# Participant Directed Programs Policy Collaborative Meeting (PDPPC)
# Wednesday October 24, 2018
# STAKEHOLDER MEETING MINUTES APPROVED

## Executive Summary:

***We got a summary of the CDASS and IHSS evaluation from TriWest along with numerous documents. The evaluation showed improved health outcomes and satisfaction but cost data was inconclusive except that participant direction is cheaper than private duty nursing or institutional care. Questions were answered. We also got a nice report from DORA about the IHSS sunset review. They recommend expansion to all other waivers and continuation for 7 years. We are getting a small pay raise 1/1/19. Rule-making committees for both CDASS and IHSS were announced as was an opening for a position based on Mallory Cyr moving to a new position. We also discussed EVV, coverage during hospital stays, and attendant pay in open forums.***

At 1:02 PM Rhyann opened the meeting and John Barry was out. Roll call was conducted and voting rights were shared.

**Minutes** September: Kevin asked if anyone had corrections or additions. There was none and a motion was made by Kevin and seconded by Linda and approved unanimously. John will post them to the website.

## Open Forum #1

1) ELECTRONIC VISIT VERIFICATION OR EVV: Renee Farmer and Curt: Electronic Visit Verification: Renee asked can we do a summary of EVV updates each month? Are other people participating in meetings? They do not always do a roll call of everyone. Curt said there is a big contingency of participant directed people there. This includes Josh Winkler, Mark Simon, Curt, and others. He said that they are still trying to figure out how to proceed on a voluntary level in January but is not sure that will happen.

On 11/7 there is a meeting with CMS to ask for feedback. We can send in items for discussion on that meeting. CMS is opening up this meeting to stakeholder feedback**. People need to send in questions by 10/26. You must use the subject line November 7 Stakeholder call feedback and send the email to EVV@cms.hhs.gov . This is a call in 1-800-837-1935, ID 33979177. It is at 11 am to 1 pm our time**. This information is online at the HCPF EVV site. Curt said there are 40 or 50 people on the call. He said there is a lot of discussion about if participant direction should be part of this at all and if not why. There is a feeling that maybe there are unintended consequences but

also some people feel there is fraud that has to be addressed and we cannot lose this program. Any changes about exempting participant direction will need to come from Congress.

2) PAYMENT FOR ATTENDANTS: Cathey Forbes reported that she came up against a problem this week while hiring a new attendant. The attendant had worked for another employer. When the time sheet was submitted the employer was informed by PPL that the employer did not have the money from that time period to pay the attendant. Kathy asked is there something that can be done because CDASS could get a bad reputation if people are not paid? Is there a remedy that the attendant can take? Rhyann said they could have a conversation offline because the only reason someone would not be paid is if they were not approved to be an employee by FMS, did not have a prior authorization request, or the funds were depleted before the certification period ended. It was also mentioned that the attendant can file a labor board complaint. This is a very serious thing. We need to assure that work performed is overseen by supervisor (client or AR) and this is important. It was suggested that the client should reach out to HCPF. Cathey heard this from a potential attendant (who was now not interested in more CDASS work) and does not know the client. Curt said in addition to the labor board people can come to PDPPC because this is for all stakeholders including workers. Mark said we need to protect attendants as well because clients on SSI and SSDI are immune from collections.

## CONSUMER DIRECTED CARE EVALUATION:

Numerous documents were sent out. TriWest gave overview. There are many documents and a lot of information. The group agreed on the approach.

Tanya said she would recommend group review the final deliverable and survey document which is the bottom line. There are three main findings.

1) Health outcomes –CDASS and IHSS are better based on lower Emergency Department (ED) and hospital use as well as self-reported health.
2) Satisfaction—much greater satisfaction with CDASS and IHSS
3) Costs—fairly inconclusive but can say costs are lower than Private Duty Nursing (PDN) or facility care. They could not give accurate assessment of a cost difference between CDASS, IHSS and agency care. There are so many variables with waivers. Overall spending trends are stable.

**Discussion:**

ED visits and hospitalization: IHHS and CDASS had lower rates of ED and hospitalizations than comparison group (agency care is comparison). However when the costs were looked at it changed, when people on CDASS and IHSS went to an ED or hospital the costs were higher, but the rates of going were lower. It was further complicated because this is Medicaid claims data. Medicare is a factor with this population. There were zero dollar claims so there was a

visit but Medicare (or some other insurance company) picked up the cost. Medicaid is payer of last resort. They are confident that rates of use are better for CDASS and IHSS (meaning we use the hospital and ED less) but the cost data was inconclusive.

The service costs looks higher for IHSS and CDASS in some waiver programs. However the per day costs was not possible to compare. IHSS and agency break out by service (health maintenance, personal care, and homemaker). We do not know what services were rendered on what day. CDASS may have a higher cost it is inclusive of all services. Using IHSS or agency care a client might have several different services in a day. It may be either much lower or much higher. Example if someone gets health maintenance plus homemaker plus personal care that daily cost would be higher, whereas if someone got only homemaker it would be lower.

The trends in price changes were consistent between programs –if costs increased in personal care for example, it would increase across programs.

Linda asked if comparisons were done by waiver. YES. The Children's waiver showed the best results between agency and IHSS. (There is no CDASS in this waiver). TriWest pointed out specific issues to the department such as repeated comments from clients that said if they were not able to receive CDASS or IHSS, they would not get services in the community due to high needs that agencies could not meet. TriWest did control for diagnosis code, gender, age, but could not control for needs that could not be met by agencies. However this issue was repeatedly heard in interviews.

TriWest did find if you compared to PDN or SNF it was much cheaper. They did not have time or have the data to understand what the cost was if you used more than one service in a day – for example home health and homemaker. They are actual costs per day. On any given day the services could be different.

Mark asked is there a comparison including hospital and ED and all other medical and non-medical waiver care received by CDASS and IHSS compares to both agency and institutional care. They did try to do that but the way the data was pulled because they were so careful about comparison group they noticed some claims were not in the data file. They are concerned that some other costs may not have been captured. They tried to look at people with comparable services. It was a time limited study—in retrospect they could have pulled all IDs not just service type but that would take more time. Mark said the overall question from legislators is what is the cost? Mark said we sold home care originally based on home care being 1/5 the cost of institutional care. Is this program fiscally sound, is it saving money? This is true but someone has to account for Medicare. This would be a more extensive study. They did not want to make a statement that a policymaker would misinterpret. At the very minimum the cost of CDASS and IHSS are still cheaper than PDN or facility care. Combine that with finding that we have lower rates of hospital and ED use there are definitely cost savings. Mark said in the future we should look at both total cost and cost to state. The all payers claims database could help but there are problems.

Overall the satisfaction with services is MUCH higher for CDASS and IHSS than for traditional services.

Other states have likely run into the same issues because when TriWest looked at other states there was no data on cost but lots of data on satisfaction. Colorado satisfaction is even better than other states. There are other studies going on that can provide more context at a later date if we do more research.

Julie asked if they knew why costs differed so much by the year. TriWest was not surprised because HCPF changed data system during this time. Costs in general spiked in 2016 for all services and no one knows why.

Linda asked if rate increases were factored in when they looked at cost increases. No, they did not factor in rate increases. Linda said this needs to be identified with legislators.

Julie said that HCPF needs to have some clarification added about inaccuracies related to comments people made, for example someone said something about a homebound requirement for IHSS which is not real. While it was a verbatim comment as these are public we need to make sure people understand. Rhyann said this is why she does the cover letter but agreed we should try to be clear as much as possible.

Rhyann does not think that this is a final product and we need to internally figure out how to get better data pulling techniques and figure out what we do to have better assessments. As they change assessment tools they have a better way to tie acuity to actual service costs. Rhyann wanted to make sure there is an accurate product with no inappropriate conclusions. Linda asked if some of us should email Rhyann any specific suggestions. Rhyann agreed. This was a lot of data.

Tanya was thanked

## IHSS SUNSET REVIEW:

If anyone wants a paper copy Erin will mail it upon request, but it was sent electronically. Hard copies were sent to the snail mail list.

Erin introduced Ellen from DORA to discuss the IHSS report. Ellen explained what a sunset review is: When there is new legislation the general assembly puts an expiration date and before it is extended her office at DORA reviews and recommends if the program should be extended and if so should there be changes. Should this exist to protect the public and is this the least restrictive based on public interest. They get feedback from as many people as possible. How is this working, it is working in a way envisioned by the general assembly. It is a ten month process.

Ellen explained the recommendations.

There are only three recommendations:

1) Continue IHSS for 7 years until 2026. The program is good and working well in recent years has been taking off. People are benefiting from it. Stakeholder feedback from participants and caregivers as positive as she has ever heard in state government. They recommended longer continuation than in the past because the program seems to be thriving.
2) Revise definition of eligible person to be anyone that can receive services for any HCBS waiver. This paves the way for expansion of this service delivery option. This gives HCPF flexibility to expand as it is feasible, which requires waiver and rule changes. This will pave the way and remove the barrier.
3) Some technical changes. Remove obsolete language.

It has been assigned to a bill drafter. Someone will draft based on this report. It will be presented in January. It will get a sponsor and go through the legislative process.

Erin and Rhyann were applauded for getting us to this. Ellen agreed that this has been a great improvement and is fulfilling its potential.

Sheryl from Mesa County asked about the definition of eligible person. It does not include the mental health waiver. The reason is to mirror the CDASS language and expand to all waivers, not calling one out. Erin said CMHS is a priority waiver to add IHSS. She is working on a memo and then there will be a lengthy department process.

Linda –there is a difference between available and mandated and she is living with 15 years of trying to get CDASS into SLS. It is a service delivery option and should be mandated. Erin said she agrees and everyone seems to want expansion. There is concern about growth and doing it well and making sure the training is good. Erin said that IHSS needs to be running really well with a strong handle on growth before expansion and she wants to make sure the expansion happens in a reasonable timeframe.

Ellen said from a global view one of the purposes of sunset is to remove statutory impediment and this will remove an impediment, there will still be other barriers. If this passes at least HCPF can implement without having to go to the general assembly.

Linda said that there should not be a fiscal impact in SLS because there are mandatory limits on costs no matter what someone needs. So a client cannot spend more than a certain amount so there is no way to spend more than a specific amount.

## **IHSS UPDATE**:

Erin said that she wants to clean up some areas of IHSS: The IHSS work group is a subcommittee of PDPPC. There have been different subgroups and she wants to add some structure. The IHSS subcommittee meets every other month. If you want to attend let her know. They will finalize the rules that they have been working on. Then, they are going to

have a couple workgroups. We need to formalize influx of providers and participants. One work group will work on a participant guide with Consumer Direct . Another group will look at rules and upcoming rule change for next year. Please email Erin.Thatcher@state.co.us if you are interested. They need more participants or ARs in IHSS to join. Louise Apodaca asked to be put on the list.

## RATE INCREASES JANUARY 01 2019:

Rhyann is in the middle of the work to implement rate increases in EBD, CHHS, BI and SCI waivers. She is doing a rate increase for waivers 1/1/2019 excluding SLS which will have a rate change 3/1/2019. This is new and exciting to have SLS. Case managers will be starting on that process after training which begins on 11/6. There are 3 or 4 trainings for case managers showing them how to do a rate change. (They only need to go to one, there are just several options). The case manager has to do a PAR and go into FMS portals to make the changes. Then the case manager will send a letter to the participant and/or AR. The AR has to receive a copy per PDPPC feedback. The letter should say what the original allocation is and what the new amount is effective 1/1/19. She has given case managers through 12/10 to get these in the mail so they have a month.

Julie asked what happens if the case managers do not get it done in time. She said the case managers at the largest SEP are completely overwhelmed and may not get to it. This is not because they are bad but just completely overworked. Rhyann said that if there is an existing PAR the old allocation should be there. If 1/1 is the start date for the certification and it does not get done that would be a problem. Rhyann is adding this issue of getting PARs done in time to training of case managers. She thinks this will work fine because in the past they had to be done in 2 weeks and this time there is a month.

Curt asked if there is a delay is it retroactive to 1/1. Answer YES.

It is up to client about how to pay attendant. Some adjust rates 1/1 others wait until 1/15. Curt said last time it was effective to beginning of cert period and it was confusing. Rhyann said the FMS should freeze account display so it shows accurate allocation amount before and after 1/1.

Kitten asked if all three categories will see a raise and this will show up as an amount and the client has discretion to increase wages, change hours, increase hours. Answer is YES: If client/AR wants to increase wages they have to get with FMS and do the paperwork for a new wage. It will not happen automatically.

Linda asked if someone does not get a raise will FMS retroactively pay the worker. Rhyann said there are two issues: The rate is what clients get. The wage is what the client directs. If a client knows they want a different wage they need to submit the paperwork before the effective date. The allocation rate increase begins 1/1/19. If there was an error and budget was not updated but someone submitted for a raise it might look overspent. This will be fixed when it is

corrected. This can be identified by the case manager to consumer direct. Julie and Rhyann said each FMS has a different procedure for raises. Work with the FMS to determine the process.

Julie said she thought that people should use the rate increase for raises to make it better

New rates for personal care and homemaker are: 15 minute rate $3.75 or $14.99 per hour

New rate for health maintenance are: 15 minute rate $6.64 or $26.56 per hour.

This is the adjusted rate with the 10.75% reduction for overhead already taken out so this is exactly what we will get for our workers.

Kitten asked if this includes the FMS cost. There is a per member per month cost to FMS that is totally separate but when we pay workers we still need to figure out employer taxes and costs (each FMS does it differently).

Katie said if they are not sure if your budget supports an increase people can call Consumer Direct. This is why they are there. If you have any questions or want an extra eye on your budget they are always available.

Curt said that people fought for the raise but it is pretty small and we need to keep pushing for increases because minimum wage went up a lot and we are way underpaid compared to other industries with comparable work.

## CDASS RULES SUBCOMMITTEE:

Rhyann said this group meets Monday 10/29 at 1:30 and is desperately missing clients and ARs. They did work before and took a break and now need to put in what the utilization review committee recommended. She also wants the group now to visit a few other areas such as looking at service limitations (e.g. no services when someone in a hospital), looking at range of motion, services out of state, and maybe even protective oversight (which may need to wait). She can provide contact information. She sent it out to people who expressed interest in the past and can have John send it out to the whole group. It is at HCPF and there is call in information. She would like as many as possible. Maria asked about a call in number and Rhyann will call her and send it out.

## OPEN FORUM #2:

Michelle: There is no CDASS coverage when someone is in the hospital but her family member does not speak and she has had serious liability if she or someone is not with him every second. They do not know what to do. Someone has to be there or they will do things that are contraindicated. One time paramedics took him to the hospital without permission and it took 45 minutes to find him. Medicaid sometimes hires people to hire people to watch people when

they are in the hospital. She has to be with him every minute when he is in the hospital. We need to have an option –can hospital hire us?

Linda S. said each hospital does it differently and you have to ask for it when you go in. They are supposed to provide this one to one care. It would be interesting to offer that they could hire the attendants to do this since they know him so well.

Julie: very important that people vote. The governor has a lot of say about Medicaid. If you use social media use #Vote4Medicaid. She said there is a ballot guide on the CCDC website. www.ccdconline.org

Rhyann:

a) Mallory Cyr now works for health policy office doing NEMT. If you know of anyone interested send them the job description. Rhyann hopes to get this position hired by mid-December. If anyone wants to sit on the interview panel from PDPPC let Rhyann know.
b) She reached out to eligibility department to ask someone to come and talk about eligibility in November. She is working on this for next month. If there are specific questions for that meeting let her know.

The meeting will be November 28, 2018 the week after Thanksgiving.

The meeting ended at 3:22 pm.

Respectfully submitted, Julie Reiskin