



**Discussion of Key Resource
Allocation Policy Issues
in Louisiana**

January 17, 2008



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Background

The purpose of this brief, in the context of ongoing consultation from the Human Services Research Institute (HSRI) to the Louisiana Office for Citizens with Developmental Disabilities (OCDD), is to explore policy issues related to resource allocation for people with developmental disabilities in Louisiana. Two particular issues are explored. The first pertains to the relative merits of prospective versus retrospective individual budgeting. The second refers to the range of service settings or categories to which individual budget models can be applied. In addition, a concluding section covers a range of potential policy issues related to individual budgets that OCDD may want to consider.

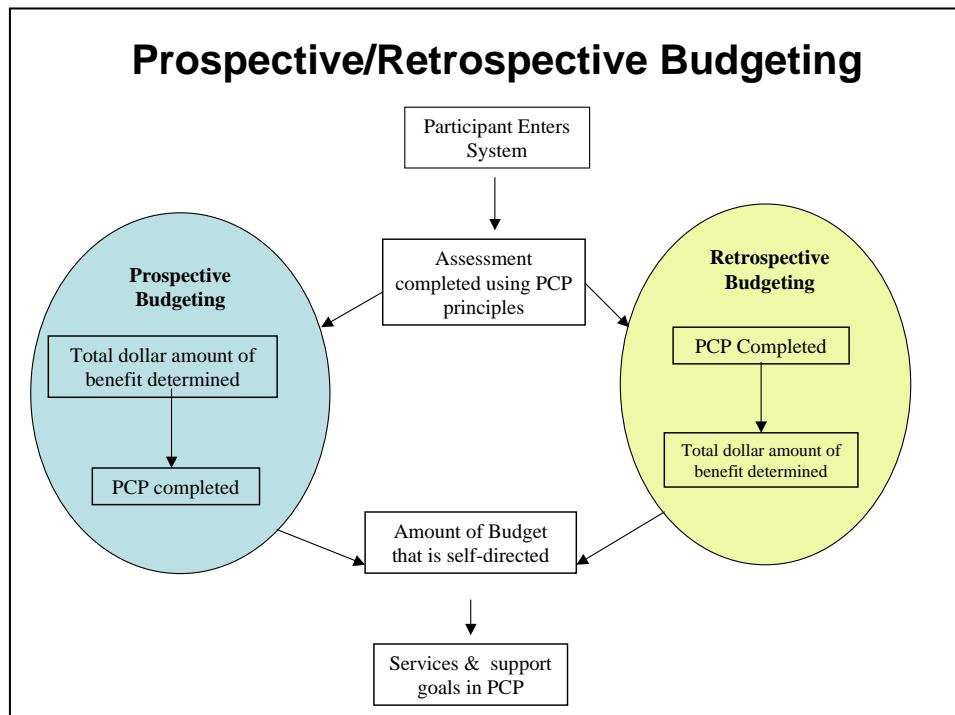
Issue 1: Prospective Versus Retrospective Individual Budgeting

Several authors have sought to define what an "individual budget" is. Consider these few definitions:

- Moseley, Gettings, and Cooper (2003) define the individual budget as a mechanism that enables an amount of funding available for an individual with disabilities to direct and manage the delivery of services she or he is authorized to receive.
- Centers for Medicare and Medicaid (CMS) (Rutgers/NASHP Community Living Exchange, 2004) define the individual budget as "the total dollar value of the services and supports, as specified in the plan of care, under the control and direction of the program participant."
- This definition was amplified by Reinhard, Crisp, Bemis & Huhtala in (2005) when they add the clarification of "that portion of the budget being participant driven."

These definitions suggest a definitive amount of funding per individual, but also imply that the individual have authority over how the allocation is spent. This latter provision is not a uniformly applied condition. Some states refer simply to an “individual budget” as the amount of funds available to the participant, not necessarily requiring participant direction. In such instances, states seek flexibility to specify their own descriptions of the individual budget or the budget amount. At the least, however, an “individual budget” implies a limit on benefit dollars per participant.

When some degree of self-direction is sought, at issue is whether the individual should be made aware of his or her budget allocation before developing a plan of support, or the budget amount should result from the planning process? In response, CMS has described two broad approaches to determining individual benefits, referring to them



as utilizing either “prospective” or “retrospective” methods. In 2004 CMS offered the following diagram to illustrate both approaches.

In the first approach, the prospective method, an individual budget is determined in advance of the person-centered plan. The amount of the individual budget is derived from a data based methodology and is open to inspections and input from the individual receiving support. Even though the modeling methods are approved by CMS, states typically consider challenges to individual allocations based on exceptional circumstances or life changes experienced by the individual. The participant may subsequently determine the spending plan, services, supports, and implementation strategy. To contrast, the retrospective method uses a person

centered plan process to determine the individual budget. New Hampshire and Vermont are two states that apply this approach.

Conceptual considerations related to self-direction. In developing a system to promote self-direction, deciding between a prospective or retrospective approach is a longstanding issue that often generates lively debate between proponents on each side. Notably, the decision carries implications for individuals and funders pertaining to the allocation of authority during the planning process and the capacity of the funder to manage overall budgets across all individuals. When evaluating the Robert Wood Johnson self determination demonstrations, Agosta et al. (1999) wrote that:

“Sites needed to decide whether individuals were going to be told of their allocation amounts at all, and if so, when would they be told -- before or after the personal planning process. Some argue that individuals should be given a pre-set budget or budget range to plan around, so that they may plan while knowing what resources are available. While this approach maximizes personal power, it subtracts discretionary power from system administrators. Critics also claim that people would likely plan to spend their full amount, resulting in few savings.

An alternative strategy is to defer any discussion of an allocation until after a personal planning process where needs are identified and budgets built to match the stated needs. Proponents maintain that the tactic is maximally “person centered” and allows systems planners to move dollars where they are needed. One drawback is that individuals are planning ‘in the blind.’ The planning coordinator (i.e., ‘the broker’ and ‘the funder’ may simply have too much discretionary power “ (p. 60).

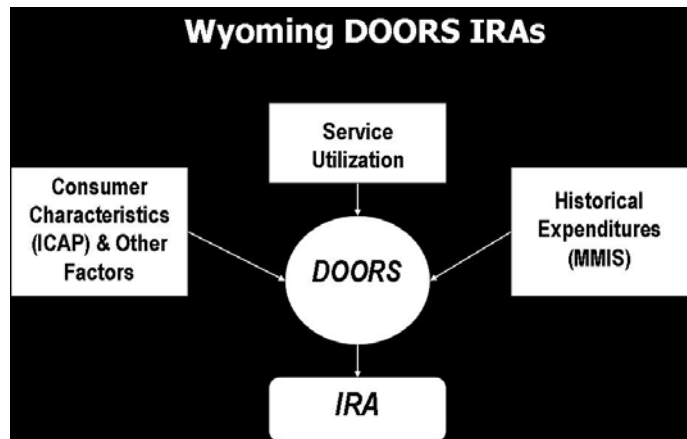
The sum of experience leans toward prospective methods. In discussing this issue among HSRI staff and staff at NASDDDS, we found a few states that use retrospective approaches, such as Vermont and New Hampshire. New Hampshire’s Real Needs, real costs unscripted “kitchen table planning,” takes this road. Participants identify needs within their person-centered plan and the budget is built as the process moves along. The agency (alone or in concert with the participant) determines benefit amount, services and supports. The participant determines spending plan, and implementation strategy. Of course, the state agency is working with a finite budget, and so limits must be ultimately placed on what individuals may plan. After all, the sum of individual budgets cannot exceed what the state agency can spend.

In response, practitioners work to build local infrastructure and capacity for case managers to plan with individuals, and do so with relative equity across the state while keeping within the allowable aggregate budget for all plans. Detractors from the method point out that even with standard questions and structured formats for negotiation, the retrospective method is more subject to differences in final rates than the prospective budgeting method. Overall, however, we observe that states

are tending to utilize prospective methods, and our team agrees that use of prospective approaches is the preferable route.

The Wyoming individual budget methodology, DOORS, was one of the first to popularize this approach, and numerous other states are following their lead. As a result, we focused our study on five states using prospective methods, including Wyoming, South Dakota, Colorado, Oregon, and Connecticut. When the results of a prospective method model are established, the individual budgets are communicated to the individuals served and their families (if appropriate), case managers and others as needed. Such communication should be completed in a timely fashion to give participants and others time to give thought to their plans. Wyoming, for example, routinely sends personal letters to the family and/or individual, as well as the individual's chosen qualified case coordinator, and the current providers in the individual's service plan when a new individual budget model is approved.

1. **Wyoming.** This rural state has a population density of five citizens per square mile and very small wait lists. Smith (1999) described in detail how individual resource allocations are set in Wyoming. The model, DOORS, has been referred to as a CMS "promising practice" since 1998. Overall, as illustrated by the accompanying diagram, the model takes into account individual characteristics, service use patterns, and historical expenditures to build individual allocations. On average, Wyoming spends about \$50,000 per person in its community waiver. In 2006 \$50,000 was the individual annual national community waiver average expenditure.



- **Benefits.** The system has been financially stable, predictable, and been used to reduce waiting lists by providing both the legislature and Governor with solid estimates of potential service costs. The individuals and families throughout Wyoming have grown accustomed to using their individual budget.
- **Challenges.** Recently a three year cost study has added a cost basis to the individual budget methodology and this has potential to keep the system financially grounded to allowable cost regulations and rules recently determined by the state. There is constant pressure between costs and individual exceptions due to the large number of individuals in the community who originated in the state's institutions for people with psychiatric challenges or developmental disabilities. Self determination has been limited.

2. **South Dakota.** One of the first protocols in the country for individual budgets is now called the “Service Based Rates” (SBR) system. It uses individual budgets to assign dollars and services in a limited statewide network of 19 providers. Since IBA’s were first implemented in SD in 1996, three models have been used. Each has been made progressively “simpler” and increased the variance in costs explained by the model. The SBR system has many of the design elements of DOORS but is, of necessity, limited and controlled due to long term fiscal restraints in South Dakota. The state is planning to remodel in 2010 with increased opportunities for individuals to choose their own service coordinator, add two new cost centers, and continue to improve the reliability and validity of their data sources. The system is trusted by providers and the small network of providers is extremely active in the formation and implementation of South Dakota’s model through an influential and knowledgeable provider subcommittee.

The SBR model currently draws information from five sources: (a) cost reports from provider agencies, (b) activity logging data including time studies which show how many units of service each person received, (c) service records including a list of services an individual receives, (d) an ICAP (Inventory for Client and Agency Planning) score to assess an individual’s adaptive skills and maladaptive behavior, and (e) economic measures including data compiled by geographic region, specific to each locale.

- **Benefits.** The state manages its system with few people on wait lists, but in an extremely frugal environment with a strong historical emphasis on cost data and monitored assessment information. The system has the ability to respond to exceptional circumstances. This system operates with an average annual expenditure of \$33,581 for the comprehensive waiver.
- **Challenges.** The overall funding for the state waiver system is thin and the individual’s choices within the system are restrained by the rationing and assignment of waiver services.

- 3 & 4. **Colorado and Oregon.** Both Colorado and Oregon are considering adult comprehensive waiver reimbursement models that are based on results of the Supports Intensity Scale (SIS) and a measure of community safety risk. These potential models are based on a framework, adapted for each state’s results of essential SIS metrics, such as the scores from selected parts to Section 1 (parts A, B & E), and scores from Section 3 regarding Medical conditions and the Behavioral difficulties.

The two states vary a great deal, however, in the number and nature of the subgroups that are formed from these scores and grouped by resource consumption, and in the timing of the possible rollout. Colorado is planning rapid implementation for the summer of 2008 for the comprehensive waiver and 2009 for their support waiver. Oregon is working through a federal waiver rate transformation grant and might begin implementation for their comprehensive

waiver rate transformation in 2011 or later. The Oregon comprehensive waiver averages \$55,000 and the support waiver averages \$7,526 annual cost. Similar but higher costs are evident in Colorado with the comprehensive waiver averaging \$59,534 and the support waiver \$16,383.

- **Benefits.** The major benefit to the both states is that their efforts to align waiver reimbursement with individual's support needs, medical and behavioral problems with waiver reimbursement better aligns the states with CMS. CMS policy recognizes using support needs of waiver recipients to shape waiver rates. In both states currently either county contracts or community center boards manage the waivers funds when CMS would encourage more state control.
- **Challenges.** Both Oregon and Colorado have current reimbursement practices that are not based on the support needs or problems of the people served on their waivers. This creates problems when assessments are done, costs are studied and new waiver rates are applied due to the impact on a wide range of providers and individuals within the two statewide systems. CMS driven deadlines in Colorado add to the pressure of the waiver rate changes. In Oregon a current legal settlement is ending and the transformation of the comprehensive waiver rates may have an impact on their support waiver that is probably one of the best in the United States. The support waiver uses individualized planning to come up with an actual budget so it is retrospective and has an annual base spending of \$9,600 and a two step cap of \$14,400 or \$19,999 based on Basic Supplemental Criteria (BCSI) score.

5 **Connecticut.** Connecticut has recently rolled out a carefully designed individual budget tool the DMR Level Assessment with cost guidelines, a level of need tool, and level of assessment tool. Currently they use a level of need tool that sets a budget range in combination with person-centered planning. This system is designed to replace an older system of master contracts with providers with negotiated rates. Both the comprehensive and individual and family support waivers incorporate full featured self-direction.

- **Benefits.** The individual budget system in Connecticut uses a careful mix of assessment and a variety of individual information in a new individual budgeting tool that is designed to form the reimbursement amount in a balanced manner with standardized rates.
- **Challenges.** The largest challenge in Connecticut has been the pressure of escalating costs in what is, admittedly, an expensive system at \$72,205 average for comprehensive waiver and \$24,443 average for the support waiver. There are additionally some pressures and challenges involved in reducing court monitored wait list time. Providers have resisted the loss of state contracts for waiver service though such contracts are now rare in the United States. The

state has also faced some difficulty gaining acceptance of providers of their new level of need tool.

The experience of states illustrates that establishing individual budgeting protocols within HCBS waivers is a challenging task.

The idea of individual budgets is simple and conceptually appealing. Simply put, people are allocated what they need, no more and no less. This simple way to shape waiver reimbursement, however, is difficult to achieve.

Still, states are pressed to adopt individual budget protocols for a variety of reasons, such as:

- fairness - individuals' supports do not always match with needs, some individuals get extensive supports, some get few supports, individuals with comparable needs sometimes get different levels of supports, etc.;
- the desire to promote self-directed systems;
- the expectation that individual budgets will help control cost and help states tackle their growing waiver registry lists;
- pressure from CMS to prompt states to revamp their waiver budgeting or rate structure; and
- demands from stakeholders to develop more rational rate systems.

Responding to these pressures with a well structured individual budget protocol has proven difficult for at least five reasons:

- a) There is already a budget and rate system in place in states for distributing dollars and managing risk. Naturally, stakeholders are invested in the status quo and may resist change, especially when they sense that their reimbursements may fluctuate.
- b) Developing a rational individual budget structure requires strong relationships between needs of individuals and the dollars allocated to them. However, increasingly we observe that the data from states illustrate that there is typically little or weak relationships between the support needs of individuals and the dollars presently allocated to support them.
- c) As a result, new means of allocating dollars, without new dollars added to the job may produce winners and losers fueling fear among providers and consumers. Meanwhile, the state has an interest in "doing no harm" to individuals or the provider network (including communities and counties).
- d) New individual budget methodologies change roles stakeholders must play, including people with disabilities and their families and providers. This also results in altering how risk is managed within a system requiring that new methods be found to manage and often share risk.

- e) Individual budget systems also challenge states to develop new infrastructure to manage the new system, better management of information, licensing, and quality assurance, staff developing, and financial budgeting.

As a result states are slow to solve the riddles these circumstances present. System design and rollout take many months, even years. Even so, states are proceeding, safe and sure being the preferred mode.

In the states of South Dakota (1996) and Wyoming (1998), Governors approved in their small, rural states with the help of state personnel in developmental disabilities the development and implementation of individual budgets years ahead of other states. This process involved at least a year of promotion and discussion with stakeholders before the individual budgets were implemented in either state.

Colorado, under extreme pressure from their CMS regional office in Denver tried to develop seven waiver payment levels in six months. Partly because of the rush it appears now that Colorado may accomplish in 18 months the use of seven SIS based waiver payment levels for their comprehensive waiver and in another 12 to 18 months SIS based caps for three levels of financial support in their Supported Living Services (SLS) support waiver.

Connecticut spent over two years developing and sharing information about their individual budgets and still faces some significant opposition to their level of need tool in the year after implementation. Part of this opposition is due to the long term historical use of master contracts that offered providers economic security and large dollars annual expenditures that continue to set Connecticut apart from other states.

Oregon, using federal grant funds, is taking more time than others with 2011 targeted as a potential date for formulating a plan to create five residential individual budget tiers and two employment and day service individual budget tiers. The process to create these budget tiers began in October 2005 with the federal award of their rate transformation grant.

Issue 2: Application of Individual Budget Models Across Settings

Louisiana services and supports for the people with developmental disabilities currently rely on four types of settings that are quite different from each other, including:

1. Children's Choice Waiver is developed in lieu of Louisiana's implementing the Katie Beckett (TEFR 124) Medicaid eligibility option due to cost concerns. 838 children live with their families and have benefited from the waiver and state plan benefits.
2. The Support Waiver provides vocational services to 1,654 individuals who live in the community, often with their parents.

3. New Opportunities Waiver (NOW) a comprehensive waiver serving about 4,973 individuals (including children) with an average of about \$69,096 and no cap. Unfortunately there is an extensive (several years) wait for entrance.
4. Large public/state ICF/DDs serve about 1,161 individuals. Approximately 213 people are served in small public/state ICF/DDs. Private ICF/DDs serve around 4,000 individuals in nonstate facilities.

(Note: Above figures of persons served in Children's Choice, Supports Waiver, and NOW waiver extracted from 12/27/07 LA WRRIS report. Public ICF/DD figures extracted from January 2008 OCDD census data. Private ICF/DD figures taken from January 2008 Health Standards information.)

It is natural to wonder if an individual budget model that promises equitable resource allocation to individuals across each of these settings could be built. Given present circumstances in Louisiana and experience elsewhere, however, we do not believe that presently this is possible. Consider that the four settings differ significantly and that to date predicting costs based on individual characteristics has been difficult. Further, care must also be taken to fit together the state's waiver options, but in doing so the means for setting individual budgets may differ.

- **The four settings differ significantly.** These four diverse residential settings greatly differ from one another on scope of service, allowable costs, rules and regulations for services and physical requirements, target populations, staffing requirements, and operating cost. HSRI is not aware of any state that uses a common individual budget model across such a range of programs. One state that is trying for universal assessment and eventual budgeting is Minnesota. They have a cross-disability system and do substantial amounts of self-directed services.

Nationally individual budgets have not yet been used in private ICF/MRs in the community, or state ICF/MRs or residential institutions. Vermont has done some individual budgeting for children on medical waivers. Vermont, New Hampshire, and Connecticut support individual budgets for people living in shared living situations. Vermont and Connecticut have a basic format for establishing individual budgets that is consistent.

While individual budgets could be used in these settings, they are designed and regulated to run at opposite ends of demands for scope of service, allowable costs, rules and regulations for services and physical requirements. The two settings, ICF/DDs and waiver, do differ in the extreme regarding staffing and physical requirements and operating cost.

While models could be made for each of these settings, it is extremely difficult to imagine that a single individual budget model would work for all of them

together. Membership in one of the four types of settings would dominate the individual budget model as a predictor of costs. This is the classic problem of cost predicting cost. Consider this approximate range of costs:

Support Waiver → Children's Choice → NOW → ICF/DDs
\$11,209 \$12,919 \$69,096 \$84,173

(Note: Wavier cost figures above extracted from UNISYS claims data reports generated December of 2007; these figures do not include acute care costs. ICF/DD cost figure represents combined average costs for public and private ICF/DDs also exclusive of acute care costs for FY 2006/07 extracted from DHH Division of Economics report.)

The two states that have really pioneered prospective individual budget technology, South Dakota and Wyoming, are both comprehensive community waiver endeavors. Wyoming is instructive in that three individual budget community waiver reimbursement models are used, one model for their adult DD waiver, one model for their child DD waiver and one for their adults with Traumatic Brain Injury waiver. Even with the experience using DOORS individual budget technology since 1998 Wyoming does not try to manage the three community waivers with a single individual budget model. The models used are custom for each waiver to gain predictive power.

- **Predicting costs based on individual characteristics has been accomplished by several states.** Campbell and Heal (1995) began using stepwise regression and building from case-mix nursing home cost studies the ideas that have led to many statistically derived individual budget systems that allow states with shared datasets to compare their waiver supports and services (Campbell, et al. 2005).

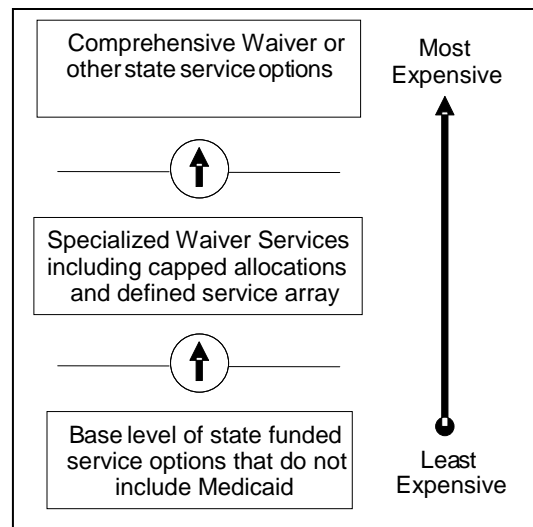
Using a third of a million people in the national dataset Rhoades and Altman (2001) confirmed the early findings in South Dakota. Stancliffe and Lakin (2005) advance these ideas to explore how state budget limitations interact with federal mandates for more individualized services and supports. *All of this fits the emerging trend in cost comparison of community and institutional residential settings by Walsh, Kastner, and Green (2003) that identifies a shift in the literature away from controlled static cost comparison studies by approaching the problem from the perspective of the individual and identifying the most favorable placement based on the characteristics of the person and the service setting together using multi-linear statistical methodology.* Louisiana has been faithfully following this overall path by giving assessments and analyzing the results.

In line with these trends, Louisiana has been working on Supports Intensity Scale and LA Plus information building toward an electronic plan of care since 2004-2005. Information has been collected on 1,275 individuals (receiving services in the Capitol Area from 1)NOW, 2)Children’s Choice, 3)Supports waivers, or 4) private ICF/DDs. Sample of 1,275 individuals also included individuals residing at two large public ICF/DDs.) with SIS and LA Plus results from another 900 people, statistically chosen from around the state to provide a statewide sample, just coming in.

Nationally, successful individual budget implementation so far has been focused on use on comprehensive waivers, though Georgia is planning to unveil an individual budget system for a new comprehensive waiver and new support waiver.

- **Fitting the Louisiana Support and Children’s Choice Waivers into the Overall System Structure.** A major challenge for Louisiana is determining how to incorporate the current waivers Children’s Choice and the Supports Waiver, and a new waiver -- the Residential Options Waiver (ROW) - intended to offer additional waiver service options and expand and diversify the overall continuum of waiver services, into the larger service system so they will complement the comprehensive NOW waiver and other state-funded options to create a seamless, cost effective approach to supporting people with developmental disabilities in the community. Currently, states are using their specialized, capped waivers or smaller waivers like Children’s Choice, ROW, and Supports Waivers as one service option among several to primarily address cost containment and wait list goals.

Several state leaders, however, view these more specialized waivers as an option within a range of supports that includes the comprehensive waiver and other state funded options, configured from least to most costly. Ideally, these options would fit together to provide a seamless, cost effective approach whereby individuals would be matched to the option that most effectively meets their needs. Individuals might start by accessing modest amounts of state funded services that may suffice without any use of waiver services. If more supports are needed, individuals could be enrolled in a specialized, capped waiver. Finally, if still more supports are needed, individuals could be enrolled in the more costly comprehensive waiver.



Current systems are not nearly as efficient. Individuals, for example, may be enrolled in a more expensive comprehensive waiver when they could be ably served in a specialized waiver. Alternatively, some may be “getting by” in a specialized waiver but might be better served in a comprehensive waiver. But specialized waivers are still relatively new and in some cases modestly funded and the individuals are not so easily assigned or re-assigned to various service options. Individuals enrolled in the comprehensive waiver, for example, cannot be transferred to a specialized waiver without their agreement.

If Children’s choice waivers, other specialized waivers, and the NOW comprehensive waiver grow apart in policy and procedure over time, the resulting community service and support system may be neither seamless nor coordinated. To prevent this from happening, Louisiana may need to continue to review and revise the boundaries between the Supports waiver, the Children’s Choice waiver, the ROW, and the NOW comprehensive waiver. It may be useful, for example, to use SIS and LA Plus results to form multiple caps for the Children’s Choice waiver or other specialized waivers allowing more individuals with greater severity differing levels of resource support.

Additional Policy Issues to Consider

Moseley (2005) notes that “no single individual budget methodology is accepted by all states and state practices differ from one jurisdiction to another, although most states use a developmental, statistical or mixed methodology.” He identifies that self direction and individual budgets are two developments that are being pursued by many states. Along the way, numerous policy issues must be worked through and decided upon. In doing so, states must balance an array of policy goals while identifying and accounting for any associated risks.

Deciding whether or not individual budgets should be retrospectively or prospectively used, and if a single methodology can be applied across service categories are two good issues. In addition, state leaders may consider these other policy issues:

- How might the state establish an individual budgeting allocation system while managing existing waiver options and working toward a more cohesive overall waiver strategy?
 - Does the NOW waiver which includes average costs higher than most other states’ comprehensive waivers need to be structured to both control expenditure and to ensure that more dollars are used for individuals with more needs?
 - Should an individual budget allocation system be utilized for new (future) waiver recipients only or retroactively for all individuals (new and existing) receiving waiver services? There are really few examples of states implementing a portion of individual budgets either with selected clientele or

regional areas, for example. Several states like Massachusetts in the greater Boston area have piloted individual budgeting schemes with their self-determination projects - allowing flexible individual budget approaches in some areas of the state and not in others. As the reader might imagine, it was chaotic in some areas. One suggestion is to ask CMS to allow Louisiana for a waiver of statewideness or specify a CMS approved number of individuals who can begin with individual budgets with some plan to increase that number over time to eventually reach everyone.

- Should the Children's Choice continue to use its current cap that is set by internal limits on the amount of specific services that can be authorized effectively?
- Should resource allocation for either state or nonstate ICF/DDs continue in the manner it is done now?
- Ultimately, Louisiana must develop and implement a rational and equitable way to allocate resources per individual. How can this outcome be best achieved?

Reinhard, Crisp, Bemis, and Huhtala (2005) note several requirements for setting individual budgets:

- States must describe the method for calculating individual budgets based on reliable costs or services utilization. By 2007, for example, several states have recently engaged in waiver cost studies to determine cost-based reimbursement for waivers for people with intellectual disabilities (i.e., IL, WY, OR, FL, MA, OH, FL, MT, WA). Good cost and utilization data form the vital underpinnings of good individual budget development for the long-term goal of finding and delivering sustainable care.
- States must develop individual budgets using a consistent methodology for all involved participants, and should review and monitor the individual budgets regularly.
- From the perspective of consumers and advocates, a viable methodology should be open to public inspection, should allow the participant to move money around, and should define a process for making adjustments in the individual budgets and for informing participants of amount authorized or changes to those authorizations.
- From the perspective of the state, the methodology should permit the state to evaluate over and under expenditures in the individual budget as well as to project system-wide expenditures through the fiscal year.
- States must provide prompt mechanisms to adjust funding in response to individual situations.
- How might individual budgets, used within the context of a supports waiver or some other waiver, help contain costs, and so achieve policy goals pertaining to

addressing requests for services registry lists and likely increases in service demand? Louisiana presently faces an 11,932 person request for services registry list (source is SRI - January 2008).

- What degree of self-direction is sought within a framework of individual budgets and what sorts of services can be purchased? Currently families have limited self direction in the Children's Choice with flexibility in the selection of services within a funding limitation. Also an agency with choice option is available. The support waivers currently have no formal mechanisms. Individual budgets can allow a great deal of self direction
- How might individual budgets help achieve policy goals pertaining to overall systems change? Such goals might involve creating new policy dynamics within the system that encourage providers to alter the nature of the service they offer or to reorganize in ways to become more flexible and agile. In this regard, how willing is the state to encourage innovation and creation of new service agencies?
- Smith (2007) suggested nine functions to self direction. If individual budget methodology were designed and implemented, how willing is the state to assure:
 - Person leads the planning process and has support of his/her own choosing in doing do
 - Person can decide which services to direct
 - Person has a budget over which person has control
 - Person has free choice among providers
 - Person can direct how services are provided, including their nature
 - Person can get help to direct services
 - Person can get help in finding community resources
 - Person can select, hire, fire and manage workers
 - Person can make decisions to redirect funds among services
- In setting individual budgets it is very likely that some individuals will be allocated more or fewer resources than they presently use. While individuals may object, such resource shifting also affects providers, who may also object. How much resource shifting is the state willing to accept? Or might such shifting be managed over time to limit its effects?
- What new roles must individuals; their families and case mangers play within a system of individual budgets? What responsibility does the state have to provide training to these parties to help them participate effectively in the new system?
- What risks to individuals, families, providers and workers result from an individual budgeting process and what must the state do to manage these risks? In this

regard, what sorts of mechanisms must be put in place to assure service quality, as well as the health and well being individuals?

- How can implementation of an individual budget model be managed to avoid significant disruption to services or undue hardship to individuals and providers?
- How might an individual budgeting process help contain costs?
- What improvements in hardware or systems are needed to properly manage information in a system utilizing individual budgets?

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Internet Resources

Wyoming Individual Budget Methodology, a CMS promising practice - 12-18-2007
<http://hcbs.org/files/67/3331/Wyoming--IndividualBudgetupdate.pdf>

Person-Centered Planning and Individual Budgeting Audio Conference - 10-12-2004 and presentations by Wyoming and New Hampshire
<http://www.hcbs.org/moreInfo.php/nb/doc/977>

HCBS Community Living Clearinghouse Exchange Collaboration
<http://www.communitylivingta.info/>

National Core Indicators

<http://www.hsri.org/nci/>

Sustainable Care Presentation by HSRI Val Bradley
http://www.hsri.org/docs/sustainfuture_OC.ppt