Oversight of Participant-Directed Services: Key Considerations for Health Plans

Adequate oversight of the delivery of personal care services in participant-directed programs is vital to ensure that members' individual service plans are being carried out correctly and to prevent fraud and abuse. However, monitoring the provision of services in participant-directed programs can be challenging because of the discretion participants have to control and adjust the timing, level, and type of services they receive. This brief is intended to assist your health plan in overseeing participant-directed services while protecting the rights of participants to manage their own services and assume autonomy. For more information on participant-directed services, see "Developing and Implementing Participant Direction Programs and Policies: A Handbook" on the National Resource Center for Participant-Directed Services (NRCPDS) website.

Key Considerations

- **Establish written operational policies, procedures, and practices for oversight and quality improvement of participant-directed services.** Your health plan should set realistic expectations and provide clear direction for staff supporting members in participant-directed models. The roles and responsibilities of health plan staff, other entities providing support, and members should be described clearly in writing and be consistent with state and federal program rules. It is important to have a clear understanding of these requirements. Oversight and quality assurance monitoring reports and activities should be identified and included in manuals. Data sources, including documented feedback from participants, and information submitted by other entities as described below, should be identified.
- **Rely on Financial Management Service (FMS) agents and agencies.** The supervision and employment responsibilities that provider agencies assume in the traditional service delivery model are transferred to participants and FMS agents in the participant-direction model. FMS agents and agencies can provide support for enrollees in participant-directed programs. Examples of FMS agencies include Centers for Independent Living, Home Health Agencies, and banks. For enrollees with limited experience in the administrative duties of participant-directed programs, these agents handle the payroll, check writing, and taxpaying associated with participants' approved spending plans, ensuring that participants do not overspend and that all spending is accurately documented. Some FMS organizations can perform as a "mini management information system" for programs and participants, providing a variety of financial reports regarding the receipt of public funds, service use, and payments. The reports inform participating enrollees about their service use and spending related to the services, and act as a fiscal or fraud monitoring tool for participants and health plan staff.
- **Rely on reporting and feedback from participants.** This feedback should be used to assess program effectiveness and appropriate strategies for improvement. Several mechanisms should be used to obtain participants' feedback regularly, including in-person or telephone participant experience

surveys, assessments and reassessments. For more information about conducting a participant survey, see Chapter 8 of the NRCPDS handbook.

- **Implement an Electronic Visit Verification (EVV) system.** EVV is a telephone and computer-based system that electronically verifies service visits and documents the precise time service provision begins and ends. A robust EVV system can ensure that personal care services are scheduled, authorized, and delivered in accordance with members' service plans. It can notify your health plan when scheduled services are not provided, which facilitates appropriate service delivery and avoids the potential for paying fraudulent claims. Methods for implementing EVV systems include telephone-based solutions, mobile phones/devices with GPS, tablet-based solutions (in which the personal care attendant obtains a signature from the member or member's caregiver upon arrival and departure from the home), or electronic random number match devices (the personal care attendant records a number from the member's home).

Electronic Visit Verification (EVV)

Major EVV vendors include:

- Ankota, Inc.
- August Systems, Inc.
- CareWatch, Inc.
- CellTrak Technologies, Inc.
- HealthWyse, Inc.
- Smart Data Solutions
- Optum, Inc.
- Sandata Technologies, LLC
- Sansio, Inc.

- **Use critical incident management systems.** When data collected from any source indicates that the health or welfare of a member directing their own services has been jeopardized, your health plan must have a system documenting and tracking the remediation of problems associated with the incident. Critical incidents vary by state, but can include: abuse, neglect, and/or exploitation; unexpected or frequent hospitalizations; deaths; serious injuries that require medical intervention or result in hospitalization; medication errors; inappropriate use of restraints; and other incidents or events that involve harm or risk of harm to participants (NRCPDS handbook Ch. 8). Automating the collection of this data allows for analyses of patterns, for instance the characteristics of persons at risk, categories of critical events, and alleged perpetrators. Service providers, including direct service workers hired by participants, must understand their legal responsibility to report such incidents.
- **Provide support for members to conduct criminal record checks.** Support should be available to help participants understand and analyze the background check results to determine if the findings are significant relative to the services the worker will provide and if the worker poses a risk. Your health plan may also consider implementing an abuse registry that participants can check before they hire a worker.
- **Safeguards.** Your health plan will be expected to implement basic safeguards on behalf of participants who direct their own services, including ensuring that services are not interrupted when transitioning from self-direction to provider-managed, depletion of the budget, and having participant individual backup plans for service delivery breakdowns.

The Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) seeks to help beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. This brief is intended to support health plans and providers in integrating and coordinating care for dually eligible beneficiaries. It does not convey current or anticipated health plan or provider requirements. For additional information, please go to https://www.resourcesforintegratedcare.com/