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The Medicaid Personal Care Services Benefit: Practices in States that Offer the Optional State Plan Benefit

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The AARP Public Policy Institute, formed in 1985, is part of the Policy and Strategy Group at AARP. One of the missions of the Institute is to foster research and analysis on public policy issues of importance to mid-life and older Americans. This publication represents part of that effort.

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Foreword

As our nation's long-term care system matures, there is a growing emphasis on the delivery of long-term services and supports in the home and community-based settings that most people prefer. The dominant delivery vehicle has been the *Medicaid waiver* program, which currently provides services to older people and other people with disabilities in every state. Also important, however, is *Medicaid's optional personal care services (PCS) program*, which uses different rules to provide assistance to people with disabilities.

While data on state spending on PCS programs have been available, little has been reported on who receives these benefits. The AARP Public Policy Institute (PPI) was interested in learning more about the characteristics of older beneficiaries who receive services under the PCS option. Only by more fully understanding the choices that states make in choosing one program over another, and for what types of beneficiaries, can we fully analyze and understand the various state long-term care systems.

PPI asked the Georgetown University Health Policy Institute to survey the states that offer the PCS programs to older people. In addition to learning more about the beneficiaries, we sought detailed information about program expenditures, services offered, and the types of service providers used in these programs.

Given the variation in state long-term care systems and the complexity of options that states use to provide services, we believe this report makes a valuable contribution to understanding an important piece of the overall long-term care framework.

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Acknowledgments

The authors would like to thank the state officials who were very generous with their time and expertise as they responded to the survey and provided clarifications afterward. We also received helpful comments from Risa Elias, Charlene Harrington, and Martin Kitchener, whose knowledge and insights contributed to an improved product. Finally, we are grateful to Enid Kassner at AARP's Public Policy Institute for her helpful support, guidance, and comments.

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Background

"Personal care services" (PCS) is a term generally used to describe the type of "hands-on" or individualized assistance with everyday activities that some people with disabilities need in order to live independently in the community rather than in an institutional setting. Many people with long-term care needs rely on informal help from family and friends for personal care. Individuals with limited sources of informal help often must turn to paid sources of care. Some people pay out of pocket for these services; others rely on public programs to help finance them.

Sources of public funds for personal care services include Social Services Block Grants, Older Americans Act funds, state and local government funds, and the Medicare and Medicaid programs, with Medicaid paying for the bulk of publicly financed home and community-based care, including personal care services. The Medicaid program offers three pathways for personal care services for adults. All states must offer home health care, which may include unskilled personal care services. States also have the option of providing personal care services through Medicaid home and community-based (HCBS) waiver programs. And states have the option of providing personal care services as a state plan benefit. At present, 26 states and the District of Columbia offer the optional state plan personal care services benefit for adults.

Purpose of This Report

In designing their long-term care systems, states attempt to provide services and supports to meet the needs of people with disabilities. Generally they must work within constrained budgets, and they must consider the sources of available funds and the program rules associated with the funding. Decisions about the financing and delivery of particular services, such as PCS, can have an impact on the nature of the services available; who receives services; where, when, and how the services are available; and ultimately whether it is possible for some people to live independently in the community. The purpose of this report is to provide policymakers and other interested parties with current descriptive information about how the Medicaid optional personal care services benefit is used in a number of states. While data on spending for these programs have been available, little information has been available about the characteristics of beneficiaries. This report attempts to provide a more thorough understanding of the PCS programs.

Methods

Georgetown University's Health Policy Institute was asked by the AARP Public Policy Institute to conduct a survey about the Medicaid optional personal care services benefit. The two organizations worked collaboratively to develop the survey instrument, which

was pretested and then sent, in June 2004, to Medicaid directors in the 26 states and the District of Columbia that offer the PCS benefit for adults.

Principal Findings

Twenty-three states and the District of Columbia (henceforth referred to as a state) responded to the survey, for a total of 24 respondents. Two states – Alaska and West Virginia – declined to participate in the survey. California provided information only about the number of beneficiaries and spending for the benefit, raising the total number of respondents in those categories to 25. Data on the number of beneficiaries and program expenditures are for 2003; all other data in the report are for 2004.

Beneficiaries

- Respondents from 25 states reported that almost 700,000 beneficiaries of all ages received personal care services in state fiscal year 2003.
- Only five respondents had sufficient data to provide complete information about the composition of the population receiving PCS benefits by category. In all five states – the District of Columbia, Montana, North Carolina, Oklahoma, and South Dakota – the largest proportions of beneficiaries were in the elderly category.

Program expenditures

- Reported expenditures for the PCS benefit in 25 states totaled $6.3 billion.
- There is substantial variation in expenditures for the program across the states, reflecting the size of the programs and the design of the benefit. The range was from $2.2 billion in California to $661,000 in New Hampshire.
- Estimates of the cost per beneficiary for the PCS benefit ranged from more than $10,000 in eight states – Massachusetts, Minnesota, New Hampshire, New Jersey, New Mexico, New York, Washington, and Wisconsin – to less than $1,500 in Oregon and South Dakota.

Eligibility determinations

- The need for assistance with activities of daily living is the criterion used most commonly to assess functional eligibility for the PCS benefit.
- Other assessment criteria include the need for assistance with instrumental activities of daily living (IADLs), the presence of medical conditions, evidence of cognitive impairment, and the need for a certain number of hours of assistance.
- Most states use a system that takes one or more of the criteria into account.
- More than three-quarters of respondents – 79 percent, or 19 states – report that the functional eligibility criteria for the optional PCS benefit are less restrictive than the criteria used for nursing facility admission in the state.

Authorization of services

- Different types of health professionals can authorize services. About 21 percent of the respondents (five states) indicate that physicians are the only health professionals who can authorize personal care services. Another 29 percent (seven

states) permit authorization by physicians or other professionals. Professionals other than physicians authorize services in the remaining states.

Settings for service delivery

- Four states – 17 percent – report that personal care services can be provided only in the home. Other respondents note that the services can be provided in community-based residential settings and in other settings where the need occurs, such as in the workplace, at a relative's home, or at a senior center. Only two states – Arkansas and Nebraska – report that personal care services are provided in adult day care settings.

Covered services

- States were asked to indicate whether assistance with particular activities was covered under the optional PCS benefit. Each of the states provides help related to bathing, dressing, toileting, and laundry, and most cover assistance with eating, transferring or positioning, ambulation, grooming, shopping, housekeeping, and meal preparation.
- Assistance with medication management is also common, provided by 17 states, or 71 percent.
- More than half of the respondents – 13 states, or 54 percent – cover supervision or cuing.
- It is important to note that because each state has a unique mix of home and community-based services, some types of assistance not covered under the optional PCS benefit may still be available to Medicaid beneficiaries through waiver programs or separate state-funded programs.

Service limits

- Some 63 percent of respondents – 15 states – say that the state limits the number of hours of service that can be provided. States differ with regard to how the hours of services are limited: on a weekly, monthly, or annual basis.
- Only 25 percent of respondents – six states – report that they place a cap on the cost of services for individuals.
- In four of the states – Maine, Maryland, Minnesota, and Missouri – the cost cap differs depending on the level of care needed.
- Three states – the District of Columbia, Maine, and Texas – use both hourly limits and cost caps to control service use by individuals.
- Maine is the only state that charges beneficiaries copayments for services.

Training and certification of personal care workers

- Most states – 88 percent, or 21 states – provide training for personal care workers, but the type of training differs.
- Some 29 percent of states – seven states – require that personal care service workers be certified. All seven of these states train the workers.

Provider supply

- Some 67 percent of respondents – 16 states – report a shortage of personal care workers in the state.
- One way that states have responded to the problem of provider shortages is to allow family members to be paid as personal care providers. Three-quarters of states – 75 percent, or 18 states – allow family members to be paid personal care providers. They include 12 of the 16 states that report provider shortages.
- All 18 states that allow family members to be paid as personal care providers require the family members to have the same qualifications and training as nonfamily providers.

Consumer direction

- Overall, 71 percent of states – 17 states – allow consumer direction for the personal care services benefit. Of those, only three states – Minnesota, New Jersey, and Texas – give consumers the discretion to purchase services within an individual budget.
- In general, the methods used to determine whether consumers are capable of directing their care are not strictly prescribed. A number of states report that a determination is made during the initial assessment process. Other states note that if there is a request for self-direction, the focus is on whether the individual or a representative will direct the care.
- The extent to which consumers have control over the set of tasks associated with consumer direction varies by state. Generally, consumers participate in preparing service plans and in screening, training, and supervising personal care workers. It is less common for consumers to negotiate compensation or to be directly involved in paying providers.
- States have procedures in place to monitor care and to ensure that the service plan will be adjusted if there is a change in the health status of consumers who are directing their own care. Consumers, family members, and providers are asked to report changes in conditions or needs.
- Most states also report that monitoring – such as visits by counselors or case managers – occurs either annually or every six months. The type of monitoring and the frequency with which monitoring occurs varies by state, and within states may vary by individual.

Conclusion

Personal care services are vitally important to many people with disabilities who wish to remain in the community but need assistance with everyday activities. All states use a variety of sources of public funding to finance personal care services, but the Medicaid program is by far the largest source of funding. With the trend toward providing more community-based care as an alternative to institutional care, the optional Medicaid PCS

benefit continues to play an important role in ensuring that people with disabilities can remain in the community.

Personal care services, like all optional Medicaid services, may receive more scrutiny as states face potential budget shortfalls. It is important to note, however, that when the provision of personal care services allows people to live independently, the cost of providing care is generally lower, on an individual basis, than the cost of institutional long-term care. The need for community-based care will likely continue to grow as the population ages. States that offer the personal care services benefit, as well as other long-term care benefits, have flexibility in providing a range of community-based long-term care services to meet the needs of a diverse population.

Introduction

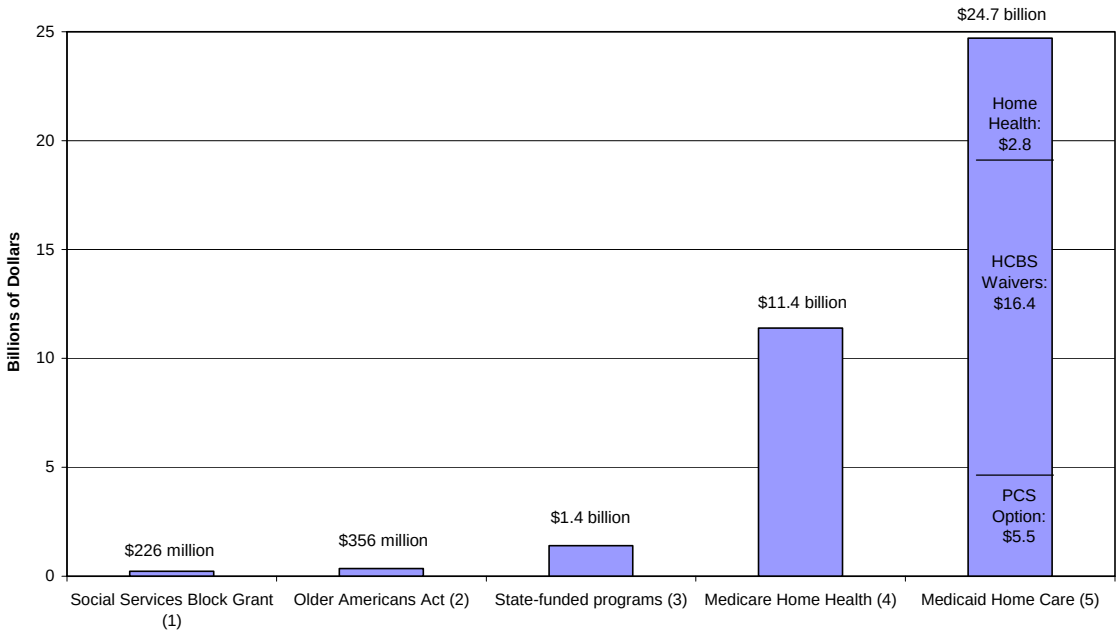
Individuals with long-term care needs often require an array of services to help them with basic daily activities. Within the range of long-term care services is a set of services, generically called “personal care.” The term generally refers to “hands-on” or individualized assistance with activities of daily living (ADLs) such as eating, bathing, dressing, toileting, and transferring to or from a bed or chair, and may also include instrumental activities of daily living (IADLs) such as shopping, preparing meals, managing money, using the telephone, and housecleaning. Skilled or unskilled medical care is not included in the definition of personal care. Personal care services (PCS) are essential for many individuals with disabilities who want to live independently in their homes or in the community.

Many people with long-term care needs rely on informal help from family and friends for personal care, but individuals with limited support must often turn to paid sources of care. Some people pay out of pocket for these services; others rely on public programs to help finance personal care services. Several sources provide public funding for personal care services. This report describes the personal care services that are available as an optional benefit for adults through Medicaid state plans. Twenty-six states and the District of Columbia offer the benefit.

Sources of Public Funds for Personal Care Services

Sources of public funds for personal care services include Social Services Block Grants, Older Americans Act funds, state and local government funds, and the Medicare and Medicaid programs. Estimates of the proportion of total spending for personal care services are not available for most of these programs, but a comparison of total spending for home and community-based services shows that the Medicaid program pays for the bulk of publicly financed home and community-based care, including personal care services (see Figure 1).

Figure 1. Sources of Public Funding for Home and Community-Based Care, 2002



SOURCES:
(1) Administration for Children and Families, *Social Services Block Grant 2002* . Represents expenditures for Home-Based Services in Federal Fiscal Year 2002.
(2) Administration on Aging, *FGS FY2002 Annual Allocation* . Represents annual allocation for Supportive Services in Federal Fiscal Year 2002.
(3) Summer & Ihara, 2004. Represents state expenditures for Home and Community-Based Services for State Fiscal Year 2002.
(4) Levit et al., 2004. Represents expenditures for Medicare home health care in Calendar Year 2002.
(5) Burwell, Sredl, & Eiken, May 13, 2003 memorandum. Represents expenditures for Medicaid home care in Federal Fiscal Year 2002.

Social Services Block Grant Funds are federal funds administered through the Department of Health and Human Services and provided to states to help them achieve a wide range of social policy goals. In federal fiscal year 2002, these grants funded home-based services in the amount of $226 million in 35 states (Administration for Children and Families, *Social Services Block Grant 2002*). If personal care services are offered as a benefit, state and local agencies may provide personal care services directly or purchase the services from qualified agencies or individuals (Administration for Children and Families, *Fact Sheet*). The administration and provision of personal care services vary by state and locality.

Older Americans Act Funds are distributed to each State Agency on Aging to be used for social service programs that enable older individuals who are frail or have disabilities to remain independent in their communities (Administration on Aging, *Layman's Guide to the Older Americans Act*). In federal fiscal year 2002, some $356 million was allocated for home and community-based supportive services (Administration on Aging, *FGS FY 2002 Annual Allocation*). States provide a variety of services, including personal care, homemaker services, chore services, home-delivered meals, adult day care, and case management. Federal funds are distributed using a formula based on the state's share of the U.S. population age 60 and older. Local Area Agencies on Aging plan, develop,

coordinate, and arrange for services within smaller geographical areas. Coordination with other state or federally funded long-term care programs varies by state (Kassner 2001).

State-Funded Programs generally supplement home and community-based care programs that are wholly or partially federally funded. States primarily use funds from general revenue, but they also use revenue from tobacco taxes, casinos, and state lotteries for these programs. Funding patterns and services differ considerably among states, but most – 76 percent – of state-funded multiservice home and community-based care programs for older people provide some personal care services. In state fiscal year 2002, states spent more than $1.4 billion to fund home and community-based care programs for older people (Summer & Ihara 2004).

The Medicare Home Health Care Benefit provides limited personal care services under its home health benefit, which are available only to beneficiaries who are homebound, need part-time skilled nursing or therapy services, and are under the care of a physician who directs their plan of care (Murtaugh et al. 2003). Medicare pays for personal care only when there is also a need for skilled care or therapies (Spector et al. 2004). Therefore, individuals who need only personal care services are not covered under this benefit.

Personal care services are generally provided by home health aides. In calendar year 2000, home health aide visits were 31 percent of all home health visits. Home health aide visit charges amounted to $1.9 billion – 20 percent of total home health visit charges (Hoffman et al. 2002). Total spending on Medicare home health care was $9.2 billion in calendar year 2000 (Levit et al. 2002) and $11.4 billion in calendar year 2002 (Levit et al. 2004). Home health aides perform tasks other than personal care, however, and other providers, such as nurses or physical therapists, may include personal care tasks as part of their services.

The Medicaid Program offers three pathways for personal care services for adults.[1] All states must offer *home health care*, which may include unskilled personal care services. Medicaid home health services can be provided to people with a wider range of needs than is possible through the Medicare home health benefit. Medicaid beneficiaries may not be eligible for Medicare home health services, which require that beneficiaries be homebound or require skilled care. Medicaid home health services must be ordered by a physician. Spending for Medicaid home health services, only a fraction of which are personal care services, amounted to about 11 percent of all Medicaid spending for home and community-based services in federal fiscal year 2002.

[1] States are also mandated to provide services through the Early Periodic Screening, Detection, and Treatment (EPSDT) Program, which entitles Medicaid-eligible children under age 21 to necessary services – including personal care – to treat any physical or mental conditions that are identified during a health screening visit. In 1989, the EPSDT mandate was strengthened, requiring states to cover all services, whether or not these services are covered in the state's Medicaid plan. Personal care services are covered under this mandate, whether or not the state provides the PCS optional benefit through its state plan (Smith et al., 2000).

States also have the option of providing personal care services through *Medicaid home and community-based (HCBS) waiver programs*, also known as 1915(c) waivers.[2] The waivers account for about two-thirds of Medicaid spending for home and community-based services. Every state has waiver programs for older people and people with disabilities, and personal care services are available in nearly all HCBS waiver programs (Smith et al. 2000).[3]

States also have the option of providing *personal care services as a state plan benefit*.[4] At present, 26 states and the District of Columbia offer the optional state plan PCS benefit for adults. Spending for the benefit represented about 22 percent of Medicaid spending for home and community-based services in federal fiscal year 2002.

States have substantial flexibility to tailor their services to the needs of the population, using the PCS benefit and HCBS waivers. Several factors may influence states' decisions about which option or options to choose. The personal care services option can be used to provide services to individuals who have functional limitations but do not necessarily meet institutional level of care criteria. Because the PCS benefit is a state plan benefit, however, it must be provided to all categorically eligible Medicaid beneficiaries who meet the functional eligibility requirements. States have the flexibility to define the specific services they will provide under the PCS benefit, but the same services must be available statewide for all eligible beneficiaries (Smith et al. 2000).[5] This means that the state cannot establish waiting lists for personal care services. Under the HCBS waivers, however, states can limit participation to particular groups of beneficiaries.

States may (and generally do) set higher financial eligibility standards for waivers than for regular Medicaid coverage, but functional eligibility criteria are stricter for the waivers; participants must meet institutional level of care criteria. Income eligibility for elderly participants in the PCS program is generally tied to the Supplemental Security Income Program (SSI), which allows beneficiaries to have up to $579 income per month in 2005. Assets generally may not exceed $2,000. Moreover, unlike nursing home eligibility rules and many HCBS waiver programs, state PCS programs may not allow spouses of beneficiaries to retain additional income or assets.

States can cover personal care services through a waiver program, the personal care option under the state plan, or both. There is substantial variation in the use of these two approaches. Some states provide the PCS benefit through their state plan to provide greater access to basic personal care services and then provide additional coverage through waiver programs to specific target populations. Some states use the PCS benefit

[2] HCBS waivers were authorized under §2176 of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (PL 97-35).

[3] Arizona does not have a 1915(c) waiver that serves older individuals because it provides these services under another waiver program, an 1115(c) waiver.

[4] The PCS option was formally incorporated into federal Medicaid law under §13601(a)(5) of OBRA of 1993, which added §1905(a)(24) to the Social Security Act to include payment for personal care services under the definition of medical assistance.

[5] The PCS optional benefit may be provided in any setting except inpatient hospitals, nursing facilities, intermediate care facilities for the mentally retarded, or institutions for mental disease (42 CFR 440.167).

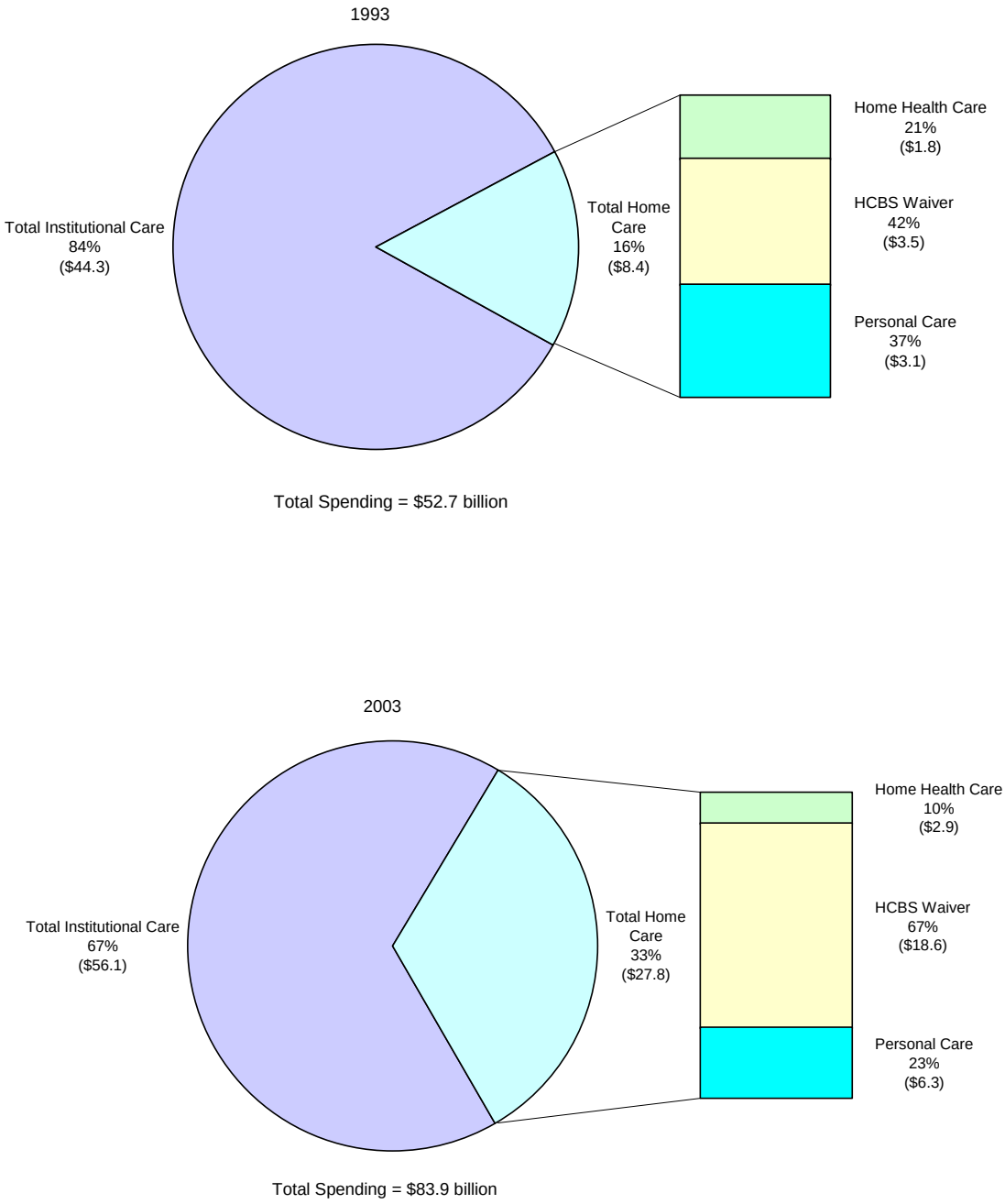
to provide services to those who do not have extensive functional impairments and therefore do not qualify for HCBS waiver programs. States also use the PCS benefit to help individuals who are eligible for HCBS waiver programs but are waiting for an available slot in the program. And states use the PCS benefit in conjunction with HCBS waiver programs as the primary means to deliver personal care to people receiving waiver services (Smith et al. 2000; Wiener et al. 2002).

Medicaid Long-Term Care Financing

State Medicaid programs provide long-term care services for individuals who meet financial and functional eligibility criteria. Medicaid is the primary source of public financing for long-term care (Summer 2003). There has been a substantial shift in the past decade from institutional to home and community-based long-term care. For example, in 2003, the proportion of Medicaid long-term care spending for home care (including personal care, home and community-based waivers, and home health care) was 33 percent, more than twice the proportion spent in 1993. Spending on HCBS waiver programs increased substantially during this period (see Figure 2).

Spending for optional personal care services more than doubled during this period – from $3.1 to $6.3 billion. At the same time, spending for home and community-based waiver services increased more than fivefold, from $3.5 billion to $18.6 billion. Thus, spending for optional personal care services represented a smaller portion of spending for home care in 2003 than in 1993.

Figure 2. Medicaid Spending on Long-Term Care, 1993 and 2003



NOTE: Spending is adjusted for general inflation to 2003 dollars using the Consumer Price Index. Years are federal fiscal years.

SOURCE: Calculations by the Health Policy Institute, Georgetown University, based on data from Burwell, Sredl, & Eiken, "Medicaid long-term care expenditures in FY 2003" (Cambridge, MA: The MEDSTAT Group).

Purpose of This Report

The choices that states make regarding the design of their long-term care systems are complicated. In designing their long-term care systems, states attempt to provide the services and supports necessary to meet the needs of people with disabilities. Generally they must work within constrained budgets, and they must consider the sources of available funds and the program rules associated with the funding. Decisions about the financing and delivery of particular services, such as personal care services, can have an impact on the nature of the services available; who receives services; where, when, and how the services are available; and ultimately whether it is possible for some people to live independently in the community. This purpose of this report is to provide policymakers and other interested parties with current descriptive information about how the Medicaid optional personal care services benefit is used in a number of states. While data on spending for these programs have been available, little information has been available about the characteristics of beneficiaries. This report attempts to provide a more thorough understanding of the PCS programs.

Study Methods

This study provides current descriptive information about the optional personal care services benefit available through Medicaid state plans. AARP's Public Policy Institute asked Georgetown University's Health Policy Institute to conduct a survey about the benefit. The two organizations worked collaboratively to develop the survey instrument, which was pretested in June 2004. It then was sent to Medicaid directors in the 26 states and the District of Columbia that offer the PCS benefit for adults.[6] A copy of the survey instrument is provided in Appendix 1. State officials were given the opportunity to respond by mail or fax, or to complete the survey online. Follow-up calls were made when necessary to clarify survey responses. Respondents were given the opportunity to review their state data tables and verify the information.

[6] Some other sources report higher numbers for PCS programs. The 27 states included in this survey are programs that offer services to adults. Therefore, states that offer personal care services only to children through the EPSDT program are not included. In other studies, states sometimes are identified as offering the PCS benefit because they report expenditures for personal care services. From conversations with state officials, however, it appears that in some cases expenditures are for personal care services that are not provided as a traditional state plan service. Rather, the expenditures are for services offered to a particular group of people, for example, those in residential care facilities. In some instances, personal care services provided through home and community-based service waiver programs may have been reported as state plan service expenditures. Researchers from the Georgetown Health Policy Institute examined programs in 33 states and concluded that 27 were appropriate for inclusion in this study.

Findings

Twenty-three states and the District of Columbia responded, for a total of 24 respondents.[7] Two states – Alaska and West Virginia – declined to participate in the survey. California provided information only about the number of beneficiaries and spending for the benefit, raising the total number of respondents in those categories to 25. Data on the number of beneficiaries and program expenditures are for 2003; all other data in the report are for 2004.

Number of beneficiaries

Respondents from 25 states reported that almost 700,000 beneficiaries of all ages received personal care services in state fiscal year 2003.[8] The size of the population served is a function of the size of the state population as well as some features of the benefit. The number of people served varies across states, with California and New York providing the benefit to the most people. New Hampshire provided the benefit to just 28 people.[9] Utah and South Dakota also served small numbers of beneficiaries (see Table 1).

Categories of beneficiaries

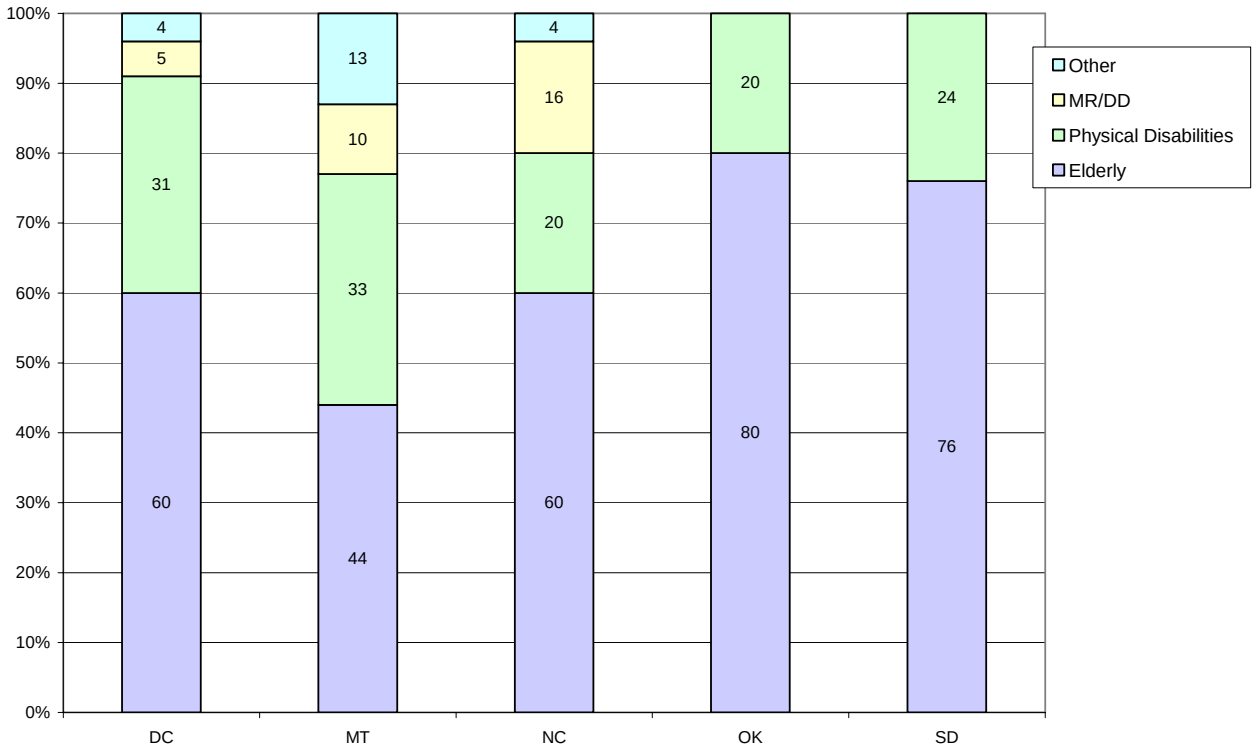
Respondents were asked to provide information about beneficiaries by category: the elderly, and those with physical disabilities, traumatic brain injury, HIV/AIDS, chronic mental illness, and mental retardation or developmental disabilities (MR/DD). Only five respondents had sufficient data to provide complete information about the composition of the population receiving benefits by category. In all five states with complete information, the largest proportions of beneficiaries were in the elderly category (see Figure 3).

[7] The term "state" in this report is used to refer to any of the 50 states or the District of Columbia.

[8] The number of beneficiaries reported here is somewhat higher than the numbers reported in some previous studies. Program growth in a number of states is one reason. Also, some states have changed the methods they use to count PCS beneficiaries in the past few years. Finally, this survey asked officials to report on the number of PCS beneficiaries in state fiscal year 2003, so the numbers reported may be somewhat higher than numbers from surveys that ask for total annual unduplicated participants, as participants may come on and off the program during the year.

[9] The benefit is available only to people who use wheelchairs and can self-direct their care. It evolved from a long-standing program formerly funded with state general revenue (LeBlanc et al. 2001).

Figure 3. Proportion of Individuals in Each Category Who Receive Medicaid PCS Benefits, 2004: Responses from Five States



NOTE: Other includes individuals with chronic mental illness, HIV/AIDS, traumatic brain injury, and other conditions not specified.

SOURCE: Georgetown University Health Policy Institute Survey: Medicaid Personal Care Services as an Optional State Plan Benefit, 2004.

In addition to the five states that provided complete information about the composition of the population served, another seven provided information about the proportion of beneficiaries who are elderly. In these 12 states, the proportion of beneficiaries who are elderly ranges from 20 percent in Massachusetts to 80 percent in Oklahoma. Six respondents provided information about the proportion of beneficiaries with physical disabilities. The range is from 20 percent in North Carolina and Oklahoma to 62 percent in Michigan. Five respondents provided information about the proportion of beneficiaries who have mental retardation or developmental disabilities. This proportion ranges from 4 percent in Michigan to 51 percent in Washington (see Table 2).

Program expenditures

Reported expenditures for the PCS benefit in 25 states total $6.3 billion.[10] There is substantial variation in expenditures for the program across the states, which reflects the

[10] Expenditure data reported here are not comparable to the expenditure data routinely reported by Medstat, an established source of data on long-term care expenditures, because the methods used to collect the data

size of the programs and the design of the benefit. California spent in excess of $2 billion and New York spent almost $2 billion, while New Hampshire and Utah spent less than $1 million (see Table 1).

Estimates of the cost per beneficiary calculated by comparing the total expenditures and the number of individuals served in state fiscal year 2003 exceed $10,000 in eight states: Massachusetts, Minnesota, New Hampshire, New Jersey, New Mexico, New York, Washington, and Wisconsin. Oregon and South Dakota have the lowest per-beneficiary expenditures – under $1,500 (see Table 1).

Ten states reported on per-beneficiary spending by category. Among the eight reporting for the elderly population, spending ranges from $1,394 in South Dakota to $22,364 in New York. Five states provided information on per-beneficiary spending for those with physical disabilities, ranging from $1,391 in South Dakota to $12,854 in Maine. Among the four states that provided information on spending for those with mental retardation or developmental disabilities, the range is from $4,357 in the District of Columbia to $10,888 in Washington (see Table 3).

Eligibility determinations

Financial eligibility for the PCS benefit is based on the state's standard eligibility criteria for people who live in the community. These criteria are generally stricter than the criteria used for institutional placement (LeBlanc et al. 2001) or for HCBS waiver eligibility.

Functional eligibility criteria for the PCS benefit must be based on medical necessity, but the definition of medical necessity is left to each state. States have the flexibility to determine how they will assess need for the program and which functional criteria they will require for eligibility. The criteria states use to assess functional eligibility include the following:

- The need for assistance with activities of daily living (ADL)
- The need for assistance with instrumental activities of daily living (IADL)
- The presence of medical conditions
- Evidence of cognitive impairment
- The need for a certain number of hours of assistance

The need for assistance with activities of daily living is the most commonly used criterion. The presence of medical conditions and the need for assistance with instrumental activities of daily living are also common assessment criteria (see Table 4).

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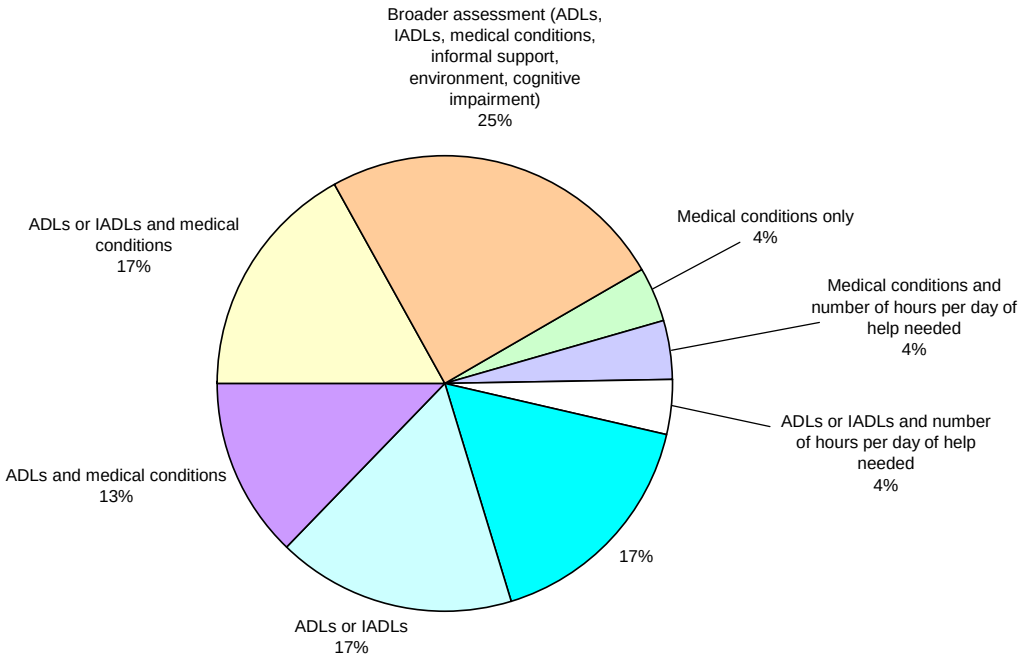
differ. Medstat data are based on CMS 64 reports, which represent state claims to the federal government of health care expenditures that states believe are eligible for federal matching funds. This survey asked state officials to report expenditures for state fiscal year 2003. Expenditure data reported here may also differ from other sources for earlier years because of program growth and because of changes in the way states collect and report data.

States use the assessment criteria in different combinations. Most use a system that takes one or more of the criteria into account, but six – Minnesota, Missouri, New Mexico, Oklahoma, Utah, and Wisconsin – report that they do not use specific formulas to assess functional eligibility. Rather, they use a more holistic approach and consider multiple factors such as medical conditions, ADL needs, IADL needs, environment, nutrition, informal support, and cognitive impairment. No state responded that it uses cognitive impairment as the sole measure for functional eligibility (see Figure 4).

Figure 4. Criteria Used to Assess Functional Eligibility for the Optional Medicaid PCS Benefit, 2004: Responses from 24 States



SOURCE: Georgetown University Health Policy Institute Survey: Medicaid Personal Care Services as a State Plan Optional Benefit, 2004

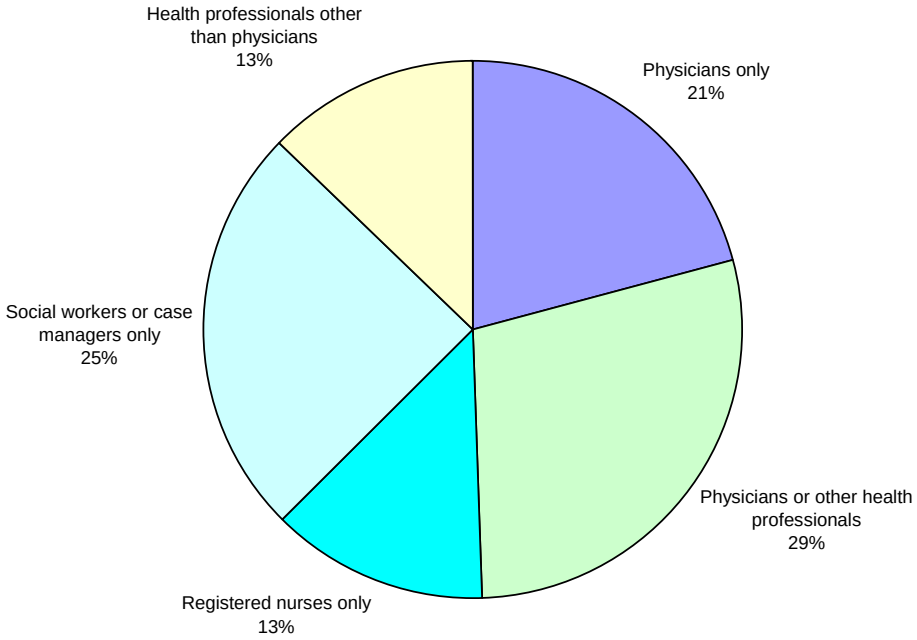
One important difference between the Medicaid optional PCS benefit and Medicaid HCBS waiver benefits is that the HCBS benefit can be provided only to individuals who meet the functional eligibility criteria for nursing facility admission, a restriction that does not apply to the optional PCS benefit. More than three-quarters of respondents – 79 percent, or 19 states – report that the functional eligibility criteria for the optional PCS benefit are less restrictive than those used for nursing facility admission in the state (see Table 5).

Authorization of services

In 1975, when Medicaid first offered the option of providing personal care services, Medicaid program rules required that the service be prescribed by a physician and supervised by a nurse. Changes to Medicaid law in 1993 removed this requirement and allowed states to use other health professionals to authorize this benefit. Currently, services can be authorized by a number of different types of health professionals (Smith et al. 2000) (see Table 6).

About 21 percent of the respondents indicate that physicians are the only health professionals who can authorize personal care services. Another 29 percent permit authorization by physicians or other professionals. In the remaining states, professionals other than physicians – such as registered nurses, nurse practitioners, physician assistants, physical or occupational therapists, social workers, and case managers – authorize services (see Figure 5).

Figure 5. Types of Health Professionals Who Can Authorize Optional Medicaid PCS Benefits, 2004: Responses from 24 States



SOURCE: Georgetown University Health Policy Institute Survey: Medicaid Personal Care Services as an Optional State Plan Benefit, 2004.

Settings for service delivery

Since 1993, states have had the option to provide personal care services in settings other than the home. Rules for the setting where personal care services can be provided differ among states. All report that they pay for personal care services provided in the home, and four – 17 percent – note that the services can be provided only in the home. Other respondents report that personal care services are provided in a variety of settings. For example, they are available in community-based residential settings in more than half the states – 13 states. In addition to providing services where people live, 58 percent of respondents, or 14 states, report that services can be provided in other settings where the need occurs, such as in the workplace, at a relative's home, or at a senior center. Only two states – Arkansas and Nebraska – report that personal care services are provided in adult day care settings, although Arkansas restricts this to beneficiaries in adult day care facilities run by the Division of Developmental Disabilities Services (see Table 7).

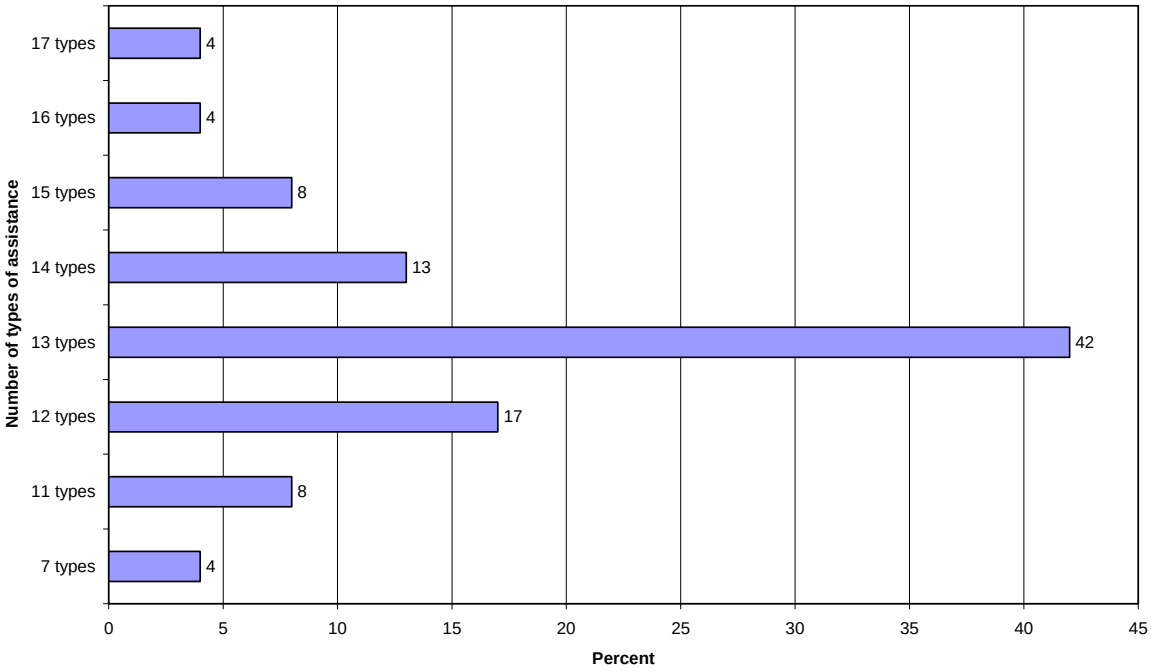
Covered Services

The federal definition of personal care services is very broad and includes hands-on assistance for tasks that individuals would normally do for themselves if they did not have a disability. Respondents were asked to indicate whether assistance with particular activities – including activities of daily living and instrumental activities of daily living – are covered under the optional PCS benefit. Each of the states provides help related to bathing, dressing, toileting, and laundry, and most cover assistance with eating, transferring or positioning, ambulation, grooming, shopping, housekeeping, and meal preparation. Assistance with medication management is also common, provided by 17 states, or 71 percent. Over half of the respondents cover supervision or cuing. Only two states – Michigan and New Jersey – report covering assistive devices or equipment under the PCS benefit (see Table 8), and in New Jersey such help is covered only in their "Cash and Counseling" demonstration program.

Respondents were asked about 18 different types of assistance that could be offered under the personal care services benefit. Most respondents – 88 percent, or 21 states – report that a broad range of assistance – 12 types or more – is available. No state offers fewer than seven types of assistance (see Figure 6).

It is important to note that because each state has a unique mix of home and community-based services, some types of assistance not covered under the optional PCS benefit may still be available to Medicaid beneficiaries through waiver programs or separate state-funded programs.

Figure 6. Proportion of Respondents Offering Different Amounts of Assistance Under the Optional PCS Benefit, 2004



NOTE: Numbers may not add up to 100% due to rounding.

SOURCE: Georgetown University Health Policy Institute Survey: Medicaid Personal Care Services as an Optional State Plan Benefit, 2004

Service limits

If personal care services are covered as a state plan benefit, the services must be made available to all individuals who are eligible for the benefit and who do not live in institutions. Therefore, there cannot be a cap on the number of people who receive this benefit, and waiting lists cannot be kept for services. States do use other methods to control utilization, however. For example, there may be limits on the amount or cost of services provided.

Some 63 percent of respondents – 15 states – say that they limit the number of hours of service that can be provided. States differ with regard to how the hours of services are limited: on a weekly, monthly, or annual basis (see Table 9).

Only 25 percent of respondents – six states – report that they place a cap on the cost of services for individuals. The cost cap differs in four of the states – Maine, Maryland, Minnesota, and Missouri – depending on the level of care needed. In Maine, for example, the caps range from $750 to $20,682 per month for five levels of care. The range is $1,183 to $28,420 per month in Minnesota and $1,390 to $2,316 per month in Missouri. Maryland, with four levels of care, has established daily caps ranging from $10 to $90. Three states – the District of Columbia, Maine, and Texas – use both hourly limits and

cost caps to control service use by individuals. Maine is the only state that charges beneficiaries copayments for services.[11]

Of the 18 states that place limits on the amount of services, 8 have a process in place for granting exceptions to the limits. Exceptions are typically requested by the local worker for approval by the central office (see Table 10).

Training and certification of personal care workers

In general, states monitor the delivery of home care services by providing oversight of home care agencies and establishing certification and training requirements. Most states – 88 percent, or 21 states – provide training for personal care workers, but the type of training differs. Six states do not have specific training criteria and rely on provider agencies to develop training protocols. In New Hampshire, the provider agency trains the consumer to train the workers, and the number of hours of training depends on the consumer's skills and needs. Most of the others have stricter criteria for training, though the number of required hours of training varies. For example, Arkansas requires 40 hours of training, 16 of which must be supervised practical training. Washington requires personal care providers to complete 16 hours of training in the fundamentals of caregiving within the first four months of employment and an additional 10 hours every year after that. Some 29 percent of states – seven states – require that PCS workers be certified. All seven of these states train the workers (see Table 11).

Provider supply

The shortage of caregivers has received a great deal of attention in recent years. Some 67 percent of respondents – 16 states – report shortages of personal care workers (see Table 12). One way that states have responded to the problem of provider shortages is to allow family members to be paid as personal care providers.[12] Three-quarters of states – 75 percent, or 18 states – allow family members to be paid as personal care providers. This total includes 12 of the 16 states that report provider shortages. Only five respondents were able to estimate how many beneficiaries choose family members as their personal care providers. The range is from less than 1 percent in the District of Columbia to 85 percent in New Mexico (see Table 12). All 18 states that report allowing family members to be paid as personal care providers require the family members to have the same qualifications and training as nonfamily providers.

[11] Maine has a sliding fee scale. Copayments are $.50–$3.00 per service, but cannot exceed $3.00 per day or $5.00 per month.

[12] Family members can become paid caregivers as long as they are not legally responsible for the care of the individual. For example, spouses or the parents of a minor child generally cannot be paid caregivers. Under certain circumstances, states have the option to pay these family members for providing certain services, such as skilled nursing services that would normally not be provided by the family.

Consumer direction

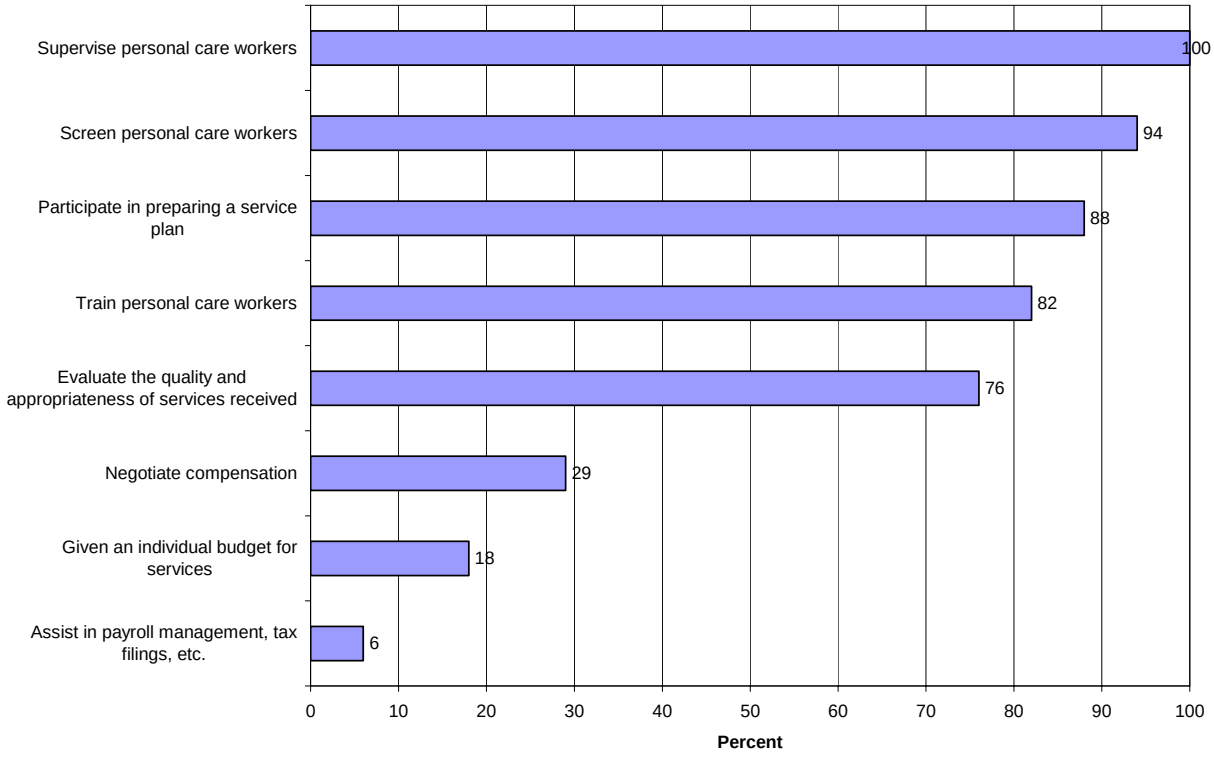
Consumer direction can help ensure that individuals receive personal care services that are tailored to their needs and preferences. Consumer direction involves some degree of decision-making about the specific services that program beneficiaries need and want, who will provide the services, how the services are provided, and how providers will be compensated. Overall, 71 percent of states – 17 states – allow consumer direction for the PCS benefit. Of those, only three states – Minnesota, New Jersey, and Texas – give consumers the discretion to purchase services within an individual budget (see Table 13).

In general, the methods used to determine whether consumers are capable of directing their care are not strictly prescribed. A number of states report that a determination is made during the initial assessment process about whether consumers are capable of self-directing their care. For example, Idaho relies on the judgment of the registered nurses who conduct the initial assessment. Other states rely on the judgment of physicians or case managers. In Maine and Utah, specific data collected to complete the assessment tool are used in making the determination. Other states note that if there is a request for self-direction, the focus is on whether the individual or a representative will direct the care (see Table 14).

Tasks associated with consumer direction

The extent to which consumers have control over the set of tasks associated with consumer direction varies by state. Generally, consumers participate in preparing service plans and in screening, training, and supervising personal care workers. It is less common for consumers to negotiate compensation or to be directly involved in paying providers of care (see Table 15). Only New Jersey allows consumers to assist in payroll management (see Figure 7). The more common approach is to have the state serve as the fiscal intermediary between consumers and providers. This occurs in one-third of the states that make provisions for consumer direction – 5 of the 17 states (see Table 13). Fiscal agents generally take responsibility for tasks such as paying service providers, withholding taxes, and conducting criminal background checks.

Figure 7. Proportion of States that Allow Consumers to Perform Different Tasks, 2004: Responses from 17 States



SOURCE: Georgetown University Health Policy Institute Survey: Medicaid Personal Care Services as an Optional State Plan Benefit, 2004

Methods to monitor consumer-directed care

States have procedures in place to monitor care and to ensure that the service plan will be adjusted if there is a change in the health or functional status of individuals who are directing their own care. Consumers or family members are asked to report changes in conditions or needs, and most states note that they rely on service providers to report changes. Some additional monitoring occurs as well. Most states report that monitoring occurs either annually or every six months. The type and frequency of monitoring vary by state, and within states may vary by individual. In Maine, for example, provider agencies visit consumers to check on the implementation of the care plan at least quarterly. A reassessment of client needs occurs every six months during the first year of care and then annually. In New Jersey, a reassessment is conducted by nurses every six months, and individuals participating in the state's Cash and Counseling program are visited quarterly by a counselor. In Texas, monitoring occurs every three or six months, depending on the service. In Utah, case managers contact consumers monthly (see Table 16).

Conclusion

Personal care services are vitally important to many people with disabilities who wish to remain in the community but need assistance with everyday activities. All states use a variety of sources of public funding to finance personal care services, but the Medicaid program is by far the largest source of funding. With the trend toward providing more community-based care as an alternative to institutional care, the optional Medicaid PCS benefit continues to play an important role in ensuring that people with disabilities can remain in the community. Personal care services, like all optional Medicaid services, may receive more scrutiny as states face potential budget shortfalls. It is important to note, however, that when the provision of personal care services allows people to live independently, the cost of providing care is generally lower, on an individual basis, than the cost of institutional long-term care. The need for community-based care will likely continue to grow as the population ages. States that offer the personal care services benefit as well as other long-term care benefits have flexibility in providing a range of community-based long-term care services that can meet the needs of a diverse population.

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Appendix 1

MEDICAID PERSONAL CARE SERVICES AS AN OPTIONAL STATE PLAN BENEFIT
AARP Public Policy Institute and Georgetown University, Center on an Aging Society

The Center on an Aging Society, located at Georgetown University, under contract to the AARP Public Policy Institute, is conducting a national survey of states that offer the optional Medicaid Personal Care Services benefit. This survey will be asking questions about the Personal Care Services optional benefit offered through your Medicaid State Plan.

If you would prefer to complete this survey electronically, please go to:
http://ihcrp.georgetown.edu/agingsociety/survey.html

State:_____ Email address:_____
Name:_____ Phone number:_____
Title:_____ Fax number:_____

PROGRAM DESCRIPTION

1. How many beneficiaries received Medicaid Personal Care Services in FY 2003? _____

2. What were the annual expenditures for Medicaid Personal Care Services in FY 2003? $ _____

3. Of all individuals who receive Medicaid Personal Care Services, what proportion are in each category?
   _____% Elderly (65 years and older)
   _____% Individuals with physical disabilities
   _____% Individuals with traumatic brain injury
   _____% Individuals with AIDS and related disorders
   _____% Individuals with chronic mental illness
   _____% Individuals with mental retardation or developmental disabilities
   _____% Other (please specify) _____
   100% Total

4. What is the **per-beneficiary** spending on Medicaid Personal Care Services for each of the following categories? (please answer all that are applicable)

   All beneficiaries _____
   Elderly _____
   Individuals with physical disabilities _____
   Individuals with traumatic brain injury _____
   Individuals with AIDS and related disorders _____
   Individuals with chronic mental illness _____
   Individuals with mental retardation or developmental disabilities _____
   Other _____

5. In your state, where can Medicaid Personal Care Services be provided? (check all that apply)
   ☐ Beneficiary's home
   ☐ Adult day care
   ☐ Community-based residential settings (e.g., assisted living facility, residential care facility, or group home)
   ☐ Other (please specify) _____

FUNCTIONAL ELIGIBILITY ASSESSMENT

Please provide a copy of your functional eligibility assessment tool with your completed survey.

6. How is functional eligibility assessed for the Medicaid Personal Care Option? (check all that apply)

☐ Medical conditions
If yes, how many medical conditions are required? _____
☐ ADL needs
If yes, how many ADL deficits are required, and which are they? _____
☐ IADL needs
If yes, how many IADL deficits are required, and which are they? _____
☐ Cognitive impairment
If yes, how is need assessed? _____
☐ Number of hours per day of assistance needed
If yes, how many hours per day are required? _____
☐ Other (please specify)_____

7. Do the functional eligibility criteria for the Medicaid Personal Care Option differ from the nursing facility criteria used in your state?
☐ Yes If yes, how? _____
☐ No

8. Are individuals with mental or cognitive impairments eligible for the Medicaid Personal Care Option?
☐ Yes
☐ No

9. Who can authorize Medicaid Personal Care Services? (check all that apply)
☐ Physicians ☐ Social workers
☐ Registered nurses ☐ Case managers
☐ Other (please specify) _____

SERVICES

10. What types of assistance are covered under the Medicaid Personal Care Services benefit?

☐ Supervision and/or cuing

ADLs:
☐ Eating ☐ Bathing ☐ Dressing
☐ Toileting ☐ Transferring or positioning ☐ Ambulation
☐ Other (please specify) _____

IADLs:
☐ Grooming ☐ Laundry ☐ Housekeeping
☐ Meal preparation/menu planning ☐ Transportation/Mobility outside home ☐ Shopping
☐ Medication management ☐ Money management/bill-paying ☐ Using the telephone
☐ Socialization ☐ Other (please specify) _____

11. Can assistive devices/equipment ever be authorized under the Medicaid Personal Care Services benefit?
☐ Yes
☐ No

12. Are Medicaid Personal Care Services limited by the number of hours or units that can be provided over a particular period of time?
    ☐ Yes If yes, what is the limit? Daily_____ Monthly_____Annually_____
    ☐ No

13. Are Medicaid Personal Care Services limited by the cost of services provided? That is, is there a cap on expenditures for personal care services per individual?
    ☐ Yes If yes, what is the limit? Daily_____ Monthly_____ Annually_____
    ☐ No

14. If there are limits, is there a mechanism for granting exceptions to these time, unit, or expenditure limits?
    ☐ Yes If yes, please describe _____
    ☐ No

15. Is there a beneficiary co-payment for services?
    ☐ Yes If yes, how much is the co-payment?_____
    ☐ No

PROVIDERS

16. Is there a shortage of personal care workers in your state?
    ☐ Yes If yes, please describe _____
    ☐ No

17. Are personal care workers required to be certified?
    ☐ Yes If yes, who does the certification, and how is certification monitored?_____
    ☐ No

18. Is training provided to personal care workers?
    ☐ Yes If yes, how many hours of training and what type of training are required? _____
    ☐ No

19. Does your state allow family members (other than the beneficiary's spouse or parents of minor children) to be paid as personal care providers under the Medicaid Personal Care Option?
    ☐ Yes If yes, what percentage of beneficiaries choose family members (other than the beneficiary's spouse or parents of minor children) as their personal care providers? _____
    ☐ No

20. Do family service providers and non-family service providers have the same qualification and training requirements?
    ☐ Yes
    ☐ No If no, how do they differ? _____

CONSUMER DIRECTION

21. Are consumers of the Medicaid Personal Care Services option allowed to direct their own services (that is, do they have the option of defining the service they need and want, or selecting, hiring, training, or managing their own caregivers)?
    ☐ Yes
    ☐ No

    If yes, continue to question 22.
    If no, thank you for your participation. No further responses are required.

22. Are consumers who are allowed to direct their own services given an individual budget for services?
    - ☐ Yes
    - ☐ No

23. What activities does consumer direction include? (check all that apply)
    - ☐ Participate in preparing a service plan
    - ☐ Negotiate compensation
    - ☐ Supervise personal care workers
    - ☐ Evaluate the quality and appropriateness of the services received
    - ☐ Screen personal care workers
    - ☐ Train personal care workers
    - ☐ Assist in payroll management, tax filings, etc.
    - ☐ Other _____

24. Does the state serve as a fiscal intermediary (e.g., handling payroll, tax withholding, liability insurance, etc.) between consumers and providers?
    - ☐ Yes If yes, what role does the state play?_____
    - ☐ No

25. What methods are used to determine if consumers are capable of self-directing care?

26. What methods are used to insure that appropriate consumer-directed services will be provided if there is a change in health status?

27. How are consumer-directed services monitored, and how frequently are they monitored?

Thank you very much for your assistance.
Please return the completed survey and <u>a copy of your functional assessment tool</u> to:

Emily Ihara
Georgetown University, Health Policy Institute
2233 Wisconsin Avenue, N.W., Suite 525
Washington, DC 20007
esi@georgetown.edu
Phone: 202-687-0886 Fax: 202-687-3110

Appendix 2

State-by-State Charts

Table 1. Medicaid Optional PCS Benefit: Number of Beneficiaries and Expenditures, State Fiscal Year 2003

State	Number of Beneficiaries	Annual Expenditures	Average Expenditures per Beneficiary *
AK			
AR	15,529	$51,991,133	$3,348
CA	303,819**	$2,243,878,145**	$7,386
DC	2,352	$10,283,304	$4,372
ID	4,550	$23,435,167	$5,151
ME	6,306	$23,165,136	$3,674
MD	4,744	$20,740,000	$4,372
MA	10,700	$195,000,000	$18,224
MI	53,727	$195,440,175	$3,638
MN	8,862	$157,643,415	$17,789
MO	38,965	$137,187,348	$3,521
MT	2,867	$21,500,000	$7,499
NE	1,515	$8,083,404	$5,336
NV	2,038***	$19,808,910***	$9,720
NH	28	$661,616	$23,629
NJ	17,707	$280,035,241	$15,815
NM	7,509	$156,656,222	$20,862
NY	83,846	$1,796,653,275	$21,428
NC	34,018	$190,000,000	$5,585
OK	4,500****	$32,000,000	$7,111
OR	3,462	$4,648,384	$1,343
SD	948	$1,321,017	$1,393
TX	51,900+	375,700,000+	$7,239
UT	468	$901,645	$1,927
WA	25,021++	$259,889,138	$10,387
WV			
WI	10,474	$113,296,271	$10,817
Total	695,855	$6,319,918,946	

SOURCE: Georgetown University Health Policy Institute Survey, Medicaid Personal Care Services as an Optional State Plan Benefit, 2004.

NOTE: Gray shading indicates no response to survey.

* Calculations by Health Policy Institute, Georgetown University.

** CA: Number of beneficiaries is average monthly census; CA provided data for Fiscal Year 2004.

*** NV: Data are for Calendar Year 2003.

**** OK: Number of beneficiaries is average monthly census.

+ TX: Number of beneficiaries is average monthly census. Data are from "Texas Medicaid in Perspective," June 2004 and are for the Primary Home Care program. Texas also has a 1929(b) program called Community Attendant Services, which provides personal care without other Medicaid benefits to individuals who meet the more generous nursing facility income limits. This program served an average of 34,979 clients at a cost of $245.7 million in SFY 2003.

++ WA: Number of beneficiaries is average monthly census.

Table 2. Medicaid Optional PCS Benefit: Beneficiaries, by Category

State	Elderly	Physical Disabilities	Traumatic Brain Injury	HIV/AIDS	Chronic Mental Illness	MR/DD
AK						
AR	72%					
CA						
DC	60%	31%		4%		5%
ID	NA					
ME	NA					
MD	62%					
MA	20%					
MI	34%*	62%	5%	< 1%	6%	4%
MN	NA					
MO	41%					
MT	44%	33%	1%	< 1%	12%	10%
NE	48%					
NV	NA					
NH	NA					
NJ	NA					
NM	NA					
NY	73%					
NC	60%	20%	1%	1%	1%	16%
OK	80%	20%				
OR	NA					
SD	76%	24%				
TX	NA					
UT	NA					
WA						51%
WV						
WI	NA					

SOURCE: Georgetown University Health Policy Institute Survey, Medicaid Personal Care Services as an Optional State Plan Benefit, 2004.

NOTE: Gray shading indicates no response to survey.

NA: Information not available.

* MI: Elderly category not mutually exclusive. Elderly with disabilities are included in the elderly percentages and in the percentages of people with various disabilities.

Table 3. Medicaid Optional PCS Benefit: Average Spending per Beneficiary, by Category

State	Elderly	Physical Disabilities	Traumatic Brain Injury	HIV/AIDS	Chronic Mental Illness	MR/DD
AK						
AR	$3,089					
CA						
DC	$4,372	$4,373		$4,376		$4,357
ID	NA					
ME		$12,854				
MD	$4,415					
MA	NA					
MI	$3,348	$3,616	$3,056	$5,209	$3,570	$5,255
MN	NA					
MO	NA					
MT	$7,499	$7,499	$7,499	$7,499	$7,499	$7,499
NE	$4,406					
NV	NA					
NH	NA					
NJ	NA					
NM	NA					
NY	$22,364					
NC	NA					
OK	NA					
OR	NA					
SD	$1,394	$1,391				
TX	NA					
UT	NA					
WA						$10,888
WV						
WI	NA					

SOURCE: Georgetown University Health Policy Institute Survey, Medicaid Personal Care Services as an Optional State Plan Benefit, 2004.

NOTE: Gray shading indicates no response to survey.

NA: Information not available.

Table 4. Criteria Used to Assess Functional Eligibility for the Optional Medicaid PCS Benefit

	How is functional eligibility assessed?						
State	Medical conditions	ADL needs	IADL needs	Cognitive Impairment	Hours per day of help needed	Other	Assessment details
AK							
AR		x	x				Must have at least one physical dependency need that can be addressed by a service that PC providers furnish.
CA							
DC		x					Must have at least 2 ADL needs.
ID		x	x		x		Determined by assessment of 18 functional needs in 2 areas: assistance required and unmet need. Both areas are scored separately using the following scale: None (0), Minimal (1), Moderate (2), Extensive (3), or Total (4). The total score must add up to 12 points. Clients must also require 1 hour of PCS per day.
ME		x	x			x	Must require at least one RN visit per month. Also must have 2 out of 7 ADL needs OR 1 out of 7 ADLs and 2 out of 4 IADLs.
MD	x	x					Must have at least one medical condition and at least one ADL need.
MA	x	x	x				Must have a long-term chronic disability and must have 2 out of 7 ADL or IADL needs.
MI	x	x	x				Must have a disability and have at least one ADL or IADL need.
MN	x	x	x	x	x	x	Determined by assessment on several domains: severity of diagnosis, medication assistance, environment, sensory status, complex medical needs, treatment and maintenance therapies, seizures, behavior, ADLs, IADLs, and appliances/aids/special equipment.
MO	x	x	x	x		x	Determined by assessment on several domains: mobility, dietary, restorative, monitoring, medication, behavior, treatments, personal care, and rehabilitation.
MT	x	x					Must have a medical condition that causes physical, cognitive, or psychological functional impairment and have at least one ADL need.
NE		x					Must have at least one ADL need.
NV		x					Must have at least one ADL need.

	How is functional eligibility assessed?						
State	Medical conditions	ADL needs	IADL needs	Cognitive Impairment	Hours per day of help needed	Other	Assessment details
NH	x				x	x	Must have a severe physical disability and require a wheelchair for mobility, need at least 2 hours of medically oriented care per day, and must be medically stable and able to self-direct care.
NJ		x	x				Must have at least one ADL or IADL need.
NM	x	x	x	x	x		Eligibility is not determined by set number of needs or conditions. Assessment tool captures both medical and functional limitations.
NY	x	x	x	x			Determined by a nursing and social assessment that documents a medical need for assistance with at least one ADL or IADL.
NC	x	x					Must have at least one medical condition and at least one ADL need.
OK	x	x	x	x		x	Determined by assessment on several domains: consumer support, environment, nutrition, ADLs, IADLs, cognitive impairment, and overall health status assessment.
OR		x	x				Determined on a care need basis; if client has any of the personal care needs.
SD	x						Must have at least one medical condition that would require a physician's order for services.
TX	x	x	x				Must have at least one medically related condition and have at least one ADL or IADL need.
UT	x	x				x	Determined by assessment on several domains: medical conditions, ADL needs, and informal support.
WA		x					Must have at least one ADL need.
WV							
WI	x	x	x	x			Determined by assessment on several domains: medical conditions, ADL needs, IADL needs, and cognitive impairment.
Total	15	22	14	6	4	6	

SOURCE: Georgetown University Health Policy Institute Survey, Medicaid Personal Care Services as an Optional State Plan Benefit, 2004.

NOTE: Gray shading indicates no response to survey.

Table 5. Comparison of Functional Eligibility Criteria for the Optional Medicaid PCS Benefit and Nursing Facility Admission

	Do the functional eligibility criteria for Medicaid PCS differ from the nursing facility criteria used?		
State	**No**	**Yes**	**If yes, how?**
AK			
AR		x	Less restrictive - Nursing facility criteria require extensive assistance in one of three ADLs (transferring, eating, or toileting) or limited assistance in two of three ADLs (transferring, eating, or toileting). Nursing facility criteria also consider cognitive impairment and medical conditions that require daily monitoring.
CA			
DC	x		
ID		x	Less restrictive - Nursing facility level of care requires a score of 12 points or higher on the Uniform Assessment Instrument.
ME		x	Less restrictive - Nursing facility level of care criteria are more extensive, including amount of skilled nursing care needed, cognition, and behavior.
MD		x	Less restrictive - Nursing facility eligibility criteria are more extensive, including skilled services, amount of extensive services needed for unstable medical conditions, functional status, and mental illness or mental retardation.
MA		x	Less restrictive - Nursing facility criteria include the need for medical nursing care.
MI		x	Less restrictive - Nursing facility level of care criteria are more comprehensive, including ADLs, cognition, unstable medical conditions, complex nursing need, and rehabilitation services.
MN		x	Less restrictive - MN has several home care ratings, which take into account the number of dependencies, level of medical need, and type of behavior (e.g., self injurious, physically injurious to others, etc.). Ultimately, the determination of whether a person is more appropriate for PCS or for a nursing facility level of care is made by the public health nurse's professional assessment and the consumer's preferences.
MO	x		
MT	x		
NE		x	Less restrictive - Nursing facility level of care criteria include ADL needs, medical need, risk factors, and cognition factors.
NV		x	Less restrictive - Nursing facility criteria require at least three functional deficits.
NH		x	Less restrictive - Participants must be medically stable, able to self-direct care, and able to live in a non-institutional environment without the need for 24-hour care
NJ		x	Less restrictive - Nursing facility level of care criteria include unstable medical, emotional, behavioral, psychological, or social conditions that limit an individual's ability to care for themselves independently or safely.
NM	x		
NY		x	Less restrictive - There is no functional eligibility threshold required for PCS, whereas nursing facility admission is contingent on achieving a minimum score on a Skilled Nursing Facility assessment instrument.
NC		x	Less restrictive - Nursing facility criteria require medically necessary skilled nursing care daily.
OK		x	Less restrictive - Nursing facility level of care requires higher scores on the Uniform Comprehensive Assessment Tool.
OR		x	Less restrictive - The assessment tool is scored differently for the PC Option than for nursing facility level of care.
SD		x	Less restrictive - Nursing facility level of care requires need for complex nursing care and daily care.
TX		x	Less restrictive - Nursing facility level of care requires a medical necessity, which means the client has a medical condition that requires the services of a licensed nurse on a daily or regular basis. Nursing care is not required or allowed for PCS in the community.
UT		x	Less restrictive - Nursing facility level of care is more extensive, including severity of illness, intensity of services needed, anticipated outcome, and setting of the service.
WA		x	Less restrictive - Nursing facility level of care requires more than supervision, protection, and assistance with personal care.
WV			
WI	NA	NA	
Total	4	19	

SOURCE: Georgetown University Health Policy Institute Survey, Medicaid Personal Care Services as an Optional State Plan Benefit, 2004.

NOTE: Gray shading indicates no response to survey. NA: Information not available.

Table 6. Health Professionals Who Can Authorize Optional Medicaid PCS Benefits

State	Physicians	Registered Nurses	Social Workers	Case Managers	Other	Please specify
AK						
AR	x					
CA						
DC	x			x		
ID	x	x	x			
ME		x				
MD	x					
MA	x				x	Nurse practitioner
MI	x		x	x	x	Physician assistants and nurse practitioners
MN	x				x	Public health nurses
MO				x		
MT	x	x				
NE		x		x		
NV		x	x	x	x	Physical or occupational therapists
NH	x					
NJ		x				
NM					x	Third-party assessor providers have nurses conduct the assessment to determine eligibility and authorize services.
NY				x		
NC	x					
OK		x				
OR				x		
SD			x			
TX				x		
UT	x	x				
WA			x	x		
WV						
WI	x					
Total	12	8	5	9	5	

SOURCE: Georgetown University Health Policy Institute Survey, Medicaid Personal Care Services as an Optional State Plan Benefit, 2004.

NOTE: Gray shading indicates no response to survey.

Table 7. Settings Where Optional Medicaid PCS Benefits Can Be Provided

State	Home	Adult day care	Community-based residential setting	Other	Please specify
AK					
AR	x	x*	x	x	Public schools for beneficiaries under age 21
CA					
DC	x		x		
ID	x		x	x	School
ME	x		x		
MD	x		x**		
MA	x		x	x	Work
MI	x				
MN	x		x	x	School, Work
MO	x		x		
MT	x				
NE	x	x	x	x	Place of employment
NV	x			x	In locations outside the home, wherever the need for personal care aide services occurs.
NH	x			x	Any other location as long as they are services that would otherwise have been provided in the home.
NJ	x		x***		
NM	x			x	In the community based on consumer's needs
NY	x		x	x	All settings except nursing homes, hospitals, or ICF-MR facilities as long as PCS is not duplicating services.
NC	x				
OK	x			x	School or work
OR	x			x	Work or in the community, for example, at senior centers
SD	x				
TX	x			x	Relative's home; Escort in the community
UT	x			x	Work site****
WA	x		x	x	Work site
WV					
WI	x		x*****		
Total	24	2	13	14	

SOURCE: Georgetown University Health Policy Institute Survey, Medicaid Personal Care Services as an Optional State Plan Benefit, 2004.

NOTE: Gray shading indicates no response to survey.

* AR provides PCS only in adult day care for beneficiaries in Division of Developmental Disabilities Services facilities.

** MD provides PCS only in assisted living facilities with limited circumstances (less than 4 beds).

*** NJ provides PCS in boarding homes and other unlicensed facilities.

**** UT provides PCS only at a work site connected to the Employment-Related Personal Assistance Services Program.

***** WI provides PCS only in facilities with 20 beds or less.

Table 8. Types of Assistance Covered under the Optional Medicaid PCS Benefit

State	Supervision and/or cuing	Eating	Bathing	Dressing	Toileting	Transferring or positioning	Ambulation	Grooming	Laundry	Housekeeping
AK										
AR		x	x	x	x	x	x	x	x	x*
CA										
DC	x	x	x	x	x	x	x	x	x	x
ID		x	x	x	x	x	x	x	x	x
ME	x**	x	x	x	x	x	x	x	x	x
MD	x	x	x	x	x	x	x	x	x	x
MA		x	x	x	x	x	x	x	x	x
MI		x	x	x	x	x	x	x	x	x
MN	x	x	x	x	x	x	x	x	x	
MO		x	x	x	x	x	x	x	x	x
MT	x***	x	x	x	x	x	x	x	x	x
NE		x	x	x	x	x	x	x	x	x
NV	x	x	x	x	x	x	x	x	x	x
NH		x	x	x	x	x		x	x	x****
NJ		x	x	x	x	x	x	x	x	x
NM	x	x	x	x	x		x	x	x	x
NY		x	x	x	x	x	x	x	x	x
NC	x	x	x	x	x	x	x	x	x	x
OK	x	x	x	x	x	x	x		x	x
OR	x	x	x	x	x	x	x	x	x	x
SD			x	x	x		x	x	x	x
TX	x	x	x	x	x	x	x	x	x	x
UT	x	x	x	x	x	x	x	x	x	x
WA	x	x	x	x	x	x	x	x	x	x
WV										
WI		x	x	x	x	x	x	x	x	x*****
Total	13	23	24	24	24	22	23	23	24	23

SOURCE: Georgetown University Health Policy Institute Survey, Medicaid Personal Care Services as an Optional State Plan Benefit, 2004.

NOTE: Gray shading indicates no response to survey.

* AR: "Incidental housekeeping" means cleaning of the floor and furniture only in the area of the service delivery location occupied by the client.

** ME: Cuing only.

*** MT: Cuing only.

**** NH: Essential housekeeping only.

***** WI: Housekeeping is defined as light cleaning in essential areas of the home used during personal care service activities. No more than 1/3 of the time spent by a personal care worker may be in performing housekeeping activities.

Table 8. Types of Assistance Covered under the Optional Medicaid PCS Benefit (continued)

State	Meal prep	Transporta-tion/ mobility outside home	Shopping	Medication management	Money management/ help paying bills	Using the phone	Socialization	Assistive devices/ equipment	Total number of services offered by states	Other (specify)
AK										
AR	x		x						11	
CA										
DC	x	x	x	x	x	x	x		17	
ID	x	x	x	x					13	
ME	x		x		x				13	
MD	x		x	x					13	
MA	x	x*	x	x					13	
MI	x		x	x				x	13	
MN	x	x	x		x	x			14	
MO	x		x	x					12	
MT	x	x	x	x		x			15	
NE	x	x	x	x					13	
NV	x		x			x			13	
NH	x		x	x					11	
NJ	x		x	x		x		x**	14	
NM	x	x	x	x					13	
NY	x		x		x				12	Assistance with essential errands
NC	x	x	x	x		x	x		16	
OK	x		x			x			12	
OR	x	x****	x	x					14	Delegated nursing tasks, supportive services
SD									7	
TX	x		x	x					13	Escort
UT	x			x			x		13	
WA	x	x	x	x		x			15	
WV										
WI	x		x*****	x					12	
Total	23	10	22	17	4	8	3	2		

SOURCE: Georgetown University Health Policy Institute Survey, Medicaid Personal Care Services as an Optional State Plan Benefit, 2004.

NOTE: Gray shading indicates no response to survey.

* MA: Transportation to medical appointments only.

** NJ: Only under the Personal Preference program (also called the Cash & Counseling program), which is an 1115 waiver program for beneficiaries of the optional Medicaid PCS benefit.

*** NC: No medical transportation allowed.

**** OR: Only mobility outside the home, not transportation.

***** WI: PCS workers can shop for the recipient, but cannot take recipient shopping.

Table 9. Time Limits and Cost Caps for the Optional Medicaid PCS Benefit

	Time Limits		Reported Limit Amount	Cost Caps		Reported Cap Amount
State	No	Yes		No	Yes	
AK						
AR		x	64 hours/month	x		
CA						
DC		x	1,040 hours/year		x	$14,040/year
ID		x	16 hours/week (for adults)	x		
ME		x	2-4 hours/week*		x	$750/month $950/month $1,550/month $3,133/month $20,682/month**
MD	x				x	$10/day $20/day $50/day $90/day***
MA	x			x		
MI		x	5-25 hours/month****	x		
MN	x				x	$1,183 to $28,420/month*****
MO	x				x	$1,390/month $2,316/month +
MT		x	1,120 hours/year	x		
NE		x	40 hours/week	x		
NV		x	50 hours/week	x		
NH	x			x		
NJ		x	25 hours/week	x		
NM		x	55.25 hours/week	x		
NY	x			x		
NC		x	60 hours/month	x		
OK	x			x		
OR		x	20 hours/month	x		
SD		x	120 hours/quarter	x		
TX		x	50 hours/week		x	$95/day (average daily nursing facility cost)
UT		x	60 hours/month	x		
WA	x			x		
WV						
WI	x		see note below ++	x		
Total	9	15		18	6	

SOURCE: Georgetown University Health Policy Institute Survey, Medicaid Personal Care Services as an Optional State Plan Benefit, 2004.

NOTE: Gray shading indicates no response to survey.

NR: No response to question.

* ME has different IADL limits, depending on the level of care. There are 5 levels of care.

** ME has a monthly cost cap per level of care. There are 5 levels of care.

*** MD has a daily cost cap per level of care. There are 4 levels of care.

**** MI limits IADL care by the type of care. Shopping is limited to 5 hours/month; light housekeeping to 6 hours/month; laundry to 7 hours/month; meal preparation to 25 hours/month.

***** MN has several cap amounts and a complex method of determining the cap amount, which is based on the assessment of the consumer's needs. For example, a person who has 0-3 dependencies in ADLs, no complex medical needs, and no behavior issues would have the lowest cap amount ($1,183/mo). A person who has 4-6 dependencies in ADLs, complex medical needs, and Level II behavior issues would have a cap amount of $3,675/month. The highest cap amount is $28,420/month and is for someone who is vent dependent at least 6 hours/day for at least 30 days.

+ MO's monthly cost cap depends on level of care. 60% of nursing facility cost ($1,390) is for basic personal care services. 100% of nursing facility cost ($2,316) is for advanced personal care services for assistance that requires devices and procedures related to altered body functions.

++ WI: All personal care services beyond 50 hours per calendar year require prior authorization. There is no hourly limit on medically necessary services that can be prior authorized.

Table 10. Mechanisms for Granting Exceptions to Time Limits and Cost Caps for the Optional Medicaid PCS Benefit in 18 States

	Are there mechanisms for granting exceptions to time limits or cost caps?		
State	**No**	**Yes**	**Specify**
AR		x	Medically necessary benefit extensions may be requested in writing
DC		x	Provider agency may request authorization beyond the 1,040 hours by submitting an extended authorization request signed by a physician and justifying the need for more hours. Requests must be resubmitted every 60 days.
ID	x		
ME	x		
MD	x		
MI	x		
MN		x	For temporary 45-day increase, the county public health nurse conducts the assessment for increased need by phone and submits the required form to the MN Department. of Human Services.
MO		x	Exceptions are reviewed by staff from the Section for Senior Services and discussed with the Division of Medical Services
MT	x		
NE		x	Exceptions are requested by local case worker to central office program specialist
NV	x		
NJ		x	Agency submits request for prior authorization of hours in excess of 25 hours/week. With approval, weekly maximum can go up to 40 hours.
NM		x	Medical Assistance Division Chief Medical Director reviews on a case by case basis to determine additional eligibility to meet the needs of that particular consumer.
NC	x		
OR	x		
SD	x		
TX		x	Only for individuals under age 21 who can get personal care services at a cost equal to their daily nursing facility cost
UT	x		
Total	10	8	

SOURCE: Georgetown University Health Policy Institute Survey, Medicaid Personal Care Services as an Optional State Plan Benefit, 2004.

Table 11. Training and Certification for Personal Care Providers

	Are personal care workers required to be certified?			Is training provided to personal care workers?		
State	**No**	**Yes**	**Who does the certification?**	**No**	**Yes**	**How many hours of training are required?**
AK						
AR		x	Registered nurses perform the required training and certification. Monitoring is the responsibility of the Medicaid Field Audit Section of the Division of Medical Services.		x	40 hours of training, 16 of which must be supervised practical training.
CA						
DC		x	Training institutions.		x	12 hours per year.
ID	x				x	Varies by agency. Training must be such to meet the needs of participants.
ME	x				x	50 hours of Department-approved curriculum.
MD	x				x	Training varies by health department.
MA	x				x	By consumer or surrogate only.
MI	x			x		
MN	x				x	Training is the responsibility of the provider agency. Before providing PCA services, the PCS provider must complete one of the following training requirements: 1) nursing assistant training program or its equivalent for which competency as a nursing assistant is determined according to a test administered by the State Board of Vocational Education. 2) Homemaker/home health aide pre-service training program using a curriculum recommended by MN Department of Health. 3) Accredited educational program for licensed registered nurses or licensed practical nurses. 4) Training program that provided the person with the skills required in order to perform the covered PCA services, or 5) for providers 16-18 years old, participation in a related school-based job-training program or completion of a certified home health aide competency evaluation.
MO	x				x	20 hours of orientation training provided for newly employed aides; 10 hours of in-service training are provided annually.
MT	x				x	NR
NE	x			x		
NV	x				x	18 hours in specific topics plus an additional 8 hours for CPR and First Aid.

	Are personal care workers required to be certified?			Is training provided to personal care workers?		
State	No	Yes	Who does the certification?	No	Yes	How many hours of training are required?
NH	x				x	Consumers are trained to train the workers. Number of hours depends on consumer's skills and needs.
NJ		x	Certification provided by NJ State Board of Nursing, following training and examination.		x	76 hour training course (60 classroom/16 clinical).
NM	x				x	12 hours per year (First Aid and CPR are required; the remainder is based upon the consumer's needs).
NY		x	Must be employed by a qualified home care agency and have completed state training and health requirements.		x	40 hours of basic training.
NC		x	DHHS, Division of Facility Services; Skills validated by RN.		x	Basic training - 40 hours; Higher level of care - 75 hours.
OK	x				x	Varies by home health care agency.
OR	x			x		No formal training, but there is a home care orientation where they are provided with basic information, such as universal precautions. Sometimes there may be a nurse who can delegate or teach home care workers about medical issues. Workers who are with agencies have their own training.
SD	x				x	Varies by provider, but in general, 70 hours/year.
TX	x				x	There is no set time; the attendants must be trained on the specific tasks the client needs.
UT		x	Office of Education.		x	Varies by agency.
WA	x				x	16 hours - fundamentals of caregiving are required within 120 days of employment and an additional 10 hours after that every calendar year.
WV						
WI		x	The employing agency does the certification and monitoring.		x	40 classroom hours or 6 months of equivalent experience.
Total	17	7		3	21	

SOURCE: Georgetown University Health Policy Institute Survey, Medicaid Personal Care Services as an Optional State Plan Benefit, 2004.

NOTE: Gray shading indicates no response to survey.

NR: No response to question.

Table 12. Availability of Personal Care Providers

	Is there a shortage of personal care workers in your state?			Does your state allow family member (other than spouse or parents of minor children) to be paid as personal care providers under the Medicaid PCS Option?			Do family service providers and non-family service providers have the same qualification and training requirements?	
State	No	Yes	If yes, please describe	No	Yes	If yes, what percentage of beneficiaries choose family members as their PCS providers?	No	Yes
AK								
AR		x	Only anecdotal evidence from providers of a possible shortage	x				
CA								
DC		x	Severe shortage of individuals entering this field of work		x	Less than 1%		x
ID	x				x	NA		x
ME		x	Provider agencies track unmet need		x	NA		x
MD		x	Shortage in some rural areas of some counties		x	NA		x
MA		x	Varies geographically		x	NA		x
MI		x	Varies by region, but no waiting lists for home help		x	48-51%		x
MN		x	Retention is an issue as well as the low wages.		x	NA		x
MO		x	Shortage due to economic factors in certain areas of the state	x				
MT		x	NR		x	NR		x
NE		x	Lists of available providers and back-ups are not readily available		x	NA		x
NV	x				x	NR		x
NH		x	Some consumers have difficulty finding workers	x				
NJ	x			x*				

	Is there a shortage of personal care workers in your state?			Does your state allow family member (other than spouse or parents of minor children) to be paid as personal care providers under the Medicaid PCS Option?			Do family service providers and non-family service providers have the same qualification and training	
State	No	Yes	If yes, please describe	No	Yes	If yes, what percentage of beneficiaries choose family members as their PCS providers?	No	Yes
NM	x				x	85%		x
NY		x	Sometimes in certain locations and for difficult to serve clients		x	NA		x
NC		x	High worker turnover	x				
OK		x	Home health agencies have great difficulty recruiting, competition is great		x	20%		x
OR	x		Not for seniors and people with physical disabilities, but there may be a provider shortage for individuals with mental retardation or developmental disabilities		x	60%		x
SD	x			x				
TX	x				x	NA		x
UT		x	NR		x	NR		x
WA		x	NR		x	NA		x
WV								
WI	NA	NA			x	NA		x
TOTAL	7	16		6	18		0	18

SOURCE: Georgetown University Health Policy Institute Survey, Medicaid Personal Care Services as an Optional State Plan Benefit, 2004.

NOTE: Gray shading indicates no response to survey.

NR: No response to question.

NA: Information not available.

* NJ: Except under the Personal Preference program (also called the Cash and Counseling program), which is an 1115 waiver program for beneficiaries of the optional Medicaid PCS benefit.

Table 13. Consumer Direction for the Optional Medicaid PCS Benefit

	Are consumers of the Medicaid PCS option allowed to direct their own services?		Are consumers given an individual budget for services?		Does the state serve as a fiscal intermediary between consumers and providers?		
State	No	Yes	No	Yes	No	Yes	If yes, what role does the state play?
AK							
AR	x						
CA							
DC	x						
ID		x	x		x		
ME		x	x		x		
MD	x						
MA		x	x		x		
MI		x	x			x	The state is the filing agent and does payroll, tax withholding, W-2s, and unemployment benefits
MN		x		x	x		
MO	x						
MT		x	x		x		
NE		x	x			x	NR
NV		x	x		x		
NH		x	x		x		
NJ		x*		x	x		
NM		x	x		x		
NY		x	x		x		
NC	x						
OK		x	x			x	Pays claims
OR		x	x			x	The state handles the payment of workers, FICA, and unemployment taxes. The providers have to do the income tax themselves.
SD	x						
TX		x		x	x		
UT		x**	x		x		
WA		x	x			x	Withholds FICA and FUTA (unemployment) taxes
WV							
WI	x						
Total	7	17	14	3	12	5	

SOURCE: Georgetown University Health Policy Institute Survey, Medicaid Personal Care Services as an Optional State Plan Benefit, 2004.

NOTE: Gray shading indicates no response to survey.

NR: No response to question.

* NJ allows consumer direction only under the Personal Preference program (also called the Cash and Counseling program), which is an 1115 waiver program for beneficiaries of the optional Medicaid PCS benefit that allows consumers to manage a monthly budget based on his/her needs.

** UT allows consumer direction only through the Employment-Related Personal Assistance Service Program.

Table 14. Methods to Determine Capability of Consumer to Self-Direct Care in 17 States

State	What methods are used to determine if consumers are capable of self-directing care?
ID	Professional judgment of RN who does the assessment.
ME	Cognitive screen questions on the medical assessment tool.
MA	Judgment of health professional at provider agencies who evaluates the consumers' need for and ability to manage consumer-directed care independently.
MI	The Comprehensive Assessment Form includes questions about behavioral issues and functional abilities.
MN	A section of the assessment form is used to determine if recipient can direct his/her own care.
MT	A capacity screen to evaluate the plan that the consumer will be able to recruit, train, supervise, and schedule attendants.
NE	Professional judgment of physician or RN who does the assessment.
NV	There is no specific determination of "capacity." The recipient may have a personal care representative who may direct care if they are available on a day-to-day basis.
NH	A service coordinator assesses the consumer's ability to self-direct care through a lengthy evaluation process.
NJ	None. Consumers needing assistance in managing their services are asked to select and appoint a representative to assist them.*
NM	None. A consumer may elect a personal representative to assist them with the direction of their care. If the consumer has a Power of Attorney or Legal Guardian, that individual may direct care for the consumer.
NY	Districts evaluate consumers for consumer-directed care utilizing the same assessment process for PCS program (physician orders, nursing and social assessment).
OK	Information from the Uniform Comprehensive Assessment Tool is used.
OR	Case managers determine capability in their assessment.
TX	Consumers complete a self-assessment, but there are no items that would disqualify the individual from participating. Based on the responses, the case manager might suggest that the individual select someone to assist them with consumer-directed services.
UT	The Minimum Data Set for Home Care (MDS-HC) Assessment form is used to help determine decision-making/self-direction skills.**
WA	Physician assessment.

SOURCE: Georgetown University Health Policy Institute Survey, Medicaid Personal Care Services as an Optional State Plan Benefit, 2004.

* NJ allows consumer direction only under the Personal Preference program (also called the Cash and Counseling program), which is an 1115 waiver program for beneficiaries of the optional Medicaid PCS benefit that allows consumers to manage a monthly budget based on his/her needs.

** UT allows consumer direction only through the Employment-Related Personal Assistance Services Program.

Table 15. Tasks Allowed Under Consumer Direction in 17 States

State	Participate in preparing service plan	Screen personal care workers	Negotiate compensation	Train personal care workers	Supervise personal care workers	Assist in payroll management, tax filings, etc.	Evaluate the services received
ID	x	x		x	x		x
ME	x	x		x	x		x
MA	x	x		x	x		x
MI	x	x			x		
MN	x	x	x	x	x		x
MT	x	x		x	x		
NE	x			x	x		x
NV		x			x		
NH	x	x		x	x		x
NJ	x*	x*	x*	x*	x*	x*	x*
NM	x	x	x	x	x		x
NY	x	x		x	x		
OK	x	x		x	x		x
OR		x			x		x
TX	x	x	x	x	x		x
UT	x**	x**	x**	x**	x**		x**
WA	x	x		x	x		x
Total	15	16	5	14	17	1	13

SOURCE: Georgetown University Health Policy Institute Survey, Medicaid Personal Care Services as an Optional State Plan Benefit, 2004.

NOTE:

* NJ allows consumer direction only under the Personal Preference program (also called the Cash and Counseling program), which is an 1115 waiver program for beneficiaries of the optional Medicaid PCS benefit that allows consumers to manage a monthly budget based on his/her needs.

** UT allows consumer direction only through the Employment-Related Personal Assistance Service Program.

Table 16. Methods to Monitor Consumer-Directed Care in 17 States

State	How are consumer-directed services monitored? What methods are used to insure that appropriate consumer-directed care will be provided if there is a change in health status?
ID	Reassessment is conducted annually and supervising RN may be assigned for monthly monitoring. Service providers are trained to report any change in health condition.
ME	Provider agencies monitor service implementation quarterly. Face-to-face reassessment occurs every 6 months during the first year and at least annually thereafter. The plan of care is revised to address identified needs. If the consumer experiences a "significant change" in health status, a reassessment is triggered.
MA	Provider agencies are responsible for evaluating consumers' need for and ability to manage consumer-direction independently. Provider agencies can request an increase or decrease in hours to reflect any changes in medical condition.
MI	There is an evaluation every six months, or office contacts and evaluations as needed.
MN	A yearly reassessment by the county public health nurse is required. The consumer or responsible party is responsible for reporting changes to the provider, public health nurse, and physician as needed.
MT	Home visits by provider agency every 180 days
NE	Annual review of personal assistance service needs by caseworker, in coordination with client. During the annual review, need is reassessed for continued personal assistance services and number of hours needed.
NV	A functional assessment and service plan is authorized on an annual basis or more frequently as warranted by changes in the recipient's condition or status. The recipient can request a redetermination for additional services at any time if their condition deteriorates or situation changes, or they may request a change of provider option to a traditional provider agency if they feel they can no longer participate in the self-directed option
NH	A review of the plan of care is required every 60 days, either by phone or in person, and reassessment is required annually. Consumers can contact the agency as needed.
NJ	Quarterly visits by Personal Preference (Cash and Counseling program) counselor and nursing reassessment every 6 months.*
NM	Quarterly audits, unless circumstances merit more frequent oversight. The provider agency is responsible for reporting health status changes to the Third-Party Assessor, which initiates an in-home assessment to determine if services are appropriate or if additional assistance is needed by the consumer.
NY	Consumer-directed services are reassessed every 6 months for continued appropriateness of service. Consumers, family members, or caregivers may notify the local district of a change in condition that necessitates new physician orders and assessments.
OK	Each individual has a case manager who is responsible for monitoring the care through home visits and regular contact with the consumer.
OR	Providers are encouraged to contact the case managers if there is a change in the client's condition. Case managers do a 6-month reassessment and have ongoing contact with the client.
TX	Clients are monitored every 90 days or every six months, depending on the service. The client can opt out of consumer-directed care if a change in his or her health prohibits self-directed care.
UT	Case managers make monthly contact and do periodic plan reviews.**
WA	Case management, at significant change or annual review in 12 months.

SOURCE: Georgetown University Health Policy Institute Survey, Medicaid Personal Care Services as an Optional State Plan Benefit, 2004.

NOTE: NR: No response to question

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