AHCCCS
Arizona Health Care Cost Containment System

Agenda

Independent Contractor Workgroup

September 23, 2015

9:30 AM – Noon

AHCCCS, 801 E. Jefferson, 4th Floor, Arizona Conference Room

Conference Call – Dial 1-877-820-7831, Passcode 548951#

Webinar Link - https://global.gotomeeting.com/join/611328741

TOPIC:	LEAD:
Welcome & Introductions 9:30 - 9:45	**Virginia Rountree** Acting Assistant Director Division of Health Care Management
State Model Research Committee Report Report (9:45 – 10:05) Q & A (10:05 – 10:15)	**Leslie Mitchell** Consumer Direct **Patti Dorgan** UnitedHealthcare
Member, DCW and Agency Considerations Committee Report Report (10:15 – 10:35) Q & A (10:35 – 10:45)	**Stephen Barkley** Tungland Corporation
Liability and Risk Mitigation Committee Report Report (10:45 – 11:05) Q & A (11:05 – 11:15)	**Monica Coury** Assistant Director Office of Intergovernmental Relations
Insurance Requirements Committee Report Report (11:15 – 11:35) Q & A (11:35 – 11:45)	**Ben Garland** Sunbelt Insurance Holdings
Next Steps and Wrap Up 11:45 - noon	

For reference – See the AHCCCS website
http://www.azahcccs.gov/commercial/

State Research Committee Report

1. State Research Committee Members

Committee Members	
Mohamed Arif (AHCCCS)	**Patti Dorgan** (United HealthCare)
Carolin Leong (Prileo Home Care)	**Leslie Mitchell** (Consumer Direct of Arizona)
Megan Neal (ResCare)	**Megan Akens** (DES/DDD)

2. Review Matrix Questions
3. Summary of Results:
   a. Found three different Models commonly used:
      i. Individual Based IC
      ii. Agency Based IC
      iii. Self-Directed/Fiscal Intermediary (using an employer/employee model)
   b. No consistent theme across all states.
   c. Determined if State allowed Independent Contractors as an Agency Based I.C. Model or an Individual Based I.C. Model , and then categorized results into three groups:
      i. Red = Independent Contractors not allowed
      ii. Yellow = Independent Contractors undetermined
      iii. Green = Independent Contractors allowed

State Models	Red	Yellow	Green	Totals # States
Individual IC Model	14	2	6	22
Agency IC Model	15	2	5	22

   d. Highlights on Green Classifications:
      i. The Individual Independent Contractor Model required the Independent Contractor to be contracted with the state Medicaid program.

      ii. Individual Independent Contractor Model was limited to certain services (HSK vs. PC); or for Personal Care Services it was only used in areas with limited network capabilities, and in cases there is oversite by a Registered Nurse.

      iii. In cases where Independent Contractors were allowed, they had a choice of going with Registry or Agency, but both options have oversite independent of the State or MCO.

      iv. There were 5 States that allowed **Agencies** Based Independent Contractors Model:
         1. Three of the five states said they pay the same reimbursement rate to Home Care Agencies whether they used Independent Contractors or employees as DCWs, stating the scope of work for the agency did not change based on employee classification.
         2. New Jersey's stated they pay a different reimbursement rate depending on the model being utilized, due to benefits being paid to agency employees ($16 self-hires & $22 for agency workers)
      v. Florida and Texas stated that they are not responsible for determining the home care agency's compliance level with Fed and/or State regulators (IRS, UI or DOL).

e. Highlights on the Red Classifications:

i. Alaska said they don't use the model because they don't want to be considered an employer.

ii. South Carolina - Previously allowed Independent Contractors, but they had an IRS ruling where domestic workers are now required to be employed by someone, therefore the state has incorporated a Fiscal Intermediary Model.

iii. States that did not allow Independent Contractor Models did allow for Self-Directed/Fiscal Intermediary model, but the Self-Directed models used always are of the employer/employee model.

Visual of State Research Results

State	Individual Base IC Model	Agency Based IC Model
Florida	Green	Green
New Jersey	Green	Green
Illinois	Green	
New York	Green	
Ohio	Green	
Pennsylvania	Green	
Georgia		Green
Hawaii		Green
Texas		Green
Alaska		
Arkansas		
Colorado		
Kansas		
Louisiana		
Minnesota		
Montana		
New Mexico		
Oklahoma		
South Carolina		
Tennessee		
Idaho	Yellow	Yellow
Washington	Yellow	Yellow

Key: Red = Independent Contractors not allowed, Yellow = Independent Contractors undetermined and Green = Independent Contractors allowed.

AHCCCS Independent Contractor Workgroup
Member, DCW, and Agency Consideration Committee

September 23, 2015

A meeting of the AHCCCS Independent Contractor Workgroup; Member, DCW, and Agency Consideration Committee was held at the offices of AHCCCS on August 24, 2015, at 1:30 p.m. The members of the Committee in attendance were: Debbie Reichow (AHCCCS), Wendy Swager (Soreo), Larry O'Connor (UHC), Francine Pechnik (UHCCP), Pat Haren (Mercy Care), Dara Johnson (AHCCCS, attending intermittently during meeting), Gwen Dean (ABIL), Keoffery Levy (All Valley Care), Phil Pangrazio (ABIL), Dan Koesser (Bridgeway), Uma Nagulapalli (My House), Coralyn Lingwall (DES/DDD), Steve Barkley (Tungland).

In anticipation of the general Workgroup meeting on September 23, 2015, the Committee agreed to focus on determining areas of consensus as well as any areas of clear disagreement. The Committee affirmed its understanding that its purpose was to provide recommendations to AHCCCS regarding the use of independent contractors as directed by the Governor following a revision to AHCCCS policy that would otherwise require exclusive use of employees by vendors.

The Committee reached consensus on the following items:

1. Scope of services. Ms. Johnson advised the Committee that the only services that would be subject to consideration by the Committee include respite, attendant care, personal care, homemaker, habilitation, and home health services. Given the different nature of home health services, the Committee agreed to exclude consideration of home health services from its recommendations at this time and make its recommendations with respect to respite, personal care, attendant care, homemaker, and habilitation services.

2. Agency Models. The Committee recommends that independent contractors must contract with an agency (i.e., qualified vendor) and AHCCCS need not be required to contract directly with individual independent contractors.

3. Contractual Obligations. Agencies, as the prime contractors, would remain responsible for the quality of the services delivered by their subcontractors. It was suggested that the current DDD Qualified Vendor Agreement contemplates the use of subcontractors and its provisions could be used as a continuing model for contractual requirements, although some of the Committee members were not familiar with the DDD QVA and had not reviewed it.

During the meeting, the Committee undertook extensive discussion regarding regulatory oversight, liability, insurance, DDD's current "independent provider" structure and practices, and other relevant topics. In general, provided that an agency remains responsible under the prime contract, the Members and AHCCCS would remain

protected. In response to issues discussed at earlier meetings regarding possible differing rates of payment for agencies that utilize independent contractors, Mr. Koesser pointed out that if agencies are contractually bound to deliver quality services regardless of the use of independent contractors, then there should be no difference in rates of payment, and the Committee concurred. Several members of the group felt that Members served by AHCCCS and DDD as well as direct care providers should be educated regarding the pros and cons of independent contractor models; however, a counterpoint was made that it would be difficult to agree on content for any such "education" given the differing points of view and business arrangements in use.

Following the meeting of August 24, 2015, the consensus items were circulated to the entire Committee for review and comment. One response affirmed the consensus items as written. In addition, the following language was submitted by three individuals, respectively.

From Patricia Harren (Mercy Care):

"AHCCCS Medical Policy Manual requirements in Chapter 1240
Agencies are responsible for meeting the AHCCCS requirements described in this chapter including being a registered AHCCCS provider, prescreening Direct Care Workers (DCW), matching DCW skills with ALTCS members, assuring that all DCWs have CPR and First Aide before providing care to members, providing supervisory visits according to the schedule in this chapter, verifying the delivery of services, maintaining records of work verification and educational requirements, and ensuring requirements with DCW educational requirements. Agencies must also report non-provisions of service to program contractors as well as any potential fraud related to the non-provision of service."

From Ann Monahan (Arizona Autism Coalition):

"One point of clarification. I was a part of a group of providers who met with Burns and Associates regarding the last Rate Rebase. As listed in their rate-rebase methodology documentation, the service rates are based on/inclusive of, the employer/employee model, NOT the independent contractor model. The service rates specifically include the overhead an agency is required to pay. Fees such as Workers Compensation, Payroll Taxes, Trainings, and other types of expenditures an employer makes. We literally spent hours working through all of these issues with Steve and Peter from Burns and Associates and the DDD team. My concern is this. If a contractor is to be paid at the same rate as an employee, would this potentially open us up to cuts? In other words, the methodology for the setting of the rates is inclusive of one model (Employer/Employee), but if we use it for another model (Independent Contractors), would those specific dollars already incorporated into the rates (that account for the items listed above) no longer be valid? This is an extremely important matter, and it impacts directly the rates we currently have, as well as any future rate rebases."

From Dara Johnson (AHCCCS):

"We require the case managers to educate (at least annually) members on the various service model options to choose from. As it stands now, the IC model would be another variation of what is termed the 'traditional' service model option. Case Managers are not in a position to recommend one model over the other, but rather support members to understand their respective roles and responsibilities within each model and walk them through a supportive decision making process to help them arrive at an informed decision. There is already a decision-tree tool that has been created to support case managers through that process. From a member perspective, it is really less about pros and cons and more about the level of the responsibility they want to have in the provision and oversight of their care."

Addendum to AHCCCS Provider Participation Agreement

Requirements for Agencies and Direct Care Workers Using Independent Contractor Model

A. **Standard Requirements for Participation.** The direct care worker (DCW) and the agency agree to the following terms.

1. The DCW is not economically dependent on the agency or the State.
2. The DCW is in business for himself.
3. The DCW's work is not integral to the State's operations. [For agencies, if applicable, please state the work is not integral to the agency's operations.]
4. The agency and State encourage the DCW to work for other agencies. The DCW may work for as many or as few members/patients and agencies as he wishes, and can choose when and where to make himself available for work.
5. The DCW can use his managerial skills and initiative to create an opportunity for either a profit or loss. The DCW's skills can lead to additional business from other members/patients or reduce the opportunity for future work. Based on the DCW's skills, a member/patient can cancel, reduce, or increase work, or can refer the DCW to other members/patients.
6. The DCW controls meaningful aspects of the work performed, including the hours he works and how frequently he wants to work. The DCW negotiates his schedule, schedules his assignments, and determines the order and sequence of work independently from the agency or the State.
7. The DCW can turn down work for any reason, including because he is too busy with other jobs.
8. The DCW decides which jobs to perform, is free to seek out and solicit work from new members/patients, determines how to find the next member/patient, negotiates contracts, and endeavors to reduce costs.
9. The DCW makes his own significant investments, which can allow the DCW to expand into new territories and markets and reduce his cost structure.
10. The DCW makes a significant investment in the materials he uses. The DCW decides whether to purchase his own materials, equipment, tools, and vehicles, advertise and market his services, and rent space. Materials, equipment, tools, vehicles, and training are not provided by the agency, but instead are purchased by the DCW. The DCW decides what tools or equipment to use, when and where to order additional tools or equipment, and the quantity to order. The DCW will incur expenses that will not be reimbursed by the agency or State.
11. The DCW submits an invoice to the agency for work performed.
12. The DCW exercises business skills, judgment, and initiative in an independent manner.
13. The DCW is subject to little direct supervision, including over the way he dresses, the tasks carried out and the order in which tasks are carried out.
14. The agency and State do not have the right to control the details of the DCW's performance, unless contracted to do so.
15. The agency's and State's degree of control over the DCW is limited to carrying out the requirements applicable under law and/or regulation.
16. The agency and State do not provide employee-type benefits, such as insurance, a retirement plan, or vacation or sick pay. The DCW is responsible for obtaining his own insurance as required

under the AHCCCS Provider Agreement, as well as occupational and accident insurance, workers' compensation, general liability insurance. [Add other as detailed by insurance workgroup]

17. The DCW acknowledges that he takes on the risk for termination for poor performance. Member/patient can terminate the services of the DCW, change DCWs, etc., at any time.

B. **Signed Agreement between DCW and Agency**. The DCW has a signed independent contractor agreement with the agency specifically stating that the parties agree the DCW is an independent contractor. That independent contractor agreement must include the terms outlined in Paragraph A. This agreement must be renewed at least annually.

C. **Signed Agreement between the DCW and the Member**. The DCW and the AHCCCS member must have a signed agreement that includes provisions contained in this Addendum. This agreement must be renewed at least annually.

D. **DCW Acknowledgement of Operations as Independent Business**. The DCW acknowledges he is not an employee of the agency or State.

E. **Acknowledgement by Agency**. The agency acknowledges the DCW is not an employee of the State.

F. **Indemnification of State by DCW**. The DCW agrees to indemnify the State against any liability incurred through the actions or omissions of the DCW, including but not limited to: harm to the member/patient; misclassification of employees; claims for overtime, minimum wage, or travel; findings and/or disallowance from the Centers for Medicare and Medicaid Services (CMS), General Accounting Office (GAO), Office of the Inspector General (OIG) or other federal or state agency for improper billing by the DCW; unemployment claims; or any program integrity or Medicaid fraud claim.

G. **Indemnification of State by Agency**. The agency agrees to indemnify the State against any liability incurred through the actions or omissions of the agency, including but not limited to: harm to the member/patient; misclassification of employees; claims for overtime, minimum wage, or travel; findings and/or disallowance from the Centers for Medicare and Medicaid Services (CMS), General Accounting Office (GAO), Office of the Inspector General (OIG) or other federal or state agency for improper billing by the agency or DCW; unemployment claims; or any program integrity or Medicaid fraud claim.

H. **Comprehensive Coverage Requirement**. Agencies and DCWs that use the IC Model must have comprehensive coverage that will support indemnity requirement in paragraph F. The Agency and DCW must provide proof of such comprehensive coverage to AHCCCS on an annual basis.

Recommendations

A. It is recommended but not required that all agencies and DCWs operating under the Independent Contractor model:
   1. Consult legal counsel to ensure the agency and contracted DCWs are able to meet the standards as required in this Addendum; and
   2. Work through a third party vendor familiar with the independent contractor model to assist with the administrative functions of operating the model.

AHCCCS
Arizona Health Care Cost Containment System

IC WORKGROUP

INSURANCE REQUIREMENTS COMMITTEE FINDINGS

Insurance Requirements Committee Focus

- Primary Focus
  - To identify the risks to the various "parties" involved in the delivery of care to members and identify how insurance can be used to mitigate the risks where possible.
  - "Parties" includes:
    - The Member
    - The Direct Care Worker (DCW)
    - The Agency
    - The MCO & The State of Arizona
- Secondary Focus
  - To ensure that there is no additional liability to the member under the IC model.
- Tertiary Focus
  - To limit and/or eliminate upstream liability to any of the "parties" based on a lack of insurance or incorrect coverage for any other insurable party.
- Quaternary Focus
  - To identify any insurance related risks that are unique to the IC model.

Disclosures

1. Any final suggestions regarding insurance requirements will need to be approved through ADOA (AZ Department of Administration) Risk Management, and
2. Prior to expanding the current long term care minimum insurance requirements and prior to our next long term care RFP bid, AHCCCS has relayed that it will include long term care plans and providers in a workgroup regarding potential changes to the insurance requirements (RFP expected to be released around 10-1-16)
3. Currently AHCCCS does not require long term care providers to obtain SAM coverage: http://www.azahcccs.gov/commercial/Downloads/MinimumSubcontractProvisions_ALTCS.pdf and for acute providers we leave it to the discretion of the plan: http://www.azahcccs.gov/commercial/Downloads/MSPsAcute7_1_15.pdf

Committee Method

- Reviewed the existing AHCCCS insurance requirements under the current model and discussed the relevant liabilities.
- Created an aggregate list of potential liabilities under the IC model for each of the various parties.
- Created a matrix to outline how each potential liability would affect the damaged party as well as how the liability could result in potential upstream losses (i.e. a DCW performs an action resulting in bodily injury to a member which results in legal action against the DCW's Agency and the MCO).
  - See "AHCCCS IC Insurance Risk Matrix.xlsx"
- Identified if the potential liabilities are insurable risks.
- Identified the relevant insurance to address each listed liability if possible.
- Included notes to guide insurance requirements.

Committee Findings

- While the committee identified a considerable number of potential liabilities, we can confidently report the following:
  - Although the method of insurance under the IC model differs from that under the current model, none of the liabilities identified were unique to the IC model (It must be noted that under the current model certain liabilities would be attributed to employees rather than independent contractors)
  - There was no liability identified where the damaged party could not be protected in some way except for misclassification fines and penalties as outlined herein
  - There was no liability identified which resulted in upstream liability where that upstream liability could not be mitigated through proper insurance.
  - There was only one liability identified where the committee was unaware of an existing insurance product that would directly address the exposure; however, the committee is aware of products that address similar exposures in other industries; thus, the committee is confident that an insurance product can be sourced. See "Misclassification of DCW as 1099 contractor" in the Risk Matrix.

Committee Findings (cont'd)

- Based on the Risk Matrix, the committee feels that liability to the MCO/State of AZ can be mitigated if the appropriate requirements are in place and are specific to the IC model.
  - Given that the committee found that the method of insurance and named insured for certain liabilities under IC model differ from that under the current model the committee strongly recommends a separate set of insurance requirements that specifically address the IC Model.
- It must be noted that under the existing model employees do not carry insurance and the Agency does; however, under the IC Model the DCW would carry insurance in addition to that carried by the Agency adding an additional layer of protection for the MCO/State of Arizona.
  - If DCW's were required to carry the necessary coverages with reasonable limits of coverage it is likely that the MCO/State of Arizona would have more insurance protection under the IC model than under the current model (assuming these coverages would not be cost prohibitive to the DCW and compliance could be effectively monitored by the MCO, State, or a qualified third party).

Financial Feasibility - Overview

- A major concern has been expressed to the committee that the cost of insurance (specifically general/professional liability and sexual misconduct) for the DCW would be so great that it would consume the majority, if not all potential profits for the DCW making the model impractical.
  - Previous estimates indicated that a DCW would have to pay multiple thousands of dollars per year to be appropriately insured.
- The workgroup should note that an insurance program has already been designed and is currently available in Arizona that contradicts the guidance previously given.
- Key DCW Coverages:
  - General liability (GL)
  - Professional liability (PL)
  - Sexual and Physical Abuse/Misconduct (SAM)
  - Occupational Accident (Occ/Acc)

Financial Feasibility – GL/PL/SAM

- Program Overview: General Liability, Professional Liability, Sexual & Physical Abuse/Misconduct
  - Carrier rating – AM Best A, VIII
  - Insured – DCW
  - General Liability – $1,000,000 per occurrence / $3,000,000 aggregate
    - Deductible - $0.00
  - Professional Liability – $1,000,000 per occurrence / $3,000,000 aggregate
    - Deductible - $0.00
  - Sexual & Physical Abuse/Misconduct – $1,000,000 per occurrence / $1,000,000 aggregate
    - Deductible - $0.00

Financial Feasibility – GL/PL/SAM

- Program Overview Continued:
  - Coverage includes administrative errors and omissions.
  - Sexual Misconduct coverage included at $1,000,000 per occurrence / $1,000,000 aggregate.
  - Blanket additional insured including primary non-contributory language as well as blanket waiver of subrogation for all insuring agreements where required by contract.
  - Defense coverage outside the limits.
  - Punitive damages where insurable by law.
- Premium rate is $125.00 per IC FTE.
  - Assumes FTE is 2,000 hours.
  - Billed hourly only for hours worked at rate of $0.0625

Financial Feasibility – Occupational Accident

- Carrier rating – AM Best A+ Superior
- Insured – DCW
- Occupational Accident –

DESCRIPTION OF BENEFITS	OCCUPATIONAL	NON OCCUPATIONAL	PASSENGER
ACCIDENTAL DEATH AND DISMEMBERMENT			
MAXIMUM BENEFIT AMOUNT	$50,000 PRINCIPAL SUM	$5,000 PRINCIPAL SUM	NOT COVERED
SURVIVOR'S BENEFIT (LUMP SUM)	($10,000 LUMP SUM) + $400 PER MONTH (UP TO 100 MONTHS)	LUMP SUM	
INCURRAL PERIOD	365 DAYS	365 DAYS	
ACCIDENTAL DISMEMBERMENT - INCLUDING PARALYSIS AND SEVERE BURN	INCLUDED IN PRINCIPAL SUM REFER TO POLICY SCHEDULES FOR BENEFITS	INCLUDED IN PRINCIPAL SUM REFER TO POLICY SCHEDULES FOR BENEFITS	
ACCIDENTAL MEDICAL EXPENSE			
MAXIMUM BENEFIT AMOUNT	$ 500,000 MAXIMUM BENEFIT AMOUNT	$ 10,000 MAXIMUM BENEFIT AMOUNT	NOT COVERED
COMMENCEMENT PERIOD	90 DAYS	90 DAYS	
DEDUCTIBLE	$0	$0	
INCURRAL PERIOD	104 WEEKS	52 WEEKS	
ACCIDENTAL DENTAL			
MAXIMUM BENEFIT AMOUNT	$1,000 PER INJURY/$10,000 LIFETIME	NOT COVERED	
CHIROPRACTIC CARE, OCCUPATIONAL THERAPY, PHYSICAL THERAPY			
MAXIMUM BENEFIT AMOUNT	NO SUBLIMIT APPLIES	NO SUBLIMIT APPLIES	
MAXIMUM NUMBER OF TREATMENTS	NO SUBLIMIT APPLIES	NO SUBLIMIT APPLIES	

Financial Feasibility – Occupational Accident

TEMPORARY TOTAL DISABILITY			
MAXIMUM BENEFIT AMOUNT	70% AVG WKLY EARNINGS UP TO $400 MAX/$250 MIN	NOT COVERED	NOT COVERED
WAITING PERIOD	7 DAYS RETROACTIVE		
DURATION MAXIMUM BENEFIT PERIOD	104 WEEKS		
COMMENCEMENT PERIOD	90 DAYS		
CERTIFICATE COMBINED SINGLE LIMIT/AGGREGATE	**$500,000**		

DESCRIPTION OF BENEFITS	OCCUPATIONAL
HERNIA BENEFIT	
MAXIMUM ACCIDENTAL MEDICAL BENEFIT PER INJURY/LIFETIME	$10,000/$15,000
MAXIMUM BENEFIT PERIOD PER INJURY	10 WEEKS
TEMPORARY TOTAL DISABILITY	
MAXIMUM BENEFIT PERIOD PER INJURY	INCLUDED IN THE ABOVE NOTED LIMITS
HEMORRHOID BENEFIT	
MAXIMUM ACCIDENTAL MEDICAL BENEFIT PER INJURY/LIFETIME	$10,000/$15,000
MAXIMUM BENEFIT PERIOD PER INJURY	10 WEEKS
TEMPORARY TOTAL DISABILITY	
MAXIMUM BENEFIT PERIOD PER INJURY	INCLUDED IN THE ABOVE NOTED LIMITS

OCCUPATIONAL DISEASE BENEFIT	
MAXIMUM ACCIDENTAL MEDICAL BENEFIT PER INJURY/LIFETIME	$10,000/$15,000
MAXIMUM BENEFIT PERIOD PER INJURY	10 WEEKS
TEMPORARY TOTAL DISABILITY	
MAXIMUM BENEFIT PERIOD PER INJURY	INCLUDED IN THE ABOVE NOTED LIMITS
OCCUPATIONAL CUMULATIVE TRAUMA BENEFIT	
MAXIMUM ACCIDENTAL MEDICAL BENEFIT PER INJURY/LIFETIME	$10,000/$15,000
MAXIMUM BENEFIT PERIOD PER INJURY	10 WEEKS
TEMPORARY TOTAL DISABILITY	

Financial Feasibility – Occupational Accident & Conclusion

- OCC/ACC Premium rate varies but can be modestly budgeted at $0.30/hour
  - Billed hourly only for hours worked at rate of $0.30
- Total Hourly Premium Burden - $0.3625/hour
- Note – this is an example of two existing programs available to customers in Arizona today; however, the committee is not recommending these programs specifically for all DCW's, rather the committee seeks only to illustrate the true cost of a reasonable solution.
- Although this program would only be available in conjunction with the appropriate controls being put in place and guaranteed compliance, the committee feels that this insurance is not cost prohibitive and addresses the risks identified in the matrix; thus, it is the committee's position that the model is financially feasible from an insurance prospective.