



Choosing Independence

*A Summary of the Cash & Counseling Model
of Self-Directed Personal Assistance Services*



Cash & Counseling is a national grant program of the Robert Wood Johnson Foundation® as well as the Office of the Assistant Secretary for Planning and Evaluation and the Administration on Aging, U.S. Department of Health and Human Services.

The Cash & Counseling national program office is housed at the Center for the Study of Home and Community Life, Boston College Graduate School of Social Work, with research assistance provided by the University of Maryland Center on Aging.

The Centers for Medicare & Medicaid Services provide participating states with technical assistance and oversight with regard to the federal waivers required to implement a Cash & Counseling program.

The evaluation of the three-state Cash & Counseling Demonstration and Evaluation program was conducted by Mathematica Policy Research, Inc. A qualitative evaluation was conducted by the University of Maryland, Baltimore County.

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Introduction

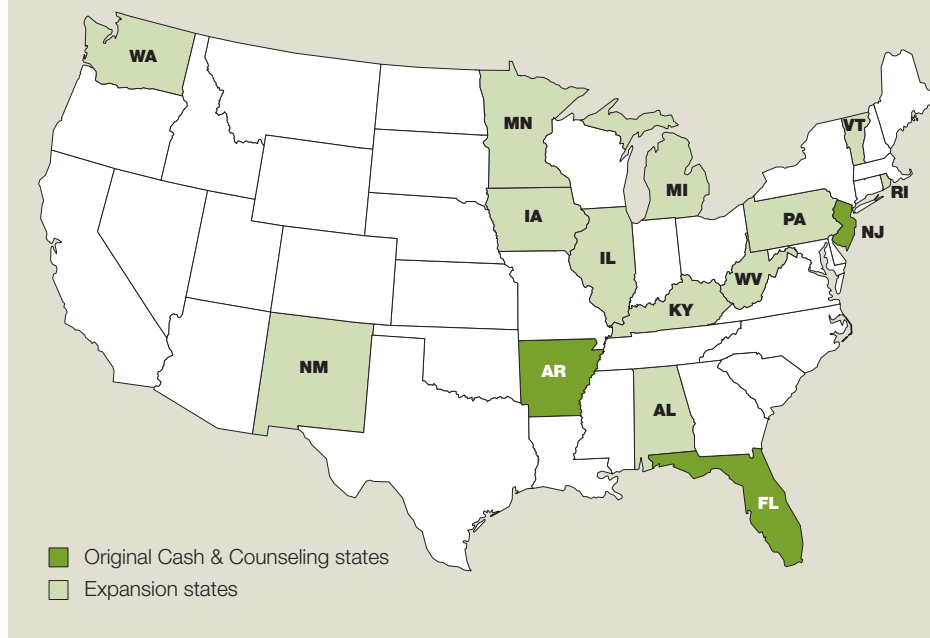
Cash & Counseling offers Medicaid consumers who have disabilities more choices about how to get help at home. It gives frail elders and adults and children with disabilities the option to manage a flexible budget and decide for themselves what mix of goods and services will best meet their personal care needs. Cash & Counseling participants may use their budget to hire their own personal care aides as well as purchase items or make home modifications that help them live independently.

Funded jointly by the Robert Wood Johnson Foundation (RWJF) and the U.S. Department of Health and Human Services (DHHS), Cash & Counseling was first launched as a demonstration project in Arkansas, Florida, and New Jersey. The large majority of those who participated in the three-state program said it significantly improved the quality of their lives. Compared to a control group, Cash & Counseling reduced participants' unmet needs for care and helped them maintain their health. It also significantly improved the lives of their primary caregivers. And initial concerns about possible Medicaid fraud and abuse as well as adverse effects on participants' health proved unfounded.

The three states found that Cash & Counseling can be implemented without costing substantially more than traditional services. Overall costs to Medicaid were somewhat higher for Cash & Counseling participants in each state, mainly because home care agencies failed to deliver approved care to consumers in the control group. But savings in other Medicaid long-term-care costs helped to offset the higher personal care costs.

Today, based on the encouraging results of the demonstration, Cash & Counseling programs are being implemented in 12 more states with support from the funders of the original three-state demonstration program. And the federal government recently made it significantly easier for any state to introduce a Cash & Counseling option through new provisions in the 2005 Deficit Reduction Act. As of January 2007, federally approved "waivers" are no longer required for states to offer flexible budgets to eligible Medicaid

Cash & Counseling States



SOURCE: Cash & Counseling national program office.

consumers and their families so that they may purchase the disability services and supports of their choosing. In addition, the 2006 reauthorization of the Older Americans Act (OAA) makes it possible to now include a Cash & Counseling option in the provision of OAA-funded services.

For those who want to know more about Cash & Counseling, this publication offers a description of the option, key findings from the three-state demonstration, and preliminary information about the program's expansion into more states. An expanded version of this publication—containing more details on the topics above as well as more consumer stories and resources for additional information—is also available through the Robert Wood Johnson Foundation's Web site (www.rwjf.org) and Cash and Counseling's Web site (www.cashandcounseling.org). You can also hear, in their own words, the stories of the people whose photographs are featured throughout this publication in a video posted on RWJF's Web site at www.rwjf.org/special/cc&cprofile.

cash & counseling consumer story

Mrs. Josie Dickey, Fort Smith, Ark.



When Josie Dickey suffered a massive stroke in August 2002, few people would have given her more than a year to live. Today her life revolves around her family and around doing as much as she is able, especially when spurred on by her daughter Brenda Terry. “The more she does, the better she is,” Brenda says of her mother, who’s 87 and suffers from serious health problems that leave her too frail to care for herself. “She’s participating in life—and that’s a great big deal.”

It wasn’t always this way. Following a stroke, Josie went to live in a nursing home. But she was neglected there and contracted pneumonia. After six weeks, Brenda brought her home to live with her. Then came a string of home health aides—about 30 in the space of three years. Josie’s care coordinator told Brenda about Arkansas’ Cash & Counseling program, called IndependentChoices. Brenda quit her \$13-an-hour job to work as her mother’s caregiver for less than half that pay.

Since then, Josie has been healthier, more active, and more engaged in her life. It used to take three people to lift Josie out of bed but, now, Brenda can manage the task on her own because Josie is much stronger. In the year that she’s been enrolled in IndependentChoices, Josie hasn’t been sick once.

Cash & Counseling Model of Self-Directed Personal Assistance Services

Cash & Counseling was created to address the serious barriers that eligible Medicaid consumers sometimes meet when seeking personal assistance services—essentially help at home with daily activities like bathing, dressing, grooming and meal preparation—from state-contracted home care agencies. Although the traditional model of agency-provided personal assistance services works well for many consumers, others get little or none of the services they need and are authorized to receive.

Home care agencies frequently experience worker shortages and high staff turnover that make it difficult to meet consumers' needs, and agencies find it difficult to tailor their standardized services to the specific needs of unique consumers. Consumers frequently can't get the services they need at the time they most want or need them. Further, these workers are not allowed to provide transportation or administer medications due to liability concerns. In addition, agencies only provide workers; they can not make home modifications—such as building wheelchair ramps—or provide assistive devices, like microwave ovens for heating up meals, so that consumers with disabilities can be more independent at home.



In contrast to the agency model, Cash & Counseling provides consumers with a flexible budget that enables them to hire (and fire) their own workers, who may be friends or family members. While Cash & Counseling was not the first program to allow consumers to hire their own personal care aides, it was the first to allow consumers to use flexible budgets to hire workers or purchase goods and services that help them live independently.

As an employer, the consumer determines her workers' schedules as well as the scope of services she needs. Cash & Counseling recognizes that consumers may have little experience as employers and provides them with support services to assist them in planning their budgets, locating workers and resources, keeping up with paperwork, and tracking expenditures.

Cash & Counseling also allows consumers to use their allowances to modify their homes or vehicles or to purchase items that help them live independently. And the program allows consumers who don't feel confident about making decisions on their own to appoint a representative—such as a family member or trusted friend—to make decisions with or for them.

Cash & Counseling is not intended to replace agency services. Instead, it provides an alternative to those who want one. Cash & Counseling may also serve as a way to increase access to personal assistance services in certain circumstances, such as when agencies are experiencing worker shortages or in rural areas where consumers are hard to reach.

Three-State Demonstration and Evaluation Program

With support from RWJF and DHHS, the Cash & Counseling model of self-directed personal assistance services was put to the test in Arkansas, Florida, and New Jersey. In 1996 all three states applied for and received grants to implement a Cash & Counseling program that was monitored by the Centers for Medicare & Medicaid Services (CMS). CMS granted the states Section 1115 research and demonstration waivers, and the program was evaluated by Mathematica Policy Research, Inc., and by the University of Maryland, Baltimore County.

Each state implemented a Cash & Counseling program that adhered to the basic tenets of the model but was also uniquely tailored to the needs and realities of enrollees in that state. The key features of each state's program are described in the table on page 6.

Key Features of Cash & Counseling Demonstration Programs in Arkansas, Florida, and New Jersey

FEATURE	ARKANSAS IndependentChoices	FLORIDA Consumer Directed Care	NEW JERSEY Personal Preference Program
Demonstration enrollment period	December 1998 to April 2001	June 2000 to July 2002 (adults) and June 2000 to August 2001 (children)	November 1999 to July 2002
Eligible population	Elderly and nonelderly adults with physical disabilities (may also have cognitive disabilities) who were eligible for the state plan Medicaid personal care program.	Elderly and nonelderly adults with physical disabilities, and children and adults with developmental disabilities who were receiving services under the HCBS [*] waiver.	Elderly and nonelderly adults with physical disabilities who were already enrolled in the state plan Medicaid personal care program.
Services included in calculating the allowance amount	Personal care	HCBS waiver services, except case management/support coordination. ¹	Personal care
Hiring restrictions	Could not hire legally responsible relatives (such as spouses or parents) or representative.	None	Could not hire representative.
Median monthly prospective allowance of all demonstration enrollees	\$313	\$829 (adults) and \$831 (children)	\$1,097
Funding for fiscal agent and counseling services	Paid for through pool of money generated from difference between \$12.36 per hour paid to agencies and \$8.00 per hour rate at which allowance was cashed out. Originally, agencies were paid a per-client per-month rate for counseling and fiscal services, which was reduced at six-month intervals. Later in the demonstration, agencies were paid a fixed rate for developing a spending plan and then paid per client per month for counseling and fiscal services.	Counseling paid for through existing Medicaid funding stream for case management and support coordination in traditional program. Fiscal agent fees paid for by schedule of fees charged to consumers (for example, \$5 per check) up to a maximum of \$25 per month.	Set aside 10 percent of care plan value to cover counseling services and some fiscal agent costs. From this pool of money, the state paid human services agencies a lump sum per consumer to complete a cash management plan and an hourly fee thereafter for consulting. State also paid fiscal agent for some tasks, such as the processing of employment-related forms. Consumers paid some fiscal agent fees (such as for cutting and stopping checks).
Entity conducting reassessment	Agencies (for traditional program) and counselors (for allowance recipients).	Support coordinators or case managers (for traditional program) and counselors (for allowance recipients).	Agencies (for traditional program) and Medicaid nurses (for allowance recipients).
Participation in other consumer-directed or home care programs	Demonstration enrollees could also participate in the HCBS waiver programs ElderChoices or Alternatives. ²	For adults with developmental disabilities, the demonstration excluded some northern counties with a state-funded consumer-directed program.	Demonstration enrollees could not participate in HCBS waiver programs or a state-funded consumer-directed program.

SOURCE: Mathematica Policy Research, Inc.

* HCBS=home- and community-based services.

¹ HCBS services covered under Florida's waiver included a wide variety of services, including behavioral therapy and personal care supplies, as well as personal care.

² ElderChoices provides nurse-supervised homemaker, chore, and respite services to nursing home-qualified elderly adults. Alternatives provides attendant care and environmental modifications to nonelderly adults and lets them choose and supervise caregivers. Among demonstration enrollees, 62 percent of the elderly participated in ElderChoices, and 9 percent of the nonelderly participated in Alternatives.

cash & counseling consumer story

Mr. Calvin Dodson, Trenton, N.J.



Calvin Dodson, who is blind, has impaired physical coordination from being struck by a car, and requires dialysis for kidney disease, remembers well the challenges of working with a home care agency.

“I used to change agencies every three months because I was so frustrated,” he says. “It seemed like I got a different worker every week. I was always having to explain everything from the beginning, every time. And those that came, usually came late or left early, and never wanted to do the jobs I needed them to do.”

Despite his physical challenges, Calvin, who is 50, wants to be independent for as long as he can. Through New Jersey’s Cash & Counseling program, called Personal Preference, Calvin has been able to hire people he knows he can rely on. “I’ve only had three different workers since I joined Personal Preference six or seven years ago,” he says. Currently, his sister works for him in the mornings and evenings.

Calvin also used part of his monthly Personal Preference allowance to purchase a voice-activated microwave so he could prepare his own food, as well as voice-recognition software for his computer so he could do his own online shopping for groceries, clothes and other necessities.

“I tell other folks in the building about Personal Preference,” he says. “I tell them it’s me who is in control, instead of the agency. I know that the money is paying for what it is supposed to pay for. And the money I’m able to pay my sister helps her out too.”

Cash & Counseling

Evaluation Results

In general, Cash & Counseling worked well for consumers of all ages—including the elderly—and their caregivers. It appears to be an excellent option for states seeking to increase access to personal care and improve the well-being of both consumers and caregivers. Despite the favorable outcomes, however, careful attention must be paid to the design and implementation of a Cash & Counseling program to ensure that the program runs efficiently and to avoid unnecessary cost increases.

Six of the most significant findings of the Cash & Counseling evaluation include:

1. **Cash & Counseling significantly reduced the unmet needs of Medicaid**

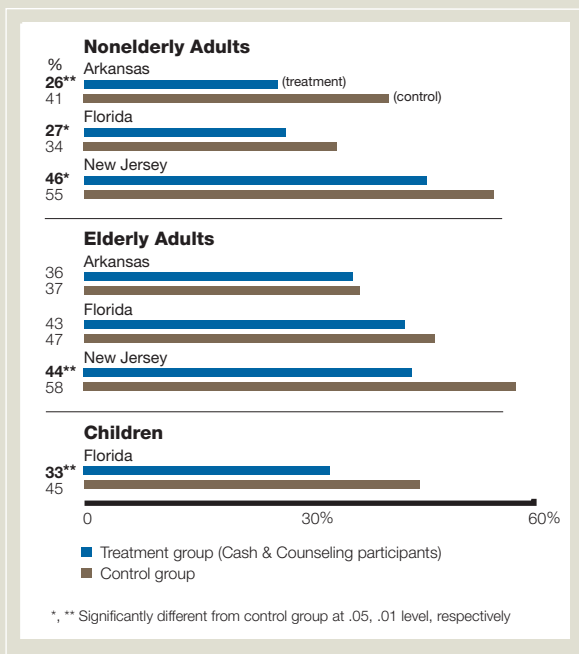
consumers who require personal assistance services. Compared to control groups, Cash & Counseling reduced the percentage of people reporting unmet needs by 10 to 40 percent in each of the three states, and significantly increased the percentage of consumers receiving services in Arkansas and New Jersey.

- In Arkansas, nine months after enrolling, 95 percent of Cash & Counseling participants reported receiving paid personal assistance services in the previous two weeks, while less than 75 percent of the control group received any paid personal assistance services. Even control group members who did receive services got only 68 percent of the care hours they were approved to receive.
- In New Jersey, nine months after enrollment, more than 90 percent of the Cash & Counseling participants received services in the previous two weeks, while about 80 percent of control group members received services in the same time period.

2. **Cash & Counseling participants experienced positive health outcomes.**

Cash & Counseling participants in all age groups in all three states were no more likely to suffer any care-related health problems than those receiving traditional agency services. In some cases, Cash & Counseling enrollees demonstrated a reduced risk of experiencing health problems, such as urinary tract infections, and adverse events, such as falls. In almost one-third of the comparisons made for the separate age groups in each state on 11 different health-related measures,

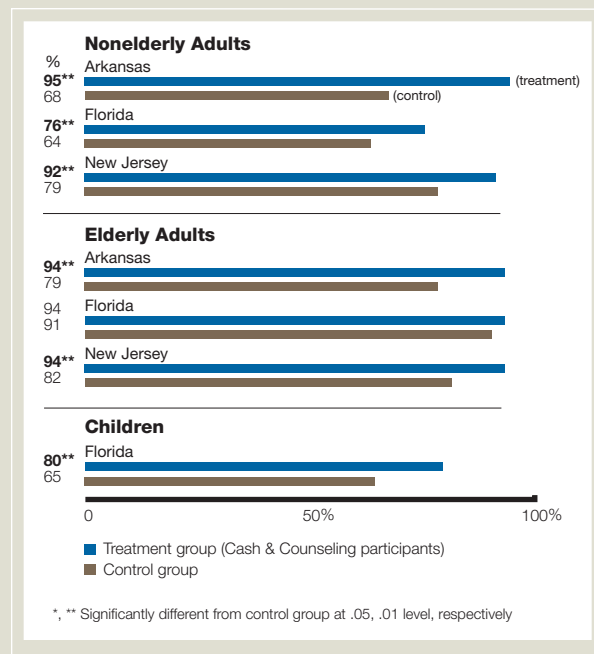
Percentage of Consumers Reporting an Unmet Personal Care Need at Nine Months



SOURCE: Mathematica Policy Research, Inc.

NOTE: Sample is restricted to consumers residing in the community at the time of the nine-month interview.

Percentage of Consumers Receiving Paid Personal Assistance at Nine Months



SOURCE: Mathematica Policy Research, Inc.

NOTE: Sample is restricted to consumers residing in the community at the time of the nine-month interview.

Cash & Counseling participants were significantly less likely to experience health problems than those receiving traditional services. For example:

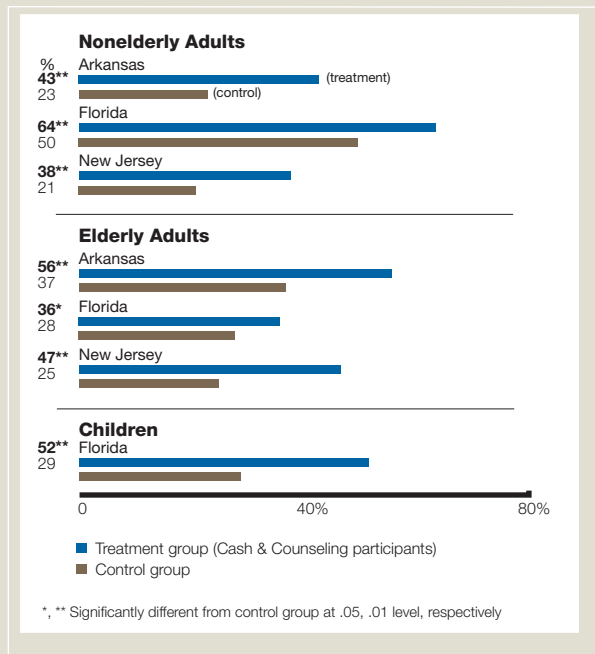
- In New Jersey, elderly and nonelderly adult Cash & Counseling enrollees were less likely than control group members to have fallen.
- In Arkansas and New Jersey, elderly Cash & Counseling participants were less likely to have had contractures develop or worsen than members of control group.
- Nonelderly adult Cash & Counseling participants in Florida were less likely than the control group to have urinary tract infections.
- Nonelderly adults in both Arkansas and New Jersey were less likely than their control group peers to have had bedsores develop or worsen.

Thus, initial concerns that Cash & Counseling might place participants at greater risk of illness or injury were unwarranted.

3. Cash & Counseling improved quality of life for participants and their caregivers.

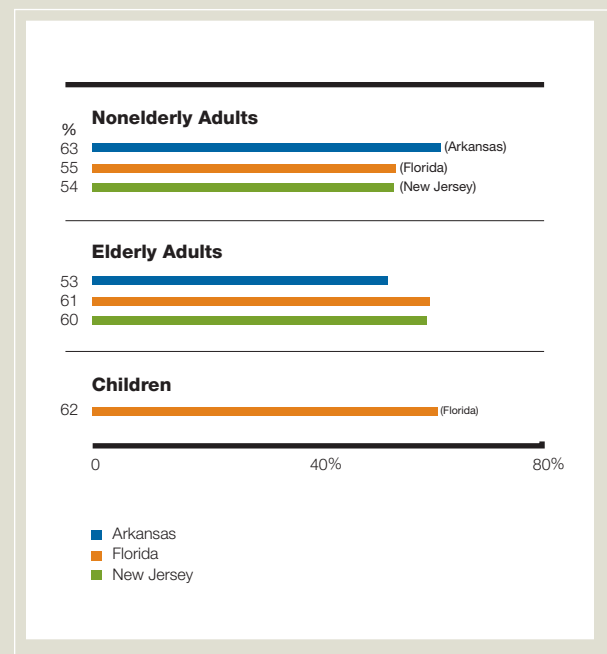
Across all three states, Cash & Counseling participants were up to 90 percent more likely than those in the control group to be very satisfied with how they led their lives. They also were half as likely to report that they were dissatisfied with their lives. Up to two-thirds of those enrolled in Cash & Counseling reported that the program had greatly improved their lives, and at least 85 percent of participants said they would recommend the Cash & Counseling program to others.

Percentage of Consumers Reporting They Are Very Satisfied with Life



SOURCE: Mathematica Policy Research, Inc.

Percentage of Consumers Reporting that Cash & Counseling Improved Their Lives a Great Deal



SOURCE: Mathematica Policy Research, Inc.

Cash & Counseling also greatly improved the quality of life for participants' primary unpaid caregivers—those who delivered the lion's share of unpaid personal assistance services to consumers before Cash & Counseling started. Examples of primary caregivers are the adult daughter of a frail elderly parent or the mother of a child with disabilities. Under Cash & Counseling, these primary caregivers were significantly less likely to report being dissatisfied with the consumers' paid care when compared to the primary caregivers of control group members.

4. **Medicaid personal care costs were somewhat higher under Cash & Counseling, mainly because enrollees received more of the care they were authorized to receive.** In Arkansas and New Jersey, higher costs under Cash & Counseling resulted from so many more consumers receiving the paid hours of service they were authorized to receive. Recipients of agency care in these two states received only a fraction of their authorized care plan hours, and some received no services at all. In Florida, the higher costs under Cash & Counseling were the result of short-term statewide increases in funding for personal care for people with disabilities, the timing of which made increased funds more available to Cash & Counseling enrollees than to consumers in the control group.
5. **Increased Medicaid personal care costs under Cash & Counseling were partially offset by savings in institutional and other long-term-care costs.** Costs for other Medicaid services, primarily nursing home and other types of long-term care,

were lower under Cash & Counseling in each state and each age group. The most significant differences in the first year after enrollment were for younger adults in Arkansas and for children in Florida. For those two groups, nonpersonal care costs were 17 percent and 15 percent lower, respectively, under Cash & Counseling compared to the control groups. For each of the other age groups in these two states and for both younger and older adults in New Jersey, nonpersonal care costs were 4 to 7 percent lower under Cash & Counseling.

In Arkansas, in particular, savings in long-term-care costs under Cash & Counseling helped offset higher personal care costs. A special, longer-term follow-up study of the Arkansas Cash & Counseling program showed that savings in long-term care persisted in the third post-enrollment year. By then, Cash & Counseling had reduced nursing facility use 18 percent over the entire three-year study period. The results are especially striking for consumers who were receiving agency services before enrolling in Cash & Counseling. For this group, the savings in other Medicaid services fully offset the higher personal care costs over the three-year grant period. In Florida and New Jersey, total Medicaid costs for Cash & Counseling participants during the second year were 8 to 12 percent higher than they would have been had those beneficiaries not enrolled in Cash & Counseling. Data from the third post-enrollment year are not available for Florida and New Jersey.

- 6. Cash & Counseling need not cost more than traditional programs if states carefully design and monitor their programs.** Cash & Counseling does not need to cost states more than its traditional Medicaid personal care programs. How? States can design their Cash & Counseling programs so that the cost per month is budgeted to match the cost per month of its traditional system, assuming that home care agencies will fully meet their care obligations. If the traditional system delivers the services beneficiaries are authorized to receive, there should be no difference in planned costs.

Additional cost-controlling strategies to consider include:

- Paying less for financial management and counseling services than home care agencies would be paid for administrative overhead, which is feasible and appropriate because consumers take over some responsibilities.
- Recovering allowance amounts that are not used. Cash & Counseling allows enrollees to carry over unused allowance funds from month to month, but states should require that any unbudgeted funds remaining at the end of the year be returned to the state.
- Regularly monitoring the costs of both Cash & Counseling and home care agency programs, and reducing allowances for Cash & Counseling consumers if they exceed spending on agency services for consumers with comparable care plans. However, Cash & Counseling consumers should not be penalized if those receiving agency services do not get all of their authorized hours.

cash & counseling consumer story

Ms. Karla Herrera, Miami, Fla.



Karla Herrera, 22, was born with microcephaly, cerebral palsy, and spastic quadriplegia. Her disabilities are severe and she requires constant help and supervision. But her mother, Yolanda Herrera, has big plans for her. “By next year,” Yolanda says, “she will be living a typical life, with assistance.”

With the resources and flexibility provided by Florida’s Cash & Counseling program, called Consumer Directed Care Plus (CDC+), Karla has made quantum leaps developmentally. Before enrolling in CDC+ five years ago, Karla received personal assistance services, mostly for basic hygiene, from a home health agency. Today, with assistance, Karla performs many of the day-to-day activities previously done for her by a home health aide. She reads on a first-grade level. She walks. She uses a portable picture-based computer system to communicate. Karla recently graduated from high school and will soon begin attending a culinary program at a vocational school.

“Karla’s disabilities are so severe that she will always need someone to guide her,” says Yolanda, “but she has done a lot in a very short time. And we’re not done yet.”

Cash & Counseling Going Forward

Today, the three original Cash & Counseling states are continuing and, in some cases, expanding their Cash & Counseling programs. And, based on the promising outcomes of the demonstration program, both the Robert Wood Johnson Foundation and the U.S. Department of Health and Human Services funded, in October 2004, an expansion of the program to 11 more states: Alabama, Iowa, Kentucky, Michigan, Minnesota, New Mexico, Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia. Another state, Illinois, was funded separately by the Retirement Research Foundation to create a Cash & Counseling option, bringing the total number of states implementing Cash & Counseling to 15. As with the original three-state program, the Cash & Counseling national program office (NPO) located at the Boston College Graduate School of Social Work coordinates and directs the replication project and provides ongoing technical assistance to the states.

As of early 2007, the Cash & Counseling expansion states were in various stages of program implementation with all states expected to be fully functioning and enrolling consumers in 2007.

Twelve States Implementing a New Cash & Counseling Option

(Note: Chart details updated since Fall 2006 version of publication)

STATE	PROGRAM NAME	GOALS	TARGET POPULATION	NUMBER OF ANTICIPATED PARTICIPANTS	AREA SERVED	WAIVER USED	LEAD AGENCY	GRANT AMOUNT
Alabama	Personal Choices	To expand consumer direction as an option in all traditional waivers.	Seniors and adults with physical disabilities currently receiving personal care or personal assistance in certain waivers.	90 in first year of enrollment	Seven counties: Bibb, Fayette, Greene, Hale, Lamar, Pickens, and Tuscaloosa	1915(j)	Alabama Department of Senior Services	\$250,000
Illinois	Cash & Counseling	To expand consumer direction opportunities for Illinois' frail elderly.	Frail elderly age 60 and over.	200 in state fiscal year 2007	Four regions containing Kankakee, Tazewell, Marshall, Stark, Woodford, Macon, Bond, Clinton, Washington, Monroe, Randolph, and Madison counties	None at this time	Illinois Public Health Association and Illinois Department on Aging	\$378,000 from Retirement Research Foundation
Iowa	Consumer Choices Option	To use public funds as investments in people's lives rather than as mere mechanisms to purchase human services.	Older Iowans and people with disabilities who are eligible for HCBS waivers.	400 in first year of enrollment	Statewide by July 2007	1915(c)	Iowa Department of Human Services	\$250,000

Twelve States Implementing a New Cash & Counseling Option (continued)

STATE	PROGRAM NAME	GOALS	TARGET POPULATION	NUMBER OF ANTICIPATED PARTICIPANTS	AREA SERVED	WAIVER USED	LEAD AGENCY	GRANT AMOUNT
Kentucky	Consumer Directed Option	To give consumers the option to control their non-medical 1915(c) waiver services,	People eligible for one of Kentucky's three 1915(c) waivers, which serve people who are elderly or have disabilities, people with mental retardation or developmental disabilities, and people with acquired brain injuries	250 in first year of enrollment	Statewide	1915(c)	Cabinet for Health and Family, Department for Aging and Independent Living	\$250,000
Michigan	Self-Determination in Long-Term Care	To empower MI Choice participants through person-centered planning and control over service provision and resource utilization.	Elders and younger persons with physical disabilities.	600+ by the end of the three-year grant period	Four pilot sites: Detroit; Upper Peninsula, Lansing area, and South-west Michigan, with statewide expansion planned	1915(c)	Office of Consumer-Directed Home- & Community-Based Services, Michigan Department of Community Health	\$250,000
Minnesota	Consumer Directed Community Supports	To create permanent, multi-point, statewide access to a consumer-directed option for older adults, adults with physical disabilities, and their family caregivers.	Older adults and adults with physical disabilities.	750 by September 30, 2007	Statewide	1915(c)	Minnesota Department of Human Services	\$350,000
New Mexico	Mi Via (My Way)	To facilitate greater participant choice and control over the types of services and supports that are purchased within an agreed-upon budgetary amount; to increase awareness and knowledge about Mi Via as a valuable waiver choice; to serve the most people possible within available resources.	Current participants in Medicaid waiver programs: Disabled and Elderly, Developmentally Disabled, HIV/AIDS, and Medically Fragile. Persons with brain injuries will also be eligible.	400 by October 2007	Statewide	1915(c)	New Mexico Aging and Long-Term Services Department	\$349,153
Pennsylvania	Cash & Counseling	To permit people with disabilities or limitations to have the right to live in the least restrictive and most integrated setting appropriate to their needs and to receive consumer-centered services.	Pilot program for frail elderly.	400 by end of three-year grant period	Initially available in pilot sites, with the goal of phasing it in statewide for more populations.	1915(c)	Governor's Office of Health Care Reform	\$250,000
Rhode Island	Personal Choice	To enable Medicaid recipients to direct their own services and supports by allowing the maximum flexibility of fund distribution to meet individual needs and preferences, while preserving necessary accountability to the state and federal governments.	Adults with disabilities and elders who are eligible for certain waivers.	400 by end of three-year grant period	Statewide	1915(c)	Rhode Island Department of Human Services, Center for Adult Health	\$250,000
Vermont	Flexible Choices	To further shift the balance to home- and community-based services, and advance current trends in consumer direction.	Elders and adults with disabilities.	50 in first year, 250 by end of grant period	Statewide	1115	Department of Disabilities, Aging and Independent Living	\$249,416
Washington	New Freedom	To implement a service system that will expand consumer-directed care to a state-of-the-art level.	Adults with disabilities and older individuals who require nursing facility level of care.	100 in first year	King County	1915(c)	The Department of Social and Health Sciences	\$250,000
West Virginia	Personal Options	To have a home- and community-based system that is driven by the needs of consumers.	INITIALLY: Seniors over age 60 and adults with physical disabilities. FUTURE: Children and adults with mental retardation and developmental disabilities.	400 by end of three-year grant period	Statewide	1915(c)	Bureau of Senior Services	\$250,000

Cash & Counseling and the 2005 Deficit Reduction Act

Cash & Counseling's success to date has created champions for the model within the federal government. The most notable evidence: the 2005 Deficit Reduction Act (DRA), which took effect on January 1, 2007 and removed the requirement that states must apply for and be granted a Section 1115 or 1915(c) waiver before adding a Cash & Counseling option to their Medicaid programs.

Specifically, the DRA makes available to states several new options for implementing a Cash & Counseling program.

- Section 6086 of the DRA created a new Section 1915(i) of the Social Security Act, which allows states to amend their Medicaid state plans to offer home- and community-based waiver services as an optional benefit to consumers whose incomes are below 150 percent of the federal poverty level.
- Section 6087 of the Deficit Reduction Act created a new Section 1915(j) of the Social Security Act, which allows states to offer, without first obtaining a waiver, a “cash & counseling” option within their regular Medicaid state plans. Section 1915(j) authorizes states to offer program participants a flexible budget as opposed to a limited number of aide visits or hours of service. States also will be able to define more broadly the range of personal care services covered under their Medicaid plans and participants in self-directing programs will be permitted to purchase goods and services (such as chairlifts and touch lamps) and make environmental modifications (such as adding wheelchair ramps to their homes) that decrease their dependence on helpers and enable them to live more independently.
- The Money Follows the Person Rebalancing Demonstration will make \$1.75 billion in competitive grants available to states that create “choice-based” financing for long-term-care services, such as implementing a Cash & Counseling option. Essentially, this federal grant program will help financially support states as they strengthen their systems of community-based supports and move more eligible Medicaid consumers with disabilities from institutional settings back to their homes and communities.

Cash & Counseling and the Older Americans Act

Other publicly funded programs, besides Medicaid, are adding self-directed personal assistance services to the care options they make available to eligible consumers. The Older Americans Act (OAA), which supports a federal, state, tribal, and local partnership known as the National Aging Services Network, has been providing services to older adults since 1965. Included in the recently reauthorized OAA are the principles of a new initiative, Choices for Independence. Part of this initiative, the Community Living Incentive, is based on the essential elements of Cash & Counseling and provides flexible funding targeted at people who are risk of nursing home placement but are not yet eligible for Medicaid. New language in the reauthorized OAA defines self-directed care and amends Title II, Section 202, adding the provision of services should include “self-directed models” that allow participants “to direct and control the receipt of support services” based on their needs and preferences, and with control over budgeting for and purchasing those services.

Conclusion

When Cash & Counseling was launched in 1996, its designers did not know if frail elderly Medicaid consumers and those with disabilities could and would successfully manage their own personal assistance services at home. Today we know that they can and will—and that they are likely to benefit as a result.

As evidenced by the independent evaluation, the Cash & Counseling model of self-directed personal assistance services significantly improves the lives of people of all ages who need such services, as well as the lives of their unpaid primary caregivers. It also increases access to personal assistance services, helps consumers maintain their health status, and it does not increase fraud and abuse. Furthermore, it does not cost more than traditional agency services, if states design and monitor their programs carefully.

Policy-makers and state program administrators have expressed concern that because Cash & Counseling allows the payment of family caregivers, Medicaid might end up paying for care that relatives would otherwise provide free. But states only authorize personal assistance services that a person's unpaid caregivers cannot provide. For example, a daughter who provides care in the evenings and on weekends may be unable to do so during weekdays because she is at work. Thus, once the state has assessed a person's need and determined the level of Medicaid-financed home care that is appropriate and necessary, it does not matter whether the paid caregiver is from an agency, a stranger hired through a newspaper ad, or a friend or relative. At that point, Medicaid has determined that the consumer requires assistance beyond what can be reasonably expected from unpaid caregivers.

The evaluation results show that Cash & Counseling is a viable option for policy-makers interested in shifting the balance of long-term-care services from institutional to community settings. By providing participants the help they need to remain at home and reducing the burden on primary caregivers, Cash & Counseling may delay or reduce nursing home use. Recently enacted federal provisions are expected to streamline or eliminate bureaucratic requirements that made it difficult for states to introduce a flexible budget option. It should now be much easier for states to implement Cash & Counseling so that thousands more consumers will have greater choice and control over the care they receive.

Visit These Web Sites for More on Cash & Counseling

Cash & Counseling National Program Office

www.cashandcounseling.org

The Cash & Counseling Web site contains extensive resources on the program and on self-directed personal assistance services in general. Among the items found here are a searchable bibliography of research papers and published journal articles as well as sample materials from individual Cash & Counseling state programs, including assessment tools, enrollment forms, sample contracts with fiscal management agencies, and outreach and marketing materials. Also available are a user-friendly interactive data tool that allows users to review data, create charts, and explore statistics from the original Cash & Counseling demonstration and qualitative interviews conducted by the University of Maryland, Baltimore County with 75 Cash & Counseling participants and their families about their experiences. The site also contains helpful links to other Web sites, including individual Cash & Counseling programs by state.

The Robert Wood Johnson Foundation

www.rwjf.org

The RWJF Web site contains both general and specific information on this national health care philanthropy and its grant programs. Cash & Counseling falls within the Foundation's Vulnerable Populations Portfolio.

Office of the Assistant Secretary for Planning and Evaluation (ASPE)

<http://aspe.hhs.gov>

Information on ASPE and on consumer direction in general and on Cash & Counseling in particular. Click on "consumer direction" or search on "Cash & Counseling" for a list of research papers available from ASPE.

Administration on Aging (AOA)

www.aoa.gov

Information on AOA and on a variety of topics related to aging, including resources for elderly consumers and their caregivers. Also includes some general information about Cash & Counseling.

Centers for Medicare & Medicaid Services (CMS)

www.cms.gov

Extensive resources available on Medicaid waiver programs, consumer direction, and the 2005 Deficit Reduction Act.



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