Vermont Developmental Disabilities Council

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TO: Agency of Human Services

RE: Comments on Vermont's Comprehensive Quality Strategy

FROM: Susan Aranoff, J.D., Senior Planner and Policy Analyst

DATE: April 20, 2020

Thank you for providing this opportunity to comment on Vermont's Medicaid Comprehensive Quality Strategy (CQS) and Statewide Transition Plan (March 19, 2020).

The Vermont Developmental Disabilities Council

The Vermont Developmental Disabilities Council (hereafter "VTDDC") is a statewide board created by the federal Developmental Disabilities Assistance and Bill of Rights (hereafter "the DD Act"), first adopted by Congress in 1970. Our constituents are healthcare users who have an important stake in the cost, quality, and availability of both traditional healthcare and disability long term services and supports (DLTSS). An estimated 86,000 Vermonters experience a developmental disability as defined by the DD Act, with approximately 5,100 receiving Medicaid-funded, community-based support through the Developmental Services System of Care or in some cases, the Choices for Care Program.

VTDDC is charged under federal law with engaging at the state level in "advocacy, capacity building and systems change activities that… contribute to the coordinated, consumer-

and-family-centered, consumer-and-family directed, comprehensive system that includes needed community services, individualized supports, and other forms of assistance that promote self-determination for individuals with developmental disabilities and their families."

Introduction

The VTDDC is compelled to comment on the Comprehensive Quality Strategy because the Council has concluded that it does not adequately address the civil rights of Vermonters with disabilities. Specifically, Vermont is failing to ensure that individuals with developmental disabilities receive person-centered planning services that are free from undue conflicts of interest. Vermonters with disabilities have been entitled to person-centered planning practices that are free from conflicts of interest as a matter of law since 2014. It appears that Vermont will be the last state in the country to come into compliance with this requirement.

The Vermont Developmental Disabilities Council was actively engaged in the State's efforts to address this issue before those activities ceased in December 2019. The Council submitted the attached letter regarding conflicts of interest and person-centered planning practices which reflects the depth and breadth of our concerns about the issue. (See Attachment A).

The Comprehensive Quality Strategy is required to specifically address person-centered planning and these comments largely concern the CQS failure to address person-centered planning practices and conflict of interest free case management. The Comprehensive Quality Strategy is largely, and impermissibly, silent about Vermont's person-centered planning practices.

The Comprehensive Quality Strategy

Vermont's Global Commitment waiver establishes the required parameters of the Comprehensive Quality Strategy.[1] The Global Commitment waiver requires the Comprehensive Quality Strategy to contain metrics related to each population served by Medicaid including individuals receiving Home and Community Based Services (HCBS) and individuals receiving Disability Long Term Services and Supports (DLTSS).

The CQS is required to include HCBS performance measures for person-centered planning and must include a special focus on DLTSS populations' person-centered planning and participant protections. Vermont's Comprehensive Quality Strategy does not have performance measures for person-centered planning practices. Nor does it include a special focus on person-centered planning or participant protections for DLTSS populations. Indeed, the CQS does not appear to address the issue of person-centered planning at all.

Person-Centered Planning Practices

On January 16, 2014, the Centers for Medicare and Medicaid Services (CMS) issued final regulations for home and community-based services (HCBS) requirements (79 FR 2947). The rule supports enhanced quality in HCBS programs, outlines person-centered planning practices, and reflects CMS's intent to ensure that people receiving services and supports under different federal authorities can fully participate in their community and can receive services in the most integrated setting of their choice. A key part of the 2014 HCBS rule is the assurance of conflict of interest free case management.

Conflict of Interest Free Case Management

[1] See Special Terms and Conditions 90 Comprehensive Quality Strategy Vermont's 115 Global Commitment Waiver

In clear violation of the 2014 HCBS Rule, Vermonters receiving HCBS services do not receive conflict of interest free case management. Federal regulations require that providers of HCBS for the individual must not provide case management activities or develop the person-centered service plan [42 CFR 441.301(c)(1)(vi)]. Case management activities must be independent of service provision. An entity, agency or organization (or their employees) cannot provide both direct service and case management activities to the same individual except in unique circumstances set forth in regulation.

The regulations provide further that "Conflict occurs not just if the entity is a provider but if the entity has an interest in a provider or if they are employed by a provider."

In Vermont, nearly all individuals receiving HCBS and DLTSS receive their direct services and case management activities from the same agency. This practice is clearly prohibited by the 2014 HCBS Rule.

Vermont has previously acknowledged that it is out of compliance with the person-centered planning practices rule. In 2019, the Agency of Human Services began to address the issue and DVHA created a webpage dedicated to the issue. According to the website, AHS assessed the status of conflict of interest-free case management in the HCBS programs listed below with the goal of ensuring compliance with applicable federal regulations

1. Choices for Care Moderate, High and Highest Needs Groups
2. Developmental Disabilities Services Program
3. Traumatic Brain Injury Program
4. Community Rehabilitation and Treatment
5. Enhanced Family Treatment (Intensive Home and Community Based Services)

During its assessment, AHS found that all its home and community-based service systems are rife with conflicts of interest. With respect to the Developmental Disability Services System, AHS found and documented the following:

CURRENT AREAS OF POTENTIAL CONFLICT OF INTEREST

1. All 15 Designated Agencies and Specialized Services Agencies provide both case management and direct services.
2. The 10 Designated Agencies review clinical eligibility, conduct the initial assessment of need, and develop the proposed level of funding for each individual who comes into the Developmental Services System of Care.
3. The 15 Designated Agencies and Specialized Services conduct periodic needs assessments for people receiving services and adjust individual budgets based on these finding.
4. The 10 Designated Agencies provide information about a person's service options, including available agencies and options for case management.
5. Individuals receiving DLTSS do not have an independent entity to which they may appeal if services are not satisfactory. Instead, service recipients must take grievances to the designated or specialized services agency that provides the services in question.

AHS reported similar findings of system-wide conflicts of interest in all its home and community-based services systems. Vermonters with developmental disabilities receive services from the Choices for Care, Traumatic Brain Injury, Community Rehabilitation and Treatment, and Enhanced Family Treatment programs. Therefore, we are concerned about the conflicts of interest that exist in all of Vermont's home and community-based service systems, and not just the conflicts of interest in the Developmental Disabilities System of Care.

AHS concluded that all its HCBS programs had significant potential for conflicts of interest, yet the CQS does not address the deficiencies. Nor does the CQS identify any plans for correcting the deficiencies and/or complying with the rules.

This is not the first CQS to fail to adequately address the patient-centered planning practices and conflicts of interest in Vermont. VTDDC and others commented on prior versions of the CQS and noted the State's failure to address the person-centered planning practices requirements and conflicts of interest in 2017.

In response the State said

> Vermont's CQS/STP includes links to all Program Systemic Assessments (i.e., documents that assess the existing Vermont regulations and standards related to HCBS delivery to determine if they meet the federal HCBS final rule requirements). A person-centered planning requirement and Vermont regulation and policy crosswalk is part of this assessment. Items in the crosswalk are scored as alignment, partial alignment, silent, or non-compliant. Links to all Program Work Plans (i.e., documents that expand upon the System Assessments by identifying subsequent action steps for the Vermont regulations and standards that did not receive a score of alignment) are also included in the CQS/STP. **The action steps in the workplan resolve the identified issue and bring the Vermont regulation and/or standard into alignment with the federal HCBS final rule.** (Emphasis Added). (See Vermont Agency of Human Services (AHS) – Global Commitment to Health Comprehensive Quality Strategy (CQS)/State Transition Plan (STP) Summary of Public Comment).

There was not a single work plan with action steps that identified the issue and brought Vermont into alignment with the federal rule in the CQS in 2017 and there are no workplans with action steps in the CQS in 2020 that will bring Vermont into compliance with the 2014 HCBS rules for person centered planning and conflict of interest free case management.

In sum, conflicts of interest are rife within Vermont's home and community-based service delivery system and a Comprehensive Quality Strategy that fails to address is not adequate, let alone "comprehensive."

Attachment A

Vermont Developmental Disabilities Council

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October 5, 2019

Acting Commissioner Camille George
Department of Disability, Aging, and Independent Living
State of Vermont
280 State Drive
Waterbury, VT 05671

Dear Commissioner George,

Thank you again for meeting with the Vermont Developmental Disabilities Council (VTDDC) on September 26, 2019 to discuss how Vermont will address the requirement that case management not be subject to "undue conflict of interest"[1] under CMS administrative rules.

At that meeting, our members shared their lived experience with case management services in the Developmental Disabilities System (the DD System) and, in the case of one member, in Choices for Care. Most of the members present expressed a clear preference for a system that provides traditional case management activities independently from the designated and specialized services agencies, a course of action the State has identified as "Option 1." Members also voiced their support for additional protections including an ombudsperson for the DD System.

The Council would like to provide a more detailed analysis that builds on the preferences expressed by our self-advocate and family members (hereafter, "public members"). While we did not take a formal vote, we have reviewed the recommendations below with the public member of the Council and believe these comments fairly represent the majority opinion. In addition, we raise the issue of conflict of interest in the delivery of "wrap services" and suggest other mitigation

[1] 42 CFR § 441.301(c)(1)(vi).

strategies that we believe to be necessary in order to come into compliance with the above cited CMS rule.

Background: Why the VT Developmental Disabilities Council is Concerned

Conflict of Interest Free Case Management has been a requirement for the delivery of home-and-community-based services (HCBS) since March 17, 2014. The Council has long advocated that the State engage stakeholders in a discussion about how Vermont will come into compliance with this rule. A review of internal documents from the Agency of Human Services, which were obtained through a Freedom of Information Act Request filed by Vermont Legal Aid in June 2018, indicated that there were conversations within AHS about seeking a waiver from the requirement as a first response to the new rule. This heightened the Council's concern that individuals and family members be fully informed about the requirement and engaged in any discussion about Vermont's response. We are pleased to see that this effort is now fully underway.

The experiences of our diverse Council members indicate that there is, indeed, conflict of interest across many service corridors in Vermont's DS System. Some of these were shared with then DAIL Commissioner Monica Hutt, when she visited the Council during our March 28, 2019 quarterly meeting. The Council's concern is reinforced by some of the findings in the 2017-18 National Core Indicators In-person Survey:

- In response to the question "Can change their case manager/service if they want to," Vermont scored in the "significantly below average category," with 81% of respondents indicating "yes" compared to the national average of 89%.[2]
- In response to the question, "Case manager/service coordinator asks person what s/he wants," Vermont scored below the national average, with 83% of respondents indicating "yes" compared to 88% nationwide.[3]
- In response to the question, "Person was able to choose services they get as part of service plan," Vermont was in the "significantly below average category," with 68% of respondents indicating "yes" compared to the national average of 79%.[4]

[2] National Core Indicators, In Person Survey, 2017-18, page 52. See: ttps://www.nationalcoreindicators.org/upload/core-indicators/17-18_IPS_National_Report_PART_I_3_20_19.pdf
[3] Ibid., page 146
[4] Ibid., page 158.

The Council acknowledges that Vermont has been an early and successful adopter of many best practices in the delivery of person-centered, individualized services, something for which the State is rightly proud. Certainly, there are other core indicators that speak well of Vermont's performance. However, this does not negate the fact that decision-makers in the Vermont DS System can be swayed by unconscious bias and misaligned financial incentives.

The impetus for reducing conflict of interest is the desire on the part of CMS to uphold the central place that person-centered planning has in the delivery of HCBS. In mitigating undo conflict of interest, the State has a duty not only to comply with the letter of the law, but to embrace the principles that have given rise to this requirement. For this reason, we have framed our recommendations based on three values we consider central to the delivery of person-centered service planning – informed choice, effective checks and balances, and the separation of financial decision-making from service planning and delivery.

A Framework for Defining Case Management

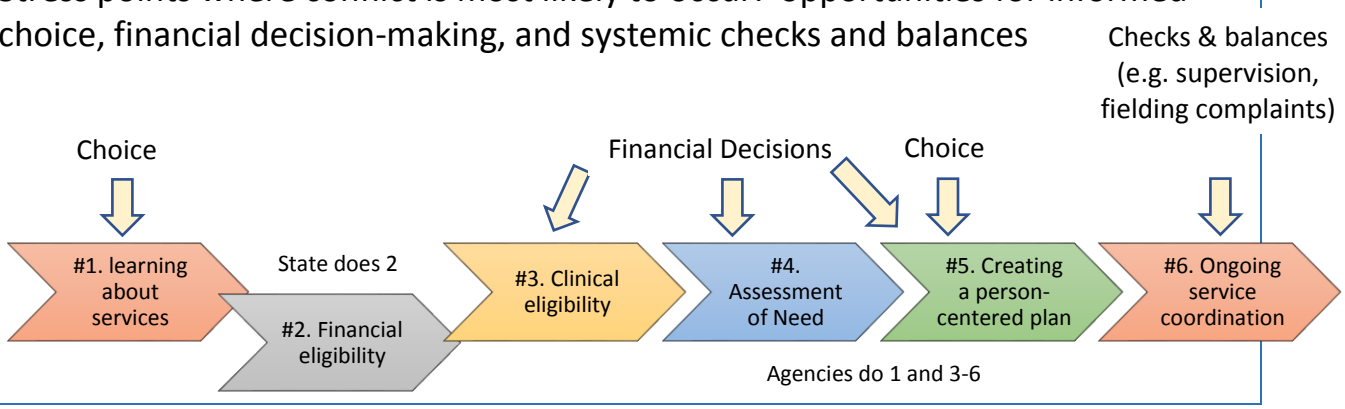
As has been noted, CMS did not provide a clear definition of "case management" in the new rule, increasing confusion about its implementation

In Vermont, case managers are engaged in a wide range of activities. These may include initially "onboarding" a new service recipient, coordinating assessments, facilitating person-centered planning sessions, screening and hiring direct support staff, recruiting home providers, and troubleshooting as service gaps and other needs arise. They act as "gate keepers" to DS funding, other public benefits, and even medical care, especially when complex arrangements need to be made. Typically, case management also includes quality assurance activities – for example, evaluating direct support providers, conducting site visits, and fielding concerns from service recipients, home providers, and staff. Case managers even step in to provide direct care or transportation when front-line staff are unavailable.

Initially, many of these case management services are encountered by individuals and families sequentially, though in some cases the activities overlap. Later, certain activities are cyclical, in that an individual can expect to be reassessed and to revise their person-centered plan periodically. The graphic below illustrates case management as a process made up of a sequence of discrete activities that can be repeated over time. All these roles except review of financial eligibility are

currently held by case managers at the designated and specialized services agencies.

Stress points where conflict is most likely to occur: opportunities for informed choice, financial decision-making, and systemic checks and balances



In speaking with individuals and family members throughout Vermont, it appears that the activities where conflicts of interest are the most likely to sway decision-making occur either: Up-front at activity 1, above, when people are first learning about their service options; and again at activities 3, 4 and sometimes 5, the points where financial decisions are made in the context of establishing eligibility, assessing need, and assigning resources to meet that need.

Individuals and family members expressed more mixed feelings about activity 5, service planning, and activity 6, the delivery of ongoing service coordination. Some highly valued their relationship with a case manager, who was described as knowing the individual well over time and going "above and beyond" to fill gaps in service and to offer support. Others described a more impersonal relationship with a case manager who changed frequently. Concerns included the failure to respond to changing service needs or personal preferences, fears that complaints might result in reprisals, and a high degree of control over the individual's living situation, community access, and resources. It was telling that self-advocates and even some family members were more likely to share these concerns when agency staff were not present.

Tools to Reduce Conflict of Interest in Case Management

The Council believes that five of the six strategies suggested by AHS in their public presentations provide important protections that should be implemented *regardless* of the structure that the State adopts for the delivery of various case management functions. We are turning to these first as they also bring some clarity around the minimum expectations under the CMS Rule. The Council has

added additional recommendations to address areas of conflict not identified by the State.

Principle 1: Informed Choice. Individuals are empowered to make well-informed choices about their services and supports; and there is more than one option wherever possible. Choice is a key tenant of person-centered service planning.

Problem to Solve: Conflict of interest may promote conscious or unconscious "steering" of the individual toward service models or providers that the case manager has reason to favor.

Recommended Strategies

A. Independent options counseling, including options counseling by trained peers, whether self-advocates or family members.

- Peer support does not replace the need for professional case management, but it does offer a cost-effective and empowering way to educate recipients of service and their families about their choices, rights, and opportunities to engage with their community.
- Vermont's independent self-advocacy organization Green Mountain Self-Advocates is a unique resource that the State can leverage to ensure that, with training, individuals and family caregivers are well supported as they learn about their options and navigate the transition into services or a major change in services.
- The presence of a self-advocate on staff has proved very useful to Northwestern Counseling and Support Services.
- Providing options counseling would align the DS System with programs available to other populations – for example, for older Vermonters through Area Agencies on Aging and for people with physical disabilities through the Vermont Independent Living Center, which employs peer counselors.
- Specifically addresses the requirement that the person-centered planning process offer "informed choices to the individual regarding the services and supports they receive and from whom" [42 CFR § 441.301(c)(1)(vii)].

B. A full list of service options in user friendly, accessible formats that can be easily accessed by individuals and family caregivers.

- This is a relatively low-cost way to ensure that individuals and families are aware of the full menu of options available to them. The same entities providing options counseling could take responsibility for keeping this information current.
- This information should also be available in languages other than English and in print for those without access to the Internet, as well as audio and video versions for individuals who do not read or who prefer information in an auditory or more visual format.
- Again, specifically addresses the requirement of informed choices as stated in 42 CFR § 441.301(c)(1)(vii).

C. The person-centered plan (the Individualized Service Plan or ISA) must document that a choice of service providers and options for case management were offered to the individual who is receiving services.

- Choice should be reinforced at each step of the service planning process.
- Specifically addresses the requirement for documentation under 42 CFR § 441.301(c)(1)(ix).

Principle 2: Checks and Balances. There is robust monitoring and oversight of services, and people served by the DS System have an independent entity that can review and, when appropriate, act on their concerns.

Problem to Solve: The DS System is overly reliant on "self-policing." There must be opportunities for independent review when conflict is suspected or interferes with an individual's right to direct their support program to the greatest degree possible and to live in a setting that has the qualities of a home rather than an institution.

Recommended Strategies

A. Ombudsperson

- The Council has heard from many service recipients that they fear reprisals if they bring a concern about their services to their case manager or to agency management. Even when these worries are

unfounded, a conflict of interest is said to exist when there is an appearance of a conflict.[5]

- Again, the Council found some concerning data in the National Core Indicators In-Person Survey for 2017-18 that may indicate the need for an independent point of contact to address concerns of individuals receiving services.
    - In response to the question, "there is at least one place the person feels afraid or scared (in home, day program, work, walking in the community, in transport, or other place)," Vermont had the highest score among the 36 states and jurisdictions surveyed, with 38% of respondents answering "yes" compared with the NCI average of 19%.[6]
    - In response to the question, "Have someone go to for help if they ever feel scared," Vermont was below the NCI average with 93% of respondents answering "yes" compared with the NCI average of 94%.[7]
- Service recipients in the Developmental Service system should enjoy the same level of protection as in other Vermont long term care programs (Choices for Care, Community Rehabilitation and Treatment (CRT)), which each have identified independent contractors providing the advocacy and systems monitoring of an ombudsperson.
- Having a single point of contact for certain types of complaints will allow the State to keep better data about the experiences that recipients of service are having, including how they may be encountering conflicts of interest. This data should be reported publicly and used in a continuous improvement process.

B. Rule review. The State should review its rules and guidelines with an eye toward explicitly addressing certain situations where a conflict of interest is more likely to arise. Traditionally, such activities include managing someone's money, hiring a family member, or covering expenses like meals, transportation, or tickets.

[5] CMS often sites the definition of Conflict found in Black's Law Dictionary, 8th Edition, Thomas West, St. Paul, MN (2004): A "real ***or seeming*** incompatibility between one's private interests and one's public or fiduciary duties." (Emphasis added).
[6] Ibid., page 259.
[7] Ibid., page 261.

- Additional guidance and protections are needed when an agency is acting as an individual's "rep payee." The Council is aware of at least one instance where an individual was not given a choice over how funds were used on his/her behalf; instead the agency reimbursed itself for expenses it had previously paid. While this individual may, indeed, have needed to pay back the agency, there was no ability to negotiate the terms of that repayment. If this individual had an independent advocate available, s/he might have, for example, enlisted a debt counseling service to negotiate a more gradual repayment.
- A distinction should be drawn between: (1) the conflict of interest inherent in hiring the family member of an agency employee or an agency sub-contractor (e.g. a home provider); and (2) the conflict of interest that may stem from hiring a family member of the individual receiving services.
    1. The former is a clear conflict that should be explicitly forbidden or mitigated by an alternative management entity. The Council is aware of several cases where oversight of a home provider or a direct support provider is compromised by the familial relationship between the community agency's director and the staff in question. Independent case management could address this type of conflict of interest.
    2. The latter may be desirable – for example, when an adult sibling provides respite. However, additional checks and balances should be put in administrative rule to ensure that this is what the individual in service truly wants.
- The use of respite funds to cover costs associated with providing this service – for example, a meal out or a movie ticket – should be reviewed with an eye toward ensuring both the prudent use of resources and avoiding the real or apparent conflict that stems from an employee (or even just a friend) receiving a benefit at public expense. The primary concern here is with the potential for an employee to suggest costly activities that reflect their own interest more than that of the individual being supported. An additional concern is the potential for this type of spending to reflect poorly on the integrity of the DS System as a whole. If there are already rules governing these expenses, the Council is aware of instances where they are not being enforced.

C. "Wrap Services." In some cases, a shared living provider is responsible for managing an individual's budget for community supports. The home provider is also responsible for the respite budget associated with the individual they are supporting. In these arrangements, the employer of record is the home provider. At a minimum, the Council believes these arrangements require increased scrutiny and greater State guidance.

- The State should strictly limit the service planning responsibilities of the home provider if they are managing an individual's community support budget. A home provider is not a case manager, nor do they typically have the training, requisite skills, and code of ethics that undergird high quality case management. As well intended as home providers generally are, this is an unregulated area where unconscious bias can drive service planning and the distribution of resources.
- The individual (and/or their guardian or a person identified as supporting the individual in decision-making) – in collaboration with a case manager -- should decide how frequently and in what setting respite services take place. For example, if an individual prefers to go away to camp for two weeks and consequently have less frequent weekend respite, this should be honored in the individual's Individual Service Agreement regardless of the home provider's preference. The State needs to recalibrate how it thinks about respite: While respite is intended to give the provider a break, this needs to occur in a way that also recognizes the individual's preferences and goals.
- The State should provide additional guidance and scrutiny when a home provider is hiring their own family and/or household members.

D. Additional Training for Providers. The State has indicated that this training would focus on "person-centered planning and program specific information." More training is always desirable. The Council would add that as a mitigating strategy, training should include information specifically about conflict of interest, how it may compromise self-determination and the integrity of the service system, and what to do if a conflict is suspected.

Principle #3: Separate financial decisions from service delivery. Decisions about access to services and to funding should not be made by agencies with a financial interest in delivering those services.

Problem to Be Solved: Fiduciary Conflicts – For example, pressure to either over or under value the budget necessary to meet an individual's needs, steer an individual toward one's own service agency or a particular service model (shared living), pressure to retain an individual's service level rather than promoting independence.

Recommended Strategies

A. Independent Assessment of Eligibility for Program

- CMS guidance on this question is clear. Under no circumstances can the entity that delivers services determine an individual's eligibility to receive those services. Moreover, 42 CFR § 431.10 requires that "the State Medicaid Agency (SMA) be responsible for eligibility determinations, and eligibility determination can only be delegated *to another governmental agency with SMA oversight*" (emphasis added). We interpret this to mean that a branch of state government, not a subcontracting agency, must be the entity responsible for carrying out eligibility determination.

B. Independent Needs Assessment for Person-Centered Plan by State staff or by a contractor of the State

- If "the needs assessment" includes reviewing whether an individual meets a system of care priority, then it has direct bearing on eligibility determination, and 42 CFR § 431.10 applies as above.
- Our understanding is that a standardize instrument will be used to assess need. Using a pool of trained interviewers, who are supervised directly by the State, to administer this tool is more efficient and ensures greater inter-rater reliability.

Structure for Case Management Services

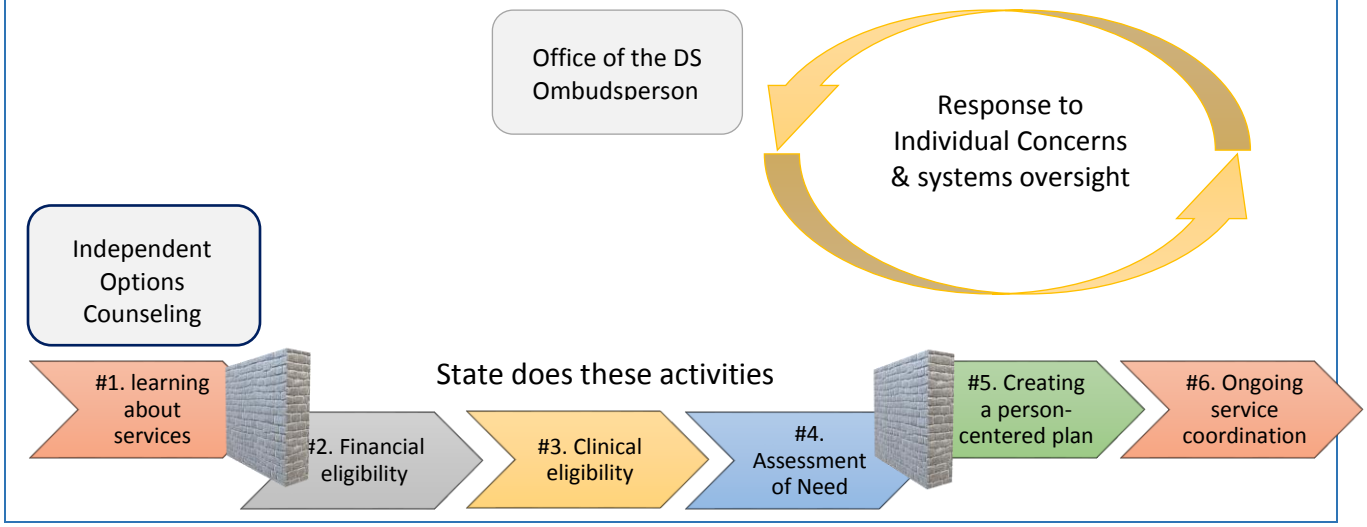
Finally, we turn to the four (4) structures that the State has described to align case management activities with the CMS rule.

Based on recommendations under Principle #3 above, a division is clearly required between activities 1-4 and activities 5-6; activities 3 and 4 must be conferred to the State. Independent options counseling also places a division between activity 1 and all the activities that follow. Finally, an independent

channel for complaints and for some systems oversight is opened by adding an Office of the Developmental Services Ombudsperson. This structure is illustrated in the graphic below, and it corresponds to what the State has identified as "Option 4," specifically, the implementation of additional protections and a waiver from CMS permitting conflict of interest to remain in place. In this model, the case management activities retained by the designated and specialized service agencies include:

- developing and revising the individual service agreement;
- recruiting, hiring, training, scheduling, and supervising direct support staff, job coaches, and home providers;
- crisis intervention and/or referral to appropriate crisis services;
- covering for direct support staff when there are gaps in service;
- ensuring compliance with State rules;
- responding to individual concerns and questions from service recipients, family members, and home support providers; and
- documenting critical incidents.

Case management activities with additional protections in place (Option 4)



Next, we review each option in order of preference, beginning with the option that the Council considers least desirable:

Option 2: Regional solutions lead by the designated agencies. The Council is concerned that:

- A mix of regional solutions will exacerbate the disparities between communities with relatively more or less resources. A stated goal of payment reform is to bring greater fairness to the DS System.
- In some regions – for example, Windham county – the designated and specialized service agencies are competitors more than they are allies.
- The designated agencies are already stretched thin addressing other aspects of payment reform.
- Some agency leaders continue to express skepticism regarding the value of and need to implement the new CMS rule, making them at best reluctant participants in finding a solution.

Option 4: Provide additional protections and seek a waiver from CMS. The Council is concerned that:

- This option fails to address conflicts of interest associated with the many financial decisions that are embedded in the individualized service agreement (Principle #3). It does not go far enough in strengthening checks and balances in the DS System.
- Based on the experiences of states like New Hampshire, Wyoming, Alaska, and South Dakota, CMS is very unlikely to accept this proposal. Pursuing this strategy wastes valuable time when the State is already late in developing its plan for compliance.

Option 3: Provide additional protections and a choice of case management entities; then seek a waiver from CMS so that recipients of service may choose to keep their case management with their service delivery agency or to move case management to an independent entity. While this adds the important element of choice, the Council is concerned that:

- Some individuals remain in a situation where their access to quality, self-directed services may be compromised due to conflicts of interest.
- This position will be very difficult to defend: Having established that there are alternative entities prepared to offer case management activities, Vermont will be hard pressed to claim 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."[8]

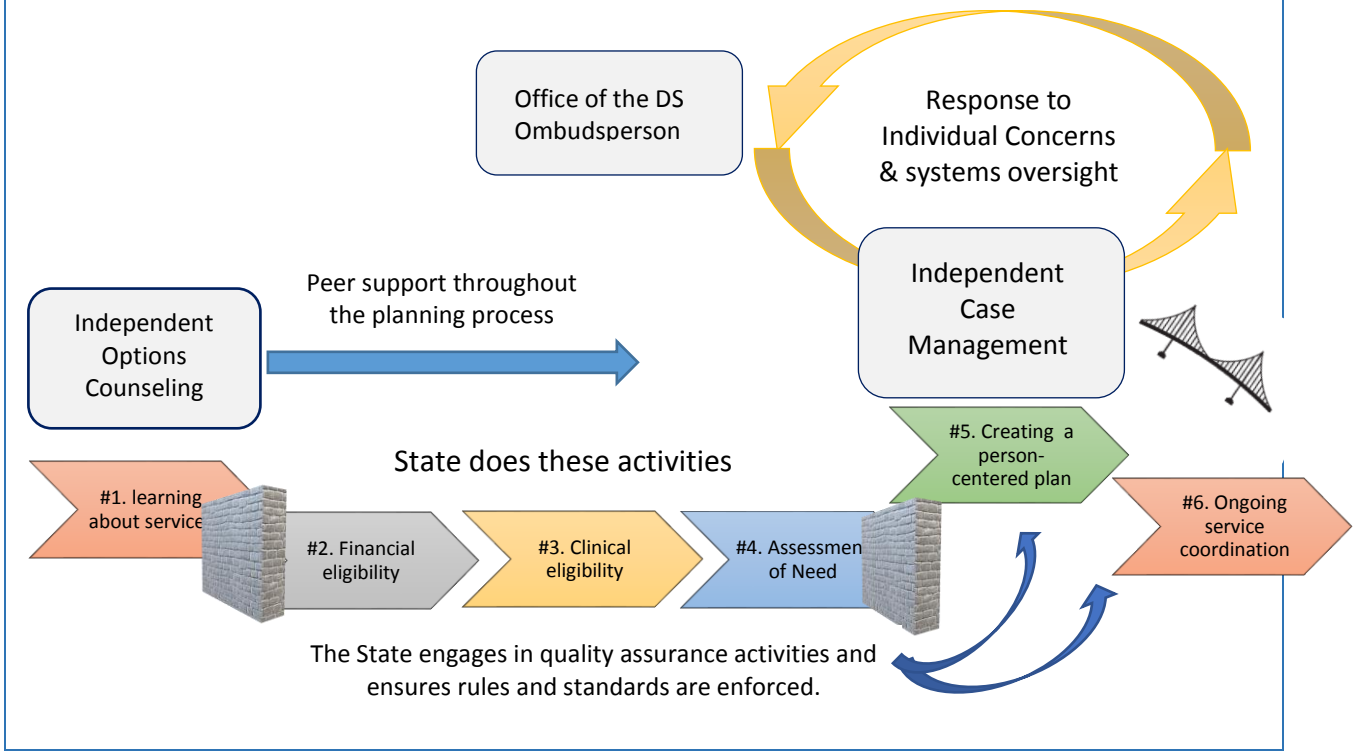
Option 4: Separate additional case management activities from the agency that delivers the individual's services. This option is preferred by the majority of the Council's public members. The specific case management activities that would be relocated to an independent entity or a group of independent entities should include: developing and revising the ISA; monitoring the quality of an individual's services and the fidelity of those services to the ISA; and negotiating between the individual and their providers when conflicts arise. The service providing agency would retain the duties associated with recruiting, hiring, scheduling, and supervising staff. The Council supports this option because:

- Every individual in the DS System will have access to a case manager who can advocate on their behalf free from potential conflict of interest.
- This option honors the plain language of the CMS Rule, which specifically calls out the development of the person-centered service plan as an activity that must not be undertaken by the same entity that delivers services.
- Service agreements will be facilitated by a professional with significant experience in developing a person-centered plan. This is an activity that requires a specific skill set and expertise that increases with practice. As a facilitator, the case manager developing the ISA does not need to know the individual well; in fact, this may increase any tendency to pre-judge what is important to and important for the individual. Rather, the case manager needs to draw the individual, the providers, and the individual's natural supports into a rich discussion about possibilities and priorities.
- Case managers will not be positioned or pressured to "cover" for direct support staff when there is a gap in service. While this may seem generous and even necessary given workforce issues, it is not efficient and should not be standard practice. Case managers, who are paid at a relatively high hourly rate, should not be providing a service that is funded at a rate that assumes a comparatively low hourly wage.

[8] 42 CFR § 441.301(c)(1)(vi).

Notice that in our final illustration (below), rather than placing a wall between the service providing agency and the case management entity, we envision a bridge. Although discussions around the implementation of the CMS rule have been challenging, agency staff, self-advocates and families, and the State need to come together once a strategy has been selected. The job parameters, training, and even the messaging about the case manager role should emphasize collaboration with agency providers. The State should establish in advance a protocol for instances when a case manager has a concern about the delivery of a service; and this process should begin with attempts to resolve the issue at the most local level. It should also avoid putting the case manager squarely in the role of policing the agency. The State remains the responsible party for enforcing rules and standards. Conversely, the provider agency should be able to look to the case manager as a resource, especially when change or challenges arise. The provider agency should be a welcome participant when developing the ISA, and the provider should seek input from the case manager when evaluating staff or the effectiveness of a service.

Case management activities with additional protections and an independent entity to engage in plan development and service monitoring (Option 1)



In closing, thank you for the opportunity to comment in detail on the State's proposals to address conflict of interest in case management activities. The Council looks forward to continued discussion about these very important issues.

Yours Sincerely,

Kirsten Murphy
Executive Director

cc. Acting Deputy Secretary Monica Hutt, Agency of Human Services
Director Clare McFadden, Developmental Services Division