FAQs – Katie Beckett Care Management

Question		Answer
1	What is the Multiple Provider policy?	Members receiving HBTS/ABA services can utilize more than one (1) provider agency to obtain necessary services. The Member and their family shall designate one (1) agency as responsible for case management services to coordinate implementation of the child/youth's treatment plan. This arrangement shall be initiated by the Member and the initial HBTS/ABA provider agency upon the determination that additional resources are needed to fully deliver the services identified in the child/youth's treatment plan. Please see the HBTS Certification Standards and HBTS/ABA Certification Standards Addendum, which are posted on our website.
2	What is "Person Centered Planning"?	"Person-centered Planning" is the formal process that organizes services and supports around a self-directed, self-determined, and goal-directed future. This includes the process by which a child's family or guardian, with the assistance of appropriate State personnel or contracted entities, Provider Agency staff, and/or healthcare professionals, identifies the most integrated setting appropriate for the child and the services necessary to enable the child to reside in the most integrated setting.
3	What is a "crisis support plan"?	A "crisis support care plan" details individuals or agencies (e.g., child's Primary Care Physician (PCP), local mental health center) for the family to contact in the event of a specific crisis and actions to take to ensure the safety of the child and family.
4	What is "Informed Choice"?	"Informed Choice" refers to the process by which the Case Manager ensures that a parent or guardian of a child determined eligible for services under "Katie Beckett" has an opportunity to make an informed decision about where his or her child will receive services. Informed Choice means a choice made after the Case Manager has provided Person-centered Planning and information about the various services that the child is eligible and appropriate to receive. Informed Choice also entails making reasonable efforts to identify and address any concerns or objections raised by the parent or guardian of a child determined eligible for services under the Katie Beckett eligibility category.

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	Question	Answer
5	What does it mean to be a "conflict free independent agency" for case management?	**THE OFFICIAL DEFINITION ON THE RI CFCM FACT SHEET:** Conflict-free case management (CFCM) means that the entity assisting a participant to gain access to services is different and separate from the entity providing those services (e.g., a home and community-based (HCBS) provider agency), as a potential conflict may exist if the same entity is providing both case management and the referred service(s). The Centers for Medicare and Medicaid (CMS) established CFCM to promote participant choice and independence by limiting conscious or unconscious bias by a case manager when assisting a participant to access services.
6	What is Care Management?	**Care management** means a set of person-centered, goal-oriented, culturally relevant, and logical steps to assure that a member receives needed services in a supportive, effective, efficient, timely and cost-effective manner. Care management emphasizes prevention, continuity of care and coordination of care, which advocates for, and links members to services as necessary across providers and settings.
7	What is Case Management?	**Case management**, a component of care management, is a set of activities tailored to meet a member's situational health-related needs. Situational health needs can be defined as time-limited episodes of instability. Case managers will facilitate access to services, both clinical and non-clinical, by connecting the member to resources that support him/her in playing an active role in the self-direction of his/her health care needs.
8	Where Can I learn more about Home Based Therapeutic Services and Applied Behavior Analysis resources through Medicaid?	For Fact Sheets, please visit: Children With Special Needs | Executive Office of Health and Human Services (ri.gov) To view certification standards for each program please visit: HBTS: HBTSJuly2016.pdf (ri.gov) PASS: PASSJuly2016.pdf (ri.gov) Respite: respite_cert_stds.pdf (ri.gov) Kids Connect: State of Rhode Island (ri.gov)
9	Who are the Provider Agencies in Rhode Island for: HBTS/ABA, PASS, Respite, and Kids Connect through Rhode Island Medicaid?	For a complete provider listing, please follow this link: The Home-Based Therapeutic Services (HBTS) Program provides intensive home and community services to children up to age 21 wit (ri.gov)

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10	Who is the EOHHS Ombudsman and how do I reach that person?	The Ombudsman is Kimberly Splendorio. You may reach her at either: OHHS.KBOmbudsman@ohhs.ri.gov or 401-462-2090
11	Will this position be available to assist with issues such as inability to get the member needed access to a provider?	As with all member children with special health care needs the MCO is expected to work with the families to develop a plan and manage access to services.
12	Where can I find the Needs Assessment Template?	Use of your existing form; please submit to EOHHS for review/approval
13	Where can I find the Family Care Plan Template?	Use of your existing form; please submit to EOHHS for review/approval
14	Active Contract Management?	This will be included in the Quarterly Case Management Report. Updated template is forthcoming.
15	What is the "Date of Initial Referral"	The date the member is assigned via the daily 834-file
15b	When does the initial contact need to be made with the member?	An initial contact letter should be sent to the member within **10 Calendar Days,** of assignment on the daily 834-file, per contractual requirement..
16	When does the Member Needs Assessment need to be completed?	This will be the plan's existing Health Risk Assessment. Assessment must be completed within **90 days**
17	Is telehealth (video and/or audio only) allowed for Member Needs Assessments?	If it is the Member's choice to complete the Member Needs Assessment via video call or telephone, it is allowable. Please note that every effort shall be made to include or have the youth present during a portion of this appointment.
18	What are the Education/Experience Requirements for a Care Coordinator?	Follow the current contractual requirements for care managers.
19	Health Risk Assessment	Use of current HRA ensuring individualized assessment of concerns and needs with the family and child using person centered planning, as further defined in #2 above.
20	Who Completes the Member Needs Assessment?	Whoever currently completes the HRA with members

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Question		**Answer**
21	What type of licenses are acceptable for signing off on the Member Needs Assessment and Family Care Plan?	Follow current process and procedures you have in place.
22	If the Member has completed a Needs Assessment through a Cedar Center, or other agency within the past year, should the MCO do another one?	Yes. The MCO shall conduct a full Health Risk Assessment and create a care plan, regardless of whether or not a current Cedar Family Care Plan exists. If the Member agrees, a Release of Information can be signed by the Member, allowing the MCO to obtain a copy of the current assessment / care plan from another agency. This shall be used for informational purposes only.
23	If the parent declines to complete the Needs Assessment, will the MCO still conduct case management services?	Yes. This Member is already a part of your MCO for the case management benefit. Continued effort to complete the Health Risk Assessment should be exercised with the family while the Member receives any immediate/urgent care coordination.
24	If a Member declines participation in Case Management/ Care Coordination, what is the expectation for future outreach by the MCO?	If a Member declines to participate in care coordination at the initial outreach following referral, that Member has the right to initiate services at any point in the future, as long as the Member continues to remain active in Katie Beckett. For reporting purposes, these members will be listed as "UNENGAGED". MCO Case Managers shall outreach to every member in the Katie Beckett eligibility category at least every six (6) months or on a cadence requested by the member from the date of their initial referral to inquire about need and readiness to participate in care management.
25	When does the Care Plan expire?	Follow your current procedures for care plan development and renewals.
26	When should the Family Satisfaction Survey Be Sent?	Surveys should be sent to each family annually, on the anniversary date of the initial referral.
27	What is the minimum expectation for outreach to families?	Follow current care management protocols.
28	May the MCO conduct an initial survey to establish a baseline regarding Member satisfaction?	Yes.

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Question		Answer
29	May the MCO utilize a third-party vendor to distribute family satisfaction surveys?	Yes.
30	How often will a file come to the MCO's with new Katie Beckett Enrollments?	Daily on the 834-file.
31	If a Member leaves the state for an extended stay, do we continue to provide care management?	Yes. If a Member continues to be eligible for Katie Beckett services through Rhode Island Medicaid, care management services shall continue.
32	Member ID cards?	Not required
33	Do Members Need a Case Management Handbook?	No. EOHHS is providing a letter to each member outlining the case management benefit. The MCO shall produce, at minimum, an outreach and welcome letter to all newly assigned Members upon receipt of the Member's enrollment information, this initial outreach should include the Ombudsman's contact information. All communications intended for Members shall be approved by EOHHS prior to distribution.
34	If a child is found ineligible for Katie Beckett, how will the plans be notified of ineligibility date?	If a child is found ineligible for Katie Beckett, they will be removed from the 834-file. A termination notification with end date will also be provided.
35	If a child moves to a higher level of care (hospitalization, residential treatment etc.), do case management services continue?	Yes. As long as the child remains eligible for Medicaid benefits through the Katie Beckett eligibility category, the child shall continue to receive care management support through the MCO.
36	What is the case load maximum ratio?	EOHHS does not have a requirement regarding maximum case load ratio, however MCOs are required to provide proper staffing ratios in alignment with best practices.

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37	What is the process for Members to follow if they wish to decline the Case Management Program and how is this documented?	A family may decline to participate in the case management at any point, however they will remain enrolled in the MCO, as a non-engaged member, and the MCO will continue to receive a PMPM for the member. The MCO shall make every effort to engage the family who is not responsive to outreach by the MCO including at least two (2) attempts at phone contact and then at least one (1) written letter explaining the care management program. All efforts shall be documented, and outreach shall be made to the family at least every six (6) months or on a cadence requested by the member For reporting purposes, these members will be listed as "UNENGAGED".
38	What is the expectation for minimum outreach expectation for flexible delivery of services?	Member choice may dictate if the Family Care Plan development sessions/updates are completed in person, via telephone, or via video call. Members who have expressed desire to be actively engaged in care management shall receive a monthly outreach by their care manager, at minimum. If a family is not responsive to this outreach (three (3) documented attempts in client record), the Member shall continue to be considered actively engaged in case management until the family declines or has been unresponsive for three (3) consecutive months.
39	What type of signatures are acceptable for families to sign off on the Family Care Plan?	Follow your current practice
40	What Is the effective date for the contractual provisions related to Katie Beckett?	Contractually the effective date is July 1, 2023; the operational start date is set for October 1, 2023.
41	For the 834-file, how will plans be able to identify these members coming thru in this population? Will the members be enrolled in RHP, RHE, RIteCare?	Beginning on October 1st the 834-file will encompass the new capitation (cap) code 55; .
42	How should MCO's approach timelines for assessments when members decide to move MCO's?, with understanding that 90 days is typical timeframe to change "without cause"?	MCOs shall approach each family as if they are not going to decide to change plans.

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43	Will EOHHS provide baseline data on highest risk members to prioritize plan engagement?	No. The system is designed for random auto-assignment, so this is not possible.
44	Will EOHHS provide contractors with a breakdown of primary sources of coverage; i.e. Commercial insurance or otherwise for these clients (TPL)?	No. This information may be obtained in the MMIS.
45	May the MCO have detailed documentation of the benefit structure and provider network currently being utilized by this population.	Each member's benefit structure will vary based on their individual commercial insurer. EOHHS does not hold this information. Any information must be requested through a release of information signed by the Member's parent/guardian and obtained by the MCO.
46	Will existing care management plans be provided to the health plans for continuity purposes?	Existing care management plans, if they exist, will not be provided with the initial referral of a Member. Should the Member desire, a release of information may be obtained for any entity who may already have a care plan and that request may be made from the MCO to the current case management entity.
47	Is the MCO able to leverage a 3rd party entity to provide some of these services, either whole or in-part? If so, what agencies are acceptable entities to provide these services?	MCO's may leverage a third-party entity to provide some of these services, either whole or in part. Acceptable entities to provide these services must be EOHHS Certified Cedar Family Centers or other qualified providers at sole discretion of EOHHS. For reporting purposes, these members will be listed as "DELEGATED" if they are receiving services from a 3rd party.
48	Current state infrastructure alerts the primary insurers of an admission, discharge, or transition (ADT) of a member on a daily basis and does not include data regarding behavioral health. What process will notify us, as the care management entity, of a member in crisis?	MCOs shall approach these youth in the same manner as the rest of their child membership.
49	Regarding active contract management, is this dialogue going to take place at Managed Care Oversight Meetings or an additional forum?	This will be an agenda item during the Managed Care Oversight Meetings.

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Question		Answer
50	Regarding the annual member satisfaction survey, can an MCO distribute through a 3rd party vendor?	Yes.
51	Can Neighborhood conduct an initial survey to establish a baseline regarding member satisfaction?	Yes.
52	In what capacity will the CEDAR centers be providing care management going forward with implementation of this new process? Is FFS still an option for these members?	Care management through the Cedar Family Centers continues to be an available option for Katie Beckett eligibility category members and their families. Payment for services are either through FFS or TPL For reporting purposes, these members will be listed as "DELEGATED" if they are receiving services from a CEDAR center.
53	Will the Plans be able to access the assigned member's medical coverage information?	Yes; utilizing the same mechanism used to determine TPL coverage.
54	We understand that the state will ask Plans to use modified existing care management reports for the Program. When will templates be available? Will the cadence for those reports remain quarterly?	A Katie Beckett Reporting Tab has been added to the existing Quarterly Care Management Report. Follow current process and procedure you have in place. An additional Communications Report must be submitted quarterly. This report will include the following information for every piece of written, informational material developed and distributed to KB members: 1. Material Name 2. Date 3. Method of Distribution 4. Name and title of recipients EOHHS has provided a template for this reporting, however we do not require that you use that. Plans may submit this information in a format/template that works best for them, as long as it includes the required information.
55	Are there expected performance metrics that will be tied to payment and have required reporting ?	There are required reporting metrics, though they are not tied to payments. A Katie Beckett Reporting Tab has been added to the existing Quarterly Care Management Report.

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Question		Answer
56	To confirm, the State will send enrollment information to the Plans via the existing 834 process following Rite Care cadence and rate cells	Yes. Enrollment information will be delivered to the MCO via the 834-file process on a daily cadence.
57	Who or how will members be enrolled?	Members will be enrolled via auto assignment.
58	Will HSRI have a new dedicated web site and work stream for that process?	No. The existing Katie Beckett eligibility process will remain in place.
60	Regarding the 45-day required assessment period and the 90-day opt out period. Will the state consider reducing the optout period to coincide ?	CLARIFICATION: There is no optout of the eligibility category; a family can choose to be "NON ENGAGED" for Case Management. The 90-Day timeline is for a request for plan change and that is not going to be reduced or removed. Initial contact must be made within **10 Calendar Days,** per contractual requirement.
61	Plans are not required to produce an ID card or a welcome Kit or a member handbook	Plans are not required to issue an ID card to these Members. EOHHS is providing a letter to each member outlining the case management benefit. The MCO shall produce, at minimum, an outreach and welcome letter to all newly assigned Members upon receipt of the Member's enrollment information. All communications intended for Members shall be approved by EOHHS, via the existing marketing review process, prior to distribution.
62	Capitation will be at rates for the given cells at the stated amount. It will be effective the first day of the month the member is assigned and continue until the member is no longer enrolled in the Program (how will we be told that?)	If a child is found ineligible for Katie Beckett, they will be removed from the 834-file and the MCO shall receive notification of the member's end date Capitation will continue even if the member/family declines care/case management. Plans have no obligation for member claims with the exception of Cedar related claims, if applicable.

		Follows the RIteCare enrollment timeframe, first day of following month.
Question		**Answer**
63	Plan will be required to make at least one contact with the family quarterly to remain eligible for the capitation.	MCO's will receive a capitation payment for all eligible Katie Beckett Members assigned to them. Plans shall follow their case/care management processes for outreach to families.
65	The State should work with Plans to develop a solution for ongoing care management once the member ages out of Katie Beckett; possibly to include supplemental funding for the development and submission of a transition plan.	The MCO should work with Members eligible for Medicaid under the Katie Beckett eligibility category just as they would with any member with special health care needs transitioning into the adult system of care for which they are eligible. It is expected that the MCO would continue to provide case management services for this eligibility category by ensuring that if eligible they transition onto Medicaid on or before their nineteenth birthday and assist families, if eligible, transitioning into I/DD services or habilitative services.
66	Would the state be able to assist with known industry standards for this population? Need clarity on required credentials – if a licensed professional is required to sign off on an assessment or Family Care Plan that will need to be part of our staffing model.	Children eligible for Medicaid under the Katie Beckett eligibility category have the same needs as all children with special health care needs otherwise eligible for Medicaid.
67	What if Plan A completes the assessment and on day 47 the member opts to move to a different plan? Is the new receiving Plan obligated to redo the assessment?	Yes.
68	Does the state have any data about the top 10 primary diagnoses qualifying members for KB?	Once again children eligible for Medicaid under the Katie Beckett eligibility category are children with qualifying special care health needs. EOHHS suggests that the MCO review their data to determine the types of diagnoses for member children currently receiving special health care needs services who qualify for HBTS etc.
69	When will each MCO receive the first set of members and how many members will each plan see?	There will be an opportunity in mid-September to engage in testing with Gainwell with a go-live date anticipated for October 1st. There will be approximately 343 members assigned to each plan.