

Participant Directed Programs Policy Collaborative Meeting

July 24, 2013

MS Society 900 South Broadway Suite 200 Denver, CO 80209

1:00-4:00 PM

Motion in italics

To do items highlighted

Executive Summary:

There were audio problems which caused limits to the phone participation. This is being worked on and until it is fixed the old phone system will be restored for the next meeting. Several important topics were covered at this meeting including a follow up on employee health benefits. The employer mandate is postponed for one year. Our attendants have to purchase health insurance through the exchange if they are uninsured on January 01.

We reviewed the status of several recommendations, and made two recommendations regarding implementation of CDASS in SLS and CES in the upcoming waiver renewals. We received information on a CDASS cost study that is in the early stages and provided input for additional questions. Public comments focused on a few issues related to PPL communication.

John Barry called meeting to order at 1:05 p.m. Introductions were made and the following people were present:

On the Phone

Kelly Morrison

Robin Bolduc

Kelly Tobin

Don Riester

Heather Jones

Margaret Proctor

Sueann Hughes

Stacia Haynes

Maria Rodriguez

Kathy Forbes

Martha Beavers

Jessica Tribolet

Mark Simon

In the Room

Mary Colecchi –Co Chair

John Barry- Co Chair

Liz Wuest

Matt Wuest

Rhyann Lubitz

Alan Wiley

Dawn Russell

David Bolin

Ann Dyer

Debbie Miller

Gabrielle Steckman

Tyler Deines

Roberta Aceves

Candie Dalton

Linda Skaflen

Linda Andre

Douglas Howey

Jose Torres-Vega

Sam Murillo

Bonnie Silva

April Boehm

Tiffani Rathbun

Sean Bryan

Louise Apodaca

Tim Thornton

Julie Reiskin

Housekeeping and Voting Rights:

- Linda explained voting policy and reviewed who is and is not eligible to vote.

- Linda will put voting protocol on one page and John will put on the back of the agenda in the future.
- The question came up of whether paid attendants who are not family members can vote. This is not addressed in the protocols (family members who are paid attendants can vote) and will be discussed and decided at the next meeting.
- Co-Chair Mary Colecchi reviewed the agreements and asked that people email her with any questions and concerns. Her email is marycolecchi@gmail.com. If people want to get on the distribution list they should contact John Barry at john.r.barry@state.co.us. All other issues should go to Mary including any new members who want a briefing on issues addressed and in process by this group.

Minutes: *Jose moved and Linda S seconded that we accept minutes as written. The motion passed unanimously. The final June minutes will be posted on the website shortly.*

Follow up on Affordable Care Act Discussion:

Candie took the lead on this discussion and passed out handouts (on website and were sent out by email).

Candie said that the minutes of the June meeting indicated that we had questions which were left unanswered.

The handout is the attempt to answer questions. The biggest issue is that the employer requirement has been pushed back one year to 1/1/15. However the individual mandate still applies on 1/1/14. This means our attendants will have to get insurance through the exchange. This allows for separation of the two issues:

- 1) What kind of Fiscal Management Service (FMS) is best for Colorado overall?
- 2) What is the best way to get our attendants insurance?

FMS: Candie said that commitment to have us involved with everything –including any changes with the FMS will be honored. She said HCPF needs to make decisions with our collaboration. She sent an email about a preliminary meeting to begin discussing this scheduled for August 6. However there are numerous conflicts with this date so she will reschedule on or about August 16th and send a new notice. Candie said this is the first of

many meetings to determine what we want in an FMS. We have to decide what structure we want. Sean was asked to get us a timeline on what has to happen throughout the procurement process. The current contract with PPL ends 12/31/14 so we have that amount of time to decide what model we want and put out an RFP/

The first meeting will begin with an overview of each model that CMS allows. Then we will use this to make a decision and that decision will inform the RFP process. Any comments or questions about this should go to Candie.

Comments:

1) Candie was asked to make sure all FMS related information that we requested is sent to us. This should include questions sent by Julie Reiskin before the last meeting. Members need to know what FMS spends on various tasks. Candie said PPL gave HCPF broad information that she will provide. They are working on obtaining narrower details.

2) How will our attendants get information on ACA requirements? HCPF will create information and vet it through this group. Candie will send us a draft before the meeting she is planning.

3) We had a discussion about sending out a “Request for Information” RFI. This would be sent to any FMS in the country along with other agencies that might want to provide some or all services, such as payroll companies. An RFI would ask them for ideas and thoughts about what services are helpful, ideas for cost effective ways to manage this program, and how they would provide health insurance to this population of workers. We could explore other models or questions about what different levels of service cost. Sean was nervous about what an RFI might do to the RFP timeline which is already laid out and complex. Julie asked Sean to ask procurement if there was any prohibition against the state using information from a NON governmental RFI process—for example if some interested entity—such as a non-profit that is not under contract

with the state puts out an RFI can that work concurrently with the education and formation process for the RFP?

Would that alleviate timeline concerns? Sean will find out and get back to us.

Expansion:

Linda Skaflen made a brief presentation on the background related to expanding CDASS into the DD waivers.

- 2005 the legislature made CDASS available in all waivers.
- 2006-2008 Changes in the DD system were prompted by audits and requirement to better track dollars.

Some of the results were implementation of the SIS (Supports Intensity Scale) which is a point based ranking system that is supposed to determine the level of need for services. In Colorado it is used to create an allocation of dollars based on a numerical score. Colorado created the SPAL (Service Plan Authorization Limits) that sets annual limits for SLS participants for the different levels of the SIS. As a result of these changes many clients using the Supported Living Services waiver lost significant amounts

of services which impaired their ability to live independently, put people at risk, and caused serious challenges to families that were trying to care for people with DD.

- 2009 Advocates and clients went to the JBC to ask that CDASS be implemented in the SLS waiver because allowing (we didn't ask for all services at that time) services to be delivered using the CDASS delivery method would alleviate some of the serious problems faced by clients in this waiver. In other words, if clients and families could have access to the CDASS service delivery option, they would be able to stretch some of their available funding to prevent service loss
- 2008-2010 Sometime during the waiver renewal process CDASS was actually put in the SLS waiver and was approved by CMS but never implemented by HCPF.
- 2010 - 2011 At some point HCPF was put on plan of correction because CMS disapproved of how we paid the fiscal agent and said we could not use a percentage and had to go to the current method of a per member per month figure. The CDASS option in the SLS waiver was removed because DDD did not think they would be able to implement it given this problem.

- 2012 After a presentation to the JBC PDPPC replaces CDASS Advisory Committee and made numerous improvements to program.—focus has always been about expansion and all issues HCPF said needed to be addressed for expansion have been addressed.
- 2012 HCPF complied with the CMS requirement and the plan of correction was lifted.
- 2013 January. The JBC was again approached about the need to have CDASS delivery method available in most or all waivers and for most HCBS services. The JBC was made aware that SLS and Brain Injury were particular needs.
- 2013 February-March PDPPC and other advocates were under the impression until recently that SLS expansion was moving and that a waiver renewal would be starting in August with implementation no later than 7/1/14.
- 2013 March-April. The fee paid to PPL of \$310 per person per month is too high and if charged to SLS clients using only personal care and homemaker as benefits would seriously impact their annual fund availability because the average allocations of SLS clients are lower than the typical allocation of EBD

clients. This is due to generally lower medical needs and no inclusion of “skilled” home health (aka health maintenance). The state considered going to the JBC with a budget request and advocates particularly Linda Skaflen and Julie Reiskin objected as this would make it appear as if CDASS was a more expensive option.

- 2013 May/June DDD stated they were not willing to include the CDASS option in this waiver rewrite. In the meantime other options have presented themselves including
 - PPL is willing to do a separate contract for these services, most clients have family helping and DD clients have higher levels of case management support so the need for “support” is less.
 - Including all SLS services would help balance services versus administration.
 - While there will likely be improvements from Community First Choice and may be improvements from waiver simplification these are long term projects that have not even been approved by the legislature yet. Many people involved with PDPPC are working on these options but for the distant future.

The current SLS system has become very problematic. The rigidity of the Service Plan Authorization Limit (SPAL) process and the lack of viable service delivery options create ongoing obstacles.

Discussion:

- 1) Should we make this about ALL waivers? Decision was NO let's stick to DD for now and come back to any others another time. This is a specific issue relative to the DDD system that needs to be addressed.
- 2) It is our understanding that Reggie Bicha during a JBC discussion indicated he was supportive of the CDASS option and it would be implemented in the SLS waiver.
- 3) The CDASS service delivery option in the CES waiver would have the same benefits as in the SLS waiver and in addition would allow parents to be paid for providing extraordinary care for a child.
- 4) In SLS due to the systemic problems caused by the Supports Intensity Scale (SIS) and SPAL, services are very much a patchwork, this means that one has numerous agencies and people in and out, the different providers do not talk to each other. This causes health problems to not be addressed and makes things worse

for people whose very disabilities require consistency. This leads to excessive administration. Having all SLS services provided using the CDASS delivery method would help reduce confusion and improve quality. This would enable the client to have his or her needs supported rather than being pawns in a system that is supporting silos and agencies. There may be a few exceptions such as Behavioral Therapy in both SLS and CES that could not be provided by family members.

5) A one year delay in implementation allows for all implementation to be addressed since the majority of the details are already in place with the current CDASS options. It also will happen after DDD moves to HCPF and the inclusion of the “Health Maintenance Service” will be easier within the same department.

Linda S. moved and Jose seconded that PDPPC formally request DDD, CDHS and HCPF to include CDASS in the current waiver renewal to be submitted by year end December 2013. The waiver should be written to allow most if not all SLS services to be delivered using the consumer directed delivery model of CDASS (client can hire whom they want to provide the support they want). The service deliver model needs to include the health

maintenance option. The recommendation includes up to a one year delay for implementation to allow the details such as a specific contract with PPL to be negotiated. This means services must be available using a consumer directed delivery model no later than 7/1/15. The motion also included that the recommendation be shared with the JBC.

Linda moved and Jose seconded that PDPPC formally request DDD, CDHS and HCPF that the current CES waiver renewal to be submitted by year end December 2013 for implementation in July 2014. The waiver should be written to allow most if not all CES services to be delivered using the consumer directed delivery model of CDASS (client can hire whom they want to provide the support they want). The service deliver model needs to include the health maintenance option. This waiver renewal should include the provision to allow parents to be paid to provide extraordinary care for their children. The recommendation includes up to a one year delay for implementation to allow the details such as a specific contract with PPL to be negotiated. This means services

must be available using a consumer directed delivery model no later than 7/1/15. The motion also included that the recommendation be shared with the JBC.

On both motions all voting members voted YES with Mark Simon abstaining because he could not adequately hear the discussion. Both motions passed

Mary Colecchi will get the recommendation sheet from Chanda and will get this formal recommendation to HCPF, DDD and CDHS and copy the JBC.

Work plan and recommendation updates

- 1) Allocation development process: Candie received some but not all results from the pilot and there were only 14 studies and all but one show increased allocation. They are not all in but this was perplexing to people and some discussion included:

- a. Was this due to clients new to CDASS who did not do initial allocation conversation properly due to not knowing what to say?
 - b. Were any of the people those with progressive conditions or other reasons to change allocation?
 - c. Is there a factor of change causing increases because the implementation of the task sheet also caused increases?
 - d. This is why ALL changes should be piloted before full implementation.
- 2) Crisis situations: Candie has started to address this and realized that the PAR process is more complex than she had thought. She has set up meetings to discuss this process and wants to do overall work to streamline which will help not only this particular recommendation but the whole system. She learned about this in the process of doing the revisions for the increase.
- 3) The physician statement will be ready to go next month. Will be required every two years. Question about if this is used for IHSS. At this point no but agreement that we should look at using the same form for both programs, so if someone is not in stable health the doctor does not have to be bothered again. Candie will

review the form they use now for IHSS and see if it is the same and then determine if we need anything different.

- 4) Protective oversight: the document will be ready for final review next month
- 5) BI expansion is on track for 1/1 start date.

Cost analysis of CDASS:

Candie explained that she had been working with Josh Winkler, Jed and several others to do a cost analysis. This is the very first step and they learned some information but more data is needed. Candie reviewed handouts and emphasized that this is the beginning of a much bigger project. We are on the cutting edge in getting this level of data and asking these important questions.

The research included a cohort analysis, a clinical risk group analysis and compared people over two years between those in CDASS for the whole period, those never in CDASS and those who started in agency care and went to CDASS..

- They were compared based on the ULTC 100.2 scores to compare similar populations.
- They looked at fiscal years 2011 and 2012.
- They did not include IHSS but will be doing a similar study with IHSS
- They did not have Medicare data
- They did use all Medicaid expenses, both acute care and other HCBS services.

This shows CDASS to be quite a bit more expensive but they realize not all the facts are in and more research is being done, they expect it will still show more expensive and we need to be able to explain why.

What they do know about consumer direction is that people get their needs met. Is the difference in cost, which is 56% solely attributable to people not getting needs met in other models? We know there are other factors including:

- There are service limitations that do not apply in CDASS such as other clients not being allowed to get care in the community.
- People previously unpaid are paid on CDASS.

They tried to look at urban and rural but did not see difference.

We need to figure out how to address falsely low ULTC scores in people whose needs are not captured because the case manager knows that there are no services available.

Other suggestions for continuing”

- Remove outlier clients, those with very high needs such as vent users who are all on CDASS and cannot be compared because they cannot be served elsewhere
- Eliminating DME as this is high cost
- For people new on CDASS how much time does it take to get healthy-especially if the person came from a nursing home
- CDASS clients have only half as much emergency room use as others.
- The Unit cost is the same so increase means that more services are being delivered.

- Quality can look different than mathematical but can be reflected in mathematical tiers and we should try to do this.
- Candie wants to participate in the Care Coordination Subcommittee of the CLAG who is looking at what is quality and how to measure it.

Candie said HCPF knows that CDASS works and quality is good and this is not being used to stop anything but used to get answers to make sure that there are valid explanations and that we have the right data in place.

The group expressed appreciation for data and is interested in pursuit of more data to answer the questions asked here.

New Business:

Candie reported that there were two issues going on regarding the allocation increase for 7/1/2013. She is trying to figure out what is going on and does not yet have an answer but is working on it.

1) A few people had decrease retroactively after the 7/1 implementation occurred. Candie assured us that there will be no negative consequences or letters for someone who appears to be overspending solely due to this issue (in other words had NO overspent funds until after 7/1 and then the overspent funds were only there due to a retroactive change.

2) Some clients got letter saying what the previous allocation was and what the new one will be but then PPL is coming up with a different number. This may be due to CDASS periods which continue to require additional explanation.

The best way to address allocation issues is by looking at cost per day. Clients do not currently get info on what units are approved for what services and are not told what their cost per day is and it was suggested that if clients could view that part of the portal that would be helpful.

Public Comments

1) Concerns expressed about how the payroll glitch of 7/23/2013 was communicated (or not communicated) to supervisors. We again asked for an email list to be set up so PPL could send an email blast when something like this happens so clients as supervisors can communicate with our employees. PPL said that they addressed the problem immediately when they learned about it and apologized and staffed up for calls and tried to call employees. PPL again said they were working on getting the email blast set up.

2) Process to get rates increased: Comments were that there should have been direction in the newsletter reminding people to do rate change forms and telling people how far in advance the forms needed to be in. People felt there should have been communication encouraging clients to pass the raise on to workers. PPL said that HCPF dictated the messaging and HCPF said they do not tell other providers how to use the raise and did not feel they should tell CDASS clients how to use it either. It is always hard to get notice ahead of time

because they cannot do anything until the governor signs the long bill. Rate change forms will apply the pay period following the one on which they are sent in—so if you send a rate change form on the 15th it will be effective the next payroll period on the 16th. If you send the form on the 2nd it will still be effective the 16th. They cannot do retroactive pay increases.

3) A future agenda item needs to be how to get the CDASS delivery model into most if not all HCBS waiver services.

4) The MS Society said they would reactivate the phone we used to have while they work on fixing the microphones.

Respectfully submitted

Julie Reiskin