CFCM/PCP Implementation

Disclaimer: This webinar will be recorded and posted on the RI EOHHS website.

July 2022

RHODE ISLAND

Agenda

- **Overview of LTSS Redesign**
- **Overview of CFCM/PCP**
- **CFCM/PCP Design Considerations**
- **Immediate Next Steps**

Meeting Objectives:

1. *Familiarize stakeholders with Rhode Island's initiative to implement CFCM/PCP*
2. *Outline key next steps and opportunities for stakeholder input*

CFCM/PCP Implementation

Overview of LTSS Redesign

RHODE ISLAND

Key Concepts and Definitions

Long-term services and supports (LTSS) encompasses a broad range of paid and unpaid medical and personal care assistance that people may need when they experience difficulty completing self-care tasks as a result of aging, chronic illness, or disability.

Home and Community-Based Services

Institutional Services

Shared Living

Which Consumers?

Consumers who want services in a home-based setting but cannot live alone because they require a considerable amount of help with the activities of daily living.

Services

Caregivers are available 24 hours per day, seven days per week. They either live in the consumer's home or the consumer lives with the caregiver.

Home Care

Which Consumers?

Those who are able to maintain some level of independence, have access to family support, or have home health aides.

Services

Home-based services for activities of daily living, including bathing, dressing and toileting, as well as activities like housekeeping and meal preparation.

Assisted Living

Which Consumers?

Assisted living is for people who need help with daily care, but not as much help as a nursing home provides.

Services

On-site, 24-hour services include: personal care, homemaker and chore services, medication management, therapeutic, social and recreational activities, and health-related transportation.

Adult Day

Which Consumers?

For consumers that require care and companionship during daytime hours. At the end of the day, the consumer returns home.

Services

Nursing supervision, recreational activities, medication management, meals and snacks, therapeutic activities, and personal care needs, if needed.

Nursing Facility

Which Consumers?

Those who have specific skilled needs that would be too difficult or complex to obtain at home.

Services

Medication management, personal care (including dressing, bathing, and toilet assistance), 24-hour emergency care, and social and recreational activities.

LTSS Redesign System Priorities and Activities

	Person-Centered	Quality Driven	Resilient
Priorities	1. **Awareness** – Consumers are fully informed of their LTSS options available before making choices 2. **Accessibility** -- The LTSS eligibility process is streamlined, timely & easy to navigate and understand 3. **Fairness** -- Business practices are organized to promote equity & respect diversity 4. **Responsiveness** – "Real" service choices are driven by consumer goals & preferences as well as their unique needs	1. **Timely and Adequate** – The scope, amount & duration of services a consumer receives is consistent with their person-centered plan 2. **Coordinated** – Agencies collaborate to prevent duplication and ensure the efficient delivery of services 3. **Monitored and Measured** – Services and providers are regularly evaluated as is the satisfaction of consumers 4. **Value-based** -- Programmatic and policy decisions are backed by data and outcome driven 5. **Competent** – The LTSS workforce is highly skilled and capable of delivering quality services	1. **Balanced** – There is equitable access to & utilization of HCBS and institutionally-based care 2. **Workforce Stability** – The LTSS highly skilled workforce adequately meets and responds to changes in consumer demand 3. **Financial soundness** -- Long-term financing supports future system growth & diversification 4. **Innovative** – The State supports LTSS providers choosing to diversify, pursue culture change models, or innovate or modernize to address shifting consumer demands
Activities	✓ Implemented Person-centered Options Counseling (PCOC) & announced OHA grant to expand access ✓ Launched MyOptionsRI microsite. ✓ Streamlined clinical eligibility determination process to shift to single assessment for HCBS (will be implemented in July "22). ✓ Purchased customer information management system (CIMS) and began development of an LTSS e-record in one place that follows customer through LTSS system	✓ Developing roadmap to implement conflict free case management statewide by end of 2023. ✓ Implemented acuity-based payment system for assisted living that assures services required to address needs are available. ✓ Prepared reports for CMS on wide array of HCBS quality measures. ✓ Conducting comprehensive review of behavioral health service access in LTSS settings. ✓ Engaged expert vendors to assist with federal compliance and developing value-based rates for LTSS services	✓ Addressed direct care workforce shortages by providing recruitment and retention incentives and developed long-term strategy for promoting an adequate supply. ✓ Provided financial incentives to HCBS providers to expand availability of and access to service options. ✓ Offered incentives & began process of removing obstacles for provider innovation and transformation. ✓ Supported increase availability of high need services across LTSS settings

CFCM/PCP Implementation

Overview of CFCM/PCP

RHODE ISLAND

Introduction

Project Charge: Implement conflict free case management (CFCM) and person-centered planning (PCP) statewide for Medicaid LTSS consumers. This work is being led by an interagency work group that comprises of BHDDH, DHS, OHA, and EOHHS.

Why is CFCM/PCP Needed?

1. The State does not comply with Federal PCP or CFCM requirements.
2. Case management services are limited or inconsistent across the State's Medicaid LTSS programs
3. The State does not use an effective IT system to manage case management activities and performance
4. Conflict of interest exists for select providers including the State's Developmental Disability Organizations (DDOs) and Community Action Agencies (CAAs)

CFCM/PCP Goals

Our goal is to create a person-centered planning and case management network that:

- ✓ Complies with federal and state requirements
- ✓ Incorporates stakeholder input
- ✓ Uses standards and IT solutions to streamline services access, foster quality, and promote person-centered goals and outcomes.

Defining PCP and CFCM

CMS's HCBS Final Rule provides the regulatory framework that drives Medicaid CFCM implementation for the State

Person-Centered Planning (PCP)

- Incorporates information about interests, relationships, preferences, strengths and outcomes desired for his/her life as a result of long-term services and supports (LTSS).
- Service planning processes are focused on the concept of person-centered-ness.

42 CFR 441.301:

The PCP Process must:

- Be driven by the individual
- Include people chosen by the individual.
- Give individuals the necessary information and support to ensure they are directing the process
- Occur at least annually and at times/locations that are convenient for the individual.
- Results in a person-centered service plan

The Person-Centered Service Plan must:

- Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals

Conflict-Free Case Management (CFCM)

- States are required to separate case management (person-centered service plan development) from service delivery functions.
- Conflict occurs not just if they are a provider but if the entity has an interest in a provider or if they are employed by a provider.

42CFR441.301(c)(1)(v) and (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**, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS."

PCP and CFCM

- ✓ PCP depends heavily on quality case management.
- ✓ The case manager's core responsibility is to use the person's preferences to identify: 1) What is important to and for the person and 2) Key outcomes
- ✓ PCP is not "fitting" the person to the system, it's finding a fit between the person's needs and preferences and paid/unpaid/generic support and service responses.

Core Elements of CFCM

Component # 1 Discovery & Information Gathering	Component #2 Development of the Person-Centered Plan (PCP)	Component # 3 Arranging for Services & Supports	Component # 4 Plan Monitoring & Follow-up
Goal: Identify and document person's goals, needs and preferences.	**Goal: Translate person's needs and wants into a person-centered plan (PCP).**	**Goal: Connect person with providers and resources to implement the PCP.**	**Goal: Monitor, evaluate, and adjust the PCP as needed to reflect shifts in person's goals, needs, preferences, and/or circumstance.**
Activities: • Taking client history. • Identifying the needs of the person by gathering information from the person and other sources (e.g., family members, medical providers, social workers, and educators).	**Activities:** • Specifying goals and actions to address medical, social, educational, and other services needed by the eligible participant. • Ensuring active participation of the person and others to develop goals. • Identifying a course of action to respond to assessed needs of the person.	**Activities:** • Linking the person with medical, social, and educational providers or other programs and services capable of providing needed services to address identified needs and achieve goals specified in the care plan.	**Activities:** • Contacts with participant, family members, service providers, or other entities to determine whether: ○ Services are furnished according to care plan. ○ Services in care plan are adequate. ○ Determine if the person has changes that impact needs or status.

Roles and Responsibilities

Person Applicant/Recipient	State	Case Manager	Direct Service Providers	MCOs
1. Apply for services based on programs identified during PCOC process 2. Direct the person-centered planning process 3. Select services, service providers, and community resources to meet identified needs	1. Complete functional assessment(s) 2. Level of care determinations 3. Determine eligibility 4. Review / approve PCP (initial and if adjustments are made) 5. Process service authorizations 6. Facilitate residential placement needs 7. Monitor quality and performance 8. Critical incident management	1. Discovery 2. Develop person-centered plan (PCP) 3. Arrange services & supports 4. Plan monitoring & follow-up 5. Critical incident reporting 6. Re-evaluate person's goals, needs, and preferences at least annually or as needed.	1. Provide direct services and supports designated in PCP 2. Participate in PCP meetings at request of person 3. Track service outcomes 4. Coordinate with CFCM as needed 5. Critical incident reporting	1. Provide medical case management 2. Coordinate with non-medical case manager Note: EOHHS's contracted health plan that administers RI's Medicare-Medicaid Plan (MMP) will provide both medical and non-medical case management services to Medicaid LTSS participants.

.

CFCM/PCP Implementation

CFCM/PCP Design Considerations

RHODE ISLAND

Where We Are

Key Activities Completed to Date

- ✓ Partnered with New Editions and Guidehouse to support the State's implementation efforts.
  - a. New Editions will provide technical assistance through Centers for Medicaid/Medicare Services (CMS) and will support the State to meet CMS's HCBS Final Rule requirements.
  - b. Guidehouse will provide project management and implementation support.
- ✓ Selected an IT vendor that will support CFCM/PCP activities for older adults and people with disabilities.
- ✓ Conducted other state research to support the State's CFCM/PCP design and implementation.
- ✓ Analyzed the state's current approach to CFCM/PCP delivery to support its future state design.
- ✓ Issued a cost survey to DD providers (the cost survey included service coordination/case management activities).
- ✓ **Developed and refined a DRAFT strategic plan to support CFCM/PCP implementation.**

Key Outstanding Tasks / Decisions

1. Identify service delivery mechanism ***(Jul. 2022)***
2. Share the State's CFCM/PCP strategic plan with stakeholders ***(Aug. 2022)***
3. Develop a detailed CFCM/PCP implementation plan ***(Sep. 2022)***
4. Update the State's 1115 waiver ***(Late 2022)***
5. Develop reimbursement rates for CFCM providers ***(Late 2022)***
6. Implement an IT system to support CFCM/PCP activities ***(Now – Summer 2023)***

How Are Stakeholders Impacted?

Stakeholders	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 service plans and provide direct care services due to CMS conflict of interest regulations.
Community Agencies that Provide Medicaid LTSS Case Management Services	High	Community Agencies may apply to provide case management services; however, the requirements and process will be different under the future state design.
State Agency Staff	High	State Agency staff will no longer provide case management services.
Person (Applicant/Recipient)	Medium	• All Medicaid HCBS beneficiaries will receive CFCM/PCP; therefore, this service may be new to some existing HCBS beneficiaries. • Medicaid HCBS beneficiaries currently receiving case management services may have a new case manager.
Direct Service Providers	Medium	Direct service providers will be required to coordinate with the case managers (as needed) and participate in the person-centered planning process (as requested)
MCOs / PACE	Low	The MCOs and PACE will continue to coordinate with the non-medical case manager
Health Home Providers	Low	Conversations are underway to determine the scope of CFCM responsibilities for Health Home providers.

Consumer Impact

Non-medical case management will be available to all Medicaid HCBS consumers that receive services through an agency/provider or through self-direction.

Eligibility Criteria:

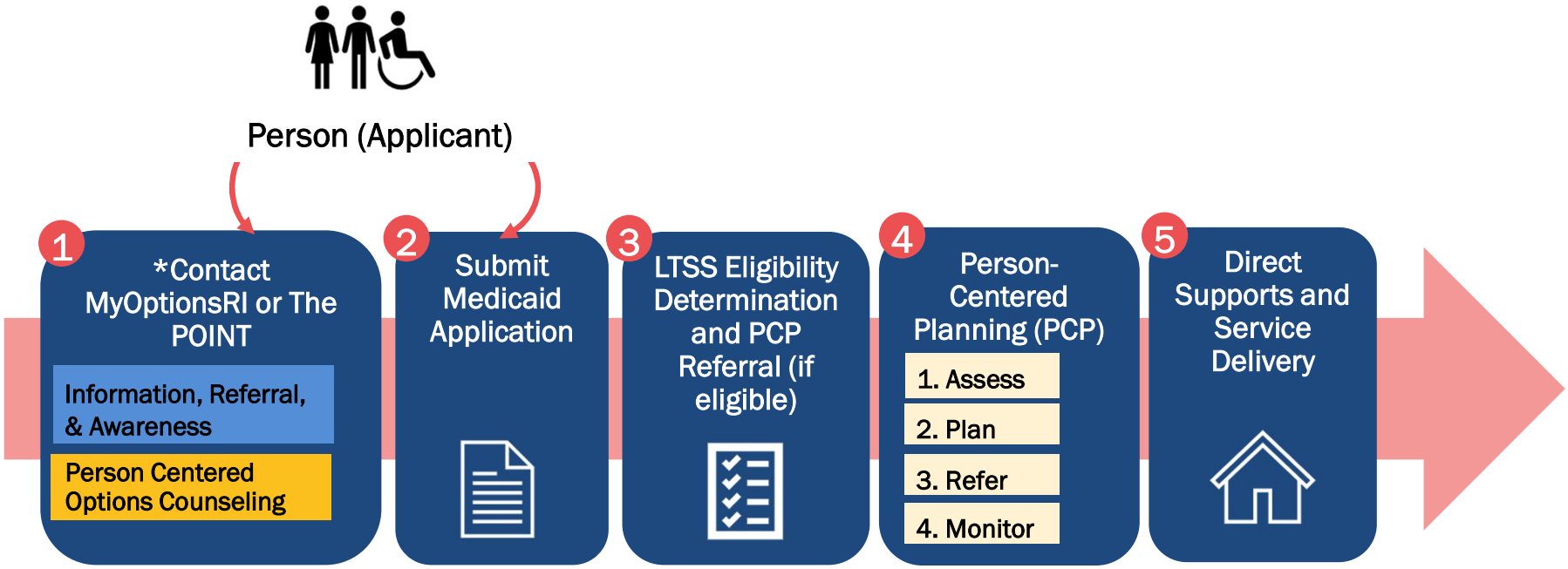
Category	Description
Target Group	Medicaid LTSS beneficiaries who are receiving home and community-based services.
Health Institutional Level of Care	The person must meet the level of care requirements of a nursing home, Intermediate Care Facilities for individuals with Intellectual disability (ICF/ID), 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.)

HCBS Providers and Settings

HCBS Program	Approx. # of Enrollees	Non-Medical Case Management Provider *(Future State)*
Community LTSS Elders and Adults with Disabilities (assisted living, shared living, personal choice, home care)	4,240	New vendor(s)
Katie Beckett Eligible Children	700	New vendor(s)
Community LTSS I/DD (shared living, self-directed, group homes, home care)	4,307	New vendor(s)
Program of All-Inclusive Care for the Elderly (PACE)	442	No change
Medicare/Medicaid Plan (MMP)	1,649 (1)	No change
Nursing Home Transition Program (NHTP) and Money Follows the Person	190	No change
Health Home Program	<1,000 (2)	No change

(1) Approximately 1,649 (12.8%) of the total MMP population (12,880) are also enrolled in Medicaid LTSS.
(2) Approximately 1,000 (16%) of the total Health Home Program population (6,225) are also enrolled in Medicaid LTSS.

Process



**An applicant may skip Step 1 if LTSS options counseling is not needed*

CFCM/PCP Requirements

Draft outline of Rhode Island's strategic plan

(A draft will be shared with stakeholders in August 2022)

1. Vision for CFCM and PCP in Rhode Island
   a. Case management delivery model
   b. Programs and consumers impacted
2. Case management services and standards
3. Case management agency qualifications and responsibilities
4. Case manager qualifications
   a. Education and experience
   b. Case manager training
   c. Criminal history and background screening
5. Conflict of interest safeguards
6. Person-centered plan of care requirements
7. Quality assurance

Other materials/requirements that will be defined AFTER the State's strategic plan is shared with stakeholders

1. Case management agency policy and procedures
2. Caseload sizes
3. Critical incident reporting
4. Documentation requirements
5. Case transfers
6. Other licensure and certification requirements (agency and individual case managers)

CFCM/PCP Implementation

Immediate Next Steps

RHODE ISLAND

Immediate Next Steps

WE ARE HERE!

July 2022

State Provides an Overview of CFCM/PCP Implementation to Stakeholders

August 2022

State Issues CFCM/PCP Strategic Plan to Stakeholders

1. State Presents its CFCM/PCP Strategic Plan to Stakeholders
2. State Posts its CFCM/PCP Strategic Plan
3. Stakeholders to Provide Feedback

Key Stakeholder Groups:

1. Consumers, Families, and Caregivers
2. No Wrong Door Partners
3. Service Delivery Provider Network
4. State Agency Staff
5. Committees:
   - IDD Quality Advisory Committee
   - Senior Agenda Coalition
   - Long term Care Coordinating Council (LTCCC)
   - MMP Council

September 2022

1. State Finalizes its CFCM/PCP Strategic Plan
2. State Releases an Implementation Plan

Anticipated Materials to Share with Stakeholders for Feedback (After September 2022):

1. Updates to existing State specific materials
2. New materials that further describe the State's CFCM standards
3. Materials that describe the State's rate setting methodology and results

Stakeholder Input

Stakeholder input is essential for successful implementation of CFCM/PCP.

Requested stakeholder feedback to the State's strategic plan *(to be released in August)*

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

RHODE ISLAND

Questions?

If you have any questions, please use one of the following options:

1. Chat function
2. Verbally (please use the “raise hand” function in Teams)
3. Email OHHS.LTSSNWD@ohhs.ri.gov.