KEY ROLES AND RESPONSIBILITIES UNDER CFCM – OCTOBER 26, 2023

Overview:
This document is a **DRAFT** and is intended to support stakeholders in understanding their roles and responsibilities under RI's new conflict-free case management (CFCM) initiative. The intended audience for this document is State agency staff, case managers, and Medicaid HCBS providers. RI EOHHS anticipates making further changes to this document based on stakeholder feedback.

This document applies to Medicaid home and community-based services (HCBS) participants who will receive case management from certified CFCM entities and receive their HCBS from Medicaid licensed or certified HCBS agencies or providers.

This document does not apply to:
1. Medicaid HCBS participants who receive their LTSS via managed care. These participants will continue to work with their managed care organization to receive case management services.
2. Medicaid HCBS participants who receive services as part of RI's shared living. RI EOHHS will provide a separate comparison for this program given its unique characteristics.

Stakeholders included:
1. *Medicaid HCBS participant*: A person who is Medicaid LTSS eligible and receives Medicaid HCBS according to their person-centered plan.
2. *State agency staff*: Refers to state staff under Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH), Department of Human Services (DHS), Office of Healthy Aging (OHA), or the Executive Office of Health and Human Services (EOHHS).
3. *Conflict-free case managers:* Conduct person-centered planning to support Medicaid HCBS participants to develop a person-centered plan that will help them gain access to services and supports (paid and unpaid), help the participant to access services and supports to achieve their identified goals, and maintain independence.
4. *Medicaid HCBS providers*: Qualified professionals or entities that render paid Medicaid services (e.g., assisted living, support broker, I/DD group home, home care services in a private residence, etc.) to Medicaid HCBS participants.

Activities included:
1. *Person-centered options counseling:* The process of informing the Medicaid HCBS participant, through an interactive decision-support process, of long-term services and supports options that align with the Medicaid HCBS participants' needs.
2. *Functional needs assessment*: The process for completing the State's functional needs assessments which are used for eligibility purposes and ancillary assessments that focus on specific areas of need or potential risks.
3. *Person-centered plan development*: The process of completing the participant's person-centered plan.
4. *Connecting to services and supports*: The process of connecting the Medicaid HCBS participant to services and supports.
5. *Person-centered plan revisions*: The process of updating the Medicaid HCBS participant's person-centered plan.
6. *Person-centered plan monitoring and oversight*: The process for monitoring the person-centered plan to ensure that the person-centered plan is effectively implemented and adequately addresses the needs of the Medicaid HCBS participant.
7. *Medicaid eligibility renewal:* The process for conducting State Medicaid eligibility renewals.

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Person-centered options counseling (PCOC)	This serves as an entry point into the long-term services and supports (LTSS) system. Participant engages in an interactive decision-support process to receive education about RI LTSS options. Participants can receive PCOC from ThePoint at the ADRC, DHS or BHDDH.			
Functional needs assessment	1. Coordinates with their case manager or state agency to complete their functional needs assessment.	1. For Elders and Adults with Disabilities (EAD), performs the initial functional needs assessment (InterRAI) 2. For participants with Intellectual and Developmental Disabilities (I/DD): (1) continues to perform the initial functional needs assessment (SIS-A) and reassessments at five-year intervals (2) conducts an additional needs questionnaire and interview every year.	1. During the person-centered planning meeting, analyzes the HCBS participant's initial functional needs assessment with an in-depth review of all sections and additional supporting information. 2. For EAD, completes an annual reassessment of functional need (InterRAI).	1. Contributes to the functional needs assessment as appropriate. *This is not applicable for Fiscal Intermediaries.*
Person-centered plan development	1. Drives the person-centered planning process and conversation to the best of their ability. 2. Chooses who they would like to participate in the planning process and who is invited to the meeting. 3. Communicates 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. 4. Signs their person-centered plan.	1. All person-centered plans are subject to review by the State for quality assurance purposes. 2. May attend meeting(s) and/or provide information.	1. Contact the HCBS participant no more than three (3) business days after the CFCM entity is notified of a new Medicaid HCBS participant. 2. Prepares and conducts information gathering: a. Gathers and reviews previous assessments and all other existing information for the HCBS participant. b. Analyzes the HCBS participant's initial functional needs assessment with an in-depth review of all sections and additional supporting information. 3. Supports/encourages the participant to lead/co-facilitate the person-centered planning process. 4. Works with the HCBS participant to develop their person-centered plan. a. Learns about the HCBS participant's vision for a good life and life experiences that have/will move them closer to their vision or away from it. b. Educates HCBS participants on the self-direction service delivery option	1. Provides details regarding the services available within their agency. 2. Submits any relevant information to the HCBS participant's case manager that may support the person-centered planning meeting. 3. Participates in the initial and annual person-centered planning meeting at the request of the HCBS participant. 4. Works with the case manager to ensure appropriate and necessary services are included in the participant's person-centered plan. 5. Assists with the establishment of units, start/end dates, etc. for identified services and confirming their accuracy within the person-centered plan. 6. Recommends revisions to the draft person-centered plan (as

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			so they can make an informed choice in choosing traditional, or self-direction service models for their service delivery. c. Assists the HCBS participant to identify person-centered goals based on identified wants and assessed needs. d. Assists the participant to build specific and measurable goals and corresponding action steps to achieve goals. e. Assists the participant to identify services and supports that align with person's goals and needs. f. Identifies 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. g. Identify how the HCBS participant wants to be assisted with each action step and who is responsible for each action step. 5. Distributes the person-centered plan to the HCBS participant, HCBS providers, and any other entity/person that is required to support the HCBS participant in implementing their plan. 6. Signs the person-centered plan.	needed) to the case manager prior to implementation. 7. Signs the person-centered plan. 8. Develops a service implementation plan (note that "plan" terminology and requirements may be different across HCBS providers based on their licensure and certification standards) that specifies how authorized services in the person-centered plan will be delivered. *This is not applicable for Fiscal Intermediaries.* 9. Coordinates with HCBS participant and case manager regarding information sharing and logistical planning prior to initiation of direct services. 10. Provides services and supports within the parameters indicated in the person-centered plan.
Connecting to services and supports	1. Chooses and selects available services and supports.	1. Processes service authorizations for Medicaid HCBS. 2. Regularly assesses Medicaid HCBS provider capacity as part of the State's quality assurance activities.	1. Accesses community resources and other programs/agencies by: a. Using resources and supports available through natural supports within the participant's community. b. Developing a thorough understanding of programs and services operated by other local, State, and federal agencies. c. Ensuring these resources are used and making referrals as appropriate. d. Coordinating services between and among the varied agencies so the services funded by agencies complement, but do not duplicate,	1. Provides assistance in scheduling healthcare appointments (if the HCBS provider is identified as the responsible party in the HCBS participant's person-centered plan). 2. See licensing, certification, and/or payment standards for other HCBS provider specific requirements on this topic.

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			services funded by the other agencies. 2. During the person-centered planning process, links 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. 3. Discusses employee selection when working with a participant who has chosen to self-direct services. 4. For Medicaid services (identified in the person-centered plan), submit a service referral. a. Conducts follow-up with HCBS providers if a response has not been received. b. If necessary, obtains additional documentation from the HCBS provider (e.g., the HCBS participant's assistance plan and resident agreement from an assisted living facility) c. Confirms the HCBS participant's acceptance of any modifications proposed by the HCBS provider. d. Assists the HCBS participant in choosing a new HCBS provider for any referrals denied by the HCBS provider or when plan modifications requested by the HCBS provider are denied by the HCBS participant. 5. For non-Medicaid services or informal networks within the community (identified in the person-centered plan), refers, advocates, and provides application assistance if requested. a. Example of non-Medicaid services includes non-LTSS Medicaid services, (e.g., medical or behavioral health services), social services (e.g., SNAP, LIHEAP, or local food banks) or community organizations	

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			and resources (e.g., Special Olympics, NEWSLINE, or local art classes). 6. Determines if the HCBS participant needs assistance with scheduling healthcare appointments. a. If the HCBS participant requires assistance, the case manager will work with the participant to identify a responsible party. The responsible party may be a family member, a community provider, or a case manager if no other party is identified. 7. Confirm connections are made and referrals are completed and followed through on. 8. Coordinate service authorization with HCBS provider(s) and the State.	
Person-centered plan revisions	1. Requests changes and approves changes to their person-centered plan. 2. Communicates any concerns or feedback with the 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.	1. Authorizes any new Medicaid services or reauthorizes changes to existing services.	1. Contacts the HCBS participant within 24 hours upon discovery of an actual or potential significant change of condition. 2. Updates the person-centered plan in response to a major change in the HCBS 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. 3. If the update to the person-centered does not require service authorization, complete person-centered plan updates as soon as possible, but no later than five (5) business days of a request or identified need. 4. If the update to the person-centered plan requires a reauthorization or change in authorization of services, update the written person-centered plan and initiate contact with HCBS providers and other resources as soon as possible, but no later than ten (10) business days of a request or identified need. a. Update the functional needs assessment tool based on the change in needs/ budget/spending	1. Communicates with the case manager if the participant's service needs/preferences may cause the need for changes to the person-centered plan or effect the provision of services. 2. As requested, participates in meetings with the case manager and the HCBS participant to update their person-centered plan. 3. If the person-centered plan changes, develop specific strategies for implementation, as noted in person-centered plan development section.

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			plan for EAD and request a SIS-A Major Life Change assessment if needed.	
Person-centered plan monitoring and oversight	1. Monitors the delivery of their services and notifies their case manager if services are not provided as intended.	1. Regularly tracks CFCM entity performance standards. 2. Adheres to CMS reporting requirements and any other licensing or quality assurance standards.	1. For new Medicaid services, contacts the HCBS providers to verify delivery of services in the amount, scope, and duration as identified in the person-centered plan. 2. Conducts a monthly non-face-to-face contact with the HCBS participant or individual representative. As part of the monthly check-in, the case manager is expected to complete a monthly monitoring form included in the State's LTSS case management system. 3. Conducts a face-to-face contact with the HCBS participant at least once every 6 months. As part of the 6-month contact, the case manager is expected to complete a 6-month monitoring form included in the State's LTSS case management system. 4. Monitors service provision, progress on goals, and the HCBS participant's satisfaction with their services. 5. Conducts additional telephonic or face-to-face contacts based on HCBS participant needs. 6. May assist, when needed, with resolution of concerns with HCBS provider.	1. Monitors service quality and ensure that its services are being delivered in accordance with the HCBS participant's person-centered plan. *This is not applicable for Fiscal Intermediaries.* 2. For new Medicaid services, communicates with the case manager before and after the scheduled service start date. The case manager will contact the HCBS provider for this discussion.
Medicaid eligibility renewal	1. Submits requested documentation to the State to support their Medicaid eligibility renewal.	1. Requests documentation from the participant to support the Medicaid eligibility renewal process. 2. Completes Medicaid eligibility renewals and notifies the participant.	1. If requested by the HCBS participant, assists in completing any forms required for annual renewal necessary to ensure that there are no service disruptions. 2. If necessary, coordinates with State agency eligibility representatives as well as with HCBS participants and their families.	1. If requested by the HCBS participant, the HCBS provider should direct the HCBS participant to existing application assistance resources (i.e., Certified Application Counselors and Navigators). A full list is available on staycovered.ri.gov. *This is not applicable for Fiscal Intermediaries.*

Glossary

Term	Definition
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
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 4. *Plan Monitoring & Follow-up:* Regular contact to review goal progress & effectiveness of services
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.
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.
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.

Term	Definition
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.
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.