RHODE ISLAND CONFLICT FREE-CASE MANAGEMENT (CFCM): RATIONALE FOR SELECT CFCM DESIGN COMPONENTS – FEBRUARY 17, 2023

Purpose:
The purpose of this document is to provide stakeholders with information about the State's rationale for including certain components in the CFCM Strategic Plan that do not appear to be explicitly mandated in the Home and Community Based Service (HCBS) Final Rule. Toward this end, the document provides a brief overview of the decision-making process used by RI EOHHS and a decision-matrix that focuses on the components of the Strategic Plan most frequently subject of questions from stakeholders: statewide approach, exclusion of individual HCBS participant plan writers and HCBS direct service providers, scope of case management contact and oversight, and well as several related requirements.

Overview: The Design Process in Brief
In general, the rationale for Plan components not expressly mandated in the HCBS Final Rule is a function of: (1) flexibility the federal government typically affords states to achieve compliance with regulations; and/or (2) other federal requirements and implementation guidance that intersect with the HCBS Final Rule. First, as is often the case with federal regulations, the HCBS Final Rule establishes the minimum requirements a state must meet to achieve compliance. Providing that these minimum requirements are met, states generally have had the flexibility to develop CFCM compliance strategies that are tailored to the needs of the unique populations they serve and the state's health care environment more generally. Second, when developing these strategies, states must also consider a host of other federal regulatory and statutory requirements applicable to HCBS quality and reporting as well as the extensive preamble to the HCBS Final Rule, various forms of technical and implementation guidance issued by the federal Centers for Medicare and Medicaid Services (CMS), and Medicaid State Plan and waiver authorities that intersect with CFCM.

The RI EOHHS interagency redesign team worked closely with a CMS technical advisory team and national experts to review all applicable federal requirements and guidance when transforming the initial proposal for CFCM prepared by stakeholders into the draft Strategic Plan. In those areas where the State opted to exercise its flexibility, the team evaluated the impact of many factors including RI's own history, existing policies and business practices, and reforms planned and underway. In addition, recent conversations with CMS related to the State's recent submission of a Corrective Action Plan (CAP) for CFCM, RI EOHHS was informed that additional federal guidance in certain areas is forthcoming. RI EOHHS plans to keep stakeholders apprised of this guidance and any impact it might have on the proposed Strategic Plan. RI EOHHS is confident that any additional changes in requirements will be minimal as the Strategic Plan reflects this thoughtful and comprehensive review of applicable federal requirements, authorities and guidance in the context of long-standing values related to person-centeredness, quality and equity.

CFCM Decision Matrix

The table below focuses on select components of the CFCM Draft Strategic Plan and associated requirements that stakeholders have identified as deviating in some way from their interpretation of the HCBS Final Rule requirements. Stakeholder concerns about these components vary considerably and range from questions about the potential for overreach (e.g., required monthly case manager contacts) to, on the other side, the underutilization of authority (e.g., permit HCBS providers to engage in case management in certain circumstances). Accordingly, the matrix endeavors to capture the general tenor of stakeholder issues with each of the components addressed rather than all sides while providing enough information about the State's rationale to show the scope of RI EOHHS' due diligence.

In reviewing the matrix, please take note of the following:

- Column A – Identifies the component associated requirements of the Strategic Plan that raised stakeholder questions.
- Column B – Lists the federal requirements and guidance and related federal decisions and materials governing the State's design decision that apply and were reviewed.
- Column C – Provides an overview of the other factors that influenced the State's decisions related to a particular component, including interpretations of the federal authorities that were reviewed, the State's experience and current practices and various other areas taken into consideration.
- Column D – Provides a rationale for the State's decision.
- Column E – Briefly outlines the difference between the component of the Strategic Plan in question and applicable federal authorities.

For the purposes of this matrix, "select" components refers to those aspects of the Strategic Plan stakeholders identified as being inconsistent with the provisions of the HCBS final rule. The terms federal authority and requirements are sometimes used interchangeably.

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Statewide Approach: Vendors are expected to serve all HCBS participants with I/DD and elders and adults with disabilities.	If the state elects to cover more than one target group identified under 42 CFR 441.301 (a) through a single waiver, the state must demonstrate that it meets the unique needs of every HCBS participants while assuring that it does not prioritize or treat preferably one specific target group to the detriment of other groups covered under the HCBS waiver. AUTHORITY: 42 CFR 441.302 (a)(i);42 CFR 441.301 (a)(2); CMS Steps to Creating a Statewide Person-Centered Planning System.	Under the State's Section 1115 demonstration waiver, the state has elected to serve all target groups identified under 42 CFR 441.301 (a) through a single HCBS program. AUTHORITY: RI Comprehensive Demonstration Waiver (11-W-00242/1).[1] Recent CMS guidance indicated that a statewide system is advantageous to HCBS participants as it facilitates freedom of choice and ease of access across programs and waivers.[2]	The State determined that the most efficient and effective mechanism for assuring equity in access and comparability under its Section 1115 waiver is to: (1) Carve out CFCM from the HCBS service delivery and centralize administrative and financing responsibilities in EOHHS; and (2) Require all certified CFCM entities to have the capacity to provide the same scope, amount and duration of services to all target populations. (3) Maximize system capacity and assure compliance with federal timelines.	The CFCM Strategic Plan includes features that are not explicitly required by the HCBS final rule authorities, but are necessary to assure equitable access, effective use of resources, and implement CFCM in accordance with the State's Section 1115 waiver core principles and requirements.
	The state must demonstrate the statewide application of Medicaid comparability of services to all target groups served under a single waiver	The state has NOT waived comparability for HCBS under its Section 1115 demonstration waiver. AUTHORITY: RI		

[1] See: RI Section 1115 Demonstration Waiver, pp. 33-38, available at: https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-04/RI-global-consumer-choice-compact-ca_STCs_07_27_20.pdf.

[2] See: *Steps to Creating a Statewide Person-Centered Planning System,* December 2019, available at: https://www.medicaid.gov/sites/default/files/2019-12/steps-creating-a-person-centered-planning-system.pdf

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	unless specifically waived by the Secretary. AUTHORITY:42 CFR 441.301 (a)(2); CMS Guidance "Conflict of Interest in Medicaid Authorities".[3]	Comprehensive Demonstration Waiver (11-W-00242/1)		
Exclusion of Individual HCBS Participant Plan Writers: The State will no longer pay for Individual HCBS participant plan writers who are not permanent or contractual employees of a certified CFCM entity.	The state must provide assurances that necessary safeguards have been taken to ensure CFCM providers are qualified and conflict free. Accordingly, the state must define standards for providers (both agencies and individuals) of HCBS and competencies for agents conducting individualized independent evaluation, independent assessment, and service plan development. AUTHORITIES: 42 CFR 441.730 (a)(c); 42 CFR 441.725 (1); 42 CFR 441.720; 42 CFR 441.740	CMS guidance specifically indicates that person-centered planning is a function of the case management entity.[4] In addition, neither HCBS Section 1915 (c) technical, which apply to the HCBS program authorized under RI's Section 1115 waiver nor recent PCP guidance from CMS[5], identify individual plan writing as a Medicaid covered service. The Technical Advisory Team assigned by CMS to assist the State, New Editions, confirmed that individual plan writing is not a Medicaid reimbursable service.	The State is drawing on the expertise of its technical advisors, colleagues in other states, and stakeholders to develop standards that meet the requirements of §441.730. Individual HCBS participant plan writers will be excluded. The State does not have the general revenue resources to finance this plan writing as a separate service without federal matching funds. Accordingly, continuing this service is not included in the Strategic Plan. However, as these plan writers have	The CFCM Strategic Plan aligns with applicable federal authorities and requirements.

[3] See: *Conflict of Interest in Medicaid Authorities*, January 2016 at: https://dhhr.wv.gov/bms/Programs/WaiverPrograms/CFCM/Documents/conflict-of-interest-in-medicaid-authorities-january-2016.pdf
[4] *Conflict of Interest in Medicaid Authorities*, January 2016. Slides 5-8.
[5] Ibid. *Steps to Creating a Statewide Person-Centered Planning System.*

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	(b); CMS Guidance Conflict of Interest in Medicaid Authorities; CMS Steps to Creating a Statewide Person-Centered Planning System.		invaluable expertise and experience, the RFP for CFCM entities will encourage bidders to hire or contract with Individual HCBS Participant Plan writers who meet the certification standards. In addition, the State is establishing an HCBS support broker network which may also provide the opportunity for continued engagement with HCBS participants they are working with now.	
Scope of Conflict Free Requirements: An agency by agency or population-based implementation approach for CFCM that separates services for I/DD and EAD will not effectively prevent conflicts of interests, assure equity in access, or increase overall capacity for all HCBS participants.	The State must demonstrate that persons or entities providing case management, including person-centered planning, do not pose conflicts of interests (COI). AUTHORITIES: 42 CFR 431.301(c)(1); 441.730 (b); 42 CFR 441.725 (1); 42 CFR 441.720; 42 CFR 441.740 (b) CMS Guidance on the Conflict of Interest in Medicaid Authorities.	Past implementation efforts have shown that the State does not have the infrastructure in the HCBS care system to comply with CFCM on an agency by agency or population basis. The potential for COIs persists and is interwoven in the way both case management and planning services are paid for and delivered. Therefore, to demonstrate the State has met the cited federal authorities and	The State determined that carving out CFCM was necessary to meet the COI standards and protect the health and welfare of HCBS participants as required by 42 CFR 431.301(c)(1)(vi) and 42 CFR 441.730 (b)The CFCM Strategic Plan specifically prohibits providers who have the potential for conflicts of interest, as defined by the	The CFCM Strategic Plan components on conflict free case management comply with but do not exceed applicable federal authorities and guidance. Using a centralized statewide approach rather than an agency-by-agency implementation strategy is essential to

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		guidance, the State must build the core components for CFCM, while leveraging existing resources to the full extent feasible.	State[6], from seeking certification as CFCM entities.	overcome structural limitations and meet CMS timelines.
Limitations on Participation of Direct Service Providers: HCBS direct service providers are excluded from participating in CFCM. This exclusion applies even in instances when they are not the direct service provider for a particular HCBS participant.	The state must demonstrate that **the only willing and qualified agent** to perform independent assessments and develop person-centered service plans ***in a geographic area*** also provides HCBS, and the State devises conflict of interest protections including separation of agent and provider functions within provider entities, which are described in the State plan and approved by the Secretary. AUTHORITY: 42 CFR 441.730 (b)(5); 42 CFR 441.301(c)(1)(vi) and for 1915(k) at 42 CFR 441.555(c)(5); CMS Conflict of Interest in Medicaid Authorities.	Due to RI's small size, there are no geographic areas in the State that are likely to meet the federal criteria established for the only willing and qualified agent exception. In addition, there are often financial arrangements (contracts, subcontracts, and shared resources) between providers and provider networks in RI. This along with the large number of HCBS participants that regularly change providers and/or receive services from multiple providers at the same time, would make the cost and administrative complexity of assuring that all COI requirements are being met prohibitive to the State. [7]	Given the CMS exception requirements in 42 CFR 441.730(c)(5), and the other relevant factors noted, the State determined that HCBS direct service providers will not be included in the CFCM network and will not be permitted to provide CFCM services to members of the target groups.	The limitation on direct service provider participation in the CFCM network is consistent with federal requirements and applicable guidance.

[6] Ibid. *Conflict of Interest in Medicaid Authorities*, January 2016. Slides 12-17
[7] Ibid. *Conflict of Interest in Medicaid Authorities*, January 2016. Slides 20-22

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Case Management Contact Frequency: At minimum, the case manager must perform monthly monitoring; however, monitoring activities and contacts may occur with the participant, family members, HCBS providers, or other entities or individuals as frequently as necessary.	The state must demonstrate it has designed and implemented an effective system for assuring that participants' choice, level of care (LOC), and health and welfare needs are being routinely met. Includes, but is not limited to, service and core touchpoints focusing on changes in service needs and preferences, critical incident advising, general health and wellness, and safety. AUTHORITY: 42 CFR 441.302; CFR 441.303; HCBS Section 1915(c) Technical Guide, Appendices D 1 and B-6-a; SMM 4442.4; SMM 4442.9[8]	Due to the variations in agency HCBS policy, systems, and procedures, the State did not have a statewide strategy capable of demonstrating full compliance with federal requirements for assuring participants have adequate choice and are receiving the level of care necessary to meet their health and welfare needs. However, CMS identified the monthly contacts with participants currently being performed by all HCBS *contractual* case management entities as a best practice that could be expanded statewide to meet these requirements across	The State has submitted a corrective action plan to CMS indicating that the CFCM implementation plan will assure health and wellness across HCBS population. Monthly calls will continue to be standard practice by case management agencies once CFCM is implemented; participants will not be adversely affected if they choose not to accept a contact. Note: health and wellness required tasks have been standardized and will be performed in the State's new WellSky Case Management System	The State has opted to require monthly contacts by the CF case manager to comply with federal mandates related to HCBS health and welfare and associated reporting requirements. It is a common best practice today that provides an opportunity for engagement and continuous quality improvement.

[8] State Medicaid Manual (SMM). HCBS is contained in Chapter 4. The SMM is located at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927 and must be downloaded as ZIP files CMS has conducted evidentiary reviews and issued findings related to other state efforts to provide the assurances necessary to meet the applicable regulatory. The written decisions in these reviews function much like court rulings that interpret law and regulations and, in doing so, set the standards in the SMM states must use to provide appropriate assurances. These standards, in turn, set the parameters for HCBS Quality reporting. Reviews related to the sections of the manual that are relevant for the purposes here are as follows: SMM 4442.9 at: https://www.dhs.pa.gov/Services/Disabilities-Aging/Documents/Intellectual%20Disability%20Services/CMS%20Consolidated%20Waiver%20Quality%20Review%20Report%20%28p_011594%29.pdf and SMM 4442.4 at: https://vnppinc.org/wp-content/uploads/2017/10/Final-Asurances-DS-Waiver.pdf.

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		programs and populations.[9] As CFCM will be provided to all HCBS participants, implementation is an opportunity to achieve compliance with federal requirements and offer all participants an opportunity to talk about their needs and wants in a free form conversation that also provides information about overall wellness, care needs, and satisfaction with the services they receive.	(WCMS). These contacts are also a key requirement for CFCM entity payment.	
	The state must demonstrate that it has designed and implemented an adequate system for reviewing the adequacy of service plans for participants. AUTHORITY: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; HCBS Section 1915(c) Technical Guide Appendix D1-D2; SMM 4442.6; SMM	See above on health and wellness. In addition, the State must document and report on all the tasks set forth in the HCBS rule related to development and review of person-centered plans. Currently, these plans are only being developed for less than half of all HCBS participants and, even then, not always in accordance with federal requirements. This not only has created inequities across programs and populations, but it	The State determined that most efficient and equitable approach for ensuring HCBS participants have access to the level of person-centered planning federal regulations require is to establish statewide standardized system that is both is robust and flexible. The Strategic Plan proposes implementing such a system through our WCMS for all HCBS	The requirements for person-centered planning established in the Strategic Plan meet but do not exceed applicable federal regulations and guidance. A statewide system for planning, although not a requirement of the HCBS final rule, is consistent with recent CMS guidance and with

[9] HCBS Section 1915(c) Technical Guide, Appendices A-D, located at: https://wms-mmdl.cms.gov/WMS/help/35/Instructions_TechnicalGuide_V3.6.pdf

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	4442.7[10]; CMS Guidance Conflict of Interest in Medicaid Authorities; CMS Guidance Steps to Creating a Statewide Person-Centered Planning System.	has also made it difficult for HCBS participants to fully understand the range of HCBS options available and to transition from one service provider or setting to another. CMS has made it clear that federal matching funds will be denied for any HCBS provider to an HCBS participant that does not have an adequate service plan.	participants. The plan will become part of an LTSS e-record that can be readily updated and follow a participant across the service continuum. The Strategic Plan delineates the roles of the CF case manager, LTSS case workers and providers in this process.	the States goal to assure equity in access and preserve the availability of federal matching funds for HCBS.

[10] State Medicaid Manual. Relevant evidentiary reviews include: https://dhhr.wv.gov/bms/Programs/Documents/IDD%20Waiver/Waiver%20and%20reports/091020134021.WV%20ID%20Waiver%20Evidentiary%20Report%20.Final.pdf; https://www.dds.ca.gov/wp-content/uploads/2021/05/HRC_Waiver_Report.pdf