Consumer Directed Care Comparison Report

Final Deliverable and Summary

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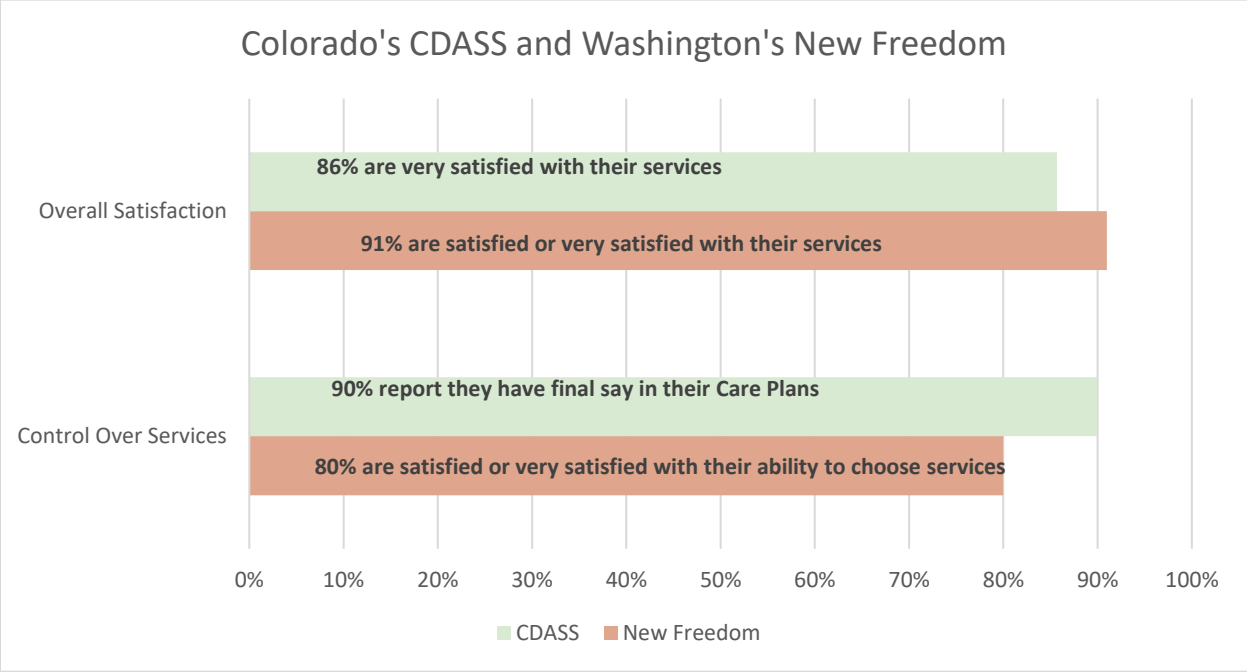
TriWest
Health + Human Service Evaluation + Consulting
4450 Arapahoe Avenue, Suite 100, Boulder, CO 80303

Despite sustained and growing interest and support in consumer-directed services, comparative cost and satisfaction analyses are lamentably rare. This should gradually improve as states and organizations continue to evaluate programs and add to the available literature. Currently, consumer-directed programs operate from the theory that greater individual control leads to greater satisfaction. This assumption seems to hold true across age, waiver, and gender.

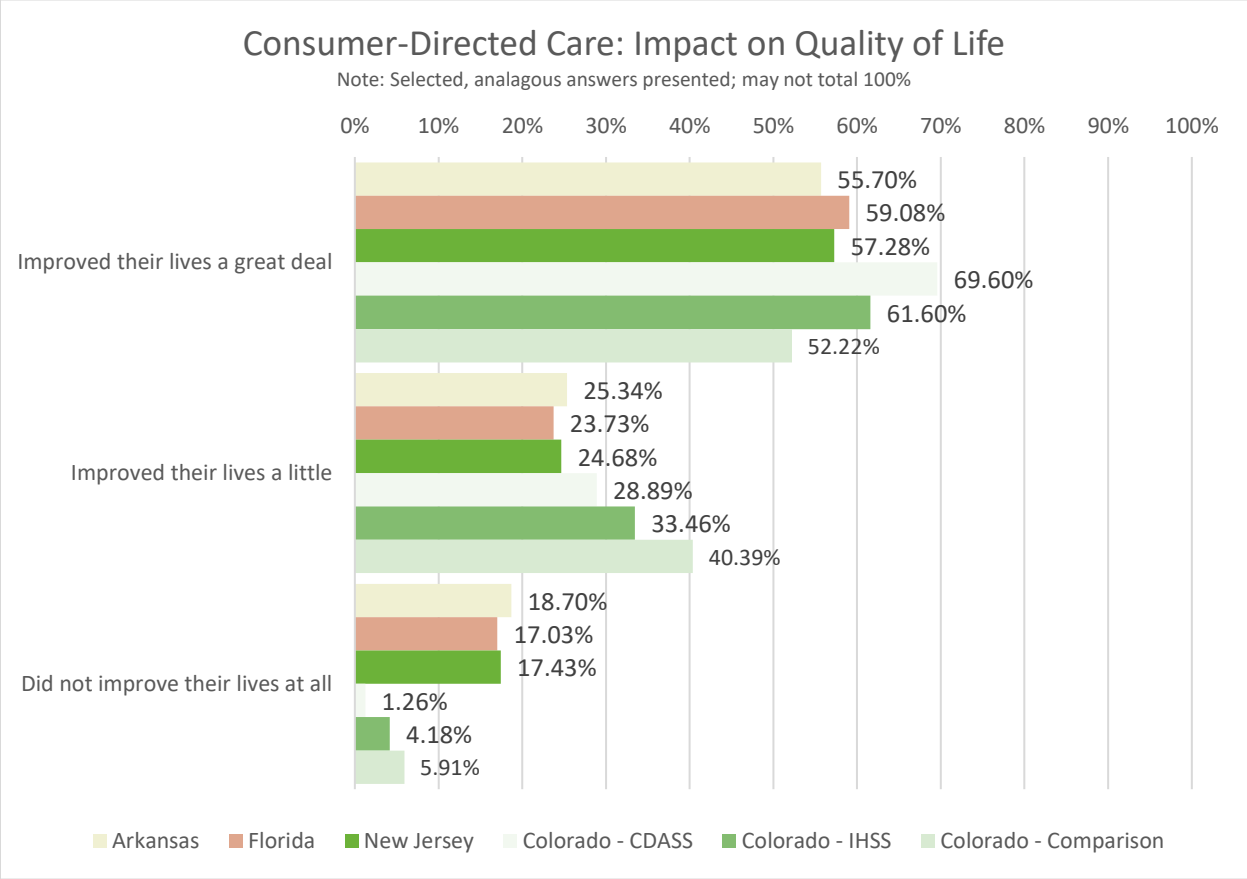
Washington State was identified early in the evaluation as a state with consumer-directed programs that are similar to Colorado's; their New Freedom and COPES programs are similar to CDASS and IHSS, respectively, with COPES and IHSS participants receiving more administrative support than CDASS/New Freedom participants.



A one-way ANOVA test was conducted to evaluate differences in satisfaction across participants' age groups. Of the five dimensions of satisfaction, health was the only dimension that had statistically significant satisfaction differences, with participants under age 60 reporting greater satisfaction with their mental and physical health than did participants who were 60 or older (p = .026). No statistically significant difference between groups (CDASS, IHSS, and comparison) were found.

Among individual measures, five questions were statistically significant when evaluated according to the participant's age: non-medical mobility; overall physical health; overall mental health; opportunities to be involved in their communities; and how often they feel sad, lonely, or depressed. Participants under age 60 were more satisfied than those who were 60 or older.

Statistically Significant Items by Age – All Participants			
Question	**Under 60 Mean**	**Over 60 Mean**	***p***
Can you get to places like work or shopping?	1.95	1.86	< .0005
How would you rate your overall health?	2.86	2.48	<.0005
Do you have opportunities to be involved in your community?	3.17	2.97	.007
How often do you feel sad, lonely, or depressed?	4.06	3.81	.028
How would you rate your overall mental or emotional health?	3.11	2.91	.023



Because of the vast chronological and programmatic differences between CDASS/IHSS and the three Cash and Counseling programs, it is inappropriate to interpret the above graph as evidence that CDASS or IHSS are superior programs. Rather, the higher satisfaction levels may

be the result of improved collective knowledge and accepted best practices over the decade that separates the evaluations. This analysis does, however, add to the body of work that suggests consumer-directed programs typically result in more satisfied participants. CDASS and IHSS satisfaction rates indicate that Colorado's programs are generally at least as satisfactory as consumer-directed programs in other states.

Direct comparisons across evaluations are difficult because of the variations in language and answer options. When matching as closely as possible, though, the satisfaction trends are consistent: participants in consumer-directed programs are generally more satisfied with their services and lives than individuals in traditional, agency-based care. This follows the predominant theory in the literature that having a greater sense of control is strongly linked to greater program satisfaction.

Comparative Costs

Finding studies that compare service delivery costs and potential savings was even more difficult. One of the most comprehensive reports on consumer-directed care costs comes from a Mathematica Policy Research (2008) evaluation contracted by the Center on Aging. Mathematica evaluated Cash and Counseling in Arkansas, Florida, and New Jersey; this program provides consumers with a monthly allowance they may use to hire attendants and purchase care-related goods and services, similar to CDASS. Cash and Counseling also offers help from financial intermediaries. While it is not a perfect match for Colorado's programs, this study represents a more thorough analysis of Medicaid costs after program enrollment and includes a comparison group.

The study found widely differing costs across the three states it compared: Arkansas, Florida, and New Jersey. This study did not provide a cost per person per day, but rather aggregated costs and averaged them across a larger time frame, making it difficult to compare to the costs presented in this evaluation. Additionally, health care costs from 2000 are not comparable to those we analyzed (2013 – 2017). Additionally, the Mathematica study did not estimate any cost savings pre-post program or in reduced hospitalizations or emergency room (ER) utilization.

Summary of Evaluation Findings

Our evaluation looked at three main areas: 1) Cost comparisons across CDASS, IHSS, and traditional agency-based services utilized by individuals in the same Medicaid waiver programs; 2) Changes in cost pre-post CDASS or IHSS program enrollment; and 3) Participant satisfaction. Our primary findings are summarized below.

1. **While average costs for ER and hospitalizations per participant were varied across all groups, IHSS and CDASS participants who were enrolled in the three biggest waiver**

programs had consistently lower rates of ER and hospital utilization than comparison group participants. This indicates better health outcomes for CDASS and IHSS participants as well as the potential for Medicaid cost savings.[1]

2. **Service costs appear to be consistently higher for IHSS participants—and for CDASS participants in certain waiver programs—than the comparison group.** However, because the services do not map completely from one to another service delivery option, these comparisons are difficult to interpret. Most cost increases seem to be driven by higher health maintenance costs in IHSS than for long-term home health (LTHH) services received by the comparison group. However, in surveys and interviews, participants repeatedly stated that they had service needs that traditional service agencies explicitly would not provide, meaning that without IHSS or CDASS, they would be in a nursing facility or other inpatient setting. These costs, along with private duty nursing, are significantly higher than any of the service costs in IHSS or CDASS.

3. **Ratings of satisfaction with services were higher among CDASS and IHSS participants than among comparison group participants.** Across most measures, both groups had significantly higher rates of satisfaction. This was particularly true in the case of the quality and reliability of attendants.

Recommendations

Findings from the cost analysis yield no recommendations at this time. While costs seemed somewhat higher for IHSS and CDASS participants, this may be due to differences in services and overall need. The pre-post analysis saw some small cost increases; however, it is unclear if participants moved from traditional agency-based services to CDASS or IHSS because of an increase in need, which would then lead to increased costs.

Consistently lower rates of ER and inpatient hospital utilization point to a potential offset in higher service costs with lower overall facility costs.

Because so little information could be found on costs in other programs, we recommend no change in this area. The Department should continue to reach out to other states and seek out other studies. Our review of the literature indicated that work is being done in this area and better cost data may be available in future years.

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[1] Average costs per visit were higher on average for some IHSS and CDASS participants, although for some particular waiver groups, especially in later years, the average costs per participant were considerably lower. As a result, the total cost savings picture is unclear. Our analysis is limited in that this study isolated costs on a year-to-year basis. Looking at costs over participants' entire participation period may show cost savings in a more meaningful way.

Participants in CDASS and IHSS clearly value the programs and available service options. Feedback from key informant interviews and individuals involved in the Participant Directed Programs Policy Collaborative (PDPPC) underscored the degree to which individuals in these service delivery options appreciate being an active part of program advisement and direction. We strongly recommend that the Department continue these efforts.

Even with high levels of satisfaction, participants did have some suggestions for program improvement. Respondents had concerns about the communication and customer service provided by interfacing agencies and entities involved in their service and care.

We recommend the Department provide a common training manual/curriculum with standardized definitions and education that target the various aspects and components of Consumer Directed Care Services and Care Plans.

Other suggestions provided by participants include the following:

- Help provide opportunities for more social events for consumers to meet and network.
- Help connect participants with other resources (e.g., respite care, Developmental Disabilities Resource Center, finding quality physical therapists).
- Assistance in finding alternative pain management methods.
- Need for greater transportation assistance.

References

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