

## **0398 Specific Waiver Programs**

### **Home-Based For Elder/Disabled**

REV: 06/1994

Since July 1982, under a Waiver approved by the Health Care Financing Administration (HCFA), DHS has operated a program to divert elderly and disabled individuals from entering a Nursing Facility (NF). This Waiver program provides to eligible participants an array of home-based services which are equal to or less than the cost of institutional care. To be eligible for Waiver services, individuals must be Categorically Needy and meet the requirements of the Long Term Care Alternatives Program.

The program is designed to supplement the existing scope of services already provided by Medical Assistance, Federal Medicare, other State and local programs, and "informal" caretakers such as relatives, friends and neighbors.

### **Waiver Services**

REV: 06/1994

The additional MA services provided under the Waiver are:

- **Case MANAGEMENT SERVICES** - a broad coordinating function which authorizes, arranges, and monitors home-based services. Case management services are provided by LTC Social Service staff.
- **HOMEMAKER/PERSONAL CARE SERVICES** - defined in Section 0530 of the DHS Policy Manual.
- **ADULT DAY CARE** - defined in Section 0514 of the DHS Policy Manual.
- **MINOR MODIFICATIONS TO THE HOME** - such as portable wheel chair ramps, grab bars, modifications to tubs and toilets.
- **MINOR ASSISTIVE SERVICES** - such as cooking and eating aids, grooming aids, and other devices which assist in the Minor Assistive Services may include payment for the installation fee and monthly monitoring fee of a Personal Emergency Response System (PERS). The PERS is an in-home, twenty-four hour electronic alarm system which allows a functionally impaired housebound individual to signal a central switchboard in the event of an emergency.

This service is limited to high risk, physically vulnerable individuals who must live alone or spend prolonged periods of time alone, and who have the mental capacity to understand the purpose of PERS and to use it properly.

Minor Assistive services requires prior authorization via an MA-505 by the individual's physician, evaluation of the individual by the LTC Case Manager and service provider (usually the hospital discharging the patient), and is subject to the approval of the Chief of Pharmacy Services in the Division of Medical Services.

The additional services provided under the Waiver are meant to fill remaining gaps in service, not to substitute for existing services for which the individual is eligible. For example, many of the individuals served under the Waiver may be entitled to Medicare-home-health aide or rehabilitation specialists such as a physical therapist. Thus, the home-based service plan written by the Case Manager would not include services already available through other programs such as Medicare.

### **Target Population**

REV: 06/1994

Under the Waiver, two groups of beneficiaries receive services. They are Categorically Needy SSI Recipients (Group I) and Newly Diverted Individuals (Group II).

- **Group I - Categorically Needy SSI Recipients**

Group I is active SSI recipients who, as of January 1, 1982, had been previously diverted from entering a NF through the use of Homemaker Services, and meet the financial and non-financial eligibility criteria for Categorically Needy MA. No new beneficiaries may be added to this group.

- **Group II - Newly Diverted**

Group II is individuals who qualify for NF care and meet the financial and non-financial eligibility criteria for Categorically Needy MA.

### **Eligibility Determination**

REV: 06/1994

Initial eligibility for Group II individuals is determined by the appropriate Long Term Care (LTC) staff as if the individual were entering a nursing facility. If the individual meets the MA technical and characteristic requirements, has income and resources within Categorically Needy limits, and meets the criteria for the Long Term Care Alternatives Program, s/he may choose home care services in lieu of institutional care. If so, the Case Manager in the LTC Unit will be responsible for the case.

### **TRANSFER OF GROUP I CASES TO THE LTC UNIT**

There are two situations in which Group I cases are transferred to the LTC Unit. A previously diverted Group I individual loses SSI eligibility, or a Group I case requires minor modifications to the Home, or Minor Assistive Devices.

- **Group I Individual Loses SSI Eligibility**

When a previously diverted Group I individual loses SSI eligibility, the Adult Services worker refers the case to the appropriate LTC unit and eligibility is determined as for an individual in Group II. The individual must have an aged, blind or disabled characteristic, have income within the Federal Cap and resources within the Categorically Needy limits. In addition to meeting MA eligibility requirements, the individual must meet the criteria for the Long Term Care Alternatives Program and choose home care services in lieu of institutional care.

When the determination of eligibility is completed, the social worker is notified. If the individual is ineligible, the social worker discontinues Homemaker Services and/or Adult Day Care Services. IF the individual is eligible under the Waiver, the Case Manager assumes responsibility for the case.

- Active Group I cases requires Modifications to Home or Minor Assistive Devices.

If a currently active Group I case requires Minor Modifications to the Home, or Minor Assistive Devices, the case responsibility is transferred to the appropriate LTC/AS Unit.

### **0398.05.20 Redetermination**

REV: 06/1994

### **GROUP II - NEWLY DIVERTED**

Redetermination of financial eligibility is conducted at least annually for Group II Waiver service recipients, or when there is a change in circumstances which would affect eligibility. The redetermination is completed by the LTC Unit of the Case Manager servicing the case. Waiver-eligible individuals with a spouse are considered to be living separately, as if in a nursing facility or medical institution. Resources of the spouse are considered as if the individual were applying for care in a medical institution.

### **GROUP I - PREVIOUSLY DIVERTED**

Redetermination of financial eligibility is conducted by the SSA, concurrently with the SSI determination. When a previously diverted case requires redetermination of need for services, the case will continue to be handled by the Adult Services worker with current responsibility for the case. Current procedures apply, except that the CP-1 and CP-1.1 are sent to the Homemaker Review Office in lieu of an HS-1 and HS-2. One copy of the CP-1 is forwarded from the Homemaker Review Office to the LTC Unit at CO.

### **Case Management Function**

REV: 06/1994

In addition to determining eligibility, and the level of care required, DHS Case Mangers coordinate the array of home-based services. Case Mangers will:

- Plan alternative services;
- Arrange and authorize services;
- Monitor and adjust the service mix; and
- Reassess to determine eligibility and need for services under the Waiver, including need for a Nursing Facility level of Care.

## **Planning Alternative Services**

REV: 06/1994

The hospital Social Service staff identifies likely candidates for home-based services under the Waiver. Potential candidates are Categorically Needy MA patients who qualify for SNF/ICF Care and express an interest in receiving those services in the community rather than a facility. The hospital social worker completes the CP-1 and CP-1.1 and notifies the DHS Case Manager.

Hospital Social Services Staff apprise each candidate of the availability of services either in an institutional setting or in a home-based setting under the Waiver program. Each recipient's choice is documented by a signed form, CP-12. The CP-12 is retained in the LTC/AS case record.

The DHS Case Manager carries out the following sequence of functions:

- The Case Manager meets (within one workday of notice when possible) with the hospital discharge team to design a care plan which compensates for all deficits identified on the CP-1 and CP-1.1. The Case Manager completes the CP-4 in order to ascertain the maximum amount available for home-based services under the Waiver. (CP-4, line 10).
- The service plan agreed to by the DHS Case Manager and the hospital discharge team is recorded by the Case Manager on the CP-3.
- The Case Manager discusses the Preliminary Care Plan with the patient and family and negotiates modifications.
- The Case Manager completes line 11-19 of the CP-4 to ensure that the planned services do not exceed the amount on line 10.
- When the plan is agreed to by the patient and family, the Case Manager completes the Individual Plan of Care (CP-5). The Case Manager discusses the allocation of the individual's income toward the cost of home-based services, and helps the individual select providers, when there is a choice.
- The Case Manager notifies the individual of his/her eligibility and the amount (if any) of contribution toward the cost of care by sending a CP-7.
- Before authorizing and arranging services, the Case Manager completes Forms CP-1, CP-1.1 or 70.1 or 72.1 as appropriate, and obtains a Level of Care from the LTC Unit at DHS Central Office, CP-3, CP-4, CP-5, and CP-99. The Case Manager will verify that the client has completed a CP-12.

## **Planning Alt Services - Comm**

REV: 06/1994

The LTC/AS staff identifies likely candidates for home-based services under the Waiver. Potential candidates are Categorically Needy MA individuals who qualify for NF care and express an interest in receiving these services in the home rather than in a facility.

LTC/AS staff appraises each candidate of the availability of services in either an institutional setting or in a home-based setting under the Waiver program. Each recipient's choice is documented by a signed form, CP-12. The CP-12 is retained in the LTC/AS case record.

The LTC/AS worker (Case Manager) carries out the following sequence of functions:

- The LTC/AS worker (Case Manager) forwards a completed 72.1 and 70.1 to the Medical Review office at CO. The level of care will be issued on a MA 510 and sent to LTC/AS.
- The LTC/AS worker (Case Manager), in concert with the candidate, designs a care plan which compensates for the deficits identified. The Case Manager completes the CP-4 in order to ascertain the maximum amount available for home-based services under the Waiver (CP-4, line 10).
- The service plan agreed to by the Case Manager and the candidate is recorded by the Case Manager on the CP-3.
- The Case Manager discusses the Preliminary Care Plan with the candidate and family and negotiates modifications.
- The Case Manager completes lines 11-19 of the CP-4 to ensure that the planned services do not exceed the amount on line 10.
- When the plan is agreed to by the candidate and family, the Case Manager completes the Individual Plan of Care (CP-5). The Case Manager discusses the allocation of the individual's income toward the cost of home-based services and helps the individual select providers, when there is a choice.
- The Case Manager notifies the individual of his/her eligibility and the amount (if any) of contribution to the cost of care by sending a CP-7.
- Before authorizing and arranging services, the Case Manager completes forms CP-3, CP-4, CP-5, and CP-99.

### **Arranging/Authorizing Serv**

REV:06/1994

As part of the Case Management function, the Case Manager arranges and authorizes a variety of services, including

- Homemaker/Personal Care Services;
- Adult Care Services;
- Devices to Adapt the Home Environment and Minor Assistive Devices; and
- Other Services.

### **0398.05.30.15 Homemaker/Personal Care Serv**

REV: 06/1994

To arrange Homemaker/Personal Care services, the Case Manager telephones the provider selected to discuss the Service Plan and the beginning date of services. The provider is informed of the total amount of service to be purchased, and what share, if any, the recipient is responsible to pay directly.

The service recipient's share of the payment must be allocated to the first hours of service delivered in a provider/payroll period (four weeks). For example, thirty hours of service per payroll period are authorized and the recipient is responsible to pay for ten hours (form CP-4, line 19) and Medical Assistance is responsible to pay for twenty hours of services. In the event the provider delivers only twenty five hours of service, the recipient is still responsible for ten hours, and Medical Assistance is responsible for fifteen hours.

Homemaker Services are authorized on form HS-3. Four copies are completed. The original is sent to the Family and Adult Services Fiscal Unit at Central Office, one copy is sent to the provider, one copy to the recipient, and one copy is kept in the case record.

When the plan for service(s) is finalized, the individual is notified of his/her eligibility and the amount of his/her contribution toward cost of care by a CP-7. Copies of the CP-5, Individual Plan for Care and the appropriate authorization form, HS-3, is also sent.

The provider receives a copy of the Individual Plan of Care (CP-5) and a copy of the Authorization for Homemaker Services (HS-3).

### **Adult Day Care Services**

REV: 06/1994

The Case Manager monitors the provision of home-based service at least once weekly for the first four weeks. If possible, the Case Manager should avoid modifying the service plan during the first thirty days to allow sufficient time for proper adjustment by the individual, family and providers.

All contacts with the recipient, family or providers are entered in the Activity Log (CP-2).

- The Case Manager is responsible to maintain appropriate contact with providers of home-based service.

The Case Manager learns the amount and duration of Home Health Services to be delivered under federal Medicare by contacting the visiting nurse who is responsible for completing the home assessment.

The Case Manager and the visiting nurse should discuss the total service plan to assure the adequacy and compatibility of the various services.

- The Case Manager will visit the recipient at home within thirty days following the start of Waiver services to reassess the service needs and to make appropriate adjustments in the service mix.

## **Dev for Home/Minor Assist Dev**

REV: 06/1994

Certain durable medical equipment can be provided when it is necessary as part of a total care plan to prevent institutionalization. These are:

- Devices to adapt the home environment, such as portable ramps, grab bars and devices for adapting tubs and toilets. Installation is included in the purchase price and modifications requiring more than incidental construction are excluded; and,
- Minor assistive devices, such as grooming, eating and cooking aids and Personal Emergency Response Systems (PERS).

Provision of these items requires prior authorization from the Chief of Pharmacy Services in the Division of Medical Services.

The Chief of Pharmacy Services may be consulted if the Case Manager is not certain which vendors provide the required items.

If time is important, the Chief of Pharmacy Services can grant verbal authorization.

The process will be facilitated if a physical/occupational therapist participates on the hospital discharge team for patients who may require these items.

The Case Manager contacts the vendor who completes an MA-505. For, PERS, in addition to the MA-505 completed by the physician and the service provider, the LTC/AS Case Manager must evaluate the individual's suitability for the service. Factors to be considered are the individual's diagnosis, living arrangements, and physical and mental ability to use the PERS equipment properly. A memo detailing the evaluation accompanies the MA-505 to the Chief of Pharmacy Services. Once prior authorization has been received, the Case Manager calls the vendor to arrange delivery and/or installation.

## **Arranging Other Services**

REV: 06/1994

The Case Manager should be familiar with the entire range of other services which may be brought to bear on existing deficits.

This includes the services provided under Medicare and Medical Assistance as well as those funded by other Federal, State, local or private sources. The Case Manger assists the individual in arranging these services.

Examples of services which may be used to complete the Individual Plan of Care are:

- Social services - from Family and Adult Services or other providers;
- Meals-on-Wheels;

- Transportation - from Senior Citizens Transportation (SCT) or informal providers;
- Recreational activities - senior citizens, church groups, service clubs;
- Universal services - beauticians or barbers who can serve the handicapped, legal services, financial advisors, consumer advisors, etc.

### **Monitoring Home-Based Service**

REV: 06/1994

The Case Manager monitors the provision of home-based service at least once weekly for the first four weeks. If possible, the Case Manager should avoid modifying the service plan during the first thirty days to allow sufficient time for proper adjustment by the individual, family and providers.

All contacts with the recipient, family or providers are entered in the Activity Log (CP-2).

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The Case Manager and the visiting nurse should discuss the total service plan to assure the adequacy and compatibility of the various services.

- The Case Manager will visit the recipient at home within thirty days following the start of Waiver services to reassess the service needs and to make appropriate adjustments in the service mix.

### **Reassessing Rec Elig and Need**

REV: 06/1994

Reassessments of levels of care are completed at least every six months, or by the date indicated on the CP-1/MA510.

Redeterminations of eligibility for the Waiver Program are conducted annually, or more often, as appropriate.

To reassess the level of care, both the CP-1 and CP-1.1 are completed:

- Completion of the CP-1 assures that the individual continues to require the level of services provided in the nursing facility which is an eligibility requirement of the Waiver Program;
- Completion of the CP-1.1 documents changes in the individual's functional ability so that the service plan can be modified accordingly.

The original and one copy of Page 1 of CP-1 are sent to the Medical Review Office at Central Office and a copy is kept in the record.

### **Home-Based For Mental Retarded**

REV: 06/1994

Since July, 1983, the Department of Human Services (DHS), in conjunction with the Department of Mental Health, Retardation and Hospitals (MHRH), has offered a program to provide home and community-based services to mentally retarded individuals who would normally receive such services in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). The program is operated under a Waiver approved by the Health Care Financing Administration of the U.S. Department of Health and Human Services. The Waiver allows the program to deviate from certain MA rules pertaining to eligibility determination and services provided to eligible recipients. This program supplements the existing scope of services already provided under Medical Assistance (MA) and by other programs and service providers. The program has become informally known as the MR Waiver Program.

The goals of the program are:

- To reduce and prevent unnecessary institutionalization by providing home and community-based services to eligible mentally retarded MA recipients; and,
- To provide the services at a cost less or equal to the cost of institutionalization.

### **Target Population**

REV: 11/1994

The program is intended to reach individuals who are (or would be if institutionalized) Categorically Needy or Medically Needy Medical Assistance recipients; and,

- 1) have requested Waiver services in lieu of admission to an ICF/MR facility, and are determined by MHRH to be at risk of institutionalization; or,
- 2) are residents of an ICF/MR who will return to the community with services under the Waiver.

MHRH Case Managers identify potential candidates from the population of ICF/MR residents and at risk applicants described in Section 0398.10.20.05 below. The Case Manager at MHRH recommends the candidate for ICF/MR level of care by forwarding a CP-1 to the Medical Review Office. At the same time, for non-SSI recipients, an application and supporting documents are obtained by the MHRH Case Manager, and forwarded to the appropriate LTC/AS district office of DHS for a Determination of Eligibility (DOE).

### **Waiver Services**

REV: 11/1994

Individuals eligible under the Waiver receive the Medical Assistance scope of services provided to Categorically Needy individuals or Medically Needy individuals, as appropriate. In addition to the

normal services, an array of special services is provided under the Waiver. The services are selected, arranged, authorized, re-mixed, monitored, and re-authorized by the Case Manager. In some cases, the individual is required to pay a part of the cost of the special Waiver services.

The special services provided under the Waiver are:

○ **CASE MANAGEMENT**

The coordination of the array of home-based services by Department of Retardation/Developmental Disabilities (DOR/DD) Case Managers who:

- Establish and update an individual plan of care;
- Arrange and authorize services;
- Monitor and adjust the service mix;
- Reassess the recipient's need for services and for ICF/MR level of care.

○ **SPECIALIZED HOMEMAKER SERVICES**

Household management and personal care services provided by licensed mental retardation agencies.

○ **FAMILY LIVING ARRANGEMENTS**

Household management in foster care homes. The individual's own income pays for room and board. The Waiver provides payment for services needed beyond room and board.

○ **HOMEMAKER SERVICES/PERSONAL CARE SERVICES**

General household duties such as cleaning, meal preparation, laundry, and personal care services (see Sec. 0530) provided when the normal provider (usually the relative with whom the recipient lives) is unavailable.

○ **HOMEMAKER/LPNSERVICES**

The monitoring of a complex or unstable medical condition such as frequent pneumonia, skin prone to breakdown, or cerebral palsy, beyond the level which can be furnished by a homemaker/personal care provider. In addition, patients must require mechanical and/or physiologic supports such as tracheotomy, colostomy, or catheter care. The service requires prior administrative approval at the level of Chief Caseworker Supervisor or above in DOR/DD.

○ **RESPIRE SERVICES**

Temporary, care-giving services in the absence of the caretaker relative.

- **EARLY INTERVENTION**

The provision of developmental activities to infants and toddlers with a developmental disability and the guidance and training offered to their parents.

- **MINOR ASSISTIVE DEVICES**

Items such as grooming, eating, and cooking aids provided as part of a total case plan to prevent institutionalization.

- **MINOR MODIFICATIONS TO THE HOME**

Minor modification to the home, such as ramps, grab bars, toilet modifications, etc. to enable the recipient who also has a physical handicap to use toilet facilities and be mobile.

Specific details of the Case Manager's functions are contained in the MHRH Division of Retardation's SOCIAL SERVICE MANUAL.

### **0398.10.15 DHS Responsibilities**

REV: 11/1994

Long-Term Care/Adult Services (LTC/AS) Units conduct determinations and redeterminations of Categorically Needy or Medically Needy eligibility for MA. The LTC/AS units also calculate the amount of a recipient's income to be allocated to the cost of care (if any) and communicate the results of these determinations to individuals through the Case Managers at DOR/DD. The LTC/AS staff authorizes vendor payments for Specialized Homemaker Services. The Long-Term Care Unit at Central Office has the responsibility to review and approve/deny the level-of-care recommendations completed by DOR/DD.

#### **0398.10.15.05 Deter. MA Eligibility, Non-SSI Recipient**

REV:11/1994

Long-Term Care/Adult Services (LTC/AS) Units conduct determinations and redeterminations of Categorically Needy or Medically Needy eligibility for individuals considered for this program. Eligibility is determined by the appropriate LTC Staff as if the individual were entering an LTC facility. The individual must meet the normal citizenship/alienage, residency, enumeration, and disability requirements. For Categorically Needy eligibility, the individual must have resources within the Categorically Needy limits, and have monthly income less than the Federal Cap, as adjusted each January.

For Medically Needy eligibility, the individual must have income and resources within the Medically Needy limits.

The cost of services to be provided under the Waiver must be less than the average cost of institutional care. All standard resource and income verification procedures must be completed (including sending of AP-91s).

Form CP-31 is completed to notify the recipient (in care of the DOR/DD Case Manager) of the

decision. The original and one copy are sent to the DOR/DD Case Manager. The third copy is retained in the case file.

In addition, a CP-30 is completed to apprise MHRH of the eligibility decision and amount (if any) of income to be applied to the cost of services. One copy is retained for the DHS case file.

If the case is REJECTED, an AP-167M is completed in duplicate.

The original is sent to the recipient, (in care of the DOR/DD Case Manager) along with the CP-30, and the copy is retained for the DHS case file.

The DHS case file is the MA eligibility record. It is maintained in the LTC/AS field office. It contains all documents relating to the determination of financial eligibility. In addition, the CP-1 received via the Office of Medical Review at Central Office, copies of CP-30s and notices sent to recipients are retained in the case file.

For cases determined to be Categorically Needy by virtue of receipt of SSI, LTC/AS maintains a case file which contains the CP-1 forms which have been routed through and approved/denied by the Office of Medical Review at Central Office and documents relating to assessments of resource transfers, if any.

#### **0398.10.15.10 Inc Alloc, Non-SSI Recip**

REV: 06/1994

Neither the SSI payment itself nor any of the other income of an SSI recipient (or former SSI recipients determined eligible for Categorically Needy Medical Assistance by SSA under 1619(B)) is allocated to the cost of Waiver services. For others, once eligibility is determined, the individual's income is reviewed to determine the monthly amount (if any) that s/he must pay toward the cost of special Waiver services.

Staff of the LTC/AS Unit utilizes the CP-30 to inform the Case Manager at MHRH and the Business Manager of the Division of Medical Services of the recipient's monthly income allocated to the cost of Waiver services. LTC/AS staff used the CP-31 to notify the recipient (in care of the DOR/DD Case Manager) of the amount allocated to the cost of services.

#### **0398.10.15.15 Redetermination of Elig**

REV:06/1994

The LTC/AS Unit conducts redeterminations of eligibility in the normal manner each year, unless a change is anticipated sooner.

The individual and Case Manager at MHRH are notified of any changes in eligibility status or allocation of income.

#### **MHRH Responsibility**

REV: 11/1994

Unlike the Long Term Care Alternatives Waiver Program for the Elderly and Disabled described in Section 0398.05, the case management function rests with staff in DOR/DD.

The case management function does not include determination of Medical Assistance eligibility or allocation of income.

The DOR/DD case management responsibilities include:

- Identifying potential Waiver services recipients;
- Determining need for ICF/MR level of care;
- Ascertaining the status of MA Categorically Needy or Medically Needy eligibility;
- Evaluating the cost-effectiveness of Waiver services;
- Ascertaining amount of income to be applied to cost of Waiver services;
- Coordinating home-based services.

### **Point of Entry**

REV: 11/1994

Case Managers apprise potential recipients of the availability of Waiver services.

Potential recipients are:

- Categorically Needy or Medically Needy individuals who reside in ICF/MR facilities;
- Individuals who have requested services in lieu of admission to an ICF/MR and who are at risk of institutionalization because of one or more of the following conditions:
  - Individual living with only one family member;
  - Individual living with parents or family members over age 60;
  - Certain severely/profoundly retarded or developmentally disabled individuals, i.e. persons requiring total care;
  - Persons with severe behavior problems requiring specific behavior interventions more than once an hour.

### **0398.10.20.10 ICF/MR Level of Care**

REV: ~~06/1994~~ [August 2014](#)

The Case Manager at MHRH Division of Retardation and Developmental Disabilities has responsibility to obtain information and evaluate an individual to determine if s/he requires the level-of-care provided in an Intermediate Care Facility/Mentally Retarded facility. If the evaluation indicates that the candidate requires an ICF/MR level of care, form CP-1 is completed by the Case Manager recommending the ICF/MR level of care. The "Waiver" block at the top of the CP-1 is checked, and the form is forwarded to

the Long Term Care Unit at Central Office for review and approval. All CP-1 forms are reviewed and approved by the Long Term Care Unit.

### **Medical Assistance Eligibility Status**

REV: 11/1994

Prior to providing services under the MR Waiver program, and at each reassessment, the Case Manager must ascertain that the applicant is eligible for Medical Assistance. The procedures vary as outlined below.

- **SSI RECIPIENTS**

SSI recipients are Categorically Needy for MA. Active SSI status must be verified at intake and reassessment. The LTC Unit has the responsibility to determine if a resource transfer exists that will impinge on Medical Assistance eligibility or eligibility for payment of nursing facility services or MR facility services.

- **NON-SSI RECIPIENTS**

All other individuals are referred to DHS LTC/AS by the Case Manager for a determination of eligibility for MA. The procedures vary depending on whether or not the individual is receiving Social Security Disability Insurance Benefits (DIB).

If the candidate RECEIVES disability benefits, the Case Manager forwards a completed and signed ~~DHS-1~~, DHS-2 and CP-30 to the appropriate LTC/AS district office.

If the candidate DOES NOT receive DIB, the Case Manager obtains a form AP-72.1 from the candidate's physician, and completes form AP-70.1 containing social information and functional abilities. Both forms are forwarded, along with the CP-1 (see above), to the Office of Medical Review at CO. The application for Medical Assistance is sent to the appropriate LTC/AS district office.

The LTC/AS district office notifies the Case Manager of the eligibility decision by return CP-30. LTC/AS also routes notices to recipients in care of the DOR/DD Case Manager.

### **0398.10.20.20 Cost-Effective of Waiver Serv**

REV: 06/1994

Home and community-based services provided to an individual as an alternative to institutional care must be cost-effective. The cost to Medical Assistance for providing Waiver services to an individual cannot exceed the average cost to provide in an institutional setting.

### **0398.10.20.25 Inc, Cost of Waiver Services**

REV:06/1994

The Case Manager provides the LTC/AS district office with accurate income information, via the

CP-30, whenever there is a change in an individual's income, so that LTC/AS can accurately determine income to be applied to the cost of Waiver services.

### **Home-Based For Deinstit Elder**

REV: 06/1994

Pursuant to Rhode Island General Laws 40-66-4, the Department of Human Services (DHS) and the Department of Elderly Affairs (DEA) jointly operate a program to allow certain institutionalized Medical Assistance recipients to return home with the provision of home-based services. The program is operated under a Waiver approved by the Health Care Financing Administration of the U.S.

Department of Health and Human Services. The Waiver allows the program to deviate from certain MA rules pertaining to eligibility determination and services provided to eligible recipients. The services of this program supplement the existing scope of services already provided by Medical Assistance, Medicare and other programs and services.

The goals of the program are:

- To reduce unnecessary institutionalization by providing home and community-based services to elderly individuals who reside in Nursing Facilities so that the recipient is able to return to the community; and,
- To provide the services at a cost which is less than or equal to the cost of institutional care.

### **Target Population**

REV: 06/1994

The program is designed to assist individuals who are:

- Over 65 years of age and receive Medical Assistance (as Categorically Needy or Medically Needy);
- Require the level of care provided in a Nursing facility; o Reside in a Nursing Facility at the point of application and are, with home-based services, potential candidates for discharge to the home where they will be homebound.

Case Managers at DEA identify candidates for the program from the population of Nursing Facility residents.

### **Waiver Services**

REV: 06/1994

Waiver services recipients receive the normal scope of Medical Assistance services. In addition to the normal MA services, five special services are provided under the Waiver. Waiver services are provided only in a home setting. In some cases, the recipient may bear a portion of the cost of the Waiver services.

Waiver services are:

- **Case Management**

Case management refers to the identification, authorization and coordination of Waiver services provided to the recipient. Case management begins with the evaluation of the individual's needs and the development of an individual plan of care. The Case Manager arranges for and authorizes the services, and monitors their provision. Adjustments in the service mix are made based on periodic reassessments of the recipient's need for services;

- Homemaker/Personal Care Services as defined in Section 0530 of the DHS Policy Manual;
- Adult Day Care as defined in Section 0514 of the DHS Policy Manual;
- Minor Modifications to the Home

Minor modifications to the home include such items as portable wheel chair ramps, grab bars, modifications to tubs and toilets.

- **Minor Assistive Services**

Minor assistive services are services such as cooking and eating aids, grooming aids and other devices which assist in the Activities of Daily Living.

Minor assistive services may include payment of the installation and monthly monitoring fee of a Personal Emergency Response System (PERS). The PERS is an in-home, twenty-four hour electronic alarm system which allows a functionally impaired homebound individual to signal a central switchboard in the event of an emergency. This service is limited to those individuals who are at high risk, physically vulnerable, who must live alone or spend prolonged periods of time alone. In addition, the recipient must be capable of understanding the purpose of the PERS and using it properly.

This service requires prior authorization by the individual's physician via the MA 505, evaluation by the LTC Case Manager and service provider (usually the hospital discharging the patient) and is subject to approval by the Chief of Pharmacy Services in the Division of Medical Services.

## **DHS Responsibilities**

REV: 01/2000

The DHS Long Term Care/Adult Services (LTC/AS) Unit determines eligibility and calculates the recipient's income to be allocated to the cost of care (if any). These determinations are communicated to the individuals and Case Managers at DEA. The Long Term Care Unit at Central Office has the responsibility to review and approve the level of care assessments completed by DEA. Specific responsibilities include:

- Determinations of Eligibility for Medical Assistance SSI recipients are Categorically Needy recipients of Medical Assistance. LTC/AS must determine if the SSI recipient has transferred

resources. If no resource transfer has been made, no further determination of eligibility (or income allocation) is required.

For those individuals who will not be SSI recipients while living at home, the LTC/AS Unit is responsible for eligibility determinations and redeterminations.

- LTC/AS staff will process new and recertification applications forwarded by DEA. Individuals applying for this program may already be Medical Assistance eligible as determined by the appropriate LTC/AS Unit, or automatically eligible as an SSI recipient. Individuals may receive services under this program as Categorically or Medically Needy.

Eligibility determinations are conducted as if the candidates were institutionalized. An applicant who meets the technical and characteristic requirements, has resources within the Categorically Needy limits and income under the Federal Cap (See Section 0386.05), is certified as Categorically Needy. If the individual's income or resources exceed the Categorically Needy limits, s/he may be Medically Needy if resources are within the Medically Needy resource limits, and monthly income is less than the cost of all medical services.

- Recipients who are certified for MA receive a Notice of Eligibility. Individuals who are rejected or closed on Medical assistance are notified in the usual manner. The LTC/AS Unit conducts redeterminations of eligibility in the normal manner each year, unless a change is anticipated sooner.

- Maintenance of DHS Case Files

The MA eligibility record that was established for the individual while s/he was institutionalized continues to be the MA eligibility record for the Waiver program. It is maintained in the LTC/AS field office and contains all documents relating to the determination of financial eligibility and income allocated to the cost of care.

- Allocation of Income to the Cost of Waiver Services Once eligibility has been determined, the DEA Case Manager calculates the individual's income to be applied to the cost of care, using forms CP-3 and CP-4. The completed forms are forwarded to the appropriate LTC/AS unit for review and approval.
- Review of Cost Effectiveness and Income Allocation The LTC/AS worker receives the completed CP-3, CP-4, CP-5A and CP-7A from DEA. S/he reviews and approves the DEA case manager's preliminary calculations of the cost effectiveness of Waiver services and the income to be applied to the cost of care. If approved, the LTC/AS worker countersigns the CP-7A and sends it and the CP-5A to the individual. If corrections are needed, the LTC/AS worker consults with the DEA Case Manager to make the necessary changes prior to notifying the individual.

## **DEA Responsibilities**

REV: 04/2007

The case management function rests with DEA. The case management function does not include determination of MA eligibility.

Specific DEA responsibilities are:

o **Point of Entry Identification**

DEA staff identifies potential candidates in the target population of aged MA recipients residing in Nursing Facilities. The DEA Case Manager evaluates the abilities and needs of the candidate and establishes a comprehensive care plan on Form CP-5A. The patient's attending physician must approve the plan to discharge the patient and provide home-based services.

o **Confirming MA Eligibility Status**

Prior to providing services under the Waiver program, and at each reassessment, the Case Manager must confirm that the candidate is eligible for Medical Assistance and has an active case number. This is done by direct contact/referral to the LTC/AS unit.

o **Preliminary Calculation of Cost Effectiveness and Allocation of Income**

The Case Manager at DEA completes a preliminary calculation of the cost effectiveness of program services, and the amount of income to be allocated to the cost of care. These determinations are subject to review and approval by the LTC/AS Unit. Once the individual plan of care is completed, Forms CP-3 and CP-4 are completed. The CP-3 worksheet is designed to assist the Case Manager to compile the monthly cost of the Individual's Plan of care. The CP-4 worksheet is used by the Case Manager to calculate the cost effectiveness of Waiver services compared to institutional services, the maximum amount that can be paid by Medical Assistance for Waiver services and the amount the individual must contribute.

o **Notification to Individuals Accepted into the Program**

Individuals accepted into the Program are notified by the Case Manager and the LTC/AS worker by use of Form CP-7A. The CP-7A also apprises the individual of the amount of his/her income which must be contributed to the cost of care. Enclosed with the CP-7A is form CP-5A, the Individual's Plan of care. The forms are completed by the DEA Case Manager. The original and one copy are forwarded to the LTC/AS district office along with completed CP-3 and CP-4 for review and approval. If approved, the LTC/AS worker countersigns the CP-7A and sends the CP-7A and CP-5A to the individual.

o **Case Management**

The case manager is the "hub" of all assessments and services to the recipient. This DEA staff person establishes and maintains the individual plan of care and subsequently monitors the provision of services to assure the individual's needs are met. The monitoring ensures that the health and welfare of the individual is protected.

Specifically, the Case Manager will:

- make a preliminary evaluation (using CP-4) of the cost-effectiveness of Waiver services and income to be allocated to the cost of services;

- secure an information release form signed by the candidate allowing DEA and DHS to share information regarding the candidate;
  - apprise each candidate in writing of the availability of services in either an institutional setting or in a home-based setting under the Waiver. The candidate's choice is recorded on the CP-12A, forwarded to the LTC/AS for filing in the MA record with a copy retained by DEA for the individual's record;
  - reassess the recipient's need for NF care at least every six (6) months;
  - coordinate with the individual and LTC/AS the allocation of the individual's income to be applied to the cost of services.
- **Redetermining Need for Nursing Facility Care**

The Case Manager at DEA has responsibility for re- evaluating every six (6) months the recipient's need for a Nursing Facility level of care. To remain eligible for the Waiver services, the individual must continue to require an institutional level of care. If the evaluation indicates nursing facility care is required, the Case Manager completes Form CP-1 and forwards it to the Long Term Care Unit at Central Office where it is reviewed and approved.

### **0398.30.05 Assisted Living Waiver Program**

REV: 12/2000

Pursuant to R.I.G.L. 42-66.8, the Department of Human Services (DHS) received approval from the Health Care Financing Administration (HCFA) to administer a home and community-based waiver for up to two hundred (200) elderly and disabled individuals residing in Assisted Living Facilities. Initiated through the combined efforts of DHS, DEA, and the Rhode Island Housing and Mortgage Finance Corporation (RIHMF), this innovative waiver not only utilizes existing facilities but, for the first time, develops and provides publicly financed housing units for assisted living purposes for frail elderly and disabled individuals.

The purpose of the Assisted Living Waiver program is to provide home and community-based services to eligible elderly and disabled individuals in qualified assisted living facilities as an alternative to nursing facility care at a cost which is less than or equal to the cost of institutional care.

#### **Target Population**

REV: 12/2000

The program is designed to assist individuals who:

- are over the age of sixty-five (65) or disabled;
- receive SSI or meet the categorically needy MA eligibility requirements for an institutionalized individual (income within the Federal Cap);
- require the level of care provided in a nursing facility; and
- reside or have the opportunity to reside in an Assisted Living Facility.

## **Waiver Services**

REV: 12/2000

In addition to the normal scope of categorically needy services, the following special services are provided under the waiver:

- **Case Management Services**

Services which assist individuals in gaining access to needed waiver, MA, and any necessary medical, social, or educational services. Case managers initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care. In addition, they are responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

- **Specialized Medical Equipment and Supplies**

Includes devices, controls, or appliances specified in the plan of care, which enable individuals to increase the ability to perform activities of daily living (ADLs), or to perceive, control or communicate in the environment in which they live.

Also includes items necessary for life support, ancillary supplies and equipment necessary to proper functioning of such items, and durable and non-durable medical equipment not available to MA eligible individuals except as provided under this waiver. Items which are not of direct medical or remedial benefit to the individual are excluded. All items must meet applicable standards of manufacture, design and installation.

- **Assisted Living Services:** 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.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to such arrangement) which must contain bedrooms and toilet facilities. The consumer has a right to privacy. 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 treat each person with dignity and respect.

Also included are medication administration and transportation specified in the plan of care.

MA payments for assisted living services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement, twenty four (24) hour skilled care or supervision.

## **Facility Certification Standards**

REV: 12/2000

In addition to meeting all requirements of Rhode Island's assisted living licensing regulations, a facility must meet the following criteria in order to participate as a provider under this waiver:

- **Affordability**

Providers must agree to make available up to 20% of their units to low-income and/or MA waiver individuals subject to demand and availability. Facilities with less than 20% low income/waiver occupancy are required to retain residents who exhaust their resources and convert from private pay to SSI/MA waiver status.

- **Design Guidelines**

The architectural design of the facility should create a residential setting that emphasizes a "home-like" environment while providing for a supportive service infrastructure.

- **Occupancy requirements**

Facilities must provide for single occupancy units with private bath and toilet. Double occupancy may be allowed in the case of consumer choice, i.e., spouses or siblings, upon approval of the Department of Elderly Affairs.

- **Service Requirements**

Each facility must provide at a minimum a service package as follows:

1. Direct assistance to residents with at least two (2) activities of daily living (ADLs) by a Certified Nursing Assistant (CNA) and including but not limited to assistance with bathing, continence, dressing, ambulation, toileting, eating and transfers.
2. Assistance with housekeeping, medication management (with M-1 licensure), linen services, laundry services (including personal laundry, exclusive of dry cleaning), and such transportation services as may be specified in the plan of care.
3. A program of social and recreational activities.
4. Twenty-four (24) hour on-site staff adequate to meet scheduled or unpredictable needs in a way that promotes dignity and independence while maintaining provider supervision, safety, and security.

- **Participation Requirements**

Owners of existing assisted living facilities who wish to participate in the Assisted Living Waiver Program must meet the standards stated above. The physical plant, financial capacity, adequacy of services, and commitment to servicing low-income individuals will be evaluated prior to approval of participation in the program.

## **DHS Responsibilities**

REV: 12/2000

The DHS Center for Adult Health has the responsibility to review and approve or deny the level of care assessments completed by DEA.

The Center for Adult Health has the responsibility for:

- initial determinations and annual redeterminations of MA eligibility;
- review and approval of DEA's calculation of the recipient's income to be allocated to the cost of waiver services (if any);
- related InRhodes approval/denial;
- notification of agency action in accordance with 0376.25; and
- maintenance of the DHS case file.

## **DEA Responsibilities**

REV: 12/2000

The case management function rests with DEA and may be performed by DEA or agency staff under contract to DEA. The case management function does not include determination of MA eligibility.

Specific DEA responsibilities are:

### **1. POINT OF ENTRY IDENTIFICATION**

DEA staff or DEA contracted staff identifies potential candidates in the target population of aged and disabled individuals residing in or seeking to reside in Assisted Living Facilities. Individuals may be referred to the waiver program by family, friends, facility staff, community based social service agencies, the LTC Ombudsman or through self-referral.

The case manager contacts the appropriate LTC office and, when necessary, assists the individual in completing an application for Medical Assistance/LTC. The application is then forwarded to the appropriate LTC office for determination of eligibility.

### **2. CONFIRMING MA ELIGIBILITY STATUS**

Prior to providing services under the waiver program, and at each reassessment, the case manager contacts the LTC unit and confirms that the individual is eligible for Medical Assistance and has an active case number.

### **3. PRELIMINARY CALCULATION OF COST-EFFECTIVENESS AND CALCULATION OF INCOME ALLOCATION TO COST OF CARE:**

The case manager completes a preliminary calculation of the cost effectiveness of program services, and the amount of income to be allocated to the cost of care. These determinations are subject to review and approval by the LTC unit. Once the individual plan of care is completed, forms CP-3 and CP-4 are completed by the case manager. The CP-3 worksheet is designed to assist the case manager in calculating the monthly cost of the individual's plan of care. The CP-4 worksheet is used by the case manager to calculate the cost effectiveness of waiver services compared to institutional services, the maximum amount that can be paid by Medical Assistance for waiver services, and the amount the individual must contribute towards the cost of care.

#### **4. NOTIFICATION TO INDIVIDUALS ACCEPTED INTO THE PROGRAM**

The CP-7A is used to notify individuals of acceptance into the program and to indicate the amount of any income which must be contributed to the cost of care. Enclosed with the CP-7A is form CP-5A, the Individual's plan of care. The forms are completed by the case manager. The original forms and one copy of each are forwarded to the appropriate LTC office along with the completed CP-3 and CP-4 for review and approval. If approved, the LTC worker countersigns the CP-7A and sends the CP-7A and CP-5A, along with forms used to request a hearing (AP-121 and 121A), to the individual.

#### **5. CASE MANAGEMENT**

The case manager evaluates and monitors the abilities and needs of the candidate and develops an individual written plan of care based upon the functional assessment used by DEA to measure the abilities, deficits and environmental modifications required. The informal supports that are available for each individual are incorporated into the plan. DEA's recommended plan of care is recorded on the CP-1 and forwarded to the DHS Office of Medical Review for approval. OMR's approval is recorded on the CP-1, and copies of the completed form are returned to DEA and the LTC office for incorporation into the case record.

The plan of care contains at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each services. A copy is retained in individual's record at both DEA and DHS for a minimum period of three (3) years.

Specifically, the case manager:

- makes a preliminary evaluation, using the CP-4, of the cost-effectiveness of waiver services and income to be allocated to the cost of services;
- secures an information release form signed by the candidate allowing DEA and DHS to share information regarding the candidate;
- appraises each candidate in writing of the availability of services in either an institutional or in a community assisted living setting under the waiver. The candidate's choice is recorded on the CP-12A, forwarded to the LTC unit for filing in the case record with a copy retained by DEA for the individual's record;

- assesses, reassesses and updates the recipient's plan of care at least every twelve (12) months to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability;
- monitors the provision of services included in the individual's plan of care; and
- coordinates with the individual, the LTC unit, and the assisted living facility the allocation of the individual's income to be applied to the cost of care.

## **6. REASSESSMENT OF NEED FOR NURSING FACILITY CARE**

The case manager has the responsibility for re-evaluating the recipient's need for a nursing facility level of care at least every twelve (12) months. To remain eligible for the program, the individual must continue to require a nursing facility level of care. If reassessment indicates nursing facility care is required, the case manager completes and forwards form CP-1 to the Center for Adult Health, Long Term Care Unit at Central Office, where it is reviewed and approved.

### **0398.30.35 Eligibility Determinations**

REV: 12/2000

To receive services under this waiver program, the aged or disabled individual must receive SSI or be eligible as a categorically needy institutionalized individual (income must be within the Federal Cap), reside in or have the opportunity to reside in an Assisted Living Facility meeting the certification requirements in Section 0398.30.20, and require a Nursing Facility level of care.

The DEA case manager assists the individual in completing the application and related forms needed to apply for Medical Assistance Waiver Services, and forwards the completed forms to the appropriate LTC office.

Individuals applying for this program may already be eligible for Medical Assistance as determined by the LTC Unit or a community MA unit, or automatically eligible as an SSI recipient. A new application is not required when a DHS-2 has been completed within the past twelve (12) months and the individual is still within a current certification period. In this case, the current case file may be used, together with any additional required documentation (e.g., information relating to trusts and transfers of resources), to determine eligibility for the program.

Eligibility determinations and redeterminations are conducted by appropriate Long Term Care (LTC) staff as if the individual were institutionalized. An applicant must meet the technical and characteristic requirements, have resources within the Categorically Needy limits and income under the Federal Cap in order to qualify.

When the individual has a community spouse, resources are evaluated in accordance with spousal impoverishment rules contained in Section 0380.40 - 0380.40.35. In the application of spousal impoverishment rules to waiver applicants or recipients, all Section 0380 references to institutionalized spouses and continuous periods of institutionalization include individuals receiving assisted living waiver services in lieu of institutional services.

Any transfer of assets must be evaluated in accordance with policy in Section 0384. The look-back period for evaluating transfers of assets is calculated from date the individual began receiving assisted living waiver services or the date of MA application, whichever is later.

Individuals are provided with written notice of eligibility or ineligibility in the usual manner. The LTC unit conducts redeterminations of eligibility each year, unless a change is anticipated sooner.

Individuals are required to report changes in circumstances, such as changes in income or resources, which could affect eligibility.

### **Maintenance of Case Files**

The LTC unit is responsible for maintenance of both the electronic (InRhodes) and paper case file, which contains all documents and information relating to the determination of financial eligibility and income allocated to the cost of care.

### **Allocation of Income to the Cost of Care**

Once eligibility has been determined the DEA Case Manager calculates the individual's income to be applied to the cost of care, using forms CP-3 and CP-4. The completed forms are forwarded to the appropriate LTC unit for review and approval.

### **Review of Cost-Effectiveness and Income Allocation**

The LTC worker receives the completed CP-3, CP-4, CP-5A, and CP-7A from DEA. The LTC worker is responsible for review and approval of the DEA case manager's preliminary calculations of the cost effectiveness of Waiver services and the income to be applied to the cost of care. If approved, the LTC worker countersigns the CP-7A and sends it and the CP-5A to the individual. If corrections are needed, the LTC worker consults with the DEA Case Manager to make the necessary changes prior to notifying the individual.

### **Allocation of Income to Cost of Care**

REV: 12/2000

All individuals receiving services under this waiver program are subject to the post-eligibility treatment of income and allocation of income to cost of waiver services. This includes those individuals receiving the enhanced SSI payment for Residential Care/Assisted Living, providing however that no part of the SSI Federal Benefit Rate (FBR) is allocated to the cost of waiver services.

The individual's income is allocated toward the cost of waiver services as follows:

**FOR A SINGLE INDIVIDUAL**

From the full gross income of a single individual the following amounts are deducted in the following order:

- **Personal/Maintenance Needs Allowance**

An amount equal to the facility's charge for room and board plus a \$100 personal needs allowance, the combined total not to exceed the SSI standard for an individual in residential care/assisted living (See Section 0402.05).

The individual is allowed to retain \$100 for personal needs, and is then responsible for paying the facility's charge for room and board.

- **Medical Insurance Premium**
- **Allowable Costs Incurred for Medical or Remedial Care FOR AN INDIVIDUAL WITH A COMMUNITY SPOUSE AND/OR DEPENDENTS**

From the gross income of the individual the following amounts are deducted in the following order:

- **Maintenance Needs Allowance** - as above
- **Spouse/Dependent Allowance**

An amount of income may be allocated for the support of the community spouse in accordance with policy contained in 0392.15.20 - 0392.15.20.10. The community spouse may reside either with the individual in the assisted living unit or in the community.

An additional amount of income may be allocated for support of other dependent family members who live with the community spouse following provisions contained in 0392.15.25.

When there is no community spouse, an amount of income may be allocated for the support of dependent family members in accordance with Section 0392.15.25.05.

- **Medical Insurance Premium**
- **Allowable Costs Incurred for Medical or Remedial Care**

Any balance of income remaining after these expenses are deducted is allocated toward the cost of the waiver services. Note that the individual is responsible for paying the facility's charge for room and board.

### **0398.35.05 Habilitative Waiver Program**

REV: 05/2002

The Department of Human Services received permission from the Centers for Medicare and Medicaid Services (CMS, formerly known as HCFA) to administer a home and community based waiver for up to twenty-five individuals who require daily habilitative and/or ongoing skilled nursing services to a degree that would be otherwise provided in a hospital, and who do not qualify for the home and community based waiver for people with Developmental Disabilities.

The purpose of the Habilitative Waiver is to provide intensive home and community-based services to eligible elderly and disabled adults residing in a community setting as an alternative to

hospital care at a cost that is equal to or less than the cost of institutional care. For purposes of this waiver, hospital level of care is defined as a need for daily habilitative and/or ongoing skilled nursing services that cannot be adequately and/or appropriately provided in a nursing facility. The services of this program supplement the existing scope of services already provided by Medical Assistance, Medicare and other programs and services.

### **Target Population**

REV: 05/2002

The program is designed to assist individuals age eighteen (18) and older who:

- meet the MA requirement for disability or age (65 or older);
- meet the categorically needy or medically needy MA eligibility requirements for an institutionalized individual;
- require the level of care provided in a hospital; and
- do not meet developmental disability criteria. For purposes of this policy section, an individual is considered to meet developmental disability criteria if found to be developmentally disabled prior to age twenty-one (21) by the RI Department of Mental Health Retardation and Hospitals (MHRH) pursuant to R.I.G.L. 40.1-21-6.1.

### **Waiver Services**

REV: 05/2002

In addition to the full scope of services provided to the Categorically Needy or Medically Needy, as appropriate, the following special services are available under the waiver:

- **Case Management Services**

Provided by PARI Independent Living Center, these services are any that assist individuals in gaining access to needed waiver, MA, and any necessary medical, social, or educational services. Case managers initiate and oversee the process of assessment and reassessment of the individual's level of care, and development and review of plans of care. The Center for Adult Health is responsible for approving all levels of care and plans of care. The case manager is responsible for monitoring provision of services and appropriateness of approved plans of care, and submitting revisions, as needed to the Center for Adult Health.

- **Residential Habilitation**

Assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Residential Habilitation does not include the costs of room and board. Residential Habilitation Providers must be licensed with the Department of Mental Health, Retardation and Hospitals to be qualified to provide residential habilitation services under this waiver program.

- **Day Habilitation**

Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which take place in a non-residential setting, separate from the home or facility in which the individual resides. Day Habilitation Providers must be licensed with the Department of MHRH to be qualified to provide day habilitation services under this waiver program.

- **Supported Employment Services**

Paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Any person using this waiver service must be ineligible for an equivalent service funded by the DHS Office of Rehabilitation Services.

- **Environmental Accessibility Adaptations**

Physical adaptations to the home, required by the individual's plan of care, which are required to ensure the health, welfare and safety of the individual, or which enable the individual to function more independently within the home, and without which, the individual would require institutionalization. Environmental Accessibility Adaptations are subject to approval for medical necessity by the Center for Adult Health.

- **Specialized Medical Equipment and Supplies**

Specialized medical equipment and supplies include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Specialized medical equipment and supplies are subject to approval for medical necessity by the Center for Adult Health.

- **Personal Emergency Response Systems (PERS)**

PERS is an electronic device, which enables individuals to secure help in an emergency. PERS services are restricted to individuals who live alone, or are alone for significant parts of the day, and have no regular care giver for extended periods of time, and who would otherwise require extensive routine supervision. Individuals can only receive this service from Center for Adult Health qualified PERS providers.

- **Private Duty Nursing**

Individual and continuous care provided by licensed nurses (Registered Nurses and/or Licensed Practical Nurses) with Physician orders within the scope of Rhode Island licensing guidelines. These services are provided only in an individual's home by Home Care or Home Nursing Care Agencies licensed with the RI Department of Health.

- **Rehabilitation Services**

Physical, Occupational, and Speech Therapy services may be provided with a physician's

orders by Rhode Island Department of Health licensed Outpatient Rehabilitation Centers. These services supplement Home Health and Outpatient Hospital Clinic rehabilitation services already available under the Rhode Island State Plan when the individual requires a specialized rehabilitation service not available from a Home Health or Outpatient Hospital provider. The Center for Adult Health will approve rehabilitation services under the waiver as part of the plan of care.

## **DHS Responsibilities**

REV: 05/2002

The DHS Long Term Care (LTC) Unit is responsible for determining MA eligibility and approving the amount of the recipient's income to be allocated to the cost of care. These determinations are communicated to the recipients and Case Managers at PARI.

The DHS Center for Adult Health has the responsibility for reviewing and approving level of care assessments and plans of care completed by PARI.

Specific DHS responsibilities related to the waiver are:

### **o DETERMINATION OF ELIGIBILITY FOR MEDICAL ASSISTANCE**

LTC workers have responsibility for processing applications forwarded by PARI and for determining eligibility for waiver services both for new MA applicants and current SSI or MA-only recipients.

A new DHS-2 is not required if one was completed within the past twelve (12) months, and the individual is within a current certification period. In this case, the current case file is used, together with documentation of any new or additional information (e.g., information relating to transfers of assets) needed to determine eligibility for the program.

Eligibility determinations for applicants of the Waiver Program are conducted as if the applicant were institutionalized. Any transfers of assets must be evaluated in accordance with policy contained in Section 0384. A recipient who meets the technical and characteristic requirements, has resources within the Categorically Needy limits and income under the Federal Cap (see section 0386.05), is certified as Categorically Needy. Individuals are certified as low income (equivalent to categorically needy) when income is at or below one hundred percent (100%) of the federal poverty level and resources are within the Medically Needy resource limits. If the individual's resources are within the Medically Needy resource limit, s/he may be Medically Needy if resources are within the Medically Needy resource limits, and monthly income is less than the cost of all medical services.

### **o REDETERMINATION OF ELIGIBILITY**

The LTC unit conducts redeterminations of eligibility in the normal manner each year, unless a change is anticipated sooner.

### **o MAINTENANCE OF THE DHS CASE FILE**

The DHS InRhodes and paper case files are the MA eligibility record. Case files are maintained in the LTC office and contain all documents relating to the determination of financial eligibility and income allocated to the cost of care. In addition, the CP-1 and plan of care received via the Center for Adult Health, and copies of the CP-40's, the CP-12, and notices to recipients are retained in case files.

○ **ALLOCATION OF INCOME TO THE COST OF WAIVER SERVICES**

Neither the SSI payment itself nor any of the other income of an SSI recipient (or former SSI recipients who are Categorically Needy under 1619(b) of the Social Security Act) may be allocated to offset the cost of Waiver services. For other recipients of Waiver services, once eligibility is determined, the recipient's income is reviewed to determine the monthly amount, if any, the recipient must pay toward the cost of Waiver services.

The LTC worker is responsible for reviewing and approving the calculation of the individual's income to be applied to the cost of care.

○ **APPROVING LEVELS OF CARE AND PLANS OF CARE**

The Center for Adult Health will review and approve all Levels of Care and Plans of Care prior to the Plans of Care being implemented. In the event of an urgent situation, the Center can give a verbal authorization.

○ **CALCULATING AGGREGATE COST NEUTRALITY**

The Center for Adult Health will review and assure aggregate cost neutrality on an annual basis.

**PARI Responsibilities**

REV: 05/2002

The case management function rests with PARI. The case management function does not include any determination of MA eligibility or post eligibility treatment of income.

Specific PARI responsibilities are:

● **POINT OF ENTRY IDENTIFICATION**

PARI staff takes referrals and identifies potential candidates in the target population to assure that the essential program criteria are met. The PARI Case Manager evaluates the abilities and needs of the candidate and works with the individual to develop a comprehensive plan of care that assures the candidate's needs are met. The PARI Case Manager is responsible for submitting the Plan of Care to the Center for Adult Health Office for approval.

○ **ASSESSING NEED FOR HOSPITAL LEVEL OF CARE**

The case manager at PARI has responsibility for evaluating the applicant's need for a level of care provided in a hospital. If the evaluation indicates the individual requires hospital level care, the Case

Manager completes form CP-1 and forwards it to the Center for Adult Health. Records of evaluations and reevaluations of level of care are maintained by case managers at PARI and at DHS.

When an individual is determined to be likely to require a hospital level of care, the individual is informed of any feasible alternatives available under this waiver, and given the choice of either institutional or home and community based services.

○ **CONFIRMING MA ELIGIBILITY STATUS**

Prior to providing services under the waiver program, and at each reassessment, the Case Manager must confirm that the candidate is eligible for the waiver.

○ **CASE MANAGEMENT**

The Case Manager is the "hub" of all assessments and services to the individual. The PARI staff person is responsible for the development and implementation of approved plans of care and subsequently monitors the provision of services to assure that individual needs are met. The monitoring assures that the health and welfare of the recipient is protected. The case manager will meet with the individual at least one time each quarter to monitor provision of services.

Specifically, the Case Manager will:

- 1 . Develop and update an individual plan of care. The Case Manager evaluates the candidate's needs in order to reside in the community, designs a plan of care with the candidate that addresses these unmet needs. The plan of care will specify the provider, goals, amount, and duration of any waiver service to be provided. The plans of care must be submitted to and approved by the Center for Adult Health prior to implementation. Copies of the plans of care must be retained by case managers for a period of at least three (3) years.
- 2 . Notify the Center for Adult Health of cases whose plans of care could exceed cost neutrality;
- 3 . Apprise each individual in writing of the availability of services in either an institutional setting or in a community-based setting under the waiver. The individual's choice is recorded on the CP-12A, signed and forwarded to the LTC for filing in the MA record;
- 4 . Arrange authorized services;
- 5 . Reassess the individual's need for hospital level care at least every twelve months;
- 6 . Coordinate with the individual, LTC/AS, and providers of services the allocation of the individual's income to be applied to the cost of Waiver services.