Application

Application of this Medical Policy applies to:
INTEGRITY for Duals (FIDE)
Application Excluded for:
RIte Care (MED), Rhody Health Partners (RHP), Rhody Health Expansion (RHE), Children with Special Health Care Needs (CSN), Substitute Care (SUB), Extended Family Planning (EFP), Commercial (HBE), Duals CONNECT (CO-DSNP)

Medicare Distinction

For INTEGRITY for Duals (FIDE) and Duals CONNECT (CO-DSNP) members: Neighborhood Health Plan of Rhode Island (Neighborhood) uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations, including medical necessity. Coverage determinations are based on applicable payment policies, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs), and other available CMS published guidance.

In the absence of an applicable or incomplete NCD, LCD, or other Medicare guidelines, then Neighborhood will apply coverage guidance from other widely used treatment guidelines with peer-reviewed scientific evidence, such as InterQual® and/or internal Clinical Medical Policies.

Description

Adult members may qualify for a Home and Community Based Waiver program through Rhode Island Medicaid (Medicaid). Home and Community Based Services (HCBS) are types of person-centered care delivered in the home and community. HCBS addresses the needs of people with functional limitations who need assistance with everyday activities and enable people to stay in their homes, rather than moving to a facility for care. Medicaid covers an array of Long-Term Services and Supports (LTSS) for adults eligible for HCBS. To be eligible for LTSS-HCBS, an individual must meet Medicaid LTSS eligibility requirements for specific programs and have at least a high level of care need for these services. LTSS eligibility is determined by Rhode Island Medicaid, not Neighborhood.

Covered services must be medically necessary, related to assessed needs, included in the person-centered plan of care, and provided in accordance with applicable program rules.

This policy establishes coverage criteria for Medicaid LTSS-HCBS delivered through two service models: the Personal Choice Program and Shared Living (RIte@Home) Program.

Contents of this policy:

Definitions

Activities of Daily Living (ADL)	Everyday routines generally involving functional mobility and personal care, including but not limited to, bathing, dressing, eating, toileting, mobility, and transfer. **This may also be referred to as personal care.**
Assessment	A meeting with the member, and their representative (if applicable) to evaluate ADLs and IADLs to determine the amount and scope of services needed. Assessments also help to identify services, equipment, home modifications, and other supports in the community that may help the member to increase their independence within the community.
Budget	The amount of Medicaid funds set aside each month for the member's personal care and homemaker services. The budget is based on the amount of assistance the member requires to meet their personal care needs as determined by the functional assessment. The budget is based on what Executive Office of Health and Human Services (EOHHS) would normally spend to purchase services from a Home Health Agency for the services necessary to allow a member to live at home.
Conviction	Per Rhode Island General Law 42-7.2-18.4, conviction means, in addition to judgments of conviction entered by a court subsequent to a finding of guilty or a plea of guilty, those instances where the defendant has entered a plea of nolo contendere and has received a sentence of probation and those instances where a defendant has entered into a deferred sentence agreement with the attorney general.

Fiscal Intermediary Services	Financial management services delivered to Personal Choice participants by an EOHHS certified Fiscal Intermediary (FI). 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 care attendants (PCAs) 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.
Instrumental Activities of Daily Living (IADL)	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. **This may also be referred to as homemaking or chore services.**
Level of Care	The amount of services and supports necessary to meet a person's needs. When associated with a licensed health care institution, the term refers to the set of services and supports the institution is authorized and typically provides to people with a specific range of needs.
Member Directed Goods and Services	Services, equipment, or supplies not otherwise provided through Medicare or Medicaid, that address an identified need and are approved in the Individual Service and Spending Plan (ISSP) (including improving and maintaining the individual's opportunities for full membership in the community). 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 their disability.
Personal Care Attendant (PCA)	A person who provides personal care services to the member. Certain people are not allowed to be the Personal care attendant including the following; a spouse, legal guardians, financial power of attorneys, and individuals with certain criminal convictions.
Personal Care Services	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. 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: • Member assistance with activities of daily living, such as grooming, personal hygiene, toileting, bathing, and dressing; • Assistance with monitoring health status and physical condition; • Assistance with preparation and eating of meals (not the cost of the meals itself);

	• Assistance with housekeeping activities (bed making, dusting, vacuuming, laundry, grocery shopping, cleaning); • Assistance with transferring; ambulation; use of special mobility devices; assisting the member by directly providing or arranging transportation.
Representative	A person designated by the member to assist them in managing some or all of the requirements of the Personal Choice 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.
Service Advisement Services	An advisement team consisting of the Service Advisor, a RN, and a Mobility Specialist whose focus is on empowering members to define and direct their own personal assistance needs and services. The Service Advisor guides and supports, rather than directs and manages the member through the service planning and delivery process. A portion of the member's monthly budget is set aside to pay the agency for the services it provides.

Personal Choice Program

The Personal Choice Program is a home and community-based, member-directed service model for individuals eligible for Long-Term Services and Supports. The program allows members to exercise choice and control over personal care services and a member-directed budget. Members may hire, supervise, manage, and dismiss individuals who provide personal care, consistent with program requirements. Members may also select a service advisement agency and fiscal agent, as appropriate, to support informed decision-making, budget management, and program administration.

Coverage Determination

Basic eligibility criteria for the Personal Choice program include, but are not limited to:

- A disability affecting either cognitive or physical capacity to complete ADL's/IADL's in a safe or timely manner.
- Eligible for Medical Assistance through the Medicaid Long Term Care eligibility rules.
- Meet either a high or highest level of care as determined by the Medicaid Office of Medical Review.
- Possesses the ability to self-direct and manage all aspects of their personal care and community living needs.
- Requested services are included in the approved person-centered plan of care and service budget, when applicable.

Members must have an active, approved Personal Choice LTSS waiver from RI Medicaid to access any benefits and supports provided in this program.

When permitted by program rules and included in the approved plan of care or budget, covered supports in the Personal Choice Program may include:

- Self-directed personal care services
- Member-directed goods and services
- Service advisement
- Fiscal support
- Budget management assistance
- Payroll-related support
- Caregiver-related administrative activities

All requested services and/or items must be covered, reasonable, necessary, safe, and non-duplicative.

Continued program eligibility requires documentation demonstrating that the member remains eligible for Medicaid LTSS, continues to meet the required level of care, has ongoing assessed service needs, and satisfies all requirements of the selected program.

The plan of care, service schedule, and budget (when applicable) must be reviewed and updated whenever there are changes in the member's condition, living environment, caregiver availability, service utilization, or personal preferences to ensure services continue to meet the member's needs.

Personal Choice Budgets

The budget represents the amount of Medicaid funding available to a member to purchase services that support their personal care needs. It is based on the amount the Medicaid agency would typically pay a home health agency to provide the services necessary for the member to remain safely at home. The monthly budget amount is determined by the member's assessed need for personal care assistance. Currently, Personal Care Attendants (PCAs) are generally paid between $16 and $21 per hour.

The budget is calculated solely on the basis of assistance required with specific Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). The calculation considers both the level of assistance needed to complete each task and the time allotted for that task. Budget amounts are subject to change at the discretion of the Medicaid agency.

The Personal Choice Budget is used to cover the costs of:

- Personal Care Attendants (PCAs) wages - These are currently between $16 and $21 per hour.

- Member-directed goods and services
- Workers' compensation insurance
- Administrative costs of the Service Advisement Agency
- Administrative costs of the Fiscal Advisement Agency

An assessment of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) is conducted by the Medicaid Agency or its contracted agency to determine a member's support needs. ADLs include bathing, toileting, dressing, grooming, transfers, mobility, skin care, and eating. IADLs include communication, shopping, housework, meal preparation, and other covered household supports necessary to maintain the member's health, safety, and ability to remain in the community.

Members are not assessed for general supervision, watching, or companionship as these services are not covered under the Personal Choice Program.

There are six (6) levels of assistance for each activity (refer to chart below). In addition to medical information and self-reporting, the assessor may observe or request the member to demonstrate their ability to complete a task. The member may direct the assessor to obtain information from friends/family who are aware of the member's abilities. Information for the assessment should not be obtained from the personal care attendant.

Assistance Level	Description
Independent	Member is independent in completing the task safely.
Set-Up	Member requires brief supervision, cueing, reminder, and/or set-up assistance to perform the task.
Minimum	Member is actively involved in the activity and requires some hands-on assistance for completion, thoroughness, or safety. Needs verbal or physical assistance with 25% of the task.
Moderate	Member requires extensive hands-on assistance but is able to assist in the process. Needs verbal or physical assistance with 50% of the task.
Extensive	Member requires verbal or physical assistance with 75% of the task.
Total Assistance	Member cannot participate or assist in the activity and requires 100% assistance with the task.
Not Applicable	This task does not apply to this member.

Based on the assessment findings, a monthly Personal Choice budget is developed according to the amount and level of assistance needed, the frequency of required tasks, and any secondary conditions that may increase the time necessary to complete those tasks. Homemaker and chore

services may be included when they are necessary to support the member's health, safety, and continued community living and are authorized in the approved plan of care.

Additional time may be authorized when a member has conditions or characteristics that directly affect their ability to complete a specific task, such as:

- Balance problems
- Behavioral issues
- Cognitive deficits
- Decreased endurance
- Open wounds
- Pain
- Seizures
- Fine motor limitations
- Shortness of breath
- Spasticity
- Oxygen use
- Hearing or vision impairment
- Living alone
- Limited range of motion

The Service Advisor also considers support provided by unpaid formal or informal caregivers when determining service needs. For example, if a spouse routinely prepares meals for the household, that support is expected to continue for the member. Requests for personal care assistance beyond typical frequencies must be supported by documented medical need. For instance, additional bathing assistance may be authorized for a member with incontinence when medically necessary; otherwise, standard bathing frequency is generally considered sufficient.

Process Used to Determine Monthly Budget

Each ADL and IADL has an amount of time allowed to complete the task.

- Unit Time = The amount of time (in minutes) allowed to complete the task if the member is unable to participate and requires total assistance with the task.
- Functional Time = The amount of time (in minutes) allowed to complete the task if the member is unable to participate and requires total assistance with the task and certain conditions or characteristics are present. Those characteristics are listed in functional characteristics table below.

Activity	Unit Time	Functional Time	Functional Characteristics
Sponge Bath	30	45	Behavioral Issues, Limited ROM, Spasticity/Muscle Tone
Shower	20	40	Balance Problems, Behavioral Issues, Limited ROM, Spasticity/Muscle Tone
Tub Bath	40	45	Balance Problems, Behavioral Issues, Limited ROM, Spasticity/Muscle Tone
Dressing	15	20	Behavioral Issues, Limited ROM, Spasticity/Muscle Tone
Eating	20	40	Behavioral Issues, Fine Motor Deficits, Spasticity/Muscle Tone
Mobility	10	10	Balance Problems, Decreased Endurance, Pain, Spasticity/Tone
Urinary/Menses	10	15	Behavioral Issues, Limited ROM, Spasticity/Muscle Tone
Transfers	5	10	Balance Problems, Limited ROM, Spasticity/Muscle Tone

Grooming	8	8	Cognitive, Limited ROM, Spasticity/Muscle Tone
Skincare	10	10	Open Wound
Bowel	30	50	Behavioral Issues, Limited ROM, Spasticity/Muscle Tone
Meal Preparation	25	25	No Functional Characteristics
Housework	12.5	25	Member Lives Alone
Communications	15	15	No Functional Characteristics
Shopping	60	60	No Functional Characteristics
Medications	2	5	No Functional Characteristics

A member's **Level of Assistance** determines the amount of time allowed for hands-on support or supervision for each task. The time assigned to each task is calculated by multiplying the **Unit Time (or Functional Time, if applicable)** by the applicable **Level of Assistance Multiplier**. The **multipliers** are as follows:

Level of Assistance	Total	Maximum	Moderate	Minimum	Set-Up	Independent
Sponge Bath	1	.75	.5	.25	.15	0
Shower	1	.75	.5	.25	.15	0
Tub Bath	1	.75	.5	.25	.15	0
Dressing	1	.75	.5	.25	.15	0
Eating	1	.75	.5	.25	.15	0
Mobility	1	1	.75	.75	.2	0
Urinary/Menses	1	.75	.5	.25	.15	0
Transfers	1	1	.75	.75	.2	0
Grooming	1	.75	.5	.25	.15	0
Skincare	1	1	.75	.75	.2	0
Bowel	1	.75	.5	.25	.15	0
Meal Preparation	1	1	.75	.5	.25	0
Housework	1	1	.75	.5	.25	0
Communications	1	1	.75	.5	.25	0
Shopping	1	1	1	1	1	0

Example #1: Mrs. M. requires an extensive level of assist in dressing and does not have any functional characteristics.

- Time Allowed: 15 minutes x .75 (multiplier) = 11.25 minutes per occurrence
- 11.25 X 2 (per day) = 22.5 min/day x 7 (days/week) = 157.50 (min/week)
- 157.50 x 4.333 (weeks/month) = 682.44 (min/month) divided by 60 (min) = 11.37 hours per month are required for assistance in dressing

11.37 x $17.17 (The dollar amount per hour used in Personal Choice to calculate budget which is based on current reimbursement rates for Certified Nursing Assistants minus a 15% discount.) = $195.31 per month for dressing.

Example #2: Mr. O requires total assistance with eating and also has a functional characteristic.

- Time Allowed: 40 minutes x 1 (multiplier) = 40 minutes per occurrence
- 40 x 3 (per day) = 120 min/day x 7 (days/week) = 840 (min/week)
- 840 x 4.333 (weeks/month) = 3639.72 (min/month) divided by 60 (min) = 60.66 hours per month are required for assistance in eating.
- 60.66 X $17.17 = $1,041.53 per month for eating

Example #3: Ms. A requires set-up assistance with her shower and has no functional characteristics.

- Time Allowed: 20 minutes x .15 = 3 minutes per occurrence
- 3 x 1 (per day) = 3 min/day x 7 (days/week) = 21 (min/week)
- 21 x 4.333 (weeks/month) = 90.99 (min/month) divided by 60 (min) = 1.52 hours per month are required for assistance in showering.
- 1.52 x $17.17 = $26.10 per month for showering

The time allowed for all ADLs and IADLs is calculated using this method. The monthly totals for each ADL and IADL are then added together to establish the member's monthly budget.

Because the Personal Choice Program is a self-directed program, deductions are made from the monthly budget to cover workers' compensation insurance and administrative costs. These deduction amounts are subject to change annually in accordance with federal and state regulations and guidelines.

NOTE: A PCA cannot be paid for duties that require a professional license.

Member Directed Goods and Services

A member may also set aside a specified amount of their budget each month to purchase services, equipment and supplies. There is not a specific list of allowable goods/services, as what may be beneficial to one member may not be of any assistance to another. The goods or services must meet a specific goal, help in promoting independence, and meet the below criteria:

1. Not be provided through their Medicaid coverage; AND
2. Address an identified need; AND

3. Be included in the approved Individual Service and Spending Plan (ISSP), AND
4. Meet the following requirements:
   - Alternative funding sources are not available, AND
   - The item or service would decrease the need for other Medicaid services; and/or
   - The item or service would promote inclusion in the community; and/or
   - The item or service would increase the member's ability to perform ADLs/IADLs; and/or
   - The item or service would increase the person's safety in the home environment.

Items purchased whose goal is to lessen the need for assistance from a caregiver will result in a redetermination of need for caregiver assistance. If the above criteria are met, a request for member-directed goods and services must be completed by the service advisor and sent to the Office of Community Services and Supports for review and disposition.

Personal Choice Program Limitations and Exclusions:

1. Budgets allowing for general supervision, watching, or companionship when no covered hands-on assistance or covered cueing/supervision need is identified as these services are not covered under the Personal Choice Program.
2. No more than ten percent (10%) of a member's monthly budget may be set aside for goods and services, so that the member continues to receive personal care services that provide for their health, welfare, and safety.
3. Member Directed Good and Services:
   - Some items or services that are medical in nature require a physician's order.
   - Items must be necessary to ensure the health, welfare and safety of the member, or must enable the member to function with greater independence in the home or community, and to avoid institutionalization.
   - Items cannot be restrictive to the member or strictly experimental in nature.
   - Items for entertainment purposes are not covered.
   - Items cannot duplicate equipment provided under Medicaid-funded primary and acute care system or through other sources of funding (i.e. Medicare, private insurance, or free services from community organizations).
   - The Personal Choice budget MAY NOT be used to purchase or fund:
     - Gifts for workers, family, or friends
     - Loans to workers
     - Rent or mortgage payments
     - Lottery tickets
     - Clothing
     - Payments to be your Representative
     - Alcoholic beverages
     - Tobacco/Nicotine products
     - Entertainment activities
     - Cell phones

- Groceries
- Housing/Utility expenses
- Televisions, stereos, radios, DVD players, GPS systems, electronic game systems, e-readers, etc.
- Services which will meet your needs and are available without charge from community organizations
- Items covered by another insurance agency or through Medicaid outside of the budget

4. See the **General Limitations and Exclusions** section of this policy.

Shared Living (RIte@Home) Program

Shared Living (RIte@Home) is a home-like service model for members who cannot live independently without considerable assistance and whose needs can be safely supported by a trained caregiver with agency oversight. Shared Living focuses on daily support, supervision, caregiver assistance, and monitoring within the approved plan of care.

There are two components to understanding Shared Living:

1. The Shared Living agency and
2. The caregiver and the host home

The **Shared Living Agency** assists members who need care in identifying and securing an appropriate host home and caregiver. The caregiver may be someone the member already knows and trusts, such as a family member, friend, or neighbor. When needed, the agency can also help match the member with a qualified caregiver. In addition, the Shared Living Agency ensures that caregivers receive the necessary training, guidance, and ongoing support to provide quality care. The Shared Living Agency will:

- ✓ Oversee and monitor services
- ✓ Provide training for the caregiver
- ✓ Ensure the safety of the host home
- ✓ Provide nursing services as needed
- ✓ Develop an individualized Shared Living Service and Safety Plan

The Caregiver /Host Home: In most cases, the caregiver lives in their own home and agrees to provide a shared living arrangement by welcoming the member into their residence. In certain situations, the caregiver may instead move into the member's home to provide support. Regardless of the living arrangement, the caregiver is responsible for providing assistance, supervision, and support based on the member's assessed needs and individualized care plan. The caregiver is responsible for:

- Being on call 24/7
- Transportation
- Chore/Homemaker services
- Providing socialization and a home-like environment

- Meals
- Personal care, including assistance with Activities of Daily Living (ADLs)

Benefits for the Caregiver include:
- A stipend for providing 24/7 care
- Respite or time off from full-time care

Neighborhood pays the Shared Living agency for its role and provides funding for caregiver stipends. However, Neighborhood does not pay for room and board. Room and board is typically paid from the client's SSI and/or Social Security check.

Coverage Determination

Basic eligibility criteria for the Shared Living program include, but are not limited to:

- Member cannot live independently without considerable assistance with activities of daily living, such as eating, dressing, and personal hygiene, etc.
- Member requires substantial assistance with ADLs, supervision, or daily routines.
- Member's needs can be safely supported in a home-like setting with a trained caregiver and agency oversight.
- Caregiver meets program requirements, including age, relationship, background check, training, and monitoring standards as applicable.

Members must have an active, approved Shared Living LTSS waiver from RI Medicaid to access any benefits and supports provided in this program.

When permitted by program rules and included in the approved plan of care or budget, covered supports in the Shared Living Program may include:

- Caregiver support
- Training
- Monitoring
- Homemaker services
- Transportation
- Medication reminders
- Nursing support when applicable
- Other services authorized in the plan of care

Continued program eligibility requires documentation demonstrating that the member remains eligible for Medicaid LTSS, continues to meet the required level of care, has ongoing assessed service needs, and satisfies all requirements of the selected program.

The plan of care must be reviewed and updated whenever there are changes in the member's condition, living environment, caregiver availability, service utilization, or personal preferences to ensure services continue to meet the member's needs.

Caregiver Stipend

Caregivers in the Shared Living Program receive a daily stipend for the care they provider to the member. The amount of the stipend is directly related to the member's level of care. An assessment is completed to determine whether the member's needs qualify for High Level of Care (High Need) or Highest Level of Care (Highest Need).

- **Highest Need**
  Highest level of care is appropriate if the member's needs-based assessment indicates that they:
  1. Require extensive assistance or total dependence with at least one of the following Activities of Daily Living (ADL): toileting, bed mobility, eating, or transferring **AND** require at least limited assistance with any other ADL; **OR**
  2. Have one (1) or more unstable medical, behavioral, cognitive, psychiatric or chronic recurring conditions requiring nursing assistance, care and supervision daily; **OR**
  3. Lack awareness of needs or has moderate impairment with decision-making skills **AND** has one of the following symptoms /conditions, which occurs frequently and is not easily altered: wandering, verbally aggressive behavior, resists care, physically aggressive behavior, or behavioral symptoms requiring extensive supervision; **OR**
  4. Require skilled nursing assessment, monitoring, and care daily for at least one of the following conditions or treatments: Stage 3 or 4 skin ulcers, ventilator, respirator, IV medications, naso-gastric tube feeding, end stage disease, parenteral feedings, 2nd or 3rd degree burns, suctioning, or gait evaluation and training; **OR**
  5. Require skilled nursing assessment, monitoring, and care on a daily basis for one or more unstable medical, behavioral or psychiatric conditions or chronic or reoccurring conditions related, but not limited to, at least one of the following: dehydration, internal bleeding, aphasia, transfusions, vomiting, wound care, quadriplegia, aspirations, chemotherapy, oxygen, septicemia, pneumonia, cerebral palsy, dialysis, respiratory therapy, multiple sclerosis, open lesions, tracheotomy, radiation therapy, gastric tube feeding, behavioral or psychiatric conditions that prevent recovery; **OR**
  6. Have a critical need for long-term care services due to special circumstances that, if excluded from highest level of care, may adversely affect the member's health and safety and be related to one of the following:
     a. Loss of primary caregiver, due to hospitalization, debilitating illness, or death of a spouse, caretaker sibling, or adult child;
     b. Loss of living situation, due to a fire, flood, foreclosure, or sale of principal residence as the result of the inability to afford to maintain housing;

c. A principal treating health care practitioner, or prior to ending an acute care hospital stay, a discharge planner indicates, based on a functional/clinical assessment, that the health and welfare of the applicant/beneficiary is at imminent risk if services are not provided or if services are discontinued;
d. The member met the highest NF level of care criteria on or before June 30, 2015 and chose to receive Medicaid LTSS at home or in a community-setting and the beneficiary reports he or she has experienced a failed placement that, if continued, may pose health or safety risks; or
e. The member was admitted to a hospital from a NF and is being discharged to the same or another NF upon discharge within any given forty (40) day period.

❖ **High Need**

High level of care is appropriate if the member's needs-based assessment indicates that they:

1. Require at least limited assistance on a daily basis with at least two of the following ADL's: bathing/personal hygiene, dressing, eating, toilet use, walking or transferring; **OR**
2. Require skilled teaching or rehabilitation on a daily basis to regain functional ability in at least one of the following: gait training, speech, range of motion, bowel or bladder control; **OR**
3. Have impaired decision-making skills requiring constant or frequent direction to perform at least one of the following: bathing, dressing, eating, toilet use, transferring or personal hygiene; **OR**
4. Exhibit a need for a structured therapeutic environment, supportive interventions and/or medical management to maintain health and safety.

Personal Choice and Shared Living Screening Qualifications

All Shared Living caregivers, and Person Choice Representative and PCAs must submit to a National Criminal Background Check and a RI Bureau of Criminal Identification (BCI) screening prior to being allowed to provide assistance to a program member. In order to act as a member's Personal Choice representative and/or be compensated as a program caregiver or PCA, the individual:

1. Must be at least 18 years old; **AND**
2. Must be authorized to work in the United States; **AND**
3. Must not have a disqualifying conviction. In accordance with Rhode Island General Law (RIGL) 42-7.2-18.4, the following Federal and/or State convictions disqualify a caregiver or PCA from providing care or assistance to the member:

- Murder
- First, Second, or Third Degree Sexual Assault

- Patient abuse
- Robbery
- Burglary
- First-degree arson
- Exploitation of elders
- Felony Assault
- Felony larceny
- Felony drug offenses
- Assault on Persons sixty (60) years of age or older
- Felony obtaining money under false pretenses
- Neglect or mistreatment of patients
- Felony conviction relating to health care fraud
- Abuse, neglect and/or exploitation of adults with severe impairment
- Voluntary or Involuntary Manslaughter
- Felony banking violations
- Felony embezzlement
- Assault with intent to commit specified felonies (murder, robbery rape, burglary or the abominable and detestable crime against nature)
- Conviction of program-related crimes - Any individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under title XVIII or under any State health care program

AND

4. Must not have a recent conviction for the following crimes:
   - Prostitution
   - Theft
   - Drug Offenses
   - Driving While Impaired (DWI) (if providing transportation to member)

AND

5. Must not appear on the Rhode Island Department of Health Office of Health Professional Regulation Abuse Registry with a current disciplinary action in place; **AND**
6. Cannot also be the member's representative, spouse, financial power of attorney, or Social Security Representative Payee; **AND**
7. If approved to provide transportation for the member, must have a valid driver's license, liability coverage and provide their own vehicle.

Exceptions to requirements:

A member may request an exception for an individual whom:

- Does appear to have a prior criminal conviction, if it is not for one of the crimes listed in RIGL 42-7.2-18.4 (Number 2 above).
- Appears in the Abuse Registry as having a previous action taken against them but has had that action rescinded.

In either case, the member must sign a statement indicating that they are aware of the issue but choose to hire the person and are aware of the risks.

General Exclusions and Limitations

1. Services provided primarily for convenience, socialization, or respite unless specifically covered under applicable program rules.
2. Services that duplicate other Medicaid, Medicare, LTSS waiver, community, or informal supports.
3. Services that exceed the member's assessed need, authorized budget, approved service limits, or approved plan of care.
4. Services that cannot be safely provided in the home or community setting.
5. Member's representative, spouse, financial power of attorney, or Social Security Representative Payee cannot serve as the paid caregiver.
6. Neighborhood does not pay for room and board.
7. Costs associated with fulfilling qualification screenings, including but not limited to background screenings, are not covered.
8. Personal Choice and Shared Living programs funded through the Department of Behavioral Health Care, Developmental Disabilities and Hospitals (BHDDH) are not reimbursed by Neighborhood.
9. Caregivers and PCAs shall not perform functions that otherwise require a professional license, certification or registration by state law and shall not perform the following duties that include but are not limited to:
   - Sterile dressing application
   - Injections
   - Vaginal Irrigations
   - Cutting toenails
   - Oxygen application
   - Tracheostomy tube care
   - Gastric lavage or gavage, including any tube feeding
   - Cutting toenails or fingernails for diabetic
   - Giving advice on medical/nursing matters
   - Any treatment to non-intact skin
   - Administer medications

References

- Code of Federal Regulation 42 U.S.C. § 1320a-7(a).
- RIGL 42-7.2-18.3 Professional responsibility - Criminal records check for personal care aides.
- RIGL 42-7.2-18.4 Professional responsibility - Criminal records check disqualifying information for personal care aides.
- Rhode Island Code of Regulations (RICR), 210-RICR-50-10-2, Self-Directed Care.
- RICR 210-RICR-50-00-5, Medicaid Long-Term Services and Supports: Functional/Clinical Eligibility.
- RICR 216-RICR-40-05-22, Nursing Assistants, Medication Aides, and the Approval of Nursing Assistant and Medication Aide Training Programs.
- Rhode Island Executive Office of Health and Human Services, Personal Choice Program Provider Manual.
- Rhode Island Executive Office of Health and Human Services, Personal Choice Program Participant/Representative User Manual.

- Rhode Island Department of Human Services. Shared Living Fact Sheet. https://eohhs.ri.gov/media/33701/download?language=en
- Contract Agreement between the State of Rhode Island Executive Office of Health and Human Services and Neighborhood Health Plan of Rhode Island Medicaid Managed Care Fully Integrated Dual Special Needs Plan, Effective January 1, 2026.

CMP Number:	**#I-012**
CMP Cross Reference:	
Created:	**August 2026**
Annual Review Month:	**August**
Review Dates:	08/19/26
Revision Dates	
UMC Review Date:	08/19/26
Medical Director Approval Dates:	08/19/26
Effective Dates:	08/19/26

Neighborhood reviews clinical medical policies on an annual basis.

Disclaimer:

Neighborhood has developed medical policies to assist us in administering health benefits. This medical policy is made available to you for informational purposes only and does not constitute medical advice. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Members should always consult their physician before making any decisions about medical care. Treating providers are solely responsible for medical advice and treatment of members. Benefits and eligibility are determined by the member's coverage plan; a member's coverage plan will supersede the provisions of this medical policy. For information on member-specific benefits, call member services. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to review and revise this policy for any reason and at any time, with or without notice.