Conflict of Interest: When Does It Exist? How Can I Fix It?

Division of Long Term Services and Supports
Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services

Today's presentation will cover:

- Brief review of case management activities
- Overview of what constitutes conflict of interest (COI) in case management activities
- Review of the HCBS rules regarding COI
- Assessing states' case management systems
- Using data to inform stakeholders and decision-making
- Developing and implementing a corrective action plan (CAP)

A note about COI and the term “case management”

- We will use the term "case management activities" to include the various functions specified in regulations that must be distinct from direct service provision, with the assumption that these activities may be performed by individuals or entities other than the case manager or designated case management entity. In some programs/benefits, the entities who perform these functions *may or may not be a case manager. For example:*
  - 1915(i) regulations do not specify COI related to "case management”, but rather to specific functions
  - 1915(c) regulations specify, "case management or develop the person-centered service plan"
  - 1915(k) identifies, “performing the assessment of need and developing person-centered service plan”

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Case Management Activities

- Are "key" or "linchpin" services in the world of long term services and supports (LTSS)
- And, both the human services system *and* the individual/family rely on case management activities
  - The "system" needs case management to keep the programs running.
  - The individual and family use case management activities to help them access needed services and supports.

Case Management: System Functions

- Oversee provider performance
- Operate front line on quality compliance/outcomes/safety
- Uphold key Medicaid requirements, such as:
  - Informed choice and freedom of choice
  - Assuring rights
- Assure compliance with regulations
  - Keep the required records, which…
  - Keeps the money flowing by supporting activities such as:
    - Level of care screens
    - CMS-required annual reviews
    - Assuring people keep financial eligibility for Medicaid
    - Assuring individual plans match billing, etc.

CMS CENTERS for MEDICARE & MEDICAID SERVICES

Case Management: Individual and Family Functions

- On behalf of the individual and family, case management activities include:
  - High quality, person-centered planning that keeps the full focus on the individual.
  - Serving as the front line for information and assistance.
  - Providing a source of knowledgeable and thoughtful strategies to help individuals make decisions about what is important *to* them and *for* them.
  - Helping individuals and families “navigate” the system.
  - Serving as the initial contact for addressing problems related to outcomes and quality.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Conflict of Interest Defined

A “real or seeming incompatibility between one’s private interests and one’s public or fiduciary duties.”*

Or, more simply put:

- Where a person or party has two contradictory interests.**

*Black’s Law Dictionary, Eighth Ed., Thomson West, St Paul, MN (2004)

**https://dictionary.thelaw.com/conflict-of-interest/

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Why COI Matters…
An illustrative example affecting choice

According to National Core Indicators (NCI™)* data, one state that allowed direct service providers to supply case management services found that:

- Individuals or their representatives indicated satisfaction with their case managers.
- 90% say case manager helped with getting what they need or want.
- ***But only 33% indicated they can make changes to their services and budget if needed – versus the national average of 73%.***
- ***Although the state's system is based on full freedom of choice of case management agency, only 53% of respondents indicated they chose their case manager.***

* NCI™ is a voluntary effort by 47 state (and one multi-county) public developmental disabilities agencies to measure and track their own performance: https://www.nationalcoreindicators.org/

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Person Centered Planning and COI

- High quality Person Centered Planning (PCP) depends heavily on assuring that individuals have full knowledge and full freedom of choice of services. The HCBS settings rules require that PCP:
  - "…Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.." and
  - "…Offers informed choices to the individual regarding the services and supports they receive and from whom"

42 CFR 441.301(c)(1)(ii) and(vii) (note that this citation is for 1915(c) waivers; similar provisions apply to 1915(i) HCBS and 1915(k) CFC State Plan programs.)

Case Management Activities and COI

COI can arise when the same entity helps individuals gain access to services, monitors those services, *and* provides services to that individual. There is potential for COI in:

- Assuring and honoring free choice
- Overseeing quality and outcomes
- The "fiduciary" (financial) relationship

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

COI and Potential Effects on Choice

- A key tenet of PCP -- and a Medicaid requirement-- is informed, full freedom of choice among supports and services and individual providers (except where CMS has authorized certain restrictions such as managed care).
- COI may promote conscious or unconscious "steering" (to particular services or service providers)
- Steering or self-referral (referral to your own agency), can also have the effect of limiting the provider pool

Quality and Outcomes: “Self-Policing”

- Self-policing occurs when an agency or organization is charged with overseeing its own performance.

- Puts the case manager in the difficult position of:
  - Assessing the performance of co-workers and colleagues within the same agency.
  - Potentially having to report concerns to their mutual supervisor or executive director.

COI and Potential Fiduciary Conflicts

Fiduciary conflicts of interest can contribute to a host of issues, including:

- Incentives for either over- or under-utilization of services
  - Person is “costing too much” or “we’re not being paid enough”

- Possible pressure to steer the individual to their own organization for the provision of services

- Possible pressure to retain the individual as a client rather than promoting choice, independence, and requested or needed service changes

Medicaid HCBS Authorities and COI Regulatory Scope

- **COI requirements apply to case management activities provided to individuals *enrolled in*:**
  - 1915(c) HCBS Waivers found at: 42 CFR 431.301(c)(1)(vi)
  - 1915(i) State plan HCBS found at: 42 CFR 441.730(b)
  - 1915(k) Community First Choice (CFC) found at: 42 CFR 441.555(c)
  - HCBS delivered under an 1115 research and demonstration waiver*

- **Federal Register** January 16, 2014,Volume 79 No.11, "Medicaid Program; State Plan Home and Community-Based Services, 5- Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers"

- ***What triggers the COI requirements is enrollment in the HCBS authorities, 1915 (c), (i), and (k). It is important to note that the COI requirements apply no matter what funding stream is used for case management activities.***

*We will not cover 1115 waivers today but will do so at a later date

Federal requirements to prevent and mitigate potential COI under 1915(c) HCBS Waiver

- 42 CFR 441.301(c)(1)(vi) requires that providers of HCBS for the individual must not provide case management activities or develop the person-centered service plan.
- 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. **

** Referenced in the 1915(c) Waiver Application, Appendix A: Waiver Administration and Operation

- 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 very unique circumstances set forth in regulation.***
- 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

CMS CENTERS for MEDICARE & MEDICAID SERVICES

Federal requirements to prevent and mitigate potential COI under 1915(i) State Plan HCBS

- Federal regulations require 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.

- *Under no circumstances can a direct service provider determine eligibility*. This exclusion applies to financial and service eligibility.

Individuals or entities that evaluate eligibility or conduct the independent evaluation of eligibility for State plan HCBS, who are responsible for the independent assessment of need for HCBS, or who are responsible for the development of the service plan *cannot:*

- Be related by blood or marriage to the individual or to any paid caregiver of the individual;
- Be financially responsible for the individual;
- Be empowered to make financial or health related decisions for the individual; or
- Have a financial interest in any entity paid to provide care to the individual.

Federal requirements to prevent and mitigate potential COI under 1915(k) Community First Choice

- Individuals or entities performing the assessment of need and developing the person-centered service plan *cannot be:*
  - Related by blood or marriage to the individual or a paid caregiver
  - Financially responsible for the individual
  - Empowered to make health-related decisions
  - Individuals who would benefit financially from service provision
  - Providers of State plan HCBS to the individual

Identification of COI in the Services System

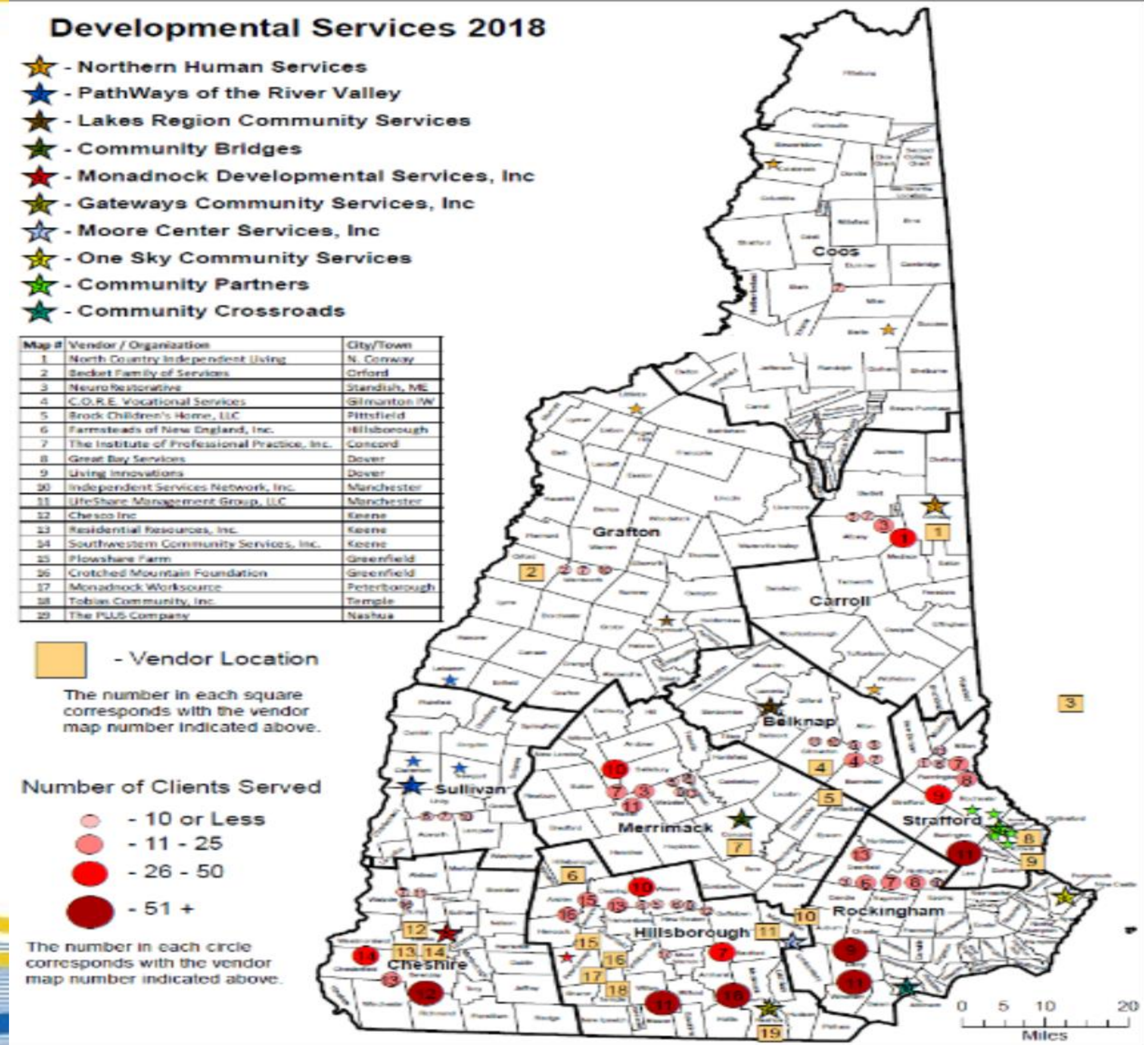
Structural review	*Functional review*	*Regulatory Review*
How are case management activities and direct services delivered presently? Are case management activities and direct services delivered by the same entity to the same individuals? Do case management providers/entities have an interest in a provider or are they employed by a provider? How many agencies or organizations are affected?	What are case manager and direct service provider responsibilities? Do providers develop the person-centered plan? Do providers conduct evaluations of eligibility or make HCBS eligibility determinations? What is the case manager role in establishing eligibility? Do case managers have a role in assigning budgets?	Do current practices comport with the requirements that the SMA, or a designated governmental agency make eligibility determinations? Do current state statutes, standards, and guidance (manuals) comport with the Federal requirements to prevent against and mitigate potential conflict of interest? What changes are needed?

Mapping the Services System

- Mapping can give a picture of COI across the system by identifying the impacts of the COI requirements on your current system
  - How many agencies are affected? What type of organizations (sub-state, providers)?
  - Where are agencies/entities located? Urban/rural?
  - How many individuals served may be impacted by the COI rules? Where are they located?
  - What distinct cultural or minority populations are affected? How many individuals?

New Hampshire's System Map: Agencies and Clients Served

In order to ascertain the scope and impact of moving to a conflict free system of case management, New Hampshire undertook a detailed systemic mapping, including review of their case management entities and provider capacity throughout every jurisdiction in the state.



Map #	Vendor / Organization	City/Town
1	North Country Independent Living	N. Conway
2	Becket Family of Services	Orford
3	NeuroRestorative	Standish, ME
4	C.O.R.E. Vocational Services	Gilmanton IW
5	Brock Children's Home, LLC	Pittsfield
6	Farmsteads of New England, Inc.	Hillsborough
7	The Institute of Professional Practice, Inc.	Concord
8	Great Bay Services	Dover
9	Living Innovations	Dover
10	Independent Services Network, Inc.	Manchester
11	LifeShare Management Group, LLC	Manchester
12	Chesco Inc	Keene
13	Residential Resources, Inc.	Keene
14	Southwestern Community Services, Inc.	Keene
15	Plowshare Farm	Greenfield
16	Crotched Mountain Foundation	Greenfield
17	Monadnock Worksource	Peterborough
18	Tobias Community, Inc.	Temple
19	The PLUS Company	Nashua

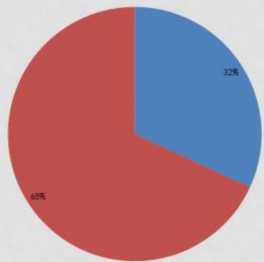
CMS

Alaska Data: Scope of COI

WHAT % OF RECIPIENTS RECEIVE CFCM CURRENTLY?

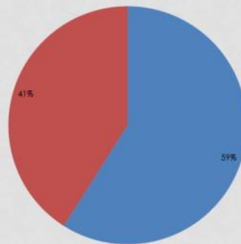
68% of ALI recipients

Alaskans Living Independently



41% of APDD recipients

Adults with Physical and Developmental Disabilities

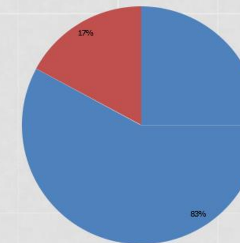


Region	Number of Care Coordinators	Number of Care Coordinator Agencies	Number of Clients	Number of Clients Served by Independent Care Coordinator	Percent of Clients Served by Independent Care Coordinator
Anchorage			**2,197**	**1,114**	**51%**
IDD	83	38	925	195	21%
ALI	87	62	1,144	882	77%
APDD	26	17	36	18	50%
CCMC	38	18	99	21	21%
Southcentral			**1,360**	**586**	**43%**
IDD	72	37	538	89	17%
ALI	76	54	716	471	66%
APDD	25	18	31	9	29%
CCMC	33	15	76	17	22%
Southeast			**320**	**64**	**20%**
IDD	31	16	192	34	18%
ALI	21	16	98	18	18%
APDD	4	3	6	4	67%
CCMC	13	9	24	8	33%
Interior			**326**	**47**	**14%**
IDD	24	14	206	16	8%
ALI	12	11	95	29	31%
APDD	5	3	5	1	20%
CCMC	10	4	20	1	5%
Northwest			**45**	**2**	**4%**
IDD	5	4	31	0	0%
ALI	2	2	2	2	100%
APDD	0	0	0	0	n/a
CCMC	4	2	12	0	0%
Southwest			**95**	**3**	**3%**
IDD	12	8	71	2	3%
ALI	3	3	4	1	25%
APDD	0	0	0	0	0%
CCMC	6	5	20	0	0%
Alaska Total			**4,343**	**1,816**	**42%**
IDD			1,963	336	17%
ALI			2,059	1,403	68%
APDD			78	32	41%
CCMC			251	47	19%

WHAT % OF RECIPIENTS RECEIVE CFCM CURRENTLY?

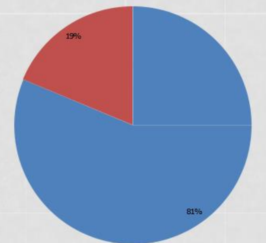
17% IDD recipients

Intellectual and Developmental Disabilities



19% CCMC recipients

Children with Complex Medical Conditions



CFCM: Conflict-free case management

CMS CENTERS for MEDICARE & MEDICAID SERVICES

www.eiseverywhere.com/file_uploads/e98c65b7ad8dcf5584a2da1147e5c33f_TRANSITION.pdf

Assessing Financial Impacts: Key Considerations

- What is the financial impact individually and collectively of addressing conflict of interest on:
  - Direct service providers
  - Case management agencies
  - Managing entities that provide case management (counties, community boards, area agencies)
  - Individual budgets
  - State agencies
- Will additional funds be needed?
- Does addressing COI affect rates paid to providers of either case management or direct services?
- What are potential sources of funding for system changes?
- How is need for additional resources affected by the state budget cycle?

NEW HAMPSHIRE MAPPING TOOL SAMPLE STRUCTURE (ACTUAL TOOL HAS MUCH MORE DETAIL)

Area Agency Function
Total Number of Individuals Served:
Total Number of Waiver-eligible/enrolled Individuals Served:

FY18 ANNUAL BUDGET:

Direct Service	Number of people using service	% provided by AA	% provided by vendor	Total Revenue by Service
Case Management				
Traditional Residential				
PDMS				
CSS				
CPS/DAY				
Supported Employment				
Medical Respite				
Respite				

Financial and Functional Considerations and Factors

As-Is Financial and Functional Analysis	Currently Reimbursed	Provided by	Percent of Job	Annual Compensation -	Comments
Intake/Eligibility:					
Conditional Eligibility Review:					
Benefits Management					
Assessments:					
Person Centered Planning Service Design: This section shows type of detail in actual mapping tool					
Transition Planning: Attending school/transition meetings, as needed					
Coordinate and arrange for Service Plan meeting, facilitate and document PCP initiatives via Service Agreements (Initial, 6-month, renewal, amendments for Service Agreements)					
Facilitate Service Plan Meeting					
Obtain all necessary signatures and releases					
Write Service Plan into HRST					
Develop progress notes, schedules, other essential documents for service delivery					
Distribute documents related to Service Plan					
Conduct Quarterly Satisfaction reviews					
Create and process amendments, as needed					
Service Development:					
Notifications					
Wait List Management:					
Budget:					
Certification:					
Committee Membership					

And there's more that’s important to know

- Based on the analysis, will legislative action be needed for rules and/or for budget increases?
- What is the timeframe within which regulatory changes could happen?
- If there are providers that currently comply with COI rules, what is their capacity to expand services?
- What are the gaps in provider capacity and where?
- Will the state need to seek an exception to the COI provisions for the “only willing and qualified entity” option? (see next slide)

Which brings us to the exception to COI provisions

- Regulations for the HCBS authorities recognize that there may be situations where the pool of available entities who can develop the service plan is limited

1915(i) State plan HCBS: 42 CFR 441.730(b)(5):**

(5) Providers of State plan HCBS for the individual, or those who have an interest in or are employed by a provider of State plan HCBS for the individual, except when the State demonstrates 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 for medical assistance and approved by the Secretary, and individuals are provided with a clear and accessible alternative dispute resolution process.

*** Similar language for 1915(c) HCBS Waiver found at: 42 CFR 441.301(c)(1)(vi) and for 1915(k) at 42 CFR 441.555(c)(5)*

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Under the HCBS authorities, the only exception to the COI provisions is when the state can:

- Demonstrate to CMS that the "only willing and qualified" entity or provider of case management activities is also, or affiliated with, a direct service provider

- Establish safeguards to ensure individual choice and the availability of a "clear and accessible alternative dispute resolution process"

Request for “only willing and qualified” entity responsible for service plan development

- Examples when request might apply:
  - Rural/frontier area "naturally" limits pool of available entities
  - Cultural considerations
  - Linguistic considerations

- Supporting documentation for request
  - Data supporting request from mapping and other sources

- State assures capacity to meet safeguards that must be approved by CMS

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Approaches to prevent and mitigate potential COI:

- If there is no other willing and qualified agent/entity the state must devise COI protections such as:
  - An alternative dispute resolution process.
  - "Firewall" policies that separate staff performing assessments and developing person-centered service plans from those that provide any of the services in the plan.
  - Meaningful and accessible procedures for individuals and representatives to appeal to the state.
  - Entities provide case management activities and services *only* with the express approval of the state.
  - State performs direct oversight and periodic evaluation of safeguards.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Additional Safeguards**

- Full disclosure to participants
- Assurance that participants are supported in exercising their right to free choice of providers
- Provide information about the full range of services, not just the services furnished by the entity that is responsible for the person-centered service plan development
- Opportunity for the participant to dispute the state's assertion of only willing and qualified provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process

****HCBS Waiver Technical Guide, January 2015 p. 180-181**

Engaging Stakeholders

- Don't wait, word gets out fast!

- Develop a planned communications strategy that:
  - Establishes your stakeholder committee with strong input from families and individuals
  - Is based on information transparency, that is sharing data and information gathered from mapping and any other surveys
  - Surveys stakeholders about their current experiences and future concerns to better understand the impacts of the COI provisions

Communication/Stakeholder Engagement

- Ohio
  - Webinar on new rules early on
  - FAQs
  - Featured articles in weekly Pipeline publication with distribution to 17,148 people
  - Quarterly scorecards on how COI remediation progressing

  http://dodd.ohio.gov/PipelineWeekly/SiteAssets/default/Scorecard%20Q1-15%20Final.pdf#search=DODD%20scorecards

- South Dakota

  "Community Conversations"-multiple regional meetings

  https://dhs.sd.gov/developmentaldisabilities/docs/CFCM_Community_Conversation_Presentation_Final.pdf

  - Set up a dedicated website
  - Sent out regular 1-2 page communications *tailored to families, self-advocates, and providers*
  - On-going information provided

  http://dhs.sd.gov/developmentaldisabilities/cfcm.aspx

What is a Corrective Action Plan (CAP)?

- When states are out of compliance with the regulation, CMS may require a detailed corrective action plan (CAP) individualized and tailored to the state's particular situation

- The CAP is the state’s roadmap to coming into compliance. A number of states have CAPs related to COI requirements when CMS has identified COI in the state***

****But no need to wait for CMS, states can of course embark on changing their system without waiting for CMS to identify COI and require a CAP. States should work with CMS if waiver or State Plan changes are needed or the exception to the COI provisions is desired.*

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Developing a CAP

- The CAP, using the information from stakeholder input, data gathering and mapping, lays out the:
  - Action items
  - Timelines: start date, target completion date, actual completion date
  - Responsible parties
  - Desired outcome for each action item
  - Milestones
    - Status of specific efforts
    - Challenges to meeting milestones

To develop a Case Management system for the State of New Hampshire that is conflict free. Target date for full compliance: August 31, 2021
N.B. this sample shows only the categories, not most activities. The actual plan is far more detailed and can be found at:
https://www.dhhs.nh.gov/dcbcs/bds/documents/nhcaptimeline.pdf

Action Items	Start Date	Completion Target Date	Responsible Office	Milestone	Desired Outcome	Status	Date	Completion Date
Sharing and Stakeholder Engagement								
Stakeholder Workgroup developed								
Assessment of current case management system functioning Develop Report								
Development of Implementation Plan								
Assessment of current case management system functioning Develop Report (continued)								
Cost Allocation Plan								
Law and Rule Review and Revision								
Rate Modeling								
Gap Plan								
Determine funding needed for implementation								
Development of Implementation Plan								
Case Management System								
Quality Improvement								
Contract Development								
Case Management Transition								

And advice on developing a CAP from those who have gone before…

- Formally engage stakeholders early and continuously (and include a state legislator)
- Continuous engagement with CMS
- Transparency is essential to building support
- Negotiate a realistic timeline for compliance
- Be ready to revise as you go-there may be unforeseen issues
- Utilize data including stakeholder survey/input before, during and after CAP implementation

Where to Find Help

- CMS Website: https://www.medicaid.gov/medicaid/hcbs/guidance/index.html
- Engage with the Regional and Central Office staff
- Request TA: http://www.hcbs-ta.org/form/request-technical-assistance
- For additional information: http://www.hcbs-ta.org

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Questions

CMS
CENTERS for MEDICARE & MEDICAID SERVICES