Rhode Island Executive Office of Health and Human Services
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DRAFT CFCM Certification Standards – Response to Public Comments
Posted for Public Comment on 10/2/2023
Comment Period Ended on 10/31/2023
Response to Comments Posted on 1/12/2024

#	Respondent	Nature of the Comments	EOHHS' Response
1.	ROBERT B. ARCHER, LICSW, ED.D Vice President of Performance, Quality & Improvement	Does Choice mean that clients/families would be assigned to Regional Service Providers unless otherwise requested (assuming all agencies participate)? I am thinking primarily about the current regionally based CM agencies.	As part of the eligibility determination process, the state informs new HCBS participants about the case management process. New participants will have the opportunity to select any case management agency anywhere in the state. If the participant does not want to make a choice, an agency will be auto assigned based on agency capacity. Existing participants will have the choice of staying with their current CM provider if that provider becomes certified as a CFCM Agency. If their current CM provider does not become certified as a CFCM Agency, the process will be the same as for new participants.
2.	ROBERT B. ARCHER, LICSW, ED.D Vice President of Performance, Quality & Improvement	The Standards are asking the agency to develop program parameters? Are you asking CM agencies to tell EOHHS what the case load size will be for the Case Manager and what the Supervisory Structure will be? a. What happened to the caseload size of 48 with 10 CM per Supervisor?	RI EOHHS does not set a mandated caseload size; rather, the Certification Standards require CFCM Agencies to develop a Caseload Policy describing how the Agency ensures that case managers have a reasonable caseload that allows them adequate time to meet the needs of their participants and to comply with EOHHS rules, regulations, and standards. The Caseload Policy must identify the Agency's maximum caseload per case manager. While a caseload size of 48 was assumed in the state's rate-setting process, this does not represent a required ratio.
3.	ROBERT B. ARCHER, LICSW, ED.D Vice President of Performance, Quality & Improvement	For Adults that are included in EAD population How many are not Older Adults/by region? a. Who currently provides Case Management for EAD who are not older Adults? b. Will there be consultation and training relative to the needs of this population for the CM agencies who currently provide support to older adults?	As of September 2023, the number of EAD members under age 65 served by DHS was approximately 1,100 individuals. DHS (and service advisement agencies, for participants in self-directed programs) currently provides case management for the EAD population that is under 65. An initial orientation will be provided by EOHHS, which will include information related to the under 65 population. CFCM agencies will also be expected to provide comprehensive training for staff.
4.	ROBERT B. ARCHER, LICSW, ED.D Vice President of Performance, Quality & Improvement	Will the CFCM Agencies be using WellSky as the primary record? a. Will the Person Centered Plan be located in WellSky? b. Will there be training for the Person Centered Plan development.	Yes, the Person-Centered Plan (PCP) will be located in Wellsky, and Wellsky will be used as the primary record. CFCM agencies are required to use the Wellsky system. Yes, there will be a training manual provided by Wellsky about using the system to develop the Person Centered Plan.
5.	ROBERT B. ARCHER, LICSW, ED.D Vice President of Performance, Quality & Improvement	Are there minimum client contacts and other activities per month?	Yes, case managers must have contact with the HCBS participant at least once each month. If the individual has opted to receive case management via telehealth, these contacts may be virtual or telephonic, except that a face-to-face meeting is required at least every six (6) months (or more often if needed to ensure an individual's health and safety).

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			In addition to contact with the participant, the case manager should conduct at least one of the following activities each month: • Contact with a collateral contact (e.g., individual representative, caregiver, family member, HCBS provider, etc. • Conduct a quality assurance activity • Make updates to the person-centered plan
6.	ROBERT B. ARCHER, LICSW, ED.D Vice President of Performance, Quality & Improvement	What happens to referrals that agencies receive during January - February? a. Will we still be receiving referrals during this time?	During January-February 2024, there will be no change to the process by which agencies currently receive referrals from the state.
7.	Mark Reinhart mark7799@comcast.net	is the federal mandate document available. It would be beneficial to see the wording of what the federal government is requesting so that the proposed implementation can be assessed in context. . For example, what options are available? What areas are mandatory versus suggested ("should" vs. "shall")?	Please review the Final Rule at 42 C.F.R. § 441.301. The Corrective Action Plan guidelines are available at EOHHS' CFCM site: Conflict-Free Case Management | Executive Office of Health and Human Services (ri.gov)
8.	Mark Reinhart mark7799@comcast.net	In this regard, independent program writers do not currently appear to be employed by or have a financial interest in a service provider(s). As discussed, neither case managers nor case management organizations exist yet. However, the gist of the program appears to replace program writers with case managers. It was offered that the overall proposed program introduces a large bureaucratic administrative load. It would seem good to apply available resources to supporting participants and their families rather than apply them to added organizational administration. Please see the proposed alternative, below. PROPOSED ALTERNATIVE An alternative is offered: Retain program writers as they are. Assure that there is no conflict, as discussed above. Develop Conflict-Free Case Management Organizations (CFCMO). It was offered that CFCM would make participants aware of supports or support organizations of which they were not previously aware. That is an excellent goal. So, establish CFCMOs with a comprehensive data base of supports and support organizations which participants, their families, program writers, and social workers can access.	Neither the HCBS Section 1915(c) Technical Guide, which applies to the HCBS programs authorized under RI's Section 1115 waiver, nor recent PCP guidance from CMS, identify individual plan writing as a Medicaid covered service. The Technical Advisory Team assigned by CMS to assist the State, New Editions, confirmed that individual plan writing is not, by itself, a Medicaid reimbursable service. The State does not have the general revenue resources to finance plan writing as a separate service without federal matching funds. CMS guidance is clear that person-centered planning is a function of the case management agency, and EOHHS anticipates that plan writers can contribute to development of the person-centered plan by serving as individual case managers. Plan writers have invaluable expertise and experience, and we encourage CFCM agencies to hire or contract with plan writers as case managers if they meet the certification standards for individual case managers.

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		Consequently, participants and their teams could draw upon CFCMO as needed.	
9.	Claire Rosenbaum	After the Introduction, lead with the section currently on p. 7 – "Case Management Agencies shall at a minimum demonstrate the following": (with sub topics - Core Components, cultural competency, Connection to Community Based Organizations, Supervision, Reporting.)	EOHHS agrees with the suggestions to move Core Components to appear immediately after the introduction and revised the Standards accordingly.
10.	Claire Rosenbaum	Only after outlining what a CFCM agency is required to do, followed by the standards for Individual Conflict Free Case Managers, only then conclude with requirements for agency policies, currently found on pp. 4-7. This at least will begin with the main functions of a CFCM agency, rather than requirements for agency policies – often required for any service providing agency.	EOHHS agrees that it is important to begin with a description of what a CFCM agency must do, and has revised the Standards so that the sub-section on the agency's written policies is the final segment of the Agency Standards section However, EOHHS believes it is useful to keep all Agency Standards together in one place, and therefore the detailed requirements for Individual Case Managers remain after the whole Agency Standards section.
11.	Claire Rosenbaum	In the Core Components section on p. 7, you state that agencies will implement the four components using "standardized automated forms and processes". Yet the HCBS rules require that the participant be supported to direct their own PCP process and that the resulting plan "reflect cultural considerations of the individual" and be "in plain language in a manner accessible and understandable to individuals with disabilities and persons who are limited English proficient". Considering the population, the processes and plan will need to be individualized and in many cases very unique to the individual – not "standardized." I recommend using the language of the HCBS rules. This requirement should take primacy over any requirements of an automated or standardized form or process.	EOHHS agrees with the suggestion to remove the phrase "standardized automated forms and process" and has revised the Standards accordingly.
12.	Claire Rosenbaum	On p. 7 – "information gathering" – change to "a comprehensive review of a Medicaid HCBS participant's strengths, preferences, needs, and goals, including any cultural considerations and person's communication support needs to enable person to direct their planning process to the fullest extent."	EOHHS agrees with the suggested language for the Information Gathering Core Component and revised the Standards accordingly.
13.	Claire Rosenbaum	Similarly, on p. 8, In core component #2 – Person-Centered Plan Development – There needs to be a stated requirement (per HCBS rules) that the participant is supported to direct their own process.	EOHHS revised the Person-Centered Plan Development Core Component to reflect that the participant must be supported to direct their own PCP process.
14.	Claire Rosenbaum	On Current page 4, "After Hour Coverage Policy" only requires that there be a system for participants to leave a message after hours. However, HCBS rules (and even these standards on p.10) require that the Planning meeting "occur at times and places of	EOHHS has updated "After Hour Coverage Policy" to include a requirement that the Agency schedule meetings with participants at night/weekend times if preferred by the participant.

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		convenience to the individual." The agency needs to be required to have staffing that will accommodate "after hours" meetings when such meetings are convenient for the individual.	
15.	Claire Rosenbaum	On page 5, "Caseload policy", the standards only state that case managers have a "reasonable" caseload. I suggest that the standards state a caseload cap so that agencies recognize the amount of time and effort it takes to support a person's plan development and monitor its implementation – I suggest a required cap of 40, personally, having provided plan development for people with IDD for at least a decade during my career. Don't leave this up to an agency policy.	Thank you for your feedback. EOHHS intends to carefully review Agency Caseload Policies to evaluate whether they adequately describe how their maximum caseload will allow time to meet participant needs and comply with all requirements.
16.	Claire Rosenbaum	Under "Individual Case Manager Standards" on p. 9, the first and primary standard for CMs should be "The case manager shall be knowledgeable and skilled in strategies to support the participant to lead their own person-centered planning process. The Case manager shall provide necessary information and support to ensure that the participant directs their own process to the extent possible and is enabled to make informed choices and decisions." (This last sentence is a direct quote from HCBS rule, but not reflected anywhere else in these standards.)	EOHHS agrees with the suggested language and placement for Individual Case Manager Standards and revised the Standards accordingly.
17.	Claire Rosenbaum	Also, under "Individual Case Manager Standards", Add – "Individual Case Managers shall be respectful of the cultural needs of participants of different racial, ethnic, class, language and religious backgrounds."	EOHHS agrees with the suggested language for Individual Case Manager Standards regarding respect for participants' cultural needs and revised the Standards accordingly.
18.	Claire Rosenbaum	On p. 9, I, #1, there is reference to a caregiver or legal representative being involved in the planning. There also needs to be a requirement that the planning shall involve any others of the person's choosing (also a requirement of HCBS rules).	EOHHS agrees with the suggested language for Individual Case Manager Standards regarding the participant's right to include any person of their choosing in the planning process and revised the Standards accordingly.
19.	Claire Rosenbaum	On page 10, item J – should read " The case manager will facilitate a participant's person-centered planning process, supporting them to direct the process to the extent possible. Process shall be timely and occur at times and locations of conveniences to the individual."	EOHHS agrees with the suggested language for Individual Case Manager Standards regarding facilitation of the person-centered planning process and revised the Standards accordingly.
20.	Claire Rosenbaum	Item L "Assessment" refers to managers serving EAD. There should be some description of how assessment happens for those serving the IDD population and/or any role of CFCM in this.	For participants with I/DD, BHDDH will continue to perform the initial functional needs assessment (SIS-A) and conduct reassessments at five-year intervals. CFCM providers will not be responsible for delivering the SIS-A or conducting any alternative functional reassessment for the I/DD population. The revised Standards clarify that case managers are not responsible for assessments/reassessments for I/DD participants.

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21.	Claire Rosenbaum	Item M is confusing. Person-centered planning should establish person-centered goals by participant, their support network and case manager, whether issues are complex or not.	EOHHS agrees with the suggestion to remove the reference to complex issues and has revised the Standards accordingly.
22.	Claire Rosenbaum	Between item N which references plan development, and O, which goes on to describe plan monitoring, the description of the HCBS required plan contents should appear here. These do appear below at P, #3, k-l, as a direct quote from the HCBS regulations, but would be more appropriate here when describing plan development. NOTE: this list excludes the HCBS listed requirement that the plan "reflect the individual's strengths and preferences." BE SURE THAT THIS REQUIREMENT IS ADDED BACK IN.	EOHHS agrees with the suggestion to list the requirement that the plan reflect the individual's strengths and preferences and has revised the Standards accordingly. EOHHS has also relocated the description of the plan within the Individual Case Manager Standards section.
23.	Claire Rosenbaum	Page 10-11 describes the required contents of a participant's paper or electronic file. Item #3 could simply read "the written version of the person-centered plan including the required components" (which in my suggested revisions would now be listed above).	EOHHS has moved the list of requirements for the person-centered plan into its own section within the requirements for individual case managers, and has revised the section on contents of the paper or electronic file accordingly.
24.	Claire Rosenbaum	Page 11, Q Modifications, #1-8 – this is also a direct quote for the HCBS rule, but actually refers to modifications to the HCBS settings requirements (access to food at any time, freedom to have visitors of their choosing, privacy in their sleeping unit – among others – see HCBS final Rule Section 441.301 , paragraph (c)(4)(vi)(A) through (D))– not any modification to the person-centered planning process per se. These could be included under the description of the plan requirements (I am recommending listing those above – not under contents of participant's file), but should be clear that these refer to requirements for modifications to any of the settings rules.	EOHHS agrees that the modifications referenced are to the settings requirements and has revised the Standards accordingly. The list of what must be documented in the person-centered plan in the case of a modification/exception to the settings rule is located among the requirements for the contents of the person-centered plan.
25.	Claire Rosenbaum	The last item on page 11 – (#9 Case notes ….) seems like it should be the final item under P – contents of the participant's paper or electronic file, not any reference to the Modifications to the settings rule.	EOHHS agrees that case notes are among the requirements for the contents of the person's file and not related to the specific requirements for person-centered plan documentation of a settings rule modification. EOHHS has revised the Standards accordingly.
26.	Claire Rosenbaum	Page 12 – Performance Standards – Nowhere in this list is the quality of the person-centered planning process or the resulting plan addressed. This is the primary function of Conflict Free Case Management and should be addressed in Performance Standards. I suggest adding, for a example, some of the following: The number and percentage of HCBS participants who were supported to lead their own planning process. The number and percentage of HCBS participants who participated in their	Thank you for your feedback. Current performance standards are based on reports that are currently built into the Wellsky system and existing HCBS quality metrics that the state is required to report to CMS, rather than self-reported metrics. Because EOHHS anticipates upcoming revisions to the federal HCBS quality reporting requirements, including changes in metrics related to person-centered planning, we will not add a Performance Standard on this topic at this time. However, EOHHS will review opportunities to add new measures on an annual basis.

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		planning. The number and percentage of HCBS participants who chose the time and location of their planning meetings. The number and percentage of HCBS participant's Person-Centered Plans which met all the requirements for plans outlined here and in the HCBS rule. The number and percentage of HCBS participants who have received a copy of their plan in a manner and language that they can understand. The number and percentage of HCBS participants who met their stated goals.	
27.	Claire Rosenbaum	It may be more important to a person that they led their process with the people they chose to support them present than whether this happens within 10 days of referral. It might take longer than ten days to effectively support someone to lead their own planning meeting and develop a meaningful plan in language that they can understand.	Thank you for your feedback. The goal is not to hold the participants to a certain amount of time, but rather to ensure that that the agency is generally ensuring a timely start to the person-centered planning process. EOHHS has revised the language for this standard to account for the possibility of a person-centered reason to take more than 10 days.
28.	Kate Sherlock, Kate Maclean and SDM coalition (including lawyer from Sherlock center)	"concerned that there are a number of references to guardians as substitute decision makers in the draft standards that do not also reference alternatives." "Since the passage of the Rhode Island Supported Decision-Making Act in 2019, the least restrictive alternative to limited guardianship available to adult Rhode Islanders with disabilities is Supported Decision-Making, as it provides individuals with disabilities the support they may need with their decision-making process while preserving their right to make their own decisions." "As a result, we recommend that any reference to guardians as substitute decision makers in the standards be changed from "guardian" or "guardians" to "authorized limited guardian/s or guardian/s". "	EOHHS agrees with the recommendation to include "authorized limited guardian" together with "guardian" throughout the Standards and has revised the Standards accordingly, by including both in the definition of Authorized Legal Representative.
29.	Kate Sherlock, Kate Maclean and SDM coalition (including lawyer from Sherlock center)	We also suggest that before referencing authorized limited guardian/s as substitute decision-makers, the standards continue to first reference the individual, and then also add alternatives to limited guardians as appropriate such as: an individual and their authorized supporters pursuant to a Supported Decision-Making Agreement, and authorized agents pursuant to a Durable Power of Attorney for Healthcare prior to referencing limited guardians/guardians. (We use "authorized" as supporters are limited to the authority in the agreement and DO NOT have decision-making authority, agents are only authorized to make those decisions an individual lacks the capacity to make [and the individual can end the agency at any time], and limited guardians are only authorized to make decisions as authorized by the probate court order.)	EOHHS agrees with the recommendation to include "authorized supporters," and "authorized agents" in addition to limited guardians and guardians and has revised the Standards accordingly, by including all of these in the definition of Authorized Legal Representative.

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30.	Kate Sherlock, Kate Maclean and SDM coalition (including lawyer from Sherlock center)	in section III. Individual Case Manager Standards, paragraph B.1. references the informed consent of an individual and/or their guardian regarding acceptable risk. As noted above, we suggest that the language be changed to an individual, an individual after consultation with their authorized supporters pursuant to a Supported Decision-Making Agreement, an authorized agent pursuant to a Durable Power of Attorney for Healthcare, other applicable alternatives to limited guardianship, or an authorized limited guardian or guardian, as appropriate.	EOHHS agrees with the recommended language regarding alternatives to guardianship and has revised the Standards accordingly.
31.	Kate Sherlock, Kate Maclean and SDM coalition (including lawyer from Sherlock center)	Any decisions to be made about plans and who to include in plans should be made by the individual. In the Emergency Management Plan section, paragraph 4 currently states that the agency will Involve and consider family caregivers and other natural supports as part of this process. Whether or not to include them in planning or as part of the plan should be the choice of the participant	EOHHS agrees with the recommended language regarding participant choice and has revised the Standards accordingly.
32.	Kate Sherlock, Kate Maclean and SDM coalition (including lawyer from Sherlock center)	Two sections reference authorization and consent, Participant Record Policy, paragraph 3. and III. Individual Case Manager Standards paragraph Q.7. These state... authorization in writing by the Participant or legal representative... and ...informed consent of the individual or their legal representative. We recommend qualifying each legal representative as authorized.	EOHHS agrees with the recommendation to modify "legal representative" with the word "authorized," and has revised the Standards accordingly.
33.	Kate Sherlock, Kate Maclean and SDM coalition (including lawyer from Sherlock center)	section IV. B regarding the number of participants (or families/legal guardians) who receive information, we recommend that the parenthetical be expanded to include supporters, agents, and limited guardians.	EOHHS agrees with the recommendation to include "authorized supporters," and "authorized agents" in addition to limited guardians and guardians in this performance standard and has revised the Standards accordingly by defining Authorized Legal Representative.
34.	Kate Sherlock, Kate Maclean and SDM coalition (including lawyer from Sherlock center)	section regarding Conflict of Interest Policy, 2.c., prohibits individuals empowered to make financial or health-related decision "sic" on behalf of the participant from being a case manager; this section should also preclude individuals empowered to make residence and relationship decisions as those are two additional areas of decision-making under Rhode Island limited guardianship/guardianship law.	EOHHS agrees with the regarding the scope of the Conflict of Interest policy and has revised the Standards accordingly.
35.	Jennifer Crosbie Director, Gov Programs Careforth	"does not appear to us that the CFCM proposed standards will streamline the authorization process or remove barriers currently impeding families seeking to access Shared Living. Our primary concern with the proposed CFCM process is that members and caregivers who choose Shared Living will experience further delays, potentially adding addition months to the authorization	Thank you for your feedback. EOHHS has met with stakeholders regarding concerns specific to Shared Living and will continue collaborating to identify ways to streamline access to this program. EOHHS does not believe that the CFCM Certification Standards will impede access to Shared Living.

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		process for Shared Living services" Based on our review of both the CFCM and Shared Living draft certification standards, it appears that much more needs to be done to remove outdated policies and practices that create barriers and significant delays for families seeking Shared Living.	
36.	Kevin Nerney RIDDC	"The proposed CFCM certification standards do not meet the standards that were developed by the community. It is unnecessarily bureaucratic and does not allow for the individual to drive the process. There is an overreliance on "case management" which diminishes the person centered cms requirements of the HCBS rule. It refers to an agency assigning a case manager and does not allow for individuals to opt for a facilitator/broker of their choices. There is not mention of individual developing their own assessments or conflict resolution strategies. " "These standards attempt to wedge individuals into a heath care system rather than allowing the individual to craft their own lives. Attempting to squeeze person centered planning into a bureaucratic system creates barriers to supports. Please see the attached "Dissent from Consensus" paper for an explanation of our concerns" Kevin_Nerney_dissent-from-consensus.pdf	CMS guidance is clear that person-centered planning is a function of the case management agency, and as these Standards describe these agencies' responsibilities, they necessarily focus on describing their role in the process. However, EOHHS has revised the Standards to further emphasize that the person-centered planning process must be directed by the participant to the fullest possible extent. Functional assessments are conducted by DHS or BHDDH, depending on the population, using standardized tools. Reassessments, whether by a case manager or BHDDH, also use standardized tools. EOHHS understands that this comment may be referring to something other than "functional assessments," but it is not clear what other assessment is at issue.
37.	Samuel Salganik, RIPIN Executive Director	"We strongly support the State's decision to use a certification process that can allow for a rolling onboarding CFCM agencies, rather than a less flexible RFP process. This will be easier and less risky for consumers, providers, and the State. As mentioned in our comments to the CFCM Strategic Plan, we continue to be concerned that the single PMPM rate structure will disincentivize CFCM agencies from serving the neediest community members. If the single PMPM model is final, then we recommend that EOHHS develop systems to ensure that CFCM agencies are not "cherry-picking" the populations, communities, and clients who are easiest to serve."	Thank you for this feedback. The State controls the process of referrals to case management agencies, which eliminates the immediate risk of cherry picking by agencies seeking less complex clients. As described in the Standards, there are requirements and limitations associated with an agency's ability to reject referrals, as well.
38.	Samuel Salganik, RIPIN Executive Director	Conflicts of Interest: The introduction to the certification standards (page 3) contains a **substantial misstatement** of the federal regulation, stating that it **"requires that providers of HCBS, or those who have an interest in or are employed by a provider of HCBS, shall not provide case management to or develop the person-centered service plan for people receiving services**." The **federal rule** actually **says** that:	EOHHS agrees with the recommended revision regarding the federal conflict of interest rule and has revised the Standards accordingly.

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		"**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…**" 42 CFR 441.301(c)(1)(vi) (emphasis added). The version of the rule as written in the introduction to the CFCM Certification Standards may be reasonable as a matter of State policy, but it is much broader than what is required in the federal rule." **See document for examples given** SamSal_ED_RIPIN Comments re CFCM Certification Standards 10.31.2023.pdf	
39.	Samuel Salganik RIPIN Executive Director	Can a provider of HCBS to children operate a CFCM program for older adults? Can a provider of HCBS services to the I/DD population operate a CFCM program for older adults? Etc. The federal rule does not appear to prohibit a provider of HCBS to one population from providing CFCM to a different population, but the description in the introduction would seem to prohibit that.	Yes, a provider of children's services could provide CFCM for adults. Similarly, a direct service provider for the I/DD population may provide CFCM to EAD only. A direct service provider for the EAD population may provide CFCM to the I/DD population only. As revised, the Standards refer to providers of HCBS *to the individual*, not whether a CFCM agency is a provider of HCBS at all.
40.	Samuel Salganik RIPIN Executive Director	What exactly counts as HCBS? The CFCM Strategic Plan is not a legally binding document and does not provide a very precise definition. For example, does **Support Brokerage for the I/DD self-directed population count as HCBS? Does Cedar support for children with special needs count as HCBS?** If any provider of any HCBS is prohibited from offering CFCM services, it becomes very important to have a comprehensive and precise definition of HCBS.	Thank you for this feedback. The program manual will provide further information related to this question, but as an interim response, Supports Brokerage does count as HCBS and Cedar support for children with special needs does not count as HCBS. Please see Attachment B of the 1115 waiver for more information
41.	Samuel Salganik RIPIN Executive Director	Referrals (not mentioned in document) – Prospective CFCM agencies and the community need to know more about how agencies will receive and accept/reject referrals. For example, **will CFCM agencies be able to refuse referrals when they are operating at capacity?** Will they be able to refuse referrals for any other reasons?	Yes, CFCM agencies are permitted to deny referral requests if they do not have sufficient capacity. Case management entities will not be allowed to deny referral requests based on the participant's location, required service needs, race, religion, political affiliation, gender, national origin, age, sexual orientation, or gender expression. If an agency denies a referral request, it must provide an explanation of the reason for the denial. Further detail regarding the mechanics of referrals to CFCM agencies will be available in the program manual.
42.	Samuel Salganik RIPIN Executive Director	How will the State decide how to distribute referrals when clients fail to express a preference?	If a participant does not express a choice of CFCM agency, they will be auto assigned based on agency capacity.

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43.	Samuel Salganik RIPIN Executive Director	What sorts of business processes with CFCM agencies need in order to connect with new clients?	Thank you for your comment. EOHHS will provide detail on the process to connect with new clients in the program manual.
44.	Samuel Salganik RIPIN Executive Director	Will outreach and marketing be important, or will the State quarterback all the referrals?	HCBS participants will be referred by the State to the CFCM agencies.
45.	Samuel Salganik RIPIN Executive Director	Will CFCM agencies need any special technology platform to process referrals?	Case management agencies will be required to use the state technology platform. More information will be provided in the program manual.
46.	Samuel Salganik RIPIN Executive Director	Transition (not mentioned in document) – We recognize that is very difficult (maybe even impossible) for EOHHS to map out the transition of current HCBS recipients into the new CFCM system before EOHHS knows who many and which CFCM agencies are participating. **That said, both the potential CFCM agencies and the public would benefit from understanding this transition better as soon as possible.** Potential CFCM agencies need to know about the often-**difficult ramp-up period**. What is the **State envisioning** for this transition, **potentially based on a few different realistic contingencies about CFCM agency capacity**?	Documents related to the transition were shared during and after the December 14th stakeholder meeting. Further information will be shared with the community as we better understand the agency landscape following certification.
47.	Samuel Salganik RIPIN Executive Director	List of Excluded Populations – We recall some prior documents that also excluded Medicare-Medicaid Plan (MMP / NHP Integrity) enrollees as well as anyone receiving their HCBS through a Medicaid Managed Care Organization (MCO) from CFCM. Please confirm whether these populations are still excluded.	As described in the Standards, CFCM does not apply to: PACE participants, Katie Beckett eligible children, Other Medicaid-eligible children who receive Medicaid services at home or in the community, Nursing Home Transition Program (NHTP) including Money Follows the Person (MFP), Integrated Health Home. It is correct that individuals enrolled in MMP will receive case management from Neighborhood Health Plan for the duration of the MMP and therefore will not receive case management from agencies certified through these Standards. In the longer term, however, participants receiving HCBS through managed care will receive case management through these agencies, as managed care organizations will contract with CFCM agencies. Therefore, the Standards do not list MCO participants as an excluded population.
48.	Samuel Salganik RIPIN Executive Director	RI Physical Presence (page 4) – We strongly support the proposed requirement that CFCM providers have a physical presence in Rhode Island.	Thank you for your comment, we appreciate your support.
49.	Samuel Salganik RIPIN Executive Director	EOHHS Background Check Policy (Page 5)– Is this policy available for review?	EOHHS has revised the Background Check Policy section to eliminate the reference to an EOHHS policy. CFCM Agencies should describe their own policies for conducting background checks.
50.	Samuel Salganik RIPIN Executive Director	Case Assignment / Max Caseload Policy (Page 6) – Any maximum caseload policy will likely need to include exceptions and contingency plans for unexpected vacancies, leaves of	EOHHS agrees that participants should not be moved from a case management agency just to resolve what would be a temporary case manager shortage in an agency. EOHHS has not set a maximum caseload in the revised Standards and

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		absence, and other exigencies. **Participants should not necessarily be shifted to new CFCM agencies to resolve temporary high caseloads caused by these kinds of every-day operational challenges.**	encourages CFCM agencies to include contingency plans for unexpected vacancies etc. in their Caseload Policy.
51.	Samuel Salganik RIPIN Executive Director	Supervision on Home Visits (Page 8, item 3) – **The wording is potentially confusing and could be read to require that the supervisor accompanies the case manager to the home visit of each client every six months.** That's likely not what was intended. We support requiring that the supervisor accompany each case manager on a home visit at least twice per year. (RIPIN policy also requires that new staff are accompanied by a supervisor or an experienced colleague for their first three home visits after hire.)	EOHHS agrees with the recommendation to clarify that the case management supervisor should observe the case manager during at least two in-person visits per year (total, not per participant) and has revised the Standards accordingly.
52.	Samuel Salganik RIPIN Executive Director	Reporting Requirements (Page 8, Item 1) – CFCM agencies will need to know more about the reporting requirements before they can commit to meeting them.	Thank you for your comment. Further information related to Reporting will be provided in the Program Manual.
53.	Samuel Salganik RIPIN Executive Director	Annual Cost Report (Page 8, Item 3) – What is the Annual Cost Report? What is its purpose? Is there a template or sample available?	Thank you for your feedback. EOHHS has removed the request for a cost report from the Standards.
54.	Samuel Salganik RIPIN Executive Director	Performance Standards / Timelines (Page 12, Letters D/E) – While we support fast turnaround for clients, these timelines feel too aggressive, particularly for clients with the most complex needs. In complex cases, case managers (and their clients!) often need to do research and trouble-shooting before and/or after the person-centered planning meeting before the plan is finalized. The timelines of holding the meeting within ten days of initial contact, and then finalizing the plan (including signature) within ten days after the meeting make that nearly impossible. For comparison, Cedar program standards allow providers 45 days to create and finalize the person-centered plan. • Please understand that this concern is not purely from the perspective of a potential CFCM provider. We worry also that patients with the most complex needs will not be well served by providers who are required to work on such tight one-size-fits-all timeframes.	Thank you for your feedback. The goal is not to hold the participants to a certain amount of time, but rather to ensure that that the agency is generally ensuring a timely start to the person-centered planning process. EOHHS has revised the language for this standard to account for the possibility of a person-centered reason to take more than 10 days. Also, note that the performance standards do not refer to the timeline for completing the plan.
55.	Samuel Salganik RIPIN Executive Director	Performance Standards / Not Receiving Service (Page 12, Letter H) – This measure is important, but it will also often be outside of a CFCM agency's control. More importantly, areas and populations facing HCBS shortages are widely known in the	EOHHS agrees that it is not necessary to retain this performance standard. The goal is to be able to identify services for which access is a challenge so that the state can work on addressing those challenges. EOHHS will be able to access data on the issue

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		State, and this measure will disincentivize CFCM agencies from engaging in those communities. • This performance measure is particularly worrisome in connection with flat PMPM reimbursement structure. It's another disincentive to serve those with the highest needs. If the reimbursements cannot be risk-adjusted, then please be very careful about the unintended (by easily foreseeable) impact of using this type of performance measure.	of participants not receiving services that are in their person-centered plans using the Wellsky tool.
56.	Samuel Salganik RIPIN Executive Director	Certification Application (Page 13, letter B) – Is the Application for Certification (Appendix A) available for review?	The application will be shared in the month of January.
57.	Samuel Salganik RIPIN Executive Director	CFCM Policy & Procedure Manual – The certification standards regularly mention a CFCM Policy and Procedure Manual. We hope that prospective CFCM agencies and the impacted community will be able to access that document once it is available.	Thank you for your comment. EOHHS will make the draft CFCM program manual available for public review in January.
58.	Suzanne Carson Tri-county	Information and Referral Policy: The policy shall state that the case management Agency shall accept and respond to requests for information and/or assistance from individuals, caregivers, and other third parties. Comment: **Are these callers consumers of CFCM? How will the agency be compensated for said information and/or assistance to any caller?**	Thank you for your comment. The Information and Referral Policy refers to the agency's response to requests from their existing clients. Outside inquiries for information and referral should be referred to The Point for additional assistance.
59.	Suzanne Carson Tri-county	Personnel Policy: Comment: what are the staff qualifications?	Thank you for your comment, The state has not set minimum education or experience requirements for CFCM staff. Agencies will be required to document their own minimum requirements within their Personnel Policies, as indicated in the Standards.
60.	Suzanne Carson Tri-county	Assignment Policy: Comment: **The policy should speak to how a CFCM agency determines being at capacity and informs EOHHS that they are no longer can accept new enrollees**.	Thank you for your comment. EOHHS agrees that CFCM agencies should have a process to determine that they are at capacity and communicate that to EOHHS. This information should be included within the agency's Caseload Policy and reported to EOHHS in the Monthly Capacity Report.
61.	Suzanne Carson Tri-county	Caseload Policy: The policy shall state how the Agency ensures that case managers have a reasonable caseload that allows adequate time to meet the needs of their assigned participants and comply with all federal and State rules, regulations, and standards. This shall include a maximum caseload size per case manager. The policy shall also address the prioritization process for people accessing case management services.	Thank you for your comment. EOHHS has revised the Standards to include more explanation of the prioritization process.

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		Comment: Please identify characteristics for prioritization: This should be universal among CFCM providers. **What factors are included? Caregiver involvement, age, history of past case management?**	
62.	Suzanne Carson Tri-county	Behavioral Support Plan Policy: The Agency shall have a policy that establishes procedures, consistent with State and federal law and regulations, that guide the case manager when a participant has a behavioral support plan. This policy shall provide for the process by which staff can identify and report. This policy shall identify the misapplication of a behavioral support plan and mechanisms for identifying and reporting such suspected misuse or misapplication as a critical incident. Comment: Is this just for I/DD participants?	Yes, the Behavioral Support Plan Policy only refers to the needs of I/DD participants.
63.	Suzanne Carson Tri-county	Supervision of Case Management Staff: Comment: What are the educational and experience qualifications for the conflict free case manager and Supervisor? Where are educational requirements for the conflict free case manager and Supervisor? With Medicaid reimbursement the service needs to be conducted by a qualified provider.	Thank you for your feedback. The requirements for case managers are designed around competencies rather than a particular educational level. The state has not set minimum education or experience requirements for CFCM staff. Agencies will be required to document their own minimum requirements within their Personnel Policies.
64.	Suzanne Carson Tri-county	Reporting: Critical Incident Report: Report all observed or suspected critical incidents. Case managers are mandatory reporters of abuse, neglect, mistreatment, and exploitation ("Critical Incidents") under State law. Critical Incidents must be reported as soon as possible to law enforcement and/or the appropriate State agency. **Comment: Critical incidents are a new concept for some providers; more a guidance from EOHHS is needed on what exactly constitutes as a critical incident.**	Thank you for your feedback. EOHHS will provide further detail on Critical Incidents and Critical Incident reporting in the Program Manual and in provider trainings.
65.	Suzanne Carson Tri-county	INDIVIDUAL CASE MANAGER STANDARDS- A case manager shall ensure that a participant has the right to receive services under conditions of acceptable risk. "Acceptable risk" is defined as the level of risk an individual and/or their guardian is willing to accept after the informed consent process. When necessary, a case manager shall work with the individual and the service provider to develop a Negotiated Risk Agreement.	Thank you for your feedback. EOHHS has deleted the reference to a Negotiated Risk Agreement from the Standards. The person-centered plan will document all agreements on acceptable risk.

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		Comment: Additional guidance on negotiated risk agreement is needed.	
66.	Suzanne Carson Tri-county	Comments for the Medicaid HCBS Roles and Responsibilities under CFCM- 1 Pager handout. Last section- additional support for participants who choose to self-direct-… Support broker: **Why is the support broker option only available be for the I/DD population? There is hundreds of EAD consumers (and growing) on self-directed.** *Why wouldn't the EAD population who choose to self-direct have access to a support broker. Isn't one of the main concepts to for CFCM is no matter what LTSS program or population the person is on they have the same access programs.*	The State has decided not to move forward with support brokers on the EAD side at this time. We will be reviewing in the future as an added service. Note that the support broker service is separate from the case management service and therefore is not directly related to CFCM Certification Standards.
67.	Suzanne Carson Tri-county	There seems to be a large amount of responsibility on the CFCM to need to know how assist consumers under all the service arrays. How/Who determines that the person is appropriate to self-direct? A lot of people might want to but don't have the capability to do so. Who appoints the representative (who in turn directs the care) the CFCM?	Thank you for your comment. The case manager helps determine whether self-direction is appropriate through use of the Self-Direction Assessment worksheet, which is currently used by the Service Advisory Agencies. The worksheet includes questions to help determine whether a person can manage the program themselves or will need assistance from a representative. A person who cannot manage the self-directed program independently can choose a representative to help them. The individual would choose this representative, rather than having them appointed by someone else.
68.	Suzanne Carson Tri-county	Same concept for Assisted living. Who decides if the person is appropriate for that setting. The CFCM can suggest a facility however- The facility determines if the consumer is medically appropriate and if they have capacity to accommodate them. The facility does their own intake assessment Dept of Health assessment to ensure they can meet the clients needs.	The process for referring a person to assisted living is not changing. The case manager will still refer participants to the appropriate setting that the participant chooses, and the facility will still determine whether the person is appropriate for their setting.
69.	Linda Ward Executive Director Opportunities Unlimited	There should be reference somewhere that the individual receiving the services of CFCM has responsibility to achieve goals as agreed. All responsibility should not be placed on CFCM and/or service provider.	Participant roles and responsibilities have been outlined in the Roles and Responsibility documents posted to the EOHHS CFCM website.
70.	Linda Ward Executive Director Opportunities Unlimited	Please clarify on p. 3, last line of paragraph two – does this mean that providers of IDD services cannot be certified to provide CFCM to EAD populations? If this is the case, it may be difficult to recruit qualified individuals/entities to provide CFCM.	If an agency provides direct services to the I/DD population but not the EAD population, then it may be certified to provide CFCM to EAD only. Conversely, if an agency provides direct services to the EAD population, but not I/DD, then it may be certified to provide CFCM to the I/DD population only.
71.	Linda Ward Executive Director Opportunities Unlimited	P. 5, number 3 under Assignment Policy does this refer to CFCM personnel or to staff providing direct service to individuals?	The Assignment Policy refers to the Agency's process of assigning participants enrolled with the Agency to individual case managers.

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72.	Linda Ward Executive Director Opportunities Unlimited	Does EOHHS have a policy for what size caseload a CFCM carries?	RI EOHHS does not set a mandated caseload size; rather, the Certification Standards require CFCM Agencies to develop a Caseload Policy describing how the Agency ensures that case managers have a reasonable caseload that allows them adequate time to meet the needs of their participants and to comply with EOHHS rules, regulations, and standards. The Caseload Policy must identify the Agency's maximum caseload per case manager. While a caseload size of 48 was assumed in the state's rate-setting process, this does not represent a required ratio.
73.	Linda Ward Executive Director Opportunities Unlimited	How will EOHHS and/or the CFCM manage grievances filed by an individual to ensure that there is not duplication with what is required by a provider licensing entity.	To the extent there are overlaps in grievance reports regarding the same provider received both by EOHHS (via the CFCM agency) and another state agency, the state agencies will collaborate and/or operate parallel investigations as appropriate. This is already well managed in other contexts, such as when critical incidents may be reported to and investigated by, e.g., both OHA and RIDOH.
74.	Linda Ward Executive Director Opportunities Unlimited	On page 7, Emergency Management Plan – what role does the service provider/agency play in this process. Current BHDDH licensing regulations have requirements in this area.	Direct service provider responsibilities regarding emergency management planning are not affected by these CFCM Standards.
75.	Linda Ward Executive Director Opportunities Unlimited	On p. 7 Core Competencies # 3 and #4, what role does a provider agency's service coordinator play in this connecting to services and supports and plan monitoring and follow up.	Service Coordination is not a separate service from Case Management. Connection to services and plan monitoring are components of the case management service. Agencies may employ Service Coordinators who meet the requirements for Individual Case Managers as case managers to qualify for reimbursement for these activities.
76.	Linda Ward Executive Director Opportunities Unlimited	On p. 9, section III, B – the expectation that a CFCM is knowledgeable about the full range of services available is somewhat daunting. Not sure anyone has knowledge of full range of services available.	Case managers are expected to be knowledge about the full range of available services relevant to the populations the case manager is serving. To help ensure this, the state plans to offer an orientation training on "Services and Supports Available in Rhode Island" which will be accessible online. State training is not a replacement for agencies' responsibility to ensure case managers are knowledgeable, but is expected to support agencies in meeting this requirement.
77.	Linda Ward Executive Director Opportunities Unlimited	On p. 9, III, I subsection 1 – doesn't the legal guardian have an expectation that he/she will be offered ability to attend Person Center Planning Meeting.	Participants may choose whom to involve in Person-Centered Planning meetings. If the participant chooses to involve an authorized legal guardian, then the guardian will be able to attend the meetings.
78.	Linda Ward Executive Director Opportunities Unlimited	On p. 10, O there is reference to CFCM Policy and Procedure manual – when will this be available for review. Would be important to have this if an entity may want to be certifies to provide CFCM services.	EOHHS will make the Program Manual available in January.
79.	Linda Ward Executive Director Opportunities Unlimited	On. P 12 Performance standards, A – 3 business days to respond is a very short timeframe	Thank you for your feedback. EOHHS believes that this is an appropriate performance standard for CFCM Agencies. To the extent that actual performance demonstrates that 3 days is not achievable, EOHHS will consider modifying the standard in the future.

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80.	Linda Ward Executive Director Opportunities Unlimited	What happens to a provider if CFCM does not submit Person Center Plan within 10 days of completing plan meeting?	For new HCBS participants, the person-centered plan must be in place before any direct services can be authorized. A direct service provider would therefore not already have an individual as their client before the plan is complete, and so there would be no consequence to that provider if more time passes before the referral is made and services (and billing) can begin. This Performance Standard has been revised to clarify that it only applies for new HCBS participants.
81.	Linda Ward Executive Director Opportunities Unlimited	Still unclear who will do the authorization (now known as the PO).	This process will be further defined in the manual.
82.	Linda Ward Executive Director Opportunities Unlimited	How will providers of service be held harmless if the CFCM does not meet timelines.	As discussed above, a direct service provider would not be impacted by missed CFCM timelines, because the service provider would not yet be providing services to an individual to whom those timelines apply.
83.	Linda Ward Executive Director Opportunities Unlimited	The funding as shared does not appear to be adequate to cover a CFCM and a CFCM Supervisor. If a CFCM Supervisor is required on day one of providing this service along with a CFCM, looking at the rate sheet provided, the CFCM entity would need to engage with 48 individuals within the first month in order not lose money. There should be some upfront funds either in start up monies (which it was explained was not in the State FY 24 budge)t or some enhanced funding for each individual who as they engage with a CFCM entity.	RI EOHHS does not set a mandated caseload size; rather, the Certification Standards require CFCM Agencies to develop a Caseload Policy describing how the Agency ensures that case managers have a reasonable caseload that allows them adequate time to meet the needs of their participants and to comply with EOHHS rules, regulations, and standards. The Caseload Policy must identify the Agency's maximum caseload per case manager. While a caseload size of 48 was assumed in the state's rate-setting process, this does not represent a required ratio.