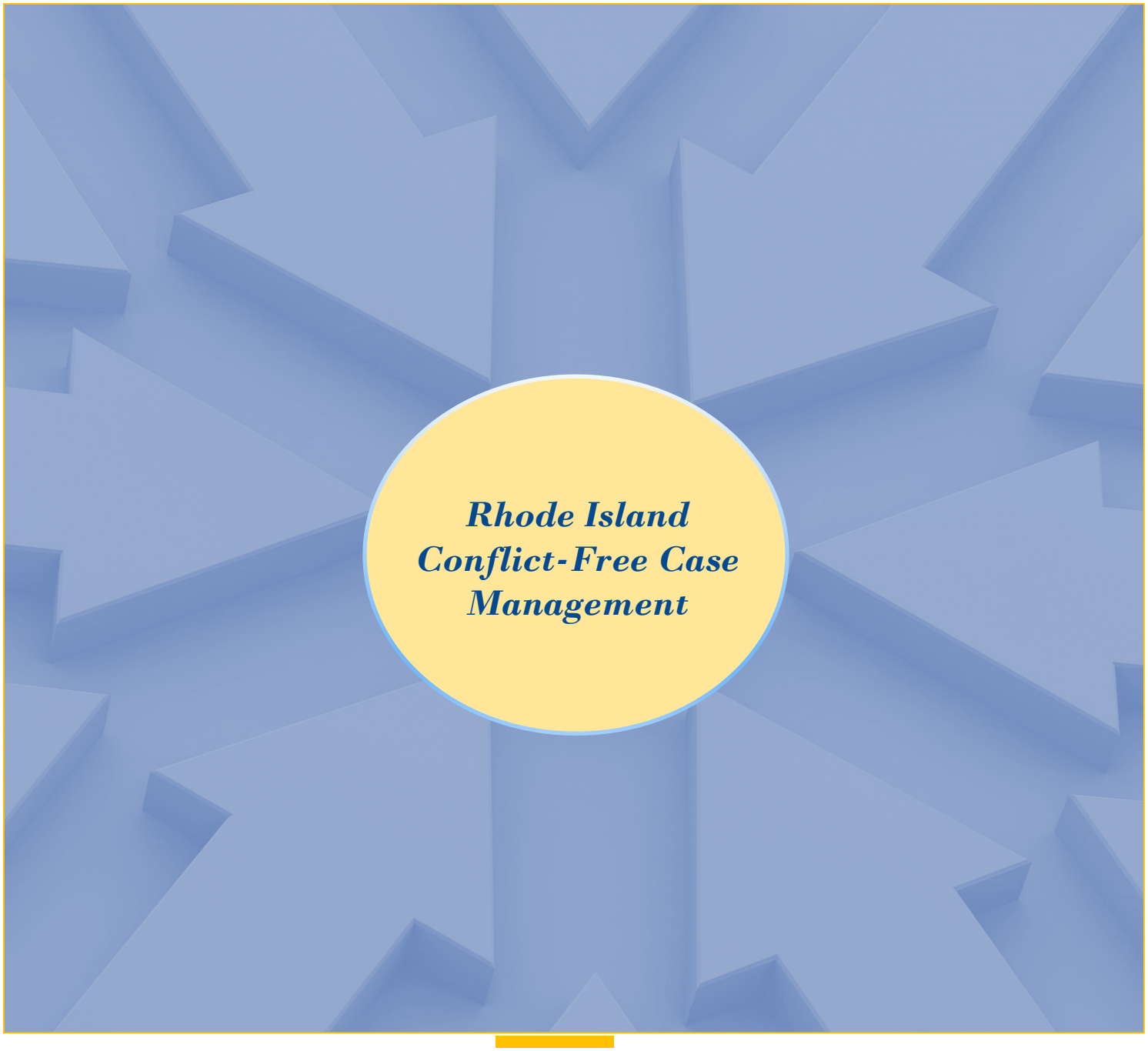


Title: Conflict-Free Case Management (CFCM) Strategic Plan – *Draft*

Prepared by: Rhode Island Executive Office of Health and Human Services (RI EOHHS)

Last Updated: 4/14/2023

The table below identifies key revisions from the State's initial CFCM Strategic Plan released in November 2022.

Revision Date	Section #	Description of Changes
4/14/23	Overall	• Modified the core components of CFCM, changed "comprehensive assessment" to "comprehensive review" • Updated language regarding the posting date of the RFI and RFP
4/14/23	2	• Added definitions for "Elders and Adults with Disabilities (EAD)" and "Participants with intellectual or developmental disabilities (I/DD)" • Updated the "assessment" definition • Clarified the "Key Distinction Between CFCM and HCBS Provider Support Coordination" under the definition "Support Coordination/Care Coordination"
4/14/23	3	• Under section 3.3: ○ Added information regarding factors impacting the State's implementation timeline ○ Updated the State's CFCM implementation timeline. Several dates were extended due to delays in posting the CFCM RFI and due to State activities related to unwinding and returning to regular operations after COVID-19.
4/14/23	5	• Under figure 6 (stakeholder impact): ○ Updated the impact description for "RI's Medicare-Medicaid Plan (MMP)" and "Integrated Health Home (IHH) Providers" ○ Moved PACE to a separate row
4/14/23	6	• Under section 6.1, updated language in paragraph #3 to provide additional rationale for why the state will require CFCM entities to have the capacity to serve all HCBS participants • Under section 6.2.2, clarified the HCBS participants excluded from this initiative • Under section 6.3, figure 8, clarified state agency staff and CF case managers roles regarding the functional needs assessment • Under section 6.5, added bullets #4-6 to further describe the WCMS functionality
4/14/23	7	• Under section 7.1, added bullet #3 to clarify the CF case manager's role in reviewing the initial functional needs assessment • Moved section 7.3.10 to 7.4.1 to clarify the "reassessment" process • Under section 7.4 (second paragraph), clarified language in the third bullet • Under section 7.5, figure 13 (minimum contract frequency), separated the initial and annual person-centered planning meetings
4/14/23	8	• Under section 8.1.2: ○ Updated bullet 2 regarding the business hour requirements ○ Clarified language for bullets #s 11 and 28 ○ Added bullets #s 12-18 • Under section 8.2.4, added training "functional needs assessment tools" • Under section 8.3, added that the CM entity is required to use the WCMS to track grievances and clarified other language throughout • Updated section 8.8
4/14/23	10	• Under section 10.1, clarified in the first paragraph that CFCM is a new service

Revision Date	Section #	Description of Changes
3/1/23	Overall	• Clarified language throughout based on stakeholder feedback • Removed the use of the term “discovery” • Renamed the CFCM component “Arranging for services & supports” to “Connecting to services & supports” • Renamed “Service Advisory Agencies” to “Service Advisement Agencies” • Renamed “Fiscal Intermediary” to “Self-Directed Fiscal Intermediary” • Renamed the CFCM component “Monitoring, reassessment & follow-up” to “Plan monitoring & follow-up” • Renamed “CFCM agency” to “CFCM entity” • Renamed “BHDDH Independent Plan Writers” to “Individual HCBS Participant Plan Writers” • Clarified role of the support broker. • Added the current number of HCBS participants eligible for CFCM by county and population • Updated the projected number of unique HCBS participants targeted to receive CFCM in 2024 • Removed Katie Beckett from this initiative since it will be handled separately • Revised certain section titles • Revised that the CFCM entity cost report is due at the end of calendar year 2024 and not “state fiscal year 2024”
3/1/23	1	Revised content throughout to align with two documents that were recently posted: 1) RI CFCM Stakeholder Feedback Dec. 2022 and 2) RI CFCM Decision Matrix Feb. 2023
3/1/23	2	• Added definitions “grievance”, “conflict of interest”, “developmental disability”, “disability”, "HCBS participant", “individual representative”, “integrated health home”, “long-term care ombudsperson program”, and “support coordination/care coordination” • Revised the “critical incident” definition
3/1/23	3	• Under section 3.1, added additional context and information • Under section 3.2, added goal #2.6 • Under section 3.3, updated the implementation timeline based on the State’s correction action plan with CMS
3/1/23	4	• Added sections 4.2 and 4.3 to provide additional background information • Under section 4.4, clarified language regarding the State’s quality strategy
3/1/23	5	• Separated sections 5.1 and 5.2 • Under section 5.1, updated the number of current HCBS participants and added a county map • Under 5.2, updated challenges to align with recent RI EOHHS presentations • Added section 5.3 • Under section 5.4, clarified impact across stakeholders
3/1/23	6	• Under section 6.1, clarified language and added additional context • Under section 6.2.1, clarified HCBS programs and populations that are included • Added section 6.2.2 to clarify which programs and populations are excluded from the CFCM initiative • Under section 6.2.4, removed requirement “Conflict-free case management agencies may not refuse any assigned or reassigned participant”

Revision Date	Section #	Description of Changes
		• Under section 6.3, clarified roles and responsibilities • Under section 6.4, updated the CFCM flowchart • Under section 6.5, added language to better describe the State's WellSky Case Management System (WCMS)
3/1/23	7	• Under section 7, added additional context and information • Under section 7.3, clarified CF case manager role regarding State evaluations • Added section 7.3.3 • Under section 7.3.4, clarified role of the conflict-free case manager regarding application assistance and referrals • Under section 7.3.5, clarified role of the conflict-free case manager regarding self-direction • Under section 7.3.8, clarified the service authorization process • Under section 7.3.9, clarified the conflict-free case managers' role in coordinating with Medicaid MCOs (Non-LTSS) • Under section 7.3.10, clarified requirements and role of the conflict-free case manager • Under sections 7.4 and 7.5, clarified monthly contact requirements and provided rationale

3/1/23	8	• Under section 8.1.2, added bullet #8 regarding language assistance
		• Under section 8.2.2:
		  ○ Added computer and organization as skills
		  ○ Added HIPAA under conflict-free case manager knowledge
		• Under section 8.2.3: Added caseload and time estimate assumptions
		• Under section 8.3:
		  ○ Clarified role of the Long-Term Care Ombudsperson
		  ○ Removed the term "compliant" since a complaint is part of the State's "grievance" definition. This is clarified in the definitions section.
		• Added section 8.8

3/1/23	9	Under section 9.2, clarified role of the conflict-free case manager regarding behavioral interventions
3/1/23	10	Revised section throughout and added the CFCM monthly payment rate
3/1/23	11	Updated section throughout to align with the executive summary
3/1/23	Appendix 1	Added appendix 1 to identify relevant federal requirements

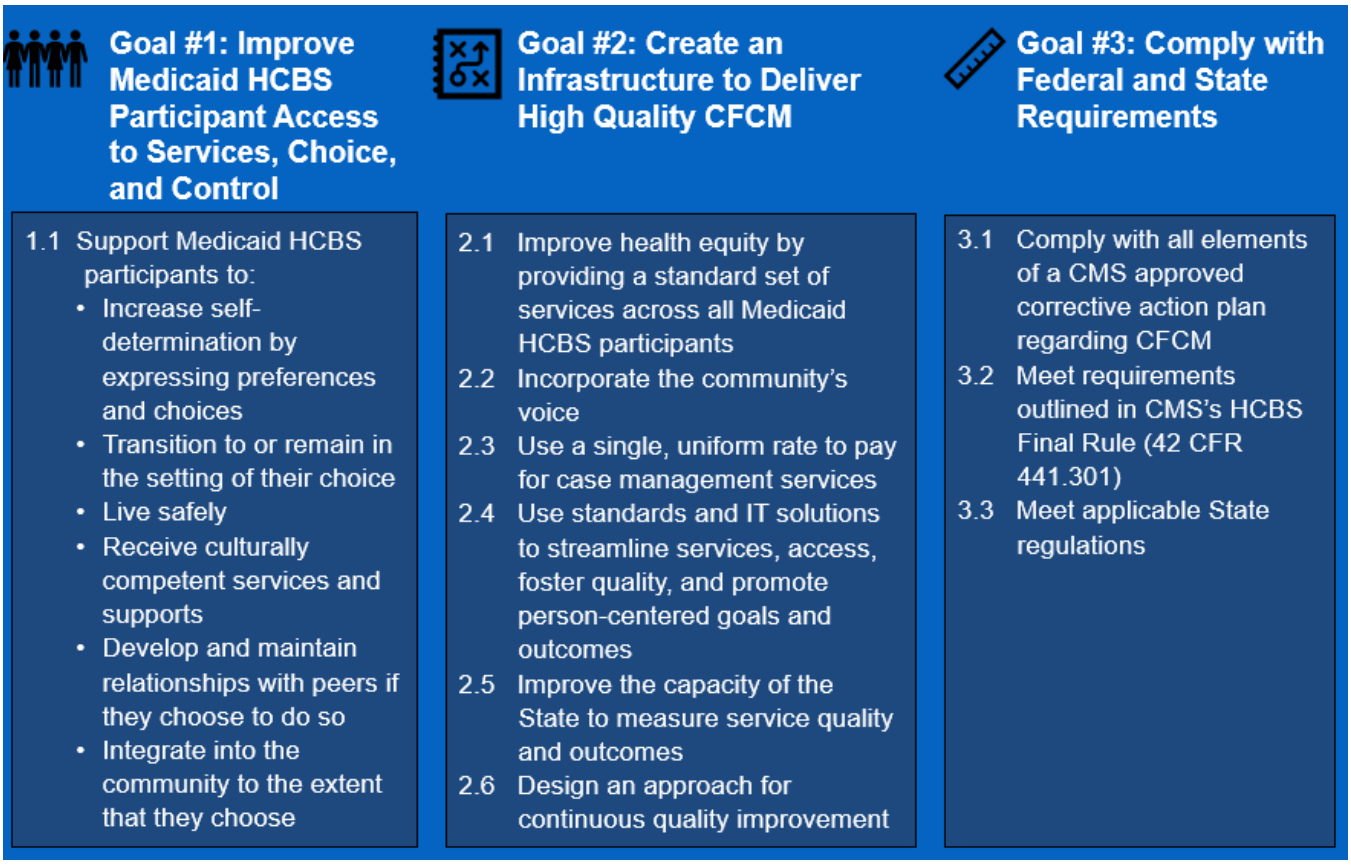
TABLE OF CONTENTS

1. EXECUTIVE SUMMARY

RI EOHHS is leading an interagency initiative to establish a statewide effort to provide conflict-free case management (CFCM) to Medicaid long-term services and supports (LTSS) beneficiaries who are participants in the State's home and community-based services (HCBS) programs. A core component of this initiative is the establishment of a contractual network of qualified CFCM entities with the capacity to serve approximately 11,000 Rhode Island HCBS participants who have a varying and changing array of LTSS needs.

The CFCM initiative is one of several the State is pursuing as part of multi-faceted, multi-year LTSS redesign effort focusing on making the system more person-centered, quality-driven, and resilient. The CFCM initiative serves these broader goals and the more specific purpose of bringing Rhode Island into compliance with federal requirements governing the Medicaid HCBS programs authorized by the State's Section 1115 Demonstration Waiver.

The goals of the CFCM initiative include:



WHY CFCM is needed:

1. RI EOHHS is under a **Corrective Action Plan with the Centers for Medicare and Medicaid (CMS)** to deliver "conflict-free" case management and person-centered planning in accordance with CMS's HCBS Final Rule (42 CFR 441.301). Approximately 7,500 or 75% of Rhode Island's Medicaid HCBS participants, who fall under CMS's HCBS Final Rule, receive case management that is not "conflict-free" (i.e., the same entity provides both eligibility assessment and enrollment service or case management services and direct services to a participant).

2. There is **inequity in HCBS participant access** to high quality case management services. Approximately 2,500 or 25% of Rhode Island's Medicaid HCBS participants, who fall under CMS's HCBS Final Rule, receive no or limited service planning and case management.
3. Case management delivery and quality is inconsistent across vendors.
4. The State's HCBS programs continue to function in **administrative silos** where different State agencies maintain separate business processes, approaches to oversight and monitoring, instruments, and IT systems for performing case management tasks.
5. The State uses **different reimbursement rates** and units of service (e.g., 15-minute increments vs. monthly) for case management services. Current payment methods create the opportunities for conflicts of interest, steering, and uneven access and choice.

WHAT is changing:

Category	Change Description
Service Standards for Medicaid HCBS Case Management	RI EOHHS created new Medicaid HCBS case management service standards to align with best practice and CMS requirements.
Use of Technology	RI EOHHS is implementing a new case management IT solution (WellSky Case Management System or WCMS) to support CFCM activities.
Reimbursement Rate	RI EOHHS anticipates using a single monthly rate of $170.87 per HCBS participant regardless of the population serviced. The State's budget for CFCM is contingent upon RI General Assembly and CMS approval.
Approach to Contracting	RI EOHHS anticipates contracting with one or more CFCM entities to create a network of providers through a competitive request for proposal (RFP). 1. Vendors will be required to have capacity to provide and manage the CFCM services system statewide or by region. 2. RI EOHHS anticipates that its CFCM RFP will include all HCBS participants including persons with I/DD and elders and adults with disabilities; therefore, vendors will be expected to serve all HCBS populations unless specifically excluded in this document. 3. Although the vendor(s) selected will be required to meet the minimum operational and performance standards established by the State, vendor(s) will have the flexibility to enter into contractual arrangements or partnerships with other qualified entities, individuals, or organizations to increase their capacity, expand their reach to priority populations or regions, and/or leverage the expertise of existing case management and/or care planning providers.
Roles and Responsibilities	Roles and responsibilities will change under the State's CFCM design. Stakeholders that will experience the most significant impact include: 1. *Developmental Disability Organizations (DDOs)*: The State's DDOs are serving as direct service providers and developing and managing care

Category	Change Description
	plans for Medicaid HCBS participants with I/DD. In the future state, the DDOs will not be allowed to develop person-centered plans and provide direct care services to the same participant due to CMS conflict of interest regulations. 2. *Individual HCBS Participant Plan Writers*: Individual plan writing is not a Medicaid covered service and is not consistent with federal regulations related to CFCM. As these plan writers have invaluable expertise and experience, the RFP for CFCM entities will encourage bidders to hire or contract with individual HCBS participant plan writers who meet the certification standards. 3. *Office of Healthy Aging (OHA) Case Management Agencies*: OHA Case Management Agencies will no longer provide case management services as they are performed today unless they apply and become a CFCM entity. 4. *Service Advisement (SA) Agencies*: The role of the SA, as currently defined, will not continue once CFCM is fully implemented. SAs may apply to provide CFCM services or support broker services. Since support broker services is considered a "direct care service" by CMS, the same entity cannot provide both CFCM and support broker services due to conflict of interest concerns.

WHEN this will happen:

Beginning January 1, 2024, RI EOHHS estimates that approximately 11,387 Medicaid HCBS participants are targeted to receive CFCM under this initiative. RI EOHHS will transition HCBS participants into CFCM throughout CY 2024 based on a HCBS Participant Transition Plan (to be released in April 2023, pending CMS approval). RI EOHHS anticipates that all HCBS participants under this initiative will be enrolled in the CFCM services system by December 31, 2024.

The figure below provides a summary of the State's implementation of CFCM. RI EOHHS will use this timeline for internal planning and project tracking. There are multiple factors influencing the State's implementation timeline including federal requirements and a BHDDH consent decree. At this time, RI EOHHS believes that its CFCM design and timeline is appropriate and attainable; however, as with any new program or service, it will regularly monitor its progress and course correct as needed based on CMS guidance.

Category	Key Activities	Target Date
Design	RI EOHHS posts an updated CFCM strategic plan	Complete ✓
	RI EOHHS posts a request for information (RFI)	Complete ✓
	RI EOHHS posts a draft HCBS Participant Transition Plan	April 2023
Build	RI EOHHS issues a request for proposal (RFP) for one or more CFCM entities	May 2023
	RI EOHHS implements a testing period for select I/DD participants	July 2023
	RI EOHHS contracts/certifies CFCM entities	August 2023
	RI EOHHS adopts and fully aligns State rules and regulations	November 2023
	The State's WellSky case management system (WCMS) is live and ready to support CFCM	December 2023
Execute	RI EOHHS begins to transition HCBS participants into the CFCM services system according to the HCBS Participant Transition Plan	January 2024
	All HCBS participants under this initiative are transitioned into the CFCM services system	December 2024

NEXT STEPS

All entities currently providing case management to HCBS participants or the populations served by HCBS programs that DO NOT provide direct services are strongly encouraged to become part of the CFCM network to build on the State's current Medicaid HCBS case management infrastructure. In addition, the RI EOHHS supports efforts by CFCM entities to hire or enter into contractual arrangements with the experienced plan writers who assisted people with intellectual/developmental disabilities (I/DD) participating in HCBS programs administered by the BHDDH. Federal requirements prohibit continuing the current practice in which plan writing and case management are treated as distinct services and paid for separately and without regard to minimum qualifications and performance standards.

The State has a real opportunity to transform the way Medicaid HCBS participants access and experience care. RI EOHHS greatly appreciates the feedback that it received from stakeholders to develop this document. Stakeholders play an essential role in our continuing efforts, and we look forward to their continued engagement and partnership.

All materials regarding this effort will be posted on Rhode Island's website: Conflict-Free Case Management (CFCM) | Executive Office of Health and Human Services (ri.gov).

2. KEY DEFINITIONS AND TERMS

Term	Definition
Activities of Daily Living (ADL)	Routine activities or tasks of everyday life related to personal care. There are six basic ADLs: eating, personal hygiene, dressing, toileting, ability to control bladder, and mobility and ambulation.
Applicant	An individual applying for Medicaid services.
Assessment	Process of learning about a person to determine their health or behavioral health status, functional capability, and need for services. For the purposes of CFCM, there are two kinds of assessments: functional needs assessments which are used for eligibility purposes and ancillary assessments which focus on specific areas of need or potential risks. There are two functional needs assessment tools that State staff will complete. The functional needs assessments are required as part of the eligibility process and are used by the LTSS agencies to determine the scope, amount and duration of Medicaid HCBS required to meet a participant's needs. This varies by population. 1. For elders and adults with disabilities (EAD): InterRAI for Home Care 2. For intellectual and developmental disabilities (I/DD): SIS-A
Caregiver	An individual, typically a family member or friend, who provides unpaid day-to-day assistance to someone who otherwise could not easily live on their own due to their needs.
Centers for Medicare and Medicaid Services (CMS)	The agency within the United States Department of Health and Human Services responsible for the administration and oversight of the Medicare and Medicaid programs.
Conflict-Free Case Management (CFCM)	CFCM means that the entity assisting a participant to gain access to services should be different than the entity providing those services (e.g., an HCBS provider agency), as a potential conflict may exist if the same entity is providing both case management and the referred service(s). CFCM is CMS's concept to prevent HCBS participants from being taken advantage of or being prevented from having access to the services they need. CFCM is a service system that includes four core components, each of which encompasses a discrete set of tasks that are specifically designed to help HCBS participants access the services they need and want. The core components of the CFCM service system include: 1. *Information Gathering*: A comprehensive review of a HCBS participant's goals, needs, and preferences 2. *Person-Centered Plan Development*: A written person-centered plan that articulates a HCBS participant's care needs, wants, and supports (paid and unpaid) that will assist a participant to achieve their goals 3. *Connecting to Services & Supports*: Connect the HCBS participant to paid and unpaid supports

Term	Definition
	4. *Plan Monitoring & Follow-up*: Regular contact to review goal progress & effectiveness of services
Conflict of Interest	CMS does not allow an entity, agency or organization (or their employees) to steer applicants and HCBS participants toward a particular program or provider and/or to provide both direct service and case management activities. When the same entity helps a HCBS participant gain access to services, monitors those services, and provides services, there is potential for conflict of interest in: 1. Assuring and honoring free choice 2. Overseeing quality and outcomes 3. The "fiduciary" (financial) relationship • Incentives for either over-or under-utilization of services • Possible pressure to steer the HCBS participant to their own organization for the provision of services
Critical Incident	A critical incident is a situation that threatens the health and safety of the individual or the community or poses a significant change in the individual's status, environment or care. All critical incidents must be reported and documented appropriately. The State's critical incident types include, but are not limited to: 1. Abuse (including physical, sexual, verbal, and psychological abuse) 2. Neglect or mistreatment 3. Exploitation 4. Medical or psychiatric emergency, including hospitalization or serious injury 5. Medication errors 6. Judicial system involvement 7. Unauthorized use of restraint 8. Death (other than by natural causes) 9. Departure or eviction from primary residence
Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH)	The State agency established under the provisions of Rhode Island General Laws (R.I. Gen. Laws) Chapter 40.1-1 whose duty it is to serve as the State's mental health authority and establish and promulgate the overall plans, policies, objectives, and priorities for State programs for adults with intellectual and developmental disabilities as well mental illness and substance abuse education, prevention, and treatment.
Department of Human Services (DHS)	The State agency established under the provisions of R.I. Gen. Laws Chapter 40-1 that is empowered to administer certain human services. Through an interagency service agreement with the Executive Office of Health and Human

Term	Definition
	Services (EOHHS), DHS determines Medicaid eligibility in accordance with applicable State and federal laws, rules, and regulations.
Developmental Disability	Means a person, eighteen (18) years old or older and not under the jurisdiction of the Department of Children, Youth and Families who is either an intellectually/ developmentally disabled adult or is a person with a severe, chronic disability that: 1. Is attributable to a mental or physical impairment or combination of mental and physical impairments 2. Is manifested before the person attains age twenty-two (22) 3. Is likely to continue indefinitely 4. Results in substantial functional limitations in three (3) or more of the following areas of major life activity: • Self-care • Receptive and expressive language • Learning • Mobility • Self-direction • Capacity for independent living • Economic self-sufficiency • Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated. For purposes of funding, it is understood that students enrolled in school will continue to receive education from their local education authority in accordance with § 16-24-1 et seq. Additional information on substantial functional limitations can be found: https://bhddh.ri.gov/developmental-disabilities/eligibility-and-application/substantial-functional-limitations
Developmental Disability Organizations (DDOs)	An organization licensed by BHDDH to provide services to adults with disabilities.
Disability	For Social Security purposes, disability means the inability of a person age 18 or older to engage in substantial gainful activity (work) by reason of any medically determinable physical or mental condition that can be expected to result in death or to last for a continuous period of not less than 12 months. In the case of children (persons age 17 and younger), the child must have a physical or mental condition that results in marked and severe functional limitations. The condition also must be expected to result in death or to last for a continuous period of not less than 12 months.

Term	Definition
Elders and Adults with Disabilities (EAD)	Medicaid eligible low-income elders who are sixty-five (65) and older and people with non-I/DD disabilities. These participants are part of the Medicaid "Integrated Health Care Coverage Group" group established by R.I. Gen. Laws Chapter 40-8.5 for adults with an SSI characteristic related to age or disability.
Eligibility	A broad term that refers to financial and clinical criteria that an applicant must meet to receive a state or federally funded service.
Executive Office of Health and Human Services (EOHHS)	The entity within the executive branch of Rhode Island State government that is designated as the single state agency to administer the Medicaid program in Rhode Island. In this capacity, it is responsible for overseeing the administration of all Medicaid-funded LTSS in collaboration with the health and human services agencies under the office's jurisdiction.
Grievance	Grievance means an expression of dissatisfaction about any matter and includes complaints about the quality of care or services provided, and aspects of interpersonal relations such as rudeness of a provider or an employee or a failure to respect an HCBS participant's rights. A grievance is not an appeal request or an action associated with an adverse benefit determination
Home and Community-Based Services (HCBS)	Types of person-centered care delivered in home and community settings. A variety of health and human services can be provided. HCBS programs address the needs of people with functional limitations who need assistance to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs). HCBS are often designed to enable people to stay in their homes and the community, rather than moving to a facility for care.
HCBS Participant	A person who is Medicaid LTSS eligible and receives Medicaid HCBS according to their person-centered plan.
HCBS Provider	Qualified professionals or entities that render paid services (e.g., assisted living, I/DD group home, services in a private residence, etc.) to Medicaid HCBS participants.
Human Rights Committee	Duly constituted group of people with developmental disabilities, advocates, volunteers, and professionals who have training or experience in the area of behavioral treatment, and other citizens who have been appointed to a provider's human rights committee for the purposes of: 1. Promoting human rights 2. Reviewing, approving and monitoring HCBS participants' plans designed to modify behavior which utilize restrictive interventions or impair the HCBS participant's liberty, or other plans and procedures that involve risks to the person's protection and rights 3. Participating in the provider's HCBS participant grievance procedures
Individual Representative	As defined in 42 CFR 441.735, the term individual representative means, with respect to an individual being evaluated for, assessed regarding, or receiving Medicaid HCBS, the following:

Term	Definition
	1. The individual's legal guardian or other person who is authorized under State law to represent the individual for the purpose of making decisions related to the person's care or well-being. In instances where state law confers decision-making authority to the individual representative, the individual will lead the service planning process to the extent possible. 2. Any other person who is authorized under § 435.923 or under the policy of the State Medicaid Agency to represent the individual, including but not limited to, a parent, a family member, or an advocate for the individual.
Information and Referral (I&R)	The process of providing information to HCBS participants or family members who are seeking LTSS services. This may include providing a referral to agencies on the HCBS participant's behalf.
Informed Consent	Means the permission given by a person who has the legal capacity to give consent to or to authorize treatment. Such person: 1. Is able to exercise free power of choice without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other form of constraint or coercion. 2. Has been given sufficient information about the risks and benefits of the proposed treatment or procedure and the elements involved to be able to make a knowledgeable and enlightened decision.
Instrumental Activities of Daily Living (IADLs)	Instrumental activities of daily living are activities related to independent living and include preparing meals, managing money, shopping, doing housework, and using a telephone. Unlike basic ADLs that relate to personal care, IADLs are more complex tasks that are necessary for truly independent living.
Integrated Health Home (IHH)	IHH is a service provided to community-based clients by professional behavioral health staff in accordance with an approved treatment plan for the purpose of ensuring the client's stability and continued community tenure. Additional information is available at: https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-11/integrated-health-home.pdf
Long-Term Care Ombudsperson Program	As defined in 218-RICR-40-00-1, the purpose of this program is: 1. Advocating on behalf of residents and identifying, investigating and resolving through mediation, negotiation, and administrative action complaints filed by residents or individuals acting on their behalf. 2. Identifying, investigating and resolving through mediation, negotiation, and administrative action complaints filed by any individual organization or government agency that has reason to believe that a long-term care facility, organization or government agency (which government agency is responsible for the regulation, inspection, visitation, or supervision of facilities or which provides services to residents of facilities) has engaged in activities, practices or omissions that constitute a violation of applicable statutes or regulations or that may have an adverse effect upon the health,

Term	Definition
	safety, welfare, rights or the quality of life of residents of long-term care facilities.
Long-Term Services and Supports (LTSS)	LTSS encompass the broad range of paid and unpaid medical and personal care services that assist with activities of daily living (such as eating, bathing, and dressing) and instrumental activities of daily living (such as preparing meals, managing medication, and housekeeping). They are provided to people who need such services because of aging, chronic illness, or disability, and include nursing facility care, adult daycare programs, home health aide services, personal care services, transportation, and supported employment. These services may be provided over a period of several weeks, months, or years, depending on a HCBS participant's health care coverage and level of need.[1]
MCO Care Manager	Some HCBS participants may be enrolled in a Medicaid managed care organization (MCO) to receive medical services in addition to HCBS. MCO care managers facilitate access to services, both clinical and non-clinical, by connecting the HCBS participant to resources that support their goals, preferences, and needs. The care manager in the MCO will have distinct and different responsibilities than the conflict-free case manager and those responsibilities will not be duplicated.
Medicaid LTSS Coverage	Medicaid is a state and federal health insurance program that assists families or HCBS participants in paying for LTSS and medical care. Medicaid LTSS coverage includes a broad spectrum of services for HCBS participants with clinical and functional impairments and/or chronic illness or diseases that require the level of care typically provided in a healthcare institution (e.g., hospital or nursing facility). In Rhode Island, Medicaid LTSS covers: 1. Skilled or custodial nursing facility/intermediate care facilities for HCBS participants with intellectual and developmental disabilities (ICF-IDD), community-based supportive alternatives, therapeutic, rehabilitative, and habilitative services, and personal care as well as various home and community-based supports. 2. Primary care essential benefits for acute care services with Medicaid as the payer of last resort if a HCBS participant also has Medicare or commercial coverage for these services.
Office of Healthy Aging (OHA)	The State office that coordinates all State activities under the purview of the Older Americans Act and administers funding under Titles III and V–I - in addition to National Family Caregiver Support programs. OHA is housed within DHS and serves as the designated State Unit on Aging. OHA administers the State Plan on Aging, in compliance with all federal statutory and regulatory requirements.
Participants with Intellectual or Developmental Disabilities (I/DD)	Participants with intellectual or developmental disabilities (I/DD) means any person who is eligible for publicly-funded developmental disability services through the Department of Behavioral Healthcare, Developmental Disabilities & Hospitals ("BHDDH") as defined in Rhode Island General Laws § 40.1-21-4.3(5) or students who are eligible for transition services and supports under

Term	Definition
	the Individuals with Disabilities Education Act, and who meet the definition found at 34 CFR § 300.8(c)(6).
Person-Centered Options Counseling (PCOC)	An interactive decision-support process whereby HCBS participants, with support from family members, caregivers, and/or others, are supported in their deliberations to make informed long-term services and support choices in the context of the HCBS participant's preferences, strengths, needs, values, and personal circumstance.
Person-Centered Planning (PCP)	A process for selecting and organizing the services and supports that an older adult or person with a disability may need to live in a home or community-based setting. Most important, it is a process that is directed by the HCBS participant who receives the support. This process is more of a conversation and includes a review of any functional needs assessments that have been completed as well as a discussion of what is important to the HCBS participant.
Person-Centered Plan	The person-centered plan is a written document that articulates a HCBS participant's care needs, wants, and services and supports (paid and unpaid) that will assist a HCBS participant to achieve their goals.
Person-Centered Thinking	Person-centered thinking is an approach to interacting with people in ways that helps identify what's important to and for them. It includes practical strategies for gathering meaningful information about a person and facilitating conversations about goal setting, problem solving, and action planning. This approach helps people feel respected and helps ensure the focus remains on the perspective of the person.
Restraint	Restricting the movement of the whole or a portion of a person's body as a means of controlling acute, episodic behavior to protect the person or others from injury. 1. "Chemical or pharmacological restraint" means medication that is given for the emergency control of behavior when the medication is not standard treatment for the individual's medical or psychiatric condition. 2. "Mechanical restraint" means the use of an approved mechanical device that restricts the freedom of movement or voluntary functioning of a limb or a portion of a person's body as a means to control his or her physical activities. 3. "Physical restraint" means the use of approved physical interventions or "hands on" holds to prevent an individual from moving his or her body to engage in a behavior that places him, her or others at risk of physical harm.
Restrictive Intervention	An action or procedure that does one or more of the following: 1. Limits an individual's movement, activity or function 2. Interferes with an individual's ability to acquire positive reinforcement 3. Results in the loss of access to other people, objects, locations, or activities that an individual values

Term	Definition
	4. Requires an individual to engage in a behavior that the individual would not engage in given freedom of choice Prohibited Restrictive intervention: In addition to those prohibited under R.I. Gen. Laws §§ 40.1-26-3, 40.1-26-4.1, and 42-158-4, the following procedures are specifically prohibited from use under any circumstances: 1. Utilizing law enforcement in lieu of a clinically approved therapeutic emergency intervention or behavioral treatment program 2. Utilization of behavioral interventions for the convenience of the staff 3. Utilization of behavioral interventions for any reason except for emergency protocol
Self-Directed Fiscal Intermediary	If a Medicaid HCBS participant chooses to self-direct their services and hire their own staff, they are required to use a self-directed fiscal intermediary. A self-directed fiscal intermediary is an organization that completes background checks of potential employees, assists with new hire paperwork, and ensures payment for services are rendered in accordance with federal and state rules. This service helps both the HCBS participant and the State to manage individual budgets and helps HCBS participants to manage the financial responsibilities of being an employer.
Self-Direction	Self-direction allows a HCBS participant to have responsibility for managing all or some aspects of service delivery (i.e., hiring, supervising, and discharging their HCBS providers) included in their person-centered plan and self-directed budget.
Service Authorization	Service authorization is documented written approval by the State for a service. The service authorization process is employed to control the use of covered items or services. When an item or service is subject to a service authorization, payment is not made unless approval for the item or service is obtained in advance by the State.
Support Broker	If a HCBS participant chooses to self-direct all or some of their services, they can request services of a support broker. Support brokers help HCBS participants develop the skills necessary to self-direct and facilitate the administrative tasks that accompany self-direction. Support broker activities include: 1. Brokering community resources 2. Information and assistance and problem solving 3. Assist the HCBS participant to develop or manage their budget if needed 4. Training the HCBS participant on how to train their hired staff to work with the participant and do the job they were hired to do 5. Providing information on recruiting, hiring, and managing employees 6. Work/collaborate with the State's self-directed fiscal intermediaries

Term	Definition
	RI BHDDH offers support broker services for HCBS participants with I/DD who self-direct their own services. RI EOHHS is currently assessing how it can leverage support broker services for other HCBS participants who self-direct including EAD. Additional information on this topic if forthcoming.
Support Coordination/Care Coordination	Support coordination/care coordination refers to the coordination and planning activities that HCBS providers provide to deliver services in accordance with the HCBS participants' person-centered plan. *Key Distinction Between CFCM and HCBS Provider Support Coordination:* CFCM is distinct and different from the responsibilities of HCBS providers. Conflict-free case managers will conduct person-centered planning to support Medicaid HCBS participants to develop a person-centered plan that will help them gain access to services (paid and unpaid), achieve their identified goals, and maintain independence at home. HCBS providers develop an implementation plan that specifics how authorized services in the person-centered plan will be delivered and provide day-to-day support coordination to implement those services.
WellSky Case Management System (WCMS)	An automated data management system that supports CFCM activities and maintains HCBS participant case records. This system is provided by WellSky.

3. INTRODUCTION AND METHODOLOGY

3.1 Introduction

RI EOHHS is leading an interagency initiative to establish a statewide effort to provide conflict-free case management (CFCM) to Medicaid long-term services and supports (LTSS) beneficiaries who are participants in the State's home and community-based services (HCBS) programs. A core component of this initiative is the establishment of a contractual network of qualified CFCM entities with the capacity to serve approximately 11,000 Rhode Island (RI) HCBS participants who have a varying and changing array of LTSS needs.

The CFCM initiative is one of several the State is pursuing as part of multi-faceted, multi-year LTSS Redesign effort focusing on making the system more person-centered, quality-driven, and resilient. The CFCM initiative serves these broader goals and the more specific purpose of bringing RI into compliance with federal requirements governing the Medicaid HCBS programs authorized by the State's Section 1115 Demonstration Waiver.[2] Rhode Island's Medicaid Section 1115 demonstration waiver operates as a single HCBS program for all Medicaid-eligible LTSS Rhode Islanders.

The federal requirements that require CFCM were established in what is commonly referred to as the HCBS Final Rule – a set of federal regulations formally adopted in January 2014 to implement provisions in the federal Affordable Care Act of 2010 for ensuring HCBS participants have full access to the benefits of community living and receive their LTSS in the most integrated settings of their choosing. Congress recently codified the HCBS Final Rule into Title XIX of the Social Security Act, the federal Medicaid law, and in doing so, heightened the stakes for states that have not met the requirements of the HCBS Final Rule and associated regulations and guidance. At risk is federal matching funding for states who do not at least have a compliance plan in place by March of 2023. It was with this in mind that the LTSS Redesign

Steering Committee[a] launched the CFCM initiative and directed an LTSS Interagency Redesign Team[b] to develop a Strategic Plan focusing on implementing on a statewide basis the requirements of the HCBS Final Rule that most directly affect HCBS participant access and pose the most significant compliance challenges: Person-centered planning, HCBS case management, and the conflict of interest (COI) provisions governing both.[c] As these requirements are closely intertwined, **RI EOHHS uses CFCM to refer to both person-centered planning and conflict-free case management in general, in this Strategic Plan and in all associated documents.**

The State designed its CFCM Strategic Plan using a multi-step approach that reflects a thoughtful and comprehensive review of applicable federal requirements, authorities and guidance in the context of long-standing values related to person-centeredness, quality and equity. The State's Strategic Plan was developed with guidance from:

- ✓ CMS federal requirements
- ✓ Key stakeholders including the State's Developmental Disability (DD) Quality Advisory Committee
- ✓ Other state approaches, design models, and materials. This includes Alaska[3], Colorado[4], Florida[5], Maine[6], Minnesota[7], North Carolina[8], Ohio[9], South Dakota[10], Utah[11], Vermont[12], and Wyoming[13]
- ✓ Feedback from CMS technical advisory team and national experts

This Strategic Plan provides an overview of how case management services are delivered today, an overview of current challenges, and a roadmap for implementing CFCM statewide and related certification standards for entities in the CFCM network. Pre-eligibility activities (e.g., application assistance) or other ongoing State efforts to redesign various Medicaid LTSS programs are not part of this report. RI EOHHS will use this document to implement CFCM and it will eventually serve as the basis for the State's certification standards for CFCM.

[a] Standing members of the Steering Committee include: The Secretary of EOHHS, the Medicaid Director, and the Directors of the departments that administer Medicaid HCBS programs – the departments of Human Services (DHS), Behavioral Healthcare, Development Disabilities and Hospitals (BHDDH), and Office of Healthy Aging (OHA). The departments of Health and Veterans Affairs are also represented via designees of the directors.
[b] The LTSS Interagency Redesign Team is an interagency work group that is comprised of RI EOHHS (the designated State Medicaid authority), the RI Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH), the RI Department of Human Services (DHS), and the RI Office of Healthy Aging (OHA).
[c] Due to the breadth of the access requirements, the provisions related to settings in the HCBS Final Rule are being addressed through a separate process.

3.2 Vision

Below is a vision statement, guiding principles, and goals and objectives for implementing CFCM in RI.

VISION STATEMENT

All Medicaid long-term services and supports (LTSS) participants have equal opportunity and the supports necessary to express their own goals and preferences, to learn about the array of service options available to them from a reliable and neutral source, and to make informed choices that assure they are empowered to retain control over the aspects of their daily lives that are important to them.

GUIDING PRINCIPLES

The following guiding principles were developed with input from the State's Developmental Disability (DD) Quality Advisory Committee and other key stakeholders and are intended to represent the role of person-centeredness in HCBS.

1. The focus is on what is important to the participant. All involved must recognize that people have different perspectives, hopes, needs, desires, fears, and vulnerabilities. The cultural beliefs, values, and needs of the participant will inform and guide connections to services, supports, and resources.
2. Service plans are person-centered, self-determined, and reflect and support what a participant wants to accomplish to realize goals related to health, safety, employment, spirituality, involvement in the community, and succeeding in choice of living arrangement. Natural supports and community inclusion are a priority.
3. Ongoing case management services are provided separate from the delivery of services, to limit any conscious or unconscious bias a conflict free case manager may have with the potential to erode a participant's choice, independence, and confidence in the integrity of the system.

GOALS AND OBJECTIVES

Goal #1: Improve Medicaid HCBS Participant Access to Services, Choice, and Control

1.1 Support Medicaid HCBS participants to:
- Increase self-determination by expressing preferences and choices
- Transition to or remain in the setting of their choice
- Live safely
- Receive culturally competent services and supports
- Develop and maintain relationships with peers if they choose to do so
- Integrate into the community to the extent that they choose

Goal #2: Create an Infrastructure to Deliver High Quality CFCM

2.1 Improve health equity by providing a standard set of services across all Medicaid HCBS participants
2.2 Incorporate the community's voice
2.3 Use a single, uniform rate to pay for case management services
2.4 Use standards and IT solutions to streamline services, access, foster quality, and promote person-centered goals and outcomes
2.5 Improve the capacity of the State to measure service quality and outcomes
2.6 Design an approach for continuous quality improvement

Goal #3: Comply with Federal and State Requirements

3.1 Comply with all elements of a CMS approved corrective action plan regarding CFCM
3.2 Meet requirements outlined in CMS's HCBS Final Rule (42 CFR 441.301)
3.3 Meet applicable State regulations

3.3 Implementation Timeline

Figure 1 provides a summary of the State's implementation of CFCM. RI EOHHS will use this timeline for internal planning and project tracking. There are multiple factors influencing the State's implementation timeline including:

1. **CMS Corrective Action Plan (CAP)**: RI EOHHS was put on notice by CMS in December 2022 and asked to submit a CAP to ensure the continued flow of HCBS federal matching funds until the State reaches compliance with the HCBS Final Rule. RI EOHHS submitted a draft CFCM CAP to CMS in March 2023 and will share its final CAP with stakeholders once it is approved by CMS.
2. **I/DD Court Order**: A BHDDH consent decree requires a phased-in implementation of the BHDDH population with manual workarounds by the July 1, 2023 deadline set by the Court.

At this time, RI EOHHS believes that its CFCM design and timeline is appropriate and attainable; however, as with any new program or service, it will regularly monitor its progress and course correct as needed based on CMS guidance.

Figure 1. Draft CFCM Implementation Timeline

#	Category	Action Steps	Target Completion Date	2023 Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2024 Jan
1	Design	**Post an updated CFCM strategic plan**	Complete ✓	★										
2		**Post a request for information (RFI)**	Complete ✓	★										
3		**Develop and post a draft HCBS Participant Transition Plan**	4/17/2023		★									
4	Build	General Assembly passes final FY2024 budget	6/30/2023											
5		Update the CFCM reimbursement rate as needed based on changes to the FY2024 budget	7/31/2023											
10		**Full alignment of State rules and regulations**	11/1/2023									★		
11		**Implement testing period for select I/DD participants**	12/31/2023					★						
12		**WCMS full launch**	12/20/2023										★	
13		**Issue a request for proposal (RFP)**	5/15/2023			★								
14		RFP open	6/15/2023											
15		**RFP responses review and contracts awarded**	8/1/2023						★					
16		Develop CFCM training materials	7/1/2023											
17		Deliver training to HCBS providers, CFCM vendors, and MCOs	12/31/2023											
18		Communicate to HCBS participants regarding conflict-free case manager transitions. This will adhere to the State's HCBS Participant Transition Plan.	12/31/2024											
19	Execute	**Begin to transition HCBS participants into the CFCM services system according to the HCBS Participant Transition Plan.** *RI EOHHS anticipates that all HCBS participants under this initiative will be enrolled in the CFCM services system by December 31, 2024.*	12/31/2024											★

★ = Milestone

4. BACKGROUND

4.1 Federal Requirements

In January 2014, CMS released the HCBS Final Rule requirements. These new requirements were driven by and developed to increase person-centeredness. Part of the HCBS Final Rule required states to separate case management from service delivery functions to reduce conflict of interest for services provided under HCBS waivers.[14] As a result of the HCBS Final Rule, RI's existing system for its long-term services and supports (LTSS) programs, including HCBS programs serving participants with intellectual and developmental disabilities (I/DD) and Elders and Adults with Disabilities (EAD) are not in compliance.

Key Highlights from CMS's HCBS Final Rule

1. Outlines person-centered planning requirements for participants in HCBS settings.
2. Requires that case management be provided without undue conflict of interest.
3. Defines what it means to live in a home and community setting.
4. Ensures that people receive services in the most integrated setting of their choice.

4.2 Defining Medicaid HCBS CFCM

The term *case management* is currently used to describe a variety of services that are currently available to Medicaid LTSS beneficiaries. These forms of case management vary in scope and purpose and, in most instances, are not designed specifically to avoid conflicts of interest. Indeed, what case management services a HCBS participant received often depends on the HCBS program door they enter. Moreover, case management is often wrapped into another service array – e.g., service advisement for Personal Choice participants or support coordination for I/DD participants – that may include elements that are in violation of the HCBS requirements requiring case management to be conflict-free. In contrast, case management for the purposes of CFCM, is clearly defined and discrete; it also encompasses other specific service components required to comply with the provisions of the HCBS Final Rule such as information gathering, person-centered planning, and monitoring. Together, the components of CFCM establish the framework for achieving the fundamental goal of federal HCBS regulations: To ensure all participants are engaged in the process for making decisions about their HCBS and, as a result, have access to the care and supports they want and need in the least restrictive setting of their choice.

Figure 2. Core Components of CFCM

Qualified Medicaid HCBS case managers are required to use the principles of person-centered thinking at every facet of the CFCM process. This means that the focus must be on the HCBS participant from the point of entry in the CFCM services system through to service delivery. Person-centered thinking is

particularly crucial in the development of a plan for care. The person-centered planning process guides the delivery of services and supports towards achieving outcomes in areas of the HCBS participant's life that are most important to them (e.g., health, relationships, work, and home). This process is more of a conversation that occurs after the CF case manager gathers information about the HCBS participant's eligibility, functional needs, service history, living environment, and other relevant factors. This information is used to create an individual profile of the HCBS participant that CF manager uses to assist HCBS participants in articulating what is important to and for them and in developing a plan that best meets their goals.

Federal regulations require that this process produce a written person-centered plan for every Medicaid HCBS participant. For the target population included in this initiative, the CF case manager contacts providers to make the necessary connections to the services included in the plan. Once the Medicaid services in the person-centered plan have been authorized by the appropriate state agency, it is signed by the HCBS participant and shared with the selected HCBS providers who, in turn, are responsible for implementing the plan. The CF manager then makes regular contacts with the HCBS participant and his or her providers to ensure the person-centered plan is being appropriately implemented. Federal regulations prohibit states from claiming Medicaid matching funds for any HCBS provided to a HCBS participant without a person-centered plan developed and authorized through this process.[15]

4.3 Conflict of Interest in Case Management

Conflict of interest refers to a real or seeming incompatibility between the private interests and the official responsibilities of a person in trust. In other words, a conflict of interest is when a person has competing influences that could affect a decision or action.

CMS requires that providers of Medicaid HCBS, or those who have an interest in or are employed by a provider of Medicaid HCBS, may not provide case management to or develop the person-centered plan for HCBS participants receiving services. CMS requires that states have CFCM which means that case management is delivered conflict free (i.e., the case manager does not provide direct services to the same HCBS participant).

Conflict of interest does not apply to:

3. State agency staff (unless the state agency staff member is related to or married to the HCBS participant)
4. Medicaid programs that have authorized restrictions (such as managed care)

4.4 CMS Assurance Requirements

CMS requires RI to make assurances and agree to HCBS program standards within its Section 1115 waiver. The assurances and standards summarized in **Figure 3** provide the foundation for the way the State will operate its HCBS programs and case management and planning services. RI EOHHS is currently designing and implementing a comprehensive HCBS Quality Improvement Strategy (QIS) that includes performance measures tied to CMS's assurance requirements. The HCBS QIS creates a foundation for collecting and analyzing individual and system-level information to evaluate whether HCBS is being provided in the accordance with the core principles in the HCBS Final Rule related to person-centered planning, conflicts of interest, freedom of choice, and integration in community settings. The state is also formalizing an HCBS Interagency Quality Team that will be responsible for all HCBS improvement activities centered around these principles.

Figure 3. CMS Assurance Requirements[16]

CMS Assurance	Requirement
Administrative Authority	RI EOHHS, as the single state Medicaid agency in RI, must demonstrate that it retains ultimate administrative authority and responsibility for the operation of the State's Medicaid HCBS program and provides administration of its Medicaid HCBS program consistent with its approved federal 1115 waiver application, including oversight of the performance of functions by other state, regional, local, and contracted entities.
Level of Care	RI EOHHS must demonstrate that it implements processes and instrument(s) for evaluating and reevaluating a HCBS participant's level of care consistent with the care provided in a hospital, nursing facility, or intermediate care facility for people with intellectual or developmental disabilities (ICF-IDD).
Qualified Providers	RI EOHHS must demonstrate that services are provided by qualified providers who meet required licensure and/or certification standards and adhere to other specified standards prior to providing services.
Service Planning	RI EOHHS must demonstrate that: 1. A HCBS participant's goals, needs, and preferences are assessed and reflected in their person-centered plan. 2. Person-centered plans are updated at least annually or as needed. 3. Services are delivered according to the person-centered plan. 4. HCBS participants are provided with a choice among services and providers.
Health and Welfare	RI EOHHS must demonstrate that it identifies, addresses, and seeks to prevent instances of abuse, neglect, and exploitation.
Financial Accountability	RI EOHHS must demonstrate that: 1. Claims are coded and paid for in accordance with the reimbursement methodology identified by the State and only for services rendered. 2. Rates remain consistent with an approved rate methodology.

Conflict-free case management entities and case managers play a critical role in helping the State meet the requirements of each assurance. Data related to each assurance will be collected by the State and reported to CMS annually. CMS uses this data to determine whether the state complies with federal requirements and whether it continues to qualify for federal funding. RI EOHHS will also use this data, as well as other information that it will collect, to monitor the outcomes from this initiative and to drive continuous quality improvement.

5. EVALUATION OF THE CURRENT STATE

5.1 Current Delivery of Case Management

Figure 4 provides a comparison of RI's current delivery of case management services to the requirements outlined in CMS's HCBS Final Rule. As of February 2022, there are approximately 9,990 HCBS participants in RI covered by CMS's HCBS Final Rule. Approximately 7,500 or 75% of RI's HCBS

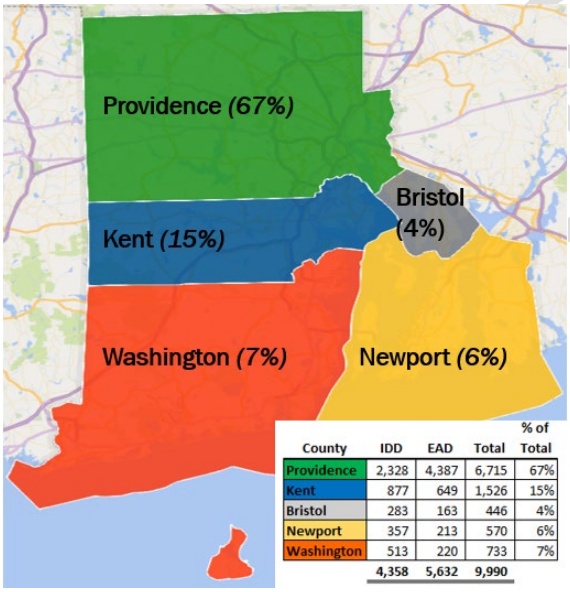
participants, who fall under CMS's HCBS Final Rule, receive case management that is not conflict-free. The remainder of the HCBS participants receive no or limited service planning and case management.

Figure 4. Current Service Delivery

Population	Service / Program	# of Participants	Case Management Provider	Current State Comparison to CMS's HCBS Final Rule				
				Conflict -Free	Information Gathering	Plan Development	Connecting to Services	Monitoring
Elders and Adults with Disabilities (EAD)	• Home care (OHA community) • Assisted living	1,928	EOHHS and OHA contracted community providers.	No	No	Limited OHA agencies only	Limited OHA agencies only	Limited OHA agencies only
	• Self directed services (independent provider and personal choice) • Shared living	1,206	• Service advisement (SA) agencies • Shared living agencies	No	No	Limited by SAs	NA	Yes
	Home care (DHS community)	2,473	DHS Social Caseworkers	NA	No	No	Limited	No
	Habilitative services/traumatic brain injury (TBI)	25	EOHHS Office of Community Programs staff	Yes	No	Limited	Limited	Yes
Intellectual / Developmental Disability (I/DD)	Group homes, self-directed, and other home and community-based services	4,358	• DDOs • Other DD providers • BHDDH Social Caseworker II	No	No	No	Limited	No
	Total	**9,990**						

Figure 5 provides a high-level summary of the current number of HCBS participants, under the CFCM initiative, by county and population (data pulled on February 6, 2023).

Figure 5. Current Number of HCBS Participants by County and Population (As of February 6, 2023)[d]



County	IDD	EAD	Total	% of Total
Providence	2,328	4,387	6,715	67%
Kent	877	649	1,526	15%
Bristol	283	163	446	4%
Newport	357	213	570	6%
Washington	513	220	733	7%
	4,358	5,632	9,990	

[d] Total number of Medicaid HCBS participants by county is accurate as of February 6, 2023 and differs from the projected number of HCBS participants eligible in January 2024 because it does not include projected increases in enrollment for 1/2024 nor the number of HCBS participants currently enrolled that are not using services.

5.2 Challenges with Case Management in Rhode Island

The LTSS Interagency Redesign Team conducted an environmental scan that examined the types of case management and care planning activities currently available to RI's HCBS participants. High-level findings are presented below:

1. Approximately 7,500 or 75% of Rhode Island's HCBS participants, who fall under CMS's HCBS Final Rule, receive case management that is not "conflict-free" (i.e., the same entity provides both eligibility assessment and enrollment service or case management services and direct services to a participant).
2. There is **inequity in HCBS participant access** to high quality case management services. Approximately 2,500 or 25% of Rhode Island's HCBS participants, who fall under CMS's HCBS Final Rule, receive no or limited service planning and case management.
3. Case management delivery and quality is inconsistent across vendors.
4. The State's HCBS programs continue to function in **administrative silos** where different State agencies maintain separate business processes, approaches to oversight and monitoring, instruments, and IT systems for performing case management tasks.
5. The State uses **different reimbursement rates** and units of service (e.g., 15-minute increments vs. monthly) for case management services. Current payment methods create the opportunities for conflicts of interest, steering, and uneven access and choice.

Due to federal requirements, RI can no longer:

1. Allow HCBS providers to develop a person-centered plan and provide case management to the same Medicaid LTSS participant.
2. Allow the potential for steering by paying for any application/assessments services only if a person enrolls in a particular program/service.
3. Use federal funds to pay for non-certified/non-credentialed individual HCBS participant plan writers. RI EOHHS encourages qualified individual plan writers to work via a subcontract with a CFCM entity.
4. Provide person-centered planning or case management in a manner inconsistent with federal specifications and reporting requirements.

5.3 System Capacity

RI EOHHS assumed an average caseload of 48 HCBS participants per case manager to calculate a monthly payment for CFCM services. A CF case managers' caseload maybe be lower or higher depending on the HCBS participant's needs and requests.

Based on an average caseload of 48 and 11,387 HCBS participants, RI EOHHS anticipates that there will be a need for approximately 237 case managers statewide. Since not all HCBS participants will transition into CFCM beginning January 1, 2024, the State expects case manager capacity to increase throughout CY 2024 as existing and new HCBS participants are transitioned into CFCM. RI EOHHS acknowledges that provider capacity is a concern and is continuously assessing needs and looking for ways to expand capacity. Further, RI EOHHS recognizes that the scope of this initiative will require building a new workforce. Accordingly, a phased in implementation over CY 2024 is an important element of the State's compliance strategy.

All entities currently providing case management to HCBS participants that DO NOT provide direct services are strongly encouraged to become part of the CFCM network and to build on the State's current Medicaid HCBS case management infrastructure. In addition, the RI EOHHS also supports efforts by CFCM entities to hire or enter into contractual arrangements with the experienced plan writers who assisted people with intellectual/developmental disabilities (I/DD) participating in HCBS programs administered by the BHDDH. Federal requirements prohibit continuing the current practice in which plan writing and case management are treated as distinct services and paid for separately and without regard to minimum qualifications and performance standards.

RI EOHHS will further assess system capacity as part of the State's RFI.

5.4 Stakeholder Impact

The LTSS Interagency Redesign Team assessed the impact of CFCM to its existing stakeholders. **Figure 6** summarizes the level of impact this initiative will have on existing stakeholders.

Figure 6. Stakeholder Impact

Stakeholder	Impact Level	Impact Description
Developmental Disability Organizations (DDOs)	High	• The State's DDOs are serving as direct service providers and developing and managing care plans for Medicaid participants with I/DD. In the future state, the DDOs will not be allowed to develop person-centered plans and provide direct care services to the same individual due to CMS conflict of interest regulations. • The DDOs will continue direct care services and play a crucial role in meeting licensing standards that require that they develop an implementation plan that specifies how each authorized service in the person-centered plan will be delivered.
Individual HCBS Participant Plan Writers	High	• Individual plan writing is not a Medicaid covered service and is not consistent with federal regulations related to CFCM. As these plan writers have invaluable expertise and experience, the RFP for CFCM entities will encourage bidders to hire or contract with individual HCBS participant plan writers who meet the certification standards.
OHA Case Management Agencies *(Community provider that currently provides Medicaid HCBS case management services)*	High	• OHA Case Management Agencies will no longer: ○ Provide case management services as it is performed today to Medicaid EAD unless they become CFCM entities. Participants receiving OHA At Home Cost Share services will not be affected by this change. ○ Complete the initial functional needs assessments for Medicaid LTSS eligibility ○ Provide application assistance for Medicaid LTSS • OHA Case Management Agencies will continue to contract with OHA for At Home Cost Share, that process will not change.

Stakeholder	Impact Level	Impact Description
Service Advisement (SA) Agencies *(Community provider that currently provides Medicaid HCBS case management services)*	High	• The role of the SA, as currently defined, will not continue once CFCM is fully implemented. SAs may apply to provide CFCM services or support broker services. Since support broker services is considered a "direct care service" by CMS, the same entity cannot provide both CFCM and support broker services due to conflict of interest concerns. • SAs will not provide application assistance or complete functional needs assessments for Medicaid HCBS participants.
State Agency Staff	Medium	• State agency staff will no longer provide case management services; however, State agency staff will provide oversight of CFCM services. • State agency staff will continue to provide supports and guidance to youth in transition.
HCBS Participants	Medium	• 11,387 HCBS participants will receive CFCM; therefore, this service may be new to some existing HCBS participants. • HCBS participants currently receiving case management services may have a new conflict-free case manager.
HCBS Providers	Medium	HCBS providers will be required to coordinate with the conflict-free case managers and participate in the person-centered planning process (as requested).
Shared Living Provider Agencies	Medium	• HCBS participants will be referred to shared living provider agencies (based on assessed needs and HCBS participant choice) after the CFCM process. Initial connections are made during the person-centered planning process, however. • Shared living providers must coordinate with the conflict-free case managers and support in implementing the HCBS participant's person-centered plan. • The State will revise the shared living provider certification standards to align with changes under CFCM.
RI's Medicare-Medicaid Plan (MMP) *(Offers LTSS In-Plan for EAD Participants)*	Medium	• MMP is the only managed care plan in RI with LTSS in-plan (for EAD participants only). EAD participants who receive HCBS will have the choice of disenrolling from Neighborhood INTEGRITY (the MCO that offers MMP) and shifting to fee-for-service (FFS) for their HCBS if they would prefer to receive person-centered planning and case management through the CFCM network rather than their MCO. ○ *Note regarding I/DD participants enrolled in MMP: Since I/DD services are carved out of the MMP, participants with I/DD that are enrolled in MMP will have access to the CFCM through the network and not through the MMP.*

Stakeholder	Impact Level	Impact Description
		• The State is planning to re-procure managed care services for LTSS participants before the MMP expires in 2025. During this re-procurement process, RI EOHHS has the flexibility to contractually obligate any new or existing participating Medicaid LTSS MCOs to establish HCBS Final Rule compliant systems comparable for CFCM or to directly partner with a certified entity participating in the CFCM network. More information on the State's decision in this area is forthcoming.
Medicaid Managed Care Organizations *(Does Not Offer LTSS In-Plan)*	Low	The responsibilities of the care manager in the MCO will have distinct and different responsibilities than the CF case manager and those responsibilities will not be duplicated. Care management for HCBS participants enrolled in a non-LTSS Medicaid MCO in which LTSS is carved out may involve contacts with HCBS providers but does not require full coordination at this time. This may change when Medicaid MCO contracts are re-procured over the next year.
Ancillary Service Providers (e.g., Meals on Wheels, employment services, community supports and other HCBS resource options)	Low	Ancillary service providers will be required to coordinate with the conflict-free case managers and not State agency staff.
Program of All-Inclusive Care for the Elderly (PACE)	Low	PACE will continue to provide both comprehensive care management services to eligible PACE participants.
Nursing Home Transition Program (NHTP) including Money Follows the Person (MFP)	Low	NHTP will continue to support HCBS participant transitions; however, data for these programs will be captured in the WCMS.
Integrated Health Home (IHH) Providers	Low	Over the course of the next year, the LTSS Redesign Team will be working with the behavioral health division of BHDDH to clearly define the roles and responsibilities of IHH providers in person-centered planning and case management for HCBS provided to participants, irrespective of FFS v. MCO delivery. In the interim, IHH participants who are not enrolled in an MCO for HCBS will have access to the CFCM network. CF case managers in the network will be expected to work closely with IHH providers to ensure an appropriate level of planning and case management.

6. CFCM DELIVERY MODEL

6.1 Contracting and Delivery Model

RI EOHHS anticipates contracting with one or more CFCM entities to create a network of providers through a competitive request for proposal (RFP). Vendors will be required to have capacity to provide and manage CFCM services statewide or by region. Although the vendor(s) selected will be required to meet the minimum operational and performance standards established by the State, **vendor(s) will have the flexibility to enter into contractual arrangements or partnerships with other qualified entities, individuals, or organizations to increase their capacity, expand their reach to priority populations or regions, and/or leverage the expertise of existing case management and/or care planning providers.**

RI EOHHS anticipates that its CFCM RFP will cover HCBS participants of all populations irrespective of eligibility characteristics or the door in which they enter. The CFCM initiative includes HCBS participants with I/DD and EAD and excludes HCBS participants identified in section 6.2.2 of this document. Accordingly, vendors must have the capacity to provide CFCM to any HCBS participants who chooses to enter through their door. The focus on targeted populations and/or agency that currently exists has led to significant inequities in access and resources and, to such an extent, that many HCBS participants are receiving no or limited service planning and case management. Our goal is to improve the quality and standards for case management services statewide for all populations.

The State opted to require CFCM entities to serve all populations after considering a multitude of other service delivery options, consulting with its technical advisors, and considering best practices in other states. To meet the expected demand for CFCM and address these deficiencies, the State determined that it is both necessary and appropriate for CFCM entities to have the capacity to serve all HCBS participants. Additionally, it is important to note that many of the community agencies in RI that serve adults do not limit the focus of their work to I/DD or EAD to the exclusion of one another. Similar trends are emerging in Medicare health plans that cross all Medicaid populations. The specialization that does exist today should be considered an opportunity to build business partnerships that recognize the challenges of an HCBS population with increasingly complex health needs that require services from across rather than just one point on care continuum.

RI EOHHS's goal is to establish a CFCM network with multiple certified entities, each of which has the capacity to serve people with varying needs. **All entities currently providing case management to HCBS participants that DO NOT provide direct services are strongly encouraged to become part of the CFCM network to build on the State's current Medicaid HCBS case management infrastructure.** RI EOHHS strongly encourages qualified vendors to work together to leverage and share their expertise to ensure all HCBS participants have access to high quality CFCM. In addition, the RI EOHHS also supports efforts by CFCM entities to hire or enter into contractual arrangements with the experienced plan writers who assisted people with intellectual/developmental disabilities (I/DD) participating in HCBS programs administered by the BHDDH. Federal requirements prohibit continuing the current practice in which plan writing and case management are treated as distinct services and paid for separately and without regard to minimum qualifications and performance standards.

6.2 Impact to HCBS Participants

6.2.1 HCBS Programs and Populations Included

CFCM is mandatory for all HCBS participants who receive Medicaid LTSS or are eligible to receive Medicaid LTSS via fee-for-service at home or in a community setting, irrespective of whether their primary care, acute and subacute services are covered through a Medicaid MCO. A person is eligible for Medicaid

LTSS if they meet the income and clinical eligibility criteria established in the State's regulations[17] and Section 1115 Demonstration Waiver.

Beginning January 1, 2024, RI EOHHS estimates that **approximately 11,387 HCBS participants are targeted to receive CFCM under this initiative. RI EOHHS will transition HCBS participants into CFCM throughout CY 2024 based on a HCBS Participant Transition Plan (to be released in April 2023, pending CMS approval).** Figure 7 provides a high-level summary of the projected number of unique HCBS participants targeted to receive CFCM in 2024.

Figure 7. Projected Number of HCBS Participants Targeted to Receive CFCM in 2024

Population	Service / Program	Approx. # of Participants	% of Total
Elders and Adults with Disabilities (EAD)	Home Care	4,539	39.9%
	Assisted Living	1,027	9.0%
	Self-Directed Services (Personal Choice Program)	793	7.0%
	Shared Living	421	3.7%
	Self-Directed Services (Independent Provider Program)	103	.9%
	Habilitative Services/Traumatic Brain Injury (TBI)	43	.4%
Intellectual / Developmental Disability (I/DD)	Group homes, self-directed, and other home and community-based services	4,460	39.2%
	Total	**11,387**	

6.2.2 CFCM Excluded Populations

HCBS participants who are excluded from the CFCM services system are generally receiving case management and care planning services through an entity that meets or is not subject to the federal conflict of interest provisions. The populations listed below are excluded from CFCM. As noted below, some of the exclusions are short term or partial, whereas other populations are outside of the CFCM network due to federal requirements.

1. **PACE participants**
2. **Katie Beckett (KB) eligible children.** The HCBS Final Rule applies to all participants who would be covered under a Section 1915(c) HCBS waiver if it were not for the State's Section 1115 waiver. In RI, KB is a Medicaid state plan eligibility category rather than a waiver authorized population. As KB eligibility is limited to children and youth, the population covered is eligible for HCBS through the EPSDT state plan provision rather than through the State's Section 1115 waiver. There are some exceptions – respite is an HCBS service. However, in general, KB services are not covered under the HCBS Final Rule. However, the state is bound to provide children eligible for HCBS under a state plan eligibility category with person-centered planning and case management. The State has discretion about the mechanism for providing these services and for guarding against conflicts of interest. *The State is currently considering various alternative strategies for providing KB children with these services until they are fully integrated into the CFCM network in SFY 2025.*
3. **Other Medicaid income eligible children who receive Medicaid services at home or in the community under the Medicaid State Plan EPSDT provision**. *The State is also exploring whether to include home and community-based services provided to children in this population as part of the CFCM network.*

4. **Medicare-Medicaid Plan (MMP) for EAD participants who decide to receive HCBS from their MCO.** Neighborhood INTEGRITY is the MCO that coordinates both Medicare and Medicaid benefits into one, integrated delivery system for eligible members. Neighborhood INTEGRITY is also the only integrated MCO that is paid to cover LTSS for EAD participants. Impact of CFCM to participants that are enrolled in MMP:

    a. ***I/DD:*** Since I/DD services are carved out of the MMP, participants with I/DD that are enrolled in MMP will have access to the CFCM through the network and not through the MMP.

    b. ***EAD:*** EAD participants who receive HCBS will have the choice of disenrolling from Neighborhood INTEGRITY and shifting to fee-for-service (FFS) for their HCBS if they would prefer to receive person-centered planning and case management through the CFCM network rather than their MCO.

    Additional context regarding MMP and Medicaid LTSS MCOs: The HCBS Final Rule mandates that all HCBS participants receive person-centered planning and case management in accordance with federal requirements related to conflicts of interest (COIs). However, under federal Medicaid policy, MCOs are not considered to be direct service providers and, as such, are exempt from the provisions of the HCBS Final Rule related to COIs. Accordingly, an MCO that provides LTSS could be held responsible by the State for providing person-centered planning and case management for the *in-plan* Medicaid HCBS they cover under contract with the State. The State is planning to re-procure managed care services for LTSS participants before the MMP expires in 2025. During this re-procurement process, RI EOHHS has the flexibility to contractually obligate any new or existing participating Medicaid LTSS MCOs to establish HCBS Final Rule compliant systems comparable for CFCM or to directly partner with a certified entity participating in the CFCM network. More information on the State's decision in this area is forthcoming.

5. **NHTP participants, including those participating in the Money Follows the Person (MFP) initiative.** Participants receiving HCBS through the NHTP will continue to receive case management in accordance with federal requirements until such time as they are appropriately transitioned to the CFCM network.

6. **Integrated Health Home (IHH)**. The purpose of an IHH as a matter of federal law and the RI Medicaid State Plan is to serve as a *whole life* care coordination entity. In this respect, IHHs are exempt from the provisions in the HCBS Final Rule related to COIs. However, one of the IHH's principal responsibilities is to develop and oversee the implementation of a person-centered plan and provide comprehensive case management that coordinates medical care as well as community services and supports. Although IHH is a State Plan service, HCBS provided to participants are covered separately, through FFS or an MCO, under the State's Section 1115 demonstration at this time. As a result, HCBS for IHH members is not being uniformly managed to the full extent federal law requires. Over the course of the next year, the LTSS Redesign Team will be working with the behavioral health division of BHDDH to clearly define the roles and responsibilities of IHH providers in person-centered planning and case management for participants that receive HCBS, irrespective of FFS v. MCO delivery. In the interim, IHH participants who are not enrolled in an MCO for HCBS will have access to the CFCM network. CF case managers in the network will be expected to work closely with IHH providers to ensure an appropriate level of planning and case management.

7. **The Office of Healthy Aging's At Home Cost Share program**. There are several reasons for excluding the OHA cost share population. First, the cost-share population is not a Medicaid LTSS eligible HCBS population due to their excess income and/or resources, even though the State does receive Medicaid matching funds under the waiver for some of the services they receive. OHA cost share participants are already provided with robust planning and case management services. As result of these two factors, requiring cost share participants to obtain the more rigorous CFCM system of services tied to federal compliance was deemed unnecessary.

RI EOHHS must ensure that HCBS participants listed above have access to the same level of person-centered planning and comprehensive case management mandated in the HCBS Final Rule unless specifically exempt by federal law or regulations. Over the next year, RI EOHHS will work with the entities serving these HCBS participants to determine the best approach for ensuring equitable access to person-centered planning and comprehensive case management going forward.

6.2.3 Communication to HCBS Participants

RI EOHHS is committed to providing new applicants and existing Medicaid HCBS participants with easy to understand and accessible information about the transition to CFCM. RI EOHHS will create a comprehensive and ongoing communication strategy that includes messaging and outreach in a variety of mediums as well as face-to-face encounters, whenever feasible, during one or more of the phases of the eligibility process. The State will also work closely with both incoming and outgoing case managers to minimize potential service disruption. Stakeholder input is especially important in informing the development of, and plans for, executing the State's communication strategy. **The State's communication strategy and timing of outreach efforts will be described in more detail in the State's HCBS Participant Transition Plan (to be released in April 2023, pending CMS approval).**

6.2.4 HCBS Participant Choice

RI EOHHS is committed to ensuring that all HCBS participants will have a choice of conflict-free case management entities. During the application and assessment process, HCBS participants will be informed about the CFCM process and their choice options. If a HCBS participant is unable to or unwilling to choose a CFCM entity, the State plans to implement an auto-assignment process that will ensure there is sufficient capacity statewide.

HCBS participants may choose to move to a different CFCM entity (if available where the HCBS participant resides) pursuant to criteria to be established by RI EOHHS, and there also may be an open enrollment period during which HCBS participants may choose to move to a different CFCM entity.

6.3 Roles and Responsibilities

All stakeholders who are involved in HCBS service delivery will work collaboratively to ensure that participants are receiving conflict-free services. Each stakeholder in the service continuum will have key roles and responsibilities as part of the CFCM process. **Figure 8** provides a summary of stakeholder roles and responsibilities.

Figure 8. Key Roles and Responsibilities

Role	Description
HCBS Participant	1. Choose who they would like to participate in the planning process and who is invited to the meeting 2. Identify what can and cannot be discussed with the CFCM 3. Drives the person-centered planning process and conversation to the best of their ability 4. Participate in the support planning meeting in a way that they choose 5. Communicate their desires, hopes, and dreams for their future, including what is working now in their life, what is not working, and what they would like to see different; this can happen anytime during the year 6. Sign the person-centered plan to indicate that the HCBS participant participated in the person-centered planning meeting

Role	Description
	7. Request and approve changes or revisions to the person-centered plan throughout the year as desired or needed 8. Communicate any concerns or feedback with the CF case manager throughout the year; if disagreements are not resolved, they may request that they are noted on the person-centered plan before signing it
Family and Friends *(as approved by the HCBS participant)*	1. Provide information based on their intimate knowledge of the HCBS participant 2. Identify strengths and positive attributes of the HCBS participant; help to identify and address known risks 3. Assist the HCBS participant to plan for their future and provide support (if requested) 4. Share with the CF case manager any concerns, disagreements, or feedback during the planning process and throughout the year 5. Be a natural support system for the HCBS participant and give meaning to their life
Individual Representative	1. Contribute to the person-centered information based on their own intimate knowledge of the HCBS participant 2. Help to identify and address known risks, health, or safety concerns 3. Assist the HCBS participant to plan for their future and provide support 4. Review and approve the person-centered plan and other documents by signing the person-centered plan 5. Share any concerns or disagreements during the planning process with the CF case manager 6. Review and approve changes to the person-centered plan throughout the year if needed 7. Share any concerns or feedback with the CF case manager throughout the year
State Agency Staff	1. Provide application assistance 2. Assist youth in transition 3. Perform the initial functional needs assessment – the InterRAI 10 -- for EAD participants (performed by DHS staff) 4. Continue to perform the initial functional needs assessment – the SIS-A – and reassessments at five-year intervals for participants with I/DD (performed by BHDDH staff) 5. Complete the initial LTSS level of care (LOC) determination and redeterminations (DD: every 5 years; EAD: every 3 years) 6. Determine eligibility and eligibility renewals 7. Manage critical need cases related to eligibility

Role	Description
	8. Coordinate and communicate with CFCM vendor(s) 9. Support HCBS participant choice and make referrals to CFCM vendor(s) 10. Review person-centered plans 11. Process service authorizations 12. Facilitate residential placement needs 13. Monitor overall service quality and performance 14. Oversee the State's critical incident management system
MyOptionsRI, The POINT, or Any Other Community Partner	1. Offer person-centered options counseling (PCOC) to help people assess and understand their long-term services and support needs, goals, and preferences.
Conflict-Free (CF) Case Manager	1. Engage in an ongoing conversation with the HCBS participant regarding what they want for their future and assist them in making changes to the support plan as necessary, documenting in the support plan when changes occur 2. Facilitate and complete the development of the person-centered plan 3. Update the person-centered plan in response to a major change in the participant's health, functional capacity, social or physical environment, formal or informal support system, or if other circumstances require re-evaluation of the person-centered plan 4. Conduct a person-centered planning process that considers all supports that can be available to the HCBS participant, whether Medicaid funded, funded by other sources, or funded by natural supports like volunteers 5. Ensure that the plan meets the HCBS participant's current service needs and complies with requirements for the chosen service setting(s) and associated funding 6. Sign the person-centered plan 7. Provide to the HCBS participant or their individual representative, via secure e-mail, U.S. mail, or hand-delivered, a copy of the person-centered plan. 8. Ensure all HCBS providers receive a copy of the approved person-centered plan 9. Monitor service provision, progress on goals, and the HCBS participant's satisfaction with their services and HCBS providers 10. Address and resolve issues by meeting with the HCBS participant and HCBS providers 11. Assist the HCBS participant in communicating with HCBS providers to help the HCBS participant achieve their desired goals and outcomes 12. For EAD, reassess all or some of the functional needs of a participant using the State's functional needs assessment tool (interRAI 10) in conjunction with the annual conjunction with the annual person-centered planning meeting. For

Role	Description
	I/DD participants, the State is currently defining what role the CF case manager will have using the functional needs assessment tool for this population. 13. Comply with the State's critical incident reporting requirements 14. Assist with obtaining documents and facilitating submission of materials to support the State's annual eligibility renewals
HCBS Providers	1. Gather and share information with the CF case manager prior to the person-centered planning meeting 2. Help identify serious risks by providing medical or other historical information 3. Participate in person-centered planning meetings at the request of the HCBS participant 4. Recommend revisions to the draft person-centered plan to the CF case manager prior to implementation 5. Upon person-centered plan approval, develop specific strategies to deliver service and supports as outlined in the person-centered plan. This may include the HCBS provider completing their own reviews. 6. Provide direct services and supports as defined in the person-centered plan 7. Communicate with the CF case manager if the HCBS participant's desired outcomes or support needs must be readdressed or updated 8. Comply with the State's critical incident reporting requirements
Self-Directed Fiscal Intermediary *(Offered under self-direction)*	1. Help HCBS participants and the State to manage individual budgets and help HCBS participants to manage the financial responsibilities of being an employer 2. Complete background checks of potential employees 3. Assist with new hire paperwork 4. Ensure payment for services are rendered in accordance with federal and state rules
Support Broker *(Offered under self-direction)*	RI BHDDH offers support broker services for HCBS participants with I/DD who self-direct their own services. RI EOHHS is currently assessing how it can leverage support broker services for other HCBS participants who self-direct including EAD. Although additional information is forthcoming, a support broker may: 1. Help HCBS participants develop the skills necessary to self-direct and facilitate the administrative tasks that accompany self-direction. 2. Broker community resources 3. Provide information and assistance with problem solving 4. Develop and manage the HCBS participant's budget

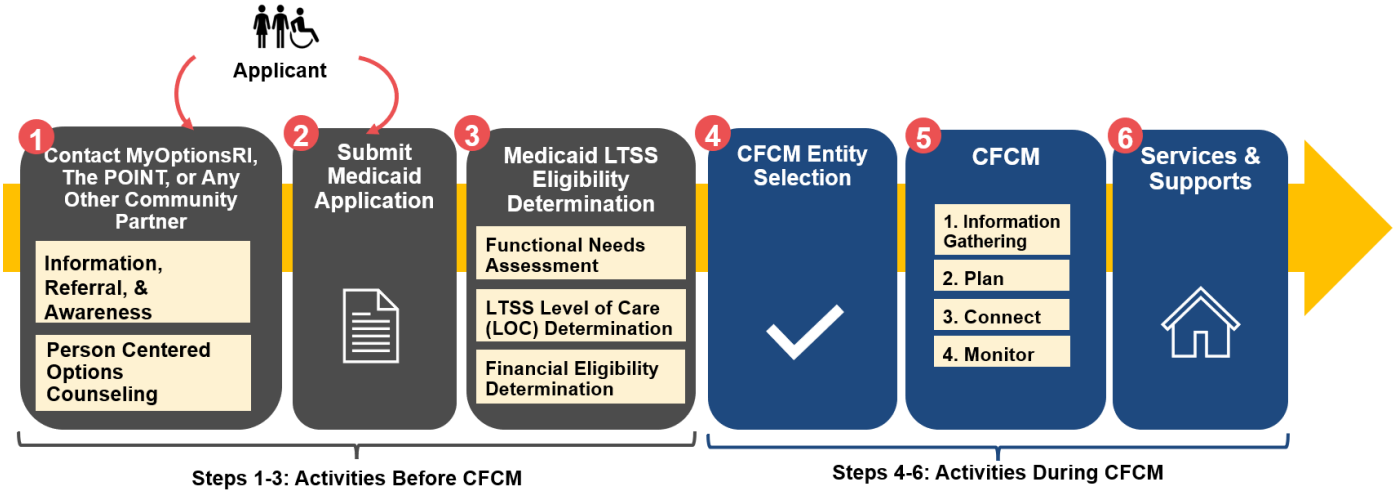
Role	Description
	5. Train the HCBS participant on how to train their hired staff to work with HCBS participants and do the job they were hired to do 6. Provide information on recruiting, hiring, and managing employees 7. Work/collaborate with the State's self-directed fiscal intermediaries
Ancillary Service Providers *(e.g., Meals on Wheels, other community resource options)*	1. Provide services and supports as defined in the person-centered plan 2. Communicate with the CF case manager if the HCBS participant's desired outcomes or support needs must be readdressed or updated 3. Comply with the State's critical incident reporting requirements

6.4 Process for Receiving CFCM

The information below includes a summary of the general process for receiving CFCM. A HCBS participant enters the CFCM system after the application for LTSS has been submitted and the functional needs assessment for eligibility is complete. As the figure below shows, from that point forward, it is the responsibility of the case manager to provide the information and support necessary for an HCBS participant to develop a plan, understand and make choices, and connect to service providers.

1. **Information, Referral, Awareness, & Person-Centered Options Counseling**: This process starts with an applicant contacting MyOptionsRI, The Point, or any other community partner to learn about their LTSS options within the State, both private and public. An applicant can also skip this step if they already know their LTSS options.
    a. The State offers person-centered option counseling (PCOC) which is an interactive decision-support process that helps people assess and understand their long-term services and support needs, goals, and preferences. In RI, a HCBS participant can connect with a MyOptions Advisor (this is someone who delivers PCOC) to learn about their LTSS options and to help identify what is important to the HCBS participant and how they can meet their goals. Additional information regarding RI's PCOC program is available at MyOptions.RI.gov.
2. **Submit Medicaid Application**: If Medicaid LTSS is the best option for the applicant based on their goals, they can apply through DHS via online, mail, or in-person.
3. **Medicaid LTSS Eligibility Determination**: The State determines Medicaid LTSS eligibility based on financial and clinical eligibility criteria.
4. **CFCM Entity Selection:** If the HCBS participant is eligible for Medicaid HCBS, the HCBS participant selects or is auto-assigned a CFCM entity. If a HCBS participant is already enrolled in Medicaid HCBS, the State will work with the HCBS participant to select a CFCM entity.
5. **CFCM**: The conflict-free case manager provides CFCM according to the standards outlined in this document.
6. **Services & Supports**: The HCBS participant receives services and supports according to their person-centered plan by a HCBS provider.

Figure 9. Process for Receiving CFCM



6.5 WellSky Case Management System (WCMS)

The LTSS Interagency Redesign Team's goal is to create a fully coordinated case management IT solution that is integrated and seamless from the HCBS participant's point of view. RI will become one of the first states in the nation to implement a single system for Medicaid HCBS participants in which "information follows the person".

The State selected WellSky as its case management system to support CFCM activities for HCBS participants with I/DD and EAD. The State's LTSS case management IT solution will be referred to as the WellSky Case Management System (WCMS) throughout this document.

State staff and conflict-free case managers will be the primary users of WCMS. All CF case managers will be expected to use the State's electronic case management system.

While the WCMS will be rolled out in multiple phases, the State anticipates that the WCMS will:

1. Create a single e-LTSS record housed on a cloud-based system for ancillary functions that supports a person from the point of entry into the system
2. Serve as the official case record for HCBS participants
3. Interface and integrate with Bridges (the State's eligibility system) and the MMIS (the State's claims payment system)
4. Support person-centered options counseling (PCOC) and functional needs assessments for elders and adults with non-I/DD disabilities
5. Support level of care determinations for the nursing facility and hospital levels of care
6. Support management of the habilitation and nursing home transition programs
7. Document CFCM activities and the person-centered plan
8. Provide a resource directory to help identify HCBS providers
9. Eventually replace the State's CSM and CDM systems

Once the WCMS is operational, the State will provide a detailed manual that describes how the system should be used and how it relates to the entire CFCM process.

7. CFCM CORE COMPONENTS & SERVICES

CFCM is a service system that includes four core components, each of which encompasses a discrete set of tasks that are specifically designed to help HCBS participants access the services they need and want. RI EOHHS refers to CFCM as a service system because, once implemented, it operates independently of the eligibility and service delivery processes it is informed by and informs.

Figure 10. Core Components of CFCM

The core components of the CFCM service system were designed to comply with requirements of the HCBS Final Rule and, as such, are relatively fixed. RI EOHHS also considered other state approaches and best practice.

7.1 Information Gathering

To develop a person-centered plan that meets the participant's needs, CF case managers must conduct a comprehensive review of the HCBS participant. The CF case manager will use the skills of observation, deduction, exploration and inquiry to obtain in-depth information about the participant's current strengths, resources (including formal and informal support systems), problems, needs, and quality-of-life goals.

When conducting the information gathering process, CF case managers should at minimum complete the following activities:

1. Take the HCBS participant's history to identify the needs of the HCBS participant by gathering information directly from the HCBS participant and other sources, such as family members, HCBS providers, medical providers, social workers, and educators
2. Gather and review previous assessments and all other existing information for the HCBS participant
3. Analyze the participant's initial functional needs assessment with an in-depth review of all sections and additional supporting information. While the functional needs assessment is a major contributor to the person-centered planning process, it should not be used as the only source of information to guide the person-centered plan. CF case managers should understand the participant's goals, preferences, and objectives, as well as review historical case notes to gain information and insight into the service needs.
4. Together with the HCBS participant, capture the HCBS participant's history, including cultural and spiritual beliefs and practices
5. Identify risks and develop applicable risk mitigation strategies

6. Conduct a survey of formal and informal community opportunities and supports that are available to the HCBS participant, and that the HCBS participant wants to leverage
7. Look at the nexus between the HCBS participant's wants and needs. Assist the HCBS participant to identify: What is important to me? How to support me? Are there things others admire about me?
8. Utilize strategies for solving conflicts or disagreements within the process
9. Build a Personal Profile to document the HCBS participant's goals, needs, and preferences
10. Set expectations for person-centered planning meetings (i.e., support and assist the HCBS participant to identify who will participate, how engaged the HCBS participant wants to be in process, what tools will be used, where to meet, preferred mode of communication, etc.)
11. Complete program required documentation for conducting information gathering activities

Standards for the information gathering process include:

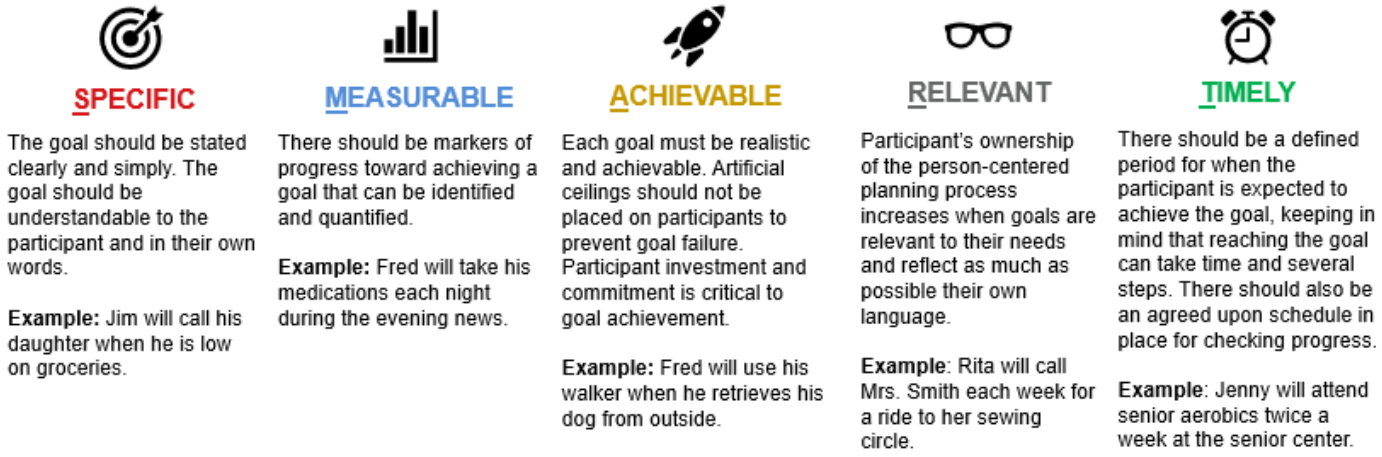
1. Participant is supported to direct the process of information sharing, planning, goal setting, and choosing supports
2. Planning process includes people and format chosen by the participant
3. Meetings are scheduled at times and locations convenient to the participant and their key supporters
4. Preferences for planning are determined by the participant
5. Participant is supported to identify their strengths, abilities, interests, goals, needs, and supports
6. Guided by the participant, information is gathered into one place through the review of previous assessments, including discussions with the participant and their key supporters, and time spent observing the participant in a variety of settings
7. A personal profile is developed with the participant and is documented in the WCMS.

7.1.1 Goal Development

The development of goals is a critical component in the information gathering process. The CF case manager's role is to guide the conversation so that participants develop meaningful goals for themselves. Participants may have more than one goal and others attending the person-centered planning meeting may also have goals for the participant. However, the participant must agree to include those goals in their person-centered plan.

The case manager should employ person-centered thinking to help the participant identify steps that can be taken to achieve the goal. As depicted in **Figure 11**, person-centered goal(s) should be written using SMART guidelines:

Figure 11. Standards for Successful Goals using SMART Guidelines



When the goal itself seems unattainable, the CF case manager should dig deeper into the goal itself to determine what is important to the participant so that they can develop a goal that gets toward what they really want. For example, the participant may want to be a fireman, but it is highly unlikely that they could meet all of the requirements. By asking the participant "why", the CF case manager may find out that they like being around big trucks, like the respect that comes from a public position, want to wear a uniform at work, etc.; and then the goal can be built around that aspect of the goal.

7.2 Person-Centered Plan Development

Development of a thorough and accurate person-centered plan helps a HCBS participant pursue their personally defined "quality of life". The person-centered plan must be based upon the information obtained from the information gathering process. A well-executed and person-centered planning process is crucial to ensuring HCBS participants have a good experience with the State's HCBS program.

When conducting the person-centered plan development process, CF case managers should at minimum complete the following activities:

1. Ensure active participation of the HCBS participant and others to consider all aspects of the HCBS participant's life to determine and develop goals
2. Assist the HCBS participant to identify person-centered goals based on identified wants and assessed needs
3. Build specific and measurable goals and corresponding action steps to achieve goals
4. Identify a course of action to respond to the assessed needs of the HCBS participant, including a timeline for action steps and who can assist with each action step
5. Identify how the HCBS participant wants to be assisted with each action step and the who that is responsible for each action step
6. Assist the HCBS participant to explore community opportunities (e.g., church) related to identified interests and goals
7. Identify transition of care needs, including future care planning (i.e., for aging parents/caregivers)
8. Describe benefits and risks involved in aligning services to wants and needs, and describe strategies to ensure informed decision making through the PCP development process
9. Assist the HCBS participant to establish a process to review and document progress towards goals

10. Determine who/how progress will be identified/measured
11. Identify an appropriate method and frequency for plan monitoring, follow-ups, and updates
12. Complete program required documentation for delivering planning activities

Standards for the person-centered plan development process include:

1. Goals are specific and achievable
2. Specific, detailed, and measurable action steps to meet goals are identified and documented
3. Timelines are identified for each action step
4. Person/organization identified to provide support with each action step
5. Community inclusion is explained and offered
6. Plan describes strategies and supports that will be used to ensure the HCBS participant is making informed choices
7. Person-centered plan is documented and shared with the HCBS participant and HCBS providers with adherence to State required components and timelines
8. A follow-up schedule/plan is agreed upon and documented

7.2.1 Person-Centered Planning (PCP) Requirements

The person-centered planning meeting and development cannot be conducted until the information gathering process is complete. RI EOHHS will work with stakeholders to operationalize CMS' PCP requirements. Pursuant to 42 CFR §441.301(c)(1), the person-centered planning process:

1. Will be led by the HCBS participant where possible. The individual representative should also have a participatory role, as needed and as defined by the HCBS participant.
2. Includes people chosen by the HCBS participant
3. Provides necessary information and support to ensure that the HCBS participant directs the process to the maximum extent possible and is enabled to make informed choices and decisions
4. Is timely and occurs at times and locations of convenience to the HCBS participant
5. Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and HCBS participants who are limited English proficient, consistent with § 435.905(b)
6. Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning HCBS participants
7. HCBS providers for the HCBS participant, or those who have an interest in or are employed by a provider of HCBS for the HCBS participant must not provide case management or develop the person-centered plan
8. Provides the HCBS participant with a clear and accessible alternative dispute resolution process
9. Offers informed choices to the HCBS participant regarding the services and supports they receive and from whom
10. Includes a method for the HCBS participant to request updates to the plan as needed
11. Records the alternative home and community-based settings that were considered by the HCBS participant

7.2.2 Person-Centered Plan Requirements

The written person-centered plan must reflect the services and supports that are important for the HCBS participant to meet the needs identified during the information gathering process, as well as what is important to the HCBS participant with regard to preferences for the delivery of services and supports. The CF case manager must ensure the person-centered plan documents assessed needs and identifies the services and supports that will address those needs.

RI EOHHS will work with its WCMS to ensure that CMS' person-centered plan requirements are part of the system design. Pursuant to 42 CFR §441.301(c)(2), the written person-centered plan must:

1. Reflect that the setting in which the HCBS participant resides is chosen by the HCBS participant. The State must ensure that the setting chosen by the HCBS participant is integrated in and supports full access to, the greater community, including opportunities to seek employment in community integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as HCBS participants not receiving Medicaid HCBS.
2. Reflect the HCBS participant's strengths and preferences
3. Reflect clinical and support needs as identified through the functional needs assessment
4. Include individually identified goals and desired outcomes
5. Reflect the services and supports (paid and unpaid) that will assist the HCBS participant to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the HCBS participant in addition to Medicaid HCBS.
6. Reflect risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed
7. Be understandable to the HCBS participant receiving services and supports, and to the individuals that are supporting the HCBS participant. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to HCBS participants with disabilities and HCBS participants who are limited English proficient, consistent with § 435.905(b).
8. Identify the individual and/or entity responsible for monitoring the plan
9. Be finalized and agreed to, with the informed consent of the HCBS participant in writing, and signed by all HCBS participants and individuals responsible for its implementation
10. Be distributed to the HCBS participant and other people involved in the plan
11. Include those services, the purchase or control of which the HCBS participant elects to self-direct, meeting the requirements of § 441.740
12. Prevent the provision of unnecessary or inappropriate services and supports
13. Document that any modification of the additional conditions, under § 441.710(a)(1)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered plan

The person-centered plan informs but does not serve as a substitute for the service plans HCBS providers must develop to comply with federal or state requirements or otherwise manage or ensure the continuity of care.

7.3 Connecting to Services and Supports

Connecting services and supports is an important part of the CFCM professional's role. This function extends well beyond information and referral activities that may have been provided earlier in the eligibility

process as it requires identifying and assigning who is responsible for implementing the person-centered plan and coordinating the implementation of the person-centered plan. When referring for services, it is imperative that CF case managers ensure that:

1. All HCBS participants have the right to choose among willing and qualified HCBS providers
2. Information shared with prospective HCBS providers complies with federal and State law and allows the HCBS provider to make an informed decision on their ability to meet the HCBS participant's specific needs and preferences

During this step in the CFCM process, CF case managers should at minimum complete the following activities:

1. Link the HCBS participant with medical, social, educational, and employment HCBS providers or other programs and services (both formal and informal) capable of providing needed services to address identified needs and achieve goals specified in the person-centered plan
2. Confirm connections are made and referrals are completed and followed through on
3. Troubleshoot any problems connecting to services and/or maintaining services
4. Assist with assessing need for enhanced funding based on clinically assessed need
5. Select HCBS providers and document in the person-centered plan
6. Coordinate service authorization with HCBS provider(s) and State
7. Complete program required documentation for delivering referral activities
8. Determine if additional evaluations are necessary in accordance with State regulations and program guidelines. CF case managers are not responsible for completing evaluations developed by HCBS providers or state staff.

Standards for the connecting to services and supports process includes:

1. Connections are self-determined and align with the HCBS participant's goals, cultural beliefs, and values
2. Resources and opportunities are identified in the community in which the HCBS participant lives and that match their interests and preferences
3. Information about a variety of possible informal and formal resources is shared, including the option to self-direct all or a portion of formal supports
4. Unbiased information about multiple potential referral sources is shared based on identified goals
5. Responsible for identifying connections for paid and unpaid supports
6. Responsible for developing and sharing knowledge of community resources
7. Follow-up contacts to ensure connections are made, services are delivered and documented

7.3.1 Freedom of Choice

All HCBS participants enrolled in Medicaid LTSS have the freedom to choose from any qualified and willing HCBS provider agency. As part of this process, the CF case manager must provide a list of all enrolled HCBS providers serving the HCBS participant's county of residence. If a HCBS participant does not know which HCBS provider agency to choose, the CF case manager can offer to assist the HCBS participant by providing resources for accessing information about the HCBS provider agency's quality, location, and/or other information based on the HCBS participant's preferences.

7.3.2 HCBS Provider Connections

For each Medicaid service, the CF case manager must submit a referral to the HCBS participant's chosen HCBS provider(s). This referral includes the specific service requested, a brief description of the tasks to be performed by the HCBS provider, the requested service frequency and duration, and any other relevant information regarding the HCBS participant's specific needs and preferences. Service referrals must be sent to HCBS providers within two (2) business days from the date of the HCBS participant's selection.

CF case managers must document in the WCMS each referral sent and to which HCBS providers. CF case managers should follow-up with HCBS providers within two (2) business days from the date the referral was sent if a response has not been received. CF case managers may need to discuss the referral over the phone with HCBS providers to clarify the information contained on the referral form.

The HCBS provider is required to review the services requested by the HCBS participant and indicate whether the HCBS provider accepts, declines, or accepts with modification (e.g., the HCBS participant prefers a male caregiver, but the HCBS provider only has a female caregiver available). The CF case manager may be required to obtain additional documentation from the HCBS provider (e.g., the HCBS participant's assistance plan and resident agreement from an assisted living facility) and must confirm the HCBS participant's acceptance of any modifications proposed by the HCBS provider.

Once the CF case manager receives communication back from the HCBS provider, the CF case manager must document the outcome (accepted, denied, request for modifications) in the WCMS. CF case manager must then follow-up with the HCBS participant, as new HCBS providers may be needed if the request was denied. For any requests where the HCBS provider indicated a modification was needed, the CF case manager must discuss this with the HCBS participant and receive the HCBS participant's approval or denial of the modification.

The CF case manager must assist the HCBS participant in choosing a new HCBS provider for any referrals denied by the HCBS provider or when modifications requested by the HCBS provider are denied by the HCBS participant.

7.3.3 Healthcare Connections

The HCBS participant's person-centered plan will identify whether the HCBS participant needs assistance with scheduling healthcare appointments. If the HCBS participant requires assistance, the responsible party will be identified in the person-centered plan. The responsible party may be a family member, a community provider (e.g., if a HCBS participant is living in assisted living, this is the role of the assisted living provider) or in unique circumstances, this may be the responsibility of the CF case manager.

7.3.4 Non-Medicaid Service and Support Connections

The CF case manager must conduct additional referral and outreach activities as necessary to confirm availability and coordinate the delivery of non-Medicaid services and supports included in the person-centered plan. CF case managers must provide information and/or additional referral assistance to HCBS participants as necessary to ensure all needs and risks identified by the information gathering process have been addressed. Referral assistance may be required to facilitate the HCBS participant's access to the Supplemental Nutrition Assistance Program (SNAP), a local food bank, Social Security, the Low-Income Energy Assistance Program (LIEAP), a senior center, the local housing authority, or other community resources. The CF case manager is not required to provide application assistance for these services, but is expected to, at a minimum, follow-up on referrals and to ensure that connections are made.

Referral assistance may consist of providing the HCBS participant with the appropriate contact information or by contacting the entity on behalf of the HCBS participant if the HCBS participant requires or requests that level of assistance. CF case managers may not be able to determine the scope, frequency, or duration of non-Medicaid services that are available to the HCBS participant. All referrals to non-Medicaid services and follow-up must be documented in the WCMS.

For example, a HCBS participant has a need for social interaction and wishes to attend the local senior center three days each week. In addition, the Medicaid approved non-medical transportation provider in the HCBS participant's county of residence is only able to provide this service one day each week. The HCBS participant informs the CF case manager that he or she has a friend who attends the same senior center and the friend's daughter has offered to drive the HCBS participant if he or she would like. With this information, the CF case manager would document in the person-centered plan that a Medicaid service, natural support, and non-Medicaid community resource are being used to address the HCBS participant's needs for social interaction and transportation. Additionally, the CF case manager would assist, if requested by the HCBS participant, in contacting the local senior center and friend's daughter to discuss the HCBS participant's needs.

7.3.5 Self-Direction Connections

For HCBS participants who have chosen the self-direction service delivery option and have been determined to meet the self-direction criteria, the CF case manager is responsible for providing information and assistance and providing on-going case management services. CFCM will not be part of the HCBS participant's budget and CFCM will not interfere with the actual choice and self-direction of services. The CF case manager plays a supportive role in developing a plan and assisting the HCBS participant in connecting to services at the direction of the HCBS participant.

Key activities of the CF case manager include:

1. Educate HCBS participants on the self-direction service delivery option so they can make an informed choice in choosing traditional, or self-direction service models for their service delivery
2. Assess the HCBS participant's desire and comfort to direct their own care
3. Facilitate the person-centered planning process and person-centered plan development—includes pre-meetings with the HCBS participant, individual representative(s) and circles of supports, HCBS providers—development of HCBS participant driven person-centered goals
4. Refer the HCBS participant to the appropriate resources where they can obtain and complete the required documents for self-direction
5. Monitor (or evaluate) self-directed service as written in person-centered plan effectiveness, quality, and expenditures, and unmet needs
    a. Follow-up with HCBS participant and the individual representative to address any identified health and safety risks
    b. When unmet needs and risks are identified, the CF case manager should respond by providing coaching, making referrals to resources, and advocating on behalf of the HCBS participant to obtain appropriate resources.

7.3.6 Finalizing the Person-Centered Plan

The person-centered plan cannot be finalized until the person-centered plan process and referral activities are complete. Prior to finalizing the person-centered plan, the CF case manager must ensure that the HCBS participant has reviewed the HCBS participant's rights and responsibilities and that all signatures are obtained. At minimum, the HCBS participant, CF case manager, and all HCBS providers must sign the person-centered plan. Additional signatures from an individual representative or anyone else involved in implementing the person-centered plan may be obtained, as appropriate.

All person-centered plans are subject to review by the State for quality assurance purposes. The completed person-centered plan must be entered into the WCMS within ten (10) business days of completing the person-centered planning meeting.

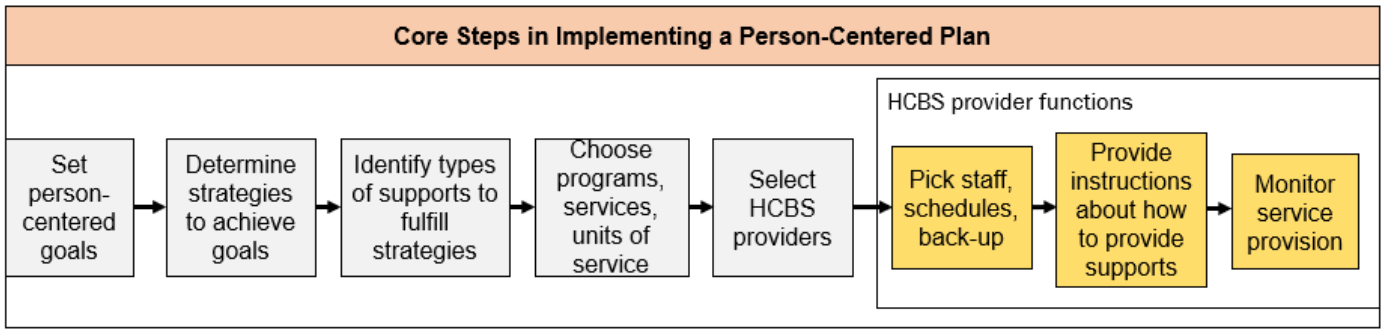
Once finalized, the CF case manager must provide a copy of the person-centered plan to the HCBS participant and role-based copies to the HCBS providers authorized to provide Medicaid HCBS. The HCBS participant must receive a complete copy of the person-centered plan while the versions sent to HCBS providers include only the necessary information for the coordination, provision, and reimbursement of Medicaid HCBS as to assure the privacy of the HCBS participant and comply with the minimum necessary standard, a key protection of the HIPAA Privacy Rule.

7.3.7 Implementing the Person-Centered Plan

Upon completion of the person-centered planning meeting, the person-centered plan will outline the goals, steps, and supports needed to achieve these goals. The CF case manager, along with the HCBS participant, developed the person-centered plan and it is the responsibility of the HCBS provider to implement the plan. The HCBS provider will play a central role in the last three steps:

1. While the CF case manager may help the HCBS participant identify preferences for which types of staff they want and when they want to receive supports, HCBS providers will likely retain primary responsibility for identifying the actual staff, setting schedules, and ensuring that back-up supports are available.
2. The support plan will include guidance about the HCBS participant's preferences about how supports are provided. However, it will be up to the HCBS provider to flesh out the details of these instructions and ensure that staff are trained and instructed to provide supports in a manner that is consistent with the person-centered support plan.
3. The CF case manager will play a monitoring role through regular contact with the HCBS participant likely including observing the provision of services. However, the HCBS provider will be monitoring daily service provision and will be responsible for notifying the CF case manager of any issues.

Figure 12. Core Steps in Implementing a Person-Centered Plan



7.3.8 Service Approval and Authorizations

All Medicaid HCBS must be approved and authorized in the Medicaid claims system for a provider to bill for services. The CF case manager plays an important role in ensuring the approval and authorization process by the appropriate State agencies occurs in a timely manner and facilitates service coordination.

The State will provide additional details regarding this process at a later date.

7.3.9 Coordination with Medicaid Managed Care Organizations (Non-LTSS)

Some HCBS participants may be enrolled in a Medicaid MCO to receive all non-LTSS health care services. As HCBS in these cases is carved out, it is crucial that CF case managers coordinate and communicate with the MCO's care coordinators/manager. While this process has yet to be defined, RI EOHHS anticipates that the CF case managers will:

1. Identify in the person-centered plan if the HCBS participant is receiving services from a Medicaid MCO

2. Identify the assigned Medicaid MCO care manager
3. Request assessments or service plans from the Medicaid MCO care manager
4. Communicate with the Medicaid MCO care manager regarding issues such as: significant change events, provisions of services, and a change in behavior and health status
5. Work with the Medicaid MCO care manager to delineate roles and responsibilities between the CF case manager and the assigned Medicaid MCO care manager to avoid duplication or gaps in services
6. Ensure that messaging on the roles and responsibilities of both entities is clear to jointly served HCBS participants

The State will provide additional details regarding this process at a later date.

7.3.10 Medicaid Eligibility Renewal Responsibilities

CF case managers must be knowledgeable about the policies, procedures, rules, and regulations governing Medicaid LTSS eligibility and HCBS programs. RI EOHHS is committed to providing conflict-free case management entities with education and training in these areas prior to start up and at least annually. In addition, CF case managers are expected to assist HCBS participants in completing any forms required for annual renewal necessary to ensure that there are no service disruptions. This may require the CF case manager to work in coordination with State agency eligibility representatives as well as with HCBS participants and their families.

CF case managers do not have a role in the eligibility determination process. DHS is the only entity with the authority to determine if an applicant or HCBS participant meets the State's Medicaid LTSS eligibility requirements.

7.4 Plan Monitoring and Follow-up

Person-centered plan monitoring and follow-up activities are necessary to ensure that the person-centered plan is effectively implemented and adequately addresses the needs of the HCBS participant. While discussing the HCBS participant rights and responsibilities, CF case managers should also inform HCBS participants of the monitoring requirements and the purpose.

At minimum, monitoring must occur monthly; however, monitoring activities and contacts may occur with the HCBS participant, family members, HCBS providers, or other entities or individuals as frequently as necessary to:

1. Ensure services are being furnished in accordance with the HCBS participant's person-centered plan
2. Evaluate the effectiveness of the person-centered plan in meeting the HCBS participant's needs
3. Determine if there has been any "significant change" in the participant's health, functional capacity, social or physical environment, formal or informal support system, or if other circumstances require re-evaluation of the person-centered plan
4. Periodically screen for any potential risks or concerns
5. Assess the HCBS participant's satisfaction with the services and supports
6. Identify any necessary adjustments in the person-centered plan or service arrangements with HCBS providers

CMS considers monthly monitoring as a best practice. It offers all HCBS participants an opportunity to talk about their needs and wants in a free form conversation that also provides information about overall wellness, care needs, and satisfaction with the services they receive. The CF case manager should also use this time to confirm that services were delivered according to the person-centered plan.

When conducting the monitoring and follow-up process, CF case managers should at minimum complete the following activities:

1. Communicate with the HCBS participant, family members, HCBS providers, or other collateral entities to review progress towards goals and determine if services, supports, and resources are being delivered according to the person-centered plan and are meeting the HCBS participant's needs and wants
2. Adjust the person-centered plan as needed to better meet the HCBS participant's evolving needs and wants
3. Address and problem-solve issues over service provision between the HCBS participant, the HCBS participant's supporters, and HCBS providers
4. Assist the HCBS participant to amend the person-centered plan as desired in a timely manner
5. Coordinate with members of the HCBS participant's support team to ensure the person-centered plan is implemented as desired
6. Complete program required documentation for delivering monitoring activities
7. Re-evaluate the HCBS participant's goals, needs, and preferences at least annually, when the HCBS participant's circumstances changes, or as needed
8. Confirm if transition of care needs are being met via the person-centered plan

Standards for the plan monitoring and follow-up process include:

1. Documentation of follow-up consistent with RI standards and a follow-up schedule agreed upon by the HCBS participant
2. Progress toward goals is discussed and barriers are addressed as requested by the HCBS participant
3. Changes to the person-centered plan are made upon request or as the HCBS participant's needs change and shared as indicated
4. Responsive and flexible – able to amend plan as needed, with a simple and clear process for changes to be made in a timely manner
5. Coordination with team members is evident
6. Referrals are made to DHS or BHDDH if the Level of Care needs to be re-reviewed
7. Outcomes are measurable

7.4.1 Person-Centered Plan Updates and Reassessments

The person-centered plan must be reviewed and updated at least annually or more frequently upon request by the HCBS participant or in response to a "significant change" in the participant's health, functional capacity, social or physical environment, formal or informal support system, or if other circumstances require re-evaluation of the person-centered plan. A "significant change" may include:

1. Loss of a primary caregiver, crucial informal supports, or an individual representative
2. A medical or behavioral health change that may impact needs, goals, and services
3. Change in service level (increase or decrease)
4. HCBS participant indicates they want to change their person-centered goals
5. Change or deterioration in the HCBS participant's condition based on a clinical assessment
6. Change in residence

7. HCBS participant choice not to use an authorized service

During the annual person-centered planning meeting, the CF case manager will evaluate whether the person-centered plan continues to be appropriate for the participant. If the person-centered plan is not appropriate, the CF case manager will prepare a new person-centered plan to better reflect the participant's current situation and needs. The annual person-centered planning meeting also provides an opportunity for the CF case manager to review a participant's progress, consider successes and barriers, and evaluate the previous period of case management activities.

In some instances, the person-centered plan must be updated based on a reassessment of functional needs. The purpose of the reassessment is to review all aspects of the participant's current functioning to develop a new person-centered plan or continue the existing person-centered plan. For EAD participants, an annual reassessment of functional need is a necessity. Therefore, the CF case manager will have to reassess all or some of the functional needs of a participant in this eligibility category using the interRAI 10 in conjunction with the annual person-centered planning meeting. By contrast, the CMS has determined that the functional needs of the I/DD population change less frequently and, as such, must be reassessed once every five years rather than annually. The State is currently defining what role the CF case manager will have using the functional needs assessment tool for this population. Additional information is forthcoming.

7.5 Minimum Contact Frequency

The table below identifies **minimum** contact frequency, along with the corresponding timeframes CF case managers will need to follow when documenting contacts or when completing certain activities.

Figure 13. Minimum Contract Frequency

Contact Type	Frequency	Timeframe
Initial outreach by the CF case manager once notified of a new HCBS participant	One-time initial outreach via telephone or face-to-face contact.	No more than three (3) business days to minimize any delays to implementing HCBS services for the HCBS participant.
Initial person-centered planning meeting	One-time for new HCBS participants	The CF case manager must complete the written plan and the corresponding service authorization within ten (10) business days of completing the person-centered planning meeting. This timeframe will allow time for the case manager to gather any pending information not available during the person-centered meeting.
HCBS provider referrals	As needed	1. Service referrals must be sent to HCBS providers within two (2) business days from the date of the HCBS participant's selection. 2. CF case managers should follow-up with HCBS providers within two (2) business days from the date the referral was sent if a response has not been received.
Plan monitoring and follow-up	1. Monthly non-face-to-face contact with the HCBS participant or collateral (e.g., caregiver, individual representative, family member, HCBS provider,	The case manager should enter contact notes in the WCMS in a timely manner.

Contact Type	Frequency	Timeframe
	etc.). A non-face-to-face contact includes a phone call; email exchange; or letter/correspondence exchange. 2. Face-to-face contact with the HCBS participant at least once every 6 months. The CF case manager is not required to conduct a monthly non-face-to-face contact in the same month as the face-to-face contact. 3. As needed telephonic or face-to-face contact based on HCBS participant needs	
Annual person-centered planning meeting	Annual person-centered planning meeting (face-to-face). The CF case manager is not required to conduct a monthly non-face-to-face contact in the same month as the annual person-centered planning meeting.	The annual person-centered planning meeting should be conducted no sooner than 60 calendar days and no later than 15 calendar days prior to the person-centered plan end date.

8. CONFLICT-FREE CASE MANAGEMENT ADMINISTRATION

8.1 Conflict-Free Case Management Entity Requirements

All conflict-free case management entities will be required to adhere to a standardized set of agency requirements. Additional details regarding the State's CFCM entity requirements will be outlined as part of the certification and licensure standards maintained by the State.

8.1.1 Qualifications

1. Be a public or private not-for-profit or for-profit agency that meets all applicable State and federal requirements and is certified by RI EOHHS to provide conflict-free case management services
2. Have a physical location in RI
3. Have a signed agreement with the State
4. Obtain a National Provider Identifier (NPI) Number
5. Be an authorized Medicaid provider of conflict-free case management services

8.1.2 Responsibilities

1. Assign one (1) person to act as the State's primary contact and assume responsibility for the CFCM entity's administration and operation

2. Be available to HCBS participants during regular business hours (8am-5pm, Monday – Friday) and provide evening/weekend coverage options.
3. Ensure HCBS participants are provided access to a CF case manager
4. Ensure each CF case manager is supervised by a supervising CF case manager
5. Meet all CFCM entity qualifications
6. Provide conflict-free case management services to HCBS participants without discrimination based on race, religion, political affiliation, gender, national origin, age, sexual orientation, gender expression, or disability
7. Maintain adequate administrative and staffing resources and emergency backup systems to deliver conflict-free case management services in accordance with all federal and State requirements
8. Provide language assistance services including bilingual staff and/or interpreter services, at no cost to the HCBS participant. Language assistance shall be provided at all points of contact, in a timely manner and during all hours of operation. As RI EOHHS is overseeing the CFCM network, it will translate all materials shared with HCBS participants into the required languages including Spanish and Portuguese.
9. Establish and maintain working relationships with community-based resources, supports, organizations, hospitals, HCBS providers, and other organizations that assist in meeting the HCBS participant's needs
10. Collaborate with other entities, as needed to support HCBS participants
11. Create a **Policies and Procedures Manual** that contains policies and procedures for all systems and functions necessary for the CFCM entity to execute case management services according to the requirements in this document. The policies and procedures manual must include written procedures regarding:
    a. Information gathering
    b. Person-centered plan development
    c. Connecting to services & supports
    d. Plan monitoring & follow-up
    e. Service denials, reductions, discontinuations, and terminations
    f. Administrative fair hearings
    g. Business continuity plan. The plan must address procedures for response to emergencies and other business interruptions.
    h. Grievances
    i. Conflicts of interest
    j. Critical incident reporting and follow-up
12. Create a **Start-Up Plan** that will describe all steps, timelines, and milestones necessary for the CFCM entity to begin providing CFCM. This plan must include:
    a. A description of all steps, timelines, and milestones necessary for the CFCM entity to be fully compliant with the requirements established in this document
    b. A listing of all personnel involved in the start-up and what aspect of the start-up they are responsible for

c. An operational readiness review for the State to determine if the CFCM entity is ready to begin offering CFCM

d. The risks associated with the start-up and a plan to mitigate those risks

13. Create a **Continuous Quality Improvement Plan.** This plan must include:
    a. How the CFCM entity oversees the work performed by CF case managers to ensure all tasks are being performed according to the State's requirements
    b. How the CFCM entity reviews work to determine whether the work is being completed in a correct and high-quality manner
    c. How the CFCM entity identifies and addresses CF case manager performance issues
    d. How the CFCM entity will track and resolve HCBS participant grievances
    e. The CFCM entity shall participate in the RI EOHHS hosted Quality Community of Practice. The Quality Community of Practice will provide an opportunity for CF case managers to share knowledge, insights, and best practice approaches
14. Submit the **Policies and Procedures Manual, Start-Up Plan, and** the **Continuous Quality Improvement Plan** to RI EOHHS for review and approval. RI EOHHS will review and approve these materials prior to the CFCM entity providing CFCM. In addition, any significant updates to these materials will require RI EOHHS approval prior to implementation.
15. Obtain and maintain all hardware necessary to access RI EOHHS data systems (e.g., the WCMS) needed to perform CFCM in accordance with requirements outlined in this document
16. Comply with State and federal rules and regulations related to overall security, privacy, confidentiality, integrity, availability, and auditing
17. Provide that security is not compromised by unauthorized access to workspaces, computers, networks, software, databases, or other physical or electronic environments
18. Notify the appropriate State agency if the CFCM entity identifies or suspects fraud, waste, and abuse
19. Facilitate access to assistive communication technology and/or interpreters for HCBS participants with hearing and/or vocal impairments and access to foreign language interpreters as necessary to conduct all required conflict-free case management activities
20. Ensure all staff and independent contractors meet established standards for qualifications and training
21. Participate in measuring and reporting quality and in continuous quality improvement activities
22. Ensure that all CF case managers successfully pass a background check in accordance with State and federal law
23. Use the WCMS and pay any associated user fees
24. Demonstrate ongoing financial sustainability and provide stability for CF case managers and HCBS providers
25. Submit a **Financial Statement** to the State for review annually
26. Complete a State developed **Cost Reporting Template** at the end of calendar year 2024 for RI EOHHS to assess rate adequacy

8.2 Conflict-Free Case Manager Qualifications

All CF case managers will be required to meet a set of standards and qualifications before providing CFCM to HCBS participants. CFCMs will need to have achieved a certain level of education and experience. In addition, before providing CFCM services, the CF case manager will be required to complete CF case manager training which includes standards of person-centered planning and the role of the CFCM in the overall person-centered planning process.

8.2.1 Education and Experience

CF case managers will be required to meet minimum education and experience requirements before they are able to serve in the role of a CFCM. CF case managers will be required to meet one of the following requirements:

1. An associate degree from an accredited college or university and one year of relevant experience (e.g., providing case management or other type of assistance) working with the target population for which they are providing case management (e.g., DD/IDD participants or elders). Degrees in the following human services fields are preferred:
    a. Counseling
    b. Education
    c. Gerontology
    d. Human Services
    e. Nursing
    f. Rehabilitation
    g. Social Work
    h. Psychology
    i. Social Services
    j. Behavioral Health Science
2. A combination of post-secondary college and two years of relevant experience (e.g., providing case management or other type of assistance) working with the target population for which they are providing case management (e.g., DD/IDD participants or elders).

CF case manager supervisors must possess a bachelor's degree from an accredited college or university and have a minimum of two (2) years of supervisory experience and two (2) years of case management experience.

8.2.2 Core Competencies

CFCM requires a set of skills and competencies that identify the HCBS participant's desired outcomes, preferences, values and needs, and the parallel creation of a person-centered plan that considers the planning and coordination of services and supports focused on the HCBS participant. [18] CF case manager competencies should align with those identified by a 2020 National Quality Forum (NQF) report regarding Person-Centered Planning and Practice.[19] CF case managers are not expected to possess all of these core competencies; however, conflict-free case management entities should use this framework in identifying CF case manager candidates and as part of its training program. The figures below presents a high-level summary of CF case manager competencies.

Figure 14. Conflict-Free Case Manager Skills

Conflict-Free Case Manager Skills	
Foundational Skills: Forming a rapport with the participant; understanding their needs and wants; and empowering them to make decisions about goals in the context of needed supports and services. *Understanding the Participant* • Informed decision making • Contextual understanding • Applying effective freedom • Group power dynamics • Understanding disparities *Empowering the Participant* • Advocacy role • Strengths-based thinking • Yielding control • Training the participant to lead the process • Creating a culture of high expectations • Supporting empowerment development • Navigating complexity of choice	**Relational and Communication Skills**: Building relationships and maintaining positive communication are central to facilitating CFCM. Through strong relational and communication skills, the conflict-free case manager can keep a creative, individualized approach to planning and can help identify non-standardized supports and services. *Relational Skills* • Negotiation • Engagement • Dispute resolution • Team building • Plan documentation and distribution *Communication Skills* • Active and reflective listening • Motivational interviewing • Alternative communication methods • Health literacy • Empathy
Computer and Technology Skills: Conflict-free case managers need basic computer skills to manage case files, use databases, and create spreadsheets as needed.	**Organization and Records Management Skills**: Conflict-free case managers should be able to multitask, manage schedules, update records, manage the person-centered planning process, and meet deadlines.

Figure 15. Conflict-Free Case Manager Knowledge

Conflict-Free Case Manager Knowledge		
Philosophy: Has competencies in the philosophical underpinnings of the participant and family-centered thinking, planning, and practice. *Generating purpose and meaning* • Cultural perspective • Effective freedom • Empowerment • Dignity of risk • Presumption of competence • Supported decision making • Trauma-informed approach *Contextual Philosophy* • Independent living philosophy • Understanding of living best life • Recovery • Ableism and ageism *Advocacy* • Self and systems advocacy • Human rights • Model of independent living	**Resources**: Has a working knowledge of how to access information and assistance of long-term services and supports and the larger healthcare system. *System Resources* • LTSS and medical system • Safety net providers • Gaps in services and supports • Service load or service coordination management • Legal issues *Community Context Resources* • Community assets and resources • Populations and subgroups • Local advocacy groups *Planning Specific Resources* • Process elements and experts • Content elements and experts • Technological solutions	**Policy and Regulation**: Has a good understanding of laws, federal and state regulations, local policies, and court decisions. The conflict-free case manager should be familiar with the laws that protect the rights of the participants they are supporting. *Laws* • Americans with Disabilities Act • Individuals with Disabilities Education Act (IDEA) • Older Americans Act • Age Discrimination Act • 21st Century Cures Act – Division B • Health Insurance Portability and Accountability Act (HIPAA) *Regulations* • CMS HCBS Settings Final Rule • RI LTSS regulations and statutes

8.2.3 Caseload Size Standards

RI EOHHS calculated an average caseload of 48 HCBS participants per CF case manager in its rate calculation. RI EOHHS assumed that 85% of a CF case managers' time would be spent providing case management services and the remaining time would be spent on administrative tasks (e.g., vacation, training, sick time, and other administrative activities). Using this assumption, an average HCBS participant would receive approximately 37 hours of support in a year. Figure 16 provides an estimated breakdown of a CF case managers' average time in a year.

RI EOHHS anticipates that CF case manager caseloads will vary depending on the HCBS participant's needs and requests. A 48-participant caseload is an estimate and does not limit the CFCM entity from going above or below this estimate. RI EOHHS will regularly assess CF case manager caseloads as part of its ongoing quality monitoring efforts.

Figure 16. Estimated CF Case Manager Average Time Spent in a Year

Category	Activity	Hours Per Participant	Annual Hours (48 Caseload)	% of Total
Case Management Service	Initial person-centered planning meeting (face-to-face)	8.5	408	20%
	Annual person-centered planning meeting (face-to-face)	4.5	216	10%
	Monthly Monitoring	24	1,152	55%
	Total	**37**	**1,776**	**85%**
Administrative (e.g., vacation, training, sick time, etc.)		**NA**	**304**	**15%**
Total Hours in a Year		**NA**	**2,080**	**100%**

Conflict-free case management entities are expected to maintain a CF case manager to supervisor ratio of not more than 10:1. Supervisors must meet with each CF case manager at least once per month to review caseloads, current case assignments, critical issues, etc. Supervisors must also hold monthly team meetings with their CF case managers to review any changes to practice standards, discuss quality assurance initiatives or activities, etc.

8.2.4 Conflict-Free Case Manager Training

CF case managers will be required to complete the trainings listed below. The State identified several of these trainings from the National Center on Advancing Person-Centered Practices and Systems (NCAPPS) Staff Competency Domains. [20] The State anticipates developing the trainings listed below (or using a vendor) and delivering these trainings to CF case managers. Conflict-free case management entities will be expected to deliver these trainings to their staff at a future date.

1. LTSS in RI. *This training will include an overview of the State's LTSS system, Medicaid LTSS eligibility requirements and process, materials required to support eligibility renewals, and available community resources in RI.*
2. Introduction to CFCM in RI
3. Person-centered plan development
4. Use of the WCMS
5. Population-specific training, including but not limited to:

a. Working with HCBS participants with disabilities
b. Working with HCBS participants with brain injury
c. Working with the aging population

6. Prevention, identification, and reporting of critical incidents
7. Health Insurance Portability and Accountability Act (HIPAA)
8. Cultural competency
9. Functional needs assessment tools (RI EOHHS is currently defining what this training will look like and the role of the CF case manager)
10. Refresher training: On-going based on quality assurance reviews and other training needs identified by the State
11. Additional trainings as determined by RI EOHHS as necessary (including training on programmatic changes and/or program or process updates)

8.3 Grievances

Grievances may be initiated by the HCBS participant or anyone involved or working with the HCBS participant. For the purposes of this plan, a grievance is a complaint or expression of dissatisfaction about a CF case manager or CFCM network agency. There is a separate formal appeals process for participants who disagree or are dissatisfied with an State agency action related to Medicaid eligibility and/or the scope, amount, and/or duration of services set forth in 210-RICR-10-05-2. When HCBS participants have grievances with case management decisions or actions, resolution attempts should begin with the CF case manager who will work to resolve the issues or concerns. If the grievance involves the HCBS participant's CF case manager, or the CF case manager is unable to address grievance, the HCBS participant should be directed to contact the CF supervisor or the appropriate State agency for resolution.

The CFCM entity is required to develop and maintain a grievance policy and procedure. The CFCM entity is required to provide the participant with written information about how to file a grievance and notify participants annually of its grievance procedure.

The role of the CF case manager will not supplant the role of the Long-Term Care Ombudsperson as defined in 218-RICR-40-00-1. The Ombudsperson will handle grievances filed by participants of long-term care facilities. "Facilities" include, but are not limited to, nursing homes, intermediate care facilities, extended care facilities, convalescent homes, rehabilitation centers, home care agencies, homes for the aged, veterans' homes, boarding homes, and adult supportive care, residential care and assisted living residences.

If an HCBS participant is receiving or plans on receiving services from a "facility" (as defined above), CF case managers must explain the role of the Long-Term Care Ombudsperson and provide contact information.

In the event a CF case manager receives a grievance from a HCBS participant or another individual, the CF case manager should work with the HCBS participant and others to resolve the grievance. Resolution may include, but is not limited to:

1. Finding a new HCBS provider
2. Contacting the HCBS provider agency to request a change of caregiver
3. Assigning a new CF case manager

4. Revising the person-centered plan based on the HCBS participant's needs
5. Conducting an internal investigation when the grievance involves the CFCM entity and reporting findings to the State
6. Referring the HCBS participant to RI's Long-Term Care Ombudsperson Program

The CFCM entity is required to report and track grievances in accordance with procedures established by the State.

8.4 Case Documentation

The WCMS will serve as the official case record for HCBS participants. The CFCM entity and case manager are responsible for completing and maintaining case documentation and for ensuring case records are complete, accurate, and timely. Activities that CF case managers must document include, but are not limited to:

1. Information gathering activities
2. Person-centered plan development and update activities
3. Referral activities
4. Attempts to contact HCBS participant to schedule a visit
5. Attempts to contact persons/agencies working with the HCBS participant
6. Phone conversations
7. Email conversations regarding the HCBS participant
8. Receipt of documents related to the HCBS participant

Case documentation is a professional record and should provide enough information for anyone reading to understand what has been done in the past, what is currently happening, and what may be needed in the future. CF case managers should remember that case documentation is part of the HCBS participant's health record, can be obtained by the HCBS participant if requested, and may be discoverable in legal proceedings.

CF case managers should use person-first language for all case documentation. The basic principle of person-first language is to name the person first and only then to describe the disability or impairment. Person-first language examples are provided below:

1. Jennifer is 20 years old. She has autism.
2. A person who uses a wheelchair (instead of "wheelchair confined")
3. People with disabilities (instead of: the disabled / the handicapped)

8.5 Conflict of Interest Safeguards

Federal regulations require that case management activities, including the development of the person-centered plan, must not be performed by any individual or entity who is employed by or has an interest in a provider of services included in the person-centered plan.

To ensure compliance with this requirement, RI EOHHS established the following conflict of interest standards:

1. The CF case manager must not be related by blood or marriage to the participant or to any person paid to provide Medicaid HCBS to the participant.
2. The CF case manager must not share a residence with the participant or with any person paid to provide Medicaid HCBS to the participant.

3. The CF case manager/CFCM entity must not be financially responsible for the participant.
4. The CF case manager/CFCM entity must not be empowered to make financial or health-related decisions on behalf of the participant.
5. The CF case manager/CFCM entity must not own, operate, be employed by, or have a financial interest in any entity that is paid to provide Medicaid HCBS to the participant. Financial interest includes a direct or indirect ownership or investment interest and/or any direct or indirect compensation arrangement.
6. Should a conflict arise, it is the CF case manager's duty to inform the participant and assist the participant in finding a new CF case manager or CFCM entity as necessary to eliminate potential conflicts of interest.

8.6 Critical Incidents

CMS requires RI to have necessary safeguards in place to protect the health, safety, and welfare of HCBS participants. Reporting critical incidents is an important method to manage HCBS participant health and safety. The State is currently developing its approach to critical incident management and reporting; however, RI EOHHS anticipates that CFCM entities and case managers will be expected to:

1. Report all incidents they observe or suspect since CF case managers are mandatory reporters. If a HCBS participant chooses not to report an incident, or declines further intervention, the CF case manager must still report the incident to the appropriate State agency.
2. Ensure that prompt action is taken to protect the safety of the HCBS participant. This may include replacing or removing CFCM entity staff.
3. Maintain policies and procedures regarding incident reporting and management.
4. Depending on the severity and type of critical incident:
    a. The CF case manager may need to revise the person-centered plan (e.g., the critical incident results in a change to the caretaker or HCBS provider).
    b. The CF case manager may need to provide additional support to the HCBS participant and document any follow-up visits. For example, the CF case manager may provide an additional face-to-face visit to ensure continued safety, help a HCBS participant to locate a new HCBS provider, or work with the HCBS provider and HCBS participant to address an abusive situation.

8.7 Quality Assurance

The CFCM entity is responsible for managing the performance of CF case managers employed by or contracted with the agency. Each CFCM entity must have internal mechanisms for assessing and managing the performance of each CF case manager. Should the CFCM entity fail to address CF case manager performance concerns to the State's satisfaction, the State may require retraining or other progressive disciplinary actions, up to and including termination of the CF case manager's status as a CF case manager. Managing conflict-free case management service quality could include such methods as:

1. New CF case managers shadowing and observing CFCM services prior to providing services independently
2. Regular, systemic review and remediation of case records and other case management services documentation, on at least a sample basis. The review should ensure that CF case managers meet all established timelines as identified in this document and that all required information is entered into the WCMS.
3. Allocation and monitoring of staff to assure that all standards and time frames are met
4. Addressing and rectifying HCBS participant grievances about a CF case manager

In addition, CFCM entities are required to create and maintain a **Continuous Quality Improvement Plan** as defined in section 8.1.2.

8.8 Administrative Fair Hearings

Participants have the right to appeal any decision regarding their Medicaid benefits, as specified in 210-RICR-10-05-2. Rhode Island's Executive Office of Health and Human Services Hearing Office is designated by law and the Secretary to serve as the appeals entity for programs served under EOHHS and other State agencies. The case manager is responsible for ensuring the participant understands their rights to request an administrative fair hearing and may assist the participant in submitting required documents. However, a case manager may not complete and submit a request for an administrative fair hearing on behalf of a participant or act as the participant's representative in the hearing process as case managers may have a vested interest in the outcome of the hearing.

In the event that an HCBS participant requests and is granted the opportunity for an administrative fair hearing, the CF case manager will receive notice from the State. HCBS participants may have the right to continue receiving services pending the outcome of the administrative fair hearing. Under these circumstances, the CF case manager cannot make changes to the service(s) already authorized in the person-centered plan until a final agency decision is rendered.

The CF case manager may be required to produce documentation or information related to the administrative hearing or to testify as a witness in the hearing. The CF case manager should also work with the HCBS participant to determine if there is a way to negotiate a resolution prior to the administrative hearing.

The CF case manager must notify all affected HCBS providers of any changes or pending changes resulting from an administrative hearing to services. Notification to the provider(s) must include the effective date of the change so that the provider(s) can prepare for service transition/termination and reduce the likelihood of uncompensated service delivery.

9. HCBS PARTICIPANT RIGHTS AND SAFEGUARDS

9.1 HCBS Participant Rights and Safeguards

CF case managers are responsible for ensuring HCBS participants are informed of their rights and responsibilities, providing HCBS participants the support needed to exercise them, and documenting that HCBS participants have been provided this information. CF case managers must explain these rights to HCBS participants in such a manner as to ensure they understand them. HCBS participants may need accommodation, protection, and support to enable them to exercise their rights, and their rights should never be limited or restricted without due process.

The HCBS participant has a right:

1. To be treated with dignity and respect
2. To have their ethnic, spiritual, linguistic, family, and cultural choices respected
3. To be safe and free from abuse, neglect, exploitation, coercion, and unauthorized restraint
4. To receive competent, considerate, respectful care from all providers
5. To make their own decisions (with help from their individual representative or someone else they choose, if appropriate)
6. To privacy and confidentiality

7. To live safely and independently in the way they choose
8. To live in the least restrictive environment
9. To be an active member of their community
10. To participate in assessments and development and implementation of their services
11. To receive information about their care and community services and to choose how their services are provided
12. To make a grievance, without fear of retaliation, when they are not happy with the services they receive
13. To appeal decisions about their care and services or about their cost share when they do not agree
14. To accept or refuse any community services and to withdraw from programs at any time

In addition to rights, participants also have responsibilities when receiving Medicaid HCBS. HCBS participants have the responsibility:

1. To know about their rights and to ask questions or request information to better understand their rights and responsibilities
2. To notify their CF case manager of changes in their income, assets, expenses, or address and to complete all paperwork necessary to maintain their Medicaid eligibility
3. To pay the cost share, if they have one. If they do not pay their cost share, their Medicaid services may be terminated
4. To participate in their assessments and the development and implementation of their person-centered goals and services
5. To follow their person-centered plan
6. To understand their back up plan and when to use it
7. To give their consent only when they understand and agree with the decision
8. To be honest about their needs and to report changes in their needs to their CF case manager and HCBS providers
9. To notify their doctors of any changes in their health or condition and to keep appointments with their doctors
10. To follow the rules of the programs and services they are enrolled in
11. To be respectful of the people who provide their services
12. To report any instances of abuse, neglect, or exploitation

9.2 Behavioral Interventions: Restraint & Restrictive Intervention

Restrictive interventions or restraints are generally prohibited, except in limited circumstances. Such procedures are allowed for a HCBS participant only when documented in a behavioral support plan reviewed and approved by clinicians, families, guardians, and the Human Rights Committee. An approved behavioral support plan must document the circumstances under which a restrictive intervention is permitted and must be strictly followed. The likely benefit of the procedure must outweigh the apparent safety risk. This process ensures that HCBS participant's consent to the use of this type of procedure and requires clinicians to exhaust other less restrictive alternatives, ensuring that the use of restrictive interventions is minimized wherever possible.

Any use of an approved restraint or restrictive intervention must be documented by the HCBS provider in a behavioral support plan and submitted to the CF case manager. The CF case manager will upload the HCBS participant's behavioral support plan to the WCMS and review the behavioral support plan during routine visits. At a minimum, CF case managers must review the behavioral support plan every six months during the in-person monitoring visit and follow-up with the HCBS provider.

When such interventions are authorized for a HCBS participant, the least restrictive method possible should be implemented. As part of the regular monitoring activities, the CF case manager must pay special attention to identify any unauthorized use or misapplication of restraints. When a restraint is used appropriately, the HCBS participant must be kept clean, get the food and fluids they need, be able to have a bowel movement or urinate when needed, be as comfortable as possible, and not injure him/herself. Any known or suspected misuse or misapplication of restraints or restrictive interventions must be reported by the CF case manager as a critical incident.

The CF case manager is not authorized to establish or assess the appropriateness or effectiveness of a behavioral support plan. The role of the CF case manager is oversight which requires reviewing the behavioral support plan to better understand the HCBS participant's needs and to identify whether there might be a misuse or misapplication of restraints or restrictive interventions.

9.3 Protected Health Information

Conflict-free case management entities and CF case managers must ensure compliance with all federal and State privacy laws and regulations regarding the treatment of Protected Health Information (PHI). The HIPAA Privacy Rule sets national standards for the treatment of PHI by three types of covered entities: health plans, health care clearinghouses, and health care providers who conduct standard health care transactions electronically. Conflict-free case management entities are considered covered entities.

10. PAYMENT FOR CFCM SERVICES

10.1 Rate Setting Approach and Methodology

RI EOHHS considers CFCM as a "new" service. Accordingly, the State built a more robust rate for CFCM that incorporates many key cost centers that have not been included in the past. RI EOHHS is hopeful that this rate will be sufficient to cover recruitment costs and encourage our community partners to become members of the CFCM network.

All conflict-free case management services will be paid via fee-for-service (FFS) using a single monthly unit of service (i.e., monthly billing per eligible HCBS participant). The monthly unit of service represents an average cost. Some HCBS participants being served will receive more and some less, but on average will receive case management valued at about what the rate represents. In accordance with 1902(a)(30)(A) of the Social Security Act, case management payment rates will be consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers. RI EOHHS will not reimburse CFCM entities for any initial start-up costs.

RI EOHHS contracted with Guidehouse to calculate a monthly reimbursement rate for CFCM and projected costs. **RI EOHHS anticipates using a monthly rate of $170.87 per HCBS participant; however, this is contingent on RI General Assembly and CMS approval.** CFCM entities should use this initial monthly rate to determine the financial viability and capacity for their organizations to provide CFCM beginning January 2024. After the CFCM budget is approved by the General Assembly, RI EOHHS will also consider using an alternative payment methodology that includes a one-time payment for the initial person-centered plan and a monthly rate.

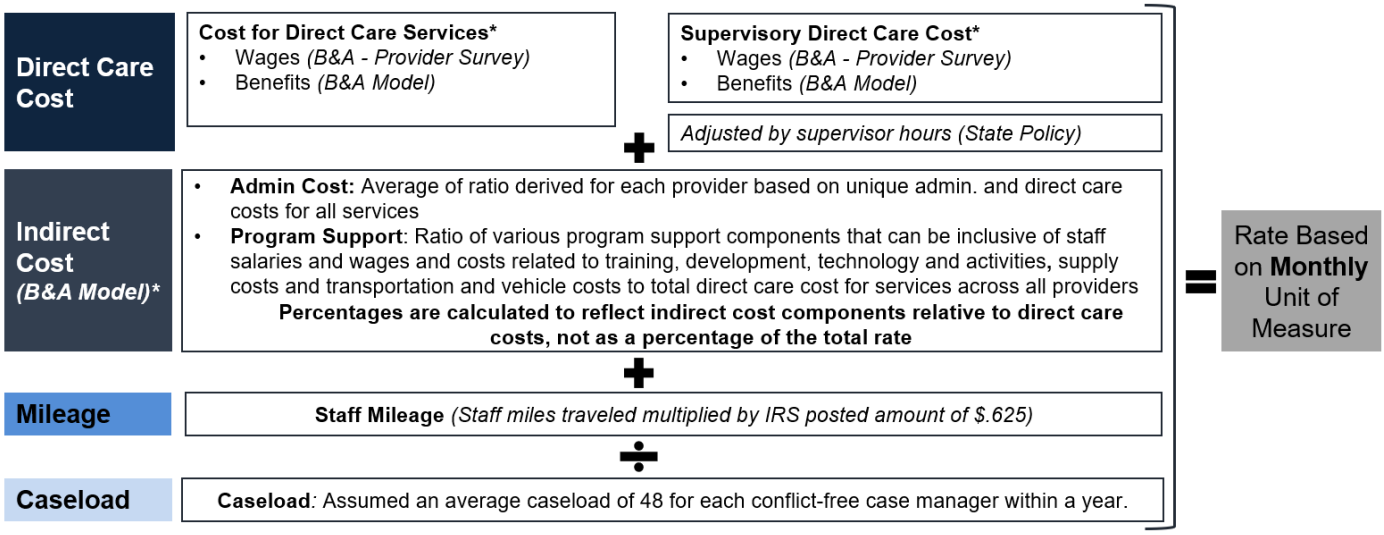
Since CFCM is defined very differently than how case management is delivered today, Guidehouse developed a CFCM reimbursement rate as a cost build-up to appropriately account for all the costs

associated with the various rate components required to provide this service. Guidehouse's rate calculation is supported by a rate setting method accepted by CMS.

Figure 17 below provides an outline of Guidehouse's rate model. Guidehouse's rate calculation considered:

1. Case manager and supervisor salaries from the U.S. Bureau of Labor Statistics
2. A supervisor ratio of 10:1
3. A 100 mile a week assumption
4. Case manager caseloads of 48 HCBS participants
5. Administrative and program support costs
6. An inflationary factor of 14.27%

Figure 17. Rate Model for CFCM



*Rhode Island contracted with Burns & Associates, Inc. (B&A) to calculate reimbursement rates (using a detailed cost and wage survey) for Medicaid DD services. For consistency, Guidehouse used several of B&A's rate calculation assumptions as part of the CFCM reimbursement rate.

10.2 Payment Requirements

The monthly unit will be billed on or after the last day of the month. To bill a monthly unit, CF case managers must meet and document two (2) of the following activities:

1. Face-to-face meeting with the HCBS participant
2. Updates to the person-centered plan
3. Non-face-to-face contact with the HCBS participant
4. Non-face-to-face contact with a collateral contact (e.g., caregiver, individual representative, family member, HCBS provider, etc.). This will count as "two" activities if more than 1 collateral contact is performed.
5. Conducted a quality assurance activity

At the end of calendar year 2024, CFCM entities will be required to submit a detailed cost report for RI EOHHS to assess rate adequacy.

10.3 Financing

The HCBS Final Rule applies to all Medicaid LTSS across HCBS settings. As compliance with the rule is a necessary condition for maintaining Federal financial participation (FFP) for HCBS, Medicaid federal funds and State general revenue are the principal payment sources.

RI EOHHS will pay for CFCM using new funds and a reallocation of existing funds:

1. *New Funds*: Implementation of the CFCM network requires the investment of new funds. Additional funds are required to pay for the broader scope of services required by CMS's Final Rule as well as to cover new populations that would be eligible for case management.
2. *Reallocation of Existing Funds*: Some of the State's funds for its existing case management services will be replaced by CFCM. As the State's existing funds or payment of case management services are not uniformly available, do not generally meet federal CFCM requirements, and the rates paid for them have not changed in well-over a decade, the funds reallocated will be insufficient to cover the costs of CFCM.

11. NEXT STEPS

All entities currently providing case management to HCBS participants or the populations served by HCBS programs that DO NOT provide direct services are strongly encouraged to become part of the CFCM network to build on the State's current Medicaid HCBS case management infrastructure. In addition, the RI EOHHS supports efforts by CFCM entities to hire or enter into contractual arrangements with the experienced plan writers who assisted people with intellectual/developmental disabilities (I/DD) participating in HCBS programs administered by the BHDDH. Federal requirements prohibit continuing the current practice in which plan writing and case management are treated as distinct services and paid for separately and without regard to minimum qualifications and performance standards.

The State has an important opportunity to transform the way Medicaid HCBS participants access and experience care. RI EOHHS greatly appreciates the feedback that it received from stakeholders to develop this document. Stakeholders play an essential role in our continuing efforts, and we look forward to their continued engagement and partnership.

All materials regarding this effort will be posted on Rhode Island's website: Conflict-Free Case Management (CFCM) | Executive Office of Health and Human Services (ri.gov).

APPENDIX 1. RELEVANT FEDERAL REQUIREMENTS

Federal requirements regarding the person-centered planning process.

#	Category	Requirement
1	Leading	441.301(c)(1) The individual will lead the person-centered planning process where possible. The individual's representative should have a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative. All references to individuals include the role of the individual's representative. 441.301(c)(1)(i) Includes people chosen by the individual.
2	Requirements	441.301(c)(1)(ii) Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions. 441.301(c)(1)(iii) Is timely and occurs at times and locations of convenience to the individual. 441.301(c)(1)(iv) Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter.
3	Conflict Resolution	441.301(c)(1)(v) Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.
4	Conflict of Interest	441.301(c)(1)(vi) Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process.
5	Informed Choices & Updates	441.301(c)(1)(vii) Offers informed choices to the individual regarding the services and supports they receive and from whom. 441.301(c)(1)(viii) Includes a method for the individual to request updates to the plan as needed. 441.301(c)(1)(ix) Records the alternative home and community-based settings that were considered by the individual.

Federal requirements regarding the written person-centered plan.

#	Category	Requirement
1	Overview	441.301(c)(2) The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the State's 1915(c) HCBS waiver.

#	Category	Requirement
2	Community Access	441.301(c)(2)(i) Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.
3	Requirements	441.301(c)(2)(ii) Reflect the individual's strengths and preferences. 441.301(c)(2)(iii) Reflect clinical and support needs as identified through an assessment of functional need. 441.301(c)(2)(iv) Include individually identified goals and desired outcomes. 441.301(c)(2)(vi) Reflect risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.
4	Services & Supports	441.301(c)(2)(v) Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of State plan HCBS. 441.301(c)(2)(xi) Include those services, the purchase or control of which the individual elects to self-direct, meeting the requirements of § 441.740. 441.301(c)(2)(xii) Prevent the provision of unnecessary or inappropriate services and supports.
5	Understandability	441.301(c)(2)(vii) Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter.
6	Monitoring, Finalizing, & Distributing	441.301(c)(2)(viii) Identify the individual and/or entity responsible for monitoring the plan. 441.301(c)(2)(ix) Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation. 441.301(c)(2)(x) Be distributed to the individual and other people involved in the plan.
7	Modifications	441.301(c)(2)(xiii) Document that any modification of the additional conditions, under paragraph (c)(4)(vi)(A) through (D) of this section, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan: (A) Identify a specific and individualized assessed need. (B) Document the positive interventions and supports used prior to any modifications to the person-centered service plan. (C) Document less intrusive methods of meeting the need that have been tried but did not work. (D) Include a clear description of the condition that is directly proportionate to the specific assessed need. (E) Include a regular collection and review of data to measure the ongoing effectiveness of the modification. (F) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. (G) Include informed consent of the individual. (H) Include an assurance that interventions and supports will cause no harm to the individual.

#	Category	Requirement
8	Review	441.301(c)(3) The person-centered service plan must be reviewed, and revised upon reassessment of functional need as required by § 441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

Other relevant federal requirements and materials.

#	Regulation / Document	Category	Requirement
1	42 CFR 447.200	Rate Setting	447.200 This subpart prescribes State plan requirements for setting payment rates to implement, in part, section 1902(a)(30) of the Act, which requires that payments for services be consistent with efficiency, economy, and quality of care. 447.201 The plan must describe the policy and the methods to be used in setting payment rates for each type of service included in the State's Medicaid program.
2	42 CFR 441.730(c)	Training	Qualifications for agents performing independent assessments and plans of care must include training in assessment of individuals whose physical, cognitive, or mental conditions trigger a potential need for home and community-based services and supports, and current knowledge of available resources, service options, providers, and best practices to improve health and quality of life outcomes.
3	42 CFR 441.730(b)	Conflict of Interest	The State must define conflict of interest standards that ensure the independence of individual and agency agents who conduct (whether as a service or an administrative activity) the independent evaluation of eligibility for State plan HCBS, who are responsible for the independent assessment of need for HCBS, or who are responsible for the development of the service plan. The conflict of interest standards apply to all individuals and entities, public or private. At a minimum, these agents must not be any of the following: (1) Related by blood or marriage to the individual, or to any paid caregiver of the individual. (2) Financially responsible for the individual. (3) Empowered to make financial or health-related decisions on behalf of the individual. (4) Holding financial interest, as defined in § 411.354 of this chapter, in any entity that is paid to provide care for the individual. (5) Providers of State plan HCBS for the individual, or those who have an interest in or are employed by a provider of State plan HCBS for the individual, except when the State demonstrates that the only willing and qualified agent to perform independent assessments and develop person-centered service plans in a geographic area also provides HCBS, and the State devises conflict of interest protections including separation of agent and provider functions within provider entities, which are described in the State plan for medical assistance and approved by the Secretary, and individuals are provided with a clear and accessible alternative dispute resolution process.
4	42 CFR 431.301(c)(1)(vi)	Conflict of Interest	Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide

#	Regulation / Document	Category	Requirement
			case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process.
5	42 CFR 431.10	Eligibility Determinations	The single State agency is responsible for determining eligibility for all individuals applying for or receiving benefits in accordance with regulations in part 435 of this chapter and for fair hearings filed in accordance with subpart E of this part. The Medicaid agency may delegate authority to make eligibility determinations or to conduct fair hearings under this section only to a government agency which maintains personnel standards on a merit basis.
6	State Medicaid Manual (SMM)	HCBS	Additional CMS guidance and requirements regarding HCBS are described in Chapter 4. SMM is available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927
7	CMS Technical Guide for HCBS	HCBS	Additional CMS guidance and requirements regarding HCBS are described throughout this document. CMS's technical guide for HCBS is available at: https://wms-mmdl.cms.gov/WMS/help/35/Instructions_TechnicalGuide_V3.6.pdf

APPENDIX 2. REFERENCES

[1] Kaiser Family Foundation, *10 Things About Long-Term Services and Supports (LTSS),* available at https://www.kff.org/medicaid/issue-brief/10-things-about-long-term-services-and-supports-ltss/ .
[2] RI Section 1115 Demonstration Waiver, pp. 33-38, available at: https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-04/RI-global-consumer-choice-compact-ca_STCs_07_27_20.pdf
[3] Alaska Association for Developmental Disabilities, *Conflict-Free Case Management System Design,* available at https://alaskamentalhealthtrust.org/wp-content/uploads/2018/05/CFCM_Report-FINAL.pdf
[4] Colorado Department of Health Care Policy and Financing, *Colorado Conflict-Free Case Management for Home and Community Based Services Implementation Plan,* available at https://hcpf.colorado.gov/sites/hcpf/files/2016%20HCPF%20Conflict%20Free%20Case%20Management%20Implementation%20Plan%20Final%20Report%207.1.2016.pdf
[5] Agency for Persons with Disabilities, *Person-Centered Support Plan Instruction Manual,* available at https://www.apd.myflorida.com/waiver/support-coordination/docs/Person%20Centered%20Support%20Plan%20Manual.%202018-04-30.pdf
[6] State of Maine Office of Aging and Disability Services, *Developmental Services Case Management Manual,* available at https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.maine.gov%2Fdhhs%2Fsites%2Fmaine.gov.dhhs%2Ffiles%2Fdocuments%2FDevelopmental-Services-Case-Management-Manual%25201.28.docx&wdOrigin=BROWSELINK
[7] MN Department of Human Services, *Case Management Redesign,* available at https://static1.squarespace.com/static/56ec52d6e707ebc0d316d46f/t/5878fa6bb3db2b5ae62a3bea/1484323438365/CM+Redesign+Background+Document_Final+Draft+for+FSI+.pdf
[8] NC Department of Health and Human Services, *Behavioral Health and Intellectual/Developmental Disability Tailored Plan,* available at https://medicaid.ncdhhs.gov/media/10743/download?attachment
[9] Ohio Department of Medicaid, *Case Management Guide,* available at https://procure.ohio.gov/static/pdf/CSP900919_MAC001_Supplement%20Two_CaseManagementGuide.pdf
[10] Division of Developmental Disabilities, *Choices Providers: Case Managers & Community Support Providers Roles & Responsibilities,* available at https://dhs.sd.gov/docs/CHOICES%20Provider%20Roles%20and%20Responsibilities%20-%2012.21.21.pdf
[11] National Association of Case Management, *Case Management Practice Standards,* available at https://dsamh.utah.gov/pdf/case_management/CM%20Practice%20Standards.pdf
[12] State of Vermont Agency of Human Services, *Revised Case Management Standards & Certification Procedures For Older Americans Act Programs & Choices for Care,* available at https://asd.vermont.gov/sites/asd/files/documents/Case_Management_Standards%20_Technical%20Edit%201_.pdf
[13] WYO Medicaid Division of Healthcare Financing, *Community Choices Waiver: Case Management Manual,* available at https://health.wyo.gov/wp-content/uploads/2020/09/CCW-Case-Management-Manual-Version-1.0.pdf
[14] CMS, *HCBS Final Regulation*, available at https://www.medicaid.gov/medicaid/home-community-based-services/guidance/home-community-based-services-final-regulation/index.html.
[15] U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services. (1999). State Medicaid Manual. Chapter 4, Services, § 4442.6.
[16] CMS, *Application for a § 1915(c) Home and Community-Based Waiver*, available at https://wms-mmdl.cms.gov/WMS/help/35/Instructions_TechnicalGuide_V3.6.pdf.
[17] Medicaid regulation for LTSS, available at: https://rules.sos.ri.gov/Organizations/SubChapter/210-50-00
[18] National Quality Forum, *Person Centered Planning and Practice Final Report,* available at https://www.qualityforum.org/Publications/2020/07/Person_Centered_Planning_and_Practice_Final_Report.aspx.
[19] Ibid.