March 10, 2013

Danice DeBerry
Senior Manager for Product Development
URAC

Dear Danice:

RE: Proposed New URAC Case Management Standards and Performance Measures

Submitted on behalf of the Consortium for Citizens with Disabilities (CCD) Task Force on Long Term Services and Supports

Context for CCD Review – National Quality Forum (NQF) MAP (Measure Applications Partnership) Identification of Gaps

CCD serves on the NQF work group on persons dually eligible for Medicare and Medicaid. CCD has identified six gaps in existing quality standards as they directly relate to persons with disabilities. We pursue these areas within NQF. These gaps are the context for our review of the URAC case management standards. The NQF interim report to CMS (Centers for Medicare and Medicaid Services) on quality measures for dually eligible persons addresses five of these six measures; employment is not addressed. The six gaps are:

1. Consumer Choice and Participant-Directed Services
2. Satisfaction: Individual Experience with Services and Supports
3. % in employment or meaningful day activity
4. % in independent housing – Consumer choice, housing appropriateness, stability
5. Integrated primary and specialty care
6. Access to timely and appropriate care

CCD Overview Comments on the URAC Case Management Standards

We commend URAC for offering its draft standards for public review and public comment.

We commend URAC for its terminology use of “consumers” (as contrasted with a typical medical sector use of the word “patients”). We commend URAC for recognizing the important role of families. We commend URAC for a focus on “consumer engagement” and services and supports “coordination.”

CCD believes that acute care case management is very different from long term services and supports case management. CMS (Centers for Medicare and Medicaid) has provided guidance on conflict free case management in its Balancing Incentives Manual which we encourage URAC to review. With that caveat, CCD offers the following suggestions.
We encourage URAC to replace the word “care” – care coordination and care transitions to “services and supports.” Care implies a paternal medical professional control model. For background information, we attach a chart comparing the “medical model” with the disability “independent living model.” We also suggest that the standards clarify that each time “consumer” is used, “or representative” is implied. For individuals with intellectual disabilities or cognitive impairments, a chosen representative may be necessary.

The URAC standards address many important areas of “case management.” However CCD believes that case management should be independent and conflict free and that far too much discretion is left to the agency and health plan in these standards. CCD would prefer more precise requirements about independent, conflict free case management. We also have some suggestions for more appropriately and more effectively addressing current best practice in the area of disability.

CM 1 – Program Description

(d) (i) Do not include “Consumer Case Management Plans” as an area for the mandatory incorporation in this section of evidence-based medicine and/or clinical practice guidelines. Consumer case management plans should be “person-centered” and based on several factors that may not lend themselves to the evidence-based standard in medicine that includes randomized trials.

CM 2 – Collaborative Communications – page 4

Consumers are not specifically mentioned as stakeholders in this section. We encourage URAC to reference in CM 2 – the expectation for compliance with CM 3 – Consumer Involvement

CM 3 – Consumer Involvement in Decision-Making - page 5

CCD is glad to see the promotion of consumer, family, and care giver involvement. The three identified areas – self-management, informed decision-making, and knowledgeable use of medications are important.

However, the disability and independent living movements have moved beyond “consumer involvement” to consumer/participant choice and direction. This is a critical omission in CM 3. The URAC standard is silent on this element. Existing Medicaid state options, such as Money Follows the Person, Community First Choice Option, Home and Community Based Services State Option, and Cash and Counseling include provisions for consumer control and direction of supports and services. The U.S. Department of Education Independent Living program is centered on consumer/participant direction. SAMHSA (Substance Abuse and Mental Health Services Administration) finances peer-coaches and peer-wellness specialists as part of the effort to promote and encourage consumer/participant direction. Consumer/participant choice and direction are fundamental to several federal agencies.
CCD believes that CM 3 needs to include components that address self-determination and person centered planning and delivery of life-long services and supports. In order to effectively support individuals, case managers must understand what person centered planning entails. The planning process includes: (a) recognition that the person is the center and driver of the overall planning and service delivery process, (b) the operation of a “person-centered” planning and review process that identifies the services and supports that are important to the individual as well as the services and supports that are important for the individual (the inclusion of these separate perspectives in the individual’s overall plan is essential to the ability to achieve a successful and satisfactory support outcomes), and (c) provisions that support the individual to personally direct and control the delivery of needed services and supports.

Likewise, case managers must understand the concept of self-determination. The Council for Quality Leadership (CQL) defines “self-determination” as a "combination of skills, knowledge, and beliefs that enable a person to engage in goal directed, self-regulated autonomous behavior and understanding of one's strengths and limitations together with a belief in oneself as capable and effective." The National Quality Forum (NQF) interim-report to CMS on persons dually eligible for Medicare and Medicaid includes this definitional citation and footnote.

CM 4 Internal Performance Monitoring

Include (d) Outcome performance measures related to consumer experience with (1)”care” and treatment, (2) personal choice and involvement in clinical and treatment related decisions, and (3) participation in activities of daily living.

CM 5 Information Support Systems P- 7

Revise: “In support of achieving its case management performance goals, the organization summarizes its information systems needs and capabilities in the following areas: [---]”

To read: In support of achieving its case management performance goals, the organization annually assesses and summarizes and reports on its information systems performance, needs and capabilities in the following areas: [--]

CM 7 – Consumer Motivation and Engagement

Revise:
(a) to read: An evidence – informed motivational change framework implemented in collaboration with the consumer

(b) Omit this alternative. Assessments to determine consumer readiness are largely worthless in practice. One must assume readiness and work with the person to become as engaged in the process as he or she is willing and able.

(c) – leave as is
(d) – **Revise to read:** Evidence – informed principles that support a consumer’s ability to identify, set and accomplish self-management goals.

**CM 13 – Assessment Categories – page15**

In its *Olmstead* decision, the United States Supreme Court stressed states’ obligation to promote and support community-based living of persons with disabilities. CCD suggests two elements that should be added to the URAC case management assessment categories:

1. Independent living skills
2. Community living goals and barriers

Regarding the URAC proposal that an assessment category be a consumer’s self-assessment and perception of their health care needs to identify potential gaps in care, see our comments on CM 3 – Consumer Involvement in Decision Making.

**CM 14 – Medication Safety Assessment – page 16**

Two fundamentally important elements are missing:

1. Currently experienced side effects
2. Side effects correction plan

**CM 15 – Case Management Plan**

The URAC draft reads – the plan “is developed by a case manager.” In keeping with the concepts of person-centered planning and self-determination as detailed in our comments on CM 3 – Consumer Involvement – we suggest that “developed” be deleted and replaced by “facilitated and documented.” We also suggest that “individuals chosen by the consumer” be added to (i).

**CM 16 – Care Coordination**

Consistent with the disability and independent living movement philosophy, we suggest that “health” be added to “care” and that “long term services and supports needs” be included.

The URAC draft states that health care services, behavioral care service, and providers be the elements of coordination. Missing are the following elements:

1. Community and social supports
2. Housing and transportation supports
3. Independent living supports
4. Family supports

The draft indicates that case managers assist consumers select providers to which case managers make referrals. The standard should clarify that the case manager makes referrals only “if the consumer requests assistance in making a referral.” CCD reiterates our belief that case
management must be independent and conflict-free. Case managers should assist consumers locate available community resources to assist with health-related issues as well as all of their individual support needs, such as community living, employment, social activities, etc.

Case managers should be conflict free so that they can effectively advise consumers as to which providers will best meet their individual support needs. LTSS case management is a very different intervention from acute care case management. Probably the best information available is the CMS Balancing Incentives Manual and recent guidance from CMS on conflict free case management.

Unfortunately there are no specific federal standards for LTSS case management in terms of competencies (there are some standards for medical care coordination is some programs). Since all states participate the HCBS waiver program, they have all articulated case management standards for LTSS programs as this is required. Both the National Core Indicators and Council for Quality and Leadership have some good outcomes/standards for case management.

A distinction is necessary between LTSS case management and care coordination of medical services. The scope of responsibility for LTSS is much greater and case managers have multiple roles from support planning to quality management of providers’ performance.

Thank you for considering our views.

Sincerely,

Consortium for Citizens with Disabilities (CCD)
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