REPORT OF THE
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

A STUDY OF CONSUMER-DIRECTED SERVICES

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 18

COMMONWEALTH OF VIRGINIA
RICHMOND
1996

COMMONWEALTH of VIRGINIA

ROBERT C. METCALF
DIRECTOR

Department of Medical Assistance Services

December 28, 1995

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
804/225-4512 (Fax)
800/343-0634 (TDD)

TO: The Honorable George Allen

and

The General Assembly of Virginia

This report contained herein is pursuant to House Joint Resolution 539, agreed to by the 1995 General Assembly.

This report constitutes the response of the Department of Medical Assistance Services to this resolution and recommends the appropriate actions related to the feasibility and advisability of amending the Elderly and Disabled Waiver to allow individuals to hire their own personal attendants.

Respectfully Submitted,

Robert C. Metcalf

Robert C. Metcalf
Director, Department of Medical Assistance Services

PREFACE

The 1995 General Assembly passed House Joint Resolution 539 which requests the Department of Medical Assistance Services to evaluate the feasibility and advisability of amending the existing Elderly and Disabled Waiver to allow individuals to hire their own personal attendants. For purposes of this study, this will be referred to as a study of *consumer-directed* services. HJR 539 was a result of the Disability Commission Subcommittee's recommendation after months of work with consumers and state and local agencies and public hearings in which the desire for consumer-directed services was expressed. When a consumer opts to receive consumer-directed services, the consumer hires, trains, supervises and, if necessary, fires their own attendant. Incorporating such a self-directed model of service into a program designed to meet the needs of a population that requires an institutional level of service necessitates careful consideration.

The Department of Medical Assistance Services convened a workgroup for the purpose of evaluating the impact of offering a consumer-directed model of Personal Care on consumers, providers and other agencies in the community. The members of the workgroup represent all stakeholders in the process as follows:

Virginia Association for Home Care	Ms. Martha Pulley
	Ms. Ann Morris
Consumer Representative for Persons with Disabilities	Mr. Bryan Lacy
Department for the Aging	Mr. T. C. Jones, IV
Consumer Representative for the Elderly	Ms. Mary Ellen Cox
Department of Social Services	Ms. Terry Smith
	Ms. Marjie Jernigan
League of Local Social Services Executives	Ms. Ann Owens-Strickler
Department of Rehabilitative Services	Ms. Martha Adams
Department of Rehabilitative Services, OBRA Waiver	Ms. Pat Lovell
Department of Mental Health/Mental Retardation & Substance Abuse Services	Ms. Linda Veldheer
Centers for Independent Living	Mr. Bill Fuller
Board of Nursing	Ms. Nancy Durrett
Virginia Board for People with Disabilities	Ms. Nicole Chase-Stewart
Department of Medical Assistance Services	Ms. Chris Pruett

Ms. Cathy Saunders Ms. Betty Cochran Mr. Richard Graffius

We wish to extend our appreciation of the time and efforts the members of the HJR 539 workgroup expended in their review and input to this report. We would like to acknowledge the contribution by the World Institute on Disability and the American Bar Association Commission on Legal Problems of the Elderly whose work on *Liability Issues Affecting Consumer-Directed Personal Assistance Services* (Charles P. Sabatino, J.D. and Simi Litvak, Ph.D, 1995) was extremely helpful. We would also like to acknowledge the Pennsylvania Department of Public Welfare staff who shared a model of consumer-directed service that they have found to be effective.

TABLE OF CONTENTS

EXECUTIVE SUMMARY 3

INTRODUCTION 5

CONSIDERATIONS FOR A MEDICAID CONSUMER-DIRECTED SERVICE 7

OTHER STATE AGENCIES' EXPERIENCE WITH CONSUMER-DIRECTED SERVICE 9

MEDICAID-REIMBURSED CONSUMER-DIRECTED SERVICE IN OTHER STATES 10

THE PENNSYLVANIA MODEL 10

QUALITY OF SERVICE ISSUES 12

- Assessment of Needs and Service Planning Process 13
- Consumer Choice and Informing Consumers of Rights, Risks & Responsibilities 14
- Service Standards 15
  - Training for Consumers 15
  - Standards for Attendants 15
- Supportive Services 18
- Oversight 19

UTILIZATION CONTROL ISSUES 20

REIMBURSEMENT ISSUES 21

EMPLOYMENT TAX AND BENEFIT LIABILITY ISSUES 24

IMPACT ON VIRGINIA'S LONG-TERM CARE SYSTEM 25

- Consumers 25
- The Provider Community 26
- Other Agencies 26
- The Medicaid Budget 27

FINDINGS AND RECOMMENDATIONS 29

- Recommendations 29

APPENDIX I 31

EXECUTIVE SUMMARY

The 1995 General Assembly passed House Joint Resolution 539 which requests the Department of Medical Assistance Services to evaluate the feasibility and advisability of amending the existing Elderly and Disabled Waiver to allow individuals to hire their own personal attendants. For purposes of this study, this will be referred to as a study of *consumer-directed* services. The Department of Medical Assistance Services convened a workgroup for the purpose of evaluating the impact of offering a consumer-directed model of Personal Care on consumers, providers and other agencies in the community. The members of the workgroup included: Virginia Association for Home Care, Consumer Representative for Persons with Disabilities, Department for the Aging, Consumer Representative for the Elderly, Department of Social Services, League of Local Social Services Executives, Department of Rehabilitative Services, Department of Rehabilitative Services - OBRA Waiver, Department of Mental Health, Mental Retardation & Substance Abuse Services, Centers for Independent Living, Board of Nursing, Virginia Board for People with Disabilities, and Department of Medical Assistance Services.

There is consensus among the Workgroup that Virginia could amend its Elderly and Disabled waiver to offer consumers who require assistance with personal care activities an option to receive those services in a consumer-directed model.. The following recommendations address the feasibility and advisability of offering a consumer-directed service and are in no way intended to fully outline all the details which must be addressed in an implementation of consumer-directed service. These recommendations were also developed without regard to Congressional Medicaid reform which could impact specific aspects of the design of community-based services. Implementation of these recommendations should be considered in conjunction with the implementation of any Medicaid reform.

Recommendations

⇒ Virginia should offer a consumer-directed model of service to elderly and disabled persons age 18 and over, who have no cognitive impairment and are able to communicate sufficiently to hire, train and provide instruction regarding their needs to attendant staff. The model developed by Pennsylvania can serve as a model.

⇒ This consumer-directed model of service should be offered in conjunction with the agency-directed service model already in place.

⇒ The Medicaid program should use agencies (e.g., providers of home health, personal care, centers for independent living, etc.) to serve as fiscal agents for the consumer-directed service. The IRS recognizes the fiscal agent as an appropriate intermediary for purposes of income tax reporting, payment of social security (FICA taxes), federal and state unemployment taxes.

⇒ The Department of Medical Assistance Services (DMAS) should provide training to the pre-admission screening assessors regarding when the option of consumer-

directed service is appropriate. DMAS should also develop clear and simple written communication that outlines the consumer's risks and responsibilities and defines the role the fiscal agent agency plays in a consumer-directed model. This is necessary to minimize the possibility that the consumer underestimates the degree of individual responsibility he or she assumes in this model. There must also be documentation that the consumer has been apprised and understands all rights, responsibilities and risks of managing the personal attendant service and has made an informed choice to assume those risks.

⇒ The consumer-directed program should include training for the consumer that assures that the consumer understands how to manage his or her service. The ideal source for this training is other consumers.

⇒ The requirements for attendants in the consumer-directed model should be: an ability to read and write, a minimum age of 18 years, and willingness to submit to a criminal record check. Although there would be no formal training or education requirements, every attendant should be provided information to assure appropriate introduction to the philosophy of consumer-directed service.

⇒ The fiscal agent should be required to employ or contract with a service coordinator who is responsible for completing periodic reassessments and for authorizing the initial service plan and any subsequent changes in the consumer service plan.

⇒ DMAS should initiate a toll-free consumer telephone line to respond to consumer issues and as a way for someone in the community to communicate concern about a specific consumer's service that may indicate needed follow-up from a service coordinator.

⇒ Reimbursement for the attendant services should include a rate sufficient for the payment of wages, FICA, taxes and a reasonable administrative overhead to the fiscal agent. There should be a separate reimbursement for service coordination and a separate reimbursement for training.

⇒ The attendant should be considered as a physical extension of the consumer's body, compensating for parts of the consumer's own body which no longer function. The mentally alert consumer is completely in control of his or her own service. Therefore, the attendant should be able to provide, at the consumer's direction, any service need without restriction.

⇒ DMAS should explore ways to reinvest any cost savings realized through use of consumer-directed service to use as payment for health insurance premiums for the aides and attendants who provide the direct service. This could improve the viability of the home care delivery system by improving the stability of the workforce.

INTRODUCTION

The Department of Medical Assistance Services provides reimbursement for Personal Care services via home and community-based waivers. Virginia has four home and community-based waivers and all four waivers include personal care or personal assistance services that can be offered to avoid or prevent more costly institutionalization. The Elderly and Disabled waiver includes three services (Personal Care, Respite Care and Adult Day Health Care). One or more of these services may be authorized for elderly persons and persons with disabilities when a nursing home pre-admission screening team determines that the person would otherwise require nursing facility care. In fiscal year 1995, DMAS spent approximately $61.5 million on Personal Care services for approximately 9,000 Elderly and Disabled waiver consumers.

The Elderly and Disabled waiver consumer is currently only able to receive their personal care from an approved personal care agency. DMAS contracts with approximately 160 agencies. The agency chosen by the consumer assumes responsibility for recruiting and hiring trained aides, assigning aides to waiver consumers based on the agency's staffing capability, supervising those aides and overseeing the consumer's service on an ongoing basis. This model of service is termed an agency-directed model of service.

Principles of consumer direction are present in an agency-directed model. The agency involves the consumer in the process of developing a plan of service based on the consumer's needs and in determining the activities the agency will instruct the aide to perform. To the extent possible, the agency provides the consumer with meaningful choices and respects the need for consumer control. Yet, in an agency-directed model, the structure of the service delivery system can minimize individual autonomy and support of individual preference. The consumer may have some choice in the aide assigned to provide service, but is largely dependent upon who the agency has available at the time the service is needed. The consumer may also have some choice regarding the hours that service is rendered, but the aides schedule is often set amidst the competing demands of the agency's other clients and the agency's need to make best use of its home care staff.

Generally, consumers who receive agency-directed service experience a higher rate of turnover in staff who provide service than that reported by persons in the disabilities community who have traditionally hired and supervised their own attendants. Persons that receive consumer-directed service also report greater flexibility on the part of the person providing service to work early mornings or late nights and weekend hours than is experienced by agency-directed consumers.

A consumer-directed model of service empowers the consumer to take responsibility for the management of his or her service. The consumer recruits, hires, trains, manages and directs his or her own provider of services, known as a personal assistant or personal attendant. The consumer is directly responsible for: determining what activities the attendant performs on a daily basis, negotiating what times the attendant

arrives and departs, having a back-up plan in place for those times when the attendant cannot provide the needed service, generating any paperwork necessary to assure accountability of public funds and notifying appropriate persons when needs change. The personal attendant is accountable to the consumer, rather than to a supervising nurse of a provider agency. The attendant acts, in effect, as an extension of the consumer and follows the consumer's directions as to how to meet his or her needs.

State experience with consumer-directed models is still in its infancy. Most consumer-directed models of service have been initiated since the 1970's within the independent living model developed by the disability advocates. Virginia's Personal Assistance Services program administered by the Department of Rehabilitation Services is typical of such consumer-directed models.

There is wide variability in the Elderly and Disabled waiver population's ability and potential desire to self-manage service. A consumer-directed model is only appropriate for those consumers who have no cognitive impairment and who can communicate adequately to supervise and train their own attendant. Approximately 31% of the elderly population in the waiver receiving personal care have some type of cognitive impairment that would preclude consumer-directed services. Of the non-elderly population with disabilities receiving personal care, approximately 27% have some type of cognitive impairment that would preclude consumer-directed services.

CONSIDERATIONS FOR A MEDICAID CONSUMER-DIRECTED SERVICE

The following concerns and considerations were outlined for the Workgroup to address in its evaluation of the feasibility and advisability of amending the Elderly and Disabled Waiver. Each of these concerns and considerations had to be explored in order to recommend the development of a consumer-directed model.

- Federal Medicaid rules prohibit Medicaid payment being made to the consumer. Consumer-directed models within the disabilities community have reimbursed the consumer directly for the purchase of services.

- DMAS has no funds for any increase in service expenditures for Personal Care. Any change to the waiver must either have a neutral impact on the budget or a request for allocation of additional funds will have to be made to the General Assembly.

- DMAS does not want to be considered the direct employer of the attendant because that requires fiscal agent activities (i.e., payment of FICA/unemployment/etc.) which could not be absorbed with current resources.

- In DMAS' present Personal Care program, the RN Supervisor provides periodic reassessment and is responsible for making changes to the plan of service or terminating services when there is a change in the consumer's condition. In a model where there is no external monitor, how do we assure that changes in service occur as needs and supports change?

- What limitations, if any, should exist for the consumer's ability to choose the consumer directed model?

- What standards (i.e., training, education, age, criminal checks, etc.) should exist for attendants in a consumer directed model?

- What safeguards are needed, if any, in a consumer directed model?

- What paperwork is required to assure accountability and who completes the paperwork in a consumer directed model?

- Will there be any restrictions on the activities of the attendant in a consumer directed model?

- What supports are available for the consumer who chooses consumer-directed service and encounters problems?

- What portion of the existing population would choose a consumer-directed program and would that population consist of elderly as well as persons with disabilities?

- What impact would a consumer-directed model have on the existing provider community?

- What impact would a consumer-directed model have on other agencies in the community such as the Department of Social Services, etc.?

These concerns and considerations can be grouped under a few general headings. Each of these general areas will be discussed later in the body of this report:

* Quality Assurance Issues

* Utilization Control Issues

* Reimbursement Issues

* Employment Tax and Benefit Liability Issues

* Impact on the Long-Term Care System

OTHER STATE AGENCIES' EXPERIENCE WITH CONSUMER-DIRECTED SERVICE

The Department of Social Services (DSS) reimburses providers of companion, homemaker and chore services to a primarily elderly population. The state agency allocates, monitors and provides training and technical assistance to local departments of social services, which are considered to be the fiscal agents acting on behalf of the attendant who is the employee of the DSS consumer. As such, the local DSS is responsible for the collection and payment of FICA and the payment of unemployment taxes. The status as fiscal agent is a recent development resulting from an agreement between the state Department of Social Services and IRS. As a result of this agreement, the local DSS agencies assumed an additional administrative burden and have had to either contract with a vendor agency or develop within their local agencies the capability to perform the fiscal agent functions. The amount of consumer direction and control varies according to the locality. Generally, the DSS programs are structured to allow greater consumer participation than the current DMAS personal care program. The local DSS caseworker develops a Purchase of Service agreement with the consumer and attendant, completes an initial assessment and authorizes hours of service, provides quarterly reassessment contacts and ongoing annual reassessments, and requires monthly timesheets signed by the consumer, attendant and casework supervisor. DSS pays the attendant for services as long as the attendant: 1) meets minimum age requirements, 2) obtains a statement from a physician or clinic that they do not have tuberculosis in a communicable form, 3) submits two references and 4) identifies any criminal record and agrees to submit to a criminal record check.

The Department of Rehabilitative Services (DRS) reimburses for Personal Assistance Services (PAS) for approximately 160 disabled persons statewide with reimbursement made directly to the assistant. DRS is subject to the same IRS ruling concerning the collection of FICA and unemployment taxes that has made the recent changes to DSS' program but changes to the PAS program have not yet been made. The consumer, as long as they have the ability to describe their own routine, has complete responsibility for the direction and control of their own services. The consumer hires and trains their own attendant without any intervention from DRS. DRS assists the consumer to develop a contract with the attendant that establishes the maximum number of hours the consumer is entitled to receive. Staff at an independent living center assist the consumer with training in the direction and management of their assistant, if requested, and complete an annual reassessment of need with changes to the plan of service accomplished through a physician's order. DRS issues a check to the consumer to pay their attendant for the agreed upon hours of service. The hours of service are documented on a time sheet completed by the consumer and signed by both the consumer and the attendant.

MEDICAID-REIMBURSED CONSUMER-DIRECTED SERVICE IN OTHER STATES

Discussions with Health Care Financing Administration (HCFA) and state representatives on the HCFA Non-Institutional Long-Term Care Advisory Group indicated that the states of Alaska and Pennsylvania are pursuing consumer-directed services through 1915(c) home and community-based waivers. HCFA recommended that we study Pennsylvania's plan since it fits most closely with Virginia's current long-term care program structure.

THE PENNSYLVANIA MODEL

Pennsylvania has recently received federal approval of a home and community-based waiver, targeted to disabled persons, which will incorporate a three-tiered model of service provision. The first model is much like Virginia's existing agency-directed service where the provider agency is responsible for hiring, supervising and firing Personal Care attendants and the consumer has some input into the process, but very little direct control. Pennsylvania's other two models allow the consumer to hire, supervise and fire their own attendant, with varying amounts of consumer involvement in the paperwork required. The following gives a brief outline of the Pennsylvania (PA) consumer-directed program:

- Any consumer who is mentally alert and able to manage their own legal and financial affairs can choose the consumer-directed model. Regardless of the model chosen, there is a service coordinator who is responsible for development of a plan of service and annual reassessments of need.

- PA will contract with provider agencies (including home care agencies such as those contracted currently in Virginia to provide waiver services as well as others such as Centers for Independent Living which are currently DRS providers in Virginia, etc.) to act as a fiscal agent to administer a consumer-directed model. This fiscal agent bills the Medicaid agency for services, makes out a check to the attendant and gives it to the consumer, withholds FICA, etc. and makes quarterly payments to IRS. These functions are performed in the more traditional provider-directed model as well. In the traditional model, however, the provider is also required to recruit, hire and train attendants, provide routine supervisory visits to the consumer to monitor service and service needs, update plans of service, and initiate termination of services. The fiscal agent is considered the attendant's employer for purposes of income tax reporting, FICA taxes and federal unemployment taxes. Thus the consumer and the fiscal agency are both employers, but for different purposes.

- Attendants must be able to read and write and be 18 years of age, there are no formal training or education requirements, and the consumer is given the choice to perform a criminal record check.

- The provider agency must provide a service coordinator who can assist the consumer, as needed and requested by the consumer, and who performs periodic reassessments and submits changes in the service plan. The provider must be able to offer training for consumers in how to effectively manage their service, as requested by the consumer.

At the time of this writing, Pennsylvania had not implemented its approved waiver. Pennsylvania does have over 10 years of experience with this model of service, however, as a state-only funded program. State representatives report that it has worked very successfully for them. Approximately 2,500 persons receive services through this consumer-directed service at an average per capita cost which is similar to Virginia's current expenditure for Personal Care services. State representatives and a consumer presented at a recent meeting of the HCFA Quality Assurance Task Force to assert the benefits to quality they have seen in their consumer-directed model.

QUALITY OF SERVICE ISSUES

The specter of decreased quality of service accompanies a consumer-directed model which lacks the usual agency control and monitoring included in an agency-directed model. In a consumer-directed model, it is imperative that consumers understand that it is *their* responsibility to manage the performance of the attendant. The consumer must ensure the quality of the service he or she receives and must know what steps to take when quality of service is less than desired (request training for themselves or the attendant, fire and recruit for a new attendant, etc.).

Providers and policymakers have much more experience and comfort with service models that rely on an external monitor to assess quality of services. Consumers in the disabilities community continue to stress that there is no one in a better position to assess the quality of a service than the consumer of that service. These consumers argue that the risks in a consumer-directed service are, if anything, less than in an agency-directed model. Unlike the agency-directed model, the attendant is directly answerable to the consumer they serve and the consumer is empowered to replace the attendant if he or she is not satisfied with the service. As long as the consumer desires to have control of their own service delivery and is mentally competent to assume that control, he or she should have the right to assess their own safety needs and to take risks, just as do any of us, in the pursuit of services to meet those needs. At least on some level, providers and policymakers do recognize that consumers are in the best position to determine the quality of the service received. In the long-term care service system, where the goal is maintenance of the consumer at home, providers and policymakers alike have tended to rely increasingly on measures of consumer satisfaction as a means of assessing quality of care. The National Rehabilitation Hospital Research Center recently conducted a study comparing consumers of Virginia's Personal Assistance Services program (the consumer-directed program provided via DRS) with consumers who received personal assistance from another source. The group of persons receiving consumer-directed service from the DRS program scored consistently higher (more satisfied) than their counterparts receiving service from another source.

This trust that the consumer knows best does not abdicate the state's responsibility for appropriately structuring a publicly-funded consumer-directed service program that minimizes the risk of injury or exploitation. The typical components of quality assurance include:

- ◊ the assessment of needs and service planning process
- ◊ freedom of choice and informed consent of the consumer
- ◊ standards for providers
- ◊ supportive services
- ◊ periodic oversight

The service assessment and planning process must assure that the needs and abilities of the person are accurately identified and the service plan provides an appropriate

means of meeting those needs and recognizing those abilities. Only those persons who are able to direct and wish to direct their own services should be offered the choice of consumer-directed service. The informed consent of the consumer must be an explicit process that clearly apportions the responsibilities and risks of the consumer. The standards established by the state must allow the consumer's flexibility and direct control while minimizing risk. The supportive services must offer the consumer alternatives of administrative, clinical and quality assurance functions without the state removing the consumer's overall autonomy and control. Finally, there must be some degree of oversight by the state agency to assure that services are being provided that meet public policy goals and objectives.

Assessment of Needs and Service Planning Process

The current preadmission screening assessment process, using the Uniform Assessment Instrument (UAI) and the established criteria for waiver services, provides a comprehensive identification of the functional, medical, and psychosocial status of the consumer as well as an assessment of their physical environment and support system. Within this assessment, the screener can objectively assess the consumer's cognitive abilities through an assessment of the consumer's orientation to person, place and time (the consumer's awareness of his or her environment) and any behaviors which may be detrimental to the life, comfort, safety and/or property of the consumer or others. The established assessment definitions and criteria for determining dependency or semi-dependency in these two areas allows for a relatively objective assessment, through a standardized process, of the person's ability to independently manage their own service. The UAI also includes an optional Mini-Mental Status Questionnaire that could be used to further assess the person's cognitive functioning if the screener had any doubts about the person's cognition. DMAS' current data base shows that approximately 30% of the total population currently enrolled in the Elderly and Disabled waiver have some cognitive impairment (disorientation and/or aggressive, abusive or disruptive behaviors) that would preclude their choice of consumer-directed service. Representatives for persons with disabilities might prefer to rely solely on whether a person had been declared legally incompetent. There are, however, many elderly persons in the waiver population being considered for whom such determination is never made despite severe cognitive impairment.

The consumer's ability and means to communicate are also assessed via the UAI. The screener would be instructed to assess the consumer's ability to communicate adequately to supervise and train his or her own attendant broadly to include any form of communication that can be understood by the attendant. Thus a consumer who used a communication board, computer, sign language or any other form of expression could be considered able to direct their own service as long as the attendant could understand that consumer's communication.

The screener would also explore with the consumer their available back-up in the event that the attendant did not show up for work. In a consumer-directed service, the burden for meeting daily activities of living if the attendant doesn't show up falls on the

consumer, unlike in the agency-directed service where an agency that has a ready supply of additional staff is responsible for providing a substitute aide. The screener would also discuss with the consumer their comfort level dealing directly with the attendant when problems arise. The role of the screener in exploring back-up and consumer comfort level with confrontation would not be to deny the choice of consumer-directed service but to assure that there is complete identification and discussion of any potential problems.

In implementing a consumer-directed model, DMAS would have to provide training to the pre-admission screening assessors regarding when the option of consumer-directed service is appropriate and when a decision to deny consumer-directed service could be made. The choice of consumer-directed services could only be offered to consumers who have no cognitive impairment and who can communicate adequately to supervise and train their own attendant. Any decision made by the screening team to deny the choice of consumer-directed service could be appealed by the consumer to DMAS.

Consumer Choice and Informing Consumers of Rights, Risks & Responsibilities

A consumer-directed model relies on the ability of the consumer to be self-directed and educated in the management of their own service. In order for a consumer-directed model to be successful, consumers must be adequately and accurately informed of their rights, risks and responsibilities at the time the assessment and plan of service are developed and the consumer is given the choice of consumer-directed service. The process of identifying consumers and planning services must be based upon the concepts of consumer choice, informed consent and assumption of risk. If the consumer-directed model were adopted, DMAS would need to rely on the skills of the pre-admission screening assessor to both evaluate the consumer's cognitive status and to explain to the consumer and consumer's family or friends the risks and responsibilities incumbent on the consumer in a consumer-directed service model.

DMAS would have to develop clear and simple written communication that outlines the consumer's risks and responsibilities and defines the role the fiscal agent agency plays in a consumer-directed model. This communication is necessary to minimize the possibility that the consumer underestimates the degree of individual responsibility he or she assumes in this model. At the point that the consumer opts to receive consumer-directed service, the screening assessor and consumer must document that the consumer has been apprised and understands all rights, responsibilities and risks of managing the personal attendant service and has made an informed choice to assume those risks. The fiscal agent agency also should be responsible for informing the consumer of his or her rights, risks and responsibilities in a consumer-directed service.

The workgroup also considered the role of family and friends in the option of consumer-directed services. Should a family member or close friend be allowed to serve as a proxy for consumer-directed services for a consumer who is cognitively impaired? The workgroup recognized that there would be requests for such proxy-directed services, especially by parents of children receiving services (less than 2% of the population in the Elderly and Disabled waiver are under age 21). The workgroup expressed concern

regarding the possibility that a family member might choose this option, but not be fully involved in the provision of services to the consumer (i.e., not be in the home when service is provided). In most instances, when the family member or close friend would be in the home, a paid caregiver would not be rendering service. The inability of the consumer to direct service when the proxy would not be present is antithetical to the concept of consumer-directed service. The workgroup therefore concluded that the option of consumer-directed service should not be extended to a surrogate or proxy for the consumer.

Service Standards

In an agency-directed model of service, the state establishes standards for the agency, standards for the direct service staff and requirements for the provision of service that ensure a minimal acceptable quality. In a consumer-directed model of service, these standards must be minimal to avoid conflict with the individual control that is the basis of consumer-direction, but sufficient to assure the provision of needed service.

Training for Consumers

An integral component of a consumer-directed service is the ready availability of consumer training in how to self manage service (including how to recruit, hire, train, supervise, manage paperwork and fire attendant staff). In the current Personal Assistance Services program, DRS indicates that it is important to have persons with disabilities who have managed their own attendants to provide training to other persons with disabilities who need to learn similar skills. DRS has developed a Personal Assistance Management Training manual to be used for this training. Persons who currently provide this training, largely associated with Centers for Independent Living, may be one source for this training for waiver consumers who choose consumer-directed service. In the elderly community, Area Agencies on Aging may be another resource for this type of training as they are actively engaged in providing training and employment opportunities for their elderly constituents. Local departments of social services may also be a resource for such training and orientation, as may fiscal agent agencies or other service providers.

Standards for Attendants

The workgroup considered whether there should be standardized requirements for attendants providing consumer-directed service. Pennsylvania requires only that the attendant be 18 years of age or older, have the required skills to perform attendant services as specified in the consumer's service plan, possess basic math, reading and writing skills, possess a valid social security number and be willing to submit to a criminal records check. There is no requirement for any infection control checks. These standards are consistent with the basic requirements of Virginia's DRS PAS program and DSS' home care requirements. Consumers tell us that the primary

determinant of the quality of service is the attitude and orientation of the person providing the service, not the amount or type of formal training that person has had. In a consumer-directed service, emphasis is placed on the consumer's ability to hire an attendant who is motivated to provide good service. Any necessary training (e.g., how to safely transfer the consumer from a wheelchair) can be provided by the consumer who knows how he or she wants service delivered. In accordance with this philosophy, the workgroup considers the Pennsylvania requirements for attendants to be sufficient. There may , however, be a need for a criminal records check required by state law and a need for requirements related to OSHA blood-borne pathogen regulations.

Secondly, the workgroup considered whether family members should be eligible to act as attendants for consumers in a consumer-directed service. Currently, Virginia's Medicaid Personal Care program prohibits persons who are members of the consumer's family (defined as parents, spouse, children, siblings, grandparents and grandchildren) or anyone who has legal guardianship or is committee for the consumer from being a personal care aide. Other less directly related family members or friends could, if they met the qualifications to be a personal care aide, be hired to care for the consumer. In an agency-directed service, the RN Supervisor is available to provide some objectivity and oversight. In a consumer-directed service, the use of family members or close friends as attendants could limit the consumer's ability to appropriately supervise and direct their own service. The workgroup decided to adopt a prohibition on the hiring of family members or close friends as attendants for consumer-directed services.

The workgroup did not believe that any formal educational training should be required for attendants in a consumer-directed service. The workgroup did conclude, however, that an orientation and introduction to consumer-directed services should be provided to new consumer-hired attendants. In Pennsylvania's consumer-directed model, the consumer is responsible for determining the degree of training needed by the attendant and whether that training should be provided by the provider agency. Unlike Pennsylvania's waiver, the workgroup suggested that orientation and introduction to attendants in the consumer-directed model should be required rather than provided at the request of the consumer. This basic orientation would not need to be through a Board of Education approved course, but could be offered in a manner similar to the attendant training developed for personal assistance services offered by DRS. This orientation for attendants might be provided from a variety of sources, depending on the consumer and location.

DMAS could reimburse for training and orientation for both consumers and attendants as an ancillary reimbursement if the training and orientation are not otherwise available. The cost for this training and orientation does not, based on the DRS experience, represent a new cost since the hourly reimbursement for the attendant's service will be less than in the agency-directed model.

A final concern rests with whether the attendant can perform the full range of activities that the consumer requires in order to function as independently and as cost-effectively as possible in the home setting. The Boards of Nursing and Pharmacy have interpreted

the Nurse Practice Act and the Drug Control Act as prohibiting the attendant from administering medications and performing certain activities that have been interpreted as nursing acts. For example, the Board of Nursing has stated that teaching the use of the glucometer to measure blood sugar levels is not appropriate in a nurse aide education program approved by the Board. The Board believes that this skill should be considered a nursing activity because it involves some assessment and nursing judgment.

Personal Care aides are not required to have completed a nurse aide education program approved by the Board and the Board's authority does not extend beyond the establishing of requirements for certified nurse aides. Nevertheless, Personal Care agencies have understood the Board to say that personal care aides may not perform blood sugar readings. It is generally understood by the home care provider community that if the Board of Nursing determines an activity should be considered a nursing act, that no one other than a nurse may provide that service, regardless of the capacity in which that person is performing.

The Board of Nursing's decision that an activity should not be taught in a nurse aide education program is based on their decision that the activity constitutes the practice of nursing. The Code of Virginia reserves the practice of nursing to registered nurses and allows licensed practical nurses to perform selected nursing acts consistent with their education. There are several exceptions to the application of the Nurse Practice Act. Most applicable is §54.1-3001.6 "General care of the sick by nursing assistants, companions or domestic servants that does not constitute the practice of nursing as defined in this chapter". According to the report, *Liability Issues Affecting Consumer-Directed Personal Assistance Services,* the American Bar Association Commission on Legal Problems of the Elderly indicates that "this type of exemption provides a fairly broad opportunity for states to avoid the application of nurse practice restrictions on personal assistance programs".

The Drug Control Act has been interpreted to prevent personal care aides from assisting consumers who are not able to independently take their medications. The aides are not allowed to assist the consumer to take a pill, a suppository, or to apply a topical ointment, even when such medications have been prefilled by a family member or when the individual is capable of instructing the aide or attendant in the amount and type of their medications needed. It is questionable that the Drug Control Act was ever intended to have such broad applicability. In Chapter 34, Article 1, §54.1-3401, the Drug Control Act definition of "Administer" does not appear to apply to the taking of drugs by an individual in their own home. The definition specifically addresses the application of a drug by a practitioner or by the patient or research subject at the direction and in the presence of the practitioner. The Board of Health Professions is considering a proposal to modify to the Drug Control Act which would remove any impediment to the consumer's ability to receive assistance with medications. The proposed language would add to §54.1-3408 "Nothing in this Title shall prohibit the administration of normally self-administered oral or topical drugs by unlicensed individuals to a person in his private residence."

The workgroup supports the position that the attendant is merely serving as a physical extension of the consumer's body, compensating for parts of the consumer's own body which no longer function. The mentally alert consumer is completely in control of their own service. Resolution of this issue is not necessary in order to recommend provision of a consumer-directed service. It is, however, an area which can be explored through legal interpretations or drafting proposals for statutory revision. This broad application of state regulations appear to restrict consumers' ability to manage their own service in their homes. It may prevent some individuals from living in the community and in other instances unnecessarily increases the cost of service.

Supportive Services

Since the consumer becomes the attendant's employer in a consumer-directed model and the provider agency's role is predominantly that of fiscal agent, the establishment of a toll-free consumer telephone line to DMAS would be recommended. This telephone line would be established so that consumers, as well as agencies and other professionals in the community, could report problems that might affect the quality of service, as well as any utilization problems. This helpline would be primarily for the consumer to communicate a problem or need for assistance which the fiscal agent agency may not be able to accommodate (e.g., consumer needs training in a specific area related to service management that the fiscal agent does not provide and the consumer wants a referral).

The Helpline would also be available to the agency or family member or other community member for the purpose of communicating concerns that may necessitate follow-up by the service coordinator or a DMAS representative. All informational materials would stress that anyone other than the consumer should always address any concerns about consumer-directed service first to the consumer. The Helpline would only be used by non-consumers when the caller has already discussed their concerns with the consumer and the consumer does not recognize the existence of a problem. In the event that it appears that there is any difficulty with the consumer's ability to self-direct, DMAS will request the service coordinator make a visit to the consumer to discuss issues raised. The service coordinator will, if it appears that there is some problem with the consumer's management of care, offer the consumer additional training or assistance. If these measures do not correct the problem and it appears that the consumer is not capable of directing his or her own services, DMAS would be responsible for removing the option of continued use of the consumer-directed model. Any such decision could be appealed by the consumer.

There already exists a requirement for reporting of any suspected abuse, neglect or exploitation to the local department of social services that must be followed when appropriate. Information regarding this requirement would be incorporated into any training for consumers and attendants.

Another support available to the consumer in the Pennsylvania model, which would be recommended for inclusion in a Virginia program is service coordination. The role of

the service coordinator is discussed in the next section as it relates to control of utilization of services. However, the service coordinator also acts as a safeguard for quality of service. The service coordinator is available to the consumer to adjust service authorization and to evaluate any problems reported and make recommendations regarding the consumer's ability to direct their own service.

Oversight

In the current agency-directed model of service, DMAS conducts an annual quality assurance review in which DMAS staff review documentation maintained by the provider agency, interview agency staff and interview the consumer and/or consumer's family or other caregivers in the consumer's home to assess the quality of services provided. This quality assurance activity would also be conducted for consumer-directed services. In addition, DMAS can periodically conduct telephone consumer satisfaction surveys and utilize client level database information and claims information in conjunction with specific outcome measures to assess quality of care. For example, the consumer's use of other acute care services, incidence of hospitalizations, etc., can be determined and compared with other similar consumers who receive both consumer-directed and agency-directed services. Through this type of oversight, DMAS can spot any unusual service utilization patterns which may indicate some problem with quality of care.

UTILIZATION CONTROL ISSUES

In the current agency-directed model, DMAS requires that the provider employ a RN Supervisor to visit the consumer's home every 30 days to monitor the provision of services. The RN Supervisor is responsible for noting any changes in the consumer's condition and the need for any change in the plan of service. In the traditional consumer-directed model used by persons with disabilities, there is no such formal monitoring and oversight provided. The provision of a consumer-directed service within the context of a Medicaid waiver inherently requires some modification to the model used by persons with disabilities in a non-Medicaid environment.

Federal regulations for waivers require that there be a formal process of periodic reevaluation of the consumer's strengths, needs and available support, authorization of any change to the plan of service and professional staff available to respond to any medical problems or change in overall needs. These regulations require that the qualifications of persons performing these functions for someone in the waiver be similar to the qualifications of persons who perform the same functions for persons entering a nursing facility. For this reason, DMAS would need to require, in a consumer-directed model, the fiscal agent agency to employ or contract with a service coordinator who is a nurse, social worker or case manager that meets the knowledge, skills and abilities established by DMAS for screening of persons for admission to an Adult Care Residence. This service coordinator would be responsible for conducting an annual reassessment and for authorizing changes to the plan of service. Although the service coordinator would not necessarily have to be a RN, the provider would have to assign a nurse as service coordinator for those instances when a consumer had a medical problem that needed to be addressed.

It is imperative that consumers understand their responsibility to report to the service coordinator any changes in their condition and social support as they occur. The workgroup was concerned about the frequency with which these changes in service needs occur within the elderly population, with whom the consumer-directed model of service has been rarely used. DMAS statistics regarding the frequency with which changes in plans of service are currently made show that 94% of all the persons over age 55 and 92% of all non-elderly persons who receive Personal Care have 2 or less changes in their plan of service per year. Despite the consumer's responsibility to direct their own services, the program will require the service coordinator to make periodic home visits to reassess and authorize revisions to the plan of service as changes in condition and social support are reported.

There is an increased risk that without the presence of the RN Supervisor in the home routinely, the consumer's condition might improve and not be reported. This could result in the plan of service not being decreased, resulting in overutilization of services. However, given that the average plan of service change is only twice a year, it appears that there is probably very little real risk of an increase in overutilization in a consumer-directed service.

REIMBURSEMENT ISSUES

Can consumer-directed services be provided at a cost that is equal to or less than the cost of the current agency-directed model of service? The Workgroup believes it can. A consumer-directed service eliminates much of the administrative responsibility that is currently included in the reimbursement rate for the agency-directed personal care service. The hourly reimbursement for a consumer-directed personal attendant can be significantly lower than the current hourly reimbursement for agency-directed service. DMAS can reimburse separately for the service coordination and training for consumers provided. It is estimated that the cost for these two supportive services should fall well within the administrative component of the current rate.

Under the agency-directed model, DMAS reimburses the provider agency $9.50 for every hour of service provided to the consumer ($11.50 per hour for providers in Northern Virginia). Although the wage paid to the aide that provides the service varies, on average the aides receive between $5 and $7 per hour (this average includes the average wage paid in Northern Virginia which is significantly higher than that paid in the rest of the state). Most provider agencies do not offer aides any benefits, although some agencies do offer stipends for transportation and additional pay for holidays and weekends. The additional $4.50 or more per hour that the agency receives for each hour of personal care provided to each consumer is applied toward administrative expenditures which include the cost of providing RN oversight, meeting OSHA requirements, performing a criminal record check and any fiscal agent responsibilities.

In 1993, DMAS completed an analysis of the personal care rate in response to questions raised by the Joint Legislative Audit and Review Commission (JLARC). This analysis estimated the total annual costs to an agency to provide personal care services (based on reasonable staff and administrative costs) and allocated these costs across billable hours. The costs allocated on an hourly basis were as shown on the following page.

From this analysis we see that consumer-directed service should cost at least 6.3% less than agency-directed service (the difference between the portion of the rate ascribed to RN supervision in the agency-directed model and the portion of the rate ascribed to service coordination in the consumer-directed model). In order to assure accountability and better track utilization of service coordination and training services, DMAS would provide a separate reimbursement for service coordination activities and any necessary training for the consumer and/or attendants. The 6.3% savings should provide more than enough reimbursement to cover the cost of the training for consumers and attendant orientation.

Personal Care rate analysis

	ROS	NOVA
* Hourly Costs for Personal Care Aide	$7.18	$ 8.78
** Hourly Costs for RN supervision	$ .76	$ .83
Combined Direct Personnel Costs	$7.94	$ 9.61
*** Overhead as Percent of Direct Costs (12.5%)	$ .99	$ 1.20
Hourly Cost for OSHA & Criminal Records Check	$ .04	$ .04
Total Cost	$8.97	$10.84
Current Rates:	$9.00	$11.00

* This hourly cost is more than is actually incurred by most agencies. The hourly cost for the aide, for rest of state, was calculated based on 125% of the minimum wage for an average hourly wage of $5.31, (156% of minimum wage was used for NOVA). A total annual cost for the aide was calculated assuming a salary for 2,080 hours per year, plus FICA, insurance cost at $100 per month, and mileage costs. This annual $13,349 was divided by 1,860 billable hours of personal care (salaried hours minus 128 hours of travel time, 40 hours paid leave and 52 hours administrative time) to obtain $7.18 per hour.

** The hourly cost for RN services was calculated at a annual rate of $28,021 plus FICA, insurance and mileage. The number of billable hours was calculated at 18 home visits within a year (only 12 are required, but 6 extra were allowed for additional visits to the home for problems which may occur) consuming 2.5 hours of the RN's time per visit for an average of 45 hours per consumer. Assuming 1,880 available hours per year (working hours minus 80 hours of annual leave, 80 hours of holiday leave and 40 hours of sick leave), and 45 hours per consumer, the average caseload that could be covered by the RN would be 41.77. The average hours per week received by a consumer is 20, therefore the average hours per year per consumer is 1,040. Therefore, the annual billable hours per RN caseload is 41.77 x 1040 or 43,449. The annual RN cost of $33,287 was then divided by 43,449 billable hours per average caseload to get an hourly cost of $0.76.

*** The administrative overhead is based on the percent distribution of home health costs where 12.41% of the costs are for office supplies, rental and other space costs and miscellaneous administrative costs. Additionally, an hourly cost for criminal record check and OSHA cost were added.

This analysis shows that the cost of providing RN supervision accounts for 8% of the overall reimbursement fee. In the consumer-directed model (assuming a model similar to Pennsylvania's), there is no requirement for RN Supervision, but there is a requirement for at least 1 visit a year from a "service coordinator". Data available on the frequency with which consumers experience a need for a change in their plan of service shows that 94% of all consumers have two or fewer changes in their plan of service per year under the current agency-directed service. In the consumer-directed service, we assume the service coordinator conducts an average of 4 visits to the consumer per year for the required visit and to respond to the changing needs of the consumer. Applying the same methodology as for the earlier analysis, we project that the cost for the service coordinator would decrease from 8% of the rate (the portion of the rate ascribed to RN supervision in the agency-directed model) to 1.7% of the hourly rate (the portion of the rate ascribed to service coordination in the consumer-directed model).

In a consumer-directed service where the consumer is the employer and the fiscal agent handles only the payment issues, we don't believe that the state requirement for a criminal record check and the OSHA requirements would apply. We have requested

clarification from the Attorney General on this issue. The cost for meeting these requirements is very minimal when spread across the billable hours and subsumed within an hourly rate. The fiscal agent responsibilities accounted for in the 1993 analysis as overhead at 12.5% of direct personnel costs would still exist in the consumer-directed model.

The actual hourly rate for consumer-directed service will have to be determined if the decision is made to offer a consumer-directed model. The 1993 analysis is provided to show that the rate for consumer-directed service can be reasonably set at a rate which is less than that paid for agency-directed service. The provider community does not, as a whole, agree that the current rate, which was increased 5.5% from the 1993 rate, is adequate to cover the cost of providing personal care services in an agency-directed model. The Virginia Association of Home Care has commissioned a study by Virginia Commonwealth University's Survey Research Laboratory to clarify the cost of providing Medicaid waiver personal care. Despite arguments that the current rate does not cover the cost of providing personal care, the number of consumers and the number of hours of personal care provided increases steadily each year. It is reasonable to project that there will be agencies that are interested in providing consumer-directed services for a reimbursement rate that is less than the current agency-directed rate given the decreased overhead required by the consumer-directed model.

Employment Tax and Benefit Liability Issues

One of DMAS' primary concerns about a consumer-directed model of home care has been what the World Institute on Disability and American Bar Association Commission report calls "the 'Hot Potato' of Employerhood". When the IRS has held that the consumer was the employer of the personal attendant, but an agency controlled the actual payment of the wages, the agency assumes the employment tax and benefit liability. This liability makes the agency the employer for the purpose of income tax reporting, payment of social security (FICA taxes), federal and state unemployment taxes and worker's compensation. In Virginia, the IRS recently determined that the Department of Social Services was responsible for these administrative responsibilities for its companions, homemakers and chore service workers. Since the Department of Social Services has local agencies that administer service delivery, the responsibility for income tax reporting, FICA taxes and unemployment taxes are the local agency's administrative burden. However, DMAS does not have a local counterpart and is not prepared to absorb the administrative responsibilities this type of arrangement would involve.

Pennsylvania developed a consumer-directed model that utilizes provider agencies that bill the Medicaid agency for services certified by the consumer as provided by the attendant. This provider agency issues checks in the attendants' names but gives the checks to consumers to retain the consumer's role as the true employer of the attendant. The provider agency reports income and pays all income and unemployment taxes. This arrangement is referred to as a fiscal agent model. The federal tax code authorizes the IRS to designate an agent for an employer. This fiscal agent assumes the payroll and bookkeeping duties with respect to federal taxes without assuming the employer role for other purposes. In the World Institute on Disability and American Bar Association Commission report, the authors note that the fiscal agent, or intermediary, presents a more limited and perhaps clearer responsibility for the state or agency serving as the fiscal agent. This fiscal agent model of service should be one on a continuum that recognizes the range of consumer abilities and preferences to self-direct services.

IMPACT ON VIRGINIA'S LONG-TERM CARE SYSTEM

Offering a consumer-directed service as an additional option for Virginia's Elderly and Disabled waiver consumers can have impact on:

* Consumers
* The provider community
* Other agencies providing supportive services to elderly and disabled consumers
* The Medicaid budget

Consumers

Consumer-directed services have a tremendous impact on consumers. Consumers who are capable of and desire to manage their own service benefit psychologically. Consumers who hire, train and supervise their own attendants report less staff turnover, greater flexibility to meet the consumer's schedule and preferences and greater satisfaction with the way that the attendant performs. Consumers are more able to obtain coverage for times that agencies typically have had difficulty covering. Conversely, consumers in a consumer-directed model must assume a great deal more responsibility and have fewer resources when problems arise than a consumer in an agency-directed service. The key to whether the impact on consumers is positive or negative rests heavily on the quality of the initial assessment and informing conducted at preadmission screening, the consumer training provided and, ultimately, on the consumer's ability to be self-directed.

Historically, the consumers who have benefited from the consumer-directed model have been young persons with disabilities within the independent living movement. In the area of gerontology, however, publicly funded services have remained predominantly agency-directed service models. This has created a dichotomous service delivery system. For the disabilities community the focus is on how we can enable persons with disabilities to attain maximum independency whereas, in the gerontology community we focus on how we can take care of people. The perspective offered to the gerontological community by the disabilities community through consumer-directed service helps us to reframe the focus on how we can support a high quality of life for all persons. An older person might prefer a high degree of management and coordination performed by staff in the provider agency. Alternatively, older people might prefer to hire and manage their own personal attendants. Issues of autonomy, choice and self determination are important to both groups and in many cases the same delivery systems can be used by consumers from both groups. Offering a consumer-directed option in Virginia's waiver will be seen as an extremely positive step by both elderly and disabled consumers of these services who wish to have more self direction.

The Provider Community

There are approximately 160 Personal Care providers that have provider agreements with DMAS. Typically, these providers offer a range of services, from home health to companion services to meals on wheels and case management. Any of these agencies could provide the fiscal agent functions described in this consumer-directed service, along with the service coordination, since these are already components of the personal care service. It would cost these agencies no more to provide this more limited type of service.

There are approximately 10 Centers for Independent Living (CILS) that may want to enroll as providers. The CILS are not likely to want to provide the agency-directed model of service in addition to the consumer-directed model. Pennsylvania requires its provider agencies to offer both models of service so that consumers who do not wish to assume full responsibility for the performance of the attendant can choose to have the agency recruit, train, hire, supervise and fire attendants. The Workgroup does not recommend such a requirement in Virginia's program.

Currently, the persons who serve as personal care aides often receive little more than minimum wage, usually receive no benefits and are largely an unstable work force. There is much competition in the marketplace for this type of person. In many areas fast food service jobs pay better than the home care field. A primary advantage of consumer-directed service is that the direct service staff are usually paid somewhat better and there is much less turnover. Typically, personal attendant services programs within the disabilities community report attendants who stay with their consumer employers for years. A consumer-directed program also opens opportunities for employment for persons who have not had the advantage of receiving training programs required by agency-directed service providers. This could specifically benefit the area agency on aging community where efforts are made to employ seniors.

Other Agencies

The Department of Social Services (DSS) and Department for the Aging (VDA) are involved in providing supportive services to adults in the community. DSS has adult protective services workers who are required by Code to investigate when a condition of abuse, neglect or exploitation is reported. VDA is responsible for an ombudsman program which investigates complaints regarding community services to elderly persons in the community. In the event that the elderly and disabled persons receiving consumer-directed service experience difficulties that they are not able to manage, these two agencies could experience an increase in demand for services. Currently, the provider agencies' role is to handle problems and coordinate services. In a consumer-directed service, the fiscal agent's role does not extend beyond annual reassessment and plan of service authorization responsibilities. The degree to which the involvement of local DSS and VDA or its designee increases will be directly related to how well the preadmission screening assessors provide informed choice and consent to potential consumers.

Another impact to these two agencies is their potential involvement as trainers for consumers and providers of orientation to attendants. We believe that the model developed by DRS where a person with a disability serves as the trainer for consumers with a disability should be extended into the elderly community. In that way, local DSS and the local Area Agencies on Aging could serve to train the trainers for either or both populations.

DRS currently provides supportive and direct services to the disabilities community. Some persons currently served by DRS and supported by DRS' budget may also be eligible for Medicaid services but have refused those services because a consumer-directed model is not available. These consumers may opt now for Medicaid consumer-directed services. This is discussed more in the next section.

The Medicaid Budget

A review of our current Personal Care services population shows that approximately 18.8 % of the persons in this waiver are non-elderly, physically disabled persons. Since no state has experience offering a consumer-directed model to elderly waiver participants, it is impossible to anticipate what portion of Virginia's elderly population would be interested in a consumer-directed model. For purposes of this study, we arbitrarily projected that 90% of the non-elderly physically disabled population without cognitive impairment will choose consumer-directed services and that 20% of the elderly population without cognitive impairment will choose consumer-directed services.

In FY'96 a total of 9,933 persons are expected to receive Personal Care services. Approximately 30% of these persons can be estimated to have some cognitive impairment. Applying the above estimates we see that there could be a potential for as many as 1,176 persons with disability and 1,613 elderly persons who might choose consumer directed services. This may be an overstatement of the use of consumer-directed service, especially in the first year's implementation.

There is a possibility that offering a consumer-directed model will encourage entry into the waiver of a population that previously chose not to participate in the waiver, even though they met programmatic and financial eligibility criteria. This might include some portion of the population currently served by DRS through its PAS program. For purposes of this study, we will project that an additional 100 non-elderly persons with disability will enter the waiver as a result of incorporating the consumer-directed model. This represents approximately half the population currently served by DRS and another 50% who are not served but would present if DMAS offered a consumer-directed service. This too, may be an overestimate.

From the earlier discussion of reimbursement, it was projected that consumer-directed service should cost at least 6.3% less than agency-directed service and that this savings should provide more than enough reimbursement to cover the cost of the training for consumers and attendant orientation. The average personal care per capita

expenditure projected for next fiscal year is approximately $6,709. A savings of 6.3% equates to $835 per person. It is anticipated that the cost for consumer training will average no more than $80 per person. The additional cost to the program of absorbing the anticipated 100 non-elderly persons with disability currently served by DRS is $670,900. The $755 per person savings more than covers this additional expenditure.

The Workgroup proposes that DMAS explore ways to reinvest any cost savings realized through use of consumer-directed service to improve the viability of the home care delivery system. One way to improve the service delivery system is to improve the stability of the workforce. DMAS can explore the possibility of using some portion of the savings and attendant reimbursement to use as payment for insurance premiums for this segment of the working poor. The advantages to this rather large group of health care workers, who themselves have no health care coverage, could have a ripple effect benefiting many segments of the health care system.

FINDINGS AND RECOMMENDATIONS

This report presents the findings of the Workgroup related to the advisability of offering a consumer-directed model of Personal Care service. The Workgroup concurs that Virginia could amend its Elderly and Disabled waiver to offer consumer-directed service, for some segment of the population that accesses this home and community-based waiver, as an alternative to the agency-directed model currently available. These findings were made in relation to the impact this model of service would have on the long-term care system and specific concerns regarding quality of service, utilization control and monitoring, liability and reimbursement issues. The recommendations made in this report are in no way intended to fully outline all the details which must be addressed in an implementation of consumer-directed service. These recommendations were also developed without regard to Congressional Medicaid reform, which could impact specific aspects of the design of community-based services. Implementation of these recommendations should be considered in conjunction with the implementation of any Medicaid reform.

Recommendations

⇒ Virginia should offer a consumer-directed model of service to elderly and disabled persons age 18 and over, who have no cognitive impairment and are able to communicate sufficiently to hire, train and provide instruction regarding their needs to attendant staff. The model developed by Pennsylvania can serve as a model.

⇒ This consumer-directed model of service should be offered in conjunction with the agency-directed service model already in place.

⇒ The Medicaid program should use agencies (e.g., providers of home health, personal care, centers for independent living, etc.) to serve as fiscal agents for the consumer-directed service. The IRS recognizes the fiscal agent as an appropriate intermediary for purposes of income tax reporting, payment of social security (FICA taxes), federal and state unemployment taxes.

⇒ The Department of Medical Assistance Services (DMAS) should provide training to the pre-admission screening assessors regarding when the option of consumer-directed service is appropriate. DMAS should also develop clear and simple written communication that outlines the consumer's risks and responsibilities and defines the role the fiscal agent agency plays in a consumer-directed model. This is necessary to minimize the possibility that the consumer underestimates the degree of individual responsibility he or she assumes in this model. There must also be documentation that the consumer has been apprised and understands all rights, responsibilities and risks of managing the personal attendant service and has made an informed choice to assume those risks.

⇒ The consumer-directed program should include training for the consumer that assures that the consumer understands how to manage his or her service. The ideal source for this training is other consumers.

⇒ The requirements for attendants in the consumer-directed model should be: an ability to read and write, a minimum age of 18 years, and willingness to submit to a criminal record check. Although there would be no formal training or education requirements, every attendant should be provided information to assure appropriate introduction to the philosophy of consumer-directed service.

⇒ The fiscal agent should be required to employ or contract with a service coordinator who is responsible for completing periodic reassessments and for authorizing the initial service plan and any subsequent changes in the consumer service plan.

⇒ DMAS should initiate a toll-free consumer telephone line to respond to consumer issues and as a way for someone in the community to communicate concern about a specific consumer's service that may indicate needed follow-up from a service coordinator.

⇒ Reimbursement for the attendant services should include a rate sufficient for the payment of wages, FICA, taxes and a reasonable administrative overhead to the fiscal agent. There should be a separate reimbursement for service coordination and a separate reimbursement for training.

⇒ The attendant should be considered as a physical extension of the consumer's body, compensating for parts of the consumer's own body which no longer function. The mentally alert consumer is completely in control of his or her own service. Therefore, the attendant should be able to provide, at the consumer's direction, any service need without restriction.

⇒ DMAS should explore ways to reinvest any cost savings realized through use of consumer-directed service to use as payment for health insurance premiums for the aides and attendants who provide the direct service. This could improve the viability of the home care delivery system by improving the stability of the workforce.

APPENDIX I

House Joint Resolution 539

LD8836761

HOUSE JOINT RESOLUTION NO. 539

Offered January 23, 1995

Requesting the Department of Medical Assistance Services to evaluate the feasibility and advisability of amending the Elderly and Disabled Waiver to allow individuals to hire their own personal attendants.

Patrons—Mayer, Diamonstein and Heilig; Senators: Miller, Y.B. and Woods

---

Referred to Committee on Rules

WHEREAS, the Department of Rehabilitative Services currently operates a Personal Attendant Service Program in which the consumer hires his own aide and is reimbursed by the Department for the cost of the care rendered, and the results of this arrangement have been positive for both the Commonwealth and the consumer; and

WHEREAS, the Department of Medical Assistance Services recently amended the waiver for persons with mental retardation to allow those individuals residing in nursing facilities who have developmental disabilities and who are served by the Department of Rehabilitative Services to hire their own personal aide after demonstrating their ability to manage and supervise the performance of that aide; and

WHEREAS, the Department of Medical Assistance Services has the option to (i) continue to contract only with agencies for the provision of personal care for other eligible clients, (ii) pay for services offered by individuals rather than agencies, or (iii) offer both options, which would be available based on the consumer's ability to manage their own care; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Medical Assistance Services evaluate the feasibility and advisability of amending the existing Elderly and Disabled Waiver to allow for the same range of options currently available to persons with developmental disabilities for the hiring of their own personal attendants.

The Department of Medical Assistance Services shall provide staff support for the study. All agencies of the Commonwealth shall provide assistance to the Department, upon request.

The Department of Medical Assistance Services shall complete its work in time to submit its findings and recommendations to the Governor and the 1996 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for processing legislative documents.

LD8836761

HJ539

1/23/95 22:45

Official Use By Clerks

Passed By The House of Delegates		Passed By The Senate	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐
Date: _____		Date: _____	
Clerk of the House of Delegates		Clerk of the Senate	