Waiver Programs: Conflict of Interest

On September 6, 2023, the Department of Health (DOH/the Department) held a 90-minute webinar to provide an overview of the upcoming waiver program Conflict of Interest (COI) requirements going into effect on November 11, 2023.

The Centers for Medicare and Medicaid Services (CMS) COI rule, passed in 2014, applies to service providers in the Nursing Home Transition and Diversion (NHTD) and Traumatic Brain Injury (TBI) programs. Simply stated, unless authorized by the state on an individual basis, neither service coordination (SC) nor SC supervision can be provided by the same entity as that providing the home and community-based services (HCBS).

Over half of the session was devoted to a robust Q&A period. This summary incorporates that material.

Note that the content of this article only applies to service provision in these two waiver programs.

Overview

In DOH's words, under the federal COI rule:

"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."

It was noted in a graphic that certain NHTD and TBI services are NOT bound by the COI rule. These include congregate and home-delivered meals, environmental modifications (E-mods), and assistive technologies.

Exceptions for COI-covered services can be made when it can be demonstrated 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." DOH indicated that this exemption will help ensure that rural and cultural needs can be met.

During the webinar, the state explained that the process for this demonstration of "the only willing and qualified provider" exception has not yet been fleshed out in policy. In the early days of implementation, these exceptions may be decided on a case-by-case basis. Once the terms of proof are defined by the Department at the state level, instructions and technical support will be available and the RRDCs will review and assess exemption submissions based on those criteria.

The DOH webinar was helpful in clarifying the effective date of the rule. There is no indefinite "grandfathering" in of current participants; all service plans must comply. However, there is a delay in the compliance date relative to the one-year "plan run out" as follows: Any service plan currently approved through November 11, 2023, does not need to immediately be in compliance. Rather, those service plans must comply by their next renewal date. It was, however, noted, that service plans take time for approval. Thus, the plan must be approved, not simply submitted, before November 11, 2023, in order to benefit from the one-year grace period. It was also stressed that perhaps a target date of October 31, 2023, is prudent since services are usually on a monthly billing cycle.

Because of the upcoming compliance date, DOH stated you may not accept a conflicted enrollee as a new client unless you are able to properly "unconflict" them from day one.

Approval of Conflicted Plans

"Conflicted plan" is the term used by DOH to describe a service plan with a conflict of interest.

As described by DOH, conflicted plans *may* be permitted when there is no other willing and able provider. The relevant RRDC will be the decision-making entity. It is hoped that forthcoming official definitions, policies, and procedures will define the "able" or "qualified" provider parameters. For example, the state cannot yet say what an acceptable geographic coverage area might look like for a provider. Is it a 5-mile radius from the patient's home? A ten-mile radius? It has not yet been determined and may vary depending on whether the area is rural or urban.

There will be additional criteria to meet for approval of conflicted plans. For example, any complaints or disputes in a conflicted plan cannot be investigated by the beneficiary's service coordinator. These situations will be handled through the RRDC or the DOH Waiver Complaint Line. The state will outline other criteria in the near future.

Non-Approved Conflicted Plans

If a conflicted plan is not approved as an exception by DOH, you must terminate one or more services for that beneficiary. Note that you may choose to continue service coordination OR choose to continue services; you cannot continue both activities.

Always contact the Department before terminating services! There is a required procedure that begins 60 days prior to any end of services. Requirements include the forwarding of current records to the new provider, 30-day advance notice to the beneficiary, and six-year storage of all records. Additionally, the terminating provider must assist the patient in finding a new provider. This is not an all-inclusive list of requirements. Contact your RRDC to ensure complete compliance.

Timeline

The compliance date is November 11, 2023.

A letter describing the COI requirements will be sent to waiver participants by the RRDCs in mid-September. The letters will indicate that the COI requirements are effective as of the beneficiary's regular plan review date. While not detailed fully in the webinar, the letter will likely not be an individualized one; that is, specific dates will not be indicated. Therefore, providers might want to be prepared for questions from clients once these letters are sent.

The Department is developing the audit and surveillance protocols for COI.

Additional Information

Several session participants referred to patient free choice relative to the COI rule. DOH iterated that it had broached this issue with CMS, and the federal agency stands by the letter of the rule: exceptions will ONLY be made if there is no other willing and able provider for the services for that beneficiary.

DOH made it very clear that ***patient preference cannot be used as a reason for exception from the COI requirements.*** If you must change a patient's SC or service provider in order for you to be COI compliant, and the patient refuses, you must release them from your agency. The beneficiary's only option is to go through the regular fair hearing process in this instance; CMS is not permitting any COI exception appeals or flexibilities.

Regarding the ability of states to request an extension on Appendix K authorities, DOH explained that COI compliance is NOT offered to states by CMS as an option for an extension request. Only Appendix K authorities for which states need more time to prepare are eligible for extension. The Department noted that since the COI rule was passed years ago, states are expected to be prepared to comply by the November deadline.

In addition to the possibility of a conflict of interest directly between SC and direct care, the state explained that COI occurs when there is a fiduciary interest between the parties determining the care plan and the parties providing the services. A two-degree separation must exist in order to be free of COI. This includes family relationship restrictions as well, so check with the Department if you have any questions regarding your particular circumstances. For example, per the DOH webinar, a client cannot be related to the agency owner or the SC. The bottom line is this: you cannot order services that will result in a financial benefit for your agency, you personally, or your family.

When asked about a possible "bottleneck" of clients needing to change providers, DOH reminded attendees that the compliance date is tied to the date of the annual plan review. Therefore, there will be a natural calendar distribution of affected clients. The Department advises providers to begin a tracking system of plan dates now so that beneficiaries don't risk losing services.