



MINUTES OF THE MEDICAID PROVIDER RATE REVIEW ADVISORY COMMITTEE (MPRRAC)

The Colorado Department of Health Care
Policy and Financing
303 East 17th Avenue, 7th Floor Conference Room

Friday, March 17, 2017
9:00 AM – 1:00 PM

1. MPRRAC Members Present (in person or via phone)

Rebecca Craig, Rob DeHerrera, Tim Dienst, Jennifer Dunn, Sue Flynn, Lisa Foster, David Lamb, Dixie Melton, Carol Morrow, Wilson Pace, Jeff Perkins, Tom Rose, Tia Saucedo, David Smart, Barbara Wilkins-Crowder, Murray Willis, Jody Wright

2. Agenda Review

MPRRAC members approved meeting minutes from January 20, 2017. Tom Rose and Lisa Foster, MPRAAC Chair and Vice Chair, reviewed the agenda and the Committee's Guiding Principles.

3. HCBS Waiver Services Presentation

For HCBS Waiver services under review in year two, Department staff presented information regarding:

- rate benchmark comparisons; and
- access analyses.

Corresponding [PowerPoint Presentation slides](#) can be accessed via the MPRRAC website. Three meeting handouts were referenced throughout the meeting and can be found on the MPRRAC website and below.

- [Preliminary Year Two HCBS Waivers Access Data](#)
- [Rate Review Process and Consumer Directed Attendant Support Services](#)
- [Department Processes for Investigating Comparator State Wages](#)

4. Stakeholder Comment

Thirty-seven people had signed up for public comment regarding HCBS Waiver services prior to the start of the stakeholder comment period; Lila noted this meant that each stakeholder would have less than 3 minutes to speak. In the interest of time, Tom asked stakeholders whose planned comments are already expressed by someone else to indicate that they agree, for the purpose of

note taking, but not to repeat the point, and that this would allow time for committee members to ask questions of those providing public comment. Lila asked those who signed up to identify the waiver/service for which they planned to provide comment and ordered speakers by waiver and/or service category. Public comment began with the Elderly Blind and Disabled Waiver.

Note: while feedback is grouped by waiver below, certain comments applied to services found across multiple waivers.

EBD Waiver Services

- Carol Mitchell with Seniors Resource Center, a provider of adult day, homemaker, personal care and non-medical transportation (NMT) services, stated that, aside from in-home services, which saw a rate increase in 2015, current reimbursement rates do not cover even half of the Center's costs. The reimbursement rate per trip under 10 miles covers just 20% of the Center's costs, which limits the agency's ability to provide rides to clients. Carol stated that, in order to provide such a ride, it needs to be close to their destination and on a route that the vehicle is already scheduled to travel. Carol stated that, in 2015, as an agency, their cost loss was about totaled roughly \$800,000, in 2016 the number of billable in-home care hours fell by 9% but non-billable hours increased by 8%. It is not uncommon for the Seniors Resource Center to turn down a request for services for someone who, for example, has been approved for six hours or more of homecare because the agency doesn't have an adequate workforce. The Center's concern is that, at the current rates, it is not able to attract and retain an adequate workforce and to ensure quality of services. Carol also expressed the Center's belief that higher wages would entice more agencies to become providers. Carol also pointed out that many of the Center's employees are Medicaid recipients themselves.

Carol provided [written comments](#) to the MPRRAC, which contain further detail.

- David Bolin, stated that, when looking at how to come up with rates, we do need to look at the labor market, what the min. wage requirements are and what quality of worker we want to provide service in HCBS field. He stated, for example, that you can't expect someone earning minimum wage to teach independent living skills, and reiterated that rates need to reflect the quality of services that we are looking to provide.

David also shared that he worked with the Colorado Cross-Disability Coalition (CCDC) on an [SLS rates position paper](#) previously provided to the MPRRAC, and that his organization supports the position paper.

- Lorin Chevalier with PeopleCare Health Services spoke on behalf of the Homecare Association, addressing personal care and homemaking rates. He pointed to a [document](#) previously submitted to the MPRRAC, by the Homecare Association, which includes compiled information representative of mid-size, Class B, personal care and homemaking providers, across waivers. He explained that the first page of the document uses the 2017 minimum wage as a base-plus against the current \$17 p/h reimbursement rate for these services and applies last year's (2016) overhead costs (including training and activities to ensure compliance). It illustrates that there will likely be a \$0.67 per-hour-worked loss to deliver personal care and homemaking services throughout 2017 under the waivers. He stated it would have taken "roughly a \$1 per-hour" increase in rates as of January of this year

(2017) to allow for those services to be provided at what is close to a break-even level. He also pointed out that these services are significant under the EBD waivers and have significant impact on those providers.

Lorin then projected into 2018, when the minimum wage is scheduled to increase to \$10.20 per hour. He pointed to a table in the document that illustrates that, on average, mid-size, Class B, personal care providers' operating loss would increase to \$1.57 per hour worked, if the reimbursement rate were to remain at \$17 per hour (again, using 2016 overhead costs). He explained that a second table in the document assumes a future 2% increase in non-direct care payroll and other overhead costs (such as rent) in 2018, which would increase operating losses to \$1.83 per hour worked if the reimbursement rate were to remain at \$17 per hour. A third table illustrates the effects of a 4% increase in non-direct care payroll and other overhead costs in 2018, which would increase operating losses to \$2.09 per hour worked if the reimbursement rate were to remain at \$17 per hour. He pointed out that the minimum wage is scheduled to increase again in 2019 and 2020 and stated that the problem will keep compounding, as illustrated on page 4 of the document submitted. He noted that some providers in the Western Slope communities have started to drop out and stated his belief that more providers will follow.

- o Rob DeHerrera asked Lorin if he felt there was something that could be done to address geographically disparities in cost across the state, such as creating a geographical modifier.

Lorin responded that, while the minimum wage is the same across the state, the costs of driving to a location and finding staff vary. He stated that there is a greater number of potential hires in the front range than there is in, for example, Cortez or Baca County or Sterling and that it can be costlier to provide services in rural areas.

- o Tom Rose observed that, within the document provided, total and administrative services are listed as 39% of the overall cost in one chart and 40% in another. He stated that these are numbers that the committee likely needs to discuss further when assessing rate adequacy, as the numbers appear relatively high to him. He shared that his non-profit is required to operate at less than 20% G & A. He appreciated the analysis and stipulated there are likely explanations for those numbers, but that the committee would need to understand what informs those percentages prior to making recommendations. Jodi Wright seconded the need for further information while also noting that he was in no way discounting the need to look at the fact the minimum wage is increasing.

Lorin responded that there was a report issued roughly two years ago by an independent accounting company, PKE, that concluded that, for a large sample of homecare providers, 40% was an appropriate G & A. The committee asked for the report and Lorin committed to providing it.

- o Jeff Perkins asked if there were any ideas regarding, for example, regulatory relief that would curb overhead costs and encouraged stakeholders to provide any such suggestions.

Lorin responded by sharing that there are several hundred providers in the state and most are

small. He postulated that, without collapsing small agencies into a larger agency structure, it would be hard to find those efficiencies.

- Lila pointed out that Julie Reiskin, executive director of CCDC, submitted three petitions (linked below) to the committee for their review. They cover the following services found in multiple waivers, including the EBD waiver:
 - [CDASS](#)
 - [NMT](#)
 - [SLS](#)

CMHS Waiver Services

- Lori Hamilton, who has an assisted living facility (also known as an alternative care facility) with CMHS and EBD residents, shared that she has not seen a rate increase in many years but that her chief concern is that minimum wages are now going up. Lori stated that she has traditionally paid her staff above minimum wage and that staff have started to inquire what will happen to their wages when minimum wage goes up. She shared that some of her employees have recently lost housing as rental rates go up. She also stated that, as the labor market improved, it becomes more difficult to find employee willing to work at odd hours. She emphasized the need to “retain good employees at a decent wage”.

Lori also stated that operating costs continue to increase as reimbursement rates remain the same. She pointed to increases in the cost of food and utilities, and large increases in facility taxes within Denver market and insurance to cover facilities; she shared that her insurance rate increased by 10% in March. She also stated that, as her residents age, there can be sudden needs to see doctor and her agency provides transportation at their cost. She ended by pointing out that there have been recent increases in regulations and licensing.

- Tom Rose stated that it would be helpful if the committee were provided information about recent increases in regulations.
- Maggie Sparks, also provided feedback regarding the CMHS waiver. She shared that she too has an assisted living facility, and pointed out that the minimum wage will be increasing 44% in next three years; a “huge increase” for them. She also pointed to new ALR (?) regulations that she anticipates will cost more money as well. She stated that, over the past ten years, rate increases have been 7%, while cost of living has gone up 20%. She shared that the most recent rate increase was \$0.25 a day in July of 2015. In the same ten years, she stated that there have also been five decreases in their rates.
- Another stakeholder, who said that the facility his colleague described started as assisted living and became a mental health facility, spoke next. He stated that he wished to echo Laurie and Maggie’s comments. He also stated that, within the rate comparison tables provided by the Department, “mental illness is behind all five states”. He also shared his belief that the mentally ill cost more than the general EBD population (as examples he stated they incur extra wear and tear on buildings, can

eat more and can wander more, etc.).

Jeff then introduced a colleague who pointed out that, in the past, their facility was compensated for, for example, episodic and chronic behavior but that they have many uncompensated costs today. He further shared his opinion that facilities like theirs should be treated separately, as they were in the past, and that the facility cannot last much longer at current funding rates (with, for example, current building upkeep and insurance rates).

- Matt Coffmen with Accolade Living Center, echoed earlier comments about the need to keep up with fixed costs. He listed examples that include increases in insurance liability costs, utility costs, property taxes and CMS requirements for more home-like environments. Employs 160 people at five facilities, the numbers are not doable. The care quality and employee accountability will drop without rate increases.

Matt provided [written comments](#) to the MPRRAC, which contain further detail.

- Dennis Quinn, owner of Sunnyslope Estate Assisted Living, with spoke next. He described his facility as a “full Medicaid facility that requires no spend-down”. He shared that he currently maintains a thirty-person waiting list and has been able to take only one person off of the waitlist so far this year. He stated that the market is grossly underserved. Dennis pointed out that a lot of other waivers don't require buildings but CMHS does. He stated that it is presently cost prohibitive to develop a new facility with building and land costs as they are. He also explained that he is required to maintain, for example, carpets and kitchens in his existing facilities. He stated that there are additional building requirements set forth in the new CMS rule on “home-like settings” which will add to those costs. Those new requirements include, for example, ensuring the availability of food and access to kitchens and the cost of redoing doors for security purposes. Lila committed to providing the committee with these new federal regulations.

Dennis also stated that the Colorado Department of Public Health and Environment is in the process of developing new regulations, currently under review.

He ended by stating that, whatever the minimum wage, he must pay \$2-3 more per hour to get staff to show up.

- Stacy Groves with Brookdale, a for-profit Alzheimer's and dementia care community in Colorado Springs, that is recognized as an alternate care facility. Stacy pointed out that while their facility's rates are the same as other alternate care facilities, as an Alzheimer's care community, they are required to maintain a staffing ratio of 1 to 6 at all times (24/7), which she stated is double what is required of other ACFs, and that this requirement “makes it virtually impossible” for their agency to work with Medicaid clients.

Stacy pointed to documents that she provided as handouts in the meeting, including [link 1](#), [2](#) and [3](#). These documents show that only eleven beds in Colorado Springs accept Medicaid members for memory care and that her facility offers five of those beds. She shared that when she started with

the company two and half years ago, there were 17 beds; an indication of how hard it is to staff at a ratio of 1 to 6 under current Medicaid reimbursement. She explained that, at night, she may have 13 or 14 caregivers on her floor where her competitors may have 2 or 3. She offered a non-fiscal solution for the committee to consider as a recommendation: help with the staffing ratio. Casey offered to share with the committee the [time studies and resulting staffing model](#) that Brookdale has put together as an alternative to the current staffing requirements.

- Jeff Perkins asked if the Department could give the committee a sense of how costs for providing care in assisted living facilities compare to costs of providing care in nursing facilities (since waiver services must cost less than the care would otherwise cost in a nursing facility).

Randie DeHerrera responded on behalf of the Department that the nursing facility rates and ACF rates are available on the Department's website.

Stacy pointed out that the Medicaid clients she turns away end up in nursing facilities and that the documents she provided to the committee include a cost savings estimate if the reimbursement rates were to increase to \$75 per day.

- A few stakeholders briefly discussed the Community Choice Transitions (CCT) program. There seemed to be some confusion as to if and how the rule that created this program has been implemented and existing funding for the program. Gretchen Hammer committed to sharing information about the CCT program.
- Lyle Campbell with St. Bernadette Assisted Living, pointed to bill 1124/1128, a pilot program to take people out of nursing homes and put them in assisted living, which he indicated was the bill an unidentified stakeholder was referencing when she commented that she was told by someone at Medicaid that there is no funding for transitioning people out of nursing facilities.

Lyle then offered a brief example of the types of additional requirements placed upon assisted living facilities, which they have no control over; in this case, a Medicare requirement that he pay a \$1500 permit fee that they can then review to inspect his Alzheimer's assisted living facility.

- Deborah Lively, from Leading Age Colorado, which represents a continuum of senior care, including adult day and nursing facility care, stated that the access analysis needs to take into account that providers need to have an appropriate mix and may not be taking new patients (despite showing as active providers in the claims data).
Deborah provided written comments to the MPRRAC, which contain further detail.
- Megan Heart from Heritage Haus Assisted Living and Primrose Place Assisted Living in Loveland, which takes clients on the CMHS waiver and is 99% utilized by Medicaid recipients, spoke next. She asked that Lila include, in the list of themes she was documenting throughout the meeting: an investigation into the cost to open, license and staff and brand new facility and how long it takes to make profit; and the average ER costs for clients in the year or two years prior to moving into assisted living (to assess cost savings). She noted that her waitlist is two years long.
- Michelle King with King Adult Day Enrichment Program at the Rocky Mountain MS Center, a

specialized adult day program for adults age 18 to 65, stated that the majority of the population her agency serves, based on their diagnoses, are not going to improve. She stated that her program is an alternative to nursing facility care and that the challenge is maintaining quality with the increased number of clients that require services. For example, when nurses have time they notice a client with UTIs and can prevent hospital stays. She emphasized the importance of assessing quality as it relates to access, including the ability to keep people in community settings.

Michelle provided [written comments](#) to the MPPRAC, which contain further detail.

CES Waiver Services (and the respite services)

- Ryan Zeiger, CEO of PASCO Home Health and IDT Services stated his support of prior statements provided regarding personal care and homemaking rates, as well as comments he stated would be made by others in the meeting regarding SLS rates. Ryan then provided feedback about respite rates. He was part of Governor's Respite Care Task Force; one of key elements of data from that work was that 25% of authorized units in respite were actually used. He pointed to a slide in a [presentation](#) he provided to Lila, that shows his agency gets reimbursed \$19.80 p/h for children's CES respite services. His agency pays direct service providers between \$12 and 13 p/h to ensure quality care. He stated that, when you take \$19.80 p/h and subtract \$13 p/h and then further subtract travel expenses, etc. you are left with roughly \$3 for admin training, benefits, liability insurance and other administrative costs.

Ryan offered a suggestion for how to reduce costs. His caseload is fairly medically fragile and he highlighted the different types of training that are required of staff (sometimes 30 hours of training for high needs clients). He offered that there may be savings to be realized by allowing staff to specialize, rather than be required to take every training.

He ended by pointing out that SLS and CES service provision at his agency is in the red and that his agency is essentially subsidizing those services by providing other services. By his calculation, for his agency to break-even on the cost of providing CES respite rates, the rate would need to increase by 25%.

The [slide presentation](#) Ryan provided to the MPPRAC contains further detail.

- A parent CNA, who provides services to her son on the CES waiver, shared their story. She stated that families are the first line of defense and provide many services to keep clients out of assisted living facilities. She stated that last September, two years after her client switched to the CES waiver, they finally were able to find a provider, through PASCO (which does pay providers above the minimum wage for respite), to provide some (not all) of his respite services. She stated that she is unable to get service providers because of low Medicaid rates and that she had to find and provide her own contractors for her son to receive services. She stated that, as of March of this year, her client is authorized to receive: 28 hours p/w of CNA services; 20 p/w of respite (receives average of 10-15); 15 p/w of community connector (receives average of 5-8); 8 p/w of homemaker, and 8 hours per month of cognitive behavior (received 6 in February). So, her client receives about a half to two

thirds of the service hours for which he is approved.

- Kristin Smock, founder of Megan's Place, a respite center for children with disabilities, stated that her agency provides respite and community connector services. She also stated that her agency probably could not provide respite services without community connector, because the agency uses community connector rates to supplement the cost of providing respite care. She stated that looking at access is just as important as looking at rates, as a lack of access should make it obvious that rates are insufficient. She provided an example of a child in need of respite services (for which they are able to provide 15% of the total hours he needs) who is only successful with one of their staff and stated that two out of the last three times they had to adjust staffing schedules, the child ended up in Children's Hospital for a week.

She reiterated the high cost of training, hiring and building maintenance. She stated that their center is only able to make it work because they are a center and can do group respite (at a 1 to 3 ratio) at a rate near the individual respite rate.

- Gretchen Hammer, Medicaid Director, asked Kristin if she believes that, were the right mix of rates and services in-place, she would be able to find the work force needed to provide these services.

Kristin responded that staffing is an ongoing struggle. She believes competitive wages would help with retention of staff. She also pointed out that, because they are a center, they are able to hire younger, less experienced staff who are supervised by someone more experienced but that, if they had to send someone out to the home, they would not be able to hire someone younger with less experience and meet those needs adequately. She noted that staff have to have passion for the work and "you can't teach passion".

Kristin also stated that her agency has been offered various grants to open a second center but that start-up costs exceed \$65,000.

- Ellen Jensby, public policy director, and Emma Hudson, legislative liaison, with Alliance, a non-profit association representing community-centered boards and service agencies that provide supports to individuals with intellectual and developmental disabilities, spoke next. Ellen stated that their members report it costs an average of \$20.20 p/h to employ a direct support professional (prior to minimum wage going into effect). She noted that many of the rates discussed in the meeting don't rise to this level. They also pointed out that the cost of doing business continues to rise. For example, in the Denver Metro area the cost of living has risen 47.5% since 2001 while reimbursement for IDD rates has only risen 14% in that same period. Ellen stated that providers are starting to be more selective about who they will serve, provide group -rather than individual – services, or close certain programs altogether. She also stated that members report a statewide direct-support staff turnover rate of 38% which, she also noted, is close to the national average. Turnover leads to discontinuity of care. Ellen stated that Alliance's recommendation is for the Department to do a comprehensive study of the costs of providing services related to access.

Emma presented the results of an access analysis using RFP data that Alliance recently concluded.

She explained that, while the RFP process is imperfect (noting prior stakeholder comments that some client families no longer send them out and some agencies no longer respond to them and that Alliance and many others do not feel it is a person-centered process), it does seem to be the best tool they have to measure access. She then explained that, within the data they collected from their members, between July and December of 2016, about 4300 RFPs went out; of those RFPs, 59% of were for new services; and of those new service requests who actually received a service placement it took, on average, 48 days for clients to receive services. Of all RFPs sent, 64% received a response (meaning at least one provider was willing to provide services) and 36% received no response whatsoever. Emma also explained that her team looked at placements that resulted from RFPs sent out between July and October of 2016. Their data indicates that, four to nine months after the RFP was sent, only 31% resulted in a client receiving that service. She further noted that the materials Alliance provided to the MPPRAC stratify placements by service and that homemaker (both enhanced and basic) and respite services have one of the worst return rates. She also pointed to the poor placement rate of day habilitation, a service that is in high-demand and is critical to supporting individuals and families.

Alliance forwarded the [materials discussed](#) post-meeting, which contain more detail. She noted that this research and analysis is ongoing on a quarterly basis and that Alliance will be able to do its first one year analysis this August.

- Tom Rose suggested that Alliance visit with the HCBS workgroup over the summer to further discuss their data, as the committee and the Department have committed to looking for other valid data sources and Alliance's work may be a valuable resource.
- Lynn Robinson with Easter Seals Colorado, representing Colorado Respite Association, agreed with what was previously been stated. She pointed to the 800+ family caregivers who provide a savings to the state. She stated that families begin to deteriorate when respite services are compromised and the state can't afford for that to happen. She also stated that most non-profit agencies operate with an 11 or 12% overhead.

Lynn provided [written comments](#) to the MPPRAC, which contain further detail. Roman Krafczyk, also with Easter Seals Colorado, also submitted [written comments](#).

- Natalie Wood with the Bell Policy Center, a research advocacy organization that focuses on economic opportunity for Coloradans, stated that Bell is interested in this topic because they have a focus on aging. She pointed to a report based on 2013-14 data that Colorado spent \$16,000 per year on each client receiving HCBS services compared to \$60,000 in a nursing facility. She stated that there have been over 40 studies published between 2005 and 2012 that show providing HCBS is less costly than facility care. She suggested that, by adequately funding these programs Colorado is demonstrating its commitment to making sound strategic investments as our aging and disabled populations grow. She also stated that Colorado has been recognized as a leader in providing this type of care and pointed to information she provided in writing about a score card that ranked Colorado fourth in the country and ninth for the percent of Medicaid and other state funds that go towards HCBS waivers and the disability community and that, while we should be proud of this success, several statewide groups point to need to continue emphasis and research into our workforce. She also pointed to two documents: The Strategic Action Plan on Aging and a report developed by the Colorado Commission on Aging, which include workforce recommendations.

Natalie asked the committee to consider drawing a parallel to primary care providers regarding value of care once those rate increases expire.

On the issue of respite, she also pointed to the Respite Care Task Force's report that offered additional areas of study to include a study of the adequacy of reimbursement rates. She further pointed to a Colorado Health Institute produced a document that quantifies the value that unpaid Colorado caregivers are providing to clients over 50; the cost to them is calculated at \$3.3 billion in forgone wages and other lost opportunities at work, costs that are projected to double by 2030.

Natalie provided [several documents](#) to the MPRRAC, which contain further detail.

- Marijo Rymer with the Arc of Colorado, an advocacy organization for individuals with intellectual and developmental disabilities (IDD), spoke next. Marijo explained that she served on the Community Living Advisory Group and co-chairs the Waiver Simplification Committee. Before providing comment on respite services, Marijo wanted to provide background on how rates were set for the three waivers that provide services to individuals receiving IDD services: DD, SLS and CES.

Marijo stated that, beginning in 2006/7, the State changed the rate setting methodology for providing services under these three waivers and moved to a retrospective fee-for-service payment system (meaning the service was delivered and then billed). Marijo explained that, prior to 2006, services for individuals with IDD were billed differently. Beginning in 2006, the Department undertook an extensive process to establish each component of the services that an individual would receive, and at what rate, with the help of a Navigant. This process was informed by stakeholders, providers and families, after a two-year period in which the Department contracted an outside consultant to help determine what the rates should be. Marijo further explained that, at about the same time, the economy went into recession and the projected Colorado revenue that would have underpinned these rates decreased. She ended by stating that the plan had been to re-determine rates annually by looking at data from the previous year regarding how many people had used, for example, respite and day habilitation services, and then to "compare that to the determined rate, multiply it, and then figure out what ought to go in the budget." However, due to the economic downturn, the State instead projected how much money would be available and then back ended the number of projected service units to determine the rates, and that in all cases the rate was lower than had been previously discussed. These rates went into effect in 2009/10; Marijo stated that they have been inadequate for the past nine years and that all involved knew they were inadequate on the first day they were implemented.

- Committee member, Rob DeHerrera, noted, after Marijo concluded her comments that, at the time the rates were reset, the budget neutrality factor was 76%.

Marijo stated that the process that was created (between 2006 and 2008) to determine the rates for services in these three waivers should not be set on a shelf. She suggested that the Department and the committee might learn more from researching that process (which considered, for example, the labor market, and included discussion of geographic modifiers) than from comparisons to other state's rates. She suggested that a recommendation might be to revisit that work.

- Gretchen Hammer, Medicaid Director, took the opportunity to remind all involved of the difference between the rate setting process and the rate reviewing process. She stated that the work of the MPRRAC is part of the *rate reviewing* process and that she appreciated the way in which Marijo summarized, in that, a recommendation of the MPRRAC might be that the *rate setting* methodology should reflect what was best from that Navigant process (i.e. that the Navigant process work should be revisited in the rate setting process). Gretchen further clarified that the charge of this committee, through the statute that drives this rate review work, is to compare rates to other states. She noted that stakeholder comments were revealing a wonderful conversation and that she simply wants everyone to keep the distinction between the rate reviewing and rate setting processes in mind as the rate review process moves into the recommendation phase.

Marijo then commented on respite services. She stated that data from her organization and from the Consortium of Citizens with Disabilities, a national entity, indicates that respite is the single most requested service among long-term services and supports recipients. She stated that in Colorado this service, especially for individuals with behavioral issues, has become increasingly difficult to find, as you can't simply hire a babysitter to take care of someone with a high level of need. She stated that rates have a lot to do with this and, in addition, there are some licensing barriers that may not be related to rates. She also mentioned homemaker services for people with very high support level needs, which she stated are increasingly difficult to find. She stated that squaring the anecdotal data that this is an issue with the available data on what is billed is a major dilemma, but that there must be a way for the Department to investigate how many units of service, or how many people have been authorized to get a service, that just can't get it (which you can't get at by just pulling claims data).

Marijo concluded by pointing to the data set that the Department presented. Under the DD Comp waiver, it indicates that the number of providers (145) has not changed over a three-year period; Marijo stated that the number of such providers approved to serve Medicaid clients has increased significantly.

- A parent of a 17-year-old son with a medically complex case, spoke next. She explained that her son has been on the CES waiver for many years and that their family has never been able to access adequate respite services. She stated this was, in part, because of the complexity of his needs (for example, g-tube feeding) and the low reimbursement rate. She recommended that the Department possibly look at clients on scale (like the CIS evaluation that signs levels to adults), based on the complexity of their case. She also noted that CNAs cannot provide certain respite services and wondered if an LPN or RN, who would be paid at a higher rate, could provide some respite. She stated anything is better than nothing.
- A parent to an adult child who requires 40 hours of respite per week, spoke next. She stated that her family also has a hard time getting their RFP filled. She reiterated that individuals with medically complex needs cannot be left with a babysitter. She stated that, as a parent CNA, she went through the 30 hours of required training she is scared to leave her child with someone who is not qualified. She noted some of the challenges parent CNAs face. For example, as her parents age they can no longer help, and she needs to work to make her house payments and keep her primary insurance, which covers some of the care that Medicaid would otherwise have to cover. She concluded by asking

how families can best provide the Department and the committee with information regarding their challenges in accessing services. She noted that Kids Mobility serves 1200 families and offered to coordinate with those families to provide data.

- Tom Rose stated that someone would reach out to Christie for more data.
- Another parent with the Respite Coalition shared her family's story. Her adult son, who has high behavioral needs, is presently in the regional center. Her goal for him had been to keep him out of the regional center but, when he turned 18 and switched waivers, the family were only able to find three providers able and willing to work with their son, at the higher Community Connector rate, and only minimally throughout the week. Due to the lack of respite providers, a group home became the necessary care alternative. She stated that her family likely saved the State a lot of money during the time her son was at home. She provided the example that her son went to the ER once while at home but twenty times in the group home. After two years, the group home could no longer take care of him based on his complex needs and he was then moved to the state institution. She stated that, to keep her son in their home, which is where her family would prefer him to be, the rate must be diversified, children aging into adulthood must be given a higher level of behavioral support, and the State must make sure two people are there to provide care to adults with her son's level of behavioral complexity. She also emphasized the emotional toll this takes on a family and thanked the Department and the committee for what she described as an amazing meeting.
- Lisa Miller, a data analyst with a behavioral services agency, seconded comments previously offered regarding the insufficiency of reimbursement to frontline providers. She stated that providers report that the cost of driving from home to home, which can also take up to three hours a day (meaning they provide direct care for only five hours a day), results in them netting "about \$500-600 a month". She also stated that the utilization metric is concerning to her because there isn't a corresponding metric on authorization. She noted also that, different community center boards will write prior authorization requests differently; some will base the units requested off of a prescription but others will base it off of provider availability (i.e. what they think the client can get, not what the client truly needs). She also reinforced earlier comments that one of the reasons respite services are not being utilized more is because the families most in need of respite services (because their children have higher levels of complexity) are the families who have difficulty finding respite providers willing to take them because they cannot accommodate that level of severity of the behavior or medical need.

Lisa offered multiple possible solutions for the Department and the committee to consider as they generate recommendations. They included:

- Matching credentialing and regulations across all waivers, which may make it easier for staff to provide additional services and cut down on agency overhead.
- Supporting the education programs in the state, both at the undergraduate level, such as establishing internships to get people into the field, and at higher education level. She stated there is one new program in Colorado to certify someone as a behavioral analyst and this does not meet the need.
- Increasing communication and efficiency regarding paying providers and avoiding late payments, which contributes to additional administrative overhead costs.
- Prioritizing care providers within the Affordable Housing program.

- Josh Winkler, representing the Colorado Cross-Disability Coalition, pointed to the three handouts CCDC submitted to the MPRRAC (see links to those documents earlier in these meeting minutes). He then made several points, building off of what was previously discussed in the meeting. He pointed out that words matter and that the first slide of the presentation states that the purpose of the committee is to assess whether rates are sufficient to ensure provider retention and client access. In his view, the purpose should be to ensure client access first, and provider retention second. He noted that, while he appreciates that the state rate comparison information was likely presented at the waiver (rather than the service) level for ease of facilitating the meeting, “at best it is meaningless and at worse it is misleading.” He noted that most providers only provide one or two services within a waiver and most clients only receive one or two services within a waiver, so looking at a waiver rate average doesn’t say much about how comparable rates are. He noted that one service rate could be at 30% while another is at 300%. Josh also stated that there is an institutional bias within Medicaid in general; at the federal level CMS states home and community based services are only required if they are cheaper than providing that care in an institutional setting. He stated that most of the time they are, but sometimes they are not. Josh stated that it is important that community based services are just that, community based, and that they are not simply institutional settings with a different sign on the door. He stated that the minimum wage increasing become an issue in the next few years. He cited the example of CDASS clients, who receive \$15.44 p/h and who, after paying employer side taxes, are only able to reimburse their caregivers, at \$12.00 p/h.

He concluded that it is important for the Department be as transparent as possible, including the importance of getting handouts and other materials up on the website prior to the meeting so that stakeholders have time to review and that, per sunshine laws, anytime two or more committee members get together (for example, in workgroups) those meetings be made public. He also requested that the Department and the MPRRAC listen to the family voices present today, especially because there is no disability representative presently on the committee.

- Lila stated that the sunshine laws do not apply to the MPRRAC. CORRECTION: The sunshine laws do apply to the MPRRAC.
- Chad Weitrack, regional director for Bethesda Lutheran Community, a non-profit entity, spoke next on both the SLS and CES waivers. He passed out a [financials handout](#) with data dating back to 2010. He summarized the handout by stated that it depicts a loss that equates to about \$74,000 every year, for a YTD total of \$500,000 since 2010. He noted that the information he provided does not include day habilitation services provided through the DD and SLS waivers, but that they are paid at the same low rate. He stated rates and access go hand-in-hand and pointed to a decision his organization is scheduled to make on March 27th regarding whether they will continue to provide these services (which could impact 100 clients).
- Tom Turner, executive director of Community Options, a community center board that serves six counties in south western Colorado, also provided [handouts](#). He explained that Community Options provides services under the DD, SLS and CES waivers to 500 people across those six counties. He explained that the handouts illustrate the 2009 rate setting process that Marijo Rymer previously described, at which time the State “backed into” the DD waiver rates at 76%. He stated that, effectively, since January 1,2009, his organization has been operating at 24% under their costs for providing those services.

Tom also pointed to the third page of the handout, which includes data from the Colorado Department of Public Health and Environment, showing that licensed group home facilities have decreased from 196 to 144 since 2007. He stated that this was due, in part, to the fact that the service model is not as popular as it used to be, but that there are still people who need or desire the service. He stated that no new group home licenses have been applied for since 2014, while 31 were relinquished in that same time. His organization recently closed a group home for five people because they cannot afford to provide that model of service anymore.

He also pointed to SLS rates on page 4 of the handout. He stated that his organization has lost \$980,000 on Medicaid SLS over the last seven years, even though their allocated overhead is between 6.1% To 9.4%. He explained that the rates don't cover their costs and attributed the loss to the felt responsibility to meet the need even if they will lose money.

5. MPRRAC Discussion

Throughout the public comment period, committee members made several observations.

- Tom pointed out that the issue of paying a living wage would likely be a recurring theme throughout the public comment period, that it is a complicated issue and that the committee will have to think about how best to address this issue in their recommendations.
- Tom stated that he thinks the committee should also factor in the documentation the Department requires providers to submit. He suggested that staff paid minimum wage may not provide quality documentation and that the time spent on the activity may not be worth the return. Tia added that new CMS regulations include additional documentation requirements, which require time, energy and money to address.
- Lila pointed out that the rate review process also requires the Department and the committee to look at non-fiscal factors. She pointed out the workforce theme present in the public comments received and encouraged stakeholder to think about, and provide comment on, were the rates to be sufficient, what other factors would still contribute to quality and access.
- While discussing personal care and homemaker services in the EBD waiver, Tom suggested that the committee may want to think about whether to recommend an upper limit on operating costs as a percentage of total funds paid to, for example, Class B agencies.
- Jeff Perkins wondered aloud to the committee if the committee should create another committee guiding principle around keeping up with mandated, hard increases in costs (like increases to the minimum wages). He invited the committee to think on this.
- Jeff Perkins stated that, if increasing reimbursement for assisted living can increase access and save the state the money that would otherwise be incurred by providing these same services in a nursing facility, it is a point that the committee should make to the legislature.
- Rob DeHerrera wanted to make sure the Department and the committee understands that, in the past few years, the waitlists for CES and SLS have been abolished. While this is a good thing, it has

also taxed the capacity of providers to provide services. He wondered if the Department could look at the number of people who requested these services vs. the number of people receiving these services, so that we can see if the spike in access is growing in proportion to the demand.

- Jeff Perkins noted that it would be helpful to compare the number of people approved to the number of people who utilized services. Lila explained that the Department did attempt to look at percent of authorized units utilized but the initial data pull was too problematic. The Department will continue to work on this but not in time for the Analysis Report.
- Tom took a moment late in the stakeholder comment period to remind stakeholders in attendance that the committee's role is to make recommendations to the Department on process and rates that may be outliers but that it cannot change rates. Ultimately, the Department will provide recommendations to the JBC, that are informed by the committee's recommendations.

6. Meeting Adjourned