

Idaho Division of Medicaid

Comments for Idaho's Proposal to Integrate Care for Dual Eligibles Sent to CMS

2012

Developing a managed care program for dual eligible participants is a statewide effort of Medicaid staff, providers, community partners and agencies, participants and families.

Idaho Medicaid held a statewide meeting of these stakeholders to gather specific recommendations and priorities on October 26th, 2011. Over 50 people participated in the meeting, which was held at the Boise Medicaid state office and video-conferenced to six other sites throughout the state.

Following this, Idaho Medicaid hosted a second videoconference on April 17, 2012 to review Idaho's draft proposal and collect feedback from stakeholders. From the feedback of the first two meetings, Idaho Medicaid developed and refined the draft proposal and encouraged stakeholders to submit their comments by mid-May, 2012.

Eight additional comments /e-mails and one checklist were sent directly to CMS, and that correspondence is contained in this document.

Idaho's Draft Proposal to Integrate Care for Dual Eligibles Comments sent to CMS

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COMMISSION FOR CASE MANAGER CERTIFICATION (CCMC) POSITION REGARDING CMS-STATE DUAL ELIGIBLE DEMONSTRATION PROPOSALS

The Commission for Case Manager Certification ("the Commission") is pleased to offer its recommendations for coordinating health care services provided to dual eligible individuals. Since 1992, the Commission has led efforts to elevate the practice of case management to better manage health care for patients with complex care needs. We are the foremost nationally-accredited organization offering licensed professionals the opportunity to be board certified as case managers.

Recommendation

We recommend that board certified case managers lead care coordination teams and case management teams for dual eligible individuals.

We recommend that all non-licensed case managers working on the care coordination team be trained in an appropriate manner for the patient population being served.

Rationale

The Commission urges States and the Centers for Medicare and Medicaid Services (CMS) to adopt these requirements for case managers as part of the CMS-State dual eligible financial alignment demonstrations.

Board certified case managers are licensed professionals who have demonstrated that they have met the highest standards for their profession.

Board certified case managers must pass a rigorous examination, hold a current licensure or certification in a health or human services discipline, and possess professional experience in case management.

Board certified case managers are uniquely qualified to lead care coordination teams that will be responsible for designing care plans, performing assessments, monitoring patient progress, and tracking patient outcomes for dual eligibles.

Given workforce shortages and an expected increase in demand for case management and care coordination services, the Commission recognizes that individuals with different backgrounds will serve on case management and care coordination teams.

The Commission has over 30,000 case managers that are currently board certified by CCMC. Other organizations also provide certification programs for case managers. In some instances, case managers will hold a professional licensure in fields such as nursing or social work, but may not be board certified. Other individuals may have unique education and experiences in care coordination or case management, but may not be licensed professionals.

Regardless of their background, individuals serving on care coordination teams must have access to appropriate training to ensure they can meet the complex needs of vulnerable dual eligible individuals. Such training would include opportunities to become licensed and board certified.



Ms. Melanie Bella Director of the Medicare-Medicaid Coordination Office Center for Medicare and Medicaid Services 7500 Security Boulevard, Baltimore, MD 21244

Dear Ms. Bella,

We are organizations representing stakeholders who depend upon Medicare and Medicaid for healthcare services. Our members are patients, seniors, veterans, caregivers, family members and professionals who work to serve them. We are writing to express our urgent concern over proposed changes which will affect the dual eligible population.

Dual eligibles, individuals who fully qualify for both Medicare and Medicaid services, are among the most vulnerable of our population. Approximately 9 million in number, this group encompasses the frailest, the poorest, the sickest and the costliest segments of the Medicare population. Moreover, dual eligibles face many other challenges in accessing care. They are more likely to be minorities, have disabilities, suffer from cognitive disabilities, be socially isolated, have educational disadvantage, or live in rural areas where care providers are scarcer. Consequently, any discontinuity in the process through which these individuals receive care, or which diminishes the safeguards that protect them, is particularly burdensome and carries with it the potential for disruptions which could have serious consequences for their health and stability.

The Centers for Medicare and Medicaid Services (CMS) has recently published guidance for the implementation of new programs affecting the dual population. They allow states to automatically enroll these beneficiaries into a variety of newly created, state-run managed care programs. One goal of this initiative is to improve care coordination for this population. All who work with this population support that goal. In addition, we are relieved to hear that CMS has promised that the critical patient protections provided in Part D prescription drug coverage will be extended to state-run programs.

However, we remain deeply concerned about other aspects of these new programs and their potential to adversely affect this at-risk population. These issues include:

- 1) The loss of Medicare protections Some states have proposed to substitute their state Medicaid formularies for Part D plan formularies meeting Medicare's extensive requirements. These states are seeking to have important provisions of Part D standards waived, in contrast to CMS guidance.
- 2) Passive enrollment /continuity of care Some states are planning to passively enroll beneficiaries into a managed care plan, giving beneficiaries no other plan in their area from which to choose. Removing dual eligibles from their current health and prescription drug plans could cause disruption particularly if they have established provider relationships or their new drug plan has a different formulary. Moreover, even

- though an opt-out exists, it would require that this group to navigate an appeals process. This can be particularly problematic for dual eligibles.
- 3) Access to care State budgets are already severely constrained. It is essential that the focus remain on achieving savings through better coordinated care and not be centered upon techniques which historically have been used to restrain spending such as cuts to providers, or limits on the number of prescriptions filled per month. Access to existing providers, specialty care, and other needed health services are critical to this special needs population.
- 4) Oversight Dozens of states have said that they intend to develop managed care programs for the dual population. Given the number of plans and their diversity, CMS will face a complex task in monitoring them for quality. Moreover, many state Medicaid programs do not have extensive experience in working with the needs of dual eligibles as the majority of their service population has been children and families. All issues regarding the sharing of essential information between the states and CMS should be resolved before plan implementation.
- 5) Equity One of the hallmarks of the Medicare system has been its universality. This principle is forever changed by transferring responsibility for Medicare beneficiaries to the individual states. Such an approach opens the door to different standards for these lowest income beneficiaries—potentially leading to lower provider payment rates and reduced access to care on the basis of income.

We ask that these issues and the risks they raise be fully addressed and resolved before the dual eligible population is subjected to disruption in their health care coverage.

Signed

RetireSafe
The Men's Health Network
National Grange
American Autoimmune Related Diseases Association
Veterans Health Council
National Council for Community Behavioral Healthcare
Mental Health America National
Psoriasis Foundation National
Alliance on Mental Illness Women
Against Prostate Cancer



April 25, 2012

Richard J. Gilfillan, M.D. Acting Director Center for Medicare and Medicaid Innovation Centers for Medicare & Medicaid Services 7500 Security Boulevard Baltimore, MD 21244

Dear Dr. Gilfillan:

The National Minority Quality Forum, and the co-signing organizations listed below, are writing to join with other concerned citizens groups to express our apprehensions about the proposed changes to the manner in which benefits for some Medicare enrollees are financed and provided. Our specific reference is to the state-based demonstrations of financial models to integrate care for Medicare and Medicaid dually eligible enrollees. We are aware of, and share, the concerns that have been communicated to you by patient advocacy groups and other organizations, but our issue with these demonstration projects is more fundamental.

According to CMS data, there are approximately 9 million dual eligibles. They encompass some of the poorest, the sickest and the costliest segments of the Medicare population. Moreover, dual eligibles face many other challenges in accessing care. They are more likely to be minorities, have disabilities, suffer from mental conditions, have educational disadvantage, or live in rural areas where care providers are more scarce.

As others, we are concerned that these demonstration projects could:

- Cause disruptions to continuity of care and the resulting risk for poor or compromised outcomes of the care, and thus increased financial risk for the system;
- Compromise access to essential health and medical services;
- Create a third-class of beneficiary that will no longer have the protections associated with the Medicare social insurance safety net;
- Lead to the abrogation of the rights of these dual eligible, who will be massenrolled into programs that are economic experiments at best, and low-income healthcare gulags at the worst; and
- Employ metrics to measure the failure or success of these demonstrations that prioritize economic efficiencies over quality of care and outcomes of care.

We have a more fundamental concern, however. We have been watching with everincreasing dismay the endless promulgation of regulations, rule-making, and



April 25, 2012 Letter to Richard J. Gilfillan, M.D. Page 2

implementation of demonstration projects which threaten to overwhelm our healthcare market. The proposed demonstration projects that this letter references are just another example of a CMS-sponsored activity that is not driven by or responsive to beneficiary demand, but is based on what, in our view, is a complete misread of how the Medicare and Medicaid programs can provide real value to the American people in shaping our future.

This avalanche of regulations and demonstration projects seems to be emanating from the idea that consumer demand for healthcare in general, and in the Medicare and Medicaid programs more specifically, will necessarily have undesirable consequences. To thwart these rising consumer expectations, there is a belief that government intervention is needed to suppress them by instituting price controls, shifting costs to beneficiaries, reducing the availability of new therapies while promoting older, less expensive treatments, and micro-regulating the practice of medicine.

Government should not be alarmed by a rise in consumer demand for healthcare. The American population is both aging and becoming more ethnically diverse. For each group there will be increased demand for quality healthcare. Rather than an undesirable factor, this is the type of consumer demand that can power our economy, ushering in a new era of American prosperity — an age in which we have a healthier, more productive, and more competitive workforce and business sector. Historically our economy has thrived on this kind of market opportunity. Government should play an active role in encouraging it to build capacity for the emerging healthcare market.

We look forward to discussing these issues with you.

Sincerely,

Gary A. Puckrein, PhD President and CEO

Co-signers:

Mervyn M. Dymally, PhD, President, Central Neighborhood Health Foundation Bambi W. Gaddist, DrPH, Executive Director, South Carolina HIV/AIDS Council Loretta Jones, Founder & Executive Director, Healthy African American Families, Phase II Randall Maxey, MD, PhD, Executive Director, Community Life Improvement Program Curren D. Price, Jr., JD, State Senator (District 26), California State Assembly Aubry Stone, President/CEO, California Black Chamber of Commerce Andre Williams, Executive Director/CEO, Association of Black Cardiologists, Inc.



June 21, 2012

Marilyn Tavenner Administrator Centers for Medicare and Medicaid Services 7500 Security Blvd. Baltimore, MD 21244-1850

Via email

RE: CMS' State Demonstrations to Integrate Care for Dual Eligible Individuals

Dear Administrator Tavenner:

I am writing on behalf of the Alliance for Patient Access (AfPA), a national network of more than 400 physicians dedicated to ensuring the highest quality of care for our patients. The AfPA appreciates the Centers for Medicare and Medicaid Services seeking input from physician groups such as ours.

AfPA supports CMS's efforts to improve the care of dual eligible patients through demonstration projects aimed at developing new and improved delivery systems. Per CMS's direction, each participating State is required to design a demonstration proposal that describes how it would structure, implement, and monitor an integrated delivery system and payment model aimed at improving the quality, coordination, and cost-effectiveness of services for dual eligible individuals. AfPA lauds CSM for requiring that each proposal ensure that certain standards and conditions are met, including critical factors such as beneficiary protections, stakeholder engagement, and network adequacy among others.

As CMS makes determinations on each individual state proposal to implement Dual Eligible demonstration projects, the AfPA requests that you ensure all meet the following basic patient safety criteria:

- Auto-enrollment protections Plans that auto-enroll patients need to be carefully structured and closely monitored to ensure that the plan is meeting the needs of the individual patient:
 - o Existing patient-doctor relationships must be maintained.
 - Existing pharmaceutical and/or biologic therapies must be continued and guaranteed automatic approval in the case of ongoing therapy at the time of enrollment.
- Such plans must not have long lock-in requirements that prevent patients from making adjustments to their plan participation.

Alliance for Patient Access 700 12th Street NW, Suite 700 Washington, DC 20005 www.AllianceforPatientAcc ess.org

- Physician notification Plans must contain protections that ensure physician notification of treatment plan and medication substitutions. The patients most often affected by these demonstrations are those with the most complicated health issues who have personalized medical treatment plans and long-standing relationships with their doctors.
- Maintenance of current benefit levels Plans must ensure that patients do not lose the
 benefits that they are currently eligible for through Medicare and Medicare Part D and
 that providers are paid in accordance.
- Robust CMS Oversight CMS must ensure that the plans are not so small and so numerous as to prevent robust, consistent oversight and monitoring to ensure patient care quality. The scope of the proposed plans must be carefully monitored so that effective plans can be duplicated and ineffective plans can be undone or overhauled in a timely and cost-efficient manner.

We appreciate the consideration of our comments. Please do not hesitate to contact us if we can provide any additional information.

Sincerely,

Brian Kennedy

Director



June 28, 2012

VIA E-MAIL: ID-MedicareMedicaidCoordination@cms.hhs.gov

Re: Request for Comments Regarding the State of Idaho Department of Health and Human Services Proposal to the Center for Medicare & Medicaid Innovation for the State Demonstration to Integrate Care for Dually Eligible Individuals

To Whom **It** May Concern:

Windsor Health Group, a wholly owned subsidiary of Munich Health North America, provides coverage to over 150,000 Medicare Advantage and Medicare-Medicaid eligible individuals in twenty states through its wholly owned Sterling Life Insurance Company and Windsor Health Plan (WHP) subsidiaries. Windsor Health Group greatly appreciates the opportunity to provide comments regarding the proposal for an Integrated Medicare/Medicaid Model (the "IMMM") issued by the State of Idaho in May 2012.

Windsor Health Plan (WHP) is committed to its members and to ensuring they receive the best care possible. Currently WHP serves approximately 4,000 members in Idaho and is looking forward to serving more Idahoans with WHP's 2013HMO expansion. WHP believes that coordination between Medicare and Medicaid plans is in the best interest of its members, and is pursuing opportunities to participate in integration demonstrations whenever possible. WHP applauds Idaho for working with the Medicare-Medicaid Coordination Office to ensure the best possible coordination of Medicare-Medicaid Eligibles.

WHP understands the importance of scale when establishing a new program, however WHP believes by including all dual eligible beneficiaries throughout Idaho that CMS and Idaho will not be able to accurately measure the program's success. The Medicare Payment Advisory Commission (MedPAC) published a June 2012 "Report to the Congress: Medicare and the Healthcare Delivery System", in this report MedPAC writes:

If most or all dual-eligible beneficiaries in one state are emolled in the demonstration, there will not be a sufficient sample of comparable beneficiaries in FFS to be able to test whether the demonstrations improved quality of care and reduce Medicare and Medicaid spending relative to FFS. CMS may instead use a research methodology that compares beneficiaries emolled in a demonstration in one state with beneficiaries in FFS

in another state. However, it will be difficult to find a comparable population in another state because Medicaid benefits, eligibility, and provider payments differ from state to state. (Page 87)

WHP recommends that Idaho and CMS consider limiting the geographic area of the demonstration to one region of the state for the first year of the proposed IMMM. This will allow CMS and Idaho to accurately measure and ensure that beneficiary access to care and quality of care are improved as a result of the IMMM. Additionally, it will allow Idaho and selected MCOs to make certain that dual eligible beneficiaries, a vulnerable population, are being properly matched to care management plans that will best meet their individual needs.

Further, WHP does not believe it is reasonable to require MCOs to serve the entire state. WHP suggests that Idaho split the state into regions, at least two, and allow MCOs to serve only one of the state's geographical regions, instead of the entire state. The proposal as written will limit Medicare Advantage Plans' ability to participate in the proposed IMMM and force beneficiaries, who are satisfied with their Medicare Advantage Plan to select a new, unfamiliar MCO if they wish to participate in the proposed IMMM.

Windsor Health Group sincerely appreciates the opportunity to offer comments on the proposal for an Integrated Medicare/Medicaid Model issued by the State of Idaho. We thank you for your consideration of these comments, and look forward to future guidance from Idaho and CMS. Additionally, we look forward to future discussions with Idaho leadership and CMS concerning the proposed IMMM and any other related matters.

Sincerely,

Christopher P. Surrell

Senior Vice President, Strategy & Development

2mles

Windsor Health Group

cc: Hassan Rifaat, M.D., President

Windsor Health Plan

Michael A. Muchnicki, Chief Executive Officer

Windsor Health Group

My name is Jason McKinley and I am the owner and Administrator of Seubert's Quality Home Care an Idaho Home Care Company providing home care services to Idaho Medicaid recipients since 1988.

My strong suggestions regarding Idaho current proposal to CMS include:

- Provider inclusion: Idaho must include a provision that at a minimum requires Managed Care to accept long-standing providers (10 years perhaps) into the Managed Care Program. It is unconscionable to think that a provider such as my agency could become an excluded provider from Idaho's Managed Care Program. My agency has been providing exceptional in home care services to Idaho's Medicaid recipients since 1988. (Idaho's current plan would allow Managed Care to decide who they will and will not work with as providers and this is unacceptable).
- Provider Reimbursement: Idaho has the lowest reimbursement rate for in home care services of any of its contiguous states. Idaho's plan freezes rates for 3 additional years (2014-2017). This means home care providers will be working with significant rate cuts taking overall reimbursement levels back to before 2008 and in some cases to the 1990's.
- Affordable Care Act Mandate: Idaho cannot ignore that the Affordable Care mandate requiring employers to insure their employees or face hefty fines. With our low reimbursement levels we cannot afford to pay for the health insurance nor can we afford to pay for the fines. The cost of this health insurance mandate will devastate the home and community based service industry in Idaho. Our reimbursement rate must go up substantially to make this work.
- Provider Requirements: Idaho cannot allow Managed Care to place new burdensome requirements on providers in order to participate in the manage care program. If we are good enough for Idaho Medicaid and CMS we should be good enough for Managed Care. Providers legitimately fear that managed care will not understand the "Capacity" of Idaho Providers to comply with new and likely unrealistic and over burdensome requirements.
- ➡ <u>Timely Reimbursement:</u> Small home care providers bill weekly and get paid weekly in Idaho. This timely reimbursement system must continue under managed care or we will have dire financial issues for providers. Insurance companies are known for payment delays of 30 days or more. Idaho Home Care Providers do not have the financial means to go 30 days without getting paid.
- Short Time line: Idaho Plans to sign contracts and have managed care entities in place in June of 2013 and then up and running by January 1, 2014. Idaho is looking at creating a disaster here. 6 months to figure out providers, billing and reimbursement, participant assessments, management of services, transitioning from state employees to private industry and all of the other components of this massive shift in how our services are provided and managed cannot be done in 6 months.
- The one critical element Idaho has said it will require of Managed Care is that Managed Care must pay providers at least what Medicaid will pay for the same service.

I would strongly recommend CMS tell Idaho to slow down....go back and have more meaningful discussion with providers and consumers and stakeholders and build a plan that is wider support of all interested parties.

Thank you,

Jason McKinley

Jason McKinley Administrator Seubert's Quality Home Care 208.743.1818 www.seubertsqualityhomecare.com

Bill Benkula - Stakeholder

I have reviewed the Idaho proposal and have the following comments to submit.

According to CMS Overview, "the programs will be evaluated as to their ability to improve quality and reduce costs." The second global criteria imposed by CMS was that Meaningful engagement with stakeholder.....".

I will focus my comments on how this proposal does not appear to be able to achieve the above goals and finish with where I believe meaningful engagement with stakeholders has not occurred. It is important to note that my comments are geared directly to the population of individuals that face a challenge of a Developmental Disability.

EVALUATION TO IMPROVE QUALITY AND REDUCE COSTS

In Idaho's Executive summary Idaho contends that Idaho's participation in this project reflects a desire to improve the quality and cost effectiveness of carte for this vulnerable population. The objectives to meet this goal are outlined below.

Objective one enter into contract that require the health plans to ensure that all necessary Medicaid and Medicare services (list of services) are provided, coordinated and managed. Out of the 17,735 individuals listed as duel eligible. Approximately 1300 of these people receive long term supports to allow them to live in community as a result of having a Developmental Disability.

Individuals who utilize services as a result of a Developmental Disability and are not institutionalized, in the State of Idaho, have multiple layers of managed care already in place. All individuals with a Developmental Disability must have a Healthy Connection physician. He must approved and order services such as Speech, O.T. and Physical therapy. He also orders Developmental and HCBS Waiver Services (Layer 1) there is an Independent Assessment done on each individual and reviewed annually utilizing a tool call the SIB-R by an organization that is a designee of the Department of Health and Welfare. Out of this assessment a budget is developed, the budget is give to the Person Centered Planning team to identify what the person's needs are going to be for the upcoming year (Layer 2). One of the people at the PCP meeting is a person called the Plan Developer. Her job is to do everything in her power to meet the individual needs of the person within that budget (Layer 3). the Plan developer is not allowed to provide and direct services. The Plan is then sent to department of Health and Welfare employees for final approval (Layer 4). If the needs are higher than the budget allows for, them a rigorous review process is followed to justify the additional dollars needed prior to approval (Layer 5). Idaho gives one example of how this system could assist someone in institutional settings reduces costs and improve quality of life if they moved into a community setting. While that may be the case, there are already systems in place to assure that this occurs on a regular basis. During surveys of ICF/ID, Nursing Facilities, and Assisted Living Facilities by the Idaho Bureau of Licensing and Certification, Level of care assessments are done annually. It should be noted that on table B page 9 of the state's proposal demographics are not identified for the individuals receiving come and community based services currently.

HCBS waiver providers nor Developmental Disabilities agencies are identified on page 10 of the proposal as Available medical and supportive service providers. it appears very little though has been put into the current Home and Community Based service system and how it would interact with the managed care system as proposed. On page 11 of the Idaho proposal the state has designed the system whereby the care management team will at a minimum consist of the participant, a care coordinator, and a primary care physician. Additional team members will be added as needed. We have been working under the Healthy Connections system for a decade or more. In all of that time the primary physician have never fully understood the services and supports available for people receiving community based supports. Why

would it be any different under this system. In addition to the 5 levels of care management already in place for this population, Idaho now proposes to add another in the form of a care coordinator. There is no mention of any of the other systems going away with the exception of the Healthy Connections Physician, and he is being replaced by a primary care physician, therefore I can only assume that the Care coordinator is layer 7 of our managed care system in Idaho for people with Developmental disabilities. Idaho lays out what the care team must do at the bottom of page 11 of their proposal. It is no different than what already occurs in HCBS waiver or Certified waiver Homes currently. On page 19 and 20 of the proposal is a list of the requirements for the contractor. Nowhere is they criteria that the contractor has to meet with regards to long term care and supports. The requirements focus entirely on medical care. Very little thought and input from advocates, service providers or participants have been given to people with Developmental Disabilities outside of institutional settings.

Meaningful engagement of key stakeholders have not occurred. Attachment two lists all of the meetings the state of Idaho has had with key stakeholders regarding this proposal. While the department met with the statewide association for institutional settings such as nursing homes, ICF/ID, assisted living facilities, and advocates for the aged such as AARP and the Idaho Commission on Aging, there have been no discussion with Disability Rights Idaho, the Council of Disabilities, LInc, or any of the community based services trade associations.

While I understand the desire to assure dollars spent in the Medicaid and Medicare programs are spent wisely, long term supports for people with Developmental disabilities has never fit well within the medical model. There are not preventative measures that can be taken to reduce or manage the support needs of a person with Mental Retardation. It is not like diabetes or heart disease. I see this proposal as written doing nothing to cut costs but rather shifting dollars away for direct care services to ineffective administrative costs. In the event that Idaho proposal is approved, I request that CMS require Idaho to care out the population designated as people with Developmental Disabilities until such time as Idaho has talked with those people being affected by this managed care pilot program. In conclusion there is another key stakeholder that appears to have been left out of the conversation entirely. I see no documentation that Idaho has met with it physicians, nor their trade organizations. Without their willingness to act as a health homes and the willingness that the become educated in the system of supports available, people will not be able to get their needs met and dollars will not be saved. Idaho is currently looking a re-designing their entire DD system. We, as a state would be better served if we carved these individuals out for the time being and fully explored the question. Can managed care result in lower costs for support services that are lifelong in nature or are we just adding a middleman and taking dollars away from the support staff that work so hard? Until that question is answered there is very little chance that the main goals of this demonstration project better care and reduced costs will remain unachievable with this population

New Initiatives – National Resource Center for Participant Directed Services – Dianne Kayala

Good Afternoon,

We reviewed the Financial Alignment Initiative Proposals to specifically look at three areas:

- 1. Will participant-directed long term services and supports be covered through a capitated arrangement?
 - a. If so, does the proposal identify how the state will assure the plans have the competency and skills to administer participant-directed service options?
 - b. What outcome measures will be collected to assure participant direction
- 2. Do the care planning/coordination strategies specifically reference or describe a person-centered approach?, and
- 3. Was there meaningful and comprehensive participant/advocacy engagement?

The Idaho proposal does not specify options for participant-direction, although appears to offer other home and community based services through a couple of approaches. We strongly recommend that Idaho consider expanding these options to include participant-direction.

Thank you for the opportunity to comment.

Best,
Dianne
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Checklist for Managed Care Organizations Implementing Participant-Directed Service Options

May 2012

INTRODUCTION

Participant direction is a service delivery system that has been growing in popularity over the last decade, and is currently available in at least one publicly-funded program in every state. As of November 2011, over 250 programs offer participant direction. In rigorous research of the Cash & Counseling program, a cutting edge participant direction program researched in 2007, members enrolled in participant direction proved to be more likely to have health needs met, to be more satisfied with life and have lower acute care costs than members using traditional services.

The essential premise of participant direction is that the member can choose who he/she hires to perform personal care services, including family and friends. The participant manages the workers and can terminate them if needed. Many programs also support participants in individual budgeting, i.e., managing and controlling how funds allocated to them are spent across approved services. The member's allocated fund amount is developed using an established methodology and should be roughly equivalent to what would be spent for personal care services in a traditional model. Once an amount is determined, the individual can decide how much to spend on each of his or her approved services within the budget.

Participant direction programs have supports in place to help participants direct and control their services. These include options counseling, to help participants get services and supports in place, and financial management services, to handle administrative duties and compliance, including paying workers and managing associated taxes.

The following checklist outlines the key infrastructure and components of a participant-directed program that should be in place prior to program inception. Many of these checklist items will be common sense to Managed Care Organization (MCO) providers, and may relate to existing policies and procedures already in place for other programs. In our experience, they are all important to assure compliance with legal requirements, and to facilitate the balance of participant control and risk mitigation. For MCO providers seeking more detailed guidance or support, contact us at info@participantdirection.org for further information.

PR	PROGRAM INFRASTRUCTURE				
Ite		In Place?	Notes		
1.	Procedures and protocols are in place to ensure the member maintains full control and decision-making capacity, especially in regard to workers				
2.	All information is provided in a range of formats to be accessible to individuals with a variety of disabilities				
3.	All members who may be eligible have the opportunity to make informed consent or refusal of the participant-directed option				
4.					
	a. Counseling supports: may include assessment, service planning support, training to self-direct, risk negotiation, or other supports				
	b. Financial management supports: operate in compliance with IRS, business, and employment regulations locally and nationally, supports for hiring workers and processing payroll				
5.	Self-direction support and MCO staff are trained in participant direction philosophy, components, and evidence-based advantages				
6.	A customer service system is in place that supports participants and any other authorized stakeholders to obtain information regarding participant direction in a timely manner				
7.	Program and member manuals are complete and include policies, procedures and reference materials for members and staff.				
8.	A designated staff holds overall responsibility that participant direction components operate in compliance with policies and assures continuous quality management				
9.	A system is in place to collect, analyze, and report process and outcome measures applicable to the goals of members that self-direct				

PR	PROGRAM COMPONENTS					
Ite	m	In Place?	Notes			
1.	The intake process meets the following criteria:					
	a. Allows for the informed choice of all members					
	b. Is goal-oriented, person-centered and comprehensive					
	 Includes written materials to describe policies, rights and responsibilities 					
	d. Includes an option to have a representative					
2.	The needs assessment process meets the following criteri	a:				
	a. Includes identification of barriers to meeting goals					
	b. Includes personal preferences for how tasks are performed					
	c. Includes assistive technology and addresses any home/community accessibility needs					
3.	There is an established methodology to determine each member's self-directed budget amount (if applicable) or number of authorized hours of employee services					
4.	Assistance with PD Service Planning features the following	g:				
	a. Reference materials and worksheets					
	b. Tools to help the participant identify potential workers and items to purchase for the plan (if applicable) including problem solving strategies to identify creative solutions to needs					
	c. Risk identification and mitigation policies in place					
	d. Emergency back-up plans are required of each member					
	e. Community resource guide/directory is available					
5.	Implementation of Participant-Directed plans feature the	following:				
	a. Curriculum and process for member training on how to be an effective employer is developed					
	 Assistance and written guidance (ex. Member Manual) is in place for employment paperwork flow, including time sheet submissions 					
	c. Process for purchase of non-employee goods and services (if applicable) is established					
	 d. Timelines and process for reassessments and changes to an established plan are in place, including identification of changes in a member's level of need 					