Organized Health Care Delivery System

FEDERAL REQUIREMENTS AND STATE PRACTICE

- OHCDS • Payment • Payment
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In order to understand the need for/use of organized health care delivery systems in Medicaid, it is important to understand a key basic, statutory requirement in Medicaid – Direct Payment of Providers.

Section 1902(a)(32) of the Act requires that the Medicaid agency make payment directly to the provider of a covered service furnished to an eligible individual. Regulations at 42 CFR Part 447 establish the rules for such payment.

“...provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise; except that [under certain circumstances]...”
Some states have identified circumstances where direct payment to the providers is not the most effective means of remitting payment for the delivery of services.

In those instances, states have explored alternative payment methodologies that may meet Federal requirements. Each alternative has its own requirements and stipulations. The alternatives include:

- Reassignment to a governmental agency
- Fiscal Agent
- Managed Care arrangements
- Organized Health Care Delivery Systems (OHCDS)
What is an Organized Health Care Delivery System (OHCDS)?

- An OHCDS is a provider under the State’s Medicaid plan or waiver.
- Services may be furnished under the auspices of an OHCDS when the services are furnished by individuals who meet the State’s provider qualifications.
- To be recognized as an OHCDS, the entity must first be a system that is organized for the purpose of delivering health care.
- To meet this test, the entity must furnish at least one Medicaid-covered waiver or State plan service itself. The entity may, of course, furnish more than one service, covered by Medicaid.
What is an Organized Health Care Delivery System (OHCDS)?

- Any reassignment of Medicaid payments must be **voluntary on the part of the provider**.
- The State cannot mandate reassignment.
- When reassignment is made the preferred reimbursement methodology, **the State must continue to make provision for direct payment of claims submitted** by providers who do not choose to reassign their rights.
What is conflict of interest?

AND WHY DOES IT MATTER?
Conflict of Interest (COI)...

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

“Private interests” are those natural to any business interested in its own survival in a competitive environment. For example, a provider might have an interest in:

- Maximizing revenue (e.g., by increasing the number of people it serves and the amount it is paid for services),
- Minimizing costs (e.g., minimizing the costs associated with meeting the needs of the people it serves), and
- Improving its competitive position relative to others (e.g., promoting awareness of its service).

When case management systems have the same entity both assisting an individual to gain access to services and providing services to that individual, there is potential for conflict of interest in:

- Assuring and honoring free choice
- Overseeing quality and outcomes
- The “fiduciary” relationship
Conflict of Interest: Choice

- Person centered planning is about informed choice
- Case managers have the responsibility to support informed choice
- Medicaid requires full freedom of choice of types of supports and services and individual providers
- In conflicted situations, service “steering” may consciously or unconsciously occur, affecting choice
Quality and Outcomes: “Self-Policing”

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

- Self-policing 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.
Self-Policing...does not work well because

- Case managers may have to negatively assess the performance of their co-workers, supervisors and leadership.

- Case managers do not have the position or degree of authority within the organization to require changes of other staff.

- On a personal level, case managers may find themselves reluctant to criticize co-workers: Self-policing puts the case manager in a VERY difficult position.

- It may lead to a focus on the convenience of the service provider rather than being person-centered—if the service is “good enough” may be no impetus to assist someone to change, even if they could benefit from the change

  - Example: Group residential to supported living; day programs to employment
Fiduciary Conflicts: Who has a financial stake??

- The organization may have incentives for either over- or under-utilization of services—may have concerns that the person is “costing too much” or “we’re not being paid enough”

- Exert pressure or interest in “steering” the individual to their own organization

- Exert potential pressure for retaining the individual as a client rather than promoting choice, independence and requested or needed service changes
HCBS Regulations: Case Management

CONFLICT OF INTEREST PROVISIONS
1915(c) HCBS Waiver COI Regulations

- Published in the Federal Register January 16, 2014
- 79 FR 2948 “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”
- Centers for Medicare and Medicaid (CMS) rules: 42 CFR 431.301(c)(1)(vi)
Before 2014, conflict of interest under the 1915(c) waivers was guidance, now it is in rules

“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...

§441.301(c)(1)(vi)

There you have it...
When COI is present, a state must:

- Demonstrate to CMS that the only willing and qualified case manager is also, or affiliated with, a direct service provider (which is not the case in NH—and no state has used this exception yet to our knowledge, including SD and WY!!)
- Provide full disclosure to participants and assurances that participants are supported in exercising their right of free choice in providers.
- Describe individual dispute resolution process.
- Assure that entities separate case management and service provision (different staff).
- Assure that entities provide case management and services only with the express approval of the state.
- Provide direct oversight and periodic evaluation of safeguards.
The requirements listed are the minimum; states may impose additional ones.

As you are aware, CMS is actively engaged in conversations with states regarding situations that arise as states submit applications and renewals, about how states will meet these requirements.
“If a state employs this exception it must guarantee the independence of this function(s) within the provider entity. We also will not permit states to circumvent these requirements by adopting state or local policies that suppress enrollment of any qualified and willing provider.”

(We’re really busted...)
So, what have we heard about exceptions?

- **Rural areas** with limited providers *may* pass muster but CMS expects a higher level of quality management and scrutiny over services by another entity such as the state or contracted quality oversight organization.

- **Managed care arrangements:** CMS has permitted care managers in the MCO to be case managers but has required that assessment be overseen and eligibility be determined by a separate entity (such as the State Medicaid agency) and that no provider of services listed on the plan do assessment or service planning.
“In certain circumstances***, we may require that states develop "firewall" policies, for example, separating staff that perform assessments and develop person-centered service plans from those that provide any of the services in the plan; and meaningful and accessible procedures for individuals and representatives to appeal to the state.”

***ONLY if the only willing and qualified provider exception is granted
Examples of safeguards**

- Full disclosure to participants and assurance 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 the person-centered service plan development;

- An opportunity for the participant to dispute the state’s assertion that there is not another entity or individual that is not that individual’s provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;

**HCBS Waiver Technical Guide p. 180
Examples of safeguards might be:

- Direct oversight of the process or periodic evaluation by a state agency;

- Restricting the entity that develops the person-centered service plan from providing services without the *direct approval of the state*; and

- Requiring the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.
But really...

- CMS is serious about conflict of interest

- If *we* are serious about protecting individuals’ choice of supports this is an opportunity to reform our systems

- We have the opportunity to create dedicated, stand-alone organizations whose only mission is case management.

- The exception is really that and CMS seems to be holding firm in their expectations *and* very rural states have shown they do not need the exception (SD, WY)
We are aware of multiple states that are engaged in transforming their case management systems.

CMS has engaged with multiple states who have developed or are in the process of developing a plan to eliminate COI.

States we’re aware of:

- AK, CO, KS, KY, ME, MO, MS, ND, OH, RI, SC, SD, VA, WY

And every solution is different!
Like NH, the individuals served were not unhappy with the system...but it did not comport with the HCBS rules.

SD shifted case management from 19 regional entities that were created in the 1970’s to serve individuals coming out of institutions.

The entities provided case management and multiple services.

SD shifted to dedicated case management agencies.

Through a transparent and inclusive stakeholder engagement process, SD transformed their system with 100% of individuals choosing a conflict-free case manager in their open enrollment period.
• Individuals and/or agencies were permitted to provide case management and other waiver services as long as they met provider qualifications to anyone on their caseload

• WY was concerned that:
  o Case managers and case manager agencies were essentially monitoring themselves
  o Case managers hired by agencies were often forced with the dilemma between advocating or keeping their job

• WY’s new system has agency based and independent individual case managers and is fully conflict-free
State Resources

- South Dakota Case Management System:
  
  https://dhs.sd.gov/developmentaldisabilities/cfcm.aspx

- Wyoming Case Management System:
  
CMS Resources

- CMS sites:

  Guidance on the HCBS rules:


  Information on HCBS waivers:

Secret Acronym Key

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<td>CMS</td>
<td>Centers for Medicare and Medicaid</td>
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