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Health, Education and Human Services Division

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January 16, 1998

The Honorable John R. Kasich
Chairman, Committee on the Budget
House of Representatives

Subject: Consumer-Directed Personal Care Programs: Department of Veterans Affairs and Medicaid Experience

Dear Mr. Chairman:

Both elderly and the younger disabled persons frequently require personal assistance in everyday activities such as eating, dressing, and bathing. Medicaid and other public programs finance these services, many of which are provided through agencies under contract to Medicaid or other public programs. However, some programs make cash payments to consumers, allowing them to hire their own caregivers.[1] Advocates of these programs argue that they maximize consumer choice and promote efficiency.

You asked us to review the Department of Veterans Affairs' (VA) Aid and Attendance (A&A) program as well as selected state Medicaid programs that permit consumers to hire their own personal care attendants. At the same time, you requested us to examine the issue of whether the government might be paying twice for persons in nursing homes who also received A&A benefits.[2] In this letter, we are reporting to you (1) whether there are any existing public

[1]"Consumer" has become the term preferred over "beneficiary" or "client" in most of the programs discussed here.

[2]VA Aid and Attendance Benefits: Effects of Revised HCFA Policy on Veterans' Use of Benefits (GAO/HEHS-97-72R, Mar. 3, 1997). The Balanced Budget Act of 1997 provided that single veterans' pensions, including A&A, should be considered income and be available for paying for care in state nursing homes, excluding the first $90. Certain veterans who receive Medicaid support for their care in nursing homes are limited to a total of $90 in VA benefits, but the $90 is not counted as income by Medicaid.

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programs that could serve as a model for Medicaid and (2) whether there is currently sufficient knowledge about consumer-directed personal care to recommend one of these programs as a model.

In summary, we found that, while such programs exist, the information currently available is not sufficient to determine whether any of the existing consumer-directed personal assistance programs that allow consumers to pay or participate in paying attendants could serve as a model for Medicaid. In terms of the programs in place, they tend to differ both in their mechanisms for paying attendants and in whether they monitor the use of the payments. VA does not monitor the use of the A&A allowance, taking the position that it has no authority to tell veterans how to use the benefit. State programs want to ensure that employer taxes are paid for personal care attendants, and this can present difficulties for the consumer/employer, who must satisfy all Internal Revenue Service reporting requirements, and for the state, which generally prefers not to be the employer of record. In most cases, the state or a fiscal intermediary makes payments and handles the taxes. Although there has been no rigorous evaluation of any of these programs to date, the four-state Cash and Counseling Demonstration, sponsored by the Robert Wood Johnson Foundation and the Department of Health and Human Services, will produce important information on its cost-effectiveness–but not until 2001.

To develop this information, we reviewed the literature, reviewed documentation, and interviewed program officials. We reviewed the A&A program as it applies to veteran beneficiaries living in the community. In addition, we selected for study two state Medicaid personal assistance programs (Massachusetts and Michigan) in which the consumer has a role in paying for care as well as managing it. We also reviewed documentation and spoke with officials who are developing and managing the Cash and Counseling Demonstration. We conducted our review between July 1997 and November 1997 in accordance with generally accepted government auditing standards.

VA A&A PROGRAM AND CERTAIN STATE MEDICAID PROGRAMS PROVIDE POSSIBLE MODELS OF CONSUMER-DIRECTED CARE

Under the VA A&A program, eligible veterans and survivors who receive compensation or pension from VA get an additional cash allowance if their disabilities make it impossible to perform such basic functions of daily living as

bathing, dressing, and eating without the assistance of another person.[3] The A&A allowance is an addition to the compensation or pension payment, and the veteran receives one check covering both. As of February 1997, about 21,000 veterans and survivors qualified for the A&A allowance under the compensation program, about 134,000 under the pension program. Compensable veterans can receive as much as $2,180 per month for A&A; pensionable veterans can receive as much as $433 per month. A similar, smaller program, the Housebound Allowance, provides smaller cash payments to veterans and survivors who are housebound. As cash payments, the programs are administered by the Veterans Benefits Administration rather than the Veterans Health Administration, which runs the VA health care system.

VA does not monitor the benefit or how it is used, taking the position that it has no authority to do so. The regulations specifically state that performance of the necessary aid and attendance by a relative is acceptable and does not prevent payment of A&A. VA points out that most recipients of the A&A benefit are VA pension recipients and, given their low income, it is likely that most of these beneficiaries spend the A&A allowance for basic commodities such as food and shelter. In general, no training in recruiting, managing, and paying aids is provided, although the VA San Diego Health Care system has a program, established with grant support from the Paralyzed Veterans of America, to train veterans with spinal cord injury in recruiting, managing, and paying their attendants.

Medicaid is a joint federal-state health financing program for the poor, administered by the states, that provides health care for about 37 million low-income families and blind, disabled, and elderly people. The enabling legislation does not authorize cash payments to beneficiaries. Nonetheless, several states allow consumers to direct their own care through hiring, training, and supervising their personal care attendants. Some states have also established processes that permit consumers to participate in paying attendants. Under federal law and HCFA regulation, legally responsible relatives (generally, spouses of recipients and parents of minor recipients) are precluded from providing Medicaid-reimbursed personal care services.

In Michigan, 34,719 consumers hire their own personal care attendants under the Home Help program, which is a part of the standard Medicaid program as

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[3]Compensation is paid to veterans with service-connected disabilities, pension to veterans with nonservice-connected disabilities. Certain survivors also qualify. Pension is income-tested; compensation is not.

specified in the Medicaid state plan. Michigan generally does not use agencies to supply personal care attendants but relies primarily on consumers to obtain and manage their own attendants. The rate paid to attendants varies by county from $4.75 to $8.00 an hour.

According to state officials, the state issues paychecks made out jointly to the consumer and the attendant. The state withholds FICA where applicable, deducting the attendant's share from the paycheck and matching centrally the employer's share. Worker's Compensation is not withheld. In the case of unemployment insurance, the state has found it more efficient to pay claims as they arise rather than withholding unemployment insurance premiums.

Workers from county family independence agencies monitor these cases and visit clients every 3 months. Apart from this monitoring, there is no program to ensure quality, but clients are free to fire workers. Payments of more than $1,000 monthly are referred to the Medical Services Administration for approval. Reported fraud and abuse have not been a significant problem.

Michigan officials state that the program is popular and cost effective, and they point to a three-state study (Maryland, Michigan, and Texas) that found that consumers in Michigan were more likely to say that they directed their own care and that also showed a strong association between consumer direction and consumer satisfaction.[4]

Massachusetts' Personal Care Attendant Program has certified 13 Medicaid providers (community-oriented agencies such as independent living centers) to evaluate clients and reevaluate them annually, give skills training to consumers in such areas as managing attendants and record keeping, and process claims for the number of hours approved and used. The consumer sends a timesheet to the Medicaid provider, which converts it to a Medicaid claim. The state pays the agency, which sends a check to the consumer. The attendant is considered an independent provider, responsible for his or her own taxes.

Massachusetts is considering changes to the program, including the elimination of cash payments directly to the consumer. The changes that are contemplated will enhance monitoring and provide quality-assurance mechanisms that do not now exist. Currently, although the consumer submits a timesheet, there is

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[4]Pamela Doty, Judith Kasper, and Simi Livak, "Consumer-Directed Models of Personal Care: Lessons from Medicaid," Milbank Quarterly, Vol. 74, No. 3 (1996), pp. 377-409.

little to back it up. The rate for personal care attendants is $7.85 per hour, but the program manager believes that consumer employers may in some cases pay either less or more than the approved rate.

Many states allow consumer direction, through, for example, recruiting, training, and dismissing attendants, as well as signing their timesheets, but pay the attendants directly (as in Alaska and Idaho) or through a fiscal intermediary, sometimes called an intermediary service organization (ISO).[5]

Not all consumers are able or inclined to do all the paperwork associated with employment taxes and other employer obligations. Typically, the ISO prepares the paychecks and withholds and pays taxes. A check may be sent directly to the attendant (as in Georgia) or to the consumer (as in Maine) to give to the attendant.

States often do not want to be the employer of record as this could increase their liability for payroll, benefits, union wages and pensions, and other costs. Nonetheless, states want to ensure that participants in the program comply with federal and state laws such as paying and withholding taxes and minimum wage and overtime rules.

RIGOROUS EVALUATION OF CONSUMER-DIRECTED CARE IS BEGINNING

Although several models of consumer-directed personal care are currently in use, there has to date been little systematic evaluation of either its cost-effectiveness or its appeal to consumers. The Robert Wood Johnson Foundation, in cooperation with the Department of Health and Human Services, is sponsoring a four-state (Arkansas, Florida, New Jersey, and New York) demonstration and evaluation of "cash and counseling." As many as 20,000 elderly and younger persons with disabilities in these four states will be enrolled in the demonstration and randomly assigned to treatment and control groups. The care plan for those in the treatment group will be "cashed out"–that is, converted to a cash payment so that consumers can purchase the care they need. Consumers can pay attendants directly, receiving training (or

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[5]For a detailed review of ISOs, see Susan A. Flanagan and Pamela S. Green, Using Intermediary Service Organizations (ISO's) to Facilitate the Use of Consumer-Directed Personal Assistance Services (CD-PAS): Key Operational Issues for State Program Administrators (Washington, D.C.: SysteMetrics, 1997).

"counseling") on the financial aspects of hiring and paying attendants, or they can choose to have a fiscal intermediary pay the attendant directly. Consumers are not required to spend all the money on personal attendants; they can bank some of it for emergencies or for large items, such as environmental modifications.

Several years of planning have gone into this demonstration, and each of the states has been working through such issues as the right balance between consumer direction and quality monitoring and whether consumers who want to manage the cash payments should be given competency tests.

A Medicaid waiver package for the four states is currently under review at the Office of Management and Budget to allow payment to consumers directly.[6] Consumers may also accumulate some cash for such purposes as buying adaptive equipment or making environmental modifications, but a Social Security Administration waiver will be required so that beneficiaries eligible for Supplemental Security Income (SSI) do not accumulate so much money that their SSI payments are jeopardized. Similar waiver arrangements are being pursued for food stamps.

Participating demonstration states hope to begin implementing the demonstration in April 1998; the final report will be due in 2001.

Given that these programs have not yet been evaluated and that there are still issues to be resolved, including the degree of interest consumers exhibit when given a choice, the most effective mechanism for paying attendants, the employment status of the attendant for tax and other purposes, and the appropriate degree and type of monitoring, it is not possible to designate any

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[6]Other waivers requested include statewideness, to permit states to operate the demonstration in only part of the state; comparability, to permit provision of services not available to other beneficiaries; the income and resource rule, to permit the exclusion of payments under the program from income and resource limits established for Medicaid eligibility; provider agreements, to permit the provision of care by persons who have not executed a provider agreement; provisions regarding direct payments to providers, to permit payments to be made directly to consumers; and provisions regarding payment review, as prepayment review may not be available for disbursements from individual consumers to their caregivers. The package also provides for costs not otherwise matchable, including expenditures to employ members of a recipient's family as caregivers.

one of these programs as the preferred model for Medicaid. The Cash and Counseling Demonstration will provide evidence on many of these issues; in the meantime, several states are proceeding with one of the variants of consumer-directed care.

AGENCY COMMENTS AND OUR EVALUATION

We sent a draft of this report to the Department of Veterans Affairs, the Health Care Financing Administration, the Massachusetts Division of Medical Assistance, and the Michigan Medical Services Administration. Their comments were of a technical nature, and we have incorporated them as appropriate.

Please call me or Phyllis Thorburn at (202) 512-7114 if you or your staff have any questions about the information in this letter. Andrew Florence, intern, also contributed to this document.

Sincerely yours,

William J. Scanlon

William J. Scanlon
Director, Health Financing and
Systems Issues

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