Integrated Care Resource Center

ICRC Study Hall Call: Participant Direction in Integrated Care Programs

July 29, 2014
3:00-4:00 PM Eastern

The Integrated Care Resource Center, an initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office, provides technical assistance for states coordinated by Mathematica Policy Research and the Center for Health Care Strategies.

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Agenda

I. Welcome, Introductions, and Roll Call

II. Integrated Care Models: How is Participant Direction Faring Nationally?

III. Participant Direction in Massachusetts' Fully Integrated Care Models

IV. Questions and Discussion

V. Concluding Remarks

Integrated Care Models
How is Participant Direction Faring?

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Participant Direction (also Known as Self-Direction and Consumer-Direction)

- Individuals control what services are provided, who provides services, when those services are provided, & how those services are provided – ***Employer Authority***
- May manage an individual budget used to purchase goods & services to increase independence – ***Budget Authority***
- Requires support services:
  - Information & Assistance
  - Financial Management Services

Prevalence Of PD

- Currently, 838,065 individuals PD
- Represents a 9% increase from 2010 to 2013
- Majority of programs have 1,000 to 5,000 participants
- Currently, 28 states have some form of managed care
- Most have adopted participant direction
- In 2013, almost 80,000 individuals participated in managed care and PD

Managed Care Entities (MCEs)

- Includes:
  - Managed Care Organizations (MCOs)
  - Health Maintenance Organizations (HMOs)
  - Primary Care Case Management (PCCM)
  - Pre-Paid Health Plan (PPHP)
  - For-profit or not-for-profit organizations
  - Capitated rate or fee-for-service arrangement

Selected Provisions from Integrated Care RFPs and Contracts: Participant Direction

- Funded by Integrated Care Resource Center
- ICRC – A TA project of CMS Medicare-Medicare Coordination Office and Coordinated by Mathematica and Center for Health Care Strategies (CHCS)
- Qualitative Case Study
- Twelve State Study of MCEs: AZ, FL, HA, KS, MA, MI, MN, NM, TN, TX, WA, & WI
- Medicare-Medicaid Coordination Office's Financial Alignment Initiative Memorandums of Understanding – CA, IL, MA, NY, OH, SC, VA, & WA

The Toolkit

- Purpose: Highlight considerations to develop RFPs, contracts between states and managed care entities (MCEs), and MOUs for Financial Alignment Initiative specific to PD
- Methodology – Examined:
  - Contracts between MCEs and State Medicaid Agencies
  - Policy and Procedures of the State and MCE
  - MOUs executed between State and CMS

Summary of MCE Findings

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Defining PD

- All provide assistance with Activities of Daily Living and Instrumental Activities of Daily Living.
- All include personal care, personal assistance services, respite, companion, homemaker and chore services.
- A few programs (AZ and TX) allow skilled services and/or therapies.

Service Coordination

- A key function to support PD.
- Generally, training provided by MCE staff
  - Many MCE solicit assistance from Aging and Disability Resource Centers; one subcontracts activity.
- A few States require verification that training has occurred.
- Service Coordinators introduce the PD option to members.
- In most cases, service coordinators continue to support those selecting the PD option on a continuous basis.

Training

- Participant
  - Orientation required – provided by the Service Coordinator.
  - A few went farther – how to be an employer and manage direct service workers.
  - TN added – how to:
    - be an employer
    - evaluate performance
    - identify and reporting fraud and abuse
- Direct Service Worker
  - Available in all programs; mandatory in half.
  - TN delegates training to the Financial Management Services contractor.

Financial Management Services (FMS)

- State requires MCE to provide in all programs.
- Typically, MCE subcontracts.
- Methods to secure:
  - State delegates authority to each MCE to select and execute a contract.
  - State requires all MCEs to use the State selected FMS.
  - FMS is secured through a contractual relationship between the State, the MCE and the FMS.

Individual Budgets

- Only four programs allowed for individual budgets.
- One omitted budget authority during transition from fee-for-service to managed care.
- Contracts specify goods and services that may be acquired or purchased.
- Methodology to calculate the budget's dollar amount is specified in contract.

Quality Assurance & Improvement

- All MCEs are required to submit a formal QA&I plans prior to implementation.
- PD is offered within the broader scope of the QA & I system.
- Some specific measures include:
  - Number of members electing PD
  - Survey of the member experience with the FMS
  - General satisfaction with the option
  - Clinical experiences
- Missing – Individual Outcomes.

Study Findings on Financial Alignment Initiative

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Financial Alignment Initiative State Review

- All programs offer PD as an option.
- Care coordinators must be trained in PD.
- Four programs specify the use of FMS.
- All states but one include as a core quality measure – "the % of care coordinators that have undergone State-based training for supporting self-direction under the demonstration."

Additional Requirements

- New York:
  - Percent of plan participants directing their own services through the PD option each demonstration year.
  - Plan to score: 1) education of PD individuals; 2) monitoring of education; 3) evaluation of PD services; and 4) monitoring/evaluation of % of members using option.
- South Carolina:
  - Plans must oversee PD by providing:
    - Incorporation of PD in care plans
    - Capacity to assess PD
    - Ability to interface with training provider
    - Ability to promptly pay attendants
- Virginia:
  - Plans must conduct training of FMS staff
  - Plans must report monthly on PD enrollee activity

NATIONAL RESOURCE CENTER *for*
PARTICIPANT-DIRECTED SERVICES

Selected Participant Direction Provisions from Medicaid Managed LTSS Programs and Financial Alignment Demonstrations

http://www.integratedcareresourcecenter.net/rfponlinetoolkit.aspx

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Participant Direction in Fully Integrated Care Models

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Senior Care Options (SCO)

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Program of All-inclusive Care for the Elderly (PACE)

Upham’s Corner Health Center

Why do we embrace participant direction?

- Philosophy
  - Honors individual autonomy/control
  - Grounds us in person-centered care
  - Cultural and linguistic competency
  - Allocates resources to households & families
  - Supports continuity in care
- Practicality
  - Workforce availability
  - Workforce flexibility
  - Market expectations

CCA SCO Background

- Massachusetts model for Dually Eligible and MassHealth only adults 65+
- FIDESNP & Medicaid MCO
- Started 2004
- 6000+ members statewide (33K+ total SCO members statewide)
- > 75% Community NHC
- ~1/3 members in Western MA
- High penetration of PCA

The Challenge

- How do we integrate participant direction into a fully-integrated, team-based model of managed care?
- Organization/Team
  - Responsible for comprehensive assessment
  - Responsible for developing individualized care plan w/ member input
  - **Accountable for fulfillment of care plan**
  - *Direct care is the key element in community-based long-term supports & services*

The Solution

- Create a hybrid that offers the best features of participant-directed and agency approaches to direct care

Hybrid Model

Self-Direction: Consumer Role/Responsibilities

- Identifies direct care worker(s)
- Informs and approves individualized care plan
- Retains control over hiring/firing
- Directs worker
- Elects/declines PCA training & education opportunities
- Elects/declines PCA communication w/ team

Agency: Team Role/Responsibilities

- Assess ability of consumer to direct care
- Provide support if needed
- Refer to outside agency for surrogate if needed (*surrogate pilot program*)
- Assess function/care needs
- Develop care plan with member
- Monitor implementation of care plan
- Complete Individualized Preference Plan (*IPP pilot program*)
- Offer training/education
- Offer communication w/ team

PACE Background

- 104 PACE Organizations nationally
- 31 States
- 32K+ participants
- Exclusively for NHC
- All-inclusive, Full risk
- PACE Center & Team
- 8 PACE Organizations in MA

PACE – Personal Care Services

Unique Features

- Prescriptive regulatory structure
- Personnel requirements
  - Health & safety screening
  - Criminal background check
  - Competency evaluation
  - Supervision
- PACE IDT
  - Assessment & care plans
  - Authorization

Upham's Corner Solutions

- *Self-selected* personal care option
- PACE hires personal care worker
- PACE assesses competencies
- PACE provides training, orientation, supervision
- Participant & team *co-direct* worker

Questions & Discussion

About ICRC

- Established by CMS to advance integrated care models for Medicare-Medicaid enrollees and other Medicaid beneficiaries with high costs and high needs
- ICRC provides technical assistance (TA) to states, coordinated by Mathematica Policy Research and the Center for Health Care Strategies
- Visit http://www.integratedcareresourcecenter.com to submit a TA request and/or download resources, including briefs and practical tools to help address implementation, design, and policy challenges
- Send additional questions to: integratedcareresourcecenter@cms.hhs.gov