Conflict Free Case Management

Federal Guidance ● State Engagement ● Impacts

Introduction & Purpose

In January 2014, the long-discussed rules for publically funded Home & Community-Based Services were finalized by the Center for Medicare & Medicaid Services (CMS). While most of the dialog in the preceding years addressed proposed rules changes centered on issues of service provision and residential settings, a lesser-recognized provision became effective in March 2014: *Conflict-free Case Management*. The Michigan Department of Health and Human Services (MDHHS, formerly the Michigan Department of Community Health) has issued no formal guidance to prepaid inpatient health plans (PIHPs), Community Mental Health Service Programs (CMHSPs) or providers defining how these rules will be applied and/or the impact of this rule on the various waiver programs within the state.

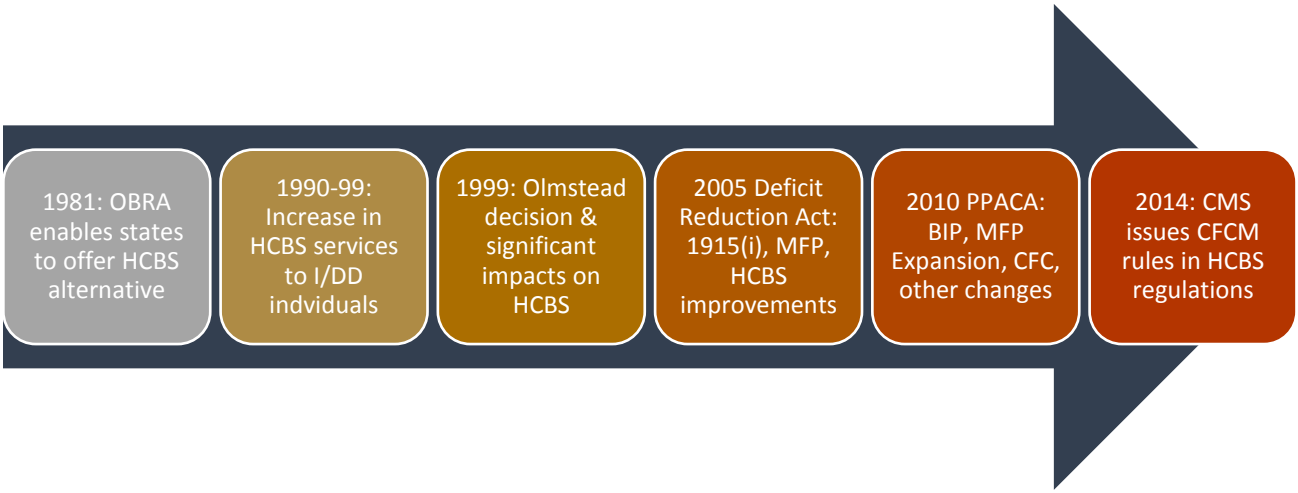
The purpose of this paper is to review the federal guidance, provide an overview of other states' strategies, and stimulate dialog with key leaders in Michigan's behavioral health system. **Lakeshore Regional Partners** (LRP) and **Mid-State Health Network** (MSHN), two Michigan-based PIHPs, have proactively collaborated to engage the opportunities and implications of CFCM by sponsoring this analysis and its independent recommendations.

In an ideal scenario, Conflict-Free Case Management (CFCM) complements the goal of improving person-centered planning while also serving as part of an effective cost-containment strategy. Through the development of firewalls that separate the distinct functions of assessment, authorization, planning and service provision, case managers are better able to objectively support and assist consumers in identifying needs and developing plans to access services. However, implementation of CFCM changes carries the risk of dismantling effective treatment corridors, potentially causing served individuals to navigate an additional layer of oversight and management outside of their primary providers. Any change must be constructed with consumer experience and outcomes at the forefront. Implementing CFCM strategies in a system focused more than ever on healthcare integration and seamless care systems is a challenge that must be addressed thoughtfully and deliberately.

The following provides an overview of Conflict-Free Case Management, the perspectives of Federal and State approaches, and the opportunities and challenges of implementation for long-term and behavioral healthcare.

Conflict-Free Case Management: A Brief History

Conflict-Free Case Management, grown within Home and Community Based Service initiatives, is rooted in statutory guidance, subsequent legal rulings (such as Olmstead v. L.C., 1999), and the development of regulatory guidance by the Center for Medicare & Medicaid Services (CMS). Regarding the latter, CMS's administrative rules for CFCM are the product of many years of consumer experiences and issues in a number of states.



At present, many long-term care and behavioral health systems allow the agent that conducts the functional assessment and/or case management[1] to also provide services to that individual. In some instances, these systems have assessors and case managers also performing quality oversight activities for services provided by their own employer. This "self-policing" has raised concerns for many years from both advocacy groups and federal authorities. A review of literature yields common concerns and identification of potential conflicts which CMS regulations that CFCM is intended to address[2]. These conflicts include:

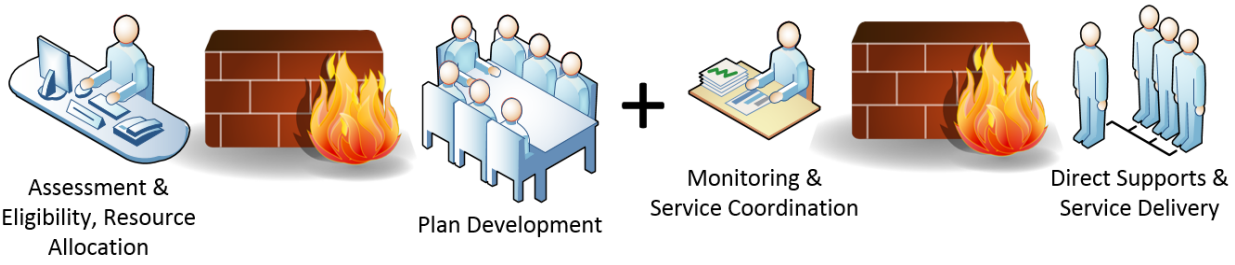
- Potential for either over- or under-utilization of services. If the agent holds multiple roles including the assessment of need, developer of the plan, and provider of services, there may be inherent conflicts resulting in provision of more or less services than the consumer needs.
- Misaligned financial incentives.
    - Agents may be reluctant to suggest providers outside their agency because the agency may lose revenue.

[1] Case management also includes support coordination services.
[2] http://www.nsclc.org/wp-content/uploads/2014/09/NSCLC-Conflict-Free-Case-Management.pdf

- Plans may focus on the convenience of the system, agent or service provider rather than being person-centered
- Interest in retaining the individual as a client rather than promoting independence
- Patterns of provider self-referral and undue influence resulting in compromised individual choice of services or providers
- Inadequate oversight of the implementation of the plan or quality of service delivery

These misaligned financial incentives have resulted in significant costs to public systems which must be addressed through role re-alignment and creating appropriate firewalls between key functions.

The following is a visual representation of where administrative and/or structural firewalls must exist between particular functions:



Assessment & Eligibility/Resource Allocation: This includes the processes for determining eligibility and assigning budgets, hours, or other units of services.

Plan Development: These are the processes that lead to a person-centered plan.

Monitoring & Service Coordination: These are the processes for ensuring that services are delivered according to guidance included in the plan. Activities include coordinating services, monitoring the quality of the services and monitoring the participant (e.g., watching for changes in needs or preferences).

Direct Supports & Service Delivery: The supports and/or services provided to the individual in accordance with the person-centered plan.

> *Note*: **Utilization Management** *activities are a separate and discrete managed-care function which sits outside of these processes, ensuring that medical-necessity criteria are met (e.g. "Right service in the right amount at the right time").*

Federal Guidance

Federal guidance has gained considerable clarity over the past few years describing the mitigation of conflict-of-interest in the provision of case management[3]. Of note is the CMS CFCM guidance found in the Balancing Incentive Program, wherein the federal agency articulates its clearest intentions, encapsulated in the following nine discrete CFCM principles:

Principle 1: Clinical or non-financial eligibility determination is separated from direct service provision

Recommendations for Strategy Development

- Individuals responsible for determining eligibility for services must do so distinctly separate from the provision of services.
- In circumstances where there is overlap, appropriate firewalls must be in place so that there is no incentive or influence for case managers to affect the revenues for their organization.

  Ideally, eligibility for services is determined by an entity or organization that has no fiscal relationship to the individual or organization providing services. This separation applies to re-determinations as well as to initial determinations.

- Individuals making eligibility determinations should not have concurrent responsibility or oversight for finances or service provision at a provider organization.
- Consider requiring case management functions and direct service provision to be located in different departments.
- Where possible, require that an agency does not case manage the clients to whom it provides other direct services. Case management is still part of the agency's portfolio of services, but there is no inherent conflict for a given client.
- Consider allowing a consumer to choose to have the same agency provide case management and other direct services as long as the choice is clearly documented.

Principle 2: Case managers and evaluators of consumers need for services are not related to the individual, their paid caregivers, or anyone financially responsible for the individual

Recommendations for Strategy Development

- Individuals cannot perform the assessment of need for services nor develop the service plan if they are:
  - Related by blood or marriage to the served individual

[3] A comprehensive review of the statutory, judicial and administrative impetus for CFCM can be found in Appendix A.

- Empowered to make financial decisions for the served individual
- Hold a financial interest in any entity that is a direct service provider to the individual
- Are paid care givers to the individual
- Are financially responsible for the individual

Principle 3: There is robust monitoring and oversight

Recommendations for Strategy Development

- A Conflict-Free Case Management system must include strong oversight and quality management to promote consumer choice. PIHPs and CMHSPs in Michigan must work alongside state leadership to ensure that the expectations for monitoring and oversight are clearly established.
- Oversight should include monitoring for evidence that the individual developing the plan of service provided the consumer with:
  - A list of agencies that provide similar services
  - A statement specifying the consumer has a right to make an independent choice of service providers
- Monitoring and oversight must include data collection demonstrating evidence of external referrals.
- If an agency provides both case management and assessment, it must:
  - Document in the service plan that it will ensure its employees act in the best interest of the participant and conflict of interest will not occur.
  - Develop a conflict of interest plan.
  - Specify methods of communication required to inform the individual consumer about the potential for conflict.
  - Document that the consumer was informed about freedom of choice.

Principle 4: There exists clear, well-known and accessible pathways for consumers to submit grievances and/or appeals for assistance regarding concerns about choice, quality, eligibility determination, service provisions and outcomes

Recommendations for Strategy Development

- PIHPs and CMHPs in Michigan must work collaboratively with MDHHS leadership in establishing these grievance and appeals mechanisms and the responsibilities of providers, payers and state agencies in those processes.
- Consumers must be clearly informed about their right to appeal decisions about plans of care, eligibility determination and service delivery.

- Clear, publicized and accessible pathways are established and provided to consumers with instructions for how to submit grievances and/or appeals to the managed care organization or state for assistance regarding concerns about choice, quality, eligibility determination, service provision and outcomes.

Principle 5: The decisions for grievances, complaints, and appeals are adequately tracked, monitored and used

Recommendations for Strategy Development

- Data related to grievances, complaints, appeals and the resulting decisions must be tracked and monitored. PIHPs and CMHPs in Michigan must work collaboratively with MDHHS leadership in establishing these tracking and monitoring mechanisms
- Information obtained is used to inform program policy and operations as part of the continuous quality management and oversight system.

Principle 6: To ensure that consumer choice and control is not compromised, State quality management staff oversee clinical or non-financial program eligibility determination and service provision business practices

Recommendations for Strategy Development

- State quality management staff could provide oversight and monitoring, or it could be delegated to health plans (e.g. PIHPs)
- Random or targeted sample audits should be utilized to determine whether assessment/eligibility determination findings match actual service needs

Principle 7: State quality management staff track and document consumer experiences with measures that capture the quality of care coordination and case management services

Recommendations for Strategy Development

- Data must be collected to document consumer experiences with assessment, planning and service provision and coordination.
- Measures should include consumer satisfaction, freedom of choice, referral patterns, to identify potential conflict.

Principle 8: In circumstances when one entity is responsible for providing case management and service delivery, appropriate safeguards and firewalls exist to mitigate risk of potential conflict

Recommendations for Strategy Development

- Person-centered plans must document that a choice of service providers was offered to the served individual, with indicators that measure the frequency with which a choice other than the case management agency is selected for service provision.
- CMS is aware that in some rural areas there may only be one provider available to serve as both the case management and service provider agency. In these instances, CMS requires the state to spell out how they will mitigate potential conflict of interest, potentially including additional oversight of the situation by the state. PIHPs and CMHSPs in Michigan must work closely with state leadership to determine circumstances in the existing payer/provider systems where a rural exception would apply.
- Use common, validated screening and assessment tools. Capture data/results electronically and use as a consistent factor in establishing service eligibility.

Principle 9: Meaningful stakeholder engagement strategies are implemented which include consumers, family members, advocates, providers, state leadership, and case management staff

Recommendations for Strategy Development

- Engage stakeholders early in the design process.
- Include consumers and advocates in the evaluation of the current infrastructure. Identify existing policies and procedures that may be the building blocks of the potential firewall.
- Determine what additional costs or unintended consequences could be incurred when implementing the components of a firewall (i.e. lack of efficiency, impact on consumers).
- Use stakeholder input when developing communication plans related to firewalls and safeguards.
- Engage consumers in the ongoing monitoring of performance on measures tied to the goals of CFCM.

State Approaches and Strategies for CFCM Compliance

As with any guidance, there can be significant variance in how states choose to interpret and implement their strategies for compliance. Based on review of multiple states' strategies, it appears

that ***there is no consensus plan for how to reach conflict-free status***. The following are examples of mitigation strategies commonly implemented, although the specifics of these vary considerably from state to state.

- Separation of assessment and eligibility functions to be either a state responsibility or contracted to an independent entity
- Refinement of case management requirements, qualifications, and training
- Increased monitoring and enforcement
- Development of independent case management agencies
- Changes to reimbursement strategies for case management services

While the rules do not explicitly rule out the provision of case management by provider agencies, many states have opted for a complete separation of case management from service provision. A key component of most states' strategies is to establish the criteria for whether service providers can own and/or serve on the boards of directors of case management agencies. Many states include explicit references in their plan to the instances where provider-based case management is allowed and the administrative firewalls required, thereby mitigating financial misalignment or other conflicts.

In many states where Managed Care Organizations operate, the state retains the assessment and eligibility functions, while the Managed Care Organizations develop the plans of care and provides care management functions. In other states, some other independent entity has delegated responsibility to implement the assessment function. In most states, utilization management units do not have any responsibilities for development of the plan of care or service provision in order to ensure an unbiased review of the medical necessity of services provided.

Appendix C provides a summary of several state Conflict-Free Case Management strategies included in current waiver applications or Balancing Incentive Program plans that may be useful to consider as Michigan develops its strategy and guidance related to this rule.

Other Considerations

In order to address these issues and comply with federal rules, states are working in cooperation with CMS to design structures that eliminate or reduce conflict of interest. Inherent in this dialog are questions such as:

- How does a state or regional service delivery system provide services to an individual in a manner that facilitates ultimate consumer choice and direction, while ensuring the overall care system is coordinated and free from conflict?
- Do states and regional authorities develop systems to work both with the existing infrastructure as well as prepare for the rapidly changing health care delivery landscape

with its unique opportunity to break down treatment silos through improved care coordination?
- How does a state or regional authority ensure that the individuals who are assessing, planning, and coordinating care truly know and understand the individual's needs?

Opponents of some states' mitigation strategies have voiced concerns that the "firewalls" and other structures being added to avoid conflict may lead to increased fragmentation in an already-complex service system. State perspectives that focus on eliminating conflict can come at a significant cost to care coordination and efficiencies. Others have voiced concerns that a strong connection between the individual and the care manager is needed throughout the assessment, planning and service delivery process is necessary for improved integration and to develop expertise and the trust, critical to a person centered planning process. This has resulted in:

- Concerns that as agencies build firewalls between assessment and case management, the delivery system can become more siloed, despite nearly universal efforts to ensure that care is more coordinated (such as healthcare integration initiatives)
- Concerns about state resources and capacity to approve eligibility or review assessment data

While the general goal is to streamline and coordinate care, the emphasis on building firewalls and barriers may actually result in further fragment services. Some have argued that a strong oversight and appeals process is actually less disruptive and more effective than firewalls and other mitigation tactics.

Due to the infancy of most state's data models related to conflict-free strategies, there is no data currently available to support one model of mitigation over another.

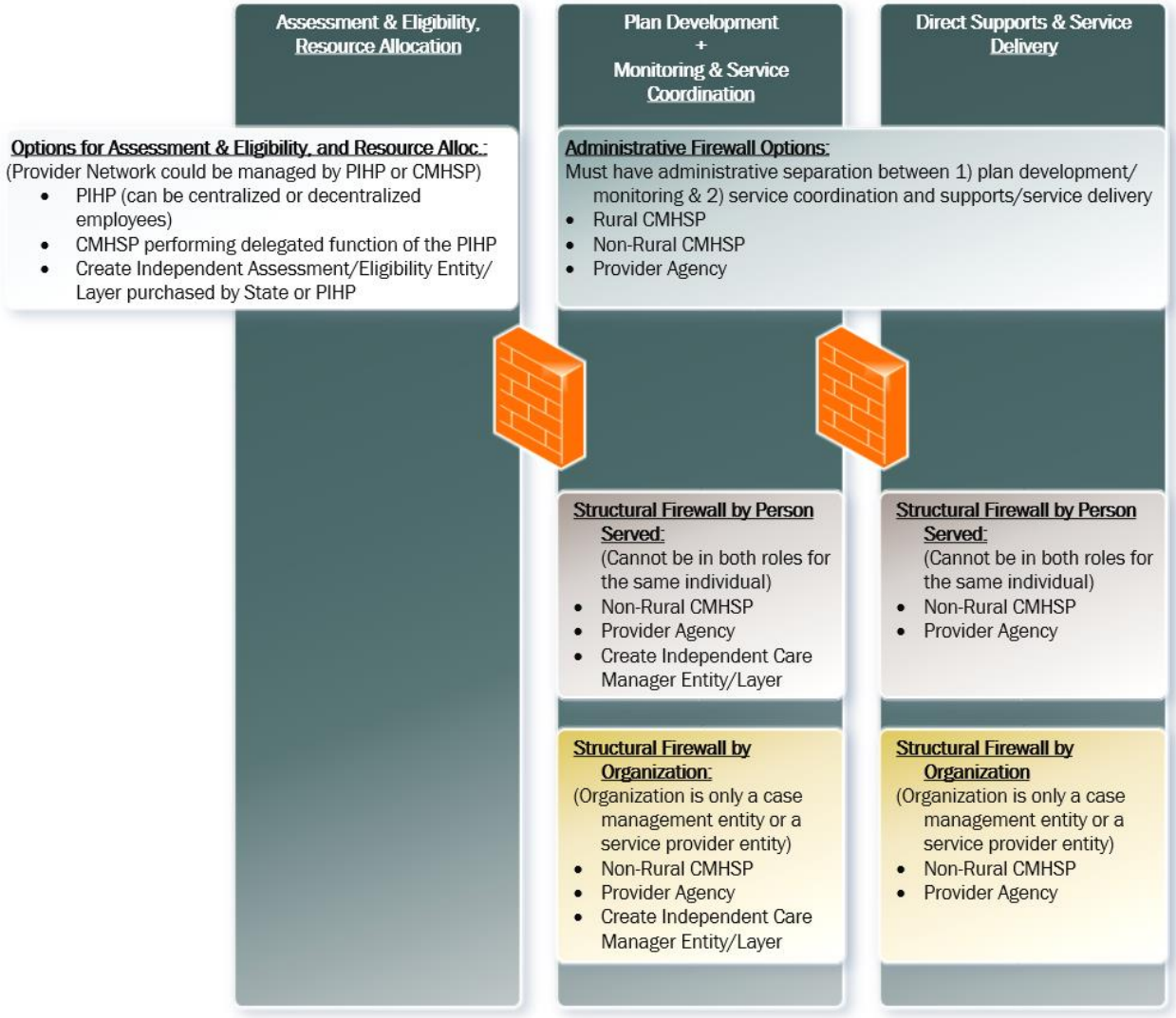
Implications for Michigan

As noted, a natural tension exists between the national impetus to improve care integration and the need to ensure a person-first, cost-effective environment of Conflict-Free Case Management.

In order to ensure the mitigation of conflicts of interest while preserving *effective* models of local service delivery, Michigan should engage a thoughtful, transparent process in determining its approach to federal compliance with CFCM. This process must include the voice of persons served and their family members, along with MDHHS, PIHPs, CMHSPs and providers.

To this end, a number of models could be considered that respect the necessary firewalls, service objectives, and cost containment strategies that require substantive change without dismantling effective public behavioral healthcare systems.

The following diagram visually represents a number of possibilities that would be viable for consideration in Michigan:



- The following key functions must be inured within any selected model:
    - Utilization management activities remain separate and discrete managed-care functions
    - Grievance and appeals processes must be readily available to address potential conflicts of interest

A balanced approach that helps ensure the mitigation of conflicts of interest, sustains effective supports and services, and enables care integration activities will offer the best solution to continue fostering care coordination that propels individuals to lead meaningful, self-directed lives.

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Lakeshore Regional Partners is the public behavioral health plan for people with mental illness, developmental disability, and substance use disorders in Allegan, Kent, Lake, Mason, Muskegon, Oceana and Ottawa counties.

MSHN
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Mid-State Health Network is the Medicaid Managed Care Organization for behavioral health services in 21 counties through contracts with 12 Community Mental Health Programs, maintaining a service delivery system for persons with Serious and Persistent Mental Illness, Serious Emotional Disturbances, Developmental Disabilities, and Substance Use Disorders.

For more information, please contact TBD Solutions:

Nationwide Toll Free: (877) 823-7348

Website: www.TBDSolutions.com

Twitter: @TBDSolutionsLLC

Facebook: www.facebook.com/TBDSolutionsLLC

Email: info@tbdsolutions.com

Appendix A

Legal Requirements and Definitions

The Center for Medicare & Medicaid Services CMS has articulated clear concern about the potential for conflicts of interest and is increasingly requiring states to detail how the potential conflicts are mitigated. While CMS policy continues to evolve with regard to case management and conflict of interest, there are some consistent principles found in recent federal guidance

The Centers for Medicare and Medicaid Services (CMS) defines **case management** as: "An activity that "assists individuals to gain access to needed care and services appropriate to the needs of an individual" Case Management includes services that assist eligible individuals to gain access to needed medical, social, educational, and other services. Targeted case management are case management services provided only to specific classes of individuals, or to individuals who reside in specified areas of the State (or both). Case management does not include the underlying medical, social, educational and other services themselves, integral components of covered Medicaid services…"[4]

Conflict-free case management. "Conflict of interest "is defined as a "real or seeming incompatibility between one's private interests and one's public or fiduciary duties."[5] When case management systems have the same entity both assisting an individual to gain access to services and providing services to that individual, the role of the case manager has potential to be conflicted.

Federal guidance related to Conflict Free Case Management can be found in the following:

1. **Targeted Case Management (TCM) rule required by the Deficit Reduction Act of 2005** (DRA)[6] The Deficit Reduction Act of 2005 had major provisions affecting numerous Medicaid and Medicare programs. This act expanded statutory language concerning Targeted Case Management Services (TCM), especially concerning the allowable scope of TCM. While parts of this rule were later rescinded due to concerns that it may limit state flexibility in structuring case management services, much of the foundation of Conflict-Free Case Management was developed in the DRA.
2. **The Balancing Incentive Program (BIP) provisions in the Affordable Care Act** (ACA)- BIP offers certain eligible states an enhanced Medicaid funding by shifting the percentage of funding allocated for institutional care toward home and community-based services (HCBS). States participating in the program must undertake three structural changes, one of which is

[4] Federal Register, December 4, 2007, Vol. 72, No. 232, 68077-68093; 42 CFR Parts 431, 440 and 441
[5] Black's Law Dictionary, Eighth Ed., Thomson West, St Paul, MN (2004),
[6] http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/downloads/cm_ta_tool.pdf

developing Conflict-Free Case Management. [7] While Michigan is not a participant in the Balancing Incentives Program, the guidance found in these regulations is consistent with other CMS guidance. The BIP manual lays out a series of key provisions required to achieve Conflict Free Case management which include both structural elements and best practices.

3. **The implementation of the Home and Community-Based Services Rule, published by the Centers for Medicare & Medicaid Services (CMS) in January 2014[8].** In January 2014, the CMS released a final rule establishing requirements for settings funded under Medicaid Home and Community-Based Services (HCBS) programs. States had to comply with the other parts of the rule, including person-centered planning and Conflict-Free Case Management, by its effective date of March 2014. In addition, these rules put a high priority on Choice of Case Manager. One of the most basic of the required assurances to all Medicaid recipients is free choice in their selection of qualified service providers (including case management providers).
4. **HCBS Waiver Applications and Renewals -** While CMS does not delineate the specific structures or methods to achieve CFCM, this emphasis on choice of case manager and mitigating potential conflict is increasingly found in waiver reviews**.** Based on review of states' waiver applications and renewals, CMS clearly has concerns about some states' practices. In particular, waiver plans and waiver applications in several states have been challenged in federal reviews where there is a sole source of case management such as Counties. Beginning with the new waiver application in 2003, CMS has required states to describe the safeguards in place to assure that conflict of interest is mitigated. In the actual application, CMS provides states the choice to indicate they do permit service plan development to be done by direct provider agencies but also requires states to establish and describe "…safeguards to ensure that service plan development is conducted in the best interests of the participant."

   CMS reiterates this same principle when asking states how they monitor service plan implementation, again requiring the state to describe safeguards when case management and direct services are provided by the same entity, noting, "Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant. The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant."

[7] Affordable Care Act (ACA) Section 10202 of the Patient Protection and Affordable Care Act;
[8] Final Rule CMS 2249F 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

"These safeguards must include full disclosure to participants and assuring that participants are supported in exercising their right to free choice of providers and are provided information about the full-range of waiver services, not just the services furnished by the entity that is responsible for service plan development. The safeguards also must include an option for the participant to choose a different entity or individual to develop the plan; direct oversight of the process or periodic evaluation by a state agency; restricting the entity that develops the plan from providing services without the direct approval of the state; and/or requiring the agency that develops the plan to administratively separate the plan development function from the direct service provision functions."[9]

5. **1915(i) State Plan HCBS**: The 1915(i) state plan home and community-based services option currently has the most stringent requirements for the separation of eligibility determination as well as assessment and service planning from direct service provision. This option carries a requirement that assessment (of needs) and service planning be separate from direct services. In the instructions/guidance regarding 1915(i) options, CMS indicates that there are three aspects of service planning, including activities to: "Determine the necessary level of services and supports to be provided; prevent the provision of unnecessary or inappropriate care; and establish a written individualized service plan." The guidance goes on to note, "To achieve the three purposes of the assessment listed above, the assessor must be independent; that is, free from conflict of interest with regard to providers, to the individual and related parties, and to budgetary concerns."

Excerpt from: 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 (Section 1915(k) of the Act) and Home and Community-Based Services (HCBS) Waivers (Section 1915(c) of the Act)[10]

42CFR441.301(c)(1)(v)--- (emphasis added)

[9] 3Application for a §1915(c) Home and Community-Based Waiver [Version 3.5], Instructions, Technical Guide and Review Criteria, Release Date: January 2008, p. 180 .

[10] https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-communitybased-services-5-year-period-for-waivers-provider

• (v) Includes strategies for solving conflict or disagreement within the process, including clear conflict-of interest guidelines for all planning participants.

• (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. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process.

(vii) Offers informed choices to the individual regarding the services and supports they receive and from whom.

§ 441.730 Provider qualifications.

(a) **Requirements.** The State must provide assurances that necessary safeguards have been taken to protect the health and welfare of enrollees in State plan HCBS, and must define in writing standards for providers (both agencies and individuals) of HCBS and for agents conducting individualized independent evaluation, independent assessment, and service plan development.

(b) **Conflict of interest standards.** The State must define conflict of interest standards that ensure the independence of individual and agency agents who conduct (whether as a service or an administrative activity) 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.

The conflict of interest standards apply to all individuals and entities, public or private. At a minimum, these agents must not be any of the following:

(1) Related by blood or marriage to the individual, or to any paid caregiver of the individual
(2) Financially responsible for the individual.
(3) Empowered to make financial or health-related decisions on behalf of the individual.
(4) Holding financial interest, as defined in § 411.354 of this chapter, in any entity that is paid to provide care for the individual.
(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.

(c) Training. Qualifications for agents performing independent assessments and plans of care must include training in assessment of individuals whose physical, cognitive, or mental conditions trigger a potential need for home and community-based services and supports, and current knowledge of available resources, service options, providers, and best practices to improve health and quality of life outcomes.

Appendix B

Excerpt from Michigan's CMS- approved §1915(i) State Plan Amendment related to Conflict –Free requirements

The following are excerpts from Michigan's CMS-approved 1915(1) State Plan Amendment for Children with Autism. MDHHS leadership has informally referenced these standards as a potential model for state-wide conflict free Case management. While this 1915(i) – SPA did address steps to mitigate conflict of interest, it is important to note that the CFCM rules had not yet gone into effect at the time of this waiver application.

For more than a decade, the PIHPs have been responsible per the approved §1915(b)/(c) waivers and the MDHHS/PIHP contract for:

1) Determining eligibility for mental health State Plan, additional [(b)(3)] and §1915(c) home and community based services (HCBS);

2) Maintaining a provider network of qualified providers;

3) Assuring the delivery of all medically necessary mental health State Plan, additional and 1915(c) HCBS to Medicaid beneficiaries;

4) Maintaining the mandated organization structure and administrative services for managed care plan, including Customer Service, Grievance & Appeals, Quality Assessment & Performance Improvement Program (QAPIP) and Service & Utilization Management.

The PIHPs must comply with all applicable federal and state laws, including the provisions of §1902(a)(4)(D) which mandates safeguards against conflict of interest.

The MDHHS/PIHP contract also requires "The organization shall have mechanisms to prevent conflict of interest between the coverage determination function and access to, or authorization of, services [Attachment P.3.1.1(VIII)(c)(iii)].

Michigan proposes to use the existing PIHP provider networks to complete the diagnosis of the targeted group and evaluate children with ASD to determine whether each meets the needs-based criteria.

Safeguards are in place to assure that evaluation, assessment, planning and service delivery of ABA are free from conflict of interest through the following:

1) The mandated separation required in the MDHHS/PIHP contract that assures the evaluators will not make determinations about the amount, scope and duration of ABA services;

2) The Medicaid Fair Hearings process to appeal decisions made related to ABA. This may include beneficiaries who believe they were incorrectly determined ineligible for ABA, beneficiaries who believe the amount, scope, and duration of services determined through the person-centered planning process is inadequate to meet their needs, and if ABA services are reduced or terminated;

3) The evaluator's test results may be used as part of the information utilized in the assessment and planning functions, but assessment and planning functions are completed by a team of individuals with a case manager or supports coordinator or other qualified staff overseeing the development of the individual plan of services (IPOS);

4) The family or authorized representative(s) may choose to use either a case manager, supports coordinator or other qualified staff or an independent facilitator to assist in developing the IPOS;

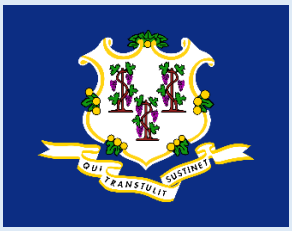
5) The PIHP or its designated entity performs the utilization management function to authorize the amount, scope and duration of ABA. Utilization management staff are completely separate from the staff performing evaluation, assessment, planning, and delivery of ABA services;

6) As part of its QAPIP, each PIHP "has mechanisms to identify and correct under-utilization as well as over-utilization" of services [MDHHS/PIHP Contract Attachment P.6.7.1.1 (XIV) (B)] MDHHS also monitors through its site review process and the External Quality Review to assure that ABA will be determined and delivered appropriate and free from conflict of interest. In addition to these existing mechanisms and because this is a new service, MDHHS will monitor through a system improvement process described in the Quality Improvement Strategy and implement changes as needed.

Appendix C

Samples of various State Approaches to addressing Conflict-Free Case Management

STATE	Conflict of Interest Mitigation Approach/Strategy
ARKANSAS 	For services to individuals with developmental disabilities, a third party vendor administers Level II assessments. This assessment determines the level of care. The DDS specialist offers the patient/client a choice of case management providers. The chosen case management provider works with the client to choose a team of direct service providers. Those providers then collaborate to create a plan of care. Since the providers create the plan of care, the following mitigating factors are in place to remove conflict: • Choice related to participants in planning meetings. • Documentation that the individual has been offered choice among all qualified providers of direct services. • Individual choice of setting of care, as well as choice among all qualified providers of direct services to protect against self-referral. • Administrative separation between those doing assessments and service planning and those delivering direct services. • Clear, well-known, and easily accessible means for consumers to make complaints and/or appeals to the State for assistance regarding concerns about choice, quality, and outcomes. Arkansas has initiated an Ombudsman program that serves as an independent and confidential resource to individuals and their families as appropriate. Ombudsman program works to inform consumers of their rights and choices, and works to facilitate fair resolution to consumer concerns. State quality management staff oversees providers to assure consumer choice and control is not compromised. State quality assurance staff conducts annual on-site visit of each licensed or certified provider. In DBHS, health homes are being developed. Health homes are required to be separate entities from direct service providers. In order to ensure this requirement is met, DBHS will certify both health homes and direct service provider agencies. An independent assessor will complete the Level II assessment, which will then be transferred to the health home. The health home will develop and maintain control of the plan of care to include not only behavioral health needs, but all medical needs, thus, ensuring that there is Conflict Free Case Management.
KANSAS	*(Excerpt from KanCare Medicaid and CHIP Capitated Managed Care Services RFP):* The Contractor(s) shall not Contract for services with any provider who

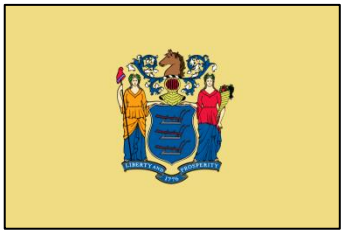
	also provides either case management or functional eligibility assessments, in order to achieve Conflict-Free Case Management for long-term care (LTC) and HCBS services. The Contractor(s) selected for this work will need to demonstrate: How they will minimize potential conflict of interest between assessment of need for services and service delivery[11]
CONNECTICUT 	To mitigate the risk of potential conflict: 1. There is a virtual firewall between the case managers and the staff who provide services within the agencies that provide both services. 2. The case managers have no oversight of the staff that may be delivering service, which provides an administrative separation of services. 3. Funding for case managers is not related to billable activity. 4. Participants are offered a choice of service provider, which is documented on the Orientation Checklist. 5. Participants may choose a different agency to provide services than the agency that provides assessments and case management. 6. If the participant's Case Manager is an entity that also provides services and the participant chooses that same entity to provide services in the community, the fact that it is the participant's choice is documented in the file. 7. A Department of Social Services (DSS) Utilization Review nurse reviews all level of care assessments and recovery plans, which is another level of review and further mitigates the risk of conflict. The State of Connecticut operates a robust Quality Assurance/Quality Improvement (QA/QI) program. Audits are conducted quarterly to monitor waiver assurances, including the participant's role in directing their own services, recovery plan development, and their right to appeal decisions about their care, eligibility determination and satisfaction with services. A fiscal intermediary conducts semiannual satisfaction surveys.
LOUISIANA 	Louisiana has a 1915(b)(c)(i) concurrent waiver program for adults and children with behavioral health needs, which is part of an approved BIP grant. Louisiana administers this through a Prepaid Inpatient Health Plan managed care contract with Magellan. The contract is capitated for adults and non-risk for children. To ensure CFCM within the program, Louisiana outlined a series of firewalls in their approved authorities. The State agency (DHH) makes the final 1915(i) enrollment eligibility decisions. All eligibility

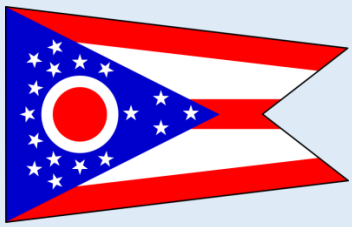
[11] http://www.nsclc.org/wp-content/uploads/2014/01/RFP-Document-Kansas-in-pdf-for-consistent-pagination.pdf

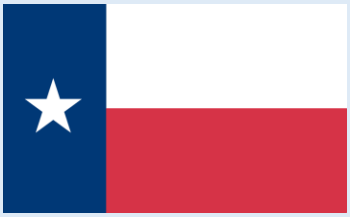
	determinations, including financial eligibility reviews for Medicaid, are performed by the current Medicaid eligibility staff. Targeting and clinical needs-based criteria assessments are performed by the plan pursuant to policies and procedures set up and approved in advance with DHH making the final enrollment determination. Individuals performing the assessments are not providers on the treatment plan. The plan conducts reviews of all individuals completing assessments and plans of care to ensure that they are not providers who have an interest in or are employed by a provider who is on the plan of care. Assessment units are administratively separate from utilization review units and functions. The clinical needs-based assessments are reviewed pursuant to the 1915(i) QIS requirements by DHH staff. Participant treatment plans are reviewed by the plan pursuant to policies and procedures set up and subject to the approval of OBH and Medicaid. Individuals can advocate for themselves or have an advocate present in planning meetings. The Case Manager documents that the individual has been offered a choice among all qualified providers of direct services. The Plan has established administrative separation between those doing assessments and service planning and those delivering direct services. The plan established a consumer council within the plan to monitor issues of choice. The plan established clear, well-known, and easily accessible means for consumers to make grievances and/or appeals to the State for assistance regarding concerns about choice, quality, and outcomes and documented the number and types of appeals and the decisions regarding grievances and/or appeals. State quality management staff oversee the plan to assure consumer choice and control are not compromised. The State documents consumer experiences with measures that capture the quality of plan of care development.
MASSACHUSETTS	Case management in Massachusetts is available through several MassHealth programs and services: (1) Ten 1915(c) Home & Community-Based Services (HCBS) Waivers ; (2) three managed or integrated care programs; (3) Targeted Case Management provided to members with intellectual disabilities enrolled in 1915(c) waivers and people with mental health needs who are served by state agencies; and (4) Community Case Management (CCM) for individuals with complex medical needs. In some instances in the Massachusetts Case Management system, case

	management is provided by the same entity that provides direct services. Various mitigation strategies are currently in place to ensure beneficiary choice and quality of care. Beneficiary choice is maintained and protected with the following procedures and structural conflict mitigation strategies. • DDS utilizes a robust quality management and improvement system (QMIS) that includes a continuous loop of quality improvement, active participation from individuals, families and other key stakeholders and integration of data from a variety of sources. • The Commonwealth of Massachusetts conducts an annual Single State Audit that includes sampling from waiver service claims. • Individual Support Plans are reviewed for content, quality, and required components through the Service Coordinator Supervisor Tool. • Participants have free choice of qualified providers. Community Living Waiver (DDS), Intensive Supports Waiver (DDS), Adult Supports Waiver (DDS)Services are provided by: • Contracted vendors (through agency-procured Purchase of Service (POS) contracts) or • DDS staff in agency-operated community programs, or • As participant-directed services where the Financial Management Services (FMS) is responsible for executing the provider agreement with an individual worker or agency.
MISSOURI 	An administrative firewall is in place that separates the case management (Bureau of IDD Support Coordination team) from the MDMH service delivery (Bureau of Community Services). Additionally, MDMH Operational Standards state that IDD support coordinators cannot also be service providers. Entities providing both case management and services must document in the service plan that, as a provider of service coordination and LTSS, the entity will ensure its employees will act in the best interest of the participant and that no conflict of interest occurs. In addition, they must develop a conflict of interest plan specific to the service delivery area and its circumstances. The plan must include: 1. Information identifying potential conflict of interest situations; 2. Planned or ongoing initiatives intended to eliminate or mitigate the occurrence; 3. Actions intended to manage those ongoing situations that cannot be eliminated. These may include, but are not limited to: an open door

	policy, non-retribution and whistle-blowers' policies, rights committee review, and grievance policy. 4. Methods of communication required to inform the individual consumer and/or guardian, if applicable, about the potential conflict.
NEW HAMPSHIRE 	New Hampshire's developmental services system revised its regulations more than a decade ago to provide its consumers with choice and control over all aspects of their services, including selection of providers. Within that approach, consumers are able to choose their service case managers. The great majority of the individuals currently receive their case management services from area agencies, geographically dispersed throughout the State, some of which also provide direct services. New Hampshire's Protocol to Remove Conflict will insure that the following mitigating factors will be in place to remove conflict: • Assuring that individuals can advocate for themselves or have an advocate present in planning meetings. • People served by the area agency have annual service planning meetings and can direct who they would like to attend and serve as advocates. • Administrative rules require that the person be given an opportunity to confirm in writing if they wish to continue being assisted by their current case manager or if they wish to choose an alternative. • Documentation that the individual has been offered choice among all qualified providers of direct services. • In establishing initial service supports the option of being served by a qualified external provider agency is presented to the person and other team members, based on the availability of such providers within the agency's catchment area. Those options are based upon a match of service capacity by the provider agency and a positive indication from them that they are able and willing to develop appropriate new services, within the available resources to the individual. The decision by the individual and/or their guardian or representative to pursue an external provider agency is documented in the Service Agreement. Any decision to consider an external provider agency is followed by a guided interview and selection process. New Hampshire will establish administrative separation between those doing assessments and service planning and those delivering direct services. • Area agencies have separate program directors for the divisions within the organization that do assessment and services planning

	and those that deliver direct services. • Establishing clear, well-known, and easily accessible means for consumers to make complaints and/or appeals to the State for assistance regarding concerns about choice, quality, and outcomes. • State quality management staff to oversee providers to assure consumer choice and control is not compromised. • Personnel employed by the not-for-profit Community Support Network Inc. (CSNI) conduct annual interviews with a randomized selection of service recipients using the National Core Indicator questionnaire that includes review of choice and control. • Clinical/non-financial eligibility processes are conducted by personnel employed by the CSNI organization with recommendations to the area agency directors. Financial eligibility is determined by the Bureau of Developmental Services. • The NH Department of Health and Human Services has established Ombudsman program that serves as an independent and confidential resource to individuals and their families as appropriate. • The DHHS Ombudsman Program is charged with assuring that the concern and/or complaint investigation and resolution process will be managed to protect from harm or any form of retaliation. DHHS Ombudsman supports individuals with disabilities and their families as they make informed choices.
NEW JERSEY 	In the Supports Program, Conflict-Free Case Management will be assured by the following: (1) Support coordinators will be entirely separated from the eligibility and budget determination processes. Individuals will choose a support coordinator and begin work with them after their eligibility assessment has been completed and a budget has been assigned based on their level of need. If a budget reassessment becomes necessary, the individual will go through a reassessment process completely separate from their support coordinator. (2) The Division's policy restricts Support Coordinators, as well as individuals who perform evaluations/assessments from being related by blood or marriage to the individual or to any of his/her paid caregivers, financially responsible for the individual, or empowered to make financial/health decisions on the individual's behalf. (3) The Division is recruiting support coordination agencies who provide support coordination exclusively, and no other Division-funded services. In some cases, the Division may allow some direct service provision by a support coordination agency, but never to the same individual. Additionally, there must be a six month gap between the

	provision of support coordination and the provision of other services to the same individual. Please note that the establishment of separate business entities to facilitate independence does not meet the requirements of the Conflict-free Policy in any case where the affiliated businesses share an Executive Director/CEO, a Board of Directors, or any financial interest. An agency can meet the criteria for the Division's Conflict Free Policy if one of the following: (1) They provide support coordination exclusively, and no other Division-funded services; - OR - (2) They provide both support coordination and other Division-funded services but the geographical areas where they provide support coordination and other services do not overlap, e.g. they provide support coordination in Essex County and employment services in Bergen County. (Please note that the rules related to never providing both services to the same individual and the six month gap still apply.); - OR - (3) They provide both support coordination and other Division-funded services in an overlapping geographical area but the direct services they provide are to a very small number of individuals or the services they provide are not easily accessible. (Please note that the rules related to never providing both services to the same individual and the six month gap still apply.) When this occurs, the Division will evaluate these proposals on a case-by-case basis and reevaluate the need periodically to ensure that the exception continues to be justified.
OHIO 	Ohio is participating in several ACA opportunities that require CFCM including My Care Ohio (Ohio's Duals Demo); Conflict free requirements are integrated into MCP's contract requirements. Firewalls were developed for AAA's due to the nature of their role within the demonstration. Ohio's previous experience with CFCM positions them to implement across the rest of the delivery system. Ohio has had established firewalls in the DD delivery system since 2009. The structure of the system and the role of County Boards of DD lent itself to conflicts of interest. Early efforts: Development of a Firewall Document, Engagement of stakeholders early in the design process. Evaluated infrastructure. Identified existing policies and procedures that may be the building blocks of the firewall.
OREGON	*From Oregon's 1915(k) "Community First Choice State Plan".* The State assures that conflict of interest standards for the functional needs assessment and development of the person-centered service plan applies to

	all individuals and entities, both public and private. The State will ensure that the individuals conducting the functional needs assessment and person-centered service plan do not have a conflict of interest. At a minimum, conflict of interest standards must ensure that the individuals or entities conducting the assessment of functional need and person-centered service plan development process are not: 1. Related by blood or marriage to the individual, or to any paid caregiver of the individual. 2. Financially responsible for the individual. 3. Empowered to make financial or health-related decisions on behalf of the individual. 4. Individuals who would benefit financially from the provision of assessed needs and services. 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 entity/entities to perform assessments of functional need and develop person-centered service plans in a geographic area also provides HCBS, and the State devises conflict of interest protections including separation of assessment/planning and HCBS provider functions within provider entities, which are described in the State plan, and individuals are provided with a clear and accessible alternative dispute resolution process.
TEXAS 	Entities that conduct eligibility determinations and provide case management are wholly independent of the entities that provide direct services. State monitors providers and conducts utilization reviews to ensure individuals receives services and supports
WYOMING 	An agency may provide: • Case management services, including Family Care Coordination, for any of the home and community based waivers for which they are certified. • Other waiver services to waiver participants, but shall not provide case management services to any participant that they are providing any other waiver services to, including self-directed services. • Qualifications. An agency which wants to be certified to provide case management services is required to:

	• Submit a Division application to become certified. If a provider is already certified as a case management agency, they would still need to complete a form to comply with the new requirements and continue as a certified agency. • Be enrolled as active Medicaid provider. • No sub-contracting for case management will be allowed. • Have policies and procedures for backup case management for each person's caseload. Sole proprietors shall complete the BHD Surrogate Form prior to starting services. All case managers shall meet with their designated backup to review all participant cases on a quarterly basis. This review shall be documented in case notes. • Have each case manager obtain proof of competency demonstrated through successful completion of the Division-approved case management training curriculum initially and annually. • Meet the conflict free requirements "How Do I Know If There is a Conflict of Interest." For any conflicts that are identified, a third party shall be involved to review and determine that there are no other available providers to provide case management.