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TITLE 210 – EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 50 – MEDICAID LONG-TERM SERVICES AND SUPPORTS

SUBCHAPTER 10 – HOME & COMMUNITY BASED LTSS

PART 2 – Self-Directed Care

2.1 Purpose

These Rules apply to two (2) consumer self-directed programs and the home and community-based services provided by Personal Care Aides (PCAs) under these programs. These Rules set out the eligibility criteria and program operations for two (2) self-directed care programs, the Personal Choice (PC) Program and the Independent Provider (IP) Program, both of which allow consumers to have responsibility for managing their long-term services and supports in a person-centered manner. Consumers choose who provides the services and when and how they are provided. Self-directed services are intended to support community tenure and consumer control, choice, and independence.

2.2 Applicability

A. Program Descriptions

1. The Personal Choice (PC) Program provides consumer-directed home and community-based services to Medicaid long-term services and supports (LTSS) eligible consumers. Personal Choice is a long-term care program for individuals with disabilities who are over the age of eighteen (18) or all individuals age sixty-five (65) or over who meet either a high or highest level of care. Services are geared toward reducing unnecessary institutionalization by providing specialized home and community-based services to qualified Medicaid consumers at an aggregate cost which is less than or equal to the cost of institutional or nursing facility care.

2. The Independent Provider (IP) Program is a self-directed pathway available to all adult LTSS consumers choosing services in an at-home setting who are seeking to self-direct only nonmedical personal care and homemaker services. The Independent Provider model is a long-term care program for individuals with disabilities who are over the age of eighteen (18) or all individuals age sixty-five (65) or over who meet either a high or highest level of care. The LTSS consumer has the flexibility to hire a trained PCA of choice and self-direct the schedule and way the IP authorized services are provided by the PCA.

B. These Regulations do not apply to Intellectual and Developmental Disabilities (I/DD) Self-Directed programs funded by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) pursuant to R.I. Gen. Laws § 40.1-1-13. To reference the BHDDH Regulations for Self-Directed services, please refer to the Rules and Regulations for Developmental Disability Organization § 212-RICR-10-05-1.10.3, Fiscal Intermediary Services, and § 212-RICR-10-05-1.2(A)(42), Definitions.

C. Pursuant to R.I. Gen. Laws § 40-8.15-2(b), nothing in this Part shall interfere with the regulatory authority of the Rhode Island Department of Health (RIDOH) over individual providers' licensing.

2.3 Authority

Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396v, provides the legal authority for the Rhode Island Medicaid Program. The Medicaid Program also operates under a waiver granted by the Secretary of Health and Human Services pursuant to § 1115 of the Social Security Act. Additionally, R.I. Gen. Laws Chapters 40-6, 40-8, 40-18, 40-8.14, and 40-8.15 serve as the enabling statutes for the Independent Provider and Personal Choice Programs.

2.4 Definitions

A. The following terms, which are listed alphabetically, are referenced in this Regulation.

1. "Activities of daily living" or "ADLs" means everyday routines generally involving functional mobility and personal care, including but not limited to, bathing, dressing, eating, toileting, mobility and transfer.

2. "Applicant" means new applicants to be determined for Medicaid eligibility.

3. "Assessment" means a meeting between the consumer, their representative (if applicable), and the Service Advisor to evaluate ADLs and IADLs to determine participant need. Assessments also help to identify services, equipment, home modifications, and other services in the community that may help the participant to increase their independence within the community. Initial assessments occur upon entry to either the Independent Provider or Personal Choice program and reassessments occur annually thereafter. A participant or representative may request a reassessment sooner if their situation has changed and there is either an increased or decreased need for assistance. The Service Advisor may also perform a reassessment sooner if there are life changes resulting in a possible increase or decrease in need for assistance.

4. "Budget" means the amount of Medicaid funds set aside for the participant's personal care and homemaker services. The budget is based

on the amount of assistance the participant requires to meet their personal care needs. The budget is based on what the Medicaid agency would normally spend to purchase services from a Home Health Agency for the services necessary to allow a participant to live at home. The Medicaid agency sets the amount of the monthly budget based on participant need for assistance.

5. "Case management services" means the coordination of a plan of care and services provided at home to individuals with disabilities who are over the age of eighteen (18) or elders age sixty-five (65) or over who meet either a high or highest level of care. Such programs shall be provided in the person's home or in the home of a responsible relative or other responsible adult, but not provided in a skilled nursing facility and/or an intermediate care facility.

6. "Consumer" means the individual, also referred to as the beneficiary or participant, who utilizes services in either of the self-directed models.

7. "Critical incident" means any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a participant. This includes, but is not limited to: physical abuse; verbal abuse; psychological or emotional abuse; sexual abuse; financial abuse; use of physical, chemical or mechanical restraint; self-neglect; neglect by another member of the home; exploitation; and unexplained death.

8. "Electronic Visit Verification" or "EVV" is a method used to verify that home healthcare visits occur by collecting data electronically about the visit.

9. "Environmental modifications" are defined as those physical adaptations to the home of the participant or the participant's family as required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant 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, are not of direct medical or remedial benefit to the participant. 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.

    a. 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

approval on an individual basis by EOHHS, Office of Durable Medical Equipment, is required.

b. Items should be of a nature that they are transferable if a participant moves from his/her place of residence.

10. "Fiscal intermediary services (FI) for the Personal Choice Program" means financial management services delivered to Personal Choice participants by an EOHHS certified Fiscal Intermediary. FI services are designed to assist participants in allocating funds as outlined in the Individual Service and Spending Plan and to facilitate employment of personal assistance staff by the participant. Personal choice financial matters are maintained by the fiscal agency and a portion of the participant's monthly budget is set aside for the services it provides.

11. "Fiscal intermediary services (FI) for the Independent Provider Program" means financial management services delivered to Independent Provider participants by an EOHHS certified Fiscal Intermediary. FI services are designed to assist participants in utilizing hours as outlined in the Individual Service Plan and to facilitate employment of personal assistance staff by the participant. The FI also functions as the human resource agency to assist in the management of financial and employer responsibilities by facilitating activities such as PCA training, PCA enrollment, timesheets, and payroll. A portion of the participant's monthly budget is set aside to pay the agency for the services it provides.

12. "Formal training" means a twelve (12) hour ADL/IADL training course.

13. "Home delivered meals" means the delivery of hot meals, frozen meals, cultural/therapeutic meals and/or shelf staples to the participant's residence. Meals are available to individuals unable to care for their nutritional needs because of a functional dependency/disability and who require 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 (1/3) 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.

14. "Home modifications" means equipment and/or adaptations to a consumer's residence to enable the consumer to remain in their home or place of residence and ensure safety, security, and accessibility.

15. "Homemaker services" include aid in grocery shopping, cooking, using the phone, looking up phone numbers, assistance with housework (cleaning, dusting, vacuuming, laundry), assistance using public transportation,

assistance paying and managing bills, and reminding the consumer to take their medication(s).

16. “In-home training” means training directed by the consumer, as opposed to formal training. This option empowers the consumer, as the employer, to train the PCA themselves and decide how services should be delivered by the PCA in order to suit the consumer’s needs.

17. “Individual service plan” or “ISP” means a written plan that provides details of supports, activities, and resources required for the consumer in the Independent Provider Program to achieve personal goals. The Individual Service Plan (ISP) is developed with the individual to articulate decisions and agreements made during a person-centered process of planning and informational gathering. The ISP can be updated annually or as the budget or other personal circumstances change.

18. “Individual service and spending plan” or “ISSP” means a written plan that shows the services that are purchased with the budget amount provided through the Personal Choice Program. The plan shows the services purchased, the rate purchased at and the total dollars spent on care. The ISSP provides information on the consumer’s goals, goods and services, as well as taxes and fees associated with their budget. The ISSP also includes a plan for handling emergencies. The ISSP can be updated annually or as the budget or other personal circumstances change.

19. “Instrumental activities of daily living” or “IADLs” means activities related to living independently in the community, including but not limited to: meal planning and preparation; managing finances; shopping for food, clothing, and other essential items; performing essential household chores; scheduling appointments; communicating by phone or other media, and traveling around and participating in the community.

20. “Mandatory orientation” means a four (4) hour training required by EOHHS for all PCAs participating in the IP program. Mandatory orientation includes program overview and structure; policy and procedure explanation; review of ethics, accountability, consumer privacy and dignity, HIPAA and EVV; coverage of critical incidents; IP PCA scope of work, responsibilities and excluded duties; infection control; and safety.

21. “Medicaid fraud” means making a false statement, misrepresentation of material fact, submitting a claim or causing a submission to obtain some benefit or payment involving Medicaid money for which no entitlement would otherwise exist. This can be done for the benefit of oneself or another party and includes obtaining something of value through misrepresentation, concealment, omission or willful blindness of a material fact.

22. “Medical necessity” or “Medically necessary services” means medical, surgical, or other services required for the prevention, diagnosis, cure or treatment of a health-related condition including services necessary to prevent a detrimental change in either medical or mental health status.

23. “Minor environmental modifications” means minor modifications to the home that 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, aides for personal care (e.g., reachers), and standing poles to improve home accessibility adaptation, health or safety.

24. “Nonmedical” means not involving, relating to, used in, or concerned with medical care or the field of medicine.

25. “Participant directed goods and services” means services, equipment or supplies not otherwise provided through Medicare or Medicaid, that address an identified need and are in the approved ISSP (including improving and maintaining the individual’s opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; AND/OR promote inclusion in the community; AND/OR increase the individual’s ability to perform ADLs or IADLs; AND/OR increase the person’s safety in the home environment; AND, alternative funding sources are not available. Participant directed goods and services are purchased from the individual’s self-directed budget through the fiscal intermediary when approved as part of the ISSP. 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 is medical in nature and requires a physician’s order or would be restrictive to the individual or strictly experimental in nature.

26. “Personal care services” means the provision of direct supportive, nonmedical services provided in the home or community to individuals in performing tasks they are functionally unable to complete independently due to illness and/or disability, based on the ISSP or the ISP. Personal care services do not include services that require a professional license, certification or registration by State law such as wound care, injections, oxygen application, and other services which are medical in nature. Personal care services may include but are not limited to:

    a. Participant assistance with activities of daily living, such as grooming, personal hygiene, toileting, bathing, and dressing;

    b. Assistance with monitoring health status and physical condition;

c. Assistance with preparation and eating of meals (not the cost of the meals itself);

d. Assistance with housekeeping activities (bed making, dusting, vacuuming, laundry, grocery shopping, cleaning);

e. Assistance with transferring; ambulation; use of special mobility devices; assisting the participant by directly providing or arranging transportation.

27. "Personal emergency response system" or "PERS" means 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 person's phone and programmed to signal a response center once a "help" button is activated. This service includes coverage for installation and a monthly service fee. Providers are responsible to ensure the upkeep and maintenance of the devices/systems.

28. "Registry" means the official list, maintained by EOHHS or its designee, of qualified PCAs who are available to provide services. Consumers may utilize the registry when hiring PCAs through the IP program.

29. "Representative" means a person designated by a participant to assist the participant in managing some or all of the requirements of the PC or IP program. A representative cannot be paid to provide this assistance. The representative also cannot be paid to provide direct care or hands on care. In other words, the representative cannot be a paid PCA.

30. "Self-directed" means a consumer-controlled method of selecting and providing services and supports that allows the individual maximum control of their home and community-based services and supports, with the individual acting as the employer of record with necessary supports to perform that function, or the individual having a significant and meaningful role in the management of a provider of service when the agency-provider model is utilized. Individuals exercise as much control as desired to select, train, supervise, schedule, determine duties, and dismiss the aid care provider.

31. "Service advisory agency" or "SA" means an agency certified by EOHHS that assesses service needs, assists with planning what services are needed and how to receive them, performs check-ins and evaluations, and is an additional resource to the consumer, representative, and/or family to promote safety and quality of care. The SA conducts quarterly home visits, one of which is unannounced, and makes phone contact with the consumer in the months where there is not a home visit. The SA guides and supports, rather than directs and manages, the participant

through the service planning and delivery process. A portion of the participant's monthly budget is set aside to pay the agency for the services it provides.

32. "Service advisement team" means a team, consisting of the Service Advisor, a Nurse and a Mobility Specialist, that focuses on empowering participants to define and direct their own personal assistance needs and services.

33. "Special medical equipment" or "Minor assistive devices" means the following:

    a. Devices, controls, or appliances, specified in the plan of care, which enable participants to increase their ability to perform activities of daily living;

    b. Devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; including such other durable and non-durable medical equipment not available through the participant's medical insurance that is necessary to address participant functional limitations;

    c. Items reimbursed with waiver funds through the Personal Choice Program are in addition to any medical equipment and supplies furnished by Medicaid and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. Provision of Specialized Medical Equipment requires prior approval on an individual basis by Medicaid.

34. "Supports for consumer direction" or "Supports facilitation" means empowering participants to define and direct their own personal assistance needs and services by guiding and supporting, rather than directing and managing, the participant through the service planning and delivery process.

35. "Taxes" mean fees deducted from the participant's monthly budget that are required to be paid on behalf of employees (PCAs):

    a. FICA (Federal Insurance Contributions Act): Finances care for the aging, disabled, and survivors, including funding for Medicare.

    b. FUTA (Federal Unemployment Tax Act): Finances employment programs at the federal level.

    c. SUTA (State Unemployment Tax Act): Finances employment programs at the state level.

d. RITDI (Rhode Island Temporary Disability Insurance): Provides income to employees who cannot work for a period of time due to illness or injury.

36. "Worker's Compensation Insurance" means funds that provide for monetary awards paid to individuals who are injured, disabled or killed on the job. Worker's Compensation Insurance is a cost of employment paid by the participant from their monthly budget.

2.5 Eligibility

A. All general eligibility Rules for Medicaid LTSS contained in the Rhode Island Code of Regulations, Subchapter 00 Part 1 of this Chapter, Medicaid LTSS Overview and Eligibility Pathways, and Subchapter 00 Part 4 of this Chapter, Long-Term Services and Supports Application and Renewal Process, apply to the Self-Directed Programs. Additional eligibility requirements for Self-Directed Programs are as follows:

1. Consumers who are either aged (age sixty-five (65) and older) or who have a disability and are at least eighteen (18) years old and are determined to have high or highest need for level of care;

2. Individuals who have demonstrated the ability and competence to direct their own care or have a qualified designated representative to direct care, and want to either remain in their home or return to their home; and

3. Individuals who have been determined to be Developmentally Disabled and are receiving services via the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) and are interested in the Personal Choice Program or Independent Provider program must be approved by BHDDH and EOHHS Medicaid.

B. Income

All income eligibility Rules contained in Subchapter 00 Part 6 of this Chapter, Medicaid Long-Term Services and Supports: Financial Eligibility, and as amended from time to time, apply. If Medically Needy eligible, the applied income cannot exceed the cost of services.

C. Resources

All resource Rules contained in Subchapter 00 Part 6 of this Chapter, Medicaid Long-Term Services and Supports: Financial Eligibility, and as amended from time to time, apply.

D. Post Eligibility Treatment of Income

Information relating to Post Eligibility Treatment of Income (PETI) can be found in Subchapter 00 Part 8 of this Chapter, Post-Eligibility Treatment of Income.

2.6 Enrollment and Disenrollment

A. Enrollment

Enrollment in all Self-Directed programs is by choice. Individuals who wish to participate and who meet all the eligibility requirements may contact a Service Advisement Agency, a Fiscal Intermediary, or visit the EOHHS website http://www.eohhs.ri.gov/.

B. Involuntary Disenrollment

1. When a Medicaid-eligible participant is involuntarily disenrolled from a Self-Directed Program, the participant is referred to EOHHS or BHDDH to explore other available options.

2. EOHHS shall notify the participant in writing that they intend to remove the participant from their Self-Directed Program, the reason for disenrollment, and shall inform the participant that services will be provided through Medicaid long-term care via a home health agency.

3. The participant shall be involuntarily disenrolled from the Self-Directed Program if they lose either Medicaid financial eligibility or level of care eligibility.

4. Disenrollment is determined by the Service Advisement Agency, and confirmed by EOHHS, based on an assessment in conjunction with the policies and procedures of that Agency, and/or the receipt of information from the Fiscal Intermediary or EOHHS. Involuntary disenrollment may also occur when:

    a. Participant or representative is unable to self-direct purchase and payment of LTSS.

    b. A representative proves incapable of acting in the best interest of the participant, can no longer assist the participant, and no replacement is available.

    c. Participant or representative fails to comply with legal/financial obligations as an employer of domestic workers and/or is unwilling to participate in advisement training or training to remedy non-compliance.

    d. If enrolled in PC, the participant or representative is unable to manage the monthly budget as evidenced by: repeatedly submitting time sheets for unauthorized budgeted amount of care;

underutilizing the monthly budget, which results in inadequate services; and/or continuing attempts to spend budget funds on non-allowable items and services.

e. If enrolled in IP, the participant or representative is unable to manage the hours to be services as evidenced by: repeatedly submitting time sheets for unauthorized amount of care; underutilizing the hours allocated, which results in inadequate services; and/or continuing attempts add more hours than allocated.

f. Participant's health and well-being is not maintained through the actions and/or inactions of the participant or representative.

g. Participant or representative fails to maintain a safe working environment for personal care.

h. EOHHS receives a substantiated critical incident report that cannot otherwise be remediated.

i. Either the participant or representative refuses to cooperate with minimum program oversight activities, even when staff has made efforts to accommodate the participant.

j. Participant or representative fails to pay the amount determined in the post eligibility treatment of income, as described Subchapter 00 Part 8 of this Chapter, Post-Eligibility Treatment of Income, to the fiscal agency.

k. There is evidence that Medicaid funds were used improperly/illegally according to local, State or Federal Regulations.

l. The Service Advisement Agency determines they are unable to provide proper service, such as the inability to meet repeated requests for services, satisfy consumer needs, and/or provide the individual with a quality working relationship.

m. Participant or representative fails to notify both the Service Advisement Agency and the Fiscal Intermediary of any change of address and/or telephone number within ten (10) days of the change.

C. Voluntary Disenrollment

1. Participant or representative may request discharge from a Self-Directed Program with a thirty (30) day written notice to the Service Advisement Agency and Fiscal Intermediary.

2. A participant's representative must provide both the Service Advisement Agency and Fiscal Intermediary with a thirty (30) day written notice stating they are no longer able to provide representative services.

D. Disenrollment Appeal

1. The Service Advisement Agency and the Fiscal Intermediary Agency shall inform the participant in writing of an involuntary disenrollment with the reason and provides the participant with a Medicaid appeal procedure and request forms.

2. The participant has the right to appeal utilizing the standard appeals process as described in Part 10-05-2 of this Title, Appeals Process and Procedures for EOHHS Agencies and Programs.

2.7 Appeals

An opportunity for a hearing is granted to an applicant/recipient or their designated representative, when a person is aggrieved by an agency action resulting in a disenrollment, suspension, reduction, discontinuance, or termination of a consumer's services or budget, or a requested adjustment to the budget or service is denied in accordance with the provisions of Part 10-05-2 of this Title, Appeals Process and Procedures for EOHHS Agencies and Programs.

2.8 Participant Rights and Responsibilities

A. Every participant has the right to:

1. Be treated as an adult, with dignity and respect at all times;

2. Privacy in all interactions with EOHHS, the SA, and the FI and freedom from unnecessary intrusion;

3. Make informed choices based upon appropriate information provided to the participant, and have questions answered and choices respected;

4. Freely choose between approved providers as appropriate or applicable;

5. Feel safe and secure in all aspects of life, including health and well-being, be free from exploitation and abuse, and not be overprotected;

6. Realize the full opportunity that life provides by not being limited by others, by making full use of the resources their self-directed program provides, and by being free from judgments and negativity;

7. Live as independently as they choose;

8. Have their individual ethnic background, language, culture and faith valued and respected;

9. Be treated equally and live in an environment that is free from bullying, harassment and discrimination;

10. Voice grievances about care or treatment without fear of discrimination or reprisal;

11. Voluntarily withdraw from their self-directed program at any time;

12. Manage PCAs by:

    a. Deciding who to hire;

    b. Deciding what special knowledge or skills the PCA must possess;

    c. Training each PCA to meet individual needs; and

    d. Replacing PCAs who do not meet individual needs.

13. Request a new assessment if needs change;

14. Know about all service advisement and fiscal advisement agency fees;

15. Receive a report on how the budget is spent; and

16. Appeal any decision made by the Service Advisement Agency, Fiscal Advisement Agency, or Medicaid Agency and expect a prompt response.

B. Every participant has the responsibility to:

1. Manage and maintain their health and access medical help as needed, or seek assistance in order to do so;

2. Demonstrate the required skills and abilities needed to self-direct PCAs without jeopardizing their health and safety, or designate a representative to assist them;

3. Be aware of the Personal Choice and Independent Provider program rules and regulations;

4. Act as a supervising employer by:

    a. Screening prospective PCAs to determine who is best able to meet the consumer's needs at the desired times;

    b. Interviewing prospective PCAs if they are not already known to the consumer;

c. Requesting and checking references for prospective PCAs if they are not already known to the consumer;

d. Completing hiring agreements with each PCA;

e. Ensuring that the PCA is oriented, trained, and understands the consumer's goals, boundaries and house rules;

f. Deciding wages and schedules for each PCA, where applicable, and ensuring that hours do not exceed forty (40) hours per week;

g. Developing a plan for communication process for the PCA to inform the consumer if they will be late or unable to report to work;

h. Supervising PCAs and ensuring they are performing their duties as needed;

i. Completing Electronic Visit Verification, unless the PCA lives in the same household;

j. Reviewing timesheets for accuracy, ensuring that time is not billed when services were not delivered by the PCA (such as when the consumer was on vacation, in an emergency room, at an adult day care center, or receiving therapies or other services), and submitting timesheets to the Fiscal Intermediary in a timely manner;

k. Following all employment laws and Regulations, including providing a safe, harassment-free working environment and treating all employees with dignity and respect;

l. Following all requirements of the Fiscal Intermediary/IRS for hiring and paying PCAs, including completing all necessary forms and paying PCAs promptly; and

m. Deciding whether and when to dismiss a PCA and notifying the Fiscal Intermediary when termination occurs.

5. Develop an emergency back-up plan in the event a PCA is unavailable;

6. Manage personal care services by:

a. Meeting and cooperating with the Service Advisor as required for completing all needed assessments and monitoring; and

b. Developing and monitoring an ISSP or ISP to address personal care service needs;

7. Report instances or concerns about critical incidents to the Service Advisement Agency and/or appropriate State agency;

8. Understand what Medicaid fraud is and how to report it;

9. Track expenses so that the budget is not exceeded and contact the Fiscal Intermediary in the event of a billing or payment complaint;

10. Notify the Service Advisement Agency and Fiscal Intermediary of absences from home that are nonmedical (vacations or trips); and

11. Notify the Service Advisement Agency of any changes in medical status, admissions to hospitals or other medical facilities, or if other services are being provided (for example, visiting nurses, hospice or adult day services).

C. The consumer may request that the PCA perform additional tasks that help them continue to live in the community. The PCA may, but is not required to, perform such additional tasks. The consumer cannot ask the PCA to support another person. The requested task cannot pose a health or safety risk to the consumer or the PCA, the PCA should feel comfortable and confident in the ability to perform the task, the task must be legal and cannot be considered fraudulent.

2.9 Screening Requirements for PCAs

A. Age: PCAs must be at least eighteen (18) years of age.

B. Work Status: PCAs must be authorized to work in the United States.

C. Relationship: Individuals cannot work as a PCA if they are the consumer's representative, spouse, legal guardian, financial power of attorney, or Social Security Representative Payee.

D. Driver's License: If the PCA is approved to provide transportation for the consumer, the PCA must have a valid driver's license, liability coverage and provide their own vehicle.

E. Training: Training requirements vary by program and how the prospective PCA is introduced to the program. PCAs will not be paid until the consumer has verified that the training occurred.

1. Personal Choice Program

    a. In-home training is provided by the participant.

2. Independent Provider Program

    a. If an individual wants to be a PCA and knows the IP consumer:

(1) Mandatory orientation is required.

(2) The consumer may choose whether the PCA will attend formal training or will complete in-home training by the consumer.

b. If an individual wants to be a PCA but does not know an IP consumer:

(1) Mandatory orientation is required.

(2) Formal training is required.

F. Certifications: All IP PCAs must receive a cardiopulmonary resuscitation (CPR) and First Aid certification, renewed every two (2) years. Exceptions may be made if the PCA is a Certified Nursing Assistant (CNA) or has an active CPR/First Aid certification.

G. Background Checks: All Personal Care Aides and consumer representatives that have direct contact with consumers must submit to a National Criminal Background Check supported by fingerprints every five (5) years, annual Office of Inspector General (OIG) screenings, and an annual Abuse Registry Record Check to be authorized to provide assistance to consumers under the Personal Choice and Independent Provider Programs.

1. The FI is EOHHS' designated agent to provide authorization for the Department of Attorney General to complete the National Criminal Background Check supported by fingerprints.

2. The individual to be fingerprinted is responsible for the cost of the fingerprint.

3. To participate in the Self-Directed programs as the consumer's representative or in a provider (PCA) capacity, there must be no evidence of disqualifying convictions as described in R.I. Gen. Laws § 42-7.2-18.4. The FI is EOHHS' designated agent to receive information about whether a disqualifying conviction appears during the background check. The Department of Attorney General will not disclose the nature of the conviction to the FI. The FI will notify EOHHS, accordingly.

4. Evidence of any disqualifying conviction will bar the individual from acting as a PCA or representative. The individual may request a copy of their record from the Department of Attorney General and request an exception from the EOHHS Office of Community Programs Review Committee. The individual may participate as a PCA or representative, notwithstanding evidence of a disqualifying conviction, only if, in the judgment of the EOHHS Office of Community Programs Review Committee, such participation:

a. Would not threaten the health, welfare, or safety of members; and

b. Would not compromise the integrity of the Rhode Island Medicaid program.

5. PCAs who have completed the fingerprint-supported background check within the last five (5) years who transition between the Personal Choice and Independent Provider Programs are not required to resubmit until the current fingerprint expires.

2.10 Personal Choice Program

2.10.1 Eligibility

A. Consumers who are either aged (age sixty-five (65) or over) or who have a disability and are at least eighteen (18) years old and are determined to have high or highest need for level of care; and

B. Individuals who have demonstrated the ability and competence to direct their own care or have a qualified designated representative to direct care, and want to either remain in their home or return to their home.

2.10.2 Assessments

A. Nursing Assessment – The Nursing Assessment is one (1) of the multiple assessments done for the individual. This assessment measures Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) which are conducted to determine participant needs and goals. A nursing assessment must be performed by a nurse licensed by RIDOH in accordance with 216-RICR-40-05-3, Licensing of Nurses and Standards for the Approval of Basic Nursing Education Programs.

B. Functional Assessment – The functional assessment rates the participant's level of assistance required to complete each task, and the number of times the task is performed. If there is a condition or characteristic in addition to the disability, the participant may require the need for more time to complete a particular task. These conditions and/or characteristics do not apply to all ADL/IADL tasks; they only apply if the condition would have a direct impact on the performance of the task.

1. In addition to medical information and self-reporting, the assessor may observe or request that the participant demonstrate their ability to complete a task.

2. When a participant is identified through the Nursing Home Transition Program/Money Follows the Person Program, a temporary assessment shall be conducted. This shall be a temporary assessment because it is conducted while the participant is in an institutional Nursing Home setting

and may not fully reflect the participant's functional abilities within a non-institutional home setting. The Service Advisement Agency selected by the participant consumer shall complete an updated assessment within ninety (90) days of the participant returning home. After the temporary assessment is completed, the Office of Community Programs staff shall review the assessment with the participant to:

a. Verify that the participant wants to participate in the Personal Choice program; and

b. Identify the participant's choice of Service Advisement Agency responsible for the additional assessments and oversight of the participant's program. The participant will have appeals rights as outline in Part 10-05-2 of this Title, Appeals Process and Procedures for EOHHS Agencies and Programs.

C. In addition to the nursing and functional assessments, staff will conduct an environmental assessment and a Mini Universal Comprehensive Assessment Tool (UCAT) assessment as part of the eligibility determination and plan of care.

2.10.3 Budget Development

A. Personal Choice monthly budgets are based on the functional assessment of participant need for hands-on assistance or supervision with ADLs (such as bathing, toileting, dressing, grooming, transfers, mobility, skincare, and/or eating) and IADLs (such as communication, shopping, housework, meal preparation, and/or food shopping), as described in § 2.9.2 and listed in the tables at the end of this Part.

B. The Service Advisement Agency will perform assessments to determine the individual's budget and Individual Service and Spending Plan (ISSP). In accordance with the service provider agreements, a budget is developed based on the amount and level of assistance required, frequency of the task, and presence of any secondary conditions that would require a need for more time to complete the task. There are six (6) levels of assistance for each activity.

1. Determine Monthly Budget Amount: Each Activity of Daily Living (ADL) and Instrumental Activity of Daily Living (IADL) has an amount of unit and/or functional time allowed to complete the task. The monthly figures for each ADL/IADL are added together to form a monthly budget. Taxes, worker's compensation insurance and administrative costs are deducted from the PCP participant's monthly budget.

a. Unit Time – the amount of time allowed to complete the task if the participant is unable to participate and requires total assistance with the task.

b. Functional Time – the amount of time allowed to complete the task if the participant is unable to participate and requires total assistance with the task and certain conditions or characteristics are present. These characteristics are listed in the table at the end of this Part.

2. EOHHS will implement a budget re-assessment for any budget which is decreased by five hundred dollars ($500.00). This second (2nd) level re-assessment will be conducted by an EOHHS nurse and social worker in the home of the consumer.

3. Written documentation of the assessment will be maintained by the Service Advisement Agency, such as the functional, mobility and health assessments.

C. The budget amount is determined by EOHHS and may be subject to change. The budget funds are set aside by Medicaid for the purchase of assistance to meet individual participant needs. The participant determines what services are required and the amount the participant is willing to pay for those services from their budget. Participants determine the hourly wage for PCA, which can range from fifteen dollars ($15.00) up to twenty-one dollars ($21.00) per hour. The budget does not allow for companionship, watching, or general supervision of a participant.

D. The service advisor will provide the participant/representative with a copy of the approved budget and the approved ISSP after sign off by the participant. Additional copies may be provided upon request.

E. The Service Advisory Agency will provide the Personal Choice fiscal intermediary with a copy of the approved budget.

2.10.4 Participant Directed Goods and Services

A. Participants may also set aside a specified amount of their budget each month to purchase services, equipment and supplies not otherwise provided by Medicaid that address an identified need, are in the approved ISSP, and meet the following requirements:

1. Alternative funding sources are not available; and

2. The item or service would decrease the need for other Medicaid services; and/or

3. The item or service would promote inclusion in the community; and/or

4. The item or service would increase the individual's ability to perform ADLs/IADLs; and/or

5. The item or service would increase the person's safety in the home environment.

B. Limitations:

1. Some items or services that are medical in nature may be reimbursed with a health care practitioner's order.

2. Items must be necessary to ensure the health, welfare and safety of the participant, or must enable the participant to function with greater independence in the home or community, and to avoid institutionalization.

3. Items for gifts or loans to others, housing and/or utility expenses, clothing, groceries, entertainment, alcohol or tobacco, or payments to a representative are not covered.

4. Items cannot duplicate equipment provided under Medicaid-funded primary and acute care or through other sources of funding, such as Medicare, private insurance or without charge from community organizations.

5. Items intended to lessen the need for assistance from a caregiver will result in a redetermination of need for caregiver assistance.

6. No more than ten percent (10%) of a participant's monthly budget may be set aside for goods and services, so that an individual continues to receive personal care services that provide for their health, welfare and safety.

2.10.5 EOHHS Responsibilities

A. EOHHS shall be responsible for the following activities:

1. Approve budgets and individual service and spending plans;

2. Authorize participant-directed goods and services;

3. Provide Personal Choice participants with notice of budget amount through a standardized letter which provides information on budget amount and any changes that occurred in the assessment process. The letter also includes information on the appeals process;

4. Certify, monitor and conduct quarterly audits of service advisement and fiscal intermediary agencies.

B. The EOHHS reviews and approves the assessment and individual service and spending plan (ISSP) for each PC participant before services begin.

C. Any changes made to a PC participant's ISSP must be forwarded to EOHHS for review and approval.

D. Once the ISSP is approved, EOHHS will notify the appropriate Service Advisement Agency who will inform the Fiscal Intermediary and participant that the ISSP will be implemented.

E. EOHHS is responsible for educating participants and PCAs about reporting critical incidents and for reviewing reported critical incidents with the Service Advisement Agency to determine feasibility of the individual continuing participation in the Personal Choice Program.

F. If Medicaid fraud is either known or suspected, EOHHS shall refer the case to the Medicaid Fraud Control Unit at the Rhode Island Department of Attorney General.

2.11 Independent Provider

2.11.1 Eligibility

A. Consumers who are either aged (age sixty-five (65) or over) or who have a disability and are at least eighteen (18) years old and are determined to have high or highest need for level of care and;

B. Individuals who have demonstrated the ability and competence to direct their own care or have a qualified designated representative to direct care, and want to either remain in their home or return to their home.

2.11.2 Assessments

A. Nursing Assessment – The Nursing Assessment is one (1) of the multiple assessments done for the individual. This assessment measures Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) which are conducted to determine participant needs and goals. A nursing assessment must be performed by a nurse licensed by RIDOH in accordance with 216-RICR-40-05-3, Licensing of Nurses and Standards for the Approval of Basic Nursing Education Programs.

B. Functional Assessment – The functional assessment rates the participant's level of assistance required to complete each task, and the number of times the task is performed. If there is a condition or characteristic in addition to the disability, the participant may require the need for more time to complete a particular task. These conditions and/or characteristics do not apply to all ADL/IADL tasks; they only apply if the condition would have a direct impact on the performance of the task.

1. In addition to medical information and self-reporting, the assessor may observe or request that the participant demonstrate their ability to complete a task.

2. When a participant is identified through the Nursing Home Transition Program/Money Follows the Person Program, a temporary assessment shall be conducted. This shall be a temporary assessment because it is conducted while the participant is in an institutional Nursing Home setting and may not fully reflect the participant's functional abilities within a non-institutional home setting. The Service Advisement Agency selected by the participant consumer shall complete an updated assessment within ninety (90) days of the participant returning home. After the temporary assessment is completed the Office of Community Programs staff shall review the assessment with the participant to:

    a. Verify that the participant wants to participate in the Independent Provider program; and

    b. Identify the participant's choice of Service Advisement Agency responsible for the additional assessments and oversight of the participant's program. The participant will have appeals rights as outline in Part 10-05-2 of this Title, Appeals Process and Procedures for EOHHS Agencies and Programs.

C. In addition to the nursing and functional assessments, staff will conduct an environmental assessment and a Mini Universal Comprehensive Assessment Tool (UCAT) as part of the eligibility determination and plan of care.

2.11.3 Service Hours

A. Independent Provider service hours are determined based on the functional assessment of participant need for hands-on assistance or supervision with ADLs (such as bathing, toileting, dressing, grooming, transfers, mobility, skincare, and/or eating) and IADLs (such as communication, shopping, housework, meal preparation, and/or food shopping).

B. The Service Advisement Agency will perform assessments to determine the individual's service hours and assist with the development of the ISP. In accordance with the service provider agreements, service hours are authorized based on the amount and level of assistance required, frequency of the task, and presence of any secondary conditions that would require a need for more time to complete the task.

1. EOHHS will implement a re-assessment for any service plan in which the number of hours is reduced or increased significantly with no corresponding documentation of a significant medical change or significant life event in the individual's assessment. This second (2nd) level

re-assessment will be conducted by an EOHHS nurse and social worker in the home of the consumer.

2. Written documentation of the assessment and ISP will be maintained by the Service Advisement Agency.

C. The hours authorized in the service plan are determined by EOHHS and may be subject to change. Service hours do not allow for companionship, watching, or general supervision of a participant.

D. The Service Advisor will provide the participant/representative with a copy of the approved budget and the approved ISP. Additional copies may be provided upon request.

E. The Service Advisory Agency will provide the Independent Provider Fiscal Intermediary with a copy of the approved budget.

F. Once approved the consumer can utilize those hours for non-medical personal care and homemaker services. The consumer must pay the PCA a minimum of fifteen dollars ($15.00) per hour. There is no allowance for differential pay to the PCA for hours worked beyond forty (40) hours (where applicable) or on Saturdays, Sundays, Holidays, or off-hours.

2.11.4 EOHHS Responsibilities

A. EOHHS shall be responsible for the following activities:

1. Approve service hours and ISPs;

2. Provide Independent Provider participants with notice of ISP and authorized service hours;

3. Certify, monitor and conduct quarterly audits of Service Advisement and Fiscal Intermediary agencies.

B. The EOHHS reviews and approves the assessment and ISP for each IP participant before services begin.

C. Any changes made to a participant's ISP must be forwarded to EOHHS for review and approval.

D. Once the ISP is approved, EOHHS will notify the appropriate Service Advisement Agency who will inform the Fiscal Agency and participant that the service plan will be implemented.

E. EOHHS is responsible for establishing rates for PCA services. These rates must be based on a minimum hourly wage of fifteen dollars ($15.00).

F. EOHHS will oversee PCA training modules and will establish terms and conditions of the workforce without infringing on rights of the consumer to hire, direct, supervise, or terminate their PCA.

1. If a prospective PCA is a family member or friend, with the written permission of the consumer, the PCA may begin providing services and receiving payment for such services after signing an attestation that they will complete the mandatory orientation within fourteen (14) days of commencing employment as a PCA. The PCA shall also attest to completing background checks in accordance with § 2.9 of this Part within fourteen (14) days of the start of employment and CPR training within ninety (90) days of the start of employment. Those actively working and receiving payment must adhere to the attestations as a requirement of continued employment. If the PCA has not completed the mandatory orientation, background checks, and CPR training within ten (10) days prior to the completion time frames, the Fiscal Intermediary will communicate to the family and the PCA that the requirement has not been completed by the PCA in the attested timeframe. The FI will again communicate to the family and the PCA within five (5) days prior to the completion time frames if there are still uncompleted requirement(s), that the PCA will not be paid for services going forward nor will there be retroactive payment. Such PCAs shall not be included on the PCA Registry until such time as they have completed all mandatory trainings.

G. EOHHS is responsible for educating participants and PCAs about reporting critical incidents and for reviewing reported critical incidents with the Advisement Agency to determine feasibility of continuing participation in the Independent Provider program.

H. If Medicaid fraud is either known or suspected, EOHHS shall refer the case to the Medicaid Fraud Control Unit at the Rhode Island Department of Attorney General.

I. A registry of qualified caregivers shall be posted by EOHHS from information validated by the Fiscal Intermediary. Listed on the registry are the PCAs who have completed training requirements and are available to provide services. The registry does not contain personally identifiable information, but rather details regarding gender, experience, additional certifications, languages spoken, town of origin, distance willing to travel, days and hours available to work, smoking habits, allergies, willingness to be called for emergency visits, and a free form self-description.

1. Individuals working as PCAs are not required to join the registry, for example when the PCA is only interested in working for one (1) dedicated consumer. PCAs will only be listed if they have expressed interest to be listed.

2. Individuals who are trained by the consumer for all additional training beyond Mandatory Orientations (required training for all PCAs participating in the IP program) are not listed in the registry and cannot work for other consumers (with the exception of other consumers who also self-train). No accommodations are made to list provisional providers on State registries/website.

3. PCAs listed on the registry have undergone formal training and meet minimum training requirements in order to participate in the IP program.

4. PCAs may self-initiate entry into the registry. Information posted on the registry is validated by the Fiscal Intermediary.

5. Consumers may use the registry to find and hire PCAs.

6. The frequency of updates to the registry is dependent on the availability of qualifying PCAs.

7. No consumer information is listed on the registry.

Attachment I Personal Choice Assessments and Budget Development

Six (6) Levels of Assistance:

Independent	LTSS beneficiary is independent in completing the task safely.
Set-Up	LTSS beneficiary requires brief supervision, cueing, reminder and/or set- up assistance to perform the task.
Minimum	LTSS beneficiary is actively involved in the activity, requires some hands- on assistance for completion, thoroughness or safety. Needs verbal or physical assistance with twenty-five (25%) of the task.
Moderate	LTSS beneficiary requires extensive hands-on assistance but is able to assist in the process. Needs verbal or physical assistance with fifty percent (50%) of the task.
Extensive	LTSS beneficiary requires verbal or physical assistance with seventy-five percent (75%) of the task.
Total Assistance	LTSS beneficiary cannot participate or assist in the activity and requires one hundred percent (100%) assistance with the task.

Not Applicable	This task does not apply to this LTSS beneficiary.

Functional Characteristics for Each ADL/IADL:

ADL/IADL	Functional Characteristics
Bowel	Behavioral Issues, Limited ROM, Spasticity/Muscle Tone
Dressing	Behavioral Issues, Limited ROM, Spasticity/Muscle Tone
Eating	Behavioral Issues, Fine Motor Deficit, Spasticity/Muscle Tone
Grooming	Cognitive, Limited ROM, Spasticity/Muscle Tone
Mobility	Balance Problems, Decreased Endurance, Pain, Spasticity/Muscle Tone
Shower	Balance Problems, Behavioral Issues, Limited ROM, Spasticity/Muscle Tone
Skin Care	Open Wound
Sponge Bath	Behavioral Issues, Limited ROM, Spasticity/Muscle Tone
Transfers	Balance Problem, Limited ROM, Spasticity/Muscle Tone
Tub Bath	Balance Problem, Behavioral Issues, Limited ROM, Spasticity/Muscle Tone
Urinary/Menses	Behavioral Issues, Limited ROM, Spasticity/Muscle Tone
Communications	No Functional Characteristics
Housework	LTSS beneficiary Lives Alone
Meal Preparation	No Functional Characteristics
Shopping	No Functional Characteristics

Activity and Time Allotments, in minutes:

Activity	Unit Time	Functional Time
Sponge Bath	30	45
Shower	20	40
Tub Bath	40	45
Dressing	15	20
Eating	20	40
Mobility	10	10
Urinary/Menses	10	15
Transfers	5	10
Grooming	8	8
Skin Care	10	10
Bowel	30	50
Meal Preparation	25	25
House Work	12.5	25
Communications	15	15
Shopping	60	60
Medications	2	5

ADL Multipliers:

Level of Assistance	Sponge Bath	Shower	Tub Bath	Dressing	Eating	Mobility	Urinary Menses	Transfers	Grooming	Skin Care	Bowel
Total Assist	1	1	1	1	1	1	1	1	1	1	1
Maximum Assist	.75	.75	.75	.75	.75	1	.75	1	.75	1	.75
Moderate Assist	.5	.5	.5	.5	.5	.75	.5	.75	.5	.75	.5
Minimum Assistance	.25	.25	.25	.25	.25	.75	.25	.75	.25	.25	.25
Set-Up Assistance	.15	.15	.15	.15	.15	.20	.15	.20	.15	.20	.15
Independent	0	0	0	0	0	0	0	0	0	0	0

IADL Multipliers:

Level of Assistance	Meal Preparation	Housework	Communications	Shopping
Total Assist	1	1	1	1
Maximum Assist	1	1	1	1
Moderate Assist	.75	.75	.75	1
Minimum Assistance	.5	.5	.5	1
Set-Up Assistance	.25	.25	.25	1
Independent	0	0	0	0

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TITLE 210 - EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 50 - MEDICAID LONG-TERM SERVICES AND SUPPORTS

SUBCHAPTER 10 - HOME & COMMUNITY BASED LTSS

PART 2 - SELF-DIRECTED CARE

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