1915(i) Conflict of Interest Requirements

This guideline contains the following information about the federal conflict of interest standards. Federal rules require separation of care coordination and other service provision between different providers. North Dakota's 1915(i) State Plan Amendment includes two exceptions to this requirement.

Applicability

This guideline applies to Human Service Zone employees determining eligibility, supportive service and care coordination providers, and 1915(i) members.

Definitions

Care coordinator – means the professional responsible for plan of care development and coordinating access to needed services.

Care coordination – means performing assessments and developing a plan of care for a Medicaid member. Care coordination is carried out by a care coordinator.

Conflict of interest – means that care coordinators are independent or separate from providers of other 1915(i) services.

Cultural background – means a shared set of beliefs, practices, traditions, and values inherited from the ancestry of a social group. For purposes of 1915(i), a specific or unique group must be identified rather than an entire population. For example, a particular Native American tribe rather than the entire Native American population or a specific refugee population rather than all refugees.

Employer Identification Number (EIN) – means a number that identifies your business for tax purposes.

Human Service Zones – means local offices in the counties (formerly known as county social service offices) who have professionals that can help people who need services and supports.

Conflict of Interest Standards

These standards apply to all individuals and entities, public or private. At a minimum, care coordinators and Human Service Zone employees must not be any of the following:

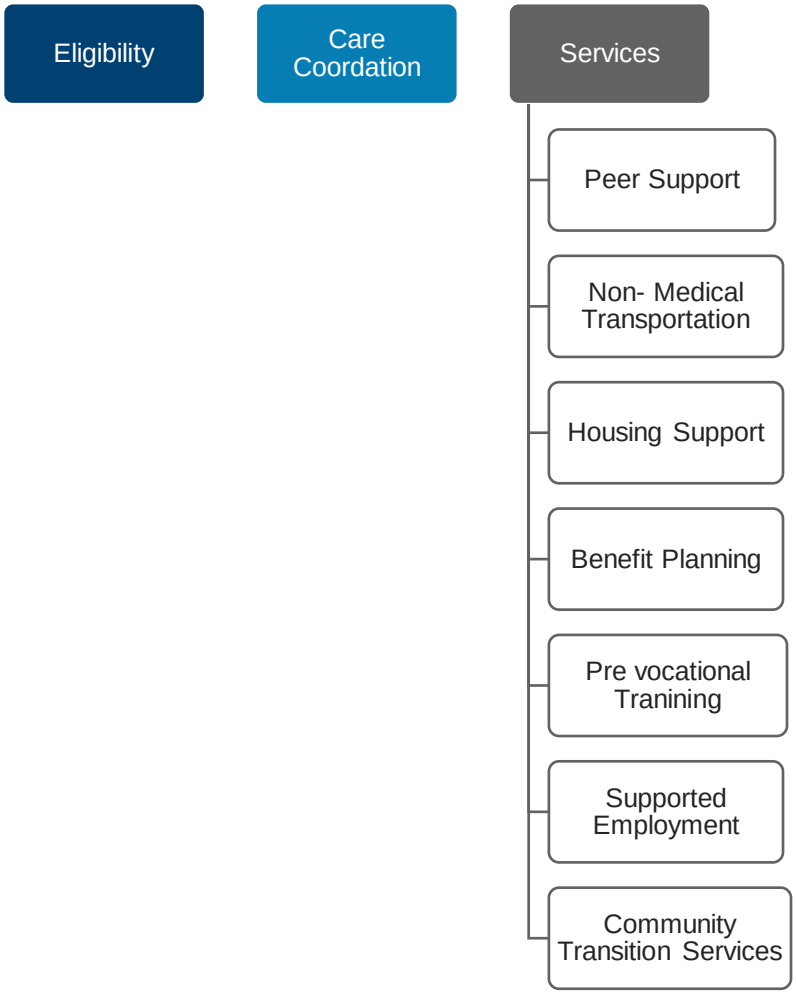
1. Be related by blood or marriage to the member, or any paid caregiver of the member.
2. Be financially responsible for the member.
3. Be empowered to make financial or health-related decisions on behalf of the member.
4. Have a financial interest, as defined in § 411.354, in any entity paid to provide care for the member.
5. Providers of other 1915(i) services for the member, or those who have interest in or are employed by a provider of other 1915(i) services.

Exception: When a provider is the only willing and qualified provider in a geographic area to serve as a care coordinator and provide the other 1915(i) services. The provider must comply with the Medicaid Expansion conflict of interest protections.

The regulation requires independence or separation of the following functions:

- Independent evaluation of eligibility, performed by the Human Service Zone.
- The assessment of need and plan of care development, performed by the care coordinator.
- Provision of other 1915(i) services (excluding care coordination), performed by service providers.

Conflict-Free Care Coordination under Federal 1915(i) Rules



Independent Evaluation of Eligibility (Human Service Zone)

The point of entry to enroll in 1915(i) services is the Human Service Zone. Human Service Zone employees determining eligibility must not be:

- Related by blood or marriage to the member, or any paid caregiver of the member.
- Financially responsible for the member; or
- Impowered to make financial or health related decisions on behalf of the member.

Care Coordination Providers

Care coordination agencies cannot provide care coordination and provide other 1915(i) services to the same member unless one of the below exemptions applies.

Exemption 1: Only Willing and Qualified Provider within the Member's County of Residence

The provider is the only willing and qualified provider within the member's county of residence. There are two ways to show a provider is the only willing and qualified provider.

1. The care coordination provider is the only provider listed on the current 1915(i) Provider List offering the service in the member's county of residence, or
2. The care coordination provider is selected by the member as their first choice to provide the service and there are documented denials of referrals from all other service providers in the member's county of residence who offer the service.

Exemption 2: Only Willing and Qualified Provider within the Member's

County of Residence based on a Common Language or Cultural Background

The provider is the only willing and qualified provider within the member's county of residence with the experience and knowledge to serve members who share a common language or cultural background. There are two ways to show a provider is the only willing and qualified provider due to a common language or cultural background:

1. The care coordination provider is the only provider listed on the current 1915(i) Provider List with the cultural background who provides the service in the member's county of residence, or
2. The care coordination provider is selected by the member as their first choice to provide the service and there are documented denials of referrals from all other service providers serving the same cultural background in the member's county of residence.

Conflict of interest exemptions do not occur at the agency level. They are made on a service-by-service basis for each member.

How providers show they are only willing and qualified provider within the members county of residence based on a common language or cultural background (Conflict of interest exemption #2)

Language exemptions only require justification when they are part of a cultural background.

If the provider is the only listed qualified/culturally specific service provider for the service in the member's county of residence, the provider must:

1. Identify as the service provider on the plan of care.
2. Medicaid Expansion will review the service authorization request and ensure there no other providers are qualified/culturally specific before approving.

When there are other qualified/culturally specific (the same language/cultural background must apply) service providers who are listed on the 1915(i) Provider List in the member's county of residence, the provider must:

1. Send service referrals through Therap to each applicable provider identified on the provider list. The requests must be in order of member choice. If an agency denies the request, the denial in Therap will be the documented proof of denial.
    - If an agency accepts the request, identify the accepting agency on the plan of care as the service provider.
    - The service agency is to respond within two business days. If an agency doesn't respond within two business days, the care coordination agency can accept that as a denial.

- If the care coordination agency will be rendering both care coordination and the other 1915(i) service(s), they must document on the Plan of Care that all other listed service providers have denied the service request. This documentation of denials from all service providers in the member's county of residence must be done at each subsequent quarterly POC review.

2. 1915(i) Navigator will review the request in Therap to ensure all providers identified on the current provider list have been identified on the Plan of Care and listed as an agency that denied the service request before approving.

Documenting denials or "only willing and qualified provider"

Documentation of being the only willing and qualified provider can look like:

- Service referral denials documented in Therap serve as proof of denials and must be referenced in the member's Plan of Care.
- Showing no provider response using screenshots from the referrals in Therap or SComms from a service provider where they state that they cannot serve a member can show service denials. Remember, lack of provider response within two (2) business days are treated as denials.

Care Coordination Agency Requirements

Care coordination agencies who qualify to provide both care coordination and services must:

1. Document the use of different individual providers and supervisors for provision of the care coordination service and different individual providers and supervisors for provision of the other 1915(i) services in the plan of care, and
2. Implement the protections listed in the Conflict of Interest Protections section below.

Provision of Other 1915(i) Services

An individual service provider affiliated with an agency may provide any combination of the other 1915(i) services, excluding the care coordination service. This means the same individual provider may provide peer support, non-medical transportation, or any of the other 1915(i) services, just not care coordination.

An individual provider affiliated with multiple provider enrollment groups or agencies cannot provide care coordination under one agency and provide the other 1915(i) services under a different agency to the same member if that individual provider is employed by both agencies.

- For example, an individual provider cannot provide care coordination under

Badlands Care Coordination Agency and peer support under Roughrider Support Agency to the same member if that individual provider is employed by both agencies.

WHODAS Administration

WHODAS administration, done for 1915(i) eligibility or redetermination, cannot be done by the same person that is also providing care coordination or 1915(i) supportive services. The WHODAS can be administered by another employee of the care coordination agency, provided that the person administering the WHODAS is not:

- Related by blood or marriage to the member or any paid caregiver of the member;
- Financially responsible for the member; or
- Empowered to make financial or health-related decision on behalf of the member.

Conflict of Interest Protections

To ensure conflict of interest standards are met, the following protections must be in place:

Member

1. The member's care coordinator will provide written documentation explaining the member's right to choose providers for each of the services specified in the plan of care and their right to change their care coordination provider or any other service provider at any time. The member selects all service provider(s) from a list of available service providers.
2. The member, and their family or guardian when applicable, are provided a form containing the following dispute resolution process:

   – If a member is uncomfortable reporting any problems or concerns to their care coordinator, they may email 1915i@bcbsnd.com or call Medicaid Expansion Contact Center at 1-833-777-5779. Care coordinators are instructed to remind members of this option at their care coordination meeting, and at a minimum of quarterly thereafter.

3. Members who receive 1915(i) services from the same agency that provides the care coordination service are protected by the followi--ng safeguards:

   – Fair hearing rights,
   – The ability to change providers, and
   – The ability to request different individual providers from within the same agency.

4. The plan of care must indicate the member was notified of the conflict-of-interest standards and the dispute resolution process, including appeal rights, and the member has exercised their right in free choice of provider after notification of the conflict-of-interest standards. The member signs an acknowledgment on the plan of care indicating their free choice of provider.

Provider

1. If applicable, providers must receive prior service authorization for services.
2. Providers are required to have written conflict of interest standards and written policy to ensure the independence of individual providers and supervisors providing the care coordination service and independence of individual providers and supervisors providing the other 1915(i) services to the same member.

1915(i) Navigator

1. 1915(i) Navigator will confirm a provider is the "only willing and qualified" provider prior to approving the plan of care.
2. 1915(i) Navigator will directly oversee and periodically evaluate conflict of interest protections.
3. 1915(i) Navigator will engage in quality management activities to promote adherence to service delivery practices including individual choice and direction in the development of the plan of care, selection of service providers, and preference for service delivery.

Agencies Creating Separate Entities

The conflict-of-interest standards refer to who employs (meaning the legal entity) the care coordinator and who employs the service provider. Care coordinators cannot have an interest in or be employed by a provider of any of the other 1915(i) services to the same member unless an exemption, as identified above, applies.

For purposes of this policy, separately employed means employed by a legal entity with a separate Employer Identifier Number (EIN).

Resource

§ 441.730 Conflict of Interest Standards

FAQs

Q: If an agency uses a translation service that offers a variety of languages, how do you want that communicated?
A: Please email that information to the 1915(i) inbox at nd1915(i)@nd.gov. We will list this on our Provider List.

Note: Using a translation service is not the same as having service providers who speak that language. Our expectation is that for a conflict-of-interest exemption for reasons of language there are service providers in your agency who speak the member's language. These service providers must still be separate – i.e. the care coordinator cannot also be the member's peer support specialist.

Q: What could it look like to be the "only willing and qualified" service provider?
A: It could look like any of the below scenarios:

- Provider is the only supportive service provider in the member's county of residence.
- Provider is the only provider that offers services in the member's language in the county of member's residence.
- Provider is the only supportive service provider that serves youth in the member's county of residence.
- Provider is the only supportive service provider that currently has the member's requested service preferences – i.e. a female peer support specialist.

Q: What does separation within a provider agency look like for conflict-free care coordination?
A: For a member, it looks like this:

- Member's care coordinator informs them of their right to choose and change service providers.
- The member and their family or guardian, when applicable, are provided a form containing the dispute resolution process.
- The Plan of Care must indicate the member was notified of the conflict-of-interest standards and the dispute process, including appeal rights, and the member has exercised their right in free acknowledgement on the Plan of Care indicating their free choice of provider.

On the provider side, it looks like this:

- Providers must have written conflict of interest standards and written policy to ensure the independence of individual providers and supervisors providing the care coordination service and independence of individual providers and supervisors providing the other 1915(i) services to the same member.

Q: If approved, how long does the conflict-of-interest exemption last?
A: The exemption lasts until the next quarterly review. At such time, the care coordinator needs to go through the entire process again to see if there are any other willing and qualified providers providing the service in question. If those providers are able to service the member, then the conflict-of-interest exemption would end.