

NWX-HHS-AOA-1

Moderator: Lauren Solkowski
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Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. During the Q&A session if you'd like to ask a question you may press Star 1 on your phone. Today's call is being recorded. If you have any objections please disconnect at this time. And now I'd like to turn the call over to Ms. Solkowski. Ma'am you may begin.

Lauren Solkowski: Great, thank you so much. Good afternoon everyone and thank you for joining us today for the Administration for Community Living Business Acumen Webinar. Today's Webinar is focused on conflict of interest. And so I'll say this, you know, this is something that has definitely been a hot topic among the members of our learning collaborative as well as other community-based organizations in the field. So we're thrilled to have Julie Hamos with Health Management Associates and Fay Gordon with Justice and Aging with us today to help shed some light on the topic.

So for the Webinar today Julie and Fay will be providing sort of an overview of the rules surrounding conflict of interest as defined through various centers for Medicare and Medicaid regulations and then also provide some insight into how some of the implications of conflicts of interest can potentially be

mitigated. I also want to just say in addition to what we'll hear from Julie and Fay today that CMS is working on FAQs related to conflicts of interest that we do expect to be released which will offer additional guidance to states on this issue. So before we begin with the - their presentations I do have a few housekeeping announcements that I would like to run through quickly.

Okay so for the first if you have not done so already please use the link that is included in your calendar appointment to get onto the WebEx so that you can follow along with our slides but also so that you can ask questions when you have them through the chat function. If you do not have access to the slides please go to WebEx.com, click on the Attend a Meeting button that is located at the top of the page and then from there you can enter the meeting number. The meeting number for today's Webinar is 409479579. Again that's 409479579. And if you're still having problems getting on to WebEx please call the technical support number at 1-866-569-3239. Again that's 1-866-569-3239.

As the operator had mentioned all Web participants are in a listen-only mode however we do welcome your questions throughout the Webinar. There are two ways that you can ask your questions the first of which is through the chat function that is in WebEx that is located there on the right-hand side of your screen. You can enter your questions there and we'll sort through them and get them answered after our speakers have presented. And then the second way to ask a question is through the audio lines. So again when the time comes the operator will give us instructions as to how to queue up to ask your question. Oh if there is any question that we are not able to answer during the course of the Webinar please feel free to email them to me Lauren Solkowski. I have entered my email address also in the chat box there a new screen.

And then lastly we are recording the Webinar. And we will post the slides, the transcript and the recording of the Webinar on the ACL Web site as well as on the MLTSS network Web site. And also for your reference I had entered these Web sites also there in the chat box on the right-hand side of the screen.

Okay so with that we I would like to introduce our speakers. First today is Julie Hamos. Julie is a Principal at Health Management Associates in the Chicago office. HMA is a national consulting firm with expertise in publicly funded healthcare primarily Medicaid. Prior to HMA Julie was the Cabinet Level Director of the Illinois Department of Health Care and Family Services responsible for Medicaid and child support services.

And next is Fay Gordon. Fay joined Justice and Aging Health Team in May of 2012 and is based in Oakland California. Prior to Justice and Aging she worked with the national aging organizations as a Public Policy Associate and as a law clerk as an elder law firm in Maryland. Fay is a graduate of the University of Maryland School of Law. So thank you again to Fay and to Julie for joining us today. And with that Julie I will turn it over to you.

Julie Hamos: Thank you Lauren. Hello everybody. So today we're going to start by talking about Medicaid home and community-based services and the conflict of interest policies in those groups of services. Next. Today so we're going to first start by reviewing the background of the new federal conflict of interest rules and really what produced them, the Medicaid services provided by the Aging and Disability networks. Then we're going to review the federal guidance on the COI rules conflict of interest roles and then proposed strategies for mitigating conflicts of interest.

So we start with the background and I think you all are aware of something fundamental here which is that the delivery of Medicaid funded long term

supports and services as we call them LTSS has shifted from nursing home to home and community-based services. (HCBS) has become more and more important to the state Medicaid programs especially as they've been rebalancing their long term care systems. And there's a lot of effort to really make sure that older adults and disabled people can live in their homes and communities with the kind of supports that you all provide.

Most states are using what we call waivers and really state plan amendments to provide services to older and disabled persons at home. And really again it's your networks that provide the types of services that are funded by the Medicaid HCBS. And I just really want to also say though before we move on that it's obvious that assuming it was true here in Illinois where I took on the role as the Director of Healthcare and Family Services that many of the organizations that were providing really important on the ground services for older adults and disabled people were using a whole set of funding streams such as the Older Americans Act and many other funding streams to provide those services. And often they were through grant programs from various social service departments. In our state that was the case.

What we're going to talk about today though are not all of those other funding streams which also have conflict of interest rules or I think there were assumptions in them that there wouldn't be conflict of interest. But today we're talking very specifically about Medicaid. And I'm hoping and guessing that all of you are now also providing Medicaid services. A lot of your beneficiaries and clients are in Medicaid - have Medicaid eligibility and it's very important that your part of the systems that are serving those clients. So again the focus today is on Medicaid.

So next. There are all slew of services that are funded under in the category of home and community-based services and they're called different things in

different states but generally speaking these are the types of services we're talking about. You know, there's information and referrals. The Medicaid eligibility determination redetermination function which is mostly kept at the state level not contracted out to community services community-based programs. Then we have the level of care determination which is a clinical eligibility determination and redetermination. Then there's a needs assessment, and reassessment, service planning which is also known as a care plan, service coordination, service authorizations, service delivery of course which is actually after all of those other pieces are in place. Then there's the actual delivery of services and then quality oversight and quality monitoring.

And again these are called different things in different states. Sometimes a slew of them could be for example clinical. They could be really part of a case management function like needs assessment, service planning, service coordination, service authorization are sometimes all bundled as case management. But this really sort of takes them apart and looks at each of the pieces. And I think the reason and in fact for sure the reason the conflict of interest rules came around is because some organizations were providing a number of these services. So they were determining eligibility. They were determining the need, planning the service, coordinating the service and also providing the service. And that's why I think there was a movement towards conflict of interest rules.

Next. These are the concerns that have been raised over time that produce the HCBS roles and the new requirements. You know, again these are potentials. They're not true in every case but these were again the concerns. And I call them potential conflicts. Sometimes they're not actual conflicts but they have the potential or they look like conflicts steering individuals to your own organization, the pressure to retain the client instead of promoting choice for the client, incentives for over or under utilization of services, undue influence

over the goals of care, the lack of consumer choice in selecting services or providers and a focus on the convenience of the service provider instead of the actual beneficiary or the consumer.

Next. So conflict of interest is defined as a real or seeming incompatibility between one's private interest and one's public or fiduciary duties. And the conflict especially is believed to occur when the CBO serves as both the agency assessing the need for services and delivering those services. The potential conflict may not be a conscious decision by the provider but really may be the result of incentives or disincentives in the system. And I think that's generally recognized. But I think that when there are multiple functions performed by one CEO that's when the conflict could arise and that's what these rules are about.

Next. So the key components of a conflict free system are that first of all the eligibility decisions are separated from the direct service provisions, that the person receiving services and then giving services are not related by blood or marriage they're not - and they're not financially responsible for that person, that there are clear paths in tracking for grievances and appeals, that the state is engaged in oversight and that the stakeholders are engaged and there's a tracking of the individual experience.

But there's also - next please, there's also a recognition that sometimes there is a conflict of interest or potential conflict of interest. And when that is the case the state needs to first of all demonstrate to CMS that the entity is the only willing and qualified provider. This is especially true in some rural areas where there really is only one provider. And that one provider is best capable of providing a number of these services. Secondly to provide full disclosure to the participants and assurances that the participants may exercise the right of free choice in providers.

Third to describe an individual dispute resolution process and to make sure that the participants know what that is. Fourth, ensure that the entities separate case management and service provision different staff. And that's again very close to number one. That's what state needs to do that these are the firewalls that we'll be talking about so that entities have separate staff, assure that the state has given express approval and finally to provide direct oversight and periodic evaluation of safeguards. So again there are ways to mitigate potential conflicts when they do arise and we'll talk about some of those strategies.

Next. So there's been federal guidance on the conflict of interest in HCBS. And please remember that in the world of Medicaid the federal CMS really gives guidance to states. The states may enact guidance as the minimum set of standards. Some states have more stringent standards than what the state – what the federal government has suggested.

And what we're going to go through and I - again this is for your information to make sure that you know that the conflict of interest rules come up in different programs in slightly different ways. But you will see them in this – in your state Medicaid programs in these various waivers and state plan amendments and programs because balancing incentive is really a program. And we're going to go through each of these in the next few slides keeping in mind that the programs do have different COI rules and that's why they're really presented here because there are differences among them.

So the next one. So the Balancing Incentive Program we're going to talk about first. The Balancing Incentive Program was in my mind a really wonderful program. It was before the Affordable Care Act and it really was pushing the states to rebalance their long term care systems by offering incentives, a

federal match if they agreed to rebalance LTSS towards home and community-based services and away from institutionalization. The state did have to enact certain structural reforms as part of that program. And this is where we first heard about and we first had to deal with conflict-free case management. That's what it was called in that program.

The BIP guidance, again the guidance is what was put out there to guide the states as they really decided or not decided to be part of the BIP program. It included nine design elements that were considered conflict-free case management. And a number of the rules that have arisen since the BIP program I think have adopted these nine design elements. You know, they are things like robust monitoring and oversight and grievances, a grievance process for the consumer and various - nine of them. The - I mentioned that again because you should be aware that your state may have a balancing incentive program but again it's in place. It has been working and it was a time limit programs. So currently there are 18 states that are I think completing the last cycle of their BIP programs and you may be in one of those states.

But it's they're - this is not a new program. It was just really the first that dealt with conflict of interest. Next slide. The most common kind of waiver for home and community-based services is the 1915(c) waivers. I think their most states they're the most frequently used because they're offered - they offer a range of services, HCBS services to various populations with LTSS needs. So for example here in Illinois we had nine different 1915(c) waivers. We had a waiver for adult disabled people and we had an older adults waiver. We had a children's waiver.

So they are different - they can be different populations. They can be different disease states. They can be different geographies. The individuals however

must meet state defined institutional level of care to be eligible. And this is pretty critical because you have to show that all of these people would otherwise be in institutional care such as nursing homes or residential programs.

The states are allowed to limit HCBS to specific geographic areas. That's what makes these waivers a waiver actually, somewhat unique. You don't have to show statewide applicability. It can be specific to a geography. The important thing to know is that the 1915(c) waivers are in fact in place in like I said in most states, a number of different ones. They do expire and the state has to renew them and there's a fairly lengthy application process or states decide to apply for new 1915(c) waivers. The conflict of interest rules will take effect as these renewals or these new waivers come up. So they're not necessarily placed in your states yet but they are being renewed conflict of interest will become an issue at that time.

Okay next. The 1915(i) state plan option is a relatively new option for states. It's now in 17 states and it allows the states to extend the same type of benefits as 1915(c) but for those who do not meet the institutional level of care. So it's a, sort of a lesser need population who would benefit from the type of home and community-based supports that we see in these waivers.

The challenge for states -- and I can tell you this as a former director -- is that because it's not a waiver it's a state plan option it cannot be limited by geography. So if a state decides that they want to extend home and community-based services to a population that wouldn't necessarily be nursing homes, they have needs but they're not the institutional level of need they have to offer it statewide. That's why I think it's only - the take-up only has been in 17 states up till now.

And in this particular state plan option the COI guidance is the most strict of all of these different programs were talking about in waivers because it really does prohibit needs assessment and service planning to be by the same provider as direct service. So it's – they must be separated. Needs assessment service planning must be separated from direct service. Your state might have a 1915I state plan and in that case I think this is already in place in your state, the COI rules.

Next the 1915(k) Community First Choice state plan option again a new waiver, a new - well it's a state plan but it's a new program came about through the Affordable Care Act. It provides a 6% increase in federal match to states who offer personal care services to those who meet the institutional level of care. So again it's a different kind of program. It's focused around personal care services. And as a state plan it cannot be limited by geography, has to be statewide. And as of just this month it's only in effect in five states but your states might be one of those. And if that's the case then there are conflict of interest standards for that particular state plan option for persons and entities conducting assessment of functional needs and person centered service planning.

Next, 1115 waivers are becoming in my mind more and more popular for states because they really do offer the most flexibility to states in designing a program, a Medicaid program. They are known - seen and known as experimental programs or pilots or demonstrations. They really do have to evaluate certain outcomes and test certain hypotheses so they really demonstrate a hypothesis but they're very interesting waivers.

And there's a lot of innovation that's going on around these waivers right now in the various states. The - they're used by some space to provide a CBS, not always so 1115 waivers can be all over the place in dealing with many

different issues. But they can cover HCBS. And CMS has indicated at this point that HCBS conflict of interest rules will apply as states develop these new 1115 waivers.

Next, there are conflicts of interest rules that also apply to managed care organizations. I think it's important for you to be aware that managed care - well I know you know that managed care has become a common service delivery vehicle in many state Medicaid programs. What is new and different is that more and more states are moving to provide LTSS, Long term Support and Services through managed care. So managed care in the past might have had responsibility for children and their family members but now they are being assigned responsibilities also to deal with older people, people - persons with disabilities and persons who need long term care, generally need long term care, children and adults.

So MCOs are new to this in some ways. I think what's important to for you to know is that if your state has now put LTSS into managed care then you have new opportunities and challenges in having your services provided and paid for by the managed care organizations. But so there's a different way to think about the payers. Not the state. It's not the state Medicaid programs. The payer in that case is the managed care organization.

But the conflict of interest rules also apply so let's go through some of these rules. The MCOs can provide case management and perform functional assessments and they often do. They do keep and hold on to case management internally. And they might perform the functional assessments to see what the person's dealing with issues are. But if they operate direct service and provide the case management then the states have to demonstrate that the MCO is the only willing and qualified case manager. So this is that same issue. In some rural areas this could be the case. But in almost every case the state - the MCO

probably is not the only willing and qualified case manager because people are required to be given choice and there's usually several MCOs in the picture and they've been developing a network of providers. But there - states again have to monitor this and make sure that there's a separation of functions.

The MCOs cannot determine eligibility for the program. And the - if they do and if for example if they perform the assessments for level of care which is a very significant part of LTSS provision which is to see what the person really needs, what kind of services then need that the state must perform a representative sampling to ensure the accuracy of the level of care. So I think what's, you know, critical here is that they don't want to see managed care companies deny care or, you know, qualified persons for a lesser level of care and fewer hours of service than is really warranted. So they - if the states in that case would have to do some kind of representative sampling. And an appeals process must be in place to address decreases in care and that appeals process must be with the state. So again managed care organizations are also subject to the same conflict of interest rules. They understand that. I think a lot of the conflict of interest rules are by now written into the MCO contracts with their states.

So let's talk about the strategies, potential strategies for CBOs in mitigating conflict. And really in my approach here I take you back step by step to really try to do assessments of your own state in your own program to start with. So first assessing your state's Medicaid program.

Again you may not have developed relationships in the past with your Medicaid program if you're fairly new to Medicaid or you've been looking at other working with other agencies in your state than the state's Medicaid program. You've been getting grants perhaps. You've been getting older American Act grants, et cetera. You may not have these relationships built.

It's a good time to start developing those relationships. So the first question then you will want to ask is under which state plan amendments or waivers do you provide home and community-based services? If you're already in the Medicaid program you are under one of these state plan amendments or waivers typically. And as I pointed out there are different waivers, different state plan amendments, different programs in different states so you'll want to do that assessment.

The second question is what is the timetable for the various waivers under which you're operating to be renewed? This is especially important for that 1915(c) waiver where the conflict of interest will take affect at the time of renewal. So you'll want to sort of chart out a timetable for the renewal.

Then you'll want to scope out whether there are new HCBS waivers, SPAS or 1115 waivers that are being considered for the same reason that as they are being considered the conflict of interest rules will kick in. You'll want to know are there home and community-based services being provided in fee for service or in managed care. This movement that I described is relatively new. Some states are in transition right now, some states have accomplished it and some states are just thinking about it. You may still be dealing in a fee-for-service environment which changes the set of relationships you will need to develop. But if in fact the long term supports and services are now being moved over to managed care then I think a good question under this one is do you have relationships with the MCOs?

Okay next, the second step is really to assess your own CBO. You know, are you a Medicaid provider. As I wondered before it's not true of every CBO. In some cases you're in transition as well in becoming a Medicaid provider. And then you'll want to really think through which HCBS services do you provide or would you like to provide? There are lots of services as I described to call

different things in different states but there are many options for the kinds of services where your organization is very important, you have the relationship with the participants, you're on the ground, you've been working with them and they should be covered under Medicaid and you'll want to I would think move them over to Medicaid. But what are those services?

Then you'll really now need to think through is there that potential conflict? You know, are you providing multiple services and where could it be seen as a potential conflict of interest? And if in your - in that situation where you're providing a number of these services then I think it's really important for you and your board members to really think through which of these services are most important. If we have to give up some or if we have to create the kind of firewalls -- we're going to be talking about that -- then what's our priority here. What do we really want to do? What's our business plan moving forward?

And then the fourth question here is are you the only willing and qualified provider in your area? As I said that will change the rules. That is certainly true that in some of the more rural areas in our nation in some of those states so that's another question too. And I - probably I would put the next bullet under here and not the previous step do you have relationships with the state Medicaid programs and the managed care companies? That I think is another way to assess where you are in this whole process.

The next step. So the next step is really the biggest challenge of all which is to develop the actual ways that you can mitigate any potential conflict. And typically we talk about these as these three for sure ways that you can mitigate. One of them is to develop firewalls between organizations. So this is where you would really look at all the different services you provide. If it looks like you're providing those multiple services you would actually make a

conscious decision, a strategy to move over some of those services to another organization or you would potentially contract with a managed care organization that they would provide the services that for some - they would provide some of the services and contract out and let you keep some of the services and pay for some of those services. So it's actually that firewall that exists between organizations. This is certainly the easiest - it's the hardest one for your organization potentially because you've been working with these beneficiaries and you know what their full range of needs are. But this strategy would suggest that you're going to separate out those functions so one organization will do something, you will do other things.

The second bullet is challenging but I think a really important new possibility, an option for your organization. And that's to develop a firewall within your CBO. Now if you're doing this and potentially doing this just keep in mind that you would have to really provide for distinct budgets for the two separate organizations that have different staffing. And you'd likely have to have different management so different, certainly different supervisory management and probably different boards of directors in doing the firewall within your CBO. And when you move in this direction you will really have to go through an evaluation of the current infrastructure of your organization, identifying policies and procedures that are necessary to build the firewall. You'd have to probably determine what additional costs would be incurred in implementing the firewall, assessing the impact on your consumers. You would have to delineate how the firewall elements would be communicated so it would be very clear that there are distinct entities. And you would have to determine how the firewall will be monitored. But at least it does allow your organization to be in the business of providing a fuller scope of services except that you would have to really put these protections in place.

And the third option here is potentially for you to retain the services that you now provide but contract them out. So you would contract with a single separate entity to conduct the assessments for example while your organization continues to provide case management or direct service. And this keeps you more so in the driver's seat but again the protections would have to be in place. How are, you know, how to make sure that this person centered care that the beneficiary has choice that they're given full assurances that they can select their service provider, that you're monitoring it, that there are grievances -- all of the kinds of elements that we talked about they have to be in place so this really can be done. And I would encourage you to consider moving in any of these three directions to really deal with the mitigation of conflict.

The fourth step is to borrow models from other states. And I listed two states here really in shorthand. There potentially are ways to write up more the models right now to make sure people know what organizations like yours know what others are doing. And I think that would be probably pretty useful. This is still pretty early in the process dealing with conflicts of interest. But as an example in Ohio the Ohio AAAs were able to contract, have a three-way contract between the federal government Ohio and the MCOs.

There is a three-week contract for dual eligibles but the AAAs were written into those and they conduct the level of care and then the MCO must contract with the AAA to perform service coordination. They had a seat at the table and they really made sure that when the dual eligibles program was being rolled out that everybody recognize that they had a role to play and they were written into the actual contracts. In Pennsylvania the AAAs are allowed to perform the level of care and then the MCOs are also contracting with AAAs for service coordination. So again there are different approaches and I think

we're almost at the point where we should start cataloguing who's able to really do this successfully so that people can learn from them.

And then finally let me just say in Step 5 next slide, I would really encourage you to be at the table. I know you can help design the new state systems. You know, I think I'm saying this. I think Fay's going to be saying this as well that this is pretty early in the process. The states are dealing with this, there grappling with this, the MCOs are grappling with it and they need to hear from you. So if you stay engaged then you can potentially help with the state level implementation of various new policies and protocols. And there's going to be various things that are really being developed, various policies like state to state monitoring and oversight, the consumer pathways to filing grievances and appeals, how do we track grievances and appeals? How do we track - how do we really evaluate and track the individual consumer experience?

I think the states really would need to I hope that they'll - you recognize how important you are as the states do need to hear from you as this process is occurring and to make sure that your best ideas are captured as part of these policies. And what I really end with is again a statement of confidence that you deserve a seat at that table. You're not going to be at the table unless you're there and your voice is heard so please do inject yourself and make sure that you're watching this closely as your state is rolling this whole process out.

Okay I'm going to end with that. And I think we're holding question until the end but this is also my contact information if you'd like to follow-up for additional help with any of this. Thank you.

Lauren Solkowski: Wonderful, thank you so much Julie and Fay. I will (unintelligible) and you're welcome to begin.

Fay Gordon: Great, thank you Julie. Thank you for that information and Lauren thank you for organizing this Webinar. I think Julie's last slide is a perfect transition to this next part of the Webinar because as you're looking at new state systems and new state opportunities in addition to everything that Julie mentioned there's also now the new Medicaid managed care regulation. And that's what I'm going to focus on the particular conflicts of interest requirements in that regulation on the choice counseling services that community-based organizations provide. So will go to the next slide.

I'm very happy to be a part of this Webinar today. Thank you again Lauren for organizing this. Our interest in long term services and support and our expertise comes from our background of (unintelligible) of working to provide affordable healthcare and economic security to low income older adults. So if you're not familiar with us please feel free to check us out on our Web site. We have a lot of different managed care and Medicaid and long term services and supports resources available. We'll go to the next slide.

So today just a few key points hoping we'll discuss. I mean I go over briefly why there is this growing interest in conflict of interest. And I'll go through that quite quickly because I think we've got a great discussion on that earlier this afternoon. And then we're going to dive into this Medicaid managed care regulation and go into detail on a component of it called the beneficiary support system. And this beneficiary support system is really what lays out the new requirements for conflict of interest for community-based providers who are providing choice counseling services. So once I go over what's actually written in the rule and what information we have from CMS then I'll have more of an exploratory discussion where I discuss the potential impact of these changes for community-based organizations. And then I'll close up and we'll have questions and discussion on both of our presentations.

So the next slide. Again why is there this growing interest in conflict of interest? And I'm on to the next slide. As Julie said there's been a sort of heightened focus on this particularly for community-based organizations like AAAs within the last five, eight, ten years as there has been enhanced focus from the federal level at CMS and from the state level with state Medicaid agencies on integrating the healthcare delivery systems. So with this push towards a more integrated delivery system there's been a focus on getting community-based organizations more integrated with healthcare systems and so the conflict of interest focus that may have been traditionally in that healthcare space is now of higher scrutiny in the community-based services space.

So we'll move on to the next slide. As Julie mentioned part of the challenge and the reason there is this focus on conflict of interest is because of the dual role that community-based organizations can provide. In the aging and disability network anytime you have an entity that's providing gatekeeping services either through eligibility, checks or through case management services we're sort of providing the gatekeeping role on services. At the same time as actually providing those services or contracting with organizations for those services that potential for steering can exist. And there becomes a concern about as again Julie I liked how you emphasized that word about that potential for conflict of interest as again just that concern about that potential conflict being there. It's not necessarily going to be there and probably actually very rare rarely there as we look at different programs across the country.

On the next slide I did want to note that while we have this enhanced focus and enhanced interest on conflict of interest through the different changes in Medicaid waivers now through the Medicaid managed care role through the

implementation of the federal HCBS role even where there's all that activity going on and a lot of discussion on conflict of interest there has there's been long-standing conflict of interest protection the AAAs have long abided by through the Older Americans Act. And so I think it's important to remember that much of the work the AAAs and CBOs are doing right now is adhering to person centered principles into conflict of interest restrictions that have already been in the OAA.

SO if we go to the next slide then we can just pass that one but I do always think it's exciting to remember that the OAA has been around for 50 years which is awesome. So the OAA has clearly stated for years that AAAs cannot act as promoters for their agencies and that they have to provide the individuals that they're serving with a clear statement telling that individual about the different choices that they have. So as much as some of what we've been talking about today may sound overwhelming and like a whole new change in systems I think it's important to remember how much good clear work has already been going on for years guided through the Older Americans Act.

So now I want to take a deeper dive in the next slide into the Medicaid managed care regulation. And this is where the discussion becomes much more evolving and a little bit more theoretical. As we know CMS issued this new regulation this spring and it was a pretty noteworthy event for Medicaid because it is the first time the federal agency has updated their requirements for managed care organizations in over a decade. SO, overall across the industry and across the states it was a pretty big deal to have this regulation came out. And then for those of us who worked in the long-term care in long-term services and support based it was very exciting because it was the first time that there were very clear federal regulations and clear federal guidance

and expectations on what CMS expects states to do when they are contracting with managed care organizations to provide long-term services and support.

So we'll go to the next slide and there were four really key areas of this regulatory update. And CMS is very clear on their goals for this regulatory update. They want to improve delivery system reform. They want to strengthen program integrity. They want to align Medicaid with other healthcare programs. But the part I want to focus on today is this fourth component and that is the emphasis throughout the (rule) to strengthen the beneficiary experience.

So there is a clear recognition from CMS in multiple different areas of this regulation of ways that states and community-based organizations and managed-care organizations can do a better job and can be more focused in their efforts to make the system easier for beneficiaries to navigate and to understand. And if we go to the next slide these are some of the major sections of the regulation that deal with long-term services and support. But where we see CMS's clear focus on improving that beneficiary experience is in their requirement that the states create what's called a beneficiary support system.

And the section citation is there for you on your slide. And this is a pretty new move but I think it as I explain it you'll see that while it's a new concept in general and a new requirement on states it draws on and pulls together a lot of the existing consumer assistance agencies that are currently in the different states. I'm going to go to the next slide. I'm just going to take a quick sip of water, sorry.

All right so a little bit more on what this provision requires and tying it together to our choice counseling discussion and our conflict of interest discussion. So states will be required under the regulation to provide support

to beneficiaries before and after they enroll in managed care programs through this beneficiary support system. And CMS says there's three key things that the system has to provide to Medicaid beneficiaries. And we can go onto the next slide.

All right so three key features are choice counseling for all beneficiaries, assistance understanding managed care including long-term services and support and then outreach and education to beneficiaries. So the part that really corresponds with our conflict of interest discussion today is this choice counseling piece. So this system will be providing choice counseling on different managed-care options for Medicaid beneficiaries.

On the next slide in addition to these sort of, you know, three basic components for individuals who receive long-term services and support the system will offer them four additional key services. And I think that we could do a whole presentation and probably multiple presentations and over the next few years as states develop the beneficiaries support system there will probably be a lot of discussion on these different key areas and on the system itself. But I'm not going to go into all of that today. I really want to focus on that choice counseling component and why it's significant with these conflict of interest discussions.

So if we go to the next slide when you're reading the regulations where it discusses choice counseling in the beneficiary support system there's a section that says any entity that's providing choice counseling on behalf of a state is considered an enrollment broker. And now as an enrollment broker that entity must meet independent and conflict of interest standards. And so this is sort of a significant shift from some of the more traditional choice counseling roles that community-based organizations have provided and it's particularly significant because of this new consideration as an enrollment broker.

So what I want to discuss now if we go to the next slide is what this means with the - what the significant, potential significant regulatory change means. And again this is going to be a lot of discussion based on what we read and what we see in the rule. Before I go into this potential impact discussion I just want to clarify a little bit more information that CMS provided in the regulation on the beneficiary support system. CMS really sees this as an opportunity for community-based organizations. They are not expecting that states will suddenly develop an entirely new consumer network. What they want states to do is look at their network of consumer assistance whether it includes the CHIP programs and the ombudsman programs. And the state has a dual eligible demonstration program, their demonstration ombudsman program and the AAAs and all of the different entities that currently help consumers navigate their states Medicaid managed care system. And they want states to come up with a more systematic way to pull these resources together and make them more cohesive and easier for a beneficiary to access and then used to navigate some of their questions in their entire Medicaid managed care process. So there is a potential for many existing community-based organizations to be a part of this system so that's a very exciting opportunity.

I do have to say that as of now just purely with reading the regulation and without any additional guidance from CMS at this time it doesn't - there's no clarity on what resources will be available for the system. It appears that there's an expectation that states will draw on their existing organizations and resources but I think that that's sort of an open discussion and an area certainly for potential advocacy to make sure that whatever states develop that they are adequately resourced and that their organizations providing these services have the support that they need to provide high-quality services.

So I again going on to the next slide there's this shift in the beneficiary support system where choice counselors are considered enrollment brokers and therefore they must be from conflict of interest standards. So if we unpack what this means and we sort of ask on the next slide - we can move on to the next slide why is there suddenly this concern about conflict of interest and choice counseling? Why CMS include this additional regulation? And again it goes back to that original concern with the potential for steering. So when you look at the choice counseling settings and you're looking at a state with Medicaid managed care and a CBO is providing choice counseling they're providing advice and referrals on the different managed-care plans that are available in their states.

The steering potential happens if that community-based organization has a financial relationship with any of those managed care organizations. So if they're contracting with those managed care organizations or anything else, you know, assuming these entities provide choice counseling and other services once they have the potential to financially benefit from that role that's where this conflict comes in to play and there is that potential for steering.

So we're going to go on to the next slide. And this again becomes further complicated with our whole new managed care environment. And as states are navigating the transition to manage long-term services and supports and managed care some of the distinctions that may have previously been in place between advice and referrals and services they can blur with some of the contracting in managed care sort of integration in the healthcare and community-based services space. So moving on to the next slide again the rule is very clear that because of this they are clarifying that choice counseling entities are enrollment brokers, that enrollment brokers must be free from conflict of interest and therefore any choice counseling entity in the beneficiary support system must adhere to conflicts of interest standards.

So we move onto the next slide. And I do want to answer what I imagine is a question you're probably asking right now which is why did CMS make this distinction that choice counseling entities are suddenly considered enrollment brokers? From the role that we've traditionally considered community-based organizations to have as choice counseling providers versus sort of the state enrollment broker systems so they're very different functions of different responsibilities. And so it is confusing why they would suddenly use the same language. And I have to say I don't have a good explanation for that.

There were quite a few comments on this during the proposal process and many organizations, community-based organizations wrote to CMS and said, "Do not consider choice counseling and enrollment broker as a separate function and it's a separate history. They should not, you know, be considered with the same language." And in the ultimate rule CMS just noted that they were not making that change and that they would consider continue to consider choice counseling to be an enrollment broker service. This doesn't mean that suddenly all of these entities that have provider choice counseling for here particularly the CHIP programs are suddenly enrollment brokers in the sense that we have considered in the past. It's just a new term that they're using sort of to cover all of these bases in the beneficiary support system.

So going on to the next slide. So now I want to talk about what this means as far as the potential impacts on community-based organizations. And before I go into that discussion I do want to be very clear that this all based on a reading of the regulations and a reading of what's in the preamble and the comment process. CMS has not at this time issued additional sub regulatory guidance on the beneficiary support system so until they do that which I imagine they are going to be issuing that and working on that we don't have a lot more clarity other than what's actually in the reg. So this is all based on

my interpretation of the rule and what you are also welcome to read in the regulation.

So moving on to the next slide so the potential impact of this shift in the managed care role of choice counselors as enrollment brokers who are required to adhere to conflict of interest standards the first potential impact is that it may very well have no impact at all. And this is very likely. It may not cause a significant change. And again this is because community-based organizations are very committed to providing conflict-free person centered care and so it shouldn't really cause a seismic shift in the way that those counseling services are delivered as they'll continue to deliver the high quality services that they have long provided.

There is another potential though that I do want to discuss on the next slide. And that's the potential that as states begin to develop their beneficiary support system it may require CBOs to make a choice. And this is a choice that I'll sort of explain more of the background on. But the choice that they may have to make will be to continue to provide the choice counseling services that they've long provided and continue to maintain their contracts with managed-care organizations or to participate in the beneficiary support system as a choice counselor but then eliminate their financial relationship that they have with managed-care organizations. I understand that this is a little bit significant and again it's purely from reading the regulations so I want to go into the background of where that potential choice comes from.

So we go on to the next slide and the reason that there is this possibility that there might have to be this choice is that the regulations clarify that any entity that provides choice counseling cannot have a financial relationship with the managed care organization. And again this is for those entities providing choice counseling in the beneficiary support system. So on your slide there

you'll see a citation to that section and I'll explain it in just the next slide if we move on. So specifically the regulations says that a CBO cannot provide choice counseling in the beneficiary support system if that CBO has - and there's a few other scenarios that I think are not as pertinent to this discussion but if that CBO has a direct or indirect financial interest in any entity or healthcare provider. So again CMS is trying to eliminate this potential for conflict of interest with steering in the choice counseling services.

So if we go to the next slide I think an actual question from that is okay but is CMS considering a managed care organization to be a healthcare entity in that particular provision? And that's where it's unclear. So this whole choice comes from that section. And it's not entirely clear if MCOs are considered an entity or health provider that the CBOs cannot have a financial relationship with it.

The preamble does interpret MCOs as falling under that umbrella. And so this is where we need some additional clarity from CMS because it is a potentially important impact for the CBOs who are contemplating how to be involved and how to help their state develop a beneficiary support system.

So continuing on to the next slide so again just pulling all of these pieces together it's a lot of information on this regulation on this beneficiary support system in particular and then the conflict of interest requirements. So backing up to all the pieces again this Medicare healthcare regulation requires states to create a beneficiary support system. As states are creating this system it's important for them to understand that the regulations says any entity in that system that provides choice counseling they must be provided to all managed-care enrollees and those choice counseling entities will be considered enrollment brokers. Any enrollment broker will be held to conflict of interest standards and any community-based organization cannot have a financial

relationship with the healthcare entity. And managed care organizations are most likely considered healthcare entities.

So moving on to the next slide this then presents a potential for a choice for the CBOs to contract with the MCOs, to not contract with the MCOs, to participate in the beneficiary support systems or not to participate, because this is still a question and still in the area of confusion what's really needed from CMS is additional sub regulatory guidance and additional information so that CBOs and advocates and everyone across the different states who are going to be working with their state to build a really robust and useful beneficiary support system will have the information and answers they need to appropriately develop that system.

We move on to the next slide. These are just a few additional resources on conflicts of interest in a Medicaid managed care role. And one more slide. I think that might actually be it. That might be the last slide.

Lauren Solkowski: Yes.

Fay Gordon: Okay great perfect.

Lauren Solkowski: Okay. Well Fay thank you so much for your presentation. So at this time we will open it up for questions. Operator if you could please provide instructions for asking a question through the phone that would be great.

Coordinator: The phone lines are now open for questions. If you'd like to ask a question please press Star 1 and record your name. If you'd like to withdraw your question press Star 2. Thank you.

Lauren Solkowski: Okay thank you. So while we wait for questions to come in let me check in our chat. I'm not yet showing a question but we'll give it a minute or two. I know say - both Fay and Julie went through a lot of information there so I'll give everyone a minute to collect their thoughts. I think I just wanted to thank them both again in the meantime for providing, you know, you both provided a very comprehensive overview of conflict of interest as related to Julie had mentioned the various home and community-based service programs and waivers and say the Medicaid managed care rule in terms of a choice counseling service.

So for anyone that joined the call late I just wanted to again mention that in addition to what we've heard today CMS is working on a frequently asked questions that we do expect to be released or in conflict of interest so hopefully that will be coming out soon and will offer additional guidance to states on this issue. Again I know - we know that this is something that does raise a lot of questions as organizations move into sort of these new roles and contracting with various organizations so is it something that hopefully we can get some more help on.

And actually let me see, I did have a question come in. So the question reads, "Do you have any insight as to why conflict of interest is such a big issue for CMS and Medicaid but not Medicare, for example vertical integration of account payor organizations, steering of consumers within a vertically integrated health system?"

Fay Gordon: So one just quick response to that is that I think that perhaps it's because Medicaid works in the long-term services and supports space in a way that Medicare is just starting to do with some of the dual-eligible demonstrations and other cases. But Medicaid really is the provider and the payor of long term services and supports. And so I think because so many community-based

organizations are the entities that coordinate and organize and contract with providers for those long term services and supports there's just been a more enhanced focus in that area. That's my interpretation but I certainly couldn't speak for CMS. I don't know Julie if you have other thoughts?

Julie Hamos: Yes. I was going to say the same thing and I think that's a good observation. I do want to point out that the caller used the word that we haven't used today yet that's very important, integrated. So the reason that I think these conflicts of interest roles have been somewhat criticized in some areas is because in some ways it goes against our goal of integrating healthcare delivery systems. And this - the conflict of interest rules seem to bifurcate or trifurcate processes that have worked pretty well before where the person is getting continuity of care from one trusted provider and this really does make it disjointed and breaks it up more so.

So that is a concern and in some ways it goes against that. And I think it's something to really protect against in providing the best possible service for these beneficiaries who are often the most frail and vulnerable people in our world. So despite the fact that we have these conflict of interest rules we're going to have to overcome that. But I think Fay's right that LTSS is really is more of a Medicaid program than Medicare.

Lauren Solkowski: Okay thank you so much. Let's see operator are there any questions coming on the phone?

Coordinator: I'm not showing any questions queue at this time.

Lauren Solkowski: Okay thank you. Okay we'll give it another minute or so. And just again she mentioned or as a reminder if you do think of anything that comes up both Fay and Julie are happy to answer your questions. I can definitely forward

anything that comes up as you know once we hang up to them and get your question answered. Let's see, okay so I'm not showing - oh, yes we have another question coming. One second I'll pull it up.

Okay a couple of questions here. Okay so let's see Fay this is for you. It says, "On one of your first slides if I can go to you mentioned that a AAA had choice in services. In our state we contract with a single service provider so our participants do not have choice for Older Americans Act services. Am I looking at this wrong or is our state model unique?"

Fay Gordon: I have to say that that is an area that I'm not as experienced in. Those are the different AAA contracting models. I don't have a background in knowing, you know, if they don't generally just do a single service provider or multiple different providers. I would imagine it - the areas across states - and there's probably quite a few that just do a single service provider but there are others that have multiple contracts. So I apologize I might have to defer to the other speakers. I'm not as familiar with the contracting process.

Lauren Solkowski: Okay. Julie you have anything to add?

Julie Hamos: No not really, sorry.

Lauren Solkowski: Okay, no that's fine. Let's see another question, "Does the conflict of interest rule affect only organizations that are providing long term care action counseling? For example we are a private nonprofit providing evidence-based health promotion programs. It doesn't look like an issue unless contracting directly with a managed care organization. Is that..."

Julie Gordon: Well, you know, I think the question is not about whether you're a private organization, are you a Medicaid provider because these are really conflict of

interest rules as part of Medicaid's home and community-based services programs. So whether you're...

Lauren Solkowski: Okay.

Julie Hamos: If you're providing Medicaid services whether it's through a managed care organization or fee for service through the state then you would be subject to these. If you're in the private commercial health plans space or not even billing health plans you're just somehow cobbling together dollars, precious dollars to provide the services or you're - or again in private health plans then you would not have these conflict of interest rules which is not to say that - but let me just make a qualification for that.

They would not be rules under federal guidance and federal requirements but the managed care health plan if you're billing health plans whether or not, you know, I don't know what services you provide. Maybe you're providing home care or some kind of a home-based care program if you're doing that privately and you're not billing health insurance at all then there may not be any rules that apply. But if you're building private health insurance those companies what we might call managed care companies they're health plans, might in fact bring over the same set of rules from Medicare to Medicaid to private plans.

There's a lot of crossover now and there's a lot of effort to really create some level of, you know, compatibility or uniformity across systems so that providers don't feel like they're subject to different payer sources in terms of what the rules are. So it really depends on what your organization is offering and who's paying the bills.

Fay Gordon: And for the new Medicaid managed care regulations the clarification and the restriction is really just trying to providing choice counseling that has also potentially been - potentially has a financial relationship with a managed care organization. So if you're not providing choice counseling for Medicaid managed care plan so again if you're a CHIP that's just doing it for Medicare plans for example this is just for Medicaid managed care plan choice counseling so it would be limited to that area.

Lauren Solkowski: Oh great, thank you for that. And I'll check back operator any questions on the phone?

Coordinator: Yes there is one question in the phone queue from (Janet). Your line is now open.

(Janet): Thank you. So we have been doing the choice counseling the eligibility assessments as well as service provision in our state for about 15 years with managed care organizations with one entity doing that eligibility and service provision. And so it's a pretty significant change to look at how that could be done differently.

And I guess we've always been thinking that because the service coordination or case management is not done in this state by that same entity while you may well be helping people make an informed decision about whether or not to enroll in a particular program you - those individuals really had no say in what a service plan looks like and whether or not any of those individual services their agency provides would be part of that service plan.

Can you talk at all about whether or not that meets any of the criteria that you believe, you know, as you've seen in the regulation for any of the firewalls

because they really don't have anything to do with what a service plan would look like?

Julie Hamos: So you're determining eligibility such as level of care?

(Janet): Right which determines eligibility so a functional assessment.

Julie Hamos: Functional assessment yes. And then if it goes to another entity to develop the service plan based on that?

(Janet): That's correct.

Julie Hamos: And then a service plan is developed and it's you provide some of the direct services there for which a person qualifies?

(Janet): That's correct.

Julie Hamos: Yes see I think that there are ways to - I mean I think that that's not a direct conflict. And I think that there are ways to show that you don't have that conflict but you're going to have some scrutiny for making sure that your state understands that.

(Janet): Sure, understood.

Julie Hamos: But I think that because there is another entity there that make some of the key decisions and again there are protections to build in to make sure that the participant has a full range of options, that they can select another service provider beside yours and there's is no opportunity for steering, that is person centered care. I mean those are just the protections the need to be built into

make sure that and you qualify and that you're not certainly violating any of the rules here. So I think...

(Janet): Right.

Julie Hamos: ...that's the important thing is to recognize that there are these rules. But they don't - they really don't say that one entity cannot perform more than one function as long as you recognize what some of the concerns are and what some of the mitigating issues are.

(Janet): Thank you.

Lauren Solkowski: Okay thank you so much. Operator any other questions on the phone?

Coordinator: I'm showing no further questions at this time.

Lauren Solkowski: Okay thanks again. I haven't had any other questions come in on the chat. So we've had some time so I think at this point we can wrap up. And I just wanted to thank our presenters again. I'm - as I mention the slides will be posted. They have their contact information on the slides. You're welcome to reach out to either Fay or to Julie or to myself for follow-up questions. And again thanks to Fay and Julie for presenting with us today. This has been extremely helpful.

Let's see do I have any other last items? I don't think so. So with that I think we'll conclude. Happy Friday everyone. I hope everyone enjoys their weekend and thank you again for joining us.

Julie Hamos: Thank you.

Fay Gordon: Thank you so much. Have a good weekend Julie.

Julie Hamos: Bye.

Fay Gordon: Thank you.

Lauren Solkowski: Thank you.

Coordinator: This concludes today's call. Thank you for your participation. You may disconnect at this time.

END