



CASH & COUNSELING PROGRAMS GIVEN MAJOR BOOST

Christina Kent

Policymakers have long discussed the importance of making the consumer the center of care. Now a Medicaid program that does just that is catching on around the country, driven by studies that show the model improves the quality of care without causing costs to skyrocket; a provision in the 2005 Deficit Reduction Act (DRA); and start-up grants given to 15 states.

The program—Cash & Counseling (C&C)—allows disabled, frail and elderly individuals who receive Medicaid personal care services to select those services and the person who should provide them. Rigorous testing in **Arkansas, Florida and New Jersey** showed that C&C improved the delivery of services, without leading to fraud or abuse of the care receiver. Congress was so impressed that it included a provision in the DRA removing the requirement that states get a waiver before instituting C&C. As of January 1, 2007, states can write a C&C option into their state Medicaid plan.

“There’s no question that the Cash and Counseling model of self-directed personal assistance services can help states...better serve the long-term care Medicaid population,” said Kevin Mahoney, national program director of the Cash & Counseling Program Office at Boston College.

Taking Care of Business

Medicaid gives states the option of covering personal care services (such as help in getting out of bed and bathing) for disabled beneficiaries. Traditionally, case managers assess beneficiaries’ needs and home care agency personnel deliver approved services.

Policy experts and advocacy groups theorized that Medicaid recipients might benefit if they had more control over their own care. So in the late 1990s, [The Robert Wood Johnson Foundation](#) (RWJF) and the [Department of Health and Human Services](#) (HHS) joined together to provide grants to the three states listed above to help them establish C&C programs. (The states had to obtain waivers from HHS to do so.)

Under the pilot project, enrollees got a budget based on the funds that would otherwise have been spent on agency care. With the help of counselors, participants decided what services (and/or devices such as wheelchair ramps or even a microwave oven) they needed and which caregivers they wanted to hire to help them. Caregivers may be family members, but all the services must be approved and obtainable within the budget. Those who desired it also received help in managing their budgets from a fiscal representative.

Participants pilot were randomly assigned to either C&C or to home care agencies. Mathematica analyzed the controlled experiment and reported that the large majority of C&C participants said the program significantly improved the quality of their lives and the lives of their primary caregivers. Concerns about fraud and abuse were unfounded.

Overall costs to Medicaid were somewhat higher for C&C participants in each state, but this occurred mostly because the home care agencies failed to deliver all the care that was approved for consumers in the control group. “In every state we wound up spending more on personal care, but less on other Medicaid services,” such as admissions to nursing homes, Mahoney said.

In 2004, RWJF and HHS came together again to help launch C&C programs in 12 additional states, providing each—**Alabama, Iowa, Kentucky, Michigan, Minnesota, New Mexico, Pennsylvania, Rhode Island, Vermont, Washington and West Virginia**—with a three-year grant of up to \$250,000. In addition, **Illinois** received a grant from the Retirement Research Foundation to start up its own C&C effort. Currently, 10 of those states have their programs up and running, and two more are in the process of creating them, said Mahoney.

A Wide Variety

No two state C&C programs are alike. “Each state adapts it to its own system, politics and culture,” said Mahoney. Political support for the programs has generally been strong, Mahoney added. “We’re one of those very rare instances where we’ve pretty much had solid bipartisan support.”

To date, only two states have passed legislation authorizing C&C; others have relied on administrative actions. The Florida Legislature passed enabling legislation ([SB 1276](#)) in 2002, and then, having received an 1115 waiver for the C&C program, “cashed out” the home- and community-based services covered under its Medicaid 1915(c) programs for disabled children and adults. Florida, like many other states, sought to ensure budget neutrality by discounting the enrollees’ monthly budgets—in Florida’s case by roughly 10 percent, depending on the population served. (States also can keep costs down by controlling enrollment—by, for example, allowing only those who are already receiving Medicaid home care services to be eligible for C&C as opposed to opening the program to new applicants.)

In 2005, Kentucky enacted authorizing legislation ([SB 116](#)) for its “Consumer Directed Option” program. State officials are enrolling individuals who are covered under one of the Bluegrass State’s 1915(c) waivers, including aged and disabled beneficiaries, and those with acquired brain injuries. The state plans to enroll 250 participants in the first year.

“It wasn’t difficult to drum up support” in the Kentucky General Assembly, said bill sponsor Representative Jimmy Lee. “But I was surprised that there were so many different ideas about what independent living should be. We had a pretty good debate.”

One of the things legislators discussed was whether family members should be allowed for C&C employment. “We decided, who better to give you a bath than your sister?” Lee said. The program should be especially useful in rural areas, where home care personnel—and jobs—may be in short supply, Lee added. “If you could get your sister to help, and help her to get compensation, that’s a win-win.”

Far From Easy

C&C appears to make so much sense that it was endorsed by the Medicaid Commission that recommended long-term Medicaid reforms to HHS Secretary Michael Leavitt late last year.

Nevertheless, implementation is far from easy, as it involves reeducating beneficiaries about their home care delivery, hiring consultants to help individuals determine which services (or devices) are desirable and helping beneficiaries to decide whether they need help from a fiscal representative to manage the financial aspects of the program (enrollees must, for example, pay taxes for their new home care employees).

The Mathematica report on Florida’s program noted that case management agencies often have their clients’ trust and can easily discourage enrollment if they are opposed to the concept of consumer direction. Also, Mathematica found, because the purchasing plan is critical to ensuring that the allowance is not abused, it must be revised to accommodate changes in consumer needs. Doing so requires a substantial amount of time from consultants and other program staff.

Regardless of how popular C&C becomes, there always will be a need for home care agencies, Mahoney said. Beneficiaries are allowed to choose between C&C and agency home care, and some prefer agency care. Also, “what if the caregiver should move away or die?” Mahoney asked.

Meanwhile, researchers are getting closer to weeding out program design features that don’t work, from those that do. “We’re getting closer and closer to having national guidelines” that states could tailor to their own needs, Mahoney said.

A wealth of information, including descriptions of individual state programs, is available at:

<http://www.cashandcounseling.org/>

<http://www.rwjf.org/>

<http://aspe.hhs.gov/>; <http://www.aoa.gov/>

www.kff.org/medicaid/upload/7579.pdf

A detailed description of all the DRA provisions that affect long-term care (including C&C, a home- and community-based state plan option, and a money follows the person demonstration project) is at www.cashandcounseling.org/resources/20060404-112138/BackgroundMemoFeb28TechAssistCall2-20-06.doc

© 2007 National Conference of State Legislatures, All Rights Reserved

Denver Office: Tel: 303-364-7700 | Fax: 303-364-7800 | 7700 East First Place | Denver, CO 80230 | [Map](#)

Washington Office: Tel: 202-624-5400 | Fax: 202-737-1069 | 444 North Capitol Street, N.W., Suite 515 | Washington, D.C. 20001