August 1, 2017

Andrew Segal, MPH
Director
Division of Long Term Care
New York State Department of Health
Office of Health Insurance Programs
One Commerce Plaza, Suite 1624
Albany, NY 12210

Dear Mr. Segal:

I am writing in relation to the State's approach to applying the federal home and community-based services (HCBS) conflict of interest (COI) rules to the Traumatic Brain Injury (TBI) and Nursing Home Transition and Diversion (NHTD) Waivers. In addition, our members are concerned about the implications of this policy for service planning conducted by provider-sponsored managed care plans, their care management subcontractors, and PACE programs, once these programs and the Community First Choice Option (CFCO) are carved into managed care.

The Department's recent communications regarding the corrective action plan for the TBI and NHTD Waivers have raised concerns that the plan may go beyond the requirements of the regulation. It is difficult to discern precisely how the Department plans to implement the COI rules under the waivers because the corrective action plan is not yet publicly available. However, it is important to recognize that an overbroad interpretation of the regulations could undermine efforts to promote service integration and erode participant choice and access. Moreover, the Department's implementation of the COI rules may also threaten the continued participation of provider-sponsored managed care plans and care management subcontractors in the 1115 waiver, as TBI, NHTD and CFCO services are incorporated into managed care. This result would disrupt care for thousands of consumers and interfere with the State's and federal government's goals of improving outcomes and reducing costs through greater integration of services.

Background

As you know, the federal COI rules have slightly different formulations for different HCBS programs. The rule for 1915(c) waivers, such as the TBI and NHTD Waivers, provides:

> 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.

13 British American Blvd. | Suite 2 | Latham, NY 12110
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42 C.F.R. §441.301(c). The Community First Choice Option (CFCO) includes a similar provision. 42 C.F.R. §441.555(c)

Notably, the Department and CMS have interpreted the COI rules to permit the same organization to provide both home and community-based services and service coordination in certain contexts under certain circumstances. Specifically, the Department's 1115 waiver allows entities that are both Health Homes and HCBS providers to conduct person-centered service planning, care coordination, and provision of HCBS, "as long as firewalls are constructed between the service planning, care coordination, and service provision."[1] Similarly, according to information available on the Department's website, in order "to promote and ensure integrated care for the best interest of the client," children enrolled in the 1915(c) waivers who are transitioning to managed care plans "may receive care management and direct care services from the same entity, however, in these instances the care management and direct service components will be under different administrative/supervisory structures of the entity."[2]

NHTD/TBI Waiver Service Coordination

The Department's recent announcement that, as of April 2018, Service Coordination Provider Agencies cannot provide other waiver services appears to be inconsistent with the precedent set by the Health Home Person-Centered Service Planning provisions of the 1115 waiver. *We request that the Department pursue a strategy for NHTD and TBI Service Coordination similar to the Health Home approach.*

If the Department and CMS are committed to an outright prohibition on the concurrent delivery of NHTD/TBI service coordination and waiver services, with exemptions only for rural and culturally-distinct providers, we ask you to avoid over-broad interpretations. In particular, Service Coordination Provider Agencies that are separate from, and operate under a common parent with, a service provider should be permitted to continue to operate. These Agencies do not "have an interest in" and are not "employed by" a provider of HCBS. Rather, it is the common parent that holds an interest in the HCBS provider. The existence of separate administrative structures and firewalls will serve to protect the independence of each component, while preserving consumer choice. We would appreciate an opportunity to provide input into any guidance related to the corrective action plan, in order to ensure that this type of structure is permitted.

Managed Care

Further, as the Department moves to carve CFCO services, as well as TBI and NHTD services, into mainstream managed care, MLTC, FIDA and PACE, we ask that you be mindful of the implications of your interpretation of the COI rules. The rules should not be interpreted to preclude provider-sponsored managed care plans or provider-sponsored care management subcontractors from developing service plans for their members. Provider-sponsored plans play an important role in all of the State's managed care programs. Clearly, in order to function, every plan must be permitted to develop or arrange for service plans for its members. The 1115 waiver Terms and Conditions recognize this by requiring that

[1] New York State 1115 Waiver Terms and Conditions, section V(4)(a), 1/19/17, accessed on 7/24/17 at https://www.health.ny.gov/health_care/managed_care/appextension/docs/2017-01-19_renewal_stc.pdf .
[2] Children's Health and Behavioral Health MRT Subcommittee, July 2015.

the person-centered service plan be developed by the enrollee "with the assistance of the MCO and other individuals that the enrollee chooses to include." According to CMS, under the COI rules, *only* those MCOs that "own and operate direct LTSS services (such as personal care and Nursing Facility) . . . must demonstrate to CMS that they are the only willing and qualified case manager", in order to provide case management.[3]

Typically, at least in the not-for-profit sector, provider-sponsored managed care plans and related providers are separately incorporated entities with separate licensure and governance, but share a common parent. They do not generally own, operate, or employ direct providers of services and should not be barred from engaging in service planning or care management.

Several plans provide care management through subcontracts with home care agencies that also provide personal care and/or home health services. As you know, the Department's Care Management Administrative Services Agreement Guidelines require care management subcontractors to be licensed health care providers (including health care facilities and agencies licensed or certified under Article 28 or 36 of the Public Health Law or under the Mental Hygiene Law), IPAs, or "an entity otherwise approved by the department as capable to render the services contemplated by [the] agreement." Thus, an expansive interpretation of the COI rules would disrupt many care management subcontracts and the care management relationships of scores of members.

We request that the Department follow the precedent set by the Health Homes and allow provider-sponsored managed care plans and care management subcontractors to conduct person-centered service planning, care coordination, and provision of HCBS, provided that firewalls are constructed between service planning and service provision.

PACE programs, by design, represent a more integrated model, in which direct service providers may be employed or owned by the program itself. However, PACE programs are subject to their own federal regulations, including interdisciplinary team requirements and safeguards to prevent conflicts of interest. Notably, they are not covered by the federal home and community-based settings standards. *If NHTD, TBI and CFCO services are to be integrated into PACE programs, PACE programs should be exempt from the COI rules.*

An expansive interpretation of the COI rules will impose new administrative expense, contribute to fragmentation of services, and create new limitations on consumer access and choice. We would like to meet with you to discuss your approach to these issues and will be contacting you in the next several days to schedule a meeting. Thank you very much for your attention to this matter.

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[3] *See* Kako E, Cooper R, Centers for Medicaid and Medicare Services, Division of Long Term Services and Supports, Disabled and Elderly Health Programs Group, Center for Medicaid and CHIP Services, "Conflict of Interest in Medicaid Authorities," slide presentation, Jan. 2016, available at https://www.medicaid.gov/medicaid/hcbs/downloads/conflict-of-interest-in-medicaid-authorities-january-2016.pdf .

Sincerely yours,

Karen Lipson
Executive Vice President for Innovation Strategies

Cc: Eric Henderson
Erin Kate Calicchia
Deborah Conley-Flora
Dave Hoffman
Beth Gnozzio