Approved: 3-14-03
Date

MINUTES OF THE PRESIDENT'S TASK FORCE ON MEDICAID REFORM.

The meeting was called to order by Chairperson Senator Stan Clark at 3:30 p.m. on March 5, 2003 in Room 234-N of the Capitol.

All members were present except:

Committee staff present: Emalene Correll, Legislative Research
Ann McMorris, Secretary

Conferees appearing before the committee:
James Frogue, American Legislative Exchange Council, Washington, D.C.
Julian Efird, private citizen

Others attending: See attached list

Approval of Minutes
Moved by Senator Lee, seconded by Senator Huelskamp, minutes for the meetings of the President's Task Force on Medicaid Reform held on February 6, 2003; February 10, 2003 at 9:30 a.m.; February 10, 2003 at 3:30 p.m.; February 13, 2003, February 17, 2003 and February 24, 2003 be approved. Motion carried.

Case History for Elderly Services
Mr. Efird, a private citizen, enumerated the various and many steps for services taken for an elderly person in the Medicaid program in a period of two years. (Attachment 1). He noted it would have been impossible for this person to handle the overwhelming paperwork without family assistance and there were occasions when diligence on the part of the family kept the elderly person from being billed for medications that were not delivered to the patient but were filled and not returned. to the pharmacy. In another instance, a wheelchair had only two months payments to be paid off and be the property of the patient and the patient was moved from that facility to another and the wheelchair was going to be sent back and another ordered at the new facility and payments started over. Family intervention kept this from happening. He commented that a savings could be realized on durable medical equipment that can be bought and moved with the patient rather than each program purchasing the same equipment for the same patient as they move through different medicaid programs.

A.L.E.C. - American Legislative Exchange Council
James Frogue, director of the Health and Human Services Task Force, A.L.E.C. spoke on The Future of Medicaid: Consumer-Directed Care. (Attachment 2) He noted Medicaid needed a fundamental shift from its current structure into a system by defined contributions. Real choice needed in medicaid. Direct control by the consumer over the dollars being spent greatly improves consumer satisfaction because it is patient-centered and consumer-directed care. Florida, Arkansas and New Jersey have a defined contribution program called "cash and counseling". This program offers direct liability protection to physicians, lower cap, and the ability and incentive for the medicaid recipient to set aside money each month to save for a more expensive item related to their care. It allows states the choice to receive about a 2% increase in their federal match. It does not cover prescription drugs nor nursing home care. There has been no major fraud or abuse found. No waivers are required.

A round table discussion ensued with Bob Day, Janis DeBoer, Kirk Lowry, Jerry Slaughter, Bob Williams, Bob Harder, others in the audience and the committee.. Following much debate on pros and cons of various aspects of the current and proposed programs, Bob Harder offered to prepare a compilation of the ideas discussed and send it to the Chair for the next meeting.

The next meeting of the Task Force on Medicaid Reform is on March 6, 2003 at 9:30 a.m.

Adjournment.

Respectfully submitted,
Ann McMorris, Secretary
Attachments - 2

President's Task Force on Medicaid Reform

DATE: MARCH 5, 2003 3:30 P.M.

Name	Representing
Bill Sneed	Merck/CHNA
Barbara Belcher	Merck
Tom Rickman	Aventis
Bob Alderson	KPSC
Tanya Dorf	SRS
[illegible]	/CMS
Robert Day	SRS
Craig Kabel	KAAAA
Bob Harder	UMC - KS
Bob Williams	Ks. Pharmacists Assoc
Vicki Whitaker	Ks Health Care Assn.
Gary Robbins	Ks Optometric Assn
Pat Hubbell	Rhuma
Christy Lane	KDOA
[illegible]	KDOA
Rosie Torres	KACIL

President's Task Force on Medicaid Reform

DATE: MARCH 5, 2003 3:30 P.M.

Name	Representing
Barb Hinton	Post Audit
Fred Lucky	Kans. Hosp. Assn.

Timeline for Elderly Services

January 2001 admitted to multilevel care facility with independent, assisted living, and long-term (skilled) nursing facilities; entered as private pay resident in assisted living apartment; required to have Medicare and MediGap insurance.

June 2001 entered hospital with broken hip under Medicare Part A.

June 2001 returned to skilled nursing facility under Medicare Part A following 8-day hospitalization. Continued private pay to maintain assisted living apartment.

August 2001 returned to private pay assisted living apartment. Medicare Part B used to pay for rehabilitation and home health care services.

April 2002 moved from private pay apartment to HCBS room after qualifying for assisted living under Frail Elderly (FE) program; monthly client payment required based on personal resources.

July 2002 moved from HCBS room to Medicaid skilled nursing facility due to health problem (doctor rescinded after one day). Returned to HCBS room.

September 2002 entered hospital for gastrointestinal problems under Medicare Part A; diagnosed with pneumonia while hospitalized.

September 2002 returned to HCBS room after four-day hospital stay.

October 2002 readmitted to hospital after three days with complications of chronic obstructive pulmonary disease and pneumonia under Medicare Part A.

October 2002 returned to skilled nursing facility under Medicare Part A. Continued HCBS monthly client payment to maintain assisted living room while in nursing facility.

November 2002 returned to HCBS room.

November 2002 admitted to hospital under Medicare Part A for senior diagnostic service evaluation after nursing staff for assisted living facility noted behavioral problems.

November 2002 returned to skilled nursing facility under Medicare Part A. Continued HCBS monthly client payment to maintain assisted living room while in nursing facility.

December 2002 returned to HCBS room.

February 2003 moved to long-term (skilled) nursing facility after nursing staff for assisted living facility indicated they could no longer provide enough needed services in that unit; transfer from HCBS to Medicaid long-term nursing home program; HCBS eligibility cancelled effective March 15, 2003, and taken off FE client list.

President's Task Force
on Medicaid Reform
March 5, 2003 #2
Attachments 1-1

Jim Frogue

Director of the Health and Human Services Task Force

Jim Frogue is the Director of ALEC's Health and Human Services Task Force. Mr. Frogue graduated from the University of Southern California with a B.A. in International Relations and Political Science. He also holds a master's degree in International Relations from Cambridge University. Prior to working for ALEC, Mr. Frogue worked as a legislative assistant for Rep. Carlos Moorhead, R-Calif. In addition, he worked in the office of the general counsel at the U.S. Chamber of Commerce, where he conducted research for a staff of five attorneys and compiled a judicial history of the Chamber's amicus briefs. He also served as a legislative assistant and principal staff advisor on health policy to Rep. Jay Kim, R-Calif. Mr. Frogue knows how Washington's health-care decisions affect American families. As a health-care policy analyst for The Heritage Foundation, he examined Medicare reform, children's health issues, and restructuring of the broader health-care system

Recent Publications

- "Improving Americans' Health Care Coverage Through Defined Contributions"(June 28, 2001),*The Heritage Foundation*
- "Top Ten Ways to Fix America's Health Insurance Market and Expand Coverage"(February 16, 2001), *The Heritage Foundation*
- "Right and Wrong Ways to Address the Needs of the Uninsured"(June 4, 2001), *The Heritage Foundation*
- "Recent Survey Points to Affordable Individual Health Insurance" (April 17, 2001), *The Heritage Foundation*
- "Vermont's Plan to Control Drug Prices For Seniors: A Bad Prescription" (April 12, 2001), *The Heritage Foundation*
- The Clinton Drug Plan; A Prescription for Massive Regulation (September 20, 2000), *The Heritage Foundation*
- "Overhauling Medicare: What It Will Take to Attract Private Providers" (Released May 18, 2001. Delivered March 6, 2001), *The Heritage Foundation*
- "Buyer Beware: The Failure of Single-Payer Health Care" (Released May 4, 2001. Delivered February 13, 2001), *The Heritage Foundation*
- "Patients' Rights? Try Prisoners' Rights" (March 28, 2001), The *The Heritage Foundation*

President's Task Force on Medicaid Reform March 5, 2003 #2 Attachments 2-1

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No. 1618 January 16, 2003

THE FUTURE OF MEDICAID: CONSUMER-DIRECTED CARE

JAMES FROGUE

Medicaid is a broken system that largely fails to serve the health care needs of its 47 million beneficiaries. Ironically, despite its consistent failure to deliver quality health care, Medicaid is also running up a rapidly growing and unsustainable tab for taxpayers. The Congressional Budget Office (CBO) projects that 2002 will be the first year that spending for Medicaid has exceeded that of Medicare. Medicaid will continue to widen its lead in the coming decade.[1] (See Chart 1.)

For fiscal year (FY) 2001, 39 of the 49 states surveyed experienced Medicaid shortfalls. For FY 2002, 28 states were anticipating shortfalls. Of the 49 states surveyed, 47 took action in 2002 to rein in Medicaid spending or are expected to take action in 2003.[2] States have been employing a wide array of strategies to control Medicaid costs. All essentially embody two approaches: asking Congress for more money and making various cuts in their programs. Both approaches will fail to bring the real reform needed.

But Medicaid's budgetary woes are only a secondary reason that the program so desperately needs attention. The primary reason is that Medicaid simply is not a good program for the people confined to it. Its structure leaves beneficiaries with limited choice—in most cases no choice—in arranging for their own health care needs. To be clear, "choice" means direct control by consumers over the dollars being spent on their behalf.

A New Medicaid Policy Direction. Congress and state officials should embark on an ambitious program of comprehensive Medicaid reform. The key structural change would be movement away from a structure of defined benefits to one of defined contributions. This change would put dollars, and with them the power, where they belong—in the hands of beneficiaries.

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This paper, in its entirety, can be found at: *www.heritage.org/research/healthcare/bg1618.cfm*

1. Congressional Budget Office, Current Budget Projections, at *http://www.cbo.gov/showdoc.cfm?index=1944&sequence=0*.
2. National Association of State Budget Officers and National Governors' Association, *Medicaid and Other State Healthcare Issues: The Current Situation*, May 2002, p. 1, at *http://www.nasbo.org/Publications/PDFs/fsmedicaidmay2002.pdf*.

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Short of comprehensive congressional reform, state officials can secure waivers from the Department of Health and Human Services (HHS) and make a down payment on solving the problems of second-tier care for beneficiaries and runaway outlays. States need to start creating a system of patient-centered and consumer-directed care in the form of defined contributions for needed services.

Patient Satisfaction. Evidence is mounting that this approach is an overwhelming success in the category that counts most: consumer satisfaction. Certain elderly and disabled Medicaid beneficiaries receiving home care in Arkansas, New Jersey, and (most notably) Florida are the first to reap the rewards of the defined contribution approach. Beneficiary satisfaction rates with this consumer-centered experiment are nearly 100 percent.[3]

WHY STATE OFFICIALS NEED TO BYPASS MEDICAID'S OUTDATED STRUCTURE

Medicaid is the joint federal–state entitlement program established by Title XIX of the Social Security Act in 1965 to finance medical care for certain low-income individuals. There are basic similarities among programs in the 50 states, the District of Columbia, and the five territories, but no two are alike. States administer their own programs and have broad authority to set eligibility standards, covered benefits, and payment rates for providers. Thus, a person eligible in one state may not be eligible in another, and even if he or she is eligible, the same treatments may not be covered.[4]

Formula-Driven Spending. In addition to setting broad policy guidelines, the federal government's role includes the Federal Medical Assistance Percentage (FMAP), commonly known as the federal match. This is the formula that dictates how much money each state receives from the federal government to supplement its Medicaid program. Ten states get the lowest federal match of 50 percent; Mississippi gets the highest at 76 percent. The national average is 57 percent.

For all states, the FMAP has inherent incentives for ever-higher expenditures on Medicaid. In Mississippi, for example, one extra state dollar of spending is worth three "free" federal dollars, whereas cutting a dollar of state spending "costs" the state three federal dollars under the FMAP system. It is easy to see why states, regardless of their match rates, are always at the federal trough. Such a system also encourages states to define "Medicaid" spending creatively, thereby further increasing the drain on state and federal funds.

There are 14 categories of mandatory services that states must include in their Medicaid programs in order to be eligible for the federal match. These include, among others, inpatient and outpatient services, childhood vaccines, prenatal care, and rural health clinic services. States are also eligible to receive additional federal match dollars for 34 optional services such as prescription drugs, diagnostic services, and prosthetic devices.[5]

Soaring Costs. According to the CBO, total Medicaid outlays for 2001 were $226 billion and total spending for 2002 is expected to be $258 billion. The CBO also projects that Medicaid spending will reach $578 billion by 2012.[6] The National Association of State Budget Officers found that total state Medicaid spending increased 10.6 percent in FY 2001 and estimated that it would increase 13.3 percent in 2002.[7] In 1992, Medicaid spending represented 17.8 percent of total state spending. For 2002, it was over 20 percent, with projections showing continued disproportionate growth.[8]

3. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, and Robert Wood Johnson Foundation, *Cash and Counseling, Demonstration and Evaluation Program*, 2002, pp. 4 and 12.
4. Centers for Medicare and Medicaid Services, *Medicaid: A Brief Summary*, at *http://www.cms.gov/publications/overview-medicare-medicaid/default4.asp*.
5. For complete lists of mandatory and optional services, see Centers for Medicare and Medicaid Services Web site at *http://cms.hhs.gov/charts/medicaid/2tchartbk.pdf*.
6. See *http://www.cbo.gov/showdoc.cfm?index=1944&sequence=0*. Figure assumes that the 57 percent federal contribution remains the average through 2012.
7. National Association of State Budget Officers and National Governors' Association, *Medicaid and Other State Healthcare Issues: The Current Situation*, p. 1.

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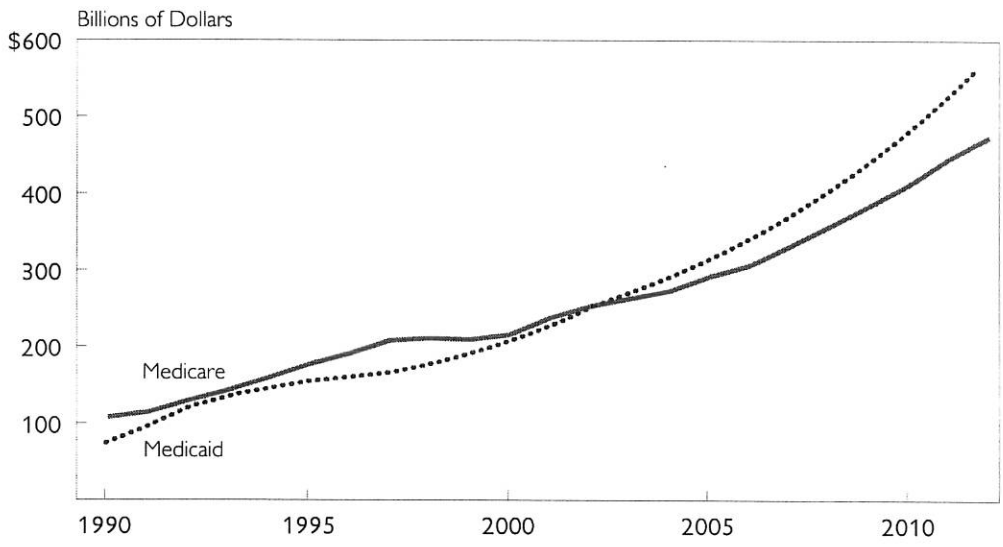
Chart 1 BG-1618



Source: Congressional Budget Office.
Note: Assumes that the 57 percent federal contribution remains the average in Medicaid through 2012.

It is also important to keep in mind that Medicaid includes spending for long-term care. In fact, this part is approaching half the Medicaid budget. With the aging of the population, this portion of Medicaid spending alone is expected to quadruple by 2020. The effect of such an increase could well leave at least some states bankrupt. State lawmakers who care about any other budget item—be it education, law enforcement, road maintenance and construction, or environmental protection—must therefore tame Medicaid spending. If they fail to do so, no money will be available for other priorities.[9]

WHY PREDICTABLE MEDICAID DEBATES ARE OFTEN UNPRODUCTIVE

Virtually all debates heard today over Medicaid policy fall into one of four general categories:

1. Raise or lower income eligibility requirements;
2. Add or subtract covered benefits;
3. Increase or decrease reimbursement rates to doctors and hospitals; and
4. Attempt to squeeze more dollars from the federal government.

Sorely lacking is the long-overdue questioning of whether or not the system itself needs a fundamental overhaul. Instead of perpetuating the same old policy discussions, the new Medicaid debate must begin to focus on how the current system can be restructured to accommodate the beneficiaries and the doctors, hospitals, and other health care professionals who serve them in the most effective manner possible.

Medicaid is a product of the 1960s—a very different era. It retains a system of rigid government price controls and a defined benefits package. Like

8. National Association of State Budget Officers, "Medicaid to Stress State Budgets Severely into Fiscal 2003," March 15, 2002, at *http://www.nasbo.org/Publications/PDFs/medicaid2003.pdf*.
9. Richard Teske, "Abolishing the Medicaid Ghetto: Putting 'Patients First,'" American Legislative Exchange Council, April 2002, p. 10.

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many other government health care initiatives, it is wide open to influence from lobbyists who represent special-interest groups before state legislatures; but, for all practical purposes, it is closed to the individuals and families who depend on the program. The interests of Medicaid beneficiaries come second to those of other players in the system.

Medicaid beneficiaries are thus dependent on the decisions of others when it comes to key components of their medical care. Beneficiaries are also limited to providers willing to accept Medicaid reimbursement rates that are generally far below what is paid by private-sector insurers, and even by Medicare. This is characteristic of all the Medicaid programs across the country. Willing providers must also accept the large and growing "hassle factor" associated with the Medicaid bureaucracy.

By restricting their options to minor tinkering with the status quo, governors and state legislators are engaged in a debate that cannot be won and will never end so long as Medicaid remains a closed system of government-defined benefits. In an age of rapid medical progress, advancing research, and increasingly sophisticated technology, politicians are unqualified to determine which benefits should or should not be covered by Medicaid and at what rate doctors, hospitals, and other health care professionals should be paid. Markets, driven by consumer choice and open competition, remain the best mechanism for efficiently producing and distributing products, including goods and services relating to health care. Moreover, patients, as consumers, should be able to rely freely on meaningful assistance from family members, appropriate aides, family doctors, or other professionals in making such important decisions.

MEDICAID CASH AND COUNSELING: PUTTING PATIENTS FIRST

Arkansas, New Jersey, and Florida were the first states to be granted Section 1115 waivers to participate in a demonstration project designed to empower certain disabled Medicaid beneficiaries by giving them a cash allowance with which to purchase needed services.[10] At the national level, this experiment is called the Cash and Counseling program.[11] Its purpose is to evaluate how Medicaid beneficiaries (consumers) would fare in a system that allows them to buy their own personal and community-based services, assisted by a consultant, with a defined contribution from their state's Medicaid program. Initial reports have concluded that the experiment is overwhelmingly popular with Medicaid beneficiaries.[12]

Before Cash and Counseling began for these eligible populations, the state typically would contract with a home care agency to provide services to an eligible Medicaid recipient without input from the beneficiary being served. This often meant the beneficiary would have little or no say with regard to how, when, and by whom they were served.

Such an approach has several obvious drawbacks. First, it was especially hard on beneficiaries who preferred care at odd hours or on weekends when agencies hired by the state might not be available. Second, because some of the services involve intimate assistance such as bathing and grooming, the beneficiary would be forced to rely on a stranger of someone else's choosing to perform such tasks. Finally, it was nearly impossible for a Medicaid beneficiary unsatisfied with his or her service to fire the bad provider and hire someone else. All of these problems are eliminated with the Cash and Counseling approach.

10. The waivers are called Section 1115 waivers after the section of the Social Security Act that authorizes them.
11. In Florida, this experiment is called Consumer Directed Care; in New Jersey and Arkansas, respectively, it is known as Personal Preference Program and Independence Plus.
12. Centers for Medicare and Medicaid Services, *Cash and Counseling, Demonstration and Evaluation Program*, and Leslie Foster *et al.*, *Cash and Counseling: Consumers' Early Experiences in Florida, Interim Memo*, Mathematica Policy Research Inc., Princeton, New Jersey, April 2002, p. 1.

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Under Cash and Counseling in all three states, the beneficiary must first be enrolled in Medicaid, meet age and eligibility requirements, and require personal assistance services.[13] Each participant receives a cash allowance, the amount of which is based on the level of professional assistance needed. Under the waiver, the program must be budget neutral, so the amount is generally equivalent to the value of services purchased by the state. While beneficiaries have considerable flexibility to hire, fire, and alter service providers, their allowance under Cash and Counseling must be spent on health care needs. A counselor or consultant reviews the list of services being purchased to ensure proper usage. The state also provides a fiscal intermediary to cut the checks, pay the appropriate taxes, and handle associated paperwork. The fiscal intermediary represents a final check on spending decisions of the beneficiary to weed out fraud and abuse.

Lessons from Florida. Of the first three states to receive Section 1115 waivers, Florida went the furthest toward empowering this group of Medicaid beneficiaries. Called Consumer Directed Care (CDC) under the state's Section 1115 waiver for the Cash and Counseling demonstration project, and with 2,820 enrolled participants, Florida's program cashed out the entire list of services covered under its Section 1915c waiver for home and community-based services. The qualifying groups included:

- Frail elders (ages 60+);
- Adults (ages 18–64) with physical disabilities;
- Children (ages 3–17) with developmental disabilities; and
- Adults (18–64) with developmental disabilities.[14]

Consumer Directed Care. Consumer Directed Care for frail elders and physically disabled adults is available in 19 counties, and statewide for developmentally disabled adults and children.[15] In early 2002, both houses of the Florida legislature voted unanimously to continue this approach and give expanded rulemaking authority to all of the necessary departments.

Two methods are used to determine the amount of money "cashed out" for each consumer. First, the consumer's expenditures in the Medicaid waiver for the previous 6–12 months are averaged. Second, if the consumer has not been in the program that long, the dollar value of a consumer's waiver care plan is calculated.

Once the amount has been determined, the consumer and his or her representative develop a purchasing plan that lays out expenditures. A specially trained consultant provides the needed technical assistance and training. The consumer can select from a wide array of allowable purchases:

- Personal care,
- Homemaking,
- Consumable medical and personal care supplies,
- Adaptive services such as wheelchair ramps and grab bars,
- Home repairs and maintenance, and
- Pest control and yard work.

The consumer is then free to hire traditional providers, family members, neighbors, or friends for various tasks and pay them a mutually agreed upon wage every two weeks. To ensure that the employer is clearly identified, the name of the Medicaid beneficiary, not the state of Florida, appears on the paycheck received by employees.

Consumers can also set aside money each month if they wish to save for a larger item related to their care. For example, a lift chair or a wider front door might better serve the beneficiary. Thus, not only does Consumer Directed Care allow consumers to choose for themselves, but it also puts the proper

13. Personal care services involve basic tasks such as housekeeping chores, bathing, meal preparation, dressing, and grooming—as defined by "Independent Choices," a brochure describing the Cash and Counseling demonstration program in Arkansas.

14. The author wishes to thank Lou Comer, Project Director, Consumer Directed Care Project, Department of Elder Affairs, and Shelly Brantley, Chief of Medicaid Health Systems Development, Agency for Health Care Administration, both of Tallahassee, Florida, for their assistance on and after November 12, 2002.

15. Florida will apply to extend its Section 1115 waiver in 2003. Upon expected approval, CDC for frail elders and physically disabled adults will be extended statewide.

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incentives in place for beneficiaries to spend wisely on their routine care.

It is important to note that participating in CDC is a choice for beneficiaries. The demonstration project has proven very popular, but it is not necessarily suitable for everyone. Some beneficiaries are content with the old system and are free to remain in it. CDC is particularly popular with parents of disabled children and adults who are willing and able to be more involved with their own care. In other words, it is suited to most Medicaid beneficiaries.

Medicaid fraud traditionally has been a serious problem across the states. However, by placing the dollars in the hands of beneficiaries, Florida's Consumer Directed Care approach has all but eliminated fraud. According to Kevin J. Mahoney of Boston College, the national program director for Cash and Counseling Demonstration and Evaluation, after three and a half years of study, the program has been "without any major instances of fraud and abuse."[16]

Satisfaction rates among beneficiaries are extraordinarily high. Mathematica Policy Research, Inc., the evaluation contractor chosen to study Cash and Counseling, released an interim memorandum in April 2002 based on a survey of 231 of the initial participants in Florida's Consumer Directed Care. Mathematica found that 99 percent of beneficiaries were "satisfied with their relationship with their caregivers" and that, of those that were satisfied, "96 percent described themselves as 'very satisfied.'"[17] Studies of participant satisfaction rates in the Arkansas and New Jersey experiments found virtually identical results.[18]

Budget Impact. Under the Section 1115 waivers, Cash and Counseling is initially budget neutral. However, it has the potential for considerable savings in the long term.

First, it moves Medicaid away from its traditional bias in favor of institutional care toward home care. As mentioned earlier, nursing home and institutional care account for the largest and fastest growing portion of Medicaid spending, approaching 50 percent of the Medicaid budget in some states.

Second, by creating the proper incentives for appropriate use of care and engaging Medicaid beneficiaries in their own health care decisions, it puts market forces in play in an arena where they have never before existed. A properly functioning market in any economic sector will always improve quality while simultaneously bringing down cost. As evidence, beneficiaries in Cash and Counseling have received more care of better quality, resulting in higher satisfaction rates.[19]

CHALLENGE FOR THE FUTURE

The initial successes of the Cash and Counseling experiments explode the myth that Medicaid beneficiaries are not capable of making their own decisions. In fact, it shows just the opposite: They can, they want to, and—once given that chance—do a very good job of it. This is amply demonstrated by satisfaction rates with the program that approach 100 percent.

The challenge going forward is for states to adopt the Cash and Counseling approach for as many 1915c beneficiaries and services as possible. States must also look to expand the consumer direction approach to other categories of Medicaid beneficiaries via the Section 1115 waiver process because consumer direction will work there as well.

The Bush Administration has shown itself to be very supportive of empowering Medicaid beneficiaries in this manner and very willing to approve waivers to this end. States should take full advantage of this opportunity.

—James Frogue is Director of the Health and Human Services Task Force at the American Legislative Exchange Council in Washington, D.C. He is also a former Health Care Policy Analyst at The Heritage Foundation.

16. Kevin J. Mahoney, "Quality Because of Choice, Not in Spite of It," *Advances*, Robert Wood Johnson Foundation, Issue 3, 2002.
17. Foster *et al.*, *Cash and Counseling: Consumers' Early Experiences in Florida*, p. 1.
18. Centers for Medicare and Medicaid Services, *Cash and Counseling, Demonstration and Evaluation Program*, pp. 4 and 12.
19. *http://www.hcbs.org/cashandcounseling/MPR_Results.ppt.*

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