



COLORADO

Department of Health Care
Policy & Financing

MINUTES OF THE COMMUNITY FIRST CHOICE DEVELOPMENT AND IMPLEMENTATION COUNCIL

303 East 17th Avenue, 7th Floor Conference Room 7B
Denver, CO 80203

August 1st, 2016

1. Roll Call

Phone: Shannon Secrest, Dennis Roy, Brian Polovoy, Chandra Matthews,

Room: David Bolin, Edward Milewski, Candie Dalton, Kirk Miller, Julie Farrar, Josh Winkler, Dawn Russell, Sarah Hoerle, Kady Hetherington, Rhyann Lubitz, Jim Vogel (Innova), Ryan Chrzan (Innova), Mallory Cyr, Lori Thompson

2. Review of Minutes

One correction from Ed Milewski on page 4 at the bottom Ed had said "What you mean supervise? They have to be there to supervise?" He talked with the group that this sentence did not make sense. He explained that what he had said further up on the page was adequate and that we could just take out this last sentence. The council agreed and Sarah will take this out.

Sarah asked if this format for the meeting minutes was
Josh asked how hard it was to complete the minutes in this format and Sarah let the group that it's not hard, but just takes a little bit longer. However, if the council found this format preferable than there would be no problem in using it going forward. The group agreed that they would like to have this type of format as the thoroughness helps because we haven't had consistent meetings. The group also found this format helpful for people who aren't able to attend, as it may help them understand what was going on better than just a one page synopsis.

Sarah will continue with this format for all subsequent meetings. Also, Sarah entered in the wrong email address for Brian Polovoy and if anyone else on the council finds that someone who was coming to the meeting is no longer coming, please let her know as she might have a wrong email address.



3. Overview of Draft Final Report

The group started to discuss the final report before Ryan and Jim from the Innova Group came to talk about their findings.

Josh Winkler: I think the report, I mean I'm excited by it because I'd be lying if I said anything else. I'm excited to hear the Innova Group discuss what all went into the report and the service packages. Why costs fell off from before. I think though the original Mission report was way too high, but once we delved down into the numbers we found that there were some issues here and there. Much like that, I'm sure these aren't really the numbers either. Somewhere in here is the number that it will really cost, but knowing that the baseline package, which has the minimum amount of services and that was a \$29 million dollar savings. Whereas the CFC council package was everything we ever dreamed that we might be able to get CMS to approve and that was a \$20 million cost. But what Innova recommended seemed to be in the middle. And the only thing that I saw that was a clear cost driver was residential services. And we weren't even sure if CMS would allow it or how it would work. So I think knowing a little more about what's driving those big changes and that uptake doesn't really affect it as big as you may think. The big chunks are a couple specific services or a couple specific waiver populations and not including those or including those could totally make it work or totally make it not work. And figuring out where we could make it work.

I also had a few of my own questions, like I don't believe there was any caps put on any of these services in the state plan and I'm actually pleasantly surprised they could come to a number anywhere near neutral without recommending that we needed to cap services in the state plan. And make clients go to waivers if they needed additional services. However, for eligibility purposes, we may need to do that anyway just because of the "300 percenters." I don't think we can say that enough. We can't forget the people in the 300% group, having been one of those. We may need to cap services in the state plan for just that reason, but it is promising that they were able to get to these numbers without implementing caps initially.

Sarah Hoerle: Thanks Josh. I think those are great questions and comments on the draft report. I know I said this in email as well but because you are the council, you received the report almost as soon as when the Department received the report. With that said, our Budget division has not yet reviewed it and will not be able to start reviewing this until mid-September. So, the Department has not approved this report as we have not had our internal folks review it. But, we wanted to get this to you as you are the CFC council and you have been working on this for so long and we wanted to have you review this as it's important for us to have your input.

Josh Winkler: And to that point Sarah, I think that emphasizes the reason why we were so demanding a few months back of why we get the reports in real time as we know that Budget has a lot going on and they can't review it until September and we would have just been sitting here for months. Does Budget have more of the back end stuff?



Sarah: They do. I know right now that August is a very busy time for them and they will start reviewing it mid-September when they have a little bit more time. And this is great time as it looks like Jim and Ryan have just gotten here from the Innova Group. Thank you again for coming today. We were just starting to go over the report and talking about some preliminary questions. Josh had some really great questions about caps in the state plan.

4. Discussion with Innova on Final Draft Report

Ryan Chrzan Do you just want me to walk through the whole report again and answer questions as they come up?

The group decided that it would be best for Ryan from the Innova Group to just go through the report.

Ryan: So if we start on slide 4, this is where the financial projections start. So what we are looking at here is the baseline projected budget, in which case it's a savings of the baseline benefit package that is being presented. So we are looking at a savings of almost \$29 million and that is including the Department recommended package which includes Personal Care, Health Maintenance, Homemaker, and PERS and then putting the Long Term Home Health, the unskilled part, into CFC. This is where a large portion of the savings is derived from.

Josh: And just real quick Ryan, most of the charts, up until about 2/3 of a way in, are based on that baseline package?

Ryan: Yes. We are either looking at this baseline or all 3 of the service packages and we will call it out if it's not baseline. So if we go to page 5 again, this is the Department recommended required services in CFC and this is a sensitivity analysis to determine what happens if utilization changes a bunch. So you can see that there is still a net benefit even if utilization goes up as high as a 100%. A further sensitivity on that package is what happens if uptake increases and more people start using the service than projected. So again, that has a smaller impact than the utilization and we are still looking at a net positive. Slide 7 is looking at what happens if there is no cap and in all of our modeling we didn't have a spending cap on any clients. So removing it, as opposed to what the current cap is on the SLS waiver, we are looking at about a \$2 million dollar difference between having a cap and no cap.

Josh: Looking at just these services?

Ryan: Correct. Here on slide 8, we are going to look at a couple different benefit options. We have the baseline scenario....

There is a quick break as someone was on the phone and we were trying to get them to mute the phone again.

Ryan: So again, we are on slide 8 that is a comparison of different packages for CFC. So we have the Baseline scenario, the council recommended services, and the consultant recommended package. So you can see the difference in terms of the budget in what we would spend there. The baseline is saving about \$29 million, the council recommended package spends significantly more and actually adds about \$47



million to the budget, and the consultant recommended package is more than the baseline but still saves about \$11 million.

Josh: So for those who weren't around when we came up with that package, it really was everything we thought CMS might allow us to put under this CFC umbrella. I don't think it was necessarily what everyone thought was going to be in the package and ultimately, I don't think it would be what the council would recommend, but we just wanted to see what it would cost if we could put everything imaginable into this program. So the difference is, did you guys add assistive technology?

Ryan: The big difference is adding residential habilitation but we will get to that a little later in the slides. Slide 9 is diving further into the council recommended, or proposed, services. As you can see behavioral, mental health, ILST, and NMT do not contribute to the budget by a large amount. The residential services sort of blow the budget up.

Julie Farrar: So I'm just playing catch-up and I feel, ugh, I was going to try not to say I feel this time because that's what women always say things. It looks like if we can pull out the consultant recommended package, well, what I like about that is that some of the services people weren't getting in the waiver services, whether they should have been getting them or offered them or not, that takes that away that conversation. It also allows the HCBS waivers to provide those services that they may or may not be providing. Basically, this is a natural evolution of us wanting CFC to be the "be all and end all" and provide some things that the waivers may not be providing and to looking at unmet needs, looking at how to meet needs, some of which we know have been huge gaps in waiver services and allow those waivers to actually have that flexibility to provide those services that CFC can't provide. I think it's a very logical progression.

Josh: I just want to make sure I'm summing up what you just said. I feel like what you're saying that this will allow waivers to provide services that CFC could not provide and the waivers could serve the populations that need those additional services still. But, the more broad services that a lot of the population would need, would fall under CFC?

Julie: I feel like we made that, through the evolution of this, we met the needs on both sides and this demonstrates that really well.

Ryan: Slide 10 and the following 5 slides are sensitivity analysis on the council proposed benefit package. What you're seeing is that yellow bar is the baseline and the purple line is that baseline plus the additional service. The blue bars below are error bars if utilization or uptake goes up or down 50%.

Josh: Real quick, how does adding behavioral services reduce the cost? Is this because of the 6% increase?

Ryan: It's because of the 6% enhanced match and the assumptions made on uptake where it's not currently offered. So you have the enhanced match on the population that is already receiving the services, which will be the high utilizers of the service. And when it will be a new expanded service, we're not assuming 100% of the clients will use it. So you have big savings from the people who are already using it and it will be lower by the new users. When we get to slide 13, with residential habilitation, that could be a huge swing with uptake and utilization. Obviously, residential may be a



tough one to swing with the budget department but it may warrant a discussion if you would like to include it in the service package.

Lori Thompson: We did get confirmation that CMS will allow residential habilitation in CFC?

Ryan: Yes. Oregon has also included it in their service package.

Candie Dalton: Do you know how Oregon implemented residential habilitation?

Jim Vogel: Yeah. Attendant services were in their state plan and residential didn't have as big an impact as you would have thought. They said that the array of benefits that they included, which were very "rich" was one of the reasons the cost was higher than they had anticipated.

Ryan: This next slide is for non-medical transportation and it was one that we are recommending that you include in your service package.

Josh: Let me see if I'm reading this correctly, NMT is actually an \$11 million dollar savings?

Ryan: No, so that's an expense of about \$11 million dollars. So adding transportation reduces savings and adding expense to the program.

David Bolin: So you did utilization where it was plus or minus 50% and uptake was plus or minus 50%. Was there a combined uptake and utilization?

Ryan: There is not.

David: Because that could be something that could easily happen.

Josh: But they're additive, right?

Ryan: Yes, they are additive. So if you stack the bars, then you will get your total range. Slide 15 is looking at the IHSS option and the CDASS option and with the historical claims, IHSS has been a bit more expensive as a service option. This slide is just showing the weight of doing all IHSS or CDASS and comparing the cost of both models. And the number \$34 million is a typo and it should read \$29 million.

David: So when you guys looked at ILST, if that had expanded, if this was expanded into the state plan, are you still looking at this service for just people with traumatic brain injuries or was it opened up to other disability types?

Jim: I think the concern was that this service is more tailored to the TBI population and so it made sense to leave it out.

Ryan: The next few slides are our recreation of the Department HCBS waiver charts. O we tried to recreate these as best as we could but there were some definite language deficiencies that we may not have picked up here. But we were trying to show services that exist in the waiver currently, those that will stay in the waiver. The middle row are services that will switch to CFC and the bottom rows are services that the waiver client is gaining through CFC.

The group felt that this was a very helpful chart and would be good to share with others so people could understand the benefit they would be gaining from having a CFC option. However, because of the deficiencies in the language on the original charts, the new waiver tables have some inaccurate data. **Sarah** volunteered to "clean" them up and send out to the group by next week. The group agreed to discuss these changes at our next council meeting.



Ryan pointed out that when looking at the children's waivers, specifically, CHCBS, by moving IHSS from this waiver, it only leaves case management. **David** thought that the Department is looking at a Katie Beckett state plan amendment and **Lori** brought up the point that a lot of services should be accessed through EPSDT. **Josh** asked how this affects children and if Innova had looked at whether we call it EPSDT (which only had a 50/50 match) or CFC (which has the 44/56 match). However, Innova did not look at that, though their assumption was that people would access it through CFC if they meet level of care. The group agreed to this assumption but it will most likely warrant a conversation with CMS.

Ryan went on with the presentation and presented a different view of the budget impact, where it is per client and not overall. An interesting piece of this is that the overall spending would go up per client but the state's amount per client would go down. A lot of the cost savings was on the assumption of moving HMA out of LTHH and getting that increased match. **Josh** wanted to verify that CMS had given their approval and **Sarah** let the council know that the central office was still reviewing this question and has yet to get back to the Department on their official response. She will let the council know as soon as she hears a definitive answer. **Jim** reported that there is precedence of this in other states so we believe they will also agree to this for Colorado. After this presentation, it was open to questions from the group.

Josh: One question I had was whether you assumed caps on any services?

Ryan: No, we didn't.

Josh: And my one fear is on waiver eligibility for some clients who may only qualify for Medicaid through a waiver. This is just something we need to keep in the back of our minds when developing a service package. We don't want to kick anyone off inadvertently.

Jim: We did see some creative solutions from some states that put in a "Patient Education Program" into the waiver so that people wouldn't lose their Medicaid eligibility with the implementation of CFC.

Josh: And it seems that case management has been used as long as it's not the only waiver service.

David: I think my bigger questions are in regards to people my age who the only way they get on Medicaid is because of being a 300% and if you take away the emergency response system, there's not much for that person to qualify for the EBD waiver. So I'm just a little concerned that the 300% won't be able to access anything if we move this service into CFC.

Josh: I thought PERS is an optional, not required, service for CFC?

Ryan: Yes, we just included it in our recommended service package.

The group started a robust discussion on what would be left in EBD or other waiver programs for a person to access monthly because people may be using personal care, homemaker and PERS and if you put all of these services into CFC, they don't have much left to access in order to maintain eligibility. The group started to discuss the idea



of leaving PERS in the waiver as it isn't a huge expense or cost savings by bringing it into the CFC option. The group also started a discussion on ILST and whether we should look at changing the service so that it could go into ILST and more people could access it or to leave it targeting people with a TBI. **David** answered that he believes that many people in the EBD, SCI, and CMHS waiver and even the children's waivers could all benefit from this program. **Brian** discussed the idea of ILST maybe being a wraparound service within the waivers, especially for children, as this could really assist them with becoming more independent. **Candie** agreed that there isn't a population out there that couldn't benefit from an Independent Living Skills program. **Julie** agreed with everyone and said that it could really benefit the aging population who may be "sliding" into residential or nursing facility level of care. However, as the program exists today or has historically, it most likely will need to be changed.

The group also discussed maybe having an ILST service in CFC but then an expanded service targeted to different populations in different waivers (as CFC cannot target a service by disability type). **Candie** also brought up the idea of tying this type of service to our centers for Independent Living as there isn't a real reason to have them separate, and we could possibly contract with the centers as they have provided this service.

Ian: Sorry, I haven't been able to hear all of the discussion today but just wanted to remind the group of our charge as the CFC council to bring services to eligible participants. Maybe in a cafeteria style, so that the consumer can choose what is needed from them to remain in the community and that people are able to access these supports as efficiently as possible. I just don't want us to lose sight of what the intent of this program is. And I know that everyone knows this but sometimes we get in these conversations about what we're going to call something and we forget the bigger picture. Thanks!

The group agreed with Ian and also thanked Jim and Ryan for coming and discussing this final report. Jim and Ryan said they would be available if we needed to clarify any other questions. The group resumed discussion on services for the waiver and services for CFC.

Ian: I have a frustration. Why do we need waivers? Isn't the idea that if I qualify for HCBS that it doesn't matter if I have a spinal cord injury or a brain injury? What if I have both? Do I just pick the program that has the most services?

Josh: Yes

Julie: That's what people have had to do.

Ian: Shouldn't all of these services be available to all people? Then the consumer can go out and work directly with the services that they need and work. I just don't understand why it has to be so complicated. I thought the idea was that I'm a person who qualifies for HCBS, so let me have access to the services that available in Medicaid



and get rid of all the red tape. Let me choose the supports that I need. Ok, that was my frustration. Thank you for listening.

David: So Ian, waivers “waive” certain things, like income. People wouldn’t be eligible for Medicaid without waiving this income requirement.

Ian: Is that a rule the can be changed?

Candie: So it’s under the Social Security Act and it goes through what the 1915(c) waivers in Colorado “waive.” So there are four things that are waived. So you have to have those, and though Colorado had a ton of waivers, and has been in the process for several years to try and consolidate these programs. So the example that you gave, if you qualify for multiple programs, you shouldn’t have to choose and you can just go and get those services. And also making those services consistent across all those waivers.

Ian: Thank you Candie that answers my question. I have been part of those discussions with the CLAG and I’m just all about having one big waiver with all these services included but that helped me understand what the barrier is.

Ed: Is this what “No Wrong Door” is working towards?

Candie: Kind of. It’s more a program that makes it easier to get where you need to be.

Julie: Yeah, but you still have to meet the qualifications. What they are trying to do is make it so you know what you qualify for and that you don’t have to go to multiple agencies to figure this out or get enrolled.

The meeting ran out of time so we started to discuss next steps and our next CFC council meeting.

5. Next Steps

- Sarah to update the waiver charts and send out to the group
- Group will discuss service packages with what Innova has presented and with thought to the 300%
- Send over a revised service package to the Budget division in order to have a more in-depth conversation
- Group decided to meet in September and Sarah to schedule meeting for September 12th from 1:00-2:30

