 20.a. Transportation - Prior authorization is required for ambulance services involving transportation outside the State of Rhode Island and for patients in Skilled Nursing and Intermediate Care Facilities who are not ambulatory.
- 20.d. Skilled Nursing Facility Services for Patients Under 21 Years of Age - Prior authorization is required for all admissions.

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Supercedes

TN No. 87-07

PAGE MISSING

Attachment 3.1-A

Page X

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

State of Rhode Island

PACE State Plan Amendment Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Categorically Needy

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

x Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

 No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

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State/Territory: Rhode Island

Amount, Duration, and Scope of Medical and
Remedial Care Services Provided to the Categorically Needy

Attachment 3.1A: Freestanding Birth Center Services

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: _____ No limitations _____ With limitations

XXX None licensed or approved

**28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in
the Freestanding Birth Center**

Provided: _____ No limitations _____ With limitations

XXX Not Applicable (there are no licensed or State-approved
Freestanding Birth Centers)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Rhode Island

CASE MANAGEMENT SERVICES

A. Target Group: See Attachment 3.1A, Supplement to page 8.

B. Areas of State in which services will be provided:

☒ Entire State.

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

☒ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☐ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services: See Attachment 3.1A, Supplement to page 8.

E. Qualification of Providers: See Attachment 3.1A, Supplement to page 8.

TM No. 87-04
Spec. codes
f No. New

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SUPPLEMENT 1 TO ATTACHMENT 3.1-A
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State/Territory: Rhode Island

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F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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SUPPLEMENT 2 TO ATTACHMENT 3.1-A

1. The State of RI provides home and community care to functionally disabled elderly individuals to the extent described and defined in this Supplement (and Appendices) in accordance with section 1929 of the Social Security Act.

2. Home and community care services are available Statewide.

X Yes* No

If no, these services will be available to individuals only in the following geographic areas or political subdivisions of the State (specify):

*To be phased in geographically.

3. The home and community care services specified in this Supplement will be limited to the following target groups of recipients (specify all restrictions that will apply):

- a. X aged (age 65 and older, or greater than age 65 as limited in Appendix B)
- b. In accordance with §1929(b)(2)(A) of the Act, individuals age 65 or older who were served under a waiver granted pursuant to section 1915(c) of the Act on the date on which that waiver was terminated. Financial eligibility standards for these individuals are specified in Appendix A. Minimum disability standards for these individuals are specified in Appendix B.
- c. In accordance with §1929(b)(2)(A) of the Act, individuals who were served under a waiver granted pursuant to section 1915(d) of the Act on the date on which that waiver was terminated. Financial eligibility standards for these individuals are specified in Appendix A. Minimum disability standards for these individuals are specified in Appendix B.

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- d. In accordance with §1929(b)(2)(B) of the Act, individuals who meet the test of disability under the State's §1115 waiver which provides personal care services under the State plan for functionally disabled individuals, and which was in effect on December 31, 1990. Financial eligibility standards for these individuals are specified in Appendix A. Functional disability standards for these individuals are specified in Appendix B.

4. Additional targeting restrictions (specify):

- a. Eligibility is limited to the following age groups (specify): _____
- b. Eligibility is limited by the severity of disease or condition, as specified in Appendix B.
- c. XX Eligibility is limited to individuals who have been shown to have a need for one or more of the services elected by the State under this benefit, not to exceed a combined total of 20 hours per week, excluding adult day care.

5. Standards for financial eligibility are set forth in Appendix A. Each individual served shall meet applicable standards for financial eligibility.

6. Each individual served will meet the test of functional disability set forth in Appendix B.

The State will provide for a comprehensive functional assessment for a financially eligible individual who meets the targeting requirements set forth in item 3 of this Supplement. This assessment will be provided at the request of the individual or another person acting on such individual's behalf. The individual will not be charged a fee for this assessment.

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8. The comprehensive functional assessment will be used to determine whether the individual is functionally disabled, as defined in Appendix B. Procedures to ensure the performance of this assessment are specified in Appendix D.
9. The comprehensive functional assessment is based on the uniform minimum data set specified by the Secretary. Check one:
 - a. The State will use the assessment instrument designed by HCFA.
 - b. X The State will use an assessment instrument of its own designation. The assessment instrument to be used is consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by HCFA. A copy of the assessment instrument can be found at Appendix D.
10. The comprehensive functional assessment will be reviewed and revised not less often than every 12 months. Procedures to ensure this review and revision are specified in Appendix D.
11. The comprehensive functional assessment and review will be conducted by an interdisciplinary team designated by the State. Qualifications of the interdisciplinary team are specified in Appendix D.
12. Based on the comprehensive functional assessment or review, the interdisciplinary team will:
 - a. Identify in each such assessment or review each individual's functional disabilities and need for home and community care, including information about the individual's health status, home and community environment, and informal support system; and

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- b. based on such assessment or review, determine whether the individual is (or continues to be) functionally disabled.
13. The results of the comprehensive functional assessment or review will be used in establishing, reviewing and revising the person's individual community care plan (ICCP).
14. An ICCP will be developed by a qualified community care case manager for each individual who has been determined, on the basis of a comprehensive functional assessment, to be a functionally disabled elderly individual.
15. All services will be furnished in accordance with a written ICCP which:
- a. is established, and periodically reviewed and revised, by a qualified community care case manager after a face-to-face interview with the individual or primary care giver;
 - b. is based upon the most recent comprehensive functional assessment of the individual;
 - c. specifies, within the amount, duration and scope of service limitations specified in Appendix C, the home and community care to be provided under the plan. The ICCP will specify the community care services to be provided, their frequency, and the type of provider to furnish each service;
 - d. indicates the individual's preferences for the types and providers of services and documents the individual's free choice of providers and services to be furnished; and
 - e. may specify other services required by the individual.

A copy of the ICCP format to be used in implementing this benefit is included in Appendix E.

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16. Each individual's ICCP will be established and periodically reviewed and revised by a qualified community care case manager, as provided in Appendix E.
17. A qualified community care case manager is a nonprofit or public agency or organization which meets the conditions and performs the duties specified in Appendix E.
18. The State will provide the following home and community care services, as defined, described and limited in Appendix C to the groups specified in items 3, 4, 5 and 6 of this Supplement.
 - a. ☒ Homemaker services
 - b. ☐ Home health aide services
 - c. ☐ Chore services
 - d. ☒ Personal care services
 - e. ☐ Nursing care services provided by, or under the supervision of, a registered nurse
 - f. ☐ Respite care
 - g. ☐ Training for family members in managing the individual
 - h. ☒ Adult day care
 - i. ☐ The following services will be provided to individuals with chronic mental illness:
 1. ☐ Day treatment/Partial hospitalization
 2. ☐ Psychosocial rehabilitation services
 3. ☐ Clinic services (whether or not furnished in a facility)

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- j. Other home and community-based services (other than room and board) as the Secretary may approve. The following other services will be provided:

1. Habilitation
 - A. Residential Habilitation
 - B. Day Habilitation
2. Environmental modifications
3. Transportation
4. Specialized medical equipment and supplies
5. X Personal Emergency Response Systems
6. Adult companion services
7. Attendant Care Services
8. Private Duty Nursing Services
9. Extended State plan services (check all that apply):
 - A. Physician Services
 - B. Home health care services
 - C. Physical therapy services
 - D. Occupational therapy services
 - E. Speech, hearing and language services
 - F. Prescribed drugs
 - G. Other State plan services (specify):
10. Other home and community based services (specify):

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19. The State assures that adequate standards for each provider of services exist and will be met. These provider standards are found at Appendix C-2.
20. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to individuals who are adversely affected by the determinations of the interdisciplinary team, or who are denied the service(s) of their choice, or the provider(s) of their choice, or who disagree with the ICCP which has been established.
21. FFP will not be claimed for the home and community care services specified in item 18 of this Supplement prior to the development of the ICCP. FFP will not be claimed for home and community care services which are not included in the ICCP.
22. The State provides the following assurances to HCFA:
 - a. Home and community care services will not be furnished to recipients while they are inpatients of a hospital, NF, or ICF/MR.
 - b. FFP will not be claimed in expenditures for the cost of room and board, except when provided as part of respite care furnished in a facility which is (1) approved by the State, and (2) not a private residence. Meals furnished under any community care service (or combination of services) will not constitute a "full nutritional regimen" (3 meals a day).
 - c. FFP will not be claimed in expenditures for the cost of room and board furnished to a provider of services.
 - d. The agency will provide HCFA annually with information on the amount of funds obligated by the State with respect to the provision of home and community care to the functionally disabled elderly in that fiscal year. These reports will begin with information relative to FFP 1990 and will be provided in the manner prescribed by HCFA. The State assures that it will provide data on its maintenance of effort, as required by section 1923(s) of the Social Security Act, in such format and at such times as are specified by HCFA.

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- e. The home and community care provided in accordance with this Supplement and Appendices will meet all requirements for individual's rights and quality of care as are published or developed by HCFA.
 - 1. All individuals providing care are competent to provide such care; and
 - 2. Each provider of services under this benefit will meet the requirements applicable to the provision of home and community care as set forth in Appendix C.
 - 3. Each individual receiving home and community care will be accorded the rights specified in Appendix F.
 - 4. Case managers will comply with all standards and procedures set forth in Appendix E.
- 23. FFP will not be claimed for the home and community care services specified in item 18 of this Supplement in any quarter to the extent that cost of such care in the quarter exceeds 50 percent of the product of:
 - a. the average number of individuals in the quarter receiving home and community care;
 - b. the average per diem rate of Medicare payment for extended care services (without regard to coinsurance) furnished in the State during such quarter; and
 - c. the number of days in such quarter.
- 24. Community care settings in which home and community care is provided will meet the requirements set forth in section 1929(g) and (h) of the Act, as applicable to the specific setting. The State assures that the requirements of Appendix G will be met for each setting in which home and community care is provided under this section.

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25. The State will refuse to provide home and community care in settings which have been found not to meet the requirements of sections 1929(g) and (h) of the Act.
26. The State will comply with the requirements of section 1929(i) of the Act, regarding survey and certification of community care settings, as set forth in Appendix G.
27. The State will comply with the requirements of section 1929(i) of the Act, regarding the compliance of providers of home and community care and reviews of this compliance, as set forth in Appendix C.
28. The State will provide for an enforcement process for providers of community care, as required by section 1929(j) of the Act. This process is described in Appendix C.
29. The State assures that payment for home and community care services will be made through rates which are reasonable and adequate to meet the costs of providing care efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards.
30. Payment will not be made for home and community care to reimburse (or otherwise compensate) a provider of such care for payment of a civil money penalty imposed under title XIX or title XI of the Social Security Act or for legal expenses in defense of an exclusion or civil money penalty under title XIX or title XI of the Social Security Act if there is no reasonable legal ground for the provider's case.
31. The State will begin provision of services under section 1905(a)(23) of the Social Security Act effective (specify date):

March 1, 1992

These services will be provided to eligible individuals for a minimum of four calendar quarters, beginning on this date.

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32. Services will be provided to eligible recipients for the duration of the period specified in item 31, above, without regard to the amount of Federal financial participation available to the State.
33. The State assures that it will monitor the appropriateness and accuracy of the assessments and reviews. Through its monitoring, the State assures the appropriateness and accuracy of the assessments and periodic reviews. The State assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the nature and severity of any deficiencies noted.

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APPENDIX C-2 TO
SUPPLEMENT 2 TO ATTACHMENT 3.1-A
Page 4

<u>SERVICE</u>	<u>MINIMUM QUALIFICATIONS OF PROVIDERS</u>
DAY TREATMENT/PARTIAL HOSPITALIZATION	Day treatment/partial hospitalization services are furnished by a hospital to its outpatients. They are furnished by a distinct and organized ambulatory treatment center which offers less than 24 hours a day.
PSYCHOSOCIAL REHABILITATION	
CLINIC SERVICES	
CORE SERVICES	
HABILITATION GENERAL STANDARDS	
RESIDENTIAL HABILITATION	
DAY HABILITATION	
ENVIRONMENTAL MODIFICATIONS	

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APPENDIX A-1 TO
SUPPLEMENT 2 TO ATTACHMENT 3.1-A
Page 1

APPENDIX A - FINANCIAL ELIGIBILITY FOR SERVICES

APPENDIX A-1 MEDICAID ELIGIBILITY GROUPS SERVED

- a. Home and community care services will be made available to individuals age 65 or older, when the individuals have been determined to be functionally disabled as specified in Appendix B.
- b. Individuals served under this provision must meet the following Medicaid eligibility criteria (check all that apply):
 1. X SSI/SSP recipients, age 65 or older who have been determined to be functionally disabled as specified in Appendix B.
 - A. X The agency uses the same methodologies for treatment of income and resources as used in the SSI program (or the optional State supplement program which meets the requirements of 42 CFR 435.230, as appropriate).
 - B. The agency uses methodologies for treatment of income and resources that differ from those of the SSI program. These differences result from restrictions applied under section 1902(f) of the Act. The methodologies are described in Supplement 5 to Attachment 2.6-A.
 2. X Medically needy, age 65 or older who have been determined to be functionally disabled as specified in Appendix B. In determining the individual's eligibility, the State may, at its option, provide for the determination of the individual's anticipated medical expenses (to be deducted from income). (Check one):
 - A. The State does not consider anticipated medical expenses.
 - B. X The State considers anticipated medical expenses of a period of 6 months (not to exceed 6 months).

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APPENDIX A-2 TO
SUPPLEMENT 2 TO ATTACHMENT 3.1-A
Page 1

APPENDIX A-2 INDIVIDUALS PREVIOUSLY COVERED UNDER A WAIVER

a. _____ The State used a health insuring organization before January 1, 1986, and had in effect a waiver under §1115 of the Act, which provides personal care services under the State plan for functionally disabled individuals, and which was in effect on December 31, 1990. In accordance with §1929(b)(2)(B) of the Act, The following individuals will be eligible to receive home and community care services. (Check all that apply):

1. _____ Age 65 or older.
2. _____ Disabled, receiving SSI.

These individuals meet the resource requirement and income standards that apply in the State to individuals described in §1902(a)(10)(A)(i)(V) of the Act.

b. _____ In accordance with §1929(b)(2)(A) the Act, individuals age 65 or older who were served under a waiver granted pursuant to section 1915(c) of the Act on the date on which that waiver was terminated. Financial eligibility standards for these individuals (which are the same as those in effect on the date on which the waiver was terminated) are attached to this Appendix.

c. _____ In accordance with §1929(b)(2)(A) the Act, individuals who were served under a waiver granted pursuant to section 1915(d) of the Act on the date on which that waiver was terminated. Financial eligibility standards for these individuals (which are the same as those in effect on the date on which the waiver was terminated) are attached to this Appendix.

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APPENDIX B-1 TO
SUPPLEMENT 2 TO ATTACHMENT 3.1-A
Page 1

APPENDIX B-1 FUNCTIONAL DISABILITY

Home and community care services, as defined in this Supplement, are provided to the following classifications of individuals who have been found on the basis of an assessment to be functionally disabled. Services will be limited to individuals who meet the following targeting criteria.

Check all that apply:

- a. ☒ Services are provided to individuals, who have been determined, on the basis of an assessment, to require substantial human assistance with at least two of the following activities of daily living: toileting, transferring, eating.
- b. ☐ Services are provided to individuals, who have been determined, on the basis of an assessment, to require substantial human assistance with each of the following activities of daily living: toileting, transferring, eating.
- c. ☒ Services are provided to individuals who have been determined, on the basis of an assessment, to have a primary or secondary diagnosis of Alzheimer's Disease, and are unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision, at least 2 of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.
- d. ☐ Services are provided to individuals, who have been determined, on the basis of an assessment, to have a primary or secondary diagnosis of Alzheimer's Disease, and are unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision, (check one):
 - 1. ☐ at least 3 of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.
 - 2. ☐ at least 4 of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.
 - 3. ☐ all of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.
- e. ☒ Services are provided to individuals who have been determined, on the basis of an assessment, to have a primary or secondary diagnosis of Alzheimer's Disease, and are sufficiently cognitively impaired so as to require substantial supervision from another individual because they engage in inappropriate behaviors that pose serious health or safety hazards to themselves or others.

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APPENDIX B-2 TO
SUPPLEMENT 2 TO ATTACHMENT 3.1-A
Page 1

APPENDIX B-2 AGE

Check all that apply:

- a. X Services are provided to individuals age 65 and older.
- b. Services are provided to individuals who have reached at least the following age (specify):
- c. Services are provided to individuals who meet the criteria set forth in item 3.b. of Supplement 2, as set forth in Appendix B-3, who were 65 years of age or older on the date of the waiver's discontinuance.
- d. Services are provided to individuals who meet the criteria set forth in item 3.c. of Supplement 2, as set forth in Appendix B-3, who were served under the waiver on the date of its discontinuance.
- e. Services are provided to individuals who meet the criteria item 3.d. of Supplement 2, as explained in appendix B-3, who fall within the following age categories (check one):
1. Age 65 and older
 2. Age greater than 65. Services are limited to those who have attained at least the age of (specify):
 3. Age less than 65. Services will be provided to those in the following age category (specify):
 4. The State will impose no age limit.

APPENDIX B-3 INDIVIDUALS PREVIOUSLY SERVED UNDER WAIVER AUTHORITY

a. _____ In accordance with §1929(b)(2)(A) of the Act, the State will discontinue the following home and community-based services waiver(s), approved under the authority of §1915(c) or §1915(d) of the Act. (Specify the waiver numbers):

_____ Last date of waiver operation: _____
 _____ Last date of waiver operation: _____
 _____ Last date of waiver operation: _____
 _____ Last date of waiver operation: _____

b. For each waiver specified in Appendix B-3-a, above, the State will furnish at least 30 days notice of service discontinuance to those individuals under 65 years of age, and to those individuals age 65 or older who do not meet the test of functional disability specified in Appendix B-1 (except those individuals who will continue to receive home and community-based services under a different waiver program).

c. Individuals age 65 years of age or older, who were eligible for benefits under a waiver specified in Appendix B-3-a on the last date of waiver operation, who would, but for income or resources, be eligible for home and community care under the State plan, shall, be deemed functionally disabled elderly individuals for so long as they would have remained eligible for services under the waiver.

d. The financial eligibility standards which were in effect on the last date of waiver operation are attached to this Appendix.

e. The following are the schedules, in effect on the last date of waiver operation, under which individuals served under a waiver identified in Appendix B-3-a were re-evaluated for financial eligibility (specify):

Waiver Number	Re-evaluation schedule
_____	_____
_____	_____
_____	_____
_____	_____

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APPENDIX C - SERVICES

APPENDIX C-1

DEFINITION OF SERVICES

§ 119.1 requests that the following services, as described and defined herein, be provided as home and community care services to functionally disabled elderly individuals under this program:

- a. X Homemaker: services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual 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. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities. This service does not include medical care of the client. Hands-on care is limited to such activities as assistance with dressing, uncomplicated feeding, and pushing a wheelchair from one room to another. Direct care furnished to the client is incidental to care of the home. These standards are included in Appendix C-2.

Check one:

1. This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
2. X The State will impose the following limitations on the provision of this service (specify): No individual shall receive more than a total of 20 service hours per week

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5. _____ Some health aide services: services defined in 42 CFR 440.70 with the exception that limitations on the amount, duration and scope of such services shall instead be governed by the limitations imposed below.

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
2. _____ The State will impose the following limitations on the provision of this service (specify): _____

c. X Personal care services: assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This service includes meal preparation, when required by the individual community care plan (ICCP), but does not include the cost of the meals. When specified in the ICCP, this service also includes such housekeeping chores as bedmaking, cleaning, shopping, or escort services which are appropriate to maintain the health and welfare of the recipient. Providers of personal care services must meet State standards for this service. These standards are included in Appendix C-2.

1. Services provided by family members. Check one:

 X Payment will not be made for personal care services furnished by a member of the recipient's family or by a person who is legally or financially responsible for that recipient.

 Personal care providers may be members of the recipient's family. Payment will not be made for services furnished to a minor by the recipient's parent (or stepparent), or to a recipient by the recipient's spouse. Payment will not be made for services furnished to a recipient by a person who is legally or financially responsible for that recipient.
Check one:

 Family members who provide personal care services must meet the same standards as other personal care providers who are unrelated to the recipient. These standards are found in Appendix C-2.

 Standards for family members who provide personal care services differ from those for other providers of this service. The standards for personal care services provided by family members are found in Appendix C-2.

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2. Personal care providers will be supervised by:

- ☒ a registered nurse, licensed to practice nursing in the State
- ☐ case managers
- ☐ other (specify): _____

3. Minimum frequency or intensity of supervision:

- ☐ as indicated in the client's ICCP
- ☒ other (specify): As required by State licensing regulations.

4. Personal care services are limited to those furnished in a recipient's home.

- ☒ Yes ☐ No

5. Limitations (check one):

- ☐ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
- ☒ The State will impose the following limitations on the provision of this service: No individual shall receive more than a total of 20 service hours per week.

TN # 92-16
Supersedes
TN # 92-05

Approved _____

JUN 17 1992

MAR 1 1992
Effective April 1, 1992

ORIGINAL

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- d. _____ Nursing care services provided by or under the supervision of a registered nurse. Nursing services listed in the ICCP which are within the scope of State law, and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Standards for the provision of this service are included in Appendix C-2.

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
2. _____ The State will impose the following limitations on the provision of this service (specify): _____
- _____
- _____
- _____

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e. _____ Respite care: services given to individuals unable to care for themselves; provided on a short-term basis because of the absence or need for relief of those persons normally providing the care. FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

1. Respite care will be provided in the following location(s):

- _____ Recipient's home or place of residence
- _____ Foster home
- _____ Facility approved by the State which is not a private residence

2. The State will apply the following limits to respite care provided in a facility.

- _____ Hours per recipient per year
- _____ Days per recipient per year
- _____ Respite care will be provided in accordance with the ICCP. There are no set limits on the amount of facility-based respite care which may be utilized by a recipient.
- _____ Not applicable. The State does not provide facility-based respite care.

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3. Respite care will be provided in the following type(s) of facilities.

- ☐ Hospital
- ☐ NF
- ☐ ICF/MR
- ☐ Group home
- ☐ Licensed respite care facility
- ☐ Other (specify): _____
- ☐ Not applicable. The State does not provide facility-based respite care.

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4. The State will apply the following limits to respite care provided in a community setting which is not a facility (including respite care provided in the recipient's home).

_____ Hours per recipient per year

_____ Days per recipient per year

_____ Respite care will be provided in accordance with the ICCP. There are no set limits on the amount of community-based respite care which may be utilized by a recipient.

_____ Not applicable. The State does not provide respite care outside a facility-based setting.

Qualifications of the providers of respite care services are included in Appendix C-2. Applicable Keys amendment (section 161a(e) of the Social Security Act) standards are cited in Appendix F-2.

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P. _____ Training for family members in managing the individual: includes training and counseling services for the families of functionally disabled elderly individuals. For purposes of this service, "family" is defined as the persons who live with or provide care to a disabled individual, and may include a spouse, children, friends, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the functionally disabled individual. Training includes instruction about treatment regimens and use of equipment specified in the ICCP and shall include updates as may be necessary to safely maintain the individual at home. This service is provided for the purpose of increasing the ability of a primary caregiver or a member of the recipient's family to maintain and care for the individual at home. All training for family members must be included in the client's ICCP.

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Provider qualifications are specified in Appendix C-2.

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- g. X Adult day care: services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the client. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Check all that apply:

1. X Physical therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of physical therapy will be included in the rate paid to providers of adult day care services.
2. X Occupational therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of occupational therapy will be included in the rate paid to providers of adult day care services.
3. X Speech therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of speech therapy will be included in the rate paid to providers of adult day care services.
4. X Nursing care furnished by or under the supervision of a registered nurse, and indicated in the individual's ICCP, will be provided by the facility as a component part of this service.
5. X Transportation between the recipient's place of residence and the adult day care center will be provided as a component part of this service. The cost of this transportation is included in the rate paid to providers of adult day care services.
6. Other therapeutic activities which will be provided by the facility as component parts of this service. (Specify): _____

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Limitations. Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
2. X The State will impose the following limitations on the provision of this service (specify): Maximum of 5 days per week.

Qualifications of the providers of this service are found in Appendix C-2.

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h. _____ Services for individuals with chronic mental illness, consisting of:

1. _____ Day Treatment or other Partial Hospitalization services that are necessary for the diagnosis or active treatment of the individual's mental illness. These services consist of the following elements:

- a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),
- b. occupational therapy, requiring the skills of a qualified occupational therapist,
- c. services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients,
- d. drugs and biologicals furnished for therapeutic purposes,
- e. individual activity therapies that are not primarily recreational or diversionary,
- f. family counseling (the primary purpose of which is treatment of the individual's condition),
- g. patient training and education (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and
- h. diagnostic services.

Meals and transportation are excluded from reimbursement under this benefit. The purpose of this benefit is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

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Limitations. Check one:

- a. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
- b. _____ The State will impose the following limitations on the provision of this service (specify): _____

Qualifications of the providers of this service are found in Appendix C-2.

2. _____ Psychosocial rehabilitation Services. Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

- o Restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);
- o Social skills training in appropriate use of community services;
- o Development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and
- o Telephone monitoring and counseling services.

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The following services are specifically excluded from Medicaid payment:

Vocational services,
Prevocational services,
Supported employment services,
Educational services, and
Room and board.

Psychosocial rehabilitation services are furnished in the following locations (check all that apply):

- a. _____ Individual's home or place of residence
- b. _____ Facility in which the individual does not reside
- c. _____ Other (Specify): _____

Limitations. Check one:

- a. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
- b. _____ The State will impose the following limitations on the provision of this service (specify): _____

Qualifications of the providers of this service are found in Appendix C-2.

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3. _____ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

a. _____ This benefit is limited to those services furnished on the premises of a clinic.

b. _____ Clinic services may be furnished outside the clinic facility. Services may be furnished in the following locations (specify): _____

Check one:

a. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

b. _____ The State will impose the following limitations on the provision of this service (specify): _____

Qualifications of the providers of this service are found in Appendix C-2.

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1. _____ Habilitation: services designed to assist individuals in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community settings. This service includes:
 1. _____ Residential habilitation: assistance with acquisition, retention or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a home or community setting. Payments for residential habilitation are not made for room and board, or the costs of facility maintenance, upkeep, and improvement. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the recipient's immediate family. Payments will not be made for routine care and supervision, or for activities or supervision for which a payment is available from a source other than Medicaid. The methodology by which payments are calculated and made is described in Attachment 4.19-9.
 2. _____ Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the recipient resides. Services shall normally be furnished 4 or more hours per day, on a regularly scheduled basis, for 1 or more days per week, unless provided as an adjunct to other day activities included in the recipient's ICCP. Day habilitation services shall focus on enabling the individual to attain or retain his or her maximum functional level.

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Check all that apply:

- A. _____ Physical therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of physical therapy will be included in the rate paid to providers of habilitation services.
- B. _____ Occupational therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of occupational therapy will be included in the rate paid to providers of habilitation services.
- C. _____ Speech therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of speech therapy will be included in the rate paid to providers of habilitation services.
- D. _____ Nursing care furnished by or under the supervision of a registered nurse, and indicated in the individual's ICCP, will be provided by the facility as a component part of this service.
- E. _____ Transportation between the recipient's place of residence and the habilitation center will be provided as a component part of this service. The cost of this transportation is included in the rate paid to providers of habilitation services.

F. _____ Other therapeutic activities
which will be provided by the
facility as component parts of
this service.
(Specify): _____

Check one:

1. _____ This service is provided to eligible
individuals without limitations on the amount
or duration of services furnished.
2. _____ The State will impose the following
limitations on the provision of this service
(specify): _____

Payment will not be made for the following:
Vocational Services;
Prevocational services;
Educational services; or
Supported employment services.

Qualifications of the providers of this service are
specified in Appendix C-2.

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1. _____ Environmental modifications: those physical adaptations to the home, required by the individual's ICCP, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home.

Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies the need for which is identified in the client's ICCP.

Adaptations or improvements to the home which are of general utility, or which are not of direct medical or remedial benefit to the client, such as carpeting, roof repair, central air conditioning, etc., are specifically excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
2. _____ The State will impose the following limitations on the provision of this service (specify): _____
- _____
- _____
- _____

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Transportation: service offered in order to enable individuals receiving home and community care under this section to gain access to services identified in the ICCP. Transportation services under this section shall be offered in accordance with the recipient's ICCP, and shall be used only when the service is not available without charge from family members, neighbors, friends, or community agencies, and when the appropriate type of transportation is not otherwise provided under the State plan. In no case will family members be reimbursed for the provision of transportation services under this section.

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Provider qualifications are specified in Appendix C-2.

Specialized Medical Equipment and Supplies: specialized medical equipment and supplies which include devices, controls, or appliances, specified in the ICCP, which enable clients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and supplies not otherwise available under the State plan. Items which are not of direct medical or remedial benefit to the recipient are excluded from this service. All specialized medical equipment and supplies provided under this benefit shall meet applicable standards of manufacture, design and installation.

Check one:

1. ☐ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
2. ☐ The State will impose the following limitations on the provision of this service (specify): _____

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m. _____ Chore Services. Services identified in the ICCP which are needed to maintain the individual's home in a clean, sanitary and safe environment. For purposes of this section, the term "home" means the abode of the individual, whether owned or rented by the client, and does not include the residence of a paid caregiver with whom the client resides (such as a foster care provider), or a small or large community care facility.

Covered elements of this service include heavy household chores such as washing floors, windows and walls, removal of trash, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access inside the home for the recipient, and shoveling snow to provide access and egress.

Chore services will be provided only in cases where neither the client, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
3. _____ The State will impose the following limitations on the provision of this service (specify): _____

Provider qualifications are specified in Appendix C-2.

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Adult Companion Services. Non-medical care, supervision and socialization provided to a functionally disabled adult. Companions may assist the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on medical care. Companion services may include non-medical care of the client, such as assistance with bathing, dressing and uncomplicated feeding. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the client. This service is provided in accordance with a therapeutic goal in the ICCR, and is not merely diversionary in nature.

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Provider qualifications are specified in Appendix C-2.

3. Services provided by family members. Check one:

- A. _____ Payment will not be made for adult companion services furnished by a member of the recipient's family or by a person who is legally or financially responsible for that recipient.
- B. _____ Adult companion service providers may be members of the recipient's family. Payment will not be made for services furnished to a minor by the recipient's parent (or stepparent), or to a recipient by the recipient's spouse. Payment will not be made for services furnished to a recipient by a person who is legally or financially responsible for that recipient.

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Check one:

1. _____ Family members who provide adult companion services must meet the same standards as other adult companion providers who are unrelated to the recipient. These standards are found in Appendix C-2.
2. _____ Standards for family members who provide adult companion services differ from those for other providers of this service. The standards for adult companion services provided by family members are found in Appendix C-2.

3. _____ Attendant Care. Hands-on care, of both a medical and non-medical supportive nature, specific to the needs of a medically stable, physically handicapped individual. This service may include skilled medical care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of the client-based care may also be furnished as part of this activity.

Check all that apply:

1. _____ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the ICCP.
2. _____ Supervision may be furnished directly by the client, when the client has been trained to perform this function, and when the safety and efficacy of client-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on observation of the client and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained with the client's ICCP.

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Provider qualifications are specified in Appendix C-2.

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B. x

Personal Emergency Response Systems (PERS). PERS is an electronic device which enables certain high-risk clients to secure help in the event of an emergency. The client may also wear a portable "help" button to allow for mobility. The system is connected to the client's phone and programmed to signal a response center once the "help" button is activated. The response center is staffed by individuals with the qualifications specified in Appendix C-2.

Check one:

1. This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
2. x The State will impose the following limitations on the provision of this service (specify): This service will be provided to clients living alone who are without support for extended periods of time.

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SUPPLEMENT 2 TO ATTACHMENT 3.1-A
Page 1

APPENDIX C-2 PROVIDER QUALIFICATIONS

- a. The following are the minimum qualifications for the provision of each home and community care service under the plan.

LICENSURE AND CERTIFICATION CHART

Cite relevant portions of State licensure and certification rules as they apply to each service to be provided.

SERVICE	PROVIDER TYPE	LICENSURE	CERTIFICATION
HOMEMAKER	X	attached	
HOME HEALTH NURSE			
PERSONAL CARE	X	attached	
ATTENDANT CARE			
NURSING CARE			
RESPIRE CARE			
IN HOME			
FACILITY BASED			
FAMILY TRAINING			
ADULT DAY CARE	X		attached
DAY TREATMENT/ PARTIAL HOSPITALIZATION			
PSYCHOSOCIAL REHABILITATION			
CLINIC SERVICES			

Licensure/Certification requirements attached.

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Page 2

SERVICE	PROVIDER TYPE	LICENSURE	CERTIFICATION
HABILITATION			
RESIDENTIAL			
DAY			
ENVIRONMENTAL MODIFICATIONS			
TRANSPORTATION			
MEDICAL EQUIPMENT AND SUPPLIES			
3	X	*	*
ADULT COMPANION			
ATTENDANT CARE			
24 HOUR NURSING			

Identify any licensure and certification standards applicable to the providers of "other" services defined in Appendix C-1 on a separate sheet of paper. Attach the paper to this Appendix.

*Licensure/Certification not required for this service in R.I.

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Page 3

d. PROVIDER REQUIREMENTS SPECIFIC TO EACH SERVICE

In addition to the licensure and certification standards cited in Appendix, the State will impose the following qualifications for the providers of each service.

N O N E

SERVICE	MINIMUM QUALIFICATIONS OF PROVIDERS
HOMEMAKER	
HOME HEALTH AIDE	Providers of Home Health Aide services meet the qualifications set forth at 42 CFR Part 484 for the provision of this service under the Medicare program.
PERSONAL CARE	
ATTENDANT CARE	
NURSING CARE	
RESPIRE CARE	
IN HOME	
FACILITY BASED	
FAMILY TRAINING	
ADULT DAY CARE	

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SERVICE	MINIMUM QUALIFICATIONS OF PROVIDERS
TRANSPORTATION	
MEDICAL EQUIPMENT AND SUPPLIES	
PERS	- All installers of telephonic and electronic equipment must conform to all State and local building and fire and safety codes. - All training must be approved by State Medicaid Agency.
ULT COMPANION	
ATTENDANT CARE	
PVT DUTY NURSING	

Identify the provider requirements applicable to the providers of each other service specified in Appendix C-1 on a separate sheet of paper. Attach the paper to this Appendix.

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- All vendors must have the capacity to fully train all recipients in the proper use of services.
- All vendors must train personnel responsible for handling emergency calls, and the proper techniques of emergency response.

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OFFICIAL

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SUPPLEMENT 2 TO ATTACHMENT 3.1-A
Page 1

APPENDIX D-1 ASSESSMENT

a. The State will provide for a comprehensive functional assessment for a financially eligible individual who meets the targeting requirements set forth in item 3 of Supplement 2.

b. This assessment will be provided at the request of the individual, or another person acting on the individual's behalf.

c. The individual will not be charged a fee for this assessment.

d. Attached to this Appendix is an explanation of the procedures by which State will ensure the performance of the assessment.

e. The assessment will be reviewed and revised not less often than (check one):

1. _____ Every 12 months

2. X Every 6 months

3. _____ Other period not to exceed 12 months (Specify): _____

f. The assessment will be based on the uniform minimum data set specified by HCFA.

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SUPPLEMENT 2 TO ATTACHMENT 3.1-A
Page 2

g. Check one:

1. _____ The State will use the assessment instrument specified by HCFA.
2. X The State will use a different assessment instrument than that specified by HCFA. A copy of this instrument is attached to this Appendix. The State certifies that this instrument is consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by HCFA. The State requests that HCFA approve the use of this instrument.

h. In conducting the assessment (or the periodic review of the assessment), the interdisciplinary team must:

1. Identify in each such assessment or review each individual's functional disabilities; and
2. Identify in each such assessment or review each individual's need for home and community care. This identification shall include:
 - A. Information about the individual's health status;
 - B. Information about the individual's home and community environment; and
 - C. Information about the individual's informal support system.
3. Determine whether the individual is, or continues to be, functionally disabled. This determination will be made on the basis of the assessment or review.

i. The interdisciplinary team conducting the assessment shall furnish the results to the Medicaid agency and to the qualified community care case manager designated by the Medicaid agency (as specified in Appendix E) to establish, review and revise the individual's ICCP.

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The Medicaid agency will monitor the appropriateness and accuracy of the assessments and periodic reviews on an ongoing basis, and whenever it is informed by a qualified community care case manager that inaccuracies appear to exist in the assessment of an individual. Through its monitoring, the State will ensure the appropriateness and accuracy of the assessments and periodic reviews. The State assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the nature and severity of any deficiencies noted.

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APPENDIX D-1

ASSESSMENT INSTRUMENT

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ATTACHMENT A

1. Alzheimer's Disease is indicated as a

☐

Primary Disease

☐

Secondary Disease

Name of physician making diagnosis _____

Attach documentation.

2. Activities of daily living

Unable to Perform

Bathing

Dressing

Toileting

Transferring

Eating

*Unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision.

3. Individual engages in inappropriate behavior

☐

Yes

☐

No

Describe _____

Inappropriate behavior poses serious health or safety hazards to themselves or others

☐

Yes

☐

No

Describe _____

SIGNIFICANT DIAGNOSES OR CONDITIONS*

Check all categories that apply and underline specific condition:

1. NEOPLASMS (e.g., cancer, malignancy, benign tumors, leukemia, Hodgkin's disease, carcinoma)
2. ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES AND IMMUNITY DISORDERS (e.g., gout, obesity, phenylketonuria acidosis, cystic fibrosis, diabetes, malnutrition, vitamin deficiency)
3. BLOOD AND BLOOD-FORMING ORGANS (e.g., anemia, polycythemia, purpura)
4. ORGANIC PSYCHOTIC CONDITIONS (e.g., senile dementia, psychotic organic brain syndrome, drug and alcohol-related organic psychoses)
5. OTHER PSYCHOSES (e.g., schizophrenia, manic and depressive disorders, autism)
6. NEUROTIC AND PERSONALITY DISORDERS (e.g., anxiety state, hysteria, depression, chronic alcoholism, drug dependencies)
7. MENTAL RETARDATION (e.g., mild, moderate, severe, profound, level unspecified)
8. NERVOUS SYSTEM AND SENSE ORGANS (e.g., brain abscess, Parkinson's disease, multiple sclerosis, cerebral palsy, epilepsy, muscular dystrophy, glaucoma, cataract, blindness, deafness)
9. STROKE INCLUDING LATE EFFECTS
10. ATHEROSCLEROSIS
11. CIRCULATORY SYSTEM OTHER THAN STROKE OR ATHEROSCLEROSIS (e.g., rheumatic fever, hypertensive disease, heart failure, cerebrovascular disease)
12. RESPIRATORY SYSTEM (e.g., asthma, bronchitis, pneumonia, influenza, emphysema, chronic obstructive lung disease, pleurisy)
13. DIGESTIVE SYSTEM (e.g., gastric, duodenal, peptic ulcer, gastritis, hernia, intestinal obstruction, irritable colon, peritonitis, chronic liver disease and cirrhosis, gallbladder disease, pancreatitis, diseases of the oral cavity)
14. GENITOURINARY SYSTEM (e.g., nephritis, renal failure, infections of urinary tract, hyperplasia and prostate, disorders of breast, vaginal bleeding)
15. SKIN AND SUBCUTANEOUS TISSUE (e.g., carbuncle, boil, abscess, pilonidal cyst, psoriasis, dermatitis, rash, eczema, decubitus ulcer, bed sores)
16. MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE (e.g., arthritis, rheumatoid arthritis, osteoarthritis, osteoporosis, intervertebral disc disorder, sciatica-lumbago, tendonitis, bursitis, myositis)
17. CONGENITAL ANOMALIES
18. INJURY AND POISONING (e.g., fractures, dislocations, sprains and strains, lacerations and open wounds, contusions, crushing injury, burns, poisonings, toxic effects, complications of surgery and medical care)
19. SYMPTOMS, SIGNS, AND ILL-DEFINED CONDITIONS (e.g., coma, unconsciousness, convulsions, chills, fever, old age, senility without mention of psychosis, spasms not otherwise specified, tremor not otherwise specified, anorexia, headache, cough, chest pain, nausea, vomiting)
20. OTHER DIAGNOSIS (e.g., infectious and parasitic diseases)
21. UNKNOWN DIAGNOSIS
22. NO DISEASE

THIS RECORD IS CONFIDENTIAL AND NOT A PUBLIC RECORD. SEE RHODE ISLAND GENERAL LAWS TITLE 38 CHAPTER 2 SECTION 2 PARAGRAPH (d)(1).

If Alzheimer's Disease is indicated as a primary or secondary diagnosis, Attachment A must be completed.

IHS-B 7/1/85

OFFICIAL

Client Name _____

HEALTH STATUS ITEMS

VISION

- 1. () Normal or minimal loss
- 2. () Moderate loss
- 3. () Severe loss
- 4. () Total blindness

HEARING

- 1. () Normal or minimal loss
- 2. () Moderate loss
- 3. () Severe loss
- 4. () Total deafness

EXPRESSIVE COMMUNICATION

- 1. () Speaks and is usually understood
- 2. () Speaks but is understood with difficulty
- 3. () Uses only structured sign language, symbol board or writes to communicate
- 4. () Uses only gestures or primitive symbols to communicate
- 5. () Does not convey needs
- 6. () Other _____

RECEPTIVE COMMUNICATION

- 1. () Usually understands oral communication
- 2. () Has limited comprehension of oral communication
- 3. () Understands by depending on lip reading, written materials or structured sign language
- 4. () Understands only primitive gestures, facial expressions, simple pictograms and/or recognizes environmental cues
- 5. () Does not understand
- 6. () Other _____

ORIENTATION AND/OR MEMORY

- 1. () Alert, able to identify needs
- 2. () Brief periods of confusion forgetfulness
- 3. () Marked confusion and disorientation with brief periods of alertness
- 4. () Obvious and persistent confusion and disorientation
- 5. () Complete stagnation of mental and emotional functions
- 6. () Not determined
- 7. () Other _____

MOOD/BEHAVIOR (check all that apply)

- 1. () Happy, cheerful
- 2. () Depressed
- 3. () Relaxed, calm
- 4. () Agitated, nervous
- 5. () Cooperative
- 6. () Abusive, aggressive
- 7. () Inability to avoid simple dangers, impaired judgment
- 8. () Wandering
- 9. () Not determined
- 10. () Other _____

COMMENTS:

Alert for danger to self and others

BASIS FOR HEALTH STATUS INFORMATION: Check all that apply

- 1. () By observation
- 2. () From client
- 3. () From relative or friend

(Name)

(Relationship)

- 4. () Other Specify: _____

(Name)

(Relationship)

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Revised

IHS-C 7/1/89

OFFICIAL

Client Name _____

FUNCTIONAL INFORMATION

MOBILITY

1. () Goes outdoors without personal help or supervision
2. () Goes outdoors with personal help or supervision
3. () Confined to house but not confined to bed
4. () Confined to bed

AMBULATION AID

1. () No
2. () Yes

KIND(S) OF AID(S)

1. () Walker
2. () Cane
3. () Wheelchair
4. () Other _____

URINE INCONTINENCE

1. () Never
2. () Occasional
3. () Frequent
4. () Chronic

FECES INCONTINENCE

1. () Never
2. () Occasional
3. () Frequent
4. () Chronic

ACTIVITIES OF DAILY LIVING

	(1) ALONE	(2) HAS HELP (Source)	(3) HAS UNMET NEED (Homemaker)
Bath complete			
Bath partial			
Shampoo			
Shave			
Dress			
Bed to chair			
On/off toilet			
Remind of medication			
Eating			
Specify Special Diet			

ADAPTIVE TASKS

	(1) ALONE	(2) HAS HELP (Source)	(3) HAS UNMET NEED (Homemaker)
Dust			
Vacuum			
Mop floors			
Wash floors			
Clean sink/tub/toilet			
Clean stove & refrig.			
Wash dishes			
Change bed linen			
Do laundry			
Do shopping			
Prepare meals			
Number of rooms			

SERVICE NEEDS

	# HOURS/DAY	# DAYS/WEEK	TOTAL SERVICE
1. () Homemaker	AM PM	M T W Th F S S	
2. () Day Care		M T W Th F S S	
3. () Combination			

PROVIDER AGENCY: _____

COMMENTS: _____

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IHS-D 7/1/85

CASE MANAGER

Client Name _____

ADDITIONAL NEEDS/REFERRALS

	Currently Receiving	Needed	Contact/Date (name of person and date)	Results
1. DEA Direct Service Aides				
2. Home Health Agency (VNA)				
3. Personal Physician				
4. Neighborhood Health Centers				
5. Mental Health				
6. Meals on Wheels				
7. Nutrition Program				
8. Senior Center				
9. Senior Companions				
10. Friendly Visitor				
11. Transportation				
12. Housing Assistance				
13. Repair, modify architectural barriers				
14. Legal Services				
15. Others				

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TITLE 38 CHAPTER 2 SECTION 2 PARAGRAPH (d) (1).

IHS-E 7/1/85

CASE MANAGER

PLEASE PRINT

Client Name

7/1/85

LONG TERM GOALS:

SHORT TERM GOALS:

SERVICE PLAN:

<u>Client Problem</u>	<u>Plan of Action</u> (Include type and frequency of service)	<u>Service Goals/Comments</u>

NARRATIVE/SUMMARY:

INFORMATION OBTAINED:

1. () From client only
2. () From family/friend only (Name) (Relationship)
3. () From client and family/friend (Name) (Relationship)
4. () Other (specify-agency, nurse, MD, etc.) (Name) (Relationship)

Case Manager's Signature

Nurse's Signature

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TITLE 38 CHAPTER 2 SECTION 2 PARAGRAPH (d)(1)

IHS-F 7/1/85

CASE MANAGER

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CONSENT FOR RELEASE OF
CONFIDENTIAL SERVICE RECORDS
AND NOTIFICATION OF SERVICE CONDITIONS

I, _____, hereby authorize the Department of Elderly Affairs' In-Home Services Program to furnish such professional information as may be necessary for case coordination and give permission to any past, present, or future, individual or organizational providers, to release such information as may be required by the Department of Elderly Affairs' In-Home Services Program for the provision of Home Care Services.

I acknowledge that I have been informed and understand that the release and/or transfer of this information is necessary to a complete investigation and assessment of the services I have received or will receive.

I acknowledge that I have been informed and understand that such information will remain confidential and will not become public information in any identifiable way under the provisions of Title 38 Chapter 2 Section 2 Paragraph (d)(1) of the Rhode Island General Laws.

I understand that the provision of services is contingent upon adequate funds being appropriated which may vary from year to year.

I understand that if for any reason my service is interrupted or terminated, it will not be reinstated and that I will be placed at the end of the eligibility list.

Date

Signature of Client

Address

Date

Signature of Witness

Address

APPENDIX D-2 INTERDISCIPLINARY TEAM

a. Initial assessments will be performed by interdisciplinary teams designated by the State. The agency will designate interdisciplinary teams that meet the following criteria (check all that apply):

1. _____ The interdisciplinary teams will be employed directly by the Medicaid agency.
2. X The interdisciplinary teams will be employed directly by other agencies of State government, under contract with the Medicaid agency.
3. _____ The interdisciplinary teams will be employed directly by agencies of local government under contract with the Medicaid agency.
4. X The interdisciplinary teams will be employed directly by nonpublic organizations which do not provide home and community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides community care or nursing facility services.

Interdisciplinary teams may utilize data gathered by other professionals, and may consult with service providers in conducting comprehensive functional assessments.

When assessments are provided under contract with an agency or organization which is not part of the Medicaid agency, the Medicaid agency will specify, as part of the contract, that the contracting agency or organization may not subcontract with another entity for the performance of the assessments without the prior written approval of the Medicaid agency.

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APPENDIX D-2 TO
SUPPLEMENT 2 TO ATTACHMENT 3.1-A
Page 2

5. Periodic reviews of assessments will be performed by interdisciplinary teams designated by the State. The agency will designate interdisciplinary teams that meet the following criteria (check all that apply):

1. The interdisciplinary teams will be employed directly by the Medicaid agency.
2. X The interdisciplinary teams will be employed directly by other agencies of State government, under contract with the Medicaid agency.
3. The interdisciplinary teams will be employed directly by agencies of local government under contract with the Medicaid agency.
4. X The interdisciplinary teams will be employed directly by nonpublic organizations which do not provide home and community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides community care or nursing facility services.

Interdisciplinary teams may utilize data gathered by other professionals, and may consult with service providers in conducting periodic reviews of the individuals' comprehensive functional assessments.

When periodic reviews of assessments are provided under contract with an agency or organization which is not part of the Medicaid agency, the Medicaid agency will specify, as part of the contract, that the contracting agency or organization may not subcontract with another entity for the performance of the periodic reviews without the prior written approval of the Medicaid agency.

c. The interdisciplinary teams conducting initial assessments shall consist, at a minimum, of (check all that apply):

1. X Registered nurse, licensed to practice in the State
2. X Licensed Practical or Vocational nurse, acting within the scope of practice under State law
3. Physician (M.D. or D.O.), licensed to practice in the State
4. X Social Worker (qualifications attached to this Appendix)
5. X Case manager
6. Other (specify): _____

Teams will consist of 2 of the above.

The interdisciplinary teams conducting periodic reviews of assessments all consist, at a minimum, of (check all that apply):

1. X Registered nurse, licensed to practice in the State
2. X Licensed Practical or Vocational nurse, acting within the scope of practice under State law
3. Physician (M.D. or D.O.), licensed to practice in the State
4. X Social Worker (qualifications attached to this Appendix)
5. X Case manager
6. Other (specify): _____

Teams will consist of 2 of the above.

APPENDIX E-1 TO
SUPPLEMENT 2 TO ATTACHMENT 3.1-A
Page 1

APPENDIX E-1: INDIVIDUAL COMMUNITY CARE PLAN (ICCP)

a. A written individual community care plan (ICCP) will be developed for each individual who has been determined, on the basis of a comprehensive functional assessment performed in accordance with Appendix D, to be a functionally disabled elderly individual, according to the criteria set forth in Appendices A and B.

b. The ICCP will be established, and periodically reviewed and revised, by a Qualified Community Care Case Manager after a face to face interview with the individual or primary caregiver.

c. The ICCP will be based on the most recent comprehensive functional assessment of the individual conducted according to Appendix D.

d. The ICCP will specify, within the amount, duration and scope of service limitations set forth in Appendix C, the home and community care to be provided to such individual under the plan.

e. The ICCP will indicate the individual's preferences for the types and providers of services.

f. The ICCP will specify home and community care and other services required by such individual. (Check one):

1. ☒ Yes

2. ☐ No

g. The ICCP will designate the specific providers (who meet the qualifications specified in Appendix C-2) which will provide the home and community care. (Check one):

1. ☒ Yes

2. ☐ No

APPENDIX E-2 QUALIFIED COMMUNITY CARE CASE MANAGERS

a. A "Qualified Community Care Case Manager" will meet each of the following qualifications for the provision of community care case management.

1. Be a nonprofit or public agency or organization;
2. Have experience or have been trained in:
 - A. Establishing and periodically reviewing and revising ICCPs;
and
 - B. The provision of case management services to the elderly.

The minimum standards of experience and training which will be employed by the State are attached to this Appendix:

3. Have procedures for assuring the quality of case management services. These procedures will include a peer review process.
4. The State will assure that community care case managers are competent to perform case management functions, by requiring the following educational or professional qualifications be met.
(Check all that apply):

- A. ☒ Registered nurse, licensed to practice in the State
- B. ☐ Physician (M.D. or D.O.), licensed to practice in the State
- C. ☒ Social Worker (qualifications attached to this * Appendix)
- D. ☒ Other (specify): Licensed Practical Nurse; or
a minimum of an associates degree and at least
2 years experience in social services for older
persons.

* Social Worker shall be defined as an individual with an undergraduate or graduate degree in social work, gerontology, or social science.

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APPENDIX E-2 TO
SUPPLEMENT 2 TO ATTACHMENT 3.1-A
Page 2

c. When community care case management is provided by a nonprofit, nonpublic agency, the agency providing the community care management will not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides home and community care or nursing facility services. (Check one):

1. X Yes

2. Not applicable. The State will not use nonprofit, nonpublic agencies to provide community care case management.

d. The State will employ procedures to assure that individuals whose home and community care is managed by qualified community care case managers are not at risk of financial exploitation due to such managers. An explanation of these procedures is attached to this Appendix.

e. The State requests that the requirements of item E-2-b be waived in the case of a nonprofit agency located in a rural area. The State's definition of "rural area" is attached to this Appendix. (Check one):

1. X Yes

2. No

3. Not applicable. The State will not use nonprofit, nonpublic agencies to provide community care case management.

The following RI communities meet the Administration on Aging definition of rural:

Foster
Glocester
West Greenwich
Middletown
Newport
Charlestown
Exeter
New Shoreham
Richmond

Refer to Appendix E-2

TN # 92-05

Supersedes

TN # NEW

Approved JUN 17 1992

Effective MARCH 1, 1992

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APPENDIX E-2 TO
SUPPLEMENT 2 TO ATTACHMENT 3.1-A
Page 3

7. Neither the ICCP, nor the State, shall restrict the specific persons or individuals (who meet the requirements of Appendix C-2) who will provide the home and community care specified in the ICCP.

TN # 92-05

Supersedes

TN # NEW

Approved JUN 17 1992

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APPENDIX E-2 DEFINITION OF RURAL

For the purposes of this option, the State of Rhode Island will use the definition of rural included in the State Plan on Aging, FY 92-95. A copy of this section is attached.

NEEDS OF ELDERLY PERSONS IN RHODE ISLAND

Part I: Demographic

Numbers of Persons 60 and Older—Urban and Rural

Using 1980 Census numbers updated by the provisional 1990 Census numbers, 180,000 persons are 60 or older, and 11,800 of these are living in rural areas.¹ (See Table 1 below, and Table 3 on page 5.)

Table 1
Number of Persons in Each
Age Group, 60 and Older

60-64	51,063
65-74	76,013
75-84	39,846
85 +	13,071
Total over 60	179,988

¹ The Administration on Aging defines rural as being outside of a SMSA. Nine towns in Rhode Islands are not included in one of the three SMSA's in Rhode Island: Fall River, MA-RI; New London-Norwich, CT-RI; and Providence-Warwick-Pawtucket, RI-MA (Number of Inhabitants, RI, Table 11. Population of Standard Metropolitan Statistical Areas (SMSA's): 1960-1980. The numbers of persons in age groups are based on the 1980 proportions. These numbers have been increased by the percentage of growth in each township indicated by provisional 1990 census data (made available by the Office of Municipal Affairs within the Division of Planning in the RI Department of Administration.

Poor and Limited English Speaking

According to the 1980 Census, 18,600 of those who are over 60 years old are poor, and less than a thousand of these poor elderly persons are minority. (See Table 2.) Five thousand persons 65 years old or older could speak English either not well or not at all (using a four category ranking: very well, well, not well, not at all).²

Table 2 Number of Poor Persons Age 60 and Over Rural and Urban, 1979				
	White	Black	Others	Total
<i>Below Poverty Level</i>				
Rural	1,284	6	8	1,298
Urban	16,542	610	211	17,363
TOTAL	17,826	616	219	18,661
<i>Below 125% of Poverty Level</i>				
Rural	2,266	6	57	2,329
Urban	27,931	748	261	28,940
TOTAL	30,197	754	318	31,269

² Poverty and rural/urban data are from Table 82, Poverty Status in 1979 of Families and Persons by Race, *General Social and Economic Characteristics: 1980 Census*. The census used a different definition of rural and urban than that required by the Administration on Aging—described on the previous page and used in Table 3.

In published data (Table 199, in *Detailed Population Characteristics: 1980 Census*) the age group 60 plus is not used for the tables describing ability to speak English.

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**Table 3: For Each Township
Number of Persons in Each Age Group
And Number and Percent in Rural Areas**

	Age 60-64	Age 65-74	Age 75-84	Age 85+	Total 60 years old and older	Number aged 60+ in rural areas	Percent aged 60+ in rural areas
Providence County							
Burrillville	706	1100	765	323	2,894	0	0%
Central Falls	695	337	325	1003	2,360	0	0%
Cranston	4675	7572	3639	1043	16,929	0	0%
Cumberland	1615	1909	934	261	4,719	0	0%
East Providence	2922	4558	2494	768	10,742	0	0%
Foster	144	224	122	35	525	525	100%
Glocester	298	531	248	35	1,112	1,112	100%
Johnston	1438	1939	897	369	4,643	0	0%
Lincoln	1106	1564	796	234	3,700	0	0%
North Providence	1891	2846	1278	421	6,436	0	0%
North Smithfield	555	784	427	63	1,829	0	0%
Pawtucket	4315	6723	3660	1007	15,705	0	0%
Providence	8094	13739	7765	2406	32,004	0	0%
Scituate	440	611	291	98	1,440	0	0%
Smithfield	838	1157	578	243	2,816	0	0%
Woonsocket	2306	3784	2300	668	9,058	0	0%
Total	32039	49380	26520	8978	116,912	1,637	1.4%
Bristol County							
Barrington	833	988	395	114	2,330	0	0%
Bristol	1152	1733	823	295	4,003	0	0%
Warren	668	1002	549	171	2,390	0	0%
Total	2653	3724	1767	581	8,723	0	0.0%
Kent County							
Coventry	1304	1657	693	196	3,850	0	0%
East Greenwich	495	685	294	76	1,550	0	0%
Warwick	4626	6657	3329	996	15,608	0	0%
West Greenwich	132	56	151	61	400	400	100%
West Warwick	1436	1873	1037	272	4,618	0	0%
Total	7994	10928	5503	1602	26,026	400	1.5%
Newport County							
Jamestown	262	404	207	34	907	0	0%
Little Compton	183	331	157	36	707	0	0%
Middletown	721	1052	500	224	2,497	2,497	100%
Newport	1202	2088	1209	391	4,890	4,890	100%
Portsmouth	716	972	358	98	2,144	0	0%
Tiverton	790	1076	419	92	2,377	0	0%
Total	3872	5923	2849	875	13,522	7,387	54.6%
Washington County							
Charlestown	322	494	226	50	1,092	1,092	100%
Exeter	192	224	111	18	545	545	100%
Hopkinton	256	385	174	51	866	0	0%
Narragansett	586	97	423	87	1,193	0	0%
New Shoreham	51	94	52	12	209	209	100%
North Kingstown	880	1372	637	262	3,151	0	0%
Richmond	190	261	94	16	561	561	100%
South Kingstown	850	1360	696	258	3,164	0	0%
Westerly	1178	1772	793	281	4,024	0	0%
Total	4506	6058	3206	1035	14,805	2,407	16.3%
State	51063	76013	39846	13071	179,988	11,831	6.5%