

CRS Report for Congress

Received through the CRS Web

Long-Term Care: Consumer-Directed Services Under Medicaid

Updated January 21, 2005

Karen Tritz
Analyst in Social Legislation
Domestic Social Policy Division

Long-Term Care: Consumer-Directed Services Under Medicaid

Summary

Medicaid is a health insurance program jointly funded by the federal and state governments that pays for health care services for certain low-income individuals. Since the program's inception in 1965, Medicaid has played a vital role in providing long-term care services to individuals with a disability or long-term illness. "Long-term care services" refer to a wide range of supportive and health services for individuals with a disability or chronic illness. Medicaid primarily finances long-term care services and supports in institutions but has increasingly supported care in home and community-based settings under an optional program benefit.

States have been developing options for Medicaid beneficiaries with a disability (consumers) to manage and direct their home and community-based services including hiring their own providers, as an alternative to a traditional model of using agency-based providers. These options for consumer direction have most often included personal care services and other home and community-based services authorized under Section 1915(c) of the Social Security Act. The premise underlying consumer-direction is that the individual receiving the service is able to determine what he or she requires and can use good judgment in purchasing those services and overseeing their delivery.

Legislation to expand consumer-directed Medicaid long-term care services has been introduced in each of the last three Congresses. The legislation would have required states to cover personal care attendant services under the Medicaid state plan for certain Medicaid-eligible individuals. The legislation also specified that the consumer (or his or her representative) must be allowed to select, manage and dismiss his or her personal care attendant(s). Similar legislation is expected to be introduced in the 109th Congress.

The Centers for Medicare and Medicaid Services (CMS) and others have undertaken initiatives to facilitate states operating consumer-directed programs. One of the more well known of these programs is the Cash and Counseling Demonstration. As Congress considers proposals to encourage development in this direction, it faces such questions as: What beneficiary protections need to be built into these programs? How does one ensure the quality of consumer-directed services, and under what circumstances should states be required to seek a federal waiver?

This report discusses options for consumer-directed services under Medicaid; factors states need to take into account in developing consumer-directed programs; and considerations for future policy development. This report will be updated as necessary to reflect any substantive program or policy changes.

Contents

Introduction	1
Precedents for Consumer-Directed Programs	4
Examples in the United States	4
Examples from Other Countries	5
Germany	6
England	6
An Overview of Consumer-Directed Medicaid Services	6
Agency-Based vs. Consumer-Directed Long-Term Care Programs	8
Scope of Consumer-Directed Long-Term Care Initiatives	10
Experience of Different Disability Groups	10
Relevant Medicaid Options	11
Medicaid State Plan Services	11
Medicaid Home and Community-Based Waivers	12
Medicaid Managed Care	13
Section 1115 Waiver	14
Independence Plus Initiative	14
Self-Directed Support Corporation	15
Recent Research and Development Initiatives	16
Cash and Counseling Demonstration	16
Self-Determination Initiative	19
Independent Choices	20
Systems Change Grants to States	21
Considerations in Implementing Consumer-Directed Services	22
Eligibility	22
Fiscal intermediary	23
Service Consultant/Support Broker/Counselor	23
Consumer Education and Training	24
Determining a Consumer's Cash Allotment	24
Who is the Employer?	24
Service Providers	25
Provider Qualifications	25
Provider Rates	25
Hiring Friends and Family Members	26
Effect on Current Service Providers	26
Compliance with State Nurse Practice Act	26
Fraud and Abuse	27
Quality	27
Considerations for Future Policy Development	28
Appendix A. Approved <i>Independence Plus</i> Waivers as of January 2005	32
California	32
Connecticut	32

Delaware	32
Florida	32
Louisiana	32
Maryland	32
New Hampshire	33
North Carolina	33
South Carolina	33

List of Tables

Table 1. Comparison of Agency and Consumer-Directed Personal Care Models	9
Table 2. Overview of Cash and Counseling Demonstration	17

Long-Term Care: Consumer-Directed Services Under Medicaid

Introduction

Medicaid is a health insurance program jointly funded by the federal and state governments that serves low-income individuals including the elderly, persons with a disability, children, pregnant women, and members of families with dependent children. Eligibility requirements are based on age, income, family structure, and disability, and are determined by the states within broad federal guidelines.

Long-term care services refer to a wide range of supportive and health services generally provided on an ongoing basis for persons who have limitations in functioning because of a disability or chronic condition. Since its inception in 1965, Medicaid has played a vital role in providing long-term care services especially nursing facility care which all states must cover for individuals over age 21. Other examples of long-term care services which may be available under Medicaid include a range of home care services including personal care services or ongoing nursing care.¹ Personal care services include assisting an individual who has limitations in activities of daily living (ADLs) such as bathing, eating, dressing, and cooking.

Medicaid long-term care services are generally offered through the Medicaid state plan and/or a home and community-based (HCBS) waiver. The Medicaid state plan is the document that states submit to the federal government for approval which describes the eligibility groups and covered services. State plan services must be available statewide and must be available to all Medicaid enrollees who qualify for the service.

Under the state plan, states must provide two long-term care services: nursing facility services for individuals over age 21 and home health services for individuals who meet certain criteria. States have the option of providing several other types of long-term care services including: nursing facility services for individuals under age 21, intermediate care facility services for individuals with mental retardation (ICF/MR) (which all states have opted to provide), personal care services,² private duty nursing, hospice, clinic services, and rehabilitation.³ Of the services listed

¹ Ongoing nursing care may be required for someone with a very significant disability, for example, an individual who requires a ventilator to breathe.

² Personal care services are also referred to as “personal assistance services” or “personal attendant services.”

³ Some states provide long-term care services such as adult day treatment and ongoing mental health services under the categories of clinic and rehabilitation services under the (continued...)

above, nursing facility and ICF/MR services are generally categorized as “institutional” services because individuals reside in and receive health care services in a specific type of certified facility. Those facilities are paid a rate that covers the individual’s room, board and services. The other Medicaid services listed above are categorized as “home and community-based” services. The individual generally lives in the community (e.g., home or apartment). Medicaid pays only for that specific type of service (e.g., an hour of personal care). Medicaid does not pay for the room and board of that individual.

States also have the option of requesting permission from the federal government to provide other home and community-based services for individuals who would otherwise be in an institution. These other services may be offered as a supplement to, or instead of, those optional services available through the state plan. This option is referred to as a “Home and Community-Based (HCBS) waiver” which is authorized under Section 1915(c) of the Social Security Act. Unlike services offered as part of the Medicaid state plan, the HCBS waiver allows states to limit the number of individuals served and to offer the services on a less-than-statewide basis. In July 2003, there were 275 such waivers in operation in all states except Arizona.⁴ These waivers include a broad range of services such as case management services, homemaker/home health aide services, personal care services, adult day health services, habilitation services, respite care, home modifications, and home-delivered meals.⁵

Based on preliminary 2002 data, total Medicaid expenditures for long-term care services were \$92.8 billion (\$66.1 billion for services in institutions and \$26.7 billion

³ (...continued)

Medicaid state plan.

⁴ In a few cases, states have funded long-term services and supports through a Section 1115 (Social Security Act) research and demonstration waiver. For example, Arizona offers similar long-term care services under a Section 1115 research and demonstration waiver.

⁵ *Adult day health services* refers to a type of service that provides assistance to multiple individuals with a disability in a group setting which generally operates during the daytime hours. Generally the individuals who receive services in this type of setting have a severe cognitive or physical disability. *Habilitation* services means those services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings. *Respite* services provide temporary services to an individual with a disability to give the normal caregiver a break from providing care. *Home modifications* refer to items such as a ramp to a home or bars installed in the shower that someone can hold onto while bathing.

for services provided in home and community-based settings). This represents 38% of total Medicaid service expenditures.⁶

Most Medicaid beneficiaries (consumers) receive their long-term care services from agency-based providers that are certified to provide Medicaid services.⁷ In some cases there may also be a case manager who plays a role in coordinating and overseeing the consumer's long-term care services. Depending upon the structure of the state's program, the case manager or the agency-based provider may consult with the consumer, assess the consumer's needs, and decide what services are needed, and what time and under what circumstances services will be provided, and monitor the care provided.

The agency-based provider is required to have an agreement with the state Medicaid agency and in the case of personal care services, workers are referred to as "direct care workers."⁸ Depending upon the state's rules and the specific provider, the consumer may have varying degrees of ability to determine:

- who comes into the home to provide the service (e.g., is this someone they know and/or trust);
- what time of day the care is received;
- where that direct care worker can go with the individual (e.g., school, church, work, medical appointments);
- how much the worker is paid; and
- the process for getting a back-up worker when the regularly scheduled worker is unavailable.

Many consumers have expressed an interest in increasing their ability to direct and manage some of these key elements of the assistance they receive. State and federal policymakers who administer community-based long-term care programs have responded to this interest by developing opportunities for consumer-direction starting with non-Medicaid programs such as state-funded long-term care programs and more recently in Medicaid long-term care programs as described below.

⁶ CRS analysis of the Centers for Medicare and Medicaid Services, Form 64, preliminary FY2002 data. Institutional long-term care expenditures include nursing facilities, mental health facilities, and intermediate care facilities for individuals with mental retardation. Home and community-based long-term care expenditures include home health, home and community-based waivers under Section 1915(c) of the Social Security Act, personal care services, hospice, and home and community care for functionally disabled elderly individuals under Section 1929 of the Social Security Act.

For additional information on Medicaid long-term care services, see CRS Report RS21518, *Long-Term Care Chart Book: Persons Served, Payors and Spending*, by Carol O'Shaughnessy, and CRS Report RL31163, *Long-Term Care: A Profile of Medicaid 1915(c) Home and Community-Based Services Waivers*, by Carol O'Shaughnessy and Rachel Kelly

⁷ In this report, the term *agency-based providers* refers to health and/or social service agencies (both public and private) that provide long-term care services such as personal care to individuals with a disability or chronic illness.

⁸ May also be referred to as a personal care attendant, attendant or aide.

Legislation has been introduced each Congress since the 105th Congress to expand consumer-directed Medicaid long-term care services. In the 108th Congress the legislation was known as the Medicaid Community-Based Attendant Services and Supports Act of 2003, (S. 971 and H.R. 2032). The legislation would have required states to cover personal care attendant services under the Medicaid state plan for certain Medicaid-eligible individuals and specified that the consumer (or his or her representative) must be allowed to select, manage and dismiss his or her personal care attendant(s). Similar legislation is expected to be introduced in the 109th Congress.

Precedents for Consumer-Directed Programs

Although consumer-directed long-term care services under the Medicaid program have increased significantly over the last decade, it is not a new concept. Several programs both in the United States and other countries have preceded the current interest in Medicaid consumer-directed options and have served as models for comparison.

Examples in the United States

In the United States, consumer-direction began in long-term care programs other than Medicaid. Prominent examples have included programs in the Department of Veterans Affairs (VA) and some programs operated by states. For the past 30 years, the VA has operated the Housebound and Aid and Attendance programs which provide additional cash benefits to qualified veterans or their surviving spouses if they require ongoing personal care services, are housebound or require nursing home services.⁹ This cash benefit provides the veteran with additional monthly income to purchase needed services and supports. There are no federal restrictions on how this additional cash benefit must be used. The veteran with a disability can determine how to spend the benefit; for example, he or she can hire friends or family members to provide personal care services.

In addition to the federal VA programs, several states, including California, Maine, Michigan, Oklahoma, Oregon, New York and Washington, have long

⁹ The amount of the VA cash benefit follows different rules depending whether or not the disability is service-related. For service-related disability (compensation), the amount is set according to the living situation and degree of disability. For non-service related disability (pension), the amount is equal to the difference between the individual's countable income and a yearly standard set by law. Effective Dec. 1, 2002, the annual standard for a housebound veteran with no dependents was \$11,843, and \$16,169 for a veteran who required special in-home care. The VA reported that in Mar. 2003 approximately 180,000 individuals or their surviving spouses received additional cash payments through a compensation or disability benefit because they required long-term care services.

histories operating state-funded, consumer-directed personal care services.¹⁰ One of the more well known of these consumer-directed programs is California's In-Home Supportive Services (IHSS) program which has been in operation since 1979. IHSS did not include federal funding in its consumer-directed program until California adopted the Medicaid personal care option in the state plan in 1993. IHSS serves an estimated 200,000 consumers annually and provides up to 283 hours of service each month including personal care, household, paramedical, protective supervision and medical transportation.

IHSS allows the consumer to choose his or her direct care worker including a family member. The state then contracts with this direct care worker as an independent Medicaid provider (described in more detail later in this report). IHSS is administered by county-based public authorities which provide support to both consumers and the large number of independent Medicaid providers by: (1) establishing a registry and referral system for consumers, (2) training both providers and consumers, and (3) serving as the employer of record for the independent providers for purposes of collective bargaining. Under IHSS, the consumer is still able to select, hire, direct and fire his or her worker.¹¹ Within IHSS, California also allows counties the option of contracting with an agency to provide personal care services under an agency-based model for individuals who are deemed unable to participate in consumer-direction. Twelve counties exercise this option. A 1996-1997 telephone survey of IHSS participants compared individuals who directed their long-term care services versus those who received agency-based services and found that individuals who participated in consumer-directed models reported more positive outcomes in the areas of safety, unmet needs and service satisfaction.¹²

Examples from Other Countries

Several European countries, including Germany and England, have developed programs that provide cash allowances to individuals based on their level of need to allow them to purchase long-term services and supports.¹³ For illustrative purposes, key features of the consumer-directed, long-term care programs operating in Germany and England are described below.

¹⁰ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Understanding Medicaid Home and Community Services: A Primer*, Oct. 2000. (Hereafter cited as *HHS-ASPE, Primer*). See also L. Williams and V. Dize, *Consumer-Directed Home and Community Based Services for Older People: An Overview of State Programs*, National Association of State Units on Aging, Apr. 2001

¹¹ P. Kumar, *California's Public Authorities: An Emerging Model for Consumer-Directed Personal Assistance Services Comes of Age*, *American Rehabilitation*, vol. 24, issue 4, winter 1998, p. 15.

¹² A.E. Benjamin, et al., *Comparing Consumer-directed and Agency Models for Providing Supportive Services at Home*, *HSR: Health Services Research* 35:1, Part II, Apr. 2000, pp. 351-366. See Appendix A for recent developments in the California, IHSS program.

¹³ For a comparative summary of long-term care models in Europe compiled by the European Union, see *Social Protection in the Member States in the EU Member States and the European Economic Area Situation on January 1st 2002 and Evolution at* [http://europa.eu.int/comm/employment_social/missoc/2002/index_chapitre12_en.htm].

Germany. In 1995, Germany established a universal, social insurance program for long-term care financed by mandatory employer and employee contributions. Eligibility for the program is not contingent on the individual having a certain level of income or assets. However, there is a maximum per-person benefit based on the individual's need. Individuals who require long-term care can choose between institutional care, home care, a cash benefit (which is about one-half the value of the home care benefit), or a combination of home care services and a cash benefit. In 1998, 76% of beneficiaries chose a cash benefit. The cash benefit option is not restricted in its use of funds and has minimal federal monitoring.¹⁴ Persons choosing the cash benefit choose how to direct and organize their care using the cash they receive.

England. Since 1996, England has offered cash payments to consumers as an option to direct the community-based services they need. The cash payment option is one type of program within a larger social services grant provided to localities referred to as "Community Care." In the cash payment option, the localities have a significant amount of decision-making to establish the eligibility criteria, make consumers aware of the program, and establish the amount given to the individual within broad national guidelines. There is no minimum or maximum on the amount paid to the individual, but it must be less than placing that particular individual in a residential facility. There are also restrictions on hiring close family members to provide care.¹⁵

An Overview of Consumer-Directed Medicaid Services

The underlying premise of consumer-direction is that the individual receiving the service knows what he or she requires and will use good judgment to purchase those services and oversee their delivery. In a recent article in the journal *Health Affairs*, A.E. Benjamin listed five factors that have influenced policymaker interest in developing options for consumer-directed services.¹⁶

- **Advocacy.** For decades, adults, primarily those with physical disabilities and under 65 have been strong advocates of increasing their ability to manage and direct their own services.
- **Olmstead decision.** In 1999, the U.S. Supreme Court, in *Olmstead v. L.C.* (527 U.S. 581) held that states had a legal obligation (within certain specified limits) to serve individuals with a disability in a

¹⁴ R. Stone, *Providing long-term care benefits in cash: Moving to a disability model*, Health Affairs, Nov/Dec 2001 and CRS Report RL30549, *Long-Term Care for the Elderly: The Experience of Four Nations* by Mayra De La Garza and Carol O'Shaughnessy.

¹⁵ J. Wiener, et al., *Consumer-Directed Home Care in the Netherlands, England, and Germany*, Public Policy Institute, AARP, Oct. 2003.

¹⁶ A.E. Benjamin, *Consumer-Directed Services at Home: A New Model for Persons with Disabilities*, Health Affairs, Nov./Dec. 2001, pp. 80-95.

setting that reflected the individuals' preferences.¹⁷ States' responses to the *Olmstead* decision have focused attention on increasing the capacity of Medicaid home and community-based services as an alternative to institutions, such as nursing homes, and developing options that respond to consumer preferences.

- **Cost.** Both federal and state governments face increasing Medicaid long-term care costs. These growing expenditures have created a willingness by some policymakers to test alternative approaches which change how Medicaid services are delivered and provide better services at a lower or equal cost to the Medicaid program.
- **Workforce shortage.** Many states are facing critical shortages in the direct long-term care workforce. Some consumers do not receive the number of service hours they are assessed to need because the provider agency cannot find staff to deliver the service. This is a particular challenge in rural areas. Consumer-directed models of delivering services may expand the labor pool by allowing a consumer to select and/or hire a friend, family member or neighbor to provide direct care services. Such persons may not have otherwise been employed by a traditional home care agency.¹⁸
- **Changing perceptions.** Many believe that providing care to persons with a disability and to frail older persons should move from a purely medical model of care to one that considers other factors (i.e., a social model of care) such as the individual's involvement in the community or his or her interest in entering the workforce. Consumer-directed models can create a flexible array of services that can be responsive to these other factors, in addition to providing necessary medical and social services in the home.

¹⁷ The case involved two women both with a cognitive and psychiatric disability who were residing in a psychiatric unit of a hospital. Although the women's doctors stated that they could be served in a community-based setting, they remained institutionalized. The women sued the state alleging that the state violated Title II of the Americans with Disabilities Act. The Supreme Court found that states are required to provide community-based treatment for persons with a disability when the state's treatment professionals determine that such placement is appropriate, the affected individual does not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with a disability.

For additional information, see the following reports: National Conference of State Legislatures, *The States' Response to the Olmstead Decision: How are States Complying?* at [<http://www.ncsl.org/programs/health/forum/olmsreport2003.pdf>] and CRS Report RL31401, *The Americans with Disabilities Act: Supreme Court Decisions*, by Nancy Jones.

¹⁸ For additional information on the supply and demand for long-term care workers see HHS, Assistant Secretary for Planning and Evaluation (ASPE) *The Future Supply of Long-term Care Workers in Relation to the Aging Baby Boom Generation: Report to Congress*, May 14, 2003 at [aspe.hhs.gov/daltcp/reports/ltcwork.pdf].

Consumer-direction is not one model of service delivery but a variety of approaches with a common goal of moving the decision-making authority for services closer to the consumer who receives those services.¹⁹ Consumer-directed Medicaid long-term care programs have most often included personal care services, but some programs have included other categories of services (e.g., adult day health, respite) particularly for individuals with a developmental disability.²⁰

Two of the more common types of consumer-directed approaches are described below. This description does not thoroughly discuss each approach, but provides a general overview of how many consumer-directed programs have been structured.

- **Individualized budget.** In an individualized budget, the state establishes a total dollar value for the services needed by the individual. The state contracts with an organization, such as a Medicaid provider, to track the individual's budget and, in some cases, to employ the direct care workers who are selected by the consumers. However, within the amount of the individual's budget, the consumer has discretion over what services he or she will receive (generally within broad state guidelines), who will provide those services, and how much that direct care worker will be paid.
- **Direct cash.** In the direct cash approach, the state also establishes a total dollar value for the services needed by the individual; however, the cash allotment is provided directly to the consumer rather than the provider. The consumer recruits, hires and manages the direct care worker. The direct care worker is employed by the consumer, does not have to be a certified Medicaid provider and is not required to have a written contract with the state. The state oversees the program but takes on a very different role as described later in this report.

Agency-Based vs. Consumer-Directed Long-Term Care Programs

Consumer-directed long-term care models differ significantly from an agency-based approach in a number of respects, including program structure and policies. These differences are summarized in **Table 1**.

¹⁹ This report does not discuss “consumer participation” in Medicaid long-term care services. Consumer participation may include consumer representation on the provider agency's board of directors, consumer surveys to evaluate the quality of the services, or peer-delivered services.

²⁰ In general, *developmental disability* refers to conditions that occurred before the age of 22 that impair cognition and functioning. Some examples of developmental disabilities include mental retardation, autism, Downs Syndrome, fetal alcohol syndrome or head injury.

Table 1. Comparison of Agency and Consumer-Directed Personal Care Models

Feature	Agency-based provider model	Consumer-directed model
Services provided	A prescribed number of service hours are authorized by the state or agency.	Variable. Some programs use an authorized number of service hours. Other programs provide cash to purchase goods and services, with the amounts of services and number of hours available dependent on the prices paid for services.
Consumer screening	None.	Variable. Some programs have no screening. Others may screen the consumer for his or her financial competency in managing an individualized budget or the direct cash option.
Hiring legally responsible family members as a provider ^a	Generally not permitted.	Variable. In some states it is not permitted. Other states permit this but use state-only funds to pay for these services. Other programs have received approval through a Medicaid waiver to use Medicaid funds to hire a legally responsible family member.
Role of case manager (service consultant)	Variable. Some states have no case managers as part of personal care programs. When there is a case manager, the duties often include assessing the need for services and locating, managing, coordinating and monitoring those services.	Variable depending on the type of program. Generally, the consumer has more independence and responsibility and assumes many of the functions of the case manager. The case manager (sometimes referred to as a “service consultant”) may take on other functions such as education, guidance, and reviewing a consumer’s expenditure plan and receipts for purchased goods and services.
Supervision of direct care worker	Agency	Consumer; or in some programs the consumer receives support from a service consultant.
Fiscal responsibilities	Agency	Variable. May be handled by the county, state, a contracted intermediary, or the consumer.
Degree of consumer choice	Variable	In most cases there is a high degree of consumer choice. ^b

a. A legally responsible relative is generally a spouse or the parent of a dependent child, but may include others depending on state law.

b. In California, most Medicaid beneficiaries are automatically assigned to a consumer-directed model of services.

Scope of Consumer-Directed Long-Term Care Initiatives

There is no comprehensive list of all consumer-directed programs. Measuring the number and types of consumer-directed programs is challenging because the definition of consumer-direction is not consistent, and there are many different program authorities. Despite this difficulty, there have been some attempts to get a general sense of the size and scope of consumer-direction. One inventory of both Medicaid and non-Medicaid programs conducted by the National Council on Aging (NCOA) in September 2001 found 139 consumer-directed service programs operating in all states except Tennessee²¹ and the District of Columbia. Fifty-eight percent of those programs served less than 1,000 individuals, but nationally about 500,000 individuals received services in these 139 programs.²²

Experience of Different Disability Groups

The consumer-direction principles are the same across types of disabilities. However, different groups of individuals with a disability have developed different initiatives to fit their specific needs and the services they receive. For individuals with a physical disability and the elderly, consumer-directed programs have generally focused on personal care services. For individuals with a developmental disability, consumer-direction has been referred to as “self-determination” and has often included other long-term care services in addition to personal care services such as respite and adult day health. For some individuals with a developmental disability, family members may also have a role directing services. For individuals with a serious and persistent mental illness, opportunities for consumers to direct their own services have not been as prevalent. There is a significant and growing interest in consumer-empowerment, peer-support services, and peer participation on the treatment team,²³ but programs for consumers with a mental illness have not developed the same capacity for individuals to manage their own services or receive a flexible array of services through an individualized budget as programs for other disability groups.

²¹ As described later in this report, Tennessee has established Self-Directed Support Corporations which are consumer-directed programs that were not captured in the survey.

²² M. Squillace and J. Firman, *Myths and Realities of Consumer-directed Services for Older Persons*, National Council on Aging, Sept. 2002, p. 19.

²³ Peer-support services is a model of providing mental health services where individuals who also have a psychiatric disability and are in recovery are trained to assist other consumers in skill building, goal setting, problem solving. They also serve as a role model for the consumers they work with. The goals of peer participation on a treatment team are similar to peer support services but may involve a peer working jointly with other mental health professionals to provide services to a consumer.

Relevant Medicaid Options

Current law permits many forms of consumer-direction in Medicaid home and community-based long-term care services. States may offer consumer-direction as part of certain Medicaid state plan services, managed care programs, home and community-based waivers, and research and demonstration waivers. The specific features of the consumer-directed program govern whether the state is able to implement consumer-direction through its existing Medicaid state plan or by requesting permission from the federal government through a waiver.

There is relatively little data available on the number of states that are operating consumer-directed programs under Medicaid. CMS does not collect data on the Medicaid state plans or the 275 home and community-based waivers in operation as of July 2003. In addition, the definition of consumer-direction varies widely so that independent surveys of states' consumer-direction programs yield different results. States' options for consumer-direction programs under the Medicaid state plan and waivers are discussed in more detail below.

Medicaid State Plan Services

States may opt to cover personal care services under their Medicaid state plans. In November 2002, 36 states offered the optional personal care benefit to at least some Medicaid beneficiaries.²⁴ Under this option, the Centers for Medicare and Medicaid Services (CMS) explicitly permits consumer-direction of personal care services. The CMS State Medicaid Manual specifies, "Medicaid beneficiaries may hire their own provider, train the provider according to their personal preferences, supervise and direct the provision of the personal care services and, if necessary, fire the provider." However, the state Medicaid agency maintains responsibility for monitoring service delivery and ensuring that qualified providers are delivering the personal care services.²⁵ The state is not permitted to provide Medicaid funds directly to a consumer to pay for the personal care services.

Some states permit friends and non-legally responsible family members²⁶ to become either employees of a Medicaid provider agency or become an independent Medicaid provider. If the friend or family member becomes an employee of the provider agency, he or she would have to take all of the training required by the agency and may be asked to provide services to other individuals who are not family members. Another option is for the friend or family member to become an independent Medicaid provider.

²⁴ Centers for Medicare and Medicaid Services, *Medicaid at-a-Glance*, 2002, CMS-11024-02.

²⁵ Centers for Medicare and Medicaid Services, *State Medicaid Manual*, CMS-45 Section 4480.

²⁶ Generally, non-legally responsible family members include all individuals except spouses and parents.

An independent Medicaid provider is not tied to a specific agency or business, but is still permitted to receive reimbursement directly from Medicaid for providing services. To qualify as an independent Medicaid provider the individual must meet the state's licensure requirements (if any) or state-prescribed qualifications and have a contract with the state Medicaid agency to provide Medicaid services. States may allow a variety of professionals or paraprofessionals to become independent Medicaid providers including speech therapists, nurses, radiologists and — most relevant for this discussion — direct care workers. For example, in the Washington and Michigan personal care programs, about one-half of the independent Medicaid providers were family members.²⁷ In cases where a friend or family member is the independent Medicaid provider, the consumer may have a considerable amount of discretion over key elements of the services, but the state establishes the reimbursement rate and pays the family member directly. The consumer is generally not permitted to change the hourly rate paid to the direct care worker, manage a flexible array of services within a particular dollar level, or receive payment directly from the state to pay for his or her personal care services. These activities are done by the state or the Medicaid provider.

The home health benefit of the Medicaid state plan also provides personal care to Medicaid beneficiaries and is a mandatory state plan service for individuals who are entitled to nursing facility services. However, the prescriptiveness of the federal certification requirements for home health providers limits a state's flexibility to develop opportunities for individuals to direct their own care and hire non-traditional providers under the home health benefit.²⁸

Medicaid Home and Community-Based Waivers

A more commonly-used method for providing consumer-directed long-term care services is under the home and community-based (HCBS) waiver authorized under Section 1915(c) of the Social Security Act. The HCBS waiver program provides a broad array of services to individuals who would otherwise be in an institution including homemaker/home health aide services, personal care services, respite care, adult day health and home-delivered meals. States have significant flexibility in identifying and defining services that will be covered under HCBS waivers. The state must identify the covered services in its waiver application to CMS including who the providers will be, and how the payment rates will be established.

Under the HCBS waivers, a state may provide significant flexibility allowing the consumer to select friends and non-legally responsible family members as independent Medicaid providers similar to the option described above in the Medicaid state plan section. The state may also establish an individualized budget and give the consumer significant flexibility with respect to the specific services covered and the rate to be paid to providers so long as these rates fall within the budgeted amount. Under an HCBS waiver, the state is not permitted to provide Medicaid funds to a consumer directly to pay for the personal care services. As

²⁷ J. Wiener et al., "Home and Community-Based Services in Seven States," *Health Care Financing Review*, Mar. 22, 2002.

²⁸ *HHS-ASPE, Primer*.

discussed above, of the 275 waivers in operation as of July 2003 there was no data regarding the number that are providing consumer-directed programs.

Medicaid Managed Care

Consumer-directed programs have also been developed under Medicaid managed care although they occur less frequently than under the state plan option or under HCBS waivers. Under Medicaid managed care, the state contracts with a plan(s) to provide an agreed-upon set of benefits. Generally, the state establishes fixed, prospective, monthly, per-person payments rate(s) referred to as a “capitation” payment for the services identified in the managed care contract. The managed care organization is responsible for selecting and paying the service providers, and under some circumstances can use savings from the program to provide enhanced services to beneficiaries.²⁹ A few states provide Medicaid long-term care services to beneficiaries through a managed care program.

The ability of the managed care organization to select and pay service providers and provide additional services from program savings creates opportunities for consumer-direction. For example, the managed care program could hire the direct care worker who is selected by the consumer, and permit the consumer to manage and train that worker. The managed care program could also use program savings to provide a flexible benefit to consumers for the purpose of increasing their independence. For example, one consumer could purchase an assistive device or piece of equipment while another could purchase transportation services. A survey of 45 Medicaid managed care plans that included long-term care services found that over half practiced some form of consumer-direction, and 32% of the programs surveyed allowed individuals to hire and fire their own workers.³⁰

It is also possible for Medicaid managed care programs to provide a cash benefit to beneficiaries to pay for services. However, payments directly to beneficiaries may be counted as resources in determining eligibility for the Supplemental Security Income (SSI) program unless they received a waiver from the Social Security Administration using the authority of Section 1110(b) of the Social Security Act. Counting these payments as additional resources could affect their eligibility for both SSI and Medicaid because eligibility determinations for these two programs are often linked.

²⁹ Savings can be used to provide additional services only if the state has received a waiver from CMS of Section 1915(b)(3) of the Social Security Act.

³⁰ M. Meiners, “Consumer-Direction in Managed Long-term Care: An Exploratory Survey of Practices and Perceptions,” *The Gerontologist*, Feb. 2002.

Section 1115 Waiver

Finally, a Section 1115 waiver offers states broad flexibility in the design of a consumer-directed long-term care program.³¹ Under the state plan, and HCBS waiver provisions described above, states cannot directly pay beneficiaries or their representatives.³² However, a state may get approval for these practices and a variety of other activities under a Section 1115 waiver, including (1) providing cash directly to individuals; (2) paying legally responsible relatives (e.g., spouses, parents); (3) changing the Medicaid eligibility requirements (e.g., allowing an individual to have more income and still qualify for Medicaid); or (4) waiving the requirement that the state only pays those agencies that have provider agreements with the state.³³ There are currently five states providing consumer-directed services through a Section 1115 waiver: Arkansas, California, Florida, New Jersey, and Oregon.

Independence Plus Initiative

Through the Medicaid state plan and waivers described above, states have been permitted to develop and implement many different consumer-directed programs. To assist states in further developing these programs and to streamline the waiver process, on May 9, 2002, the Bush Administration released the *Independence Plus template*. The Independence Plus template does not change current Medicaid law; it facilitates requests by states for waivers to develop consumer-directed programs by outlining the specific waiver application elements required of states and by providing technical assistance on key features of a consumer-directed program.

The Independence Plus template also established a minimum set of program design features that states must document in their waiver application for a consumer-directed program in order to receive approval from CMS. The six features comprise: a person-centered planning process, an individualized budget, fiscal intermediary services, a support broker who serves at the direction of the consumer, a quality

³¹ Authorized under Section 1115 of the Social Security Act, this research and demonstration waiver authority allows the Secretary of HHS to waive many provisions of Medicaid law. The waiver must be budget neutral over five years, meaning that it cannot cost the Medicaid program any more under the waiver than the state would have spent in the absence of the waiver.

³² Section 1902(a)(32) of the Social Security Act and 42 CFR 447.10(d) specify who can receive payment for Medicaid services. An exception is allowed for certain beneficiaries to pay for physician or dentist services; see 42 CFR 447.25 for additional information.

³³ Some of the individuals who are receiving cash payments directly may also be receiving cash benefits through the Supplemental Security Income (SSI) program — a means-tested program for individuals with a disability who are low-income, but also have a small amount of assets/resources. Payments directly to individuals for long-term care services under Medicaid would not be considered income, but in some cases would be counted as a resource. For the consumer-direction programs in Arkansas, New Jersey, Florida, and Oregon, the Commissioner of the Social Security Administration has used the authority of Section 1110(b) of the Social Security Act to waive payments to Medicaid beneficiaries for consumer-directed services from being counted as resources for the purposes of SSI eligibility (63 Federal Register 59902 and 66 Federal Register 9406).

assurance and quality improvement system, and consumer protections such as an emergency back-up system and an incident management system.

There are two ways to establish an Independence Plus Initiative depending on the state's objectives. Waiver templates have been developed for both the Section 1915(c) and 1115 waivers. The state must submit a Section 1915(c) waiver (HCBS) if it wants to provide services through an individualized budget, or have individuals manage some or all of their HCBS waiver services (e.g., respite, transportation, personal care services, or home modifications). The state *is required* to submit a Section 1115 waiver if it wants to (1) provide cash directly to individuals, (2) pay legally responsible relatives, (3) change the Medicaid eligibility requirements, or (4) waive the requirement for provider agreements (i.e., use non-Medicaid providers). See **Appendix A** for a description of approved waivers under the *Independence Plus* template.³⁴

Self-Directed Support Corporation

Another approach to consumer-directed services operating under current Medicaid law in a few states is known as the Self-Directed Support Corporation (SDSC).³⁵ The SDSC approach has generally been used by interested friends and family of a consumer with a significant cognitive disability as an alternative to the traditional agency-based system. The SDSC generally consists of a small group of individuals who know the consumer and establish a legally recognized organization to assist that consumer in coordinating and receiving his or her services. With the state's permission, the SDSC either becomes a licensed provider of Medicaid services for one individual with the ability to hire and supervise staff, or operates under the auspices of a third-party agency which is the employer and certified Medicaid provider but acts at the direction of the Self-Directed Support Corporation.³⁶

Although SDSC programs are not widespread, interest and activity are growing. States active in this area include Maryland, Michigan, Missouri, Tennessee and Oregon. For example, Tennessee has formed The Tennessee Microboard Association to provide assistance and training for interested individuals and families.³⁷

³⁴ This is not an exhaustive list of all Medicaid consumer-directed programs. Only those states which have received approval for new waivers or amendments to existing waivers using the *Independence Plus* template are included here. Prior to the announcement of the *Independence Plus* waiver template, states that wanted to implement consumer-directed programs would submit a waiver or state plan amendment to CMS, and the proposal would be considered through the normal review process. CMS has not tracked all consumer-directed programs available through both the Medicaid state plan and waivers.

³⁵ This approach for consumer-directed services originated in British Columbia, Canada, and is also referred to as a "Microboard ©".

³⁶ For additional information, with questions and answers and information about state projects, see the Inclusion Research Institute's website at [<http://www.self-determined.org>].

³⁷ For additional information, see [<http://www.tnmicroboards.org/>].

Recent Research and Development Initiatives

Highlighted below are several recent research and demonstration initiatives that demonstrate various approaches for consumer-directed long-term care services. These initiatives many of which started in the late 1990's expanded the options under a consumer-directed model by permitting consumers to pay workers directly and to manage a flexible benefit within a given dollar value. These initiatives have quickened the pace of development of Medicaid consumer-directed options by providing funding and technical assistance to states. Some of the initiatives described below have limited information about the extent of implementation, the numbers of individuals served and the findings or outcomes from the initiative; this information is provided or referenced whenever possible.

Cash and Counseling Demonstration

The Cash and Counseling Demonstration is one of the most well-known and largest demonstrations in consumer-directed long-term care under Medicaid. In 1996, the Robert Wood Johnson Foundation partnered with the Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (HHS, ASPE) and CMS to conduct the demonstration in Arkansas, Florida and New Jersey.³⁸ The Robert Wood Johnson Foundation and ASPE provided funding to implement and evaluate the demonstration, and CMS granted Section 1115 waivers to permit these states to pay consumers directly and employ legally responsible relatives as direct care workers.

The purpose of the demonstration was to assess the impact of providing a cash allotment to an individual for managing and directing his or her own personal care services.³⁹ Participation in the demonstration was voluntary. Individuals were randomly assigned to either receive the cash allotment as part of a treatment group, or use a traditional agency-based provider as part of a control group. **Table 2** describes the primary features of each state's demonstration.⁴⁰

³⁸ Oregon implemented a similar demonstration separate from the Cash and Counseling Demonstration in Dec. 2001.

³⁹ [<http://www.hhp.umd.edu/AGING/CCDemo/>]

⁴⁰ Ibid.

Table 2. Overview of Cash and Counseling Demonstration

	Arkansas	New Jersey	Florida
State program name^a	Independent Choices	Personal Preference	Consumer-Directed Care
Implementation date^a	December 1998	November 1999	May 2000
Authority for personal assistance services^a	Medicaid state plan: personal care option	Medicaid state plan: personal care option	Section 1915(c) Home and Community-Based Waivers
Populations served^a	Elderly and adults with a physical disability	Elderly and adults with a physical disability	Elderly, adults with a physical disability and children with a developmental disability
Territory covered^a	Statewide	Statewide	Central and South Florida: Elderly and adults with a physical disability Statewide: Children and adults with developmental disabilities
Average monthly cash allotment	\$350 ^b	\$1,300 ^c	\$300 ^d
Formula for determining cash allotment	A rate corresponding to an individual's assessed number of hours of personal care reduced between 9% and 30% to account for actual number of hours service used versus projected use. ^b	Amount based on the numbers of hours in the individual's previous personal care assessment multiplied by the state's hourly rates for personal care. ^c	Individual's historical Medicaid HCBS waiver expenditures reduced between 8 to 17% to account for actual use of services versus projected use. ^d
Final caseload (for evaluation)^a	2,008 persons	1,762 persons	2,820 persons

a. University of Maryland, Center on Aging, Cash and Counseling At-a-Glance, at [\[http://www.hhp.umd.edu/AGING/CCDemo/ataglace.html\]](http://www.hhp.umd.edu/AGING/CCDemo/ataglace.html).

b. B. Phillips and B. Schneider, *Moving to Independent Choices: The Implementation of the Cash and Counseling Demonstration in Arkansas*, Final Report, May 2000 Mathematica Policy Research, Inc. [<http://www.hhp.umd.edu/AGING/CCDemo/Products/C%20&%20C%20Arkansas%20Implementation.pdf>]

c. B. Phillips and B. Schneider, *Enabling Personal Preference: The Implementation of the Cash and Counseling Demonstration in New Jersey*, Final Report, Mar. 2000, Mathematica Policy Research Inc., at [\[http://www.hhp.umd.edu/AGING/CCDemo/Products/NJ%20Eval%20Main%20Report.pdf\]](http://www.hhp.umd.edu/AGING/CCDemo/Products/NJ%20Eval%20Main%20Report.pdf)

d. Testimony of Terry White, in U.S. Congress, House Energy and Commerce Committee, Subcommittee on Health, June 5, 2003.

Under the Cash and Counseling Demonstration, each state gave the consumer a monthly allotment to pay for personal care services according to a budget developed by the individual and approved by the state. The individual hired, supervised, and managed the services provided by the direct care worker(s). The individual was also permitted to save money from the allotment to purchase items that increased his or her independence (e.g., microwave, accessible ramp).

Two organizations received funding to help administer and evaluate the program. The University of Maryland, Center on Aging received funding to coordinate the Cash and Counseling Demonstration, to provide technical assistance to the states, and to develop written materials summarizing the demonstration's features. Mathematica Policy Research (MPR) received funding to conduct a quantitative analysis of the demonstration's effect on consumers, caregivers, and public costs, and to evaluate who participated in the demonstration, and how the demonstration was implemented.⁴³

Initial findings from Arkansas have been released. MPR found that participants in the Arkansas Cash and Counseling Demonstration as compared to a control group: (1) were more satisfied with the services they received; (2) reported a higher quality of life; (3) had fewer unmet needs for personal care, household activities and transportation; (4) received more paid care (especially adults under age 65); and (5) did not have more adverse events or health problems.⁴¹

In November 2003, MPR also released the following information on the effect of the Arkansas Cash and Counseling project on Medicaid expenditures for two years following an individual's enrollment.

- **Effect on Medicaid personal care expenditures:** Medicaid personal care expenditures for individuals enrolled in the Cash and Counseling project were higher than those in the control group and they received more paid care. The study attributes this difference in expenditures to the (1) the number of individuals in the control group who received no paid help, and (2) the smaller-than-expected ratio of services actually received by the control group compared to the number of hours they were assessed to need. Both of these factors may be the result of a shortage of direct care workers to assist persons in the control group.
- **Effect on Medicaid expenditures for other long-term care services:** Medicaid spending for other long-term care services such as nursing facilities, home health services and home and community-based waiver programs were lower for individuals enrolled in the Cash and Counseling project than the control group particularly in the second year after the individual's enrollment.

⁴¹ L. Foster et al., "Does Consumer Direction Affect the Quality of Medicaid Personal Assistance in Arkansas?" *Mathematica Policy Research*, Mar. 2003, at [<http://www.mathematica-mpr.com/PDFs/condirect.pdf>].

- **Effect on total Medicaid expenditures:** The total Medicaid expenditures for individuals enrolled in the Cash and Counseling Demonstration were higher in the first year than the control group, but in the second year there was no significant difference between the two groups in total Medicaid expenditures.⁴²

The experience of the three states led the Robert Wood Johnson Foundation to award additional funding to the Boston College, Graduate School of Social Work in the fall of 2002 to assess if other states would be interested in replicating the demonstration. Based on this assessment, in January 2004, the Robert Wood Johnson Foundation announced a \$7 million grant program for the replication and expansion of the Cash and Counseling demonstration. In October 2004, eleven new states received this three year grant including Alabama, Iowa, Kentucky, Michigan, Minnesota, New Mexico, Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia.⁴³ ASPE and the HHS, Administration on Aging have also provided funding for the expansion of this initiative.

Self-Determination Initiative

In 1997, the Robert Wood Johnson Foundation established the Self-Determination Program for Persons with Developmental Disabilities and awarded \$5 million to 19 states to explore consumer-directed alternatives to providing long-term care services to individuals with a developmental disability.⁴⁴ The following 19 states received grant awards: Arizona, Connecticut, Florida, Hawaii, Iowa, Kansas, Maryland, Massachusetts, Michigan, New Hampshire, Minnesota, Ohio, Oregon, Pennsylvania, Texas, Utah, Vermont, Washington and Wisconsin.

The projects varied in their scope and activities from broad-based planning and system reform to small pilot projects. For example, Utah established a statewide foundation for self-determination which built on its preexisting efforts to change the role that consumers played in discussing the services they needed with professionals. Wisconsin, on the other hand, focused its initiative on three demonstration counties and developed an initiative to support approximately 300 individuals to direct their own services and supports through an individualized budget. The evaluator of the project, the Human Services Research Institute (HSRI) made general observations about the projects a few of which are described below:

- States that had already built flexibility into their service delivery system found it easier to develop, manage and finance consumer-direction;

⁴² S. Dale et al., “The Effects of Cash and Counseling on Personal Care Services and Medicaid Costs in Arkansas,” *Health Affairs*, Web exclusive, Nov. 19, 2003, at [<http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.566v1.pdf>].

⁴³ For additional information about state projects, see [<http://www.cashandcounseling.org/about/map.html>].

⁴⁴ Ten other states received small technical assistance grants.

- State contracting policies were, at times, barriers to purchasing services and supports that were responsive to an individual's needs because they were outside the pool of state-approved contractors;
- The self-determination projects became a vehicle for increased self-advocacy among individuals with developmental disabilities and their representatives; and
- HSRI indicated that “‘self-determination’ is a concept that is evolving across the states with resulting variance in definition and operations.”⁴⁵

Independent Choices

In 1997, the Robert Wood Johnson Foundation funded 13 projects to test a variety of strategies for increasing consumer-direction for a variety of different disability groups. The National Council on Aging (NCOA) received funding to coordinate the 13 projects. Of the projects funded, nine were demonstrations and four were research projects. For example, the demonstration project in Oakland, California developed an emergency hotline for individuals who were unable to receive personal care services because of a worker absence or cancellation. A research project at the Family Caregiver Alliance in San Francisco examined the extent to which individuals with mild and moderate cognitive disabilities could express their preferences. This project found that these individuals could consistently state their preferences and choices and could play a role in decisions about their care. This project also found that close family members often had inaccurate perceptions of the individual's preferences.⁴⁶

In 2002, the Robert Wood Johnson Foundation awarded additional funding to the National Council on the Aging (NCOA) and the National Association of State Units on Aging (NASUA) to continue to work with states to develop, promote and facilitate consumer-direction including assisting states in assessing their long-term care systems, holding public forums, and developing a plan to address specific barriers to consumer choice and control in their programs. The focus of this initiative included both Medicaid and non-Medicaid programs (e.g., programs established under the authority of the Older Americans Act). In addition to the state-specific activities, NASUA and NCOA continue to develop resource materials to promote consumer-direction in aging services including surveys of program administrators, case studies of particular programs, and a guide for consumers to evaluate degree of consumer-direction in their state's programs.⁴⁷

⁴⁵ V. Bradley, et. al., *The Robert Wood Johnson Foundation Self-Determination Initiative: Final Impact Assessment Report*, Human Services Research Institute, Nov. 2001.

⁴⁶ A. E. Benjamin and R. Snyder, “Consumer Choice in Long-term Care, To Improve Health and Health Care V,” *The Robert Wood Johnson Anthology*, 2003, Chapter 5. For additional information, see [http://www.rwjf.org/publications/publicationsPdfs/anthology2002/chapter_05.html]. P. Nadash, “Independent Choices,” *American Rehabilitation*, vol. 24, no. 3, summer/autumn 1998, at [<http://www.independentliving.org/docs4/ar3983.html>]

⁴⁷ This assessment tool was also developed in collaboration with the Home and Community-Based Resource Network, an organization working with states and the aging and disability (continued...)

Systems Change Grants to States

In fiscal years 2001 through 2004, Congress appropriated a total of \$205 million in grants to states to increase opportunities for community living for individuals of any age with a disability or long-term illness as part of CMS' discretionary research appropriation. Of the \$205 million, CMS targeted \$23.5 million in two different grant categories to increase consumer-direction in Medicaid personal care services; the grants were referred to as the "Community-Integrated Personal Assistance Services and Supports" grant (CPASS) and "Independence Plus Initiative."⁴⁸ All grantees were selected through a competitive bidding process.⁴⁹

The purpose of the CPASS grant is to improve personal assistance services that are consumer-directed or offer maximum individual control. Some activities under this grant category include conducting outreach on existing consumer-directed programs, evaluating the expansion of consumer-direction, building support networks for individuals engaged in consumer-directed services, and improving the recruitment and retention of direct care workers.

The purpose of the Independence Plus grant is to assist states in meeting the federal expectations established by CMS for the approval of self-directed program waivers and demonstration projects within the Independence Plus framework. The federal guidelines include areas such as developing an individual budget, creating the capacity for fiscal intermediaries and service brokers, and designing a quality assurance and improvement systems.

- In FY2001, nine states and one territory were awarded CPASS grants totaling \$7.6 million: Alaska, Arkansas, Guam, Michigan, Minnesota, Montana, Nevada, New Hampshire, Oklahoma, and Rhode Island.
- In FY2002, seven additional states and the District of Columbia received CPASS grant awards totaling \$6 million: Colorado, District of Columbia, Hawaii, Indiana, Kansas, North Carolina, Tennessee and West Virginia. CPASS grant activities vary widely from strengthening the consumer training component of an existing

⁴⁷ (...continued)

communities to improve long-term care services. [<http://www.consumerdirection.org>].

⁴⁸ The balance of funds above the \$23.5 million were state grants targeting other long-term care efforts including, for example, nursing facility transition, resource centers for the elderly and individuals with disabilities, and the transformation of mental health systems. All of the grants are designed to assist states in increasing opportunities under Medicaid for community living for individuals with a disability or long-term illness.

⁴⁹ Grantees selected through the competitive bidding process were required to contribute at least 5% of the project's total cost. The federal grant provided the remaining funds.

consumer-directed program to initiate a consumer-directed program from the earliest stages of development.⁵⁰

- In FY2003, eight states received a CPASS grant totaling \$4.5 million: Arizona, Connecticut, Louisiana, Massachusetts, Nebraska, Oregon, Texas and Virginia. States that received funding in FY2001 or FY2002 were ineligible to apply for CPASS grant funds in FY2003.
- In addition to the CPASS grant, HHS also awarded \$5.4 million in grants to 12 states to develop the infrastructures necessary to develop and/or implement an *Independence Plus* waiver. The states that received *Independence Plus* awards are Colorado, Connecticut, Florida, Georgia, Idaho, Louisiana, Maine, Massachusetts, Michigan, Missouri, Montana and Ohio.⁵¹

Considerations in Implementing Consumer-Directed Services

As described earlier, the traditional Medicaid provider model for most beneficiaries receiving home and community-based services is through an agency. The provider must meet certain qualifications and have an agreement with the state Medicaid agency. The direct care worker is an employee of the provider agency, and the consumer has varying degrees of discretion over how services are provided. Although there is wide variation in consumer-directed long-term care programs, most states implementing these programs must shift the focus or redesign some of their administrative structures or program policies if the state wants to move their agency provided service model to a consumer-directed one. This section outlines some of the administrative and policy considerations for state Medicaid agencies in developing consumer-directed programs.

Eligibility

To participate in consumer-directed Medicaid long-term care programs, the individual must be Medicaid eligible and demonstrate need for that type of service (e.g., personal care). This means meeting financial standards and having a given level of impairment/disability. In some programs, a state may also require that the individual pass a cognitive or competency test to determine whether or not he or she is capable of directing the service and managing the cash allotment. Many programs

⁵⁰ For a description of state grant activities, see [<http://www.cms.hhs.gov/systemschange/compendium01-02.pdf>].

⁵¹ CMS, *Invitation to Apply for Real Choice Systems Change Grants for Community Living: To Improve Community Services for Children and Adults Who Have a Disability or Long-Term Illness*, May 30, 2003 at [<http://www.cms.hhs.gov/newfreedom/2003solicitation.pdf>], and HHS Press Release at [<http://www.hhs.gov/news/press/2003pres/20031002a.html>].

allow a family member or legal guardian to direct the services on behalf of a child or an individual who is unable to express his or her preferences.

Fiscal intermediary

In a traditional agency-based system, the provider agency bills the state for the Medicaid services it provides according to an established rate. In a consumer-directed model, the state or its contracted agency may take on other functions including tracking an individual's budget, paying different rates for different workers (if allowed by the program), and additional reporting requirements.

Several states implementing consumer-directed models have contracted with an organization usually referred to as a "fiscal intermediary" to assist in the administration of the cash benefit or individualized budget.⁵² The fiscal intermediary assists the consumer with a variety of tasks depending on the program's design and policies including collecting the direct care workers' time sheets, issuing the checks to the direct care workers, or tracking the consumer's expenditures. Other responsibilities for the fiscal intermediary may include conducting criminal background checks of the direct care workers, filing tax reports, or making sure that amounts are withheld from the workers' earnings for Social Security and Medicare, unemployment insurance, and worker's compensation and other tax-related contributions.⁵³ Generally, the states pay fiscal intermediaries through Medicaid administration funding (50% state funding, 50% federal Medicaid funding), as an expense in each person's cash allotment (e.g., \$10 per month, 5% of the cash allotment), or as a separate service under the home and community-based waiver program.

Service Consultant/Support Broker/Counselor

Most consumer-directed programs have an individual available to provide consultation and support to the consumer. The activities of the service consultant may include assisting the individual in developing his or her service plan or consulting with the consumer on any employer-employee issues (e.g., recruiting, firing). The role of this individual differs from the more traditional role of "case manager" in which the case manager is responsible for assessing the individual's needs, and coordinating and overseeing all of the services the consumer receives by provider agencies.

⁵² The term "intermediary service organization" is also used.

⁵³ For a typology of fiscal intermediaries, see S. Flanagan and P. Green, *Consumer-Directed Personal Assistance Services: Key Operational Issues Using Intermediary Service Organizations*, The MEDSTAT Group, Oct. 24, 1997.

Consumer Education and Training

Under a consumer-directed program, consumers take on new roles and responsibilities including directing and managing workers, working with a fiscal intermediary to submit time sheets, and developing an individualized budget. States have offered various methods of training and ongoing support for these consumers. Some of these methods include conducting a formal training session, providing individual discussions with an individual's service consultant, matching consumers with other individuals with a disability who are also participating in consumer-directed programs, and developing written training materials. For example, a consumer-directed program in New Jersey has developed a consumer guide for individuals not using a fiscal intermediary; the guide contains information on filing for tax status as an employer, workers' compensation, and paying wages and overtime.⁵⁴

Determining a Consumer's Cash Allotment

Under the current Medicaid system, individuals are generally assessed to see how many hours of a particular service are required to meet their needs. The consumer is then eligible to receive that number of hours of service unless the number of hours exceeds the state's limits on the amount of services that can be provided and/or if the cost of those services exceeds amount permitted under a Section 1915(c) home and community-based waiver.

Under a consumer-directed approach, the state establishes a *total dollar value* to cover the participants' service(s). The formula to calculate the amount of this allotment can be based on a variety of factors including:

- The number of hours that would have been provided to the individual (based on an assessment of need) for receiving services through an agency-based model multiplied by the state's rate for personal care services;
- Historical expenditures of a particular individual or group (e.g., the average amount over the last three years);
- A decrease in the amount to reflect the average number of service hours actually used versus the number of planned hours (e.g., due to unplanned worker absences); and/or
- A periodic opportunity to reassess the allotment if the consumer's needs change.

Who is the Employer?

A key consideration in implementing a consumer-directed Medicaid long-term care program is who will be the legal employer of the individual(s) providing the service (e.g., the direct care worker). The options for who serves as the employer include the following:

⁵⁴ [<http://www.hhp.umd.edu/AGING/CCDemo/ccbook/>]

- the consumer;
- an organization that provides services to an individual;
- a fiscal intermediary;
- a provider agency that is participating in a consumer-directed model;
- the state Medicaid agency; or
- a self-employed direct care worker who is an “independent Medicaid provider.”

These options show the great variation that can exist in a consumer-directed model.

The employer assumes certain fiscal and legal responsibilities based on federal and state laws. For consumers who have not previously been an employer, sorting out the federal requirements, the state laws, and the associated responsibilities can be confusing and administratively burdensome. These requirements can include employer contributions to Social Security and Medicare, federal and/or state unemployment taxes and workers’ compensation.⁵⁵ Not surprisingly, in cases when consumers have been the employers, most states have contracted with a fiscal intermediary to assist consumers with these obligations.⁵⁶ Most consumers found this assistance to be very helpful.⁵⁷

Service Providers

There are four primary issues for states to address in determining who can provide services under a consumer-directed long-term care program:

Provider Qualifications. Medicaid law requires states to have standards for determining which providers may participate in the Medicaid program. Federal law provides explicit standards and certification processes for some providers, such as home health agencies and nursing homes. For other providers, standards and procedures are generally governed by state laws, regulations, and licensure requirements. For example, the state may require that direct care workers complete a criminal background check. In general, independent Medicaid providers, as discussed earlier, must meet the same requirements for training and certification as direct care workers who are employed by an agency. For other types of consumer-directed programs, the state has flexibility in establishing the standards and requirements for who is allowed to provide personal care services.

Provider Rates. Under Medicaid, states have considerable latitude in determining how much providers will be paid for a particular service; however, the rates must be approved by CMS. Generally, states establish a single rate for a

⁵⁵ For additional information, see M. Kapp, “Consumer-Direction in Long-Term Care: A Taxonomy of Legal Issues,” *Generations*, fall 2000 and S. Flanagan and P. Green, *Consumer-directed Personal Assistance Services: Key Operational Issues Using Intermediary Service Organizations*, The MEDSTAT Group, Oct. 24, 1997.

⁵⁶ Federal law allows a third party to act on behalf of consumers and their workers without being considered the employer.

⁵⁷ S. Flanagan and P.S. Green, “Fiscal Intermediaries: Reducing the Burden of Consumer-Directed Support,” *Generations*, fall 2000, pp. 94-97.

particular category of provider. Under a consumer-directed model, some states have permitted consumers to establish the rate that would be paid to their particular direct care worker(s) so long as it fits within the individual's budgeted amount or allotment.

Hiring Friends and Family Members. Many individuals in consumer-directed programs are interested in hiring friends and family members to provide their services. Personal care services are quite intimate (e.g., bathing, dressing), and individuals may be more comfortable having someone they know provide this type of care. In many cases, hiring friends and non-legally responsible family members is permitted under Medicaid. The friend or family member can either become an employee of a Medicaid provider agency or, if permitted by the state, be self-employed as an independent provider (which is described in the Medicaid State Plan section). The one exception is if the state wants to pay *legally* responsible relatives as a direct care worker which generally requires a waiver under Section 1115.⁵⁸

Paying legally responsible relatives to provide care has caused some debate about an individual's responsibilities to provide care to a family member. Opponents say that legally responsible relatives have an obligation to provide care for a family member and that we are using public funds to pay for care that would otherwise be provided for free (informally). Proponents note that the care required can be intensive and can affect a parent's or spouse's ability to hold other employment and that paying family members can help ease the shortage of direct care workers which many states are experiencing.

Effect on Current Service Providers. Finally, some states implementing consumer-directed programs have encountered significant opposition from traditional agency-based providers who believe that consumer-directed options will negatively affect their businesses by drawing away consumers. The state may have to work with the provider community to overcome opposition to consumer-directed programs, particularly those types of programs that provide cash directly to the consumer to select his or her direct care worker.

Compliance with State Nurse Practice Act

Most states have laws and/or regulations that govern the practice of nursing broadly referred to as the "Nurse Practice Act." These laws and regulations generally prohibit certain types of services from being conducted by anyone other than a *licensed* nurse. The types of services most relevant for this discussion tend to be routine, daily needs for some individuals with a disability such as medication administration (both oral and injectable), urinary catheterization, gastrostomy tube

⁵⁸ The State Medicaid Manual cites an exception under Section 1915(c) home and community-based waivers for paying legally responsible relatives for "extraordinary services requiring specialized skills (e.g., skilled nursing, physical therapy) which such people are not already legally obligated to provide." In addition some states may pay legally responsible relatives without a Section 1115 waiver, but pay for the services with 100% state funding.

feedings, and suctioning for individuals with a tracheostomy.⁵⁹ In developing a consumer-directed program, the state will need to review its laws and regulations to ensure that the consumer-directed program complies with the Nurse Practice Act.

There is significant variation in (1) the extent to which states' Nurse Practice Acts permit consumer-directed services and (2) the clarity with which the issue is addressed. Two specific vehicles used by states which are relevant for consumer-direction include *exemption* and *delegation*. An *exemption* provision describes in law or regulation who is not governed by the Nurse Practice Act. Some Nurse Practice Acts provide a general exemption for individuals who are providing personal care assistance to a family member. Under *delegation*, a nurse can delegate certain activities to another individual, but the nurse has oversight responsibility for those services.⁶⁰ If the state allows for delegation, the consumer-directed program will need to have processes in place for a nurse to delegate and oversee specific activities.

Fraud and Abuse

A commonly raised concern by policymakers in consumer-directed programs is the potential for fraud and abuse either by consumers who are given a cash allotment to purchase their services or by others who may exploit the consumer. According to Kevin Mahoney, the national program director for the *Cash and Counseling* demonstration (described later), after three and a half years the demonstration has found "no major instances of fraud and abuse."⁶¹ Many consumer-directed programs include policies and procedures to minimize fraud and abuse and maintain accountability for public funds such as approving the consumer's plan for using the funding, tracking utilization of services and collecting receipts.

Quality

A final consideration for states in implementing consumer-directed programs is how to assure the quality of services provided to a consumer. Medicaid law and regulations prescribe quality of care standards in nursing homes that participate in Medicaid, and federal and state governments have a substantial role in surveying and certifying nursing homes.

⁵⁹ Gastrostomy tube feedings occur when an individual has a condition in which he or she has difficulty or is unable to take in food through the mouth and has a tube surgically inserted through the skin into the stomach to receive nutrients. Feeding the individual is generally required at least daily and often several times per day. A tracheostomy is a surgically implanted opening directly into the trachea, which is used when there are difficulties with the individual's airway; the tracheostomy allows the individual to breathe. Suctioning periodically (e.g., every few hours) may be required to remove secretions.

⁶⁰ S. Reinhard, "Consumer Directed Care and Nurse Practice Acts," *Rutgers' Center for State Health Policy*, June 2001, at [<http://www.aspe.hhs.gov/daltcp/reports/nursprac.htm>].

⁶¹ Testimony of National Program Director Kevin Mahoney, Boston College, in U.S. Congress, House Committee on Energy and Commerce, hearings, June 5, 2003 at [<http://energycommerce.house.gov/108/Hearings/06052003hearing949/Mahoney1513.htm>]

Most community-based long-term care services do not have a similar level of federal requirements and oversight. Under the Medicaid state plan, states must set provider standards but otherwise have significant flexibility in how they monitor and implement community-based long-term care services. In the HCBS waivers, states are required to provide assurances to CMS that the health and welfare of the HCBS waiver participant is protected and, in some cases must provide annual documentation to support these assurances.^{62,63} CMS has been somewhat more proactive in recent action that required additional documentation from states for approval of Independence Plus waivers.

In most existing consumer-directed programs, consumers take on the primary responsibility of quality assurance. “Governmental quality assurance activities in consumer-directed programs are fairly minimal, consisting mostly of responding to complaints, periodic home visits and telephone contact with beneficiaries.”⁶⁴ Although governmental activities have been limited, existing research has found that consumers have generally reported comparable or higher levels of satisfaction with the quality of their care and their own quality of life in consumer-directed models compared to agency-based models.⁶⁵

Considerations for Future Policy Development

Consumer-directed home and community-based long-term care services are of increasing interest for individuals with a disability. Policymakers at both the federal and state levels have focused research and demonstration efforts as well as Medicaid program initiatives at expanding opportunities for consumer-directed services. There is also congressional interest in expanding opportunities for consumer direction. As discussed earlier, bills have been introduced in several recent Congresses that would have expanded consumer-direction for personal attendant services under Medicaid. Congress also enacted a demonstration project for consumer-directed chronic outpatient services as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Section 648, P.L. 108-173). The provision requires the Secretary of HHS to establish a budget-neutral demonstration within the Medicare program that permits beneficiaries with chronic conditions to direct their own personal care services within two years of enactment.

There has been some interest by policymakers in exploring whether consumer-direction would be appropriate for services other than personal care and home and community-based waivers. A few federal grant programs sponsored by HHS have provided an allotment for individuals to purchase other health care services including

⁶² Section 1915(c)(2)(A) and 1915(c)(2)(E) of the Social Security Act, and 42 CFR 441.302.

⁶³ CMS has taken some steps to improve the quality of HCBS services by establishing guidelines for a quality assurance and improvement system which are needed for approval of Independence Plus waivers, by developing a protocol for CMS regional offices in reviewing HCBS waivers and by providing technical assistance to states.

⁶⁴ J. Tilly and J. Wiener, *Consumer-Directed Home and Community Services: Policy Issues*, Urban Institute, Occasional Paper Number 44.

⁶⁵ *Ibid.*

mammogram screening for women in rural areas,⁶⁶ and primary care visits for migrant workers.⁶⁷ The purposes of these allotments were to increase access to a particular service and to encourage utilization of primary care using a capped funding source. Under these initiatives, the allotment required relatively minimal effort by consumers in both the time and level of responsibility required. In contrast, most of the consumer-directed long-term care programs described in this report required ongoing participation and responsibility by consumers and a higher level of state infrastructure to implement and oversee the projects.

The potential for future activities in consumer-directed care, including program growth and policy implications, has not yet been fully explored. However, initial findings from research and demonstration activities have shown increased consumer satisfaction, reduced unmet service needs, and in one project a one-year increase in Medicaid expenditures with offsetting decreases in other service expenditures in the second year. As it considers legislation related to consumer-direction and evaluates the experience of existing federal and state programs, Congress faces the following questions.

- **Should participation in consumer-directed programs be voluntary or mandatory?** Most existing consumer-directed programs are voluntary. Depending upon the program and type of service, there may be tasks that are time-consuming or challenging, such as managing the cash allotment, finding and making informed decisions about qualified providers, or supervising workers. Some consumers using long-term care services or other health care services may be unable or unwilling to assume these tasks or may be satisfied with the services they receive from a traditional provider.
- **What types of services are most compatible with a consumer-directed model?** Existing consumer-direction programs have generally included services that are ongoing and predictable such as personal care. Other services that follow this pattern may be appropriate for consumer-direction (e.g., home health services, physical therapy, and adult day care). However, current models of consumer-direction may be less viable for services that are less predictable (e.g., inpatient hospital visit) or for conditions that are subject to acute flare-ups.
- **How much financial risk should the consumer have? For example, should standards be established for determining an individual's cash allotment?** The existing consumer-directed models have minimal financial risk for the consumer. The programs are voluntary, the cash allotment is based on an assessment of needs, the service utilization pattern is generally ongoing and

⁶⁶ T.J. Stoner, et al., "Do Vouchers Improve Breast Cancer Screening Rates? Results from a Randomized Trial," *Health Services Research*, Apr. 1998, pp. 11-28.

⁶⁷ D.P. Slesinger and C. Ofstead, "Using a Voucher System to Extend Health Services to Migrant Farmworkers," *Public Health Reports*, v. 111, Jan./Feb. 1996, pp. 57-62.

predictable, and the individual's functional limitations are periodically reassessed.

- **To what extent does the consumer have access to and information about potential service providers?** Many individuals who volunteered for the existing consumer-directed programs had a pool of individuals willing to provide direct care services. In addition, the work required minimal skills, and the consumer generally knew the qualifications of the individual providing the services. Three considerations in consumer-direction for other services are (1) the potential pool of qualified providers, (2) consumer's access to those providers, and (3) the availability of information to distinguish between the qualifications and services of different providers.
- **Is the administrative infrastructure available to support a consumer-directed model?** Fiscal intermediaries have played a significant role in implementing existing consumer-directed services. However, these types of organizations have generally maintained a fairly specialized role in the marketplace. If consumer-direction were expanded, the number of fiscal intermediaries available may need to expand and their activities may need to change depending on the type of service.
- **For consumer-directed programs under Medicaid, under what circumstances should states be required to seek federal permission via a waiver?** As discussed earlier, states must seek a Section 1915(c) waiver to provide additional home and community-based services to individuals and develop an individualized budget. States must seek a Section 1115 waiver to pay consumers directly, pay legally responsible relatives, pay individuals who are not Medicaid providers and change Medicaid eligibility. Some policymakers have proposed removing the requirement that states get permission via a federal waiver for certain types of consumer-directed programs. Others have suggested broadening the definition of personal care services under Medicaid law to allow more flexible supports such as home modifications and assistive technology (e.g., a ramp to a home, voice-activated telephone).⁶⁸
- **Should state Medicaid programs be permitted to pay legally responsible relatives to provide care for a family member without a Section 1115 waiver? If so, under what circumstances?** Generally, states are not permitted to pay legally responsible relatives without a Section 1115 waiver. In addition, the state assessment process to determine how many personal care hours a

⁶⁸ Testimony of Secretary of Florida Department of Elder Affairs Terry F. White, in U.S. Congress, House Committee on Energy and Commerce, hearing, June 5, 2003 at [<http://energycommerce.house.gov/108/Hearings/06052003hearing949/White1515.htm>]

particular consumer needs generally evaluates the amount of informal (unpaid) care that is currently being provided and determines the number of additional hours required. As discussed earlier, paying legally responsible relatives has caused some debate. Congress may want to consider (1) the circumstances, if any, in which it is appropriate to pay legally responsible relatives to provide services; (2) should paying legally responsible relatives continue to require a Section 1115 waiver, and (3) when, if ever, is it appropriate to substitute unpaid care for paid care.

- **What role, if any, should the federal government have in assuring the quality of consumer-directed services?** Designing a system of quality in community-based long-term care services that balances the consumer's preferences, the individual's safety, and accountability to the public is an ongoing challenge for both state and federal policymakers. Some policymakers believe that the current monitoring and regulatory approach applied to institutions to assure quality is not appropriate for community-based services and see an expanded role for consumer-directed approaches in improving quality. They suggest that opportunities for consumers to direct and manage their services will increase quality because the consumers can define "quality" based on what is important to them, choose providers who can meet those preferences, and oversee the delivery of those services. On the other hand, others counter that consumers may be less likely to report or fire a friend or family member who is not providing quality services. It appears likely that if consumer-directed services were expanded more broadly, policymakers may need to develop more specific quality assurance mechanisms that would insure that consumers get the services they need.

Appendix A. Approved *Independence Plus* Waivers as of January 2005

California. In August 2004, California received approval for an *Independence Plus* Section 1115 waiver to provide self-directed personal care assistance for individuals who are elderly or have blindness or a disability. The waiver is statewide and will include approximately 66,000 Medicaid beneficiaries who need personal care or other supports and who select a spouse or parent to provide those services to them. This program was previously operating through a state-funded portion of the In-Home Supportive Services (IHSS) program known as the “Residual Program.” The Residual Program was to be eliminated from the state’s budget. The approval of the Section 1115 waiver preserved these services for Medicaid beneficiaries.

Connecticut. In January 2005, Connecticut received approval to implement an *Independence Plus*, Section 1915(c) waiver. The waiver will offer services such as personal care, supported employment, group day services, vehicle modification, companion services and family training. The state expects to serve over 3,000 individuals with mental retardation or developmental disabilities in this waiver.

Delaware. In November 2004, Delaware received approval for an *Independence Plus*, Section 1915(c) waiver. The waiver is expected to serve 30 individuals who are elderly or have a physical disability. The waiver services will include attendant services, personal care services, adult day health, respite, supports brokerage, fiscal and employer agent services and medical equipment and supplies.

Florida. In May 2003, Florida received approval to amend its existing Section 1115 waiver through the *Independence Plus* template to offer the Cash and Counseling program (described above) statewide, rather than selected counties, and to remove random assignment of enrollees. The waiver will continue to be voluntary for Medicaid beneficiaries, but does require enrolled consumers to use a fiscal intermediary to administer the cash benefit. The waiver will serve individuals who are elderly, adults with a physical or developmental disabilities, children with developmental disabilities, or former *Choice and Control* participants (a previously state-funded consumer-directed program in which funding was eliminated). The waiver is projected to serve 3,500 individuals statewide.⁶⁹

Louisiana. In April 2003, Louisiana received approval for an *Independence Plus*, Section 1915(c) waiver to develop a long-term care program for individuals with mental retardation or a developmental disability. The waiver will provide home and community-based services to 4,200 Medicaid beneficiaries. The consumer-directed component will be phased-in over a three-year period starting with 100 participants in the first year. The fourth year and thereafter, it is expected that the consumer-direction service option will become available to all waiver recipients.⁷⁰

Maryland. In October 2004, Maryland received approval for an *Independence Plus*, Section 1915(c) waiver to provide self-directed long-term care services for

⁶⁹ [<http://www.cms.hhs.gov/medicaid/1115/fl1115cdc.asp>]

⁷⁰ [<http://www.hhs.gov/news/press/2003pres/20030424.html>]

individuals with developmental disabilities. This waiver referred to as the “New Directions” waiver, will provide services that include respite, supported employment, personal support services, assistive technology and adaptive equipment. Participating individuals will have the ability to select and direct their direct care worker and may use a portion of their individual budget for non-traditional goods and services.

New Hampshire. In December 2002, New Hampshire received approval for an *Independence Plus*, Section 1915(c) waiver to offer consumer/family-direction of services for children with a developmental disability. The waiver is intended to serve 300 children statewide. Families will be involved in planning all aspects of service delivery, including the selection of service providers. The total cost of services must fall within an individualized budget.⁷¹

North Carolina. North Carolina has received approval for two *Independence Plus* waivers. The first is a Section 1915(c) waiver was approved in December 2004 and is expected to serve 335 individuals who are elderly or have disabilities. The services covered under this waiver include adult day health, respite, care advice, financial management, personal assistant, telephone alert, home delivered meals, in-home aide, home mobility aids, waiver supplies and consumer-designated goods and services.

The second *Independence Plus* waiver was a 1915(c) waiver which has been combined with a Section 1915(b) waiver to provide these home and community-based services under a managed care program. This waiver was approved in October 2004. This waiver is expected to be implemented in April 2005 and will provide consumer-directed services to approximately 275 individuals with developmental disabilities in five counties (Cabarrus, Davidson, Rowan, Stanley, and Union). The waiver will provide personal care services, adult day services, respite services, and home delivered meals. It also helps coordinate a range of other services that people with developmental disabilities or cognitive impairments need in order to help them maintain their independence.

South Carolina. In March 2003, South Carolina received approval for an *Independence Plus* 1915(c) waiver for adults with a physical disability and the elderly. The waiver will be offered in three counties (Spartanburg, Cherokee, and Union) and is expected to serve 900 individuals over three years. Under the HCBS waiver, Medicaid beneficiaries will receive personal care services, adult day services, respite services and other services needed to help them maintain independent lives. The consumer will have significant flexibility in planning for and directing the services he or she needs within an individualized budget and will be assisted by a “care advisor” and a financial management service.⁷²

⁷¹ [<http://www.cms.hhs.gov/medicaid/1915c/nh0397.asp>]

⁷² [<http://cms.hhs.gov/newfreedom/528scc.pdf>]