

Report to the Twenty-Fourth Legislature
State of Hawaii 2008

PURSUANT TO ACT 204 (S.B. NO. 1916, S.D. 2, H.D. 3, C.D. 1), PART 7, SECTION 11,
REQUESTING THE EXECUTIVE OFFICE ON AGING TO RESEARCH THE CASH AND
COUNSELING PROGRAM AND ITS IMPLEMENTATION IN OTHER STATES

PREPARED BY:

State of Hawaii
Department of Health
Executive Office on Aging
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EXECUTIVE SUMMARY

Cash and Counseling is a promising program that ensures consumer-directed home- and community-based care for elders and persons with disabilities. There are essentially two basic components to this program. First, the “Cash” portion is the method through which recipients are able to pay for the services or products that they choose to receive. “Counseling” refers to the services provided by an agency where a case manager collaborates with the recipient to construct a needs assessment and budget in order to make a determination about services and/or products.

Cash and Counseling provides elders and persons with disabilities an opportunity to have a voice in their care through a highly-collaborative approach. Consumers participate in every stage of the process of obtaining and maintaining services and products that are necessary for an optimal quality of life. Initially a successful three-state Medicaid waiver demonstration program, Cash and Counseling has been replicated in 12 additional states.

The National Program Office Director, along with contact personnel from the various state Cash and Counseling programs, were contacted in an effort to explore their programs. Interviews with the Department of Human Services-Adult and Community Care Services (DHS-ACC) and the Department of Health-Developmental Disabilities Division (DHS-DD) were conducted in order to ascertain the availability of services to elders and persons with disabilities in the state of Hawaii. Additionally, evaluation research data from Mathematica Policy Inc. was collected from the Cash and Counseling web site.

The evaluation research data strongly indicate that Cash and Counseling is a consumer-directed approach that promises positive results for elders and persons with disabilities. Based on the evaluation data from the three-state demonstration project, both consumers and caregivers who participated in Cash and Counseling reported higher levels

of satisfaction than consumers and caregivers who received traditional program services. However, this satisfaction came at a cost. Medicaid costs for services under Cash and Counseling were significantly higher than costs under traditional services.

While caution must be taken with regard to the financial aspect of Cash and Counseling, the program appears to provide beneficial consumer-directed option for home- and community-based services for elders and persons with disabilities that allows for increased collaboration between the consumer and the agency. Although the state of Hawaii currently offers home- and community-based services to its elders and persons with disabilities, through DHS-CCS and DOH-DD, there are limitations. Elders and persons with disabilities who wish to take advantage of these services must be Medicaid eligible. Thus, the non-Medicaid population that includes elders and persons with disabilities who do not qualify for Medicaid, but are still unable to pay for services, are not covered and receive no assistance. Elders that are Medicaid eligible and receive traditional personal care services are not able to hire a spouse or child to provide these services.

In considering the adoption of Cash and Counseling for the state of Hawaii, it is important to consider recommendations that stem from the “lessons learned” from past implementations. Additionally, potentially providing this program to non-Medicaid eligible elders and persons with disabilities should be examined. As the number of elders continues to grow in our state, attention to the availability of consumer-directed home- and community-based services must increase as well. Cash and Counseling is a viable option that has been successful in many states. It provides a voice for elders and persons with disabilities who previously did not have one.

Introduction

Act 204 (2007) requested the Executive Office on Aging (EOA) to research the Cash and Counseling program and its implementation on other states, including Arkansas, New Jersey, and Florida. In completing the research, EOA was required to: (a) contact the national program office at the Boston College Graduate School of Social Work, which coordinates replications of a Cash and Counseling program; (b) consult with the Robert Wood Johnson Foundation, the Office of the Assistant Secretary for Planning and Evaluation at the United States Department of Health and Human Services, the Administration on Aging, and the State's Departments of Health and Human Services; and (c) examine models that include individuals receiving Medicaid personal care services or home- and community-based services, as well as individuals who are not Medicaid recipients. Act 204 also requires EOA to submit an interim report of its research findings to the Joint Legislative Committee on Family Caregiving.

EOA contracted with the Center for Training, Evaluation, and Research of the Pacific, a unit of the University of Hawaii School of Social Work. EOA would like to acknowledge and thank Dr. Felix Blumhardt for conducting the research and preparing this report.

This report begins by describing the factors that led to the establishment of Cash and Counseling and then explains the key elements of a Cash and Counseling program. Next, the report reviews how Cash and Counseling was implemented in Arkansas, New Jersey, and Florida. Finally, the report summarizes the lessons learned and explains the extent to which Cash and Counseling is implemented in Hawaii.

Background

For many years, Medicaid recipients who were disabled and/or elders have had to rely on agencies to provide home- and community-based personal care. The agency that housed Medicaid, typically the Department of Human Services (DHS), would provide a case manager who would determine the needs of the recipient or client and attempt to match a service agency with that need. Often, this resulted in a mismatch which not only impacted the client, but the caregiver, as well. Because the recipient lacked a “voice” in the decision, services provided were not always optimal and left the recipients with unmet needs. Additionally, the recipients would continue to rely on family members or other unpaid caregivers to fill in the voids that the mismatch left.

Over the last 15-20 years, the nature of this care has changed. During the late 1980's and early 1990's, Medicaid recipients began to be able to make choices about their care as a result of the Medicaid Personal Care Services Benefit Option. In 1992, the Clinton Administration Task Force on Health Care Reform continued to facilitate the trend towards consumer directed services. In 1999, the Olmstead Act specifically directed agencies to ensure that disabled consumers be afforded the opportunity to receive care outside of an institution (retrieved from www.accessiblesociety.org/topics/ada/olmsteadoverview.htm). This trend towards consumer directed services continues today. Many states have adopted new policies that focus on care that is more consumer-directed and allows for flexibility in application and services. The foundation of conceptual framework on which these services are based rests on the belief that clients know their needs the best. In addition, clients are able to determine the best plan for their own care, once resources are made available.

Historically, it has been difficult for elders and persons with disabilities to find reliable service care providers. Some states avoided this issue by utilizing home care, or medical equipment, agencies but the cost for this was approximately twice as high as the hourly rate as paying service providers directly. However independently hired providers required an elder to do payroll processing/tax reporting tasks with which they were unfamiliar so these services have been unsuccessful at this point in time in achieving their true goal, or potential, in providing an alternative option to nursing home care.

Several different models for consumer-directed care have been developed over the last decade. One of the most promising options for consumer-directed care is the Cash and Counseling Program. Cash and Counseling is a program that is co-funded by the Robert Wood Johnson Foundation (RWJF) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services (DHHS), and coordinated through the Boston College of Social Work. Initially funded as a demonstration project in three states in 1998, the program has expanded to 15 states with more expected to adopt this approach toward consumer-directed care. As well, two of the states have significantly increased the scope of Cash and Counseling in their implementation.

Historically supportive services were contracted *for* recipients from service agencies that were considered “approved” by Medicaid. Under the consumer-directed approach, the recipient is able to shop for services and hire family members, relatives, and/or friends to assist with his/her care. This approach is attractive to the disabled and elderly since their care, which at times may be very personal, may now be provided by someone who they may know.

Overview

Cash and Counseling is a consumer-directed program that empowers individuals receiving Medicaid or their representatives, who are often family members or relatives, to make decisions about support services and/or products that will allow them to remain in their community. Individuals are provided a monthly allowance, usually payable to the provider through a fiscal agent, that may be used to purchase services and goods. They may also enlist family and friends to assist with decision-making as well as care.

There are essentially two basic components to this program. First, the “Cash” portion is the method through which recipients are able to pay for the services or products that they choose to receive. “Counseling” refers to the services provided by an agency where a case manager collaborates with the recipient to construct a needs assessment and budget in order to make a determination about services and/or products. Specific elements of this program are listed in the table below.

Key Elements for Cash and Counseling

(taken from www.CashandCounseling.org)

State Responsibilities and Accountabilities	<ul style="list-style-type: none">- Provide information and outreach to ensure that individuals have access to this option- Establish the individual budget amount using a transparent, equitable and consistent methodology- Identify and address potential conflicts of interest in the design and operations of the program (for example, the representative hiring him/herself as a paid worker)- Establish expectations and standards for the supports system and build sufficient capacity to sustain the system and serve participants in a timely manner- Ensure that participants/representatives are involved in the design and operation of the program- Establish a process of review and approval of spending plans- Establish a quality management system
System of Supports:	<ul style="list-style-type: none">- Provide the participant/representative with information about the concepts of self-direction and participant rights and responsibilities- Assist the participant in identifying his/her goals and needs using a

Supports Broker and Fiscal Management Services (specifically Fiscal/Employer Agent) Type Functions	<ul style="list-style-type: none"> participant-centered-planning-process - Assist the participant in developing his/her spending plan - Provide clarification and explanation about program allowable expenditures and documentation/record keeping - Assist the participant/representative in developing an individual back-up plan - Provide training and assistance to participants/representatives on recruiting, hiring, training, managing, evaluating and dismissing self-directed workers - Assists the participant/representative in monitoring expenditures under the spending plan - Assists the participant/representative in revising his/her spending plan - Assist the participant/representative in obtaining services included in spending plan - Instruct and assist participant/representative in problem-solving, decision making and recognizing and reporting critical events - Coordinate activity between support entities, participants/representatives and state program - Process hiring package for directly hired workers - Process payroll for directly hired workers in accordance with federal, state and local tax, labor and worker compensation laws for domestic service employees and government or vendor fiscal/employer agents operating under Section 3504 of the IRS code - Process and make all payments for goods and services in accordance with the participant's approved spending plan - Issue easily understood reports of budget balances to participants/representatives and support brokers periodically and upon request - Issue programmatic and financial reports to government program agency/Medicaid agency periodically and upon request
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The table above provides a somewhat detailed description of the requirements of this program. Clearly, the agency under which the program falls is obligated to ensure these steps are taken. There is flexibility, however, in terms of the application. This is seen when a comparison between states is done.

The Cash component varies from state to state, both in terms of how it is determined and how it is processed. Median monthly allowances vary state by state. Some states focus on services only while others consider payment for both services and products. For example, in some states recipients have requested personal chore services such as bathing, dressing, and cooking. In other states, services have been expanded to

include in-home nursing and professional therapies. Additionally, products have included ramps, bathroom renovations, and appliances (Table A).

Though the basic tenets of Cash and Counseling remain throughout, states have implemented this program differently. The most recent evaluations conducted on Cash and Counseling focus on both the strengths and limitations of this program. The overall preliminary data indicate that Cash and Counseling is a viable option and that it promotes independence in the elderly and disabled populations. It is an option that, while not necessarily the only one, may be made available to the elderly and disabled populations for which a consumer-directed approach is not available and that could not otherwise afford these choices without assistance.

Implementation Review

As mentioned previously, the implementation of Cash and Counseling is varied throughout the states as to whom it is available, how it is administered, and what is available, in terms of services and products. Arkansas, Florida, and New Jersey were the first states to adopt Cash and Counseling, and did so as part of a three-state demonstration program. From its inception, evaluations have taken place concurrently throughout the development and implementation of this program in those three states. Mathematica Policy Research, Inc. (MPR) conducted on-going evaluations which have been published (Brown et al., 2007; Dale et al., 2005). As a result, it is possible to learn from those experiences in an effort to consider the adoption of this approach for the state of Hawaii.

Administration and Demand

The three states chosen for the demonstration program were Arkansas, Florida, and New Jersey. Upon comparing the programs, differences among the three states become evident. These differences include the population on which the state intended to focus.

In the Arkansas demonstration, the program was open to all elders and persons with disabilities who were eligible for the Medicaid state plan Personal Care Services (PCS). This included those who were already receiving the services as well as those who were not. In addition, beneficiaries who were enrolled under other consumer-directed programs, such as ElderChoices or Alternatives, could also enroll in the demonstration program (Dale et al., 2005).

In Florida, the demonstration was open to Medicaid beneficiaries in a portion of the state who were receiving Home and Community Based Services (HCBS) under the state's Developmental Disabilities (DD) Waiver or the Aged/Disabled Adult (ADA) Waiver. Persons falling under these waivers were the frail elderly, adults with physical disabilities, and children with disabilities (Dale et al., 2005).

The New Jersey demonstration program included adult Medicaid beneficiaries who were already enrolled in PCS or were eligible and were not currently enrolled in a HCBS Waiver programs or a state-funded consumer-directed program. Individuals from all three states who were eligible to enroll in the demonstration program were allowed to do so if they or their representative believed they could manage their responsibilities as consumers. None of the three states screened beneficiaries or their representatives for the ability to manage their responsibilities (Dale et al., 2005).

Approximately six to ten percent of eligible adults enrolled overall while 16 percent of Florida's Medicaid children with developmental disabilities enrolled prior to the

termination of the enrollment period (Brown et al., 2007). Enrollees were typically eligible recipients who qualified for somewhat larger allowances, those who were already receiving personal or waiver services prior to enrollment, and those who were alive throughout the enrollment period (Brown et al., 2007).

Eligible recipients in all three states received an allowance but the amount and the time that it took to process varied significantly. While Arkansas was able to provide cash allowances to individuals as early as the third month, Florida recipients had to wait much longer. Counselors in Florida were not clear about how much help they should give to clients who were trying to develop their budget. Because they were also concerned about how much help would be needed, they did not attempt to provide all of the help.

Allowance also varied among the states. New Jersey offered a median allowance of \$1,097 compared with Arkansas which offered \$313. Florida offered a median allowance of \$829 for adults and \$831 for children (Brown, et al., 2007). Not only did the states differ in the monthly amounts but the methods used to determine the amounts. While all three based the allowance amounts on the consumers' care plans, Arkansas and Florida decreased their amounts by 10 to 20 percent to account for the historic differences between the hours of care recommended and approved in the care plans and the hours consumers actually received under the traditional service model (Brown et al., 2007). Further, state allowances varied due to the costs and availability of services within their own state.

With financial assistance programs such as Cash and Counseling, there is often concern about the misuse of funds. The three states reported very few cases of abuse or neglect of the consumer, or fraudulent spending of the allowance. Because the fiscal agent

writing the checks would not endorse expenditures that were not on the approved spending plan, allowances were less likely to be misused (Brown et al., 2007).

Overall, most consumers were very pleased with the program – more than 85 percent of consumers in any age group in the state would recommend the program to others who needed personal care or waiver services (Brown et al., 2007). However, more than 30 percent of adults in all three states had disenrolled by the 12th month after enrollment, typically because of difficulties finding or replacing a worker (Brown et al., 2007).

Consumer Impact

Evaluation of the three state demonstration project determined that the positive impact of Cash and Counseling on consumer personal care and well-being was substantial. Although Cash and Counseling recipients generally received more paid hours of care, they received less unpaid care than recipients receiving traditional agency services, resulting in slightly-to-moderately lower total hours of care for elderly and non-elderly adults in all states and for children in Florida (Brown, et al., 2007). In addition, Cash and Counseling recipients were much more likely than to have their needs met, and to be very satisfied with their care. Elderly recipients in Florida were the only subgroup for which there were no favorable effects on satisfaction (only 42% received their allowances) (Brown et al., 2007).

Cash and Counseling recipients were no more likely to experience care-related health problems than other recipients. Further, about one-third of the 77 estimates obtained by MPR, the Cash and Counseling recipients had a significantly lower rate of adverse events such as falling or bedsores (Table B). Therefore, the care appears to be as good, if not better, than under traditional agency care (Brown et al., 2007). Above all, Cash

and Counseling recipients were far more satisfied than recipients receiving traditional agency services (Table C) and reported that the program had improved their lives a great deal (Brown et al., 2007).

Impact on Cost

Cash and Counseling was not designed to save money but to place more control over personal care in the hands of elders and persons with disabilities. The evaluation literature indicates that Cash and Counseling costs were significantly higher than traditional program costs. The magnitude of the cost differences vary among the states (Brown et al., 2007). In Arkansas, Cash and Counseling costs were double the average costs for recipients receiving traditional care services while Florida experienced only about a 15 percent difference. Following the first year of enrollment, costs in Arkansas fell and the savings in other Medicaid costs grew; however, this did not remain true for the second year (Brown et al., 2007). Overall, Cash and Counseling appeared to increase costs for the agency in all three states (Tablet D).

Effects on Caregiving

In the three state Cash and Counseling demonstration program, Cash and Counseling caregivers reported a high level of satisfaction with the program. The majority of the caregivers hired under Cash and Counseling were family members. Not unlike the caregivers under the traditional programs, Cash and Counseling caregivers reported that caregiving had a serious impact on their lives, however, Cash and Counseling caregivers reported more satisfaction with life, i.e., less stress, fewer changes in lifestyle, fewer financial burdens (Table E). This may possibly be a result of the fact that they were providing care for a family member or for someone whom they knew (Brown et al., 2007).

The vast majority of workers hired under Cash and Counseling were previously unpaid caregivers. They were mostly family members who also continued to provide unpaid care in addition to that covered under Cash and Counseling. Cash and Counseling caregivers were overall more content with pay than their counterparts who fell under traditional agency services. The primary source of discontent arose from the stress of being a family member or relative and dealing with family dynamics as well as having the feeling that one was “on call” (Brown et al., 2007).

Implications

Overall, the three-state demonstration program indicates good success with Cash and Counseling. Clearly Cash and Counseling appears to provide increased flexibility and control in the hands of elders and persons with disabilities that previously did not have the same options for personal care services and products. There is higher satisfaction on the part of the consumers as well as the caregivers (Phillips et al., 2003, Mahoney & Simone, 2005, and Brown et al., 2007).

Satisfaction with Cash and Counseling: Preliminary Results from Interviews with the First 200 Consumers from Each State

	Percent of Respondents		
	Arkansas	New Jersey	Florida
Overall Satisfaction			
Would Recommend Program	93.3	86.1	90.0
How Much Quality of Life Was Improved			
A great deal	78.7	70.1	73.0
Somewhat	21.3	29.9	27.0
Number of respondents	194	216	219

Source: Foster, L., Brown, R., Carlson, B., Phillips, B., Schore, J. (2000,2002a, 2002b) Mathematica Policy research Inc.'s Nine-Month Cash and Counseling Evaluation Interview

Consumers were satisfied with counseling and fiscal services, as well as being able to hire their worker of choice (Schore & Phillips, 2004). Hired workers, mostly family members, were satisfied with their jobs and how they were treated (Foster, 2000). Generally, consumers and caregivers were satisfied with Cash and Counseling.

The biggest limitation of this program stems from the increased Medicaid cost associated with it. Some scrutiny about these costs is required in order to grasp why this is this case. The evaluations conducted indicate that the difference in costs between the two types of services, Cash and Counseling and traditional agency services, is a result that those individuals who were eligible for traditional agency services were not receiving all the services to which they were entitled and therefore the differential is larger. This gap might have been smaller had recipients received all of the services for which they were eligible at the time of comparison. Too, due to the inexperience in the area of counseling, realistic or optimal budgets may not have been set.

Because there is indication that Cash and Counseling has fiscal challenges, states that intend on adopting this program for consumer-directed care must take this under consideration while in the stages of development in order to attempt to develop ways in which to manage this issue. Should Hawaii decide to implement Cash and Counseling, attention must be paid to the impact this program may have on Medicaid costs.

Lessons Learned

Due to the success of the three-state Cash and Counseling Demonstration Project, 15 states now offer this program as their consumer-directed option. As states continue to adopt this approach, changes in implementation are made as a result of the lessons learned from the earlier experiences. Several lessons may be gleaned from these experiences (Phillips, Mahoney, & Foster, 2006):

Lessons Learned

Starting the Program	Counseling and Fiscal Services	Controlling Program Costs	Preventing Allowance Misuse and Consumer Exploitation
<p>Recognize the concerns of the existing Medicaid providers</p> <p>Estimates of recipients should be as accurate as possible and caseloads should build quickly</p> <p>Avoid initially assigning responsibility for outreach and enrollment to agencies that provide traditional services</p> <p>After enrollment staff build caseloads, program counselors should inform prospective enrollees</p>	<p>Careful consideration to counseling and fiscal services must be given</p> <p>Be cautious when asking traditional case management agencies to provide counseling services</p> <p>Ensure counselor caseloads</p> <p>Fiscal agents should have technical expertise and interact well with consumers</p> <p>Be prepared for transition from one fiscal organization to another</p> <p>Expect consumers to need substantial assistance with the initial spending plan</p> <p>Streamline allowance – planning procedures and offer direct assistance to consumers</p> <p>Make help for recruiting workers available</p> <p>Give counselors the authority to approve most spending plans</p>	<p>Pay counselors a flat rate to assist with development of the spending plan</p> <p>Assign responsibility for assessment and subsequent care planning to an external party who will not advocate for the consumer</p>	<p>Require review of spending plans, timesheets, and check requests, but not receipts</p> <p>Prevent consumers from overspending their allowances</p> <p>Use home visits and telephone calls to monitor consumer welfare</p>

Based on these recommendations, the three states from which these lessons were drawn have made modifications to their Cash and Counseling programs. As a result of these lessons, the 2004 grant solicitation for other states to participate in Cash and Counseling included a mandatory continuous quality improvement process (Phillips, Mahoney, & Foster, 2006).

Larger thematic lessons have been learned, as well. The following outcomes discussed by Mathematica Policy Research, Inc. (2007) provide insight into Cash and Counseling and should be explored.

1. Few Medicaid beneficiaries enrolled. Out of the total number of eligible recipients who had received personal care for two years prior to Cash and Counseling only 5-10% in each state enrolled in Cash and Counseling. On the other hand, the target enrollment of 1,000 children (16%) was reached in only 15 months (Brown et al., 2007).

2. Consumers and caregivers benefited. Consumers' satisfaction greatly increased with Cash and Counseling as they experienced more flexibility and control over their services. Care was as good, if not better, under Cash and Counseling. Caregivers who were providing unpaid care were paid and thus, satisfaction on their end increased. Directly hired caregivers received comparable wages to agency workers. Because consumers were able to hire relatives, less stress occurred on the part of the consumer, and needs for care were met.

3. Medicaid costs were problematic. Medicaid costs were significantly higher than traditional service programs. This is attributed to the fact that traditional programs were flawed in their efforts to reach eligible recipients, therefore the disparity increased. Thus, some states were able to save money by not meeting their obligations. Additionally, allowances were higher than expected. However, these costs were temporarily offset in every state by lower costs for other Medicaid services (Brown et al., 2007).

4. Some unfavorable aspects remain. The results from the three-state evaluation suggest that other states may experience problems unless issues stemming from lessons learned are addressed. Costs could increase if persons who were previously eligible but not enrolled, decided to take advantage of the Cash and Counseling option. Lastly, many Cash and Counseling recipients who participated in the three-state demonstration never received an allowance. This was partly due to difficulty hiring caregivers.

5. Cash and Counseling is successful in providing consumers with better access to care but states must design programs carefully in order to avoid replicating mistakes previously made. States should be realistic in their expectations and recognize that their costs may increase.

6. Cash and Counseling is an excellent option for states seeking increased access to care. Twelve additional states have implemented Cash and Counseling since the demonstration program and are taking advantage of the lessons learned.

As we consider the implementation of Cash and Counseling in Hawaii, recognition of these lessons is imperative in order to avoid mistakes that might otherwise occur.

Consumer Directed Care in Hawaii

Most states currently offer some form of consumer-directed care. While 15 of those states have chosen Cash and Counseling, others have opted to use models that differ from Cash and Counseling in terms of their application and funding. The research indicates that Cash and Counseling has been successful in attaining the goals it intended to reach. That having been stated, Hawaii must carefully consider whether or not this program would be beneficial and how it might be implemented in our state.

Cash and Counseling is a consumer-directed program that focuses only on elders and persons with disabilities who are Medicaid eligible. It does not provide services to those individuals who require supportive services, don't qualify for Medicaid, and are not able to afford care or products. Currently, the only state that is in the process of implementing the Cash and Counseling program with non-Medicaid recipients is Illinois (personal communication, 2007). Illinois is in the process of piloting four areas in that state in an effort to determine if this program will work with the non-Medicaid population. Several other states intend to follow this lead (personal communication, 2007).

Illinois' implementation of Cash and Counseling for both Medicaid and non-Medicaid recipients incorporates changes from earlier programs, such as hiring case management agencies and using general revenue funds that are later matched and reimbursed through the Federal government (personal communication, 2007). Additionally, providers do not know the status of the consumer and whether or not they receive Medicaid. Currently, Illinois is tackling several different issues, such as service–cost maximums, worker wage rates, and case management care coordinator rates.

Elders and persons with disabilities receive services from numerous agencies and individuals throughout the state of Hawaii. The Department of Human Services Adult and Community Care Services Branch is responsible for providing services to Medicaid-eligible elders. These individuals may receive services through Chore and Personal Care Services if they qualify for assistance. Personal Care Services is a consumer-directed program that allows recipients to choose home and community based services (personal communication, 2007). Additionally, it allows consumers to employ relatives as their caregivers with the exception of hiring a spouse or adult child. The primary difference between Personal Care Services and Cash and Counseling appears to be fiscal. Under Personal Care Services in Hawaii, recipients are not as involved in the budget process or the financial management. Once services are chosen by the recipient and case manager, the rest of the implementation takes place through the agency. Also, Personal Care Services does not allow for the option of purchasing products that may be useful for clients in maintaining their independence.

As of October 2007, recipients of Medicaid will be rolled over into a managed care program. This restructuring may impact consumer-directed care on some level, however, that will not be able to be determined until this takes place. Because managed care

agencies are not as used to working with community- or home-based services, there may be some challenges during the transition. Steps must be taken in order to prevent consumers from falling through the cracks during this time. Too, because managed-care tends to dictate services, an alternative that includes the consumers in the decision-making process may be welcome. It is unclear at this time how elder consumers feel about alternative services since no formal consumer-driven evaluation with respect to available services has been conducted.

The Hawaii Department of Health Developmental Disabilities Division provides consumer-directed services to persons with disabilities who are Medicaid-eligible. Under their consumer-directed services, the Medicaid recipient or his/her representative would have the flexibility to hire and retain caregivers. Caregivers may be relatives or family members, with the exception of a spouse. Recipients are assigned a case manager who educates them about the program and collaborates with them to develop a plan. Rates for services are predetermined. Consumers may only purchase services, not products. Though only 3 ½ years old, the consumer-directed option is a popular one. Approximately 380 out of 2500 recipients have chosen this route. Caregivers also appear to be satisfied with this program. In a survey conducted in 2005, almost 70% of caregivers stated that they were happy with this program. The division plans to conduct a survey of consumers in the near future in order to determine the effectiveness of the consumer-directed program.

Neither the Department of Human Services nor the Department of Health offer consumer-directed care for persons who are non-Medicaid eligible. As our elder population in Hawaii continues to grow, care needs by the elderly will grow, as well. Hawaii has one of the lowest number of nursing facility beds (retrieved from www.statehealthfacts.org), a demand which has the majority of facilities at capacity. As a result, increasing numbers of

elders rely on home and community based services, not only by choice, but because they lack of other options. Though elder Medicaid recipients and recipients with disabilities have consumer-directed services as an option, non-Medicaid recipients who remain on the cusp of qualifying for assistance are in jeopardy. Consumer-directed assistance appears to be available to those individuals who can afford it and those who are Medicaid-eligible and fall under Chore and Personal Care Services. Considerable focus may need to be given to the gap that exists in services for non-Medicaid recipients. In terms of prioritizing the implementation of Cash and Counseling, non-Medicaid elders seem to require the most immediate attention.

The consumer-directed programs for elders and persons with disabilities in Hawaii appear to be satisfactory in terms of providing expanded control over decisions about one's care. However, given the success of Cash and Counseling, these existent programs may want to remain somewhat flexible and allow for modifications to better accommodate its population of focus. Further, based on the current limitations of services, as well as the transition to managed care, the State of Hawaii may consider pursuing Cash and Counseling as an option for elders and persons with disabilities, both non-Medicaid and Medicaid eligible, for whom this might be attractive.

Conclusion

Cash and Counseling is a successful program that has had a positive effect on many lives. It continues to be the program of choice for many states and would be a viable option for the state of Hawaii. Given the current state of consumer-directed programs available to the elder population and persons with disabilities in Hawaii, non-Medicaid elders and persons with disabilities appear to have the least coverage in terms of home-

and community- based services. As a result, implementation of Cash and Counseling or the expansion of consumer-directed services may need to focus on this population.

Consumer-directed care for elders and persons with disabilities appears to be the growing trend in our nation. Cash and Counseling is a model that continues to be utilized by many states. Currently 15 states have adopted this model, based on its previous success (see State Comparison Chart for a breakdown of the components of Cash and Counseling for 12 states). Overall, there appears to be marginal risk in the adoption of Cash and Counseling as the consumer-directed program of choice for the state of Hawaii. Clearly, as the research indicates, close attention to the financial aspects of how this program might operate in our state is of importance. When the improvement of the lives of elders and persons with disabilities is the primary goal, Cash and Counseling makes it a goal that is attainable.

TABLE A

**TREATMENT GROUP'S USES OF MONTHLY ALLOWANCE
(In Percentages)**

	Arkansas		Florida			New Jersey	
	18 to 64	65+	3 to 17	18 to 59	60+	18 to 64	65+
Used Allowance to ^a :							
Pay worker(s)	88.6	87.7	62.4	63.4	78.9	86.7	85.8
Purchase equipment or supplies ^b	50.0	60.0	28.3	17.1	6.6	13.4	4.5
Modify home or vehicle	2.0	2.3	1.3	0.8	0.0	0.8	1.1
Received Cash for Incidental Purchases ^c	35.5	38.6	40.2	31.9	59.0	55.6	47.2
Among Those Using Allowance to Pay Worker(s), Had a Worker Who Was Their:							
Spouse	0.0	0.0	0.4	0.6	5.0	4.3	0.5
Child	28.9	52.9	0.0	1.9	47.1	24.3	59.4
Parent	13.9	0.2	28.6	36.3	0.0	22.2	0.5
Other relative	26.7	24.5	39.9	36.9	22.7	24.3	21.7
Had Only Unrelated Paid Workers	30.5	24.3	41.6	33.8	37.8	33.0	22.2
Sample Size	220	498	311	235	166	239	267

Source: Foster, L., Brown, R., Carlson, B., Phillips, B., Schore, J. (2007) Mathematica Policy research Inc.'s Final Report

Data on use of the allowance during Month 8 are from each program's fiscal agent or bookkeeper. Data on who the beneficiary hired are from telephone interviews with consumers conducted by Mathematica Policy Research, Inc. nine months after consumers' random assignment.

Note: All data are for use of monthly allowance during Month 8 after random assignment.

^aPercentages exclude consumers who had disenrolled or died before Month 8 or who were still enrolled but had no record for Month 8 with the fiscal agent/bookkeeper.

^bEquipment includes equipment to assist with mobility, transferring, bathing, communicating, personal safety, preparing meals, and housekeeping. Supplies include diapers or pads to protect bedding, ostomy supplies, and feeding equipment.

^c In Arkansas and New Jersey, consumers could receive up to 10 percent of the monthly allowance as cash for incidental purchases. In Florida, consumers could receive up to 20 percent of the monthly allowance as cash.

TABLE B
CARE-RELATED HEALTH PROBLEMS AND EVENTS
(In Percentages)

	Arkansas		Florida			New Jersey	
	18 to 64	65+	3 to 17	18 to 59	60+	18 to 64	65+
Had a Fall	28.4	19.0	27.3	14.5	17.5	18.7	13.2
Treatment	28.7	18.6	36.2	17.5	19.7	28.0	20.4
Control	-0.4	0.4	-8.9**	-3.0	-2.2	-9.3**	-7.2**
Difference	(.931)	(.869)	(.004)	(.235)	(.468)	(.004)	(.009)
<i>p</i> -Value							
Contractures Developed/Worsened							
Treatment	26.0	15.9	9.4	9.0	20.0	24.5	17.5
Control	25.2	19.7	13.4	14.0	21.9	28.1	27.1
Difference	0.8	-3.9	-4.0*	-5.0*	-2.0	-3.7	-9.6**
<i>p</i> -Value	(.826)	(.089)	(.049)	(.021)	(.534)	(.269)	(.002)
Bedsore Developed/Worsened ^{a,b}							
Treatment	5.9	7.5	3.0	4.1	7.9	9.0	7.2
Control	12.6	6.8	6.0	5.9	9.3	13.0	7.1
Difference	-6.7*	0.7	-3.0*	-1.8	-1.4	-4.1	0.1
<i>p</i> -Value	(.012)	(.670)	(.033)	(.252)	(.511)	(0.94)	(.970)
Had a Urinary Tract Infection ^b							
Treatment	19.4	18.2	2.5	7.7	19.5	16.6	15.7
Control	21.6	21.0	6.0	11.7	21.5	19.4	15.8
Difference	-2.2	-2.8	-3.5*	-4.0*	-2.0	-2.8	-0.1
<i>p</i> -Value	(.560)	(.230)	(.011)	(.043)	(.516)	(.329)	(.966)
Sample Size	462	1,164	857	808	696	668	742

Source: Nine-month evaluation interview, conducted by Mathematica Policy Research, Inc. between September 1999 and March 2002 for Arkansas, March 2001 and May 2003 for Florida, and August 2000 and June 2003 for New Jersey.

Note: Means were predicted using logit models. Sample sizes for some variables in this table were smaller because of differences in item nonresponse and skip patterns.

^aEffects were estimated by pooling the two adult age groups and including an age*treatment status interaction term in the model.

^bFor Florida children, impact could not be estimated from the logit model. Results presented are the unadjusted means and treatment-control differences.

*Significantly different from zero at the .05 level, two-tailed test.

**Significantly different from zero at the .01 level, two-tailed test.

TABLE C
USES OF AND SATISFACTION WITH PROGRAM SERVICES
(In Percentages)

	Arkansas		Florida			New Jersey	
	18 to 64	65+	3 to 17	18 to 59	60+	18 to 64	65+
Consumers Reporting that Program Counselors Had:							
Helped them develop allowance spending plan	87.4	81.7	74.7	65.6	65.1	72.9	70.7
Advised them about recruiting workers (among those who tried to hire)	57.0	49.4	43.4	35.3	42.2	39.4	44.6
Advised them about training workers (among those who hired)	55.7	53.6	28.3	36.6	42.3	32.2	35.4
Among Those Receiving Allowance:							
Consumers Reporting that They Used Fiscal Agency Services	93.6	95.1	98.4	96.2	94.4	95.7	98.1
Consumers Reporting that Program:							
Improved their lives a great deal	62.6	53.1	61.9	54.5	60.5	54.2	60.0
Improved their lives a little	21.5	26.8	22.5	27.0	21.7	26.7	22.9
Improved their lives not at all	15.5	19.9	14.7	18.0	15.8	17.8	17.1
Made their lives worse	0.5	0.2	1.0	0.5	2.0	1.3	0.0
Consumers Reporting that They Would Recommend Program to Others							
	95.7	97.5	89.0	88.2	85.3	90.9	97.2
Sample Size (Maximum)	254	670	479	440	421	367	416

Source: Telephone interviews with treatment group consumers conducted by Mathematica Policy Research, Inc. four and nine months after consumers' random assignment in Arkansas, and six and nine months after consumers' random assignment in Florida and in New Jersey.

TABLE D

COST PER RECIPIENT PER MONTH FOR PCS/WAIVER SERVICES

	Year 1				Year2 ^a	
	Nonelderly	Elderly	All Adults	Children	All Adults	Children
Arkansas						
Treatment	513	420	445	—	467	—
Control	422	336	359	—	369	—
Difference	91 **	84 **	86 **	—	98 **	—
<i>p</i> -Value	<.001	<.001	<.001	—	<.001	—
Florida						
Treatment	1,884	983	1,460	1,378	1,814	1,660
Control	1,593	967	1,292	1,099	1,630	1,251
Difference	291 **	16	168 **	279 **	184 **	409 **
<i>p</i> -Value	<.001	.509	<.001	<.001	<.001	<.001
New Jersey						
Treatment	1,153	1,170	1,164	—	1,264	—
Control	1,106	1,172	1,140	—	1,219	—
Difference	41 *	-2	25	—	45	—
<i>p</i> -Value	.043	.926	.112	—	.051	—
Sample Sizes						
Arkansas	454	1,269	1,723	—	879	—
Florida	910	894	1,804	997	1,275	996
New Jersey	745	855	1,600	—	1,121	—

Source: Medicaid claims data. See Dale and Brown (2005) for adults and Dale et al. (2004) for children. Mathematica Policy Research, Inc. (2007)

^aYear 2 results were calculated only for those early enrollees for whom complete Medicaid claims data for their second year were available at the time the claims data were provided by the state. Early enrollees were those who enrolled in the demonstration before May 2000 in Arkansas, January 2002 in New Jersey, and October 2001 in Florida.

PCS = personal care services.

*Significantly different from zero at the .05 level, two-tailed test.

**Significantly different from zero at the .01 level, two-tailed test.

TABLE E
EMOTIONAL, PHYSICAL, AND FINANCIAL STRESS ON
PRIMARY CAREGIVERS

Outcome	Adults			Children
	Arkansas	Florida	New Jersey	Florida
Emotional Indicators				
Caregiving Limits Privacy				
Treatment	38.7	52.3	41.1	61.0
Control	52.7	57.1	50.5	65.9
Difference	-14.1 **	-4.8	-9.4 **	-4.9
<i>p</i> -Value	<.001	.084	.001	.125
Limited Free Time/Social Life				
Treatment	52.5	66.9	54.8	80.9
Control	63.8	73.3	60.1	81.6
Difference	-11.3 **	-6.5 **	-5.3	-0.7
<i>p</i> -Value	<.001	.008	.061	.778
Experienced Great Deal of Emotional Strain Due to Caregiving				
Treatment	26.8	35.7	42.3	39.4
Control	34.3	38.6	49.4	41.6
Difference	-7.5 **	-2.9	-7.1 *	-2.2
<i>p</i> -Value	.002	.286	.017	.495
Financial Indicators				
Wanted to Look for Job but Did Not Due to Caregiving				
Treatment	23.5	35.1	33.9	52.7
Control	38.6	41.8	44.1	57.0
Difference	-15.1 **	-6.7	-10.3 **	-4.3
<i>p</i> -Value	<.001	.011	<.001	.192
Missed Work or Arrived Late Due to Caregiving				
Treatment	48.6	60.9	53.6	84.0
Control	60.6	67.1	65.8	82.6
Difference	-12.0 **	-6.2	-12.2 **	1.4
<i>p</i> -Value	.001	0.95	.002	.657
Experienced Great Deal of Financial Strain Due to Caregiving				
Treatment	22.4	39.9	30.0	43.7
Control	35.7	38.9	38.6	55.6
Difference	-13.3 **	-9.0 **	-8.6 **	-11.9 **
<i>p</i> -Value	<.001	.001	.001	<.001

TABLE E (continued)

Outcome	Adults			Children
	Arkansas	Florida	New Jersey	Florida
Physical Well-Being Indicators				
Experienced Great Deal of Physical Strain Due to Caregiving				
Treatment	23.0	28.4	31.7	34.5
Control	32.0	38.8	41.8	42.1
Difference	-9.0**	-10.4**	-10.1**	-7.6*
<i>p</i> -Value	<.001	<.001	<.001	.020
Physical Health Has Suffered Due to Caregiving				
Treatment	23.6	32.7	30.7	41.8
Control	34.3	44.9	40.3	55.4
Difference	-10.7 **	-12.2 **	-9.6 **	-13.6 **
<i>p</i> -Value	<.001	<.001	.001	<.001
Current Health Was Fair/Poor relative to Peers				
Treatment	35.5	31.8	30.3	27.4
Control	46.7	39.6	42.3	36.8
Difference	-11.2 **	-7.8 **	-12.0 **	-9.4 **
<i>p</i> -Value	<.001	.004	<.001	.003
Overall Satisfaction with Life				
Very Satisfied				
Treatment	51.3	47.0	51.6	36.9
Control	39.9	35.2	37.5	23.8
Difference	11.4 **	11.8 **	14.1 **	13.2 **
<i>p</i> -Value	<.001	<.001	<.001	<.001
Dissatisfied				
Treatment	13.1	16.7	15.2	16.7
Control	23.2	22.8	27.3	31.1
Difference	-10.1 **	-6.1 **	-12.2 **	-14.4 **
<i>p</i> -Value	<.001	.008	<.001	<.001
Number of Respondents	1,433	1,193	1,042	829

Source: Survey of primary caregivers conducted by Mathematica Policy Research, Inc. See Foster et al. (2005a and 2005b).

*Significantly different from zero at the .05 level, two-tailed test.

**Significantly different from zero at the .01 level, two-tailed test.

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State Comparison Chart

State	Operating Agency	Program Name	Waiver Type	Geographic Area Covered	Population Served	Date Enrollment Began	Enrollment Goal	Entity Conducting Enrollment	Model/Type of FMS
ALABAMA	Department of Senior Services	Personal Choices	1915j	7 Counties in Western Alabama	Children, Adults with Disabilities, Aging	August-07	90 in pilot area	Area Agency on Aging of West Alabama	Vendor F/EA
IOWA	Department of Human Services	Consumer Choices Option	Amendments to 6 existing 1915c waivers	Statewide with Phase-In Schedule	All populations	December-06	400	Current Case Manager or Service Worker (Called different titles in different waivers.)	Vendor F/EA
ILLINOIS	Department on Aging	My Choices	N/A: State funded	4 pilot sites	Elders	May-07	200	Case Coordination Units that employ case managers.	Vendor F/EA
KENTUCKY	Department of Aging and Independent Living	Consumer Directed Option	1915c amendments to existing waiver:	Statewide with Initial Implementation at 4 Pioneer Sites	Aged & Disabled, MR/DD, Acquired Brain Injury	September-06	500	Directly hired dedicated staff (3 individuals)	Vendor F/EA
MICHIGAN	Department of Community Health	Self Determination in Long Term Care	1915c amendment to Mi Choice waiver	Statewide	Adults with Physical Disabilities, Aging	December-06	400	AAAs who serve as Waiver Agents or OHCDs	Vendor F/EA
MINNESOTA	Department of Human Services	Consumer Directed Community Supports	1915c amendments to existing waivers; state funded Alternative Care Program	Statewide	Children; adults with development/physical disabilities; elderly	November-04	743	Lead agencies: counties under FFS; 9 contracted health plans for MSHO and County Based Purchasing; tribes	Agency with Choice; Vendor F/EA, Govt. F/EA, Fiscal Conduit
NEW MEXICO	Aging and Long Term Services Department	Mi Via	1915c New Waiver Applications for consumer-direction	Statewide	All Current Waiver Populations (D&E, DD, MedFrag, AIDS with BI added as a new population under LTC)	December-06	400	Aging & Long Term Services and NMDOH - State employees	Vendor F/EA
PENNSYLVANIA	The Governor's Office of Health Care Reform	Services My Way	1915 c -PA Dept on Aging HCBS Waiver, 1915 c Attendant Care Waiver	21 pilot areas/counties	Elderly, adults with physical disabilities	October-07	400	TBD	Vendor F/EA and Government F/EA
RHODE ISLAND	Department of Human Services	PersonalChoice	1915 c	Statewide	Elders, Adults with Disabilities (over 18)	March-06	400	State Program Office	Vendor F/EA
VERMONT	Department of Aging and Independent Living	Flexible Choices	1115	Statewide	Elderly, physically disabled adults	July-06	250	State long term care coordinators and existing case managers refer to contractor for consulting	Vendor F/EA Hybrid of Government F/EA for payroll functions and Vendor F/EA for other financial management services functions
WASHINGTON	Department of Social and Health Services	New Freedom	1915 c	King County (Seattle)	Elderly, physically disabled adults	May-07	400	Preparing solicitation for separate subcontractor for enrollment	
WEST VIRGINIA	Bureau of Senior Services	West Virginia Personal Options	1915 c Aged and Disabled Waiver	Statewide	Elderly, adults with disabilities	May-07	400	West Virginia Bureau of Senior Services verifies participant eligibility then PPL completes enrollment.	Government F/EA - Bureau for Medical Services (the Medicaid office)

# of Fiscal Entities	Reimbursement Method	Fiscal Management Services (FMS) Services Offered	Describe Support Broker Model	# of Support Broker Entities
1	Monthly fee	Payroll, payment of G&S, CBC, Orientation, Skills training, CDM training	Agency	1 agency in initial implementation
2 or more	Per member per month	Payroll, payment of G&S, CBC, FMS focused orientation and skills training, will enter budget into state ISIS system	Individuals selected by Consumers	No limit
1	Per member per month	Meet with consumer to assist with completion of employer forms, payroll and tax functions, process employee paperwork, conduct Criminal Background Checks, worker skills training per request of consumer.	Existing Case Managers employed by Case Coordination Units that serve existing Community Care Program.	1 per pilot site
15 Area Development Districts	Per member per month	Payroll and tax functions, payment of G&S, process employee paperwork, audits, monitor	Support Brokers from 15 Area Agencies on Aging	Fifteen AAAs serving statewide
Unknown at present	Probably Per member per month		Agency with possibility of consumers identifying independent SB as well. ISB is not a service in the current amendment but considered for future. Optional. SB called Flexible Case Manager (FCM). FCM assists with community support plan development and implementation, facilitates plan approval, assists w/ employer mgmt. functions, linking with community resources, advocate.	21 waiver agencies (OHCDS) and they will serve as the SB entity.
18	Per consumer with CDCS budget	Payroll, payment of G&S, CBC, FMS focused orientation and skills training.		250 certified flexible case managers
1	Per member per month	Payroll, payment of G&S, process employee paperwork, background check, provide family friendly reports	Consultant Agency and state set qualifications and competencies for consultants	1 Consultant Agency with many individually selected consultants
TBD	Per member per month through consumer's budget	Payroll, payment of G&S, FMS focused orientation and skills training, process employment paperwork, complete CHBC	Use existing case managers in the local Area Agencies on Aging; administrative function	13 AAAs serving the 21 counties in the pilot
2	FMS only	Payroll, background checks, purchases of goods/services, assist with Spending Plan development	State set standards and accepted all who qualified and enrolled	2
1	Monthly fee	Payroll, payment of G&S, limited training on how to fulfill employer responsibilities	Separate consulting and financial management services; both provided under contract to state by local human services agencies	1
1 for payroll; 1 for other financial services	Payroll: Thru existing state budget. Other: Monthly fee for consulting and non-payroll financial services		Separate consulting and financial management services; consulting provided under contract to state by local human services agency	1
1	Administrative Per member per month Function	Payroll and Tax Functions, Conduct Criminal Background Checks, Verify provider and vendor qualifications and SB Functions.	Combined with Government FEA providing advise and clarification to participants of program responsibilities as a participant / employer.	1

Reimbursement Method	Is there another case management-type Entity?	Services Converted to Budget
TBD	Case managers, who will retain responsibility for assessment and reassessment	Homemaker, personal care, companion, unskilled respite, personal assistance
Hourly pay through the individualized budget	Yes, every consumer will have a case manager or support worker for traditional waiver services.	Non-skilled waiver services. Any services under the waiver that does not require a license or group setting away from the home.
Existing Comprehensive Care Coordination reimbursement structure.	Existing Case Management structure is being utilized.	Any services provided in the home. Personal Care, Homemaker, Companion, Attendant Care, Respite, Community Living Supports, Supported Employment, Adult Day Training, Goods & Services in the Aged & Disabled, Waiver. Will submit waiver amendments to MRDD and ABI waivers.
Per member per month	Consumers must use Support Brokers for CDO and blended services	Personal care, homemaker, chore, non-medical transportation and home mods. Adding goods and services and FI.
Daily rate	The support coordinator will do care management for traditional services that are not self-directed. The FCMs can work through an agency or individually, but to be paid the person must be certified.	4 categories developed: personal assistance; treatment and training; envir. Mod.; and self-direction support activities
Per consumer with CDCS budget	The required case management function to provide case oversight and authorization remains intact with the lead agencies (e.g., county, health plan, tribes).	
Per member per month	Only in other State traditional waiver programs	All services are consumer-directed
Per member per month	The support coordinator will do care management for traditional services that are not self-directed.	Personal care, home support, companion, respite, non-medical transportation, G&S, FMS
SB only	Only in other State waiver programs	Personal assistance services and other goods and services
Monthly fee per enrolled participant	Yes for state's existing cd program	All services under current consumer-directed waiver (personal care, case management, respite, personal emergency response, equipment/ home modifications, financial management fees, adult day care)
Monthly fee	Yes for state's existing cd program	Must be participating in current consumer-directed waiver to enroll in New Freedom. Service plan not converted to budget; see method of calculating
Admin/PMPM	CM under waiver is monetized as part of budget when person does self-direction. CM is an optional service participants may budget for.	Homemaker, case management, nursing (homemaker supervision), transportation

Method of Calculating Budget

What is included in the Budget?

Limitations on Benefits

Based on value of personal care, personal assistance and other applicable services. The amount of services hours required will be multiplied by the current Medicaid reimbursement rate and discounted 15%.

G&S, Savings, Cash

Based on benefit limits in current waivers.

Based on historical utilization for each service. Is not established by individual but in the aggregate.

G&S, SB fee, FMS fee, Savings

Some waivers have waiver caps for services and these will remain in effect. Exceptions may be requested.

Utilizing the existing homemaker monthly service cost maximum derived from the consumers level of impairment and unmet needs.

G&S, F/EA fee, Savings as needed.

Utilizing existing homemaker monthly service cost maximum based on consumer's level of impairment and unmet need, no duplication of state plan services.

Based on historical usage minus 5% administrative costs, Exceptional requests for budget increases

G&S, Services, SB fee, FMS fee

Based on benefit limits in current waivers. Non-medical, non-residential services. Needs assessment based.

The average monthly costs for the last 12 months for the individual or the average cost for the services need for someone with no history.

G&S, FMS fee, Savings

None

Average value of state plan home care and waiver services for persons eligible for CDCS during the CYear prior to the start of the state FY in which the budget will be applied. Budgets will be adjusted by case mix and by the dept based on inflationary increases or other cost changes authorized in law.

G&S, SB fee, FMS fee

Per established budget by Case Mix category for Elderly Waiver and state-funded Alternative Care Program

Initially, based on historical utilization or historical usage by an individual demographically similar when no history exists with a 10% discount, which represents traditional agency administrative costs. This discount combined with case management costs will be used to pay for consultant services, FMS and Utilization Review. Application with CMS now allows state to do average aggregate budget based on need.

G&S, Reserve

Need assessment-based; No duplication of state plan services

TBD

G&S, saving, FMS fee

Individual Budget is limited to non-medical services; no other limitations

Based on historical spending and needs assessment

G&S, SB fee, FMS fee, Savings

Needs assessment-based

Cash out current care plan at prevailing hourly or other cost to state. Adult day costs are limited to use for Adult Day Services

G&S, SB fee, FMS fee, Savings, Cash

Only \$500 in saving carries over across state's fiscal year. Cash limited to \$50 per two week period.

State uses systematic assessment instrument which yields a dollar amount for budget. SSPS and Sunrise Services funded separately.

G&S

None

Homemaker level of service based on hours needed (4 levels = A, B, C, D, each is a range of hours) Will monetize at highest number of the range; Casemangement = the monthly flat rate for CM; nursing = the value of 6 units per month plus an annual assessment; transportation = monetized value of average utilization in the waiver. Total minus 15% for administration.

G&S up to \$1000 annually, Savings

On the goods and services - \$1000 annually

Permit hiring of Spouses?	Criminal Background Checks (Required? For Whom? By Whom?)	Quality Survey
	Required, FMA does them	Survey questions to assess satisfaction with services are included.
	Required for ISB. Directly hired workers may have a CBC based on the request of the consumer.	Participants will be asked about experiences. Still working on the specifics about what exactly will be asked of participants and when.
Yes (at current time)	Required for personal care worker. F/EA does them for consumer as part of first per member, per month fee.	Yes. Still determining content of survey and who will conduct the survey.
Yes	Required for all directly hired workers who provide hands on assistance in the home. Support Brokers obtain the CBC.	Still determining the content of survey.
Yes	Required for all hands on direct service workers, OHCDs or FI does them If participant opts for Agency with Choice model then agency usually requires CBC. Consumer decides on other fiscal models. Done by FSE agency if using AWC model. Billable to state MA program if consumer requires it but only on F/EA and fiscal conduit models. For AWC provider pays. Cost cannot come out of person's CDCS budget.	Yes Y, to be completed by contracted evaluator
Yes	Required for all directly hired workers who provide hands on assistance in the home and consultants. FMA will do directly hired workers in the home and the Consultant Agency will do the checks for consultants. It is part of the PMPM rate.	Survey has been developed for Mi Via program that assesses consumer satisfaction. It is under revision for brevity.
No	Criminal history background checks (CHBC) are not required for personal assistance workers and support service workers when employed by a participant or their representative. Participants and their representatives have the right to request a criminal history background check, and to employ a worker regardless of the outcome of the background check. Conducted by the FMS at no cost to the participant.	PA is working with Penn State to develop a standardized consumer satisfaction survey across all waiver programs.
No	Required for representatives and workers. Done by FMS at no cost.	Still determining the content of survey.
Yes (as of May 2007)	Required for all consumer/employed staff. Done by ARIS (FMS) as part of the admin fee.	Participants are asked about goals and satisfaction with the Flexible Choices Program. Survey designed by state for use across all consumer directed programs is being used along with instrumentation about goals.
No		Consumers will be asked about satisfaction with program.
No	FEA processes required CIB check for participant's employee at the cost of the employee.	PES for all waiver participants will be used. West Virginia will include questions related to fiscal intermediary and resource consultant. The Fiscal Intermediary/Resource Consultant update and report to the QA/QI Council on a quarterly basis.