COLORADO

Department of Regulatory Agencies

Colorado Office of Policy, Research & Regulatory Reform

2018 Sunset Review:
In-Home Support Services

October 15, 2018

COLORADO
Department of Regulatory Agencies
Executive Director's Office

October 15, 2018

Members of the Colorado General Assembly
c/o the Office of Legislative Legal Services
State Capitol Building
Denver, Colorado 80203

Dear Members of the General Assembly:

The Colorado General Assembly established the sunset review process in 1976 as a way to analyze and evaluate regulatory programs and determine the least restrictive regulation consistent with the public interest. Since that time, Colorado's sunset process has gained national recognition and is routinely highlighted as a best practice as governments seek to streamline regulation and increase efficiencies.

Section 24-34-104(5)(a), Colorado Revised Statutes (C.R.S.), directs the Department of Regulatory Agencies to:

- Conduct an analysis of the performance of each division, board or agency or each function scheduled for termination; and

- Submit a report and supporting materials to the office of legislative legal services no later than October 15 of the year preceding the date established for termination.

The Colorado Office of Policy, Research and Regulatory Reform (COPRRR), located within my office, is responsible for fulfilling these statutory mandates. Accordingly, COPRRR has completed the evaluation of In-Home Support Services. I am pleased to submit this written report, which will be the basis for COPRRR's oral testimony before the 2019 legislative committee of reference.

The report discusses the question of whether there is a need for the regulation provided under Part 12 of Article 6 of Title 25.5, C.R.S. The report also discusses the effectiveness of the staff of the Colorado Department of Health Care Policy and Financing in carrying out the intent of the statutes and makes recommendations for statutory changes in the event this regulatory program is continued by the General Assembly.

Sincerely,

Marguerite Salazar
Executive Director

COLORADO
Department of Regulatory Agencies
Colorado Office of Policy, Research & Regulatory Reform

2018 Sunset Review
In-Home Support Services

SUMMARY

What is regulated?
In-Home Support Services (IHSS) is a service delivery option that allows Medicaid beneficiaries to continue to live in their communities and avoid placement in institutional care. Under IHSS, participants may select their own attendants, typically friends or family members. The attendants then enter the employment of a home health agency that is a certified IHSS provider agency. The agency trains the attendants, pays them wages based upon reimbursement rates established for IHSS, and provides additional services, such as backup attendants, as required by Colorado law.

Why is it regulated?
The Colorado Department of Health Care Policy and Financing (HCPF) oversees IHSS to safeguard the use of public dollars.

Who is regulated?
In fiscal year 16-17, there were 78 certified IHSS provider agencies serving 2,478 participants.

How is it regulated?
HCPF, in cooperation with the Colorado Department of Public Health and Environment (CDPHE), certifies home health agencies to provide IHSS. Certified IHSS provider agencies are then eligible to receive reimbursement from Medicaid. Case managers at single-entry point (SEP) agencies—public, non-profit, or private agencies through which adults can access long-term care services—are responsible for determining whether individuals are eligible for IHSS and for referring eligible individuals to certified IHSS provider agencies.

What does it cost to administer IHSS?
In fiscal year 16-17, HCPF spent $68,171 to administer IHSS, and there was one full-time equivalent employee associated with its administration.

KEY RECOMMENDATIONS

Continue IHSS for seven years, until 2026.
IHSS offers a unique combination of independence and institutional support. It allows participants the freedom to direct their own care, while having an IHSS-certified agency on hand to provide administrative assistance and resources, including 24-hour backup attendants. Among stakeholders interviewed for this review, there is strong, often passionate, support for IHSS. Not only is IHSS well-received and increasingly popular, it is also cost-effective. HCPF data demonstrate that long-term care services provided via IHSS cost on average 30 percent less than those delivered via nursing facilities. IHSS provides an invaluable way for people to receive health care services from attendants they trust in their own homes and communities, with the support, expertise and guidance of licensed home-care agencies. It has proven itself a robust, viable, and cost-effective alternative for people seeking Medicaid long-term care services.

Revise the definition of "eligible person" to include anyone who is eligible to receive services under any home and community-based services waiver for which HCPF has federal waiver authority.
Currently, in order to participate in IHSS, a person must be enrolled in one of three Medicaid waivers: the home and community-based services (HCBS) waiver for the Elderly, Blind and Disabled (EBD), the Children's HCBS waiver, or the Spinal Cord Injury waiver. Rather than enumerating the specific waivers, the IHSS statute should define "eligible person" as any person who is eligible to receive services under any HCBS waiver that offers IHSS. This approach would allow HCPF flexibility in phasing in additional waivers. Making this statutory change would make the IHSS statute parallel with the statute governing another popular Medicaid-waiver service delivery option that HCPF administers, the Consumer Directed Attendant Support Services, and remove one barrier to future expansion.

METHODOLOGY

As part of this review, Colorado Office of Policy, Research and Regulatory Reform staff attended IHSS workgroup meetings; interviewed IHSS participants, representatives of home-care agencies, and HCPF staff; reviewed Colorado statutes and rules; and reviewed the laws of other states.

MAJOR CONTACTS MADE DURING THIS REVIEW

Colorado Department of Health Care Policy and Finance
Colorado Department of Public Health and Environment
Colorado Home Care Association
Participant-Directed Programs Policy Collaborative

What is a Sunset Review?

A sunset review is a periodic assessment of state boards, programs, and functions to determine whether they should be continued by the legislature. Sunset reviews focus on creating the least restrictive form of regulation consistent with protecting the public. In formulating recommendations, sunset reviews consider the public's right to consistent, high quality professional or occupational services and the ability of businesses to exist and thrive in a competitive market, free from unnecessary regulation.

Sunset Reviews are prepared by:
Colorado Department of Regulatory Agencies
Colorado Office of Policy, Research and Regulatory Reform
1560 Broadway, Suite 1550, Denver, CO 80202
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Background

Introduction

Enacted in 1976, Colorado's sunset law was the first of its kind in the United States. A sunset provision repeals all or part of a law after a specific date, unless the legislature affirmatively acts to extend it. During the sunset review process, the Colorado Office of Policy, Research and Regulatory Reform (COPRRR) within the Department of Regulatory Agencies (DORA) conducts a thorough evaluation of such programs based upon specific statutory criteria[1] and solicits diverse input from a broad spectrum of stakeholders including consumers, government agencies, public advocacy groups, and professional associations.

Sunset reviews are based on the following statutory criteria:

- Whether regulation by the agency is necessary to protect the public health, safety and welfare; whether the conditions which led to the initial regulation have changed; and whether other conditions have arisen which would warrant more, less or the same degree of regulation;
- If regulation is necessary, whether the existing statutes and regulations establish the least restrictive form of regulation consistent with the public interest, considering other available regulatory mechanisms and whether agency rules enhance the public interest and are within the scope of legislative intent;
- Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures and practices and any other circumstances, including budgetary, resource and personnel matters;
- Whether an analysis of agency operations indicates that the agency performs its statutory duties efficiently and effectively;
- Whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates;
- The economic impact of regulation and, if national economic information is not available, whether the agency stimulates or restricts competition;
- Whether complaint, investigation and disciplinary procedures adequately protect the public and whether final dispositions of complaints are in the public interest or self-serving to the profession;
- Whether the scope of practice of the regulated occupation contributes to the optimum utilization of personnel and whether entry requirements encourage affirmative action;

[1] Criteria may be found at § 24-34-104, C.R.S.

- Whether the agency through its licensing or certification process imposes any disqualifications on applicants based on past criminal history and, if so, whether the disqualifications serve public safety or commercial or consumer protection interests. To assist in considering this factor, the analysis prepared pursuant to subparagraph (i) of paragraph (a) of subsection (8) of this section shall include data on the number of licenses or certifications that were denied, revoked, or suspended based on a disqualification and the basis for the disqualification; and
- Whether administrative and statutory changes are necessary to improve agency operations to enhance the public interest.

Types of Regulation

Consistent, flexible, and fair regulatory oversight assures consumers, professionals and businesses an equitable playing field. All Coloradans share a long-term, common interest in a fair marketplace where consumers are protected. Regulation, if done appropriately, should protect consumers. If consumers are not better protected and competition is hindered, then regulation may not be the answer.

As regulatory programs relate to individual professionals, such programs typically entail the establishment of minimum standards for initial entry and continued participation in a given profession or occupation. This serves to protect the public from incompetent practitioners. Similarly, such programs provide a vehicle for limiting or removing from practice those practitioners deemed to have harmed the public.

From a practitioner perspective, regulation can lead to increased prestige and higher income. Accordingly, regulatory programs are often championed by those who will be the subject of regulation.

On the other hand, by erecting barriers to entry into a given profession or occupation, even when justified, regulation can serve to restrict the supply of practitioners. This not only limits consumer choice, but can also lead to an increase in the cost of services.

There are also several levels of regulation.

Licensure

Licensure is the most restrictive form of regulation, yet it provides the greatest level of public protection. Licensing programs typically involve the completion of a prescribed educational program (usually college level or higher) and the passage of an examination that is designed to measure a minimal level of competency. These types of programs usually entail title protection – only those individuals who are properly licensed may use a particular title(s) – and practice exclusivity – only those individuals

who are properly licensed may engage in the particular practice. While these requirements can be viewed as barriers to entry, they also afford the highest level of consumer protection in that they ensure that only those who are deemed competent may practice and the public is alerted to those who may practice by the title(s) used.

Certification

Certification programs offer a level of consumer protection similar to licensing programs, but the barriers to entry are generally lower. The required educational program may be more vocational in nature, but the required examination should still measure a minimal level of competency. Additionally, certification programs typically involve a non-governmental entity that establishes the training requirements and owns and administers the examination. State certification is made conditional upon the individual practitioner obtaining and maintaining the relevant private credential. These types of programs also usually entail title protection and practice exclusivity.

While the aforementioned requirements can still be viewed as barriers to entry, they afford a level of consumer protection that is lower than a licensing program. They ensure that only those who are deemed competent may practice and the public is alerted to those who may practice by the title(s) used.

Registration

Registration programs can serve to protect the public with minimal barriers to entry. A typical registration program involves an individual satisfying certain prescribed requirements – typically non-practice related items, such as insurance or the use of a disclosure form – and the state, in turn, placing that individual on the pertinent registry. These types of programs can entail title protection and practice exclusivity. Since the barriers to entry in registration programs are relatively low, registration programs are generally best suited to those professions and occupations where the risk of public harm is relatively low, but nevertheless present. In short, registration programs serve to notify the state of which individuals are engaging in the relevant practice and to notify the public of those who may practice by the title(s) used.

Title Protection

Finally, title protection programs represent one of the lowest levels of regulation. Only those who satisfy certain prescribed requirements may use the relevant prescribed title(s). Practitioners need not register or otherwise notify the state that they are engaging in the relevant practice, and practice exclusivity does not attach. In other words, anyone may engage in the particular practice, but only those who satisfy the prescribed requirements may use the enumerated title(s). This serves to indirectly ensure a minimal level of competency – depending upon the prescribed preconditions for use of the protected title(s) – and the public is alerted to the qualifications of those who may use the particular title(s).

Licensing, certification and registration programs also typically involve some kind of mechanism for removing individuals from practice when such individuals engage in enumerated proscribed activities. This is generally not the case with title protection programs.

Regulation of Businesses

Regulatory programs involving businesses are typically in place to enhance public safety, as with a salon or pharmacy. These programs also help to ensure financial solvency and reliability of continued service for consumers, such as with a public utility, a bank or an insurance company.

Activities can involve auditing of certain capital, bookkeeping and other recordkeeping requirements, such as filing quarterly financial statements with the regulator. Other programs may require onsite examinations of financial records, safety features or service records.

Although these programs are intended to enhance public protection and reliability of service for consumers, costs of compliance are a factor. These administrative costs, if too burdensome, may be passed on to consumers.

Sunset Process

Regulatory programs scheduled for sunset review receive a comprehensive analysis. The review includes a thorough dialogue with agency officials, representatives of the regulated profession and other stakeholders. Anyone can submit input on any upcoming sunrise or sunset review on COPRRR's website at: www.dora.colorado.gov/opr.

The functions of the Colorado Department of Health Care Policy and Finance (HCPF) as enumerated in Part 12 of Article 6 of Title 25.5, Colorado Revised Statutes (C.R.S.), shall terminate on September 1, 2019, unless continued by the General Assembly. During the year prior to this date, it is the duty of COPRRR to conduct an analysis and evaluation of In-Home Support Services (IHSS) pursuant to section 24-34-104, C.R.S.

The purpose of this review is to determine whether the currently prescribed service delivery option should be continued and to evaluate the performance of the Department. During this review, HCPF must demonstrate that IHSS serves the public interest. COPRRR's findings and recommendations are submitted via this report to the Office of Legislative Legal Services.

Methodology

As part of this review, COPRRR staff attended IHSS workgroup meetings; interviewed IHSS participants and their families, representatives of home care agencies, and other stakeholders; reviewed records; and reviewed Colorado statutes and rules.

Profile of In-Home Support Services

Colorado's In-Home Support Services (IHSS) service delivery option is an example of how states can offer home and community-based services (HCBS) in cooperation with the Centers for Medicare & Medicaid Services (CMS), the federal agency that regulates and provides funding for long-term care in all 50 states. Generally, HCBS provide an alternative to traditional, institutional skilled nursing facilities and other institutional settings, by allowing people who are Medicaid beneficiaries to receive health care services in their homes and communities.

Section 1915(c) of the Social Security Act authorizes CMS to exempt HCBS from certain regulatory requirements. This exemption, typically called the HCBS waiver, allows states to use federal monies that would otherwise be spent on traditional long-term care to develop and maintain service delivery options that allow Medicaid beneficiaries to continue to live in their communities, avoiding placement in institutional care. Service delivery options operating under the waiver are exempt from the requirement that state-run medical assistance plans be offered statewide, as well as the requirements relating to comparability of services and certain income and resource rules.

These exemptions allow states to tailor HCBS to the specific needs of their residents. The designated Medicaid agency in each state—in Colorado, HCPF—can apply to CMS for the HCBS waiver. States may develop several service delivery options under a single waiver, and there is no limit on the number of options a state may develop.

Under IHSS, participants may select their own attendants, typically friends or family members. The attendants then enter the employment of a home health agency that is licensed by the Colorado Department of Public Health and Environment and authorized by HCPF as a Medicaid and an IHSS provider. The agency trains the attendants, pays them wages based upon reimbursement rates established for IHSS, and provides additional services, such as backup attendants, as required by Colorado law.

Attendants may perform personal care services, such as bathing and dressing; homemaker services, such as cooking and laundry; and health maintenance tasks, which are routine, skilled nursing tasks that would typically be provided by a nurse or certified nurse aide.

Legal Framework

History of Regulation

The General Assembly created In-Home Support Services (IHSS) in 2002 when it passed Senate Bill 02-027.

In creating IHSS, the General Assembly established an alternative to traditional long-term care for elderly, blind or disabled people, including disabled children. IHSS was intended to provide a way for people who need the level of health care provided in a skilled nursing facility to receive services in their homes and to select their own attendants, which could include family members.

IHSS underwent sunset review in 2007. In the sunset report, the Colorado Office of Policy, Research, and Regulatory Reform (COPRRR) recommended continuing IHSS for three years and made several administrative recommendations to the Department of Health Care Policy and Financing (HCPF) on how to improve the administration of IHSS.

IHSS underwent sunset again in 2010. Senate Bill 11-105 continued it for three years, required HCPF to implement an accurate system for tracking the number of IHSS participants, to develop and provide comprehensive training for single entry point agencies, and to submit an annual report to the General Assembly.

In 2014, the General Assembly passed House Bills 14-1357 and 14-1358, which extended IHSS for five years, expanded the eligibility criteria for IHSS to include people enrolled in the spinal cord injury pilot program, increased the number of hours family members could provide under IHSS, and required HCPF to develop a plan to expand IHSS to include people enrolled in the brain injury and community mental health supports waivers, as well as children entitled to extensive support services.

Legal Summary

Section 25.5-6-1201, *et seq.*, Colorado Revised Statutes (C.R.S.), establishes IHSS and vests HCPF with the responsibility for developing and administering it. HCPF's responsibilities include securing the funding for the IHSS[2] as well as the appropriate federal authorizations,[3] tracking the number of people receiving IHSS services, providing training to single entry point (SEP) agencies,[4] promoting effective and efficient delivery of IHSS, and reporting annually to the General Assembly.[5]

[2] § 25.5-6-1204(2), C.R.S.
[3] § 25.5-6-1203(1), C.R.S.
[4] § 25.5-6-1203(7), C.R.S.
[5] § 25.5-6-1206, C.R.S.

The State Medical Services Board is responsible for promulgating rules to implement IHSS.[6]

The purpose of IHSS is to allow disabled children and elderly, blind, and disabled adults, including those with spinal cord injuries, to receive services in their homes and communities. Section 25.5-6-1202, C.R.S., defines "in-home support services" to include:[7]

- **Health maintenance activities**, defined in IHSS rule as "routine, repetitive skilled health-related tasks that [people] with a disability would carry out if they were physically able, or that would be carried out by family members or friends if they were available."[8]

- **Homemaker services**, defined in IHSS rule as "general household activities provided…to maintain a healthy and safe home environment for a client, when the person ordinarily responsible for these activities is absent or unable to manage these tasks."[9]

- **Personal care services,** defined in IHSS rule as services that "meet the client's physical, maintenance and supportive needs, when those services are not skilled personal care, do not require the supervision of a nurse, and do not require a physician's order."[10]

While IHSS is intended to be self-directed, the delivery of IHSS depends upon collaboration among people eligible for services (participants) and:

- **Single entry point (SEP) agencies**, local nonprofit, private, or county agencies that connect people with long-term care services,[11] that determine whether people are eligible for IHSS;[12]

- **Attendants**, often participants' family members or spouses, who provide IHSS services to participants;[13] and

- **IHSS agencies**—home-care agencies licensed by the Colorado Department of Public Health and Environment (CDPHE) and certified by HCPF to offer IHSS[14]—that employ, train, and provide backup care for the attendants.

[6] § 25.5-6-1205(3), C.R.S.
[7] § 25.5-6-1202(6), C.R.S.
[8] 10 CCR 2505-10, § 8.552.1.G, In-Home Support Services Rules.
[9] 10 CCR 2505-10, § 8.552.1.H, In-Home Support Services Rules.
[10] 10 CCR 2505-10, § 8.552.1.N, In-Home Support Services Rules.
[11] § 25.5-6-106(2), C.R.S.
[12] § 25.5-6-1203(5), C.R.S.
[13] § 25.5-6-1202(1), C.R.S.
[14] § 25.5-6-1202(5), C.R.S.

SEP case managers are responsible for determining an individual's eligibility for IHSS. As part of this process, the SEP case manager administers the Uniform Long Term Care form (ULTC), a tool SEP case managers use to assess applicants' memory, cognition, behavior, and their ability to perform six activities of daily living, including:

- Bathing,
- Dressing,
- Toileting,
- Mobility,
- Transferring, and
- Eating.

Applicants having deficits in two or more activities of daily living, or cognitive impairments or behavioral issues exceeding certain specified levels, are determined to functionally qualify for Medicaid long-term care services.

If an applicant functionally qualifies for Medicaid long-term care services, then the SEP case manager must determine whether the applicant is eligible for the home and community-based services (HCBS) waiver for the Elderly, Blind and Disabled (EBD), the Children's HCBS (CHCBS) waiver, or the Spinal Cord Injury (SCI) waiver.[15] In addition, adult applicants must have an income less than three times the Supplemental Security Income limit per month and have countable resources less than $2,000 for a single person or $3,000 for a couple. The eligibility of child applicants does not rely on their parents' income: children whose parents do not qualify financially can still be eligible for HCBS.

Each waiver also has specific eligibility requirements:

- The EBD waiver requires applicants to be either over the age of 65 and have a functional impairment, or between the ages of 18 and 64 and be blind or physically disabled or have a diagnosis of HIV/AIDS.

- The CHCBS waiver requires applicants to be under the age of 18 and in need of long-term support services comparable to those provided in a hospital or skilled nursing facility.

- The SCI waiver requires applicants to be 18 years of age or older, have a diagnosis of a spinal cord injury resulting in significant functional impairment, and live in one of five metropolitan-Denver counties (Adams, Arapahoe, Denver, Douglas, or Jefferson).

In addition to qualifying for Medicaid long-term care services and one of the above waivers, IHSS participants must be willing to participate[16] and have a statement from

[15] §25.5-6-1202(3)(a), C.R.S.
[16] §25.5-6-1202(3)(b), C.R.S.

their primary care physician affirming that they have sound judgment and are capable of directing their own care, or have an authorized representative[17] to act on their behalf.

Under IHSS, participants (or their authorized representatives) may direct their own care. They may select, train, schedule, manage and supervise their attendants and dismiss attendants who do not meet their needs. They may determine the level of support they require from the IHSS agency[18] and transition to alternative service delivery options at any time.[19]

Attendants must be at least 18 years old and demonstrate that they are competent to provide the care that participants need.[20] They are exempted from the Nurse Practice Act and the Nurse Aide Practice Act, meaning that they do not need to be licensed nurses or certified nurse aides to provide services.[21] They must, however, undergo agency-provided training that includes an overview of IHSS and covers:[22]

- Interpersonal skills focused on addressing the needs of people with disabilities;
- Basic first aid administration, safety and emergency procedures, and infection control techniques, including universal precautions; and
- Mandatory reporting procedures.

Attendants must also be able to pass a skills validation test, administered by a licensed health care professional, wherein they demonstrate they are competent to provide the services the participant needs.[23]

People who have had their nursing or nurse aide licenses suspended or revoked, or whose applications for such licenses have been denied, are ineligible to serve as attendants.[24]

IHSS agencies must be:

- Licensed by CDPHE as a home care agency,
- Enrolled through HCPF as a Medicaid provider, and
- Authorized to serve as an IHSS provider agency.

To qualify to offer IHSS, an agency must provide independent living core services,[25] which support and promote the independence of people with disabilities and help

[17] §25.5-6-1202(2), C.R.S., defines "authorized representative" as an individual who the person receiving services (or his or her parent or guardian, if applicable) designate to help him or her acquire and use IHSS services.
[18] § 25.5-6-1203(2), C.R.S.
[19] 10 CCR 2505-10, § 8.552.4.A.6, In-Home Support Services Rules.
[20] 10 CCR 2505-10, §8.552.6.K.1 and 3, In-Home Support Services Rules .
[21] § 25.5-6-1203(3), C.R.S.
[22] 10 CCR 2505-10, § 8.552.6.I, In-Home Support Services Rules.
[23] 10 CCR 2505-10, § 8.552.6.G.1, In-Home Support Services Rules.
[24] § 25.5-6-1203(3), C.R.S.
[25] § 25.5-6-1202(5), C.R.S.

them live outside of institutions. Examples of such services include referral services, independent living skills training, peer and cross-disability peer counseling, and services allowing transition from institutional nursing care to home and community-based living.[26]

IHSS agencies must provide participants with 24-hour backup services in the event that participants' designated attendants are not available[27] and employ or contract with a licensed health care professional, who is at least a registered nurse, [28] to meet oversight and supervisory requirements, including training attendants and validating that they are competent to provide services.[29]

IHSS agencies are attendants' legal employers and must comply with all state and federal laws and applicable rules.[30]

IHSS services are delivered pursuant to a written care plan developed by the participant (or his or her authorized representative), the IHSS agency, and the SEP agency.[31] The care plan must include the number of allowable attendant hours and a description of the "frequency, scope, and duration of all services to be provided to the client."[32] Both a care plan and a prior authorization request (PAR) must be in place before a client can receive IHSS.[33] The IHSS agency must send the care plan to the SEP case manager for review and approval, and review the care plan with the client at least annually. A change in a client's health condition might necessitate revising the care plan.[34]

The provider reimbursement rates differ depending on the type of service: homemaker or personal care services are reimbursed to agencies at $17.52 per hour, while health maintenance services are reimbursed at $29.08 per hour. IHSS agencies determine their employees' wages.

HCPF must submit an annual report on IHSS to the Joint Budget Committee, the Senate Health and Human Services Committee, and the House of Representatives Health, Insurance and Environment Committee. The report must include the number of people receiving IHSS services, address the cost-effectiveness of IHSS, and discuss how to increase the number of people receiving IHSS.[35]

[26] 10 CCR 2505-10, § 8.552.1.J, In-Home Support Services Rules.
[27] § 25.5-6-1203(4)(a), C.R.S.
[28] § 25.5-6-1203(4)(a), C.R.S. and 10 CCR 2505-10, § 8.552.6.G, In-Home Support Services Rules.
[29] 10 CCR 2505-10, § 8.552.6.G.1, In-Home Support Services Rules.
[30] 10 CCR 2505-10, § 8.552.6.C, In-Home Support Services Rules.
[31] 10 CCR 2505-10, § 8.552.1.C, In-Home Support Services Rules.
[32] 10 CCR 2505-10, § 8.552.6.F.1, In-Home Support Services Rules.
[33] 10 CCR 2505-10, § 8.552.8.A, In-Home Support Services Rules.
[34] 10 CCR 2505-10, § 8.552.6.F.2, In-Home Support Services Rules.
[35] § 25.5-6-1206, C.R.S.

Program Description and Administration

The Colorado Department of Health Care Policy and Financing (HCPF) administers In-Home Support Services (IHSS). Currently, the funding for IHSS is split equally between the state's General Fund and federal Medicaid dollars.

Table 1 illustrates HCPF's costs to administer IHSS and the number of dedicated full-time employees (FTE) dedicated to IHSS for the five fiscal years indicated.

Table 1
IHSS Administrative Costs

Fiscal Year	Administrative Costs	FTE
12-13	$72,792	1.0
13-14	$78,775	1.0
14-15	$45,017	1.0
15-16	$47,610	1.0
16-17	$73,424	1.0

HCPF's administrative costs consist entirely of salary and benefits for its employees.

In July 2018, there were two HCPF employees who dedicated a portion of their time to IHSS:

- Participant Directed Liaison (0.75 Policy Analyst IV) works directly with IHSS agencies, clients, single entry point (SEP) representatives, the Colorado Department of Public Health and Environment (CDPHE), and other stakeholders to administer IHSS.
- Participant Directed Programs Supervisor, (0.25 Program Manager I), provides general oversight and management for IHSS and other participant-directed service delivery options.

The Participant-Directed Liaison position was vacant for several months in fiscal year 14-15 and again 15-16, leading to a decrease in expenditures for those years.

Table 2 shows, for the five fiscal years indicated, the number of IHSS participants and agencies.

Table 2
IHSS Participants and Agencies

Fiscal Year	Total Participants	Total Agencies
12-13	576	23
13-14	877	28
14-15	1,218	34
15-16	1,694	48
16-17	2,748	78

IHSS has experienced extraordinary growth over the five years examined, with the number of participants increasing by a remarkable 477 percent and the number of agencies increasing by 339 percent. This growing trend continues into fiscal year 17-18: by March 1, 2018, there were a total of 102 CDPHE-approved IHSS agencies, with 23 more pending enrollment in the Medicaid billing system.

Numerous factors could explain the overall increase in participation, including improved education and outreach by HCPF and a growing interest in alternatives to institutional nursing facilities. The single most significant reason for this period of expansion, however, is likely the passage of House Bill 14-1357 (HB 1357), which exempted family members from the statutory limit[36] on the number of personal care service hours that family members can provide to participants. Prior to HB 1357, family members could only provide 444 hours of personal care services per year,[37] but the current IHSS rule permits attendants who are family members to provide up to 40 hours per week.[38] The increase in allowable hours made IHSS a more viable option for families: people could now earn a modest income providing their family members with services instead of being compelled to work outside the home while paying someone else to provide them.

Table 3 shows, for the five fiscal years illustrated, the number of participants by the waiver they were enrolled in—the home and community-based services (HCBS) waiver for the Elderly, Blind and Disabled (EBD), the Children's HCBS waiver (CHCBS), or the Spinal Cord Injury (SCI) waiver—and the type of services—health maintenance, homemaker, and personal care—received. Note that under the CHCBS waiver, clients may receive health maintenance services only.

[36] § 25.5-6-310(2), C.R.S.
[37] Parents providing care to disabled children were always exempted from the 444 hour cap.
[38] 10 CCR 2505-10, 8522.8.E, In-Home Support Services Rules.

Table 3
IHSS Participants by Federal Waiver and Services Received

Waiver/Service	FY 12-13	FY 13-14	FY 14-15	FY 15-16	FY 16-17
CHCBS	129	184	237	285	498
EBD/SCI*: Health Maintenance	389	597	901	1,308	2,060
EBD/SCI: Homemaker	94	209	290	420	765
EBD/SCI: Personal Care	143	222	340	591	908
EBD/SCI: Relative Personal Care	141	168	266	431	968

*The EBD/SCI category includes those participants who are on either the EBD or SCI waiver.

Because adult clients tend to receive more than one kind of service (i.e., health maintenance and personal care), the numbers in this table do not match the participant totals in Table 2.

Generally, participation has increased significantly across all waivers and service types.

One of the underlying principles of IHSS is that allowing people to direct their own care can also provide cost-savings to the State of Colorado. To that end, the General Assembly requires HCPF to maintain data on the cost of IHSS relative to the cost of care provided in a traditional nursing facility.

Table 4 shows, for the five fiscal years indicated, the comparison of IHSS and nursing facility costs.

Table 4
IHSS and Nursing Facility Cost Comparison

Fiscal Year	Total IHSS Participants	Average Cost Per Person: IHSS	Total Nursing Facility Residents	Average Cost Per Person: Nursing Facility
12-13	576	$27,617	14,573	$36,782
13-14	877	$27,995	14,571	$38,699
14-15	1,218	$29,122	14,866	$38,960
15-16	1,694	$26,961	15,253	$40,564
16-17	2,748	$26,319	15,542	$41,819

The per-participant cost of IHSS is consistently significantly lower than care delivered in a traditional nursing facility. Over the past five years, IHSS cost an average of 29.9 percent less per participant.

Collateral Consequences – Criminal Convictions

Section 24-34-104(6)(b)(IX), C.R.S., requires the Colorado Office of Policy, Research and Regulatory Reform (COPRRR) to determine whether the agency under review, through its licensing processes, imposes any disqualifications on applicants or registrants based on past criminal history, and if so, whether the disqualifications serve public safety or commercial or consumer protection interests.

Although IHSS agencies are licensed by the state, CDPHE, not HCPF, issues the license. The statutes addressing agency licensing lie outside of the IHSS statute and are not subject to this sunset review. However, COPRRR is concurrently conducting a sunset review of home care agencies. Please reference "2018 Sunset Review: The Regulation of Home Care and Placement Agencies."

Analysis and Recommendations

Recommendation 1 – Continue In-Home Support Services for seven years, until 2026.

In-Home Support Services (IHSS) is a service delivery option that allows Coloradans who qualify for Medicaid long-term care services and meet other specific criteria to receive such services in their homes instead of in nursing facilities. IHSS is housed within the Colorado Department of Health Care Policy and Financing (HCPF). The statutes governing IHSS are located in section 25.5-6-1201, *et seq.*, Colorado Revised Statutes (C.R.S.).

The General Assembly created IHSS in 2002 to provide individuals in need of long-term care services an opportunity to stay in their homes and communities and direct their own care. Under IHSS, participants may continue to live in their own homes and receive health maintenance, personal care, and homemaker services from attendants they select themselves, typically friends or family members. The attendant enters the employment of a home health agency that is a certified IHSS provider. The agency trains the attendants, pays them wages based upon reimbursement rates established for IHSS, and provides additional services, such as backup attendants, as required by Colorado law.

The central question of this sunset review is whether IHSS serves to protect the public health, safety and welfare.

IHSS offers a unique combination of independence and institutional support. Another Medicaid-waiver service delivery option that HCPF administers, Consumer Directed Attendant Support Services (CDASS), gives participants exclusive authority to hire, train, oversee and establish pay rates for attendants independently, without working through an agency. CDASS participants must also manage an annual budget. At the opposite extreme, traditional nursing facilities have exclusive control over hiring, training and managing attendants, budgeting and paperwork.

IHSS offers a middle ground. It allows participants the freedom to direct their own care, while having an IHSS-certified agency on hand to provide administrative assistance and resources, including 24-hour backup attendants. IHSS represents an excellent option for people who wish to retain control over their own care without being responsible for the considerable administrative and managerial tasks that CDASS participants are.

Over the course of this review, a representative of the Colorado Office of Policy, Research, and Regulatory Reform (COPRRR) interviewed numerous adult IHSS participants as well as parents and guardians of participants who are children, and received written testimonials from many more. Among these stakeholders, there is strong, often passionate, support for IHSS. Many parents mentioned the difficulty of

maintaining employment outside the home when they have a child with complex medical needs: they value the opportunity to care for their children while also providing some income for the household. Adult participants appreciate being able to receive care from people they know and trust without taking on undue administrative responsibilities.

Not only is IHSS well-received and increasingly popular, it is also cost-effective. HCPF data demonstrate that long-term care services provided via IHSS cost on average 30 percent less than those delivered via nursing facilities.

The strong participation in IHSS, its popularity with participants, and its cost-effectiveness justify its continuation.

The merits of IHSS were not always so apparent. For the first 11 years of its existence, IHSS was fraught with administrative problems, staff turnover, and a lack of resources and institutional support. Consequently, IHSS showed very little growth.

This stagnation is reflected in the fact that COPRRR conducted three sunset reviews of IHSS in just six years, which is unusual. While COPRRR consistently recognized the considerable potential of IHSS, and continued to recommend its continuation, the ongoing implementation problems led to COPRRR recommending short, three-year continuation periods, reasoning that continued scrutiny would lead to greater accountability. When IHSS underwent its first sunset review, in 2007, it had 95 participants and five certified provider agencies. In the 2010 sunset review, HCPF reported there were still just 95 participants and six provider agencies. By the time of the 2013 review, IHSS had finally begun to demonstrate its potential, reporting a total of 408 participants and 20 provider agencies.

During this sunset review period, in fiscal year 16-17, HCPF reported 2,748 participants and 78 IHSS agencies. These numbers demonstrate that IHSS is now thriving.

The successful implementation of IHSS requires significant coordination among many parties—including two state agencies, single-entry point (SEP) case managers, IHSS agencies, and attendants—under the direction of the participant. Accordingly, many factors have contributed to the remarkable growth of IHSS during this five-year sunset review period: robust institutional support at HCPF; increased expertise in IHSS at the Colorado Department of Public Health and Environment's (CDPHE's) Health Facilities Division, which is responsible for licensing and inspecting home-care agencies wishing to provide IHSS; critical statutory changes that allowed an increase in the number of allowable personal care hours; word of mouth among participants and their families; better advocacy for IHSS by SEP case managers; and vocal commitment to IHSS from veteran home-care agencies.

This rapid expansion has not come without challenges. The influx of home-care agencies seeking to provide IHSS has sometimes taxed the resources of both HCPF and

CDPHE. Newly authorized IHSS agencies sometimes struggle to implement IHSS, which is quite different from traditional home care. HCPF must assist IHSS agencies in complying with laws and rules; provide consistent and timely training to SEP agencies, which can be difficult given staff turnover among case managers; and address the concerns of new participants and their attendants, all while preserving IHSS's commitment to allowing participants to direct their own care.

In April 2018, the Colorado Medical Services Board (Board) enacted a significant IHSS rule revision that attempts to provide greater consistency and uniformity within IHSS. The new rules place more responsibility on case management agencies and change the process for how agencies develop and modify care plans and estimate the number of care hours needed. Because these changes are in rule, the Board, in cooperation with HCPF, will be able to tailor and revise them in collaboration with stakeholders if necessary. In any case, the state must resist the temptation to handle growth by imposing unnecessarily proscriptive rules that would make IHSS more similar to a traditional medical home-care model: the General Assembly intended IHSS to be self-directed and it must remain so.

After a rocky start, current staff and leadership at HCPF have ushered in a new era for IHSS, and this once-neglected service delivery option has finally begun to fulfill the potential that COPRRR recognized in the previous three sunsets. IHSS provides an invaluable way for people to receive health care services from attendants they trust in their own homes and communities, with the support, expertise and guidance of licensed home-care agencies. IHSS is no longer a pilot program. It is no longer on probation. It has proven itself a robust, viable, and cost-effective alternative for people seeking Medicaid long-term care services.

For these reasons, the General Assembly should continue IHSS for seven years, until 2026. This extension is commensurate with the scope of the proposed change in Recommendation 2 below.

Recommendation 2 – Revise the definition of "eligible person" to include anyone who is eligible to receive services under any home and community-based services waiver for which HCPF has federal waiver authority.

Currently, in order to participate in IHSS, a person must be enrolled in one of three Medicaid waivers: the home and community-based services (HCBS) waiver for the Elderly, Blind and Disabled (EBD), the Children's HCBS waiver, or the Spinal Cord Injury waiver.[39]

There is considerable interest among stakeholders in expanding IHSS—namely, allowing people who qualify for long-term care services under other Medicaid waivers

[39] § 25.5-6-1202(3)(a), C.R.S.

to participate in IHSS. The General Assembly also expressed support for expansion in 2014, when it revised the legislative declaration to state that:[40]

> allowing clients more self-direction in their care is a more effective way to deliver home- and community-based services to clients with major mental illnesses and brain injuries, as well as to clients receiving home- and community-based supportive living services and children's extensive support services. Therefore, the General Assembly declares that it is appropriate for [HCPF] to develop a plan for expanding the availability of in-home support services to include these clients.

The General Assembly directed HCPF to submit the plan to the House Public Health and Human Services Committee and the Senate Health and Human Services Committee on or before March 1, 2015. HCPF completed the report on April 20, 2015.

The published report identifies the tasks that would need to be completed to successfully expand IHSS, including amending the additional HCBS waivers to include IHSS as a service option; recruiting additional IHSS provider agencies; securing additional fiscal support; and revising the statute to permit the other waivers.

Most of the enumerated tasks fall beyond the scope of this sunset review. However, the third sunset criterion asks whether an agency's operation is "impeded or enhanced by existing statutes."[41] Arguably, the current statutory language impedes HCPF in its efforts to expand IHSS. It is within the scope of this review to consider changing the statute to pave the way for future expansion of IHSS.

Rather than enumerating the specific waivers, the IHSS statute should define "eligible person" as any person who is eligible to receive services under any HCBS waiver that offers IHSS. This approach would allow HCPF flexibility in phasing in additional waivers.

To be clear, making this change would not render people who were previously ineligible for IHSS automatically eligible. HCPF would still have to amend each proposed additional federal waiver to include IHSS, and CMS would still have to approve each amended waiver. Then, the Board would have to revise the definition of "eligible person" in its IHSS rules to include each additional, approved waiver. HCPF might also need to seek additional personnel or resources before such an expansion is possible.

Still, removing the specific waiver names from statute removes one of the barriers to IHSS expansion. It would free HCPF from having to seek legislation to change the statute whenever it amends a federal waiver to allow IHSS. HCPF would still have to work closely with the General Assembly if it wishes to increase its allocation to accommodate any expansion.

[40] § 25.5-6-1201(2), C.R.S.
[41] § 24-4-104(6)(b)(III), C.R.S.

Making this change would also make the IHSS statute parallel with the CDASS statute, which defines an "eligible person" as a person who is eligible to receive services under any HCBS waiver for which the HCPF has federal waiver authority.[42]

Expanding IHSS has broad stakeholder support, but such expansion should be made thoughtfully, with appropriate cost controls in place. Making this statutory change would remove one barrier to future expansion. Therefore, the General Assembly should revise the definition of "eligible person" to include anyone who is eligible to receive services under any home and community-based services waiver for which HCPF has federal waiver authority.

Recommendation 3 – Make technical changes to the law.

The law contains an instance of obsolete language that can be repealed. This change is technical in nature, meaning that it has no substantive impact on the regulation of IHSS in Colorado.

The General Assembly should make the following technical change:

- **Section 25.5-6-1203(1.5), C.R.S.** Repeal this provision because HCPF produced the expansion plan as required.

[42] § 25-6-1101, C.R.S.