Conflict Free Access and Planning Workgroup Meeting Notes

Meeting Details

Meeting Name:	Conflict-Free Access and Planning
Meeting Date & location:	March 18, 2022 @ 11:00a.m. – 12:30p.m. – Teams Meeting
Call in number	Teams Meeting
Leader/Facilitator:	Remi Romanowski-Pfeiffer, Belinda Hawks
Next Meeting:	April 27, 2022 @ 8:30a.m. – 10:00a.m.

Key Discussion Points

Departmental Reorganization

- The reorganization is intended to show a united voice behind multiple service delivery areas.
- Phil Kurdunowicz from the newly formed Children's Bureau will become a regular attendee moving forward.
- Belinda Hawks will remain the state lead on this project. Her area is now called the Division of Adult Home and Community Based Services.

Project Timeline

- The workgroup remains in the "inform" phase.
- As we transition to the frame phase, we will categorize feedback into different areas and discuss the impacts of potential policy options.
- The feedback portion will be about organizing and documenting feedback, including strengths and weakness and important factors for the state to consider.

Journey

Parallel projects: *There have been HSAG corrective action plans (CAPs) around conflict-free case management and mitigating conflict of interest. PIHPs are wondering what will happen if they develop a CAP that doesn't look like where this group is going.* MDHHS will work with HSAG to understand the connections between these activities and mitigate against conflicting guidance.

Is the planned implementation date too close to the Federal deadline? MDHHS will work to make a list of deadlines that have to be met for policy, contract changes, etc.

Path not determined: MDHHS and TBD Solutions want to be clear that the state has not decided on a path—this will be very much driven by the feedback from this workgroup.

Legislative involvement*: Has anyone from MDHHS presented these conflict free considerations to the House or Senate in Michigan as they move forward with behavioral health systems legislation?* No.

Inform-Frame-Feedback

Can you share the readiness assessment document? This will be shared when available. MDHHS and TBD Solutions may seek group input on developing that tool.

How do you define an "organization" for the purposes of this project? The key is to think about how your organization might fit into different conflict-free models. It will be important for the readiness assessment to consider- and for it to be applicable to a variety of organizational types.

Reviewing resources: A participant shared that it was very helpful to go over the CMS requirements for conflict-free, specifically the focus on HCBS services.

Definitions: Firewall

Definition: A firewall is a structural bifurcation between eligibility, needs assessment, and planning on one hand and direct service on the other hand. Using the strictest definition, the provider of one cannot have a financial interest in the provider of the other.

Independent facilitation*: In Michigan, there has been a big push for independent, planned facilitation. However, with this, it's just the plan that's conflict free. How can access also be separate?* MDHHS sees independent facilitation as one method to mitigate conflict. It's the first step in that process.

Point of concern: A participant stated that they don't want to lose the progress that has been with the safeguards around the planning process.

Should there be a firewall between planning and service delivery? Would that result in a service barrier? This should just be a wall for eliminating financial conflict, not a barrier to access.

It would be helpful to clarify whom the facilitator is independent from. The readiness tool intends to allow for the examination of relationships between organizations and entities, such as the relationship between those who facilitate planning and other organizations.

Have the standards/requirements we are trying to address been distributed? Although MDHHS hasn't put a list of all the standards and requirements up on the website, the rules are cited throughout the meeting PowerPoints. The PowerPoints are made available on the project website.

Definitions: Safeguard

Definition: A safeguard is a process that can guard against conflict—examples include independent facilitation, supports brokers, etc. However, CMS says risk is not fully mitigated with just safeguards. Safeguards are not meant to be a statewide approach to CFA&P, although in some cases it may be possible that they could be deployed as an exception for certain regions. This is the strict interpretation from CMS.

How is MDHHS defining whether or not there is a willing and qualified provider in a specific region? With support from this workgroup, MDHHS must first decide if exceptions will be allowed. Then we will work on defining exceptions.

Worth noting: A participant asked that when we discuss person-centered planning, we remember this is not synonymous with Family-Driven/Youth-Guided planning and practice for children and families.

Where does certified community behavioral health clinic (CCBHC) care coordination for Designated Collaborating Organizations (DCOs) fit into the safeguard model? MDHHS will review this.

More on CCBHCs: *A participant was curious about the care coordination role in CCBHCs. She said it is necessary to have CCBHCs participate and ensure that the proper person-centered planning (PCP) process is occurring in planning meetings. Could this be an element of a safeguard process?* This was not developed by the same group who developed the conflict-free language. It is up to states to figure out how to weave a path between these two standards. ~~It will be necessary to set these requirements beside each other and live with both.~~

Is it as straightforward as saying safeguards aren't enough and Michigan needs firewalls? There is an array of approaches. The strictest interpretation is safeguards alone are not sufficient. However, there are lots of areas in between. It's not an "either or." Even just separating entities financially doesn't lead to the ideal state we want for the system. The way things get implemented together leads to a lot of potential options.

Parallel projects: *MDHHS has also expressed systemic conflict of interest concerns for years (payer/manager/provider) - at some point will there be a more global discussion to integrate/synthesize concepts to address both related concerns together?* MDHHS is looking at that.

Sample Options for Firewall Approach

- Family 1: The PIHP funds and oversees direct service providers. The State oversees Access and Planning providers.

Reaction: The visual is helpful to consider that the state could oversee access and planning.

Reaction: It is important to consider the space between access and planning and direct service. Effective service delivery happens best when planning and direct service happen together and are all on the same page. If we move to this model, we must continue to nourish and develop those relationships.

Reaction: This model has benefit in that access and planning would be consistent across the state. But there has to be a connection between planning and direct service.

Reaction: If access and planning is not housed in the community, there has to be an understanding of what specifically is available in that community.

Reaction: I'm thinking about a trauma-informed perspective. What's it like if people served have to go to multiple settings and tell their story?

Reaction: I love the comment about navigation of "the system" being an issue for individuals and families. In my own health care--I prefer one-stop shopping so I don't have to deal with records transfers, telling my story time and again, lack of information/communication between providers. End user experience is a priority consideration.

Example: In South Dakota, there are at least two access and planning providers in each region.

What is the volume of cases on for each case manager in the South Dakota model? Unknown, but TBD Solutions may be able to find additional information.

Worth noting: South Dakota ranked higher than Michigan in the national comparison data from "The Case for Inclusion" report generated by United Cerebral Palsy (UCP).

- Family 2: State oversees PIHP, PIHP oversees planning as well as direct services.

Is it expected that the provision of telehealth with be available to support the implemented model? *This will offer a lot of design freedom, assist with issues of "network availability", and could enhance quality.* Telehealth will be a part of any process adopted.

Reaction: For organizations that are both PIHP and CMHSP, it's important to think about how structurally those could be separated.

Reaction: Does anyone else remember when the state contracted directly for access and planning services and also contracted directly with providers for other services? There were challenges in communication and the relationship between the two provider types (1980s).

Reaction: State oversight I believe has been a large part of the challenge of implementation and compliance of self-determination. This needs to be discussed in examples.

What Medicaid services are considered in the "direct service provider" category? It's a question of functions as defined in CMS policy, not service codes. This should go on our list of issues that need further definition.

Reaction: Does anyone know this interacts with mental health parity, where mental health services cannot be provided in a manner that is more restrictive than medical services? It appears more restrictive.