

The Effects Of Cash And Counseling On Personal Care Services And Medicaid Costs In Arkansas

Arkansas' experience shows that states can develop consumer-directed services at no greater cost than traditional agency care.

by Stacy Dale, Randall Brown, Barbara Phillips, Jennifer Schore, and Barbara Lepidus Carlson

ABSTRACT: The Cash and Counseling Demonstration gives Medicaid beneficiaries who are eligible for personal care services a consumer-directed allowance in lieu of traditional agency services. Using survey and Medicaid claims data on 2,008 adult applicants randomly assigned to treatment or control groups, we find the program increased the receipt of paid care but reduced unpaid care. The treatment group had higher Medicaid personal care expenditures than controls did, because many controls received no paid help, and recipients obtained only two-thirds of entitled services. By the second year after enrollment, these higher personal care expenditures were offset by lower spending for nursing homes and other Medicaid services.

MEDICAID PERSONAL CARE SERVICES (PCS) assist beneficiaries with routine activities, such as bathing and getting in and out of bed. These services are intended to improve beneficiaries' quality of life and allow them to live in their homes, rather than in nursing facilities. However, beneficiaries often do not receive authorized services, which raises concerns about whether they receive adequate care.¹ Moreover, because the PCS benefit is traditionally provided through agencies, beneficiaries' choices are sometimes limited about how and when their care is provided, especially since agencies generally do not provide care on weekends or outside normal business hours. Finally, the PCS benefit does not cover assistive technologies or home modifications that could reduce dependency on human assistance.

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States are increasingly interested in improving the well-being of beneficiaries who are eligible for PCS by allowing them to plan and direct their own care. Advocates for consumer-directed care believe that individuals, not agencies, are best suited to make decisions about the care they receive and the workers they hire. However, critics are concerned that consumers might misuse the funds intended for their care, receive inadequate care, or use a cash benefit to pay family members to provide care once provided for free. States are wary that the program might raise total Medicaid costs.

The national Cash and Counseling Demonstration permits the first rigorous comparison of PCS use under agency- and consumer-directed approaches. In a previous *Health Affairs* paper we showed that the IndependentChoices program in Arkansas, the first of the three states to implement the demonstration, greatly improved consumers' satisfaction and reduced their unmet need for many types of assistance without increasing their likelihood of experiencing adverse health problems.² Our current paper explores the program's effect on the receipt, timing, and amount of PCS that beneficiaries receive; the modifications and purchases they make to help them perform daily activities independently; and their Medicaid expenditures for personal care and other services.

Background

The Cash and Counseling model of consumer-directed supportive services gives eligible beneficiaries who choose to participate a flexible monthly allowance to purchase disability-related goods and services (including hiring relatives as workers). The program also provides counseling and fiscal assistance and allows consumers to designate representatives (such as family members) to make decisions on their behalf. These features make the model adaptable to consumers of all ages and with all types of impairments.

Arkansas' IndependentChoices was open to adults who were at least eighteen years old and who were eligible for PCS under the state's Medicaid plan. About 11 percent of PCS users (2,008 beneficiaries) in Arkansas enrolled in the demonstration between December 1998 and April 2001. Enrollees completed a baseline telephone interview and were then randomly assigned to the treatment or control group. Control-group members continued relying on agency services or, if newly eligible for Medicaid PCS, received a list of home care agencies to contact for first-time services. Treatment group members were contacted by an IndependentChoices counselor, who helped them develop written plans for spending their allowance. Allowance spending plans could include hiring workers (excluding spouses or representatives) and purchasing other services or goods related to their

needs, such as supplies, assistive devices, and home modifications. Counselors also monitored satisfaction, safety, and use of funds.

Data Collection And Methods

We drew data from two computer-assisted telephone surveys of enrollees (a baseline survey and a follow-up survey conducted nine months after each sample member's random assignment) and from Medicaid claims data. Service-use outcomes (including the type, timing, and amount of assistance received and the purchases made) were constructed from the nine-month survey, which was completed by 87 percent of the full sample. Data on spending for personal care and other Medicaid services were drawn from Medicaid claims data for the twelve months after enrollment for the full sample and for the twenty-four months after enrollment for a cohort of "early enrollees" (those who enrolled before May 2000).

PCS expenditures recorded in the claims data for those receiving agency services were equal to actual hours of care delivered, multiplied by \$12.36, the rate paid by Arkansas Medicaid for agency services. PCS expenditures for treatment-group members receiving the allowance included the amount of the allowance itself, plus fiscal agent and counseling fees. Arkansas set the allowance equal to \$8, times the number of care plan hours (discounted to reflect the historic difference between the hours of care agencies actually delivered and care plan hours). Counseling and fiscal agent fees were expected to be covered, in the aggregate, by the difference between Medicaid's \$12.36 per care plan hour and the \$8 per hour allowance. (Treatment-group members did not have to actually use their allowance to purchase the number of hours of care in their care plan, nor did they have to pay wages of \$8 per hour.) Treatment-group PCS expenditures also included any payments to agencies for services delivered after randomization but before consumers' allowance started or, for disenrollees, after leaving the program.

We estimated program impacts using linear regression and logit models that controlled for the sample member's baseline characteristics, including measures of demographic characteristics, care plan hours, health and functioning, use of personal assistance, satisfaction with care and life, unmet needs, and work and community activities. As expected under random assignment, the characteristics of the treatment and control groups were very similar; our models ensure that any differences between the two groups in these characteristics that might have arisen by chance or by different nonresponse patterns do not distort our estimates.³ We estimate effects separately for elderly and nonelderly adults because the types and amounts of care they need could differ.

Study Results

■ **Likelihood of receiving paid assistance.** IndependentChoices greatly increased the likelihood that beneficiaries received paid assistance. Elderly community residents in IndependentChoices were much more likely than controls were to

receive paid assistance during their two most recent weeks at home prior to the nine-month interview (Exhibit 1). The difference for the nonelderly was even larger.

The lack of any paid assistance among control-group members was striking, particularly among “new applicants”—those who were not receiving publicly funded home care services when they enrolled in the demonstration (about a quarter of the sample). Fifty-one percent of new applicants in the control group, compared with only 8.1 percent of new applicants in the treatment group, did not have a paid caregiver nine months after enrollment (data not shown), despite being eligible for PCS. Among those receiving publicly funded home care at enrollment, the treatment-control difference in the percentage of consumers without paid assistance at nine months was statistically significant but much smaller (5.1 percent for treatments versus 13.7 percent for controls). Among treatment-group members, about two-thirds hired family members, and most others hired friends or acquaintances (data not shown). A minority of those hired lived with the treat-

**EXHIBIT 1
Estimated Effects Of Independent Choices On The Receipt, Timing, And Amount Of Assistance Received In The Previous Two Weeks, 1999–2002**

Outcome	Ages 18–64 (n = 473)		Age 65 and older (n = 1,266)	
	Predicted treatment-group mean	Predicted control-group mean	Predicted treatment-group mean	Predicted control-group mean
Lived in the community	93.1%	95.7%	86.1%	87.8%
Of those living in the community				
Received paid assistance	94.5%	67.8%****	94.2%	78.8%****
Received unpaid assistance	97.1	95.0	93.7	90.5*
Received assistance				
On weekday evenings	80.2%	75.0%	73.2%	68.3%**
On weekends	85.4	79.1*	78.2	76.2
Early mornings/evenings or weekends	90.7	81.8***	80.2	78.2
Total hours of care	99.3	120.0**	125.3	128.8
Paid hours	24.7	22.2	23.3	16.6****
Unpaid hours	74.6	97.8**	102.0	112.1
Total help received (hours) ^a				
0–42 (0–3 per day)	34.7%	36.0%	34.1%	36.4%
43–126 (3–9 per day)	35.1	23.2	23.2	19.8
127–210 (9–15 per day)	20.7	23.7	19.0	18.9
210+ (15+ per day)	9.5	17.1	23.7	24.9
Paid hours among those with paid care received ^a				
1–14 (<1 per day)	17.9%	30.7%	17.5%	38.5%
15–70 (1–5 per day)	76.3	55.9	77.9	56.1
70+ (5+ per day)	5.8	13.4	4.7	5.4

SOURCE: Nine-month evaluation interview, conducted by Mathematica Policy Research between September 1999 and March 2002.

NOTES: The analysis of hours of care received includes only the 421 nonelderly and 1,138 elderly sample members who had complete data for each component of total hours. Asterisks denote statistically significant effects of treatment-group status.

^a Chi-square tests of the treatment-control differences in the distribution of total hours of help received and hours paid for were performed for each of the age categories. *P*-values were < .01 except for total help received, ages 65 and older (*p* = .550).

p* < .10 *p* < .05 ****p* < .01 *****p* < .001

ment-group member.

■ **Hours during which care was received.** IndependentChoices addressed a limitation of agency care for some: access to care during nonbusiness hours. Among the elderly sample, treatment-group members were more likely than controls were to receive assistance during the evening (Exhibit 1). For the nonelderly sample, the treatment group was more likely to receive assistance during any nonbusiness hours (early morning, evening, or weekend).

■ **How personal assistance needs were met.** IndependentChoices affected the way that nonelderly people met their personal assistance needs. Nonelderly treatment-group members received an average of 99.3 total hours of care during the previous two weeks, 20.8 fewer than nonelderly control group members (Exhibit 1). This difference stems from the fact that a far greater percentage of the control group than the treatment group received more than 210 hours of help.

Nonelderly treatment- and control-group members received comparable amounts of paid care, but the treatment-group members averaged 23.2 fewer hours of unpaid care than control-group members. Among those receiving paid assistance, treatment-group members were less likely to get very high or low levels of paid care; this was largely attributable to the fact that control-group members who qualified for many hours of paid care were much more likely to actually receive paid assistance.

Nonelderly treatment-group members might have received fewer hours of total care because they reduced their need for human assistance. Treatment-group members were more likely than control-group members to obtain equipment to help with personal activities and communications, such as specialized telephones, lifts, or emergency response systems (Exhibit 2). The program also increased the proportion of nonelderly consumers making any purchase or modification.

For the elderly, the number of paid hours of care is about 40 percent greater for the treatment group than for the control group, but total hours of care are essentially equivalent for the two groups. The program had no effect on the purchases or modifications made by the elderly.

■ **Impact on Medicaid spending.** Medicaid expenditures were larger for the treatment group because the control group received a smaller-than-expected share of the services authorized for them. Control-group members received much less care than was authorized, resulting in annual PCS spending per sample member that was almost twice as high for the treatment group as for the control group during the first postenrollment year (Exhibit 3). The \$2,256 difference in PCS spending was partly offset by a \$421 reduction in spending for non-PCS long-term care Medicaid services (including nursing facility, home health, and other home health waiver programs called Alternatives and ElderChoices) and by a \$348 reduction in other non-PCS Medicaid spending (driven mainly by hospital inpatient services). Thus, total annual Medicaid spending per sample member was \$1,486 higher for the treatment group (\$1,693 for the elderly and \$1,294 for the nonelderly) (data not shown).⁴

EXHIBIT 2
Estimated Effects Of Independent Choices On Home Modifications And Equipment Purchases Or Repairs, 1999–2002

Outcome since enrollment	Ages 18–64 (n = 473)			Age 65 or older (n = 1,266)		
	Predicted treatment-group mean (%)	Predicted control-group mean (%)	Estimated effect (p-value)	Predicted treatment-group mean (%)	Predicted control-group mean (%)	Estimated effect (p-value)
Modified house	30.1	26.2	3.8 (.338)	28.0	25.0	3.0 (.223)
Modified car or van	2.7	5.1	-2.4 (.131)	3.6	2.5	1.1 (.299)
Obtained special equipment or supplies for meal preparation or housekeeping	20.9	15.6	5.2 (.140)	12.7	12.9	-0.2 (.901)
Obtained equipment or supplies to help with personal activities/communication	29.3	21.2	8.0 (.043)	28.3	31.2	-2.8 (.263)
Repaired equipment used to help client	20.5	17.4	3.0 (.372)	12.3	13.1	-0.8 (.665)
Modified home or vehicle or purchased any equipment or supplies	60.2	49.6	10.7 (.013)	55.0	54.5	0.5 (.855)

SOURCE: Nine-month evaluation interview, conducted by Mathematica Policy Research between September 1999 and March 2002.

The lower long-term care costs for treatment-group members suggest that Cash and Counseling enables consumers to substitute personal care services at home for other, more costly services, particularly nursing facilities. To assess whether such savings grow over time, we examined costs during the second postenrollment year for sample members whose Medicaid data were available in time for this analysis. For this early cohort (about half the sample), results for the first year were similar to those for the full sample, but total Medicaid spending during the second year was only 5 percent (\$528) higher for the treatment group than for the control group, a statistically insignificant difference. While the treatment group's average PCS spending was \$2,014 higher than that of the control group, treatment-group members' spending for non-PCS long-term care services was \$1,057 lower, and their spending for other non-PCS services were \$429 lower.

The higher PCS spending under Independent Choices is not surprising, given the much higher proportion of treatment-group members receiving paid care. About half of the cost difference is attributable to the difference in the proportion receiving care. The remainder is attributable to treatment-group recipients' higher PCS spending than control-group recipients, as reflected in the treatment group's higher cost per person month of PCS benefit received—\$445 for the treatment group versus \$359 for controls, a 24 percent difference (data not shown).

The difference in cost per person month of PCS benefits is surprising because the two groups had equal average hours per month in their care plans at enrollment (about forty-five), and the cash allowance was discounted to account for the historical discrepancy between planned and actual hours. However, during

EXHIBIT 3
Estimated Effects Of Independent Choices On Medicaid Spending, 1999–2002

	Predicted treatment- group mean (\$)	Predicted control- group mean (\$)	Estimated effect (\$ (p-value))
Full sample: first-year postenrollment spending (n = 2,008)			
PCS spending	4,605	2,350	2,256 (.000)
Non-PCS long-term care Medicaid spending ^a	3,084	3,505	-421 (.023)
Other non-PCS Medicaid spending ^b	4,791	5,139	-348 (.109)
Total Medicaid spending	12,480	10,994	1,486 (.000)
Early cohort: first-year postenrollment spending (n = 1,312)			
PCS spending	4,855	2,402	2,452 (.000)
Non-PCS long-term care Medicaid spending ^a	2,892	3,396	-505 (.025)
Other non-PCS Medicaid spending ^b	4,576	5,142	-566 (.044)
Total Medicaid spending	12,322	10,940	1,386 (.001)
Early cohort: second-year postenrollment spending (n = 1,312)			
PCS spending	3,853	1,839	2,014 (.000)
Non-PCS long-term care Medicaid spending ^a	3,253	4,310	-1,057 (.003)
Other non-PCS Medicaid spending ^b	4,212	4,640	-429 (.182)
Total Medicaid spending	11,317	10,789	528 (.339)

SOURCE: Medicaid claims data.

NOTES: Those in the “early cohort” enrolled in the Cash and Counseling Demonstration before May 2000. Means were predicted using ordinary least squares (OLS) regression models. Elderly and nonelderly subgroups are combined here, because treatment-control cost differences were similar for the two groups. PCS is personal care services.

^a Includes spending for nursing facilities, home health services, and the ElderChoices and Alternatives waiver programs.

^b Includes spending for hospital inpatient services, prescription drugs, physician services, durable medical equipment, hospice, and other Medicaid services.

months when they received PCS, control-group members received an average of only 68 percent of their authorized care plan hours; historically, PCS recipients in Arkansas had received an average of 86 percent of their authorized hours. Thus, treatment-group spending per recipient was greater than control-group spending, because agencies delivered only 79 percent of the care they were expected to ($0.68/0.86 = 0.79$).

Discussion

Our study addressed one program in one state over a limited time period. Impacts might differ for programs with other features (for example, those that target children, allow spouses to be paid workers, or have more or less generous PCS benefits). Furthermore, our findings can be generalized only to the extent that demonstration participants are representative of those who would enroll in an ongoing program. Finally, estimated program effects might depend in part on whether the local supply of home care workers is adequate to meet the demand for

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services. Thus, results might be quite different for 2003 than they were for the 1999–2002 period studied here, when the labor market was quite tight. Future analyses will assess the robustness and generalizability of the findings by examining the effects of Cash and Counseling on adults in the other two demonstration states—Florida and New Jersey—and on children in Florida.

Although the generalizability of the results is uncertain as yet, the findings for IndependentChoices are clear: The program greatly increased consumers’ access to care and ability to purchase needed equipment and supplies. However, the results raise two issues that could concern policymakers: (1) Paid care could substitute for previously unpaid care, and (2) consumer direction could raise Medicaid spending.

■ **Paid and unpaid care.** Both elderly and nonelderly treatment-group members received fewer hours of unpaid care than controls received. However, the great majority of their total hours of assistance still were provided by unpaid helpers. The reduction in hours of unpaid care, including some substitution of paid for unpaid help, is consistent with easing the burden on family caregivers, which is a generally accepted goal of publicly funded home care.

The program also reduced total hours of care for the nonelderly. This would be disturbing if the decrease in hours had been accompanied by an increase in the unmet needs or adverse events among consumers. However, our companion research showed that IndependentChoices decreased consumers’ unmet needs, increased their satisfaction with care, and did not increase the likelihood of the adverse health events we examined.⁵ Taken together, these findings suggest that IndependentChoices increased the likelihood that nonelderly consumers received the help they needed, but with fewer hours of human assistance.

How might these nonelderly consumers be meeting their needs more effectively than control-group members but requiring less assistance? First, by increasing the percentage of the nonelderly that purchased equipment, IndependentChoices might have decreased the need for human assistance. For example, a number of consumers purchased microwave ovens and washing machines, so that they could prepare meals and do laundry without help. Second, agency workers are often restricted from performing certain tasks, such as administering medication or providing transportation, while the treatment group’s workers were not so restricted. Thus, because a single caregiver can perform a variety of tasks in one visit, care might be provided more efficiently under consumer direction. Finally, workers hired by consumers might have provided more and better care than agency workers, in less time.

■ **Medicaid spending.** The second concern is that Medicaid spending for PCS

during the year after enrollment was higher for IndependentChoices participants than for controls. The large increase in the proportion of eligible beneficiaries receiving paid assistance at nine months is laudable if it is attributable to family members and friends' providing care to consumers who, because of shortages of agency workers, would not have received paid help without the demonstration. However, some control-group members not receiving PCS at enrollment might have declined to seek agency services because they were only interested in the monthly allowance ("induced demand"). Although this would imply that the traditional program was unacceptable to some eligible beneficiaries, it also suggests that IndependentChoices might have increased state Medicaid spending by providing cash payments to people who (although entitled to services) would not otherwise have sought agency care.

We cannot fully sort out how much of the increase in the proportion receiving paid assistance was attributable to worker shortages and how much to induced demand. Had induced demand been widespread, we would have expected a large influx of new personal assistance users during the demonstration period. However, the ratio of new to continuing PCS users among IndependentChoices enrollees was never greater than the analogous ratio for the state's PCS recipients in the year preceding the demonstration start-up. In addition, some people who were not willing to accept agency services were deterred from enrolling by the requirement that demonstration enrollees agree beforehand that they would seek agency services if assigned to the control group. Furthermore, as we learned in follow-up interviews with agencies, worker shortages were common and at times severe during the demonstration period, sometimes forcing them to turn away clients, especially new ones. The fact that agencies supplied a much smaller-than-usual proportion of the hours authorized in the care plan suggests that they had insufficient staff to meet even the needs of their existing patients.

While worker shortages definitely account for some of the treatment-control difference in the receipt of paid care, the high rate of new control-group members receiving no paid care suggests that the difference is also partly attributable to induced demand. There are a number of possible reasons why some beneficiaries chose not to accept the agency services for which they were eligible, including past dissatisfaction with such services. Whatever the reason, IndependentChoices met a key goal: It increased the likelihood that beneficiaries receive paid help with the services they need and are authorized to receive.

Ultimately, what matters to states is the net effect of Cash and Counseling on all Medicaid costs. Increased spending for PCS because of induced demand were offset somewhat by lower spending for other long-term care services during the first postenrollment year and offset almost entirely during the second. Offsetting savings in these long-term care spending could grow even more over time.

ARKANSAS' EXPERIENCE HAS DEMONSTRATED that states can design a “cash and counseling” program that meets recipients’ needs better at no greater cost per month of service than historically incurred under the traditional agency approach (“budget-neutrality” under the definition of the Centers for Medicare and Medicaid Services, or CMS). Even if total costs for PCS are higher than they would have been as a result of the improved access to care or induced demand, they appear to be offset by reduced need for other long-term care services. The better the traditional agency model is at meeting authorized needs, the greater the likelihood of immediate savings from a “cash and counseling” alternative. The worse the agency model performs, the greater the likelihood that spending will increase initially under the cash and counseling model, but the greater the need for this option to ensure adequate access to home care as an alternative to higher-cost Medicaid services, especially nursing home care.

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NOTES

1. U.S. General Accounting Office, *Long-Term Care: Federal Oversight of Growing Medicaid Home and Community-Based Waivers Should Be Strengthened*, Pub. no. GAO-03-576 (Washington: GAO, 20 June 2003).
2. L. Foster et al., “Improving the Quality of Medicaid Personal Assistance through Consumer Direction,” 26 March 2003, www.healthaffairs.org/WebExclusives/Foster_Web_Excl_032603.htm (27 October 2003). This paper also provides further details about the Cash and Counseling program.
3. For methodological details and mean baseline characteristics of the sample, see S. Dale et al., “The Effect of Consumer Direction on Personal Assistance Received in Arkansas” (Princeton, N.J.: Mathematica Policy Research Inc., April 2003).
4. The pattern of expenditure impacts was similar for the elderly and the nonelderly, although the increase in PCS spending and the offsetting decrease in non-PCS spending were both greater for the nonelderly.
5. Foster et al., “Improving the Quality of Medicaid Personal Assistance.”