



TO: IHSS and CDASS Stakeholders
FROM: Grace Herbison
DATE: July 15, 2015
Subject: IHSS Expansion Plan Budget Estimates and Timeline Questions

- 1) What was the sample size of the clients used to come to the 56% and 128% increase figures outlined in the excerpt below?**
 - a. EBD – 132 clients
 - b. CHCBS - 57 clients
 - c. Both samples were generated randomly and represent a 95% confidence level with a 5% interval.

- 2) What percentage of the total IHSS population did the client sample represent?**
 - a. EBD - 132/447 or 29.53% of total IHSS clients on EBD
 - b. CHCBS – 57/129 or 44.19% of total IHSS clients on CHCBS

- 3) What were the ages of the CHCBS clients entering IHSS included in the sample size?**
 - a. Average age for the CHCBS IHSS clients is 8.88. Ages range from one to seventeen.

- 4) How long had the clients included in the client sample, been eligible for any sort of Medicaid benefits (state plan, EBD or CHCBS waiver benefits) before they accessed IHSS?**
 - a. All clients were eligible for Medicaid before entering IHSS.
 - i. The 132 EBD clients sampled were enrolled on average for 9.61 months in the preceding 12 months before entering IHSS.
 - ii. The 57 CHCBS clients sampled were enrolled on average for 8.71 months in the preceding 12 months before entering IHSS.
 - iii. All of the figures were based on Full Time Enrollment (FTE) so that comparisons could be drawn.
 - b. Did these clients receive other LTSS services prior to entering IHSS? If so, what was the difference in cost between IHSS and the other LTSS services? If not, were they Medicaid eligible and if eligible, is there visibility into why they didn't access LTSS services?**



Yes, clients did receive other LTSS services prior to entering IHSS services and the table below provides a summary and comparison of client counts and costs. In the 12 months preceding entering IHSS on EBD, 80 clients utilized Waiver services, while 39 clients utilized home health services (of the 132 EBD clients sampled).

In the 12 months preceding entering IHSS on CHCBS, 56 clients utilized Waiver services, while 20 clients utilized home health services (of the 57 CHCBS clients sampled).

It is not possible to determine from the claims data why clients may not have accessed LTSS services.

FY 2012-13 IHSS EBD IHSS New Client Sample LTSS Pre and Post Cost Per Full Time Enrollee				
Row	EBD	Unique Clients	Cost Per FTE*	Notes
A	Pre-Waiver Utilization	80	\$8,079.31	This is the Cost Per FTE For Waiver Services in the 365 Days prior to entering IHSS
B	Pre-Home Health	39	\$26,697.37	This is the Cost Per FTE For All Home Health Services in the 365 Days prior to entering IHSS
C	Pre-Overall Total Utilization	132	\$27,961.53	This is the Cost Per FTE For All Medicaid Services in the 365 Days prior to entering IHSS
D	Post-Waiver Utilization	132	\$30,076.63	This is the Cost Per FTE For Waiver Services in the 365 Days after to entering IHSS
E	Post-Home Health	34	\$9,918.70	This is the Cost Per FTE For All Home Health Services in the 365 Days after to entering IHSS



F	Post-Overall Total Utilization	132	\$43,568.65	This is the Cost Per FTE For All Medicaid Services in the 365 Days after to entering IHSS
*Cost Per FTE is not additive because you have a different number of FTE utilizing each service category. Therefore, Overall Cost per FTE includes all costs and all FTE.				

FY 2012-13 IHSS CHCBS IHSS New Client Sample LTSS Pre and Post Cost Per Full Time Enrollee				
Row	EBD	Unique Clients	Cost Per FTE*	Notes
A	Pre-Waiver Utilization	56	\$930.83	This is the Cost Per FTE For Waiver Services in the 365 Days prior to entering IHSS
B	Pre-Home Health	20	\$36,637.29	This is the Cost Per FTE For All Home Health Services in the 365 Days prior to entering IHSS
C	Pre-Overall Total Utilization	57	\$29,430.46	This is the Cost Per FTE For All Medicaid Services in the 365 Days prior to entering IHSS
D	Post-Waiver Utilization	57	\$53,772.57	This is the Cost Per FTE For Waiver Services in the 365 Days after to entering IHSS
E	Post-Home Health	11	\$8,198.63	This is the Cost Per FTE For All Home Health Services in the 365 Days after to entering IHSS



F	Post-Overall Total Utilization	132	\$69,187.40	This is the Cost Per FTE For All Medicaid Services in the 365 Days after to entering IHSS
*Cost Per FTE is not additive because you have a different number of FTE utilizing each service category. Therefore, Overall Cost per FTE includes all costs and all FTE.				

5) Was there an assessment of the overall ADL/Medical needs of the client population studied in IHSS relative to the client ADL/Medical needs in home health?

No. This study was specifically to look at the effects of clients entering IHSS and what their costs were before and after they began using IHSS so that we could estimate the cost of expanding IHSS to other waivers.

It's possible to compare similar ADL/Medical need profile clients across LTHH and IHSS to get to a relative "cost effectiveness" per capita of each service delivery option with like client profiles. However, the analysis would require a significant amount of resources due to the large amounts of data, research, and combination of disparate data sources.

6) Is there any way to understand whether the "average" ADL/Medical need profile of a client in IHSS is different than that in home health and is there any way to assess this with data in the Medicaid system?

"An analysis of IHSS client expenditure and utilization indicates that clients would utilize IHSS Health Maintenance Activities (HMA) at a substantially higher rate than Long-Term Home Health (LTHH). Using data from the Department's existing implementations of IHSS, the Department identified that IHSS clients realized a total cost of care per full time enrollee (FTE) increase of about 56% for HCBS-EBD clients and about 128% for CHCBS clients. To reach this conclusion, the Department compared client utilization from one year prior to entering IHSS was compared to client utilization from the first year of IHSS."

Yes, although very resource heavy, this analysis would require a significant amount of resources due to the large amounts of data, research, and



combination of disparate data sources. However, this analysis can serve as a starting point due to the utilization of both services for clients included in the sample

7) Is it possible that these cost increases are due to access issues, staffing issues at HH agencies, or other reasons that have to do with how home health agencies accept new clients or don't accept new clients? For example for children, if there are significant behaviors and Mom/Dad aren't CNAs, then most agencies will not take the children on.

The Department does not know for certain the cause of the increased utilization. Evaluating access to home health could help the Department better understand the cost increases associated with IHSS. However, this type of research could not be accomplished with the Department's existing resources.

8) Is it possible some of the increased cost are driven by IHSS consumers who are considered difficult cases that other provider types are not willing to consider?

The Department does not know for certain the cause of the increased utilization. Evaluating access to home health could help the Department better understand the cost increases associated with IHSS. However, this type of research could not be accomplished with the Department's existing resources.

9) Are the personnel costs built into this budget truly "net new" costs to HCPF, or are their current staff built into the current HCPF budget where some of the responsibilities outlined would already be expected to fall under that existing position?

Yes, the personnel costs would be new costs. The Department does not currently have a full-time employee specifically delegated to IHSS policy and program administration. Currently, the Department's responsibilities for In-Home Support Services are delegated to staff who are also responsible for administering other programs. Additional personnel resources would be needed to ensure the expansion is implemented successfully.



10) Is it possible for members of the PDPPC to get visibility into the different projected growth rates referenced on Page 9 of the report for each service type?

The growth in enrollment projected for each waiver is available by viewing the individual HCBS waivers on the CMS website, http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html. The information about projected growth can be found under Section J of each waiver. However, it is important to note that projected growth did not substantially contribute to cost. Most of the cost attributed to IHSS is related to projected utilization of the Health Maintenance Activities service.

11) Is it possible for members of the PDPPC to get visibility into the projected assumptions that were referenced in Page 10 under the heading: "IHSS Personal Care Services and IHSS Homemaker Services" that resulted in increased utilization rates?

"However, the Department estimates that utilization rates for IHSS Personal Care Services and Homemaker Services would be greater than agency-based Personal Care Services and Homemaker Services due to the program's increased flexibility in hiring attendants. The additional units utilized are projected to incrementally increase costs of providing Personal Care Services and Homemaker Services to clients enrolled in the HCBS-CMHS, HCBS-BI, HCBS-CES and HCBS-SLS waivers. "

Historically, clients utilize about half of their service plan under the traditional (agency based) delivery method for homemaker and personal care. The Department assumed that clients accessing IHSS homemaker/personal care would utilize 100% of authorized units on their service plans once utilizing under the IHSS delivery option.

12) Part of what is included in this budget and part of the "project activities" are already being conducted by the Department. Why is agency recruitment and IHSS case management training included as part of this timeline when this has been an IHSS requirement for the Department for the last 10 years (as directed by the Legislature at the first Sunset Review)? Also the Department contracted with Consumer



Direct to provide both CDASS and IHSS training to case management agencies and HCPF staff.

Currently In-Home Support Services is not available to any of the home and community based waivers administered by the Division for Intellectual and Developmental Disabilities. If the Department expanded In-Home Support Services to the CES and SLS waivers, we would need to insure providers and Department staff understand the service delivery option and were able to properly administer the program. Additionally, while the participant direction training vendor would provide the IHSS trainings to case managers, Department staff would need to collaborate with the training vendor to ensure the trainings were adapted properly for instruction to the Community Centered Boards. In regards to the question about provider recruitment activities, while the Department does currently engage in agency recruitment, the Department would need perform additional provider recruitment to serve the projected number of additional clients who would access IHSS from the BI, CMHS, SLS and CES waivers.

13) The timeline being proposed for implementation appears to be unnecessarily extended. It appears there are repetitive rule and waiver changes. Is it possible the changes can be added in 2016, waiver amendments submitted to CMS in 2016, and rewrites of the Colorado Interchange could be done in 2016? Ultimately, can the timeline be tightened to cut one year off of this process? We know the consumer direction staff are busy, but some of this work will be done by other LTSS staff. Creating a template and utilizing the expansion experience of CDASS into SLS should allow staff to make the IHSS specific waiver amendments more efficient.

The IHSS Expansion would require authorizing legislation before implementation could begin. As such, the project schedule assumed the General Assembly passes authorizing legislation in the 2016 legislative session and work beginning after the Department hires the necessary staff. The Department thoughtfully developed and reviewed the timeline for the proposed expansion of IHSS to ensure timeframes were realistic for successful implementation.

15) Were any of the clients in the sample, facility to IHSS transitions and if so what was the cost difference in those cases?



There were 10 clients in the EBD sample that had nursing facility stays in the previous 12 months prior to utilizing IHSS, costing \$26,697.37 per FTE. More analysis is needed to determine the exact cost of waiver services for the 10 utilizers who had SNF stays prior to entering IHSS. Overall, the cost per FTE for wavier service in the first 12 months of IHSS for all 132 clients in the sample was \$30,079.63. Using this data, the difference appears to be an increase of \$2,855.85 per FTE after they enter IHSS. Of the waiver services used in the first 12 months, IHSS (personal care, homemaker, and health maintenance) accounted for 90.26% of total waiver expenditure.

