

Selected Provisions from Integrated Care RFPs and Contracts: Participant Direction

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Programs that allow participants to direct their own home and community-based services (HCBS) are important to many Medicare-Medicaid enrollees with long-term care needs. For many of these individuals, participant-directed¹ long-term services and supports (LTSS) models offer greater control over the services they access, enabling them to fulfill their unmet personal care needs, improve their health outcomes, increase their satisfaction with their services, and reduce costs to the Medicare and Medicaid programs by avoiding or delaying the need for institutional care.²⁻⁴

While participant direction models are well established in a number of state Medicaid managed LTSS (MLTSS) programs, they are generally not used in Medicare Advantage, which includes only very limited coverage of LTSS. If, therefore, a state intends to include participant-directed options for LTSS benefits in its Centers for Medicare & Medicaid Services (CMS) financial alignment demonstration, or in other integrated care initiatives, it is critical that requests for proposals (RFPs), contracts with managed care plans and other accountable entities, and other guidance documents incorporate detailed language that describes the options and requirements for participant-directed LTSS.

This technical assistance tool identifies language that appears in: (1) existing state MLTSS RFPs, contracts, policies and procedures, and program authorities; and (2) states' financial alignment demonstration MOUs and three-way contracts. This examination of existing state materials highlights examples of participant direction language and guidance that states seeking to incorporate participant direction in integrated programs or Medicaid-only MLTSS programs would find useful.

IN BRIEF: This technical assistance tool covers key issues in the development of RFPs and contract provisions related to participant-direction options in Medicaid managed LTSS (MLTSS) or integrated Medicare and Medicaid programs. The tool reviews participant-direction provisions from the RFPs, contracts, and related documents of 11 states' Medicaid MLTSS programs and from the memoranda of understanding (MOUs) and three-way contracts of states participating in the CMS financial alignment initiative. The technical assistance tool is organized as follows:

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Guide to this Technical Assistance Tool

The purpose of this technical assistance tool is to give an overview of potential considerations in the development of RFPs and three-way contracts between plans, states, and CMS related to participant-directed services for Medicare-Medicaid enrollees in integrated care programs. It looks first at existing MLTSS contracts between managed care

CMS Guidance on Participant Direction in MLTSS Programs

Recent CMS guidance describes essential elements of effective MLTSS programs that are intended to be used as CMS review and approval criteria for section 1115(a) demonstrations and 1915(b) waivers.

Essential Element #6, “Person-Centered Processes” instructs states with MLTSS programs to “encourage participant self-direction and provide opportunities for self-direction of services,” particularly in states that offer self-direction through Medicaid fee-for-service (FFS). “When self-direction is offered the state must ensure that participants have adequate supports to understand and effectively use the various self-directed service options, such as budget authority and/or employer authority, and, where applicable, that participants are able to handle the financial and business aspects of self-direction (i.e. FMS and Supports Broker). Contract language must reflect state expectations around self-direction opportunities (including the availability of an individual to educate and assist the participant in self-direction) and how to facilitate participant self-direction.”

(CMS’ “Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs” can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf>.)

organizations (MCOs) and state Medicaid agencies that contain provisions specific to participant direction, including definitions, services to be participant-directed, financial management services, and information and assistance provisions. This technical assistance tool then looks at the MOUs executed between CMS and states participating in the financial alignment model to determine the extent to which participant direction is a part of these demonstrations. The results of that review are shown in Exhibit 1.

As states consider including participant-directed services in new demonstrations to integrate Medicare and Medicaid, they should take into account relevant differences between the programs they are developing and those in the states covered in this technical assistance tool. Appendix 1 provides an overview of the major features of the 11 state MLTSS programs reviewed that include participant-directed services.

Each section of this tool summarizes key participant direction requirements, notes where these requirements can be found in RFPs, contracts, and related documents and includes excerpts of actual contract and related language for illustration purposes. States are encouraged to use these documents for reference and adapt the sample language to their own programs and goals.⁵

State Documents Reviewed

Appendix 2 lists the MOUs, RFPs, contracts, state rules and regulations, and state policy manuals reviewed along with links to the documents.

Understanding Participant Direction

Participant direction is based on the premise that people with disabilities can and should make their own decisions about the services and supports they receive. Using a budget model, an employer authority model, or a combination of both, resources are allocated to meet individual needs and preferences for supports and services. Budget authority allows participants to manage a flexible budget for needed LTSS, and employer authority allows participants to select and manage their direct service workers.⁶ To adequately support participants in self-directing their care, managed care plans must provide or arrange for information/assistance and financial management services. Typically, information and assistance is provided by existing plan case managers or through contracts with separate support entities. Providing information and assistance includes: (1) aiding the individual to develop a budget based on his or her person-centered plan; (2) offering assistance with recruiting, hiring, managing, and dismissing employees, and (3) training participants and direct service workers. Financial management services include: (1) managing employment taxes and insurance; (2) managing payroll processing; (3) tracking and reporting of individual budget balances and expenditures; and (4) processing of invoices for goods and services.

Definition of Terms

Following are terms frequently used in discussion of participant direction:

- **Agency-directed service model:** The traditional agency-directed model manages all facets of the delivery of HCBS in the home including recruiting, interviewing, hiring, training, supervising, setting the schedule and rate of pay, specifying what duties will be performed, dismissing direct service workers, and providing services related to activities of daily living (ADL) and instrumental activities of daily living (IADL).
- **Budget authority:** Budget authority provides participants with a flexible individualized budget or allocation to purchase a range of permissible goods and services that either reduce the reliance on human assistance or serve to increase the individual's independence or community inclusion.
- **Direct service worker:** A direct service worker is the person hired or referred to the agency for hiring by the participant to provide services. He or she is the employee of the participant or is an individual referred to an agency for hire on behalf of the participant.
- **Employer authority:** Employer authority enables participants to recruit, interview, select, hire or refer for hiring, train, supervise, specify tasks to be performed, and dismiss (or dismiss from the home) direct service workers.
- **Financial management services (FMS):** FMS are participant-directed supports that: (1) ensure the employment of the direct service worker is in compliance with federal, state, and local taxes and insurance requirements; (2) process direct service worker payroll and other employment tasks; (3) manage and direct the distribution of funds contained in the participant-directed individualized budget; and (4) perform fiscal accounting and create expenditure reports to the participant and/or family, the MCO and state authorities.
- **Participant direction:** Participants, or their representatives if applicable, have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports. The participant-directed service delivery model is an alternative to traditionally delivered and managed services, such as an agency-directed service model. Participant direction of services allows participants to have the responsibility for managing all aspects of service delivery in a person-centered planning process.
- **Person-centered planning:** A person-centered planning process addresses health and LTSS needs in a manner that reflects individual preferences, clearly defined outcomes, and personal goals. The planning process is directed by the individual and may include a representative chosen by the individual to contribute to the process. The plan should reflect personal preferences and choices made by the individual.
- **Service coordinator:** Service coordinators (often referred to as case managers, care managers, counselors, consultants, or support brokers) provide participant-directed supports that: (1) guide the participant in directing their services including recruiting, selecting, hiring, managing, evaluating and dismissing the direct service worker; (2) assist with the management of the individual budget; (3) coordinate activities with the FMS; (4) serve as a liaison between the individual and the program; and (5) support participants as they direct their own services and supports. This function may appear as an addition to existing support roles (e.g., be added to a service coordinator's existing duties) or be a newly created support function (e.g., self-directed counselor).

Participant Direction in Integrated Medicare and Medicaid Programs

Medicaid is the largest funder of participant-directed programs, serving approximately 800,000 individuals nationwide. Medicare's experience with participant direction is very limited, however, since Medicare generally does not cover LTSS, especially the non-medical personal care services that are most commonly the focus of participant direction programs.⁷ As a result, managed care plans participating in the financial alignment initiative and other integrated care programs whose experience is primarily in Medicare may have difficulty initially in incorporating participant-directed services into the overall package of benefits available to enrollees. MCOs, whose primary experience has been with Medicaid programs for younger women and children, may face a similar challenge, but MCOs with Medicaid MLTSS experience should be able to build readily on that experience in integrated programs. Medicare-Medicaid enrollees stand to benefit from integration of participant-directed LTSS with their acute care and other services.

Participant Direction in State MLTSS Programs

While there are similarities across the 11 states operating MLTSS programs reviewed in this tool, participant direction differs in several key design features, including the federal authority used, services available through self-direction, FMS available to help participants administer their benefit, authority granted to participants, and quality assurance and improvement activities.

A wide array of federal Medicaid authorities is used to implement participant-directed MLTSS in the 11 states:

- Four states use section 1915(b)/(c) combination waivers to coordinate LTSS and allow a managed care delivery system for Medicaid services that offer HCBS, but may restrict providers.
- Four states use section 1115(a) demonstrations.
- One state uses section 1932(a) state plan authority to create a managed care arrangement using the state plan option. (This authority may require mandatory enrollment except for a few select Medicaid eligibility groups including those dually eligible for Medicare and Medicaid.)
- One state uses both section 1115(a) and section 1915(c).
- One state uses section 1915(a)/(c).

Most managed care plans are given broad discretion in developing and managing participant-directed service delivery options (see the Financial Management Services section of this brief for details), but there are a number of commonalities across states. Following are examples of contract and RFP language by specific topic: (1) participant-directed service delivery options; (2) financial management services; (3) flexible individual budgets; and (4) quality assurance and improvement.

1. Participant-Directed Service Delivery Provisions

Defining Participant Direction

Most managed care plan contracts define participant direction as the ability to manage a direct service worker to provide assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Covered services typically include personal care, personal attendant services, respite, companion, homemaker, and chore services. The following are examples of definitions of participant direction and included services from MCO contracts from the 11 states reviewed:

- **Arizona:** Allows participant direction for limited skilled services (e.g., non-sterile wound care) in addition to personal care, homemaker, and companion services (AHCCCS Medical Policy Manual, Ch. 1300, Policy 1321)
- **Hawaii:** Includes personal care, attendant care, and respite care services in participant direction and defines participant direction as “the opportunity to have choice and control over their providers (referred to as self-direction).” (Hawaii Request for Proposals for QUEST Expanded Access Managed Care Plans, Sec. 40.770)
- **Texas:** Offers more expanded options to include personal attendant and respite care as well as nursing, physical therapy, occupational therapy, and speech or language therapy. (STAR+PLUS Handbook, Sec. 8212)

Sample Contract Language: Defining Participant Direction

Tennessee

“Consumer direction of HCBS: The opportunity for a member assessed to need specified types of HCBS including attendant care, personal care, homemaker services (provided only as part of attendant care or personal care visits), in-home respite, companion care and/or any other service specified in TennCare rules and regulations as available for consumer direction to elect to direct and manage (or to have a representative direct and manage) certain aspects of the provision of such services—primarily, hiring, firing, and day-to-day supervision of consumer directed workers delivering the needed service(s).” (TennCare II Medicaid Section 1115 Demonstration, Definitions)

Introduction and Orientation to Participant Direction

The managed care plan's role in participant direction includes introducing and discussing the option with the individual during initial eligibility stages and during subsequent assessments and reassessments. Most states require the managed care plan to document such offerings.

- **Tennessee:** Requires managed care plans to offer and provide information on consumer direction during the initial intake visit, and during any face-to-face visit (TennCare Request for Proposals for Managed Care Organizations, RFP # 31865-00368, Sec. A.2.9.5.2.3.4; and 2.9.6.2.5.11)

Sample Contract Language: Introduction and Orientation to Participant Direction

Texas

MCOs must provide information to members on the three available options to self-direct care. In addition, MCOs "must provide orientation in the option selected by the Member."

There are three (3) options available to STAR+PLUS Members desiring to self-direct the delivery of: 1. Primary Home Care (PHC) (which is available to all STAR+PLUS Members), and 2. Personal Attendant Services (PAS); in-home or out-of-home respite; nursing; physical therapy (PT); occupational therapy (OT); and/or speech/language therapy (SLT) for (which are available to Members in the HCBS STAR+PLUS Waivers).

These three (3) options are: 1) Consumer-Directed; 2) Service Related; and 3) Agency. The MCO must provide information concerning the three (3) options to all Members: (1) who meet the functional requirements for PHC Services and the requirements for PAS (the functional criteria for these services are described in the Form 2060), (2) who are eligible for in-home or out-of-home respite services in the SPW; and (3) who are eligible for nursing, PT, OT and/or SLT in the SPW. In addition to providing information concerning the three (3) options, the MCO must provide Member orientation in the option selected by the Member. (Texas Health and Human Services Commission, Uniform Managed Care Contract, Attachment B-1, Sec. 8.3.5), Version 2.10.

Service Coordination

Service coordination, or providing information and assistance to individuals electing to direct their own services, is a key supportive function of participant direction. Most contracts allow managed care plans to develop their own operational strategies to provide service coordination. While states may use different terms for this service (e.g., participant direction counseling, service coordination, case management, or care coordination) and may define it somewhat differently, the service typically includes a common set of activities including assessing the needs of the participant using person-centered practices, developing a service plan, and monitoring the delivery of services. Several contracts specify that managed care plans must submit a service coordinator plan to the state for review and approval prior to program implementation. As part of this plan, managed care plans must specify: (1) service coordinator qualifications; (2) service coordinator training; and (3) monitoring and oversight to assess performance of service coordinators. Most managed care plans are required to orient and train service coordinators, and a few states (Arizona, Florida, and Tennessee) require documentation of training dates, attendance, and state review and approval of training materials. Most commonly, managed care plans employ service coordination staff internally; however, a few states (e.g., Minnesota) subcontract out these services.

- **Hawaii:** Limits managed care plan service coordinators' caseload ratio to 1:40 for self-directing participants, as compared to 1:50 for traditional HCBS participants who meet nursing home level of care and 1:120 for nursing facility residents. Hawaii recognizes that more time is needed to enroll and orient participants as they transition to self-direction, at least initially, and considers this in developing staffing ratios. (Hawaii Request for Proposals for QUEST Expanded Access Managed Care Plans, Sec. 40.770)
- **Michigan:** Requires managed care plans to encourage participants to work with a certified peer support specialist who can provide information to participants on their choices. (Agreement Between Michigan Department of Community Health and PIHP, Part II, Sec. 3.0)

- **Tennessee:** Requires each managed care plan to provide care coordination. This function includes: (1) offering self-direction to participants (participants may elect the participant-directed option at any time); (2) assessing needs and developing a service plan; (3) identifying services that participants can self-direct; (4) conducting a participant assessment to screen for the need of a representative or proxy; (5) working with the participant to develop a back-up plan; (6) ensuring representatives meet qualifications; (7) ensuring traditional services are in place while a participant transitions to self-direction; and (8) ensuring there is continuity of services. The managed care plan care coordinators in Tennessee are required to visit self-directing participants at least monthly, communicate with the counseling function and the FMS routinely, and report abuse and neglect. (TennCare Request for Proposals for Managed Care Organizations, RFP # 31865-00368, Sec. A.2.9.5, A.2.9.6)

Training for Participants

Participant training is an important component of self-directed programs and is available in all 11 states. While states may review and approve training curricula, most training is conducted by the managed care plan.

- **Florida:** Requires health plans to educate enrollees about their ability to self-direct care (intermittent and skilled nursing services) and to designate staff or network providers who will provide this education. (Florida 2012-2015 Health Plan Model Contract, Sec. IV.A.6.a.(18)(d); Participant Direction Option Manual, p.1)
- **Hawaii:** Requires participant training on topics that include understanding roles within the program, selecting workers, being an employer, conducting administrative tasks, and developing back-up plans. (Hawaii Request for Proposals for QUEST Expanded Access Managed Care Plans, Sec. 40.750.3)
- **Tennessee:** Includes many of the same training topics as Hawaii, as well as scheduling and managing workers, evaluating worker performance, preventing and reporting fraud and abuse, and reviewing and approving electronically-captured visit information. The Tennessee contract also specifies that the FMS provider (called the Fiscal Employer Agent (FEA) in Tennessee) is responsible for training each participant and must validate that training was conducted prior to the participant directing his/her own services and supports. (TennCare Request for Proposals for Managed Care Organizations, RFP # 31865-00368, Sec. A.2.9.6.7.4)

Sample Contract Language: Training for Participants

Arizona

“The case manager will assist the member to assess his/her own training needs as they relate to directing his/her own care. These training needs will be determined by using the “What are my Training Needs” Form (available in the SDAC Member Manual). There is no mandatory member training for SDAC participation. Training is available to assist the member to succeed in directing his/her own care. Training requires prior authorization from the case manager.” (AHCCCS Medical Policy Manual, Sec. 1323)

Training for Direct Service Workers

Training for direct service workers is available in most state programs, and some states require it. Like training for users of participant direction, many programs require the state to review and approve the training curriculum that the managed care plan uses to train direct service workers.

- **Arizona:** Direct service worker training is mandatory and includes instruction on universal precautions and Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. (AHCCCS Medical Policy Manual, Ch.1300, Policy 1340; see also Arizona Direct Care Worker Training and Testing Program)
- **Tennessee:** The state requires training for FMS, its staff, and subcontracted supports brokers. The FEA must also provide initial and ongoing training of all workers, which must be completed prior to providing services. Training topics include caring for elderly and disabled populations, identifying and

reporting abuse and neglect, providing CPR and first aid, reporting critical incidents, submitting required documentation and withholdings, and using the electronic verification system. (TennCare Request for Proposals for Managed Care Organizations, RFP # 31865-00368, Sec. A.2.9.6.7.4)

2. Financial Management Services

In most states, the minimum qualifications for employer authority include the participant's ability to select, hire (or refer for hiring), train, schedule, evaluate, and dismiss workers. Hawaii and Tennessee also offer participants the ability to set their workers' pay. To assist participants with these tasks, states require health plans to provide FMS.⁸

Key Elements of FMS

Financial management services are an essential design element of participant direction. The primary duties of an FMS provider are to: (1) make payments on behalf of the participant in accordance with the participant's authorized spending plans and program rules; (2) generate reports for participants and program administrative agencies showing expenditures and individual budget information; and (3) manage all employer tax and insurance responsibilities using federal and state regulations governing domestic workers. These functions are critical to maintaining program integrity by preventing, reducing, and/or eliminating fraud and abuse in participant-directed Medicaid programs.

Across the 11 states, there are three common approaches to establishing a relationship with FMS providers: (1) the state delegates the authority to each managed care plan to select and contract with providers (typical in most states); (2) the state requires the managed care plan to use existing FMS providers from the FFS system (Texas); or (3) the state and the managed care plan contract directly with a FMS provider selected by the state (Tennessee).

Most of the state contracts reviewed delegate the selection and contractual management responsibilities to the various managed care plans and the plan is held responsible for the management of these contracts.

- **Kansas:** Specifies that the contractor(s) shall utilize the state's existing FMS providers. CMS, in approving the section 1115(a) demonstrations and 1915(c) waivers used for the program, also specified that participants self-directing their services use a payroll agent to assist in processing claims and payments to their direct support workers. (RFP for KanCare Medicaid and CHIP Capitated Managed Care Services, Sec.2.2.8.17)
- **Massachusetts:** Does not specify requirements for the selection and management of FMS. Nevertheless, managed care plans have adopted, with some modifications, the system used for the MassHealth State Plan Personal Care option, which serves more than 20,000 self-directing participants.⁹
- **Tennessee:** Requires the plan to contract with the state's single designated FEA and exempts the plan from liability associated with verifying worker qualifications, which is the responsibility of the FEA. The contract then goes into detailed instruction on the duties of the FEA, day-to-day management, and quality reporting and benchmarks. (TennCare Request for Proposals for Managed Care Organizations, RFP # 31865-00368, Sec. A.2.26.6 and A.2.9.6.3)
- **Texas:** Requires the MCO to work with either a Consumer Direct Service Agency (CDSA) if the participant serves as the employer of record, or a Home and Community Support Services Agency (HCSSA) in the MCO's provider network if the co-employment model (Agency with Choice) is used. Both the CDSA and HCSSA organizations are enrolled and licensed by the Texas Department of Aging and Disability Services (DADS). (STAR+PLUS Handbook, Sec. 8000)

Sample Contract Language: Financial Management Services

Tennessee

“The CONTRACTOR shall contract with TENNCARE’s designated FEA [Fiscal Employer Agent] to provide assistance to members choosing consumer direction of eligible CHOICES HCBS. The CONTRACTOR shall not be liable for any failure, error, or omission by the FEA related to the FEA’s verification of worker qualifications.”

“The FEA shall fulfill, at a minimum, the following financial administration and supports brokerage functions, as specified in the CONTRACTOR’s contract with the FEA and the FEA’s contract with TENNCARE, for all CHOICES members electing consumer direction of eligible CHOICES HCBS:

- Assign a supports broker to each CHOICES member electing to participate in consumer direction of eligible CHOICES HCBS;
- Notify the member’s care coordinator upon becoming aware of any additional risk associated with the member participating in consumer direction that may need to be addressed in the risk assessment and plan of care processes;
- Provide initial and ongoing training to members and their representatives (as applicable) on consumer direction and other relevant issues;
- Verify worker qualifications, including, as specified by TENNCARE, conduct background checks on workers, enroll workers into Medicaid, assign provider Medicaid ID numbers, and hold Medicaid provider agreements;
- Provide initial and ongoing training to workers on consumer direction and other relevant information;
- Assist the member and/or representative in developing and updating service agreements;
- Receive, review, and process electronically captured visit information;
- Resolve discrepancies regarding electronically captured visit information;
- Develop and implement processes to support members in maintaining documentation of service delivery to support payments for services provided and periodically monitor such documentation;
- Withhold, file and pay applicable: federal, state and local income taxes; employment and unemployment taxes; and worker’s compensation;
- Pay workers for authorized services rendered within authorized timeframes;
- Facilitate resolution of any disputes regarding payment to workers for services rendered;
- Assist in developing a schedule for the member’s workers, in managing and monitoring payments to workers, and in identifying and training new workers;
- As needed: assist in developing job descriptions, locating, recruiting, and interviewing workers; and
- Report to the CONTRACTOR upon identification of critical incidents.”

(TennCare Request for Proposals for Managed Care Organizations, RFP # 31865-00368Section A.2.9.6.3)

3. Flexible Individual Budgets

A flexible individual budget not only allows participants to hire, manage, and dismiss service workers but offers a means to purchase supplies, equipment, activities that support community inclusion, home modification, and assistive devices to enhance the participant’s independence. Not quite half the states reviewed give participants hiring authority as well as control of their individual budgets (Michigan, New Mexico, Texas and Wisconsin). Each state describes the purpose of the individual budget and specifies the methodology to calculate the budget’s dollar amount in their contract or associated policies and procedures.

- **Wisconsin:** Self-direction option includes the option for participants to accept a fixed budget that can be used to authorize the purchase of services or support items from any qualified provider. The individual budget for the supports that participants have chosen to self-direct is based on a comprehensive assessment and person-centered planning process. (Family Care MCO Contract, Sec. VI)
- **Michigan:** Bases the individual budget on the estimated costs of the services and supports needed to accomplish the participant’s goals and objectives. This budget may be flexible and used for specialty services related to mental health and developmental disabilities to meet individual goals. The budget must be approved for a specified period of time. (Agreement Between Michigan Department of Community Health and PIHP, Sec. 11A-IIE)

4. Quality Assurance and Improvement

All Medicaid MCOs are required to submit formal quality assurance and improvement (QA/I) plans to the state for review and approval prior to the plan enrolling beneficiaries. These QA/I plans typically include an ongoing quality improvement plan to objectively and systematically monitor and evaluate the quality and appropriateness of the services and care provided. The goal of the QA/I plan is to promote quality of care and quality of participant health outcomes. The QA/I plan must also include oversight of plan staff, the provider network, and all subcontractors. For the most part, managed care plans include the participant-directed option within the broader scope of their overall QA/I plans. However, states that require a specific quality management approach to participant-directed services can require managed care plans to report specific information that allows for more thorough monitoring and oversight.

Some quality measures or data requirements that states may include in a quality management approach include: (1) participant enrollment and disenrollment figures; (2) information on the effectiveness of counseling and FMS support; (3) expenditure rates and information on the kinds of services purchased; (4) participant satisfaction; and (5) clinical quality measures such as critical incidents, emergency department visits, and hospitalization.

- **Tennessee:** Requires the FEA and MCO to submit a quarterly CHOICES Consumer Direction HCBS Report, which includes but is not limited to the following: (1) number of participants electing the participant-directed option; (2) number of participants referred to the FEA for enrollment in participant direction; (3) average and maximum time from FEA referral to receipt of services; (4) number and percent of participants enrolled in consumer direction who began initial enrollment in consumer direction; and (5) (specific to MCOs) the number and percent who have a representative to assist the participant in consumer direction, receive consumer directed services by type of service, and the number that withdrew from consumer direction. Monthly reports must be submitted on the following: (1) number of scheduled visits with self-directing participants; (2) number of late or missed home assessment visits; and (3) the reason for late visits. (TennCare Request for Proposals for Managed Care Organizations, RFP # 31865-00368, Sec. A.2.30.6.6, & A.2.30.6.5)

Sample Contract Language: Quality Assurance and Improvement

Tennessee

“The contractor shall assist TENNCARE in meeting the five (5) annual benchmarks established for the MFP Rebalancing Demonstration...

Benchmark #5: Increase Participation in Consumer Direction: Increase the number of persons receiving Medicaid-reimbursed HCBS participating in consumer direction for some or all services during each year of the demonstration.”

(TennCare Request for Proposals for Managed Care Organizations, RFP # 31865-00368, Sec. A.2.9.8.13.1.5)

Projected Participation in Consumer-Directed HCBS

Calendar Year	# in Consumer Direction
2011	600
2012	900
2013	1150
2014	1400
2015	1550
2016	1650

Backup Plan

States always require managed care plans to have in place a backup service plan to address instances when regularly-scheduled workers are not available to provide critical services for participants.

- **Arizona:** Requires the contractor to resolve gaps in critical services within two hours. Contractors are required to have back-up caregivers available on-call to fill any unforeseeable gaps in critical services.¹⁰

Sample Contract Language: Back-Up Plan

Hawaii

“A back-up plan outlining how members will address instances when regularly scheduled providers are not available shall be included in the member’s care plan. Back-up plans may involve the use of non-paid caregivers and/or paid providers.” (Hawaii Request for Proposals for QUEST Expanded Access Managed Care Plans, Section 40.770)

5. Participant Direction in CMS’ Financial Alignment Initiative

The memoranda of understanding (MOUs) signed between eight states (California, Illinois, New York, Massachusetts, Ohio, South Carolina, Virginia, and Washington) and CMS under the Medicare-Medicaid Financial Alignment Initiative also provide examples of language outlining the participant direction option in integrated managed care environments. Three-way contracts from capitated model demonstration states, including Massachusetts, Illinois, and Virginia, also contain more detailed language than the MOUs. This section provides a summary of the participant direction provisions included in these documents as well as an exhibit summarizing specific references for each state.

Summary of Participant Direction Provisions in Financial Alignment Initiative MOUs and Three-Way Contracts

All eight states’ MOUs stipulate that participant direction must be offered as an option to demonstration participants (Exhibit 1). Illinois and Massachusetts also include provisions for supporting and training participants to successfully employ personal assistants. Illinois’ MOU expressly states that “Enrollees will serve as co-employer of personal assistants, and Demonstration Plans will be responsible for supporting Enrollees in their role as co-employers. Demonstration Plans must assure that Care Coordinators or another participant of the care team are properly trained and have the skills and resources to be able to train Enrollees in employing their own personal assistant.” (Memorandum of Understanding Between the Centers for Medicare and Medicaid Services and The State of Illinois p. 66) The Massachusetts three-way contract also contains network adequacy requirements for personal care management services. The state includes standards for the number and types of agencies that demonstration plans must contract with to provide these services (Contract Between United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with The Commonwealth of Massachusetts, p. 83-84).

Four states (MA, OH, SC, and VA) stipulate that demonstration plans use FMS entities to assist with duties related to making payments for services, tracking individual budget information and managing employer tax and insurance responsibilities. Virginia’s MOU specifically says that many Virginians enrolled in the Elderly or Disabled with Consumer Direction Waiver “will be able to achieve greater independence if they hire and manage their own attendants rather than depend solely on home health care/nurses/aides or family members. Participating Plans will be required to use one state-wide Fiscal/Employer Agent (F/EA) to manage the F/EA services for individuals using consumer-direction” (Memorandum of Understanding Between the Centers for Medicare and Medicaid Services and The State of Virginia, p. 67).

Three states (IL, NY, and SC) plan to use participant direction as an element to monitor a demonstration plan’s ability to meet participant needs. New York includes self-direction requirements in models of care that will be used to score health plan applicants. Elements that will be scored include (1) education of consumers/caregivers on self-directed option, (2) monitoring of education, (3) evaluation of self-directed services, (4) monitoring/evaluation of percentage of consumers using option (Memorandum of Understanding Between the Centers for Medicare and Medicaid Services and The State of New York, p. 73).

All but one state (NY) include among their core quality measures for the demonstration, “percent of care coordinators that have undergone State-based training for supporting self-direction under the demonstration.” New York includes a different core quality measure, “percent of participants directing their own services through the consumer-directed personal assistance option at the plan each Demonstration Year” (Memorandum of Understanding Between the Centers for Medicare and Medicaid Services and The State of New York, p. 106).

Exhibit 1. Participant Direction in Financial Alignment Demonstration MOUs and Three-Way Contracts

State	Participant Direction Option	Financial Management	Training in Participant Direction	Monitoring	Participant Direction Measures
California	Demonstration plans must accommodate participant direction and provide enrollees with choice to self-direct their own care. (MOU p. 2, 15, 80) Note that CA demonstration plans share responsibility with the county-administered In-Home Supportive Services (IHHS) program for services that may be directed by participants (MOU, pp. 77-79)				Percent of care coordinators who have undergone state-based training for supporting self-direction under the demonstration. (MOU p. 112)
Illinois	Same as CA (MOU p.4, 12) Enrollees can serve as co-employer of personal assistants, and demonstration plans will support them in their role as co-employers. (MOU p. 66)		Demonstration plans must assure care coordinators or another care team member are trained and have skills and resources to train Enrollees in employing their personal assistants (MOU p. 66, three-way contract p. 69)	CMS/state monitoring of demonstration plans include oversight in area of participant direction. (MOU p. 67)	Same as CA (MOU p. 89)
New York	Same as CA (MOU p. 12, 64)			State has self-direction requirements for demonstration plans models of care that will be used to score plan applicants. Elements that will be scored include (1) education of consumers/ caregivers on self-directed option, (2) monitoring of education, (3) evaluation of self-directed services, (4) monitoring/ evaluation of percentage of consumers using option. (MOU p. 73)	Percent of participants directing their own services through the consumer-directed personal assistance option at the plan each demonstration year. (MOU p. 106)
Massachusetts	Same as CA (MOU p. 3, 12) Demonstration plans must contract with Personal Care Management (PCM) Agencies that are under contract with the Executive Office of Health and Human Services (EOHHS) to provide services to Enrollees accessing Self-directed services (three-way contract p. 83). Enrollees must be given a choice of at least two PCM Agencies, one of which must be an Independent Living Center (ILC) operating as a PCM where geographically feasible. Enrollees over the age of 60 must be offered the option of receiving PCM Services through an Aging Services Access Point (ASAP) operating as a PCM. (three-way contract p. 84)	Demonstration plans must contract with Fiscal Intermediaries (FIs) under contract with EOHSS to support Enrollees in fulfilling their employer required obligations related to the payment of PCAs. (three-way contract p. 84)	Demonstration plans must provide information, choice and needed supports to promote self-direction of PAS by Enrollees. Demonstration plans must inform Enrollees that they may identify a surrogate to help them if they choose Self-directed PCA Services. (three-way contract p. 83-84)		Same as CA (MOU p. 99)

State	Participant Direction Option	Financial Management	Training in Participant Direction	Monitoring	Participant Direction Measures
Ohio	Same as CA (MOU p. 1, 9, 56)	Participant direction includes both employer and budget authority. Demonstration plans will use one statewide fiscal management services entity to assist with these activities. (MOU p. 56)			Same as CA (MOU p. 82)
South Carolina	Same as CA (MOU p. 15) Same as IL regarding support for Enrollees (MOU p. 77) Transitioning of HCBS responsibilities to demonstration plans will occur over three phases. Demonstration plans do not assume responsibilities for self-directed attendant care until the final phase of HCBS transition. (MOU p. 78)	To facilitate payment, health plans must utilize the state's financial management contractor, with the state covering all administrative costs. (MOU p. 77)	Health plans must support enrollees in directing their own care. (MOU, p. 77)	State will conduct benchmark reviews of demonstration plans at each phase of the HCBS transition. For the Phase II review, plans must show "authority to oversee self-directed attendant care" by proving (1) incorporation of self-directed care plans, (2) capacity to assess self-direction, (3) ability to interface with organization providing training supports, and (4) ability to promptly pay attendants. (MOU p 86)	Same as CA MOU (MOU p. 117)
Virginia	Same as CA (MOU p. 3 and 13, 3 way-contract p. 41)	Participating plans will be required to use one state-wide Fiscal/Employer Agent (F/EA) to manage the F/EA services for individuals using consumer-direction. (MOU p. 67, three-way contract p. 41)	Plans must conduct training of F/EA staff on topics such: responsibilities of care managers; communications with the plan and enrollees; customer service requirements; and complaint and appeal processes (3 way contract, p. 43) Providers must be trained on person-centered planning, self-determination and related philosophies. (three-way contract p. 65)	Plans must report monthly enrollee-level data on consumer-directed payroll activity to the state. (three-way contract, p. 43)	Same as CA (MOU p. 92)
Washington (Capitated)	Same as CA (MOU p. 4, 16, 87)				Same as CA (MOU p. 119)

Conclusion

The financial alignment initiative and other efforts to integrate Medicare and Medicaid services for Medicare-Medicaid enrollees provide states, managed care plans, and CMS with opportunities to build on the successes of participant direction in Medicaid MLTSS programs. The lessons learned from those programs have and can be further incorporated into RFPs, contracts, and related documents being used in these demonstrations and other initiatives. This technical assistance tool provides examples of contract provisions used by states to facilitate the effective use of participant direction by Medicare-Medicaid enrollees.

Additional Resource on Participant-Directed Services

The National Resource Center for Participant-Directed Services (NRCPPDS) has identified additional guidance and resources for states developing participant-directed services:

- **2013 FMS Conference – Glossary of Common Managed Care Term Handout.** A Glossary of Managed Care Terms Developed for the Financial Management Services Conference held November 4-5, 2013: <https://bcweb.bc.edu/libtools/details.php?entryid=405&page=1&topics=4,&types=5,&keyword=MLTSS>.
- **Best Practices in Consumer Direction.** A report that examines Medicaid and Participant Direction entitled “Best Practices in Consumer Direction”: <http://aspe.hhs.gov/daltcp/reports/CMS-CDBestPractices.pdf>.
- **Aging and Disability Network Participant Direction Toolkit.** An Aging and Disability Network Resource Toolkit that provides comprehensive information about all aspects of implementing a participant-directed program: <http://www.bc.edu/content/bc/schools/gssw/nrcpps/tools/toolkit.html>.
- **Issue Brief Summary: Participant Direction & Managed Care: A Case Study.** This issue brief reflects NRCPPDS research conducted in a three-state survey on managed care: <https://bcweb.bc.edu/libtools/details.php?entryid=377&page=1&topics=&types=&keyword=Managed%20Care>.
- **Guiding Principles: For Partnerships with Unions and Emerging Worker Organizations When Individuals Direct Their Own Services and Supports.** A collaborative approach to collective bargaining and participant direction: <http://www.seiu.org/Guiding%20Principles%20w%20Signatures.pdf>.
- **Consumer Choices and Continuity of Care in Managed Long-Term Services and Supports: Emerging Practices and Lessons.** An AARP Report discussing consumer choice and continuity of managed care services with a section on self-direction. http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/consumer-choices-report-full-AARP-ppi-ltc.pdf.

Appendix 1: Major Features of Participant-Directed HCBS Programs for Medicare-Medicaid Enrollees in Selected States

State	Program Name and Start Date	Federal Authority	Number and Name of Plans	Population Served	Self-Directed Services	Estimated Number of Self-Directing ^a	FMS Selection ^{b,c}	FMS Model	Employer/Budget Authority
Arizona	Arizona Long-Term Care System (ALTCS) (1988)	§1115(a)	3: Mercy Care Plan, Bridgeway, & Evercare Select	Adults with physical disabilities, individuals with developmental disabilities & adults age 65+	Attendant care, homemaker, general supervision, limited skill care	3,489	Qualified Providers	Agency with Choice and Fiscal Employer Agent	Employer
Florida	Long-Term Managed Care Program (1998)	§1915 (b)/(c)	17: American Eldercare, Amerigroup, Vista Health Plan Inc., Hope Choices, Humana, Little Havana Forever Home Program, Neighborly Care Network, Project Independence at Home, Simply Healthcare, Sunshine State Tango Plan, United HomeCare, United HealthCare of Florida, Universal Health Care, Urban Jacksonville Senior Connection, Worldnet, & YourCare Brevard	Adults with physical disabilities & adults age 65+	Personal care	595	Qualified Providers	Fiscal Employer Agent	Employer
Hawaii	QUEST Expanded Access Program (QExA) (2009)	§1115(a)	2: United Healthcare & Ohana Health Plan	Adults with physical disabilities & adults age 65+	Personal assistance, respite, attendant care	1,792	Health Plan contract with Ceridian	Fiscal Employer Agent	Employer ^d

^a Numbers supplied from NRCPPS national inventory, July 2013.

^b P. Saucier, J. Kasten, B. Burwell, and L. Gold. The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update. Prepared for the Centers for Medicare & Medicaid Services (CMS) by Truven Health Analytics. 2012. Available at: http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf.

^c FMS vendors are selected by two methods: (1) issuing an RFP and selecting the most qualified entity or entities; and (2) establishing provider qualifications and allowing any willing and qualified provider to enroll as an FMS vendor.

^d Employer authority is available in Hawaii. See: <http://hawaii.gov/spo2/health/rfp103f/attachments/rfp10091375755966.pdf>.

State	Program Name and Start Date	Federal Authority	Number and Name of Plans	Population Served	Self-Directed Services	Estimated Number of Self-Directing ^c	FMS Selection ^{d,c}	FMS Model	Employer/Budget Authority
Kansas	KanCare (1/1/13)	§1115(a) & §1915(c)	3; Amerigroup, Sunflower (Centene), & United HealthCare	Adults with physical disabilities, individuals with developmental disabilities, individuals with TBI, individuals needing technology assistance & adults age 65+	Attendant care services	13,825	Qualified Providers	Agency with Choice and Fiscal Employer Agent	Employer
Massachusetts	Senior Care Options (2004)	§1915 (a)/(c)	4: Commonwealth Care Alliance, NaviCare, United HealthCare, & Senior Whole Health	Adults age 65+	Personal care assistance	4,582	Contract with CPMA, NEARC and Stavros	Fiscal Employer Agent	Employer
Michigan	Medicaid Managed Specialty Supports and Services Waiver (1998)	§1915 (b)/(c)	10: NorthCare Network, Northern Michigan Regional Entity, Lakeshore Regional Entity, Southwest Michigan Behavioral Health, Mid-State Health Network, Community Mental Health Partnership of Southeast Michigan (Washtenaw Community Health Organization), Detroit Wayne Mental Health Authority, Oakland County Community Mental Health Authority, Macomb County Community Mental Health, St. Clair County Community Mental Health	Persons with developmental & mental health disabilities	Flexible services and supports	7,053	Qualified Providers	Agency with Choice and Fiscal Employer Agent	Employer and Budget

^c Numbers supplied from NRCPDS national inventory, July 2013.

^d P. Saucier, J. Kasten, B. Burwell, and L. Gold. The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update. Prepared for the Centers for Medicare & Medicaid Services (CMS) by Truven Health Analytics. 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf.

^e FMS vendors are selected by two methods: (1) issuing an RFP and selecting the most qualified entity or entities; and (2) establishing provider qualifications and allowing any willing and qualified provider to enroll as an FMS vendor.

^d Employer authority is available in Hawaii. See: <http://hawaii.gov/spo2/health/rfp103f/attachments/rfp10091375755966.pdf>.

State	Program Name and Start Date	Federal Authority	Number and Name of Plans	Population Served	Self-Directed Services	Estimated Number of Self-Directing ^e	FMS Selection ^{f,c}	FMS Model	Employer/Budget Authority
Minnesota	Senior Care Plus (2005)	§1915 (b)/(c)	8: Blue Plus, Health Partners, Itasca Medical Care, Medica, Metropolitan Health Plan, Prime West, South Country Health Alliance, & UCare	Adults age 65+	State Plan personal care, disabled/elderly waiver, customized living adult foster care and adult day care	Not Available	Qualified Providers	Agency with Choice and Fiscal Employer Agent	Employer
New Mexico	Centennial Care 1/1/14	§1115	4: United HealthCare, Presbyterian, Molina, and Blue Cross Blue Shield	Adults with physical disabilities & aged	Homemaker, personal care services	7,300	State contract with Xerox	Fiscal Employer Agent	Employer and Budget Authority
Tennessee	TennCare/CHOICES (2010)	§1115(a)	3: United HealthCare, Amerigroup, & Volunteer State Health Plan	Adults with physical disabilities & adults age 65+	Personal care, attendant care, in-home respite & companion services	1,600	State & Health Plan contract with Public Partnership	Fiscal Employer Agent	Employer
Texas	STAR+PLUS (1998)	§1115(a)	5: Amerigroup, Molina, Superior HealthPlan (Centene), United HealthCare, & HealthSpring	Children with disabilities, adults with physical disabilities & adults age 65+	Personal assistance, primary home care, nursing, therapies, and respite	2,683	Qualified Providers	Fiscal Employer Agent/ Agency with Choice	Employer and Budget
Washington	Medicaid Integration Partnership (WMIP) (2005)	§1932(a)	1:Molina	Adults with physical disabilities & adults age 65+	Personal care services	250	Health Plan contract with AccentCare	§3401(d)	Employer
Wisconsin	Family Care (FC) (1999)	§1915 (b)/(c)	9: Care Wisconsin, Community Care of Central Wisconsin, Community Care, Community Health Partnership, Lakeland Care District, Milwaukee County Dept. of Family Care, NorthernBridges, Southwest Family Care, & Western Wisconsin Cares	Adults with disabilities including DD and adults age 65+	HCBS and State Plan personal care	4,148	Health Plans have separate contracts	Varies by MCO	Employer and Budget

^e Numbers supplied from NRCPPS national inventory, July 2013.

^f P. Saucier, J. Kasten, B. Burwell, and L. Gold. The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update. Prepared for the Centers for Medicare & Medicaid Services (CMS) by Truven Health Analytics. 2012. Available at: http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf.

^c FMS vendors are selected by two methods: (1) issuing an RFP and selecting the most qualified entity or entities; and (2) establishing provider qualifications and allowing any willing and qualified provider to enroll as an FMS vendor.

^d Employer authority is available in Hawaii. See: <http://hawaii.gov/spo2/health/rfp103f/attachments/rfp10091375755966.pdf>.

Appendix 2: RFPs, Contracts, State Rules and Regulations, and Policy Manuals Reviewed

Arizona:

- Arizona Long Term Care System (ALTCS) Elderly & Physically Disabled (E/PD) Contract for Contractors, http://www.azahcccs.gov/commercial/Downloads/Solicitations/BiddersLibrary/YH12-0001/General/General_SectionA_F_YH12-0001_1_31_11FINALCLEAN.pdf
- AHCCCS Contractor Operations Manual, Chapter 100-Administration, 101 Marketing Outreach and Incentives, <http://www.azahcccs.gov/shared/Downloads/ACOM/ACOM.pdf>
- AHCCCS Medical Policy Manual (AMPM), Chapter 1300 – Member-Directed Options, <http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap1300.pdf>
- Direct Care Worker Training and Testing Program, <http://www.azahcccs.gov/commercial/DCW/default.aspx>

California:

- Memorandum of Understanding Between the Centers for Medicare and Medicaid Services and The State of California Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees. California Medicare-Medicaid Alignment Initiative, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAMOU.pdf>

Florida:

- Florida 2012-2015 Health Plan Model Contract Attachment II – Core Contract Provisions, www.fdhc.state.fl.us/mchq/managed_health_care/mhmo/docs/contract/1215_Contract/2012-2015/Jan2013/2012-15_HP-ContractAtt-II_GEN-AMEND1-JAN-2013-CLEAN.pdf
- Participant Direction Option Manual, http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/LTC/PDO_Manual.docx

Hawaii:

- Hawaii Request for Proposals for QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals who are Aged, Blind, or Disabled, www.medicaid.gov/mltss/docs/hirfp.pdf

Illinois:

- Memorandum of Understanding Between the Centers for Medicare and Medicaid Services and The State of Illinois Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees. Illinois Medicare-Medicaid Alignment Initiative, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/ILMOU.pdf>
- Contract Between United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with State of Illinois Department of Healthcare and Family Services. Issued November 5, 2013. <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/IllinoisContract.pdf>

Kansas:

- RFP for KanCare Medicaid and CHIP Capitated Managed Care Services, <http://www.scribd.com/doc/80944466/Kansas-Rfp-Evt0001028>
- Kansas Health Plan Contract, www.medicaid.gov/mltss/docs/hirfp.pdf

Massachusetts:

- Massachusetts Senior Care Options Contract for Senior Care Organizations, http://www.chcs.org/usr_doc/2010_contract.pdf
- Massachusetts: Duals Demonstration Request for Responses From Integrated Care Organizations, issued June 18, 2012, awarded November 2, 2012, <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/120730-duals-demo-rfr.pdf>
- Contract Between United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with The Commonwealth of Massachusetts and Commonwealth Care Alliance, Inc., Fallon Community Health Plan, Network Health, LLC. Issued July 11, 2013. <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassachusettsContract.pdf>

Michigan:

- Agreement Between Michigan Department of Community Health and PIHP for the Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program, www.michigan.gov/documents/mdch/FY09-10MAContractwithallattachments_312218_7.pdf

Minnesota:

- Minnesota Department of Human Services Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services, 2011 MSHO/MS+ Contract (MCO) , http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_156513
- Minnesota Department of Human Services Contract for Medical Assistance and MinnesotaCare Medical Care Services, UCare Minnesota 2013 Special Needs Basic Care (SNBC) Contract, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_166055
- Consumer Directed Community Supports – Lead Agency Operations Manual, <https://edocs.dhs.state.mn.us/lfservlet/Public/DHS-4270-ENG>

New York:

- Memorandum of Understanding Between the Centers for Medicare and Medicaid Services and The State of New York Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees. New York Medicare-Medicaid Alignment Initiative, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/NYMOU.pdf>

Ohio:

- Memorandum of Understanding Between the Centers for Medicare and Medicaid Services and The State of Ohio Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees. Ohio Medicare-Medicaid Alignment Initiative. <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/OHMOU.pdf>

South Carolina:

- Memorandum of Understanding Between the Centers for Medicare and Medicaid Services and The State of South Carolina Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees. South Carolina Medicare-Medicaid Alignment Initiative. <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/SCMOU.pdf>

Tennessee:

- Contractor Risk Agreement State of Tennessee, 2006. <http://www.tn.gov/tenncare/forms/middletnmco.pdf>
- TennCare Request for Proposals for Managed Care Organizations, RFP # 31865-00368, Attachment 6.12 (*Pro Forma* Contract), http://tn.gov/generalserv/cpo/sourcing_sub/documents/31865-00368.pdf
- TennCare II Medicaid Section 1115 Demonstration, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/tn-tenncare-ii-ca.pdf>

Texas:

- Texas Health and Human Services Contract General Terms and Conditions, <http://www.hhsc.state.tx.us/medicaid/managed-care/UniformManagedCareContract.pdf>
- Texas Uniform Managed Care Manual (UMCM), <http://www.hhsc.state.tx.us/medicaid/managed-care/umcm/>
- STAR+PLUS Handbook, <http://www.dads.state.tx.us/handbooks/sph/index.htm>

Virginia:

- Memorandum of Understanding Between the Centers for Medicare and Medicaid Services and The State of Virginia Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees. Virginia Medicare-Medicaid Alignment Initiative, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/VAMOU.pdf>
- Contract Between United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership

with the Commonwealth of Virginia Department of Medical Assistance Services. Issued December 4, 2013, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/VirginiaContract.pdf>

Washington:

- Memorandum of Understanding Between the Centers for Medicare and Medicaid Services and The State of Washington Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees. Washington Medicare-Medicaid Alignment Initiative, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WACAPMOU.pdf>

Wisconsin:

- Family Care MCO Contract, <http://www.dhs.wisconsin.gov/ltcare/StateFedReqs/cy2013mcocontract.pdf>

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The **Integrated Care Resource Center** is a national initiative of the Centers for Medicare & Medicaid Services to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees and other high-need, high-cost Medicaid beneficiaries. The state technical assistance activities provided within the **Integrated Care Resource Center** are coordinated by Mathematica Policy Research and the Center for Health Care Strategies. For more information, visit www.integratedcareresourcecenter.com.

Endnotes

1. Participant-directed, consumer-directed, and self-directed are used as interchangeable terms in this technical assistance tool.
2. S.B. Dale and R.S. Brown. "How Does Cash and Counseling Affect Costs?" *Health Services Research*, 42, no. 1p2, (2007): 488-509.
3. P. Doty, K.J. Mahoney, and M. Sciegaj. "New State Strategies to Meet Long-Term Care Needs." *Health Affairs*, 29, no. 1 (2010): 49-56.
4. B.L. Carlson, L. Foster, S.B. Dale, and R. Brown. "Effects of Cash and Counseling on Personal Care and Well-Being." *Health Services Research*, 42, no. 1p2 (2007) 467-487. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955332>.
5. Additional documents that may be useful to reference are: (1) the Arizona Marketing Outreach and Incentives Policy at <http://www.azahcccs.gov/shared/Downloads/ACOM/ACOM.pdf>; and (2) the Texas Uniform Managed Care Manual (UMCM) at <http://www.hhsc.state.tx.us/medicaid/umcm>.
6. Within employer authority, two models are offered to designate the employer of record. The Fiscal Employer Agent (FEA) model, assigns the participant as the employer of record for taxes and insurance purposes. The Agency with Choice (AwC) model specifies the employer as the Agency for tax purposes with the participant as co-employer.
7. P. Nadash and S. Crisp. "Best Practices in Consumer Direction." Prepared for the Centers for Medicare & Medicaid Services. (July 19, 2005). This report examines the challenges in adopting participant direction in a Medicare environment. Available at <http://aspe.hhs.gov/daltcp/reports/CMS-CDBestPractices.pdf>.
8. Selection of an FMS in typical fee-for-service Medicaid programs depends on the state's program design. If Medicaid FMS agencies are reimbursed as a service, provider qualifications are developed and any willing and eligible FMS provider may enroll. If Medicaid FMS agencies are reimbursed as an administrative function, the state may restrict selection through an RFP process and limit the number of FMS providers.
9. Personal communication with Jan Levinson, Senior Vice President for Senior Care Options, Commonwealth Care Alliance. May 3, 2013.
10. This requirement resulted from law suits filed in 2000, 2005, and 2010 citing the state's obligation to provide critical care. For a copy of the February 2013 Settlement Agreement in this litigation, see: <http://www.azahcccs.gov/publicnotices/courtordered/BallBetlach.aspx>.