



# Cost Analysis of Consumer Directed Services and Supports

State of Colorado

Department of Health Care Policy and Financing



## Introduction

### Background

Colorado offers two consumer-directed options to clients who receive Medicaid-funded long term services and supports. One of those options, Consumer Directed Attendant Support Services (CDASS) started as a pilot program in 2001, and is now Colorado's **largest consumer directed option** with over **2,300 clients** directing their own services or who have appointed an authorized representative to direct the services.

### Benefits

#### Employer Authority

- Select attendants, including friends and family
- Dismiss attendants
- Determine when and where services are provided

#### Budget Authority

- Set the wages for attendants up to a capped maximum
- Adjust frequency and duration of services based on life circumstances within an annual allocation

#### Flexible Requirements for Attendants

- Attendants are not required to be licensed or certified health professionals to provide skilled care services

#### Community and Societal

- Family preservation by compensating previously unpaid caregivers
- Services can be provided in the community allowing clients to work

#### Personal

- Independence and autonomy
- Flexibility in day-to-day life
- Allows for a higher quality of life

### Risks and Challenges

#### Financial

- Increased costs

#### Programmatic

- Monitor for misuse of services
- Monitor the health and safety of Medicaid recipients

## Study Design

The study reviewed data for **clients who are eligible and enrolled** in Colorado's Home and Community Based Services – Elderly Blind and Disabled (HCBS-EBD) waiver and who live in their own homes during fiscal years 2010-2011 and 2011-2012.

### The study included three HCBS-EBD population subsets:

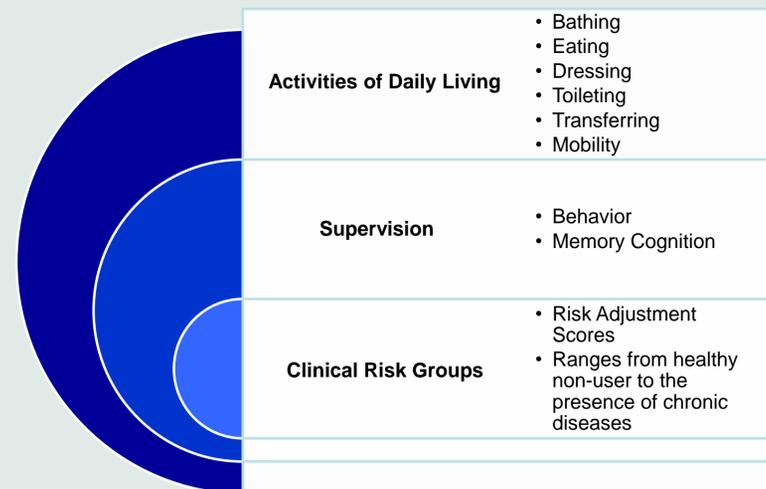
1. Clients who never participated in CDASS
2. Clients who were not in CDASS originally, but then selected and received CDASS
3. Clients who were in CDASS throughout the study period

### The study used three acuity measures for each subset:

1. Clinical Risk Group (CRG) scores
2. Scores from Colorado's Level of Care Functional Assessment (ULTC 100.2) assessing activities of daily living needs
3. Scores from the ULTC 100.2 assessing behavior or memory/cognition needs

The study analyzed the **total cost of care** for all clients reviewed. Total cost of care includes all home and community based services, acute and long term home health, pharmacy, durable medical equipment, primary care services, behavioral health, etc.

In addition to cost of care, the study included a review of the **health outcomes** for clients. Outcomes included emergency room visits and nursing facility admissions.



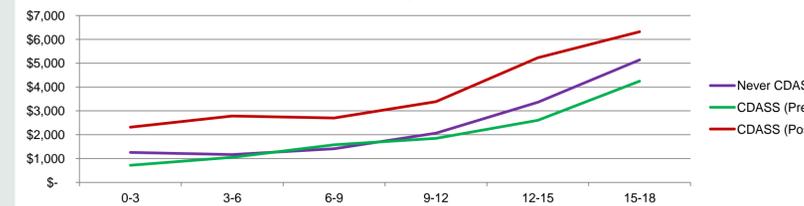
## Principle Findings

The principal finding of this study is that **true cost effectiveness cannot be determined** because the sample of clients for whom data was available prior to CDASS and post CDASS was **too small** to draw significant conclusions.

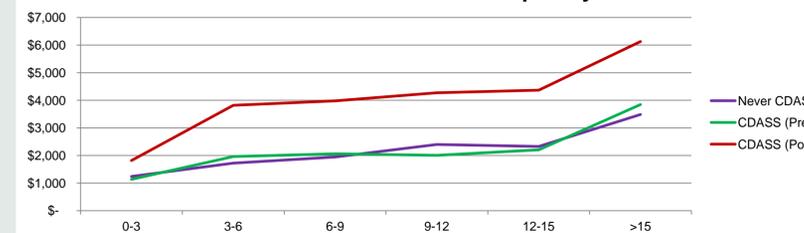
The results of this study show the cost of delivering CDASS is more expensive than services delivered and managed by an agency. This is consistent across all acuity measures.

Emergency room visits **decrease** for CDASS clients. The cost savings from fewer emergency room visits was not a significant amount to offset the increased expenditures.

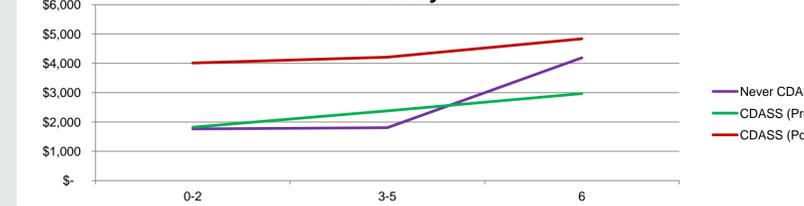
Cost Per Client Per Month When Grouped by Functional Acuity Scores



Cost Per Client Per Month When Grouped by CRG Scores



Cost Per Client Per Month When Grouped by Supervision Acuity



## Conclusions

### CDASS costs on average:

- 86% per client per month more when grouped by CRG scores
- 58% per client per month more when grouped by functional acuity scores
- 68% per client per month more when grouped by supervision acuity scores

### Reasons for this increase in cost include:

- Many CDASS clients report that **prior to consumer direction their needs were not being met** either because agencies were not available or because agency staff were unreliable. This **problem is largely resolved** when clients hire their own attendants
- Many CDASS clients receive support from family or friends that **prior to consumer direction was uncompensated**. This mutual benefit **preserves families and allows clients to remain in their own homes** without the added stress of financial hardship when the primary caregiver is unable to work due to the high needs of their loved one
- CDASS **allows clients to receive services in any setting** as necessary and appropriate to meet the needs. This can include school, workplace, or other community locations
- CDASS does not have the same service or unit limitation for services provided by agencies
- CDASS clients **have greater access to services** than clients with similar needs who are not directing their own care

### Only the Beginning

Further data and program analysis is ongoing to identify all of the reasons why the cost to serve CDASS clients is greater than HCBS-EBD clients.

### Next steps include:

- Review each subset and category to identify potential cost outliers
- Review additional outcome indicators such as family providers, prevalence of critical incidents, and hospital admissions
- Review clients by different demographics such as age and gender

## References

- National Council on Disabilities. (2013). *The Case for Medicaid Self-Direction: A White Paper on Research, Practice, and Policy Opportunities*.
- National Resource Center for Participant Directed Services. (2010). *Developing and Implementing Self-Direction Programs and Policies: A Handbook*.
- 3M Health Information Systems. (2011). *3m Clinical Risk Groups: Measuring Risk, Managing Care*.