

# Conflict of Interest Workgroup – Meeting #1

3:00 – 5:00 PM  
July 10, 2023

## Meeting Attendance

Organization	Representatives
WSU CEI	Carri McMahan
N/A	Judy Stengel
Cottonwood CDDO	Lynette Goldizen
N/A	Linda Misasi
Choices Network	Andrea Swenson
JOCO CDDO	Monica Pfannes
Cowley County CDDO	Susan Slothower-Gober
KDADS	Paula Morgan
Sunflower Diversified Services	Tina Harkness
Johnson County Developmental Services	Sarah Vallandingham
KUCDD	Sean Swindler
Goodwill Industries	Genelle Neal
Sunflower MCO	Stephanie Rasmussen
N/A	Kathy Brennon

## Welcome/Introduction

Agreements Suggested:

The group added the following to the suggested agreements:

- Every question is a good question.
- Listen with intent to understand each other's ideas & opinions.

## Workgroup Background

Paula & Carri shared information about the workgroup background and formation process.

Questions from the workgroup:

- These requirements aren't new, why are workgroups being formed now?
  - In the IDD renewal, CMS is looking at who is doing assessments and compliance with the Final Rule. Kansas has to ensure we have addressed conflict of interest. CMS language is clear about what has to be addressed and KDADS needs to do more to meet the requirements. CMS is asking more pointed questions.

## Purpose & Resources

Paula & Carri shared information about this specific group's purpose and the resources provided and reviewed the regulation language together.

Questions from the workgroup:

- What do you mean by assessment – is that program eligibility assessment and/or functional assessment?
  - Specifically functional assessment, but conflict of interest requirements apply to both.
- What constitutes a “state agency”?
  - KDHE as the State Medicaid Agency, and KDADS as the delegate.
- Does the regulation prohibit delegation beyond KDADS?
  - Unsure, Paula will seek guidance.
- What constitutes separation of a provider of HCBS, Targeted Case Management? For example, if they share the same board are they separate?
  - One example is a provider of day services and Targeted Case Management.
  - Unsure about shared board, need to get clarification from CMS.
- What is the scope of ‘who’ KDADS can delegate to?
  - The group can make recommendations about who these tasks can be delegated to.
  - F/U to last question: justification may need to be made to and negotiated with CMS
- In Kansas, MCO makes the person centered service plan, TCM creates the person centered support plan. What is CMS’ definition of the person centered service plan?
  - Carri will find the CMS definition of person centered service plan & TCM activities for the group to review.
- A change may be needed to allow TCMs to bill for the full range of TCM services.
- Will addressing conflict of interest require a statutory change? For example, statute states that CDDOs are designated by the County.
- Do counties count as government agencies for this purpose?
  - Believe this is state only, Paula will follow up and report back

Paula shared that at it's most basic CMS says that conflict exists if a CDDO is part of a service provider, if the CDDO is separate there isn't a conflict.

- (comment) TCM & residential being provided by the same provider has always felt like a conflict to workgroup member.
- ADRC's complete assessments for other Waivers, are they considered to have a conflict?
  - No because they don't provide TCM or HCBS services, they're a little different than CDDO.

## Discussion

The group spent the bulk of their meeting asking clarifying questions. They discussed how other Waiver do or may not have addressed this through using ADRCs for eligibility and assessment, it was unclear whether ADRCs as county entities are considered state agencies by CMS.

The group also discussed how other states have addressed conflict of interest in eligibility and assessment. In Missouri & South Dakota- their state's equivalent of KDADS completes assessments. In Iowa the State does assessments and the TCM completes the person centered service plan.

## Wrap Up

Things to do prior to the next meeting:

- Paula will seek clarification related to what counts as a state agency (specifically whether the state can delegate assessment and eligibility to county agencies) & whether the assessing organization has to be the state.
- Paula will seek clarification related to what constitutes separation of entities/providers, for example a shared board.
- Carri will find and share the CMS definition of person centered service plan.
- All members are encouraged to review resource materials ahead of the next meeting, especially the CMS PowerPoints.

Next meeting:

- Carri will send a Doodle Poll to help find a date for the next meeting.
- Agenda will include reviewing CMS person centered service plan definition together.

## Conflict of Interest Workgroup

Time: 10:00 a.m. – 12:00 p.m.

Date: 7/25/23

### Meeting Attendance

Organization	Representatives
WSU	Carri McMahon, Lisa Jones
KDADS	Paula Morgan
N/A	Andrea Swenson
Sunflower Diversified Services	Kristina Harkness
Goodwill Industries	Genelle Neal
JCDS	Sarah Vallandingham
JOCO CDDO	Monica Pfannes
Cottonwood CDDO	Lynette Goldizen
N/A	Sean Swindler
Sunflower	Stephanie Rasmussen
N/A	Linda Misasi
N/A	Judy Stengel
Cowley County CDDO	Susan Slothower-Gober
DRC	Rocky Nichols

### Welcome/Introduction

#### Purpose & Resources

Carri reminded the group of the resource documents available. Paula shared responses to the questions from meeting #1.

Two outstanding questions:

1. Definition of government agency (CMS)
  - a. Leadership: Government agency means any government: entity, state, county or local.
  
2. How to define Person Centered Service Plan?
  - a. Any plan that provides services and needs of the individual. (TCM does play a role in service planning.) Clarification on TCM role in person-centered plan. Support plan and service plan have duplications.

Group Feedback:

Families duplicating efforts when TCMs and MCOs don't work well together. Persons served time is not being respected by our process. Have more definition. What each plan does FOR the person served.

Better standardization – having a collaborative between entities with regular training, expectations, etc. To have state-wide. (And make sure TCMs are paid in addition to MCO CCs)

## **Discussion**

The group reviewed CMS' 2018 presentation about Conflict of Interest, then used their suggested Structural and Functional Review questions for discussion.

### **Feedback from presentation from CMS:**

Possible solutions: Having complete separation. Independent case managers. CDDOs independent of providers. (Cowley as a model) No shared board, fundraising, governance, etc. And a legal separation of entities.

What about rural areas where that may not be an option? (Regarding above)

Consider potential emotional impacts to the persons-served of the conflicts of interest. Trying to manage from the outside the internal politics.

Reimbursement rates should be higher, have a transition plan to make sure they still want to work in the field. Zero conflict can work, but if the rates aren't enough to cover over-head, there will be a loss of staffing. Making sure TCMs are being paid for trainings, meetings, etc.

Have multiple options, while still mitigating conflict of interest

## **Functional review**

What are case manager and direct service provider responsibilities? (11:37)

Four things TCM can bill for – where they cannot provide service. Oversight to existing services, QA and monitoring. CM – role in support plan development. Sometimes the BSP are done by a provider – humans rights committee oversees both, without

TCM Keeps team together. Advocacy.

Do providers develop the person-centered plan?

TCMs write the plan sometimes with significant input from providers.

Writing behavior support plans are not always understood and can become disrespectful of the person served. Professionals need to be involved. (Come back to this later)

MCO assigns the budget (POC). Needs assessment. Overlaps with person centered plan. TCM is more trusted relationship, versus MCO. Having to repeat hard information, especially to not as trusted entities. CM having central role, have MCO just do budget role.

What is the case manager role in establishing eligibility?

Crisis when person comes into system. Advocacy role for eligibility. TCM schedules meetings – sometimes CDDOs

Do case managers have a role in assigning budgets?

MCOs currently. TCMs role in future?

### **Structural review**

How are case management activities and direct services delivered presently?

Rural vs. urban – case management is conflicted.

Are case management activities and direct services delivered by the same entity to the same individuals?

Yes and no, depending on area. Ind. Case managers don't do direct support. However rural areas CM are in the system. It's almost impossible without entity financial support. Willing and qualified in rural areas vs. urban

Do case management providers/entities have an interest in a provider or are they employed by a provider?

Both. Individual and "conflicted" case management. 19, 4, 14, 3. Rural vs. urban, again.

How many agencies or organizations are affected?

From these discussions, the group brainstormed options for how to address CMS' requirement that TCM providers not also provide HCBS services.

Options for change:

- Making sure to preserve true choice by separating TCM fully.
- Separation. TCM sep. for day/res
- CO has one entity total across state for TCM
- Health home/Care management team (MO example)

Comment: Needs to be well thought out and not rushed. Realistic timeline and be able to afford overhead for separating. Not removing long time TCM without a choice, but also considering how it removes choice if someone cannot keep same TCM and HCBS service provider.

Completed a Zoom poll to see which of the four options to explore further. Moved forward two options – separation of services and not allow people to receive services from same provider. Two small workgroups formed to dig into these options and report back pro/cons of each at the next meeting.

### **Wrap Up**

The two small groups will meet between now and our next meeting to explore the options.

Carri will send out dates for our next option by Doodle poll.

# Conflict of Interest Workgroup – Meeting #3

Time: 3:00 p.m. – 5:00 p.m.

Date: 8/23/23

## Meeting Attendance

Organization	Representatives
WSU	Carri McMahon, Lisa Jones
KDADS	Paula Morgan
Advocate	Andrea Swenson
Provider Staff	Kristina Harkness, Genelle Neal, Sarah Vallandingham
CDDO Staff	Monica Pfannes, Lynette Goldizen, Susan Slothower-Gober
Person served/family member	Sean Swindler, Linda Misasi, Judy Stengel
MCO	Stephanie Rasmussen

## Welcome/Introduction

Agreements Suggested:

## Discussion

Small group meetings updates: Two small groups were formed at the last meeting, to explore the pros and cons around two models. Group 1 explored not allowing providers to provide case management and HCBS services to same member. Group 2 explored not allowing providers to provide both case management and services.

**Group 1** (Not allowing providers to provide case management and HCBS services to the same person): Priorities – maximize choice for people being served. How separate does the target case manager need to be from provider? How do processes look? Rural areas – how will that work? Mileage differential for places that have no TCM. If mitigation strategies (exceptions to have same provider) aren't an option? Fear that we will lose our TCMs. Who will step up to take care of? It is doable if the state will put forth the dollars. Concern: addressing quality issue within TCMs in areas with small provider network in the area. Emphasis on mileage to serve people effectively – has to be addressed. Marketing for IDD system: townhall meetings, timeline published, increased training for case managers and a rate increase, especially if they are separated. (Notes will be sent from Monica to Carri from group 1) Maintaining choice for their providers and case management. Not having choice list TCM or provider list in KS. Makes our IDD waiver special is having choice.

Last RFP: MCOs playing a role in mitigating COI. Doing extra checks with members to make sure they actually made the choices. Is there a process in place for same place TCM/provider – MCO could potentially play a role in the mitigation.

(Lots of support for separation of provider and TCM.) Conflicted TCMs are sometimes worse than no case manager at all. TCM that is on same team as provider on CAP explains why they might not have felt empowered to do what they need to do for the person served.

**Group 2** (Not allowing providers to provide both case management and HCBS services): Reimbursement should be higher and equitable for private TCM providers to hire/retain staff. Alternatives – TCMs with providers in same building – at minimum move TCMs out of building where they have a different director/board. Using technology to our advantage. Hiring someone in a rural area that the TCM provider doesn't live out of. Concerning of lack of processes in KS for TCM – not as much accountability. Could we have more? The state will need to give extensive guidelines. Not having TCM and provider in same chain of command. Trainings have to happen in order to make all of this work. And for TCMs to feel like they have support. Consistency of it is also crucial. Access to health insurance for TCMs. What is a way for the MCOs to provide a low-cost health insurance plan for them. We are worried about losing TCMs, but if that is our concern, what are we doing to keep them?

Rate study for waiver – include TCM – what it looks like with private vs. larger corp.

Chat comment: Let's also not forget the right to risk for people served. We can't 100% keep everyone from bad things. There will never be a good enough "PCSP" to avoid it 100%.

Some places do have empowerment of TCMs. It depends on person and organization. And culture of the organization. TCMs were discouraged from making reports before provider had a chance to look at it. (Huge COI). What are our expectations of TCMs, trainings – needs to be clear from state. How do we support people going through the process to keep TCM from feeling retaliation?

Chat comment: With the new rate of \$75/hour; the maximum benefit for a member would be 60 hours per year x \$75 = \$4,500. For a caseload of 30 persons, this is \$135,000 per year. I know not everyone uses the maximum but this is what it would be.

Very few use maximum, and the state is "stingy" on extra hours for those who need more than the 60 hours. Only 4 things that are billable – a lot of work within TCM is not billable.

MCOs have talked with state about going back to "encounter" monthly rate instead of what is/isn't billable.

At least a retainer amount – so TCM knows person on their case load is going to get them some revenue.

Chat comment: Great point...there are limits to what a CM can bill for and they struggle to "word" things in a manner that is billable or acceptable.

### **The rest of the group's discussion centered on barriers, questions, and guidance for KDADS.**

What would you tell KDADS they need to preserve about case management?

- Choice (broad group support for this)
- Make sure children with TCM don't get left behind+
  - o Need to consider TCM for children different from that of adults (specialization or additional training for Child TCM)
- TCM role in completing the PCSP and monitoring progress, helping the individual with referrals to waiver and non-waiver services, helping with social determinants needs, advocacy and role in adverse incidents and APS/CPS reports should all continue. Helping monitor the quality of services. Positive behavioral supports planning

Change/questions/options:

- Service monitoring – more frequent than quarterly; contact at least monthly; document choice of person to not receive monthly contact.
- Is CMS open to a transition where provider can't provide TCM & HCBS to the same person then change to full separation?
- Can people keep TCM/grandfather in if they acknowledge and accept possible conflict?
- Need to do pre-work to identify willing and capable providers
- Regardless of which direction they go – ask all TCM providers their intentions re: continuing to provide services
- What happens if providers close – back up plan.
- What happens if you don't have willing providers and then providers become available?

What would be the biggest **barriers** if the state pursued not allowing providers to provide TCM and HCBS services to the same person

- Provider capacity
- Timeline/process
  - o Addressing changing needs of individuals during the transition
  - o Solutions:
    - Everyone receiving case management needs to be brought in as soon as possible
- This option limits choice of providers

What would be the biggest barriers if the state pursued not allowing providers to provide both TCM and HCBS services

- Provider capacity – especially smaller areas
  - o Solutions:
    - Tap CILs and others to provide TCM services
    - Provide incentives to providing independent TCM services
- Reimbursement rate for TCM to make it financially sustainable
- Loss of benefits for TCMs
  - o Help provide options and incentives for TCM
- Loss of jobs for TCMs or transitioning to different roles
  - o Intentional and long transition timeline
- Start-up costs for independent TCMs & guidance, liability for providers.
  - o Provide guidance on start up, contracting with MCOs, handholding through processes
  - o Establish minimum requirements, best practices, templates for start up TCMs
- Ensuring & validating choice of person served

What should the state keep in mind re: transition process?

- The time needed for transition of services, new provider set up
- Provide tools for people wanting to start up a TCM provider – collaborative, panel discussion, video.
- Information to people served about transition – FAQ, how to choose a provider, etc., peer conversations
- Engage stakeholders and network for support
- Ensure that people understand they can choose

Advice for KDADS:

- Be sensitive to people who are transitioning and the impact
- Take lessons from 2012 when other systems lost TCM services
- Provide training on technology TCMs should be using
- For independent providers – software can be expensive – can the state/county help subsidize?
- Make decisions early about software that is going to be required (before people invest)
- May be helpful if the state has a statewide system for documentation – and technology is accessible/communicates across systems (reduce duplication of asking questions) – VR, MCO, TCM, other providers,

## **Wrap Up**

WSU & KDADS will send a poll to schedule the next meeting.

WSU will send out assessment/eligibility separation requirements and discussion questions ahead of next meeting.

# Conflict of Interest Workgroup – Meeting #4

Time: 2:00 p.m. – 4:00 p.m.

Date: 9/13/23

Organization	Representatives
WSU	Carri McMahon, Lisa Jones
KDADS	Paula Morgan
Advocate	
Provider Staff	Kristina Harkness, Genelle Neal, Sarah Vallandingham
CDDO Staff	Monica Pfannes, Lynette Goldizen
Person served/family member	Judy Stengel
MCO	Stephanie Rasmussen

## Discussion

The group reviewed and discussed the regulatory language around conflict of interest in Waiver eligibility and assessment, the language (pasted below) requires that these tasks be completed by the State Medicaid Agency (SMA) or delegated to another government agency with SMA oversight.:

- **42 CFR 431.10:** requires that the State Medicaid Agency (SMA) be responsible for eligibility determinations and eligibility determination can only be delegated to another governmental agency with SMA oversight.
- **42 CFR §435.217** special home and community-based services waiver eligibility group, waiver providers are not permitted to be the agencies that perform the level of care waiver eligibility evaluation. This can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA.

Following the review of the requirements, the group discussed that currently CDDOs complete these tasks and CDDO structures vary across the state. The group reviewed the structures used throughout the state and identified which of the models complies or meets the criteria for eligibility and level of care assessment.

For each structure, the group identified whether the structure is:

- **Compliant:** is not a provider and is a government agency
- **Noncompliant:** is an HCBS service provider
- **Doesn't meet criteria:** is not a government agency.

## Current CDDO Structures:

- County Government (compliant)

- Provider & CDDO (noncompliant)
- Stand Alone Entity (doesn't meet criteria)
- County Gov & Provider (noncompliant)
- County Subcontract (noncompliant)
- Subcontract (noncompliant)

### **Discussion Questions:**

#### **What options are there to ensure Kansas meets regulations?**

- County Gov & Provider – separate departments
- Incorporate ADRC & CDDO
- County regions to complete assessment
- State agency – in a regional office (Missouri)
- State require CDDOs to meet assessment/eligibility requirement in order to contract and CDDOs respond with how they will comply.
- California has quasigovernmental regional offices that do eligibility/assessment

#### **What should KDADS keep in mind when choosing a model?**

- Some areas comply already
- Don't lose sight of county investment in these services (county mill)

**Discussion of Models:** Based on their discussion, the group preferred the option of the State requiring CDDOs to meet the assessment/eligibility requirement in order to contract and CDDOs respond with how they will comply. They discussed this option more in depth:

#### **What should the transition process look like?**

- Extended transition period
- Offer ideas for what could work, structure examples
- Clear guidance on what is / isn't allowed
- Educational sessions on compliance, boundaries, example structures
- Funding for transition, establishing entities
- Review DDRA to ensure there's no conflict with the plans, look at other changes that may be able to be made with a statewide lens (affiliate agreement honored across CDDO areas vs. individual agreement in each CDDO)
- How MFEI transition impacts level of care assessment transition -

#### **What are the barriers KDADS is likely to see in transition?**

- Clarification of who sets boundaries for/designates CDDOs
- If there's no willing/able/qualified entity to complete

- Implications to State budget/who at state would complete eligibility & level of care assessment.
- Lack of knowledge of what solutions could be
- Unsure what the timeline is for transitioning.
- Comfortability/trust concerns from persons served & families (potentially going from local partnerships to a state or regional level partnership)
- Risk of loss of providers due to no longer sharing costs
- Learning curve for ADRCs

**What should KDADS keep in mind:**

- How long the current system has been in place, how ingrained it is in the IDD system, the potential harm if this is not done thoughtfully & carefully.
- Buildings, leases, contracts, shared space/staff/technology entities have and may need to terminate if they are no longer providing these services.

**Following discussing their preferred model, participants broke in two small groups to discuss two other models that had some support.**

**State agency – in a regional office (Missouri)**

- Problem with rural areas. Would be difficult for families or CDDO employees that may have to travel up to 2 hours just for eligibility/BASIS
- Costs associated – hiring of new employees, new facilities, infrastructure in general
- Loss of county funding
- State/regional feels more removed from a relationship standpoint. People are used to and more comfortable using local.
- Time – how long it would take to set this up – a big shift from where we are right now.

**Incorporate ADRC/CDDO:**

- County issues with funding – levies
- County might feel threatened when told how to spend money
- Risk of losing providers due to no longer cost-sharing
- Learning curve for ADRCs – more than just eligibility

**Questions from the group:**

- What if a county doesn't want to do the assessment?
  - Could be designated by the state
- What about areas that cover multiple areas?
- Would compliant counties have to change?

- Do ADRCs comply? Will the eligibility/assessment process have to change for other Waivers?

**Possible recommendation:**

- Preserve compliant areas.
- Combining CDDOs to create new entity. (Allowing each geographical area to decide what is best for them based on population, availability of services/providers, etc.)

Another option that surfaced late in the conversation was to retain CDDOs to complete tasks unrelated to eligibility and functional assessment and have state or local government staff complete eligibility & functional assessment. This may present an opportunity to co-locate CDDO and eligibility/assessment staff. There wasn't time to discuss this option further.

**Next steps:** WSU & KDADS will review progress so far, regarding where we are at as far as having the conversations (suggestions, models, concerns, etc.) needed from this group. That will help determine if another meeting is needed and what will need to be discussed. Be on the lookout for meeting time polls, invites or communication around if we need another meeting.