COLORADO
Department of Health Care Policy & Financing

MINUTES OF THE COMMUNITY FIRST CHOICE DEVELOPMENT AND IMPLEMENTATION COUNCIL

August 14, 2017
1:00 pm – 2:30 pm
303 E. 17th Avenue Conference Room 7B
Denver, CO 80203

Phone number: 877-820-7831
Access code: 511120#

1. Roll Call

Phone: Lori Thompson, Shannon Secrest, Beverly Hirsekorn, Candie Dalton, Valerie Baker-Easley, Kady Harrington

Room: Sarah Hoerle, Mary Colecchi, Dawn Russell, Josh Winkler, Ed Milewski, Ellen Jensby, Carol Meredith, Kyra Acuna, Anaya Robinson

2. Review of Previous 6 Months

Sarah asked the group to review last 6 months as there has been lots of action at the federal level concerning Community First Choice (CFC). Josh asked if he could do a quick recap of the last 6 months. Josh explained that CFC was specifically called out in the proposed health care bills, as a program that would no longer receive the enhanced federal match. This made it difficult to plan for the future as the council agreed that without the 6% enhanced match, CFC would not be an affordable option for Colorado. Even though the bill died, Josh explained that it may not be over yet but is optimistic that it would be hard to come at it as broad as the AHCA and the BRCA were. He's also optimistic that because the bill died specifically around Medicaid, it will hopefully make it that much harder to come back and make cuts to Medicaid if they come at it from a new angle.

Ed also replied that the point was that in 2009 it cost $202 a day in a nursing home. $30,000 a year in services and $6,000 for Section 8, which is under $40,000 and $30,000 dollars cheaper to be in the community than in a nursing facility, and you still get to keep all of your social security. What's not to agree with? Josh also brought up that we did get one Colorado Republican, Coffman, to vote against the House Bill and even before the Senate Bill was voted on, he came out publically with his own skeleton

bill. One of the main tenants of this plan was no changes to traditional Medicaid. So we need to keep letting people know at the state and federal level know why home and community based services are the right thing to do.

Carol brought up that though there are people who will cost more than $36,000 a year to live in the community, hopefully we can come up with some sort of median cost to show that this program will be cheaper in the long run. Not to mention the quality of life of the person can be much better. The unfortunate thing is that people who are voting on these bills at the state and federal level may not understand the long term care system. The more we can use the work of this group to help people understand CFC.

Mary added to the conversation about cost of individuals in the community that those who may have more care needs are actually producing jobs for people so we need to take that into consideration as well.

3. Discussion *on The Innova Group* Reports

Sarah moved the discussion to the reports and asked the group what were first thoughts and impressions so far. The group started to discuss the *HCBS Waiver Benefits Continuity Concept Paper* as it was the shortest of the 3 documents that were sent out. Sarah gave an overview of the report and explained why the contractor decided to look into this information. Sarah also directed everyone to the first page inside of the document that is a disclaimer that a number of factors could change the total cost to implement CFC including assumptions, administrative costs, and program changes. Only program has approved these documents and they have not yet been approved by our Budget or Rates divisions.

Sarah explained that this document was created as it has been determined that some waiver clients who become eligible for Medicaid under the buy-in options available under the HCBS waiver program or by meeting the 300% FPL financial eligibility requirements, may inadvertently lose their Medicaid eligibility if services they have received on the waiver are all moved over onto a state plan option. Under the CFC rule §441.510(d), “individuals under the special home and community-based waiver eligibility group defined at section 1902(a)(10)(A)(ii)(VI) of the Act must meet all section 1915(c) requirements and receive at least one home and community-based waiver service per month.” This report was created to look at potential options for the Department to keep all its CFC participants eligible for Medicaid by meeting this monthly requirement. The document looked at 3 options that included the following:

- Guidelines to assign at least one waiver service per month via service coordinators
- Targeted Case Management Services
- Wellness and Education Service newsletter

Josh commented that this was a big concern as many people would lose Medicaid eligibility as the services they were receiving once per month were all being moved over into the CFC state plan option. Dawn reiterated that she was glad that the council was looking at this proactively. Many other states have experienced this issues, such as Oregon and Washington, and have found solutions to ensure everyone continues to have Medicaid. Josh wanted to see if there was a way to do an enhanced waiver benefit through the RAEs that could maybe fit within that realm. Since this already exists in the state plan, could there be an enhanced benefit that is in the waiver, like additional service coordination?

The council discussed that there may be a fear that if there is no cap on the number of hours, there is a fear that it could be incredibly costly to move services, such as Consumer Directed Personal Care, into the state plan. The group agreed that having a realistic cap on services would be necessary but to possibly expand the service limits within the waiver for individuals who need additional supports.

Carol asked what "Natural Waiver Service Utilization" was on the document created by *The Innova Group.* The group determined that this was a service performed by "service coordinators" who would identify what waiver services are needed for the client to remain eligible and provide necessary support. It is not Targeted Case Management but possibly a "service" that case managers could perform like "eligibility checkers."

Josh brought up that there is a rule that individuals may not be enrolled on a waiver for the sole purpose of enabling them to secure Medicaid eligibility. This is correct as explained in the "Instructions, Technical Guide, and Review Criteria" released by CMS in 2015. The criteria CMS has established is that in order for an individual to be considered to require a level of care specified for the waiver, it must be determined that the person: (a) requires at least one waiver service (as evidenced by the service plan) and (b) requires the provision of waiver services at least monthly to assure health and welfare. Individuals may not be enrolled in a waiver for the sole purpose of enabling them to secure Medicaid eligibility as members of the §435.217 group. Entrance to the waiver is contingent on a person's requiring one or more of the services offered in the waiver in order to avoid institutionalization.

The group determined that this new service in CFC would need to demonstrate that it assures the client's health and welfare and without it, may be at risk for institutionalization.

The Innova Group recommended the Wellness Education Service as Targeted Case Management may have a high cost associated with it. The contractor talked with Texas who were very happy with the service but cautioned that it was also highly expensive.

The group discussed what would the Education Wellness Service look like and that this service may actually be beneficial to Medicaid clients. Josh said that there is often a

challenge with clients not knowing if there are changes to Medicaid, what they are, how this may affect them, as well as maybe providing information on the denial notices and what this looks like and what to do with it. Carol also brought up a great point that her commercial insurance sends out a newsletter monthly on things like how to reduce stress, healthy habits, and basic medical information. Many people on the council thought that this would be a normal way to provide health coverage across the board as many people like to read the newsletters they receive. The state of Washington who implemented this reported that follow-up surveys are revealing that almost 44% of newsletter recipients state that the newsletter articles helped elicit new behaviors that have positively influenced their health.

The council started discussion on the Service Package Concept Paper created by *The Innova Group*. Sarah gave some background on the report in that the contractor had updated their model and wanted to include not only financial feasibility but to look at how ongoing initiatives at the Department might affect this implementation. Several themes emerged from this research providing Three Pillars for Implementation. These Three Pillars include:

- Person-Centered Access
- Fiduciary Control
- Coordinated Delivery

Sarah posed a question to the group about one of the recommendations from the contractor on coordinated delivery which is to include an in-home visit by the Utilization Review Contractor (URC) staff as part of the assessment process to assess the client, environment, and attendant needs. Some of council discussed that how, in theory, this may lead to a more uniformed assessment and that they may a really helpful step in taking away some of the conflict associated with case management and providing services. Sarah reported that there are some states where nurses will go out and do the assessment and many people did not find that this would be a good solution. Dawn explained that a nurse would not know about her home and community based needs and that by having a nurse do the assessment we could have a medicalized model as a result. Josh brought up that we should bring in agencies to this discussion, like PASCO and AIO, as they have used nurses to do these assessments and that they have said that their CNAs could do these as well. Carol reiterated this and said that it doesn't matter what letters you have after your name but whether or not you understand the breadth and depth of who the individual is and what their needs are. However, the group did agree that there should be an option as they have had very positive experiences with nurses who had new ideas and were very innovative. Josh related that this would continue with the choice that occurs in CDASS where you don't have to hire someone with certain credentials but there is nothing precluding you from not hiring an RN. The group did want to look at whether this assessment could be put into what the RAEs are doing. Conceptually, there is a lot of crossover and this could streamline the system well. Within the broad structure of how Medicaid is provided in the state, this

may be a really good option as they have the social determents of health in their contract. This could help mitigate things that the waiver misses, such as social isolation.

Sarah talked about the CFC packages and checked in with the group if the very lean package was what we wanted to continue with. This package includes the following services: CDASS, IHSS, Community Transition Services (CTS), Health Maintenance, Homemaker, PERS, and Personal Care. The Contractor recommended package includes all of these services plus Non-Medical Transportation and Behavioral Services. The group discussed again which package would be the most beneficial for clients while also being something that will not cost the state more money. Sarah agreed that we can continue to play around with the numbers and add and subtract services in until the council is satisfied with the result. The group discussed at length the benefits of including or removing behavioral services in CFC. Josh brought up the question of whether it would be possible to put behavioral health services into CFC, receive the 6% enhanced match, which would then assist the BHOs in delivering the necessary behavioral health services to Medicaid clients. The group ended with the decision to go with the contractor recommended package as it still shows a possible cost savings and if need be, the council can remove services as conversations progress.

4. State Legislation

Discussed history of where we are with legislation and CFC. The group discussed how we are more optimistic than a few months ago but that there is still some uncertainty with the ACA. The group talked about how CFC would not be implemented before 2021 at the earliest because of legislation and waiver/system changes. The group also discussed the possibility that the numbers may change, especially if the feds take away the enhanced match. Josh said that he could reignite conversations with some sponsors so that there may be a JBC bill.

5. Next Steps

- Sarah to post draft minutes to website and Sarah to send out link
- Sarah to develop Survey monkey for September meeting