

210-RICR-50-10-1

TITLE 210 – EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

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

SUBCHAPTER ~~10~~ – HOME AND COMMUNITY-BASED SERVICES

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

1.1 Overview and Purpose

- ~~A. Medicaid LTSS was only available to beneficiaries in institutional settings until 1983 when Congress amended Title XIX of the Social Security Act to add Section 1915 (c) which established the authority for home and community-based service (HCBS) waivers. Rhode Island was among the first states to pursue this authority and, in that first year alone, received approval for four (4) Section 1915 (c) waivers. By the time Rhode Island sought approval for its program-wide Medicaid Section 1115 waiver demonstration, the State was administering eleven, separate Section 1915 (c) waivers, many of which had distinct eligibility requirements. The State consolidated these separate HCBS waivers in 2009 when the federal government approved Rhode Island's innovative Section 1115 demonstration waiver.~~
- ~~BA.~~ Under the broad authority of the State's Section 1115 waiver granted pursuant to § 1115 of the Social Security Act, 42 U.S.C. § 1315, Rhode Island has established a core set of home and community-based services (HCBS) which are available to long-term services and supports (LTSS) beneficiaries in multiple living arrangements and community settings. Home and community-based services enable participants to receive needed care and supports in the least restrictive setting of their choice as an alternative to institutional LTSS, as described in Subchapter 05 of this Chapter.
- ~~B.~~ The scope of HCBS options available to a beneficiary varies somewhat depending on: the type of institutional-clinical eligibility a person is seeking (i.e., nursing facility (NF), intermediate care facility for persons with intellectual or developmental disabilities (ICF/I-DD), or long term care hospital (LTH)); as determined under Subchapter 00 Part 05 of this Chapter; level of need as measured by the applicable evaluation instrument (e.g., high or highest need for the NF services or service intensity scale for ICF/I-DD); and the person-centered planning process. The purpose of this Part is to identify the full range of Medicaid HCBS options that are available to LTSS beneficiaries, depending on their level of need, as determined in Part 50-00-1 of this Title.

1.2 Legal Authority

- A. This Chapter is promulgated pursuant to the following federal and state authorities:
1. Federal Law: ~~— Title XIX of the U.S. Social Security Act, 42 U.S.C. §§ 1396a, 1115, 1902, 1903, 1905, 1915, 1919, 1929, and 1934 (a) 42 U.S.C. §§ 1396-1396w-7.~~
 2. Federal Regulations: ~~— 42 C.F.R. Parts 431, 440, and 441, including §§ 441.180, 441.300 to 310, 441.350 to 365 and 42 C.F.R. §§ 430.25, 435.217, 440.180, 441.700, and 460.92(b).~~
 3. The ~~R.I.~~ Medicaid State Plan and the Section 1115 waiver granted pursuant to § 1115 of the Social Security Act, 42 U.S.C. § 1315. Title XIX, Section 1115 (a) Demonstration Waiver (11-W-00242/1), effective through December 31, 2018.
- B. State Authority: ~~R.I. Gen. Laws— §§ 40-8.9-9; and chapters 40-8.10, 40-8.13, 40.1-22 and 42-66; and 40.1-22.~~

1.3 Incorporated Materials

- A. These Regulations hereby adopt and incorporate 42 C.F.R. § 431.53 (2023) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these Regulations.
- B. These Regulations hereby adopt and incorporate 42 C.F.R. § 440.170 (2023) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these Regulations.
- C. These Regulations hereby adopt and incorporate 42 C.F.R. § 441.301 (2024) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these Regulations.
- D. These Regulations hereby adopt and incorporate 42 C.F.R. § 441.310 (2023) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these Regulations.
- E. These Regulations hereby adopt and incorporate 42 C.F.R. Part 483 (2023) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these Regulations.

1.43 Definitions

- A. For the purposes of this Part, the terms below are defined as follows:

1. “Conflict-Free Case Management” means that providers of HCBS for a participant (or those who have an interest in or are employed by a provider of HCBS for a participant) must not provide case management or develop the person-centered service plan, per Federal regulation at 42 C.F.R. § 441.301(c)(1)(vi) (2024), and specifically means the requirements for conflict-free case management established herein. This federal regulation requires that participants must be provided with a clear and accessible alternative dispute resolution process. Conflict-free case management shall include services to develop a service plan, arrange for services and supports, support the participant (and, if appropriate, the participant’s caregivers) in directing the provision of services and supports for the participant, and conduct ongoing monitoring to assure that services and supports are delivered to meet the participant’s needs and achieve intended outcomes.
2. “HCBS living arrangement” means an HCBS participant’s residence and may include any of the following: a private home in which a beneficiary lives, or a community-based supportive care residence as defined in R.I. Gen. Laws § 40-8.13-12 and § 1.6(A)(4) of this Part that has been certified by Medicaid and authorized by the State, by licensure or certification standards, to provide long-term care services and supports to one or more persons. This category includes assisted living residences, State and provider operated group homes (residential habilitation), shared living arrangements, the home of the beneficiary and other private residences.
3. “Participant” or “HCBS participant” means an individual who is eligible for LTSS and has chosen to receive HCBS authorized under the Section 1115 waiver.
24. “Programs of All-Inclusive Care for the Elderly” or “PACE” means the Medicaid State Plan service delivery option for beneficiaries who are dually eligible for Medicare and Medicaid. PACE is available for beneficiaries opting for HCBS who meet the NF nursing facility level of care at the “high” or “highest” level.
35. “Rite@Home” means the shared living, supportive care living arrangement administered by the Executive Office of Health and Human Services (EOHHS) for persons who have with LTSS needs that who meet the NF nursing facility level of care.
6. “Section 1115 waiver” means the waiver authorized pursuant to § 1115 of the Social Security Act, 42 U.S.C. § 1315.

1.54 Accessing Medicaid Home and Community Based Services

- A. Medicaid LTSS is available to ~~applicants and beneficiaries~~ individuals who meet the non-financial, financial, and functional/clinical eligibility criteria ~~for eligibility~~

set forth in this Chapter. ~~Under the terms of the State's Section 1115 demonstration~~ waiver, a person seeking Medicaid LTSS must have an established need as set forth in Subchapter 00 Part ~~4-5~~ of this ~~Title Chapter~~ but is not required to be receiving long-term care at the time an application is made. In addition, it is not necessary for an applicant to make a choice of the type of LTSS ~~—(HCBS or health institution)—~~ when requesting Medicaid coverage. As indicated in Subchapter 00 Part 5 of this Chapter, a person's level of need in the functional/clinical eligibility determination process affects the range of Medicaid LTSS options and settings that may be available.

- B. Persons seeking Medicaid HCBS are subject to a functional assessment that includes a standard set of evaluation criteria that consider the full range of the person's physical, medical, behavioral health and social needs. This assessment takes a variety of forms and may be performed by ~~a state~~ agency representative or, in some cases, a ~~contractual entity~~ conflict-free case management agency. All initial assessments must be completed by a state agency representative. The assessment is a component of the person-centered planning process, ~~when feasible~~, and is one of several factors reviewed when determining whether and to what extent a person has the need for an institutional level of care and the scope of HCBS authorized for payment under the person-centered plan.
- C. The Medicaid State Plan and ~~Rhode Island's~~ Section 1115 ~~demonstration~~ waiver authorize the State to implement certain conditions affecting access to Medicaid HCBS including:
1. No room and board coverage -- Medicaid does not provide coverage for room and board costs when LTSS is provided in a home ~~or a~~ and community-based setting under 42 C.F.R. § 441.310 (2023). ~~The post-eligibility treatment of income process, set forth in Subchapter 00 Part 8 of this Title, provides various allowances that protect -- that is, treat as unavailable -- a portion of beneficiary's a participant's income for to cover room and board costs, accordingly.~~ Other forms of public assistance are also available to help pay shelter and food costs, including the federal Supplemental Security Income (SSI) and Supplemental Nutrition Assistance (SNAP) programs and the State's optional Supplemental Payment (SSP) program, as well as a variety of publicly funded housing and meal support programs. Agency representatives are available to assist ~~applicants and beneficiaries~~ individuals seeking these additional forms of assistance.
 2. Needs-based ~~—~~ The scope, amount, and duration of authorized HCBS a beneficiary participant receives is determined by needs level, as specified in Subchapter 00 Part 5 of this ~~Title Chapter~~, and within these parameters the goals and outcomes the beneficiary participant establishes in the person-centered planning process. Only the HCBS that have been authorized by the Medicaid State Plan and Section 1115 ~~demonstration waiver~~ are covered and, therein, only the service array associated with a

~~beneficiary's participant's~~ LTSS level of need ~~—high or highest—~~ may be accessed unless the exceptions established in Subchapter 00 Part 5 of this ~~Title Chapter~~ apply.

3. Expedited eligibility – Expedited eligibility for persons seeking Medicaid LTSS in a home and community-based setting is available in certain circumstances. ~~The provisions governing expedited eligibility for Medicaid LTSS are located in Subchapter 00 Parts 1 and 5 of this Title Chapter.~~

1.56 Person-Centered Planning and Conflict-Free Case Management

- A. Federal regulations at 42 C.F.R. § 441.301(c) (2024) require states providing HCBS ~~through Section 1915 and Section 1115 Medicaid waiver authorities under a waiver~~ to implement a person-centered planning process (PCPP) ~~to develop each participant's service plan, known as the person-centered plan, that is~~ This process must be driven by the participant/Medicaid beneficiary. The State ensures access to person-centered planning for all HCBS participants through the case management service as defined in § 1.7 of this Part.
- B. Federal regulations at 42 C.F.R. § 441.301(c) (2024) require that providers of direct services for the participant, or who have an interest in or are employed by a provider of HCBS for the participant, cannot provide case management or develop the person-centered plan. The state has a network of certified conflict-free case management (CFCM) agencies with trained conflict-free case managers available to ensure that the development and case management of each HCBS participant's service plan is both person-centered and conflict-free to maximize each participant's choice in the services they receive. In cases where a CFCM agency is not utilized, for example when case management is provided by State staff or a managed care organization, the principles of person-centered planning and conflict-free case management must still be observed.
- C. The case management process is administered in accordance with the following principles: The PCPP serves as the basis for the authorization of the Medicaid HCBS.
 1. Choice -- HCBS participants have the ability to choose which CFCM agency and conflict-free case manager best meets their needs. HCBS participants are advised of the option to choose a CFCM agency or to be randomly assigned by the State if they prefer. HCBS participants may request to change case managers and/or CFCM agencies at any time, though the transition to a new case manager or CFCM agency may require up to thirty (30) days unless there is good cause or an imminent risk to the participant that requires immediate action.
 2. Conflict-free – The person-centered planning process must be administered by appropriate State staff or a trained conflict-free case manager through a certified CFCM agency. An HCBS provider that

delivers services to a participant has an interest in the amount, duration, and scope of services a participant receives and, therefore, is not permitted to develop the person-centered plan. Such providers may participate in the person-centered planning process at a participant's request, however.

3. Accountable and responsive – All HCBS participants must have equitable access to the same high-quality conflict-free case management services regardless of how they enter the Medicaid LTSS system. Accordingly, the case management process has been standardized and is performed in a single information technology system which establishes an electronic record that follows the person from the point of entry into the LTSS system throughout the service delivery process. The case management process is person-centered at every phase which ensures that there is sufficient flexibility for conflict-free case managers to respond to and address the unique needs of every participant.

D. To the extent that any provision of this Part related to conflict-free case management shall conflict with the provisions of 212-RICR-10-00-1 and 212-RICR-10-05-1 (Rules and Regulations for Developmental Disability Organizations), this Part shall supersede 212-RICR-10-00-1 and 212-RICR-10-05-1 unless effect may be given to both provisions which are in conflict.

1.6.1 Principles of Person-Centered Planning

A. All Medicaid HCBS case management services in the state must adhere to the principles of person-centered planning and conflict-free case management.

1. General principles -- The person-centered planning process must be led by the participant and include any other individuals chosen by the participant. Person-centered planning strives to:
 - a. Inform and support by providing the information and support necessary for the participant to direct the process to the maximum extent possible;
 - b. Avert service delays by arranging meetings in a timely manner, at times and locations chosen by the participant;
 - c. Reflect personal values and preferences by conducting meetings in a manner that respects the values and prioritizes the preferences of the participant and in a language and format that the participant understands;

- d. Facilitate person-centered consensus-building by including strategies for resolving disagreements in a manner that supports the participant's interests and informed choices;
- e. Offer informed choice by describing the full range of HCBS service options available to the participant to maximize the participant's choice of services and providers;
- f. Promote community participation and integration by identifying how the participant's needs and goals are strengthened and supported by social relationships, community participation, employment, income and savings, healthcare and wellness, education and others;
- g. Encourage independence by maximizing choice and identifying which services are self-directed, if any; and
- h. Manage risks by identifying potential risks and strategies for mitigating them, including back-up plans and providers.

1.6.2 Case Management and Person-Centered Planning

- A. Once the conflict-free case manager selection process is complete, the case management process for HCBS participants is initiated and involves the following components that may proceed through a series of sequential steps or occur simultaneously in accordance with the participant's preferences or unique circumstances:
 - 1. Information Gathering – Prior to the initiation of each person-centered planning session and thereafter, the case manager is responsible for learning about the HCBS participant through conversations with the participant and others in the participant's life along with the results of assessments, health care records and previous care and service plans. This information is used to build an individual profile which is updated on a regular basis and assists the case manager to help identify the array of HCBS options that align with the participant's goals and explain the risks and benefits associated with each.
 - 2. Choice Counseling -- Every HCBS participant has the right to be informed of the full range of service options available to them. An important facet of the case management process, particularly in the development of the person-centered plan, is HCBS choice counseling. The goal of this process is to ensure the participant has the information necessary to make informed choices about their care from a trusted, unbiased source.
 - 3. Person-centered planning -- Federal regulations require states providing HCBS to implement a person-centered planning process that is driven by the participant. The person-centered planning process serves as the basis

for the person-centered plan and authorization of Medicaid HCBS. The development of a person-centered plan is a multifaceted process that may start prior to making a request for Medicaid LTSS if a prospective applicant and their family are seeking information and referral through the person-centered options counseling program. In instances in which an applicant bypasses these options, the person-centered planning process typically starts after a functional assessment is completed and the participant is connected with a case manager. The person-centered planning process continues from the point services have been authorized and on an ongoing basis while a person remains eligible for Medicaid HCBS. The required elements of the person-centered planning process include, but are not limited to:

- a. Mandatory -- Completion of a person-centered plan is a mandatory condition of eligibility and authorization of Medicaid LTSS in HCBS settings.
- b. Person-centered -- HCBS person-centered planning supports a person's right and ability to share their desires and goals, to consider different options for support, and to learn about the benefits and risks of each option. The person-centered planning process assists the participant in identifying and accessing a personalized mix of paid and unpaid services and supports to assist them in achieving their own personally defined goals and outcomes in the most inclusive community setting. The person-centered planning process is directed by the participant. The participant's strengths, preferences, needs, and goals become the core of the individualized person-centered plan. The process is driven by the participant to the maximum extent possible. The participant may choose to include any representatives of their choice to participate in the person-centered planning process, if desired, and define the role of each person in the process. The participant's representative(s) should have a participatory role, as needed and as defined by the participant, unless state law confers decision-making authority to the representative.

4. Development of the Person-Centered Plan (PCP) -- The person-centered planning process serves as the basis for the authorization of services. The participant sets the planning goals and desired outcomes in collaboration with any representative(s) the participant includes in the process. The conflict-free case manager facilitates the person-centered planning process and development of the PCP alongside the participant and the participant's representative(s), if any. The PCP incorporates both the participant's personally defined outcomes and outlines the training supports, therapies, treatments, and or other services the participant is authorized to receive to achieve those outcomes.

- a. The PCP must be written in plain language and in a manner that is understandable to the participant, including participants with limited English proficiency. The PCP must incorporate the participant's goals and desired outcomes and the agreed upon roadmap for achieving them including, but not limited to: choice of setting; clinical and support needs; caregivers and service providers, both paid and unpaid, and their respective roles and responsibilities for meeting the participant's needs; self-directed care, if any; and integrated employment opportunities and requirements. The participant must indicate agreement with the PCP by signing the PCP. The case manager shares the PCP, as appropriate, with others involved in the person-centered planning process and responsible providers included in the PCP. The State offers a PCP template to ensure these requirements are met which is included in the State's information technology system.
 - b. The PCP shall be reviewed and updated with the participant at least annually, utilizing a person-centered planning process, or more frequently if the participant requests and/or if there is a significant change in the participant's life that would alter the amount, duration, and/or scope of services and supports needed. The annual review includes a reassessment of needs to inform any changes to the PCP.
5. Connecting to services – Once the HCBS participant has selected a service option and the PCP is developed, the case manager is responsible for contacting the participant's chosen providers to determine whether they have the capacity to meet the participant's needs, expectations and goals and, failing that, to help identify alternative providers and vet them with the participant.
6. Service authorization – Upon completing the connection to services, the case manager and participant sign the final PCP and the final PCP is shared with the appropriate State agency for review, approval and service authorization. For Medicaid LTSS coverage to begin, services must be authorized.
7. PCP implementation – HCBS providers are responsible for developing a plan to implement the PCP in accordance with the applicable State regulations and federal requirements related to the proper administration of health services and supports and participant health and safety. Case managers are responsible for ensuring that HCBS providers are delivering Medicaid LTSS to participants within these boundaries by making contact with the participant at agreed upon intervals.
8. Monitoring and Quality Assurance – Case management is an ongoing process and continues after Medicaid HCBS is initially authorized and

Medicaid payment begins. The State is required to support the continued engagement of a participant and/or their representative(s) during the period in which services are authorized and, in particular, when conducting reassessments and/or redeterminations of LTSS functional/clinical eligibility that may precipitate or necessitate changes in the PCP and/or the available service options.

a. Case managers are required to contact HCBS participants at agreed upon intervals and in a manner selected by the participant to assess whether HCBS providers are delivering authorized services in accordance with the PCP, update PCP goals when necessary, check on a participant's general health and safety, and make note of achievements and setbacks. As required under the Section 1115 waiver, case managers must ensure there is an in-person check in with the participant at least every six (6) months. Case managers must also address grievances that may arise about HCBS providers and report grievances to the Executive Office of Health and Human Services (EOHHS).

~~B. The person-centered planning process is directed by a Medicaid LTSS applicant/beneficiary (or family members) for the purposes of identifying the strengths, capacities, preferences, needs and desired outcomes that become the core of an individualized plan of LTSS care. The applicant/beneficiary will lead the person-centered planning process where possible. The applicant's/beneficiary's representative should have a participatory role, as needed and as defined by the applicant/beneficiary, unless State law confers decision-making authority to the legal representative.~~

~~C. The LTSS applicant/beneficiary may invite others to participate in the PCPP who may enable or assist in identifying and accessing a personalized mix of paid and unpaid services and supports that will assist him or her in achieving personally defined outcomes in the most inclusive community setting. The applicant/beneficiary sets the planning goals for achieving these outcomes in collaboration with the other PCPP participants he or she has selected. The plan of care incorporates both the personally defined outcomes of the applicant/beneficiary and the training supports, therapies, treatments, and/or other services the individual is to receive to achieve these outcomes.~~

1.5.1 Principles of Person-Centered Planning

~~A. State agencies that administer programs that provide Medicaid LTSS in the home and community-based settings adhere to the principles of the PCPP to the full extent feasible pending full implementation of the process EOHHS-wide.~~

~~1. General principles -- The PCPP must be led by applicant/beneficiary and include participants chosen by the applicant/beneficiary. The PCPP strives to:~~

~~a. Inform and support. Provide the information and support necessary for the applicant/beneficiary to direct the process to the maximum extent possible;~~

~~b. Avert service delays, at times and locations of convenience to the applicant/beneficiary;~~

~~c. Reflect personal values and preferences. Be conducted in a manner that respects the values and prioritizes the preferences of the applicant/beneficiary and in plain language;~~

~~d. Facilitate person-centered consensus-building. Includes strategies for solving disagreements in a manner that supports the interests and informed choices of the applicant/beneficiary;~~

~~e. Offer informed choice. Describes the full range of HCBS service options within the applicable level of care tier or classification;~~

~~f. Promote community participation and integration. Identifies how the outcomes and goals of the applicant/beneficiary are strengthened and supported by social relationships, community participation, employment, income and savings, healthcare and wellness, education and others.~~

~~g. Encourage independence. Identifies what services are self-directed.~~

~~h. Manage risks. Potential risks and strategies for mitigating them, including back-up plans and providers.~~

~~2. Person-centered plan (PCP) -- The principles of the PCPP inform the determination of functional/clinical eligibility and therefore the scope of service options available based on level of need. The PCP must be written in plain language and in a manner that is understandable to persons with disabilities or limited English proficiency and incorporates the goals and desired outcomes of the beneficiary within this context and the agreed upon roadmap for achieving them including, but not limited to: choice of setting; clinical and support needs; caregivers and service providers, both paid and unpaid and their respective roles and responsibilities for~~

~~meeting those needs; self-directed care, if any; and integrated employment opportunities and requirements. The applicant/beneficiary must indicate agreement with the plan and shares the plan of care, as appropriate, with other participants in the PCPP process and responsible providers.~~

~~B. The PCPP is ongoing and continues after Medicaid HCBS is initially authorized and Medicaid payment begins. The State is required to support the continued engagement of a Medicaid beneficiary and/or his or her family during the period in which services are authorized and, in particular, when conducting reassessments and/or redeterminations of LTSS functional/clinical eligibility that may precipitate or necessitate changes in a plan of care and/or the available service options.~~

1.67 Medicaid Home and Community-Based Long-Term Services and Supports

A. ~~The HCBS options a LTSS beneficiary is authorized to receive depends on the determination of needs level and the person-centered care planning process (PCPP) involving the beneficiary, provider and family members or authorized representatives.~~ The following are the Medicaid HCBS options currently authorized under the Medicaid State Plan and Section 1115 demonstration waiver available based on need to beneficiaries:

1. Adult Companion Services -- Non-medical care, supervision, and socialization, provided to a functionally impaired adult. Companions may assist or supervise the beneficiary participant with such tasks as meal preparation, laundry, and shopping. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the beneficiary participant. This service is provided in accordance with a therapeutic goal in the service plan.
2. Assisted Living Services -- Personal care and supportive services (homemaker, chore, attendant services, companion services, meal preparation) that are furnished to HCBS beneficiaries participants who reside in a setting that meets the HCBS setting requirements (described in § 1.9 of this Part) and includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming, and medication assistance (to the extent permitted under State law).

a. Services that are provided by third parties must be coordinated with the assisted living provider.

- b. Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services.
- c. Payment is not made for 24-hour skilled care. Medicaid covered assisted living services also include social and recreational programming, and medication assistance.
- In addition, the assisted living residence must be Medicaid certified provider and, as such, adhere to the following:
 - a. Medicaid covered services that are provided by third parties must be coordinated with the assisted living provider.
 - b. Services must be furnished in a manner that meets are required to meet a beneficiary's participant's LTSS needs in a manner that promotes self-reliance, dignity and independence.
 - e. Services may be provided in settings licensed by the state at various levels that reflect their capacity to provide different kinds of Medicaid services, depending on a participant's level of care needs based on their licensure authority and capacity to provide specific packages of services to Medicaid participants with varying levels of acuity needs.
 - f. Personalized care is furnished to a participant who resides in their own living unit (which may include dually occupied units when both occupants consent to the arrangement), which may or may not include kitchenette and/or living rooms, and which contain bedrooms and toilet facilities.
 - g. The participant has a right to privacy.
 - h. Living units may be locked at the discretion of the participant, except when a physician or mental health professional has certified in writing that the participant is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door.
 - i. This requirement does not apply where it conflicts with fire code.
 - i. Each living unit is separate and distinct from each other unit.
 - j. The facility must have a central dining room, living room, or parlor, and common activity center(s) (which may also serve as living room or dining room).
 - k. The participant retains the right to assume risk, tempered only by the participant's ability to assume responsibility for that risk.

~~l. Care must be furnished in a way that fosters the independence of each participant to facilitate continued community tenure. Routines of care provision and service delivery must be participant-driven to the maximum extent possible, and must treat each person with dignity and respect. The beneficiary has a right to privacy and has the freedom to move about unless a health practitioner has certified in writing that the beneficiary has a cognitive impairment or similar condition as to be a danger to self or others if given the opportunity to lock the door.~~

~~m. Costs of room and board are excluded from payments for assisted living services.~~

~~c. Assisted living residences with the appropriate State licensure and Medicaid certification may provide an enhanced or specialized package of services, such as dementia care, when necessary to meet a beneficiary's acuity needs. Prior authorization by the State or a Medicaid managed care plan is required.~~

~~d. Personalized services must be provided to a beneficiary residing in a single or double living unit, when both occupants consent to the arrangement, that contains sleeping and toilet facilities. Each living unit is separate and distinct from each other unit. The residence must have a central dining room, living room, or parlor, and common activity center(s) (which may also serve as living room or dining room).~~

~~e. The beneficiary must retain the right to assume risk, tempered only by his or her ability to assume responsibility for that risk.~~

3. Assistive Technology – An item, piece of equipment, service animal or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants, optimize their health and promote independence and self-care. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. The services under the Section 1115 waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Assistive technology includes:

a. The evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the assistive technology and appropriate services to the participant in the customary environment of the participant;

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- b. Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;
- c. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
- d. Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;
- e. Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and
- f. Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

4. Career Planning -- A person-centered, comprehensive employment planning and support service that provides assistance for HCBS participants to obtain, maintain or advance in competitive employment or self-employment. It is a focused, time-limited service engaging a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state's minimum wage. The outcome of this service is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

5. Case Management -- Medicaid coverage is available for case management Services that assist beneficiaries participants in gaining access to needed HCBS Section 1115 waiver and other State pPlan services, as well as medical, social, educational and other services, regardless of the funding source for these services to which access is gained. Case management may be delivered using telehealth or other electronic methods of case management delivery if this meets the individual's needs and preserves the health and welfare of the individual. All participants, including those who choose to receive case management through an electronic delivery method, must receive an in-person contact at least once every six (6) months. If the participant's initial or annual assessment shows they need an in-person contact more than once every six (6) months, or if it is the participant's preference to receive in-person contact more frequently, the case manager must provide an in-person

contact more frequently than every six (6) months. Case managers are responsible for ongoing monitoring of the provision of services included in the participant's PCP; contact requires a response from the participant in order to be considered monitoring. Case managers initiate and oversee the process of assessment and reassessment of the participant's level of care and review of plans of care on an annual basis and when there are significant changes in participant circumstances.

a. As described above, case management includes the person-centered planning process and the development of a PCP. Under federal regulations, case management and PCP development must be conflict-free.

64. Community-Based Supported Living Arrangements (CSLA) -- Enhanced and specialized HCBS for ~~persons~~ participants with more intensive LTSS needs provided through Medicaid certified community-based providers – including certain assisted living residences, group homes for persons with developmental or behavioral health disabilities, and other adult supportive care homes. These providers are authorized by the State to address high level functional/clinical needs that otherwise would require care in an institutional-setting. To participate in the program, HCBS providers must meet standards set by the State related to minimum licensure and certification and establish and maintain an acuity-based, tiered service and payment system that ties reimbursements to: ~~beneficiary's~~ participant's clinical/functional level of need; the scope of HCBS authorized and provided; and specific quality and outcome measures. Occupancy limits on the number of residents allowed in such arrangements may apply in accordance with State licensure and/or certification requirements.

7. 5. Community Transition Services -- ~~Community transitions services are a~~ Non-recurring set-up expenses for ~~applicants and beneficiaries~~ participants who are transitioning from an institutional or another provider-operated ~~setting~~ living arrangement to a living arrangement in a private residence where the ~~person~~ participant is directly responsible for ~~his or her~~ their own living expenses. Allowable expenses are those necessary to enable a ~~person~~ participant to establish a basic household that do not constitute room and board and may include:

a. Allowable expenses include, but are not limited to: s Security deposits that are required to obtain a lease on an apartment or home;

- b. ~~e~~Essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
- c. ~~s~~Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
- d. ~~s~~Services necessary for the person's health and safety such as pest eradication and one-time cleaning prior to occupancy;
- e. ~~m~~Moving expenses;
- f. ~~n~~Necessary home accessibility adaptations; ~~and~~
- g. ~~a~~Activities to assess need, arrange for and procure needed resources; ~~and~~
- h. Assistance with obtaining needed items for housing applications (e.g., assistance with obtaining and paying for a birth certificate or a state identification card, transportation to the local Social Security office).

~~storage fees; weather appropriate clothing; assistance with obtaining needed documentations for housing agreements.~~

b. ~~Allowable expenses for Ccommunity transitions services~~ are furnished only covered to the extent that they are reasonable and necessary as determined through the PCPPservice plan development process, ~~are~~ clearly identified in the person-centered service planPCP, and the person-participant is unable to meet such expense afford paying for the transition services, or or when the services cannot be obtained from other sources.

86. Consultative Clinical and Therapeutic Services -- Clinical and therapeutic services that assist unpaid caregivers and/or paid support staff in carrying out individual treatment/support plans, and that are not covered by the Medicaid State Plan, and are necessary to improve the participant's independence and inclusion in their community. Clinical and therapeutic services are provided by professionals including nursing, psychology, nutrition, counseling and behavior management. The service may include assessment, the development of a home treatment/support plan, training and technical assistance to carry out the plan and monitoring of the participant and the provider in the implementation of the plan. This service may be delivered in the participant's home or in the community as described in the service plan.

9. Day treatment and supports -- Services that are necessary for the diagnosis or treatment of a ~~beneficiary's-participant's~~ behavioral health

condition, mental illness, or disability. The purpose of this service is to maintain the ~~beneficiary's-participant's~~ condition and functional level and to prevent relapse or hospitalization. ~~Range of services available includes~~ 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. ~~The s~~Services of trained psychiatric nurses, social workers, and other professionals and paraprofessionals trained to work with individuals with psychiatric illness;
- d. Drugs and biologicals furnished for therapeutic purposes, that are otherwise not covered by Medicaid or Medicare;
- e. Individual activity therapies that are not primarily recreational or diversionary;
- f. Family counseling (the primary purpose of which is treatment of the ~~beneficiary's-participant's~~ condition);
- g. Training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment); and
- h. Diagnostic services.

710. Habilitation services – Services designed to assist ~~beneficiaries~~ participants in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully in a home or community-based setting. May be included as part of integrated day services or residential habilitation services, as indicated below:

- a. ~~D~~Integrated day habilitation and supports. ~~R~~Provision of regularly scheduled ~~habilitative services and related~~ activities in a non-residential setting, ~~apart~~ separate from the ~~beneficiary's~~ participant's private residence or other residential living arrangement, such as assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that enhance social development and develop skills in performing activities of daily living and community living. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence, and personal choice. Services are furnished

consistent with the participant's person-centered plan. Meals provided as part of these services shall not constitute a full nutritional regimen (three (3) meals per day). These day-Day habilitation services focus on enabling a beneficiary, the participant to attain or maintain his or her their maximum potential and are shall be coordinated with any needed therapies in the PCP individual's person-centered service plan, such as physical, occupational or speech therapy.

- b. Residential habilitation and supports. Individually tailored ~~habilitation services and~~ supports that assist with the acquisition, retention, or improvement in targeted at improving skills related to living in the community. These supports include Includes adaptive skill development, assistance with ~~the~~ activities of daily living, community inclusion, transportation, adult educational supports, employment supports, and the development of social and leisure skill development, s that assist the beneficiary participant in living to reside in the most integrated setting appropriate to their needs. ~~In addition, the service~~ Residential habilitation also includes covers personal care and protective oversight and supervision. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

118. Homemaker services – ~~T~~Services that consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the beneficiary or caretaker individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself themselves or others in the home.

129. Home delivered meals -- The delivery of hot meals and shelf staples, including frozen meals and culturally appropriate meals, to the beneficiary's participant's residence. ~~These services~~ Meals are available to a beneficiary participant who is unable to care for their own nutritional needs because of has a functional dependency/disability that limits the ability to prepare meals and who requires food preparation and delivery this assistance to live in the community. Meals provided under this service do not constitute a full daily nutritional requirement. Home delivered m Meals must provide a minimum of one- third (1/3) of the current recommended dietary allowance and generally do not meet the full daily nutritional requirement. Provision of home delivered meals result in less assistance being authorized for meal preparation for individual participants, if applicable.

1340. Individual directed goods and services – ~~The s~~ Services, equipment, or supplies not otherwise covered by Medicaid that address an identified need in the beneficiary's service plan, PCP (including improving and

maintaining the ~~beneficiary's participant's~~ opportunities for full membership in the community) and meet the following requirements:-
~~Individual directed goods and services are purchased from the beneficiary-directed budget. To be covered, the beneficiary must not have the funds to purchase the item or service or the item or service must not be available through another source and the item or service must:~~

- a. ~~The item or service would~~ decrease the need for other Medicaid services; AND/OR
- b. Promote inclusion in the community; AND/OR
- c. Increase the ~~beneficiary's participant's~~ safety in the home environment; AND,
- d. The participant does not have the funds to purchase the item or service or the item or service is not available through another source. Not be an experimental or prohibited treatment.

Individual directed goods and services are purchased from the participant-directed budget through the self-directed option. Experimental or prohibited treatments are excluded. Individual directed goods and services must be documented in the service plan.

1414. Integrated supported employment -- Integrated employment supports are services and training activities provided in regular business and industry settings for ~~beneficiaries-participants~~ who have disabilities. The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which the ~~beneficiary participant~~ is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

- a. Supports may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefits management, transportation and career advancement services. Other workplace support services may include services not specifically related to job skill training that enable the HCBS ~~beneficiary participant~~ to be successful in integrating into the job setting.
- b. Supported employment must be provided in a manner that promotes integration into the workplace and interaction between

~~beneficiaries-participants~~ and people without disabilities in those workplaces.

1512. Medication management/administration – Pharmacologic management including review of medication use, both current and historical, if indicated; evaluation of symptoms being treated, side effects and effectiveness of current medication(s), adjustment of medications if indicated, and prescription, provided by a medical professional practicing within the scope of ~~his or her~~ licensure.

16. Non-Medical Transportation -- Assurance of transportation is provided to enable HCBS participants to gain access to HCBS and other community services, activities and resources, as specified by the service plan when the participant has no other means of transportation. Under 42 C.F.R. § 431.53 (2023) and 42 C.F.R. § 440.170(a) (2023), the assurance of transportation to and from medical services provided under the State Plan is also provided. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.

17. Peer supports -- Provided by Peer Support Specialists that bring to the participant a unique vantage point and the skills of lived experiences in either managing a health condition or disability, or in serving as the primary caregiver for a family member with a health condition or disability. This service is intended to provide individuals with a support system to develop and learn healthy living skills, to encourage personal responsibility and self-determination, to link individuals with the tools and education needed to promote their health and wellness (as well as the health and wellness of those that they are caring for, if applicable), and to teach the skills that are necessary to engage and communicate with providers and systems of care. Peer Support Specialists work under the direction of a licensed healthcare practitioner or a non-clinical peer support supervisor. In addition to providing wellness supports, the Peer Support Specialists utilize their own experiences to act as a role model, teacher, and guide who both encourages and empowers the participant to succeed in leading a healthy, productive lifestyle.

1813. Personal care -- A range of ~~services and supports~~ assistance to ~~that~~ enables HCBS ~~beneficiaries-participants~~ to accomplish tasks that they would normally do for themselves if they did not have ~~functional and/or clinical limitations~~ a disability. ~~Personal care~~ This assistance may take the form of hands-on assistance (actually performing a task for the participant) or cuing to prompt the ~~beneficiary-participant~~ to perform a task. Personal care services that take the form of verbal cuing may be delivered using telehealth or other electronic methods of service delivery. The Personal care services may be provided on an episodic or on a continuing basis and may be provided by a home health aide, personal care attendant, or

direct service worker. Personal care services may be delivered in an acute care hospital setting if these services are: described in the participant's person-centered plan; provided to meet needs of the participant that are not met through the provision of hospital services; not a substitution for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the participant's functional abilities.

1944. Personal Emergency Response System (PERS) -- PERS is an electronic device that enables HCBS ~~beneficiaries~~ participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the ~~beneficiary's~~ participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein.
4520. Prevocational Services – Services intended to develop and teach general skills that lead to competitive and integrated employment including, but not limited to the ability to: communicate effectively with supervisors, co-workers and customers; follow directions; attend to tasks; solve workplace problems; engage in appropriate work conduct and meet applicable norms related to grooming and dress; and adhere to health and safety standards.
- a. Participation in prevocational services is not a required prerequisite for HCBS individual or small group supported employment services.
 - b. Includes volunteer work and other non-paid work that facilitate the development of general, non-job-task-specific strengths and skills that enhance a ~~beneficiary's~~ participant's employability.
 - c. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as determined by the ~~beneficiary~~ participant in the PCPP person-centered planning process with the assistance of the health professionals and other participants in that process. ~~Beneficiaries~~ Participants receiving prevocational services must have employment-related goals in their person-centered ~~service~~ plan and their general habilitation activities must be designed to support such employment goals.
4621. Private duty nursing -- Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within their ~~scope of practice under~~ State law. These services are provided to a ~~beneficiary~~ participant at home.

22. Remote supports and monitoring -- Also known as surveillance monitoring, remote supports uphold independence by combining technology for service delivery with limited contact with trained staff when the participant requires assistance. For participants who may need 24-hour support but who do not always need hands-on support from an on-site staff person, this service facilitates access to more support than would be possible if all the support were delivered in person. Access to more hours of support (delivered remotely) allows the participant to remain in or move into a more independent living situation. In addition, supports such as live two-way communication allow participants to engage in community activities without in-person staff, with greater independence.

- a. As part of the person-centered planning process, in consultation with the case manager, individuals determine which services they choose to receive through remote supports rather than in-person supports. The choice of whether to receive remote supports rather than in-person supports is subject to any assessment of the individual's functional needs to protect the individual's health, safety, and well-being. In consultation with the case manager, where individuals choose to have a combination of in-person and remote supports for a particular service, the person-centered plan identifies the times of day during which each will be provided to ensure that there is no overlap in delivery of the same service both remotely and in person.
- b. Technology Services include: Motion sensing system; Live video feed and or audio feed; Web-based monitoring system; Sensor detection monitoring systems; and/or Another device that facilitates live two-way communication. All technology must be HIPAA-compliant. Radio frequency identification is a component of some remote support equipment, used to track the equipment and thereby provide a location of an individual as well as to detect falls. Motion sensing system and sensor detection monitoring systems are only used inside the home. Other technology services can be used inside or outside the home.
- c. Participants are given information to support their decision-making regarding whether to use remote supports. Services are detailed in the individual's person-centered plan based on the individual's preferences and a risk assessment to determine if the service meets the individual's support needs. In cases where an individual's needs could potentially be met by either a Personal Emergency Response System (PERS) or a Remote Support Technology Service, the person-centered plan indicates which is being used to meet the particular need. An individual may use PERS to meet certain needs while using Remote Supports for

others, but an individual may not receive both services to address the same need.

- d. Any monitoring is only deployed with the express agreement of the participant. If a participant resides with someone else, the other resident must also agree for the monitoring to be deployed. Individuals have control over their devices and are able to turn off any remote support/monitoring technology. Cameras are not placed in certain areas like bedrooms and bathrooms.
- e. Providers must either be licensed Developmental Disabilities Organizations or a National Organization providing remote support services. Providers offer 24-hour on-call services with real time audio/visual or other live two-way communication and offer an in-person response if necessary to resolve a call.
- f. Providers of Remote Supports check in with the participant on a bi-weekly basis for the first two (2) months to ensure the participant is feeling safe and comfortable with the use of remote supports. These providers' check-ins are either on-site or remote as documented in the individual's PCP. The participant's case manager also checks in on a monthly basis and asks questions regarding the supports the participant is receiving.
- g. Service providers must ensure that there is a plan in place for participant if there is a failure with the technology. Providers must ensure that participants have back up batteries and that staff is available to go out in person when there is a power failure or have a plan in place with other unpaid supports to assist. These plans are detailed in the participant's PCP.

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47. Respite ~~care~~-- Services provided to ~~beneficiaries~~participants, within parameters established by the State, who are unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the ~~beneficiary~~participant.

2448. Shared-living – A supported living arrangement in which necessary core HCBS~~s~~ (e.g., personal care, homemaker, chore, companion services and medication oversight) are bundled and provided in a private residence to a ~~beneficiary~~participant by a principal caregiver who shares the home. The scope of HCBS available in shared living arrangements, and service agencies, varies depending whether a ~~beneficiary~~participant requires a NF or ICF/I-DD level of care and the extent of ~~his or her~~their acuity needs. The State pays the principal caregiver through the service agency for the

HCBS provided to the beneficiary-participant and for assisting in coordinating access to other needed services. Separate payment is not made for homemaker or chore services furnished to the beneficiary participant as these services are integral to and inherent in the provision of the shared living arrangement.

a. Shared living may be authorized through the RItE @ Home program for elders and adults with disabilities (EAD), or through the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) for adults with intellectual/developmental disabilities (I/DD).

~~2549.~~ Skilled nursing -- Services listed in the PCP ~~plan~~ that are within the scope of ~~a nurse's area of practice under State law~~ the State's Nurse Practice Act and are provided by a. HCBS skilled nursing is distinguished from private duty nursing in that it is part time or intermittent and provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse in either the beneficiary's home or Medicaid-certified community living arrangement, licensed to practice in the State.

~~20.~~ Specialized medical equipment and supplies -- Specialized medical equipment and supplies are devices, controls, or appliances, specified in the plan of care, that enable beneficiaries to: increase their ability to perform activities of daily living; perceive, control, or communicate with the environment in which they live; ensure life support; or address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items. Also includes:

a. ~~Other durable and non-durable medical equipment and medical supplies not covered under the State Plan that are necessary to address a beneficiary's functional limitations.~~

b. ~~Remote devices that enable appropriately licensed health care professionals to monitor certain aspects of a beneficiary's health at home or in other residential living arrangements.~~

c. ~~Items covered under HCBS funds are in addition to any medical equipment and supplies furnished under the State Plan and exclude those items that are not of direct medical or remedial benefit to the beneficiary.~~

d. ~~All items must meet applicable standards of manufacture, design and installation.~~

~~2426.~~ Supports for consumer direction or supports facilitation – ~~The services and supports provided by a facilitator – referred to as the service advisement agency – that focuses on empowering beneficiaries participating in self-directed "personal choice" service delivery options under Part 2;~~

~~subchapter 10 of this Chapter~~ participants to define and direct their own personal assistance needs and services; guides and supports, rather than directs and manages, the beneficiary-participant through the service planning and delivery process. The facilitator counsels, facilitates, and assists in development of a person-centered plan ~~the PCP~~ which includes both paid and unpaid services and supports designed to enable the beneficiary-participant to live at home and participate in the community. A back-up plan is also developed to assure that the needed assistance will be provided in the event that regular services identified in the PCP are temporarily unavailable.

- B. ~~Medicaid LTSS beneficiaries receiving core HCBS~~ HCBS participants are entitled to all primary care essential benefits authorized under the Medicaid State Plan including home care, special medical equipment, minor environmental modifications, and home modifications. Unless self-directed, HCBS are delivered by Medicaid certified providers through PACE, a Medicaid managed care plan, or on a fee-for-service basis, in accordance with the provisions set forth in Part 40-10-1 of this Title.

1.78 Limitations on the Availability of Medicaid HCBS

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

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

- A. The limitations that apply for when waiting lists or other limitations on HCBS occur for ~~beneficiaries-participants~~ who need a NF or LTH level of care are set forth in State law.
1. Highest level -- ~~Beneficiaries-Participants~~ with the highest need have the option of seeking admission to a NF or LTH while awaiting access to the full scope of home and community-based services. Accordingly, ~~applicants/beneficiaries/individuals~~ deemed to be in the highest category for a NF level of care or meet the requirement for a LTH level of care are entitled to services and must not be placed on a waiting list for Medicaid LTSS in an institutional setting under R.I. Gen. Laws § 40-8.9-9. If a community placement is not initially available, ~~beneficiaries-participants~~ with the highest need may be placed on a waiting list for transition to the community while receiving services in a licensed health facility that provides the type of institutionally based LTSS that meets their needs.
 - a. Priority Status. In the event that a waiting list for any home and community-based service becomes necessary, the EOHHS must provide services for ~~beneficiaries-participants~~ determined to be NF or LTH highest need before providing services to ~~beneficiaries-participants that who~~ have a high need. ~~Beneficiaries with high need are given priority access to services over beneficiaries qualifying for LTSS preventive services.~~
 - b. Continuation of Services. Services for ~~beneficiaries-participants~~ with the highest need must continue in the appropriate setting unless or until their condition improves to such an extent that they no longer meet the same clinical/functional eligibility criteria.
 2. High Need -- ~~Beneficiaries-Participants~~ with a high level of need may be subject to waiting lists for certain HCBS. However, for the NF level of care, ~~beneficiaries-participants~~ with a high need are afforded priority status for any such services over ~~beneficiaries-participants~~ who have a preventive level of need under R.I. Gen. Laws § 40-8.10-3. ~~Beneficiaries-Participants~~ who meet the functional/clinical eligibility criteria for the high level of long-term hospital (LTH) care must be provided with required services in an institutional setting until HCBS become available. ~~Rules pertaining to the LTSS preventive level of need are located in Part 40-05-1 of this Title.~~

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

- A. The State must adhere to the requirements set forth in the Section 1115 ~~demonstration~~ waiver if waiting lists or other restrictions are established for HCBS for persons with developmental disabilities. -The goal is two-fold: -1) Ensure care is available for those whose medical needs cannot otherwise be

addressed; and 2) Limit the availability when any community-based alternative is available.

1. Highest need -- As placement in an ICF/I-DD is not generally available, the State must give ~~beneficiaries participants~~ with the highest needs levels in Tiers D and E, as specified in Subchapter 00 Part 50-00-5 of this ~~Title Chapter~~, priority access for any home and community-based services that are restricted over ~~beneficiaries participants~~ with a high need. Placement in an alternative living arrangement that provides the same or a more robust service array, including a NF or LTH, may be provided on an interim basis for any ~~applicant or beneficiary individual~~ who has clinical or functional needs requiring medical care.
2. High need -- ~~Beneficiaries-Participants~~ with high needs levels in Tier C are given priority access over ~~beneficiaries participants~~ with needs levels in Tiers B and A. Accordingly, ~~beneficiaries participants~~ with needs levels in Tier A have limited access to any restricted HCBS until ~~beneficiaries participants~~ with greater needs have been served.
3. Exceptions – The State may make exceptions to the priority access standards set forth herein in accordance with the provisions in Subchapter 00 Part 5 of this ~~Title Chapter~~, as appropriate, or rules, regulations and procedures promulgated specifically for that purpose by the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH).

1.89 HCBS Setting Requirements

- A. The federal government regulations beginning at 42 C.F.R. § 441.~~301(c)(4)700~~ (2024) establish standards and criteria that states must follow when determining whether Medicaid coverage is available for certain HCBS services and settings. ~~This section incorporates the federal standards and establishes the core HCBS for long-term services and supports.~~ The federal standards and requirements for HCBS are designed to: provide states with more flexibility when using federal funds to pay for Medicaid in non-institutional settings; and establish a set of standards for HCBS that ensures ~~Medicaid LTSS beneficiaries participants will~~ have full access to the advantages of community life and health services in integrated settings. ~~The EOHHS is committed to implementing a federally approved, stakeholder-driven transition plan that assures the State is maintaining compliance with these requirements by the deadline for adoption in 2022. Failure by any HCBS setting to observe these requirements constitutes grounds for provider sanctions as described in Part 20-00-1 of this Title.~~
1. HCBS settings include any location where Medicaid-funded HCBS, as defined in § 1.7 of this Part, are provided.

2. The following HCBS setting types are required to demonstrate initial and continued compliance with 42 C.F.R. § 441.301(c)(4) (2024) through regular licensing, certification, and/or on-site surveys, as a condition of participation in the Medicaid program:
 - a. Assisted living residences;
 - b. Shared living placements in a non-family home;
 - c. Residential habilitation settings; and
 - d. Day habilitation settings.
3. As permitted by the Centers for Medicare and Medicaid Services (CMS), a participant's private residence and family shared living arrangements are presumed to comply with 42 C.F.R. § 441.301(c)(4) (2024), and are not subject to regular reviews for compliance. These regulations hereby adopt and incorporate 42 C.F.R. § 441.700 et seq. (2014) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these regulations.

B. HCBS setting requirements include the following characteristics:

1. The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as applicants/beneficiaries/individuals not receiving Medicaid HCBS.
2. The setting is selected by the applicant/beneficiary/participant from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the applicant's/beneficiary's/participant's needs, preferences, and, for residential settings, resources available for room and board.
3. Ensures an applicant's/beneficiary's/participant's rights of privacy, dignity and respect, and freedom from coercion and restraint.
 - a. Freedom from coercion and restraint means that the use of restrictive interventions, including restraint and/or seclusion, in HCBS settings is prohibited except in limited circumstances as identified in § 1.9(B)(3)(b) of this Part below.
 - i. For the purposes of this Part, restraints include physical, mechanical, chemical or pharmacological restraints.

- (1) Units have entrance doors lockable by the ~~applicant/beneficiary~~ participant, with only appropriate staff having keys to doors;
 - (2) ~~Applicants/beneficiaries~~ Participants sharing units have a choice of roommates in that setting; and
 - (3) ~~Applicants/beneficiaries~~ Participants have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- c. ~~Applicants/beneficiaries~~ Participants have the freedom and support to control their own schedules and activities, and have access to food at any time;
- d. ~~Applicants/beneficiaries~~ Participants are able to have visitors of their choosing at any time;
- e. The setting is physically accessible to the ~~applicant/beneficiary~~ participant; and
- f. Any modification of the additional conditions, under ~~§§ 1.9(B)(6)(a)-through-(e) of this Part~~ paragraphs (a)(i)(vi)(A) through (D) of this section, must be supported by a specific assessed need and justified in the ~~person-centered service plan~~ PCP. The following requirements must be documented in the ~~person-centered service plan~~ PCP:
- (1) Identify a specific and individualized assessed need.
 - (2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
 - (3) Document less intrusive methods of meeting the need that have been tried but did not work.
 - (4) Include a clear description of the condition that is directly proportionate to the specific assessed need.
 - (5) Include regular collection and review of data to measure the ongoing effectiveness of the modification.
 - (6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
 - (7) Include the informed consent of the ~~applicant/beneficiary~~ participant.

(8) Include an assurance that interventions and supports will cause no harm to the ~~applicant/beneficiary~~ participant.

C. HCBS settings licensed by the Department of BHDDH shall demonstrate compliance with the above requirements through the licensing process as described in 212-RICR-10-00-1 and 212-RICR-10-05-1.

D. HCBS settings located outside the State of Rhode Island are required to demonstrate compliance with the above requirements as a condition of Rhode Island Medicaid reimbursement for HCBS delivered in such settings. Out of state providers shall be held to the same standards as HCBS providers delivering the same or comparable services within the State of Rhode Island.