State of Rhode Island

Transition Plan to Implement the Settings Requirement for Home and Community Based Services CMS Final Rule January 2014

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Summary:

In January 2014 the Centers for Medicare and Medicaid Services (CMS) issued a final rule regarding Medicaid-funded home and community based services (HCBS). The rule applied to HCBS provided under 1915(c) authorities. Rhode Island's authority to claim Federal Medicaid match for HCBS is under our 1115 Waiver.

The intent of the rule is to ensure that Medicaid–funded HCBS are provided to individuals in a setting that is integrated and supports full access to the community; are selected by the beneficiary; ensure an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint; optimize autonomy and independence in making life choices; facilitate individual choice regarding services and supports, and who provides them; and are based on a person centered service plan.

Components addressed in this Transition Plan:

Rhode Island's Transition Plan will encompass the following:

1) A description of the State's process for compliance with Medicaid-funded HCBS rules.

2) A description of areas of vulnerability with remedial actions that ensures compliance with full implementation by March, 2019.

3) Two statements of public notices and request for public input.

Materials included in the Transition Planning Document:

a) Background 1115 Waiver
b) State Team Responsibilities
c) Existing Settings in HCBS Programs-Assessment Tool Review Process
d) Rhode Island's Statewide Transition Plan Matrix –Areas of Vulnerability and Remedial Actions
e) Statements of Public Notice
f) List of Providers
g) Provider Self-Assessment Tools for Residential and Non-Residential Settings

A. Background-1115 Waiver

All of Rhode Island's Medicaid-funded HCBS are authorized under an 1115 Waiver. Our Waiver application was approved by CMS for five (5) years, from December 23, 2013 through December 31, 2018.

Medicaid-funded HCBS authorized in the 1115 Waiver are provided to the following populations when they meet both clinical and financial eligibility requirements:

Aged, blind and disabled individuals

Individuals at risk for LTC with income at or below 250 percent of the FPL, who are in need of home and community-based services

217 like Categorically Needy Individuals receiving HCBS waiver-like services & PACE-like participants in the Highest need group.

217 like Categorically Needy Individuals receiving HCBS waiver-like participants in the High Need group.

217 like Medically Needy receiving HCBS waiver-like services in the community (High and Highest group). Medically Needy PACE-like participants in the community.

Adults living with disabilities with incomes at or below 300 percent of the SSI with income and resource lists above the Medicaid limits.

Adults aged 19-64 who have been diagnosed with Alzheimer's disease or a related Dementia as determined by a physician, who are at risk for LTC admission, who are in need of home and community care services, and whose income is at or below 250 percent of the FPL.

The Settings that will be reviewed are the following:

1) Residential Settings
2) Shared Living Setting
3) Day/Employment Programs
4) Assisted Living Sites
5) Adult Day Programs

A statistically valid sample will be done for all settings. After July1, 2015 on-site evaluations, quality review and consumer surveys will be completed to complete the assessment process.

Also a list of Core Services of the 1115 Waiver are defined in Attachment A (p. 32-39)

B) State Team Responsibilities:

The State Team consists of the Executive Office of Health and Human Services (EOHHS) and the Departments that are under the EOHHS umbrella: the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals, the Department of Health, the Department of Children, Youth and Families, and the Department of Human Services, Division of Elderly Affairs, as well as provider and advocacy groups such as, Advocates in Action (AIA),

Community Provider Network of Rhode Island (CPNRI), Rhode Island Developmental Disabilities Council and The Paul V. Sherlock Center on Disabilities

Consumers and advocacy groups will provide input, review and be at the table during the development and implementation of the transition plan. In order to strengthen the transition plan, and assure the consumer voice is represented, separate meetings will occur with consumer and advocacy groups.

The State Team Responsibilities will be on-going over the next four (4) years and there is a clear understanding of the work plan and timelines needed for full implementation. Continued stakeholder input and engagement to review the findings of the assessment tool; the regulations; policy and statute crosswalk will be critical to fully implementing the Final Rule by 2019.

These engagement meetings will serve as process for educating the public about the new rules as well as an opportunity for feedback. Until the Final Rules are fully implemented, the Transition Plan will be an open document/process that works with all stakeholders to gradually roll out the plan.

Vision for Training and Compliance:

In order to ensure that Rhode Island has the capacity to implement the Transition Plan, the State Team will be implementing an inter-departmental training, technical assistance and compliance team.

The State is implementing a three pronged approach to assessment(State Assessment, Provider Self-Assessment and a State Team 12 month Assessment), as the State Team identifies vulnerabilities within the State agencies and service providers, a team of state led trainers and technical assistance staff will be available to assist agencies.

Depending on the need of each agency, more intensive technical assistance may be offered to bring programs, policies and practices into compliance; therefore, the training team will incorporate extensive technical support to providers.

Finally, the State Team will utilize its compliance resources to lead an inter-departmental team to monitor agencies' compliance. Monitoring may be supplemented by interns from the University of Rhode Island and Rhode Island College's Masters' programs. Both educational institutions have areas of study that focus on human services, including Developmental Disabilities, Elder Care, Nursing and Social Work. The State feels that utilizing our State college and university will provide a benefit to the state as well as the students by providing practical experience and supplementing the State Department's staff.

C) Existing Settings in HCBS Programs Assessment Tool Review Process:

The current Rhode Island standards, rules, regulations, statutes and other requirements for HCBS settings will be reviewed for compliance with federal regulations.

Consumers, caregivers, providers, and all other stakeholders will have input into the review process and identify areas that need to be strengthened for full compliance by March 2019.

Rhode Island is implementing a three pronged approach to the assessment tool. Each Department will form an internal review committee and use the tool to identify initial areas that are in compliance or need remedial action. The second prong will be a provider self -assessment. The self-assessment process will be used to identify those areas of vulnerability at a provider level. The third part of the assessment will be done by teams over the next 12 months. This approach will allow the State to begin to target technical assistance to providers who have been identified or have self-identified as being the furthest from compliance. As the State provides technical assistance and agencies move toward the work of their individual agency's transition plan, the team of assessors can track progress.

See Provider Self-Assessment Tools for Residential and Non-Residential Settings (p.19-30)

D) Rhode Island's Statewide Transition Plan Matrix:

The Executive Office of Health and Human Services has created a comprehensive transition plan. Our Transition Plan includes the following:

- Stakeholders acceptance of Assessment Tool and Transition Plan
- Outreach and engagement to stakeholders and the public with information about implementation of the Assessment Process and the Transition Plan
- Public Comment Input process for the Transition Plan
- Plan for changing statutes, regulation, and policy
- Implementing assessment process (on-site, self -assessments, who is responsible)
- Identify settings that require compliance strategies/monitoring plan

Waiver	Item	Start Date	End Date	Sources	Key Stakeholders	Deliverable	Completed
1115	1. Stakeholders acceptance of Transition Plan and Assessment Tool with buy-in through inclusion and participation of stakeholders, consumers and providers during the development of the tool and the transition plan	1/26/2015	6/30/2015	Comments and responses from state team meetings, Comments and responses from EOHHS Monthly Task Force meeting, EOHHS website,	OHHS, BHDDH, DOH, CPNRI, DCYF, DHS/DEA, Sherlock Center, Advocates in Action, RI Developmental Disability Council	Acceptance of Transition Plan and Assessment Tool 6/30/15	Assessment tool completed 3/09/15
	List all steps and actions to assure progress towards deliverable: 1) On-going meetings to review and approve Assessment Tool Process and Transition Plan. 2) Each state department will identify provider network and advocacy groups that are to be involved in the Assessment Tool Process and Transition Plan. 3) Post Assessment Tools, and Transition Plan on Web Site by April 15, 2015, 4) Report off at each monthly EOHHS Task Force. 5) On-going communication to consumers, providers, stakeholders through posting and comments of tool and transition plan on web-site and meetings with stakeholders, providers and consumers during development. 6) From public comments made from public forum 4/30/15 and through comments sent to EOHHS, make changes to the document and submit to CMS no later than 6/30/15						In Process
1115	2. Outreach and engagement to stakeholders and the public with information about the implementation of the Assessment Process and tracking and remediation of the Transition Plan	4/30/2015	6/1/2017	Comments and responses from EOHHS Monthly Task Force meeting, EOHHS website, E-mail and non-electronic mail or distribution at Stakeholder meeting	OHHS, BHDDH, DOH, CPNRI, DCYF, DHS/DEA, Sherlock Center, Advocates in Action, RI Developmental Disability Council	Communication to all relevant stakeholder on Transition Plan, Assessment Process and updates to Transition plan over the next 18-24 months	In process
	List all steps and actions to assure progress towards deliverable: 1) On-going state team meetings to review and disseminate all information to relevant stakeholders to communicate updates and changes in the transition plan. First change to plan will occur after Public Comment meeting on April 30 and will be posted for final comment prior to submission to CMS. 2) Subsequent to the June 30 2015 submission of the plan, remediation to the plan and the tracking of the plan will be done through monthly state team meetings. The goal is to work to have a full plan for remediation 12 months after submission of the plan. 3) Each state department will identify provider network and advocacy groups that are to be involved in the implementation and remediation of the Transition Plan. 4) Post information on Web Site of any change during this time frame. 5) Report off at each monthly EOHHS Task Force.						In process

	6) Send correspondence by E-mail to all who participate in EOHHS task force, 7) Send out electronic and non-electronic communications as needed.						
1115	3. Public Comment Input process for the Transition Plan	1/26/2015	6/1/2015	Comments and responses to EOHHS Monthly Task Force meeting, EOHHS website, E-mail and non-electronic mail or distribution at Stakeholder meeting	OHHS, BHDDH, DOH, CPNRI, DCYF, DHS/DEA, Sherlock Center, Advocates in Action, RI Developmental Disability Council	All stakeholders provided two opportunities to comment on Transition Plan prior to submission	In Process
	List all steps and actions to assure progress towards deliverable: 1) Post on EOHHS web site; send out electronic and non-electronic communications by April 15, 2015. 2) Record and store each comment and make changes as needed to the Transition Plan. 3) Provide two opportunities for public comment after April 15, 2015. First Public input will occur on April 30, 2015 via public forum. Second opportunity will also be via website and non-electronically through correspondence with the State. (See Section E Statement of Public Notice). 4) After submission of Transition Plan, the process will continue where the public is able to send comments to any change to the plan as they are notified through the monthly EOHHS task force, website, e-mail, or non-electronically through postings of changes and sending correspondence to the state.						
1115	4. Plan for changing statutes, regulation, and policy	2/1/2015	1/1/2016	Reviews all information of statutes, regulation and policy.	State Team to review statutes, regulations and policy.	All statutes, regulations and policy in compliance by March 2019	In Process
	List all steps and actions to assure progress towards deliverable: 1) State team reviews all completed assessment and then begins to meet with individual providers to make them aware of possible changes to statutes, regulations and policies. 2) Works to identify and prioritize any changes to statutes, regulations and policies six months after submission of the Transition Plan. 3) State team will develop, adopt and revise policies, procedures and standards to address ongoing compliance and monitoring, to be completed by 1/1/2016. State team works to identify and prioritize any changes to statutes, regulations and policies six months after the submission of the Transition Plan. These updates may require legislative updates that are to be completed by January 2019. 4) Implement the Rule making process to changes statutes, regulations, and policies, which includes a public comment process, until full implementation by March 2019. 5) As part of the provider enrollment process, all new providers will be required to meet the new HCBS setting rule at the time of enrolling to be a Medicaid provide						

1115	5. Implementing assessment process (on-site, self -assessments, who is responsible)	2/1/2015	6/30/2016	State Team	State Team.	Implement three prong assessment process by June 2016	In process
	List all steps and actions to assure progress towards deliverable: 1) Design statewide remediation strategy starting July 1, 2015 with completion for 6/30/16. The state team will design a remedial strategy for settings to be found noncompliant. The strategy will include on-site assessments, technical assistance and consultation and consumer surveys. 2) As part of the remediation strategy starting July 1, 2015 and ending 2/1/2016, a list of all settings that are assumed to be in compliance and out of compliance with the Final Rule will be made. 3) The State team will integrate quality reviews lead by consumer surveys and quality reviews starting 2/1/2016 to complete the assessment process 4) State Team reviews all assessments and over the next 12 months provides technical assistance and compliance towards the final rule. Follow up includes on-site assessments to validate sample settings.						
1115	6. **Identify settings** that require compliance strategies/monitoring plan	2/1/2015	9/30/18	Reviews all completed assessments, surveys , action plans and surveys sent to state team	State Team to provide Technical Assistance	All setting in compliance by March 2019	In process
	List all steps and actions to assure progress towards deliverable: 1) Design statewide remediation strategy starting July 1 2015 with completion for 6/30/2016. The state team will design a remedial strategy for settings to be found noncompliant. The strategy will include on-site assessments, technical assistance and consultation and consumer surveys.						

2) As part of the remediation strategy starting July 1, 2015 and ending 2/1/2016, a list of all settings that are assumed to be in compliance and out of compliance with the Final Rule will be made.

3) The State team will integrate quality reviews lead by consumer surveys and quality reviews starting 2/1/2016 to complete the assessment process

4) After 12 month of completed assessments, state team to prioritize and identify those settings that require immediate assistance. Priority will be given to those settings that would require new setting/placements for individuals.

5) The State Team will work with all individual non-compliant settings to develop and implement action plans. Periodic updates to the state team on progress to assure compliance by 9/30/2018. Any setting that remains out of compliance, the state will work with individuals in the residential setting to transition to a new setting that is integrated and choice base by 3/2019.

6) As part of the provider enrollment process, all new providers will be required to meet the new HCBS setting rule at the time of enrolling to be a Medicaid provider.

Preliminary Areas of Vulnerability and Remedial Actions:

Residential/Shared Living Provider Setting:

Provider Self-Assessments were sent in from nineteen (19) residential settings and three (3) Shared Living providers. The settings were reported to provide and comply with the following for their residents:

1) Opportunity to engage in community life
2) Ensure freedom from coercion and restraint
3) Provide a setting that ensures dignity and respect
4) The person or the person chosen by the individual has an active role in the development and update of the individual's person-centered plan
5) Optimizes interaction, autonomy and independence in making life choices
6) Provides opportunity for privacy
7) Freedom to furnish their sleeping units
8) Has control over their schedules
9) Able to have visitors at any time
10) Has access to food at any time
11) Setting is physically accessible to the individual.
12) No setting was reported to be in a public or privately-owned facility that provides inpatient treatment and or on the grounds of, or immediately adjacent to a publicly-funded healthcare institution.

Follow up assessments will be done to validate provider self-assessment by June 2016.

The areas of vulnerability most noted in our survey were specific to certain choice issues that can be influenced by the overall management needs of an entire group living in a setting.

Specific areas of vulnerability were the following:

1) Individuals scheduling his /her days services and or arrival and departure times
2) Access to public transportation
3) Opportunities to control personal resources
4) Choice regarding available options regarding where to live/receive services
5) Choice regarding the provider or staff who render the services they receive
6) Choice of roommates
7) Lockable entrance doors with individuals and staff having keys as needed to the bedroom and bathroom.

As remedial actions, Rhode Island proposes the following:

1) Design statewide remediation strategy starting July 1 2015 with completion for 6/30/16. The state team will design a remedial strategy for settings to be found noncompliant. The strategy will include on-site assessments, technical assistance and consultation and consumer surveys.
2) As part of the remediation strategy starting July 1, 2015 and ending 2/1/2016, a list of all settings that are assumed to be in compliance and out of compliance with the Final Rule will be made.
3) The State team will integrate quality reviews lead by consumer surveys and quality reviews starting 2/1/2016 to complete the assessment process.
4) State team will develop, adopt and revise policies, procedures and standards to address ongoing compliance and monitoring, to be completed by 1/1/2016. State team works to identify and prioritize any changes to statutes, regulations and policies six months after the submission of the Transition Plan. These updates may require legislative updates that are to be completed by January 2019.
5) The State Team will work with all individual non-compliant settings to develop and implement action plans. Periodic updates to the state team on progress to assure compliance by 9/30/2018. Any setting that remains out of compliance, the state will work with individuals in the residential setting to transition to a new setting that is integrated and choice based by 3/2019
6) Implement the rule making process and process to change statutes, regulations and policies, which include public comment process, until full implementation by March 2019.
7) All new providers will be assessed with revised policies, procedures and standards to ensure HCBS setting compliance to providing services.

Another area of vulnerability that has been identified is that of the legally enforceable agreement that is comparable to a lease. Many of Rhode Island's providers have identified this as an area of concern. For example, Shared Living Arrangements (SLA) has traditionally utilized a home based approach that provides for self-determination and choice, but does not have agreements that are legally enforceable to that of a lease.

As remedial actions, Rhode Island proposes the following:

1) Design statewide remediation strategy starting July 1 2015 with completion for 6/30/16.
2) State team will collect and review any signed agreements between the consumer within six months after submission of the Transition plan or by 1/1/2016
3) The State Team will work with all individual non-compliant settings to develop and implement action plans. Periodic updates to the state team on progress to assure compliance by 9/30/2018. Any setting that remains out of compliance, the state will work with individuals in the shared living setting to transition to a new setting by 3/2019
4) As part of the provider enrollment process, all new providers will be required to meet the new HCBS setting rule at the time of enrolling to be a Medicaid provider.

Day/Employment Programs:

As noted earlier in our Transition Plan the intent of the final rule is to ensure that Medicaid-funded HCBS are provided to individuals in a setting that is integrated and supports full access to the community. The Department of Justice has also forcibly asserted that integration is to be in all aspects of the consumer's life, to include areas such as employment and day program settings. Rhode Island is presently under a Department of Justice consent decree working towards transitioning individuals from center based services to community based integrated employment and day services. Therefore our remedial actions toward this issue will be the following:

1) Review of the current plan of correction with the Department of Justice and work closely with the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), to design a remedial strategy that is consistent with consent decree by 6/30/2016.
2) Follow milestones and timetables with the consent decree to assure compliance with the Final Rule of services and employment in an integrated community setting
3) The State Team will work with all individuals in non-compliant settings to develop and implement action plans consistent with consent decree by March 2019.
4) As part of the remedial design, consumers will be given the opportunity to have an active role in choosing the support and services needed to transition from center based services to community based integrated employment and day services.
5) April 2015, a survey will be done by the Paul V. Sherlock Center on Disabilities. The survey will focus on Employment and Day Programs and focus on obtaining data on integrated paid employment, facility based paid work, community based non-work activities and facility based non-work activities. This survey will be integrated into the remedial design strategy for 6/30/2016.

In addition, a total of five (5) Day Program/Employment settings were sampled with our Provide Self-Assessment Tool. All eleven questions from our tool were reported to have compliance except for the area of integrated employment settings. As mentioned above, this area will be addressed by a remedial design that works closely with BHDDH and incorporates the survey of the Paul V. Sherlock Center to move this issue forward.

Follow up assessments will be done to validate provider self-assessment by June 2016.

Assisted Living Sites:

Provider Self-Assessments were sent in by nine (9) Assisted Living Sites. The settings were reported to provide and comply with the following for their residents:

1) Opportunities to engage in community life
2) Ensure freedom from coercion and restraint
3) Provide a setting that ensures dignity and respect

4) The person or the person chosen by the individual has an active role in the development and update of the individual's person-centered plan
5) Optimizes interaction, autonomy and independence in making life choices
6) Provide opportunity for privacy
7) Freedom to furnish their sleeping units
8) Freedom to furnish their sleeping units
9) Has control over their schedules
10) Able to have visitors at any time
11) Has a legally enforceable agreement comparable to a lease

Follow up assessments will be done to validate provider self-assessment by June 2016.

The areas of vulnerability most noted in our survey were specific to certain choice issues that can be influenced by the overall management needs of an entire group living in a setting.

Specific areas of vulnerability were the following:

1) A facility is on the grounds of a nursing facility, therefor will be reviewed for Heightened Scrutiny
2) Opportunities to control personal resources
3) No locks on bathroom doors
4) Physically accessible to kitchen and laundry areas
5) Allowing access to food at any time

As remedial actions, Rhode Island proposes the following:

1) Design statewide remediation strategy starting July 1 2015 with completion for 6/30/2016. The state team will design a remedial strategy for settings to be found noncompliant. The strategy will include on-site assessments, technical assistance and consultation and consumer surveys.
2) As part of the remediation strategy starting July 1, 2015 and ending 2/1/2016, a list of all settings that are assumed to be in compliance and out of compliance with the Final Rule will be made.
3) The State team will integrate quality reviews lead by consumer surveys and quality reviews starting 2/1/2016 to complete the assessment process.
4) State team will develop, adopt and revise policies, procedures and standards to address ongoing compliance and monitoring, to be completed by 1/1/2016. State team works to identify and prioritize any changes to statutes, regulations and policies six months after the submission of the Transition Plan. These updates may require legislative updates that are to be completed by January 2019.
5) The State Team will work with all individual non-compliant settings to develop and implement action plans. Periodic updates to the state team on progress to assure compliance by 9/30/2018. Any setting that remains out of compliance, the state will work with individuals in the residential setting to transition to a new setting that is integrated and choice based by 3/2019

6) Implement the rule making process and process to change statutes, regulations and policies, which include public comment process, until full implementation by March 2019.
7) As part of the provider enrollment process, all new providers will be required to meet the new HCBS setting rule at the time of enrolling to be a Medicaid provider.

Heightened Scrutiny:

The State will review the facility (and any other facilities) for Heightened Scrutiny and follow the process by CMS. The State will begin that process after submission of the plan and works toward resolving the issue over the following six months or by 1/1/2016.

Adult Day Programs:

Provider self-assessments were sent in from six (6) Adult Day Programs. The settings were reported to provide and comply with the following:

1) No setting was reported to be in a public or privately-owned facility that provides inpatient treatment and or on the grounds of, or immediately adjacent to a publicly-funded healthcare institution.
2) Opportunities to control personal resources.
3) Ensure freedom from coercion and restraint.
4) Provide a setting that ensures dignity and respect.
5) The person or the person chosen by the individual has an active role in the development and update of the individual's person-centered plan.
6) Optimizes interaction, autonomy and independence in making life choices
7) Health information is kept private.
8) Plans include a description of the condition that is directly proportional to the assessed need, data to support ongoing effectiveness of the intervention, time limits for periodic reviews to determine the ongoing necessity of the modification, informed individual consent, and assurance that the intervention will not cause the individual harm.

Specific areas of vulnerability were the following:

1) Opportunities to engage in Community Life.
2) Options for services
3) Physical Accessibility in regards to locked doors.

As remedial actions, Rhode Island proposes the following:

1) Design statewide remediation strategy starting July 1 2015 with completion for 6/30/2016. The state team will design a remedial strategy for settings to be found noncompliant. The strategy will include on-site assessments, technical assistance and consultation and consumer surveys.

2) As part of the remediation strategy starting July 1, 2015 and ending 2/1/2016, a list of all settings that are assumed to be in compliance and out of compliance with the Final Rule will be made.
3) The State team will integrate quality reviews lead by consumer surveys and quality reviews starting 2/1/2016 to validate the assessment process
4) State team will develop, adopt and revise policies, procedures and standards to address ongoing compliance and monitoring, to be completed by 1/1/2016. State team works to identify and prioritize any changes to statutes, regulations and policies six months after the submission of the Transition Plan. These updates may require legislative updates that are to be completed by January 2019.
5) The State Team will work with all individual non-compliant settings to develop and implement corrective plan actions. Periodic updates to the state team on progress to assure compliance by 9/30/2018. Any setting that remains out of compliance, the state will work with individuals in the setting to transition to a new setting that is integrated and choice based by 3/2019
6) Implement the rule making process and process to change statutes, regulations and policies, which include public comment process, until full implementation by March 2019.
7) As part of the provider enrollment process, all new providers will be required to meet the new HCBS setting rule at the time of enrolling to be a Medicaid provider.

E) Statements of Public Notice:

The State held public meetings on April 30, 2015 and May 5, 2015 for comment on the transition plan. At this meeting individuals received a copy of the Transition Plan. Prior to the meeting the following Public Notice was advertised in the Providence Journal on April 15, 2015. This notice enabled the public to comment electronically and non-electronically to the transition plan until May 30, 2015.

Public notice was also made available through EOHHS Website and notification of to EOHHS task force April 15, 2015. Public comment was available until May 30, 2015.

Below is the notification that was placed in the Providence Journal on April 15**, 2015.**

STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVCES

NOTICE OF PUBLIC COMMENT

Public Input into Transition Plan for Home and Community Based Services (HCBS) for the

Center of Medicare and Medicaid Services (CMS) Final Rule of January 2014

The Executive Office of Health and Human Services is advertising for public comment on the proposed Transition Plan that will be submitted to the Center for Medicaid and Medicare Services no later than June 30, 2015.

In January 2014 the Centers for Medicare and Medicaid Services (CMS) issued a final rule regarding Medicaid-funded home and community based long-term services (HCBS). The rule requires that each state develop a Transition Plan for compliance with the new rule. Rhode Island is planning to submit their Transition Plan on **June 30, 2015.** That plan will propose **June 30, 2019** as the date by which we will be compliant with the new requirements.

The summary of the intent of the Final Rule of January 2014 was to ensure that Medicaid HCBS services are provided to individuals in a setting that is **integrated** and supports full access to the community; is selected by the beneficiary; ensures an **individual's rights** of privacy, dignity and respect, and freedom from coercion and restraint, optimizes autonomy and independence in making **life choices**; **facilitates individual choice** regarding services and supports, and who provides them; and, where possible, the person leads the process of developing his or her service plan.

A public hearing will be held to consider the proposed Transition Plan on **Thursday, April 30, 2015 at 9:00 am at the Hewlett Packard 203 Conference room, 301 Metro Center Blvd., Warwick, RI 02886.** Persons wishing to testify and provide comments at the meeting may do so by signing up at the meeting or by submitting written comment by May 30, 2015**,** to Thomas G. Martin, Implementation Director, Executive Office of Health and Human Services, Louis Pasteur Building # 57, 57 Howard Avenue, Cranston, RI 02920, or via email Tom.martin@ohhs.ri.gov.

A copy of the Transition Plan can be obtained through the following means:

1) EOHHS website for Home and Community Based Services.

http://www.eohhs.ri.gov/ReferenceCenter/HomeandCommunityBasedServices.aspx

Scroll over to the Reference Center there is a clickable headline "Home and Community Based Services". A final version of the Transition Plan will be on the website.

2) Request a version by contacting:
   Thomas G. Martin
   Implementation Director
   Executive Office of Health and Human Services
   Louis Pasteur Bldg. #57, 57 Howard Avenue
   Cranston, RI 02920
   401-462-2596 **Fax:** 401-462-3677
   E-mail: Tom.Martin@ohhs.ri.gov

The public hearing will begin at 9:00 am and will conclude when the last speaker finishes. The seating capacity of Hewlett Packard Conference room will be enforced and therefore the number of persons participating in the hearing may be limited at any given time by the hearing officer, in order to comply with safety and fire codes.

The Hewlett Packard building is accessible to individuals with disabilities. Individuals with hearing impairments may request an interpreter's presence by calling 711 or Relay RI 1-800-745-6575 (Voice) and 1-800-745-555 (TDD). Requests for this service must be made at least 72 hours in advance of the meeting date. Please refrain from wearing scented products to the meeting. What may seem to be a mild fragrance can constitute a toxic exposure for a person with an environmental illness. The Executive Office of Health and Human Services does not discriminate against individuals based on race, color, national origin, sex, gender identity or expression, sexual orientation, religious belief, political belief or handicap.

Elizabeth H. Roberts, Secretary
Signed this day of March 2015

Enclosed is a summary of public comment with the State's response to those comments. (INSERT table/document)

F) List of Providers:

Rhode Island Assisted Living Association (RIALA)
Advocates in Action
Rhode Island Council of Developmental Disabilities
Paul V. Sherlock Center on Disabilities
Community Provider Network of Rhode Island (CPNRI)
Rhode Island Parent Information Network
Executive Office of Health and Human Services Task Force (list server of over 175 individuals)

G) Provider Self-Assessment Tools for Residential and Non-Residential Settings

CMS HCBS Community Rule: Assessment and Planning Tool for Settings

Residential Settings

In March, CMS finalized its HCBS Community Rule that defines and sets criteria for what constitutes a community setting for services delivered under the Home and Community Based Services Waiver Program (HCBS). The intent of the rule is to assure that individuals receiving long-term services and supports through HCBS programs have full access to the benefits of community living and the opportunity to receive services in integrated settings. The accompanying summary of the CMS Community Rule provides more information and further context for the Community Rule may be found here: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html

Rhode Island provides Medicaid-funded HCBS under the authority of an 1115 Waiver. While the final rule does not apply to states operating their HCBS under an 1115 Waiver, we support the intent of the rule and therefore will seek to comply with the requirements.

In order to meet the requirements of the new rule, states will need to develop a Transition Plan, "detailing any actions necessary to achieve or document compliance with setting requirements". States will have up to 5 years to implement their stated plan.

An integral component of the transition plan is a self-assessment/plan of existing settings to determine how closely they currently comply or don't comply with the Community Rule and if they don't comply, what is needed in terms of a plan, over the next 5 years, to come into compliance.

Attached is a tool to assist you in conducting the residential setting self-assessment. Please answer each question (bold or bullet) with either "Yes" or "No" by checking the appropriate box. To help you answer the bold question, we have provided sub-questions (in a bulleted list) underneath each bold question. These bulleted questions are additional questions for you to answer and will help guide you to answer "Yes" or "No" to the bold question. Answer each and every question with a "Yes" or "No".

Given the nature of your specific setting and given CMS guidance around settings that may not immediately comply with all aspects of the Community Rule, it may be more challenging to meet these requirements and be able to answer "Yes" to all bold and all bulleted questions. We assume, however, that you do aspire to achieve the outcomes articulated in the HCBS Community Rule over the next 5 years. So please be critical in your answers. We are not expecting you to answer "Yes" to every question.

Please complete and return then enclosed assessment by March 18, 2015.

Thank you for assistance!

To ensure that all community settings in which individuals receive a Medicaid Home and Community Based Service (HCBS) meet the spirit of the new CMS regulatory requirements, providers have been asked to assess their current settings and practices against the new requirements. CMS exploratory questions have been provided below to guide this assessment.

All questions must be answered. Note: The answers to bulleted questions may help you answer the bold question leading each section**.**			
1. **Is the setting integrated in and supportive of the same degree of access to the greater community for individuals whether or not they receive Medicaid HCBS?**	**Yes**	**No**	**Comments:**
• Is the setting in a public or privately-owned facility that provides inpatient treatment?			
• Is the setting on the grounds of, or immediately adjacent to a publicly-funded healthcare institution?			
• Do individuals shop, attend religious services, schedules appointments, have lunch with family and friends, etc., in the community, as they choose?			
• Do individuals schedule his/her days of service and or arrival and departure times based on his or her preferences?			
• Do individuals in the setting have access to public transportation? If not, are other resources provided for the individual to access the broader community?			
• Does the setting offer opportunity for individuals to receive multiple types of services and activities OFF-site and not setting-operated, including day services, medical, behavioral and social/recreational services? (Note: If most of the individuals receive multiple types of services and activities ON-site, then answer "No" to this question.)			
• Is the setting in the community among other private residences, retail businesses?			
2. **Does the setting provide opportunities to engage in community life?**	**Yes**	**No**	**Comments:**
• Do individuals participate regularly in meaningful non-work activities in integrated community settings for the period of time desired by the individual?			
• Are individuals aware of or have access to materials to become aware of activities occurring outside of the setting?			
3. Is the individual employed or does the individual attend day services outside of	**Yes**	**No**	**Comments:**

All questions must be answered. Note: The answers to bulleted questions may help you answer the bold question leading each section.			
the setting?			
• Do individuals work in an integrated community setting?			
• If an individual is of working age, are there activities with the individual to pursue work as an option?			
• If work is not a goal, do individuals participate in meaningful day activities outside the setting?			
4. **Does the setting provide opportunities to control personal resources?**	**Yes**	**No**	**Comments:**
• Do individuals have a checking or savings account or other means to control funds?			
• Do individuals have access to their funds?			
5. **Does the setting ensure freedom from coercion and restraint?**	**Yes**	**No**	**Comments:**
• Is information about filing a complaint posted in an obvious location and in an understandable format?			
• Are individual's comfortable discussing concerns?			
• Do individuals know how to make a complaint?			
6. **Does the setting ensure dignity, and respect?**	**Yes**	**No**	**Comments:**
• Are individuals, who need assistance with grooming, groomed as they desire?			
• Are individuals dressed in clothes that fit, are clean, and are appropriate for the time of day, weather, and preferences?			
• Does staff address individuals in the manner in which the person would like to be addressed as opposed to routinely addressing individuals as 'hon' or 'sweetie'?			
• Is informal (written and oral) communication conducted in a language that individuals understand?			
• Does staff talk to other staff about individual(s) with dignity and respect?			
• Does staff ensure that conversations about individuals occur privately and not within earshot of other persons living in the setting?			
7. **Does the individual, or a person chosen by the individual, have an active role**	**Yes**	**No**	**Comments:**

All questions must be answered. Note: The answers to bulleted questions may help you answer the bold question leading each section.			
in the development and update of the individual's person-centered plan?			
• Is/are the individual/chosen representative(s) aware of how to schedule Person-Centered Planning meetings?			
• Can individuals and chosen representatives explain the process to develop and update their plan?			
• Were individuals present during their last planning meeting?			
• Did/does the planning meeting occur at a time and place convenient individuals to attend?			
8. **Does the setting facilitate choices regarding services and supports and who provides them?**	**Yes**	**No**	
• Are individuals given a choice of available options regarding where to live/receive services?			
• Were individuals given opportunities to visit other settings?			
• Does staff ask individuals about their needs and preferences?			
• Are individuals aware of how to make a service request?			
• Can individuals choose the provider or staff who render the services they receive?			
9. Does the setting optimize interaction, autonomy and independence in making life choices?	**Yes**	**No**	**Comments:**
• Are individuals given information to assist them to make informed decisions?			
• Are individuals learning skills to enable them to maximize independence?			

All questions must be answered. Note: The answers to bulleted questions may help you answer the bold question leading each section.			
10. **Is there a legally enforceable agreement comparable to a lease?**	**Yes**	**No**	**Comments:**
• Do individuals know their rights regarding housing and when they could be required to relocate?			
• Does the written agreement include language that provides protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant laws?			
11. **Are there opportunities for individuals to have privacy?**	**Yes**	**No**	**Comments:**
• Do staff or other residents always knock and receive permission prior to entering an individual's living space?			
• Can an individual have private visits with family and friends?			
• Is health information about individuals kept private?			
• Do individuals have a private cell phone, computer or other personal communication device or have access to a telephone or other technology device to use for personal communication in private at any time?			
12. **Do individuals have choice of roommates?**	**Yes**	**No**	**Comments:**
• Do individuals have their own bedroom?			
• If not, are individuals given a choice of a roommate? (Note: For individuals who room-share)			
• Do individuals know how to request a roommate change?			
13. **Do individuals have freedom to furnish their sleeping units?**	**Yes**	**No**	**Comments:**
• Are individual's personal items, such as pictures, books, and memorabilia are present and arranged as they desire?			
• Do the furniture, linens, and other household items reflect the individual's personal choices?			
14. **Do individuals have control over their schedules?**	**Yes**	**No**	**Comments:**

All questions must be answered. Note: The answers to bulleted questions may help you answer the bold question leading each section.			
• Do individual's schedules vary from others in the same setting?			
• Do individuals have access to such things as a television, radio, and leisure activities that interest them and can they schedule such activities at their convenience?			
• Are individuals able to follow their own flexible (i.e., not set) schedule for waking, bathing, eating, exercising, activities, etc.?			
15. **Are individuals able to have visitors at any time?**	**Yes**	**No**	**Comments:**
• Are visitors welcomed and encouraged?			
• Is the furniture arranged as an individual prefers and does the arrangement encourage the comfort and conversation with visitors?			
16. **Do individuals have access to food at any time?**	**Yes**	**No**	**Comments:**
• Do individuals have a meal at the time and place of his/her choosing?			
• Can individuals request an alternative meal if desired?			
• Are snacks accessible and available anytime?			
• Can individuals sit in any seat in a dining area? (no assigned seats)			
• If an individual desires to eat privately, can s/he do so?			
17. **Do the rooms have lockable entrance doors, with individuals and staff having keys as needed?**	**Yes**	**No**	**Comments:**
• Can individuals close and lock the bedroom door?			
• Can individuals close and lock the bathroom door?			
18. **Is the setting physically accessible to the individual?** • Do individuals have full access to typical facilities in a home such as a kitchen, cooking facilities, dining area, laundry, and comfortable seating in the shared	**Yes**	**No**	**Comments:**

All questions must be answered. Note: The answers to bulleted questions may help you answer the bold question leading each section**.**			
areas?			
• For those individuals who need supports to move about the setting as they choose, are supports provided, such as grab bars, seats in the bathroom, ramps for wheel chairs, viable exits for emergencies, etc.?			
• Does the setting ensure that there are no gates, Velcro strips, locked doors, or other barriers preventing individuals' entrance to or exit from certain areas of the setting?			
• Is the setting physically accessible and there are no obstructions such as steps, lips in a doorway, narrow hallways, etc., limiting individuals' mobility in the setting or if they are present are there environmental adaptations such as a stair lift or elevator to ameliorate the obstruction?			
• Are appliances accessible to individuals (e.g. the washer/dryer are front loading for individuals in wheelchairs)?			
• Are tables and chairs at a convenient height and location so that individuals can access and use the furniture comfortably?			
19. **Are modifications of the setting requirements for an individual supported by an assessed need and justified in the person-centered plan?**	**Yes**	**No**	**Comments:**
• Does documentation note if positive interventions and supports were used prior to any plan modifications?			
• Are less intrusive methods of meeting the need that were tried initially documented?			
• Does the plan include a description of the condition that is directly proportional to the assessed need, data and information to support ongoing effectiveness of the intervention, time limits for periodic reviews to determine the ongoing necessity of the modification, informed individual consent, and assurance that the intervention will not cause the individual harm?			

G) Appendix A-Provider Self-Assessment Tools for Residential and Non-Residential Settings

CMS HCBS Community Rule: Assessment and Planning Tool for Settings

Non-Residential Settings

In March, CMS finalized its HCBS Community Rule that defines and sets criteria for what constitutes a community setting for services delivered under the Home and Community Based Services Waiver Program (HCBS). The intent of the rule is to assure that individuals receiving long-term services and supports through HCBS programs have full access to the benefits of community living and the opportunity to receive services in integrated settings. The accompanying summary of the CMS Community Rule provides more information and further context for the Community Rule.

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html

Rhode Island provides Medicaid-funded HCBS under the authority of an 1115 Waiver. While the final rule does not apply to states operating their HCBS under an 1115 Waiver, we support the intent of the rule and therefore will seek to comply with the requirements.

In order to meet the requirements of the new rule, states will need to develop a Transition Plan, "detailing any actions necessary to achieve or document compliance with setting requirements". States will have up to 5 years to implement their stated plan.

An integral component of the transition plan is a self-assessment/plan of existing settings to determine how closely they currently comply or don't comply with the Community Rule and if they don't comply, what is needed in terms of a plan, over the next 5 years, to come into compliance.

Attached is a tool to assist you in conducting the non-residential setting self-assessment. Please answer each question (bold or bullet) with either "Yes" or "No" by checking the appropriate box. To help you answer the bold question, we have provided sub-questions (in a bulleted list) underneath each bold question. These bulleted questions are additional questions for you to answer and will help guide you to answer "Yes" or "No" to the bold question. Answer each and every question with a "Yes" or "No".

Given the nature of your specific setting and given CMS guidance around settings that may not immediately comply with all aspects of the Community Rule, it may be more challenging to meet these requirements and be able to answer "Yes" to all bold and all bulleted questions. We assume, however, that you do aspire to achieve the outcomes articulated in the HCBS Community Rule over the next 5 years. So please be critical in your answers. We are not expecting you to answer "Yes" to every question.

Please complete and return then enclosed assessment by March 18, 2015.

Thank you for assistance!

To ensure that all community settings in which individuals receive a Medicaid Home and Community Based Service (HCBS) meet the new CMS regulatory requirements, providers have been asked to assess their current settings and practices against the new requirements. CMS exploratory questions have been provided below to guide this assessment.

All questions must be answered. Note: The answers to bulleted questions may help you answer the bold question leading each section.			
1. **Is the setting integrated in and supportive of the same degree of access to the greater community for individuals whether or not they receive Medicaid HCBS?**	**Yes**	**No**	**Comments:**
• Is the setting in a public or privately-owned facility that provides inpatient treatment?			
• Is the setting on the grounds of, or immediately adjacent to a publicly-funded healthcare institution?			
• Do individuals shop, attend religious services, schedules appointments, have lunch with family and friends, etc., in the community, as the individual chooses?			
• Do individuals schedule his/her days of service and or arrival and departure times based on his or her preferences?			
• Do individuals in the setting have access to public transportation? If not, are other resources provided for the individual to access the broader community?			
• Does the setting offer opportunity for individuals to receive multiple types of services and activities OFF-site and not setting-operated, including day services, medical, behavioral and social/recreational services? (Note: If most of the individuals receive multiple types of services and activities ON-site, then answer "No" to this question.)			
• Is the setting in the community among other private residences, retail businesses?			
2. **Does the setting provide opportunities to engage in community life?**	**Yes**	**No**	**Comments:**
• Do individuals participate regularly in meaningful non-work activities in integrated community settings for the period of time desired by the individual?			
• Are individuals aware of or do they have access to materials to become aware of activities occurring outside of the setting?			

All questions must be answered. Note: The answers to bulleted questions may help you answer the bold question leading each section.			
3. Is the individual employed or does the individual attend day services outside of the setting?	**Yes**	**No**	**Comments:**
• Do individuals work in an integrated community setting?			
• If individuals are of working age, is there activity with the individual to pursue work as an option?			
• If work is not a goal, do individuals participate in meaningful day activities outside the setting?			
4. **Does the setting provide opportunities to control personal resources?**	**Yes**	**No**	**Comments:**
• Do individuals have a checking or savings account or other means to control funds?			
• Do individuals have access to their funds?			
5. **Does the setting ensure freedom from coercion and restraint?**	**Yes**	**No**	**Comments:**
• Is information about filing a complaint posted in an obvious location and in an understandable format?			
• Are individual's comfortable discussing concerns?			
• Do individuals know how to make a complaint?			
6. **Does the setting ensure dignity, and respect?**	**Yes**	**No**	**Comments:**
• Are individuals who need assistance with grooming, groomed as they desire?			
• Are individuals dressed in clothes that fit, are clean, and are appropriate for the time of day, weather, and preferences?			
• Does staff address individuals in the manner in which the person would like to be addressed as opposed to routinely addressing individuals as 'hon' or 'sweetie'?			
• Is informal (written and oral) communication conducted in a language individuals understand?			

All questions must be answered. Note: The answers to bulleted questions may help you answer the bold question leading each section.			
• Does staff talk to other staff about individual(s) with dignity and respect?			
• Does staff ensure that conversations about individuals occur privately and not within earshot of other persons in the setting?			
7. **Does the individual, or a person chosen by the individual, have an active role in the development and update of the individual's person-centered plan?**	**Yes**	**No**	**Comments:**
• Is/are the individual/chosen representative(s) aware of how to schedule Person-Centered Planning meetings?			
• Can individuals and chosen representatives explain the process to develop and update their plan?			
• Were individuals present during their last planning meeting?			
• Did/does the planning meeting occur at a time and place convenient for individuals to attend?			
8. **Does the setting facilitate choices regarding services and supports and who provides them?**	**Yes**	**No**	
• Are individuals given a choice of available options regarding where to receive services?			
• Are individuals given opportunities to visit other settings?			
• Does staff ask individuals about their needs and preferences?			
• Are individuals aware of how to make a service request?			
• Can an individual choose the provider or staff who render the services s/he receives?			
9. Does the setting optimize interaction, autonomy and independence in making life choices?	**Yes**	**No**	**Comments:**
• Are individuals given information to assist them to make informed decisions?			

All questions must be answered. Note: The answers to bulleted questions may help you answer the bold question leading each section**.**			
• Are individuals learning skills to enable them to maximize independence?			

9. Is health information about individuals kept private?	**Yes**	**No**	**Comments:**
10. **Is the setting physically accessible to individuals?**	**Yes**	**No**	**Comments:**
• For those individuals who need supports to move about the setting as they choose, are supports provided, such as grab bars, seats in the bathroom, ramps for wheel chairs, viable exits for emergencies, etc.?			
• Does the setting ensure that there are no gates, Velcro strips, locked doors, or other barriers preventing individuals' entrance to or exit from certain areas of the settings?			
• Is the setting physically accessible and there are no obstructions such as steps, lips in a doorway, narrow hallways, etc., limiting individuals' mobility in the setting or if they are present are there environmental adaptations such as a stair lift or elevator to ameliorate the obstruction?			
• Are tables and chairs at a convenient height and location so that individuals can access and use the furniture comfortably?			
• Are modifications of the setting requirements for an individual supported by an assessed need and justified in the person-centered plan?			
• Does documentation note if positive interventions and supports were used prior to any plan modifications?			
• Are less intrusive methods of meeting the need that were tried initially documented?			
11. Does the plan include a description of the condition that is directly proportional to the assessed need, data and information to support ongoing effectiveness of the intervention, time limits for periodic reviews to determine the ongoing necessity of the modification, informed individual consent, and assurance that the intervention will not cause the individual harm?	**Yes**	**No**	**Comments:**

Core and Preventive Home and Community-based Service Definitions
CORE SERVICES

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

Environmental Modifications (Home Accessibility Adaptations): Those physical adaptations to the home of the member or the member's family as required by the member's service plan, that are necessary to ensure the health, welfare, and safety of the member or that enable the member to attain or retain capability for independence or self-care in the home and to avoid institutionalization, and are not covered or available under any other funding source. A completed home assessment by a specially trained and certified rehabilitation professional is also required. Such adaptations may include the installation of modular ramps, grab-bars, vertical platform lifts and interior stair lifts. Excluded are those adaptations that are of general utility, and are not of direct medical or remedial benefit to the member. Excluded are any re-modeling, construction, or structural changes to the home, i.e. (changes in load bearing walls or structures) that would require a structural engineer, architect and/or certification by a building inspector. Adaptations that add to the total square footage of the home are excluded from this benefit. All adaptations shall be provided in accordance with applicable state or local building codes and prior approved on an individual basis by the EOHHS Office of Long Term Services and Supports is required. Items should be of a nature that they are transferable if a member moves from his/her place of residence.

Special Medical Equipment: Specialized Medical Equipment and supplies to include Ceiling or Wall Mounted Patient Lift, Track System, tub slider system, rolling shower chair and/or Automatic Door Opener, which enable a member to increase his/her ability to perform activities of daily living , including such other durable and non-durable medical equipment not available under the Medicaid-funded primary and acute care system that is necessary to address participant functional limitations. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the Medicaid-funded primary and acute care system and exclude those items that are not of direct medical or remedial benefit to the member. Medical equipment funded under the primary and acute care system includes items such as wheel chairs, prosthetics, and orthotics. These services that were provided under the authority of the Rhode Island State Plan prior to the 1115 Waiver approval. These items are still available under the 11115 Waiver and are described on the EOHHS website. All items shall meet applicable standards of manufacture, design and installation. Provision of Special Medical Equipment requires prior approval on an individual basis by the EOHHS, Office of Long Term Services and Supports and a home assessment completed by a specially trained and certified rehabilitation professional. Items should be of a nature that they are transferable if a member moves from his/her place of residence. Excluded are any re-modeling, construction, or structural changes to

the home, (i.e. changes in load bearing walls or structures) that would require a structural engineer, architect and/or certification by a building inspector.

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

Meals on Wheels (Home Delivered Meals): The delivery of hot meals and shelf staples to the waiver recipient's residence. Meals are available to an individual who is unable to care for his/her nutritional needs because of a functional dependency/disability and who requires this assistance to live in the community. Meals provided under this service will not constitute a full daily nutritional requirement. Meals must provide a minimum of one-third of the current recommended dietary allowance. Provision of home delivered meals will result in less assistance being authorized for meal preparation for individual participants, if applicable.

Personal Emergency Response (PERS): PERS is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the individual's phone and programmed to signal a response center once a "help" button is activated. Trained professionals staff the response center, as specified by Center for Adult Health contract standards. This service includes coverage for installation and a monthly service fee. Providers are responsible to insure the upkeep and maintenance of the devices/systems.

LPN Services (Skilled Nursing): Licensed Practical Nurse services provided under the supervision of a Registered Nurse. Licensed Practical Nurse Services are available to participants who require interventions beyond the scope of Certified Nursing Assistant (C.N.A.) duties. LPN services are provided in accordance with the Nurse Practice Act under the supervision of a registered nurse. This service is aimed at individuals who have achieved a measure of medical stability despite the need for chronic care nursing interventions. Individuals are assessed by a Registered Nurse (RN) in the EOHHS, Office of Community Programs.

Community Transition Services: Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the individual is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable an individual to establish a basic household; these expenses do not constitute room and board and may include: security deposits that are required to obtain a lease on an apartment or home, essential household furnishings, and moving expense, set-up fees or deposits for utility or service access, services necessary for the individual's health and safety and activities to assess need, arrange for, and procure needed resources. Community Transition Services are furnished only to the extent that the services are reasonable and necessary as determined through the service plan development process, the services are clearly identified in the service plan, and the individual is unable to meet such expense or the services cannot be obtained from other sources.

The services do not include ongoing shelter expenses, food, regular utility charges, household appliances or items intended for recreational purposes.

Residential Supports: 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 his/her own home and a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance (where applicable), or upkeep and improvement.

Day Supports: Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Day supports focus on enabling the individual to attain or maintain his/her maximum functioning level, and are coordinated with any other services identified in the person's individual plan.

Supported Employment: Includes activities needed to sustain paid work by individuals receiving waiver services, including supervision, transportation and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision, and training required by an individual receiving waiver services as a result of his/her disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported Living Arrangements: Personal care and services, homemaker, chore, attendant care, companion services, and medication oversight (to the extent permitted under state law) provided in a private home by a principal care provider who lives in the home. Supported Living Arrangements are furnished to adults who receive these services in conjunction with residing in the home. Separate payment will not be made for homemaker or chore services furnished to an individual receiving Supported Living Arrangements, since these services are integral to and inherent in the provision of adult foster care services.

Private Duty Nursing: Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of state law and as identified in the Individual Service Plan (ISP). These services are provided to an individual at home and require an assessment to be completed by a Registered Nurse (RN) from the Office of Community Programs.

Supports for Consumer Direction (Supports Facilitation): Focuses on empowering participants to define and direct their own personal assistance needs and services; guides and supports, rather than directs and manages, the participant through the service planning and delivery process. The Facilitator counsels, facilitates, and assists in development of an ISP which includes both paid and unpaid services and supports designed to allow the participant to live in the 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 Individual Service Plan are temporarily unavailable.

Participant Directed Goods and Services: Participant Directed Goods and Services are services, equipment, or supplies not otherwise provided through this waiver or through the Medicaid state plan that address an identified need, that are in the approved ISP (including improving and maintaining the individual's opportunities for full membership in the community), and that meet the following requirements: the item or service would decrease the need for other Medicaid services; AND/OR the item or service would promote inclusion in the community; AND/OR the item or service would increase the individual's ability to perform ADLs or IADLs; AND/OR the item or service would increase the person's safety in the home environment; AND alternative funding sources are not available. Individual Goods and Services are purchased from the individual's self-directed budget through the fiscal intermediary when approved as part of the ISP. Examples include a laundry service for a person unable to launder and fold clothes, or a microwave for a person unable to use a stove due to his/her disability. This will not include any good/service that would be restrictive to the individual or strictly experimental in nature.

Case Management: Services that assist participants in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Case managers are responsible for ongoing monitoring of the provision of services included in the individual's plan of care. Case managers initiate and oversee the process of assessment and reassessment of the individual's level of care and review of plans of care on an annual basis and when there are significant changes in client circumstances.

Senior Companion (Adult Companion Services): Non-medical care, supervision, and socialization provided to a functionally impaired adult. Companions may assist or supervise the 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, which are incidental to the care and supervision of the participant. This service is provided in accordance with a therapeutic goal in the service plan of care.

Assisted Living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under state law), therapeutic social and recreational programming, provided in a home-like environment in a licensed community care facility in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility; but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.
Personalized care is furnished to an individual who resides in his/her own living units (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. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the Rhode Island

opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other unit. 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). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each individual to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and must treat each person with dignity and respect. Costs of room and board are excluded from payments for assisted living services.

Personal Care Services: Personal Care Services provide direct support in the home or community to an individual in performing Activities of Daily Living (ADL) tasks that he/she is functionally unable to complete independently due to disability. Personal Care Services may be provided by:
1. A Certified Nursing Assistant which is employed under a State licensed home care/home health agency and meets such standards of education and training as are established by the State for the provision of these activities.

2. A Personal Care Attendant via Employer Authority under the Self Direction option.

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

PREVENTIVE SERVICES:

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

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

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

Respite Services: Temporary caregiving services given to an individual unable to care for himself/herself that is furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care for the participant. Respite services will be recommended and approved by EOHHS, Office of Long Term Services and Supports.

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

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

HABILITATIVE SERVICES:
Residential habilitation is individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care and protective oversight and supervision.

Payment is not be made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

Day habilitation is provision of regularly scheduled activities in a non-residential setting, separate from the 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" (3 meals per day).

Day habilitation services focus on enabling the participant to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the individual's person-centered services and supports plan, such as physical, occupational, or speech therapy.