ISSUE BRIEF • OCTOBER 2014

NSCLC
National Senior Citizens Law Center

Conflict Free Case Management: Themes in States Working to Implement New Systems

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Introduction

The Affordable Care Act[1] offers states several opportunities to shift the balance of delivering Medicaid long-term services and supports (LTSS) away from institutions to care at home and in the community. One innovative option, the Balancing Incentive Program, offers participating states a financial incentive to make significant structural changes to their LTSS delivery system in return for enhanced federal Medicaid funding. For the past three years, participating states have worked toward complying with the Balancing Incentive Program's (hereinafter BIP) requirement to provide conflict-free case management services.[2] In one year, on September 30,

1 Patient Protection and Affordable Care Act, (Pub. L. 111-148).

2 Centers for Medicare and Medicaid Services, State Balancing Incentive Payments Program Initial Announcement, CFDA 93.778, available at www.downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/Final-BIP-Application.pdf.

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This project was supported, in part by grant number 90BC0019, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration for Community Living policy.

2015, they will reach the statutory deadline for making these changes.[3]

In addition to BIP's conflict-free case management (CFCM) requirements, the recent federal rule for 1915(c) home and community-based services (HCBS) waivers, and 1915(i) State plan HCBS, includes requirements to mitigate conflict of interest.[4]

The requirements of both these programs force states to grapple with a core LTSS delivery tension: how does a state deliver services to an individual in a manner that facilitates ultimate choice and consumer direction, while ensuring the overall care system is coordinated and free from conflict? Further, how does a state develop this system to work both with the existing aging and disability services infrastructure and in the rapidly changing health care delivery landscape?

A review of existing CFCM literature and guidance, as well as conversations with representatives in four BIP states, reveals that CFCM continues to be an ideal to strive for, but an overwhelming challenge in reality. States are working in earnest toward compliance and organizing robust stakeholder workgroups and system reviews. However, with a year remaining before the BIP deadline, a clear model for CFCM eludes states, agencies and stakeholders.

This issue brief provides background on CFCM and reviews existing regulations and CFCM guidance. Through a review of state BIP proposals, working documents and interviews with state officials, area agency personnel and consumer advocates in four BIP states, this issue brief highlights outstanding areas of concern along the road to CFCM compliance, as well as state models for CFCM.

The brief is intended to help Area Agencies on Aging, Centers for Independent Living, state policy planners and advocates to better understand CFCM requirements and potential strategies and challenges with implementation. It is not intended as a guide to best practices or an endorsement of any state approach. Rather, one year prior to the BIP deadline, the brief aims to highlight the outstanding questions and challenges states face as they develop conflict-free case management systems.

Section 1: Background
Section 2: What is Conflict-Free Case Management? Federal and State Guidance
Section 3: State Perspectives and Themes in Developing a CFCM System

Section 1: Background

Overview of the LTSS Landscape:

Three major policy initiatives at the state and federal level are driving an enhanced focus on conflict-free case management. All advance the same shared state and federal goal of strengthening the delivery of long-term service and supports (LTSS) in the community. The first, the Balancing Incentive Program (BIP), was created by the Affordable Care Act (ACA).[5] BIP offers states an unprecedented opportunity for enhanced Medicaid LTSS funding by shifting the percentage of funding allocated for institutional care toward home and community-based services (HCBS).

States participating in the program must undertake three structural changes, one of which is developing a conflict-free case

3 Section 10202 of the Patient Protection and Affordable Care Act; 42 U.S.C. 1396n(i)(1)(H)(2).

4 42 C.F.R. §§ 441.301(c)(1)(vi), 441.730(b).

5 Section 10202 of the Patient Protection and Affordable Care Act; 42 U.S.C. 1396n(i)(1)(H)(2).

management system.[6]

The second regulatory change pushing states to develop CFCM systems is the implementation of the Home and Community-Based Services Rule, published by the Centers for Medicare & Medicaid Services (CMS) in January 2014.[7] Among other requirements, these regulations require states to include a person-centered planning process for HCBS that protects against conflicts of interest.

As states move toward compliance with these regulatory changes, many are shifting the delivery of LTSS from the state agencies to contracted managed care organizations (MCOs). Whether through a dual eligible financial alignment demonstration, or through Medicaid waiver authority under Sections 1115, 1115A, or 1915(b)/(c), the integration of LTSS into managed care continues to change the health care delivery system. This tectonic shift in care management and delivery brings innovation as well as uncertainty to providers, agencies and consumers.

Why is conflict free case management important for the consumer?

The Affordable Care Act directs states to develop LTSS delivery systems that respond to needs and choices of individuals receiving HCBS and maximize independence and self-direction.[8] Person-centered planning (PCP) should be the foundation of any HCBS delivery system. At the core of person-centered planning is the recognition that individuals are in the best position to determine what they need from their care and what is needed to achieve that care.[9] Recent guidance from the Department of Health and Human Services highlights the importance of focusing the person-centered planning process on the individual's personal goals, preferences, supports, financial resources and other areas important to the individual.[10]

The case manager is key in the person-centered process. The case manager's role is to enable and assist the consumer to identify and access a personalized mix of paid and non-paid services, and to provide support during planning.[11] During the process and throughout implementation, the individual's personally defined outcomes and preferred methods for achieving them drive the person-centered planning process.[12] If the person-centered planning process is honored, there is less potential for conflict in the case management process, as the individual's

6 To qualify for BIP funding, states must implement three structural changes in their systems of community-based LTSS: a No Wrong Door/Single Entry Point eligibility determination and enrollment system; Core Standardized Assessment Instruments, and Conflict-Free Case Management. For more information, *see*: The Balancing Incentive Program: Implementation Manual (BIP Manual), available at: www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Downloads/BIP-Manual.pdf.

7 42 C.F.R. § 441.730(c)(1)(vi) and §441.7330(b). See 79 Fed. Reg. 2948-3039 (January, 2014).

8 Section 2402(a) of the Patient Protection and Affordable Care Act.

9 National Senior Citizens Law Center, Long-Term Services and Supports: Beneficiary Protections in a Managed Care Environment (NSCLC LTSS Protections Guide), available at: www.dualsdemoadvocacy.org/consumer-protections/ltss/person-centered-care-planning.

10 Guidance to HHS Agencies for Implementing Section 2402(a) of the Affordable Care Act, pg. 4, available at: www.acl.gov/Programs/CDAP/OIP/docs/2402-a-Guidance.pdf.

11 Id.

12 NSCLC LTSS Protections Guide.

needs and preferences dictate the care plan and delivery of services.

What is the potential for conflict in case management services?

As defined by CMS, conflict may occur when a social service organization serves as both the agency assessing the individual for services and the agency delivering the services.[13] When one agency is both the gatekeeper and provider of care and services, there is a clear potential for conflict. For example, an agent at a single community-based organization may conduct an assessment for individual services. Based on that assessment, the same agent may work with the individual to determine a care plan that meets the beneficiary's needs. If the service provider identified in that care plan is funded by or has a relationship with the organization, that agent may be drawn to include that provider in the care plan. This conflict--the service delivery and referral bias--is the tension that a CFCM system aims to eliminate.[14] As CMS notes in its technical assistance guide, this conflict of interest may not be a conscious decision on the part of the agent, but may be a result of incentives or disincentives built in the system.[15]

13 Balancing Incentive Program Implementation Manual (BIP Manual), available at: www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Downloads/BIP-Manual.pdf.

14 BIP Manual at 29.

15 Id.

CMS guidance highlights three potentials for conflict in case management:[16]

Assessment: The agent may have an incentive during the assessment to assess for more or less services than the individual needs.

Financial interest: The agent may be interested in a care plan that retains the individual as a client than one that assists with independence. The agent may not suggest outside providers due to concerns over lost revenue.

Convenience: The agent or service provider may develop a care plan that is more convenient for the provider than a plan that is person-centered.

Section 2: What is Conflict Free Case Management? Federal and State Guidance

The emphasis on conflict-free case management is not new or unique to BIP. States are defining the concept based on existing CFCM practices, statutory definitions, and guidance from CMS. States are not developing CFCM protections in a vacuum, and they are not limited to singular guidance on CFCM policies. Instead, states are attempting to comply with both historical and new case management requirements in a rapidly changing care delivery landscape.

The federal requirements for a CFCM system are found in:

- The Older Americans Act;[17]

16 Id.

17 42 U.S.C. §3026(a)(8).

- CMS guidance for the Balancing Incentive Program;[18] and
- The Federal HCBS Rule.[19]

In addition to the federal regulatory requirements, states place requirements on managed care organizations to deliver case management services without conflict in their state MCO contracts for managed LTSS.[20]

As explained on pg. 6, at the core of each requirement is the goal that the beneficiary receives a care plan that is person-centered and free from agency bias. However, the specific requirements of each program do not always overlap or align perfectly:

Older Americans Act and CFCM

For the aging network, the Older Americans Act[21] has long included requirements aimed at limiting conflict in case management services delivered by area agencies on aging (AAA). Under the OAA, Area Agencies on Aging must provide coordinated, non-duplicative case management services.[22] The OAA provision includes two core tenets of conflict mitigation: eliminating intra-agency bias and ensuring consumer choice. Under the OAA, case management agencies cannot act as promoters for the agency providing services to the individual. Also, to protect consumer choice, case management agencies should give individuals a statement explaining that the individual has a right to make an independent choice of service providers.

CMS Guidance for the Balancing Incentive Program

CMS BIP guidance on CFCM includes a definition of case management services, as well as a checklist of key requirements for conflict-free case management. BIP guidance defines case management as "services to develop a service plan, arrange for services and supports, support the beneficiary (and, if appropriate, the beneficiary's caregivers) in directing the provision of services and supports for the beneficiary."[23] In its guidance, CMS offers states a list of key elements to include in designing a conflict-free case management system:[24]

1. Separation of Eligibility Determination and Care Planning from Service Provision:
   a. Clinical or non-financial eligibility determination and care plan development are separate from direct service provision.
   b. The entity determining eligibility for services does not have a fiscal relationship with the beneficiary.

18 Centers for Medicare and Medicaid Services, Patient Protection and Affordable Care Act Section 10202 State Balancing Incentive Payments Program Initial Announcement, CFDA 93.778, available at www.downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/Final-BIP-Application.pdf. *See* also www.balancingincentiveprogram.org/resources/example-conflict-free-case-management-policies and BIP Manual.

19 42 C.F.R. §441.301(c)(1)(vi) and § 441.730(b).

20 For a library of state managed care contracts, see Advocate's Library of Managed Long Term Services and Supports Contract Provisions (Contract Library), available at: www.nsclc.org/index.php/ltss-contracts-index-appeals-notices.

21 42 U.S.C. §3026(a)(8).

22 Id.

23 Section 10202(c)(5)(B) of the Patient Protection and Affordable Care Act (Pub. L. 111-148); 42 U.S.C. 1396n(i)(1)(H)(2).

24 BIP Manual.

Conflict Free Case Management Guideline	Source Of Guidance			
	OAA[1]	BIP[2]	HCBS[3]	MCO Contracts[4]
Assessment: The agent who assesses need for HCBS is not financially responsible for consumer, related to any paid service provider for the consumer, financially responsible for the consumer, empowered to make the consumer's financial or health related decisions, and does not hold a financial interest in any paid entity to provide "care" for the consumer.		X	X[5]	
No promotion: Prohibition on case management agency promoting agency providing services.	X			
Statement of choice: The case management agency must give individual a statement specifying individual has a right to make an independent choice of service providers.	X			
Eligibility: The entity determining clinical eligibility is separate from entity providing direct service.		X	X	
Eligibility: The evaluator of the beneficiary's need is not related to the beneficiary by blood or marriage. The entity determining eligibility for HCBS is not financially responsible for the consumer, related to any paid service provider for the consumer, empowered to make the consumer's financial or health related decisions, and does not hold a financial interest in any paid entity to provide "care" for the consumer.		X	X[6]	
Eligibility: The MCO is separated from the initial eligibility determination and enrollment counseling.				X
Eligibility: The MCO does not contract with provider of case management services or eligibility assessments.				X
Provider developing plans: In general, service planning cannot be performed by HCBS provider			X[7]	
Case manager separation: The case manager/service plan developer is not related to the consumer by blood or marriage. The agent who develops the service plan is not financially responsible for consumer, related to any paid service provider for the consumer, financially responsible for the consumer, empowered to make the consumer's financial or health related decisions, and does not hold a financial interest in any paid entity to provide "care" for the consumer.		X	X[8]	
Firewalls and standards: Appropriate firewalls and safeguards exist to mitigate risks of conflict.		X	X	
State oversight: The state conducts robust monitoring and oversight.		X	X	

Conflict Free Case Management Guideline	Source Of Guidance			
	OAA[1]	BIP[2]	HCBS[3]	MCO Contracts[4]
Quality management: The state's quality management staff oversees clinical or non-financial program eligibility determinations and service provision practices.		X		
Quality management: The case management agency tracks and documents consumer experience with measures that capture quality of care coordination.		X		
Stakeholder engagement: The state implements meaningful stakeholder engagement strategies.		X		
Grievance and appeals: The state and MCO have established clear, well-known and accessible pathways for a beneficiary to submit grievances and/or appeals to the MCO or the State.		X		
Grievance and appeals: The consumer has the right to grieve or appeal a consumer-centered plan.				X
Grievance and appeals: The case manager must explain enrollee's rights including procedures for filing a grievance, appeal and fair hearing.				X
Grievance and appeals: If a consumer disagrees with an assessment or authorization of services, case manager must provide written notice of a right to file an appeal.				X
Grievance and appeals: The consumer has access to an alternative dispute resolution process.				X

1 Older Americans Act, 42 U.S.C. §3026(a)(8).

2 Based on list in CMS' Balancing Incentive Payment Guidance, available at, www.balancingincentiveprogram.org/resources/example-conflict-free-case-management-policies.

3 The person-centered service planning rules for Medicaid HCBS programs are similar, but not identical. See 42 C.F.R. §441.301 for planning rules for 1915(c) HCBS waivers, §441.540 for planning rules for Community First Choice, and §441.725 and §441.730 for 1915(i) State plan HCBS.

4 Selection of state-managed care organization contracts. For a library of state managed care contracts, see, www.nsclc.org/index.php/ltss-contracts-index-appeals-notices.

5 Applies to 1915(i) State plan HCBS.

6 Applies to 1915(i) State plan HCBS.

7 An exception exists if the State demonstrates that, within a particular geographic area, an HCBS service provider is the only entity "willing and qualified" to develop a service plan or provide case management.

8 Applies to 1915(i) State plan HCBS.

c. If eligibility and service provision do overlap, the agency has firewalls in place to mitigate risk of potential conflict.

d. The evaluator of beneficiary's needs is not related to beneficiary by blood or marriage. The evaluator is also not related to the beneficiary's paid family caregivers, or to anyone financially responsible for the beneficiary, or empowered to make health related-decisions on the beneficiary's behalf.

2. Separation of Case Manager from Service Provision:

   a. The entity that provides case management does not provide direct services. The case manager is not related to the beneficiary by blood or marriage. Case manager is also not related to the beneficiary's paid family caregivers, or to anyone financially responsible for the beneficiary, or empowered to make health related-decisions on the beneficiary's behalf.

   b. If case management and service provision do overlap, the agency has firewalls in place to mitigate risk of potential conflict.

3. Oversight and monitoring:

   a. The state conducts robust monitoring and oversight.

   b. The state's quality management staff oversees clinical or non-financial program eligibility determinations and service provision practices.

   c. The case management agency tracks and documents consumer experience with measures that capture the quality of care coordination.

4. Grievances and appeals:

   a. The state and MCO have established clear, well-known and accessible pathways for a beneficiary to submit grievances and/or appeals to the MCO or the state.

   b. The state monitors and tracks grievances, complaints, appeals and resulting decisions.

5. Stakeholder engagement:

   a. The state has implemented meaningful stakeholder engagement strategies. This includes engaging with beneficiaries, family members, advocates, providers, state leadership, managed care organization leadership and case management staff.

1915(c) and 1915(i) HCBS Final Rule:

The HCBS final rule includes requirements to prevent conflict in person-centered planning.[25] To comply with the rule, all 1915(c) HCBS waiver services and 1915(i) state plans must include a person-centered care planning process.[26] The central conflict of interest protection in the HCBS rule is the restriction on an HCBS provider, its employees and related entities, from providing service planning or case

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25 The person-centered service planning rules for Medicaid HCBS programs are similar, but not identical. See 42 C.F.R. §441.301 for planning rules for 1915(c) HCBS waivers, §441.540 for planning rules for Community First Choice, and §441.725 and §441.730 for 1915(i) State plan HCBS.

26 For more on the person-centered care planning process in the HCBS Rule, see NSCLC, "Just Like Home: An Advocates Guide to Consumer Rights in Medicaid HCBS," p. 16-17, available at: www.nsclc.org/wp-content/uploads/2014/04/Advocates-Guide-HCBS-Just-Like-Home-05.06.14-2.pdf.

management to the consumer.

However, if the HCBS provider is the only entity that is "willing and qualified" to develop a service plan, or provide case management, within a particular geographic area, there may be an exception to the above restriction. In these instances, the state must develop, and CMS must approve, conflict of interest standards. These standards must include information on how the entity separates those responsible for person-centered service planning from those responsible for direct services. In addition, the entity must provide participants with a clear and accessible alternative dispute resolution process.

In addition, for 1915(i) State plan HCBS, each state must define conflict of interest standards that ensure the independence of the entities who evaluate for HCBS, assess for need of HCBS, or develop person-centered service plans.[27] At a minimum, these entities cannot be:[28]

- related by blood or marriage to the consumer;
- related to any paid service provider for the consumer;
- financially responsible for the consumer;
- empowered to make the consumer's financial or health related decisions; or
- hold a financial interest in any entity paid to provide care for the consumer.

State-MCO contracts for Managed LTSS:

As states contract with MCOs, states should address case management in the state contracts with MCOs. While transferring responsibility for delivering LTSS to managed care has the potential to mitigate conflict between the state, case management agency, and service provider, the MCO may face internal conflicts similar to the state or area agency. This potential for conflict should be addressed early and clarified in state-MCO contracts.

Existing MCO contracts include a range of provisions addressing case management and conflict;[29] however, no clear template for eliminating conflict exists. Below are examples of language from existing state-MCO contracts that address case management and eliminate conflict within the managed care organization:

Holistic case management:

- The case manager must use a holistic approach to community resources, not just MCO-covered services.[30]

Person-centered case management:

- The MCO must make the consumer the center of the planning process.[31]

Consumer involvement in case management:

- The care planning process must include face-to-face discussion with consumer, consumer's representative, and any other consumer-approved person.[32]

27 Id.

28 42 C.F.R. 411.730(b).

29 *See* Contract Library.

30 *See* e.g. Arizona MLTSS Contract, p. 40, available at: www.nsclc.org/wp-content/uploads/2013/11/Arizona-Contract.pdf. *See* also: Florida MLTSS Standard Contract (FL Contract), Att. II, Exh. 5, p. 35, available at www.nsclc.org/wp-content/uploads/2013/11/Florida-Contract.pdf.

31 *See* e.g. New Mexico MLTSS Contract (NM Contract), p. 46, available at: www.nsclc.org/wp-content/uploads/2013/11/New-Mexico-Contract.pdf.

32 FL Contract, Att. II, Exh. 5, p. 36.

- The consumer must be involved and in control during development of the individual service plan.[33]

Consumer's right to disagree with service plan:

- The consumer has the right to appeal consumer-centered plan.[34]
- The case manager must explain the enrollee's rights including procedures for filing a grievance, appeal and fair hearing.[35]
- If the consumer disagrees with assessment or authorization of services, the case manager must provide written notice of rights to file appeal.[36]

Providing information about all service options:

- The MCO must ensure that the consumer, consumer's family, and consumer's physician are informed of all service options available to meet needs in the community.[37]

Removing conflict during assessment:

- The MCO must be separated from initial eligibility determination and enrollment counseling functions, consistent with state and federal guidelines.[38]
- The MCO cannot contract with a provider for services if the provider also provides case management or functional eligibility assessments, in order to achieve conflict-free case management.[39]

Section 3: State Perspectives and Themes in Developing CFCM Systems:

There is no clear conflict-free case management template that states can insert into the design of their existing LTSS delivery system. Rather, with three different layers of federal guidance, and the overlay of a shift to managed long-term services and supports, incorporating CFCM into a complex LTSS infrastructure is a challenge. After a review of state BIP proposals and conversations with local and state stakeholders in four BIP states,[40] the following themes emerged, not all of which are consistent:

1. States are still designing CFCM systems and have more questions than answers.

Conflict-free case management is one piece in an evolving BIP compliance process. Under the BIP requirements, states must make two additional structural changes: develop a core standardized assessment instrument and create a No Wrong Door/Single Entry Point system for accessing LTSS services.[41] States are working to develop the structural changes by the September 30, 2015 deadline while preparing for other significant transitions

33 NM Contract, p. 44.

34 Wisconsin MLTSS Contract (WI Contract), pp. 144-45, available at: http://www.nsclc.org/wp-content/uploads/2013/11/Wisconsin-Contract.pdf.

35 FL Contract, Att. II, Exh. 5, p. 34.

36 FL. Contract, Att. II, Exh. 5, p. 39.

37 Texas MLTSS Contract at 8-132, available at: www.nsclc.org/wp-content/uploads/2013/11/Texas-Contract.pdf.

38 WI Contract, p. 21.

39 Kansas Contract, p. 40, available at http://www.nsclc.org/wp-content/uploads/2014/01/RFP-Document-Kansas-in-pdf-for-consistent-pagination.pdf.

40 New York, Indiana, Illinois and Ohio.

41 Centers for Medicare and Medicaid Services, State Medicaid Director Letter #11-010, available at: www.downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/11-010.pdf.

under the HCBS rule.
States continue to sort through the rule, BIP guidance, and are working to understand the relationship between each regulation and existing state programs. One state aging and disability agency shared that a clearinghouse of best practices for CFCM would be helpful as the state grapples with many structural changes.[42] As states are still developing CFCM practices, it is too early for this paper to highlight best models. However, states shared the following ideas on different approaches to eliminate conflict in case management.

See chart on page 12.

2. Agencies already provide case management services without conflict, per the OAA requirements.

Several area agencies pointed out that BIP and HCBS rules simply reiterate their agency's long-standing practice of delivering conflict-free case management. Under the Older Americans Act, agencies have faced similar restrictions against conflict in case management for many years. The agencies adhere to the goal that consumer choice is central, and that the role of the agency is to serve as an advocate in developing a plan that works best for the consumer. Following this practice limits the opportunity for conflict or self-promotion. While other agencies expressed concern that the BIP and HCBS rule compliance may be disruptive to existing delivery systems, these agencies did not envision a significant change. As one agency pointed out, the mitigation strategies envisioned under BIP are already common practice.

3. States should be aware of the variety of working case management models in different Medicaid programs.

A common theme from state representatives is their struggle to build CFCM guidelines that respect the needs and care models of all Medicaid waiver populations. For example, as a result of OAA requirements, some aging agencies have long established administrative strategies to remove conflict. Other populations have historically deliberately linked the assessment and care planning process, an approach that appeared to be consistent with the preference of consumers. For example, in Illinois' Medicaid Community Mental Health Services Program, the trust established through this coordination has been a hallmark of the program. Developing a CFCM system to respect this trusted system and ensure that changes do not disrupt care is an ongoing challenge.

4. Implementing CFCM mitigation tactics may cause additional fragmentation to HCBS care delivery.

Some state representatives cautioned that the focus on eliminating conflict can come at a cost to care coordination. At times, a connection between the assessor and case manager is needed for improved integration and to develop expertise. As agencies build firewalls between assessment and case management, the delivery system can become more siloed, despite nearly universal efforts to ensure that LTSS is more coordinated. They suggest that, in a sense, the emphasis on CFCM can be incongruous with all other efforts to integrate LTSS. While the general theme of LTSS reform is to streamline and coordinate care, the emphasis on building firewalls and barriers may further fragment services. To protect

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42 CMS' catalog of state activities and examples of Conflict Free Case Management Policies is available at: www.balancingincentiveprogram.org/resources/example-conflict-free-case-management-policies.

STATE STRATEGIES FOR CONFLICT-FREE CASE MANAGEMENT

FIREWALLS

- Administrative oversight: enrollment assistance on one side of the Area Agency on Aging (AAA) with waiver service coordination on the other side.
- The agency does not case manage the clients to which it provides direct services.

DOCUMENTATION AND WAIVERS

- If an AAA provides both case management and assessment, it must:[1]
    - Document in the service plan that it will ensure its employees act in the best interest of the participant and conflict of interest will not occur.
    - Develop a conflict of interest plan.[2] The plan must:
        - Identify potential conflict of interest situations;
        - Include planned or ongoing initiatives intended to eliminate or mitigate the occurrence;
        - Include actions intended to manage those ongoing situations that cannot be eliminated; and
        - Specify methods of communication required to inform the individual consumer about the potential for conflict.
    - Document that beneficiary was informed about freedom of choice.

SEPARATING ORGANIZATION/CONTRACT OUT

- AAA divests from one service and only offers the other. For example, divests from providing services and only conducts assessments.
- AAA creates a separate corporation or board for case management services.
- AAA contracts with a single, separate entity to conduct an assessment. AAA continues to provide case management services.

INTEGRATING MANAGED CARE

- Establishing three entities to avoid conflicts. AAA conducts the original level of care determination. The MCO or a contracted entity conducts a comprehensive assessment. The MCO contracts with the AAA to perform waiver service coordination as a part of the care management process. The MCO develops a care plan that integrates waiver service coordination. The MCO contracts with outside providers to deliver services under the care plan.[3]

COMMUNICATION AND IT SYSTEMS

- The state utilizes new IT systems created under the development of the core standardized assessment tool. The state uses the new IT system to conduct administrative oversight of assessment and case management process.

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1 For 1915(c) and 1915(i), this situation will only exist when the state demonstrates that the Area Agency on Aging is the only willing and available entity to provide the case management service.

2 *See* Missouri's Conflict-Free Case Management Strategies, available at: http://www.balancingincentiveprogram.org/resources/example-conflict-free-case-management-policies.

3 *See* Ohio Three-Way Contract, p. 35-46, available at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/OhioContract.pdf.

that coordination, in the BIP program, CMS emphasizes separating service provision from case management and assessment, and not on separating case management from assessment.

5. Policies addressing interim or preliminary authorization are needed to avoid delay in access to services.

The effects of a siloed or fragmented care system may be compounded without specific policies that protect continuous access to services. New CFCM policies sometimes result in confusion over the validity of interim or preliminary care plans and/or retroactive authorization of services. One state consumer advocate noted that, since full compliance with CFCM procedures takes time, temporary alternative procedures may be needed to ensure continuous access to needed services for eligible individuals, such as those transitioning from private pay to Medicaid-funded HCBS. To ensure continuous, coordinated access to care and services in the community, states should continue to honor provider-created interim care plans.

6. A strong oversight and appeals process is less disruptive and more effective than firewalls and other mitigation tactics.

Conflict mitigation can have two components: administrative firewalls separating assessment and service planning, and oversight on the back end to address problematic business practices. A clear message throughout state conversations and review of existing CFCM proposals is the concern that building conflict firewalls into the existing LTSS system can be disruptive to the coordination process. BIP requires a thorough oversight and appeals process, and states echoed the value of conflict review as an effective mitigation tactic. State representatives emphasized that, at its core, CFCM implementation is about discouraging the few agencies and providers who may be self-promoting or prioritizing the agency over the needs and desires of the consumer.

State representatives recommended shifting the focus from breaking up existing systems to conducting more rigorous oversight to identify problematic business practices within agencies and providers may be a more effective way to reduce conflict. This requires a rigorous review and appeals process.

7. States should approach managed care and conflict-free case management requirements holistically.

States shared that integration of LTSS into managed care, coinciding with other significant delivery system changes, is both an opportunity and a challenge. Introducing managed care to case management may reduce the potential for conflict within an agency or state service planning process. For example, in capitated dual eligible demonstration programs,[43] states are relying on managed care companies to develop the care plan. For example, in Virginia,[44] the state Medicaid agency, state waiver services, and MCO have distinct roles in the assessment, care plan and service delivery process.

While integrating MCOs may provide an additional conflict barrier, states interviewed cautioned against assuming that simply introducing managed care to LTSS eliminates conflict. Managed care invites additional

43 For more on the Financial Alignment Initiative, also known as the dual eligible demonstration, see: www.dualsdemoadvocacy.org.

44 Virginia Three-Way Contract, pp. 44-53, available at: www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/VirginiaContract.pdf.

conflict if the assessment, care plan, and service delivery all fall under the managed care organization.

In addition to the potential for conflict, the task of incorporating new systems is challenging. One local agency pointed out that while some MCOs have experience in LTSS, many are still building provider networks and competencies. As one state consumer advocate stressed, the LTSS system changes require a holistic approach, and states should consider BIP, HCBS and MLTSS implementation as a whole when designing integrated system change.

8. Introducing conflict-free requirements may further strain existing community resources.

Implementing conflict-free case management principles into managed care integration creates an additional expertise challenge. In many areas, professionals with the skills, credentials and experience needed to perform assessment and care planning functions are a scarce resource. Separating these functions may result in dilution of individual and programmatic expertise, either in a particular organization or across a community. For instance, several state consumer advocates noted that managed care companies lack LTSS expertise and community networks. As a result, some managed care organizations hire staff away from community-based organizations. However, a large scale departure of organization staff may threaten the sustainability of a community-based group. Alternatively, a managed care organization might decide to contract directly with a community-based group to build an internal LTSS network, but this arrangement may reintroduce case management conflict. With limited resources and expertise, the best route to resolving this tension is not clear. States should consider the need to increase overall program funding when implementing new CFCM policies, in order to preserve stability and, in the long term, increase availability of qualified personnel.

Conclusion

LTSS delivery system reform offers states an important opportunity to rebalance the delivery of LTSS to the community. Each of the several initiatives now underway requires states to seriously reevaluate care delivery and pushes states to reinvent program design so the consumer, not the LTSS system, drives the transformation of care. However, with only one year remaining until the BIP deadline, it is clear that states are still getting started. Many of the elements of conflict-free case management compliance are still theoretical and some states continue to struggle with questions of how the pieces work together. How does a state deliver services to an individual in a manner that facilitates ultimate choice and consumer direction, while ensuring the overall care system is coordinated and free from conflict? There is no one- size-fits-all answer to this question, but states continue to move in earnest toward reaching those two goals.

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