Department of Regulatory Agencies

Office of Policy, Research and Regulatory Reform

# 2010 Sunset Review: In-Home Support Services

October 15, 2010

Consumer Protection

Department of Regulatory Agencies

**Executive Director's Office**
Barbara J. Kelley
Executive Director

Bill Ritter, Jr.
Governor

October 15, 2010

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 mission of the Department of Regulatory Agencies (DORA) is consumer protection. As a part of the Executive Director's Office within DORA, the Office of Policy, Research and Regulatory Reform seeks to fulfill its statutorily mandated responsibility to conduct sunset reviews with a focus on protecting the health, safety and welfare of all Coloradans.

DORA has completed the evaluation of the Colorado In-Home Support Services program (IHSS). I am pleased to submit this written report, which will be the basis for my office's oral testimony before the 2011 legislative committee of reference. The report is submitted pursuant to section 24-34-104(8)(a), of the Colorado Revised Statutes (C.R.S.), which states in part:

> The department of regulatory agencies shall conduct an analysis of the performance of each division, board or agency or each function scheduled for termination under this section...
>
> The department of regulatory agencies shall 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 report discusses the question of whether there is a need for the program created in Part 12 of Article 6 of Title 25.5, C.R.S. The report also discusses the effectiveness of the 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 program is continued by the General Assembly.

Sincerely,

Barbara J. Kelley
Executive Director

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# 2010 Sunset Review:
# In-Home Support Services

## Summary

***What Is the In-Home Support Services program?***
The In-Home Support Services program (IHSS) is a Medicaid-waiver program, meaning that Colorado pays for the program using monies that would otherwise be spent on traditional Medicaid long-term care. In general, Medicaid-waiver programs allow 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.

***How is IHSS administered?***
The Colorado Department of Health Care Policy and Financing (HCPF) is responsible for administering IHSS. HCPF, in cooperation with the Colorado Department of Public Health and Environment (CDPHE), certifies home health agencies to provide services via IHSS. Case managers at single-entry point (SEP) agencies—that is, 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 referring eligible individuals to certified IHSS provider agencies.

***How many participants are there?***
According to HCPF, there are currently 95 individuals enrolled in IHSS statewide. According to CDPHE, there are six certified IHSS provider agencies.

***What Does It Cost?***
In fiscal year 09-10, IHSS cost $575,845, or $6,062 per participant.

***Where Do I Get the Full Report?***
The full sunset review can be found on the internet at: www.dora.state.co.us/opr/oprpublications.htm.

## Key Recommendations

**Continue IHSS for three years, until 2014.**
According to stakeholders interviewed for this report—including IHSS provider agencies, representatives of state government, and consumer advocates—IHSS fills an important niche among the long-term care options available to Colorado consumers. It allows consumers to stay in their homes and play a considerable role in their healthcare decisions while relieving them of some of the administrative responsibilities participants in other programs must assume. Further, according to HCPF, long-term care delivered via IHSS is significantly less expensive than traditional long-term care. Although there have been persistent problems with HCPF's administration of IHSS, it is a worthwhile program, and enrollment may well grow with improved administration.

**Implement a system to effectively and accurately track IHSS participants.**
The 2007 sunset report made an administrative recommendation that HCPF develop a system for accurately tracking the number of individuals enrolled in IHSS. HCPF did not implement this recommendation. There is still a serious discrepancy between the number of participants reported by HCPF and the number reported by the IHSS provider agencies. Without reliable data demonstrating the number of the participants over time, it is impossible to gauge the effectiveness of the program, identify areas for improvement, or determine whether adequate resources are allocated to the program.

**Implement periodic training seminars for SEP case managers regarding IHSS.**
Recognizing the critical role that SEP case managers play in referring eligible individuals to IHSS, the 2007 sunset report made an administrative recommendation that HCPF develop a comprehensive IHSS training program for SEP case managers. HCPF did not implement this recommendation. Increased awareness of IHSS among the SEP case managers could positively affect enrollment in IHSS.

## Major Contacts Made During This Review

Accent on Independence
Adult Home Care Services, Inc.
Center for Independence
Center for People with Disabilities
Colorado Cross-Disability Coalition
Colorado Department of Health Care Policy and Financing
Colorado Department of Public Health and Environment
Colorado Springs Independence Center
Independent Life Center, Inc.
Personal Assistance Services of Colorado
Personal Assistance Services of Colorado, Southwest
Sangre de Cristo Independent Living Center
Southwest Center for Independence

## What is a Sunset Review?

A sunset review is a periodic assessment of state boards, programs, and functions to determine whether or not 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:
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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 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;
- Whether administrative and statutory changes are necessary to improve agency operations to enhance the public interest.

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

Not all of these criteria apply to sunset reviews of programs that do not regulate professions or occupations. However, DORA must still evaluate whether a program needs to exist to protect the public health, safety and welfare; whether the level of regulation established for the program is the least restrictive consistent with the public interest; whether the state administers the program efficiently and effectively; and whether administrative and statutory changes are necessary to enhance the public interest.

## *Sunset Process*

Programs scheduled for sunset review receive a comprehensive analysis. The review includes a thorough dialogue with agency officials and other stakeholders. Anyone can submit input on any upcoming sunrise or sunset review via DORA's website at: www.dora.state.co.us/pls/real/OPR_Review_Comments.Main.

The In-Home Support Services program (IHSS) administered by the Colorado Department of Health Care Policy and Financing (HCPF) pursuant to Part 12 of Article 6 of Title 25.5, Colorado Revised Statutes (C.R.S.), shall terminate on July 1, 2011, unless continued by the General Assembly. During the year prior to this date, it is the duty of DORA to conduct an analysis and evaluation of IHSS pursuant to section 24-34-104, C.R.S.

The purpose of this review is to determine whether IHSS should be continued for the protection of the public and to evaluate the performance of HCPF. During this review, HCPF must demonstrate that IHSS serves to protect the public health, safety or welfare, and that it represents the least restrictive form of government consistent with protecting the public. DORA's findings and recommendations are submitted via this report to the legislative committee of reference of the Colorado General Assembly.

## *Methodology*

As part of this review, DORA staff interviewed HCPF staff, staff of long-term care and home health agencies, and consumer advocates; and reviewed Colorado statutes and rules, federal laws and regulations, and the laws of other states.

## *Home and Community-Based Long-Term Care*

In the past, if the needs of elderly or disabled people reached a certain point, they had only one alternative: to relocate to a nursing facility or other institution where they could get the care they needed.

Over the past decade, there has been a trend toward consumer-directed healthcare. Consumer-directed models promote independence and flexibility by putting consumers in charge of their own healthcare decisions. The development of home and community-based services (HCBS), which offer an alternative to traditional, institution-based long-term care, reflects this trend.

Generally speaking, HCBS programs allow participants to receive a wide range of services—for example, nursing care, homemaker services, and non-medical transportation—in their homes or communities.

The Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Human Services, which regulates and provides funding for long-term care in all 50 states, may exempt HCBS programs from certain regulatory requirements. This exemption, typically called the HCBS waiver, is authorized by section 1915(c) of the Social Security Act. The waiver allows states to use federal monies that would otherwise be spent on traditional long-term care to develop and maintain programs that allow Medicaid beneficiaries to continue to live in their communities, avoiding placement in institutional care. Programs 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.[2] These exemptions allow states to tailor HCBS programs 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. When applying, the state agency must provide a comprehensive description of the proposed waiver, including its administrative and operational structure, the target groups it will serve, the HCBS services it will offer to participants, and the opportunities it presents for participants to direct their own care.[3]

The initial waiver is valid for three years; thereafter, states must renew the waiver every five years.

States may develop several programs under a single waiver, and there is no limit on the number of discrete programs a state may develop. Programs may provide both traditional medical services (e.g., skilled nursing services) as well as non-medical services (i.e., case management, environmental modifications). Family members and friends may provide services in HCBS programs as long as they meet the specified provider qualifications.[4]

[2] 42 U.S.C. §1396n(c)(3).
[3] Application for a Section 1915(c) Home and Community-Based Services Waiver.
[4] Centers for Medicare & Medicaid Services. *HCBS Waivers—Section 1915(c).* Retrieved on June 28, 2010, from http://www.cms.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp

In 2008, roughly half of HCBS programs nationwide focused on the elderly and disabled communities, while the remaining programs focused on individuals with specific health conditions, such as spinal injuries, mental illness, or autism spectrum disorders. According to CMS, 48 states and the District of Columbia operate HCBS waiver programs, and there are a total of 287 such programs currently in place nationwide.[5]

A 2007 report from the Kaiser Family Foundation identified a growing demand for HCBS, finding that the number of individuals receiving such services via Medicaid grew an average of seven percent annually from 1999 to 2005, outpacing the 5.6 percent average annual increase in total Medicaid enrollment in the same period.[6] Although most Medicaid long-term care dollars still go toward institutional care, the percentage of Medicaid spending on HCBS nationwide has more than doubled from 19 percent in 1995 to 41 percent in 2007.[7]

Currently, there are eleven HCBS waivers in place in Colorado. Of these, two are pertinent to IHSS: HCBS for the Elderly, Blind and Disabled (HCBS-EBD), and HCBS for Children. Individuals who qualify for either of these waivers may apply for IHSS.

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.

[5] Centers for Medicare & Medicaid Services. *HCBS Waivers—Section 1915(c).* Retrieved on September 22, 2010, from http://www.cms.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp

[6] Terence Ng, Charlene Harrington, and Molly O'Malley, "Medicaid Home and Community-Based Service Programs: Data Update," Kaiser Commission on Medicaid and the Uninsured (December 2008), p. 3.

[7] Terence Ng, Charlene Harrington, and Molly O'Malley, "Medicaid Home and Community-Based Service Programs: Data Update," Kaiser Commission on Medicaid and the Uninsured (December 2008), p. 1.

# Legal Framework

## *History of Regulation*

In 2001, the General Assembly appointed a Health Care Task Force to develop expertise in a variety of healthcare areas, including long-term care. The Task Force ultimately submitted seven bills and one resolution for consideration during the 2002 legislative session, including Senate Bill 02-027, which ultimately created the In-Home Support Services program (IHSS).[8]

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 healthcare 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 Department of Regulatory Agencies (DORA) found that the program itself was worthwhile and recommended its continuation, but also identified numerous problems in the way the Department of Health Care Policy and Financing (HCPF) administered IHSS. Specifically, DORA found that HCPF:

- Did not provide clear guidance to agencies wishing to apply to provide services via IHSS, and the application process was fraught with unexplained delays;
- Had no system for tracking the number of people enrolled in IHSS, and was unable to provide any historical census data for the program; and
- Could not provide information on the cost-effectiveness of IHSS even though section 25.5-6-1206, Colorado Revised Statutes (C.R.S.), specifically requires HCPF to track this information.

In the report, DORA recommended four administrative changes HCPF should make to improve administration of IHSS. Because these were administrative recommendations, however, they were not enshrined in statute. With the passage of House Bill 08-1210, the General Assembly extended IHSS for three years.

[8] *Sunset Review of In-Home Support Services*, Colorado Department of Regulatory Agencies (2007), p. 6.

## *Summary of Statute and Rules*

Section 25.5-6-1201, *et seq*., C.R.S., establishes IHSS and vests HCPF with the responsibility for developing and administering the program, including securing all federal authorizations. The General Assembly intended IHSS to deliver home and community-based services (HCBS) to Medicaid-eligible individuals, including the elderly, blind, and disabled, as well as disabled children. IHSS is intended to allow consumers to direct their care, while also reducing Medicaid expenditures.[9]

Participants in IHSS are entitled to the following types of services:[10]

- Personal care services, including assistance with activities of daily living, such as bathing, dressing and eating;
- Homemaker services, such as housekeeping and meal preparation; and
- Health maintenance activities, defined as routine and repetitive tasks necessary for health and normal bodily functioning, including catheter irrigation; administration of medication, enemas, and suppositories; and wound care.[11]

In order to participate in IHSS, a person must:[12]

- Be eligible for the Home and Community-Based Services for the Elderly, Blind, or Disabled (HCBS-EBD) waiver or the Children's HCBS waiver;
- Be willing to participate in the program; and
- Provide a statement from his or her primary care or treating physician that indicates the person has sound judgment and the ability to direct his or her own care, except that:
    - If the eligible person is a child, the parent or guardian may direct care; or
    - If the person has designated an authorized representative, that representative may direct care. The attendant who will be providing services to the person cannot serve as the authorized representative.[13]

Single-entry point (SEP) agencies—defined in statute as public, non-profit, or private agencies through which adults can access long-term care services[14]—are responsible for determining eligibility.[15]

[9] § 25.5-6-1201, C.R.S.
[10] §25.5.-6-1202(6), C.R.S.
[11] In-Home Support Services Regulation 8.552.1.
[12] § 25.5-6-1202(3), C.R.S. and In-Home Support Services Regulation 8.552.2.A.
[13] § 25.5-6-1202(2), C.R.S.
[14] § 25.5-6-106(2), C.R.S.
[15] § 25.5-6-1203(5), C.R.S.

Under IHSS, participants—the eligible person, or the person's parent, guardian, or authorized representative—have the following rights and responsibilities:[16]

- To present a person of their own choosing to the IHSS agency as a potential attendant;
- To train and schedule attendant(s) to meet their needs; and
- To dismiss attendants who are not meeting their needs.

Family members, with the exception of spouses, may serve as attendants.[17] Attendants 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.[18] They must, however, undergo training before providing services. IHSS agencies must provide the training, which addresses at least the following subject areas:[19]

- Development of interpersonal skills focused on addressing the needs of persons with disabilities;
- Overview of IHSS; and
- Instruction on basic first aid administration, safety and emergency procedures, and infection control techniques, including universal precautions.

If attendants can demonstrate that they are already competent in any of the training areas, the training may be modified accordingly.[20]

In addition to providing training to attendants, agencies wishing to provide services via IHSS must:[21]

- Offer participants peer counseling that includes, at a minimum, cross-disability peer counseling, information and referral services, and individual and systems advocacy;
- Provide 24-hour back-up service to participants whenever a scheduled attendant is not available, whether the attendant's absence is anticipated or not;
- Provide intake and orientation service to participants who are new to IHSS; and
- Assist participants in selecting an attendant, if needed.

[16] § 25.5-6-1203(2), C.R.S. and In-Home Support Services Regulation 8.552.3.A.
[17] In-Home Support Services Regulation 8.485.201.
[18] § 25.5.-6-1203(3), C.R.S.
[19] In-Home Support Services Regulation 8.552.5.H.
[20] In-Home Support Services Regulation 8.552.5.I.
[21] In-Home Support Services Regulation 8.552.5.

IHSS agencies must also contract with or have a licensed registered nurse (RN) on staff. The RN must:[22]

- Verify that attendants are competent to perform IHSS and basic consumer safety procedures;
- Counsel attendants on difficult cases and potentially dangerous situations;
- Consult with the participant or attendant in the event a medical issue arises;
- Investigate complaints and critical incidents within 10 working days; and
- Assure that the attendant is following directives found in the IHSS plan.

Before the attendant can start providing services, a written agreement between the participant and the IHSS agency must be in place. The plan must state the allowable number of attendant and personal care service hours; specify the amount, scope and duration of services to be provided, and who will be providing each service; and describe the process for resolving disputes.[23] The IHSS agency is responsible for ensuring that a current IHSS plan is in the participant's record. IHSS agencies typically have policies in place that require a staff member, usually an RN, to meet with the participant at least every three to six months to assure that the IHSS plan still accurately reflects the participant's needs.

If the plan is changed, the agency must notify the appropriate SEP agency case manager within five days.[24]

The state Medical Services Board is responsible for setting the rates at which agencies are reimbursed for each type of service.[25] As of July 1, 2010, the reimbursement rates were:[26]

- $26.32 per hour for skilled care for health maintenance activities; and
- $13.96 per hour for personal care and homemaker services.

Attendants may be reimbursed for a maximum of 444 hours per year for personal care services, approximately 37 hours per month. This limit does not apply to parents caring for their adult children.[27] There is no limit on the number of hours IHSS attendants may be reimbursed for providing health maintenance activities.

[22] In-Home Support Services Regulation 8.552.5.F.
[23] In-Home Support Services Regulation 8.552.1.
[24] In-Home Support Services Regulation 8.552.5.E.
[25] § 25.5-6.1205(2), C.R.S.
[26] *Provider Bulletin,* Department of Health Care Policy and Financing (June 2010), Attachment B.
[27] HCBS-EBD General Provisions Regulation 8.485.204.D.

The SEP case manager must ensure cost-effectiveness and non-duplication of services by:[28]

- Documenting the discontinuation of any previously authorized long-term home health services that are replaced by IHSS;
- Documenting, for new clients, the long-term home health services that are available in lieu of IHSS;
- Documenting and justifying any need for both long-term home health services and IHSS;
- Ensuring all required information is in the client's IHSS plan;
- Authorizing cost-effective and non-duplicative services via the prior authorization request (PAR); and
- Reviewing the IHSS PAR and giving approval prior to rendering services.

HCPF is responsible for assuring public money is properly safeguarded and promoting the effective and efficient delivery of services via IHSS.[29]

[28] In-Home Support Services Regulation 8.552.6.A.
[29] §25.5.-6-1205(1), C.R.S.

# Program Description and Administration

The Colorado Department of Health Care Policy and Financing (HCPF) is responsible for overseeing the In-Home Support Services program (IHSS).

Currently, the funding for IHSS is split equally between the state's General Fund and federal Medicaid dollars.

For this sunset review, the Department of Regulatory Agencies (DORA) asked HCPF to provide five fiscal years of historical data for IHSS. This is DORA's standard practice for every sunset review it conducts. HCPF was able to provide data for fiscal years 06-07 and 07-08 in some categories, and data for fiscal year 09-10 in others.

Table 1 illustrates the number of people receiving each kind of IHSS service, and the IHSS expenditures for the two fiscal years indicated.

**Table 1**
**IHSS Participants and Expenditures**

| | Fiscal Year 06-07 | Fiscal Year 07-08 |
|---|---|---|
| Participants receiving health maintenance services | 76 | 121 |
| Participants receiving personal care services | 78 | 127 |
| Participants receiving homemaker services | 16 | 31 |
| Total program expenditures | $1,897,288 | $3,447,500 |

Although the above numbers do not necessarily reflect the total number of people enrolled in IHSS, since some participants might be receiving more than one type of service, they seem to indicate considerable growth in the program, especially considering the increase in program expenditures.

HCPF was able to provide the total number of unique participants in the program for one fiscal year: 95 participants in fiscal year 09-10. This figure raises more questions than it answers, however, for three reasons.

First, this number seems to conflict with the data in Table 1, above. For example, according to Table 1, 127 individuals received homemaker services via IHSS in fiscal year 07-08, which means that there were at least 127 unique participants in IHSS at that time. If there were truly just 95 participants in fiscal year 09-10, this implies that there was a 25 percent decrease in the number of IHSS participants from fiscal year 07-08 to 09-10, a conclusion that is not supported by data from the IHSS provider agencies.

Second, according to data from the IHSS provider agencies, the total number of participants statewide in August 2010 was 190, nearly twice HCPF's number. According to HCPF, the number it provided is based on the number of claims paid, and it is possible that individuals are enrolled with an IHSS agency but are not yet on record as having submitted claims. This makes sense, but it still seems unlikely that almost half of the current IHSS participants have not submitted claims.

Third, at the time of the 2007 sunset review, HCPF also reported there were 95 participants. This would indicate that has been no variation in the size of the program in three years, even though expenditures have increased significantly and IHSS provider agencies report three times the number of participants in 2010 than there were in 2007.

Table 2 compares the total number of participants and total expenditures for individuals in nursing facilities and individuals enrolled in IHSS for fiscal year 07-08.

**Table 2**
**Number of Participants and Costs**
**Nursing Facilities and In-Home Support Services**
**Fiscal Year 09-10**

| | Nursing Facilities | IHSS |
|---|---|---|
| Total number of participants | 13,713 | 95 |
| Total expenditures | $497,931,993 | $575,845 |
| Average annual cost per participant | $36,311 | $6,062 |

These figures seem to indicate that far less public money is spent per person on long-term care delivered via IHSS than on care provided in a nursing facility.

However, the figure for IHSS expenditures in fiscal year 09-10 is dramatically lower than the number reported for fiscal years 06-07 and 07-08 in Table 1 on page 10. According to HCPF, the data in Table 2 were pulled from the paid claims database. Although HCPF could not determine with certainty the source of the data in Table 1, a representative of HCPF stated that they may have been pulled from reports required by Centers for Medicare and Medicare Services (CMS) that project client enrollment and costs.

## *Application Process for Individuals Seeking Services*

Individuals interested in applying for IHSS must go through one of 23 Medicaid single-entry point (SEP) agencies, which provide case management services for individuals needing long-term care.

There are four steps to enrolling in IHSS.

1) **Establish that applicant qualifies for Medicaid long-term care services.** In order to begin the process for enrolling in IHSS, individuals must first complete the Uniform Long Term Care form (ULTC) which is administered by a SEP case manager.

   The ULTC provides a tool for SEP case managers to assess applicants' memory, cognition, behavior, and their ability to perform six activities of daily living, including:

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

   Under this assessment tool, applicants having deficits in two or more activities of daily living, or cognitive impairments or behavioral issues exceeding certain specified levels, are determined to qualify for Medicaid long-term care services. These applicants then may proceed with the IHSS application process.

2) **Establish that the applicant qualifies for the HCBS for the Elderly, Blind and Disabled (HCBS-EBD) or the Children's HCBS waiver.** The SEP case manager is responsible for determining whether an applicant is eligible for either waiver, but some of the primary eligibility criteria are described below.

   In order to qualify for either waiver, applicants must have an income less than $1,986 (300 percent, or three times, the Supplemental Security Income allowance) per month and countable resources less than $2,000 for a single person or $3,000 for a couple.[30]

   To qualify for the HCBS-EBD waiver, applicants must be either over the age of 65 and have a functional impairment, or between the ages of 18 and 64, and be either blind or physically disabled.

[30] A person's house is generally excluded from his or her countable resources, provided the applicant, the applicant's spouse, or a dependent child resides there. Exclusion criteria may differ for homes worth more than $500,000. Source: Colorado Division of Insurance. *Resources and Qualifying for Medicaid.* Retrieved on June 29, 2010, from http://www.dora.state.co.us/insurance/senior/stern5.pdf

To qualify for the Children's HCBS waiver, applicants must be under 18 years of age, live at home with parent(s) or guardian, and have a disability that places them at risk of nursing facility or hospital placement.

Before enrolling an individual in a HCBS waiver program, the SEP case manager must determine that such enrollment would be cost-effective.[31]

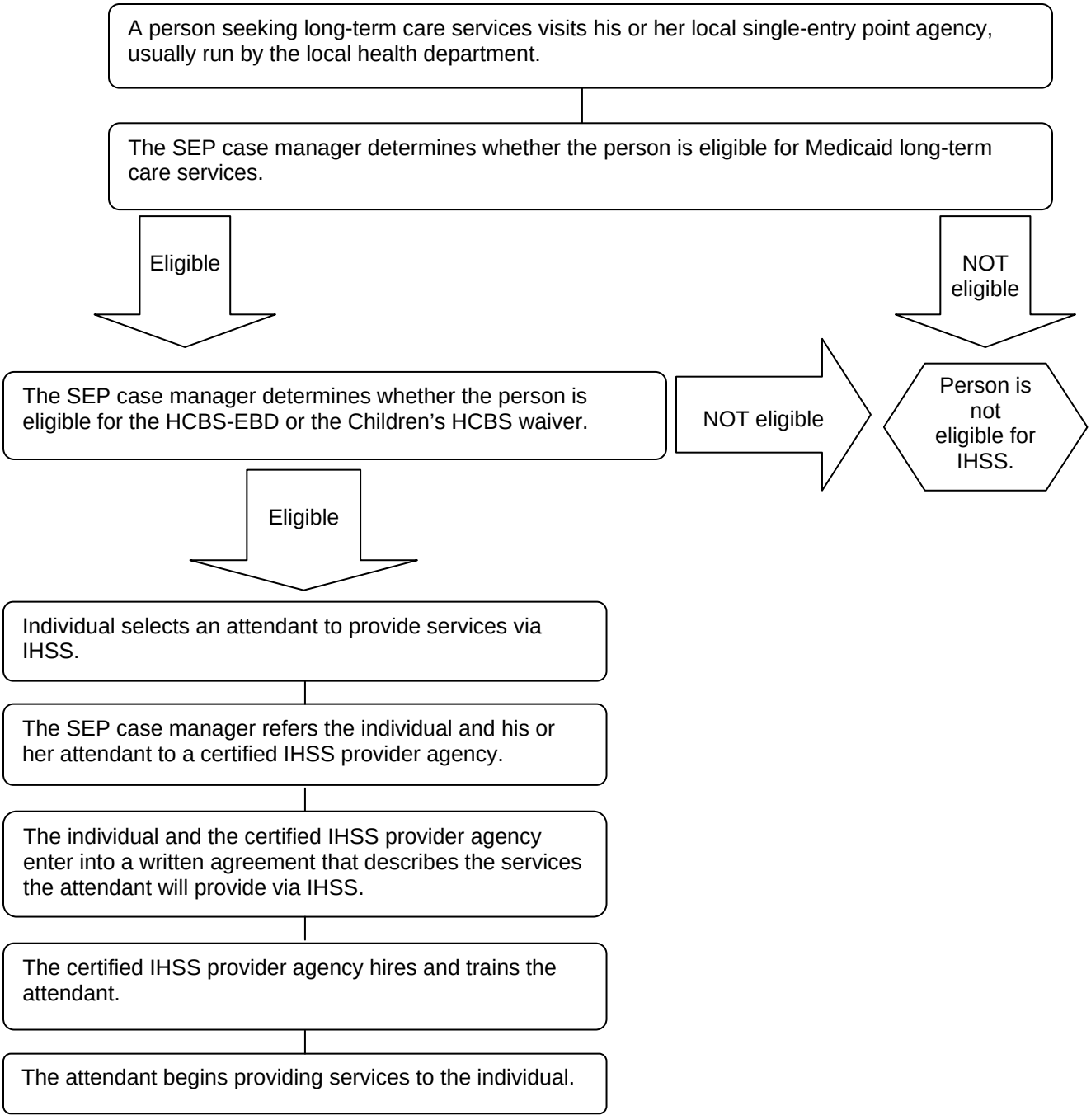
3) **Select an attendant.** The applicant, or his or her parent, guardian, or authorized representative, must select a person to provide attendant services via IHSS. The person may be a friend or family member. The applicant may also ask an IHSS provider agency for help in finding an attendant.

4) **Select an agency to employ the proposed attendant.** With the guidance of the SEP case manager, the IHSS applicant must select an agency certified by the Colorado Department of Public Health and Environment (CDPHE) to participate in IHSS. The selected agency then hires, trains, and pays the attendant to provide services.

[31] Children's HCBS Waiver Program Regulations Rule 8.506.11.A.6 and HCBS-EBD General Provisions Regulation 8.485.61E.

Figure 1 gives an overview of the process for individuals wishing to receive services via IHSS.

**Figure 1**
**IHSS Process for Individuals**



### *Certification Process for IHSS Provider Agencies*

There are three basic steps for agencies seeking certification as IHSS providers.

1) **Enroll as a Medicaid provider under the Colorado Medical Assistance Program.** HCPF administers this application process. The agency must be specifically authorized to provide health maintenance activities, support for activities of daily living, personal care services and/or homemaker services.

2) **Obtain a license from CDPHE to provide non-medical home care services.** The applying agency must send a Letter of Intent to CDPHE requesting a Class B license application.[32] CDPHE then directs the applicant to an online application. The agency completes the application, and CDPHE schedules an inspection of the agency. Once the agency meets all the criteria and passes inspection, CDPHE issues the license.

3) **Obtain authorization from HCPF to serve as an IHSS Provider Agency.** In the application, to HCPF, agencies must:[33]

   - Provide basic contact information and their Medicaid provider number;
   - Describe the types of Medicaid services they currently provide;
   - Specify the city(ies) and county(ies) where they provide services;
   - Specify where they anticipate providing IHSS services; and
   - Indicate the number of eligible clients interested in IHSS, if any.

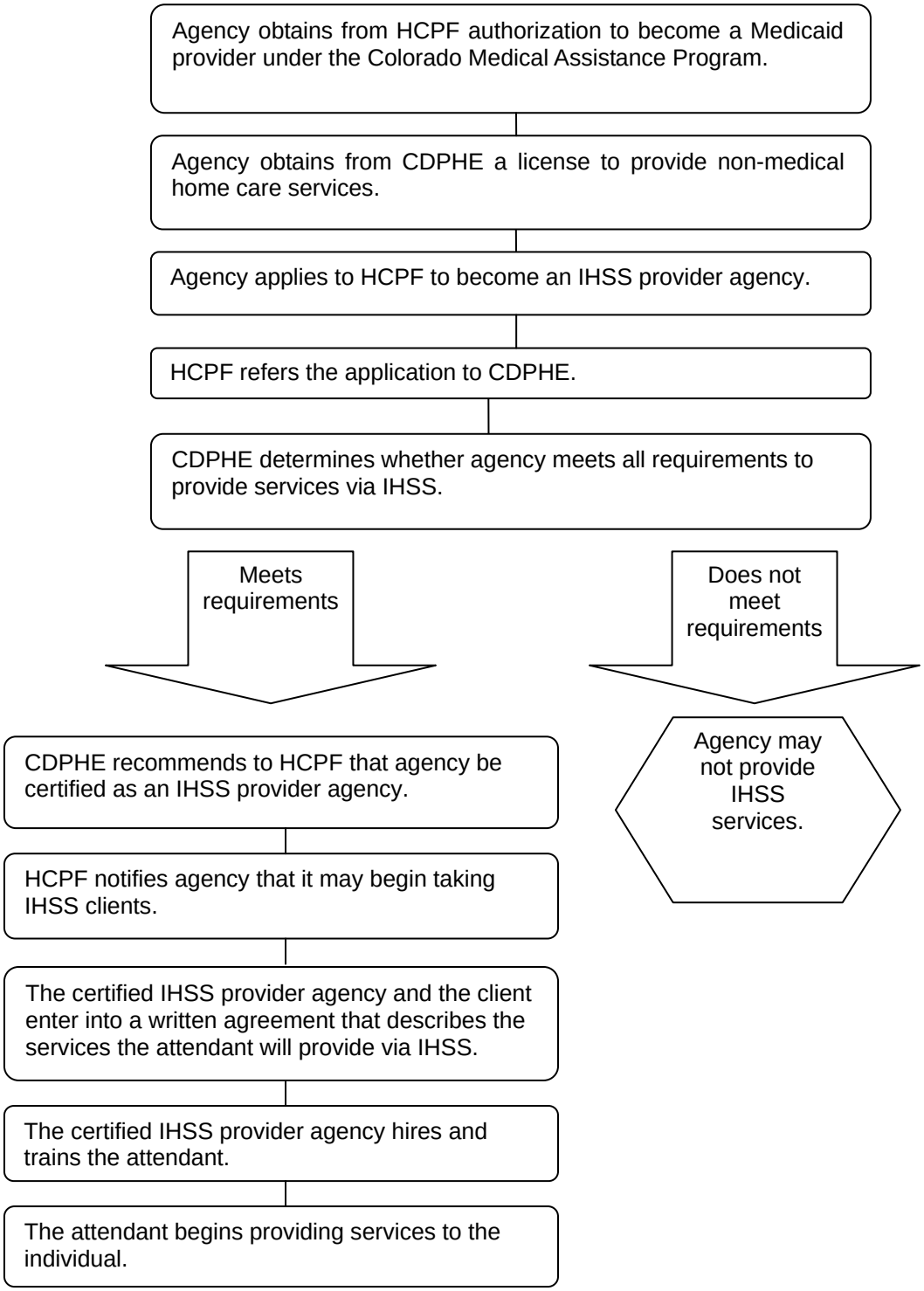
Although the application is sent to HCPF, HCPF actually has an interagency agreement with CDPHE to review applications and conduct on-site surveys of agencies seeking IHSS certification. This application and inspection is in addition to the application and inspection required to obtain a Class-B license as described above. CDPHE recommends whether the applying agency should be certified, and HCPF makes the final determination.

If CDPHE recommends certification, the applying agency must contact HCPF to complete the certification process. IHSS provider agencies must renew their licenses every year. The CDPHE conducts periodic re-certification surveys, which are intended to ensure that participating agencies are in compliance with the original licensing standards, and current IHSS regulations.

[32] Pursuant to Home Care Agencies Rule 5.1 (A), CDPHE issues Class B licenses to home care agencies that provide only personal care services, that is, no skilled healthcare services.
[33] Department of Health Care Policy and Financing, IHSS Provider Agency Application.

Figure 2 gives an overview of the process for agencies wishing to provide services via IHSS.

**Figure 2**
**IHSS Application Process for Agencies**



Currently, there are six long-term home healthcare agencies certified to provide IHSS to eligible participants:

- Three in the Denver metropolitan area;
- One in Colorado Springs;
- One in Delta; and
- One in Cortez.

# Analysis and Recommendations

***Recommendation 1 – Continue the In-Home Support Services program for three years, until 2014.***

The In-Home Support Services program (IHSS) is a Medicaid-waiver program 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 to provide individuals with significant health problems an alternative to institutional nursing care. Under the IHSS program, 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 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.

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

Little has changed since the Department of Regulatory Agencies (DORA) conducted the last sunset review of IHSS in 2007. According to stakeholders interviewed for this report—including IHSS provider agencies, representatives of state government, and consumer advocates—IHSS still fills an important niche among the long-term care options available to Colorado consumers.

To demonstrate the particular advantages of IHSS, it is helpful to look at where it fits among all the long-term care options available to Coloradans. For example, Consumer Directed Attendant Support Services (CDASS) is a Medicaid-waiver program that offers participants considerably more self-direction than IHSS, but also requires participants to take on significantly more responsibilities. If all long-term care options were on a continuum, with traditional, institutional skilled nursing institutions on one end, and CDASS on the other, IHSS would fall somewhere in the middle. It allows consumers to stay in their homes and play a considerable role in their healthcare decisions, including selecting their own attendants, while relieving them of some of the administrative responsibilities participants in other home and community-based services programs must assume.

For example, under CDASS, consumers must hire, fire, and establish the payment rates for their attendants. Under IHSS, the IHSS provider agency handles the hiring and firing of attendants, and the Medical Services Board establishes hourly reimbursement rates. Under CDASS, there is no guaranteed 24-hour backup available if an attendant is unable to come to work; IHSS offers 24-hour backup.

IHSS can offer additional benefits to the attendants themselves: some provider agencies offer health insurance, paid time off, and retirement plans to attendants as employees of the agency.

Although enrollment in IHSS is still relatively low—between 95 and 190,[34] compared with the 13,907 people living in nursing facilities—participants in the program find it suits their needs and allows them to maintain a considerably high quality of life.

Unfortunately, HCPF's performance in managing the program has also changed little since the last sunset review. HCPF has not resolved most of the problems DORA identified in the previous sunset report. There is still no reliable tracking system in place for IHSS participants. Several applicants for IHSS provider agencies report withdrawing their applications because of their confusion over the requirements and the lack of responsiveness of HCPF. HCPF still does not provide the single-entry point (SEP) case managers with any training about IHSS.

Over the course of just seven months, DORA cycled through three different contact people at HCPF. Each time a contact person was replaced, there was apparently no transfer of institutional knowledge from one employee to the next, so DORA was compelled to re-orient each new contact to the sunset process. These staffing issues call into question HCPF's ability to provide consistent guidance to agencies seeking to become IHSS providers, and to consumers wishing to enroll.

DORA was forced to request data multiple times, and when data was received, it was often flawed. For example, DORA asked for a list of approved IHSS provider agencies. HCPF provided a list of 15 agencies. However, according to staff with the Colorado Department of Public Health and Environment (CDPHE), the department that recommends certification of IHSS provider agencies, only 4 of the 15 agencies on the list were actually approved for IHSS. Further, there were two agencies that are approved for IHSS that were not included on the list.

The 2007 sunset review gave HCPF the benefit of the doubt: IHSS had been implemented fairly recently, and it seemed reasonable to expect some growing pains. Three years later, HCPF has made two noteworthy changes. It has improved the IHSS website, as recommended by Administrative Recommendation 3 in the 2007 sunset report, and, as of July 2010, it has established a designated staff person responsible for overseeing all consumer-directed programs, including IHSS.

While these are encouraging developments, in light of the persistent administration problems, and the low number of IHSS participants, some might suggest that IHSS simply be allowed to sunset. DORA strongly rejects this argument. To sunset this program would effectively punish the participants enrolled in the program. IHSS is a worthwhile program, and enrollment may well grow with improved administration.

[34] According to data from HCPF, in August 2010, there were 95 participants in IHSS statewide. According to data from IHSS provider agencies, there were 190. According to HCPF, the number it provided is based on the number of claims paid, and it is possible that individuals are enrolled with an IHSS agency but are not yet on record as having submitted claims. This makes sense, but it still seems unlikely that almost half of the current IHSS participants have not submitted claims.

DORA considered another proposal: transferring the administration of IHSS to another state department. While this might seem like a viable option, the fact that HCPF is Colorado's designated Medicaid agency makes it the most appropriate place to house the program.

Consumers are more interested than ever in staying in their own homes as long as possible. Cash-strapped states are more interested than ever in the cost-effectiveness of Medicaid-waiver programs such as IHSS. According to HCPF, long-term care delivered via IHSS is significantly less expensive than traditional long-term care (please see Table 2 on page 11).

IHSS is needed now more than ever. That is why DORA is recommending that the General Assembly put into statute the administrative recommendations from the 2007 sunset review, and continue IHSS for three years, until 2014. This should give HCPF plenty of time to implement these recommendations.

### *Recommendation 2 – Implement a system to effectively and accurately track IHSS participants.*

Administrative Recommendation 1 in the 2007 sunset report found:[35]

> During this sunset review, DORA requested the total number of active IHSS participants as of the end of fiscal year 06-07 (June 30, 2007). The long-term home health care agencies reported to DORA that there were a total of 62 active IHSS participants. HCPF reported that there were 95 participants. The discrepancy between the participating agencies and HCPF is rather large given the relatively small number of participants in IHSS.
>
> There are several concerns with the large discrepancy of the number of participants between the long-term home health care agencies and HCPF. As a result, HCPF is not able to identify any trends or major issues that need to be addressed either at the agency level or through the participants of IHSS.
>
> Under the current tracking system, HCPF does not know when IHSS participants are entering or exiting. In order to identify issues within IHSS, HCPF should implement a system that actively and accurately monitors the number of participants utilizing the services.

For this sunset review, HCPF was able to provide data on the number of participants for a single fiscal year. In order to be able to "identify trends or issues," as described above, it is critical that HCPF implement a system that tracks the number of participants over a period of years.

[35] *Sunset of In-Home Support Services,* Department of Regulatory Agencies (2007), p. 19.

More troubling is the fact that there is still a serious discrepancy between the number of participants reported by HCPF (95 participants), and the number reported by the IHSS provider agencies (190 participants). As the agency with the statutory authority to administer IHSS, HCPF is responsible for determining the source of the discrepancy with the provider agencies and developing a plan for resolving it.

In discussing why the 2007 administrative recommendation had not been implemented, a representative of HCPF told a representative of DORA that while such statistics might be of interest to academics and researchers, they were not important to HCPF. DORA does not agree with this assessment. Without reliable data demonstrating the number of the participants over time, it is impossible to gauge the effectiveness of the program, identify areas for improvement, or determine whether adequate resources are allocated to the program.

Moreover, section 25.5-6-1206, C.R.S., specifically requires HCPF to report to the General Assembly the number of people participating in IHSS.

For these reasons, the General Assembly should require HCPF to implement a system to track the total number of participants in IHSS.

### *Recommendation 3 – Implement periodic training seminars for SEP case managers regarding IHSS.*

Administrative Recommendation 2 in the 2007 sunset report addressed the apparent lack of knowledge about IHSS among SEP case managers:[36]

> …responses from the SEP agencies were not favorable to the HCPF training regarding IHSS. In fact, one response stated, "What is IHSS?" This is problematic from an administrative standpoint. If SEP case managers are not comfortable with IHSS, as well as knowledgeable about the eligibility requirements for participation, they are not likely to encourage potential eligible individuals to participate in IHSS. As a result, IHSS will continue to experience low participation in Colorado. In order to address the low participation rate regarding IHSS, HCPF should implement a comprehensive training program for all 23 SEP agencies, which includes, but is not limited to:
>
> - The current eligibility requirements;
> - How many long-term home health care agencies are participating in IHSS; and
> - Where the long-term health agencies are located in Colorado.

[36] *Sunset of In-Home Support Services,* Department of Regulatory Agencies (2007), pp. 19-20.

> A comprehensive training program related to IHSS will potentially foster an environment that encourages SEP case managers to encourage eligible participants to enter IHSS(.)

In discussing why HCPF had not implemented the recommendation to develop an IHSS training program for SEP case managers, a representative of HCPF told a representative of DORA that training sessions cover only what is requested by the SEP case managers themselves: no SEP case managers requested training on IHSS, so HCPF did not provide it. This response suggests an unlikely scenario where SEP case managers, who might never have heard of IHSS, would somehow know to request training on IHSS.

Interestingly, all six IHSS provider agencies interviewed for this sunset review credited a few specific SEP case managers with enrolling individuals in IHSS. This implies that increased education among the SEP case managers could positively affect enrollment, thereby allowing more Coloradans to take advantage of IHSS—and avoid institutional care—while saving taxpayer dollars. Therefore, the General Assembly should require HCPF to provide regular training sessions to SEP case managers on IHSS.

***Recommendation 4 – Require HCPF to report to the General Assembly on the cost-effectiveness of IHSS on or before January 1, 2012.***

Section 25.5-6-1206, C.R.S., requires HCPF to:

> On or before January 1, 2008, the state department shall provide a report to the joint budget committee of the general assembly and the health and human services committees of the house of representatives and the senate, or any successor committees, on the implementation of in-home support services. At a minimum the report shall include the cost-effectiveness of providing in-home support services to the elderly, blind, and disabled and to eligible disabled children(.)

HCPF did not present this report to the General Assembly.

When the General Assembly created IHSS, it did so partly because it was seeking a cost-effective way to deliver services to the elderly, blind, and disabled. Although the data comparing the cost of care provided in nursing facilities with the cost of care delivered via IHSS (included in Table 2 on page 11) reveals that IHSS was cost-effective during fiscal year 09-10, it is essential to collect such data over a period of years to assure that the program is consistently cost-effective. Further, the data have never been formally presented to the General Assembly as required by law.

Therefore, the General Assembly should require HCPF to collect and report on the cost-effectiveness of IHSS on or before January 1, 2012.