



**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

June 6, 2016

### **1. Roll Call**

Phone: Leah McMahon, Pat Cook, Julie Reiskin, Shannon Secrest, Dennis Roy, Cathy Kaufman

Room: David Bolin, Edward Milewski, Kirk Miller, Julie Farrar, Josh Winkler, Dawn Russell, Carol Meredith, Sarah Hoerle, Kady Hetherington, Marijo Rymer, Rhyann Lubitz, Colin Laughlin, Jim Vogel

### **2. Review of Minutes**

There were no corrections to the minutes. Sarah will have them posted to the website for March.

### **3. Introduction of Sarah Hoerle**

Sarah introduced herself as the new Community First Choice option manager for the Department of Health Care Policy and Financing. Sarah gave some background on her career and has previously worked at the Department as the Community Mental Health Supports and Spinal Cord Injury waiver manager. She is very excited to be back at HCPF and working with this group.

### **4. Discussion with Innova**

Innova was hired in May to refine the previous modeling developed by Mission Analytics and look at some options around what benefits could be offered for Community First Choice option in Colorado. One of the goals was to be as close to budget neutral as possible for these service packages.

Jim Vogel, lead of the Innova Group. Discussed the economics of this project.



Edward Milewski asked about the assessment and who will be doing this and how this will be weighted between financial and quality of life? Jim responded that this is a great question and that the council and the Department will have to make some decisions in the near future. Jim also let us know that Innova will be providing some options though not a definitive answer as Innova was asked to look at a range of options we could evaluate and that absolutely this is a lot more than cost.

Jim talked about process of the project and that by the end of the week they will have finished talking to most of the other states who have implemented CFC to learn what they are doing well, advice for us, and strategies that could help Colorado benefit from their experience with implementing this program. He also talked about the other deliverables that are due such as evaluating alternative services, do we want the program to look a little bit like CDASS or IHSS or some other hybrid for self-direction. And then also looking at Long Term Home Health (LTHH) with the potential to wrap some of those services into this program.

Jim went through a previous chart on Outcomes and discussed how this is where the council's opinions are going to be essential. He discussed how CFC is about whether we can expand access to people who haven't had access before, having self-direction for attendant services, efficiency, and continuity of care.

Innova would like the Council to think about our options in self-direction and whether we want a CDASS, IHSS, or even a hybrid of those. So within those three delivery options that give consumers more self-direction over employment and budget, what packages and benefits can we add to those? Jim wanted to reiterate that we have to be aware that if we increase self-direction, we may see an uptake or increased utilization and that there will be a tradeoff and there may be some economic impacts.

Jim went through some charts and showed the impact of PAS per waiver. EBD is the largest consumer of these services at 88% and this excludes residential services. They were also trying to show the balance of the self-directed programs and the utilization of CDASS and IHSS within each waiver program and that, to date, IHSS has fewer participants and expenditures than CDASS.

Innova also looked at Long Term Home Health (LTHH) Colorado has the potential to move services into the CFC option in order to get an enhanced match. It also could have great benefits associated with continuity for our clients (instead of accessing several programs, only having to access CFC).

Currently waiver clients use 115 million of Long Term Home Health (LTHH) Home Health Attendant (HHA). If we could move HHA into CFC along with the existing non-residential attendant services which could be about \$13 million dollars of new money from CMS that we could use to expand the program.



However, if you think about personal attendant services within the waiver and LTHH, it's about \$400 million dollars. So if you think about \$13 million out of \$400 million is not a big percentage gain. So we need to think about the benefit and what can we do so this doesn't "surprise" us and so we don't have a whole lot of unexpected uptakes of new users or we don't have as much variability in the budget for current users.

Jim asked for questions from the group:

**Julie Farrar:** So if the CFC eligible services moved over to the state plan than the self-directed requirement would be met through IHSS-like or CDASS-like implementation? There would not be a choice of traditional agency based model? I guess I'm a bit confused.

**Jim:** There could be.

**Julie F.:** I thought that it had to be an option, or at least I had hoped that it would be an option that would help drive the more traditional agencies to incorporate that or be left out. But this sounds like they may be left out.

**Jim:** The agencies can participate in IHSS, right? And we can absolutely look at agency-based models as that will be one likely scenario.

**Julie F.:** And you said you were talking to other states and I think that we really need to look at those states who participated for cost savings because we can then see what the intended consequences are and the unintended consequences for us and how we mitigate that and also to have a realistic look at where the cost is really going to be. Because that's why they chose it which is a little different than our motivation.

**Jim:** Great points, thank you.

**Josh Winkler:** I just wanted to make sure, that you made a comment on all the CFC eligible services, there is kind of the hanging question. It was asked of CMS a few years ago by Martha Beavers about including Long Term Home Health and CMS' response was to the question they wanted to hear and not to the question that was asked. And it was like, "no you can't just move all of home health over." And we were like that wasn't really our question. So I think there's still a little bit of ambiguity on whether or not all of those LTHH services could be included.

**Julie F.:** So that's a good question. Does that ambiguity still remain?

**David Bolin:** So my question kind of tags onto them. I noticed that CNA (Certified Nursing Assistant) services could be included but not necessarily skilled nursing therapy services could be included in CFC. Is that really what it is?

**Jim:** I don't really know if that is the case. We are asking CMS that question. As we know, a fair amount of waiver clients are using PDN for example, so we are asking that question. They may exclude skilled providers from the program but we do know what



services they will allow. And we are also asking a specific list of all the things that can be delivered in residential. Do they view any of those as categories that should be excluded? So we're hoping to get answers pretty quickly.

**David:** Ok. Because that's my biggest question. Because we can move CNA into CFC even with that agency model. That's quite a bit of money. Because in LTHH, that's really the bulk of what you get. You get some PDN but those high dollar costs are not with a lot of people. There's not a lot of nurses that will do it. So that's my concern. If we can move CNA in there, that would allow us to make it a little more palatable for the Joint Budget Committee.

**Julie R.:** Doesn't this have to do with how we define it and the Nurse Practice Act? If we call something CNA in one place and health maintenance in another place and we also could look at defining personal care more broadly. And that doesn't really get to the nursing stuff but maybe we could call some of the nursing stuff health maintenance. I just think a lot of it has to do with how we define things and that falls into place. That of course has implications that I don't think we can define things one way or one funding stream and define it a different for another but I just think our definitions have a lot to do with it. Or I may be wrong.

**Jim:** No, you're absolutely right and we're consulting other states and they do define nursing roles and delegation differently from each other but that was a great point. I think what we're trying to do is understand what services are clearly attendant related in the current LTHH benefit and are they allowable. And if so, what are the Nurse Practice Act requirements to allow unlicensed potentially, if we determine we want to waive it like we did for CDASS and IHSS or alternatively do we want to require certification like we've done for home health for parents in traditional state plan program. But, also to your point, we're looking at the two home health attendant levels, not the whole program. I think we all know that LTHH can serve people under level of care. We also need to understand through CMS if they will let us roll everyone who is above level of care into a long term program, if we will move that entire segment into this program or not.

**Edward Milewski:** One thing, if you're allowed to go back to Medicare or Medicaid, get out of the hospital, get physical therapy, get the paper to tell you what to do, you don't have to have a physical therapist at home or a speech therapist, but you have your CNA do it. You just have to bring the instructions to do it and the CNA can do it, you don't have to have a physical therapist do it. Just stand by while you do the effort to do it, watch you do it.

**David:** But it's under supervision of the therapist. As long as you're in LTHH it has to be supervised

**Carol Meredith:** Does that have to be formally delegated?



**David:** No. There are certain tasks, like range of motion, that a CNA can do after they have been trained either by a nurse or a therapist. And then that nurse or therapist still has to supervise that particular task.

**Ed:** What you mean supervise? They have to be there to supervise?

**David:** They have to come in and supervise the CNA every two weeks, when there's a therapist, if you're in LTHH, or by the nurse because as long as there is nursing and therapy in there, the supervision has to be every two weeks.

**Jim:** We have not seen these therapies included in CFC programs in other states either and I'm not sure CMS even allows it but we can ask the question to CMS again.

**Julie F.:** I guess I feel like my concern here is that we've been ambiguous on purpose but now when we're tightening things, I feel like the devil is going to be in the details and we don't get what we don't want and we do get what we do want. As we firm up our definition. I think that's why we look at the ones who are trying to do it for cost containment purposes.

**Josh:** And to that point, I think we are in a much better place now than when we were two years ago because we are at 6 states now that have implemented and we can see what they did, why they did to understand it a little bit more. Even though they're not Colorado and they have their own reasons for doing CFC. We can at least learn from them on that. Like Oregon, where the floodgates were open and now they can't control the cost of it as people are using 5 times as much as they anticipated and you've created an infrastructure to provide those and you can't just take those back.

**Jim:** That's a great point. Some states have been pretty successful like Connecticut and Montana in either being budget neutral or saving money.

Jim circled back to the handout and their goals for Colorado, namely, talking to other states and learning as much as they can about what did and didn't work with implementation. Currently they have talked to 5 states. Some states wanted to improve access to attendant services, especially those who were on waitlists. Some wanted to enhance their existing services as they had attendant services in their state plan but wanted to address some gaps. Some wanted to offer more participant direction for their attendant services. Though I don't think it was their main reason, some states have saved some money but then put it back into their programs as the federal government requires a maintenance of effort for the first 12 months of implementation.

Julie R. brought up a great point that in Connecticut they are making a lot of cuts and have thrown off about 17,000 MAGI folks off. So they may not be really putting that back into their existing system.

Innova said that every state did say that they wanted to shift as much over to CFC so they could get the enhanced federal match. It was also interesting to see who used



what model and though there was a variation in all of the programs, employer authority was more common than budget authority.

Some of the states see the CFC option as the “first line of care” and then consider the waivers as wraparounds. We think that is a smart approach. Most states already had personal care in their state plan and interestingly enough, most states also had experience in self-direction either through grant funded programs or their waiver programs.

Jim discussed the different cost control strategies and that there are usually two different types: Caps and Limits and Service Delivery Design. Under Caps and limits you have the following:

- Program level –budget ceilings
- Benefit level –unit and budget limits
- Client level –Person Centered Budgets

The group discussed different benefit caps and limits, looking at how Connecticut has a limit of \$5,818 a month which is roughly the cost of nursing facility care though Innova thinks there is a better way than doing this. Maryland has a year limit of \$76,360 which is about the same as nursing facility care cost of a year. However, Maryland has an exception process.

The big takeaway from most of the conversations with other states is how effective your assessments are with having a resource assignment. Colorado has a lack of precision of the assessment tools and that it could be any number of things. However, the assessment and the enforcement of the exception process are critical to control budget. Innova talked a lot about tiers based on the needs and acuity of the client. He said that the goal for most states was to get a consistent assessment tool.

**Julie F.:** I feel like those of us who participated in the redesign of the tool and we were talking about the SIS and how it doesn't really fit with the way we do the other assessments. I feel like what I heard from the Department somewhat out loud that there was this move towards tiers that looks more like what the DD system is doing but not in the “bad way” I guess. So I just want to say out loud that I think that is the way the state is moving and we should just be aware of that. Because it wasn't necessarily said out loud when we were looking at the assessments tools but it was maybe implied? I just feel like the Department is already looking at those and that is the way they want to move.

Discussion in the group was whether or not the Department wanted to keep the SIS.

**Marijo Rymer:** What we did through the legislature is that there will be one assessment process. It could include elements that are unique to persons with intellectual and developmental disabilities, which could be SIS-like. So as advocates of



this community, we believe that you shouldn't have to go through two extensive assessment processes but we also believe that the assessment tools need to be specific for individuals with intellectual and developmental disabilities. And that is the understanding that we have with the Department and that is the way they will move. Whether its pieces of the SIS or something like it, I don't know. Again, the SIS itself is not the problem. What is problematic is that Colorado is not adding additional elements to determine level of need and of course, when the SIS was first implemented in the middle of the recession and tied it to support levels, they were inadequately funded. But the SIS itself does provide norm-referenced, well tested assessment of an individual with intellectual and developmental needs.

**David:** It's just not a good tool for developing budgets.

**Marijo:** It's not what it was intended for.

**Julie R.:** I just think that whatever we do, we need to look at all types of disabilities and look at people with brain injury and dementia who may have some of those same cognitive and behavioral support needs and make sure that there is one tool and we aren't making one group go through more interrogation than another but also understanding because there are different groups who have similar needs and we shouldn't say that one group should get the same things because they don't have a group working for them.

**Colin Laughlin:** To that point, we are going to try and coordinate with the work that is going on with Tim and his group and the assessments. That is absolutely correct. It's not just limited to the IDD population. The current assessment tool isn't great for brain injury, dementia or mental health so there are a lot of things that are left to be desired from the ULTC 100.2. So the goal is to take a more nuanced approach for all disability types instead of for just one. One of the main goals is trying to get a sense of what people need and that's to have more interrogation and more assessments piled on but what can we do to make it easier for these populations to receive the services they need.

**Julie F.:** We just need to make sure that pieces such as employment are a part of it much like the medical portion and they inform each other and you have that information for the whole person. So they aren't telling the same story over and over again but are working in collaboration.

**Shannon Secret:** I know I spoke to Jim about the children's aspects of the disabilities but I'm just wondering if when we're looking at tools for the disability community that they are appropriate for kids, the targeting criteria is appropriate and how those all work with the existing waivers too. So I'm just throwing my voice out there that kids need to be looked at too. People around the room agreed with Shannon.



The group turned to a discussion on Personal care after Innova went over more of the handout on other states exception processes, assessments, and some of their best practices. Shannon brought up the point that the way personal care looks right now might not be the best for the children's world. We know that there are very few kids using personal care in the state right now and so obviously it's not a robust or highly utilized service.

**Julie R.:** But isn't that the way that it's been set up a poorly managed? And that kids can't use it because no one is really providing it?

**Shannon:** I think some of the glitches have been fixed but still goes back to the philosophy of how parents feel about others coming into their home and trying to coordinate the care.

**Julie R.:** But if it was consumer directed, would it work for kids?

**Shannon:** To an extent. I guess what I would like to tack on, well, you know the state has said that it will never pay for protective oversight. And so one of the things we have said all along is that I get that personal care is hygiene but part of the thing with protective oversight is that you need to make sure those individuals are safe to avoid the injury or danger. My son is deaf and obviously he isn't going to hear a car coming and he also has autism so he isn't going to have the cognitive wherewithal that the car is going to hit him. But he does need protective oversight so he doesn't die or get a brain injury. And so on some level we need to have preventative care. When I think of personal I care, I think of taking care of the person not the hygiene.

**Julie R.:** I think this is the bigger issue for everyone.  
Everyone agreed.

**Julie R.:** I think the important part is how we define personal care. I think what the state has said that you can't do 24/7 for everyone. So how do you figure out how to give people something and have their family or the person manage it the best way they can.

**Josh:** I know we discussed how queuing could be used. But again, under CFC, this is for a particular task.

**Carol:** It's just that you can't be engaged in a task 24/7. You have to have free time and some people can manage their free time by watching tv but others can't so this is where protective oversight comes in.

**Josh:** Yeah, I just can't remember if there was a piece of CFC that wasn't just the hands on piece.

**Carol:** So it makes it hard to define personal care as what I just described as it's not hands on body.



**Josh:** Yeah, we may have to see if there is another way to do this.

**Carol:** So it's supervision of a task

**Julie R.:** I think we need to have a benefit, again understanding that we aren't going to have 24/7 for everyone because we just can't. However, for those who do need 24/7 supervision, here is a dollar amount and then they make a decision. Because just saying that we aren't going to do it and there has to be a task associated with it, isn't getting us anywhere and it's causing a lot of problems. Sometimes, I think it causes overutilization in other areas because people are so desperate to make things work. So it just seems like to keep ignoring this and saying we don't do it is really unproductive in my opinion.

**Josh:** Maybe the answer isn't putting it into CFC but maybe if we have budget neutrality or a couple bucks extra, let's put this in the waivers.  
Absolutely

## 5. Legislative Timeline Discussion

Sarah introduced the next topic which is a legislative timeline discussion. We want to look at the broad overview and when do we need to start work. We also wanted to discuss if bringing CFC forward would be something the community would do as oppose to the Department.

**Zach Lynkiewicz:** The direction that we have been given, based on what happened this session with the hospital provider fee not passing, and there is no revenue, the situation does not look good. So while I can't officially say what will be in our budget or our legislative amendment until November, I'm strongly hinting that there will not be large benefit increases or designs being proposed by the Department as there are a lot of competing interests with all of the Departments. So I would encourage you, if it CFC is cost positive, to start thinking of ways that you can move this forward as a community. I think the Department has been explicit in saying that we would support this moving forward but may be somewhat constrained based on the budget environment. I would strongly encourage you to start talking to members, particularly members of the Joint Budget Committee, this would be a bill that would be in your benefit to get in the long bill, or a placeholder in the long bill. Representative Young may be a good person to go to.

**Josh:** I think we all kind of figured this was where things were but I do think we are in a more positive place than a year or two ago with the numbers before. Hopefully with looking at the multiple options Innova gives us we will be able to have a real conversation

**Zach:** Yeah, I think there were a few bills that you brought us in early in order to get our feedback and technical advice, like Julie. That's always really helpful before it's introduced and as it's more of a collaborative effort. So I'm more than happy to engage



in that discussion with you if you're interested in bringing something forward for this session about what the actual language would look like. And we could work with our Budget staff to get a proactive view of what we will be submitting to the council for a fiscal note so that no one's surprised.

**Julie R.:** I think one of the most important things is that our messaging from the community, the providers, and the Department is similar.

**Josh:** So my question to the council is if this is not a Department led bill, which it probably won't be, how do we best work together? I know a lot of folks on the council have been involved with Legislative efforts so I want to know how it's best to get the right people lined up.

**Marijo:** The new numbers from the report are due at the end of this month?

**Sarah:** Yes, they are.

**Marijo:** And so we'll see them...when?

**Sarah:** We should see them in July. Obviously this will be a draft form. I know that since Innova has had an incredibly quick turnaround timeline, so that's why we are shooting for the beginning of July.

The group discussed next meeting dates and it was determined that the first of August would be best as the 4<sup>th</sup> of July was the first week in July. Josh also wanted the group to make a note that even though we can't do protective oversight in CFC, we may need to make a recommendation to do this elsewhere.

## 6. Next Steps

- Review final DRAFT report from Innova and discuss service packages at our next meeting
- Sarah to schedule meeting for August 1, 2016 from 1:00-3:00

