Implementation Lessons on Basic Features of Cash & Counseling Programs

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Abstract: Many of the basic features initially adopted by the Cash and Counseling demonstration programs in Arkansas, Florida, and New Jersey functioned well; others did not. During the first few years of the demonstration, each state learned from its experience. Each redesigned and refined its program to eliminate unsatisfactory features or minimize their effects. Based primarily on interviews with demonstration staff and other stakeholders, this paper draws lessons from their learning process on the design of basic features of Cash and Counseling programs. The lessons pertain to cooperating with existing service providers; outreach and enrollment; counseling and fiscal services; consumer spending plans and allowances; controlling program costs; and preventing misuse of the allowance and exploitation of the consumer.
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As several papers in this issue show, the Cash and Counseling demonstration programs achieved many of their intended effects. Consumer satisfaction with care and quality of life were significantly higher in the treatment than in the control group (Carlson et al.), and caregiver burden was significantly lower (Foster, Dale, and Brown). Consumers were generally satisfied with the counseling and fiscal services the programs provided and, above all, valued the opportunity to choose their own paid workers (Schore). For their part, these directly hired workers were satisfied with their jobs and the way consumers treated them (Foster, Dale, and Brown). Program counselors concurred that consumers and their representatives ably directed their care (Schore).

Long before program outcomes were measured and reported, of course, the states chosen to participate in the demonstration had to take a broadly defined model of consumer-directed personal assistance services and transform it into three real programs. As Phillips and Schneider describe in this issue, the states faced challenges garnering support from existing service providers, meeting enrollment targets required for the evaluation, and controlling program costs. They also decided to modify the way they structured counseling and fiscal services and helped consumers develop plans for spending the program allowance. States took steps to prevent misuse of the allowance and exploitation of consumers and they reported few actual problems in these areas.

With the advantage of hindsight, this paper draws on the experiences of Arkansas, Florida, and New Jersey to present lessons about launching and running effective Cash and Counseling programs. The lessons are not absolute or proscriptive, but are meant to help other states think ahead about the possible benefits and drawbacks of some of the decisions they may face while designing and implementing a program of consumer-directed Medicaid supportive services.

DATA SOURCES

The information in this paper comes mostly from interviews. MPR staff visited each of the demonstration programs about 18 months after they began to operate (March 2000 in Arkansas, January 2002 in Florida, and April 2001 in New Jersey). We conducted semi-structured, in person interviews with roughly 30 people in each state, including officials from the state agencies involved in the demonstration, the directors and other staff members of the Cash and Counseling programs, representatives of the states' existing supportive services industries, and staff members of the organizations selected to provide counseling and fiscal services to consumers. In 2004, some two years after enrollment for the evaluation was completed, we conducted telephone interviews with demonstration officials at the national and state levels to ask about program experiences at that time.

This paper has limitations. It includes only information that interview respondents chose to divulge. Moreover, the lessons presented here were gleaned by the authors. They do not necessarily represent the opinions of the demonstration states, the Cash and Counseling National Program Office, the organizations that funded the demonstration and evaluation, or other stakeholders.

BACKGROUND

Prior to the introduction of Cash and Counseling, most eligible beneficiaries in the demonstration states received supportive services through a Medicaid state plan or home- and community-based services waiver program. These were mostly agency-based delivery systems, in which case managers or support coordinators developed the beneficiary's care plan, personal care attendants delivered the services therein, and nurses provided supervision. These systems of service delivery are criticized for being overly medicalized and too inflexible to meet

individual needs (Stone 2000; Eustis 2000; Doty, Mahoney, and Simon-Rusinowitz, in this issue).

By contrast, the Cash and Counseling demonstration gave eligible beneficiaries much more choice about their Medicaid supportive services. Beneficiaries chose whether or not to enroll in the demonstration, and enrollees assigned to the treatment group had the opportunity to: (1) receive a monthly allowance to hire workers and purchase services and goods within state guidelines; (2) designate a representative, such as a relative or friend, to help them make decisions about managing their care; and (3) use program-provided counseling and fiscal services to help them handle their program responsibilities.

LESSONS ABOUT PROGRAM IMPLEMENTATION

Existing Service Providers

Although consumer direction in publicly funded programs is becoming more common and more accepted by policymakers (Knickman and Stone in this issue), it remains a concern for existing providers of Medicaid supportive services. Thus, during the design phase of the demonstration, program staff conducted community outreach activities to garner backing for the demonstration from the supportive services industry and advocacy organizations.

Identify and Address Provider Concerns. Judging from the experiences of the demonstration states, existing providers of Medicaid supportive services will likely have two major concerns about consumer-directed programs. First, they may worry about beneficiary health, safety, and vulnerability to exploitation in the absence of professional oversight. Second, providers will likely worry about their own economic welfare. Consumer direction could threaten their market share and revenues. Moreover, if self-directing consumers hire agency aides, it could reduce the agency labor force.

Cash and Counseling programs can take several steps to address these concerns. The New Jersey program adopted a policy of discouraging consumers from hiring agency aides, and informed allowance recipients of the policy in writing. The program also attempted to appease personal care agencies by relieving them of hard-to-please clients. At a point when enrollment was lagging behind expectations, the program director expressly invited personal care agencies to refer dissatisfied clients to Cash and Counseling. Arkansas averted agency antagonism by

"cashing out" only its state personal care program, leaving a Medicaid waiver program for nursing-home eligible elderly beneficiaries to deliver services as usual. In Florida, senior state officials and staff from the consumer-directed program met multiple times with the executives of case management agencies to address their staff members' concerns that elderly beneficiaries were too frail to handle the responsibilities of consumer direction.

Outreach and Enrollment

Once the demonstration states were poised for program implementation, they used some combination of direct mailings, telephone calls, and home visits to reach eligible beneficiaries and explain Cash and Counseling in detail to those who were interested.

Despite mounting intense outreach efforts, each of the demonstration states took at least a year longer than expected to meet enrollment sample-size targets required by the evaluation. Slow enrollment is less worrisome outside an evaluation context, and other designers of consumer-directed programs have also overestimated enrollment levels (Eustis 1999; Arntz, Michaelis, and Spermann 2006). However, even if states *expect* to serve only a small minority of eligible beneficiaries through consumer-directed programs, they will need to build caseload quickly enough so that organizations providing counseling and fiscal services can do so efficiently.

To build caseload initially, avoid assigning responsibility for outreach and enrollment to agencies that provide traditional services. If traditional case management agencies do not support Cash and Counseling, their staff members will not be effective recruiters for the program. In light of agency concerns about Cash and Counseling, Arkansas and New Jersey limited agencies' involvement in outreach and enrollment activities. Instead, they hired or contracted for specialized enrollment staff to describe the program to those who were eligible and to enroll those who decided to participate. In contrast, Florida initially assigned responsibility for outreach and enrollment to the case managers and support coordinators in its existing Medicaid waiver programs. Enrollment levels lagged far behind expectations, however, in part because case managers and support coordinators were opposed to consumer direction or were pressed by other responsibilities. After several months of faltering enrollment, Florida too

hired temporary state employees as specialized enrollment staff. The pace of enrollment then increased in Florida.

After specialized enrollment staff build caseload, have program counselors explain Cash and Counseling to prospective enrollees. As noted, Arkansas and New Jersey initially hired specialized enrollment staff and Florida later did so. In each case, the specialized staffs were funded at least partly with grant funds. Later, when evaluation sample size targets had been met and most counselors and many consumers had experience with Cash and Counseling, each of the three states made program counselors responsible for outreach and enrollment. This approach proved workable and sometimes contributed to efficiency. When sample-size targets set by the evaluation had been met and the number of new enrollees was smaller, counselors were able to successfully complete their outreach and enrollment *and* counseling tasks. Efficiency gains were achieved by enrolling the consumer and beginning the development of the spending plan during the same home visit.

While all three demonstration programs found that they needed to devote substantial effort to outreach to prospective enrollees to inform them of the availability of a new program, each program gained acceptance over time—among consumers and existing providers—as its benefit for some consumers became evident. Word of mouth among Medicaid beneficiaries and their families helped maintain enrollment levels throughout the demonstration period.

Counseling and Fiscal Services

The provision of counseling and fiscal services is a key feature of Cash and Counseling. Counselors interacted with consumers to (1) develop, review, and revise written plans for spending the monthly allowance in permissible ways; (2) offer advice about recruiting, hiring, and training workers; (3) monitor consumer well-being; and (4) monitor use of the allowance. The fiscal services offered to consumers included preparing and submitting payroll tax returns and check writing.

When the demonstration began, some existing consumer-directed programs were struggling to determine what types of organizations would perform counseling and fiscal services well (Nadash and Flanagan 1996). Traditional home care agencies were thought by

some to be inherently paternalistic and thus unsuited to supporting consumer control. It was also unclear whether counseling and fiscal functions should be split between different organizations. Separation, some argued, would make program oversight and coordination more difficult. On the other hand, separation might provide checks and balances against misuse of the allowance.

Consider efficiency *and* practicality before combining counseling and fiscal services in a single host organization. Arkansas initially combined counseling and fiscal services in a single organization, and New Jersey moved to this approach when it found that having numerous agencies providing consulting was inefficient. When counseling and fiscal services are in the same organization, efficiency is enhanced through streamlined communication and clear accountability. When members of the counseling and fiscal staff are employed by different organizations, questions are sometimes addressed to the "wrong" organization, and there may be a tendency to "pass the buck" between organizations.

Nonetheless, combining the two functions may be impractical. It may be difficult for a state to find an organization with all the necessary expertise to provide fiscal services itself or to supervise a fiscal subcontractor. This was the case in Florida, where many case management agencies were reluctant to participate in Cash and Counseling at all, and few, if any, had the necessary expertise to provide or subcontract for fiscal services. Combining counseling and fiscal services may be impractical for other reasons as well. In Florida, funds to pay existing providers of case management and support coordination services had already been committed, and diverting them to other organizations seemed likely to cause more contention than a key state agency was willing to risk. In addition, over a hundred entities provided case management or support coordination in Florida; economies of scale would be lost were each to provide fiscal services.

Proceed carefully before asking traditional case management agencies to provide counseling services. Due to concern about opposition to Cash and Counseling from agencies providing state-plan personal care, Arkansas and New Jersey did not rely on these agencies to provide counseling services to self-directing consumers. In Florida, as noted, bypassing agencies providing traditional case management was deemed impractical. Florida asked agencies providing traditional case management to provide counseling for their former clients who decided to enroll in Cash and Counseling. Many of these agencies were not initially

supportive of Cash and Counseling, and, as explained below, they had small Cash and Counseling caseloads. One consequence was that development of spending plans—and thus allowance receipt—lagged as many counselors failed to provide timely assistance to consumers. Florida devoted considerable effort to gaining the support of agencies providing traditional case management. Among other activities, it published a newsletter to keep these agencies informed about the progress of Cash and Counseling. The newsletter included "success stories" of how consumers had benefited from the program. Support for Cash and Counseling grew gradually among case management agencies, as their skepticism about consumers' ability to direct their own services proved unfounded.

Ensure counselor caseloads. Counselors who do not have a sufficient Cash and Counseling caseload to occupy a substantial minority of their working hours tend to give low priority to their Cash and Counseling responsibilities and are not likely to remain well versed in the program. The need for each counselor to have a sufficient caseload generally dictates that a limited number of organizations provide counseling. Both New Jersey and Florida initially had a large number of entities offering counseling, and individual counselors tended to have small caseloads. Counseling responsibilities tended to get lost in the press of other responsibilities. In contrast, Arkansas had a small number of agencies and counselors tended to work full-time on Cash and Counseling. After a number of months, both New Jersey and Florida decreased the number of counselors. Florida did so by assigning the entire Cash and Counseling caseload at a given agency to one or two counselors. New Jersey began to assign newly enrolled consumers to the best performing counseling agencies and gradually transferred other consumers to these agencies. After a few years, New Jersey opted to have a single agency provide counseling services, through many fewer counselors.

Choose fiscal agents that have technical expertise and a human touch, and clearly delineate their responsibilities. The responsibilities of a fiscal agent under Cash and Counseling are more complex than those of most organizations that handle only payroll. Cash and Counseling fiscal agents must (1) handle complex payroll tasks, including processing different rates of pay for a worker who is employed by different consumers; (2) process invoices for non-labor goods and services; (3) reconcile payments to the spending plan; and (4) provide consumers (some of whom have limited education or reading skills) with timely,

accurate, and understandable financial statements. Fiscal agent staff members must perform these technical tasks while interacting with consumers in a spirit of caring and cooperation.

The three Cash and Counseling demonstration programs experienced few problems with inaccurate fiscal services (such as issuing checks for the wrong amount). However, achieving good customer service initially proved difficult in New Jersey and Florida. Although both states had deliberately selected human services organizations with the goal of ensuring that the fiscal agent was sensitive to consumer needs, consumers reported both non-responsiveness and rudeness. Eventually, consumer service improved in those states following clarification of the responsibilities of the fiscal agent and changes in senior personnel within the fiscal agent organization.

In contrast, the quality of consumer service was never a serious issue in Arkansas. The difference may be partly attributable to the fact that Arkansas combined counseling and fiscal services in a single organization, while the other states did not. Counselors in Arkansas knew consumers well, which may have helped them address fiscal issues with particular sensitivity. In addition, the initial consumer service problems in New Jersey and Florida may been exacerbated by the inability to realize economies of scale when caseloads were small. Economies of scale were critical in Florida, where the payment per consumer was capped at only $25 per month for the first years of the program. Combining counseling and fiscal services may have given Arkansas program managers more flexibility, allowing them to operate efficiently with a small initial caseload.

Plan ahead to transition from one fiscal organization to another. Transitions from one fiscal services organization to another are to be expected, whether because of re-competition or unsatisfactory performance. Both Arkansas and Florida experienced difficult transitions to a new fiscal agent. Awaiting resolution of outstanding accounting issues, Florida consumers did not have access to all their funds for several months, which seriously inconvenienced some of them and created confusion and concern. Heroic effort on the part of Arkansas program staff was required to ensure a smooth transition for consumers when that state terminated the contract of an existing fiscal agent due to financial irregularities. The experience of Arkansas and Florida suggests that transitions could be smoother if contracts included a transition plan, with specific tasks and a timeline for transition to a new organization and perhaps financial

penalties for failure to meet the transition timeline. Programs should also write contracts that specify required accounting practices and standard record formats to ease transition from one fiscal agent to another.

Planning for and Starting on the Allowance

One of the most surprising and dismaying findings of the Cash and Counseling demonstration was the sizeable proportions of consumers in Florida and New Jersey (43 and 33 percent, respectively) who did not receive their program allowance within a year of enrollment (Foster, Phillips, and Schore 2005a and 2005b). Consumers could not begin to receive their allowance until they developed an approved spending plan; however, two of the demonstration states seemed to underestimate the how much counselor assistance consumers would need with the paperwork and practical aspects of plan development.

In fact, the implementation literature available at the start of the demonstration also failed to anticipate this need for basic assistance. Writing about consumer-directed programs, the National Council on Aging (NCOA) said the goal of counseling is to "empower consumers or their representatives to make informed decisions that work best for them, are consistent with their needs, and reflect their individual circumstances" (NCOA 1997). As states implemented the Cash and Counseling model, the larger goal of empowerment may have overshadowed comparatively mundane practicalities that are also part of consumer direction.

Expect consumers to need substantial assistance with the initial spending plan. The experience of all three demonstration states was that consumers generally do not have difficulty deciding what goods and services they would like to include in spending plans, but that some need substantial help from counselors in handling paperwork and preparing a budget. A consumer may need help in understanding program procedures and help with arithmetic to compute the cost of the plan.

Apparently, some Florida counselors were initially uncertain about how much hands-on assistance to provide to consumers. When consumers or their representatives failed to grasp the requirements of the program and develop spending plans quickly, some consultants questioned the consumer's suitability for consumer direction. These counselors offered very limited assistance with developing the spending plan and, as noted, many Florida consumers never completing a spending plan or received the program allowance. After many months, Florida's

state program identified counselor uncertainty as a source of delay in completion of spending plans and began to re-train counselors to provide additional assistance.

A consumer's need for help in developing the initial spending plan does not indicate inappropriateness for Cash and Counseling. Even beneficiaries who struggle with completing the plan can usually manage their own day-to-day care once the plan has been developed.

Streamline allowance-planning procedures and offer direct assistance to consumers. In all three Cash and Counseling programs, the time from enrollment to receipt of the first allowance ranged from less than a month to nine months or more, but consumers in Arkansas were much more likely than those in New Jersey or Florida to have received the allowance within a year of enrollment (the proportions were 85, 67, and 57 percent, respectively) (Schore and Phillips 2004). Consumers who experienced long delays in receipt of the allowance tended to disenroll. The delays were commonly due to changes in life circumstances (such as acute illness), difficulty identifying a worker, and counselor failure to provide timely assistance.

If lags prove long, programs can streamline their procedures or offer additional assistance. For example, whereas New Jersey initially gave Medicaid personal care agencies 30 days' notice to stop serving a client who had enrolled in Cash and Counseling, it later shortened this "holding" period to 10 days. In all three states, state program staff eventually began to contact consumers who had not received an allowance 90 days after enrollment to identify the source of the delay and offer additional assistance as needed. Florida implemented this procedure some months after the other two states did so.

Make recruiting help available. In all three Cash and Counseling programs, consumers had difficulty hiring a worker if they did not have a relative or friend who was interested in that role. Those who could not identify a worker within a few weeks almost always left the program. Perhaps in part because the program was designed to promote consumer control, counselors initially were not always sure how much advice to give consumers about recruiting workers.

Each of the three states eventually strengthened counselor training on recruiting. New Jersey developed written materials with recruiting tips that counselors could review with and give to consumers. Arkansas counselors approached recruiting advice this way: "We have them visualize a circle around them and we say we want to start close, working outward, widening

the circle as we need to. So we start thinking about friends and neighbors, then someone in church, then someone a relative or friend knows." If consumers had to hire a worker who was a stranger to them, counselors helped consumers think about how they would conduct a job interview and they helped consumers practice interviewing.

After our site visit, New Jersey received a federal Systems Change grant to develop worker registries such as might be used in consumer-directed programs. It remains to be seen how effective this method will be in fostering participation in Cash and Counseling by those who do not have particular person in mind to hire as a worker.

Give counselors authority to approve most spending plans. In New Jersey and Florida, all spending plans were reviewed by a state- or district-level office. This procedure was costly and sometimes caused delays in plan approval. Arkansas did not require program approval for plans containing only goods and services on a pre-approved list; and delay in plan approval was not a serious issue there. Use of a pre-approved list is an efficient procedure for reviewing spending plans. It can be coupled with audits to ensure that counselors are abiding by the requirement to seek further approval for plans that include a good or service not on the preapproved list. The pre-approved list can be modified over time, as permissible uses of the allowance change or if it becomes clear that counselors are not able to make appropriate judgments about some items.

Controlling Program Costs

Although Cash and Counseling is primarily about improving the quality of life of people with disabilities, federal willingness to test the model stemmed in part from "the potential of consumer direction to provide a less costly approach to delivering Medicaid waiver and personal care services, through reductions in administrative costs and discounted dollars being targeted more efficiently" (Knickman and Stone in this issue). For their part, states will consider potential costs of the program to their Medicaid programs. We present a few straightforward lessons about cost controls here. A comprehensive analysis of program costs is provided by Dale and Brown in this issue.

Pay counselors a flat rate to assist with development of the spending plan. A payment methodology that limits payment for assisting with the development of the spending plan can prevent excessive costs for counseling services if the completion of a spending plan is prolonged. New Jersey had initially adopted a flat rate for the development of the spending plan

(with an hourly rate and a cap on the number of hours thereafter). Arkansas effectively lowered its counseling costs by changing its payment methodology from a monthly rate beginning at enrollment to a flat rate for the development of the spending plan and a monthly rate for counseling services thereafter.

Assign responsibility for assessment and subsequent care planning to an external party who will not advocate for the consumer. Acting as advocates for consumers, and perhaps less constrained by the supply of workers than traditional agencies, counselors in Arkansas and Florida apparently authorized more hours of care than would have been authorized in traditional care plans. By contrast, New Jersey assigned responsibility for assessment and subsequent care planning to Medicaid nurses who were not otherwise involved in Cash and Counseling. While it is certainly desirable for consumers to get the services they need, it is arguably inequitable for them to have more state resources devoted to their care than to that of beneficiaries with comparable needs in the traditional program because the latter's care plans are more constrained. Moreover, the Cash and Counseling program's ability to control costs may be threatened if resources are increased in the care plans of Cash and Counseling participants, without regard to costs in programs serving similar beneficiaries.

Arkansas and Florida found it impractical to re-assign responsibility for assessment to an external party, but both eventually found ways to limit the likelihood that counselors would increase services in care plans beyond what they would have been under the traditional program. Arkansas required documentation of the changes in consumer circumstances that necessitate increased hours. Florida developed standardized care plan protocols for all its waiver programs, compared care plans for consumers in Cash and Counseling to those for clients in the traditional program with similar levels of impairment, and emphasized to counselors during training that consumers are responsible for only decisions on how to expend resources, *not* for determining the *amount* of resources available. These procedures should help keep Cash and Counseling expenditures closer to those in traditional programs of Medicaid supportive services.

Preventing Allowance Misuse and Consumer Exploitation

Preventing the misuse of public funds and the exploitation of vulnerable consumers without oversight from home care agencies and hands-on involvement of case managers was a major concern of state program administrators at the onset of the Cash and Counseling

demonstration (Lagoyda and Cameron 1996; Nadash and Flanagan 1996). Program administrators and policymakers worried that consumers might use their allowance for items not related to personal care or the ability to live independently. They also worried that families members hired as workers might exploit consumers by not providing agreed-upon care.

Require review of spending plans, timesheets, and check requests, but not receipts. Misuse of the allowance was never a serious problem during the demonstration, probably because the programs took the *potential* for problems very seriously. Two procedures were critical. First, review of the spending plan by counselors or the program office ensured that only permissible goods and services were included. Second, counselors and/or fiscal staff reviewed worker time sheets and consumer check requests involving funds managed by the fiscal agent to ensure consistency with the spending plan. This was the case for the vast majority of funds because very few consumers elected to manage the entire allowance without the assistance of a fiscal agent (Schore in this issue).

The three Cash and Counseling programs differed with respect to review of receipts for consumer purchases. One did not require counselors to review receipts; one required review of receipts for incidental purchases with cash; and one required review of receipts for expenses *other than* incidental purchases with cash. The fact that misuse of the allowance was almost nonexistent in all three programs—despite the differences in review of receipts—indicates that review of receipts was not critical to preventing misuse of funds, not when the vast majority of funds were disbursed by the fiscal agent and only modest amounts could be taken by the consumer as cash for incidental purchases.

Prevent consumers from overspending their allowances. Consumers did occasionally overspend their monthly allowance. For example, some consumers did not understand that their allowance was *prospectively* credited to their program account each month and that there was sometimes a lag of two or three weeks in deducting costs for services. These consumers mistakenly believed they had accumulated savings from the previous month. If they used these "savings" to purchase additional care hours from a paid worker, the fiscal agent would be legally obligated to issue a paycheck for all the hours indicated on a signed time sheet, leaving the program to recoup the difference from consumers' future allowances. In Florida, such overspending went undetected for some time; it came to light only in the transition to a new fiscal agent. The overspending would have been prevented had the fiscal agent used an accrual

accounting system, rather than a cash accounting system. Under an accrual system, payment for expenditures accrued during a given month would be made from the allowance for that month (or from savings accumulated in earlier months specifically for that purpose). In addition, consumers might need training in how to read financial statements prepared by the program's fiscal agent.

Use home visits and telephone calls to monitor consumer welfare. In each of the three Cash and Counseling programs, instances of possible exploitation of consumers were very rare (less than five in all) according to our interviews with program staff and other stakeholders. Of these, some were identified at the time of the counselor's initial home visit and resolved before the program allowance was disbursed. The three programs developed formal procedures for counselors to report suspicious cases, which included notifying the program office and/or an adult protective services agency.

As a matter of course, each program required that counselors periodically telephone and visit consumers. Arkansas initially required monthly telephone calls and quarterly visits. With experience, the state took a more individualized approach. Some consumers were visited more than quarterly, but most were telephoned monthly and visited semiannually. New Jersey required monthly telephone calls for the first six months following enrollment and quarterly visits. Florida required monthly telephone contact and a visit two and 12 months afater enrollment.

Information or impressions gleaned in a telephone contact—both the consumer and the representative (if any) should be telephoned—often can signal the need for a discretionary visit by a counselor to investigate a questionable situation.

CONCLUSIONS

This paper has drawn lessons about implementing Cash and Counseling programs from the people in Arkansas, Florida, and New Jersey who were most deeply involved in designing and running the three-state demonstration.

To improve their programs, Arkansas, Florida, and New Jersey re-designed some features of their Cash and Counseling programs and refined other features over the course of the demonstration. Some of the re-design involved fundamental program structure. For example, New Jersey dramatically reduced the number of agencies offering counseling and

eventually assigned responsibility for both counseling and fiscal services to a single host organization. Refinements were also quite important. For example, Florida re-trained counselors to ensure that they understood that consumers have no control over the *amount* of the allowance and that consumers need counselor assistance to develop the spending plan. Arkansas and Florida learned that timesheets and invoices for a given month must be reconciled against the allowance *for that month* in order to prevent overspending of the allowance. Viewed broadly, the re-design and refinements in Arkansas, Florida, and New Jersey are the result of an extensive process of continually re-examining program operations to see which aspects of the program were working as planned and which were not. This process yielded lessons about the implementation of the Cash and Counseling model that demonstrate the value of such re-examination and the breadth of improvements that are possible. Partly as a result of this experience, the 2004 grant solicitation calling for additional states to implement Cash and Counseling programs mandated that these expansion programs implement a continuous quality improvement process.

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