Title: Conflict-Free Case Management (CFCM) Strategic Plan – *Draft*

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1. EXECUTIVE SUMMARY

The Rhode Island Executive Office of Health and Human Services (RI EOHHS) is leading an interagency team to implement a statewide system for providing conflict-free case management (CFCM) and person-centered planning (PCP) for all Medicaid home and community-based services (HCBS) participants. RI EOHHS has three primary goals for CFCM and PCP:

WHY CFCM and PCP are needed:

1. The current service array of **case management and planning services is not financed or delivered in accordance with the CMS's HCBS Final Rule** (42 CFR 441.301); therefore, the State is at risk of losing federal dollars if it is does not come into compliance with federal CFCM requirements.
2. **Conflict of interest exists** for select providers including the State's Developmental Disability Organizations (DDOs) and some community providers.
3. The State's HCBS programs continue to function in **administrative silos** where different State agencies maintain separate business processes, instruments, and IT systems for performing case management and planning tasks.
4. The State uses **different reimbursement rates** and units of service (e.g., 15-minute increments v. monthly) for case management services.

WHAT is changing:

1. Population	2. Service Standards	3. Technology	4. Reimbursement
There are approximately 12,000 Medicaid HCBS participants that will receive CFCM. This includes Medicaid HCBS participants with I/DD, elders and adults with disabilities, and children enrolled in Katie Beckett.	RI EOHHS revised its case management service standards to align with best practice and CMS requirements.	All conflict-free case managers are required to use the State's LTSS consumer information management system (CIMS) to support CFCM activities.	RI EOHHS will use a single monthly rate to pay for CFCM statewide regardless of the population served. *RI EOHHS will share its anticipated monthly reimbursement rate with stakeholders once the RI EOHHS's budget is approved by the Governor's office.*

5. Contracting	6. Roles and Responsibilities
RI EOHHS anticipates contracting with one or more conflict-free case management agencies to provide CFCM through a competitive request for proposal (RFP). 1. Vendors will be required to have capacity to provide and manage CFCM services statewide or by region. 2. RI EOHHS anticipates that its CFCM RFP will include HCBS consumers with I/DD and elders and adults with disabilities (EAD); therefore, vendors will be expected to serve all HCBS consumers with I/DD and EAD in their assigned region or statewide. RI EOHHS is in the process of determining the appropriate delivery system for Katie Beckett eligible children. 3. Vendor(s) will have the flexibility to establish partnerships with other entities or organizations that will increase their capacity, expand their reach to priority populations or regions, and/or leverage the expertise of existing case management and/or care planning providers.	All of RI's existing case management providers may have a role in RI's Long-Term Services and Supports (LTSS) system; however, roles and responsibilities will be different under CFCM. Stakeholders that will experience the most significant impact include: 1. *Developmental Disability Organizations (DDOs)*: The State's DDOs provide direct services and case management. In the future state, the DDOs will not be allowed to develop person-centered plans and provide direct care services due to CMS conflict of interest regulations. 2. *Community Providers that Provide Medicaid HCBS Case Management Services*: Community providers that currently provide Medicaid HCBS case management services may apply to provide CFCM; however, the requirements and process will be different under the future state design.

WHEN CFCM and PCP will happen:

Contingent upon federal and RI legislative approval, **the State will begin to enroll Medicaid HCBS participants into CFCM starting January 2024.** Rhode Island's high-level CFCM implementation plan is shown in the figure below.

		2022	2023				2024
Category	Key Activities	Q4	Q1	Q2	Q3	Q4	Q1
Design	Collect stakeholder feedback and post an updated CFCM Strategic Plan						
	Issue an RFI to potential CFCM vendors						
Build	Implement an LTSS consumer information management system (CIMS)						
	Implement a pilot program to test CFCM tools and the State's LTSS CIMS						
	Issue an RFP for CFCM services						
	CFCM contracting and State provided training						
Execute	Begin CFCM transition for all Medicaid HCBS consumers (By Jan. 2025 all Medicaid HCBS consumers are receiving CFCM)						

STAKEHOLDER INPUT REQUESTED

RI's CFCM Strategic Plan is a DRAFT! The purpose of this document is to summarize Rhode Island's initial CFCM design and requirements and to obtain feedback from stakeholders. Stakeholder feedback will be essential to help ensure the State's approach is reasonable and best meets the needs of Rhode Islanders. Requested stakeholder feedback to the State's CFCM Strategic Plan include:

1. Are the State's CFCM goals clear?
2. Does the State's plan meet the needs of Rhode Island's Medicaid HCBS participants?
3. Is it clear how Rhode Island's LTSS system will be affected by this initiative?
4. What do you think of the proposed conflict-free case manager and agency requirements?
5. What challenges or risks should the State be aware of in implementing CFCM?
6. Are there missing components in the State's CFCM Strategic Plan that the State should consider?

To submit feedback, please email OHHS.LTSSNWD@ohhs.ri.gov by December 23, 2022. The State will review all stakeholder feedback and post an updated CFCM Strategic Plan by January 31, 2023.

All materials describing Rhode Island's CFCM strategy and implementation activities are posted on the RI EOHHS website: Conflict-Free Case Management | Executive Office of Health and Human Services (ri.gov).

2. KEY DEFINITIONS AND TERMS

Term	Definition
Activities of Daily Living (ADL)	Routine activities or tasks of everyday life related to personal care. There are six basic ADLs: eating, personal hygiene, dressing, toileting, ability to control bladder, and mobility and ambulation.
Applicant	An individual applying for Medicaid services.
Assessment	Process of learning about a person to determine their health or behavioral health status, functional capability, and need for services.
Caregiver	An individual, typically a family member or friend, who provides unpaid day-to-day assistance to someone who otherwise could not easily live on their own due to their needs.
Centers for Medicare and Medicaid Services (CMS)	The agency within the United States Department of Health and Human Services responsible for the administration and oversight of the Medicare and Medicaid programs.
Conflict-Free Case Management (CFCM)	CMS requirement which states that case management activities must be independent of service provision. An agency or organization (or their employees) cannot provide both direct service and case management activities to the same participant except in very specific circumstances set forth in regulation. 42 CFR 441.301(c)(1)(vi): *"Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan".*
Consumer Information Management System (CIMS)	An automated data management system that supports CFCM activities and maintains participant case records.
Critical Incident	An alleged, suspected, or actual occurrence of: 1. Abuse (including physical, sexual, verbal and psychological abuse); 2. Mistreatment or neglect; 3. Exploitation; 4. Serious injury; 5. Death other than by natural causes; 6. Other events that cause harm to a participant or indicate risk to a participant's health and welfare.
Department of Behavioral	The State agency established under the provisions of Rhode Island General Laws (R.I. Gen. Laws) Chapter 40.1-1 whose duty it is to serve as the State's

Term	Definition
Healthcare, Developmental Disabilities, and Hospitals (BHDDH)	mental health authority and establish and promulgate the overall plans, policies, objectives, and priorities for State programs for adults with intellectual and developmental disabilities as well mental illness and substance abuse education, prevention, and treatment.
Department of Human Services (DHS)	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.
Developmental Disability Organizations (DDOs)	An organization licensed by BHDDH to provide services to adults with disabilities.
Eligibility	A broad term that refers to financial and clinical criteria that an applicant must meet to receive a state or federally funded service.
Executive Office of Health and Human Services (EOHHS)	The entity within the executive branch of Rhode Island State government that is designated as the single state agency to administer the Medicaid program in Rhode Island. In this capacity, it is responsible for overseeing the administration of all Medicaid-funded LTSS in collaboration with the health and human services agencies under the office's jurisdiction.
Fiscal Intermediary	If a Medicaid HCBS participant chooses to self-direct their services and hire their own staff, they are required to use a fiscal intermediary. A fiscal intermediary is an organization that completes background checks of potential employees, assists with new hire paperwork, and ensures payment for services are rendered in accordance with federal and state rules. This service helps both the participant and the State to manage individual budgets and helps participants to manage the financial responsibilities of being an employer.
Home and Community-Based Services (HCBS)	Types of person-centered care delivered in home and community settings. A variety of health and human services can be provided. HCBS programs address the needs of people with functional limitations who need assistance to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs). HCBS are often designed to enable people to stay in their homes and the community, rather than moving to a facility for care.
HCBS Provider	Qualified professionals or entities that render paid services (e.g., assisted living, I/DD group home, services in a private residence, etc.) to Medicaid HCBS participants.
Human Rights Committee	Duly constituted group of people with developmental disabilities, advocates, volunteers, and professionals who have training or experience in the area of behavioral treatment, and other citizens who have been appointed to a provider's human rights committee for the purposes of: 1. Promoting human rights; 2. Reviewing, approving and monitoring individuals' plans designed to modify behavior which utilize restrictive interventions or impair the participant's

Term	Definition
	liberty, or other plans and procedures that involve risks to the person's protection and rights; and 3. Participating in the provider's participant grievance procedures.
Information and Referral (I&R)	The process of providing information to participants or family members who are seeking LTSS services. This may include providing a referral to agencies on the participant's behalf.
Informed Consent	Means the permission given by a person who has the legal capacity to give consent to or to authorize treatment. Such person: 1. Is able to exercise free power of choice without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other form of constraint or coercion; and 2. Has been given sufficient information about the risks and benefits of the proposed treatment or procedure and the elements involved to be able to make a knowledgeable and enlightened decision.
Instrumental Activities of Daily Living (IADLs)	Instrumental activities of daily living are activities related to independent living and include preparing meals, managing money, shopping, doing housework, and using a telephone. Unlike basic ADLs that relate to personal care, IADLs are more complex tasks that are necessary for truly independent living.
Long-Term Services and Supports (LTSS)	LTSS encompass the broad range of paid and unpaid medical and personal care services that assist with activities of daily living (such as eating, bathing, and dressing) and instrumental activities of daily living (such as preparing meals, managing medication, and housekeeping). They are provided to people who need such services because of aging, chronic illness, or disability, and include nursing facility care, adult daycare programs, home health aide services, personal care services, transportation, and supported employment. These services may be provided over a period of several weeks, months, or years, depending on a participant's health care coverage and level of need.[1]
MCO Care Manager	Some participants may be enrolled in a Medicaid managed care organization (MCO) to receive medical services in addition to HCBS. MCO care managers facilitate access to services, both clinical and non-clinical, by connecting the participant to resources that support their goals, preferences, and needs. The care manager in the MCO will have distinct and different responsibilities than the conflict-free case manager and those responsibilities will not be duplicated.
Medicaid LTSS Coverage	Medicaid is a state and federal health insurance program that assists families or participants in paying for LTSS and medical care. Medicaid LTSS coverage includes a broad spectrum of services for participants with clinical and functional impairments and/or chronic illness or diseases that require the level of care typically provided in a healthcare institution (e.g., hospital or nursing facility). In Rhode Island, Medicaid LTSS covers: 1. Skilled or custodial nursing facility/intermediate care facilities for participants with intellectual and developmental disabilities (ICF-IDD), community-based supportive alternatives, therapeutic, rehabilitative, and

Term	Definition
	habilitative services, and personal care as well as various home and community-based supports. 2. Primary care essential benefits for acute care services with Medicaid as the payer of last resort if a participant also has Medicare or commercial coverage for these services.
Office of Healthy Aging (OHA)	The State office that coordinates all State activities under the purview of the Older Americans Act and administers funding under Titles III and VII - 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	A person who has been found Medicaid eligible and receives Medicaid HCBS according to their person-centered plan.
Person-Centered Options Counseling (PCOC)	An interactive decision-support process whereby participants, with support from family members, caregivers, and/or others, are supported in their deliberations to make informed long-term services and support choices in the context of the participant's preferences, strengths, needs, values, and personal circumstance.
Person-Centered Planning (PCP)	A process for selecting and organizing the services and supports that an older adult or person with a disability may need to live in a home or community-based setting. Most important, it is a process that is directed by the participant who receives the support. This process is more of a conversation and includes a review of any needs assessments that have been completed as well a discussion of what is important to the participant.
Person-Centered Plan	The person-centered plan is a written document that articulates a participant's care needs, wants, and services and supports (paid and unpaid) that will assist a participant to achieve their goals.
Person-Centered Thinking	Person-centered thinking is an approach to interacting with people in ways that helps identify what's important to and for them. It includes practical strategies for gathering meaningful information about a person and facilitating conversations about goal setting, problem solving, and action planning. This approach helps people feel respected and helps ensure the focus remains on the perspective of the person.
Restraint	Restricting 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

Term	Definition
	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	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; 4. Requires an individual to engage in a behavior that the individual would not engage in given freedom of choice. Prohibited Restrictive intervention: 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 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. 3. Utilization of behavioral interventions for any reason except for emergency protocol.
Self-Direction	Self-direction 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	Service authorization is documented written approval by the State for a service. The service authorization process is employed to control the use of covered items or services. 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.
Support Broker	If a Medicaid HCBS chooses to self-direct all or some of their services, they can request services of a support broker. Support brokers help participants develop the skills necessary to self-direct and facilitate the administrative tasks that accompany self-direction. Support broker activities include: 1. Brokering community resources 2. Information and assistance and problem solving 3. Developing and managing budget 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

Term	Definition
	5. Providing information on recruiting, hiring, and managing employees 6. Work/collaborate with the State's fiscal intermediaries

3. INTRODUCTION

3.1 Federal Requirements

In March 2014, the Centers for Medicare and Medicaid Services (CMS) implemented a Final Rule requiring states to separate case management from service delivery functions to reduce conflict of interest for services provided under home and community-based services (HCBS) waivers.[2] This rule addresses conflicts of interest that may arise when one entity is responsible for both performing case management functions and providing direct services. As a result of these federal regulations, Rhode Island's existing system for its long-term services and supports (LTSS) programs, including HCBS programs serving participants with intellectual and developmental disabilities (I/DD) and participants served through Medicaid's Elders and Adults with Disabilities (EAD) program, are not in compliance.

Key Highlights from CMS's HCBS Final Rule

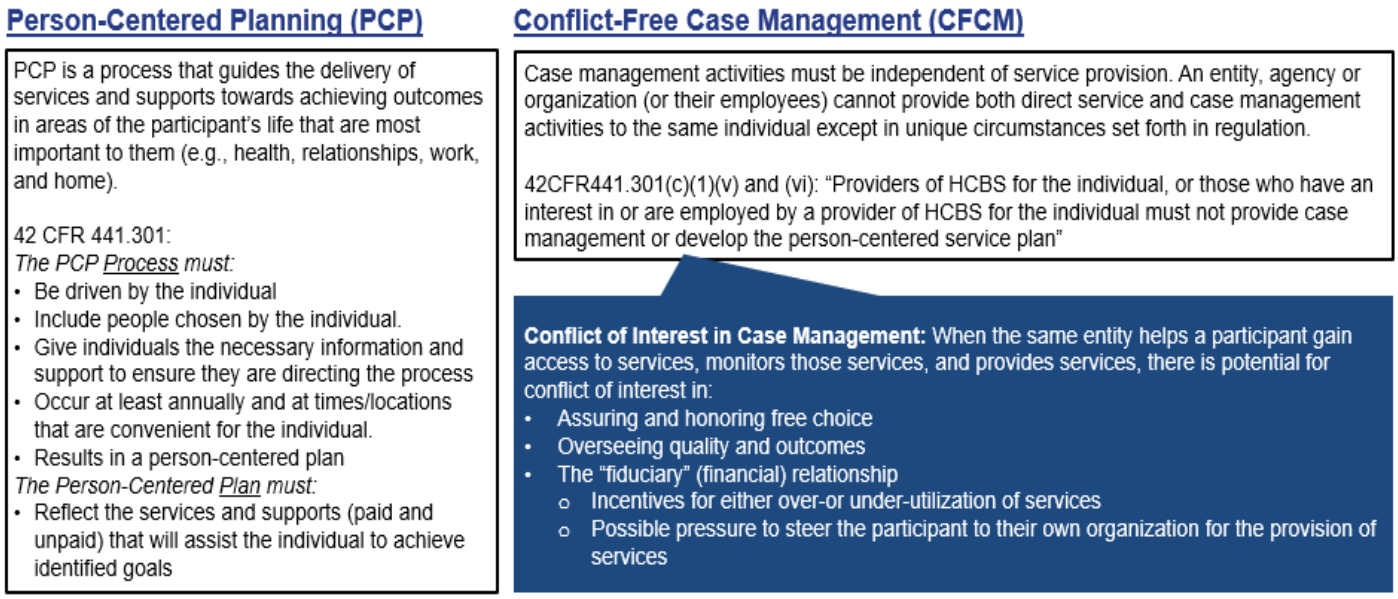
1. Outlines person-centered planning requirements for participants in HCBS settings.
2. Requires that case management be provided without undue conflict of interest.
3. Defines what it means to live in a home and community setting.
4. Ensures that people receive services in the most integrated setting of their choice

Federal regulations also require a written person-centered plan for Medicaid HCBS. The use of Federal funds is not approved for Medicaid HCBS that are provided without a person-centered plan.[3]

All states are expected to provide CFCM and PCP in accordance with CMS's HCBS Final Rule. To retain federal matching funds, Rhode Island is required to have a roadmap for implementing all facets of the HCBS Final Rule by no later than March 17, 2023. Based on the State's HCBS expenditures for SFY 2021, there are approximately $300,000,000 in Medicaid federal matching funds at risk if the State fails to comply with the person-centered and conflict-free provisions of the HCBS Final Rule.

An overview of CMS' federal requirements for CFCM and PCP are shown in **Figure 1** below. Rhode Island's CFCM Strategic Plan adheres to these requirements.

Figure 1. Defining PCP and CFCM



CFCM is both a set of principles about the proper separation and ordering of public and private interests in the organization, finance, and delivery of HCBS and a group of four inter-related tasks – discovery, person-centered plan development, arranging for services and supports, and monitoring - that are designed to translate those principles into everyday practice. Although the State's LTSS agencies (BHDDH, DHS, EOHHS, and OHA) and their contractual partners currently perform some version of these tasks, they are generally not provided in the scope, amount, duration, or manner required by CMS. Accordingly, this initiative differentiates between these existing services and the conflict-free and person-centered practices mandated by the HCBS Final Rule by referring to the latter inclusively as "CFCM".

3.2 Center for Medicare and Medicaid Services (CMS) Assurance Requirements

CMS requires Rhode Island to make assurances and agree to HCBS program standards within its 1115 waiver. The assurances and standards summarized in **Figure 2** provide the foundation for the way the State will operate its HCBS programs and case management services. RI EOHHS is currently designing and implementing a comprehensive HCBS Quality Improvement Strategy (QIS) that includes performance measures tied to CMS's assurance requirements and that creates a foundation for collecting and analyzing individual and system-level information. The state is also formalizing an HCBS Interagency Quality Team that will be responsible for all HCBS improvement activities.

Figure 2. CMS Assurance Requirements[4]

CMS Assurance	Requirement
Administrative Authority	RI EOHHS, as the single state Medicaid agency in Rhode Island, must demonstrate that it retains ultimate administrative authority and responsibility for the operation of the State's Medicaid HCBS program and provides administration of its Medicaid HCBS program consistent with its approved federal 1115 waiver application, including oversight of the performance of functions by other state, regional, local, and contracted entities.

CMS Assurance	Requirement
Level of Care	RI EOHHS must demonstrate that it implements processes and instrument(s) for evaluating and reevaluating a participant's level of care consistent with the care provided in a hospital, nursing facility, or intermediate care facility for people with intellectual or developmental disabilities (ICF-IDD).
Qualified Providers	RI EOHHS must demonstrate that services are provided by qualified providers who meet required licensure and/or certification standards and adhere to other specified standards prior to providing services.
Service Planning	RI EOHHS must demonstrate that: 1. A participant's goals, needs, and preferences are assessed and reflected in their person-centered plan. 2. Person-centered plans are updated annually and when needed. 3. Services are delivered according to the person-centered plan. 4. Participants are provided with a choice among services and providers.
Health and Welfare	RI EOHHS must demonstrate that it identifies, addresses, and seeks to prevent instances of abuse, neglect, and exploitation.
Financial Accountability	RI EOHHS must demonstrate that: 1. Claims are coded and paid for in accordance with the reimbursement methodology identified by the State and only for services rendered. 2. Rates remain consistent with an approved rate methodology.

Conflict-free case management agencies and case managers play a critical role in helping the State meet the requirements of each assurance. Data related to each assurance will be collected by the State and reported to CMS annually. CMS uses this data to determine whether the state complies with federal requirements and whether it continues to qualify for federal funding. RI EOHHS will also use this data, as well as other information that it will collect, to monitor the outcomes from this initiative and to drive continuous quality improvement.

4. BACKGROUND

4.1 Methodology

The Rhode Island Executive Office of Health and Human Services (RI EOHHS) is leading an interagency team to design and implement a statewide system for providing person-centered planning (PCP) and conflict-free case management (CFCM) for Medicaid participants opting to receive long-term services and supports (LTSS) in a home or community-based setting. The LTSS Interagency Redesign Team is an interagency work group that is comprised of EOHHS (the designated State Medicaid authority), the RI Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH), the RI Department of Human Services (DHS), and the RI Office of Healthy Aging (OHA).

The implementation of CFCM is a component of a broader effort to redesign Rhode Island's LTSS system to make it more person-centered, quality driven, and resilient. The development and design of this initiative is funded by a CMS Money Follows the Person (MFP) capacity building grant.

In late 2021, the LTSS Interagency Redesign Team partnered with New Editions Consulting, Inc. and Guidehouse to design and support implementation of CFCM. New Editions comprises of HCBS specialists and provides technical assistance through CMS. Guidehouse provides project management and implementation support.

Rhode Island designed its CFCM Strategic Plan using a multi-step approach. The State's Strategic Plan was developed with guidance from:

- ✓ CMS federal requirements
- ✓ Key stakeholders
- ✓ Other state approaches, design models, and materials. This includes Alaska[5], Colorado[6], Florida[7], Maine[8], Minnesota[9], North Carolina[10], Ohio[11], South Dakota[12], Utah[13], Vermont[14], and Wyoming[15].
- ✓ Feedback from subject matter experts from Centers for Medicare & Medicaid Services (CMS) sponsored, HCBS-Technical Assistance center and Guidehouse

4.2 Rhode Island's Current Delivery of Case Management and Planning

The LTSS Interagency Redesign Team conducted an environmental scan that examined the types of case management and care planning activities currently available to Rhode Island's HCBS participants. High-level findings are presented below:

1. The current service array of **case management and planning services is not financed or delivered in accordance with the CMS's HCBS Final Rule** (42 CFR 441.301); therefore, the State is at risk of losing federal dollars if it is does not come into compliance with federal CFCM requirements.
2. **Conflict of interest exists** for select HCBS providers including the State's Developmental Disability Organizations (DDOs) and some community providers.
3. The State's HCBS programs continue to function in **administrative silos** where different State agencies maintain separate business processes, instruments, and IT systems for performing case management and planning tasks.
4. The State uses **different reimbursement rates** and units of service (e.g., 15-minute increments v. monthly) for case management services.

Figure 3 provides a comparison of Rhode Island's current delivery of case management services to the requirements outlined in CMS's HCBS Final Rule. There are approximately 12,000 Medicaid HCBS participants in Rhode Island covered by CMS's HCBS Final Rule. Approximately 67% of Rhode Island's Medicaid HCBS participants, that fall under CMS's HCBS Final Rule, receive case management that is not conflict-free.

Figure 3. Current Service Delivery

Population	Service / Program	# of Participants	Case Management Provider	Current State Comparison to CMS's HCBS Final Rule				
				Conflict -Free	Discovery	Plan Development	Service Arrangement	Monitoring
Elders and Adults with Disabilities (EAD)	• Home care (OHA community) • Assisted living	2,370	EOHHS and OHA contracted community providers.	No	No	Limited OHA agencies only	Limited OHA agencies only	Limited OHA agencies only
	• Self directed services (independent provider and personal choice) • Shared living	1,279	• Service advisement (SA) agencies • Shared living agencies	No	No	Limited by SAs	NA	Yes
	Home care (DHS community)	3,034	DHS Social Caseworkers	NA	No	No	Limited	No
	Habilitative services/traumatic brain injury (TBI)	42	EOHHS Office of Community Programs staff	Yes	No	Limited	Limited	Yes
	Katie Beckett eligible children	913	DHS clinical eligibility team *(Offered upon request only)*	NA	No	Limited	No	No
Intellectual / Developmental Disability (I/DD)	Group homes, self-directed, and other home and community-based services	4,330	• DDOs • Other DD providers • BHDDH Social Caseworker II	No	No	No	Limited	No
	Total	**11,968**						

4.3 Stakeholder Impact

The LTSS Interagency Redesign Team assessed the impact of CFCM to its existing stakeholders. **Figure 4** summarizes the level of impact this initiative will have on existing stakeholders.

Figure 4. Stakeholder Impact

Stakeholder	Impact Level	Impact Description
Developmental Disability Organizations (DDOs)	High	The State's DDOs provide direct services and case management. In the future state, the DDOs will not be allowed to develop person-centered plans and provide direct care services due to CMS conflict of interest regulations.
Community Providers that Provide Medicaid HCBS Case Management Services	High	Community providers that currently provide Medicaid HCBS case management services may apply to provide CFCM; however, the requirements and process will be different under the future state design.
BHDDH Plan Writers	High	There will be no independent plan writers if they are not part of a CFCM agency. Person-centered planning will be part of CFCM.
State Agency Staff	Medium	• State Agency staff will no longer provide any of the components of CFCM; however, State agency staff will provide oversight of CFCM services. • State Agency staff will continue to provide supports and guidance to youth in transition.

Stakeholder	Impact Level	Impact Description
Medicaid HCBS Participants	Medium	• 12,000 Medicaid HCBS participants will receive CFCM; therefore, this service may be new to some existing HCBS participants. • Medicaid HCBS participants currently receiving case management services may have a new conflict-free case manager.
HCBS Providers	Medium	HCBS providers will be required to coordinate with the conflict-free case managers and participate in the person-centered planning process (as requested).
Medicaid Managed Care Organizations (Non-LTSS)	Low	The responsibilities of the care manager in the MCO will have distinct and different responsibilities than the CF case manager and those responsibilities will not be duplicated.
RI's Medicare-Medicaid Plan (MMP) for LTSS and Program of All-Inclusive Care for the Elderly (PACE)	Low	RI's MMP for LTSS and PACE will continue to provide both comprehensive care management services to eligible MMP and PACE participants.
Ancillary Service Providers (e.g., Meals on Wheels, other community resource options)	Low	Ancillary service providers will be required to coordinate with the conflict-free case managers and not State agency staff.
Nursing Home Transition Program (NHTP) including Money Follows the Person (MFP)	Low	NHTP will continue to support participant transitions; however, data for these programs will be captured in the State's LTSS consumer information management system (CIMS).
BHDDH Health Homes for Behavioral Health	Low	Conversations are underway to determine the scope of CFCM responsibilities for Health Home participants.

5. ROADMAP FOR CFCM

5.1 Vision

Below is a vision statement, guiding principles, and goals and objectives for implementing CFCM in Rhode Island.

VISION STATEMENT

All Medicaid long-term services and supports (LTSS) participants have equal opportunity and the supports necessary to express their own goals and preferences, to learn about the array of service options available to them from a reliable and neutral source, and to make informed choices that assure they are empowered to retain control over the aspects of their daily lives that are important to them.

GUIDING PRINCIPLES

The following guiding principles were developed with input from the State's Developmental Disability (DD) Quality Advisory Committee and other key stakeholders and are intended to represent the role of person-centeredness in HCBS.

1. The focus is on what is important to the participant. All involved must recognize that people have different perspectives, hopes, needs, desires, fears, and vulnerabilities. The cultural beliefs, values, and needs of the participant will inform and guide connections to services, supports, and resources.
2. Service plans are person-centered, self-determined, and reflect and support what a participant wants to accomplish to realize goals related to health, safety, employment, spirituality, involvement in the community, and succeeding in choice of living arrangement. Natural supports and community inclusion are a priority.
3. Assessment and ongoing case management services are provided separate from the delivery of services, to limit any conscious or unconscious bias a CF case manager may have with the potential to erode a participant's choice, independence, and confidence in the integrity of the system.

GOALS AND OBJECTIVES

Goal #1: Improve Medicaid HCBS Participant Access to Services, Choice, and Control

1.1 Support Medicaid HCBS participants to:
- Increase self-determination by expressing preferences and choices
- Transition to or remain in the setting of their choice
- Live safely
- Receive culturally competent services and supports
- Develop and maintain relationships with peers if they choose to do so
- Integrate into the community to the extent that they choose

Goal #2: Create an Infrastructure to Deliver High Quality CFCM

2.1 Improve health equity by providing a standard set of services across all Medicaid HCBS participants
2.2 Incorporate the community's voice
2.3 Use a single, uniform rate to pay for case management services
2.4 Use standards and IT solutions to streamline services, access, foster quality, and promote person-centered goals and outcomes
2.5 Improve the capacity of the State to measure service quality and outcomes

Goal #3: Deliver CFCM in Accordance with Federal and State Requirements

3.1 Meet requirements outlined in CMS's HCBS Final Rule (42 CFR 441.301)
3.2 Meet applicable State regulations
3.3 Comply with CMS's HCBS quality assurance requirements

5.2 Implementation Timeline

Figure 5 provides a high-level summary of the State's implementation of CFCM.

There are six key milestones to highlight for stakeholders:

1. **January 2023**: The State will review all stakeholder feedback and post an updated CFCM Strategic Plan.

2. **March 2023**: RI EOHHS will release a request for information (RFI) to identify interested CFCM bidders and to solicit feedback from stakeholders regarding the State's proposed procurement strategy.
3. **July 2023**: Rhode Island's LTSS Consumer Information Management System (CIMS) will be available to support CFCM activities. All CF case managers will be expected to use the State's LTSS CIMS.
4. **July 2023**: RI EOHHS will conduct a pilot program to test CFCM tools and the State's LTSS CIMS. The pilot program will include several small HCBS programs currently receiving limited case management services. While RI EOHHS has not determined which of its programs will participate in its pilot program, the State's pilot program may include:
    a. Elders and Adults with Disabilities (EAD) Self-Directed Programs – Offered by Service Advisory Agencies.
    b. Nursing Home Transition Program (NHTP) including MFP - Offered by EOHHS Office of Community Programs staff.
    c. Habilitative Services/Traumatic brain injury (TBI) Program - Offered by EOHHS Office of Community Programs staff.
5. **July 2023**: RI EOHHS issues a request for proposal (RFP) for one or more vendors to provide CFCM statewide.
6. **January 1, 2024**: The State begins to enroll Medicaid HCBS participants into CFCM according to its participant transition plan. By January 1, 2025, all Medicaid HCBS participants have access to high quality CFCM from a CF case manager that has met the minimum standards established by the State.

Figure 5. Draft CFCM Implementation Timeline

			2022	2023												2024
#	Category	Activity	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
1	Design	**Collect stakeholder feedback and post an updated CFCM Strategic Plan**		★												
2		Governor submits proposed FY2024 budget														
3		General Assembly passes final FY2024 budget														
4		**Issue an RFI to potential CFCM vendors**				★										
5		Post a draft Consumer Transition Plan for public comment														
6	Build	Update existing State specific materials (e.g., provider manuals, rules and regulations)														
7		**Implement an LTSS consumer information management system (CIMS)**								★						
8		**Implement a pilot program to test CFCM tools and the State's LTSS CIMS**								★						
9		Develop additional CFCM materials to support service delivery (e.g., certification manual, instructional guide, etc.)														
10		Initiate rule making process (includes public comment process)														
11		Obtain Federal approval for CFCM changes (SPA and 1115 waiver)														
12		CMS review and approval of the State's Consumer Transition Plan														
13		**RI EOHHS issues an RFP for 1 or more vendors to provide CFCM statewide *(Requires approval from State purchasing)***								★						
14		Conflict-free case management contracting														
15		Conflict-free case manager training														
16		Communication to consumers regarding conflict-free case manager transitions														
17	Execute	**Medicaid HCBS consumers *(By Jan. 2025 all Medicaid HCBS consumers are receiving CFCM)***														★

★ = Milestone

6. CFCM DELIVERY MODEL

6.1 Contracting and Delivery Model

RI EOHHS anticipates contracting with one or more conflict-free case management agencies to provide CFCM through a competitive request for proposal (RFP). Vendors will be required to have capacity to provide and manage CFCM services statewide or by region. Although the vendor(s) selected will be required meet the minimum operational and performance standards established by the State, **vendor(s) will have the flexibility to establish partnerships with other entities or organizations that will increase their capacity, expand their reach to priority populations or regions, and/or leverage the expertise of existing case management and/or care planning providers.**

RI EOHHS anticipates that its CFCM RFP will include HCBS participants with I/DD and elders and adults with disabilities; therefore, vendors will be expected to serve all HCBS participants with I/DD and elders and adults with disabilities in their assigned region or statewide. RI EOHHS is in the process of determining the appropriate delivery system for Katie Beckett eligible children.

All of RI's existing case management providers may have a role in RI's LTSS system; however, roles and responsibilities will be different under CFCM. Community providers that currently provide Medicaid HCBS case management services may apply to provide CFCM; however, the requirements and process will be different under the future state design.

RI EOHHS will release a request for information (RFI) in March 2023 to identify interested CFCM bidders and to solicit additional feedback from stakeholders regarding the State's proposed procurement strategy.

6.2 Impact on Participants

6.2.1 Eligibility Requirements

Case management is a mandatory service for all Medicaid HCBS participants that receive services or are eligible to receive services through an agency/provider or through self-direction.

The eligibility criteria for participants receiving Medicaid HCBS are summarized in **Figure 6** below.

Figure 6. HCBS/CFCM Eligibility Criteria

Category	Description
Target Group	Medicaid LTSS participants who are receiving or are eligible to receive home and community-based services.
Facility / Institutional Level of Care	The person must meet the level of care requirements of a nursing home, intermediate care facilities for individuals with intellectual disabilities (ICF/IID), or long-term care hospital
Living Arrangement	At home, in the home of another, or community-based residence (e.g., assisted living, group homes, etc.)

6.2.2 HCBS Programs and Populations Affected

The conflict free provisions of CFCM apply to all Medicaid HCBS eligible participants that are not enrolled in a whole life health home or LTSS managed care plans. Excluding participants in these plans, there are **approximately 12,000 Medicaid HCBS participants that will be directly affected by the implementation of CFCM.** Note, however, the State must ensure that Medicaid HCBS participants enrolled in whole life health homes and LTSS managed care plans have access to the same level of person-centered planning and comprehensive case management mandated in the final rule, including

those participants in PACE, the Medicare-Medicaid managed care duals demonstration and any successor LTSS managed care plans, and BHDDH health homes and centers of excellence. Over the next year, RI EOHHS will work with the entities serving these Medicaid HCBS participants to determine the best approach for ensuring equitable access to person-centered planning and comprehensive case management going forward.

In addition, participants receiving HCBS through the NHTP will continue to receive case management in accordance with federal requirements until such time as they are appropriately transitioned to the CFCM network. As the Office of Healthy Aging's (OHA) At Home Cost Share program is exempt from the HCBS final rule, the current process for providing case management to these participants will not change with the implementation of CFCM.

Figure 7 provides a high-level summary of the approximate number of unique participants who will receive CFCM by program.

Figure 7. Estimated Number of Participants That Will Receive CFCM

Population	Service / Program	Approx. # of Participants	% of Total
Elders and Adults with Disabilities (EAD)	Home Care	4,407	36.8%
	Assisted Living	997	8.3%
	Katie Beckett Eligible Children *(The appropriate delivery system for this population is TBD)*	913	7.6%
	Self-Directed Services (Personal Choice Program)	770	6.4%
	Shared Living	409	3.4%
	Self-Directed Services (Independent Provider Program)	100	0.8%
	Habilitative Services/Traumatic Brain Injury (TBI)	42	0.4%
Intellectual / Developmental Disability (I/DD)	Group homes, self-directed, and other home and community-based services	4,330	36.2%
	Total	**11,968**	

6.2.3 Communication to Participants

RI is committed to providing new applicants and existing Medicaid HCBS participants with easy to understand and accessible information about the transition to CFCM. RI EOHHS will create a comprehensive and ongoing communication strategy that includes messaging and outreach in a variety of mediums as well as face-to-face encounters, whenever feasible, during one or more of the phases of the eligibility process. The State will also work closely with both incoming and outgoing case managers to minimize potential service disruption. Stakeholder input is especially important in informing the development of and plans for executing the State's communication strategy. **The State's communication strategy and timing of outreach efforts will be described in more detail in the State's Participant Transition Plan (to be released by April 2023).**

6.2.4 Participant Choice

RI EOHHS is committed to ensuring that all Medicaid HCBS participants will have a choice of conflict-free case management agencies. During the application and assessment process, participants will be informed about the CFCM process and their choice options. If a participant is unable to or unwilling to choose a conflict-free case management agency, the State plans to implement an auto-assignment process that will ensure there is sufficient capacity statewide.

Participants may choose to move to a different conflict-free case management agency (if available where the participant resides) pursuant to criteria to be established by RI EOHHS, and there also may be an open enrollment period during which participants may choose to move to a different conflict-free case management agency. Conflict-free case management agencies may not refuse any assigned or reassigned participant.

6.3 Roles and Responsibilities

All stakeholders that are involved in HCBS service delivery will work collaboratively to ensure that participants are receiving conflict-free services. Each stakeholder in the service continuum will have key roles and responsibilities as part of the CFCM process. **Figure 8** provides a summary of stakeholder roles and responsibilities.

Figure 8. Key Roles and Responsibilities

Role	Description
Medicaid HCBS Participant	1. Choose who they would like to participate in the planning process and who is invited to the meeting 2. Participate in the support planning meeting in a way that they choose 3. Communicate their desires, hopes, and dreams for their future, including what is working now in their life, what is not working, and what they would like to see different; this can happen anytime during the year 4. Sign the person-centered plan to indicate that the participant participated in the person-centered planning meeting 5. Request changes and approve changes or revisions to the person-centered plan throughout the year as desired or needed 6. Communicate any concerns or feedback with the CF case manager throughout the year; if disagreements are not resolved, they may request that they are noted on the person-centered plan before signing it
Family and Friends *(as approved by the participant)*	1. Provide information based on their intimate knowledge of the participant 2. Identify strengths and positive attributes; help to identify and address known risks 3. Assist the participant to plan for their future and provide support (if requested) 4. Share with the CF case manager any concerns, disagreements, or feedback during the planning process and throughout the year 5. Be a natural support system for the participant and give meaning to their life
Legal Representative *(e.g., guardian,*	1. Contribute to the person-centered information based on their own intimate knowledge of the participant

Role	Description
trustee, POA, etc.)	2. Help to identify and address known risks, health, or safety concerns 3. Assist the participant to plan for their future and provide support 4. Review and approve the person-centered plan and other documents by signing the person-centered plan 5. Share any concerns or disagreements during the planning process with the CF case manager 6. Review and approve changes to the person-centered plan throughout the year if needed 7. Share any concerns or feedback with the CF case manager throughout the year
State Agency Staff	1. Provide application assistance 2. Assisting youth in transition 3. Complete functional need assessment(s) 4. Complete the initial LTSS level of care (LOC) determination and redeterminations (DD: every 5 years; EAD: every 3 years) 5. Determine eligibility and eligibility renewals 6. Manage critical need cases related to eligibility 7. Coordinate and communicate with CFCM vendor(s) 8. Support consumer choice and make referrals to CFCM vendor(s) 9. Review person-centered plans 10. Process service authorizations 11. Facilitate residential placement needs 12. Monitor overall service quality and performance 13. Oversee the State's critical incident management system
MyOptionsRI or The POINT	1. Offer person-centered options counseling (PCOC) to help people assess and understand their long-term services and support needs, goals, and preferences.
Conflict-Free (CF) Case Manager	1. Engage in an ongoing conversation with the participant regarding what they want for their future and assist them in making changes to the support plan as necessary, documenting in the support plan when changes occur 2. Facilitate and complete the development of the person-centered plan 3. Conduct a person-centered planning process that considers all supports that can be available to the participant, whether Medicaid funded, funded by other sources, or funded by natural supports like volunteers 4. Ensure that the plan meets the participant's current service needs and complies with requirements for the chosen service setting(s) and associated funding 5. Sign the person-centered plan

Role	Description
	6. Provide to the participant or their legal representative, via secure e-mail, U.S. mail, or hand-delivered, a copy of the person-centered plan. 7. Ensure all HCBS providers receive a copy of the approved person-centered plan 8. Monitor service provision, progress on goals, and the participant's satisfaction with their services and HCBS providers 9. Address and resolve issues by meeting with the participant and HCBS providers 10. Assist the participant in communicating with HCBS providers to help the participant achieve their desired goals and outcomes 11. Comply with the State's critical incident reporting requirements 12. Re-evaluate participant's goals, needs, and preferences at least annually or as needed 13. Assist with obtaining documents and facilitating submission of materials to support the State's annual eligibility renewals
HCBS Providers	1. Gather information and shares it with the CF case manager prior to the person-centered planning meeting 2. Help identify serious risks by providing medical or other historical information 3. Participate in person-centered planning meetings at the request of the participant 4. Recommend revisions to the draft person-centered plan to the CF case manager prior to implementation 5. Upon person-centered plan approval, develop specific strategies to deliver service and supports as outlined in the person-centered plan. This may include the HCBS provider completing their own assessment. 6. Provide direct services and supports as defined in the person-centered plan 7. Communicate with the CF case manager if the participant's desired outcomes or support needs must be readdressed or updated 8. Comply with the State's critical incident reporting requirements
Fiscal Intermediary *(Offered under self-direction)*	1. Helps both the participant and the State to manage individual budgets and helps participants to manage the financial responsibilities of being an employer 2. Completes background checks of potential employees 3. Assists with new hire paperwork 4. Ensures payment for services are rendered in accordance with federal and state rules
Support Broker *(Offered under self-direction)*	1. Help participants develop the skills necessary to self-direct and facilitate the administrative tasks that accompany self-direction. 2. Broker community resources 3. Provide information and assistance and problem solving 4. Develop and manage the participant's budget

Role	Description
	5. Training the participant on how to train their hired staff to work with the participant and do the job they were hired to do 6. Providing information on recruiting, hiring, and managing employees 7. Work/collaborate with the State's fiscal intermediaries
Ancillary Service Providers *(e.g., Meals on Wheels, other community resource options)*	1. Provide services and supports as defined in the person-centered plan 2. Communicate with the CF case manager if the participant's desired outcomes or support needs must be readdressed or updated 3. Comply with the State's critical incident reporting requirements
Other Entities *(If applicable)*	1. *Medicaid Managed Care Organizations (Non-LTSS)*: Provide clinical care management and coordinate to the extent appropriate with the conflict-free case manager. 2. *RI's Medicare-Medicaid Plan (MMP) for LTSS and Program of All-Inclusive Care for the Elderly (PACE)*: Continue to provide both comprehensive care management services to eligible MMP and PACE participants. 3. *Nursing Home Transition Program (NHTP) including Money Follows the Person (MFP)*: Continue to support participant transitions; however, data for these programs will be captured in the State's LTSS consumer information management system (CIMS). 4. *BHDDH Health Homes for Behavioral Health*: TBD - Conversations are underway to determine the scope of CFCM responsibilities for Health Home participants.

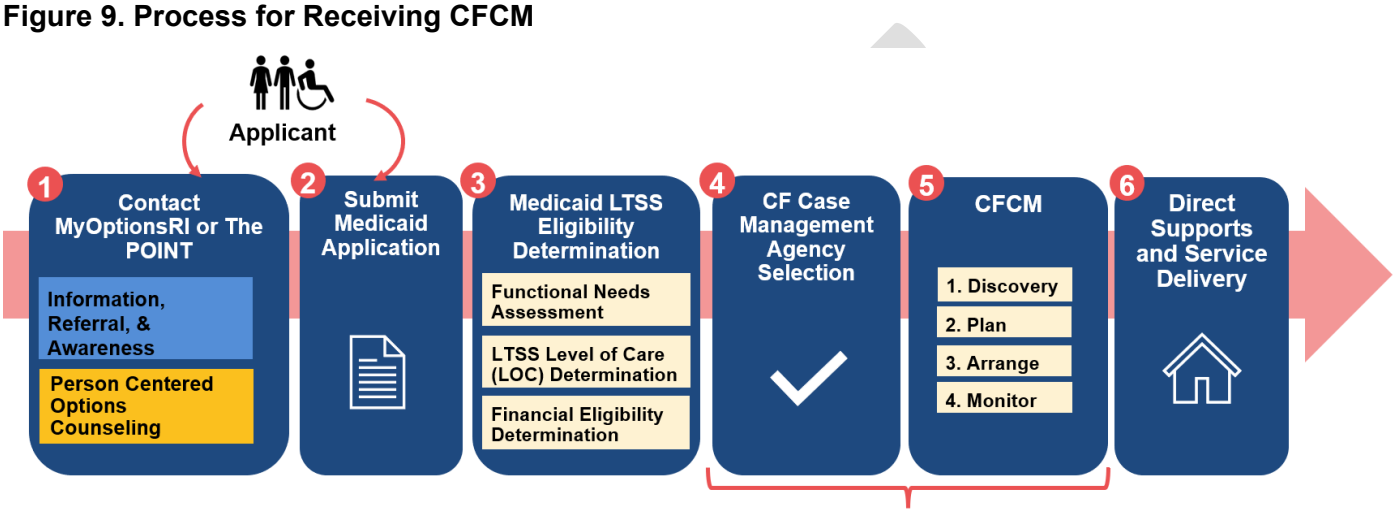
6.4 Process for Receiving CFCM

The information below includes a summary of the general process for receiving Medicaid HCBS case management and direct services. If the participant is not currently receiving Medicaid HCBS, they will start by contacting MyOptionsRI or The Point or by filling out a Medicaid application to apply for HCBS. If the participant is already enrolled in Medicaid HCBS, the State will work with the participant to select a conflict-free case management agency.

1. **Information, Referral, Awareness, & Person-Centered Options Counseling**: This process starts with an applicant contacting MyOptionsRI or The Point. Both entities provide RI participants with important information regarding LTSS options within the State, both private and public. A RI participant can also skip this step if they already know their LTSS options.
    a. The State offers person-centered option counseling (PCOC) which is an interactive decision-support process that helps people assess and understand their long-term services and support needs, goals, and preferences. In Rhode Island, a participant can connect with a MyOptions Advisor (this is someone that delivers PCOC) to learn about their LTSS options and to help identify what is important to the participant and how they can meet their goals. Additional information regarding RI's PCOC program is available at MyOptions.RI.gov.
2. **Submit Medicaid Application**: If Medicaid LTSS is the best option for the applicant based on their goals, they can apply through DHS via online, mail, or in-person.

3. **Medicaid LTSS Eligibility Determination**: The State determines Medicaid LTSS eligibility based on financial and clinical eligibility criteria.
4. **CF Case Management Agency Selection:** If the participant is eligible for Medicaid HCBS, the participant selects or is auto-assigned a conflict-free case management agency.
5. **CFCM**: The conflict-free case manager provides CFCM according to the standards outlined in this document.
6. **Direct Supports and Service Delivery**: The participant receives services according to their person-centered plan by a HCBS provider.

Figure 9. Process for Receiving CFCM



1. CFCM happens after an applicant is determined eligible for Medicaid HCBS!
2. This visual represents the process for receiving CFCM. There is a separate case management process for participants enrolled in PACE, the Medicare-Medicaid managed care duals demonstration, NHTP, BHDDH Health Homes for Behavioral Health, or OHA's At Home Cost Share program.

6.5 LTSS Consumer Information Management System (CIMS)

The LTSS Interagency Redesign Team's goal is to create a fully coordinated LTSS consumer information management system (CIMS) that is integrated and seamless from the participant's point of view. All CF case managers will be expected to use the State's electronic LTSS CIMS. The State selected WellSky as its LTSS CIMS to support CFCM activities for older adults and people with disabilities and participants with intellectual and developmental disabilities.

Once the State's LTSS CIMS is operational, the State will provide a detailed manual that describes how the system should be used and how it relates to the entire CFCM process.

7. CFCM CORE COMPONENTS & SERVICES

All Medicaid HCBS participants in Rhode Island will be eligible for CFCM. CFCM facilitates the development of a person-centered plan and coordinates the implementation of the person-centered plan. To be effective in this work, the CF case manager's role is to provide education and information to support participants in the person-centered plan development process. CF case managers accomplish this in a multitude of ways, however, at minimum CF case managers:

1. Ensure participants are afforded the authority to determine who is included and/or excluded from the person-centered plan development process

2. Provide and explain materials regarding LTSS
3. Ensure the participant's communication needs are met by providing or procuring communication supports, including but not limited to preferred language interpreters or assistive communication technology
4. Consider the participant's cultural beliefs and values in planning process and matching to community opportunities and referrals
5. Use practices that support the development of respectful relationships with the participant and their supports
6. Support participants to lead the process to the maximum extent possible

CFCM consists of deliberate activities to organize and facilitate the appropriate delivery of HCBS and can be broken into four key components:

1. Discovery and information gathering
2. Person-centered plan development
3. Arranging for services & supports
4. Monitoring, reassessment & follow-up

7.1 Discovery and Information Gathering

To develop a person-centered plan that meets the participant's needs, CF case managers must conduct a comprehensive assessment of the participant. This assessment helps the CF case manager and the participant identify any medical, educational, social, or other service needs that should be addressed in the person-centered plan.

When conducting the discovery process, CF case managers should at minimum complete the following activities:

1. Take the participant's history to identify the needs of the participant by gathering information directly from the participant and other sources, such as family members, HCBS providers, medical providers, social workers, and educators
2. Gather and review previous assessments and all other existing information for the participant, such as reassessments or diagnostic materials
3. Together with the participant, capture the participant's history, including cultural and spiritual beliefs and practices
4. Together with the participant, gather information and complete informal assessments of participant's abilities, needs, wants, natural supports, goals, and family system
5. Identify risks and develop applicable risk mitigation strategies
6. Conduct a survey of formal and informal community opportunities and supports that are available to the participant, and that the participant wants to leverage
7. Look at the nexus between the participant's wants and needs. Assist the participant to identify: What is important to me? How to support me? Are there things others admire about me?
8. Utilize strategies for solving conflicts or disagreements within the process
9. Build a Personal Profile to document the participant's goals, needs, and preferences
10. Set expectations for person-centered planning meetings (i.e., support and assist the participant to identify who will participate, how engaged the participant wants to be in process, what tools will be used, where to meet, preferred mode of communication, etc.)

11. Complete program required documentation for delivering assessment and discovery activities

Standards for the discovery and information gathering process include:

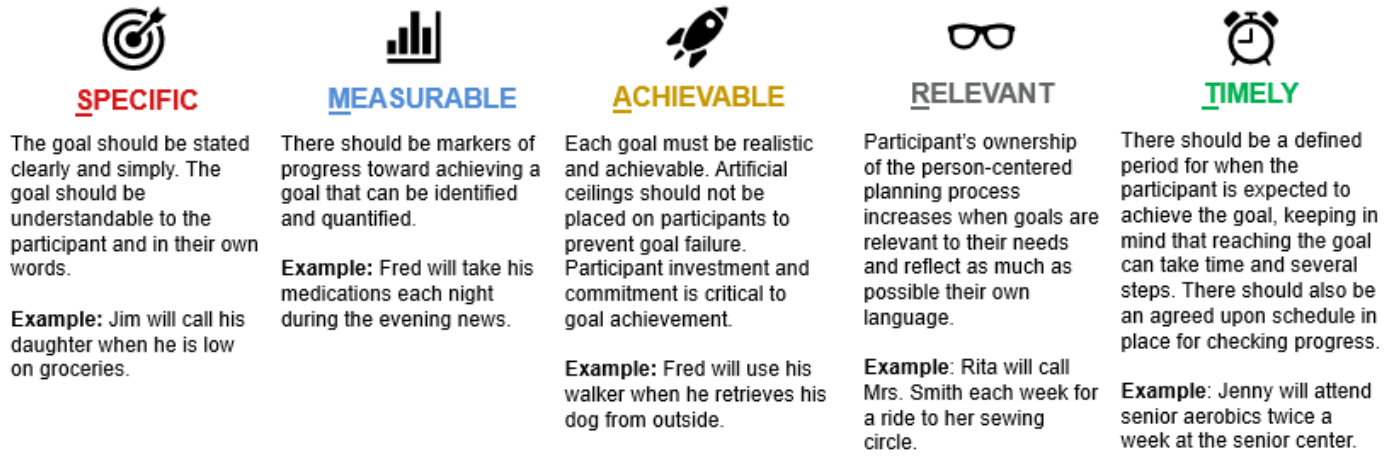
1. Participant is supported to direct the process of information sharing, planning, goal setting, and choosing supports
2. Planning process includes people and format chosen by the participant
3. Meetings are scheduled at times and locations convenient to the participant and their key supporters
4. Preferences for planning are determined by the participant
5. Participant is supported to identify their strengths, abilities, interests, goals, needs, and supports
6. Guided by the participant, information is gathered into one place through the review of previous assessments, including discussions with the participant and their key supporters, and time spent observing the participant in a variety of settings
7. A personal profile is developed with the participant and is documented in the State's LTSS CIMS.

7.1.1 Goal Development

The development of goals is critical component in the discovery and information gathering process. The CF case manager's role is to guide the conversation so that participants develop meaningful goals for themselves. Participants may have more than one goal and others attending the person-centered planning meeting may also have goals for the participant. However, the participant must agree to include those goals in their person-centered plan.

The case manager should employ person-centered thinking to help the participant identify steps that can be taken to achieve the goal. As depicted in **Figure 10**, person-centered goal(s) should be written using SMART guidelines:

Figure 10. Standards for Successful Goals using SMART Guidelines



When the goal itself seems unattainable, the CF case manager should dig deeper into the goal itself to determine what is important to the participant so that they can develop a goal that gets toward what they really want. For example, the participant may want to be a fireman, but it is highly unlikely that they could meet all of the requirements. By asking the participant "why", the CF case manager may find out that they like being around big trucks, like the respect that comes from a public position, want to wear a uniform at work, etc.; and then the goal can be built around that aspect of the goal.

7.2 Person-Centered Plan Development

Development of a thorough and accurate person-centered plan helps a participant pursue their personally defined “quality of life”. The person-centered plan must be based upon the information obtained from the discovery process. A well-executed and person-centered planning process is crucial to ensuring participants have a good experience with the State’s HCBS program.

When conducting the person-centered plan development process, CF case managers should at minimum complete the following activities:

1. Ensure active participation of the participant and others to consider all aspects of the participant’s life to determine and develop goals
2. Assist the participant to identify person-centered goals based on identified wants and assessed needs
3. Build specific and measurable goals and corresponding action steps to achieve goals
4. Identify a course of action to respond to the assessed needs of the participant, including a timeline for action steps
5. Identify how the participant wants to be assisted with each action step and the who is responsible for each action step
6. Assist the participant to explore community opportunities (e.g., church) related to identified interests and goals
7. Identify transition of care needs, including future care planning (i.e., for aging parents/caregivers)
8. Describe benefits and risks involved in aligning services to wants and needs, and describe strategies to ensure informed decision making through the PCP development process
9. Assist the participant to establish process to review and document progress towards goals
10. Identify an appropriate method and frequency for plan monitoring, follow-ups, and updates
11. Complete program required documentation for delivering planning activities

Standards for the person-centered plan development process include:

1. Goals are specific and achievable
2. Specific, detailed, and measurable action steps to meet goals are identified and documented
3. Timelines are identified for each action step
4. Person/organization identified to provide support with each action step
5. Community inclusion is explained and offered
6. Plan describes strategies and supports that will be used to ensure the participant is making informed choices
7. Person-centered plan is documented and shared with the participant and HCBS providers with adherence to State required components and timelines
8. A follow-up schedule/plan is agreed upon and documented

7.2.1 Person-Centered Planning (PCP) Requirements

The person-centered planning meeting and development cannot be conducted until the discovery process is complete. RI EOHHS will work with stakeholders to operationalize CMS’ PCP requirements. Pursuant to 42 CFR §441.301(c)(1), the person-centered planning process:

1. Will be led by the participant where possible. The participant's representative should have a participatory role, as needed and as defined by the participant.
2. Includes people chosen by the participant.
3. Provides necessary information and support to ensure that the participant directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.
4. Is timely and occurs at times and locations of convenience to the participant.
5. Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and participants who are limited English proficient, consistent with § 435.905(b).
6. Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.
7. HCBS providers for the participant, or those who have an interest in or are employed by a provider of HCBS for the participant must not provide case management or develop the person-centered plan.
8. Participant must be provided with a clear and accessible alternative dispute resolution process.
9. Offers informed choices to the participant regarding the services and supports they receive and from whom.
10. Includes a method for the participant to request updates to the plan as needed.
11. Records the alternative home and community-based settings that were considered by the participant.

7.2.2 Person-Centered Plan Requirements

The written person-centered plan must reflect the services and supports that are important for the participant to meet the needs identified in the assessment process, as well as what is important to the participant with regard to preferences for the delivery of services and supports. The CF case manager must ensure the person-centered plan documents assessed needs and identifies the services and supports that will address those needs.

RI EOHHS will work with its LTSS consumer information management system (CIMS) vendor to ensure that CMS' person-centered plan requirements are part of the system design. Pursuant to 42 CFR §441.301(c)(2), the written person-centered plan must:

1. Reflect that the setting in which the participant resides is chosen by the participant. The State must ensure that the setting chosen by the participant is integrated in and supports full access to, the greater community, including opportunities to seek employment in community integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as participants not receiving Medicaid HCBS.
2. Reflect the participant's strengths and preferences.
3. Reflect clinical and support needs as identified through an assessment of functional need.
4. Include individually identified goals and desired outcomes.
5. Reflect the services and supports (paid and unpaid) that will assist the participant to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the participant in lieu of State plan HCBS.

6. Reflect risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.
7. Be understandable to the participant receiving services and supports, and the participants important in supporting them. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to participants with disabilities and participants who are limited English proficient, consistent with § 435.905(b).
8. Identify the individual and/or entity responsible for monitoring the plan.
9. Be finalized and agreed to, with the informed consent of the participant in writing, and signed by all participants and individuals responsible for its implementation.
10. Be distributed to the participant and other people involved in the plan.
11. Include those services, the purchase or control of which the participant elects to self-direct, meeting the requirements of § 441.740.
12. Prevent the provision of unnecessary or inappropriate services and supports.
13. Document that any modification of the additional conditions, under § 441.710(a)(1)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered plan.

The person-centered plan informs but does not serve as a substitute for the service plans HCBS providers must develop to comply with federal or state requirements or otherwise manage or ensure the continuity of care.

7.3 Arranging for Services and Supports

Arranging services and supports is an important part of the CFCM professional's role. This function extends well beyond information and referral activities that may have been provided earlier in the eligibility process as it requires identifying and assigning who is responsible for implementing the person-centered plan and coordinating the implementation of the person-centered plan. When referring for services, it is imperative that CF case managers ensure all participants have the right to choose among willing and qualified HCBS providers and that the CF case manager provides enough information in each referral so that HCBS providers can make an informed decision on the HCBS provider's ability to meet the participant's specific needs and preferences.

When conducting the arrangement of services and supports process, CF case managers should at minimum complete the following activities:

1. Linking the participant with medical, social, educational, and employment HCBS providers or other programs and services (both formal and informal) capable of providing needed services to address identified needs and achieve goals specified in the person-centered plan
2. Confirm connections are made and referrals are completed and followed through on
3. Troubleshoot any problems connecting to services and/or maintaining services
4. Assist with assessing need for enhanced funding based on clinically assessed need
5. Select HCBS providers and document in the person-centered plan
6. Coordinate service authorization with HCBS provider(s) and State
7. Complete program required documentation for delivering referral activities

Standards for the arrangement of services and supports process includes:

1. Referrals are self-determined and align with the participant's goals, cultural beliefs, and values

2. Resources and opportunities are identified in the community in which the participant lives and that match their interests and preferences
3. Information about a variety of possible informal and formal resources is shared, including the option to self-direct all or a portion of formal supports
4. Unbiased information about multiple potential referral sources is shared based on identified goals
5. Responsible for identifying referrals for paid and unpaid supports
6. Responsible for discussing the need for full transparency and disclosure of any information that would delay or prevent timely and appropriate access to services, supports and resources
7. Responsible for developing and sharing knowledge of community resources and maintaining a network of community contacts
8. Follow-up contacts with referrals to ensure connections are made, services are delivered and documented

7.3.1 Freedom of Choice

All participants enrolled in Medicaid LTSS have the freedom to choose from any qualified and willing HCBS provider agency. As part of this process, the CF case manager must provide a list of all enrolled HCBS providers serving the participant's county of residence. If a participant does not know which HCBS provider agency to choose, the CF case manager can offer to assist the participant by providing resources for accessing information about the HCBS provider agency's quality, location, or other information based on the participant's preferences.

7.3.2 HCBS Provider Referrals

For each Medicaid service, the CF case manager must submit a referral to the participant's chosen HCBS provider(s). This referral includes the specific service requested, a brief description of the tasks to be performed by the HCBS provider, the requested service frequency and duration, and any other relevant information regarding the participant's specific needs and preferences. Service referrals must be sent to HCBS providers within two (2) business days from the date of the participant's selection.

CF case managers must document in the State's LTSS CIMS each referral sent and to which HCBS providers. CF case managers should follow-up with HCBS providers within two (2) business days from the date the referral was sent if a response has not been received. CF case managers may need to discuss the referral over the phone with HCBS providers to clarify the information contained on the referral form.

The HCBS provider is required to review the services requested by the participant and indicate whether the HCBS provider accepts, declines, or accepts with modification (e.g., the participant prefers a male caregiver, but the HCBS provider only has a female caregiver available). The CF case manager may be required to obtain additional documentation from the HCBS provider (e.g., the participant's assistance plan and resident agreement from an assisted living facility) and must confirm the participant's acceptance of any modifications proposed by the HCBS provider.

Once the CF case manager receives communication back from the HCBS provider, the CF case manager must document the outcome (accepted, denied, request for modifications) in the State's LTSS CIMS. CF case managers must then follow-up with the participant as well, as new HCBS providers may be needed if the request was denied. For any requests where the HCBS provider indicated a modification was needed, the CF case manager must discuss this with the participant and receive the participant's approval or denial of the modification.

The CF case manager must assist the participant in choosing a new HCBS provider for any referrals denied by the HCBS provider or when modifications requested by the HCBS provider are denied by the participant. Participants can change HCBS providers at any time. Participants do not need to provide

advance notice to current HCBS providers but must coordinate with their CF case manager before a new HCBS provider can begin services.

7.3.3 Information and Assistance in Support of Self-Direction

For participants who have chosen the self-direction service delivery option and have been determined to meet the self-direction criteria, the CF case manager is responsible for providing information and assistance and providing on-going case management services. Key activities of the CF case manager include:

1. Educate participants on the self-direction service delivery option so they can make an informed choice in choosing traditional, or self-direction service models for their service delivery.
2. Assess the participant's desire and comfort to direct their own care.
3. Facilitate the person-centered planning process and person-centered plan development—includes pre-meetings with the participant, participant's authorized representative(s) and circles of supports, HCBS providers—development of participant driven person-centered goals.
4. Refer the participant to the appropriate resources where they can obtain and complete the required documents for self-direction.
5. Monitoring (or evaluating) self-directed service as written in person-centered plan effectiveness, quality, and expenditures, and unmet needs
    a. Follow-up with participant and participant's authorized representative to address any identified health and safety risks.
    b. When unmet needs and risks are identified, CF case manager should respond by providing coaching, making referrals to resources, and advocating on behalf of the participant to obtain appropriate resources.

7.3.4 Additional Assistance and Support

The CF case manager must conduct additional referral and outreach activities as necessary to confirm availability and coordinate the delivery of non-Medicaid services and supports included in the person-centered plan. CF case managers must provide information and/or additional referral assistance to participants as necessary to ensure all needs and risks identified by the assessment process have been addressed. Referral assistance may be required to facilitate the participant's access to the Supplemental Nutrition Assistance Program (SNAP), a local food bank, Social Security, the Low-Income Energy Assistance Program (LIEAP), a senior center, the local housing authority, or other community resources.

Referral assistance could 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. CF case managers may not be able to determine the scope, frequency, or duration of non-Medicaid services that are available to the participant. However, the CF case manager must document all non-Medicaid services in the person-centered plan.

7.3.5 Finalizing the Person-Centered Plan

The person-centered plan cannot be finalized until all discovery/assessment, person-centered plan development, and referral activities are complete. Prior to finalizing the person-centered plan, the CF case manager must ensure that the participant has reviewed the participant's rights and responsibilities and that all signatures are obtained. At minimum, the participant, CF case manager, and all HCBS providers must sign the person-centered plan. Additional signatures from a legal representative or anyone else involved in implementing the person-centered plan may be obtained, as appropriate.

All person-centered plans are subject to review by the State for quality assurance purposes. The completed person-centered plan must be entered into the State's LTSS CIMS within ten (10) business days of completing the person-centered planning meeting.

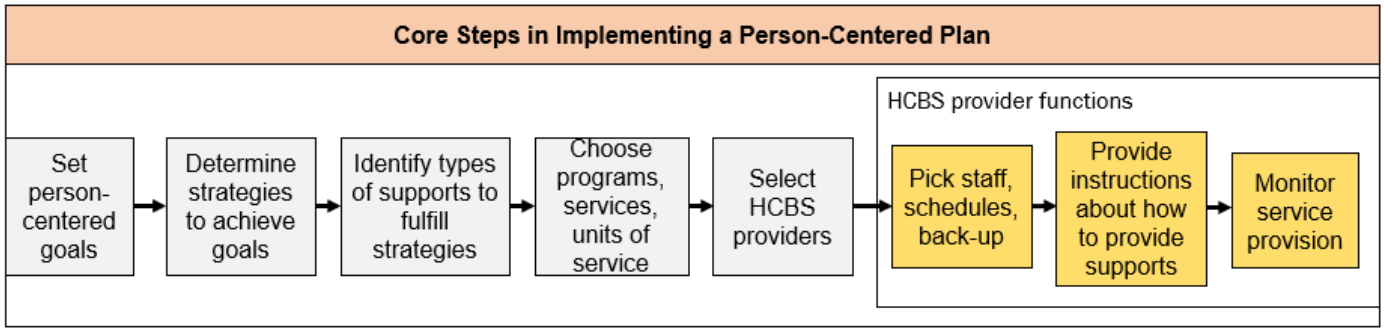
Once finalized, the CF case manager must provide a copy of the person-centered plan to the participant and role-based copies to the HCBS providers authorized to provide Medicaid HCBS. The participant must receive a complete copy of the person-centered plan while the versions sent to HCBS providers include only the necessary information for the coordination, provision, and reimbursement of Medicaid HCBS as to assure the privacy of the participant.

7.3.6 Implementing the Person-Centered Plan

Upon completion of the person-centered planning meeting, the person-centered plan will outline the goals and steps and supports needed to achieve these goals. The CF case manager, along with the participant, developed the person-centered plan and it is the responsibility of the HCBS provider to implement the plan. The HCBS provider will play a central role in the last three steps:

1. While the CF case manager may help the participant identify preferences for which types of staff they want and when they want to receive supports, HCBS providers will likely retain primary responsibility for identifying the actual staff, setting schedules, and ensuring that back-up supports are available.
2. The support plan will include guidance about the participant's preferences about how supports are provided. However, it will be up to the HCBS provider to flesh out the details of these instructions and ensure that staff are trained and instructed to provide supports in a manner that is consistent with the person-centered support plan.
3. The CF case manager will play a monitoring role through regular contact with the participant likely including observing the provision of services. However, the HCBS provider will be monitoring daily service provision and will be responsible for notifying the CF case manager of any issues.

Figure 11. Core Steps in Implementing a Person-Centered Plan



7.3.7 Prior Authorizations

All Medicaid HCBS require a prior authorization and approval before the HCBS provider can be reimbursed to render services. Prior authorization reviews facilitate coordination and minimize the duplication of Medicaid benefits to ensure the most effective use of public resources.

The State will provide additional information regarding this process at a later date.

7.3.8 Coordination with Medicaid Managed Care Organizations (Non-LTSS)

Some participants may be enrolled in a Medicaid managed care organization (MCO) to receive medical services in addition to HCBS. It is crucial that CF case managers coordinate and communicate with the MCO's care manager. At a minimum, the CF case managers must:

1. Determine if the participant is receiving services from a Medicaid MCO.
2. Identify the assigned Medicaid MCO care manager.
3. Request assessments or service plans from the Medicaid MCO care manager.
4. Communicate with the Medicaid MCO care manager regarding issues such as: significant change events, provisions of services, and a change in behavior and health status.
5. Work with the Medicaid MCO care manager to delineate roles and responsibilities between the CF case manager and the assigned Medicaid MCO care manager to avoid duplication or gaps in services.
6. Ensure that messaging on the roles and responsibilities of both entities is clear to jointly served participants.

7.3.9 Person-Centered Plan Review and Updates

The person-centered plan must be reviewed and updated at least annually but may be reviewed more frequently upon request by the participant or in response to a significant change in the participant's condition or circumstances. A significant change may include:

1. Loss of a primary caregiver or legal representative
2. An acute medical condition or behavioral health change that results in hospitalization or outpatient surgery
3. Change or deterioration in the participant's condition based on a clinical assessment
4. Change in residence
5. Participant choice not to use an authorized service

The CF case manager, the participant, and any other individuals freely chosen by the participant may participate in the person-centered plan review and update process. The CF case manager facilitates a discussion among the individuals participating in the person-centered plan review process to confirm/update the participant's assessed needs, preferences, goals, and overall health status and to identify any necessary modifications to the participant's existing person-centered plan. The CF case manager may conduct other assessment modules that are part of the State's LTSS CIMS as needed to document changes in the participant's condition or circumstances. Modifications to the person-centered plan are made and the services and supports are coordinated in accordance with the initial person-centered plan development and referral procedures.

7.4 Monitoring and Follow-up

Person-centered plan monitoring and follow-up activities are necessary to ensure that the person-centered plan is effectively implemented and adequately addresses the needs of the participant. While discussing the participant rights and responsibilities, CF case managers should also inform participants of the monitoring requirements and the purpose.

At minimum, monitoring must occur monthly; however, monitoring activities and contacts may occur with the participant, family members, HCBS providers, or other entities or individuals as frequently as necessary to:

1. Ensure services are being furnished in accordance with the participant's person-centered plan
2. Evaluate the effectiveness of the person-centered plan in meeting the participant's needs
3. Identify any changes in the participant's condition or circumstances
4. Periodically screen for any potential risks or concerns

5. Assess the participant's satisfaction with the services and supports
6. Identify any necessary adjustments in the person-centered plan or service arrangements with HCBS providers

When conducting the monitoring and follow-up process, CF case managers should at minimum complete the following activities:

1. Communicate with the participant, family members, HCBS providers, or other collateral entities to review progress towards goals and determine if services, supports, and resources are being delivered according to the plan and are meeting the participant's needs and wants
2. Adjust plan as needed to better meet the participant's evolving needs and wants
3. Address and problem-solve issues over service provision between the participant, the participant's supporters, and HCBS providers
4. Assist the participant to amend the plan as desired in a timely manner
5. Coordinate with members of the participant's support team to ensure the plan is implemented as desired
6. Respond to crisis using community resources, natural supports, and other State funded support services to stabilize crisis as needed
7. Complete program required documentation for delivering monitoring activities
8. Re-evaluate the participant's goals, needs, and preferences at least annually, when the participant's circumstances changes, or as needed
9. Confirm any transition of care needs are being met via the person-centered plan

Standards for the monitoring and follow-up process include:

1. Documentation of follow-up consistent with Rhode Island standards and a follow-up schedule agreed upon by the participant
2. Progress toward goals is discussed and barriers addressed as requested by the participant
3. Changes to the plan are made upon request or as the participant's needs change and shared as indicated
4. Responsive and flexible – able to amend plan as needed, with a simple and clear process for changes to be made in a timely manner
5. Coordination with team members is evident
6. Annual reassessments are completed and referrals are made to DHS or BHDDH if the Level of Care needs to be re-reviewed
7. Outcomes are measurable

7.5 Contact Frequency

The table below identifies **minimum** contact frequency, along with the corresponding timeframes CF case managers will need to follow when documenting contacts or when completing certain activities. The minimum contact requirements below will apply to each participant unless the participant expresses preference for fewer contacts and this preference is documented in the person-centered plan of care and reviewed with the supervising CF case manager. The CF case manager also has the discretion to conduct more regular visits with the participant.

Figure 12. Contract Frequency

Contact Type	Frequency	Timeframe
Initial outreach by the CF case manager once receive a new participant	One-time initial outreach via telephone or face-to-face contact.	No more than three (3) business days to minimize any delays to implementing HCBS services for the participant.
Person-centered plan resulting from a person-centered planning meeting	1. Initial person-centered planning meeting (face-to-face). 2. Annual person-centered planning meeting (face-to-face). 3. As needed person-centered planning meeting based on changes in the participant's needs (face-to-face).	The CF case manager must complete the written plan and the corresponding service authorization within ten (10) business days of completing the person-centered planning meeting. This timeframe will allow time for the case manager to gather any pending information not available during the person-centered meeting.
HCBS provider referrals	As needed.	1. Service referrals must be sent to HCBS providers within two (2) business days from the date of the participant's selection. 2. CF case managers should follow-up with HCBS providers within two (2) business days from the date the referral was sent if a response has not been received.
Ongoing monitoring contacts	1. Monthly non-face-to-face contact with the participant or collateral (e.g., caregiver, HCBS provider, etc.). A non-face-to-face contact includes a phone call; email exchange; or letter/correspondence exchange. 2. Face-to-face contact with the participant at least once every 6 months. The CF case manager is not required to conduct a monthly non-face-to-face contact in the same month as the face-to-face contact. 3. As needed telephonic or face-to-face contact based on participant needs.	The case manager should enter contact notes in the State's LTSS CIMS in a timely manner.

7.6 Case Documentation

The State's LTSS CIMS will serve as the official case record for participants. The conflict-free case management agency and case manager are responsible for completing and maintaining case documentation and for ensuring case records are complete, accurate, and timely. Activities that CF case managers must document include, but are not limited to:

1. Discovery/assessment activities
2. Person-centered plan development and update activities
3. Referral activities
4. Attempts to contact participant to schedule a visit
5. Attempts to contact persons/agencies working with the participant
6. Phone conversations
7. Email conversations regarding the participant
8. Receipt of documents related to the participant

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. CF case managers should remember that case documentation is part of the participant's health record, can be obtained by the participant if requested, and may be discoverable in legal proceedings.

CF case managers should use person-first language for all case documentation. The basic principle of person-first language is to name the person first and only then to describe the disability or impairment. Person-first language examples are provided below:

1. Jennifer is 20 years old. She has autism.
2. A person who uses a wheelchair (instead of "wheelchair confined")
3. People with disabilities (instead of: the disabled / the handicapped)

7.7 Medicaid Eligibility Renewal Responsibilities

CF case managers must be knowledgeable about the policies, procedures, rules, and regulations governing Medicaid LTSS eligibility and HCBS programs. RI EOHHS is committed to providing conflict-free case management agencies with education and training in these areas prior to start up and at least annually. In addition, case managers are expected to assist participants in completing any forms required for annual renewal necessary to ensure that there are no service disruption. This may require the CF case manager to work in coordination with State agency eligibility representatives as well as with participants and their families.

CF 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 State's Medicaid LTSS eligibility requirements.

8. CONFLICT-FREE CASE MANAGEMENT ADMINISTRATION

8.1 Conflict-Free Case Management Agency Requirements

All conflict-free case management agencies will be required to adhere to a standardized set of agency requirements. Additional details regarding the State's conflict-free case management agency requirements will be outlined as part of the certification and licensure standards maintained by the State.

8.1.1 Qualifications

1. Be a public or private not-for-profit or for-profit agency that meets all applicable State and federal requirements and is certified by the State department to provide conflict-free case management services
2. Have a physical location in Rhode Island
3. Have a signed agreement with the State
4. Obtain a National Provider Identifier (NPI) Number
5. Be an authorized Medicaid provider of conflict-free case management services

8.1.2 Responsibilities

1. Assign one (1) person to act as the State's primary contact and assume responsibility for the conflict-free case management agency's administration and operation
2. Be available to participants during regular business hours (8am-5pm, Monday – Friday) plus a minimum of 21 hours per week to provide evening/weekend coverage options
3. Ensure participants are provided access to a CF case manager
4. Ensure each CF case manager is supervised by a supervising CF case manager
5. Meet all conflict-free case management agency qualifications
6. Provide conflict-free case management services to participants without discrimination based on race, religion, political affiliation, gender, national origin, age, sexual orientation, gender expression, or disability
7. Maintain adequate administrative and staffing resources and emergency backup systems to deliver conflict-free case management services in accordance with all federal and State requirements
8. Establish and maintain working relationships with community-based resources, supports, organizations, hospitals, HCBS providers, and other organizations that assist in meeting the participant's needs
9. Collaborate with other entities, as needed to support participants
10. Develop written procedures sufficient to execute conflict-free case management services. Conflict-free case management agencies are required to develop written procedures that include:
    a. Discovery and information gathering
    b. Person-centered plan development
    c. Arranging for services & supports
    d. Monitoring & follow-up

e. Authorization of services
f. Service denials, reductions, discontinuations, and terminations
g. Complaints and grievances
h. Conflicts of interest
i. Critical incident reporting and follow-up

11. Facilitate access to assistive communication technology and/or interpreters for participants with hearing and/or vocal impairments and access to foreign language interpreters as necessary to conduct all required conflict-free case management activities
12. Ensure all staff and independent contractors meet established standards for qualifications and training
13. Participate in measuring and reporting quality and in continuous quality improvement activities
14. Ensure that all CF case managers successfully pass a background check in accordance with State and federal law
15. Use the State designated LTSS consumer information management system and pay any associated user fees
16. Demonstrate ongoing financial sustainability and provide stability for CF case managers and HCBS providers
17. Submit a financial statement to the State for review annually
18. Submit a cost report at the end of state fiscal year 2024 for RI EOHHS to assess rate adequacy

8.2 Conflict-Free Case Manager Qualifications

All CF case managers will be required to meet a set of standards and qualifications before providing CFCM to participants. CFCMs will need to have achieved a certain level of education and experience. In addition, before providing CFCM services, the CF case manager will be required to complete CF case manager training which includes standards of person-centered planning and the role of the CFCM in the overall person-centered planning process.

8.2.1 Education and Experience

CF case managers will be required to meet minimum education and experience requirements before they are able to serve in the role of a CFCM. CF case managers will be required to meet one of the following requirements:

1. An associate degree from an accredited college or university and one year of relevant experience (e.g., providing case management or other type of assistance) working with the target population for which they are providing case management (e.g., DD/IDD participants or elders). Degrees in the following human services fields are preferred:
    a. Counseling
    b. Education
    c. Gerontology
    d. Human Services
    e. Nursing
    f. Rehabilitation
    g. Social Work

h. Psychology
i. Social Services
j. Behavioral Health Science

2. A combination of post-secondary college and two years of relevant experience (e.g., providing case management or other type of assistance) working with the target population for which they are providing case management (e.g., DD/IDD participants or elders).

CF case manager supervisors must possess a bachelor's degree from an accredited college or university and have a minimum of two (2) years of supervisory experience and two (2) years of case management experience.

8.2.2 Core Competencies

CFCM requires a set of skills and competencies leading to the discovery and documentation of the participant's desired outcomes, preferences, values and needs, and the parallel creation of a person-centered plan that considers the assessment, planning, and coordination of services and supports focused on the participant. [16] CF case manager competencies should align with those identified by a 2020 National Quality Forum (NQF) report regarding Person-Centered Planning and Practice.[17] CF case managers are not expected to possess all of these core competencies; however, conflict-free case management agencies should use this framework in identifying CF case manager candidates and as part of its training program. The tables below present a high-level summary of CF case manager competencies. Please refer to the NQF report for additional details regarding each of the core components presented below.

Figure 13. Conflict-Free Case Manager Skills

Conflict-Free Case Manager Skills	
Foundational Skills: Forming a rapport with the participant; understanding their needs and wants; and empowering them to make decisions about goals in the context of needed supports and services. *Understanding the Participant* • Informed decision making • Contextual understanding • Applying effective freedom • Group power dynamics • Understanding disparities *Empowering the Participant* • Advocacy role • Strengths-based thinking • Yielding control • Training the participant to lead the process • Creating a culture of high expectations • Supporting empowerment development • Navigating complexity of choice	**Relational and Communication Skills**: Building relationships and maintaining positive communication are central to facilitating CFCM. Through strong relational and communication skills, the conflict-free case manager can keep a creative, individualized approach to planning and can help identify non-standardized supports and services. *Relational Skills* • Negotiation • Engagement • Dispute resolution • Team building • Plan documentation and distribution *Communication Skills* • Active and reflective listening • Motivational interviewing • Alternative communication methods • Health literacy • Empathy

Figure 14. Conflict-Free Case Manager Knowledge

Conflict-Free Case Manager Knowledge		
Philosophy: Has competencies in the philosophical underpinnings of the participant and family-centered thinking, planning, and practice. *Generating purpose and meaning* • Cultural perspective • Effective freedom • Empowerment • Dignity of risk • Presumption of competence • Supported decision making • Trauma-informed approach *Contextual Philosophy* • Independent living philosophy • Understanding of living best life • Recovery • Ableism and ageism *Advocacy* • Self and systems advocacy • Human rights • Model of independent living	**Resources**: Has a working knowledge of how to access information and assistance of long-term services and supports and the larger healthcare system. *System Resources* • LTSS and medical system • Safety net providers • Gaps in services and supports • Service load or service coordination management • Legal issues *Community Context Resources* • Community assets and resources • Populations and subgroups • Local advocacy groups *Planning Specific Resources* • Process elements and experts • Content elements and experts • Technological solutions	**Policy and Regulation**: Has a good understanding of laws, federal and state regulations, local policies, and court decisions. The conflict-free case manager should be familiar with the laws that protect the rights of the participants they are supporting. *Laws* • Americans with Disabilities Act • Individuals with Disabilities Education Act (IDEA) • Older Americans Act • Age Discrimination Act • 21st Century Cures Act – Division B *Regulations* • CMS HCBS Settings Final Rule • RI LTSS regulations and statutes

8.2.2 Caseload Size Standards

RI EOHHS assumed an average caseload of 48 in its rate calculation. A CF case managers' caseload maybe be lower or higher depending on the participant's needs and requests.

Conflict-free case management agencies are expected to maintain a CF case manager to supervisor ratio of not more than 10:1. Supervisors must meet with each CF case manager at least once per month to review caseloads, current case assignments, critical issues, etc. Supervisors must also hold monthly team meetings with their CF case managers to review any changes to practice standards, discuss quality assurance initiatives or activities, etc.

8.2.3 Conflict-Free Case Manager Training

CF case managers will be required to complete the trainings listed below. The State identified several of these trainings from the National Center on Advancing Person-Centered Practices and Systems (NCAPPS) Staff Competency Domains[18]. The State anticipates developing the trainings listed below (or using a vendor) and delivering these trainings to CF case managers. Conflict-free case management agencies will be expected to deliver these trainings to their staff at a future date.

1. LTSS in Rhode Island. *This training will include an overview of the State's LTSS system, Medicaid LTSS eligibility requirements and process, materials required to support eligibility renewals, and available community resources in Rhode Island.*
2. Introduction to CFCM in Rhode Island
3. Person-centered plan development
4. Use of the State's LTSS CIMS

5. Population-specific training, including but not limited to:
    a. Working with participants with disabilities
    b. Working with participants with brain injury
    c. Working with the aging population
6. Prevention, identification, and reporting of critical incidents
7. Health Insurance Portability and Accountability Act (HIPAA)
8. Cultural competency
9. Refresher training: On-going based on quality assurance reviews and other training needs identified by the State.
10. Additional trainings as determined by RI EOHHS as necessary (including training on programmatic changes and/or program or process updates)

8.4 Complaints and Grievances

Complaints and grievances may be initiated by the participant or anyone involved or working with the participant. The conflict-free case management agency should have internal policies and procedures for the resolution of complaints and grievances.

At minimum, CF case managers must provide the participant with contact information for the CF case manager and the CF case manager's supervisor during the initial enrollment and annual person-centered plan meetings.

In the event a CF case manager receives a complaint or grievance from a participant or another individual, the case manager should work with the participant and others to resolve the complaint. Resolution may include, but is not limited to:

1. Finding a new HCBS provider
2. Contacting the HCBS provider agency to request a change of caregiver
3. Assigning a new CF case manager
4. Revising the person-centered plan based on the participant's needs
5. Conducting an internal investigation and reporting findings to the State

The conflict-free case management agency or case manager must document all complaints and grievances received as it relates to the services provided by the agency or those authorized to provide services for the participant.

8.5 Conflict of Interest Safeguards

Federal regulations [42 CFR §441.301(c)(1)(vi)] require that case management activities, including the development of the person-centered plan, cannot be conducted by any individual or entity who is employed by or has an interest in a provider of services included in the person-centered plan.

To ensure compliance with this requirement, RI EOHHS has established the following conflict of interest standards:

1. The CF case manager must not be related by blood or marriage to the participant or to any person paid to provide Medicaid HCBS to the participant.
2. The CF case manager must not share a residence with the participant or with any person paid to provide Medicaid HCBS to the participant.

3. The CF case manager/case management agency must not be financially responsible for the participant.
4. The CF case manager/case management agency must not be empowered to make financial or health-related decisions on behalf of the participant.
5. The CF case manager/case management agency must not own, operate, be employed by, or have a financial interest in any entity that is paid to provide Medicaid HCBS to the participant. Financial interest includes a direct or indirect ownership or investment interest and/or any direct or indirect compensation arrangement.
6. Should a conflict arise, it is the CF case manager's duty to inform the participant and assist the participant in finding a new CF case manager or conflict-free case management agency as necessary to eliminate potential conflicts of interest.

8.6 Critical Incidents

CMS requires Rhode Island to have necessary safeguards in place to protect the health, safety, and welfare of Medicaid HCBS participants. Reporting critical incidents is an important method to manage participant health and safety. The State is currently developing its approach to critical incident management and reporting; however, RI EOHHS anticipates that CF case management agencies and case managers will be expected to:

1. Report all incidents they observe or suspect since CF case managers are mandatory reporters. If a participant chooses not to report an incident, or declines further intervention, the CF case manager must still report the incident to the appropriate State agency.
2. Ensure that prompt action is taken to protect the safety of the participant. This may include replacing or removing CF case management agency staff.
3. Maintain policies and procedures regarding incident reporting and management.
4. Depending on the severity and type of critical incident:
    a. The CF case manager may need to revise the person-centered plan (e.g., the critical incident results in a change to the caretaker or HCBS provider).
    b. The CF case manager may need to provide additional support to the participant and document any follow-up visits. For example, the CF case manager may provide an additional face-to-face visit to ensure continued safety, help a participant to locate a new HCBS provider, or work with the HCBS provider and participant to address an abusive situation.

8.7 Quality Assurance

The conflict-free case management agency is responsible for managing the performance of CF case managers employed by or contracted with the agency. Each conflict-free case management agency should have internal mechanisms for assessing and managing the performance of each CF case manager. Should the conflict-free case management agency fail to address CF case manager performance concerns to the State's satisfaction, the State may require retraining or other progressive disciplinary actions, up to and including termination of the CF case manager's status as a CF case manager. Managing conflict-free case management service quality could include such methods as:

1. New CF case managers shadowing and observing case management services prior to providing services independently.
2. Regular, systemic review and remediation of case records and other case management services documentation, on at least a sample basis. The review should ensure that CF case managers meet all established timelines as identified in this document and that all required information is entered into the State's LTSS CIMS.

3. Allocation and monitoring of staff to assure that all standards and time frames are met.
4. Addressing and rectifying participant complaints about a CF case manager.

9. PARTICIPANT RIGHTS AND SAFEGUARDS

9.1 Participant Rights and Safeguards

CF case managers are responsible for ensuring participants are informed of their rights and responsibilities, providing participants the support needed to exercise them, and documenting that participants have been provided this information. CF case managers must explain these rights to participants in such a manner as to ensure they understand them. Participants may need accommodation, protection, and support to enable them to exercise their rights, and their rights should never be limited or restricted without due process.

The participant has a right to:

1. To be treated with dignity and respect.
2. To have their ethnic, spiritual, linguistic, family, and cultural choices respected.
3. To be safe and free from abuse, neglect, exploitation, coercion, and restraint.
4. To receive competent, considerate, respectful care from HCBS providers.
5. To make their own decisions (with help from their legal representative or someone else they choose, if appropriate).
6. To privacy and confidentiality.
7. To live safely and independently in the way they choose.
8. To be an active member of their community.
9. To participate in assessments and development and implementation of their services.
10. To receive information about their care and community services and to choose how their services are provided.
11. To make a complaint, without fear of retaliation, when they are not happy with the services they receive.
12. To appeal decisions about their care and services or about their cost share when they do not agree.
13. To accept or refuse any community services and to withdraw from programs at any time.

In addition to participant rights, participants also have responsibilities while participating in Medicaid HCBS. Participants have the responsibility to:

1. To know about their rights and to ask questions or request information to better understand their rights and responsibilities.
2. To notify their CF case manager of changes in their income, assets, expenses, or address and to complete all paperwork necessary to maintain their Medicaid eligibility.
3. To pay the cost share, if they have one. If you do not pay their cost share, their Medicaid services may be terminated.
4. To participate in their assessments and the development and implementation of their person-centered goals and services.
5. To follow their person-centered plan.

6. To understand their back up plan and when to use it.
7. To give their consent only when they understand and agree with the decision.
8. To be honest about their needs and to report changes in their needs to their CF case manager and HCBS providers.
9. To notify their doctors of any changes in their health or condition and to keep appointments with their doctors.
10. To follow the rules of the programs and services they are enrolled in.
11. To be respectful of the people who provide their services.
12. To report any instances of abuse, neglect, or exploitation.

9.2 Behavioral Interventions: Restraint & Restrictive Intervention

Restrictive interventions or restraints are generally prohibited, except in limited circumstances. Such procedures are allowed for a participant only when documented in a behavioral support plan reviewed and approved by clinicians, families, guardians, and the Human Rights Committee. An approved behavioral support plan must document the circumstances under which a restrictive intervention is permitted and must be strictly followed. The likely benefit of the procedure must outweigh the apparent safety risk. This process ensures that participants consent to the use of this type of procedure and requires clinicians to exhaust other less restrictive alternatives, ensuring that the use of restrictive interventions is minimized wherever possible.

Any use of an approved restraint or restrictive intervention must be documented by the HCBS provider in a behavioral support plan and submitted to the CF case manager. The CF case manager will upload the participant's behavioral support plan to the State's LTSS CIMS and review the behavioral support plan during routine visits. At a minimum, CF case managers must review the behavioral support plan every six months during the in-person monitoring visit and follow-up with the HCBS provider.

When restraints or restrictive interventions are authorized for a participant, the least restrictive method possible should be implemented. As part of the regular monitoring activities, the CF case manager must pay special attention to identify any unauthorized use or misapplication of restraints. When a restraint is used appropriately, the participant must be kept clean, get the food and fluids they need, be able to have a bowel movement or urinate when needed, be as comfortable as possible, and not injure him/herself. Any known or suspected misuse or misapplication of restraints or restrictive interventions must be reported by the CF case manager as a critical incident.

9.3 Protected Health Information

Conflict-free case management agencies and CF case managers must ensure compliance with all federal and State privacy laws and regulations regarding the treatment of Protected Health Information (PHI). The HIPAA Privacy Rule sets national standards for the treatment of PHI by three types of covered entities: health plans, health care clearinghouses, and health care providers who conduct standard health care transactions electronically. Conflict-free case management agencies are considered covered entities.

10. PAYMENT FOR CFCM SERVICES

10.1 Payment Requirements

The State is currently calculating reimbursement rate(s) for conflict-free case management services. Conflict-free case management will be paid via fee-for-service (FFS) where all conflict-free case management providers, regardless of the population served, are reimbursed using a monthly unit of service (i.e., monthly billing per eligible participant). The monthly unit of service represents an average cost. Some

participants being served will receive more and some less, but on average will 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 will be consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers.

The monthly unit will be billed on or after the last day of the month. To bill a monthly unit, CF case managers must meet and document two (2) of the following activities:

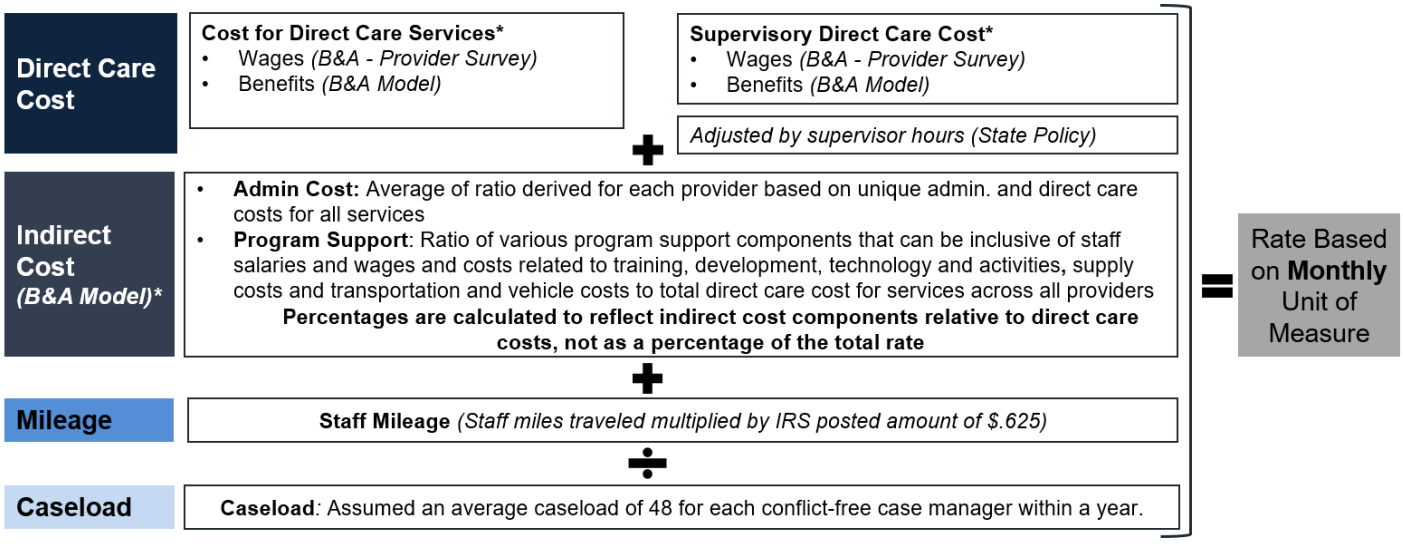
1. Face-to-face meeting with the participant.
2. Updates to the person-centered plan.
3. Non-face-to-face contact with the participant.
4. Non-face-to-face contact with a collateral contact (e.g., caregiver, HCBS provider, etc.).

10.2 Rate Setting Approach and Methodology

RI EOHHS contracted with Guidehouse to calculate a monthly reimbursement rate for CFCM and the resulting projected costs. The State's anticipated monthly reimbursement rate is currently under review by the Governor's office. RI EOHHS will share its anticipated monthly reimbursement rate with stakeholders once the RI EOHHS's budget is approved by the Governor's office.

Since CFCM is defined very differently than how case management is delivered today, Guidehouse developed a CFCM reimbursement rate as a cost build-up to appropriately account for all the costs associated with the various rate components required to provide this service. Guidehouse's rate calculation considered wages of staff, employee related expenses, supervision ratios, mileage assumptions, case manager caseloads, administrative costs, program support costs, and an inflationary factor of 14.27%. **Figure 15** below provides an outline of Guidehouse's rate model.

Figure 15. Rate Model for CFCM



*Rhode Island contracted with Burns & Associates, Inc. (B&A) to calculate reimbursement rates (using a detailed cost and wage survey) for Medicaid DD services. For consistency, Guidehouse used several of B&A's rate calculation assumptions as part of the CFCM reimbursement rate.

10.3 Financing

The HCBS Final Rule applies to all Medicaid LTSS across HCBS settings. As compliance with the rule is a necessary condition for maintaining Federal financial participation (FFP) for HCBS, Medicaid federal funds and general revenue are the principal payment sources.

Rhode Island will pay for CFCM using new funds and a reallocation of existing funds:

1. *New Funds*: Implementation of the CFCM network requires the investment of new funds. Additional funds are required to pay for the broader scope of services required by CMS's Final Rule as well as to cover new populations that would be eligible for case management. There are an estimated 11,968 existing Medicaid HCBS participants that would be eligible to receive the monthly case management rate.
2. *Reallocation of Existing Funds*: Some of the State's funds for its existing case management services will be replaced by CFCM. As the State's existing funds or payment of case management services are not uniformly available, do not generally meet federal CFCM requirements, and the rates paid for them have not changed in well-over a decade, the funds reallocated will be insufficient to cover the costs of CFCM.

11. NEXT STEPS

The LTSS Interagency Redesign Team requests stakeholder feedback regarding its CFCM Strategic Plan (the contents of this report). Stakeholder feedback will be essential to help ensure the State's approach is reasonable and best meets the needs of Rhode Islanders. To submit feedback, please email OHHS.LTSSNWD@ohhs.ri.gov by December 23, 2022. The State will review all stakeholder feedback and post an updated CFCM Strategic Plan by January 31, 2023. After this time, there will be more opportunities for stakeholders to provide feedback. In March 2023, RI EOHHS will release a request for information (RFI) to identify interested CFCM bidders and to solicit feedback from stakeholders regarding the State's proposed procurement strategy.

All materials related to this effort will be posted on Rhode Island's website: Conflict-Free Case Management (CFCM) | Executive Office of Health and Human Services (ri.gov).

APPENDIX 1. REFERENCES

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