

Consumer Direction in Managed Long-Term Care: An Exploratory Survey of Practices and Perceptions

Mark R. Meiners, PhD,¹ Kevin J. Mahoney, PhD,² Dawn M. Shoop, PhD,¹

Purpose: This article presents results of a survey of the attitudes and practices of managed care organizations (MCOs) concerning consumer direction. The study focused on understanding several alternative measures of consumer direction and the factors that are associated with the MCOs concerning those measures. **Design and Methods:** The MCOs that were surveyed provided capitated managed long-term care benefits to their Medicaid-eligible clients and were chosen because personal assistance service is a likely area for consumer-direction interest or practice. **Results:** Although the majority of the responding MCOs were found to be practicing some form of consumer direction, the experience is limited and underdeveloped. Two areas of concern seem to be most important in an organization's decision to adopt a consumer choice or consumer-direction model: the balance of concerns about unprofitability and the perceived interest and benefit of the clients. **Implications:** This study suggests managed care and consumer direction can work together and provides a baseline to assess further development of their compatibility.

Key Words: Long-term care, Personal assistance services, Consumer choice, Consumer satisfaction, HMO

Over the last decade there has been a tremendous growth in interest in self-determination or consumer direction of personal assistance services (PAS) among the aging network as well as the disability community (Simon-Rusinowitz, Bochniak, Mahoney, & Hecht, 2000; Simon-Rusinowitz & Hofland, 1993). Surveys conducted in preparation for the National Cash and Counseling Demonstration and Evaluation

Address correspondence to Mark R. Meiners, University of Maryland, Center on Aging, Room 1240 HHP Building, College Park, MD 20742. E-mail: mm56@umail.umd.edu

¹University of Maryland, Center on Aging, College Park.

²Boston College Graduate School of Social Work, Chestnut Hill, MA.

³The National Council on the Aging, Research and Demonstrations Division, Washington, DC.

and Marie R. Squillace, PhD³

indicate that at least one third of the elderly adults and one half of the younger adults with disabilities receiving Medicaid personal care services (in Arkansas, Florida, New Jersey, and New York) would be interested in at least exploring managing their own service dollars (Mahoney et al., 1998; Simon-Rusinow et al., 1997).

At the same time there has been a remarkable growth in the number of persons who receive their health care through managed care organizations (MCOs) and an increasing interest in folding in long-term care (Regenstein & Stephanie, 1998). Some states view integrating their aged and disabled populations into managed care as a key component in their overall management strategy over the next few years (University of Maryland Center on Aging, 2001).

But are these trends compatible? More specifically, can consumer direction work in a managed long-term care setting? The experts are divided. Simon-Rusinow and colleagues (2000) interviewed 20 policy experts from the aging and disability areas, asking them to discuss important issues and barriers to the implementation of consumer-directed services. One expert said, "In managed care, there's clearly tension (because it) takes the control out of the hand of the consumer and puts it in control of the risk bearer, the provider. But on the other hand, I don't see them as being totally antithetical" (p. 114).

Another expert was concerned that managed care would have a negative impact: "You have a problem that you have to overcome with managed care before you can get to the issue of consumer-direction; that it is a medically dominant model and they don't consider . . . consumer direction to be very important, period" (p. 114).

Two conceptual articles show why and how managed care can and should be able to provide fertile territory for consumer direction of PAS (Stone, 1997; Kodner, Mahoney, & Raphael, 1997). Stone suggested that the two concepts "can be compatible, but the devil is in the details in terms of how a delivery system is designed" (p. 3). Stone also suggested that there is another set of ethical issues in the areas of malfeasance, justice, and fidelity. But Kodner, Mahoney, and Raphael pointed out that MCOs have a number of basic attributes (such as concern for outcomes and flexible use of benefits) that provide more fertile ground for the development of consumer-directed options: "Under managed care, the money already follows the client rather than being locked into rigid categories of services" (p. 4).

There has been no empirical research to date looking at attitudes toward and the practice of consumer direction in managed care, particularly managed long-term care. In this study, therefore, we set out to identify and describe the universe of MCOs covering long-term care services (including home and community-based care) with Medicaid funding. The focus is on long-term care because the core PAS are basically nonmedical care (Morris, Caro, & Hansan, 1998), so consumer direction is especially feasible. Furthermore, it is in PAS that seminal consumer-direction efforts have been developed in the fee-for-service delivery system (Benjamin, Matthias, & Franke, 1998; Doty, Kasper, & Litvak, 1996; Feinberg & Whitlach, 1996). The focus is on Medicaid because it is the dominant payment source for long-term care in the context of managed care. If researchers are to find consumer direction anywhere in managed care, we would expect to find it where there are Medicaid capitation agreements covering long-term care.

The motivation for conducting this inquiry was not only to understand whether and why (some of) these MCOs are discussing consumer direction, but also to identify the attributes and practices of MCOs in which consumer direction is playing a major role. In addition to understanding the status quo, the intent is to provide a baseline against which to monitor future changes. However, what consumer direction means in practice is not straightforward or definitive.

The most generally accepted definition of *consumer direction* first appeared in "Principles of Consumer-Directed Home and Community-Based Services" published by the National Institute of Consumer-Directed Long-Term Care Services (NICDLTS, 1996). It read as follows:

Consumer direction is a philosophy and orientation to the delivery of home and community-based services

whereby informed consumers make choices about the services they receive. They can assess their own needs, determine how and by whom these needs should be met, and monitor the quality of services received. Consumer direction ranges from the individual independently making all decisions and managing services directly, to an individual using a representative to manage needed services. The unifying force in the range of consumer-directed and consumer choice models is that individuals have the primary authority to make choices that work best for them, regardless of the nature or extent of their disability or the source of payment for services. (p. 4)

In this study we tried to remain true to the notion that consumer direction means the consumer has the primary responsibility; that, in a consumer-directed model, the provider reports directly to the consumer. But, in this exploratory work, there also was interest in capturing elements that fell short of consumer direction but built in opportunities for consumer choice.

Methods

Sample

Given the lack of any formal list of MCOs with Medicaid capitation agreements covering long-term care services (including home and community-based care), the first task was to identify the universe of MCOs that met this criteria. Sources included the Centers for Medicare and Medicaid Services (CMS) and Robert Wood Johnson Foundation supported initiatives: the Program of All-Inclusive Care for the Elderly (PACE) demonstration, the Social Health Maintenance Organization demonstration, the Medi-care/Medicaid Integration Program, Independent Choices, Self-Determination for Persons with Developmental Disabilities, and the Cash and Counseling Demonstration and Evaluation. Additional searches were conducted by accessing the following web sites: CMS (www.hcfa.gov), Arizona Health Care Cost Containment System (www.ahccs.az.us), The U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (www.aspe.hhs.gov/daltcp/home.htm), and the National Chronic Care Consortium (www.ncccconline.org). At each step of the investigative procedure, potential respondents were contacted and evaluated for inclusion in the study. When, over time, it was apparent that no more sites could be identified that met the inclusion criteria, a list of 73 potential respondents was considered complete.

Instrumentation

Two survey instruments were developed for this study. The Managed Care Organizational Questionnaire (MCOQ) asked about the characteristics of the organization and the Medicaid long-term care capitation agreement. The Consumer Direction Questionnaire (CDQ) also focused on two areas: (a) assessment of general discussion of consumer direction and the potential reasons for practicing consumer direction, including perceived benefits and drawbacks, and (b) specific consumer direction activities within the organization. To refine the instruments, we conducted a series of face-to-face interviews with representatives of state programs in Wisconsin ($n = 3$), Arizona ($n = 2$), Missouri ($n = 2$), and Connecticut ($n = 1$). These interviews focused on assessing the administration time, language appropriateness, and understanding of the survey questions.

Procedures

Data were collected by mail surveys between January and March of 1999. Five additional surveys were collected after identification of additional sites in November of 1999. Mail surveys were chosen to al-

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low respondents time to give thoughtful answers to their responses and to seek out records and documents (as necessary) to accurately complete the questionnaires. A total of 73 pairs of surveys (MCOQ and CDQ) were sent. We asked the contact person to complete both surveys or direct them to the person or persons best able to respond for the MCO. Four follow-up telephone calls were made to an MCO before they were considered a nonrespondent.

Data were coded and entered independently by two coders. Coding discrepancies were identified

and corrected through additional consultation. Data were analyzed using SPSS, Version 10.0, for personal computers (SPSS, Inc., 2001).

Response Rate and Nonrespondent Data

Of the 73 surveys sent to the identified MCOs, 9 were deemed ineligible on return, as the MCOs had either not yet begun enrollment or were not yet receiving capitation for long-term care benefits (although such was pending). These organizations were removed from this analysis. Forty-five of the 64 remaining eligible organizations responded to one or both surveys, resulting in a 70% response rate. Of those 45 MCOs who completed at least one survey, 42 responded to both the MCOQ and the CDQ, 1 responded to the MCOQ only, and 2 responded to the CDQ only. Thus, a total of 43 operating MCOs completed the MCOQ, and 44 completed the CDQ. Responding organizations were located in 17 states and served both rural and urban populations.

To determine whether survey respondents were similar to nonrespondents, we used the only variable known for all potential respondents: PACE status. The PACE program is a capitated managed care benefit primarily for frail elderly adults (55 and older). It is provided by a not-for-profit or public entity that features a comprehensive medical and social service delivery system using a multidisciplinary team approach in an adult day health center, supplemented by in-home and referral services in accordance with participants' needs (<http://www.hcfa.gov>). For respondents, 21 organizations (47%) were non-PACE and 24 (53%) were PACE organizations, defined to include both "pre-PACE" sites capitated only for Medicaid as well as those sites capitated for both Medicare and Medicaid. For nonrespondents, 8 (42%) were non-PACE sites and 11 (58%) were PACE sites. Chi-square analysis revealed no significant difference for PACE status by respondent versus nonrespondent.

Characteristics of MCOs

Most MCOs were part of a larger organization (70%), although the managed care operation dealing with long-term care tended to be small, with no more than 1000 clients receiving a capitation for long-term care (82%). The MCOs' experience with Medicaid capitated long-term care was most often under 5 years (68%). Still, 9 MCOs served more than 1000 clients and 15 MCOs had 6 to 16 years of experience operating under a capitation payment for long-term care. Most (65%) focused on older adults (broadly defined, at least by PACE organizations, to include those age 55 and older) but 12 MCOs served developmentally disabled, nonelderly, or mixed specialty

Table 1. Managed Care Organization (MCO) Operating Characteristics

Characteristic	No.	%	Range	<i>M</i>	<i>SD</i>
MCO is part of larger or umbrella organization (<i>n</i> 43)	30	70			
Number provided with health benefits by larger organization (<i>n</i> 16)			780–500,000	129,624	157,570
Annual budget for MCO (<i>n</i> 38)			\$300,000–\$307,000,000	38,200,000	73,600,000
Length of operations (<i>n</i> 42)			1–20 years	5.5 years	4.8
Number enrolled in MCO (<i>n</i> 43)					
100 or less	14	33			
101–1000	20	46			
1001–125,000	09	21			
Characteristics of groups of clients served (<i>n</i> 43)					
Elderly only	28	65			
Multi special populations	09	21			
Developmentally disabled only	02	5			
Nonelderly	01	2			

No special population	02	5	
Missing	01	2	
Number of clients provided with long-term care benefits under the Medicaid capitation agreement (<i>n</i> = 43)			
0–100	14	33	
101–1000	21	49	
1001–19,000	08	18	
Length of time MCO had received capitation under the Medicaid agreement (<i>n</i> = 43)			
Less than 1 year	05	12	
1–5 years	23	53	
6–16 years	15	35	
Medicaid capitation amount covering long-term care per member per month (<i>n</i> = 43)			\$1657–\$4070

(e.g., frail aged and disabled) populations. Table 1 provides further operating characteristics of the MCOs responding to the survey.

Consumer Direction Discussion and Perceptions

To assist respondents in working from a common understanding for this study, we provided the following definition of consumer direction: “Consumer direction is a model in which consumers play a major role in determining their own needs, deciding how and by whom these needs should be met, and evaluating the quality of services received.” Twenty-nine (66%) organizations responding to the CDQ indicated that consumer direction was being discussed within the organization, whereas 13 organizations (30%) indicated no discussion, and 2 (4%) did not respond to this item. The 29 respondents who indicated discussion of consumer direction were asked the reasons for the MCO’s interest in consumer direction. Twenty-seven organizations responded to this open-ended question (multiple reasons could be cited). The most frequent response was that consumer direction increased consumer satisfaction (*n* = 11), closely followed by improved quality effectiveness (*n* = 10), increased cost effectiveness (*n* = 8), and creation of a better care plan (*n* = 6). Other reasons for interest in consumer direction (mentioned by 4 or fewer respondents) included that it is part of their plan model, it improves quality of life for clients, it expands the network of services, clients can and should be able to self-direct, it provides better buy-in from clients, it increases client understanding, it enhances the reputation of the MCO, it provides better use of the organization’s resources, it is an alternative to nursing home care, and it prevents further functional decline.

Four potential reasons for interest in consumer direction were presented to all respondents with the request that they rate each response individually on a scale of 1 to 10, with 1 being “not an important reason to practice consumer direction” and 10 being “a very important reason to practice consumer direction.” Results of these ratings, (see Table 2), show that overall, respondents rated better quality service (*M* = 7.8) and consumer independence (*M* = 7.5) as more important reasons for practicing consumer direction than cost efficiency (*M* = 6.1) or competitiveness (*M* = 5.8) of the MCO. In addition, two organizational characteristics, being a PACE organization (mean difference = 2.29, *p* = .05) and serving only elderly clients (mean difference = 2.36, *p* = .05), were significantly associated with lower ratings of competitiveness as important reasons for practicing consumer direction.

A follow-up open-ended format question for all respondents asked “What *other* benefits does or would your organization see in consumer direction?” Additional benefits were cited by 19 respondents: helps consumers understand the limits of the MCO, provides better MCO responsiveness to cultural diversity, makes consumer a better health care utilizer, increases consumer self-care, causes better administrative efficiency, enhances MCO reputation, and increases the pool of service providers. Again, respondents could indicate multiple benefits.

Nine potential problems with consumer direction were presented to assess if organizations had or would anticipate concerns with these issues. Results are summarized in Table 3. In general there was not so much concern about client interest being too much or too little, but most of the other potential problems suggested to the respondents were acknowledged as worries. Indeed, at least 70% of the respondents indicated concerns about clients being taken advantage of, finding it too complicated, or making inappropriate choices as well as concerns about problems related to program administration and management. Given the opportunity to elaborate on these answers or indicate other problems, organizations cited two other problems with consumer-directed care: client inability and home-care worker shortage.

Several organizational characteristics were found to be significantly associated with specific concerns. Given the exploratory nature of this study, findings at the $p .10$ level are reported. Organizations that had received capitation for 6 to 16 years were more likely to be concerned with clients being taken advantage of than were those who had received capitation for less than 6 years (87% vs. 57%, $p .10$)— and the former were more likely to be concerned with liability for providers (85% vs. 50%, $p .10$). Organizations serving elderly clients only versus those serving other clients were less likely to anticipate a problem with too many clients interested (4% vs. 29%, $p .10$). The largest organizations, serving

Table 2. Managed Care Organization's (MCO's) Mean Ratings of Proposed Benefits of Consumer Direction by Consumer Direction Level

Consumer Direction Would	Consumer-Direction Level			
	Overall (<i>n</i> 38)	No Major Say (<i>n</i> 8)	Major Say (<i>n</i> 18)	Hire/Fire Worker (<i>n</i> 12)
Allow MCO to provide better quality service*	7.8	5.2	8.2	8.9
Make MCO more competitive	5.8	5.5	5.4	6.1
Enhance MCO's cost efficiency*	6.1	3.1	6.4	7.2
Increase consumer independence*	7.5	5.7	7.1	9.0

Notes: All responses ranged from 1 to 10; *ns* vary slightly because of missing responses. The statistical significance level refers to the overall relationship between the stub variable and the column header variable.

* $p .05$.

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Table 3. Percentage of Managed Care Organizations Indicating Potential Problems With Consumer-Directed Care by Consumer Direction Level

Problems	Consumer Direction Level			
	Overall (<i>n</i> 38)	No Major Say (<i>n</i> 8)	Major Say (<i>n</i> 18)	Hire/Fire Worker (<i>n</i> 12)
Clients making inappropriate choices	74%	75%	81%	50%
Management or administrative problems	73%	100%	63%	67%
Clients finding it too complicated	72%	87%	60%	60%
Clients being taken advantage of	70%	100%	50%	73%
Liability for providers	64%	57%	60%	58%
Regulatory agencies or regulations	61%	50%	75%	42%
Unprofitability**	49%	14%	87%	17%
Client disinterest in the program*	40%	71%	57%	17%
Too many clients interested	13%	29%	7%	0%

Notes: Given the exploratory nature of this study, findings at the $p .10$ level are reported.

ns vary slightly because of missing responses. The statistical significance level refers to the overall relationship between the stub variable and the column header variable.

p .10; * p .05; ** p .001.

over 1000 clients in the MCO, were more likely to be concerned with clients being taken advantage of than were midsized (100–1000 clients) or small (less than 100 clients) organizations (89% vs. 78% vs. 36%, p .05). The largest organizations, compared with midsized and small organizations, were also most likely to be concerned with too many clients being interested (33% vs. 12% vs. 0%, p .10).

Respondents were asked if their overall experience with consumer direction had been good or bad or if they had too little experience to tell. Of the 36 respondents who answered this item, 28% indicated that their experience had been good, no respondents indicated bad, and 72% indicated that they had too little experience to tell.

Consumer Direction Practice Within the MCO

More specific questions about the nature of consumer-directed activities were asked, and respondents were grouped into three levels of consumer-direction activity. Twelve respondents (32%) allowed consumers to hire and fire their own workers, including 9 who allowed hiring and firing of friends and relatives. All 12 of those also indicated that clients had a major say in determining the type and amount of personal care services. Eighteen respondents (47%) allowed clients a major say but did not allow hiring and firing of workers. Eight respondents (21%) allowed neither option.

Respondents who indicated “yes” to the item concerning clients having a major say in determining the type and amount of personal care services were further probed as to the nature of their consumer-directed services. Twelve (40%) of the 30 eligible respondents indicated that there was a screening or eligibility process for consumer-directed programs. Twenty-five (83%) indicated that there are procedures or policies in place within the organization for representation by surrogate decision makers when the client is not totally capable of self-direction. An open-ended question asked respondents to describe support systems available for clients who choose to self-direct care. Sixteen of the 30 (53%) provided information concerning these support systems and the following supports were cited: case manager (n 8), fiscal intermediary (n 5), interdisciplinary care team (n 5), client training (n 3), and client counseling (n 1). Eight organizations indicated that use of support systems was mandatory and 7 indicated the clients were required to keep records. Again, respondents were free to cite more than one example.

In response to the item assessing the organization’s experience with consumer direction, no organization indicated that its experience was bad. Those organizations practicing little or no consumer direction all indicated that they had too little experience to tell, whereas 31% of the organizations giving just a major say indicated their experience was good and 50% of those allowing hiring and firing indicated good experience (vs. too little to tell).

Factors Associated With Consumer Direction Measures

Relationships with organizational characteristics (see Table 1) and attitudes (see Tables 2 and 3) were assessed for the three levels of consumer direction activity: (a) those practicing little or no consumer direction, (b) those allowing just a major say, and (c) those who also allowed hiring and firing of assistants. All bivariate analyses are based upon nonmissing responses to each item. No organizational characteristics significantly distinguished the three levels of consumer-direction activity.

Those practicing little or no consumer direction generally rated the four potential benefits of practicing consumer direction the lowest, and those allowing hiring and firing rated them the highest (see Table 2). Analysis of variance (ANOVA) and subsequent contrasts revealed that three of the four importance-ratings factors significantly distinguished between the groups. For the better quality service benefit the low-consumer-direction group gave a significantly lower importance rating than either the major-say group (mean difference 3.0, p .05) or the hire/fire group (mean difference 3.7, p

.05). For the enhanced cost efficiency benefit, the low-consumer-direction group also gave a significantly lower importance rating than either the major-say group (mean difference 3.3, p .10) or the hire/fire group (mean difference 4.1, p .05). However, for the consumer's independence benefit, it was the hire/fire group's higher importance ratings that differed significantly from both the low-consumer-direction group (mean difference 3.3, p .05) and the major-say group (mean difference 1.9, p .10).

Concerns about unprofitability strongly distinguished the three levels of organizations (see Table 3). Organizations allowing little or no consumer direction were least likely to consider this a problem (14%), along with organizations allowing hiring and firing (17%). However, organizations allowing just a major say were much more likely to be concerned about unprofitability (87%).

Organizations practicing little consumer direction were most likely to anticipate a problem with client disinterest (71%), followed by those giving just a major say (57%) and those allowing hiring and firing (17%). To a lesser extent this same pattern was found across the three groups regarding concerns about too many clients being interested in consumer direction. Twenty-nine percent of those MCOs that did not allow a major say were also most likely to anticipate a problem with too many clients interested in consumer direction compared with 7% of those allowing just a major say and 0% of those allowing hiring and firing. Finally, organizations practicing little or no consumer direction were most likely to consider clients being taken advantage of a problem (100%), followed by those allowing hiring and firing of assistants (72%) and those allowing a major say for clients (50%).

Discussion and Conclusion

Consumer direction and managed care are two important emerging areas of interest in long-term care that seem inconsistent. Consumer-directed services are intended to allow informed consumers to assess their own needs, which then can be met as personal care provided by a home-care worker selected, trained, and supervised by the consumer. In contrast, managed care typically represents the agency-directed approach in which case managers or provider-agency staff make service decisions. But consumer satisfaction is receiving growing recognition as a measure of quality in managed care, and some difference of opinion in the literature has been noted, suggesting consumer direction and managed care could be compatible.

Whether consumer direction and managed care existed together at all was the first line of inquiry. The common element among the MCOs surveyed in this study was that they provided capitated managed long-term care benefits (including PAS) to their Medicaid eligible clients. These organizations were selected on the assumption that they were the most likely managed care candidates for consumer-direction interest or practice.

Although the majority of the responding MCOs indicated discussion of consumer direction, 50% of even the most "consumer-directed" group indicated they still had too little experience to judge the results of their experience. The MCOs represented a range of organizational structures within which to examine how far they had gone toward consumer-directed care and their attitudes about this approach to care.

The primary motivations for organizations to discuss consumer direction were improved consumer satisfaction, quality effectiveness, better care plans, and cost-effectiveness. But an interesting array of other reasons was given that suggest creative thinking about the value of consumer-direction opportunities. These included preventing further functional decline, providing better client buy-in, enhancing the MCO's reputation, increasing the pool of service providers, and causing better MCO responsiveness to cultural diversity. Apparently a variety of motivations may underlie an organization's general interest in consumer direction.

A variety of concerns were indicated as well. Indeed, nearly three quarters of the respondents indicated concerns about clients making inappropriate choices, program administration and management, and clients finding consumer direction too complicated. With both positive and negative attitudes toward consumer-directed care expressed, we were interested in identifying the specific attitudes that distinguished actual practice.

The freedom to hire and fire the worker is the measure most closely reflecting the consumer direct-

ing his or her own care. One third of respondents answered “yes” to this measure. The major-say item was intended to distinguish those MCOs that practiced at least the consumer-choice level of client involvement in their own care (NICDLTS, 1996). About three quarters of the MCOs answered “yes” to this measure, indicating a substantially higher comfort level with consumer choice than with consumer direction.

There were several factors that distinguished those MCOs that practice little or no consumer choice (versus the consumer-choice and consumer-direction groups). The low-consumer-choice group showed a relative lack of concern or conviction that consumer direction would result in better quality service or that it would result in increased cost efficiency. Although all three groups were concerned with clients being taken advantage of, the MCOs practicing little or no consumer choice were most likely to be concerned with this issue, and all of the groups anticipated management and administration problems. Moreover, this no-major-say group of MCOs was much more likely to anticipate problems with client interest—either too much or too little—than the consumer-choice and consumer-direction groups were. All this begs the question as to why they were less concerned about the issue of

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profitability, at least compared with the consumer-choice group.

Overall, respondents were very evenly split as to whether they thought allowing for consumer direction would be unprofitable, and yet this turned out to be a key factor associated with whether the MCOs practiced consumer direction, as well as the level of that practice. That is, organizations that allowed a major say for clients, but did not go so far as to allow clients to hire and fire workers, were far more likely to have concerns about profitability than either of the other two groups. This finding can be understood two ways. One suggestion is that concerns about unprofitability are increased in a consumer-choice environment, but are diminished when consumer direction is implemented. This explanation might suggest that the lack of concern about profit is a rational, after-the-fact, assessment—that organizations may find that consumer choice draws on more organizational resources than do either the conventional arrangement or a consumer-directed model. An alternate explanation is that the lack of concern with unprofitability motivates organizations to move from consumer choice to more consumer-directed programs. Or, put another way, the simple perception of unprofitability is indeed what keeps those organizations that have been otherwise motivated to adopt at least a consumer choice model from moving further in the direction of consumer direction.

Examination of the other factors that distinguished the consumer-choice group from the consumer-direction group is informative also. The organizations practicing consumer direction were significantly more likely than the others to consider increasing consumer independence an important reason to practice consumer direction. In addition, the group practicing consumer direction was much less likely to anticipate a problem with client disinterest. These two findings suggest that for those organizations practicing consumer direction, a heightened concern with client issues, perhaps reflecting a greater responsiveness to perceived interest among clients, may override any original concerns about profitability. Other potential problems, such as regulations, clients finding consumer direction too complicated, and liability for providers, failed to distinguish the three groups. The decision to adopt a consumer-choice or consumer-direction model seems to depend on the balance of concerns about unprofitability and the perceived interest of and benefit to the clients.

The results of this survey suggest that consumer direction and managed care may indeed be compatible, but the state of the art is still very new and underdeveloped. Among those MCOs thought to be likely candidates for thinking about consumer direction, most are considering it in one form or another. The most common form is to allow their clients what the organization considers a major say in their care. Although unprofitability remains a concern for some MCOs, at least a few pioneer organizations appear to be acknowledging and responding to client interest in consumer direction by allowing clients to hire and fire their own workers, including family and friends. It will be interesting to see if recent research from Europe and California showing that full scale consumer direction can be at least as efficient as agency-controlled services (Benjamin et al, 1998; Tilly, Wiener, & Cuellar, 2000) will affect MCOs' perceptions of profitability.

Focusing on the needs and preferences of consumers seems on the surface to be obvious, but it is

not. Knowing when and how to involve the consumer in his or her own care is something that has not been central to the way that most insurers or providers do business. With the emergence of the concept of consumer direction has come increased interest in more clearly defining what this can and should mean in practice. This survey provides a baseline against which researchers can begin to track these next steps.

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