DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-15
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

SMDL # 04-005

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Dear State Medicaid Director:

The Centers for Medicare & Medicaid Services (CMS) has supported states in the implementation of the principles of money follows the person (MFP) by providing resources and technical assistance. We are committed to continuing to assist states in implementing the principles of MFP under existing authorities.

A number of states have pursued strategies under existing authority that can be useful models to states interested in making immediate changes to their delivery systems. Previously, we highlighted MFP in two State Medicaid Director letters on August 13, 2002, and September 17, 2003, and provided technical assistance to states through the dissemination of "promising practices" on our Web site. In particular, we have highlighted innovative states including Arizona, Colorado, Indiana, Texas, Florida, New Jersey, Oregon, Utah, Vermont, Washington, and Wisconsin. Still other innovations are occurring under current law with the support of Real Choice Systems Change Grants for Community Living (Attachment #1).

As you know, the term "Money Follows the Person" refers to a system of flexible financing for long-term services and supports that enables available funds to move with the individual to the most appropriate and preferred setting as the individual's needs and preferences change. It is a market-based approach that gives individuals more choice over the location and type of services they receive. A system in which money follows the person is also one that can incorporate the philosophy of self-direction and individual control in state policies and programs.

We are committed to continuing to assist states in implementing the principles of MFP under existing authorities and hope to address areas of confusion that may be impeding efforts to rebalance long-term support systems. This letter intends to clarify a few issues that have been brought to our attention.

Issues Identified to Date

Home and Community-based Services (HCBS) Waiver Capacity and Cost Neutrality: Although states may implement MFP strategies without a waiver context, states that anticipate using HCBS waivers as part of their rebalancing strategy may be concerned about waiver capacity and demonstrating the cost neutrality of proposed waiver services. States may request to amend their current HCBS waiver program to include additional participants. States that do so are still required to demonstrate the continued cost-neutrality of those programs;

however, most states have found that in the aggregate waiver programs continue to demonstrate cost neutrality even with the addition of waiver participants. Any state that has concerns in this area is asked to work with CMS to assess the underlying assumptions and structural issues of its cost neutrality estimates.

Backfilling of Nursing Home Beds:
States that implement MFP strategies will begin to achieve a more equitable balance between the proportion of total Medicaid long-term support expenditures used for institutional forms of service and the proportion of combined funds used for home health and personal care services under the state plan and waiver services. We anticipate that as individuals have greater choices in service delivery, a smaller proportion of individuals will choose institutional care. We encourage states to reduce nursing facility beds to assist a state in rebalancing its long-term care service system, but this is not a requirement.

Self-Directed Models:
Over the past several years, individuals and families have advocated for directly involving persons who receive Medicaid funded services and supports in the decisions that affect their lives, and providing those individuals with greater choices and control of their services and supports. For individuals to naturally select community services over institutional services, states must ensure that a broad array of quality services are provided under a long-term care system that recognizes service delivery options that are diverse and flexible. CMS is committed to supporting and further implementing models such as those contained in the *Cash and Counseling Demonstration and Evaluation Project* and the *Independence Plus* initiative. These programs not only realize MFP principles but use an individual budget to provide participants direct opportunities to make personalized decisions about the allocation of available resources. While CMS continues to encourage states to consider these system reforms, we also recognize other strategies for the provision of HCBS that expand the level of individual choice and control without making major modifications to state infrastructures. Quality community programs offer not just one model of delivering community services but rather a continuum of options in order to allow individuals to select the service delivery method that best meets their preferences, desires, and personal outcomes. The selection as to which option is best may vary depending on the level of other community supports available, or simply the inclination of the individual. Along this continuum, CMS has identified the following four basic service delivery models related to services and supports of personal attendant:

1. Traditional Model
2. Traditional Model Supporting Choice
3. Agency with Choice Model
4. Fiscal/Employer Agent

A description of these models and examples of state innovation is included in Attachment #2.

We will continue to help provide opportunities for people to live in the communities of their choice. We welcome your input and hope you find this information useful.

Sincerely,

/s/

Dennis G. Smith
Director

Enclosures

cc:
CMS Regional Administrators

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Attachment #1

Examples of State Innovation
Under the Real Choice Systems Change Grants for Community Living:
Money Follows the Person Rebalancing Initiative

California

The California Department of Health Services (DHS) is developing models and systems that enable money to follow the person from institutional to home and community-based settings. Specifically, it is developing standardized protocols and processes, including a consumer-focused quality assurance model, a standardized consumer-oriented nursing facility transition care planning model, and a uniform assessment tool and protocol. A pilot project will test the developed tools and protocols, and inform statewide policy decisions about a Money Follows the Person Initiative in California using individual and aggregate data and fiscal analysis based on case examples.

Maine

The Maine Department of Behavioral and Developmental Services is adopting a standardized assessment and budgeting process for mental retardation waiver services that results in consistent, predictable, and truly portable budgets. The State is directing resources toward more person-centered, consumer-driven services offered in the most integrated and appropriate setting and identifying cross-system performance measures that enable Maine to comprehensively and coherently assess its success at achieving a balance of services across systems. Maine is piloting an individual budget tool and assessing its impact on consumer satisfaction, providers, budget neutrality, staffing requirements, and Medicaid management information systems.

Nevada

The Nevada Department of Human Resources is rebalancing the State's long-term services programs so that community services and supports are the primary source of support for people with disabilities. It is identifying individuals for community integration, implementing their transitions, and using peer advocates to assist in the transition process. In addition, Nevada is establishing a Housing Specialist at the Nevada Developmental Disabilities Council to help individuals locate affordable housing and access State and local housing assistance programs. The State is also revitalizing the Nevada Home of Your Own program, an initiative to help people with disabilities secure housing, and developing and maintaining a registry of affordable, accessible housing in Nevada.

Additional examples can be found on the CMS Web site at www.cms.gov/newfreedom.

Attachment # 2

Service Delivery Models for Attendant Care

Service delivery models have been evolving over the last decade and continue to be refined and clarified. The following are four basic models that CMS has identified based on state experiences. Each of these design approaches can be used by states to enable them to employ money follows the person principles. States are not limited in the various strategies they may employ.

Traditional Agency Model

Under a traditional agency model, an agency assumes responsibility for recruiting, hiring, managing, training, and dismissing employees who are hired to provide, at a minimum, basic assistance with activities of daily living to individuals living in the community. The agency sets the wages and hours, and directs the actions of the employee while in the participant's home and provides necessary back-up as needed. Services are provided based on a standardized assessment of needs typically performed by a medical professional. A Medicaid agreement executed with the Medicaid agency, and the provider agency, clearly articulates the scope of the services and identifies allowable tasks that may be performed. The agency is paid by the Medicaid agency to provide personal assistance services.

Traditional Model Supporting Choice

Many traditional provider agencies honor the principles of choice, control, and the person-centered planning process. These progressive agencies allow, or even encourage, participants to identify and refer to the agency, attendants they have selected and offer training in the philosophy of self-direction. Many agencies also provide a list of potential attendants that participants may interview. Back-up is provided by the agency. Attendants are expected to respect participant preferences. States implementing this model may do so without modifying their state plan or waiver services since the provider agency continues to operate under a traditional Medicaid Provider Agreement to provide personal assistance services and is reimbursed for providing these services. The agency continues as the responsible entity over the provision of personal assistance services and over the attendants who provide this service. While the participant has the ability to select his or her attendant, the agency continues its role as the employer of the attendant and retains responsibility for the oversight of the personal attendant service. The Trinity Respite Care in Lawrence, Kansas is an example of a Medicaid provider agency that gives its clients the opportunity to select their own attendants.

Agency with Choice

This model, first described in a research document entitled *Consumer-Directed Personal Assistance Services: Key Operational Issues for State CD-PAS Programs Using Intermediary Service Organizations* (1997) by Susan Flanagan and Pamela Green, provides an increased level of responsibility by designating the participant as the ***managing employer*** without becoming the common law employer (employer of record) of his or her attendant. For IRS purposes and other employment considerations, including making payment to the provider, the agency is the common law employer. The participant recruits, interviews, and selects the attendant care provider and refers him or her to an agency for the completion of payroll responsibilities. An individual budget may or may not be used to determine the available resource allocation. The

participant generally establishes the wages and sets the working hours. Once hired, the participant manages the attendant including the approval of timesheets. The participant may elect to train the individual or may direct the agency to provide training on his or her behalf. The agency may offer additional services to support the participants' ability to self-direct. These supports may include making other purchases (included in the individualized budget) on behalf of the participant, assisting with managing the individual budget or providing training on how to hire and manager attendants. While the agency and the participant share employer responsibilities, the agency executes a Medicaid Provider Agreement with the Medicaid agency to provide the personal care services and any supportive services. The agency may offer a traditional service model along with Agency with Choice services model, but clearly there is a formal distinction between the two models. The New Hampshire *Independence Plus* initiative, *In-Home Supports Wavier for Children with Developmental Disabilities,* adopts the Agency with Choice model.

Fiscal/Employer Agent Model:

The Fiscal/Employer Agent model provides Medicaid program participants with the greatest level of flexibility and empowerment. In this model, the participant or participant's designated representative is recognized as the common-law employer of his or her individually hired attendant(s). However, the representative generally delegates the employer-related responsibilities related to payrolling and filing of employer-related payroll taxes to an organization that serves as the program participant's "employer agent." The agency may offer a broad host of services that support the participant as he or she experiences self-direction, including skills training, brokering other benefits such as Workers Compensation or health insurance, or other support functions including assistance with managing the individual budget. The agency may be reimbursed for financial management services as a waiver service or as an administrative function. Many states, including all but one of the "Cash and Counseling" and "Independence Plus" waiver states (Arkansas, Florida, New Jersey, Louisiana, North Carolina, and South Carolina), use this model to allow Medicaid program participants and their families to self-direct.