Independence Plus
Frequently Asked Questions

Q1. Why has CMS developed these program initiatives?
The Independence Plus initiative assists States to achieve the goals established in President Bush's New Freedom Initiative. The President's initiative is intended". .. to ensure that all Americans have the opportunity to live close to their families and friends, to live more independently, to engage in productive employment and to promote community life." - President George W. Bush, Executive Order 13217.

Many State officials representing long term care populations have encouraged CMS to explore options related to self-direction. For example, a recent survey of State Medicaid Directors, Mental Retardation/Developmental Disabilities Administrators and Vocational Rehabilitation Administrators indicated that 69% of the responding administrators were interested in advancing self-directed programs for persons with disabilities and 64% supported self-directed programs for older persons. State officials expressed concern that complex Medicaid laws present barriers to promoting self-directed programs. They requested the Centers for Medicare and Medicaid Services (CMS) simplify the process for States to establish or amend Home and Community-Based Services (HCBS) and other waiver programs. In response, CMS developed the Independence Plus initiative.

The initiative is intended to:

- Delay institutional or other high cost, out-of-home placement by strengthening supports to families or individuals, thereby permitting the individual with a disability to live with their family or in their own home.
- Recognize the essential role of the family or individual in the planning and purchasing of health care services and supports by providing control over an agreed upon resource amount.
- Facilitate cost effective decision-making in the purchase of supports and services.
- Increase family and individual satisfaction by facilitating control and choice, concepts expressed by participants in a National Listening Session - New Freedom Initiative.
- Facilitate the States' abilities to meet legal obligations under the Americans with Disabilities Act (ADA) and the Supreme Court Olmstead decision.

Q2. Why are two different templates provided (§1915(c) and §1115)?
The §1915(c) Waiver and §1115 Demonstration Applications have different approaches and distinctly different authorizing provisions of the Social Security Act. States should review their intended goals and objectives to determine which option best suits their proposed program design. The chart below compares the two application approaches:

Issue	**Section 1115 Demonstration Authority**	**Section 1915(c) HCBS Waiver Authority**

Cash Allowance	Participants may manage the cash allowance directly	Participant does not manage cash allowance directly
Hiring legally responsible individuals	States may hire legally responsible individuals	States may hire legally responsible individuals
Provider Agreements	Provider agreements may be waived	Provider agreements must be executed
Direct payment to providers	Direct payments by the Medicaid agency to providers may be waived	Direct payments by the Medicaid agency to providers may be waived
Payment for services made prior to delivery of services	Services may be reimbursed prior to delivery	Services must be delivered prior to payment
Level of Care	Level of care may vary	Individuals meeting institutional level of care
Services which may be self-directed	State plan or HCBS services	HCBS services only
Combining populations	States may combine any population	Combining populations is limited: • Aged/disability • Mental retardation/developmental disability • Mental illness, or • Any subgroup thereof

Q3. What is new or innovative about this initiative?
This initiative provides guidance and assistance to States wishing to implement programs to support the self-direction of services and supports by persons with disabilities and their families.

Q4. What is meant by "self-direction"?
Self-direction refers to a service delivery system whereby families, elderly persons or persons with disabilities have control and choice in identifying, accessing and managing the services they obtain to meet their personal assistance and other health related needs using an individual budget. CMS defines a self-directed program as a State Medicaid program that presents participants with the option to control and direct Medicaid funds identified in an Individual Budget. Independence Plus programs are required to have the following elements

- Person Centered Planning,
- Individual Budgeting,
- Self-Directed Supports, and
- Quality Assurance and Improvement

Q5. Can anyone self-direct?
CMS is committed to the philosophy that everyone can direct their own care regardless of their level of disability. All people have the basic right to decide how services and

supports will be delivered, who will deliver them and the goals that will be achieved as a result. The specific supports built into a self-direction, including person-centered planning, individual budgeting, supports brokerage and quality management ensure that the principles of participant choice and control are honored.

Q6. Has DHHS permitted or approved this type of service delivery system previously?

Yes. CMS has approved several Independence Plus projects through 1915(c) and 1115 waiver authorities. **LINK TO ANITA'S TABLE**. There are eleven (11) approved Independence Plus programs in ten (10) States (NH, SC, FL, LA, NC (2), CA, MD, DE, NJ, and CT). Collectively, these States permit 34,456 individuals with long term care needs to self-direct their services. Additionally, CMS awarded $5.4 million in Real Choice Systems Change grants to twelve (12) States (CO, CT, FL, GA, ID, LA, MA, ME, MI, MO, MT, OH) to develop Independence Plus programs. Numerous other States are in the planning stage.

The National Cash and Counseling Demonstration and Evaluation Project, cosponsored by DHHS and the Robert Wood Johnson Foundation (RWJF), operated in the States of Arkansas, Florida and New Jersey under the authority of § 1115 of the Social Security Act. These demonstrations used an experimental approach to randomize enrollees into a treatment or control group. Treatment group participants included elderly and younger Medicaid beneficiaries with significant long-term functional disabilities; family caregivers serve as representatives, if necessary. Participants in the Cash and Counseling Demonstrations self-directed their personal assistance services. They used a cash allowance to purchase services or items needed to meet their personal care needs. An equal number of recipients were randomized into a Control Group. The control group participants remain in the traditional service delivery program. The evaluation compares the level of satisfaction, utilization and expenditures between the two groups – **LINK TO THE CASH AND COUNSELING WEBSITE**.

Similarly, nineteen pioneer States developed "self-determination" programs as a result of a Robert Wood Johnson Foundation National Program grant. The Self-Determination programs generally operate under the § 1915(c) authority and emphasize "freedom, authority, support and responsibility" for participants. While Cash and Counseling is a Medicaid Demonstration Program with a major emphasis on research design, the emphasis in the Self-Determination initiative is on experimentation of program approaches. Thus a diverse array of program and research outcomes are being realized through the Self-Determination projects.

Q7. Are States required to provide matching funds?

Yes. This initiative is part of Medicaid and must comply with basic Medicaid requirements. The Federal Government matches expenditures according to the State's Federal Medicaid assistance payment rate.

Q8. How should a State proceed if it wishes to amend an existing 1915(c) Waiver or §1115 Demonstration to incorporate one of the elements of self-direction (e.g..

Financial Management Services. Individual Budget or Supports Brokerage)?
States wishing to add one of the new self-directed components prior to the renewal period should contact CMS to discuss the anticipated changes. To understand fully the proposed templates if they wish to obtain an expedited Federal review. Further, by using the template format, States are assured that Federal compliance criteria are identified.

Q9. How does the Independence Plus Initiative assure State fiscal accountability?
Use of the Independence Plus §1115 Demonstration or the §1915(c) Waiver application maintains State fiscal responsibility by continuing to require States to meet statutory or regulatory requirements. Budget neutrality policy for the § 1115 Demonstration limits Federal expenditures so that they do not exceed the levels that would have been realized had there been no demonstration. The similar requirement for the § 1915(c) version is cost neutrality, which requires Federal funding to be no more than the institutional costs that would have been incurred for waiver participants. In addition, States must ensure the availability of Financial Management Services and options for self-directed supports for the individual.

Q10. Are the Federal requirements for safeguarding the health and welfare of program participants the same for self-directed programs?
Yes, the federal requirements are the same for both service delivery methods; however, the process by which States meet the requirements may differ. In order to comply with Federal mandates, traditionally managed programs implement a system of checks and balances to establish certain safeguards in their home and community-based service delivery systems. Generally, these systems involve: I) establishing specific provider standards, such as requiring staff certifications and training; 2) assigning contractual obligations and assurances to providers clearly delineating responsibility; 3) outlining expectations through detailed State policies and regulations; and 4) performing routine provider reviews and audits to ensure contractual obligations are met and policy is followed.

Self-direction represents a divergence from the traditional approach in that many of the responsibilities assumed by provider agencies are transferred to the individual or family. Therefore, under self-direction, the establishment of certifications, standards, policies regulations, reviews and audits alone, may prove insufficient to meet the requirements of the law. For example, requiring strict licensure and certification standards for service workers under self-direction may severely limit a program participant's ability to select the service worker of his /her choice.

The Independence Plus template format, then, offers new ways to meet the Federal requirements to assure that sufficient safeguards are in place to protect the health and welfare of persons selecting the self-directed option.

Q11. How does the Independence Plus initiative assure the health and welfare of the individuals who choose to self-direct?
Assuring the health and welfare of individuals under a self-directed service model is accomplished using many traditional mechanisms and many uniquely identified to self-

direction. The Independence Plus Template Applications recommend to States the following as sufficient safeguards:

Elements of Self-Direction
Drawing heavily from the insights gathered in implementing self-directed programs, CMS has identified four elements associated with a successful self-directed program. These include:

- Person Centered Planning,
- Individual Budgeting,
- Self-Directed Supports, and
- Quality Assurance and Improvement

The essential elements are applied to each Independence Plus program.

Person-Centered Planning
Person-centered planning is a process, directed by the participant, with assistance as needed from a representative. It is intended to identify the strengths, capacities, preferences, needs and desired outcomes of the participant. The process may include other individuals freely chosen by the participant who are able to serve as important contributors to the process.

The person-centered planning process enables and assists the participant to identify and access a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally-defined outcomes in the most inclusive community settings. The identified personally-defined outcomes and the training, supports, therapies, treatments and/or other services become part of the person-centered plan.

The Individual Budget
The individual budget is the total dollar value of the services and supports, as specified in the plan of care, under the control and direction of the program participant. While States have the discretion to include both Medicaid and non-Medicaid funded services and supports in the individual budget, there must be a clear audit trail delineating the Medicaid funding stream. An individual budget is not and expenditure cap on the amount of services an individual may receive under the waiver. An individual must receive all medically necessary services and supports provided under the waiver.

The State should assure that the individual budget is:

1. developed using a person-centered planning process;
2. based on actual service utilization and derived from reliable data, preferably the State's Medicaid Management Information System (MMIS)
3. developed using a consistent methodology to calculate the resources available to each participant;
4. open to public inspection, and
5. reviewed according to a specified method and frequency.

Further, the State must describe how the participant and/or representative are informed of the following:

1. the methodology used to calculate the individual budget;
2. the total dollar value of the services authorized;
3. any policies that apply to the participant's management of the individual budget; and
4. the procedures that he/she must follow in order to request an adjustinent of the individual budget.

Self-Directed Supports

Under the Medicaid self-direction option, States are required to develop a system of activities that assist the participant to develop, implement and manage the support servies identified in his/her individual budget. Generally, these activities link the participant with community resources and enhance personal skills.

The extent to which the participant uses the supports may vary with his/her abilities and preferences. States should assure a range of supports and services to respond to participant capacity and preference for self-direction.

States may design these support activities in a variety of ways including: 1) combine with existing services, 2) create a new service category to include all or some of the activities, or 3) identify as an administrative function.

Generally, self-directed support activities fall under three general categories:

1. Information regarding system processes, individual rights and resources
2. Assistance with planning, budgeting and managing self-direction
3. Assistance with Financial Management Services

The State should assure that the above activities are available to each participant electing to self-direct some or all of his/her services and supports.

Self-Directed Quality Assurance and Improvement

The self-directed quality assurance and improvement model will build on the existing foundation formally introduced under the CMS Quality Framework in the State Medicaid Director's Letter of August 29, 2002 **(LINK TO LETTER)** and subsequent correspondence. By way of summary, the framework delineates the functions of quality:

- Design. - designing quality assurance and improvement strategies into the home and community-based program at the initiation of the program.
- Discovery - engaging in a process of discovery to collect data and direct participant experience sin order to assess the ongoing implementation of the program, identifying both concerns as well as other opportunities for improvement.
- Remediation - taking actions to remedy specific problems or concerns that anse.

- Improvement - utilizing data and quality monitoring to engage in actions that assure continuous improvement in the self-directed program.