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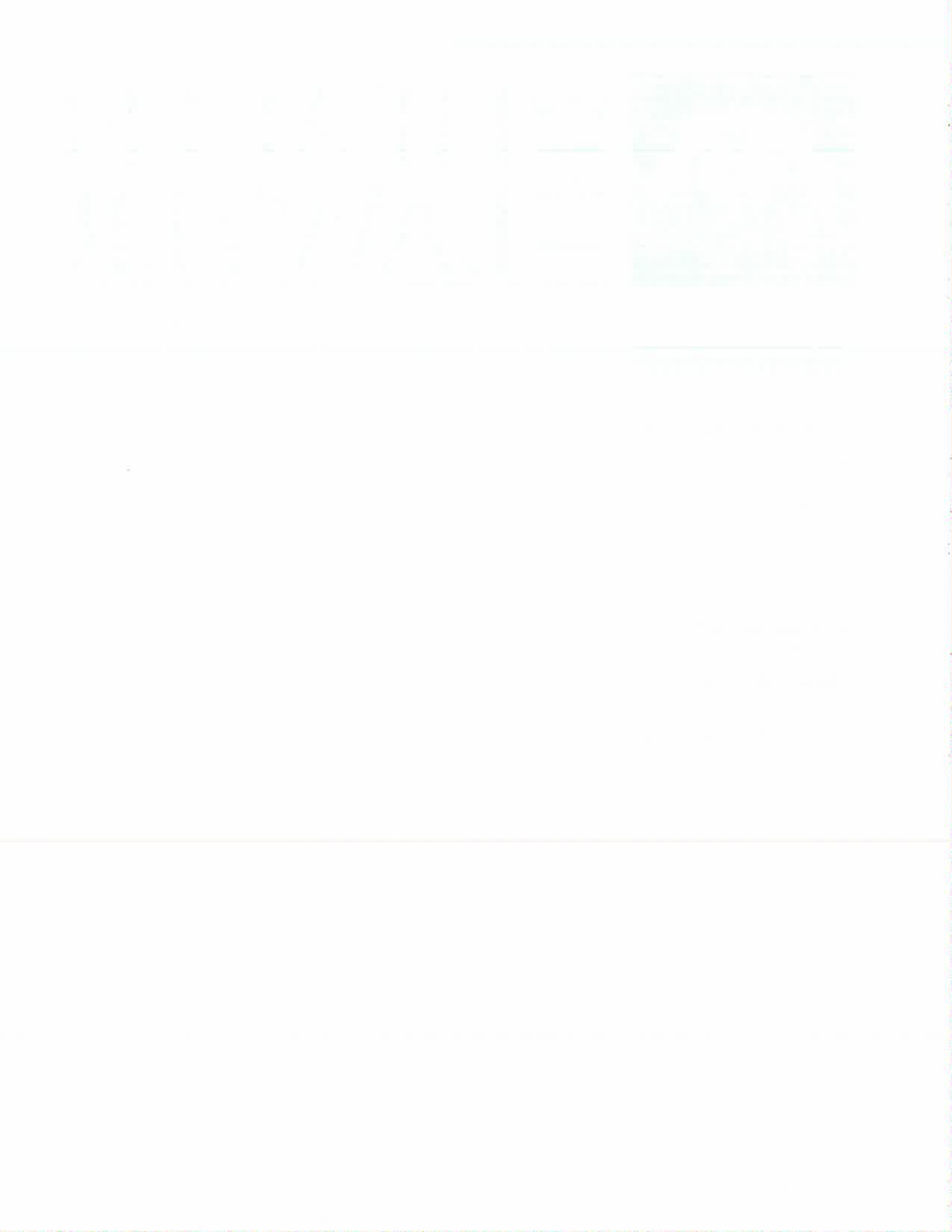

'CONFLICT-FREE CASE MANAGEMENT' ON COLLISION COURSE WITH INTEGRATED CARE

David Ivers, Esq.
Mitchell, Blackstock, Ivers, Sneddon & Marshall, PLLC
Little Rock, AR

Introduction

While most of the healthcare system attempts to hold providers accountable for both coordinating and delivering care, the Centers for Medicare & Medicaid Services ("CMS") is taking a different approach for long term services and supports ("LTSS").[1] Recent regulations require separation of LTSS service delivery from care coordination, ostensibly to achieve "conflict-free case management."

In Medicaid, care coordination is part of case management. In CMS's view, direct care providers – the organizations that deliver LTSS to Medicaid enrollees – have a conflict of interest if they also provide case management to the enrollees they serve. CMS's rationale is that direct care providers may maximize their business interests at the expense of their LTSS clients' best interests. However, the conflict of interest does not arise when direct care providers perform actual care coordination. It arises when direct care providers handle the resource allocation functions of case management.

CMS's failure to make this distinction puts LTSS squarely at odds with the dominant trend in healthcare today, where payors are vesting responsibility for care coordination with the direct care provider to produce an "integrated" model of service delivery. This is true even within other areas of Medicaid.

CMS can reconcile conflict-free case management with integrated care, but it will require a more targeted approach, one distinguishing among the types of activities encompassed within the ubiquitous concept of "case management." If a course correction is not made soon, the agency risks sacrificing integrated care on the altar of conflict-free case management.

The new regulations on conflict-free case management went into effect in March 2014 as part of a large package of new requirements for home and community-based services.[2] Rather than make all states come into immediate compliance with conflict-free case management, CMS enforcement has been focused on compliance when a state applies to renew its waiver program to provide home and community based services.[3] Thus the impact and resulting confusion have been building gradually. A state's failure to comply could result in CMS denying approval of its home and community-based program, which would make the program ineligible for federal matching funds.

This article offers: (1) a brief background on LTSS, care coordination and case management; (2) a summary of the CMS conflict-free case management regulations; (3) a discussion of the rationale behind the regulations; and (4) possible solutions to address CMS concerns without foreclosing integrated service delivery.

LTSS Difficult to Coordinate

Individuals receiving LTSS are among those with the greatest need for care coordination. They include the frail elderly, individuals with physical disabilities, intellectually and developmentally disabled persons, and sometimes individuals with serious behavioral health diagnoses. LTSS are notoriously "siloed" by program funding streams. In addition, LTSS are largely disconnected from the medical side of care, leaving enrollees "lost, frustrated, and overwhelmed with confusing, often inaccessible, and disconnected encounters in both systems."[4]

Because Medicare and most private insurers do not cover LTSS, the joint state-federal Medicaid program is the primary payor for these services.[5] LTSS account for a third of total spending in Medicaid.[6] To qualify for LTSS, individuals must fall below certain Medicaid income thresholds and meet medical necessity criteria.

LTSS encompass a broad range of services and supports that people need over an extended period of time, often for a lifetime in the case of those who are disabled. In the past, most LTSS were provided in nursing homes or other institutions, but the trend in recent years has tilted strongly toward home and community-based services.[7] The conflict-free case management debate centers on these home and community-based services in LTSS, not care in institutions.

States offer home and community-based services through a wide range of state plan and waiver programs[8] with different program configurations. They pay direct care providers,[9] often non-profit organizations, to deliver the services, which include attendant care,[10] meals, adaptive equipment, personal emergency response systems, habilitation, and supported employment. Attendant care, which often constitutes the bulk of direct care, includes assistance with activities of daily living, such as eating, bathing, toileting and dressing, and instrumental activities of daily living, such as preparing meals, light housekeeping, shopping and managing medications. Because one person may need several different types of LTSS, often multiple providers serve the same individual.[11]

continued on page 20

continued from page 19

Care Coordination of Vital Importance

Lack of coordinated care is responsible for much of the "overuse, underuse, and misuse" in the U.S. healthcare system.[12] It can lead to serious complications, including medication errors, preventable hospital readmissions, higher costs, and unnecessary pain and suffering for individuals struggling to navigate a complex and fragmented healthcare system.[13] The Agency for Healthcare Research and Quality ("AHRQ") defines care coordination as "deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care."[14]

In practical terms, care coordination in LTSS includes developing and monitoring the individual's plan of care; arranging appropriate involvement of family and other informal caregivers; identifying needed referrals to medical providers and community resources; facilitating communication among the individual's various healthcare providers; participating in discharge planning from various settings; offering health education; and generally addressing problems that arise.[15]

When direct care providers are responsible for both the service they deliver and overall coordination of a Medicaid enrollee's care, then the service delivery is "integrated." It is integrated from the payor's point of view in that the payor can hold a single entity accountable for outcomes, and, most importantly, it is integrated from the Medicaid enrollees' point of view in that they have a single point of contact for their care.

Care Coordination Under Case Management

In Medicaid, care coordination has traditionally been provided as part of case management. Case management can mean many different things in healthcare, depending on the context.[16] In its broadest sense, case management is an activity that assists an individual in gaining access to medical, social, educational or other services – but it does not consist of the underlying service itself.[17] Even within Medicaid, CMS approaches case management differently depending on the setting.

For primary care, under Social Security Act Section 1915(b), Congress authorized states to establish "primary care case management" ("PCCM") systems. The primary care provider is in charge of "case-management related services," which are defined to "[i]nclude location, coordination, and monitoring of primary health care services."[18] In most PCCM programs, the state, directly or through a PCCM organization, pays primary care physicians a fee to provide case management (care coordination) to their Medicaid patients – the same patients to whom they provide direct care.

For LTSS, Congress authorized states to pay for case management under Section 1915(c) home and community-based waivers.[19] CMS has defined case management broadly in the LTSS context as services which assist individuals "in gaining access to needed medical, social, educational, and other services."[20] In 1986, Congress also authorized "targeted" case management services for states that choose to provide case management to specific groups, such as the elderly or disabled.[21]

Emerging Medical Models Hold Direct Care Provider Accountable

While case management has been part of Medicaid since 1981, in recent years there has been an increasing awareness that improved models of care coordination are needed. Private and public payors and providers have responded with new approaches in the primary and acute care settings. A notable example is the patient-centered medical home ("PCMH"), which incentivizes providers to be responsible for delivering and coordinating patient care.[22] The success of the popular PCMH is largely attributable to CMS and state Medicaid officials, who provided early support.[23] Some 46 states have included PCMHs in their Medicaid and/or CHIP programs.[24]

Like the traditional PCCM models, the primary care provider in a PCMH is paid to deliver the underlying medical care and to coordinate the patient's overall care. However, the PCMH is a more intensive model. The PCMH characteristically includes a clinical team led by a primary care physician who oversees most of the patient's medical care. The team is in charge of direct care and also coordination with other providers, monitoring patient progress, prevention and wellness, and providing a patient-centered approach such as caregiver education and shared decision-making, along with extended office hours and 24/7 phone availability.[25] Providers may qualify for financial incentives by reducing the cost of care and meeting quality metrics.

No Consensus Model Has Emerged for LTSS Coordination

No consensus has emerged regarding how to improve LTSS coordination. Indeed, a single model is unlikely to work in all states due to historical differences in how LTSS programs developed.[26] Options include making the LTSS case manager part of the PCMH team,[27] using a separate LTSS "health home,"[28] contracting

with managed care organizations,[29] or using a combination of approaches.[30] Expanding the PCMH to include LTSS would achieve full integration of all services for individuals in the LTSS populations. However, for a variety of reasons many primary care practices are not equipped to coordinate LTSS.[31] This is due not only to limited resources but to philosophical differences in the "medical model" of primary care versus the "social model" of LTSS.[32] Thus, while efforts continue to bridge the gap between medical care and LTSS, at least for the near future in most states there will be both medical care coordinators and LTSS care coordinators. The question is whether the integrated approach used on the medical side should be permitted for LTSS, as well.

Case Management Is Many Things in LTSS

Longstanding Medicaid regulations organize case management into four general categories: assessment of needs; development of a care plan; referrals and related activities such as scheduling appointments; and monitoring and follow-up activities.[33] In its Technical Guide for home and community-based waivers, CMS provides more detailed guidance, identifying the following non-exclusive list of case management functions:[34]

- Evaluation and/or re-evaluation of level of care;
- Assessment and/or reassessment of the need for waiver services;
- Development and/or review of the service plan;
- Coordination of multiple services and/or among multiple providers;
- Linking waiver participants to other federal, state and local programs;
- Monitoring the implementation of the service plan and participant health and welfare;
- Addressing problems in service provision;
- Responding to participant crises; and
- For waivers with cost or service duration limits, monitoring to detect and resolve situations when the needs of an individual might exceed the limit(s) to ensure health and welfare of waiver participants.

Where Is the Conflict of Interest?

In the CMS list above, the first three activities are where potential conflicts of interest can arise:

1. *Eligibility evaluations.* For LTSS, evaluations for level of care determine whether individuals have sufficient functional limitations to make them eligible for LTSS. Because providers only get paid if they deliver services, they have an incentive to overqualify individuals.
2. *Functional needs assessments.* Assessments are a formal process driving the determination of what services the individual will receive. CMS does not want providers who will provide the services to also conduct assessments that determine the type and amount of services an individual will receive.[35]
3. *Care plan development.* The needs assessment informs the development of a care plan, sometimes called a "service plan."[36] This is a person-centered approach identifying, among other things, the individual's care goals; the type, amount, and frequency of services and supports needed to accomplish the goals; and the providers who will deliver the services and supports. CMS has long required states to ensure that providers do not dictate selection of providers or services, but its 2014 Rule went further by including the rest of the care plan development process as a conflict of interest.[37]

It is these first three steps — eligibility evaluations, needs assessments, and care planning, i.e., the resource allocation activities — that have embroiled CMS, states, providers, and enrollees in the quagmire of conflicts of interest and conflict-free case management.

CMS Guidance Evolving

Since 2003 CMS has required states to mitigate perceived "conflicts of interest" in LTSS home and community-based programs, but its policy has shifted over time.[38] CMS first issued formal guidance on conflict-free case management through the Balancing Incentives Program ("BIP"), specifically in the BIP Implementation Manual, which was issued in 2011 and revised in 2013.[39] Under BIP, CMS discouraged direct care providers from performing determinations of eligibility and evaluations of the need for services. However, CMS permitted such arrangements if mitigating measures were used, such as administrative safeguards and firewalls.[40] CMS also recognized consumer choice as a reason to grant an exception: "A consumer can choose to have the same agency provide case management and community LTSS as long as the State documents the consumer choice."[41] BIP only applied to the thirteen states that were participating in that particular program, which ran from October 1, 2011 through September 30, 2015.[42]

Not only was BIP limited to states participating in the grant, it was also not mandatory; thus its impact was muted. However, in 2014 CMS finalized a comprehensive rule[43] governing all LTSS home and community-based services (sometimes called "HCBS") under 1915(c) waivers,[44] the state plan Community First Choice program[45] and state plan 1915(i)program.[46] This rule is now an obstacle to any state seeking to use an integrated model for delivery and coordination of home and community-based services in LTSS.

For instance, the portion of the rule governing 1915(c) waiver services is far broader than any previous CMS position: "*...providers of HCBS...must not provide case management or develop*

continued on page 22

continued from page 21

the person-centered service plan...."[47] Thus, the waiver regulation appears to apply to all case management, not just resource allocation.

Interestingly, in the section of the rule governing Community First Choice and 1915(i) state plan services, CMS does *not* prohibit direct care providers from conducting all case management activities. In fact, it does not use the term "case management" at all in this context. Instead, it simply prohibits providers from performing the resource allocation activities identified above: eligibility determination; functional needs assessment; and development of the service plan.[48] However, because Community First Choice and 1915(i) services are relatively new programs covering far fewer individuals, far more services are impacted by the broader prohibition contained in the waiver regulation.

Moreover, in all three HCBS programs, CMS no longer allows the consumer any choice in the matter.[49] This is in contrast to BIP, which allowed consumers to choose the same provider for LTSS and case management.[50] It is a striking departure from the rest of the 2014 HCBS rule, in which the overriding theme is consumer choice, particularly the right of LTSS consumers to choose their providers and settings.[51]

The evolving guidance from CMS has left states struggling with how to adapt. Few if any states have a completely conflict-free system.[52] After a study of four states' efforts to address conflict-free case management under BIP, Justice in Aging concluded that conflict-free case management "continues to be an ideal to strive for, but an overwhelming challenge in reality."[53] The 2014 rule only exacerbates the situation. Alaska and Wyoming recently transitioned to CMS's broad view of conflict-free case management but in doing so triggered enormous upheaval across their LTSS systems.[54] A more nuanced approach is desperately needed, one that recognizes the distinction between resource allocation and care coordination.

CMS's Rationale for Conflict-Free Case Management in LTSS

While CMS did not elaborate on its rationale for conflict-free case management in the 2014 HCBS rule, it is known from a variety of sources what the agency's concerns are. Beginning in the 1980s, as Medicaid LTSS systems developed, community-based organizations often handled case management activities as well as direct care. In the BIP Implementation Manual, CMS said that this structure led to conflicts of interest, such as misaligned incentives for over or under-utilization of services; interest in retaining the individual as a client rather than promoting independence; and a focus on the convenience of the service provider rather than the client.[55]

CMS also does not believe that direct care providers should monitor service plan implementation or client health and welfare — viewing this as "self-monitoring."[56] Finally, CMS casts a critical eye at the usual role of case managers within a provider organization's chain of command. "Problems arise because assessors and case managers are typically not the direct line supervisors of the other workers and therefore do not have the authority to require changes."[57]

Problems with CMS's Rationale

Underlying CMS's conflict-free case management regulation is the premise that LTSS case managers will be inclined to further their employer's business interests at the sake of the client's interests or program costs. However, the agency does not express the same distrust for case managers on the medical side in the PCMH where the entire model is built around the patient's direct care provider. This different treatment is hard to reconcile, since misaligned financial incentives are present on the medical side, as well. For example, in fee-for-service reimbursement, which is still the most prevalent form of reimbursement, the more services medical clinics provide and the more of their own diagnostic tests they order, the more they get paid, regardless of whether the services improve the patient's health.

CMS's concern over provider "self-monitoring" in LTSS is also difficult to parse out. Is it concerned about providers monitoring their own clients or the provider itself? If the agency means that self-monitoring refers to monitoring the individual client, then who is in a better position to do that – a direct care provider who sees the person several times a week or a separate entity that may see the person only once a quarter? If direct care providers cannot be trusted to monitor the progress of the individuals they are serving, then it begs the question of whether they should be trusted to deliver the care in the first place. If, on the other hand, CMS literally is concerned about providers monitoring themselves, that is different. That is a quality assurance function, not care coordination.

The remaining rationale — CMS's concern about the role of case managers within an organization's chain of command — ignores why that particular situation exists. Before the 2014 rule, CMS required states without conflict-free case management to "mitigate" the conflict by ensuring that LTSS providers administratively separated their case managers from their direct care staff.[58] By definition, then, no case manager can supervise direct care staff.

However, the point CMS makes about this administrative composition is well taken. When one separates the case manager/care coordinator from the direct care staff, a team-based approach is being hindered. A team-based approach is central to the PCMH concept, and its value to healthcare has been recognized for more than a decade.[59] Unfortunately, the LTSS sector lags behind in the team-based approach, and the CMS regulations on conflict-free case management could set it back further.

In short, conflict-free case management in LTSS is counter to the efforts in every other part of the healthcare system incentivizing providers to coordinate care rather than just delivering their particular service. The overriding goal is to make providers accountable for quality and outcomes, not just delivering care. When LTSS providers have no ability to direct or monitor care, they cannot be held responsible for the outcomes. Stakeholders are confused by a system in which medical care providers are encouraged and paid to coordinate care but LTSS providers are prohibiting from doing so.

The Arkansas Experience

Indeed, requiring the direct care provider and the care coordinator to be separate entities can create inherent problems of its own. Arkansas' experience is an illustrative example. It implemented a conflict-free case management approach to LTSS in 1989 with the initiation of its 1915(c) waiver program for individuals with developmental disabilities.[60] The majority of provider organizations chose to be direct care providers, leaving too few case managers in many parts of the state. Some case managers had little or no knowledge of the operational realities of direct care, which led them to create unrealistic expectations for clients. Conversely, some direct care providers did not understand the duties of case managers. Also, the state found that some case management functions fit within a third-party approach, but others, particularly day-to-day care coordination, needed the presence of on-site staff.[61]

The end result was significant confusion regarding which entity should perform a wide variety of functions and a great deal of frustration for clients. Consequently, Arkansas abandoned this approach around 1995. Consumers are now offered a choice. Tellingly, the vast majority choose the same provider for direct care and case management.[62] In recent years, Arkansas has been working toward a more intensive provider-led model of care coordination, but the 2014 CMS regulation could present a significant barrier to that effort.[63]

Managed Care Proposed Rule – More Confusion, More Conflict

Adding another layer of complexity and confusion is the CMS proposed rule for Medicaid managed care. Many states have transitioned to capitated contracts with private managed care organizations ("MCOs") to deliver primary/acute care services in the Medicaid program.[64] In the last few years, there has been a rapid move among some states to also turn over their Medicaid LTSS programs to MCOs.[65]

Largely in response to the addition of LTSS to Medicaid managed care, CMS on June 1, 2015 issued a proposed new rule,[66] the first major changes to Medicaid managed care since 2002. In the proposed rule, CMS would allow MCOs to use their internal staff to provide some aspects of case management, including assessments and care plan development, something not currently permitted under existing CMS rules.[67] Consider that if *providers* handle resource allocation, the fear is they may be incentivized to overbill or encourage use of their own services. However, for MCOs – which are at risk for the cost of care – there is an equally great concern that they will be incentivized to use the resource allocation role to reduce needed services. Yet the proposed rule does not seem to recognize conflict on the part of MCOs involved in this process.[68] Simply introducing managed care does not eliminate conflict if the same organization is both assessing need and paying for services.[69] In sum, managed care does not resolve the conflict – it merely moves it. The final rule is expected late spring or early summer of 2016.

Health Homes Promote Provider-Led Coordination

In contrast to CMS's conflict-free case management policy under the 2014 HCBS final rule, Congress specifically authorized provider-led coordination under Section 2703 of the Patient Protection and Affordable Care Act ("PPACA"). Section 2703 created an optional state plan benefit called "health homes." Health homes are organized care delivery models similar to the PCMH, but designed to encompass the healthcare "neighborhood," including LTSS. Section 2703 incentivizes state Medicaid programs to create health homes by giving them eight quarters of 90 percent federal matching funds to jump start this integrated care delivery model. Health homes serve individuals with chronic conditions, which can include individuals receiving LTSS, and Section 2703 specifically requires that they be led by providers.[70]

CMS has encouraged states to adopt the health homes option under PPACA.[71] The agency clearly contemplates that direct care providers will be providing the underlying care as well as coordinating care.[72] "Health home providers will integrate and coordinate all primary, acute, behavioral health and long term services and supports to treat the 'whole-person' across the

continued on page 24

continued from page 23

lifespan."[73] However, to date, most health homes are largely medical models aimed at specific chronic conditions, particularly mental illness, and do not reach the LTSS populations or utilize LTSS providers to a great degree. States like New York that want to address LTSS are grappling with how health homes interface with or replace traditional case management.[74] This will be an issue for any state attempting to create a health home with LTSS providers playing a role. Clarification from CMS on conflict-free case management could encourage greater use of this integrated model for LTSS.[75]

Practical Steps Toward a Solution

There are steps CMS could consider to address its concerns about conflicts of interest in LTSS without sacrificing integrated care. It may be possible, for example, to keep case management in the form it now exists but more clearly delineate which activities must be "conflict free." In other words, CMS could issue interpretive guidance that only resource allocation activities are implicated by the conflict-free regulations. The Community First Choice and 1915(i) regulations already contain language consistent with this approach;[76] the 1915(c) waiver regulation is broader but imprecise.[77]

On the other hand, it may be time to administratively separate care coordination from the Gordian knot of case management within Medicaid. CMS could create a separate service category of care coordination (by whatever name) distinct from the resource allocation functions of case management, which means care coordination would not be subject to the conflict-free case management rule at all. Conceptually, CMS appears willing to do this through health homes. Also, many states are turning to the flexibility offered by Section 1115 demonstration waivers, which, if CMS approves, may be another useful way to provide care coordination through direct care providers.[78]

It may also be instructive for CMS to look at why the PCMH has been successful on the medical side. Misaligned financial incentives are present there, as well. However, rather than prohibiting the medical community from coordinating care for their patients, CMS and states have incentivized them to do it the right way through shared savings under the PCMH.

Using the same concept in LTSS, CMS could choose to incentivize LTSS direct care providers to achieve an integrated, whole-person approach.[79] This could be done through a health home model. Also, depending on the size, number, and business capabilities of their LTSS organizations, some states could move toward an LTSS "accountable care" approach with shared savings or other incentives for providers who meet cost or quality benchmarks.

This brings up the question of which LTSS provider should take the lead. Typically the direct care organization providing attendant care has the most extensive contact with the individual and is thus best positioned to be the LTSS care coordinator, just as the primary care physician is the focal point in the medical setting. Attendant care providers often deliver care to their clients on a daily basis. Thus, they have the advantage of frequent contact with the client, identified as a key to successful care coordination.[80] Moreover, the employees who provide this care often develop family-like bonds with their client, and are much more likely to be able to, among other things, promote treatment adherence, get the client to a doctor appointment, and notify family members of important instructions. If the client begins to deteriorate, fails to take medication, or develops a crisis, this provider will be the first to notice, not an independent case manager who may see the client only a few times a year.

Some will no doubt posit that medical care and LTSS are inherently different, and that the elderly and disabled individuals receiving LTSS need an independent advocate separate and apart from their direct care provider. Yet, it need not be a choice of advocacy over integrated care. An integrated model does not mean direct care providers must be the sole advocates for individuals receiving LTSS. Some individuals and families are capable of advocating for themselves. States also may want to enhance their own role in this regard or may look at placing that role with options counselors, ombudsman, or other entities, some of whom may already be assigned to handle resource allocation. The state can advance the interests of older adults and people with disabilities without foregoing an integrated approach to LTSS care delivery.

Conclusion

A clear model has yet to emerge when it comes to care coordination in LTSS. The 2014 HCBS rule creates a more, not less, fragmented approach to care for LTSS enrollees. The bifurcated approach is contrary to the movement in the rest of healthcare to integrate service delivery and care coordination. It removes the ability of states to hold direct care providers more accountable for outcomes, and it sacrifices a key advantage LTSS providers have in care coordination – frequent contact with the enrollee. CMS may want to revisit and revise its policies to address conflicts of interest in resource allocation while still

encouraging states and LTSS providers to take an integrated approach to delivering and coordinating care.

David Ivers, Esq. is a partner at Mitchell, Blackstock, Ivers, Sneddon & Marshall, PLLC in Little Rock, Arkansas, where he is an attorney and healthcare policy and legislative consultant. He is the author of several healthcare articles, including "Medicaid Community First Choice Option Full of Promise and Peril" and "Crossing the Data Chasm: A Data Extraction Roadmap for Healthcare Providers." He has extensive experience in healthcare reform and the development and negotiation of numerous policy and regulatory initiatives on behalf of healthcare clients. He is a past chair of the Arkansas Bar Association's Health Law Section. He can be reached at *divers@mitchellblackstock.com*.

Endnotes

1 Long term services and supports, formerly called long term care, refers to the wide range of assistance provided in a variety of settings beyond acute medical care. *See* discussion below and also note 4.

2 79 Fed. Reg. 2948-3039 (January 16, 2014), conflict-free provisions codified at 42 C.F.R. §§ 441.301, 441.555, and 441.730. Home and community-based services, discussed in more detail below, refer to a wide range of LTSS that help older adults or people with disabilities maintain their health and independence at home and in the community.

3 *Making the Transition to Conflict-Free Case Management in Alaska, Colorado and Wyoming: Lessons from the Front Lines*, HCBS Conference Presentation, National Association of States United for Aging and Disabilities (NASUAD) (September 2015). Waivers, as explained more fully below, waive certain Medicaid requirements to furnish home and community based services for Medicaid enrollees. Waiver services complement and/or supplement services available through the Medicaid state plan and other public programs. Waivers are typically renewed for five-year periods at a time.

4 SCAN Foundation, *Bridging Medical Care and Long-Term Services and Supports: Model Successes and Opportunities for Risk-Bearing Entities (April 2012)* at 2, *available at:* http://calswec.berkeley.edu/files/uploads/tsf_policy_brief_6_model_successes_3.pdf.

5 A helpful background resource for LTSS is available from Kaiser Family Foundation: *Medicaid and Long Term Services and Supports: A Primer* (December 15, 2015), available at: https://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/SCProposal.pdf.

6 S. Eiken, K. Sredl, B. Burwell & P. Saucier, *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013: Home and Community-Based Services were a Majority of LTSS Spending*, Truven Health Analytics, (June 30, 2015), at 11, available at: http://medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf.

7 *Id.* at 7.

8 A Medicaid "state plan" is an agreement between a state and the federal government describing how that state administers its Medicaid programs. The state agrees to abide by federal rules and in return may claim federal matching funds for its program activities, which are spelled out in the plan. "Waivers" are the legal authorities for states to waive certain federal requirements to provide Medicaid services through alternative means, e.g., 1915(c) waivers allow states to provide LTSS in home and community-based settings rather than exclusively in institutions.

9 This article addresses the traditional "agency" model in which a provider organization employs the workers who deliver care to an enrollee. Another model is called "self-directed," in which the enrollee acts as the employer. However, some of the same concerns could arise in a self-directed model if the consumer receives case management/care coordination as a support and chooses the same provider organization that the consumer uses for direct care.

10 Attendant care is known by various names in each state, including personal care, homemaker, chore services, companion, and supported living.

11 Some states are turning to managed care organizations to help better coordinate care in LTSS and the rest of Medicaid. However, managed care organizations often contract with providers for some or all care coordination as well as direct care. Thus, the issues presented here still must be resolved even in states that adopt managed care for LTSS. *See, e.g.*, P. Saucier & B. Burwell, *Care Coordination in Managed Long-Term Services and Supports*, Truven Health Analytics for AARP Public Policy Institute (July 2015).

12 Institute of Medicine, CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY (March 2001) at 23, available at National Academy Press, http://nap.edu/books/0309072808/html. *See also* R. Cebul, J. Rebitzer, L. Taylor, and M. Votruba, "Organizational Fragmentation and Care Quality in the U.S. Health Care System," *Journal of Economic Perspectives*, 22(4): 93-113 (Fall 2008).

13 *See* National Quality Forum website, which contains numerous resources on care coordination, at: http://qualityforum.org/Topics/Effective_Communication_and_Care_Coordination.aspx.

14 AHRQ web site, http://ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html. AHRQ is a federal agency that functions as a research arm of the Department of Health and Human Services to help improve the quality of healthcare.

15 Actual definitions of care coordination vary. The most detailed are often in state contracts with managed care companies. For examples pertaining to LTSS, *see* J. Thorpe & K. Hayes, *Selected Provisions from Integrated Care RFPs and Contracts: Care Coordination*, Integrated Care Resource Center (July 2013), available at: http://integratedcareresourcecenter.net/pdfs/ICRC%20Care%20Coordination_FINAL_7_29_13.pdf.

16 The term "case management" is used by healthcare practitioners, as well as health maintenance organizations ("HMOs") and insurance companies. Compounding the problem is loose nomenclature: "case management," "care management," "care coordination," and "service coordination" are often used interchangeably.

17 72 Fed. Reg. 68077 at 60879 (interim final rule on case management, December 4, 2007).

18 42 C.F.R. § 440.168(a)(1).

19 Social Security Act § 1915(c), codified at 42 U.S.C. § 1396n(c). *See also* 42 C.F.R. §§ 440.180(b), 440.181(b). Case management in the LTSS context usually is paid at a significantly higher rate than PCCM to reflect the greater intensity of the service.

20 42 C.F.R. § 440.169(a).

21 Social Security Act § 1915(g)(1), codified at 42 U.S.C. § 1396n(g)(1). *See also* 42 C.F.R. § 440.169(b). Case management also may be provided by the state as a Medicaid administrative activity rather than as a waiver service.

22 PCMH is just one example. Others include accountable care organizations and the CMS Bundled Payment for Care Improvement Initiative.

23 American Academy of Family Physicians, *State Medicaid Programs Drive PCMH Initiatives Forward*, AAFP News (April 4, 2013), available at: http://aafp.org/news/government-medicine/20130404statemedicaid.html.

24 National Academy for State Health Policy, Medical Homes and Patient-Centered Care Maps (January 12, 2015), available at: http://nashp.org/medical-homes-map. CHIP is the Children's Health Insurance Program, which provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid.

25 *See, e.g.*, P. J. Cunningham, "Many Medicaid Beneficiaries Receive Care Consistent with Attributes of Patient-Centered Medical Homes," *Health Affairs*, 34(7): 1105 (July 2015).

26 *See, e.g., Selected Provisions from Integrated Care RFPs and Contracts*, *supra* n. 15 at 3.

27 *See, e.g.*, "State Demonstration to Integrate Care for Dually Eligible Individuals," South Carolina Department of Health and Human Services Proposal to CMS (May 25, 2012) at 7, available at: https://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/SCProposal.pdf.

28 *See, e.g.*, Arkansas Center for Health Improvement, *Arkansas Health Care Payment Improvement Initiative*, available at: http://achi.net/pages/OurWork/Project.aspx?ID=47.

continued on page 26

continued from page 25

29 *Care Coordination in Managed Long-Term Services and Supports*, *supra* n. 11.

30 *See, e.g.*, Texas Health and Human Services Commission, *Texas Medicaid Patient-Centered Medical Home Report*, (December 2013), available at: http://hhsc.state.tx.us/reports/2013/SB7-Medicaid-Patient-Centered.pdf.

31 E. Rich, D. Lipson, J. Libersky, M. Parchman, *Coordinating Care for Adults With Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions*, Prepared by Mathematica Policy Research for Agency for Healthcare Research and Quality (January 2012). Most physicians still practice in small settings of fewer than ten physicians. The authors cite a national demonstration project in which virtually all of the primary care practices had difficulty integrating with community services.

32 *See, e.g., Bridging Medical Care and Long-Term Services and Supports*, *supra n. 4*; and National Association of Area Agencies on Aging, *The Role of the Aging Network in Medicaid Managed Care for LTSS* (July 2012), available at: http://n4a.org/files/n4a_policybrief_July2012_web.pdf.

33 42 C.F.R. § 440.169(a).

34 CMS, *Instructions, Technical Guide and Review Criteria (for Application for a 1915(c) Home and Community-Based Waiver)*, CMS, (January 2015) at 105, available at: http://nasddds.org/uploads/documents/Version3.5InstructionsJan2015.pdf.

35 States are quickly adopting standardized assessment instruments. P. Black & K. Leitch, *Analysis of State Approaches to Implementing Standardized Assessments*, C.E. Reed and Associates for SCAN Foundation (April 2012), available at: http://chhs.ca.gov/OLMDOC/The%20SCAN%20Foundation%20Funded%20Report%20on%20Uniform%20Assessments.pdf; G. Engquist, C. Johnson, & W. Johnson, *Systems of Care for Individuals with Intellectual and Developmental Disabilities: A Survey of States*, Center for Health Care Strategies, Inc. (September 2012), available at: http://chcs.org/media/IDD_State_Priorities_and_Barriers_Snapshot_082812.pdf. Also note that some assessment instruments include both eligibility evaluations and needs assessments.

36 Care plans in LTSS tend to be lengthier than those in medical settings, containing person-centered goals, selected providers, service schedules, allowable units or amounts of service, and related features.

37 As long as providers do not control who the client selects as a provider or the types or amounts of services, the exclusion of providers from care plan development is arguably counterproductive since the plan will be worth little if it does not match provider capability. CMS gives some latitude here, allowing provider input as long as an independent agent has "final responsibility." 79 Fed. Reg. 2948, 2993-2994.

38 TBD Solutions, *Conflict Free Case Management: Federal Guidance, State Engagement, Impacts* (April 2015) at 13, available at: http://tbdsolutions.com/published/CFCM_White_Paper_April2015.pdf.

39 CMS, *Balancing Incentive Program: Implementation Manual* (February 2013), available at: https://medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/balancing/downloads/bip-manual.pdf. BIP was a program under the Patient Protection and Affordable Care Act ("PPACA") that incentivized states to spend a greater portion of their LTSS funds on home and community-based services as opposed to institutional care. (PPACA § 10202.) One of three key requirements was conflict-free case management.

40 BIP Implementation Manual, *supra* n. 39. Examples of mitigating measures include administratively separating case management and direct care employees within the same agency; a robust beneficiary complaint process; and tracking referral patterns. *See* CMS, BIP Frequently Asked Questions at: http://balancingincentiveprogram.org/resources/what-are-some-examples-mitigation-strategies-conflict-free-case-management.

41 *Id.*

42 CMS, Balancing Incentive Program website: https://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Balancing-Incentive-Program.html.

43 79 Fed. Reg. 2948 (January 16, 2014). Because the 2014 HCBS rule contained other controversial provisions, particularly related to criteria that providers must meet to qualify as a HCBS setting, the conflict-free case management section initially attracted little attention.

44 42 C.F.R. § 441.301(c).

45 42 C.F.R. § 441.555(c). Community First Choice is a state plan option for home and community-based services made available to states in 2010 through the Patient Protection and Affordable Care Act and carrying an additional 6% in federal matching funds.

46 42 C.F.R. § 441.730 (b). Section 1915(i) of the Social Security Act allows states to provide home and community-based services to individuals whose acuity does not rise to the level of institutional care as required by other home and community-based programs. Section 1915(i) was authorized under Section 6086 of the Deficit Reduction Act of 2005, but few states utilized it until several limitations were removed in 2010 through the Patient Protection and Affordable Care Act.

47 Codified at 42 C.F.R. § 441.301 (c)(1)(vi)) (emphasis added). The regulatory wording is confusing because it references both case management and development of the service plan; development of the service plan is part of case management.

48 Codified at 42 C.F.R. § 441.555(c) and 441.730(b).

49 The sole exception to the prohibition in the new regulation is a situation where the state demonstrates that a direct service provider is the only willing and qualified case management provider in a particular geographic area. 42 C.F.R. § 441.301(c)(1)(vi); 441.555(c)(5); 441.730(b)(5).

50 CMS, BIP Frequently Asked Questions at: http://balancingincentiveprogram.org/resources/what-if-consumer-chooses-have-same-agency-provide-case-management-and-community-ltss. ("A consumer can choose to have the same agency provide case management and community LTSS as long as the State documents the consumer's choice.")

51 79 Fed. Reg. 2948 (January 16, 2014) at 3030 and *passim*. *See also* 42 C.F.R. § 441.301.

52 S. Barth and A. Lind, *Balancing Incentive Program: Strengthening Medicaid Community-Based Long-Term Services and Supports*, at 2 (September 2012), Center for Health Care Strategies, Inc.

53 F. Gordon, *Conflict Free Case Management: Themes in States Working to Implement New Systems*, Justice in Aging, Issue Brief, at 2 (October 2014) ("*Themes in States*"). Justice in Aging, formerly the National Senior Citizens Law Center, is a national non-profit legal advocacy organization that fights senior poverty through law.

54 NASUAD presentation, *supra* n. 3.

55 *BIP Implementation Manual*, *supra* n. 39 at 29.

56 *Instructions, Technical Guide and Review Criteria*, *supra* n. 34 at 188.

57 *BIP Implementation Manual*, *supra* n. 39 at 29.

58 Instructions, Technical Guide and Review Criteria, *supra* n. 34, at 181, 188. (Since the implementation of the 2014 rule, CMS allows mitigating measures to suffice only where the state demonstrates that a direct service provider is the only willing and qualified case management provider in a particular geographic area.)

59 Olsen LA, Saunders RS, McGinnis JM, editors, "Team-Based Care and the Learning Culture." Patients Charting the Course: Citizen Engagement and the Learning Health System: Workshop Summary. Institute of Medicine, National Academies Press (US); (2011) at 8, available at: http://ncbi.nlm.nih.gov/books/NBK92080.

60 Arkansas Department of Human Services, Division of Developmental Disabilities Services, *Overview of DDS ACS HCBS Medicaid Waiver*, available on DDS web site: http://humanservices.arkansas.gov/ddds/Pages/waiverServices.aspx.

61 Interview with Mike McCreight, former director of Arkansas Division of Developmental Disabilities Services, (1989-1999), conducted January 8, 2016.

62 *Id.*

63 *Id.*

64 *See Avalere Analysis: Medicaid Managed Care Enrollment Set to Grow by 13.5 Million* (October 23, 2014) available at: http://avalere.com/expertise/managed-care/insights/avalere-analysis-medicaid-managed-care-enrollment-set-to-grow-by-13.5-milli. For a

chart showing Medicaid managed care enrollment on a state-by-state basis, see Kaiser Family Foundation, *Total Medicaid Managed Care Enrollment*, available at: http://kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment.

65 CMS, *Medicaid Managed Long Term Services and Supports*, available at: https://medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/medicaid-managed-long-term-services-and-supports-mltss.html.

66 80 Fed. Reg. 31098.

67 80 Fed. Reg. 31098, 31141 and 31276 ("This change is intended to permit a MCO, PIHP, or PAHP to use internal staff for service coordination, even though those staff would not be considered providers and, thus, not permitted to perform assessments under current regulation."). PIHPs (prepaid inpatient health plans) and PAHPs (prepaid ambulatory health plans) are managed care plans that receive a capitated payment for a limited array of services, such as hospital, behavioral health, or dental.

68 This is contrary to CMS's 2013 Guidance on managed Medicaid LTSS, where it stated "MCOs may not be involved in any eligibility determination or *functional assessment* for a potential participant prior to the participant enrolling in the MCO." CMS, *Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs*, at 10 (emphasis added), available at http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf.

69 *Themes in States*, *supra* n. 53, at 13-14.

70 To date CMS has approved health homes in 19 states. *See* https://medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/approved-health-home-state-plan-amendments.html.

71 CMS offers planning grants, technical assistance, and other resources. *See Health Home Information Resource Center*, https://medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html.

72 CMS, State Medicaid Directors Letter #10-024 (November 16, 2015), available at: https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf.

73 CMS, "Health Homes (Section 2703) Frequently Asked Questions," at 1, available at: http://medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/health-homes-faq-5-3-12_2.pdf.

74 E. M. Patchias, A. Detty, and M. Birnbaum, *Implementing Medicaid Health Homes in New York: Early Experience*, Medicaid Institute at United Hospital Fund, (February 2013), available at: http://medicaidinstitute.org/assets/1351.

75 In response to state questions about how to reconcile conflict-free case management with the integrated health home model, CMS did not respond directly. *See* CMS, *State Questions Regarding Conflict-Free Case Management and Conflict of Interest Requirements*, Balancing Incentive Program National Call (January 21, 2015), available at: http://balancingincentiveprogram.org/sites/default/files/BIP_grantee_questions_about_CFCM_21Jan2015_w%20responses_FINAL_0.pdf.

76 42 C.F.R. § 441.555(c) and 441.730(b). *See supra* n. 48.

77 42 C.F.R. § 441.301 (c)(1)(vi)).

78 Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs.

79 CMS itself has aptly stated the guiding principle in this area: "A whole-person approach to care looks at all the needs of the person and does not compartmentalize aspects of the person, his or her health, or his or her well-being." *Supra* n. 58 at 8.

80 D. Peikes, A. Chen, J. Schore, R. Brown, "Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries: : 15 Randomized Trials," *Journal of the American Medical Association* 301(6):603-18 (February 11, 2009). *See also*, D. McCarthy, J. Ryan, S. Klein, *Models of Care for High-Need, High-Cost Patients: An Evidence Synthesis*, The Commonwealth Fund (October 2015), at 4 ("emphasizing person to person encounters").