MSHN
Mid-State Health Network

MID-STATE HEALTH NETWORK
POLICIES MANUAL

Chapter:	**Service Delivery System**		
Title:	**Conflict Free Case Management**		
Policy: ☒ **Procedure:** ☐ **Page:** 1 of 2	**Review Cycle:** Biennial **Author:** Clinical Leadership and Utilization Management Committee	**Adopted Date: 03.01.2022** **Review Date:**	**Related Policies:** Utilization Management Access Person-Centered Planning

Purpose

The Centers for Medicare and Medicaid Services (CMS) Home and Community Based Settings Regulations (known commonly as the HCBS Final Rule) requires that assessment and coordination of services are separate from the delivery of services with the goal of limiting any conscious or unconscious bias that a case manager may have and safeguarding against financial conflicts of interest. The intent is that a single agency is not both assessing what services an individual needs and then providing those services to them as required in conflict-free case management policies in states using Medicaid funds from the Balancing Incentive Program, Community First Choice (1915 k), and 1915(i).

The purpose of this policy is to ensure that Mid-State Health Network (MSHN) and its Community Mental Health Service Program (CMHSP) participants have a consistent definition and operational guidance for the provision of services and supports that are free from conflicts of interest, also referred to as conflict-free case management (CFCM).

Policy

1. MSHN and its CMHSP participants follow established conflict of interest standards for the assessment of functional need and the person-centered service plan development process that apply to all individuals and entities, public or private. At a minimum, the individuals or entities conducting the assessment of functional need and person-centered service plan development process are not:
    a. Related by blood or marriage to the member, or to any paid caregiver of the member.
    b. Financially responsible for the member.
    c. Empowered to make financial or health-related decisions on behalf of the member.
    d. Individuals who would benefit financially from the provision of assessed needs and services.
    e. Providers of HCBS for the member, or those who have an interest in or are employed by a provider of HCBS for the member must not provide case management or develop the person-centered service plan, except when MDHHS 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, MDHHS must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Members must be provided with a clear and accessible alternative dispute resolution process.

2. Administrative and/or structural firewalls should exist between functions, whenever possible:
    a. Assessment & Eligibility/Resource Allocation: This includes the processes for determining eligibility and assigning budgets, hours, or other units of services.
    b. Plan Development: These are the processes that lead to a person-centered plan.
    c. Monitoring & Service Coordination: These are the processes for ensuring that services are delivered according to guidance included in the plan. Activities include coordinating services, monitoring the quality of the services, and monitoring the individual (e.g., watching for changes in needs or preferences).
    d. Direct Supports & Service Delivery: The supports and/or services provided to the individual in accordance with the person-centered plan.
    e. Utilization Management: Utilization management activities are a separate and discrete managed-care function that sit outside of the other processes of assessment/eligibility, plan development, plan

monitoring, and service delivery. Utilization management activities ensure that medical-necessity criteria are met for all services and supports.

3. The CMHSP participants that comprise the MSHN PIHP region are diverse in size, geographic location, rural/urban settings, and resource availability. In instances where complete separation of functions may not be possible CMHSP participants will employ safeguard strategies and robust oversight to limit potential conflicts of interest. Safeguard strategies may include, but are not limited to:
    a. Required training on the principles of conflict-free case management for all case managers and supports coordinators
    b. Use of consumer advocates and independent facilitators in the person-centered planning process
    c. Ensure that all consumers are offered choices of providers at regular intervals (annually, at minimum) and their preference is documented in the plan of service
    d. Random or targeted case reviews should be utilized to determine whether assessment/eligibility determination findings match actual service needs

Applies to

☒ All Mid-State Health Network Staff
☐ Selected MSHN Staff, as follows:
☒ MSHN CMHSP Participants: ☒ Policy Only ☐ Policy and Procedure
☒ Other: Sub-contract Providers

Definitions/Acronyms:

CMHSP: Community Mental Health Service Programs
Case Management: Refers to an activity that assists individuals to gain access to needed medical, social, educational, and other services as appropriate to the needs of the individual.
Consumerism: Means active promotion of the interests, service needs, and rights of consumers receiving mental health and/or substance use disorder services.
Customers/Consumers/Members: Refers to those individuals who are eligible to receive specialty mental health and substance use disorder services, as well as those currently receiving such services and their families/guardians. For the purpose of MSHN policy, these terms are used interchangeably.
HCBS: Home and Community Based Services
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan

References/Legal Authority

1. MDHHS Person Centered Planning Policy and Practice Guideline
2. 42 CFR 441.301(c)(1)(vi)
3. 42 CFR 441.555(c)(1-5)
4. 42 CFR 441.730(b)(1-5)
5. The Balancing Incentive Program (BIP) provisions in the Affordable Care Act
6. Final Rule CMS 2249F 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

Change Log:

Date of Change	Description of Change	Responsible Party
01-2022	New policy	Director of Integrated Care and Utilization Management