

Idaho's End-Stage Renal Disease Program

Evaluation Report
November 2011

Office of Performance Evaluations
Idaho Legislature



Report 11-07

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Idaho's End-Stage Renal Disease Program

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Office of Performance Evaluations

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November 21, 2011

Members
Joint Legislative Oversight Committee
Idaho Legislature

Last March you directed us to evaluate Idaho's end-stage renal disease program. The program, administered by the Division of Vocational Rehabilitation, was established in 1970 to provide financial assistance to individuals suffering from chronic renal disease.

Today, Medicare and full-coverage Medicaid cover expenses for end-stage renal disease, which makes the original intent of Idaho's program less relevant. In addition, Idaho's program lacks sufficient procedures and safeguards needed to enforce eligibility requirements. As a result, program participants have received payments for services that they were not eligible to receive.

In the report, we discuss three program options for legislative consideration. The first option recommends that the Legislature gradually phase out the program. In their formal responses to our evaluation, the Governor, the State Board of Education, and the Department of Health and Welfare concur with this option. Their responses are included at the end of the report.

We thank program officials and staff for their cooperation and assistance in conducting this evaluation.

Sincerely,

A handwritten signature in blue ink that reads "Rakesh Mohan".

Rakesh Mohan

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Executive Summary

Idaho's End-Stage Renal Disease Program

End-stage renal disease is permanent kidney failure, requiring regular treatment of dialysis or a kidney transplant.¹ People with end-stage renal disease are eligible for Medicare under the Social Security Amendments of 1972.

Idaho is one of sixteen states we identified with an end-stage renal disease program. The program is administered by the Division of Vocational Rehabilitation and covers the cost of services not covered by Medicare such as medications, travel expenses, insurance premiums, and limited transplant services. In fiscal year 2011, the program was appropriated \$527,700 and served 169 participants.

Some legislators are concerned that a duplication of covered expenses exists between Idaho's end-stage renal disease program and other state-funded assistance programs, particularly Medicaid. They also questioned whether the program may be more appropriately housed within the Department of Health and Welfare.

The Program Lacks Sufficient Procedures and Safeguards Needed to Enforce Requirements

We found the program lacks clearly articulated procedures to enforce its eligibility requirements, which has resulted in inconsistencies among staff and regions. Individuals receiving full-coverage Medicaid are not eligible for the program. However, we found that Medicaid restrictions are not made clear in the program's field manual or application documents. Additionally, staff are limited in their ability to verify or enforce the program's Medicaid restrictions. We found evidence that suggests duplication exists for medical expenses covered by Medicaid.

We found that ten percent of program participants from fiscal year 2011 have received a paid Medicaid claim since July 2008.² Of those participants, 12 received paid Medicaid claims with a primary code of end-stage renal disease

¹ Centers for Medicare and Medicaid Services, *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services*, CMS product no. 10128.

² After revisions to the 2008 field manual, individuals receiving full-coverage Medicaid are no longer eligible for the end-stage renal disease program.

since July 2008. Since that time, the program has paid a total of \$49,024 to these 12 participants.

In addition to these payments, we found the end-stage renal disease program paid nearly \$116,000 to another 13 percent of participants for services that they were not eligible to receive after July 2008. As a result, the program is not in compliance with Idaho Administrative Code and may potentially be in violation of state law.

Options for Moving Forward

Given legislative concerns about duplicative expenses and questions about the appropriate placement of the program, as well as our own findings, we identified three options for the Legislature to consider when deciding the future of the program.

1. **Phase out the program over the course of several years.** This option would allow current participants to indentify other sources of financial assistance and make necessary adjustments rather than abruptly losing services.

If the Legislature chooses to continue the program, it may decide between one of two options.

2. **Keep the program intact.** This option would require the Division of Vocational Rehabilitation to clarify the eligibility requirements and determination process in its field manual and possibly in Idaho Code.
3. **Move the program to the Department of Health and Welfare.** This option would parallel the majority of counterpart programs in other states. If the Legislature elects to move the program, the Department of Health and Welfare will need to clarify the eligibility requirements and determination process.

Acknowledgements

We appreciate the assistance of the Division of Vocational Rehabilitation, the Department of Health and Welfare, the Office of the Attorney General, legislative Budget and Policy Analysis, the Division of Financial Management, the Department of Administration, and the Legislative Library.

Hannah Crumrine of the Office of Performance Evaluations conducted this study, and Margaret Campbell copy edited and desktop published the report. Dr. Kathleen Sullivan, professor and former director of the Center for Education Research and Evaluation at the University of Mississippi, conducted the quality control review.

Chapter 1

Introduction

Program History

Kidney disease is divided into five stages of illness ranging from initial kidney damage to kidney failure. The fifth stage is commonly known as end-stage renal disease and is defined as permanent kidney failure, requiring regular treatment of dialysis or a kidney transplant.¹ Idaho is one of sixteen states we identified with an end-stage renal disease program.

Original Legislative Intent

Idaho's end-stage renal disease program was implemented in 1970 with the passage of House Bill 467. The bill established a program within the Division of Vocational Rehabilitation to provide financial assistance for individuals unable to pay the cost of services.² House committee meeting minutes from 1970 further explain that the program would make dialysis machines available to participants. At that time, dialysis treatment and kidney transplants were relatively new and neither was covered by insurance. The actual legislative intent as written in Idaho Code is broader than just dialysis machines:

It is the intent of the legislature of Idaho to [e]nsure the establishment of a program for the care and treatment of persons suffering from chronic renal diseases. This program shall assist persons suffering from chronic renal diseases who require lifesaving care and the treatment for such renal diseases, but who are unable to pay for such services on a continuing basis.³

Three years after the implementation of Idaho's program, Medicare began covering treatment for kidney failure with the passage of the Social Security Amendments of 1972. According to program officials, after Medicare started covering the majority of dialysis costs, Idaho's program began covering

¹ Centers for Medicare and Medicaid Services, *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services*, CMS product no. 10128.

² The Division of Vocational Rehabilitation's mission is to assist individuals with disabilities in gaining employment.

³ IDAHO CODE § 33-2307.

participant Medicare co-payments. As the program continued to evolve, it also began covering the cost of medications, travel expenses, and insurance premiums.

Program Today

In 2008, concerns about the program’s statutory authority to pay for some services led program officials to consult with the Office of the Attorney General. As a result, statute was changed that same year to allow the program to cover the cost of insurance premiums and travel to and from dialysis treatment. Statutory

Medicare funds
must be used
before state funds.

changes also clarified that Medicare funds would be used before state dollars. Although not part of the statutory changes, the division’s field manual was revised to exclude individuals receiving full-coverage Medicaid from program participation.

Today, the program covers the cost of medications, transportation to and from dialysis treatment, insurance premiums, and some transplant services. These services are listed in the field manual, which is incorporated by reference in Idaho Administrative Code.⁴ The services provided by the program have changed over time but the mission and purpose of the program remain the same:

To provide financial assistance for lifesaving medical care and treatment to Idaho residents who are experiencing end-stage renal disease; and who do not have the financial resources to meet all their end-stage renal disease medical needs.⁵

Staff from the general vocational rehabilitation program work with end-stage renal disease participants. There are no dedicated program staff. As shown in exhibit 1.1, participants access services in eight regions throughout the state that are overseen by a regional manager. Staff make program eligibility determinations using five requirements determined by the division and outlined in the program’s field manual.

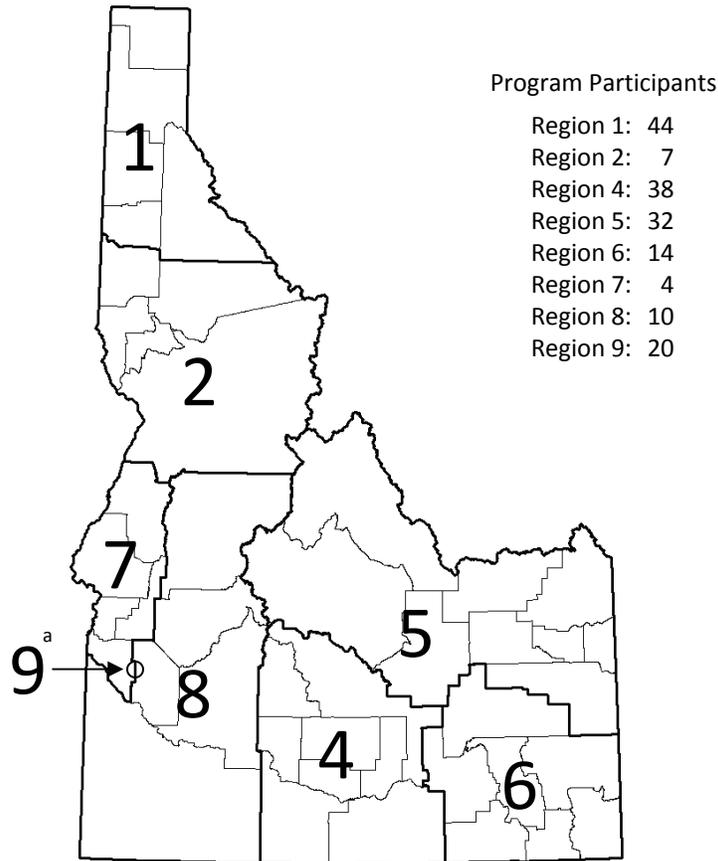
Idaho’s End-Stage Renal Disease Population

According to the Northwest Renal Network, 1,130 individuals received dialysis treatment in Idaho during calendar year 2010. In fiscal year 2011, Idaho’s end-stage renal disease program served 169 dialysis and transplant patients. In June 2011, there were 39 names on the program’s waiting list. Exhibit 1.1 shows the number of program participants in each region for fiscal year 2011.

⁴ IDAPA 47.01.01.004.02.b.

⁵ Idaho Division of Vocational Rehabilitation Strategic Plan, 2008–2012.

EXHIBIT 1.1 NUMBER OF PARTICIPANTS IN THE END-STAGE RENAL DISEASE PROGRAM BY REGION, FISCAL YEAR 2011



Source: Information from the Division of Vocational Rehabilitation, July 2011.

Note: Region 3 is Treasure Valley Special Programs and does not serve end-stage renal disease participants. It is not represented on the map.

^a Region 9 is Treasure Valley Corrections, which currently serves end-stage renal disease participants because of recent staff relocations. Region 9 would not typically serve these participants.

Legislative Interest

Some legislators expressed concern that a duplication of covered expenses exists between Idaho's end-stage renal disease program and other state-funded assistance programs, particularly Medicaid. They also questioned whether the program may be more appropriately housed within the Department of Health and Welfare.

At its March 2011 meeting, the Joint Legislative Oversight Committee approved a request to review the end-stage renal disease program with a focus on the original intent of the program, the potential for duplication of covered expenses,

and the appropriateness of the program placement. Appendix A contains a complete list of the study scope questions.

Methodology

To better understand the program's legislative intent, its operations and procedures, duplication of expenses covered by other assistance programs, and where the program should be placed, we used a variety of research methods:

- Interviewed officials and staff from the Division of Vocational Rehabilitation within the State Board of Education, and the divisions of Public Health, Medicaid, and Welfare within the Department of Health and Welfare.
- Surveyed 20 vocational rehabilitation regional managers and field staff to identify individual and regional similarities and discrepancies in the eligibility determination process.⁶
- Reviewed the Division of Vocational Rehabilitation field manual and application documents, Idaho Code, and Idaho Administrative Code. We consulted with the Department of Administration to clarify questions we had about administrative rules.
- Identified end-stage renal disease program participants enrolled in the program during fiscal year 2011 who also received a paid Medicaid claim from July 2008 to May 2010.⁷
- Identified end-stage renal disease program participants enrolled in the program during fiscal year 2011 who received services they were not eligible for as a Qualified Medicare Beneficiary enrollee after the July 2008 revisions to the field manual.
- Conducted file reviews of the eight regions serving end-stage renal disease program participants. We visited four of the regional offices, where we conducted 72 onsite file reviews.
- Consulted with legislative Budget and Policy Analysis staff to reconcile discrepancies in expenditure data.

⁶ Our survey findings come from the responses of 18 managers and program staff who reported they work directly with end-stage renal disease participants. The 18 survey respondents represent 90 percent of the 20 staff positions (12 program staff and 8 regional managers) reported by the division.

⁷ After revisions to the 2008 field manual, individuals receiving full-coverage Medicaid were no longer eligible for the end-stage renal disease program.

- Consulted with the Office of the Attorney General to ensure we responsibly and correctly handled participant Medicare and Medicaid information.
- Contacted all 50 states to determine which states have similar end-stage renal disease programs. We surveyed the 15 states we identified with similar programs.
- Interviewed national and local end-stage renal disease organizations to learn more about financial assistance available to individuals with end-stage renal disease.

Report Organization

The report is organized in the following chapters:

- Chapter 2 is an overview of the end-stage renal disease program and the eligibility determination process.
- Chapter 3 discusses the program's safeguards and identifies potential insufficiencies.
- Chapter 4 discusses program placement, offers suggestions for moving forward, and provides the Legislature with three options to consider.

Chapter 2

Program Eligibility

Medical Expenses Covered by the Program Are Limited

Since the 2008 statutory changes, the end-stage renal disease program primarily pays for medications, transportation, and insurance premiums. Program staff use a field manual developed by the division to identify the services and expenses covered by the program. The program reimburses both to participants and to vendors.

Services and Expenses Covered by Idaho's Program

As outlined in the field manual, the program may pay for medications, transportation, and insurance premiums directly related to chronic end-stage renal disease that are not covered by Medicare or full-coverage Medicaid.

Medications. The program may pay for all medications prescribed by the participant's nephrologist (kidney disease specialist), including over-the-counter medications. Under program guidelines, staff assume that any medications prescribed by the nephrologist are related to the disease. A participant must have a letter proving a relationship for medications that are prescribed by a physician other than a nephrologist. The maximum coverage for medications is \$400 a month.

Transportation. The program may pay for transportation costs to and from dialysis treatment using general reimbursement guidelines established for all division programs. Reimbursement is based on the actual cost of public transportation up to \$200 a month.

Insurance Premiums. The program may pay supplemental or primary medical insurance premiums if staff determine that premiums are more cost effective than paying for the medications and transportation. The program may pay all or part of the premium.

Miscellaneous Coverage. Some specific costs associated with transplants are covered:

- If not covered by Medicare, the program may pay for dental work, vision exams, or similar services recommended by the participant's

nephrologist. Some participants need these services before they can be placed on a transplant waiting list.

- The program may pay for transportation and per diem costs to and from a transplant center, and lodging before hospital admittance and after discharge. These costs can also be extended to one person assisting the participant.
- After the transplant, the program may pay for transportation costs to and from follow-up appointments for up to 12 months (maximum \$200 a month), any medications other than anti-rejection drugs (maximum \$400 a month), and supplemental or primary insurance premiums. There is no defined limit of duration for the last two services.

Services and Expenses Not Covered by Idaho's Program

The program *will not* cover the following services:

- Dialysis treatment
- Physician visits at dialysis centers
- Dietary products
- Homeopathic remedies
- Prosthetics or orthotics
- Medicare premiums, with the exception of Medicare Part D supplemental insurance
- Family members serving as dialysis technicians
- All dialysis treatments, medication, and transportation costs paid by Medicaid
- Medications for non-end-stage renal disease conditions
- Some transplant costs
 - Getting participants on a transplant list
 - Transplant services covered by Medicare
 - Physician follow-up visits after transplant
 - Anti-rejection medications

The Process for Determining Eligibility Is Inconsistent Among Regions

Program eligibility is determined by vocational rehabilitation staff in eight regions, using requirements outlined in the program's field manual.¹ The actual process for determining eligibility may vary among staff and regions, creating inconsistencies in how the process is completed.

¹ The division has nine regions but only eight serve end-stage renal disease program participants.

Eligibility Requirements

Individuals must meet five eligibility requirements to participate in the program:

1. Have chronic end-stage renal disease as diagnosed by a physician
2. Be Medicare eligible at time of eligibility determination
3. Be an Idaho resident
4. Demonstrate financial need
5. Meet one of the following additional criteria:
 - a. Unable to work because of age or severity of disease
 - b. Currently employed but unable to afford kidney disease expenses on a continuing basis
 - c. Referred to the Division of Vocational Rehabilitation for its general vocational services program

Medicare eligibility is a requirement to participate in the program. Additionally, individuals are required to apply for medical insurance premium assistance from the American Kidney Fund and research assistance from the National Kidney Foundation and Medicare Part D.² Veterans must apply for veteran benefits and Native Americans must apply for Indian Health Services.

The program also requires that all potential participants apply for benefits through the Department of Health and Welfare, specifically the Qualified Medicare Benefits program, the Specified Low-Income Medicare Beneficiary program, and full-coverage Medicaid.³ As of July 2008, individuals receiving full-coverage Medicaid are not eligible for the program.

Individuals receiving full-coverage Medicaid are not eligible for the

Qualified Medicare Benefits and Specified Low-Income Medicare Beneficiary are savings programs funded by Medicaid. They help certain relatively low-income Medicare enrollees cover some of the costs required to participate in Medicare Parts A and B. These programs are not considered full-coverage Medicaid. Therefore, enrollees receiving benefits from either of these Medicaid savings programs are eligible for participation in the end-stage renal disease program.

Eligibility Determinations and Enrollment Process

Program staff are not given specific guidelines or a specific process to follow when making eligibility determinations. Consequently, staff have more than one way to determine eligibility, which creates regional inconsistencies in the

² Appendix B describes the details of these programs.

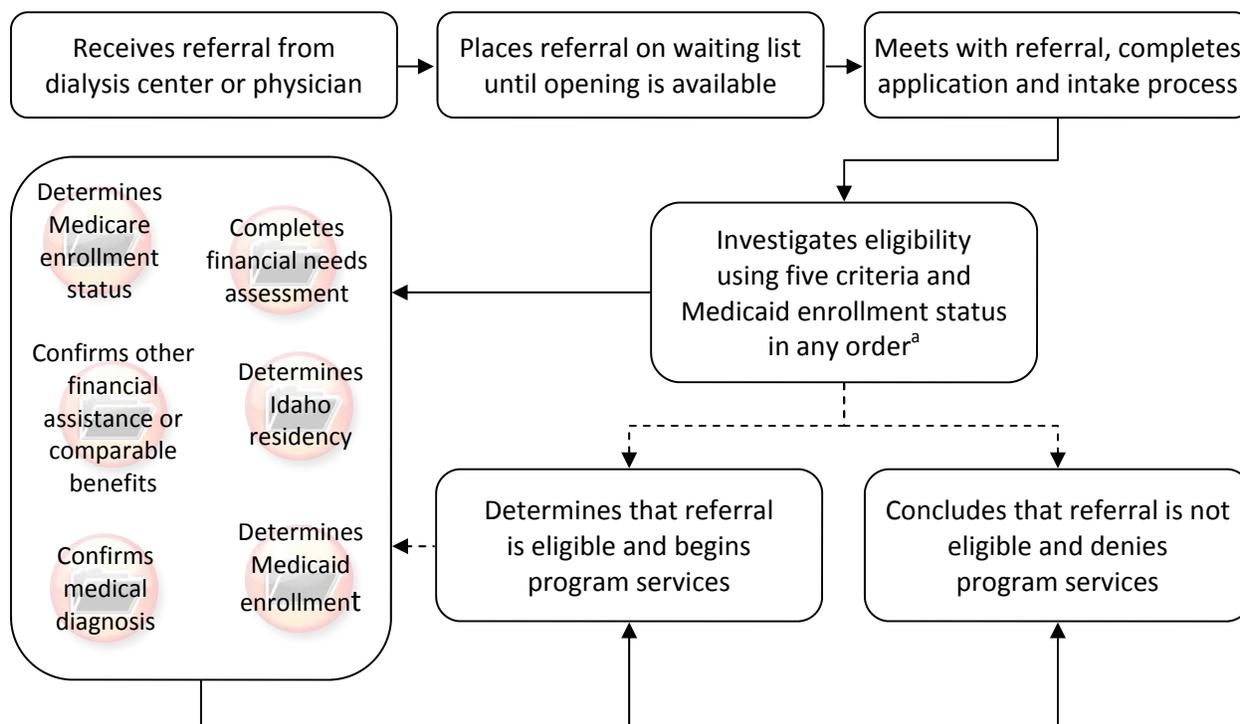
³ Appendix C discusses Medicaid programs in greater detail.

process. Exhibit 2.1 is an example of the general eligibility determination process.

Typically, an individual is referred by his or her physician to a dialysis center. Social workers at the dialysis center screen individuals and refer them to the end-stage renal disease program where they are put on a waiting list. Program staff do not check the five eligibility requirements at this point, so an ineligible individual could potentially be placed on the list.

When a participant leaves the program, a new spot becomes available. Because the program operates on a first come first serve basis, there is no priority placement, meaning the program may not be serving the neediest individuals first. Therefore, the first individual on the waiting list meets with program staff to begin the intake process and complete the application packet. The division uses a general application for all its clients, including individuals with end-stage renal disease. Not all of the application information is applicable to individuals with end-stage renal disease, so some sections may be left blank.

EXHIBIT 2.1 VOCATIONAL REHABILITATION’S END-STAGE RENAL DISEASE PROGRAM APPLICATION AND ELIGIBILITY DETERMINATION PROCESS



Source: Office of Performance Evaluations.

^a Eligibility can be determined at any point in the process and before each requirement is confirmed.

Program staff discuss the eligibility requirements with applicants during the intake process and as part of the application. At the close of the intake process, the applicant signs an agreement stating he or she understands and will comply with the terms of the program. The applicant also signs a medical disclosure form allowing program staff to access his or her medical records.

Eligibility is determined according to the application packet and the information collected during the intake process. Staff may work alone or in consultation with a supervisor to determine applicant eligibility.

When determining eligibility, staff do not follow a defined sequence of steps. For instance, staff are not required to complete a financial needs assessment during the intake process. Consequently, program eligibility may be determined *before* the financial needs assessment is completed. As shown in exhibit 2.1, program eligibility can be determined before each requirement has been confirmed. The potential inefficiencies and other effects of these sequencing problems are discussed in chapter 3.

A Majority of Program Funding Goes to Participant Services

The end-stage renal disease program does not have dedicated funds and does not receive federal assistance. The program is supported entirely by the state general fund. In fiscal year 2011, the program was appropriated \$527,700.

Operating and Personnel Expenditures

According to program officials, the Division of Vocational Rehabilitation, in consultation with the Division of Financial Management and the Legislative Services Office, decided to eliminate operating expenditures in fiscal year 2010. The decision was made in response to a nearly nine percent reduction in the program's overall budget in fiscal year 2009. Rather than lose funding for participant services, the division opted to move the program's annual \$54,600 appropriation for operating expenditures to trustee and benefit expenditures.

Although the program no longer receives an appropriation for operating expenditures, it does receive an appropriation for personnel costs. In fiscal year 2011, the program spent \$67,300 on 1.5 full-time positions.

Participant Service Expenditures

In fiscal year 2011, the program spent \$419,000 on participant services.⁴ Funding for these services is appropriated by the Legislature under the

⁴ Approximately \$25,000 had been encumbered from fiscal year 2010.

expenditure classification of trustee and benefit. The division coded program expenditures from fiscal year 2011 mainly in four categories:

1. Medical assistance reimbursed to vendors
2. Rehabilitation services reimbursed to participants
3. Rehabilitation services reimbursed to vendors
4. Other educational and assistance training

As seen in exhibit 2.2, rehabilitation services reimbursed to participants was the largest spending category. According to program officials, direct reimbursement to participants for travel expenses to and from dialysis treatment falls under this category.

The second largest spending category was medical assistance reimbursed to vendors. According to program officials, this category captures payments made directly to vendors for participants' medications or payments made directly to insurance companies for participant insurance premiums. Transplant related transportation costs may also be included in this category.

The third largest spending category was other educational and training assistance. In the past, the program covered the cost of training individuals for administering home dialysis treatments, but we were told that very little training is done today. Program officials think this category has been miscoded.

EXHIBIT 2.2 END-STAGE RENAL DISEASE PROGRAM EXPENDITURES, FISCAL YEAR 2011

Expenditure Classification	Expenditures by Category (\$)	Expenditures by Classification (\$)
Personnel Costs		67,300
Operating Expenditures		0
Trustee/Benefits		419,061
1. Medical assistance reimbursed to vendors	76,682	
2. Rehabilitation services reimbursed to participants	305,169	
3. Rehabilitation services reimbursed to vendors	10,398	
4. Other educational and training assistance	18,462 ^a	
5. Rents and lodging to vendors	7,031 ^b	
6. Payments to participants	1,319	
Reversion to general fund		<u>41,338</u>
Total		527,700

Source: Legislative Budget and Policy Analysis and the Division of Vocational Rehabilitation, September 2011.

Note: Total may not sum because of rounding.

^a Payments for transportation, medications, and insurance premiums were incorrectly coded to this service category.

^b The division was unable to account for payments made to this service category.

Our review of the services listed under this category in fiscal year 2011 supports their conclusion.

Expenditure Discrepancies

The trustee and benefit expenditure data we received from the Division of Vocational Rehabilitation did not match the expenditure data we received from Budget and Policy Analysis. Some of the discrepancy was caused by reporting differences for encumbrances. However, a \$7,000 discrepancy remains unresolved under the division's fifth category of rents and lodging to vendors.

As outlined in our scope, we examined the division's financial data and found that 79 percent of funding was provided for participant services in fiscal year 2011. Because of the miscoding in other educational and training assistance and the discrepancy in rents and lodging to vendors, however, we were unable to accurately report how payments for services were spent.

Chapter 3

Program Safeguards

The Program Lacks Sufficient Safeguards

The program field manual offers little guidance on how to conduct the eligibility determination process, leading to vague and undefined program procedures. Additionally, staff differ in their approach to conducting the eligibility determination process. Restrictions about Medicaid participation are particularly unclear, and program staff are limited in their ability to identify applicants enrolled in Medicaid and to enforce restrictions. As a result, the program is not able to effectively prevent a duplication of medical expenses covered by other assistance programs.

Overall Process Safeguards

Although the program has defined eligibility requirements, it does not have defined procedures. As a result, staff and regions differ in how they interpret and conduct the eligibility determination process, which does not ensure consistency in the process and leaves room for potential errors and oversights. We identified four areas of the process that lack sufficient safeguards.

Medicare

As an eligibility requirement, all program participants must be enrolled in Medicare. The field manual does not provide guidance on how to confirm Medicare enrollment. Program officials told us that staff typically make a copy of the applicant's Medicare card to confirm enrollment.

As part of our evaluation, we conducted onsite file reviews in four of the eight vocational rehabilitation regions that serve end-stage renal disease participants. Of the 72 files we reviewed, just 18 files contained a copy of the participant's Medicare card.

75 percent of the files we reviewed did not contain a copy of the participant's Medicare card.

Fourteen files contained an application for Medicare. Evidence that an applicant has applied for Medicare does not confirm Medicare eligibility or enrollment. Nevertheless, the program eligibility determination

process includes no safeguards to prevent staff from opening a case plan before confirming the approval of an applicant's Medicare application.

Staff seem to work under an assumption that all end-stage renal disease patients are enrolled in Medicare. However, according to the Northwest Renal Network, 2.3 percent of Idaho's dialysis patients in 2010 were not enrolled in Medicare. Additionally, Medicare coverage for end-stage renal disease ends 12 months after dialysis treatment stops or 36 months after a kidney transplant. Because Medicare enrollment is a program requirement, staff should officially confirm applicant status before making an eligibility determination.

Financial Assistance and Comparable Benefits

The field manual states that applicants must apply for all comparable benefits and that benefits must be documented in the case file. According to program staff, comparable benefits are usually identified while applicants are on the program's waiting list.

Despite this safeguard, eligibility determinations can be made without first confirming all of the applicant's comparable benefits. In the absence of defined procedures, program officials told us that staff typically do one of three things:

1. Open an application file but hold off on making an eligibility determination
2. Find the applicant eligible but hold off on developing a case plan
3. Find the applicant eligible, develop a case plan, and modify the plan once all comparable benefits have been identified

To learn more about potential regional differences in staff determinations of eligibility, we surveyed all Division of Vocational Rehabilitation regional managers and program staff.¹ Interestingly, more than half of program staff respondents answered that a case plan cannot be built without first confirming these benefits. Regardless, some staff may recreate or update case plans that were drafted before all types of financial assistance or comparable benefits were confirmed. But most concerning, staff might also accept an applicant that is not eligible for the program.

¹ Our survey findings come from the responses of 18 managers and program staff who reported they work directly with end-stage renal disease participants. The 18 survey respondents represent 90 percent of the 20 staff positions (12 program staff and 8 regional managers) reported by the division.

We also found that staff do not consistently collect the same types of documentation to confirm financial assistance or comparable benefits. Four out of twelve program staff respondents answered that documentation is not required to confirm these benefits.

4 out of 12 program staff respondents answered that documentation is not required when confirming financial assistance or comparable benefits.

Because the program is intended to assist participants who cannot afford the costs associated with end-stage renal disease, accurately documenting all types of financial assistance or comparable benefits is essential to a correct determination of eligibility and helps prevent a duplication of medical expenses covered by other assistance programs.

Financial Needs Assessment

Demonstration of financial need is a program eligibility requirement. Program officials told us that the financial needs assessment may be completed *after* they determine eligibility but *before* they develop the case plan. Our survey found that 67 percent of program staff respondents reported completing the financial needs assessment during the intake process. However, 25 percent of program staff respondents reported that they complete the assessment *after* the eligibility determination is made. As a result, some applicants may be told they are eligible for the program before one of the requirements, evidence of financial need, is established.

Although demonstration of financial need is an eligibility requirement, 25 percent of program staff respondents reported that they complete the assessment *after* the eligibility determination is made.

Because demonstration of financial need is an eligibility requirement, staff should complete the assessment before an eligibility determination is made to maintain consistency among regions and to ensure applicant resources fall short of covering the costs of end-stage renal disease services.

Federal Poverty Level Guidelines. Staff use an in-house financial needs assessment to determine whether the applicant meets this requirement. According to program officials, the current assessment does not rely on the federal poverty level guidelines or any other income restrictions to determine need. Instead, applicants must demonstrate that their available resources fall short of the total costs associated with end-stage renal disease services.

At the time of this evaluation, the Division of Vocational Rehabilitation was in the process of updating its financial needs assessment after looking at other states. The new assessment tool would have used the federal poverty level guidelines to determine financial need and would have applied to the end-stage renal disease program. However, the division has currently delayed the change

but might move forward during the 2012 legislative session. By implementing a new financial needs assessment, the program will join 11 of its counterpart state programs already relying on the federal poverty guidelines to determine need.

Oversight and Supervision

Most program staff work independently and make eligibility determinations without input from other staff or supervisors. Additionally, program officials told us that some regional managers are inexperienced or uninterested in administering the end-stage renal disease program, although each region does have an experienced staff person who can provide assistance.

As a quality assurance measure, the program requires that regional managers review all closed cases. One-third of respondents reported practices that were not consistent with this policy. For instance, 3 out of 12 program staff respondents answered that someone other than their regional manager signs off on closed plans.

The program does not require regional managers to review eligibility determinations or case plans. Our survey found that 3 out of 12 program staff respondents make eligibility determinations without input from other staff or a regional manager. Additionally, 3 out of 12 program staff respondents reported they finalize case plans without input from other staff or a regional manager.

Working in isolation or without adequate supervision creates opportunities for mistakes and oversights. Additionally, the quality assurance process should start at the beginning of the eligibility determination process rather than at the closing of a case, helping regional managers in identifying staff training needs and inconsistencies among staff procedures.

Medicaid Specific Safeguards

Full-coverage Medicaid recipients are not eligible for the end-stage renal disease program. However, our review of the program materials found that this requirement is not made clear to either program staff or participants. Additionally, not all staff recognize the differences between full-coverage Medicaid and the Medicare savings programs discussed in chapter 2. Combined, these issues prevent staff from making consistent eligibility determinations and could potentially lead to mistakes and oversights during the eligibility process or a duplication of medical services paid specifically by Medicaid. We identified two areas of the process specific to Medicaid that lack sufficient safeguards.

Program Materials

The field manual is the only official document stating that individuals receiving full-coverage Medicaid are not eligible for the program. Idaho Administrative

Code incorporates the 2008 field manual by reference but does not explicitly mention Medicaid or the end-stage renal disease program.²

Additionally, the exclusion of full-coverage Medicaid enrollees was not part of the 2008 statutory changes, although both Medicaid and Medicare were discussed in committee meetings and appeared in the statement of intent. A letter sent to program participants explaining the 2008 changes also did not mention Medicaid.

Nowhere does the program application state that full-coverage Medicaid enrollees are not eligible for the program. Without an explicit statement, the program relies solely on staff to orally inform applicants of the full-coverage Medicaid restriction. Conversely, the program application includes a full page informing applicants of the medical documents necessary to determine program eligibility. Applicants are asked to bring these documents to the intake meeting to avoid a delay in determining eligibility.

As part of the intake process, applicants sign forms stating they meet the eligibility requirements and understand the applicant's responsibilities if he or she is determined eligible for the program.

According to program officials and staff, the application forms are legal documents requiring applicants, and later participants, to inform staff of any changes in financial assistance, including Medicaid. However, our review of the documents revealed no explicit mention of financial assistance. Additionally, nowhere does the application or the forms requiring a signature specifically state that the applicant must inform program staff if he or she is currently receiving full-coverage Medicaid benefits or later becomes eligible for full benefits.

Medicaid Verification

The field manual states that individuals receiving full-coverage Medicaid are not eligible for the program. However, it does not outline how staff should verify whether an applicant has Medicaid. We found that some staff typically use one of two methods to determine an applicant's Medicaid status: (1) obtain a denial letter from the Department of Health and Welfare, or (2) confirm the status of an applicant's Supplemental Security Income through the Social Security Administration.

Denial Letter. Program officials told us that during the intake process, staff should require applicants to submit a denial letter from the Department of Health and Welfare to verify they are not receiving Medicaid. The program field manual states that verification of denial is required. However, program officials do not know whether this requirement has been well enforced or whether staff have interpreted this requirement in the field manual differently.

² IDAPA 47.01.01.004.02.b.

Our survey of program staff confirms that staff have different ideas about the submission of a Medicaid denial letter. Three out of twelve program staff respondents answered that unofficial letters or a phone call to the Department of Health and Welfare could be submitted in place of the denial letter.

86 percent of the files we reviewed did not contain an official Medicaid denial letter.

Of the 72 case files we reviewed, 62 did not contain an official Medicaid letter of denial from the Department of Health and Welfare. Four files contained a denial letter for other Health and Welfare assistance programs but not specifically Medicaid. We also saw files that contained handwritten notes with information about Medicaid benefits. Handwritten notes are not a sufficient substitute for an official denial letter.

Furthermore, program officials told us that eligibility determinations can be made without first receiving a Medicaid denial letter as long as services are not provided before the letter is received and documented.

These varied interpretations and discrepancies among staff and within the case files point out inconsistencies in the eligibility process specific to determining Medicaid status. Without clearly defined procedures, staff lack the detailed guidelines necessary to effectively enforce program requirements. The absence of sufficient safeguards also makes it possible to duplicate covered medical expenses.

Supplemental Security Income Verification. Although not required, some staff informally verify Medicaid status through the Social Security Administration. The division has an agreement with Social Security, through the Department of Health and Welfare, that allows staff to check an applicant's Supplemental Security Income and Social Security Disability Insurance. Program staff send an electronic form to Social Security and receive a report that accurately identifies which benefit the applicant receives. The report is used for the general vocational rehabilitation program.

According to some program officials, the report has the added benefit of identifying potential Medicaid enrollees because most people receiving Supplemental Security Income are automatically eligible for Medicaid. Therefore, most people receiving Supplemental Security Income are not eligible for the end-stage renal disease program. However, the report is optional and does not actually identify or confirm Medicaid status.

Program Staff Are Not Enforcing Medicaid Restrictions

After revisions to the 2008 field manual, individuals receiving full-coverage Medicaid were no longer eligible for the end-stage renal disease program. The July 2008 revisions also limited the services available to participants receiving Qualified Medicare Beneficiary coverage to medications only. We found that some program participants have received a paid Medicaid claim since July 2008. We also found that the majority of participants who received Qualified Medicare Beneficiary coverage have also received payment or reimbursement for services other than medication.

Individuals receiving full-coverage Medicaid are not eligible for the end stage renal disease

Paid Medicaid Claims

Working with staff from the Division of Medicaid, we identified 17 participants from the fiscal year 2011 end-stage renal disease program who also had a paid Medicaid claim from July 2008 and May 2010 even though the program prohibits the enrollment of full-coverage Medicaid enrollees.³ Since July 2008, the program has paid a total of nearly \$74,000 to these 17 participants.

10 percent of participants in the fiscal year 2011 end-stage renal disease program received a paid Medicaid claim from July 2008 to May 2010.

In addition, we checked the Medicaid code for primary end-stage renal disease and found that more than half of the 17 Medicaid enrollees received paid Medicaid claims under this primary code. Since July 2008, the program has paid a total of \$49,024 to these participants who also received paid Medicaid claims under the primary code for end-stage renal disease.

Medicare Savings Programs

Our survey results indicated that not all program staff understood the eligibility differences between full-coverage Medicaid and the Medicare savings programs. For instance, 2 out of 12 program staff respondents reported that individuals receiving Qualified Medicare Beneficiary coverage and Specified Low-Income Medicare Beneficiary benefits were only sometimes eligible for the program. However, program policies indicate that these individuals are eligible.

³ Because of the possibility of unreliable data, our search excluded any paid Medicaid claims after May 2010. As such, the number of participants receiving a paid Medicaid claim may actually be greater than reported.

Another misunderstanding among staff had to do with program participants who received Qualified Medicare Beneficiary coverage. As stated earlier, these participants may only receive payment for medications.

Since July 2008, the program has paid nearly \$116,000 to participants for services they were not eligible to receive.

Since July 2008, however, we found that 96 percent of participants who received Qualified Medicare Beneficiary coverage also received a total of nearly \$116,000 in program payments or reimbursements for services other than medications. The majority of these participants received a total of \$72,500 for transportation, and five of these participants received a total of nearly \$34,000 for insurance premiums.

The Program Is Not Compliant with Administrative Code

Because Idaho Administrative Code incorporates the 2008 field manual by reference, content written in the manual is part of code and enforceable. By not enforcing or monitoring the full-coverage Medicaid restriction, the program is potentially in violation of state law. This violation opens the door for possible court action should anyone appeal or question the eligibility determinations made by program staff.

The 2008 field manual states that program participants who are also enrolled in Qualified Medicare Beneficiary coverage may *only* receive assistance for medications. The program is potentially in violation of state law by allowing these participants to receive assistance for transportation and insurance premiums.

Chapter 4

Moving Forward with Options for the Future

Legislative Decision

Before any decisions can be made about the future of the end-stage renal disease program, the Legislature should first determine whether the program has outlived its relevance. Although the program meets legislative intent, soon after Idaho implemented its program in 1970, Medicare services were expanded to include coverage for people with end-stage renal disease. Likewise, private insurance companies and state-funded Medicaid programs have also started covering the cost of dialysis and transplants.

Furthermore, we found many weaknesses in the program that need to be addressed. In addition, the Division of Vocational Rehabilitation has not developed a well-structured program independent of its general program. These issues should also be considered when looking at the future of the program.

Knowing that other comprehensive coverage options exist, is it still the intent of the Legislature to provide financial assistance to those individuals who need help with the cost of end-stage renal disease treatments? When discussing this question, the following factors should be considered:

- Medicare covers the cost of most services associated with end-stage renal disease.
- Medicaid also covers the cost of services associated with end-stage renal disease, including medications, transportation, and insurance premiums.
- Private insurance companies cover the cost of most services associated with end-stage renal disease.
- The program provides financial assistance for medications, travel expenses, and insurance premiums.
- The program's eligibility determination process is not consistently implemented.

The Legislature should determine whether the state wishes to continue offering financial assistance to individuals with end-stage renal disease.

- The program needs a field manual with defined procedures and training to promote compliance to consistently enforce its policies.

Recommended Options for the Future

Given legislative concerns about duplicative services and questions about the appropriate placement of the program within state agencies, as well as our own findings, we identified three options for the Legislature to consider when deciding the future of the program.

Option One: Phase Out the Program

The Legislature may conclude that, as a policy decision, the program has outlived its relevance and decide to stop providing funding for the program. If the Legislature chooses this option, it should consider phasing out the program over the course of a few years rather than abruptly ending services. This process would allow current participants to identify other sources of financial assistance and make necessary adjustments. To further prevent a disruption in services, the program should remain in the Division of Vocational Rehabilitation while it is being phased out.

Option Two: Keep the Program Intact

The Division of Vocational Rehabilitation has administered the program for over 40 years. However, no vocational rehabilitation staff work solely with end-stage renal disease participants. Instead, selected staff from each region are assigned to work both general program cases and end-stage renal program cases. The division has never developed forms or application documents specific to the end-stage renal disease program. The procedures of the end-stage renal disease program are vague and not well defined. In essence, the division has never fully developed the program.

In addition, the mission of the program is not relevant to the missions of the Board of Education and the Division of Vocational Rehabilitation.

Board of Education mission statement: To provide leadership, set policy, and advocate for transforming Idaho's educational system to improve each Idaho citizen's quality of life and enhance global competitiveness.¹

¹ Idaho State Board of Education Strategic Plan, 2012–2016.

Division of Vocational Rehabilitation mission statement: Preparing individuals with disabilities for employment and community enrichment.

End-stage renal disease program mission statement: To provide financial assistance for lifesaving medical care and treatment to Idaho residents who are experiencing end-stage renal disease; and who do not have the financial resources to meet all their end-stage renal disease medical needs; and for whom work is not an option; or are employed, but unable to afford lifesaving kidney related expenses on a continuing basis.²

The board and the division are focused on education and employment while the end-stage renal program is focused on providing financial assistance for lifesaving treatment. Furthermore, some officials we spoke to from the Board of Education and the Division of Vocational Rehabilitation questioned the relevance of the program today.

If the Legislature decides to continue funding the program through the Division of Vocational Rehabilitation, OPE recommends the division take the following actions, which are essential to strengthening the program:

- Clearly define in its official documents that full-coverage Medicaid participants are ineligible.
- Work with the Department of Health and Welfare to confirm the Medicaid status of all program applicants.
- Define the order of events in the eligibility determination process and provide staff training.
- Seek input from staff about other program areas that need to be reexamined and better defined such as duration of coverage for transplant related services.
- Identify the specific types of documents needed at intake to determine eligibility.
- Consider creating documents and forms specific to the program.
- Consider implementing a quality assurance process at the beginning of each new case that would also ensure staff decisions are not made without some form of oversight.

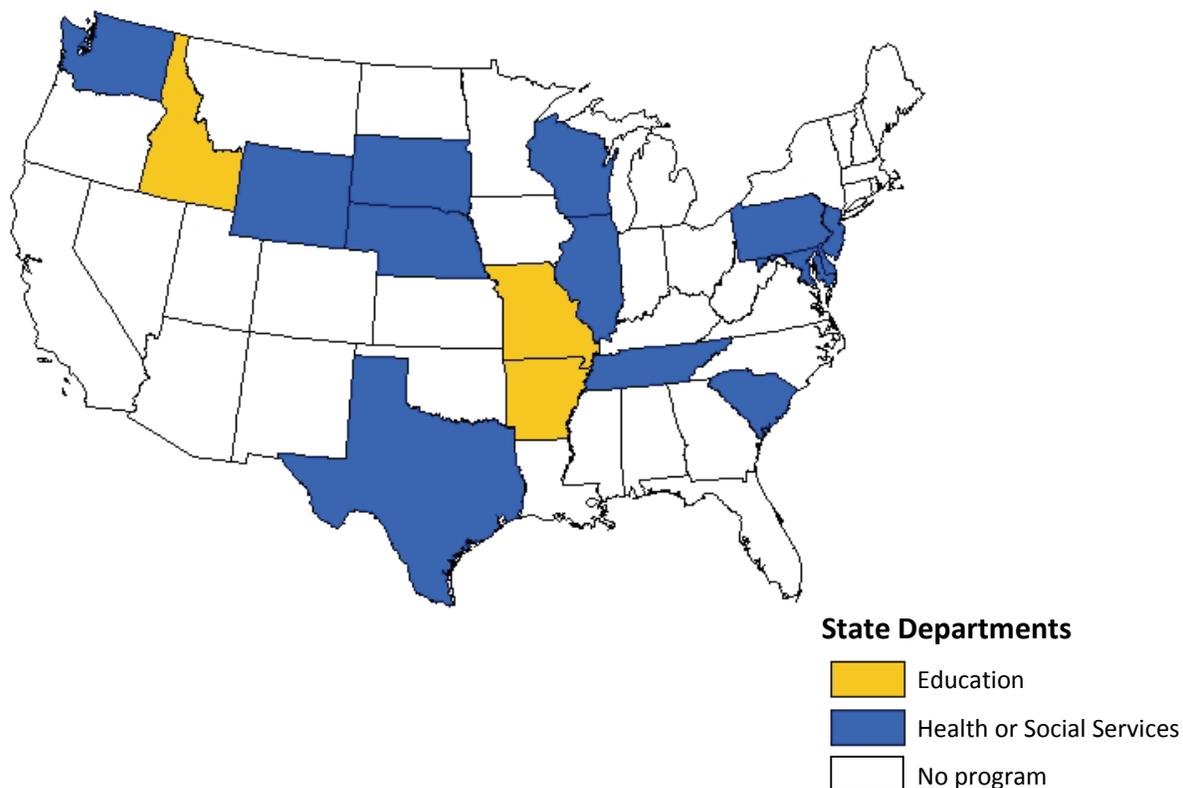
² Idaho Division of Vocational Rehabilitation Strategic Plan, 2008–2012

Option Three: Move the Program to the Department of Health and Welfare

We identified 15 other states with similar programs, but just two of those states house their programs in education departments. As seen in exhibit 4.1, the remaining 13 state programs are housed in health or social services departments.

The mission of the end-stage renal program aligns more closely with the mission of the Department of Health and Welfare, which is to promote and protect the health and safety of Idahoans.³ The department is tasked with certifying dialysis centers and has access to Medicaid and some Medicare enrollee information. Knowing this, if the Legislature decides to continue funding the program, it should consider moving the program to the Department of Health and Welfare.

EXHIBIT 4.1 ADMINISTRATION OF OTHER STATES' END-STAGE RENAL PROGRAMS



Source: Office of Performance Evaluations.

³ Idaho Department of Health and Welfare Strategic Plan, FY2011–FY2015.

Officials from the department see the Division of Medicaid or the Division of Public Health as likely choices for the end-stage renal disease program, if it is relocated. However, the department does not believe it has the infrastructure to support the program and does not wish to administer the program for a variety of reasons. Additionally, according to department officials, they have very little experience with single disease programs. The only similar program was a cystic fibrosis program, which was recently terminated.

According to department officials, federal regulations restrict the types of activities Medicaid staff perform. Because of that, it would be extremely difficult to budget for or to manage the program through the Division of Medicaid.

Furthermore, the Division of Public Health is a population-based program that focuses on changing behaviors through policy, education, and media campaigns. Its staff are centrally located in Boise and the division does not provide direct client services. Department officials also told us that the division does not currently have the capacity to bill for services.

Because the Division of Welfare administers assistance programs for low-income families and individuals, we spoke to officials from this division. We were told that administering the end-stage renal program likely requires familiarity and expertise in areas outside of the division's current knowledge and judgment.

Department officials are also concerned about the timing of a potential relocation because of the projected 2014 health care reform. They question whether the program would still be relevant in the event of a universal health care program because most individuals would receive health insurance coverage through Medicaid or mandated coverage.

If the Legislature chooses option three, the option will require a collaboration of efforts between the Division of Vocational Rehabilitation and the Department of Health and Welfare to create a seamless transition for program participants. As part of the relocation, the department needs to incorporate the same programmatic changes mentioned in option two.

Appendix A

Scope Questions

Legislative Intent

What was the original legislative intent of the end-stage renal disease program? What is the current mission and purpose of the program? Does the program comply with legislative intent and state law?

Program Operations

What is Idaho's current need for state funded end-stage renal care? What is the process for determining program eligibility? What medical expenses are covered by the program? What percentage of funds provides for client services and what percentage goes toward program administration? How do the medical expenses covered by the program differ from the expenses covered by Medicare? Do the two programs cover any of the same medical expenses? What other programs, such as Medicaid, provide assistance to people with end-stage renal disease? What safeguards are in place to prevent a duplication of medical expenses covered by Medicare or other programs? Are those safeguards followed and enforced by program staff?

Program Placement

Does the mission of the program align with the mission of the Division of Vocational Rehabilitation and the Board of Education? Where would the program be most effectively administered?

Appendix B

Additional Assistance Programs

In addition to Medicaid, Idaho's end-stage renal disease program has identified a variety of other assistance programs as comparable benefits. Program guidelines require that staff document in a case plan all comparable benefits that the participant is either eligible for or receiving.

Medigap

Medigap is a private health insurance policy specifically created to supplement Medicare Part A and Part B. Medigap will pay copayments, coinsurance, and deductibles not paid by Medicare Part A and Part B. There are a variety of standardized policies created by Medigap insurance companies that adhere to state and federal laws. The Department of Insurance approves all Idaho Medigap plans and premium rates.

Indian Health Service

The Indian Health Service is a federal agency within the US Department of Health and Human Services. It provides medical, dental, and mental health care services to federally recognized American Indian and Alaska Native tribes through both tribal health programs and contracts with private providers. The Indian Health Service is not an insurance program, a benefits package, or an entitlement program.

Veterans Affairs Benefits

The US Department of Veterans Affairs offers federal health care benefits to eligible veterans. Benefits include inpatient and outpatient medical treatment, dental, and pharmacy. Disability compensation and pension benefits are also available to eligible veterans. Certain veterans may be required to make a copayment in order to receive services or medications. Reimbursement for travel costs may be available to eligible veterans when traveling for approved medical care.

Social Security Disability Insurance

Social Security Disability Insurance is available to individuals with a medical condition that is expected to last at least one year or leaves them unable to work and results in death. The program is managed by the US Social Security Administration. Eligible enrollees must meet two different earnings tests before determinations are made for whether the enrollee meets the criteria for disability benefits.

Enrollees receive a check every month. The amount of the check is based on each enrollee's average lifetime earnings. Additionally, the amount a participant receives each month may be affected if he or she is also receiving other government benefits. Enrollees automatically receive Medicare coverage after two years of receiving disability benefits.

Supplemental Security Income

Supplemental Security Income is available to low-income individuals who are 65 or older, blind, or disabled. The program is managed by the US Social Security Administration. Unlike the Social Security disability program, the program is supported by US Treasury general funds.

The program has certain eligibility requirements and each state sets its own income limits for determining eligibility. The basic monthly payment is the same across the nation, although states can add to it. Idaho does not add supplemental money to its monthly basic payment. Individuals receiving Supplemental Security Income may also be eligible for other Social Security benefits and many usually receive Medicaid as well.

American Kidney Fund

The American Kidney Fund is a national nonprofit organization that offers its Health Insurance Premium Program to patients on dialysis. The program pays primary and secondary health insurance premiums with eligibility requirements mainly centered on demonstrating financial need. The program is funded entirely by provider contributions and is considered a payer of last resort. The American Kidney Fund also offers the Safety Net Program to help pay for pharmacy needs, durable medical supplies, transportation, kidney donor and transplant expenses, mobility aids, transient dialysis, and home dialysis. The maximum award for the Safety Net Program is \$175, and individuals can apply to program every six months.

In 2010, the organization provided assistance to 277 Idaho residents, totaling \$353,568.

National Kidney Foundation

The National Kidney Foundation is a nonprofit organization that offers up to \$350 a calendar year in grant assistance for qualifying dialysis patients. The grant may pay for transportation costs to and from dialysis treatment, medical bills, utilities, and housing. Additionally, the organization offers educational scholarships. Patients can apply for the educational scholarship twice each calendar year. The eligibility requirements for the scholarship include monthly income and state assistance.

The organization estimates that it helped 600 dialysis patients in Idaho during 2010.

Appendix C

Medicare and Medicaid Coverage for End-Stage Renal Disease

Medicare Covers Most End-Stage Renal Disease Services

Medicare provides health insurance for individuals 65 and older, individuals under 65 with disabilities, and individuals of any age with end-stage renal disease. Medicare is administered by the federal government and is divided into several parts: the first two parts—Part A and Part B—are known as Original Medicare. Medicare Part A insures for inpatient hospital care and does not typically require a monthly premium. Medicare Part B insures for outpatient care and requires individuals to pay a monthly premium based on income.¹ To receive full Medicare benefits for dialysis and kidney transplant services, individuals with end-stage renal disease must be enrolled in both Part A and B.

Exhibit C.1 shows the dialysis and kidney transplant services covered by Medicare Part A and Part B. Medicare typically pays 80 percent of the cost of services listed in this exhibit. Enrollees are responsible for paying the remaining 20 percent. The 20 percent copayment is in addition to the Part B monthly premium payment.

Enrollees in Medicare Part A and Part B can elect to join Medicare Part C, which is a Medicare Advantage Plan. These plans are offered by private companies and approved by Medicare. Advantage plans have additional benefits like Medicare managed care plans or Medicare preferred provider organization plans. Some enrollees may be required to pay a monthly premium. Not all individuals with end-stage renal disease are eligible for Medicare Part C.

Medicare also offers an elective prescription drug coverage plan, Part D. Private companies, approved by Medicare, administer Part D coverage. Most enrollees pay a monthly premium based on income for Medicare Part D. This premium is paid in addition to the Medicare Part B monthly premium. Not all enrollees meet the requirements for transplant immunosuppressive drug coverage under Medicare Part B and, in some instances, may be able to get coverage for the drugs by electing to participate in Medicare Part D.

¹ According to the Centers for Medicare and Medicaid Services, the 2011 Part B premium is \$115.40 per month and may be higher based on income.

EXHIBIT C.1 DIALYSIS AND TRANSPLANT SERVICES COVERED BY MEDICARE PART A AND PART B

Medicare Part A	Medicare Part B
Inpatient dialysis treatments	Outpatient dialysis treatments
Inpatient services in an approved hospital	Outpatient doctor services
Kidney registry fee	Self-dialysis training
Tests needed to evaluate medical condition	Home dialysis equipment and supplies
Tests needed to evaluate medical condition of potential kidney donors	Certain home support services
Costs of finding a proper kidney for patient’s transplant surgery	Other services and supplies that are a part of dialysis
Full cost of care for the kidney donor	Most drugs for home dialysis
Additional inpatient hospital care for the donor in case of problems because of surgery	Doctors’ services for the kidney donor during his or her hospital stay
Costs of processing and giving packed red blood cells and blood components for transplants	Doctors’ services for kidney transplant surgery
	Immunosuppressive drugs
	Costs of processing and giving packed red blood cells and blood components for transplants

Source: Centers for Medicare and Medicaid Services, *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services*, CMS product no. 10128.

Similar Medicare Services

Some enrollees receiving Medicare Part C may be eligible to receive transportation to and from dialysis treatment. Medicare also offers ambulance service to and from dialysis treatment if medically necessary.

Because of the way Medicare Part C enrollment is tracked and reported, we were unable to investigate whether any end-stage renal disease program participants receive transportation benefits under Medicare Part C.² However, if any participants had received transportation benefits under Part C and transportation benefits from the program, they would have received a duplicate reimbursement.

Medicaid Plans and End-Stage Renal Disease Coverage

Medicaid is a state-run program for low-income eligible individuals. Each state determines the eligibility criteria and the covered services for its program within federal guidelines. Idaho offers a standard state plan and three benchmark plans:

² According to Department of Health and Welfare officials, the only way to verify Medicare Part C coverage is through the Centers for Medicare and Medicaid Services.

basic, enhanced, or Medicare/Medicaid coordinated. The state allows enrollees to choose a plan, although most are only eligible for the standard or basic plans.

Plans Not Eligible for Participation in the End-Stage Renal Disease Program

The standard plan and the benchmark plans are considered full-coverage Medicaid plans by the end-stage renal disease program. According to program officials, before changes to the 2008 field manual, staff had an unwritten agreement that enrollees receiving both Medicare and Medicaid probably did not need the additional assistance offered by the end-stage renal disease program. However, if a participant was receiving assistance from both Medicare and Medicaid and still showed a need, the end-stage renal disease program would provide assistance. After revisions to the 2008 field manual, individuals receiving full-coverage Medicaid were no longer eligible for the end-stage renal disease program.

According to staff from the Division of Medicaid within the Department of Health and Welfare, most Medicaid enrollees participate in the basic benchmark plan. This plan is designed for low-income children and adults. Another plan, the enhanced benchmark plan, is for Medicaid enrollees with disabilities or special health care needs. Both plans include primary care, hospital services, prescription drugs, dental, vision, transportation, and additional services that provide care for individuals with end-stage renal disease.³

The Medicare/Medicaid coordinated benchmark plan is for those enrolled in both the Medicare and Medicaid programs. The coordinated plan allows enrollees to receive Medicaid benefits through their Medicare Part C Advantage Plan. Individuals with end-stage renal disease are not eligible for the Medicare/Medicaid coordinated benchmark plan.

Plans Eligible for Participation in the End-Stage Renal Disease Program

The state offers Medicare savings programs to individuals who are not eligible for full-coverage Medicaid. These Medicaid programs are designed to help low-income individuals save money.⁴ Individuals enrolled in Medicare savings programs are eligible for the end-stage renal disease program.

³ In July 2011, dental benefits were limited to emergency procedures for all adults.

⁴ Individuals participating in savings programs are not eligible to receive transportation or dental benefits through Medicaid.

- Qualified Medicare Beneficiary coverage pays for Medicare Part A and Part B monthly premiums, Medicare coinsurance, and Medicare deductibles.
- Specified Low-Income Medicare Beneficiary benefits pay for Medicare Part B monthly premiums.

For participants receiving Qualified Medicare Beneficiary coverage, the end-stage renal disease program may only pay for medications. This restriction was added to the field manual in 2008.

Responses to the Evaluation



C. L. "BUTCH" OTTER
GOVERNOR

November 8, 2011

Rakesh Mohan, Director
Office of Performance Evaluations
954 W. Jefferson St.
Boise, ID 83702

Dear Rakesh,

Thank you for the opportunity to respond to the Idaho's End-Stage Renal Disease Program report for the Division of Vocational Rehabilitation.

This State financial assistance program for kidney failure treatment originated over 40 years ago, but advances in federal health care assistance and medical technology bring into question the need for such a program to exist.

The Office of Performance Evaluations (OPE) has accurately identified the many issues related to the existing program and identified three possible options for its direction. Keeping the program intact or moving it to the Department of Health and Welfare are not considered optimal choices. After considering the issues raised by OPE's comprehensive report, phasing out the program is the most reasonable choice.

In order to address the needs of current clients and to allow them to be directed to alternative arrangements, it is therefore my recommendation to phase out the program, with full termination resulting by June 30, 2013.

Thank you for your research and recommendations regarding Idaho's End-Stage Renal Disease Program.

As Always – Idaho, "Esto Perpetua"

A handwritten signature in black ink, appearing to read "C.L. Butch Otter".

C.L. "Butch" Otter
Governor of Idaho

CLO/tp



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November 16, 2011

Rakesh Mohan
PO Box 83720
Boise, ID 83720-0055

RE: End-Stage Renal Program

Dear Mr. Mohan:

This report represents a thorough review of the end-stage renal program. Thank you for the opportunity to comment on the final report.

The Board of Education is in agreement with the recommendations made in this report. In particular, the Board of Education agrees with the report's conclusion that the end-stage renal program's mission is "not relevant to the missions of the Board of Education and the Division of Vocational Rehabilitation (IDVR)." Therefore we would recommend that the program not remain with the Division of Vocational Rehabilitation.

The report identified several recommendations for strengthening the program. IDVR agrees with the need for these recommendations. If it is the Legislature's decision to have the end-stage renal program remain with IDVR then IDVR will implement a series of improvements to ensure that the program is run in complete compliance with state rules and program standards.

Thank you again for this timely and objective review of the end-stage renal program.

Sincerely,

Mike Rush
Executive Director

MR/DA/jwp



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER - GOVERNOR
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November 16, 2011

Rakesh Mohan, Director
Office of Performance Evaluations
P.O. Box 83720
Boise, ID 83720-0055

Dear Director Mohan:

We received a copy of the final draft of *End-Stage Renal Disease Program* and reviewed it for technical accuracy as requested by the Office of Performance Evaluations (OPE). We compliment the report's thorough explanation of the history of the program, current eligibility and management issues, accountability and budget concerns, and options to consider regarding the program's future.

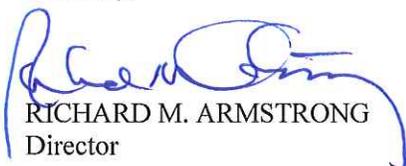
When Idaho's End-Stage Renal Disease Program was established within the Division of Vocational Rehabilitation over 40 years ago, new treatment and services for individuals suffering from chronic renal disease were not covered by insurers. Thankfully, today that scenario has changed with Medicare, Medicaid, and private insurance recognizing the value of essential treatments for kidney damage and failure. However, there remain many diseases and conditions competing for limited dollars and other resources. It is, therefore, more important than ever to review the practicality and equity of disease-specific programs during a time of significant change in which the way health care is provided and reimbursed.

The Department of Health and Welfare supports Option One of the OPE Report – phasing out the End-Stage Renal Disease Program. We also agree that the program should remain in the Division of Vocational Rehabilitation to not only prevent a further disruption of services, but to avoid the unnecessary creation and duplication of infrastructure necessary to administer the program.

The Department stands ready to work with the legislature, the Department of Vocational Rehabilitation, and stakeholders in planning for the smooth discontinuation of the program and identification of other sources of financial assistance or services for current participants.

I would like to express the gratitude of the Department of Health and Welfare for the studious commitment the OPE analysts made in providing a thorough and organized review of this program. We appreciate the opportunity to provide our input and look forward to working with our partners in addressing the wishes of the legislature.

Sincerely,



RICHARD M. ARMSTRONG
Director

RMA/eb

Office of Performance Evaluations Reports, 2008–Present

Publication numbers ending with "F" are follow-up reports of previous evaluations. Publication numbers ending with three letters are federal mandate reviews—the letters indicate the legislative committee that requested the report.

Pub. #	Report Title	Date Released
08-01	Governance of Information Technology and Public Safety	March 2008
08-02F	State Substance Abuse Treatment Efforts	March 2008
08-03F	Virtual School Operations	March 2008
09-01	Public Education Funding in Idaho	January 2009
09-02F	Higher Education Residency Requirements	January 2009
09-03	Idaho Transportation Department Performance Audit	January 2009
09-04	Feasibility of School District Services Consolidation	February 2009
09-05F	School District Administration and Oversight	February 2009
09-06F	Use of Average Daily Attendance in Public Education Funding	February 2009
09-07F	Child Welfare Caseload Management	February 2009
09-08F	Public Education Technology Initiatives	February 2009
09-09F	Management in the Department of Health and Welfare	March 2009
09-10F	Governance of Information Technology and Public Safety	April 2009
10-01	Operational Efficiencies in Idaho's Prison System	January 2010
10-02	Increasing Efficiencies in Idaho's Parole Process	February 2010
10-03F	Use of Average Daily Attendance in Public Education	March 2010
10-04	Governance of EMS Agencies in Idaho	November 2010
10-05F	Governance of Information Technology and Public Safety	November 2010
11-01	Distribution and Sale of Liquor in Idaho	January 2011
11-02	Coordination and Delivery of Senior Services in Idaho	February 2011
11-03F	Increasing Efficiencies in Idaho's Parole Process	February 2011
11-04F	Idaho Transportation Department Performance Audit	March 2011
11-05	Delays in Medicaid Claims Processing	March 2011
11-06	Equity in Higher Education Funding	November 2011
11-07	Idaho's End-Stage Renal Disease Program	November 2011
11-08F	Distribution and Sale of Liquor in Idaho	November 2011

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