Choice and Control – Putting Ohioans First

o4a Annual Conference

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National Trends

- Managed Care Entities (currently 30 states)
  - Negotiate a capitated rate (per member per month)
  - Integrated approach to services and supports
  - Over 25 offer self-direction under managed care
- Home and Community-Based Home Care Setting Rule – Not only in the community but engaged in the community
- Financial Alignment Demonstration (Dual Eligible) (Medicare/Medicaid) - Increase movement toward integrated service systems (13 states actively enrolling)
- Expectation for more choice and control and promotion of self-direction - (Section 2402(a) of the Affordable Care Act
- Using legislation to support self-direction (House Bill 64 in Ohio).

What are Self-Directed Services?

Long-term care services and supports that help people of all ages across all types of disabilities maintain their independence and determine for themselves what mix of services and supports work best for them.

Sometimes referred to as
"consumer-directed" or "participant-directed" services

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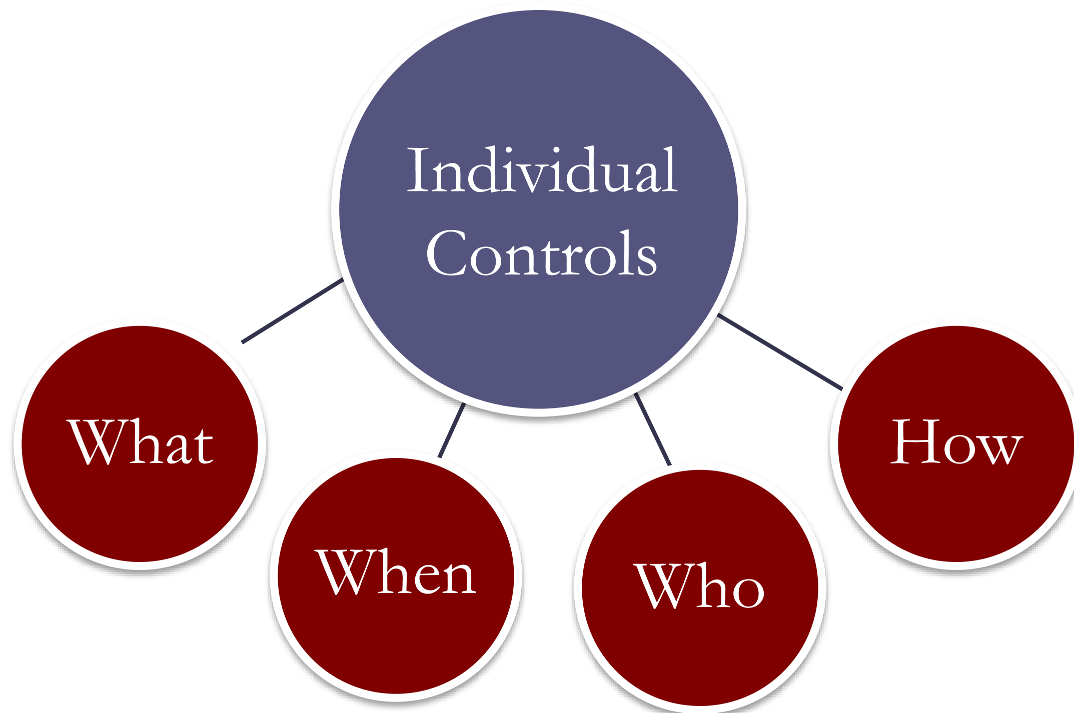
Defining Self-Direction



"Not doing things by yourself –but being in charge of how things are done."

Judith Heumann

McInnis-Dittrich, Simone, and Mahoney (April, 2006)

Self-directing participants were up to 90% more likely to be very satisfied with how they led their lives.

Caregivers of self-directing participants are very satisfied with overall care.

Participant direction does not increase incidence of fraud and abuse.

"Among a representative group of AARP members over the age of 50, **75% preferred managing services for themselves** over receiving care from an agency."

-AARP Public Policy Institute

Prevalence Of Self-Direction

- The National Inventory of Participant-Directed Programs was conducted in 2013 by NRCPDS.
- Currently, 277 programs in the US.
  - Ninety-five Intellectual/Developmental Disabilities.
- Serving over 850,000 individuals each day.
- Represents a 9% increase from 2010 to 2013.
- Two hundred and twenty-three programs funded by Medicaid (1915(c), (i), (k), (j), (b) (b/c) and 1115(a) Demonstration

http://www.bc.edu/schools/gssw/nrcpds

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Assumptions of Self Direction

PD options should be available regardless of source of payment

Participants are experts when it comes to their own lives

Participants prefer to make their own decisions related to their needs

Some participants will choose to take a more active role in meeting their needs

Services provided are typically not medical services

Participants will exercise their choices and spend money wisely

PD may save money with lower service & administrative costs

McInnis-Dittrich, Simone, and Mahoney (April, 2006)

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PD

Elements of Self Direction

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Person-Centered System

- Now a **REQUIREMENT** with Medicaid Authorities (as of March, 2014),
- Respects and responds to individual needs, goals and values.
- Works in full partnership to guarantee that each person’s values, experiences, and knowledge drive the creation of an individualized plan to the deliver services.
- Supports are individualized and adapt to the person.

Individual Budget

- Allows a person to hire staff and make purchases that are:
  - Tied to an assessed need.
  - Promotes independence.
  - Reduces the reliance for human assistance.
- Developed with consistency and transparency.
- Purchases must be listed on the service plan for payment to occur.
- Methodology: What are programs basing their budgets on:
  - Assessed needs – 53%
  - Combination of assessed needs & historic expenditures – 42%
  - Historic expenditures only 4%

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Representatives

- Assist the individual with decision-making.
- For those with significant cognitive impairments, makes decisions on what the individual what would have preferred.
- Must be familiar with individual and know his or her preferences and desires.
- State should have representative policy and procedures and require the representative to sign a commitment letter.
- Should periodically reconfirm representative's commitment.
- Only one program does not allow representatives.

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General Statements about Training

- Offer training – 47% programs in our inventory
- Require training – 33% programs in our inventory
- No Training – 21% programs in our inventory
- Most program require Red Cross CPR and Universal Procedures Training.
- Some states require as much as 40 hours of training prior to the hire.
- With new Department of Labor rules, the more the program requires training, the greater the state is considered a co-employer.

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Why a Support System?

- Required for all Medicaid authorities:
  - Information and Assistance (I&A)
  - Financial Management Services (FMS)
- Studies have found this system is essential to a successful self-directed program
- When participants have questions, they must know where to go
- When supports are not available, how do you monitor and measure the integrity of your program?

Information and Assistance is Different from Care Management

- Care management:
  - Through the person-centered planning process:
    - Assesses functional, social, and behavioral needs
    - Develops service/recovery plan
    - Determines individual budget allocation
    - Monitors the provision of services
    - Links participant with community resources
    - Safeguards health and welfare

Information and Assistance

- Distinct support system to self-direction
- Provides information, assistance, and support through the person-centered planning process
- Tasks include:
  - Providing orientation to self-direction
  - Explaining program permissibles
  - Making informed hiring and managing decisions
  - Identifying additional supports or resources
  - Assisting with training staff
  - Developing a back-up plan for emergency situations
  - Assisting with FMS negotiations
  - Offers practical skills training

Employer Authority

- Two models of employer authority:
  - The individual is the employer of record for taxes and insurance purposes. The Financial Management Services helps the individual meet all the tax and insurance obligations. (70% of programs).
  - An agency agrees to hire the person selected by the individual and he/she becomes an employee of the agency but the individual manages the worker.(13% of programs).
    - Popular when individuals lack confidence to be an employer
- Both models are acceptable although when the individual is the employer of record he/she may have greater control over the worker.
- Some programs offer both options to give the individual a full selection. (11% of programs).

Budget Authority

- Budget Authority means that a person has choice and control over what goods and services to purchase within their spending plan.
- CMS says the purchase must be tied to an assessed need and promote independence or reliance on human assistance.
- The FMS entity's role is to:
  - Maintain separate accounting for each person's directed budget
  - Process invoices (vendors) & timesheets (workers) in accordance with each person's budget
  - Only pay those invoices and timesheets that are approved in the budget and meet other program requirements
  - Prepare reports showing budget amounts, spending and amounts remaining

Financial Management Services (FMS)

Why does FMS Exist?

- IRS has made clear that nearly always:
  - the worker is an ***employee***
  - the participant or representative is the ***common law employer***
- IRS has special tax procedures for publicly-funded, participant-directed home care
- Most payroll companies are unwilling and unable to operate in accordance with rules
- FMS providers do more than payroll: they add controls and help maintain compliance

Independent Contractor Designation

- Prior to the early 1990s, most publicly funded self-direction programs considered workers hired directly by participants as "self-employed independent contractors."
- Left states with significant liability for unpaid taxes.
- The 2001 IRS Tax Payer Advocate Report stated that directly hired home-based service workers are "employees" and typically they do not meet the IRS' independent contractor criteria.
- Self-directed programs using the independent contractor approach have virtually vanished.

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Financial Management Services (FMS)

FMS Supports the Participant & Program

FMS providers perform administrative responsibilities so that:

- Participants can focus on managing their services and supports
- Tax, employment and insurance regulation compliance is maintained
- Payments to participants' providers are made in accordance with budget
- Additional controls are in place to detect and prevent fraud and abuse

A Quality System for Self-Direction is Built in the Design Stage

- Policy and procedures are in place
- Staff training is conducted frequently and evaluated
- Assessments are conducted in a standardized manner
- Supports are in place and effective
- Monitoring strategies are established
- Performance indicators are in place
- Method to capture and analyze data is in place
- Feedback systems are in place and data reviewed

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New Quality of Life Indicators

- Number of medical events not as important
- What is increasingly becoming important:
  - What is most important to the person?
  - What does the person say they need?
  - What does the person enjoy and like?
  - What supports does a person need to get what they want?
  - Is person getting what they say they need?

Fair Labor Standards Act (FLSA) Home Care Rule Changes

- In the past, home care workers were exempt from minimum wage, overtime, and travel time.
- 1/1/15 changed all that.
- Full enforcement is 1/1/16:
  - Companionship definition changed – 20%
  - Identifies a joint employer if someone other than the participant:
    - Has the power to hire and fire
    - Controls wages or other employment benefits
    - Sets hours and scheduling
    - Supervises, directs, or controls the work
    - Performs payroll and other admin functions
    - Other factors

How are Managed Care and Self-Direction Faring?

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Managed Care Defined

- Traditional System is Fee-for-Service (FFS)
- For-Profit/Non-Profit entities receive fixed amount to provide health care to a target population (Per member per month)
- Began with acute – now includes acute, primary, behavioral and long-term services & supports (LTSS) including nursing facility services
- Health Plans selected by State through a request for proposal process (RFP)
- Contract determines target population, service package, reimbursement, level of risks, reporting, incentives, and value-added options
- Centers for Medicare & Medicaid uses the term Managed Care Entities (MCE)

Managed Care is Changing the Health Care Landscape

- Medicaid Agencies shift from implementation of the Medicaid program to contract oversight and assuring quality
- Existing provider network may or may not continue to be engaged
- Provider performance is evidence-based
- Achieving personal outcomes is now a focus of quality
- Waiting lists are disappearing
- Incentives provide services in the least restrictive/most cost effective setting

Current View of Managed Care

Implemented MLTSS

Considering MLTSS on or before 2016

Not planning to implement MLTSS

Why the Growth?

- Significant growth in Medicaid continues
  - Thirty states have adopted the Affordable Care Act expansion option
- Managed Care allows states to predicted their costs and to transfer financial risk to health plans through a capitated rate and risk-based contracts
- Purported savings to States:
  - Reduction in preventable hospitalizations
  - Effective payment error reduction
  - Fraud and abuse strategies reduce activities
- Coordinated Care between Medicaid and Medicare/Medicaid is easier under a managed care approach

NRCPDS Research

- Reviewed 12 states with support from the Integrated Care Resource Center coordinated by Mathematica Policy Research and the Center for Health Care Strategies and funded by the MMCO
  - Request for proposals (RFPs)
  - Contracts
  - Policy and procedures
- Under this same project, NRCPDS reviewed 8 state Memorandums of Understanding (MOUs) to determine the extent of participant-directed contractual language
- Reviewed and interviewed 5 states with support from Truven Health Analytics funded by the Office of the Assistant Secretary for Planning and Evaluation (ASPE)
- Since 2013 – monitor the web for new managed care programs or changes

Service Coordination

- As an add-on - introduce the self-directed option, answer questions, complete enrollment and provide orientation to interested members
- Training Support Coordinators on self-direction (philosophy and operations) typically happens internally and generally is inconsistent
- Most contracts are silent on the self-directed tasks of Service Coordination tasks

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Service Coordination - Issues

- During interviews, service coordinators complained of the time self-direction takes
  - Hawaii limits caseload 1:40 for caseloads involving self direction; 1:50 for traditional HCBS
- MCEs complain that the cost of introducing, enrolling and providing on-going support to those electing the self-directed option was not calculated in their capitated rate
- Some MCEs have transferred the self-directed information and assistance to FMS vendors (FL, TN, and NJ)

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Financial Management Services - Issues

- Claims processing problems:
  - Once claim suspends – takes weeks to resolve
  - Billing strictly by unit rate is not compatible with flexible individual budgets or rate of pay differentials
- Prior authorizations may cause delays in accessing services
- Enrollment into the program is slow due to support coordinators referrals

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Quality Assurance & Improvement

- No oversight on Care Managers providing self-directed information, assistance and support
- MCEs may not understand how beneficial FMS providers might be to their program
- When asked "how do you know the FMS provider is doing it's job?" Response: "*We would receive a complaint*"
- Specific performance indicators tied to FMS are becoming more prominent

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Promising Practices

- Introduction to each member is not based on the biases of a care manager.
- Staff are provided sufficient time and encouragement by the system to introduce, enroll, and continual support members who select self-direction.
- Staff working with self-direction are training on not only philosophy but how the program operates.
- Person-centeredness is built into the system and practiced on a day-to-day basis.
- Information and assistance is provided effectively with highly trained staff.

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Promising Practices

- Information and assistance is monitored to ensure it is happening.
- FMS is monitored to ensure timesheets are processed timely and accurately, suspended claims are resolved quickly, and payments do not exceed service plan allocations.
- Participants are fully informed of their responsibilities.
- Quality indicators truly offer a clear picture of the integrity of the program.

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Questions?

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