Conflict-Free Case Management (CFCM) Program Manual

Medicaid Home and Community-Based Services

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The table below tracks revisions made to this manual since its initial release date.

Version	Date	Change Summary
1.0	7.10.2024	Original submission.
2.0	12.19.2025	Section IV. Selection and Assignment of a CFCM Agency 1. Choosing a CFCM Agency – language referring to the CFCM transition was removed, this is no longer applicable 2. Process for Changing CFCM Agencies – language was updated to clarify which State agency a CFCM needs to connect with if a participant requests to change agencies 3. Also added language on how to handle CFCM agency changes for participants in the Personal Choice program Section VII. E.2 Self-Directed Service Delivery 1. Added clarifying language about the delivery of self-direction services, and that these cannot be duplicated with agency based care Section VII. F. Changing Service Delivery Settings 1. Added language for when a participant changes their setting (i.e. moves from an ALF to homecare, or homecare to a nursing home), and what documentation must be sent to DHS Section VIII. Finalizing the Person-Centered Plan and Service Authorization 1. B. Guidance on Signatures a. Added language clarifying the process for new versus existing providers 2. D. Authorization of Services Included in the Person-Centered Plan a. Added language about when a reassessment is required b. Added language stating service changes must be reflected in the person centered plan XI. Participant Disenrollment 1. Updated language related to the MMP transition 2. Changed the number of days a CFCM supports a participant in an institutional setting from 60 to 90 days Attachment F. Program Timeframes and Attachment G. Reporting and Notification Requirements 1. Current process flow requires a CFCM to complete the following: a. Contact the participant no more than 3 business days after the participant assignment b. Conduct the initial person centered planning meeting within 10 days of the initial contact c. Complete the PCP within 20 days of the initial person centered planning meeting 2. New process flow will be the following:

Version	Date	Change Summary
		a. Within 45 calendar days of initial contact, the case manager must conduct a person centered planning meeting and submit completed person-centered plan to the State for approval Attachment H. Guidance on Noncompliant Participants 1. Documentation was shared with the CFCM agencies in March 2025; adding it to the program manual Overarching changes 1. Highlighted areas where process flows will occur within the State's LTSS case management platform at a future date (i.e. service authorizations, referrals, etc.) 2. Added the Office of Community Programs (OCP) as a point of contact for the CFCM agencies; previously only listed EOHHS, DHS and/or BHDDH 3. Anywhere the manual states "participant and/or legal representative", wording was changed to "participant and/or their legal representative (e.g., legal guardian or power of attorney)"

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I. INTRODUCTION AND PURPOSE

This manual outlines the requirements for the delivery of conflict-free case management (CFCM) services for Medicaid home and community-based services (HCBS) participants. It provides instructions and references regarding the roles and responsibilities of case managers to provide effective, responsive, and reliable CFCM. This manual contains additional resources to aid new case managers in gaining the skills necessary to effectively coordinate supports and services for the participants on their caseload. Although this manual is written primarily for case managers and certified CFCM agencies, it can also be used as a resource for participants, families, and other HCBS providers. **Attachment A** includes definitions for terms used throughout the manual. For the purposes of this manual, "case management" only refers to case management of HCBS, and not case management that may be provided outside of the HCBS service delivery system, and "CFCM agency" only refers to those providers certified by the Executive Office of Health and Human Services (EOHHS) to deliver HCBS CFCM.

To become certified as a CFCM agency, refer to the CFCM Certification Standards and application form available on the CFCM webpage: https://eohhs.ri.gov/conflict-free-case-management

EOHHS will update this manual as policies change, processes are developed or amended, or as improvements are made to the implementation of CFCM. While EOHHS will keep providers apprised of changes in policies and regulations, providers must also be familiar with all current rules and regulations governing the Medicaid Program. This manual does not contain all Medicaid rules and regulations, nor does it supersede Medicaid policy and is not to be used in lieu of Medicaid policy. Questions or requests for manual revisions should be directed to OHHS.LTSSNWD@ohhs.ri.gov.

II. ORGANIZATION AND ADMINISTRATION

A. CFCM Agency Requirements

1. Be certified by EOHHS to deliver CFCM according to the CFCM Certification Standards issued by EOHHS.

B. CFCM Agency Responsibilities

1. Ensure each participant has a designated case manager.
2. Provide CFCM to participants without discrimination based on race, ethnicity, religion, political affiliation, gender, national origin, age, sexual orientation, gender expression, or disability.
3. Facilitate access to assistive communication technology and/or interpreters for participants with hearing, visual and/or vocal impairments and access to foreign language interpreters as necessary to conduct all required CFCM activities.
4. Maintain adequate administrative and staffing resources and emergency backup systems to deliver CFCM in accordance with all federal and State requirements.
5. Collaborate with other entities, as needed to fully support participants.
6. Maintain feedback mechanisms (i.e., surveys, advisory boards, etc.) for individuals with lived experience, individuals receiving services and their families to provide input to supports and policies.
7. Comply with State and federal rules and regulations related to overall security, privacy, confidentiality, integrity, availability, and auditing.
8. Provide that security is not compromised by unauthorized access to workspaces, computers, networks, software, databases, or other physical or electronic environments.

9. Maintain all records in accordance with the CFCM agency's policies, including but not limited to participant, personnel, and financial records.
10. Notify EOHHS Program Integrity Unit if the CFCM agency identifies or suspects fraud, waste, and/or abuse.
11. Ensure all staff and independent contractors meet established standards for qualifications and training.
12. Participate in measuring and reporting quality and in continuous quality improvement activities.
13. Maintain a sound approach to financial management including:
    a. Timely billing for services.
    b. Developing and working within a budget.
    c. Regular review of income and expenditure reports.
    d. Operating on a sound financial basis according to acceptable accounting practices.
14. Ensure that each case manager has a caseload that allows them to have adequate time to meet the needs of their participants and comply with EOHHS rules, regulations, and standards.
15. Ensure that there is sufficient case management staff to provide good customer service and assure the provision of quality services to all participants in a timely manner.

III. OVERVIEW OF HCBS CASE MANAGEMENT

Case management is required for all Medicaid Home and Community-Based Services (HCBS) participants with intellectual and developmental disabilities (I/DD) and Elders and Adults with Disabilities (EAD) who receive Medicaid Long-Term Services and Supports (LTSS) at home or in a community-based setting. Case management is a service utilized to empower participants to make informed decisions about their care, and to protect the health and welfare of all participants. A person is eligible for Medicaid LTSS if they meet both the financial and clinical eligibility criteria established in the State's Medicaid State Plan and 1115 Waiver and further described in Title 210 of the Rhode Island Code of Regulations.

Case management is defined as a set of activities to ensure that every Medicaid HCBS participant is fully informed to choose the services and supports that meet their individual needs, and to select who provides those services and supports. Case management is provided by a case manager who assists the participant in developing their person-centered plan and coordinates and monitors the implementation of that plan. The key components of case management services are:

- Supporting the participant to identify and meet personal goals.
- Advocating and creating conditions for participant self-determination and choice.
- Applying person-centered practices in assisting with the development of a person-centered plan.
- Providing culturally competent care.
- Gathering and reviewing the participant's initial functional needs assessment completed by the State and compiling all other existing information for the participant to assist the participant in creating their initial person-centered plan.
- Assisting participants in obtaining needed information and accessing all available resources and services to maximize the development of supports to maintain their independence and live in a

setting of their choice (e.g., assisting with Medicaid financial recertification and providing participants with choice regarding setting options).

- Connecting the participant to paid and unpaid supports, including making referrals and ensuring that the appropriate authorizations are in place.
- Troubleshooting problems and identifying solutions related to coordination of care and services.
- Conducting routine monitoring with the participant to ensure participant satisfaction, health and welfare, and access to high quality and culturally competent care and services.
- Operating in a capacity that is free from conflict of interest.
- For EAD participants, completing an annual reassessment of functional need using the State-sponsored EAD assessment instrument and utilizing the results to assist the participant in updating their person-centered plan.
    - Note: The Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) completes all assessments, including the initial assessment and all reassessments, for I/DD participants using a State-sponsored I/DD assessment instrument. The CFCM case manager shall utilize the results from these assessments to assist the participant with the development of their person-centered plans.

While the participant leads the person-centered planning process, the case manager is responsible for providing participants with choice, education, and information to support them throughout the person-centered planning process and while the participant is receiving Medicaid HCBS. Case managers must be knowledgeable about all the Medicaid HCBS requirements, rules, services, and participant rights and responsibilities. **Attachment B** includes a detailed roles and responsibilities comparison. **Attachment C** describes participant rights and responsibilities.

The HCBS case management process is coordinated and centralized in the State's LTSS case management platform. A separate manual for the State's LTSS case management platform will be shared with CFCM agencies.

A. Populations to Receive CFCM

1. This manual applies to all case management services provided to Medicaid participants with I/DD and EAD who receive Medicaid LTSS at home or in a community setting.
2. CFCM agencies may choose to support two (2) populations (participants with I/DD and EAD) or choose to serve one (1) population only.
3. This manual and CFCM requirements DO NOT apply to:
    a. PACE participants;
    b. Children;
    c. Other Medicaid-eligible children who receive Medicaid services at home or in the community;
    d. Nursing Home Transition Program (NHTP) including Money Follows the Person (MFP);
    e. Integrated Health Homes;
    f. Medicaid's Targeted Case Management benefit;
    g. Case management provided outside the context of HCBS (e.g. Certified Community Behavioral Health Clinics or Community Health Workers); or
    h. The Office of Healthy Aging's At Home Cost Share program

B. Person-Centered Planning

The person-centered planning process is led by the participant and guided by the case manager. This process is the most critical activity to help a participant live well and develop strategies to achieve a life based upon their choices. Person-centered planning discovers and organizes information that focuses on each individual participant's strengths, choices, and preferences. Person-centered planning involves bringing the participant together with other people the participant wishes to include in the planning process, listening to the participant, comprehensively describing the participant with a focus on understanding who they are, and helping the participant dream and imagine the possible ways things could be different, both today and tomorrow. The person-centered planning process is more than just filling out a form; it is about following through on plans to improve lives. It is a process for creating a person-centric vision of what each participant wants for their future, and helping the participant map out how they can get there and achieve their goals and vision. Person-centered planning is not a one-time event but an evolving continuum of care and services as the person's preferences, needs, and goals change.

There are many types of planning methods or tools that may be used to support the person-centered planning process. These include, but are not limited to:

1. Using paper or white boards to record ideas and use as a visual aid for communication;
2. MAPs (Making Action Plans);
3. PATH (Planning Alternative Tomorrows with Hope);
4. LifeCourse Framework and Tools; and
5. Creating picture boards to help participants to see and communicate their choices.

Most person-centered planning tools share common values (e.g., community participation and developing meaningful goals) and have similar steps. The selection of the method which might work best for the participant depends on each participant and their chosen planning team.

Case managers are expected to adhere to the following requirements:

1. Case managers must be proficient in different person-centered planning approaches and tools; however, the use of the template provided by the State is mandatory.
2. Case managers must use a person-centered approach that complies with 42 C.F.R. § 441.301(c)(1) when helping develop the participant's person-centered plan. At a minimum, case managers must:
    a. Ensure that the participant drives the person-centered planning process and that others included in person-centered planning meetings act in a supportive role. This includes providing information and open communication, asking questions, and supporting the participant to articulate their preferences to drive the planning process to the maximum extent possible.
    b. Ensure that the participant chooses who is included in the person-centered planning process. It is important to include people who know the participant well, as the participant may want others to assist by offering detailed information about their preferences, strengths, and needs. This might include friends and family members, natural supports, providers of services (in particular, direct care staff), and others who support the participant throughout the day, such as therapists or clergy. Case managers may offer suggestions, but the participant must ultimately decide who, if anyone, they would like to have involved in the planning process. Since relationships fluctuate and change, the case manager must regularly inform the participant of their right to change the members of the planning team at any time (e.g., during a monitoring visit or by phone call).

i. If a participant chooses to include a direct service provider in the person-centered planning process, the case manager must ensure that it is the participant's choice and the direct service provider acts in a supportive role and does not develop the person-centered plan or dominate the person-centered planning process.

c. Ensure that participants have the information necessary to make an informed choice of the services and providers they add to their person-centered plan. This includes documenting the alternative home and community-based settings that were presented to and considered by the participant, including institutional settings (such as a nursing facility).

d. Ensure that the person-centered planning process reflects cultural considerations of the participant. In doing so, case managers must be cognizant of their own power and privilege, cultural assumptions, psychological development and temperament, personality dynamics, and prejudices to avoid imposing their beliefs on the process. Similarly, case managers must be aware of the values and cultural biases of the service system and recognize that the participant's values and culture may not align with the system's values and culture. Culturally competent case management includes learning about a person's cultural and linguistic preferences and experiences of trauma (personal or historical) and draws on this learning when partnering with the person in the planning process. The case manager recognizes cultural and linguistic factors, such as individualism and collectivism, language and communication, values and beliefs, customs and rituals, relationships to authority figures, avoidance of uncertainty, relationships to time, and other cross-cultural differences that need to be understood and respected.

e. Ensure that information is provided in plain language and in a manner that is accessible to participants with disabilities and persons with limited English proficiency, consistent with 42 C.F.R. § 435.905(b) and 42 C.F.R. § 441.301(c)(1)(iv). The case manager must be respectful of and sensitive to the lived experience of the participant and family, including cultural considerations. If an alternate means of communication is used or if the participant's primary language is not English, the person-centered planning process should utilize the individual's primary means of communication.

f. Ensure that Medicaid HCBS providers for the participant, or those who have an interest in or are employed by the Medicaid HCBS provider, do not provide case management or develop the person-centered plan.

g. Ensure that planning meetings are timely and occur at times and locations chosen by and convenient for the participant.

h. Ensure that strategies for solving conflict or disagreements are used throughout the process, and that clear conflict of interest guidelines are in place for all individuals involved in the person-centered planning process.

i. Ensure that an explanation of the participant's specific needs, preferences, and overall goals, as well as a brief description of the specific tasks that the provider is expected to perform to address the participant's needs, preferences, and goals, is included in the service referral.

j. Ensure that the participant understands how to request updates to their person-centered plan as needed.

C. Conflict of Interest Safeguards

1. CFCM agencies are expected to adhere to the conflict of interest standards outlined in the CFCM Certification Standards issued by EOHHS.

2. Should a conflict arise, it is the case manager's duty to inform the participant and assist the participant in finding a new case manager or CFCM agency as necessary to eliminate potential conflicts of interest.

3. The CFCM agency must disclose potential conflicts of interest and financial and ownership relationships to EOHHS.

IV. SELECTION AND ASSIGNMENT OF A CFCM AGENCY

A. Choosing a CFCM Agency

1. State eligibility staff work with the participant to obtain their choice of CFCM agency. State eligibility staff explain the case management service and provide participants with CFCM agency fact sheets to aid in selecting their CFCM agency. If the participant does not have a preference, the participant may choose to be auto-assigned to a CFCM agency based on the State's auto-assignment criteria.
2. If an applicant contacts the CFCM agency directly prior to being eligible for LTSS-HCBS (e.g., Medicaid eligible but not determined eligible for LTSS, not yet Medicaid eligible, or receiving Medicaid LTSS in an institutional setting), the CFCM agency may provide Medicaid LTSS application assistance or refer the applicant to existing community organizations or agencies that provide application assistance.
    a. The CFCM agency can also refer these applicants to the RI Department of Human Services (DHS) the RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), or the Office of Community Programs (OCP) as appropriate, to complete a Medicaid LTSS application.
    b. A participant will not be auto-assigned to a particular CFCM agency based on the agency having provided Medicaid LTSS application assistance.

B. Auto-Assignment Criteria

1. If a participant does not wish to select a CFCM agency, DHS, BHDDH, or OCP auto-assigns the participant based on the following auto-assignment criteria:
    a. Provider capacity to support I/DD or EAD (i.e., the CFCM agency can support the participant population).
    b. Certification to support participants under specific State agency programs (e.g., personal choice, habilitation, etc.).
    c. Participant level of need, as determined by the initial functional needs assessment.
    d. Capacity limitations as reported monthly by each CFCM agency to EOHHS.

C. Provisions for Referral Denial

1. Once a participant selects a CFCM agency or is auto-assigned, DHS, BHDDH, or OCP formally refers the participant to the CFCM agency through the State's LTSS case management platform. CFCM agencies only receive referrals for participants who are determined eligible for Medicaid LTSS-HCBS.
    a. DHS, BHDDH, or OCP will assign the participant to the Case Manager Supervisor, who will assign the participant to the case manager according to the CFCM agency's assignment policy.

2. The CFCM agency must accept or deny referral requests within two (2) business days of receiving the request.
    a. Generally, the CFCM agency must accept the referral and assign the participant to a case manager according to the CFCM agency's assignment policy.
    b. The CFCM agency may decline a referral only in the following situations:
        i. The CFCM agency does not have sufficient capacity.
            1. Capacity is determined by the CFCM agency based on their staffing levels and experience and reported to EOHHS in the monthly capacity report according to the CFCM Certification Standards.
            2. The CFCM agency shall immediately notify EOHHS in writing (by email to ohhs.ltssnwd@ohhs.ri.gov) when the agency is no longer able to accept new participants based on available capacity. DHS, BHDDH, or OCP will not refer participants to these agencies after such notification is submitted, until the agency notifies EOHHS that capacity is available again. CFCM agencies at full capacity are expected to continue submitting monthly capacity reports even when at full capacity.
        ii. The referral is not aligned with the population(s) supported by the CFCM agency.
        iii. There is a conflict of interest as defined in the CFCM Certification Standards.
        iv. The CFCM agency does not have and cannot obtain the appropriate expertise to address the needs of the referred participant.
        v. There is an extraordinary reason identified by the CFCM agency, which is reviewed and approved by EOHHS as an appropriate denial.
    c. CFCM agencies shall not deny referral requests based on the participant's location, required service needs, race, ethnicity, disability, religion, political affiliation, gender, national origin, age, sexual orientation, or gender expression.
    d. If a CFCM agency denies a referral request, it must explain why the referral was denied to EOHHS in writing (by email to ohhs.ltssnwd@ohhs.ri.gov).
        i. If EOHHS determines that the denial is not appropriate, the referral will be sent back to CFCM agency.

D. Process for Changing CFCM Agencies

1. Participants can switch CFCM agencies at any time by notifying the State as described below. It is the responsibility of the State to explain the transition process to the participant once notification is received by the State.
2. To change CFCM agencies, the participant, or a representative, contacts their current case manager to make a change.
    a. The case manager notifies their case manager supervisor
        i. Any documentation not stored in the State's LTSS case management platform must be scanned and uploaded to the platform before the participant can be assigned to a new CFCM agency.
        ii. For EAD participants, the case manager supervisor contacts the DHS Supervisor assigned to their CFCM agency through the State's LTSS case management system.

iii. For participants with I/DD, the case manager supervisor contacts BHDDH by emailing bhddh.cfcm@bhddh.ri.gov.

3. When a new CFCM agency is selected or auto-assigned using the process outlined in **Section (IV)(A)-(B)**, the transferring and receiving CFCM agencies cooperate fully.
4. The current CFCM agency must continue to provide case management services in accordance with State and federal requirements and fully complete any outstanding case files or notes until a new CFCM agency is assigned.
    a. Transfers will be initiated on the first day of the following calendar month.
5. The transferring CFCM agency must adhere to its Participant Record Policy.
6. Participants who select Personal Choice may need to switch to a new CFCM agency, if their original CFCM agency does not support Personal Choice. The participant, or a representative, should contact their current case manager. The case manager should follow the process outlined below:
    a. Case manager submits a referral to OCP to refer the participant to a CFCM agency supporting Personal Choice
        i. Send secure email to OHHS.OCP@ohhs.ri.gov with the following information:
            1. Participant's first and last name
            2. Date of birth and/or MID
            3. Current CFCM agency
            4. Any current services, e.g., whether the person is receiving home care from an agency, enrolled in Shared Living, etc.
            5. Whether the participant has identified a personal care attendant (PCA) or not
    b. The current CFCM agency should continue working with the participant until an opening is available at a new CFCM agency that supports Personal Choice. This includes assisting the participant with enrolling in other programs or services, such as Shared Living or agency-based home care, while the person waits for a referral to a CFCM agency that supports Personal Choice.
    c. OCP will refer the participant to the new CFCM agency and inform the current CFCM agency when the referral is completed.
7. Participants transitioning from the Office of Healthy Aging's At Home Cost Share program to Medicaid LTSS:
    a. Agencies certified to support the At Home Cost Share program and which are certified CFCM agencies, can continue working with the participant once the participant is determined Medicaid LTSS eligible. The participant can request to remain with the agency, or be assigned to a new CFCM agency, based on the reported available capacity.

E. Process for Changing Case Managers Within a CFCM agency

1. Certified CFCM agencies are required to have internal policies and procedures for changing case managers within the agency. If the participant wishes to change case managers within the same CFCM agency, these processes are followed to ensure that a participant has an opportunity to select a new case manager.
2. The CFCM agency must make every effort to accommodate the request and assign a new case manager to the participant.

3. The participant's change request must be documented in the State's LTSS case management platform including the request, decision, and rationale for the CFCM agency's decision.
4. The CFCM agency must ensure a smooth transition from one case manager to another, with the new case manager in place within no more than thirty (30) calendar days from the time the participant formally requested a change.

V. PERSON-CENTERED PLAN

Under federal regulations at 42 C.F.R. § 441.301(b)(1), Medicaid HCBS must be furnished under a person-centered service plan. Each Medicaid participant must have a person-centered plan that is developed using a person-centered planning process as described in **Section (III)(B)** and **Section (VI)** of this manual.

The person-centered plan, described at 42 C.F.R. § 441.301(c)(2), is a written document that reflects the services and supports that are important to and chosen by a Medicaid participant and serves as the basis for authorization of services. The participant's person-centered plan serves as a single document that drives holistic services grounded in the participant's strengths, preferences, needs, and goals captured during the person-centered planning process. The case manager supports the Medicaid participant to drive the development of their person-centered plan and provides a copy of the completed plan to the participant, in a format and language that is understandable and accessible to the participant. The case manager also works with the participant to update the person-centered plan as described herein.

A. Operating Principles

1. The person-centered plan must be driven by the participant and centered upon the participant's strengths, preferences, needs, and goals.
2. The person-centered plan must be based upon individual evaluations and assessments in addition to the participant's individual goals and preferences.
3. Services identified in the person-centered plan must be designed to support the participant to meet their personally defined goals and live as independently and successfully as possible.
4. The plan must address utilizing resources and assistance available through natural supports or other State agencies. Services funded by Medicaid are considered only when other resources and supports are insufficient or unavailable.
5. When developing the person-centered plan, the participant and their planning team, as defined in **Section (VI)(B)**, must consider the participant's unique circumstances as expressed by the participant and others who know the person, such as family, friends, and service providers. Goals, services, and providers identified in the person-centered plan should be consistent with assessed needs and:
    a. Recognize and respect the participant's rights and responsibilities;
    b. Encourage independence;
    c. Recognize and value dignity and the right to self-determination;
    d. Respect cultural needs and preferences;
    e. Promote employment, if employment is a goal;
    f. Promote social inclusion and belonging;
    g. Reflect risk factors and measures in place to minimize them, including an individualized backup plan;
    h. Support strengths;

i. Maintain quality of life;

j. Enhance all domains/areas of development;

k. Promote safety; and

l. Promote economic security.

6. The case manager must understand different communication styles while working with the planning team. Planning team members must be experienced in listening to and understanding the participant's communication style. All communication is purposeful, and all people have a need to communicate. Some participants may have difficulty communicating. Most people express ideas, feelings and desires through words, gestures, and body language to convey messages and to respond to others. Communication requires a willingness to use all available means in order to understand and to be understood (e.g., pictures, sign language, gestures, body language, augmentative devices, interpreters, etc.). Alternative methods, including interpreters, as needed for communication, should always be available at the planning meeting.

B. Person-Centered Plan Requirements

1. The person-centered plan must be completed by the case manager in the State's LTSS case management platform using the template provided by the State. Instructions for completing the person-centered plan template are provided in the separate manual for the State's LTSS case management system.
2. When preparing the person-centered plan, the case manager works with the participant and their planning team to identify all services and supports that are necessary for the participant to meet their assessed needs.
3. The person-centered plan must be:
    a. Consistent with the requirements of 42 C.F.R. § 441.301(c)(2).
        i. If any modifications to the provisions of 42 C.F.R. § 441.301(c)(4)(vi)(A)-(D) are required, the modification must be based on the individual's assessed needs and clearly documented within *Section 6* of the person-centered plan template ("My Assessed Needs (Risks)"). A modification means any deviation from the federal rights outlined in 42 C.F.R. § 441.301(c)(4)(vi)(A)-(D) when the participant resides in a provider owned or controlled residential setting (e.g., the participant does not have a lock on their door, does not have access to food at any time, etc.). If there are multiple modifications included in the person-centered plan, each modification must be documented in a separate field within the "My Assessed Needs (Risks)" of the person-centered plan template.
        ii. Proper documentation of a modification includes:
            1. Identification of a specific and individualized assessed need related to the modification ("Assessed Needs").
            2. Documentation of the positive interventions and supports used prior to any modifications ("Mitigation").
            3. Documentation of less intrusive methods of meeting the need that have been tried but did not work ("Mitigation").
            4. A clear description of the condition that is directly proportionate to the specific assessed need ("Interventions").
            5. Regular collection and review of data to measure the ongoing effectiveness of the modification ("Mitigation").

6. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated (“Mitigation”).
7. Informed consent of the individual (“Review and Approval” section).
8. An assurance that interventions and supports will cause no harm to the individual (“Mitigation”).

b. Based upon the participant’s strengths, preferences, needs, and goals as determined through the person-centered planning process.

c. Reviewed and updated at least annually, or sooner if the participant's circumstances or needs change significantly or the participant requests a change.

d. Understandable to the participant receiving services and supports, and the individuals important in supporting the participant.

e. Written in plain language and in a manner that is accessible to participants with disabilities and persons with limited English proficiency.

4. Under federal authority approved March 21, 2024, Rhode Island is permitted to reimburse HCBS Personal Care services provided to a participant during a stay in an acute care hospital. The services in question must already be included in the participant’s person-centered plan – in other words, services would not be added specific to a hospital stay but would be services the person is supposed to receive in the home and community setting. The services must be provided to meet needs that are not met by the hospital and cannot be a substitute for services that the hospital is obligated to provide as part of the hospital stay.
   When preparing the person-centered plan, the case manager should work with the participant (and any other individual the participant wishes to include in the discussion) to identify any Personal Care services that would be necessary for the person to receive during a potential hospital stay in order to safely engage and communicate with hospital staff, maintain their functional abilities and ensure a smooth return home after the hospital stay. The case manager should explain that help with IADLs is not appropriate for the hospital setting, and that help with ADLs must be limited to services that go beyond what a hospital would provide during the person’s stay. The total authorized hours/budget for personal care services will not increase during the hospital stay; this option simply allows a participant to receive certain authorized services while in the hospital.
   If the case manager and participant identify that there are certain personal care services that the participant should receive during a potential hospital stay, the case manager should document this the person-centered plan template (“My Crisis and Safety Plan”). In the section for “Other unexpected event,” fill in the following information as applicable:
   “If I need to stay overnight in an acute care hospital, my personal care attendant will accompany me to provide assistance with [list applicable ADLs, such as eating, repositioning in bed, etc.] This assistance is required to ensure a smooth transition from the hospital back to my home/community setting and to preserve my functional abilities. I (or my representative) will notify my case manager if I go to the hospital, either in advance of a scheduled hospital stay or as soon as practicable after admission for an unplanned hospital stay.”

   Pending full availability of the person-centered plan template in the state’s LTSS case management system, case managers should insert the language above where most appropriate in existing templates.

VI. PERSON-CENTERED PLANNING MEETINGS

A. The Initial Contact

1. The CFCM agency uses the State's LTSS case management platform to send welcome/introduction letters to the participant and any Medicaid HCBS provider that currently supports the participant. This letter includes a notice that the case manager will contact the participant initially via phone.
2. Within three (3) business days after the participant is assigned to the case manager, the case manager must contact the participant via phone to schedule the initial person-centered planning meeting. This phone call is considered the initial contact.
    a. Refer to **Attachment H** if the case manager is unable to contact the participant.
3. Generally, within forty-five (45) calendar days after the initial contact, the case manager must conduct the initial person-centered planning meeting face-to-face and submit a completed person-centered plan to the Sate for approval.

B. Planning Team Membership

1. The planning team includes, at a minimum:
    a. The participant
    b. The case manager
    c. A legal guardian, authorized representative, and/or authorized supporter, as appropriate
    d. Any person chosen by the participant, which may include a caregiver, family member, friend, service provider, or any other person whom the participant selects to include.

C. Notice of Planning Meetings

1. The case manager must notify all members of the planning team of person-centered planning meetings.
2. The date, time, and location of the meetings must be chosen by the participant and shared by the case manager to members of the planning team.
    a. Meeting locations may include a face-to-face meeting, telephone call, or two-way audio and video communication (e.g., Microsoft Teams, FaceTime, Skype, Zoom, or similar technology). Meetings must be conducted in a method chosen by and accessible to the participant.
3. Written confirmation of scheduled meetings is preferred, unless otherwise indicated by a participant's preferences.

D. Meeting Process

1. The case manager facilitates the planning team meeting, ensures all planning team members are introduced, explains each team member's role, and describes the purpose of the meeting. The case manager explains that the planning team operates as an interdisciplinary team, with the participant driving decisions about their care, and that every effort will be made to reach consensus. In the event consensus cannot be achieved, the participant's thoughts, opinions, decisions, preferences, and needs must be prioritized.
2. The case manager ensures that the participant is treated with respect and dignity throughout the meeting by making sure that the participant leads the conversation, comments are directed to the participant rather than in third person language, and sensitive issues are discussed with respect for privacy and dignity. The case manager also ensures that all planning team members are given an opportunity to provide input and that issues are thoroughly discussed before decisions are reached.
3. The standard agenda for a meeting should consist of the following:

a. Discussion of the person-centered planning process and purpose of the person-centered plan;
b. Discussion of the participant's current status, preferences, strengths, needs, and vision for the future;
c. Review of the last person-centered plan, if applicable;
d. Review of professional evaluations and assessments, as needed;
e. Development of goals;
f. Discussion of services and supports (paid and unpaid) needed to attain goals; and
g. Discussion of other actions necessary to implement the services and supports (paid and unpaid), achieve the participant's goals, and meet the participant's needs.

E. Materials to Share with the Participant

1. During the initial person-centered planning meeting, the case manager provides the participant with the following hard-copy materials:
   a. **Attachment C**: Detailed Participant Rights and Responsibilities
   b. **Attachment D**: Participant Rights Fact Sheet (I/DD population only)
   c. **Attachment E**: Critical Incident Fact Sheet
   d. Information about the right and process to file a grievance with the CFCM agency, according to the agency's grievance policy.
   e. BHDDH/DDD Leave Behind Packet (I/DD population only)
2. During the participant's annual reassessment (if applicable) and all person-centered planning meetings, the case manager provides the participant with additional copies of **Attachment C**: Detailed Participant Rights and Responsibilities, **Attachment D**: I/DD Participant Rights Fact Sheet (if applicable), and **Attachment E**: Critical Incident Fact Sheet.
3. Participants may also receive additional materials, such as Informed Consent or other rights and responsibilities materials from HCBS providers, based on the services and providers that they select.

VII. ACCESSING SERVICES AND SUPPORTS

This section describes how case managers arrange and coordinate services and supports, both within and external to Medicaid, to meet each participant's needs and goals as identified in the person-centered plan. Medicaid services should be considered only when other resources and supports are insufficient, unavailable, or do not meet the participant's needs and goals. The person-centered plan must be signed by the participant before it is shared with any party outside of the CFCM agency, including before submitting referrals to direct service providers.

A. Connecting to Medicaid Services and Supports

1. Case managers must be knowledgeable about available Rhode Island Medicaid HCBS programs and services, community resources, and non-Medicaid funded services. This includes being knowledgeable about the eligibility requirements and referral pathways for these programs and services.

2. After the participant chooses their services and the provider(s) to deliver their services and signs the person-centered plan, the case manager submits a referral to the provider(s). The referral includes the following information:
    a. Copy of the signed person-centered plan.
    b. Completed referral form.
    c. Additional relevant documents about the participant's needs.
3. Case manager standards for connecting the participant to services and supports include:
    a. Connections are self-determined and align with the participant's goals and values.
    b. Resources and opportunities are identified in the location of the participant's choice and that match their interests and preferences.
    c. Information about a variety of possible informal and formal resources is shared to maximize participant choice, including the option to self-direct all or a portion of formal supports, and to ensure free choice of service providers in accordance with § 1902(a)(23) of the Social Security Act (42 U.S.C. § 1396a(a)(23)) and 42 C.F.R. § 431.51.
        i. The case manager must document in the State's LTSS case management platform that participants are informed of their right to choose willing and qualified providers and freely choose their provider(s) from among a variety of options presented.
    d. If a participant with I/DD self-directs their community services and chooses to utilize a Support Broker, the case manager can refer the client to a Support Broker.

B. Connecting to Community Resources and Non-Medicaid Funded Services

1. During the initial plan meeting and at least annually thereafter, the case manager is responsible for providing information regarding potential willing and qualified providers for services. Providers that are qualified to provide a service necessary to support the person's assessed needs and achievement of the participant's goals are reviewed with the participant. At a minimum, after the participant selects the provider, the case manager must contact the provider to ensure they are capable of providing the services necessary to assist the participant in progressing toward their personally defined goals as identified in their person-centered plan.
2. Case managers must help the participant identify both community resources and non-Medicaid funded services to meet the participant's needs and goals. Services through community resources may include, but are not limited to: advocacy, adaptive and/or medical equipment, enabling technologies, nutrition assistance, housing, legal assistance, recreation, transportation, and utility assistance. Additional information regarding these resources is available at: https://www.unitedwayri.org/get-help/2-1-1/.
    a. For other State or federally-funded programs (e.g., Supplemental Nutrition Assistance Program (SNAP), Low Income Home Energy Assistance Program (LIHEAP)), case managers are required to provide both referral assistance and application assistance.
    b. For all other community services, the case manager is expected to provide referral assistance only. Referral assistance may consist of providing the participant with the appropriate contact information or by contacting the entity on behalf of the participant if the participant requires or requests that level of assistance and signs the necessary release of information to authorize sharing the participant's information.
3. The case manager must document all community or non-Medicaid funded services in the person-centered plan, including the specific service and support to be provided and a brief description of the tasks to be performed.

C. Medical Appointments

1. The case manager can schedule primary care, specialty care, behavioral health, dental, and other medical appointments, if requested by the participant.

D. Unpaid Caregiver Assessment

1. The case manager is required to offer the Caregiver Assessment to the participant's primary caregiver and/or helper. The caregiver can choose to opt out of completing the assessment.
    a. The assessment is housed in the State's LTSS case management platform and is completed by the case manager annually. The case manager also provides documentation developed by the State to provide information about supports and resources available to caregivers.
2. Information about the participant's primary caregiver and/or helper is also located within the assessment and/or the participant's demographic profile within the State's LTSS case management platform.

E. Connecting to Medicaid HCBS Providers

A key component of person-centered planning is ensuring that the participant has a choice of who provides their services. The case manager must ensure that the participant has access to the list of providers that offer the participant's selected services. Once the participant makes their selections, the case manager is responsible to make prompt referrals to those providers.

Due to provider capacity constraints in Rhode Island, some services may require the participant to wait several months before they are able to access services. If this occurs, the case manager works with the participant to identify and coordinate referrals to alternative service options during the waiting period and regularly check on the status of any pending referrals.

Case management is required regardless of the participant's choice of agency-based or self-directed service delivery. Case management is not part of the participant's budget under self-direction or cost of care calculation.

E.1 Agency-Based Service Delivery

Most Medicaid HCBS waiver services are provided by qualified agency-based service providers, such as a home care provider, assisted living residence, or developmental disability organization, among others. When a participant selects an agency-based service provider, the agency-based service provider is responsible for hiring, training, and evaluating the staff members who provide the participant's services. The agency-based provider is responsible for ensuring that the participant's services are delivered in accordance with their person-centered plan.

If a participant selects the shared living service option, the case manager is expected to refer the client to:

- For the EAD population, a certified RIte @ Home Shared Living agency; or
- For the I/DD population, submit a referral to the BHDDH Residential Team.
- Any EOHHS certified CFCM agency can provide case management to a participant utilizing the shared living service option.

E.2 Self-Directed Service Delivery

The self-directed service option allows the participant to take a direct role in hiring and managing their direct care staff. Case management does not interfere with the participant's choice and self-direction of services.

The case manager is expected to complete the following activities related to self-directed service delivery:

1. Informing participants about the self-directed opportunities available under Medicaid HCBS when they are developing their initial person-centered plan and during any person-centered plan updates.
2. Informing participants who express an interest in self-direction of the potential benefits, liabilities, risks, and responsibilities associated with that service delivery option.
3. Referring the participant to the appropriate resources where they can obtain and complete the required documents to enroll in self-direction.
    a. If a participant with I/DD self-directs their community services and chooses to utilize a Support Broker, the case manager can refer the client to a Support Broker.
4. Supporting the participant with fulfilling the participant's responsibilities to the Fiscal Intermediary (FI).
    a. This only pertains to a participant who self-directs their community services.
5. Contacting the FI to discuss the FI's provision of services to the participant.
    a. This only pertains to a participant who self-directs their community services.

For a given service that is available under Self-Direction, participants must choose to receive it through either an agency or through Self-Direction; a given service cannot be delivered through both systems at the same time. Additionally, a participant cannot receive duplicative services at the same time, whether or not they are provided through an agency or self-direction. Notably, this means that participants receiving shared living or assisted living services cannot separately receive personal care or homemaker services.

E.3 Finding Medicaid HCBS Providers

Case managers are expected to use EOHHS and other State resources to find available Medicaid HCBS providers. The State provides a listing of enrolled Medicaid HCBS providers, including but not limited to: 1) licensed Developmental Disability Organizations (DDOs) for each available service, 2) Support Brokers (available under the I/DD self-directed service delivery model), 3) Shared Living provider agencies, 4) Fiscal Intermediaries (FIs), 5) Assisted Living providers, and 6) Home Care providers.

E.4 Sending Referrals to Medicaid HCBS Providers

The case manager submits a referral to each HCBS provider chosen by the participant. Service referrals must be sent to the participant's chosen HCBS providers within two (2) business days from the date of the participant's selection.

1. While it is important for the participant to choose the HCBS provider they want to deliver their services, the HCBS provider ultimately decides if they can provide the service(s). If the initial HCBS provider chosen by the participant declines the referral, the case manager must share a list of available providers with the participant for the participant to choose a new HCBS provider to deliver their services. The process for selection of and referral to alternative HCBS providers proceeds in the same fashion.

Case managers also obtain additional documentation from the HCBS provider (e.g., a resident agreement from an assisted living residence), and confirm the participant's acceptance of any adjustments to how the HCBS service was outlined in the person-centered plan proposed by the HCBS provider, if applicable.

1. Case managers are required to follow-up with HCBS providers within four (4) business days from the date the referral was sent if a response has not been received.

For Medicaid HCBS available to EAD participants, case managers are expected to submit referrals based on the following two approaches which varies based on service type:

1. Home Care services: Case managers are expected to make referrals via the State's home care referral system.

a. At a future date, referrals for home care services will be made within the State's LTSS case management platform.

2. All other Medicaid HCBS: The CFCM agency will submit the referral form to each provider in a method that is HIPAA compliant. Case managers are expected to utilize alternative contact formats as needed to complete the referral request. The referral contact and contact method should be documented in a case note.

For Medicaid HCBS available to participants with I/DD, case managers are expected to submit referrals based on the following two approaches which varies based on service type:

1. Licensed I/DD Services: Case managers are expected to submit and receive all licensed provider Medicaid HCBS referral requests through BHDDH.

    a. At a future date, referrals for I/DD services will be made within the State's LTSS case management platform.

2. Support Broker Services: Case managers are expected to place a phone call, email, or other format as determined by the Support Broker to make the referral request. This referral contact and contact method should be documented in a case note.

For Durable Medical Equipment (DME)/Home Modifications

1. The case manager assists the participant, as needed, in obtaining a physician's prescription for DME or an assessment by a PT, OT, or mobility specialist as needed. The physician or mobility specialist makes a referral to the DME/Home Modification vendor. The case manager documents the support provided in the person-centered plan. The case manager also documents DME/Home Modifications in the person-centered plan, if the participant notifies the case manager that they received this service independently.

E.5 Changing Providers

Participants can change providers at any time. Although it is best practice for participants to notify their current provider in advance, participants are not required to do so. If the participant would like to change providers or if a provider is unable to provide previously authorized services, case managers work with the participant to update the participant's person-centered plan and obtain service authorization from the State.

1. Providers may not exert influence when the participant is considering a transition to a new provider.
2. The case manager assists the participant in exercising choice in transitioning to a new provider.
3. A participant's transition to a new provider shall be accomplished in the time frame desired by the participant, to the maximum extent possible.
4. The case manager works with the participant, current provider, and new provider to ensure a smooth transition. The case manager coordinates the transition planning activities, including scheduling and participating in all transition planning meetings, during the transition period.

F. Changing Service Delivery Settings

A participant can receive LTSS at home or in a community-based setting, or in an institutional setting. A case manager needs to inform the appropriate State agency (OCP, DHS, or BHDDH, depending on the program(s) and service(s) selected) when these changes occur.

1. If a participant transitions from HCBS to an institutional setting, and the participant is in the institutional setting for more than sixty (60 consecutive days, the case manager must complete the LTSS Change Form and submit the form to DHS via mail or email.

    a. For case managers supporting I/DD participants: the case manager must also inform BHDDH of the transition at bhddh.cfcm@bhddh.ri.gov.

2. If a participant transitions into or out of an assisted living residence, the case manager must complete the LTSS Change Form
    a. The case manager must also update the participant's person-centered plan to reflect the changes in participant's selected service delivery.
3. Any service delivery transitions that do not involve an institutional setting or an assisted living residence does not require the completion of the LTSS Change Form (i.e. home care to shared living)
    a. Refer to **Section IV.D.6** for transitions into the Personal Choice program.
    b. All changes in service delivery must be updated in the participant's person-centered plan

VIII. FINALIZING THE PERSON-CENTERED PLAN AND SERVICE AUTHORIZATION

When the functional needs assessment is complete, the case manager develops, and the participant signs the person-centered plan. After providers accept service referrals, the case manager sends the final, signed person-centered plan to the participant, anyone on the person-centered planning team authorized to receive the final person-centered plan, and any providers listed in the person-centered plan. Once final signatures are obtained on the person-centered plan, and the person-centered plan is approved by the appropriate State agency (EOHHS, DHS, and/or BHDDH, depending on the program(s) and service(s) selected), the case manager submits service authorizations for Medicaid services. All Medicaid HCBS waiver services are authorized by the appropriate State agencies.

All person-centered plans are subject to review by the State at any time for quality assurance purposes.

A. Updating the Person-Centered Plan

1. All person-centered plans are subject to review by the State for quality assurance purposes.
2. In accordance with 42 CFR § 441.301(c)(3), the person-centered plan must be reviewed and updated:
    a. At least annually;
    b. At the request of the participant; or
    c. In response to a significant change in the participant's health, functional capacity, social or physical environment, formal or informal support system, or in other circumstances that require re-evaluation of the person-centered plan. A significant change may include, but is not limited to:
        i. Loss of a primary caregiver or helper, crucial informal supports, or an individual representative;
        ii. A medical, behavioral health, and/or oral health change that may impact needs, goals, and services;
        iii. Change in person-centered goals;
        iv. Change (improvement or deterioration) in the participant's condition based on a clinical assessment, resulting in a change in the scope, amount and/or duration of Medicaid HCBS authorized services;
        v. Change in residence; or
        vi. Participant chooses not to use an authorized service.

3. The case manager also supports participants in the annual renewal of Medicaid eligibility. This includes financial eligibility determination to remain eligible for Medicaid LTSS.
    a. The case manager can set a reminder for the annual Medicaid renewal in the State's LTSS case management platform.
4. For case managers supporting EAD participants:
    a. DHS completes the participant's initial functional needs assessment. The initial functional needs assessment is valid for twelve (12) months. The case manager is then responsible for completing an annual reassessment of functional needs at least every twelve (12) months.
        i. The case manager can set a reminder for the reassessment date in the State's LTSS case management platform.
    b. The case manager is required to complete an annual reassessment of functional need using the State-sponsored EAD assessment tool in conjunction with the annual person-centered planning meeting.
    c. An annual reassessment of functional needs and an updated person-centered plan must be completed no sooner than sixty (60) calendar days and no later than thirty (30) calendar days prior to the current person-centered plan end date.
5. For case managers supporting participants with I/DD:
    a. The case manager is not required to complete any functional needs assessments for this population; however, the case manager must review the current assessment results for understanding and use in person-centered planning discussions with the participant and their planning team.
    b. The annual person-centered planning meeting and an updated person-centered plan must be completed no sooner than sixty (60) calendar days and no later than thirty (30) calendar days prior to the current person-centered plan end date.
    c. Case managers submit to BHDDH any requests for supplemental funding, change in level of need (updated assessment), or residential services/supports.
        i. Supplemental Funding Requests
            1. The "S106" form for supplemental funding is a request for funding above and beyond the individual's annual funding allocation for I/DD services based on emergent need. The S106 form is completed by the case manager and sent to the BHDDH Clinical Team for review and approval. The S106 request is reviewed within seven (7) calendar days from when the request is submitted.
                a. Examples may include emergent living situation, significant health or medical condition, repeated incidents related to health and safety, or new serious mental health diagnosis.
            2. The "S109" form for supplemental funding is a request for funding above and beyond the participant's current individual funding level. The S109 form is completed by the case manager and sent to the BHDDH Clinical Team for review. The S109 is reviewed within thirty (30) calendar days from when the request is submitted.
                a. S109s are for longer term services needed in addition to funding.
                b. These requests must be specific in nature, address a goal or risk within the person-centered plan, and outline the dollar amount requested with

number of hours and service type. Supporting documentation is to be submitted with the form.

3. The result of an S106 or S109 is documented by BHDDH in an S107 or S110. These forms outline the approval or denial of the request. The decision may also result in a "change in situation" assessment being requested to be sure the assessment process accurately captures the participant's current needs.
4. Supplemental Funding Forms
    a. S106-Form-11-02-2020.pdf (ri.gov)
    b. S109_11-02-2020.pdf (ri.gov)

ii. Residential Referrals (for I/DD participants)

1. Referrals for Residential level of support that includes a group home or shared living arrangement are executed by the residential team at BHDDH. The residential needs form is completed by the case manager and sent to the residential administrator at BHDDH for review.
2. BHDDH seeks to provide residential services in the least restrictive environment.
3. **Criteria of Residential Need (Group Home or Shared Living)**
    a. Meet clinical requirements of twenty-four (24) hour level of care in a community setting: extraordinary medical need requiring medical supports and/or Extraordinary behavioral need requiring 1:1 supervision for significant portion of the day.
    b. Hospitalized and unable to return to previous residence or less restrictive environment due to clinical need.
    c. Primary caregiver unable to meet clinical need.
    d. Acute need due to caregiver/environmental change.
    e. Does not require a higher level of care, i.e., hospital, skilled nursing facility, etc.
    f. Meet assessed level of need via Tier level for residential setting.
    g. Ability to pay room and board (SS benefits, employment, or other income) and be Waiver eligible.
4. Participants assessed at Tiers B, C, D, and E are eligible for Shared Living. Participants assessed at Tiers C, D, and E are eligible for residential support. An additional form called a "DDD residential situational assessment form" may also be requested to be submitted with the needs request. The BHDDH Residential Team contacts the CFCM if a situational assessment is required. A situational assessment outlines the exceptional needs of the individual that justify the need for residential level of care based on caregiver, housing, or health and wellness.

B. Guidance on Signatures

1. The person-centered plan must be signed by the participant before it is shared with any party outside of the CFCM agency, including before submitting referrals to direct service providers and when implementing the person-centered plan.
    a. Referrals to new service providers: the case manager must receive the participant's written consent before sharing the person-centered plan and service referral to service provider the participant is not currently receiving services from.

b. Referrals to existing service providers: the case manager may submit the person-centered plan to a provider the participant is currently receiving services from.

2. Signatures are collected from anyone involved in implementing the person-centered plan. At a minimum, this includes the HCBS participant and/or their legal representative (e.g., legal guardian or power of attorney), case manager, and Medicaid HCBS providers who are deemed responsible for implementing the person-centered plan. Providers who deliver purchased-item services (e.g., assistive technology, durable medical equipment, etc.) do not need to sign the person-centered plan.
    a. Medicaid HCBS providers sign the person-centered plan after it is approved by DHS, BHDDH or OCP. A signature is collected after the Medicaid HCBS provider accepts the referral request for the services outlined in the person-centered plan.
3. The person-centered plan must be signed, at minimum, after the initial and annual person-centered planning meeting and if there is a significant change in the person-centered plan with newly identified needs, goals, services, and/or providers. Significant changes (e.g., any change in the amount, duration, frequency and/or scope of services) always require dated signatures whereas informational changes (such as clarification to any information already noted in the person-centered plan) do not. Only the Medicaid HCBS provider affected by the change needs to provide a signature. If the case manager is uncertain if a change is significant, the Medicaid HCBS provider's signature should be obtained.
4. Acceptable signatures include a handwritten signature, initials, a stamp or mark, or an electronic signature.
5. Person-centered plan signatures and other materials created by the case manager as part of the person-centered planning process (e.g., the case manager creates an abbreviated person-centered plan to help the participant better understand their person-centered plan) shall be uploaded to the State's LTSS case management platform under the Notes Tab.
6. If the participant and/or their legal representative (e.g., legal guardian or power of attorney) is unable or unwilling to sign their person-centered plan, the case manager must document the following in the State's LTSS case management platform under the Notes Tab: 1) measures taken to obtain the participant's signature and when; and 2) reason why a signature was not obtained.
    a. If the participant and/or their legal representative (e.g., legal guardian or power of attorney) does not sign the person-centered plan, the person-centered plan cannot be implemented.
7. The case manager must make at least two (2) attempts to obtain a provider's signature.
    a. First attempt: Completed within five (5) business days of the referral form was reviewed and agreed to (verbally or by email) by the Medicaid HCBS provider.
    b. Second attempt: Completed within thirty (30) calendar days of the referral form was reviewed and agreed to (verbally or by email) by the Medicaid HCBS provider.
    c. If the case manager does not receive the HCBS provider's signature after two (2) attempts, the case manager has satisfied this requirement. The case manager must document the following in the State's LTSS case management platform under the Notes Tab: 1) measures taken to obtain the HCBS provider's signature and when; and 2) reason why a signature was not obtained.
    d. If the provider does not sign the person-centered plan, the case manager cannot submit authorizations for services by the provider. The case manager must share a list of available providers with the participant to choose a new HCBS provider to deliver their services.

C. Sharing the Person-Centered Plan and Other Materials

1. The person-centered plan must be signed by the participant and/or their legal representative (e.g., legal guardian or power of attorney) before it is shared with any party outside of the CFCM agency.
2. The case manager must provide a copy of the person-centered plan to the participant and/or their legal representative (e.g., legal guardian or power of attorney), anyone involved in implementing the person-centered plan and anyone the participant elects to receive a copy of the plan.
    a. Distribution of the person-centered plan should be noted in the State's LTSS case management platform.
3. The person-centered plan may be shared via secure email, fax, mail, in-person, or other secure platform (e.g., State information system).
4. If an EAD participant chooses to receive services under the EOHHS RIte @ Home Shared Living program, the case manager sends the following information to the Shared Living Provider Agency chosen by the participant:
    a. Results from the State's level of care evaluation, including level of care category and effective date;
    b. Assessment results; and
    c. Approved person-centered plan.
    d. Referral Form
5. The CFCM is a resource to HCBS providers and should supply relevant information as needed to providers to effectively carry out the services outlined in a participant's person-centered plan.

D. Authorization of Services Included in the Person-Centered Plan

1. All Medicaid HCBS waiver services require service authorization and approval by the State before the provider can be reimbursed for delivering services.
2. Backdating of service authorizations is not permitted. Providers cannot be reimbursed for services that were delivered prior to the date of the service authorization.
3. Service authorizations are submitted using two (2) different platforms:
    a. *Service Authorization for EAD Services*: Case managers must use the State's EAD authorization system to send service authorizations.
        i. At a future date, service authorizations will be made within the State's LTSS case management platform.
        ii. A request by the participant to increase the service authorization by ten (10) or fewer hours per week can be approved by the case manager supervisor.
            a. This can happen one (1) time per year without the case manager completing the State-sponsored EAD Assessment tool
            b. The case manager must reflect this change in the participant's person-centered plan
            c. The case manager must enter a note in the State's LTSS case management platform documenting the change to the participant's person-centered plan and include the following:
                a. The reason for the change

b. The action taken related to the change (examples include: service authorization updated, additional service hours added to the provider referral portal, additional provider agency added to support additional service hours, etc.)

iii. A request by the participant to increase the service authorization by more than ten (10) hours per week is a significant change of condition, and requires the case manager to complete the State-sponsored EAD assessment tool

a. The case manager must reflect this change in the participant's person-centered plan

b. The case manager must enter a note in the State's LTSS case management platform documenting the change to the participant's person-centered plan and include the following:

a. The reason for the change

b. The action taken related to the change (examples include: service authorization updated, additional service hours added to the provider referral portal, additional provider agency added to support additional service hours, etc.)

iv. Any request or outcome of the State-sponsored EAD assessment tool equal to or greater than ninety (90) hours per week must be submitted to the State for review and approval

b. *Service Authorization for I/DD Services*: Case managers are expected to use the State's I/DD authorization system to send debit authorizations.

i. At a future date, debit authorizations will be made within the State's LTSS case management platform.

4. Depending on the authorizations requested, OCP/DHS (EAD services) or BHDDH (I/DD services) reviews submitted service authorizations and responds to the case manager within seven (7) business days of receiving the written person-centered plan from the case manager. If additional information is needed, the State will submit a request through the State's LTSS case management platform and the case manager has up to three (3) business days to respond to such a request.

IX. PERSON-CENTERED PLAN MONITORING

Case managers conduct monitoring and follow-up activities to ensure that the person-centered plan is effectively implemented and adequately addresses the participant's needs, and to ensure the participant's health and welfare. The case manager is responsible for conducting ongoing monitoring of all participants on their caseload.

A. Required Monitoring Contacts

1. **Monthly Monitoring Contact**: Conducted within the next calendar month from the start date of the person-centered plan and within every calendar month thereafter. The case manager completes the monthly monitoring form included in the State's LTSS case management platform to document monthly monitoring contacts.

a. Although a monthly contact cadence is preferred, the participant can request a different cadence that must be noted in the person-centered plan. For the purposes of this document, the term "monthly monitoring contact" means regularly scheduled monitoring check-ins with the participant according to the schedule chosen by the participant, even if these contacts do not necessarily occur on a monthly basis.

b. The primary contact attempt should be with the participant unless the participant asks the case manager to contact another person.

c. A monthly contact may include a face-to-face contact, telephone call, or two-way audio and video communication (e.g., Microsoft Teams, FaceTime, Skype, Zoom, or similar technology). Communication must be conducted in a method chosen by and accessible to the participant. If the participant's health and/or safety requires monthly face-to-face contact, or if the participant wants all face-to-face meetings, the case manager must conduct the contacts face-to-face. Email, texting, or other methods of communication are not acceptable to meet the mandatory minimum monitoring requirements. However, email can be utilized to gather information prior to the monthly contact to streamline the process. Email must remain confidential and HIPAA compliant.

2. **Six (6) Month Face-to-Face Contact:** A face-to-face (in person) contact is required at least once every six (6) months, regardless of the communications platform used for other contact with the participant. Face-to-face contact must be conducted more frequently than every six months if needed to ensure a participant's health and/or safety. Annual person-centered planning meetings that occur in person are considered one (1) of the two (2) required annual face-to-face contacts. If the person-centered planning meeting is conducted in person, a second face-to-face contact must be conducted during the sixth calendar month from the date of the development of the person-centered plan. If the person-centered planning meeting is conducted remotely, the timing may differ (for example, face-to-face contacts could take place at months three and nine) but face-to-face contacts still must occur at least every six (6) months.

   a. The case manager must complete the six (6) month monitoring form included in the State's LTSS case management platform.

   b. The case manager must conduct their face-to-face meetings at a location selected by the participant, such as the participant's place of residence or where the services are delivered, or if not feasible, at a different location.

   c. The case manager is not required to conduct a separate monthly contact in the same month as the six (6) month face-to-face contact.

3. **Annual Person-Centered Planning Meeting:** Under federal regulations, the person-centered plan must be updated at least annually. The case manager facilitates the person-centered planning process with the planning team and continually updates and revises the person-centered plan as service needs may change throughout the course of the year.

   a. The annual person-centered planning meeting and an updated person-centered plan must be completed no sooner than sixty (60) calendar days and no later than thirty (30) calendar days prior to the current person-centered plan end date.

   b. The case manager is not required to conduct a separate monthly contact in the same month as the annual person-centered planning meeting but is expected to complete regular monitoring activities during the annual person-centered planning meeting.

4. **Other**: The case manager must contact Medicaid HCBS providers to verbally confirm the delivery of services in the amount, scope, and duration as identified in the person-centered plan no later than three (3) business days after the scheduled service start date. This must be done for any new Medicaid HCBS service. The case manager must also verify service delivery with participants during their regular check-ins.

5. Refer to **Attachment H** if the case manager is unable to complete the required monitoring contacts with the participant.

B. Monitoring Activities

1. When conducting monitoring, the case manager is expected to:
    a. Assess the participant's health and welfare.
    b. Verify that services are being delivered according to the person-centered plan.
    c. Assist the participant to amend the person-centered plan as desired by the participant and/or to better meet the participant's evolving needs and wants.
    d. Communicate with participant-approved contacts, including family members, HCBS providers, or other collateral entities, as needed to determine if services, supports, and resources are being delivered according to the person-centered plan.
    e. Address and problem-solve if there are issues with services or other conflicts between the participant, the participant's supporters, and HCBS providers.
    f. Coordinate with the participant and other members of the participant's person-centered planning team if changes are needed to the person-centered plan.
2. Monitoring activities may lead to follow-up activities that the case manager must complete, including helping the participant update their person-centered plan. Monitoring activities may also result in the case manager taking additional actions such as reporting a critical incident or making a referral to Adult Protective Services, law enforcement, Medicaid Program Integrity, the Medicaid Fraud Control Unit, or any other regulatory agency.
3. If the participant's health and welfare is in jeopardy, the case manager must work with the participant to understand their options, which may include the case manager doing the following:
    a. The case manager has a duty to report critical incident(s) to the appropriate state agency. The CFCM agency is responsible for maintaining a record of critical incidents that are reported and submitting the report to EOHHS monthly. EOHHS provides the report template to the CFCM agency to track reports made by the CFCM agency. The report template does not replace the CFCM agency's duty to report critical incidents.
        i. RIDOH: Report incidents that occur in a nursing facility, assisted living residence or other institution or incidents involving licensed agencies providing care to a participant, such as a home care provider.
        ii. OHA/Adult Protective Services: Report incidents involving people aged sixty (60) or older who are abused, neglected, or exploited by a caregiver or who are self-neglecting.
        iii. BHDDH: Report incidents involving adults with I/DD and individuals with disabilities between the ages of 18 and 59 who are abused, neglected, mistreated, or exploited.
    b. Transferring the participant from the place of the incident, upon request of the participant.
    c. Making a referral for a medical or dental examination or a behavioral health evaluation.
    d. Implementing the participant's backup plan to provide needed support.
    e. Assisting the participant to change providers if desired.
    f. Modifying services or scope, frequency, or duration of services in the person-centered plan.
    g. Referring the participant to other support agencies.

X. PERFORMANCE AND QUALITY

A. Quality Assurance

1. The Program Director and other leadership staff from the CFCM agency are expected to participate in EOHHS hosted meetings to discuss program updates and to answer CFCM agency questions. EOHHS schedules and prepares agendas for these meetings.
2. In addition to activities outlined in the CFCM agency's Continuous Quality Improvement Plan, each CFCM agency is required to perform the following quality assurance activities:
    a. Regular, systematic review and remediation of case records to ensure that case managers meet all established timelines and are supporting participants using person-centered practices as identified in this document and that all required information is properly entered into the State's LTSS case management platform.
    b. Address and rectify participant grievances about a case manager or other person working on behalf of the CFCM agency.

B. Grievance System

1. The CFCM agency must develop and maintain a grievance policy and procedure that is readily available both on paper and electronically and is accessible to participants with limited English proficiency. This includes a policy regarding the agency's response to internal grievances (about a case manager or other person working on behalf of the CFCM agency) and grievances about other providers.
2. Each CFCM agency must have a process for addressing grievances made by participants about CFCM agency decisions or actions.
    a. Resolution attempts begin with the case manager who works directly with the participant and/or the complainant to resolve the issues or concerns that led to the grievance.
    b. Internal grievances that cannot be resolved should be reported to EOHHS (ohhs.ltssnwd@ohhs.ri.gov).
3. The CFCM agency is not required to resolve grievances about providers outside of the CFCM agency but is required to report such grievances to EOHHS for resolution.
4. The CFCM agency is required to track and report internal grievances to EOHHS on a quarterly basis.
5. The CFCM agency must provide each participant with written information in the participant's preferred language and that is accessible to participants with limited English proficiency about how to file a grievance and notify participants annually of the CFCM agency's grievance procedure.

C. Performance Standards and Reviews

1. EOHHS may conduct performance reviews, evaluations, or unannounced visits of the CFCM agency at any time.
2. In situations where, in the opinion of EOHHS, significant irregularities in billing or utilization are revealed, the CFCM agency may be required to do a complete self-audit in addition to making repayments.
3. In situations where significant and/or recurring performance issues are identified, technical assistance in developing and implementing a plan of corrective action, where appropriate and applicable, is offered by EOHHS.
4. The CFCM agency provides all information necessary for EOHHS to complete all performance reviews or evaluations.

5. See **Attachment G** for the performance standards that EOHHS uses to assess CFCM agency compliance.

D. Program Timeframes

1. To ensure that case management is delivered in a consistent and timely manner, EOHHS established a listing of program timeframes included in **Attachment F**.

E. Reporting and Notification Requirements

1. See **Attachment G** for a listing of reporting and notification requirements.

F. Sanctions

1. EOHHS reserves the right to apply a range of sanctions to CFCM agencies that are out of compliance with the CFCM Certification Standards or the Medicaid Provider Agreement. These may include, but are not limited to:
    a. Additional reporting requirements;
    b. Corrective Action Plans;
    c. Suspension of new referrals;
    d. Recoupment of funds when violations of Medicaid regulations occur;
    e. Suspension of Medicaid Provider Agreement;
    f. Loss of certification status; or
    g. Referral to appropriate legal authorities.

G. Corrective Action Plan

1. If EOHHS determines that the CFCM agency is not in compliance with Medicaid requirements, EOHHS will provide written notice indicating the CFCM agency must prepare and submit a Corrective Action Plan for the EOHHS' review and approval. The CFCM agency will have five (5) business days of receipt of the non-compliance/deficiency identified by EOHHS to submit a Corrective Action Plan.
2. Upon written notification by EOHHS, the CFCM agency is required to develop and comply with Corrective Action Plan. Corrective Action Plans may include, but not be limited to:
    a. A detailed description of actions to be taken;
    b. The number of impacted participants;
    c. Supporting documentation, if applicable;
    d. A detailed timeframe specifying the actions to be taken;
    e. Staff responsible for implementing the actions; and
    f. The implementation timeframes and a date for completion.
3. The CFCM agency is required to ensure that all supporting documentation is submitted within the timeframes established in the Corrective Action Plan.
4. Failure to follow a corrective action plan is grounds for additional sanctions.

H. Critical Incidents

1. CFCM agencies and case managers are required to:
    a. Educate and provide information to participants to understand, identify, and report critical incidents.

b. Report all observed or suspected critical incidents. Case managers are mandatory reporters. If a participant chooses not to report an incident, or declines further intervention, the case manager must still report the incident to the appropriate State agency.

c. Ensure that prompt action is taken to protect the safety of the participant. This may include replacing or removing CFCM agency staff.

d. Maintain policies and procedures regarding critical incident reporting and management.

e. Depending on the severity and type of critical incident:

   i. The case manager may work with the participant to revise the person-centered plan (e.g., the critical incident results in a change to the caretaker or HCBS provider).

   ii. The case manager may provide additional support to the participant and document any follow-up visits. For example, the case manager may provide an additional face-to-face visit to ensure continued safety, help the participant to locate a new HCBS provider, work with the HCBS provider and participant to address a critical incident, or assure the participant has appropriate medical, dental or behavioral health supports.

I. EOHHS Oversight and Quality Monitoring

The Centers for Medicare and Medicaid Services (CMS) requires EOHHS to make assurances and agree to HCBS program standards within its 1115 Demonstration Waiver. CMS' assurances and standards provide the foundation for EOHHS' operation and oversight of its HCBS programs and case management and planning services. As such, CFCM agencies are subject to audits and formal reviews of fiscal and programmatic functions. EOHHS evaluates services and requires corrective action when necessary.

EOHHS monitoring activities may include:

1. Monitoring and addressing characteristics and behaviors affecting the health and safety of participants;
2. Monitoring the use of restrictive interventions;
3. Monitoring and preventing instances of abuse, neglect, and exploitation of participants;
4. Evaluating appropriate level of care and access to services;
5. Monitoring timeliness standards;
6. Monitoring training requirements and completion of training;
7. Monitoring of person-centered plans and service delivery;
8. Monitoring participant choice and trends in referrals by CFCM agencies;
9. Monitoring participant and family satisfaction with services;
10. Monitoring participant goals and goal attainment; and
11. Monitoring and auditing Medicaid claims data.

CFCM agencies and case managers play a critical role in helping EOHHS meet the federal HCBS quality assurance requirements as described in the 1115 Waiver. Data related to each assurance is collected by EOHHS and reported to CMS. CMS uses this data to determine whether EOHHS complies with federal requirements and whether it continues to qualify for federal funding. EOHHS also uses this data, as well as other information collected, to monitor outcomes and drive continuous quality improvement.

XI. PARTICIPANT DISENROLLMENT

1. EOHHS may disenroll a participant from CFCM if one or more of the following circumstances occur:
    a. The participant loses eligibility for Medicaid and/or LTSS, due to a change in financial or clinical eligibility factors, incarceration, voluntary disenrollment, change in state residency, or otherwise.
    b. The participant enrolls in the Neighborhood INTEGRITY Medicare-Medicaid Plan or Neighborhood INTEGRITY for Duals Special Need Plan (D-SNP).
    c. The participant is placed in an institutional setting (e.g., hospital, nursing facility) for more than ninety (90) consecutive days.
    d. The participant is physically or verbally abusive toward providers or case managers.
    e. The case manager or EOHHS has reasonable cause to believe that the participant has been or is engaged in willful misrepresentation, exploitation, Medicaid fraud, or abuse.
    f. The participant dies.
2. EOHHS makes the final determination regarding involuntary disenrollments of participants.
3. Any decision resulting in a change in the scope, amount, duration, or delivery of a Medicaid service is subject to appeal in accordance with the rules set forth in 210-RICR-10-05-2.
4. Case management responsibility may shift from the CFCM agency to the State in extenuating circumstances.

XII. STAFFING

A. Program Director

1. Each CFCM agency assigns one (1) person to serve as the Program Director.
2. The Program Director acts as the State's primary contact and assume responsibility for the CFCM agency's administration and operation.

B. Case Managers

1. Each CFCM agency has a sufficient number of case managers to meet the needs of participants enrolled with the CFCM agency, in accordance with the agency's Caseload Policy.
2. Each CFCM agency must ensure the case managers satisfy all requirements outlined in the CFCM Certification Standards.
3. The following skills and abilities are encouraged:
    a. Ability to communicate effectively with participants, members of the person-centered planning team, providers, coworkers and supervisors;
    b. Knowledge of the participant population they are supporting;
    c. Ability to cultivate community-based partners and connections on behalf of participants;
    d. Ability to engage persons of various cultures and lifestyles in the helping process;
    e. Ability to work with various cultures and the sensitivity required to empower the family system;
    f. Knowledge of social, health, and behavioral health interventions;
    g. Skills and techniques for crisis intervention and problem solving;
    h. Ability to critically analyze and make immediate decisions;

i. Ability to actively listen;

j. Skills in time management, organizational development, and planning;

k. Ability to empower participants and to accept the participant's choices;

l. Knowledge of federal, State, and local policies with regard to Medicaid HCBS programs;

m. Ability to effect change through advocacy on behalf of the participant;

n. Ability to initiate and sustain trusting relationships; and

o. Basic computer and technology skills to manage case files, use databases, and create spreadsheets if needed.

C. Case Manager Supervisors

1. All case managers must have an assigned supervisor. Case management supervisors do not have participant caseloads and are expected to provide oversight and management of the case managers they oversee.
2. The following skills and abilities are encouraged:
   a. Ability for strong interpersonal communication;
   b. Ability to plan and conduct supervisory meetings at least twice per month;
   c. Ability to provide ongoing guidance and support to staff and participants;
   d. Ability to design participant and program goals, policies, and procedures that can be adjusted to the changing needs of participants and policy makers;
   e. Ability to conduct in-service training and provide ongoing professional growth of staff members;
   f. Ability to evaluate case manager's skills on an ongoing and annual basis;
   g. Ability to establish clear and measurable objectives for case managers and other staff;
   h. Ability to coordinate and network with a wide variety of agencies and professionals involved in providing services to participants;
   i. Ability to collect and use data required by EOHHS; and
   j. Knowledge of state and federal regulations and policies pertaining to conflict-free case management of HCBS.
3. The CFCM agency ensures that the individual who is responsible for the supervision of case management staff completes tasks as described in the CFCM Certification Standards.
4. CFCM agencies are encouraged to maintain a case manager to supervisor ratio of not more than 10:1.

D. Other Staffing Requirements

CFCM agencies supporting participants in the HAB or Personal Choice programs are required to employ a registered nurse (RN) or other qualified health professional acting within their scope of practice as permitted by the Rhode Island Department of Health. They must also employ a person who is trained to conduct community-based assessments for accessibility and adaptive equipment as it pertains to improving independence and safety of participants. This person may be a may be a licensed physical therapist (PT) or occupational therapist (OT), a certified occupational therapy assistant (COTA), and/or a certified Assistive Technology Practitioner as certified by RESNA (Rehabilitation Engineering and Assistive Technology Society of North America). The CFCM agency may directly employ staff or have agreements with consultants or other agencies to meet these additional staffing requirements.

The nurse, or other qualified health professional acting within their scope of practice as permitted by the Rhode Island Department of Health, is required to assess the participant's medical condition and effects on daily functioning, at least annually, and to provide education and resources about medical conditions, wellness, and health promotion.

The person providing accessibility assessments does so annually and makes recommendations on home modifications, adaptive equipment, or assistive technology that would increase the participant's independence or safety. The person also assists in identifying resources for obtaining equipment or modifications and provide training in safe use of equipment or modifications.

XIII. REIMBURSEMENT

All conflict-free case management services are paid via fee-for-service (FFS) using a single monthly unit of service (i.e., monthly billing per eligible participant). The monthly unit of service represents an average cost. Some participants being served require more effort and some less, but on average receive case management valued at about what the rate represents. In accordance with § 1902(a)(30)(A) of the Social Security Act, case management payment rates are consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that care and services are available.

A. Conditions of Payment

1. Only EOHHS certified CFCM agencies may bill for CFCM.
2. The CFCM agency may not provide or bill for duplicative services.
3. Medicaid reimbursement is considered payment in full and the CFCM agency may not seek further payment from the participant.
4. To bill a monthly unit, case managers must either 1) conduct and document a monitoring contact with the participant as described above or 2) complete one of the following activities:
    a. Updates to the person-centered plan;
    b. Other contact with the participant or individual representative;
    c. Other contact with a collateral contact (e.g., caregiver, family member, HCBS provider, etc.);
    d. Submit a referral for a program or service; or
    e. Respond to an inquiry or request from the participant.
5. The monthly unit is billed on or after the last day of the month in which the billable activity occurred.
6. Additional billing guidance can be found in the EOHHS webpage for Medicaid Provider Manuals: eohhs.ri.gov/providers-partners/provider-manuals-guidelines/medicaid-provider-manual/conflict-free-case

B. Caseload and Capacity

EOHHS utilized an average caseload of 48 participants per case manager in its rate calculation. EOHHS anticipates that individual case manager caseloads will vary depending on experience and the needs and requests of the participants on their caseload. Thus, the 48-participant caseload is an estimate and does not limit the case manager from having a caseload above or below this estimate.

1. EOHHS does not have a mandated caseload ratio; however, CFCM agencies must ensure that case managers have a reasonable caseload that allows them adequate time to meet the needs of their participants and comply with EOHHS rules, regulations, and standards.

2. EOHHS monitors caseload sizes and may institute caseload limits if a particular CFCM agency is not fulfilling its roles and responsibilities or if there is an overall concern regarding ratios and its impacts on participant services.

XIV. OTHER ACTIVITIES

A. Training

1. The CFCM agency ensures that all case managers receive orientation training (delivered by the State and by each CFCM agency) prior to being assigned independent case management duties.
2. *Orientation Training (Delivered by Each CFCM agency)*: The following trainings are recommended:
    a. *General Staff Orientation*: All new case management staff are recommended to receive a complete orientation to the CFCM agency's policies and procedures and resources in the community. At time of orientation, the agency must distribute a copy of the CFCM agency's educational plan and professional development guidelines that address continuing educational opportunities for case management staff.
    b. *Population-Specific Training*: Training that educates case managers on how to work with the specific populations (e.g., I/DD, EAD, supporting individuals co-occurring behavioral health conditions) whom they support.
    c. *Health Insurance Portability and Accountability Act (HIPAA)*: Overview of the requirements under HIPAA and how it relates to case management services.
    d. *Person-Centered Planning*: Overview of person-centered planning concepts and tools that can be used to support participants. This training should also cover person-centered thinking, motivational interviewing, trauma-informed care, social determinants of health, and communicative and cultural awareness (i.e., how culture may impact the person-centered planning process).
3. *Orientation Training (Developed by the State or External Vendors):* Case managers are encouraged to participate in trainings developed by the State or external vendors. This may include:
    a. Trainings for all case managers:
        i. Introduction to Medicaid HCBS Case Management
        ii. Case Management Service Delivery
        iii. Services and Supports Available in Rhode Island
        iv. LTSS Case Management Platform
        v. HCBS Provider and Direct Support Professional Training (annual)
    b. Trainings for case managers who support EAD:
        i. EAD Assessment Tool
        ii. EAD Information System
    c. Trainings for case managers who support participants with I/DD
        i. I/DD Assessment Tool
        ii. I/DD Information System

4. *Train the trainer*: The State will initially develop and deliver trainings regarding its case management platform and EAD assessment tool for case managers supporting the EAD population. CFCM agencies are encouraged to train their staff on these topics using the State provided training materials and resources.
5. *Competitive Integrated Employment*: Overview of the case manager's role with employment support, specifically competitive integrated employment. This training is recommended for case managers who support participants with I/DD and is offered through the Supported Employment Leadership Network (SELN).
6. *Ongoing trainings:* Case managers are encouraged to participate in periodic trainings offered by:
    a. DHS, EOHHS, or BHDDH regarding State program changes or process updates.
    b. Community resources or other state agency trainings.
7. The CFCM agency may elect to perform additional trainings not outlined in this manual, but applicable to case management services.

B. Administrative Fair Hearings

1. The case manager is responsible for understanding the State's Administrative Fair Hearings process as defined under 210-RICR-10-05-2.
2. The case manager is responsible for ensuring the participant understands their right to request an administrative fair hearing and may assist the participant in submitting required documents.
3. A case manager may not complete and submit a request for an administrative fair hearing on behalf of a participant or act as the participant's representative in the hearing process, as case managers may have an interest in the outcome of the hearing.
4. The case manager may be required to produce documentation or information related to the administrative hearing or to testify as a witness in the hearing.
5. The case manager works with the participant and advocates for a resolution prior to the administrative fair hearing.

C. Platforms and Systems

1. Case managers are required to use the following platforms and systems in delivering case management services:
    a. *LTSS case management platform*: All case managers are required to use the State's LTSS case management platform. This platform serves as the official case record for participants.
        a. This platform is used to: 1) Conduct person-centered planning; 2) Develop and update the person-centered plan; 3) Document all case management activities; and 4) Complete assessments and reassessments (for EAD participants only).
    b. *I/DD Information System*: Case managers who support participants with I/DD are expected to use the I/DD information system to: 1) Find available Medicaid HCBS providers; 2) Submit and receive most Medicaid HCBS referral requests; 3) Find historical information on existing participants (e.g., the participant's previous plan); and, 4) Send service authorizations to the State.
        a. At a future date, the I/DD information system will be sunset and all case managers supporting participants with I/DD will utilize the State's LTSS case management platform as the official case record for participants.
    c. *EAD Information System*: Case managers who support EAD are required to use the EAD information system to: 1) Make referrals to home care providers; and, 2) Send service

authorizations to the State.

a. At a future date, referrals for home care services and service authorizations will be made within the State's LTSS case management platform.

D. Case Documentation

1. The CFCM agency and case manager are responsible for completing and maintaining case documentation and for ensuring case records are complete, accurate, and timely.
2. Documented activities in the State's LTSS case management platform include, but are not limited to:
   a. Information gathering activities;
   b. Person-centered plan development and updates;
   c. Referral activities;
   d. Monitoring contact forms;
   e. Unsuccessful contact attempts with the participant or individual representative; and
   f. Successful contacts with the participant, individual representative, or collateral contacts (e.g., caregiver, family member, HCBS provider, etc.).
4. Case documentation is a professional record and should provide enough information for anyone reading to understand what has been done in the past, what is currently happening, and what may be needed in the future.
5. Case managers must ensure compliance with all federal and State privacy laws and regulations regarding the treatment of Protected Health Information (PHI).
6. CFCM agencies are responsible for the collection, validation, and storage of documentation in support of claims and the State's reimbursement requirements.

E. Behavioral Interventions: Restraint & Restrictive Intervention (participants with I/DD only)

1. The case manager is not authorized to create a behavioral support plan.
2. CFCM agencies are required to have clearly established procedures, consistent with State and federal law and regulations, that assist in guiding the case manager in instances in which a participant has a behavioral support plan.
3. If a participant has a behavioral support plan, case managers are required to:
   a. Review the participant's behavioral support plan to better understand the participant's needs.
   b. Report any suspected misuse or misapplication of restraints or restrictive interventions as a critical incident.

F. Written Materials for Participants

1. EOHHS translates all formal State program materials shared with participants into other languages, including Spanish and Portuguese.
2. The CFCM agency is required to ensure that all written participant-facing materials:
   a. Meet all noticing requirements of federal regulations related to nondiscrimination at 45 C.F.R. Part 92.
   b. Are culturally and linguistically appropriate to the participant.
   c. Are at or below an average 6th grade reading level. This requirement does not apply to language that is mandated by Federal or State laws, regulations or agencies.

d. Use person-first language.

e. Are written in a manner and format that may be easily understood and is readily accessible. Readily accessible is defined as electronic information and services that comply with modern accessibility standards, such as Sections 504 and 508 of the Rehabilitation Act.

f. Are directed and centered upon the participant receiving services regardless of the participant's disability.

3. The CFCM agency is required to create the following materials for participants:

   a. *CFCM agency Fact Sheet/Overview*: Overview of the CFCM agency. The State provides this document to participants during the enrollment process. This document includes the following information: 1) who the CFCM agency is 2) where they are located 3) phone number 4) languages spoken and 5) any other information that the CFCM agency would like to provide. This document must be one (1) single-sided page.

   b. *Grievance Procedure*: Document that describes how participants can file grievances with the CFCM agency. This document shall be one (1) page.

G. Medicaid Eligibility Renewal Responsibilities

1. Case managers are required to assist participants in completing any forms required for annual Medicaid renewal necessary to ensure that there are no service disruptions. This may require the case manager to work in coordination with State eligibility representatives as well as with participants and their authorized representatives.

2. Case managers do not have a role in the eligibility determination process. DHS is the only entity with the authority to determine if an applicant or participant meets the Medicaid LTSS financial eligibility requirements. Clinical eligibility requirements are established by EOHHS and BHDDH and are administered in accordance with established rules, regulations, and procedures.

3. Participant specific inquiries regarding Medicaid eligibility can be sent to the following
   a. EAD Participants: DHS.CFCMInquiries@dhs.ri.gov
   b. I/DD Participants: DHS.DDCFCMInquiries@dhs.ri.gov

ATTACHMENT A. DEFINITIONS

“Activities of Daily Living” or “ADLs” means routine activities or tasks of everyday life related to personal care. ADLs include: bathing, personal hygiene, dressing, ambulating, transfer, toilet use, bed mobility, and eating.

“Applicant” means an individual applying for Medicaid services.

"Assessment” is a tool used to collect comprehensive information about an individual’s functional needs and determine need for home and community-based services (HCBS).

“Assisted Living” is a community-based service provided by a state-licensed Assisted Living Residence. Assisted living residences provide on-site, 24-hour services including: personal care, homemaker and chore services, medication management, therapeutic, social and recreational activities, and health-related transportation.

“Caregiver” refers to an individual who helps care for someone who has a disability or functional limitation and requires assistance. Unpaid or natural caregivers are relatives, friends, or others who volunteer their help. Paid caregivers provide services in exchange for payment for the services rendered.

“Case Management” is a set of activities that are undertaken to ensure that a participant receives appropriate and necessary services. Case management is led by a case manager who performs the following core activities: (1) reviews the participant’s goals, needs, and preferences; (2) develops a written person-centered plan; (3) connects the participant to paid and unpaid supports; and (4) conducts regular contact with the participant to ensure satisfaction. For the purposes of this manual, case management only refers to conflict free case management of HCBS services, and not case management that may be done by other providers and agencies outside of HCBS.

“Case Manager” is the primary individual who delivers HCBS case management services on behalf of a CFCM agency. The case manager serves as an advocate to support, guide, and coordinate HCBS by assessing, planning, facilitating, and providing care coordination of options and services to meet a participant’s comprehensive needs with the goal of enhancing well-being and facilitating engagement in community life. The case manager authorizes and implements the person-centered plan and monitors the services delivered.

“Centers for Medicare and Medicaid Services” or “CMS” is the agency within the United States Department of Health and Human Services responsible for the administration and oversight of the Medicare and Medicaid programs.

“CFCM Agency” is an entity certified by EOHHS to carry out the activities and services of CFCM.

“Conflict-Free Case Management” or “CFCM” means that the entity assisting a participant to gain access to services (e.g., case management provider) must be different than the entity providing those

services (e.g., direct service provider), as a potential conflict of interest may exist if the same entity provides both case management and the referred service(s). CFCM is CMS' concept to prevent participants from being taken advantage of or barred access to the services they need.

"Conflict of Interest" means that an entity, agency, or organization (or their agents) cannot steer applicants and participants toward a particular program or provider and/or to provide both direct service and case management activities to the same individual. When the same entity helps an participant gain access to services, monitors those services, and provides services, there is potential for conflict of interest in:

1. Assuring and honoring free choice;
2. Overseeing quality and outcomes; and/or
3. The fiduciary (financial) relationship (such as incentives for either over- or under-utilization of services or pressure to steer the participant to their own organization for the provision of services).

"Critical Incident" means a situation that threatens a participant's health, welfare, and/or safety. This includes abuse, neglect, and/or exploitation. Critical incident types and reporting requirements vary by population or setting (e.g., home care, assisted living, I/DD, etc.) as indicated in **Attachment E**.

"Department of Behavioral Healthcare, Developmental Disabilities and Hospitals" or "BHDDH" is the State agency established under the provisions of Rhode Island General Laws (R.I. Gen. Laws) Title 40.1 whose duty it is to serve as the State's mental health authority and establish and promulgate the overall plans, policies, objectives, and priorities for State programs for adults age eighteen (18) or older with intellectual and developmental disabilities as well mental illness and substance abuse education, prevention, and treatment.

"Department of Human Services" or "DHS" is the State agency established under the provisions of R.I. Gen. Laws Chapter 40-1 that is empowered to administer certain human services. Through an interagency service agreement with the Executive Office of Health and Human Services (EOHHS), DHS determines Medicaid eligibility in accordance with applicable State and federal laws, rules, and regulations.

"Disability" is a term, for Social Security purposes, that means the inability of a person age eighteen (18) or older to engage in substantial gainful activity (work) by reason of any medically determinable physical or mental condition that can be expected to result in death or to last for a continuous period of not less than twelve (12) months. In the case of children (persons under the age of eighteen (18)), the child must have a physical or mental condition that results in marked and severe functional limitations. The condition also must be expected to result in death or to last for a continuous period of not less than twelve (12) months.

"Elders and Adults with Disabilities" or "EAD" means Medicaid eligible low-income individuals who are age sixty-five (65) and older and people with non-I/DD disabilities. These participants are part of the Medicaid coverage group established by R.I. Gen. Laws Chapter 40-8.5 for adults with an SSI characteristic related to age or disability.

"Eligibility" is a broad term that refers to financial and clinical criteria that an applicant must meet to receive Medicaid-funded HCBS.

"Executive Office of Health and Human Services" or "EOHHS" is the entity within the executive branch of Rhode Island State government that is designated by R.I. Gen. Laws Chapter 42-7.2 as the single state agency to administer the Medicaid program in Rhode Island. In this capacity, EOHHS is responsible for overseeing the administration of all Medicaid-funded LTSS in collaboration with the health and human services agencies under EOHHS' jurisdiction.

"Fee-for-Service" or "FFS" is a reimbursement model where providers are reimbursed for each specific service provided, rather than a set fee for the whole encounter.

"Grievance" is a term that is used to identify an expression of dissatisfaction about any matter and includes complaints about the quality of care or services provided, and aspects of interpersonal relations such as rudeness of a provider or an employee or a failure to respect a participant's rights. A grievance is not a critical incident, an appeal request, or an action associated with an adverse benefit determination.

"Home and Community-Based Services" or "HCBS" describes the person-centered Medicaid services authorized under the State's 1115 Waiver and delivered in home and community settings to address the needs of people with functional limitations who need assistance to perform ADLs and IADLs. HCBS are available to participants who are Medicaid LTSS eligible and are often designed to enable people to stay in their homes and the community, rather than moving to a facility for care.

"HCBS Provider" is defined as a qualified professional or entity that renders paid HCBS (e.g., assisted living, I/DD group home, services in a private residence, etc.) to Medicaid participants.

"Individual Representative" is the term that means, with respect to an individual applying for or receiving Medicaid HCBS, the following:

1. The individual's legal guardian or other person who is authorized under State law to represent the individual for the purpose of making decisions related to the person's care or well-being. In instances where state law confers decision-making authority to the individual representative, the participant must lead the person-centered planning process to the maximum extent possible.
2. Any other person who is selected by the participant including but not limited to, a parent, a family member, or an advocate for the individual.

"Information & Referral" or "I&R" is the process of providing information to individuals who are seeking LTSS services. This may include providing a referral to agencies on the individual's behalf.

"Instrumental Activities of Daily Living" or "IADLs" are certain everyday tasks related to living independently in the community and include meal preparation, ordinary housework, shopping, and transportation.

"Intellectual and Developmental Disability" or "I/DD" is defined in R.I. Gen. Laws § 40.1-1-8.1.

“Long-term Services and Supports” or “LTSS” encompass the broad range of paid and unpaid medical and personal care services that support ADLs and IADLs. Medicaid LTSS coverage is provided to people who need such services based on clinical need due to age, chronic illness, or disability. These services may be provided over a period of several weeks, months, or years, depending on a person’s health care coverage and level of need.

“LTSS Case Management Platform” is the automated data management platform that supports CFCM activities and maintains participant case records. This platform is provided by EOHHS.

“Medicaid” is a state and federal health insurance program that assists individuals in paying for LTSS and medical care.

“Medicaid LTSS Coverage” includes a broad spectrum of services for individuals 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. Institutional (nursing facilities, intermediate care facilities for individuals with intellectual and developmental disabilities (ICF-IDD), and long-term care hospitals) and home and community-based supportive alternatives, including therapeutic, rehabilitative, and habilitative services.
2. Primary care essential benefits for acute care services with Medicaid as the payer of last resort if an individual also has Medicare or commercial coverage for these services.

“Office of Healthy Aging” or “OHA” is the State office that coordinates all State activities under the purview of the Older Americans Act and administers funding under Titles III and VI - in addition to National Family Caregiver Support programs. OHA is housed within DHS and serves as the designated State Unit on Aging. OHA administers the State Plan on Aging, in compliance with all federal statutory and regulatory requirements.

“Participant” is a person who is Medicaid LTSS eligible and receives Medicaid HCBS according to their person-centered plan.

“Participants with I/DD” means a participant who is eligible for publicly-funded developmental disability services through BHDDH or students who are eligible for transition services and supports under the Individuals with Disabilities Education Act, and who meet the definition found in 34 C.F.R. § 300.8(c)(6).

“Person-Centered Plan” *(Previously referred to as the Individualized Service Plan (ISP) by BHDDH)* means a written document that articulates a participant’s care needs, wants, strengths, and services and supports (paid and unpaid) that assist the participant to achieve their goals. The conflict-free case manager is responsible for documenting the participant’s needs and goals into their person-centered plan.

“Person-Centered Planning” is the process for selecting and organizing the services and supports that a participant may want and need to live in a home or community-based setting. Person-centered planning helps the participant construct and articulate a vision for the future, consider various paths, engage in decision-making and problem solving, monitor progress, and make needed adjustments in a timely manner. This process is directed by the participant and supported by a case manager.

“Prohibited Restrictive Intervention” means, in addition to those prohibited under R.I. Gen. Laws §§ 40.1-26-3, 40.1-26-4.1, and 42-158-4, the following procedures which are specifically prohibited from use under any circumstances:

1. Utilizing law enforcement in lieu of a clinically approved therapeutic emergency intervention or behavioral treatment program;
2. Utilization of behavioral interventions for the convenience of the staff; and
3. Utilization of behavioral interventions for any reason except for emergency protocol.

“Restraint” is a term used to describe a tool that restricts the movement of the whole or a portion of a person's body as a means of controlling acute, episodic behavior to protect the person or others from injury.

1. “Chemical or pharmacological restraint” means medication that is given for the emergency control of behavior when the medication is not standard treatment for the individual's medical or psychiatric condition.
2. “Mechanical restraint” means the use of an approved mechanical device that restricts the freedom of movement or voluntary functioning of a limb or a portion of a person's body as a means to control his or her physical activities.
3. “Physical restraint” means the use of approved physical interventions or "hands on" holds to prevent an individual from moving his or her body to engage in a behavior that places him, her or others at risk of physical harm.

“Restrictive Intervention” is an action or procedure that does one or more of the following:

1. Limits an individual’s movement, activity, or function;
2. Interferes with an individual’s ability to acquire positive reinforcement;
3. Results in the loss of access to other people, objects, locations, or activities that an individual values; or
4. Requires an individual to engage in a behavior that the individual would not engage in given freedom of choice.

“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 for participants who choose self-direction. This service helps both the participant and the State to manage individual budgets and helps participants to manage the financial responsibilities of being an employer, including the payment of federal and state taxes. If a Medicaid participant chooses to self-direct their services and hire their own staff, they are required to use a self-directed fiscal intermediary.

“Self-Direction” is a model that allows a participant to have responsibility for managing all or some aspects of service delivery (i.e., hiring, supervising, and discharging their HCBS providers) included in their person-centered plan and self-directed budget.

“Service Authorization” identifies the documented written approval by the State for a service. The service authorization process is employed to control the use of covered items or services and verify that they are medically necessary. When an item or service is subject to a service authorization, payment is not made unless approval for the item or service is obtained in advance by the State.

“Shared Living” is a model that allows the direct service provider assisting the participant with ADLs and IADLs to live together in a shared home.

“Support Broker” helps participants develop the skills necessary to self-direct and facilitate the administrative tasks that accompany self-direction. BHDDH offers support broker services for participants with I/DD who choose self-direction. Support broker activities include:

1. Brokering community resources;
2. Information and assistance and problem solving;
3. Assisting the participant to develop or manage their budget if needed;
4. Training the participant on how to train their hired staff to work with the participant and do the job they were hired to do;
5. Providing information on recruiting, hiring, and managing employees; and
6. Working/collaborating with the State’s self-directed fiscal intermediaries or support brokers.

ATTACHMENT B. ROLES AND RESPONSIBILITIES

Below is a high-level roles and responsibilities comparison. Please see the State's CFCM webpage for more detailed versions.

MEDICAID HCBS: ROLES & RESPONSIBILITIES UNDER CFCM

This document summarizes roles and responsibilities under RI's new conflict-free case management (CFCM) initiative. Per federal requirements, CFCM is required for all Medicaid HCBS participants who receive their long-term services and supports (LTSS) at home or in a community setting. *This comparison does not apply to participants who receive their LTSS via managed care. These participants will continue to work with their managed care organization to receive case management services.*

Starting the LTSS Journey

1. Participant interested in LTSS can receive person-centered options counseling (PCOC) from ThePoint at the ADRC or from state agency staff.

Medicaid HCBS Participant

1. Selects a CFCM entity and their service providers.
2. Drives the person-centered planning process and conversation to the best of their ability.
3. Access services and supports to achieve their identified goals and maintain independence.
4. Requests changes and approves changes to their person-centered plan.

State Agency Staff

1. Offers PCOC, available through MyOptionsRI.gov, to help Rhode Islanders understand the choices they have for LTSS.
2. Determines Medicaid eligibility.
3. Explains CFCM and offers choice of CFCM.
4. For Elders and Adults with Disabilities (EAD), performs the initial functional needs assessment (InterRAI).
5. 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.

Conflict-Free Case Managers

1. Acts as an HCBS system "service navigator" for the participant.
2. Supports/encourages the participant to lead/co-facilitate the person-centered planning process.
3. Facilitates and completes the development of the person-centered plan.
4. Helps the participant to access services and/or supports that will assist them in achieving their goals.
5. Monitors progress.
6. For EAD, completes an annual reassessment of functional need.

Service Providers and Other Supports

1. Contributes to the person-centered planning process.
2. Attends person-centered planning meetings as requested by the participant.
3. Performs activities and supports that assist the participant in achieving their goals.

Shared Responsibilities of Case Managers and Service Providers and Other Support:

1. Focuses on the participant and what matters most to them.
2. Reviews and signs the person-centered plan.
3. Maintains and updates documentation in support of claims and the State's reimbursement requirements.
4. Informs each other of discovered life changes and/or service changes of the participant.

Additional support for participants who choose to self-direct their own services:

- ***Fiscal Intermediary***: Helps participants with their individual budgets and to manage the financial responsibilities of being an employer.
- ***Support Broker*** *(Available for participants with I/DD):* Supports a participant in managing and directing their services and supports.

ATTACHMENT C. DETAILED PARTICIPANT RIGHTS AND RESPONSIBILITIES

1. Every participant has the **right**:
    a. To be treated with dignity and respect;
    b. To have their ethnic, spiritual, linguistic, family, and cultural choices respected;
    c. To be free of discrimination regarding race, color, national origin, sex, sexual orientation, religion, or gender orientation;
    d. To be encouraged and assisted to exercise constitutional and legal rights including the right to vote;
    e. To be informed of their medical condition and the right to refuse treatment;
    f. To be safe and free from abuse, neglect, exploitation, coercion, and unauthorized restraint;
    g. To receive competent, considerate, respectful care from all providers;
    h. To make decisions (with help from their individual representative or someone else they choose, if appropriate) regarding the kinds of services and supports they need and want;
    i. To make decisions that affect their life, including the right to design their own plan, to choose the people who assist in the development of the plan and the right to provide informed consent to the implementation of the plan, or have an advocate provide informed consent on their behalf;
    j. To manage own financial affairs unless unable to do so;
    k. To privacy and confidentiality;
    l. To see all of their files, including their case record, medical, and professional reports, and obtain a copy of their record if desired;
    m. To live independently in the way they choose;
    n. To live in a safe, secure, and supportive environment;
    o. To live in the least restrictive environment;
    p. To be fully integrated in and be an active member of their community;
    q. To have access to and participate in activities of social, religious, and community groups;
    r. To participate in assessments and development and implementation of their services;
    s. To receive information about their care and community services and to choose how and by whom their services are provided;
    t. To have services and supports explained to them in a manner that they can understand;
    u. To make a grievance, without fear of retaliation, when they are not happy with the services they receive;
    v. To appeal decisions about their care and services or about their cost share when they do not agree;
    w. To accept or refuse any community services and to withdraw from programs at any time;
    x. To choose traditional or self-direction service models for their service delivery; and
    y. *If the self-direction delivery model is selected:* To manage staff by:

i. Deciding who to hire.

ii. Deciding what special knowledge or skills their staff must possess.

iii. Deciding what training is required for staff.

iv. Replacing staff who do not meet the participant's needs.

2. Participants have the **responsibility**:

a. To know about their rights and to ask questions or request information to better understand their rights and responsibilities;

b. To notify their case manager of changes in their income, assets, expenses, or address and to complete all paperwork necessary to maintain their Medicaid eligibility;

c. To pay the cost share, if they have one. If they do not pay their cost share, their Medicaid services may be terminated;

d. To participate in their assessments and drive the development and implementation of their person-centered goals and services;

e. To meet and cooperate with case managers or State staff as required, and completing all needed assessments and monitoring requirements;

f. To develop and follow their person-centered plan;

g. To develop and understand their emergency backup plan and when to use it;

h. To give their consent only when they understand and agree with the decision;

i. To be honest about their needs and to report changes in their needs to their case manager and HCBS providers;

j. To notify their doctors of any changes in their health or condition and to keep appointments with their doctors;

k. To follow the rules of the programs and services they are enrolled in;

l. To be respectful of the people who provide their services;

m. To report any instances of abuse, neglect, or exploitation;

n. *If the self-direction delivery model is selected:* To demonstrate the required skills and abilities needed to self-direct staff without jeopardizing health and safety, or designate a representative to assist them;

o. *If the self-direction delivery model is selected,* to act as a supervising employer by:

i. Deciding wages and schedules for their employees;

ii. Completing hiring agreements with each staff member;

iii. Following all employment laws and regulations;

iv. Following all requirements of the Fiscal Intermediary/IRS regarding the hiring and paying of all personal care assistants or staff including: completing all necessary forms, reviewing time sheets for accuracy, submitting them in a timely manner, and paying personal care assistants promptly; and

v. Treating all employees with respect and dignity,

p. *If the self-direction delivery model is selected,* to manage services by:

i. Developing and monitoring a spending plan to address personal care assistance needs within the requirements of State's self-direction program;

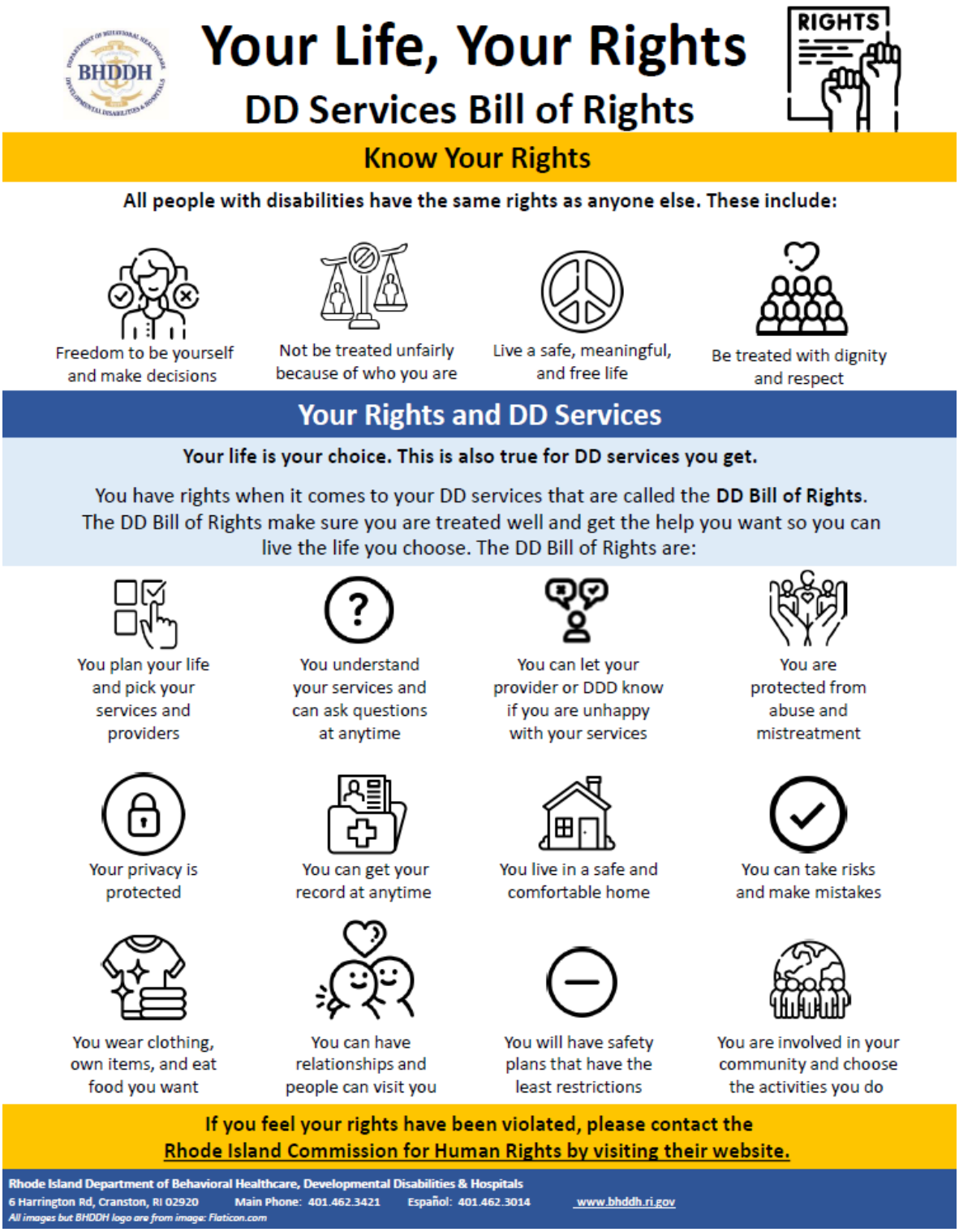
ii. Hiring and supervising staff and ensuring they are performing their duties as specified in their spending plan;

iii. Providing orientation and training to staff as needed;

iv. Tracking expenses to ensure monthly spending plan is not exceeded; and

v. Ensuring a safe working environment for staff.

ATTACHMENT D. I/DD PARTICIPANT RIGHTS FACT SHEET



ATTACHMENT E. CRITICAL INCIDENT FACT SHEET

FAQ – IDENTIFYING AND REPORTING MISTREATMENT

You have a right to feel safe and to be treated with dignity and respect. If you feel mistreated, or are concerned about someone you know, we can help.

Call or text 911 if you, or someone you know, is in immediate danger.

WHO SHOULD REPORT?

Everyone! Under Rhode Island law, anyone who knows about, or suspects mistreatment must make a report. Reports can be anonymous.

WHAT SHOULD I REPORT?

Any risk to a person's health and safety should be reported. The person responsible may be a provider, a family member, a friend, or another person in the community.

- **Physical Abuse** - purposely causing pain or injury, or inappropriate use of restraints
- **Sexual Abuse** - unwanted sexual contact or touching
- **Emotional Abuse** - purposely causing emotional harm (name calling, threatening, or yelling)
- **Neglect** - lack of needed care, poor supervision, isolation, or abandonment by caregiver
- **Self-Neglect** - failure of a person to provide themselves with necessary things to stay safe and healthy
- **Exploitation** - improper use of a person's money or property by someone else

If you are unsure about reporting a concern, please call us for support!

WHAT ARE THE SIGNS?

- Unexplained cuts, bruises, or other injuries
- Verbally aggressive or demeaning caregiver
- Fear or withdrawal to caregiver
- Poor hygiene or bed sores
- Lack of proper food or medical care
- Unpaid bills or unknown expenses
- Unexplained sexually transmitted infection(s)
- Lack of proper supervision
- Isolation or confinement

WHEN SHOULD I REPORT A CONCERN?

As soon as possible!

FAQ – IDENTIFYING AND REPORTING MISTREATMENT

HOW DO I REPORT?
The State has several resources to help when you suspect abuse, neglect, or exploitation. All can be reached using RI Relay (TTY 711).

If the concern involves an individual...	Who to contact	How to contact
Age 0-18 **OR** Age 18-21 in DCYF custody	DCYF Child Protective Services dcyf.ri.gov/services/child-protective-services	24/7 Hotline: 1-800-RI-CHILD (1-800-742-4453)
Age 18-59 with a disability OR Any age with a developmental disability*	BHDDH Office of Quality Assurance bhddh.ri.gov/quality-management-report-suspected-abuse/report-suspected-abuse	24/7 Hotline: 401-462-2629
Age 60+	OHA Adult Protective Services oha.ri.gov/what-we-do/protect/elder-protective-services	24/7 Hotline 401-462-0555 Report Online: oha.ri.gov/report-elder-abuse
Any age involving a nursing home, assisted living, hospice, or home care provicer	RI Department of Health health.ri.gov/complaints/ **AND** Alliance for Better Long Term Care alliancebltc.org/ombudsman-program/overview/	Phone: M-F 8:30am-4:30pm 401-222-5200 After Hours: 401-276-8046 Report Online: health.ri.gov/complaints/ Phone: M-F 9:00am-5:00pm 401-785-3340

*If the person is under 18, a report should also be made to Child Protective Services. If the person is age 60 or over, a report should also be made to Adult Protective Services.

ATTACHMENT F. PROGRAM TIMEFRAMES

Case managers are expected to adhere to the following timeframes:

Activity	Timeframe
State referrals to the CFCM agency	The CFCM agency must approve or deny referral requests within two (2) business days of receiving the request.
Initial outreach by the case manager once notified of a new participant	The case manager must contact the participant no more than three (3) business days after the assignment of the participant to the case manager.
Initial person-centered planning meeting and person-centered plan development	Within forty-five (45) calendar days of the initial outreach to a new participant, the case manager must conduct a person-centered planning meeting and submit a completed person-centered plan to the appropriate State agency for approval.
HCBS provider connections	a. Service referrals must be sent to HCBS providers within two (2) business days from the date of the participant's selection. b. Case managers are required to follow-up with HCBS providers within four (4) business days from the date the referral was sent if a response has not been received.
Finalizing the person-centered plan and signatures	a. The case manager makes a total of two attempts to get a provider's signature on the person-centered plan. i. First attempt: Completed within five (5) business days of the date the person-centered plan was reviewed and agreed to (verbally or by email) by the Medicaid HCBS provider. ii. Second attempt: Completed within thirty (30) calendar days of the date the person-centered plan was reviewed and agreed to (verbally or by email) by the Medicaid HCBS provider. b. EOHHS requires that case managers attempt to obtain signatures from the participant and from Medicaid HCBS providers prior to submitting the service authorization. Case managers should attempt to obtain signatures within five (5) business days of the date the person-centered plan was reviewed and agreed to (verbally or by email) by the participant and the Medicaid HCBS provider(s). If the case manager does not receive the HCBS provider's signature after two (2) attempts, the case manager has satisfied this requirement. The case manager must document the following in the State's LTSS case management platform under the Notes Tab: 1) measures taken to obtain the HCBS provider's signature and when; and 2) reason why a signature was not obtained.
Person-centered plan updates	a. Plan updates do not require service authorization: The case manager must complete person-centered plan updates within five (5) business days of a request or a change in or addition of identified need made by or on behalf of the participant.

Activity	Timeframe
	b. Plan updates require service authorization: If the plan update requires a reauthorization or change in authorization of services, the case manager must update the written person-centered plan in the LTSS case management platform within ten (10) business days of a request or a change in or addition of identified need made by or on behalf of the participant.
Significant change of condition	The case manager must contact the participant within two (2) business days of the case manager's discovery of an actual or potential significant change of condition, the need for a new functional needs assessment, living arrangement or safety and health that may require a change in the scope, amount and/or duration of Medicaid authorized services. Such changes must be documented in the participant's record.
Monitoring	a. *Contact*: Must be conducted within the next calendar month from the date of the person-centered planning meeting and within every calendar month thereafter, or on the agreed-upon schedule if the participant requests otherwise. b. *Six Month Face-to-Face Contact*: Must be conducted during the sixth calendar month from the date of the development of the person-centered plan. c. *Annual Person-Centered Plan*: The annual person-centered planning meeting and an updated person-centered plan must be completed no sooner than sixty (60) calendar days and no later than thirty (30) calendar days prior to the annual person-centered plan end date. Note that for EAD participants, case managers are required to complete their annual reassessment of functional needs during the participant's annual person-centered planning meeting. d. *Medicaid HCBS provider monitoring (For new Medicaid services)*: The case manager must contact Medicaid HCBS providers to verify delivery of services in the amount, scope, and duration as identified in the person-centered plan no later than three (3) business days after the scheduled service start date. This must be done for any new Medicaid service.

ATTACHMENT G. REPORTING AND NOTIFICATION REQUIREMENTS

Reporting Requirements to EOHHS

PERFORMANCE STANDARDS

EOHHS will use the following performance standards to assess Agency compliance with these standards. Satisfactory performance is defined as a minimum of eighty-six percent (86%) compliance with these performance standards. EOHHS will pursue corrective action if performance with any standard is less than eighty-six percent (86%). EOHHS monitors performance with the following metrics through the State's case management platform, unless indicated otherwise:

A. The number and percentage of participants contacted within three (3) business days after the Agency was notified of a new participant enrolled with the Agency. Performance is monitored monthly.

B. The number and percentage of new participants who had their initial person-centered planning meeting and submitted the person-centered plan to the State within forty-five (45) calendar days of their initial contact, unless there is a person-centered reason for deviating from that standard (e.g., to ensure attendance of a person chosen by the participant). Performance is monitored monthly.

C. The number and percentage of participants who were offered choice of services and providers. Performance is monitored monthly.

D. The number and percentage of participants whose service plans address assessed needs, risks, and personal goals. Performance is monitored quarterly.

E. The number and percentage of participants that had a documented monthly contact. Performance is monitored monthly.

F. The number and percentage of participants whose person-centered plans were updated at least annually or when there was a change in the participant's needs. Performance is monitored quarterly.

G. The number and percentage of participants (or families/authorized representatives/Authorized Legal representative (e.g., legal guardian or power of attorney) who received information on how to identify and report a Critical Incident. Performance is monitored quarterly.

H. The number and percentage of Critical Incidents involving participants that are identified and reported based on state policy. Performance is monitored monthly using the Monthly Critical Incident Report.

Notification Requirements to EOHHS

1. When a change of ownership or operation or location of a CFCM agency is planned or when discontinuation of services is contemplated, EOHHS must be given written notice ninety (90) calendar days in advance of any proposed changes in location, name, or ownership of the CFCM agency, or CFCM agency closure.
2. The CFCM agency must notify EOHHS within five (5) business days of receiving a draft or final audit report that contains a qualified option or an exception to an unqualified opinion (e.g., going concern, scope limitation, disagreement with management, GAAP compliance).
3. The CFCM agency must immediately notify EOHHS when they are no longer able to accept new participants based on their available capacity. The State will not assign participants to these agencies after this notification is submitted.

4. The CFCM agency must immediately notify EOHHS of:
    a. The occurrence of any event that it reasonably anticipates will materially impact its business, services to participants, cashflow, or financial condition of the CFCM agency. This notice must specify the nature and duration of the event and what action the CFCM agency intends to take to maintain operations and service delivery.
    b. Any instance in which the CFCM agency discovers that it is out of compliance with the State's CFCM requirements.
    c. When it believes that the participant is no longer eligible to receive Medicaid HCBS.
    d. The occurrence of any default or event of default on any financial instrument or other obligation. This notice must specify the nature and duration of the default and what action the CFCM agency intends to take to remedy the default.
    e. Any criminal convictions for events occurring in the agency's workplace.
    f. Any plans to discontinue to provide services to participants. The CFCM agency will work with EOHHS to ensure continuity of care and that there is a successful handoff of the case to another CFCM agency.

ATTACHMENT H. GUIDANCE ON NONCOMPLIANT PARTICIPANTS

Initial Outreach (new referral)

1. If the case manager/CFCM agency is unable to contact the participant within the 3 business day timeframe, the case manager/CFCM agency continues regular attempts to contact the participant for at least 90 calendar days thereafter
    a. All contact attempts and outcomes must be documented in the State's LTSS case management system
    b. In addition to attempting contact with the participant, the case manager attempts to contact any authorized representative to schedule the initial person-centered planning meeting
    c. Contacts are made on different days of the week, different times of day (morning, afternoon, evening), and utilize all known methods of contact (telephone, email, etc.)
    d. CFCM agency cannot bill if the PCP is not developed and contact attempts are unsuccessful
2. After 30 calendar days, the case manager mails a letter to the participant and/or authorized representative requesting an initial meeting with the participant.
3. After 60 calendar days, the case manager mails a second letter to the participant and/or authorized representative requesting an initial meeting with the participant.
4. If case manager/CFCM agency is still unable to contact the participant and/or an authorized representative, case manager/CFCM agency informs the appropriate State agency (DHS or BHDDH)
    a. Oversight of the participant will be transferred from the CFCM Agency to the appropriate state agency
    b. The CFCM agency will submit a note alert to their assigned State Supervisor (at DHS or BHDDH) within the State's LTSS case management platform stating they are unable to contact the participant and/or authorized representative after following the CFCM Guidance on Noncompliant Participants.
5. The State Agency (DHS or BHDDH) will review all contact attempts made by the CFCM Agency in the State's LTSS case management platform
6. The State agency (DHS or BHDDH) follows the process for contact attempts outlined in section 2 above:
    a. State agency representative attempts initial outreach within 3 business days after the participant is transferred back to the State agency.
    b. If initial outreach is unsuccessful, state agency should continue attempts to contact the participant for at least 90 calendar days after the participant is transferred back to the State agency.
    c. All contact attempts and outcomes are documented in the State's LTSS case management system
    d. State staff must attempt to contact the participant and/or any authorized representative
        i. The state contact should inquire why the participant has not been responsive, clarify expectations for LTSS HCBS and counsel the participant back to the assigned CFCM agency, if there is still availability, or to a new CFCM agency

e. Contacts are made on different days of the week, different times of day (morning, afternoon, evening), and utilize all known methods of contact (telephone, email, etc.)

7. After 30 calendar days, the case manager mails a letter to the participant and/or authorized representative requesting an initial meeting with the participant.
8. After 60 calendar days, the case manager mails a second letter to the participant and/or authorized representative requesting an initial meeting with the participant.

Existing Participant (participant with an active person-centered plan)

1. By signing the person-centered plan, the participant agrees to engage with the case manager.
2. Review and Approval language from the person-centered plan:
    a. I understand that my Case Manager will provide a face-to-face visit every 6 months to the full extent possible and a check-in every month or as agreed to in my person-centered plan.
    b. I understand that by choosing home and community-based services, I will be required to grant reasonable access to my home by services providers or direct care.
    c. I understand that I can decide at any time that I no longer want to receive home and community-based services and supports.
    d. The people who have signed below understand and agree to participate in implementing my plan.
3. *Scenario 1:* participant is not responsive to contact attempts by the case manager
    a. All contact attempts and outcomes are documented in the State's LTSS case management system
    b. Following the completion and approval of a PCP, the CFCM agency continues to attempt work with the participant for at least 1 calendar year
        i. CFCM Agency attempts to complete the monitoring contact at least once every 6 months
            1. CFCM agency can bill for other billable activities (as outlined in the CFCM Program Manual)
    c. If the case manager cannot complete 2 monitoring contacts over the course of 1 year, oversight of the participant will be transferred from the CFCM Agency to the appropriate state agency (DHS or BHDDH)
        i. The CFCM agency will submit a note alert to their assigned State Supervisor (at DHS or BHDDH) within the State's LTSS case management platform stating they are unable to contact the participant and/or authorized representative after following the CFCM Guidance on Noncompliant Participants.
    d. The State Agency (DHS or BHDDH) will review all contact attempts made by the CFCM Agency in the State's LTSS case management platform
    e. The State agency (DHS or BHDDH) continues outreach to the participant:
        i. All contact attempts and outcomes are documented in the State's LTSS case management system
            1. Contacts must be made on different days of the week, and different times of day (morning, afternoon, evening)
        ii. The State agency must continue working with the participant for at least 6 months

1. The state contact should inquire why participant has not been responsive, clarify expectations for LTSS HCBS and counsel the participant back to the assigned CFCM agency if there is still availability or to a new CFCM agency

4. *Scenario 2:* participant does not select a direct service (i.e. home care, shared living, etc.)
    a. According to HCBS technical guidance, the participant must be receiving at least 1 service. CFCM is an HCBS service (i.e., the participant can receive CFCM only).
    b. CFCM Agency continues working with the participant if the participant is engaging in the monthly monitoring contacts
        i. **NOTE**: If the participant does not select a direct service, and is only receiving case management, **monthly monitoring contact with the participant is required** and it cannot be any less frequent
    c. Case manager continues evaluating the PCP and offering different HCBS to the participant and verifying the PCP is person centered
5. *Scenario 3:* participant has been referred to a direct service provider but is not responsive to the direct service provider (i.e., not responding to attempts to initiate services)
    a. CFCM Agency is the conduit between the direct service provider and the participant
        i. Case manager works with the direct service provider to coordinate services
    b. If the case manager is also unable to contact the participant, case manager should follow the steps outlined in *Scenario 1* or the participant can receive CFCM only as outlined in *Scenario 2.*
6. *Scenario 4*: participant is receiving direct services but not responsive to the case manager
    a. Case manager may lean into the direct service provider to attempt contact (for example, ask the direct service provider to speak with the participant about responding to the case manager). If this is unsuccessful, follow the steps outlined in *Scenario 1*. The case manager must be able to make contact with the participant to meet the requirements of a monitoring contact. This can include a visit to the participant while they are receiving services from the direct service provider. The direct service provider cannot attest to information about the participant's health and welfare.

Additional Guidance:

1. **Monitoring Contact:** this refers the to the face-to-face (or other acceptable forms of communication as outlined in the CFCM Program Manual) contact completed by the case manager with the participant
    a. Other contacts, such as with an authorized representative or a service provider, do <u>not</u> meet the monitoring contact requirements
    b. A case manager must complete a face-to-face monitoring contact at least once every six months
    c. A monitoring contact is required to ensure the health and/or safety of the participant
    d. For participants enrolled in the Personal Choice program
        i. A monthly monitoring contact is required for all participants
        ii. If unable to complete the monthly monitoring contact, please contact the Office of Community Programs (OCP)
2. **Monthly Contact:** this can either be a monitoring contact (with the participant only) or other acceptable collateral contacts as outlined in the CFCM Program Manual