The Public/Private Partnership behind the Cash and Counseling Demonstration and Evaluation: Its Origins, Challenges, and Unresolved Issues

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Objective. To discuss why and how the Cash and Counseling Demonstration came to be designed, implemented, and evaluated through a partnership between the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the Robert Wood Johnson Foundation (RWJF).

Principal Findings. This public/private partnership was created by two colleagues who were motivated by the need for funding to conduct a large-scale demonstration and evaluation, the prestige that both organizations brought to the project, the ability to draw on both organizations' experience and expertise, and the potential to maximize flexibility in the design and implementation of the demonstration. The partnership, which has lasted over a decade and has supported two generations of Cash and Counseling programs, overcame several challenges including getting approval for the project through their respective bureaucracies, managing the decision making process and the ongoing program across the two organizations, dealing with leadership and staff turnover, and reaching consensus on how to apportion credit for the success of the program. Several unresolved issues remain, including how the program gets operationalized within each state, how case management is addressed within the context of a consumer-directed model like Cash and Counseling, how quality is assured in this type of program, and how the Internal Revenue Service views and treats Cash and Counseling and other consumer-directed programs.

Conclusion. This public/private partnership is an illustration of how public dollars can be leveraged effectively to examine a pressing policy issue and to produce information that can be translated into better policy and practice. The ASPE/RWJF collaboration made it possible to develop, test, and expand a policy-oriented demonstration project that has become a pivotal strategy in most states' efforts to build their home and community-based service systems.

Key Words. Cash and Counseling, home and community-based services, consumer direction

For the past 30 years, a quiet, persistent revolution has gathered steam and shaped America's thinking about how to care for people with disabilities. Before the 1970s, the vast majority of physically and cognitively impaired elders and younger people with significant developmental or physical disabilities received services informally by family members and friends on an unpaid basis. While individuals and families with sufficient resources might be able to purchase home care and personal care services in the private market, federal, state, and, to a lesser extent, local funds largely supported care in nursing homes, intermediate care facilities for the mentally retarded, and other institutional settings.

In response to mounting pressure from advocates who expressed a strong preference for services to be delivered in the community and their own concerns about escalating Medicaid and other state expenditures, policy makers began to experiment with publicly funded home and community-based care as a less expensive and preferable alternative to nursing homes and other institutional settings. The de-institutionalization movement of the 1970s helped transfer many people with developmental disabilities and mental illness to smaller community-based housing arrangements (Lamb and Weinberger 2001). Many states used their own funds to create home care and personal care programs and the proliferation of Medicaid waivers beginning in the late 1970s provided states with flexibility in their use of Medicaid funds. For the first time, the federal government allowed states to pay for various forms of home and community-based services for elderly and younger disabled individuals who were deemed eligible for institutional care (Kane, Kane, and Ladd 1998).

The most common type of community-based service was (and continues to be) a package of home care services developed through a care plan and delivered by a trained aide or personal care worker employed by a formal home care agency (Kane, Kane, and Ladd 1998). For the most part, individuals who used services had little choice about who they could hire to care for them and little say in the approach to care the worker used or the decision to terminate a worker. Owing to logistics and efficiency considerations, home care and personal care workers typically had prescribed schedules not conducive to addressing the service needs or maximizing the quality of life of the

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disabled person. Workers, for example, might not be available to provide meals at the times preferred by an individual client or be available to transfer individuals to and from bed at times desired by the disabled person.

Consumer direction in long-term care starts with the premise that individuals with long-term care needs should be empowered to make decisions about the services and supports they receive, including having primary control over the nature of the services, and who, when, and how the services are delivered (Baldock and Evers 1991). The concept reflects a continuum of approaches based on the level of decision making, control, and autonomy allowed in a particular situation. At one end of the spectrum, the cash model offers the consumer the most flexibility and potential for empowerment. Professionally managed service packages are at the other end of the consumer direction continuum. Many approaches, however, lie within these two extremes. These include programs that allow individuals to hire and fire their own workers (including family members) and voucher programs that, with certain constraints, afford consumers great flexibility in how and where benefits can be used (Stone 2006).

The purpose of this article is to discuss why and how the Cash and Counseling Demonstration and Evaluation (referred to as Cash and Counseling) came to be designed, implemented, and evaluated through an ongoing partnership between the Office of the Assistant Secretary for Planning and Evaluation (ASPE) within the U.S. Department of Health and Human Services (DHHS) and the Robert Wood Johnson Foundation (RWJF). Following a brief summary of the origins of consumer direction, the authors will review the evolution of the partnership, focusing on the incentives for a federal agency and a private philanthropy to collaborate, the previous knowledge and beliefs of and investments by each partner that set the stage for this partnership, the challenges that were faced in launching and continuing this effort as a partnership, and the value to each organization and the broader society. The article concludes with a discussion of some key unresolved issues as Cash and Counseling enters its second generation.

ORIGINS OF CONSUMER DIRECTION

Thirty years ago, disabled consumers, their families and other advocates began to express concerns about the lack of autonomy and choice in the home and community-based service system and the failure of professionally determined and delivered service programs to respond adequately and

appropriately to the diverse needs and preferences of their clients. In the mid-1970s, the self-advocacy and self-determination movements catalyzed the development of state-based, consumer-directed programs for people with developmental disabilities and mental retardation that encouraged and enabled these individuals to directly control the resources provided and the services they received (Shapiro 1993; Eustis 2000). A parallel revolution—the independent living movement—had its roots in the 1960s among physically disabled young people and veterans who set up their own programs of housing and services on college campuses to maximize their potential for getting a college education (Shapiro 1993). The independent living and disability rights movements became intertwined in the 1970s, paving the way for the development of new programs where the consumer is in charge of the service provider to minimize dependency on others (Batavia, De Jung, and McKnew 1990). A study of Medicaid attendant care programs for younger people with disabilities conducted by researchers at the World Institute on Disability in 1988 found that 46 percent of these programs permitted the beneficiaries to hire and manage their caregivers directly (Doty, Kasper, and Litvak 1996).

Advocates for frail and disabled elderly consumers were much more ambivalent about consumer-directed approaches, raising doubts about the desire of many elderly clients to make their own hiring and firing decisions and the appropriateness of such programs for elderly individuals with Alzheimer's disease and related dementias (Benjamin 2001; Stone 2001). In contrast to this ambivalent position, several Western European countries (the Netherlands, Austria, Germany) had explored consumer-directed options for elderly as well as younger people with disabilities and had included this approach in the benefit structure of their national long-term care social insurance programs (Tilly, Weiner, and Cuellar 2000). Austria's program provides only a consumer-directed benefit while beneficiaries in Germany and the Netherlands can choose between a consumer-directed and agency-directed/defined service package model.

In 1992, President Clinton created a health care reform task force to address gaps in the U.S. health and long-term care systems. In the process of designing its plan for long-term care reform, the work group charged with this responsibility obtained the input from a wide range of advocates and state-level policy makers, including many stakeholders who supported a consumer-directed approach to home and community-based services. The legislative proposal that emerged from this process—a national home and community-based services program to be administered by the states—contained several provisions intended to enhance consumer direction. States that accepted the

enhanced federal matching dollars proposed under the plan would be required to offer services through both consumer-directed and agency-delivered modes. The proposed legislation would also have allowed states, at their discretion, to offer self-directing consumers maximum choice and control by providing benefits in the form of a cash allowance in lieu of defined services (Doty 2000).

Although the Clinton long-term care reform legislative proposal was not enacted, this effort—the culmination of a rich 30-year history of consumer-directed advocacy and program development—helped set the stage for Cash and Counseling, developed in the mid-1990s through a partnership between ASPE and RWJF. The architects of this program recognized, and, in fact, had supported some of the early federal and state initiatives in consumer direction. They also believed that in order for the philosophy and practice to expand beyond small programs and become integrated into public policy at the state and federal levels, there would need to be an evidence base to support consumer direction and to identify for whom and under what circumstances such approaches were appropriate and viable.

THE BASIS OF ASPE'S SUPPORT FOR CASH AND COUNSELING

In 1993, a new division was created within ASPE—the Office of Disability, Aging and Long-Term Care Policy (DALTCP)—to support policy development and research related to the long-term care needs of people of all ages. Since 1980, DHHS had been focusing increased attention on the development and expansion of home and community-based care options to help elderly and younger people with disabilities remain in their own homes and avoid or delay institutionalization. With the creation of DALTCP, however, ASPE's role in studying and advancing new models of service delivery for people of all ages became even more pronounced. DALTCP viewed consumer direction as a potentially important strategy for achieving more efficient and effective home and community-based care. Staff developed a policy research agenda to investigate the advantages and disadvantages of various consumer-directed models, including the most radical approach that would allow individuals to receive cash and make their own decisions about how to spend the funds. Cash and Counseling, an initiative that became one of DALTCP's signature projects, was motivated by both policy and research concerns.

Policy Motivation

DALTCP was interested in examining consumer directed approaches for several reasons. First, the division was charged with monitoring policy development for people with disabilities across the age span and consumer direction has been a preference and policy goal for disability advocates for several decades. Advocates from the disability movement had, in fact, been largely responsible for the development of many consumer-directed programs, primarily state-funded, that already existed across the country. Second, DALTCP was interested in exploring the extent to which this approach was appealing to and appropriate for elderly people with long-term care needs, particularly those with cognitive impairments. Third, 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 increased interest in the concept at the federal level. Fourth, home care providers and consumers had experienced severe worker shortages in the early 1990s, and DALTCP was interested in examining the extent to which consumer direction could help expand the labor pool (e.g., by allowing consumers to pay family and friends to deliver services).

The DALTCP staff had previously investigated the extent to which states and other countries paid relatives to care for their disabled family members (Stone and Keigher 1994) and had also examined the experiences of several western European countries that had implemented consumer-directed long-term care in the public sector through options ranging from caregiver and disability allowances to cash benefits administered through social insurance programs. It is interesting to note that concerns about fraud and abuse and accountability had not emerged as major deterrents to implementation in these countries. In contrast, many policy makers at the state and federal levels expressed grave concerns about potential fraud and abuse, particularly where cash might be offered in lieu of a defined service package. It was assumed that at least a proportion of consumers and their families would either use the funds for non-long-term care purchases or would be incapable of making prudent decisions. Many policy makers also had serious reservations about paying family members for services that policy makers felt should be provided for free. Much of the opposition to consumer direction also reflected concerns about the lack of accountability and mechanisms for protecting vulnerable consumers from physical and emotional harm.

Research Motivation

In addition to DALTCP's role in policy monitoring and oversight, the division had a major role to play in conducting and supporting applied research related to a range of long-term care policy issues. In 1979, the precursor office to DALTCP had developed and funded the National Channeling Demonstration, a large scale, multistate study that was one of the first research efforts to evaluate the effects of home and community-based care (Kemper 1988). DALTCP staff was also responsible for developing the long-term care provisions of the Clinton health care plan (referred to in the previous section), which included a consumer-directed option in its proposed national home and community-based program.

Recognizing the increasing interest in consumer direction among disability advocates and some state policy makers, the DALTCP staff became convinced that this issue should be a high priority on its research agenda. To date, few evaluations had been conducted of this approach to home and community-based service delivery. The reports of European successes were based primarily on anecdote. Many policy makers at the federal and state levels were dubious about consumer direction, arguing that consumers or their families would spend the funds frivolously. Others were concerned that for those consumers who chose to hire a relative or friend, many of these individuals would be abused by their workers or would receive less than quality care. Some home health and home care providers were vehemently opposed to consumer direction, particularly a program that would give the funds directly to individual consumers, because they feared that this approach would seriously impinge on their business. Finally, as noted in the previous section, many noted that frail elderly people might prefer to have their care managed professionally rather than to have to make their own care decisions.

DALTCP, therefore, recognized the need to conduct a study that would examine these issues using a scientifically rigorous methodology. Absent such an evidence base, the advocates and critics would continue to fight over the value and viability of consumer-directed options for at least a subset of home and community-based service consumers. A large-scale demonstration that could test the key hypotheses raised by many stakeholders would help to inform better policy and program design. Additionally, the impact of consumer-directed programs on a wide range of stakeholders including the consumers, their families, workers, extant care managed programs, and long-term care costs could be examined.

THE BASIS OF SUPPORT FOR CASH AND COUNSELING AT THE RWJF

The RWJF, whose mission is to improve the health and health care of all Americans, had a long-standing focus on improving the delivery of care to elders. Throughout the 1980s and 1990s, a focused part of the foundation's grant-making involved efforts to improve long-term care services for frail elders and for the disabled more generally. The strategies pursued evolved over the 20-year period but the general focus has been to support grantees attempting to improve access to long-term care services and to expand the choices for individuals who need long-term care services.

In the 1980s, the major RWJF grant-making programs in this area focused on changing systems of care at the state and community level (Alper and Gibson 2001). The premise of these early programs that focused on specific subsets of the disabled population was that the fragmentation of state funding sources made it difficult to coordinate the various types of services that a disabled person needed. The hope was to better integrate providers so that all needs could be addressed and to make sure that funding sources were not over supporting some types of needs (e.g., health care needs) but undersupporting other types of needs (e.g., needs for assistance with activities of daily living). These early initiatives supported demonstration programs at the state level and included distinct programs directed at people with chronic mental health problems, HIV, Alzheimer's disease, and physical disabilities.

The theme of integrating acute and long-term care continued in initiatives that tested what eventually became the PACE/On Lok program and Social HMOs (Master and Eng 2001). These programs combined medical care and long-term care financing in the hands of one provider who accepted a capitated payment to deliver a range of acute and long-term care services (Capitman 2003). The notion was to "stretch" existing resources targeted to people with chronic illness and disabilities and to allocate them as efficiently as possible to meet the needs of these individuals in a balanced manner.

The foundation drew on its experience from the programs in the 1980s to develop a three-pronged strategy to help improve long-term care for people with disabilities across the age span:

- (1) To encourage balancing the long-term care system so that community-based services were used and paid for by funders whenever possible instead of focusing most public resources on nursing home

- care. This element was based on overwhelming evidence that people wanted to stay in communities whenever possible.
- (2) To encourage better systems of financing long-term care. This element was based on the obvious reality that elders did not have enough money to pay for most long-term care services using out-of-pocket funds.
 - (3) To encourage new approaches to “stretching” resources by finding lower cost methods of providing services to people with disabilities and by encouraging voluntarism and by supporting informal caregivers when possible. This element was based on the assessment that society would never fund all needs for services with formal, costly services.

A range of initiatives focused on balancing the long-term care system. The foundation funded research through its Home Care Research Initiative to identify models that worked to balance the system (Feldman 2003). It supported state-based demonstrations of efforts to rebalance systems through a national program called State Initiatives in Long-Term Care and another initiative called Building Health Systems for People with Chronic Conditions (Alper and Gibson 2001).

To encourage better systems of financing long-term care, the foundation hedged its bets by supporting policy analysis and research that explored the feasibility of federally funded or state funded insurance systems for long-term care and by supporting efforts to strengthen the private long-term care insurance market. The most ambitious foundation effort in the financing area was the Program to Promote Long-Term Care Insurance for the Elderly which helped three states test a new type of insurance that blended private insurance and Medicaid to create a more affordable long-term care insurance option for the middle class (McCall 2001). In 2005, Congress gave approval for other states to implement this public-private insurance.

Cash and Counseling, from RWJF’s perspective, was viewed as a key way to stretch available resources to meet more of the long-term care needs of people with significant disabilities. Economists have long emphasized that cash payments to people lead to more efficient use of resources than support of defined benefits (which may or may not be highly valued by a specific individual). People with disabilities often reported that it was more expensive to pay an agency-based long-term care provider than to use a fixed amount of resources to pay for neighbors, friends, or relatives who might be available to provide care to individuals. It might also be possible to pay for assistive

technology or home modifications that could avoid the need for an actual caregiver.

The foundation concurred with DALTCP that the idea of letting people use cash directly would require strong evidence that people did not misuse the money and that their care needs actually were met. This belief was the basis for embedding the demonstration initiatives within a rigorous research evaluation involving random assignment and careful analysis of process and outcomes related to the program.

Cash and Counseling was one of three key investments by RWJF in consumer choice initiatives in the mid-1990s. A companion program, called Independent Choices, supported nine demonstration initiatives in states and communities nationwide to experiment with a range of approaches to giving people with disabilities more choice and control in managing resources allocated to their long-term care (Benjamin and Snyder 2002). Independent Choice demonstrations included efforts such as a restructuring of the Ohio Medicaid waiver program to add choices to the services frail elders receive and a “rapid response” program to address unmet service needs of home care clients in Alameda County, CA. The third RWJF initiative on consumer choice was the Self Determination Program which supported 18 states to design and implement service systems for the developmentally disabled that gave families more choice in determining the services they receive (Benjamin 2001). The new approach to services was built on four key principles: person-centered planning that allowed individuals and their families to define their needs, case managers to assist families, defined individual budgets that individuals could use to purchase the services needed, and fiscal intermediaries to manage payments to caregivers.

Cash and Counseling also was viewed by the foundation as a companion program to the ambitious investments it was making in encouraging voluntarism in the long-term care area. The foundation experimented with approaches to encouraging voluntarism in the 1980s through its support of “service credit banking” initiatives that gave healthy elders “credits” if they helped frail elders with activities of daily living (such as driving or cooking). In turn, the idea was for the healthy elders to be able to use their “credits” for services in the future when they began to need assistance. While this concept never caught on in many communities, the spirit of the program motivated Faith in Action, a \$100 million investment by RWJF that supported faith-based groups to initiate programs organizing volunteers to meet the service needs of frail community members. This initiative has resulted in hundreds of such community-based volunteer groups getting started nationwide.

Cash and Counseling is similar in spirit to Faith in Action in that it attempts to marshal available community resources to meet the needs of a growing elderly population requiring assistance with activities of daily living. The programs recognize that the large demands for service require creative thinking about how to use less formal sources of care to complement the important roles played by home care agencies and housing-based long-term care in assisted living facilities and nursing homes.

MEETING THE CHALLENGES OF THE PARTNERSHIP

Policy makers and foundation leaders often talk about the importance of having the private sector—through philanthropic efforts—and the public sector work collaboratively to address pressing social concerns. Such partnerships, however, are difficult to initiate and sustain because of the very different cultures and constraints in the two sectors. Although both RWJF and ASPE decided early on that working collaboratively on the initiative was essential, the partnership was not without its challenges. The first obstacle was obtaining support for the program from the leadership of their respective bureaucracies. In the case of Cash and Counseling, the status of each of the program developers provided the leverage to get an audience with and support from their respective bosses.

The second challenge was how to manage the decision making process and the communication between RWJF and ASPE. The partners quickly addressed this problem by jointly creating a national program office at the University of Maryland (later moved to Boston College) to oversee the demonstration program and to ensure that all parties, including the program officers at the foundation and ASPE, were always in the communication loop. This national program office also was responsible for working with both partners to develop the competitive Request for Proposals from the states, to manage the decision-making process and to provide technical assistance to the demonstration sites.

A third challenge to the implementation and sustainability of this partnership and the program was the potential for leadership and staff turnover. Over the course of Cash and Counseling, there was an administration change within the executive branch of the federal government and a change of leadership at RWJF. These changes could have posed a tremendous threat to the continuation and expansion of the demonstration program. But, due in large part to the longevity of the project officers within both the foundation and

ASPE and the direction of the national program office, Cash and Counseling has not only survived but has supported a second generation of demonstration states.

A fourth challenge to this type of public/private partnership is the potential battle over how to apportion credit for the success of a program. The partners were able to share in the credit and over the past decade have continued to acknowledge the important roles each other played in making Cash and Counseling a reality. While RWJF has been the most visible partner to the outside world because of its investment in the demonstration activity, ASPE and the DHHS more generally have been acknowledged as important contributors to increasing our scientific understanding of this approach and its expansion in public policy.

A fifth challenge was how to develop a working relationship with the states that would be participating in the demonstration and evaluation. While there is often tension between the federal and state governments in hashing out the details of new Medicaid programs, the partnership between ASPE, RWJF, and the national program helped facilitate the negotiation between HCFA's Medicaid office and the state officials who agreed to implement the demonstration. While the details involved in implementing this demonstration in Arkansas, Florida, and New Jersey were sometimes daunting—as described in other articles in this volume—the public/private partnership helped the participants to work their way through a complex and unique planning and implementation process that also included a rigorous, standardized evaluation study. The partnership approach to the initiative continuously brought each player together at one table and ultimately made the project and the learning that has resulted from the project possible.

A number of factors contributed to the ability of this public/private partnership to meet the challenges and to design and implement an initiative that has been successful. These include:

- (1) The two individuals leading the effort at RWJF and ASPE knew each other and worked collaboratively on other projects. Both leaders, furthermore, were personally interested and invested in the topic and in getting the program approved and supported.
- (2) The culture of ASPE and the Research and Evaluation Division at RWJF are very similar. Both organizations have a tradition of working on large-scale, analytical projects and both value objective, rigorous evidence.

- (3) The Cash and Counseling initiative for most of its life was under the radar screen. It was not one of RWJF's large investments and it was just one of many initiatives underway at ASPE. Thus, the demonstration took place relatively quietly.

NEXT PHASE OF THE PARTNERSHIP

Over a decade after the initial investment in the Cash and Counseling Demonstration and Evaluation, a growing body of evidence is emerging to support the value of this approach to many consumers, workers, families, and policy makers. Major insights into how to design and implement these programs have been learned. Several researchers have observed that in the wake of positive evaluation results from the Cash and Counseling evaluation, Real Choice Systems Change planning grants offered by the Centers for Medicare and Medicaid Services (CMS) beginning in 2001 have provided incentives for states to design and implement new models of community-based care that incorporate various elements of consumer choice (Spillman, Black, and Ormond 2006).

Based on the experience and research findings from the initial three-state study in Arkansas, Florida, and New Jersey, RWJF and ASPE are currently supporting a second phase of the program. Specifically, the foundation is funding 11 additional states (Alabama, Iowa, Kentucky, Michigan, Minnesota, New Mexico, Pennsylvania, Rhode Island, Vermont, and West Virginia) to implement Cash and Counseling and the Retirement Research Foundation has joined the partnership through its support of an initiative in Illinois.

ASPE, with some contribution from the Administration on Aging, continues to support the national program office at Boston College to provide technical assistance to the new grantees. This includes bringing together the original grantees and the new grantees for information sharing and informal consultation and the maintenance of a program-wide website. In addition, ASPE is supporting researchers to provide a descriptive analysis of phase two, including lessons learned about how to get to the tipping point in viewing consumer direction as an option that should be incorporated into all home and community-based services programs.

UNRESOLVED ISSUES

The partnership continues to face some unresolved issues. First, policy makers and consumer advocates tend to talk about the merits of Cash and Counseling

in the abstract but the devil is in the details in terms of operationalizing this concept, particularly within the Medicaid program. Lower-level bureaucrats at both the federal and state levels, who are responsible for the Medicaid program, continue to raise issues about how the waivers are to be implemented, who can get paid as a caregiver, and how resources will be allocated.

A related unresolved issue is how case management is addressed within the context of programs like Cash and Counseling. At the state and local levels, there are still many advocates for a case managed approach, particularly among the area agencies on aging who administer many of the waiver programs in communities. Given the push toward more consumer direction, many of these agencies are trying to transform themselves from traditional case managers to fiscal intermediaries who would provide intake assessments and some periodic reviews. Many, however, cling to the old, sometimes paternalistic approach to case management, even when the consumer has opted for a consumer-directed service program. Another unresolved issue is how Cash and Counseling and other such programs relate to CMS' Home and Community Based Services Quality Initiative that involves a relatively top-down emphasis on the health and safety of the consumer and encourages states to impose regulations and licensing and certification of staff. This focus is not appropriate for consumer direction and has created some problems in trying to expand Cash and Counseling.

Finally, there continue to be unresolved issues with respect to how the Internal Revenue Service (IRS) views and treats Cash and Counseling and other consumer-directed programs. These issues include the tax status of consumers who are also employers and how they should handle the benefits for their workers. Despite a decade of work with this agency, the IRS has yet to simplify and streamline the procedures so that Cash and Counseling programs and participants are clear about how they can comply with the law.

In conclusion, over more than a decade, ASPE and RWJF staff have worked together to design the demonstration and the evaluation, select the demonstration sites and independent evaluator, and support a national program office to oversee the activities. This public/private partnership is an illustration of how public dollars can be leveraged effectively to examine a pressing policy issue and to produce information that can be translated into better policy and practice. The ASPE/RWJF collaboration allowed the federal government to invest in the development of a strong evidence base and the foundation to support and expand a policy-oriented demonstration project that may ultimately become a pivotal strategy in most states' efforts to build stronger home and community-based service systems.

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