Policy Innovation Profile

Self-Directed Budget Enhances Access to Home Health and Other Needed Services, Resulting in Fewer Unmet Needs, Better Health Outcomes, and High Satisfaction for Medicaid Beneficiaries

Snapshot

Summary

As a voluntary alternative to traditional agency-delivered home care, a joint public-private program known as *Cash & Counseling* gives Medicaid enrollees a monthly allowance for home care and related services that they can spend at their own discretion. Participants receive a budget allocation based on their unique needs that they can use not only to hire home health workers (including friends and relatives), but also to purchase goods and services to allow them live independently. Participants receive assistance in developing and executing their spending plans, and have access to services to help them manage their finances. Compared to traditional agency-based home care, *Cash & Counseling* enhanced access to personal care services, reduced unmet needs, improved selected health outcomes (such as the likelihood of a fall or bed sore), and increased beneficiary satisfaction, without increasing the risk of fraud or abuse.

Evidence Rating (What is this?)

Strong: The evidence consists of a randomized controlled trial (RCT) comparing various outcomes for Cash & Counseling participants to those receiving traditional agency-delivered home health services, including service use, unmet needs, incidence of health problems, participant satisfaction, and incidence of fraud and abuse. The study evaluated care in the first three states to implement the program--New Jersey, Arkansas, and Florida.

Developing Organizations

Administration on Aging; Office of the Assistant Secretary for Planning and Evaluation in the United States Department of Health and Human Services (ASPE/DHHS); Robert Wood Johnson Foundation; The Cash & Counseling National Program Office

The program was developed in collaboration with the Centers for Medicare & Medicaid Services (CMS) by a group of organizations in the public and private sectors, including the Administration on Aging, the Robert Wood Johnson Foundation, the Office of the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services, and the Boston College Graduate School of Social Work.

The National Program Office of *Cash & Counseling* is located at the National Resource Center for Participant-Directed Services of the Boston College Graduate School of Social Work. The University of Maryland Center on Aging provides research assistance to the program, while Mathematica Policy Research, Inc. and the University of Maryland, Baltimore County have conducted formal evaluations of the program.

Date First Implemented

1998
The original demonstration project took place between 1998 and 2003 in Arkansas, Florida, and New Jersey, after which the program was replicated in 12 additional state Medicaid programs between 2004 and 2009. The 2006 re-authorization of the Older Americans Act fostered similar efforts with the agency network. The Veterans-Directed Home and Community-Based Services program, which is modeled after *Cash & Counseling*, began in 2008 and is operated as a partnership of the Administration for Community Living (formally Administration on Aging) and Veterans Health Administration.

Patient Population

Age > Aged adult (80 + years); Vulnerable Populations > Disabled (developmentally); Disabled (physically); Frail elderly; Impoverished; Insurance Status > Medicaid; Vulnerable Populations > Military/Dependents/Veterans; Age > Senior adult (65-79 years)

What They Did

Back to Top

Problem Addressed

Medicaid beneficiaries (particularly the frail elderly and those with disabilities who live in rural or high-crime urban areas) often do not receive high-quality home care and other support services needed to remain independent. Barriers to providing such support include staff shortages, the inability to tailor services to beneficiary needs, and limitations on the scope of services that can be offered.

- **Staff shortages:** Home care agencies serving Medicaid enrollees often experience worker shortages and high staff turnover, making it difficult for them to meet beneficiary needs, particularly for those living in rural and high-crime urban areas.
- **Suboptimal quality**: Medicaid beneficiaries often express dissatisfaction with the services offered by traditional home care agencies. Common complaints include lack of reliability and the failure to complete all assigned tasks; neglect or abuse can also occur.[1]
- **Little flexibility**: Home care agencies often cannot tailor services to meet individual consumer needs, particularly in relation to language preferences and scheduling (since most agencies do not provide evening or weekend care).[1]
- **Limited scope of services:** Liability concerns prevent traditional agency workers from providing transportation or administering medications, two services that are often needed by beneficiaries who require long-term support. Also

administering medications), two services that are often needed by beneficiaries who require long-term support. Also, many agencies will not pay for equipment (e.g., microwaves, air conditioners) or home modifications (e.g., lift chairs, wheelchair ramps) that facilitate independence and safety.[1]

Description of the Innovative Activity

As a voluntary alternative to traditional agency-delivered home care, *Cash & Counseling* gives Medicaid beneficiaries a monthly allowance for community-based home care and related services that they spend at their own discretion. Participants receive a budget allocation based on their unique needs that they can use not only to hire home health workers (including friends and relatives), but also to purchase goods and services that allow them to live independently. Participants receive assistance in developing and executing their spending plans, and have access to services to help them manage their finances. Key elements of this policy-based initiative are detailed below:

- **Outreach and enrollment:** Outreach and enrollment processes vary by state. Typically, current home care clients (often the frail elderly and those with disabilities) receive a letter and brochure about the program, and/or are told about it during an in-person home care assessment. Marketing materials are designed to be easy to understand and reflect the language diversity of the populations served. Enrollment in this voluntary program typically occurs during a home visit by a *Cash & Counseling* representative. Those who enroll do so in lieu of receiving the traditional Medicaid home care benefit for which they qualify.

- **Setting budget amount:** The program gives participants a fixed monthly budget they can use to pay for goods and services they choose to meet their individual health needs. The budgeted amount is based on a program representative's assessment of the individual's need for community-based services, with the allotment intended to reflect the monetary value of the needed services. A small amount may be subtracted to offset the cost of counseling and administrative services.
- **Participant-directed spending:** Participants are responsible for developing and following a spending plan, although they get assistance from program representatives in doing so (as described below). Those unable or unwilling to manage the budget on their own can appoint a representative to assist them. With the budget provided, they hire and manage home health and other support services, often hiring a friend or family member to provide such support. They can also use the money to pay for other goods and services to help them remain independent, such as home modifications, transportation, yard work, and appliances (e.g., washing machine, dryer, microwave oven, air conditioner).

- **Support services for participants:** *Cash & Counseling* staff offer counseling and financial management services to participants who need such help, as outlined below:

    - **Counseling:** Program staff help beneficiaries consider the broad range of goods and services needed, create a budget based on these needs, manage the paperwork required to pay employee wages and withhold taxes, track expenditures, and develop a backup plan if the participant-hired support worker cannot continue to support the individual. Counselors may also help participants use a registry (if available) to locate home care workers in situations where no friends or family members are available to fill this role.

    - **Financial management services:** The program offers various financial management services at little or no direct cost to participants, including bookkeeping, check writing, and filing tax returns.

- **Ongoing program monitoring:** Each state has its own process for monitoring program quality and facilitating quality improvement.[2] CMS requires the development of a system to monitor the quality of *Cash & Counseling* programs.

References/Related Articles

Mathematica Policy Research. Cash & Counseling: Improving the Lives of Medicaid Beneficiaries Who Need Personal Care or Home and Community-Based Services. Available at: http://www.mathematica-mpr.com/publications/pdfs/CCpersonalcare.pdf (If you don't have the software to open this PDF, download free Adobe Acrobat Reader® software External Web Site Policy.).

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Cash & Counseling Program. Web site provides program information, FAQs, resources and publications, and data and analysis tools. Available at: http://www.participantdirection.org/ and http://www.hcbs.org

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Innovator Disclosures

Dr. Mahoney has not indicated whether he has financial interests or business/professional affiliations relevant to the work described in this profile; however, information on funders is available in the Funding Sources section.

Did It Work? Back to Top

Results

Compared to traditional agency-based home care, *Cash & Counseling* enhanced access to personal care services, reduced unmet needs, improved selected health outcomes (such as the likelihood of a fall or bed sore), and increased beneficiary satisfaction, without increasing the risk of fraud or abuse.[1,3]

- **Enhanced access to services:** In an RCT comparing *Cash & Counseling* to traditional home care, the program significantly enhanced access to services in two of the three states studied (Arkansas and New Jersey, but not Florida). In these two states, participants were more likely to get paid help with housekeeping and routine health care, including assistance with medications, blood pressure checks, and exercise. For example, in Arkansas, 95 percent of elderly participants and 94 percent of nonelderly participants received services, compared to 68 and 79 percent of those receiving traditional agency-based home care under Medicaid.
- **Fewer unmet needs:** The program reduced the proportion of beneficiaries reporting unmet needs by 10 to 40 percent across the three states.
- **Equal or better health outcomes:** *Cash & Counseling* participants were significantly less likely than those receiving traditional agency-based services to experience many common health problems affecting Medicaid beneficiaries. Overall, program participants experienced a lower incidence for roughly a third of these problems. For example, in New Jersey, 19 percent of nonelderly adult participants experienced a fall, well below the 28-percent fall rate among similar individuals receiving traditional agency-based home health care. In Arkansas, bed sores developed or worsened in only 6 percent of nonelderly adult participants, compared with 13 percent of those receiving traditional care. No differences were found for the remaining two-thirds of health conditions studied.
- **Higher satisfaction:** Program participants in all three states were up to 90 percent more likely than those receiving traditional care to be "very satisfied" with the way they led their lives.
- **Cost savings in some states:** In Arkansas, the program saved $5.6 million over a 9-year period. In other states, total personal care costs increased under the program, as enrollees received more care they were authorized to receive. However, this increase was partially or fully offset by savings on institutional and other long-term care.
- **Virtually no fraud and abuse:** Although most participants hired family members and other people they knew, an evaluation uncovered virtually no fraud or abuse in this program.

Evidence Rating (What is this?)

Strong: The evidence consists of a randomized controlled trial (RCT) comparing various outcomes for Cash & Counseling participants to those receiving traditional agency-delivered home health services, including service use, unmet needs, incidence of health problems, participant satisfaction, and incidence of fraud and abuse. The study evaluated care in the first three states to implement the program--New Jersey, Arkansas, and Florida.

How They Did It Back to Top

Context of the Innovation

As stated earlier, Cash & Counseling was developed and sponsored by the Robert Wood Johnson Foundation and the Office of the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services, in close collaboration with CMS. The impetus for the program came from a desire to improve access to and satisfaction with home care services in light of current and projected home care workforce shortages. Currently, the National Program Office of Cash & Counseling is located at the National Resource Center for Participant-Directed Services of the Boston College Graduate School of Social Work.

The original *Cash & Counseling* demonstration project was conducted in Arkansas, New Jersey, and Florida beginning in 1998. Over time, national legislation facilitated spread of the program. *The Deficit Reduction Act of 2005* included Title 1915J, which, as of January 2007, allowed State Medicaid plans to offer the *Cash & Counseling* option without first obtaining a waiver. *The Older Americans Act*, reauthorized in 2006, included new provisions that encourage states to set up home- and community-based service programs for elderly individuals who are marginally above the income and asset-level thresholds for the Medicaid program. These provisions require these programs to include a consumer-directed option similar to that offered under the *Cash & Counseling* program. The Administration on Aging has supported this legislation by giving grants to 20 states to finance the provision of home- and community-based service programs; these grants also require inclusion of a *Cash & Counseling* option.

Planning and Development Process

Selected steps included the following:

- **Web-based software development:** Program staff developed Web-based, consumer-directed software to allow faster communication between participants and their support team, and to generate reports on participant expenditures.
- **Research to identify registries:** Program staff in different states identified worker registries (e.g., http://www.rewardingwork.com) to help find home health workers for participants who had no relatives, friends, or neighbors available to fill this role.
- **Training:** Faculty at Boston College Graduate School of Social Work developed a training curriculum for counselors. States implementing *Cash & Counseling* retrain existing case managers and/or hire and train new counselors to help participants manage the responsibilities of self-directed care. The National Resource Center assists with this training.
- **Quality management system:** Researchers developed a quality management system to assess ongoing program management in each state.[2] This work has informed development of requirements for Federal agencies related to *Cash & Counseling* quality management systems.
- **Program expansion:** After the three-state demonstration project proved successful, program funders provided grants in 2004 to replicate the program in 11 additional states. That same year, the Retirement Research Foundation provided funding to replicate the model in a 12th state. Since that time, many other states have adopted various elements of the program. In 2009, the Veterans Health Administration established the Veteran-Directed Home and Community Based Services Program, a similar program that serves the needs of veterans who require long-term service and support. As of 2012, 28 Veterans Administration Medical Centers in 18 states and the District of Columbia have such programs, which collectively serve more than 1,000 veterans. The program is expected to expand to 13 additional states.

Resources Used and Skills Needed

- **Staffing:** Staffing requirements vary widely by state, based on the roles designated to program staff. Additional information systems personnel may be required to address increased electronic monitoring and reporting requirements. More information about staffing, required training, and case load is available in "Developing and Implementing Self-Direction Programs and Policies: A Handbook" (see Tools and Other Resources, below).
- **Costs:** Detailed information on program-related costs, including staffing, can also be found in the handbook.

Funding Sources

Administration on Aging; Robert Wood Johnson Foundation; Veterans Health Administration; Office of the Assistant Secretary for Planning and Evaluation in the United States Department of Health and Human Services (ASPE/DHHS); The Cash & Counseling National Program Office; Atlantic Philanthropies Foundation

Tools and Other Resources

Applebaum R, Schneider B, Kunkel S, Davis S. A guide to quality in consumer-directed services. Oxford, Ohio: Scripps Gerontology Center, Miami University, 2004.

"Developing and Implementing Self-Direction Programs and Policies: A Handbook," a 10-chapter handbook on how to establish a consumer-directed Cash & Counseling program, is available at http://www.bc.edu/content/bc/schools/gssw/nrcpds/tools/handbook.html .

A report that summarizes "lessons learned" from the implementation experience, "Implementing Self-Direction Programs with Flexible Individual Budgets: Lessons Learned from the Cash & Counseling Replication States," is available at:

http://web.bc.edu/libtools/downloadfile.php?filename=1308260008_Report.pdf .

Adoption Considerations

Back to Top

Getting Started with This Innovation

- **Take advantage of available assistance:** Would-be adopters can benefit from the resources of the National Resource Center on Participant-Directed Services, including technical assistance and information provided on the center's Web site.

- **Directly target potential beneficiaries:** Along with community-wide education and marketing, engage in direct outreach efforts to target eligible beneficiaries.
- **Obtain agency buy-in:** Devote considerable effort to securing the cooperation of agencies providing traditional services, as their leaders may see the program as a threat and hence not be supportive of it.
- **Solicit participant suggestions:** Obtain input from participants, families, and other stakeholders when designing, implementing, and improving the system of support services to be included in the program.
- **Facilitate access to service providers:** Develop mechanisms such as registries or informal lists of potential workers to help participants find and hire service providers, particularly those who do not have family or friends who can play this role. In addition, allow participants to hire the services of traditional agencies as a part of the program, as some may not want to hire their own workers.
- **Arrange for multiple service providers**: Have multiple, qualified organizations available to offer counseling and/or financial management services, in case one organization withdraws or performs unsatisfactorily.
- **Develop marketing materials in several languages:** Develop easy-to-understand resources and marketing materials that address the language diversity of the Medicaid population.

Sustaining This Innovation

- **Take steps to prevent abuse:** Continually monitor spending plans to ensure that they include only allowable goods and services. In addition, check worker time sheets and review any participant requests against plans. Finally, make periodic telephone calls and visits to ensure that participants are not exploited as their situations change.
- **Monitor and revise budgets as needed:** Review and revise the allocated budget and spending plans periodically to reflect changes in participant needs.

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Additional Considerations and Lessons

Use By Other Organizations

As noted earlier, after the initial demonstration program in Arkansas, Florida, and New Jersey, the *Cash & Counseling* program was adopted in other states, including Alabama, Illinois, Iowa, Kentucky, Michigan, Minnesota, New Mexico, Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia. Also as noted, a similar program for veterans operates in 18 states and the District of Columbia, with plans to expand to 13 additional states going forward.

Many states that have not formally adopted *Cash & Counseling* offer similar alternatives. In fact, by 2011, 298 participant-directed programs existed across the country, serving roughly 810,000 participants. Every state now offers at least one program with a participant-directed option (i.e., the ability to directly hire workers), while 44 states offer some type of individual authority over a budget.

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[1] Choosing independence: an overview of the Cash & Counseling model of self-directed personal assistance services. Princeton, NJ: Robert Wood Johnson Foundation; 2006. p. 7. Available at: http://www.hcbs.org/files/109/5420/RWJ_CC_final_nov22.pdf .

[2] Applebaum R, Schneider B, Kunkel S, et al. A guide to quality in consumer-directed services. Oxford, Ohio: Scripps Gerontology Center, Miami University; 2004. Available at: http://www.hcbs.org/moreInfo.php/doc/819 .

[3] Dale SB, Brown R. Reducing nursing home use through consumer-directed personal care services. Med Care. 2006 Aug;44 (8):760-7.

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