



**Certification Standards for Conflict-Free Case  
Management (CFCM)**  
*Medicaid Home and Community-Based Services*

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## I. INTRODUCTION

This document establishes the Rhode Island Medicaid certification standards for conflict-free case management (CFCM). These certification standards apply to case management services provided to Medicaid home and community-based services (HCBS) participants, including programs serving participants with intellectual and developmental disabilities (I/DD) and Elders and Adults with Disabilities (EAD). The Rhode Island Executive Office of Health and Human Services (RI EOHHS) shall maintain a separate CFCM program manual describing how the standards outlined herein shall be operationalized.

CFCM ensures that clinical or non-financial eligibility determination is separated from direct service provision. The federal Centers for Medicare and Medicaid Services (CMS) regulation at 42 C.F.R. § 441.301(c)(1) (Regulation) requires that HCBS programs use a person-centered planning process which includes ways to solve conflict or disagreement and that the guidelines around conflict of interest are clear to everyone involved in the planning process. The Regulation also requires that providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual, cannot provide case management or develop the person-centered service plan.

The practice of case management is a professional and collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet a participant's needs and goals.

Under federal regulations, CFCM is mandatory for all Medicaid HCBS participants who receive Medicaid long-term services and supports (LTSS) at home or in a community setting. CFCM Agencies may choose to support two (2) populations (participants with I/DD and EAD) or choose to serve one (1) population only.

These standards DO NOT apply to:

1. PACE participants.
2. Katie Beckett eligible children.
3. Other Medicaid-eligible children who receive Medicaid services at home or in the community.
4. Nursing Home Transition Program (NHTP) including Money Follows the Person (MFP).
5. Integrated Health Home.
6. The Office of Healthy Aging's At Home Cost Share program.

RI EOHHS has the authority to establish standards for providers of case management services as the designated single state Medicaid authority under R.I. Gen. Laws § 42-7.2-2. Such services are described under Rhode Island's approved Section 1115 Demonstration Waiver.

A certificate issued by EOHHS is required for a Medicaid provider to receive reimbursement for providing case management services to Medicaid HCBS participants, and the issuance of such a certificate requires full compliance with these CFCM certification standards. The issuance of such a certificate does not commit or bind RI EOHHS or the State of Rhode Island to the funding of any particular program or entity.

## II. AGENCY CASE MANAGEMENT STANDARDS

Case management agencies (“Agency” or “Agencies”) shall meet all applicable State and federal requirements. The Agency shall have a physical location in Rhode Island or a border community as defined in 210-RICR-20-00-3.6 that is welcoming, safe, publicly accessible and complies with all Americans with Disabilities Act (ADA) guidelines.

Agencies shall be knowledgeable of and in compliance with all relevant State and federal laws and requirements. Agencies shall also ensure the requisite policies are in place as described herein. The Agency is responsible for ensuring that all case managers providing services on behalf of the CFCM Agency comply with these certification standards and related CFCM Agency policies as well as any regulations or guidance documents promulgated by EOHHS.

Agencies shall have a sound organizational approach to ensure the provision of effective, timely, and high quality CFCM services. An organizational chart that includes the names and titles of those in leadership roles shall be made available to EOHHS. This organizational chart shall be updated on a yearly basis and be maintained as Agency personnel changes.

### **Agencies shall demonstrate the following, at a minimum:**

#### Core Components:

The Agency shall demonstrate its capacity to implement the four (4) core components of CFCM utilizing a person-centered planning approach:

1. **Information gathering:** A comprehensive review of a Medicaid HCBS participant’s strengths, preferences, needs, and goals, including any cultural considerations and the person’s communication support needs, to enable the person to direct their planning process to the fullest extent.
2. **Person-centered plan development:** Development of a written person-centered plan that articulates a Medicaid HCBS participant’s needs, wants, and services and supports (paid supports and natural unpaid supports) that will assist the participant in achieving their goals. When developing the participant’s person-centered plan, the process must follow a person-centered approach that complies with 42 C.F.R. § 441.301(c)(1), including that the participant will be supported in directing the development of the plan to the maximum extent possible.
3. **Connecting to services and supports:** Connect the Medicaid HCBS participant to paid supports and unpaid natural supports described in the person-centered plan. Natural supports are unpaid supports that develop, strengthen and maintain community integration and are provided voluntarily to the participant in lieu of paid services.
4. **Plan monitoring and follow-up:** Regular contact with the participant to review goal progress and quality and effectiveness of services.

#### Cultural Competency:

The Agency shall demonstrate its ability to work effectively in multiple community and cultural settings with people of different racial, ethnic, economic, linguistic, and religious backgrounds, as well as gender expressions and sexual orientations. The Agency shall ensure that the person-centered planning process is respectful of each participant’s culture.

### Connections with Community-Based Resources:

The Agency shall demonstrate its ability to establish and maintain working relationships with community-based resources, supports, hospitals, HCBS direct service providers, and other organizations that assist in meeting the HCBS participant's needs.

### Supervision of Case Management Staff:

The Agency shall demonstrate that the individual(s) responsible for the supervision of case management staff do the following:

1. Review case records and ensure that documentation is adequate and up-to-date and that participant records and reports meet federal and RI EOHHS guidelines;
2. Meet at least once per month with each case manager under their supervision to assist them with person-centered plan implementation and problem-solving;
3. Regularly observe face-to-face meetings between case managers and participants for each case manager under their supervision;
4. Observe and document each case manager's interpersonal skills, person-centered plan review, knowledge of services provided, and active listening skills; and
5. Hold quarterly team meetings with case managers under their supervision to review any changes in practice standards, discuss quality assurance initiatives or activities, etc.

### Financial Audit:

The Agency shall submit as part of initial certification and recertification, an independent financial audit that is no more than eighteen (18) months old to demonstrate that the Agency is financially sound and operates in accordance with accounting best practices and principles.

### Reporting:

The Agency shall demonstrate the ability to submit the following required reports:

1. **Monthly Capacity Report:** Provide EOHHS with a report detailing the Agency's capacity to support participants. EOHHS shall use this information to educate participants on the available Agencies. This report shall be submitted monthly to EOHHS by the twentieth of the following month. This report shall be submitted in Excel and include the following fields:
  - a. Current number of case managers as of the end of the previous month
  - b. Number of participants assigned to each case manager in the previous month
  - c. Total number of new participants the Agency can support in the following month
2. **Quarterly Internal Grievances:** Provide EOHHS with reports detailing all internal grievances, as described below, received from and made by participants and family members with resolutions and timelines. This report shall be submitted quarterly to EOHHS by the twentieth of the following month of the reporting period (January, April, July, October). This report shall be submitted in Excel and include the following fields:
  - a. Person Submitting Complaint Name and Role
  - b. Person Affected Name and Role
  - c. Date Received
  - d. Description of Grievance

- e. Summary of Resolution
  - f. Date of Resolution
  - g. Days to Resolve
3. **Monthly Critical Incident Report:** Report all observed or suspected critical incidents. Case managers are mandatory reporters of abuse, neglect, mistreatment, and exploitation (“Critical Incidents”) under State law. Critical Incidents must be reported within twenty-four (24) hours to law enforcement and/or the appropriate State agency. Agencies shall also provide EOHHS with a monthly summary of critical incidents that are reported to law enforcement and/or the State. This report shall be submitted monthly to EOHHS by the twentieth of the following month of the reporting period.
  4. **Fraud, Waste, and Abuse:** Report any known or suspected misuse of Medicaid funds and/or system abuse to the RI EOHHS’ Program Integrity Unit at (401) 462-6503 and the Office of the Attorney General’s Medicaid Fraud Control Unit.

RI EOHHS reserves the right to ask for further information as deemed necessary to monitor the performance of Agencies providing conflict-free case management services.

**Agencies shall have the following written policies and protocols:**

**Conflict of Interest Policy:**

At a minimum, the policy shall:

1. Define conflict of interest;
2. Describe that the case manager developing the person-centered plan shall not be any of the following:
  - a. Related by blood or marriage to the participant or to the paid caregivers of the participant;
  - b. Financially responsible for the participant;
  - c. Empowered to make financial, health-related, residence, and/or relationship decisions on behalf of the participant;
  - d. Hold financial interest in an entity that is paid to provide care for the participant. Financial interest includes a direct or indirect ownership or investment interest and/or any direct or indirect compensation arrangement;
  - e. A landlord of the participant;
  - f. Share a residence with the participant or with any person paid to provide Medicaid HCBS to the participant.
3. Describe the Agency’s process for preventing conflicts of interest;
4. Describe how and when case managers shall report potential conflicts of interest to their supervisor;
5. Describe the Agency’s process for identifying and correcting conflicts of interest when they occur; and
6. Describe other limitations as required by CMS and in alignment with federal rules.

### Information and Referral Policy:

The policy shall state that the Agency shall accept and respond to requests for information and/or assistance from individuals, caregivers, and other third parties.

### Timeline Policy:

The Agency shall have a policy describing how the Agency shall adhere to the following timelines:

1. Within three (3) business days after the Agency is notified of a new participant enrolled with the agency:
  - a. The Agency must send a welcome/introduction letter to the participant and/or their legal representative (e.g., legal guardian or power of attorney)
  - b. The Agency must attempt to contact the participant and/or their legal representative (e.g., legal guardian or power of attorney)
2. The Agency must conduct the initial person-centered planning meeting with the participant and submit a person-centered plan to the State within forty-five (45) calendar days after 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).

### After Hour Coverage Policy:

The Agency shall be available to participants during regular business hours (8am-5pm, Monday-Friday) and provide scheduled evening/weekend coverage upon request. The protocol shall, at a minimum, ensure that participants can leave a message with the Agency after close of business. The policy shall also include evening and weekend coverage to be available to meet the needs of participants, including scheduling meetings with participants at night/weekend times if preferred by the participant.

### Smoking Policy:

The Agency shall have a smoking policy that, at a minimum, prevents staff from smoking in the presence of participants.

### Limited English Proficiency Policy:

The Agency shall have a policy that describes how individuals with limited English proficiency shall be assured meaningful access to services provided by the Agency. The policy shall comply with all State and federal laws and regulations.

### Training Policy:

The Agency shall have policies and procedures for initial and ongoing training designed to ensure that case managers shall have the necessary range of knowledge, skills, and abilities to provide high quality conflict-free case management services. The training policy shall include the requirement for case managers and other relevant staff to attend Conflict-Free Case Management focused training provided by the State, and any training required by the State for Medicaid providers.

### Personnel Policy:

The Agency shall have policies that address how the Agency selects, screens, hires, and trains personnel. This policy shall at minimum provide for and describe:

1. Governance structure;

2. Minimum education and/or work experience requirements for case management and supervisory staff;
3. Method for conducting employee screening and background checks as mandated by State and federal law;
4. Method for verifying staff qualifications;
5. Orientation procedures for new case management staff;
6. How supervision is provided including accessibility of supervisors, review of client records, ongoing feedback between the supervisor and case manager, and frequency of performance evaluations of case managers; and
7. Criteria and procedures for employee performance reviews.

#### Background Check Policy:

The policy shall outline the background checks required by the Agency for a person to be employed as a case manager.

#### Assignment Policy:

The Agency shall have a policy regarding the Agency's process for assigning participants to case managers. This policy shall describe:

1. How a case manager shall be assigned to the participant, including but not limited to procedures for participant choice of case manager.
2. The process for how participants can change case managers. The Agency is required to make reasonable efforts to accommodate the request to change case managers and assign a new case manager to the participant.
3. Methods utilized to ensure adequate program staffing and alternate coverage during periods of staff unavailability, such as vacation, holidays, or sick leave.

#### Caseload Policy:

The policy shall state how the Agency ensures that case managers have a reasonable caseload that allows adequate time to meet the needs of their assigned participants and comply with all federal and State rules, regulations, and standards. This policy shall include a maximum caseload size per case manager. The policy shall also address the prioritization process for people accessing case management services.

"Prioritization process" refers to the method by which the agency determines the order in which individuals receive case management services, if needed because the agency is at or nearing capacity and may not be able to serve everyone concurrently. This process is intended to ensure that those with the most immediate and/or severe needs are attended to promptly when the agency is at or nearing its capacity.

#### Grievance Policy – Internal Grievances:

This policy shall outline how the Agency will respond to participant grievances that involve the Agency, case manager, or other individual acting on behalf of the Agency and how the Agency will communicate information about participant grievances to EOHHS. This policy shall discuss at a minimum:

1. Methods for ensuring participants are informed of their right to report a grievance.
2. Process to review, report, investigate, and respond to grievances, and associated timelines.

3. Approach to trend analyses and addressing issues identified.

In addition, the Agency shall have a policy which outlines the Agency's response to employee grievances. This policy shall discuss at a minimum the acceptance and resolution of grievances brought by employees as a result of Agency management practices.

**Grievance Policy – Other Providers:**

This policy shall outline how the Agency will respond to participant grievances involving direct service providers that come to the attention of the Agency and how the Agency will communicate information about such grievances to EOHHS.

**Mandated Reporting of Abuse, Neglect, and Exploitation Policy:**

The policy shall address how the Agency will respond in cases of suspected abuse, neglect, and/or exploitation ("Critical Incidents") of vulnerable adults in compliance with State and federal requirements. This policy shall further address how case managers identify, respond to, and report Critical Incidents in accordance with RI EOHHS standards.

**Behavioral Support Plan Policy:**

The Agency shall have a policy that establishes procedures, consistent with State and federal law and regulations, that guide the case manager when a participant has a behavioral support plan. This policy shall provide for the process by which staff can identify a completed Behavioral Support Plan (BSP) and report the misuse or misapplication of a BSP as a Critical Incident to the Division of Developmental Disabilities.

**Participant Record Policy:**

The policy shall include:

1. The procedure governing the use, storage, and removal of participant records;
2. The conditions for release of information contained in the participant record;
3. The requirements of authorization in writing by the Participant or Authorized Legal Representative for release of information;
4. The maintenance of all records relating to the delivery and documentation of case management services for a minimum of seven (7) years and the maintenance of all financial records for a period of seven (7) years; and
5. Compliance with the Health Insurance Portability and Accountability Act (HIPAA).

**Continuous Quality Improvement Plan:**

The policy shall outline the Agency's ongoing quality improvement plan regarding case management services. This plan shall include:

1. How the Agency oversees the work performed by case managers to ensure all tasks are performed according to federal and State requirements;
2. How the Agency reviews case managers' work to determine whether the work is being completed in a correct and high-quality manner; and
3. How the Agency identifies and addresses case manager performance issues.

### Financial Management and Billing Policy:

The Agency shall have policies that outline the operational steps for conducting internal controls for claim submission, billing process, oversight of recordkeeping, monitoring expenditure controls, and clearly define staff roles and responsibilities.

### Emergency Management Plan:

The Agency shall have a plan describing how it will identify the critical functions and services it performs that shall continue in the event of an emergency and include a plan as to how those functions and services will be provided during that time. The plan shall describe how the Agency shall collaborate and cooperate with local emergency planners and other local providers. The plan shall also describe how the Agency will:

1. Identify participants who require specific assistance during an emergency;
2. Provide information and encourage individuals to develop a personal emergency preparedness plan;
3. Provide assistance in developing the plan as necessary for needed assistance and support in the event of a natural or other emergency which may result in disruption of service and/or personal harm; and
4. Involve and consider family caregivers and other natural supports as part of the process, if the participant chooses to involve these individuals.

### Written Materials for Participants:

The Agency shall create the following materials for participants, at a minimum:

1. **Agency Fact Sheet/Overview:** Overview of the Agency. EOHHS will provide this document to participants during the selection and enrollment process. This document shall include the following information: 1) Agency background, 2) physical location, 3) phone number, 4) language capacity, including American Sign Language, and 5) any other information that the Agency would like to provide. This document shall be one (1) single-sided page.
2. **Procedure for Internal Grievances:** Document that describes how participants can file internal grievances with the Agency, as described above. This document shall be one (1) single-sided page, available in multiple languages, and meet standards for those with limited English proficiency.

## III. INDIVIDUAL CASE MANAGER STANDARDS

The Agency shall demonstrate the following standards for individual case managers to ensure that case managers are:

- A. Knowledgeable of and skilled in strategies to support the participant to lead and be maximally responsible for their own person-centered planning process. The case manager shall provide necessary information and support to ensure that the participant directs the process to the fullest extent possible and is enabled to make informed choices and decisions.
- B. Knowledgeable of and comply with all Agency policies and standards.
- C. Knowledgeable about the full range of services available to participants and shall ensure that participants are informed of available resources and services. The case manager shall make any needed referrals.

1. A case manager shall ensure that a participant has the right and option to receive services under conditions of acceptable risk. “Acceptable risk” is defined as the level of risk a participant—after consultation as appropriate with their Authorized Legal Representative, as defined below—is willing to accept after the informed consent process.
- D. Competent to assist participants in completing any necessary forms for the annual Medicaid renewal or other Medicaid eligibility forms needed to ensure that there are no service disruptions.
  - E. Able to effectively communicate the participant’s opportunity to self-direct, inform participants of the potential benefits, liabilities, risks and responsibilities associated with choosing self-direction, and support the participant in fulfilling participant responsibilities to the Fiscal Intermediary.
  - F. Capable of providing services in an efficient, effective, and collaborative manner to avoid duplication of services, costs, and administrative tasks.
  - G. Responsive to requests for information and/or assistance from individuals in a timely manner.
  - H. Capable of informing all participants of the Agency’s grievance procedures in keeping with participants’ preferred language and English proficiency.
  - I. Capable of informing all individuals regarding the right to be free from abuse, neglect, and exploitation, and how to identify and report Critical Incidents, consistent with participants’ preferred language and English proficiency.
  - J. Respectful of the cultural needs of participants of different racial, ethnic, economic, linguistic, and religious backgrounds.
  - K. Capable of ensuring that participants receive person-centered services in the least restrictive and most appropriate setting in accordance with their needs and preferences, as required by State and federal law and the U.S. Supreme Court *Olmstead* decision.
  - L. Respectful of the participant’s rights, strengths, values, and preferences, encouraging the participant to create, direct, and participate in their individualized written person-centered plan to the fullest extent possible.
    1. The participant may involve a caregiver, Authorized Legal Representative, or any other chosen representative in decision making. Participants have the right of self-determination and shall be encouraged and supported to make their own decisions and decide with whom they wish to associate and who they want to be involved in decision making. “Authorized Legal Representative” includes an authorized supporter pursuant to a Supported Decision-Making Agreement, an authorized agent pursuant to a Power of Attorney, and/or an authorized limited guardian or guardian.
  - M. Capable of facilitating a participant’s person-centered planning process, supporting them to direct the process to the fullest extent possible. The process shall be timely and occur at times and locations chosen by and convenient to the individual. Person-centered planning shall reflect a process which ensures that the settings in which the individual receives services are chosen by the individual from among setting options. The case manager shall ensure that the participant chooses who is included in and excluded from the person-centered planning process (e.g., friends and family members, natural supports, and others who support the participant throughout the day, such as therapists or clergy).

- N. Capable of supporting the participant and their support network in establishing person-centered goals.
- O. Capable of using the information from assessments and considering the participant's person-centered goals to discuss all available options with the individual and their support network and agree upon strategies built upon the strengths of the individual to achieve these goals. Strategies shall describe the specific services or supports to be provided, the person responsible for carrying out the strategies and the target date as agreed upon by the participant.
- P. Capable of supporting a participant to develop a person-centered plan driven by the participant's choices, needs, interests, preferences and wishes, the development of which provides the participant with options, meaningful choices and opportunities, utilizing the EOHHS template. The person-centered plan shall:
  - a. Reflect clinical and support needs as identified through an assessment of functional needs.
  - b. Reflect the services that will enable the participant to live fully supported in the least restrictive setting. The development of such supports and services shall be based on both the needs identified through a functional needs assessment of the individual and the preferences, choices, and priorities of the participant.
  - c. Reflect preferences, goals, and desired outcomes identified by the individual or their representative.
  - d. Identify the services and supports (paid and unpaid) that will assist the participant to achieve identified goals and desired outcomes, and the providers of those services and supports, including natural supports and services which the participant elects to self-direct, if applicable.
  - e. Reflect that the settings in which the participant receives services are chosen by the participant from among a meaningful array of setting options and choices.
  - f. Reflect risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.
  - g. Be written in such a manner that is understandable to both the participant receiving services and supports, and the individuals supporting them. The written plan shall be written in plain language and in a manner that is accessible to participants with disabilities and participants who are limited English proficient in compliance with 42 C.F.R. § 435.905(b).
  - h. Be finalized and agreed to, with the informed consent of the participant and/or Authorized Legal Representative in writing, and signed by all individuals and providers responsible for its implementation.
  - i. Be distributed to the participant and other individuals involved in the plan.
  - j. Prevent the provision of services and supports that are duplicative or do not align with the participant's person-centered plan.
  - k. Fully document any modifications, or exceptions, to the CMS required HCBS settings rule at 42 C.F.R. § 441.301(c)(4). Modifications to the HCBS settings rule shall be documented in the person-centered plan and satisfy the following:
    - i. Identify a specific and individualized assessed need for the modification;
    - ii. Document the positive interventions and supports used prior to any modifications to the person-centered service plan;

- iii. Document less intrusive methods of meeting the need that have been tried but did not work;
  - iv. Include a clear description of the condition that is directly proportionate to the specific assessed need;
  - v. Include a regular collection and review of data to measure the ongoing effectiveness of the modification;
  - vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
  - vii. Include informed consent of the individual or their authorized legal representative; and
  - viii. Include an assurance that interventions and supports will cause no harm to the individual.
- I. The participant's person-centered plan, including the participant's goals and strategies as applicable, shall be updated at least annually or more frequently if the participant requests and/or if there is a significant change in the participant's life that would alter the amount and type of formal and informal services and supports needed.
- Q. Capable of maintaining all current and previous, complete, and accurate paper or electronic records in a file for each participant, in accordance with the Participant Record Policy. Participant records shall include, but are not limited to:
- a. A written Authorization to release information or documentation as to why a written Authorization to release information could not be obtained.
  - b. Current demographic and assessment information regarding the participant.
  - c. Current and historical person-centered plans.
  - d. Case notes that shall focus on the individual's progress and any emergent issues that need to be addressed.
  - e. Any other correspondence received or sent which is relevant to the participant.
  - f. Other documents required by specific programs and services, such as copies of applications, notice of decisions, etc.
  - g. If the case manager is taking direction from an Authorized Legal Representative of the participant, there shall be a copy of the participant's designation of the Authorized Legal Representative or other legal documentation maintained in the individual's case management records. If applicable, Guardianship/Power of Attorney and other advanced directives.
- R. Capable of monitoring the implementation of the person-centered plan to ensure that services are being provided as planned, to ensure that the participant's identified needs are being met, and goals are being pursued.
- 1. Monitoring shall include at least monthly contact with the participant via a method of contact chosen by the participant and agreed upon in the person-centered plan. If the participant chooses monitoring through telehealth, monitoring must include a face-to-face visit at least once every six (6) months. Any other individual chosen by the participant, including an Authorized Legal Representative, may also participate in monitoring; however, participation by other individuals is in addition to the participant's involvement and shall not be a substitute for required contact with the participant.

- S. **Assessment:** The Agency shall demonstrate that case managers are capable of conducting reassessments for the EAD population.
  1. For case managers serving Elders and Adults with Disabilities (EAD), the Rhode Island Department of Human Services (DHS) shall administer the initial assessment. On an annual basis (or more frequently if there is a significant change in the participant's life), a case manager serving the EAD population, with input and participation by the participant and their support network, shall reassess the individual's strengths and needs using the assessment tool(s) approved by EOHHS. The case manager shall make every effort to assure the completeness and accuracy of the reassessments and utilize the reassessment to update the person-centered plan as indicated above.
  2. Case managers serving I/DD participants will not conduct assessments or reassessments.

#### IV. ORGANIZATION AND ADMINISTRATION

Agencies shall meet the following organization and administrative requirements:

- A. Be a public or private not-for-profit or for-profit entity that meets all applicable State and federal requirements.
- B. Provide case management services statewide.
- C. Adhere to the staffing requirements of the Habilitation Services (HAB) and Personal Choice programs if the Agency will serve participants in those programs.
- D. Have a physical location in RI. The location must:
  1. Be publicly accessible.
  2. Be on a public transportation line or in a community where public transportation is available and provided to the specific location.
  3. Comply with the Americans with Disabilities Act (ADA) guidelines.
  4. Meet all applicable State or local inspection requirements for health, fire, and safety.
- E. Be an authorized Medicaid provider. The enrollment process is to be completed online and will include a Provider Agreement.
- F. Provide case managers with company assigned email addresses to maintain data security. Case managers are not allowed to use personal emails. Case managers are to use encrypted email. Email correspondence must remain confidential and HIPAA compliant.
- G. Provide a toll-free telephone number and allow for secure email communication.
- H. Protect itself by providing professional insurance protection/malpractice insurance/errors and omission protection coverage. The Agency shall maintain customary commercial general liability insurance (including automobile coverage) and professional liability insurance in commercially reasonable amounts, and any additional bonding that RI EOHHS may require.
- I. Obtain and maintain all hardware necessary to access RI EOHHS data needed to perform CFCM.

#### V. PERFORMANCE STANDARDS

RI EOHHS shall 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 will monitor performance with the following metrics through the State's case management system, 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 within ten (10) business 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 Representatives) 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 described in Section II.

## VI. CERTIFICATION PROCESS

### Certification Period:

RI EOHHS certification periods include:

- A. **Initial certification:** One (1) year following the initial certification date, unless sooner suspended or revoked.
- B. **Recertification:** Two (2) years following the date of renewal, unless sooner suspended or revoked.

### Certification Process:

- A. The initial certification process applies to prospective entities that are not already certified to provide CFCM. The recertification process applies to entities with an active CFCM certificate.
- B. Applicants shall apply for initial certification using the Application for Certification.
- C. Applicants shall apply for recertification using the Application for Recertification published by EOHHS no sooner than ninety (90) days or later than forty-five (45) days prior to the expiration date of the provider's existing certification.
- D. The State will convene a CFCM Application Review Committee to evaluate applications. A periodic review process will be established by the State, depending on the submission of applications.
- E. Prior to technical review, submitted applications will be reviewed for completeness and for compliance with core expectations. Incomplete applications will be returned without further

review. A full application is required for resubmission following a determination of incompleteness.

- F. Initial certification will be effective on the date specified by RI EOHHS once RI EOHHS determines that the Agency is in compliance with these certification standards and other applicable laws and regulations.

#### Issuance and Transfer or Assignment of Certificate:

Upon receipt of a completed application for a certificate, RI EOHHS shall issue a certificate if the Agency meets the requirements of the standards included herein. A certificate issued hereunder shall be the property of the State and loaned to such certified Agency. Each certificate shall be issued only for the premises and persons named in the application and shall not be transferable or assignable except with the prior written approval of RI EOHHS.

#### Change of Ownership, Operation, or Location:

- A. When a change of ownership or operation or location of a certified Agency is planned or when discontinuation of services is contemplated, RI EOHHS shall be given written notice ninety (90) calendar days in advance of any proposed changes in location, name, or ownership or closure of the Agency.
- B. A certificate shall immediately become void and shall be returned to RI EOHHS when operation of an Agency is discontinued or when any changes in ownership occur.
- C. When there is a change in ownership or in the operation or control of an Agency, RI EOHHS reserves the right to extend the expiration date of such certificate, allowing the Agency to operate under the same certificate which applied to the prior certificate holder for such time as shall be required for the processing of a new application or reassignment of participants, not to exceed six (6) weeks.

#### Denial, Suspension or Revocation of Certificate or Curtailment of Activities:

RI EOHHS is authorized to deny, suspend or revoke the certificate or curtail activities of any Agency that receives State or federal funding and:

- A. Has failed to comply with EOHHS rules and regulations;
- B. Has failed to comply with the standards herein;
- C. Has offered or provided services to participants outside of the scope of its certificate;
- D. Has jeopardized the health and safety of any participant; or
- E. Has been excluded from the Medicaid Program by and State or Federal agency.