CONCEPT PAPER FOR WAIVER SIMPLIFICATION IN COLORADO

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Waiver Simplification Concept Paper

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Colorado has historically been a leader among states providing supportive services to people with all types of disabilities, enabling them to live in the least restrictive settings possible. Shortly after 1915(c) waivers became available to states, Colorado obtained approval for the second and sixth waivers granted by the Centers for Medicare and Medicaid Services (CMS), first for individuals with developmental disabilities and then for individuals who are elderly, blind, or disabled. In the early 1990s, Colorado became one of the first states to implement a single entry point (SEP) system, using a network of entities to determine eligibility for Medicaid and functional eligibility for most of its waivers. Today, Colorado is one of only three states to have a waiver that provides services to individuals with serious mental illness.

While Colorado continues to be a model of community long-term services and supports (LTSS) in many regards, its waiver system has become excessively complex. With 12 waivers offering different service packages, the system often fails to meet the needs of individuals and families, and it has become cumbersome for the state to administer. To serve individuals and families better, and to steward public dollars more effectively and efficiently, Colorado has undertaken a large-scale redesign of its Medicaid-funded LTSS system. As one step toward this redesign, Colorado proposes to simplify its waiver system. This concept paper lays out the state's plan for this simplification.

As a first principle, Colorado is committed to the idea that individuals have a right to exercise choice and control over how they receive services; to have their needs addressed in an equitable, person-centered fashion; and to receive the right services at the right time in the right setting. Moreover, Colorado is committed to involving stakeholders throughout its reform efforts so that individuals and families have as many opportunities as possible to help shape the reform process.

Colorado's waiver simplification efforts align closely with the principles that CMS has articulated in recent years in its proposed and final rules for various HCBS authorities, including the 1915(c) Home and Community Based Services waiver, the Section 1915(j) Cash and Counseling State Plan option, the 1915(i) "Home and Community-Based Services" State Plan option," the 1915(k) "Community First Choice" State Plan option, and the Section 1115 demonstration waiver.

Section 1 briefly describes the existing waivers available for adults and for children. Section 2 reviews the complexities and challenges that this system creates, both for individuals and
families and for state administration. Section 3 outlines a series of related initiatives, programs, and work groups in Colorado that support the goal of systems redesign and rebalancing away from institutional care and toward community-based care. Section 4 sketches the state's proposal for simplifying its waiver system, which would ultimately reduce the number of waivers in the state from 12 to four (4); it also discusses the challenges that such a proposal might present. Section 5 summarizes the state's efforts to obtain public input on its waiver simplification efforts to date, and its plans to solicit additional feedback in the future. Finally, Section 6 presents a series of key dates in the simplification plan.

1. **Review of Existing Community LTSS Services**

In this section, we first describe Colorado's long-term home health benefit, which is a mandatory benefit under the State Plan. Next, we review the set of existing waivers for adults and for children. We summarize key features of each waiver: eligibility criteria; a selection of services; the waiver's enrollment cap; and whether the waiver has a wait list. Notably, all of Colorado's waivers have an income threshold of 300 percent of Supplemental Security Income (SSI) – the so-called "special income group" for whom coverage is optional under 1915(c), and all children's waivers disregard parental income. We conclude this section by reviewing the three service delivery options that currently provide individuals the opportunity to self-direct personal assistance services: In-Home Support Services (IHSS), Consumer-Directed Supports and Services (CDASS), and Family Caregiver.

1.1 **Long-Term Home Health**

The Home Health benefit for Colorado Medicaid clients provides services from a licensed and certified Home Health Agency for clients who need intermittent home health services. Home health services include skilled nursing (provided by a registered nurse or licensed practical nurse); certified nurse aide (CNA) services; physical therapy; occupational therapy; and speech/language therapy.

There are two types of Home Health services: 1) acute home health services, which are provided to clients who experience an acute health care need that requires skilled home health care; and 2) long-term home health, which is provided to clients who require ongoing home health services beyond the acute home health period. To be eligible for home health, individuals must require services to treat or ameliorate an illness, injury, or disability, and be unable to perform health care tasks for themselves. Individuals must also require services that cannot appropriately or effectively be provided in an outpatient treatment office or clinic, or for which the client’s residence is the best setting in which to meet the client’s needs.

1.2 **Waivers for Adults**

Colorado currently maintains seven waivers for adults, described below.
The waiver for **Persons with Brain Injury (BI)** provides services to individuals with a brain injury, aged 16 to 64. The waiver provides adult day services; specialized medical equipment and supplies; behavioral management; day treatment; home modifications; mental health counseling; non-medical transportation; personal care; respite care; substance abuse counseling; supported living; transitional living; and personalized emergency response system (PERS). BI requires hospital or nursing home level of care. For waiver year 1, it has a cap of 313 individuals and increases slightly each year thereafter. There is no wait list, but there is currently insufficient capacity to provide supported living to all individuals who want it. Individuals who cannot access supported living can still access all other services in the waiver.

The **Community Mental Health Supports (CMHS)** waiver provides services to individuals aged 18 and older who have been diagnosed with a major mental illness. The waiver provides adult day services; alternative care facilities; CDASS; PERS; home modifications; homemaker services; non-medical transportation; personal care; and respite care. CMHS requires nursing home level of care. It has a cap of 3,104 individuals for waiver year 2, which increases slightly each year thereafter. There is no wait list.

The waiver for **Persons Living with AIDS (PLWA)** provides services to individuals of all ages with a diagnosis of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS). The waiver provides adult day services; PERS; homemaker services; non-medical transportation; and personal care. PLWA requires nursing home or hospital level of care. It has a cap of 200 individuals. There is no wait list.

The waiver for **Persons who are Elderly, Blind and Disabled (EBD)** provides services to individuals aged 65 and older with a functional impairment, or to adults aged 18 through 64 who are blind or physically disabled. The waiver provides adult day services; alternative care facilities; community transition services; CDASS; PERS; home modifications; homemaker services; IHSS: non-medical transportation; personal care; and respite care. EBD requires nursing home level of care. It has a cap of 23,506 individuals for waiver year 1, which increases slightly each year thereafter. There is no wait list.

The waiver for **Persons with Spinal Cord Injury (SCI)** provides eligibility to individuals aged 18 and older who have a spinal cord injury. The SCI waiver is a pilot program that runs through June 2015. It provides adult day services; alternative therapies (acupuncture, massage and chiropractic care); CDASS; IHSS;PERS; home modifications; homemaker services; non-medical transportation; personal care; and respite care. The waiver has an independent evaluation to measure the cost-effectiveness and improved quality of life for eligible participants who are enrolled on the waiver and utilize the alternative therapy services. The waiver requires nursing home level of care. It has a cap of 67 individuals. There is no wait list.
The **Supported Living Services (SLS)** waiver provides services that help individuals aged 18 and older with developmental disabilities to live in their own home, family home, or rental unit that qualifies as an SLS setting. The waiver provides services as an alternative to institutional placement for individuals with developmental disabilities, but it does not provide 24-hour supervision. To be eligible for SLS, individuals must either live independently with supports, or already receive services from other sources, such as family members. The waiver provides assistive technology; behavioral services; day habilitation services; dental services; supported employment; prevocational services; home modifications; homemaker services; mentorship; personal care; PERS; professional services (e.g., hippotherapy); respite services; specialized medical equipment and supplies; transportation; vehicle modifications; and vision services. SLS requires a level of care that meets that of intermediate care facility for individuals with intellectual disabilities (ICF/IID). The waiver has a cap of 3,241 individuals. There is a wait list.

The **Comprehensive Waiver for Persons with Developmental Disabilities (DD)** provides services to individuals aged 18 and older who have a developmental disability. The waiver provides behavioral services; day habilitation; prevocational services; dental services; residential services (24-hour individual or group); transportation; specialized medical equipment and supplies; supported employment; and vision services. The DD waiver requires ICF/IID level of care. It has a cap of 4,525 individuals. There is a long wait list.

### 1.3 Waivers for Children

Colorado currently maintains five waivers for children, described below.

The **Children's HCBS (CHCBS)** waiver provides services to medically fragile children aged birth through 17 who have a disability. The CHCBS waiver does not require a child to have a developmental disability or delay, but it does serve children with developmental disabilities or delays who have concurrent medical conditions. The waiver provides case management and IHSS. CHCBS requires hospital or nursing home level of care. It has a cap of 1,308 children. There is a wait list.

The **Children with Autism (CWA)** waiver provides services to children aged birth through five who have a diagnosis of autism. The waiver provides just one service: behavioral therapy. CWA requires ICF/IID level of care. It has a cap of 75 children. There is a long wait list; children who are most in need due to the severity of their disability are prioritized for enrollment.

The **Children’s Extensive Support (CES)** waiver provides services to children aged birth through 17 who have a developmental delay or disability. To be eligible for CES, children must also have intensive behavioral or medical needs. The waiver provides adapted therapeutic recreation; assistive technology; behavioral services; community connections (to allow children to participate in community-based activities); home accessibility adaptations; homemaker
services; parent education; personal care; professional services (e.g., hippotherapy); respite; specialized medical equipment and supplies; vehicle modification; and vision services. CES requires ICF/IID level of care. Funding was recently allocated to eliminate the wait list, a process that should be complete by the end of fiscal year 2013-2014. At that time, the cap will be 659.

The Children’s Habilitation Residential Program (CHR P) waiver provides services to children and youth aged birth through 20 who are in foster care and who have a developmental disability and extra needs. CHR P provides cognitive services; communication services; community connections; emergency services; personal assistance services; self-advocacy; supervision; and travel. CHR P requires ICF/IID level of care. It has a cap of 200 children. There is no wait list.

The waiver for Children with a Life-Limiting Illness (CLLI) provides services for children aged birth through 18 who have a life-limiting illness. To be eligible for the waiver, children must need hospital level of care and have a life-limiting illness where death is probable before adulthood. CLLI provides counseling/bereavement services; expressive therapy; palliative/supportive care; and respite care. It has a cap of 200 children. There is a wait list.

1.4 IHSS, CDASS, and Family Caregiver
In four waivers, individuals have the option to choose service delivery models that are more in line with consumer direction. IHSS and CDASS give individuals more control over who provides their personal care, homemaker, and health maintenance services. The Family Caregiver model of service delivery in the DD waivers allows family members to be hired to provide a variety of support services regardless of where the individual resides.

Under the CHCBS waiver, IHSS offers Health Maintenance. Under the EBD and SCI waivers, IHSS also offers support for activities of daily living (ADLs) through Personal Care and Homemaker services. IHSS agencies provide core independent living skills, including Cross-Disability Peer Counseling; Information and Referral; Independent Living Skills Training; and Individual and Systems Advocacy. To receive IHSS, individuals must be eligible for a waiver that provides the service; they must demonstrate a need for attendant supports; they must have a stable health condition; and they (or their representatives) must demonstrate the ability to direct their care. In order to qualify as an IHSS agency, an entity must offer independent living core services, provide 24-hour back-up services, and contract with or have on staff a health professional who will be responsible for the training of attendants. Attendants selected by clients are employed by an IHSS agency of their choice.

CDASS is a consumer-directed service delivery option that permits individuals to:

- Hire attendants, even friends and family, based on qualifications that they set;
- Train, supervise, and dismiss attendants;

• Decide when and where they receive services;
• Set wages for attendants, within an annual budget; and
• Choose someone they trust to act as an authorized representative to help them manage their care.

With CDASS, Medicaid funds are set aside for individuals to control, rather than paying a home health agency or personal care agency to provide their attendant care. The individual's case manager determines his or her individual annual allocation. After individuals (or their authorized representatives) complete training and enroll in services, they are responsible for managing these funds to meet their needs. To receive CDASS, individuals must be eligible for a waiver that offers the service (CMHS, EBD, or SCI); they must demonstrate a need for attendant supports; they must have a stable health condition; and they must demonstrate the ability to direct their care.

Family Caregiver is an option available in Colorado's three waivers for individuals with developmental disabilities – CES, DD, and SLS. It permits individuals to receive services at home from a person of their choosing. Authorized in 2008 under Colorado's Family Caregiver Act (SB 08-002), this service delivery option allows individuals to live in their homes or in the homes of family members, and receive services from a family member or from staff or providers of a Program Approved Services Agency (PASA). Family Caregiver does not permit full employer authority or budget authority, and is therefore not a traditional self-directed program. However, the ability of individuals to choose family members as caregivers does represent a limited form of self-direction.

2. Complexity and Challenges of the Current Waiver System

In its current form, Colorado's waiver system creates a number of significant challenges for individuals and families. The management of 12 waivers across three agencies also creates several administrative challenges.

2.1 Problems Created for Individuals and Families

To individuals and families, the system often seems complex and unpredictable. In many cases, they do not know which waivers provide which services. When individuals are enrolled in a waiver, they do not always receive complete information about the array of services in that particular waiver (e.g., that the EBD and SCI waivers offer both IHSS and CDASS). The system is not sufficiently transparent. Individuals and families may know what they need, but not how to navigate the systems that manage and deliver the appropriate services.

Individuals and families are often required to choose among waivers, which are built around diagnosis or disability type rather than need. Because individuals can enroll in only one waiver, and because services differ by waiver, individuals may only get some of the services they need.
As a result, individuals and families must sometimes make difficult choices. For example, an individual with an intellectual or developmental disability who wishes to receive supported employment services cannot self-direct their personal care because the SLS waiver – which offers supported employment – does not offer IHSS or CDASS.

To many individuals and families, the focus of the Medicaid-funded LTSS system appears to be the system itself, not individuals. Greater emphasis seems to be placed on the compliance of the system than on the quality of care that individuals receive and the overall quality of their lives.

The amount of time it takes for individuals to be moved off a wait list and on to a waiver can create enormous hardships. Wait lists can be years long, even when individuals or their family members know enough about the system to place their names on the wait list many years before they will need the services of a given waiver. This problem regularly occurs in the transition from adolescence to adulthood, when an individual with ID/DD may need to move from school services to the SLS or DD waivers. Wait lists also pose a problem when the severity of an individual's needs change over time. Often, individuals who only need SLS care will accept a DD waiver enrollment even if they do not need care for 24 hours, because their names come up on the DD waiver wait list before they come up on the SLS waiver wait list; the reverse can also happen. These mismatches make it difficult for individuals and families to obtain effective, appropriate, person-centered services. Moreover, these mismatches can lead to the over-utilization of services by one group and the under-utilization of services by another group – an inefficient use of scarce public dollars.

The current waiver system also makes it difficult for individuals and agencies to find and retain qualified direct service workers (DSWs). There are at least three reasons for this. First, reimbursement rates for DSWs are typically low, and DSWs receive few or no benefits (e.g., sick time or paid vacation). Second, reimbursement rates for DSWs do not adequately capture the level of an individual's needs; the skills, training, and experience of the worker; travel time; or regional differences in the cost of living in Colorado. Finally, the qualifications for DSWs vary markedly from waiver to waiver. It is difficult even for highly experienced workers to gain the certifications they need to offer services across waivers to multiple populations with varying needs. (We return to the issue of the DSW workforce below, which also poses an administrative challenge for the state.)

Individuals and families would like to self-direct many more services than the system currently permits. IHSS and CDASS are available only in a handful of waivers, and there is no systematic way to self-direct in the ID/DD system. Individuals and families would like to have the option to self-direct their personal assistance services without having to make difficult choices among service packages. Longer-term, individuals would like to self-direct a wider array of services,
and possibly have budget authority as well as employer authority (i.e., direct control over funds which can be used to purchase goods and services that substitute for human assistance). As the state makes self-direction more widely available across the Medicaid-funded LTSS system, it will also explore the feasibility of budget authority as an option in at least some of its waivers.

One of the most serious barriers individuals face is the lack of housing options. While Medicaid cannot pay for ongoing housing costs, attempts to improve the LTSS system in Colorado must address housing in some fashion.

In sum, individuals and families want a person-centered system that will help them get the right services at the right time in the right place, with as much self-direction and self-determination as they choose. The state is committed to transforming its system to achieve these goals.

2.2 Problems Created for Administration

The complexity of Colorado's waiver system creates challenges for the state agencies that oversee or operate those waivers. As the Single State Medicaid Agency, the Colorado Department of Health Care Policy and Financing (HCPF) has the fiduciary relationship with CMS under Title XIX of the Social Security Act (SSA), and is therefore responsible for the oversight of all Medicaid-funded LTSS. HCPF also operates all but four waivers: the SLS, DD, CES waivers, operated by the Division for Developmental Disabilities (DDD), and the CHRP waiver, operated by the Division of Child Welfare Services (DCWS). All agencies must track waiver expenditures to claim the state's federal match; HCPF must integrate and report those expenditures to CMS quarterly (on CMS form 64). The operating agencies must conduct evidentiary reviews and prepare waiver renewals, which HCPF must submit to CMS. A simplified, streamlined system of Medicaid-funded community LTSS would reduce the burden on staff and free up resources that the state could use to expand the array of services that it provides to its citizens and to improve the quality of care they receive.

Colorado has already taken a crucial step in this direction. In 2013, the Governor signed a bill that will move the responsibility for administering programs for individuals with intellectual and developmental disabilities from the Colorado Department of Human Services (CDHS) into the newly created Division of Intellectual and Developmental Disabilities (DIDD) within HCPF (HB 13-1314). By March 1, 2014, HCPF will administer all but one waiver — CHRP. If CHRP is combined with CES (as proposed in Section 4.2 below), HCPF will ultimately administer all of Colorado's waivers.

As noted in Section 2.1, the requirements for DSWs vary from waiver to waiver. These variations increase the administrative load on the agencies that certify these workers. As the population of Colorado ages, and the need for DSWs grows, the state has a vested interest in growing and sustaining the size and quality of the DSW workforce, whether DSWs are full-time
professionals employed by agencies or family members employed part-time by the individuals who receive services.

3. **Related Programs, Initiatives, and Work Groups**

Colorado's approach to transforming its LTSS system has been holistic, progressive, and supported at the highest levels of state government. Before describing the state's proposal for simplifying its current waiver system, we briefly review the context in which the waiver simplification effort is taking place. We also describe several related programs, initiatives and work groups that demonstrate Colorado’s ongoing commitment to serving individuals in the least restrictive setting.

3.1 **High-Level State Support for Community LTSS**

In June 2009, Governor Bill Ritter, Jr. issued an Executive Order (D 011-09) called “Directing the Development of a Strategic Plan to Promote Community Based Alternatives for the Disabled Citizens of Colorado." In the words of that Order:

> The State of Colorado rejects the institutionalization of individuals with disabilities when such institutionalization is not justified and has continued to serve as a national leader in providing service programs that expand and improve community-based alternatives for the disabled. Yet, 10 years after the Court’s disposition in *Olmstead*, barriers still exist that impede the ability of the disabled to live and receive treatment in less restrictive environments. This Executive Order directs the development of a strategic plan that will promote the policies laid out in *Olmstead* by guarding against unjustifiable isolation and enhancing Colorado’s ability to provide community-based treatment programs and facilities for the disabled.

The order directed the Long-Term Care Advisory Committee within HCPF to "review relevant state policies and bring together key stakeholders in order to develop a long-term strategy for improving access to community-based treatment programs and facilities for qualified individuals with disabilities."

In July 2010, HCPF met the mandate of this Order by releasing a report entitled "*Olmstead*: Recommendations and Policy Options for Colorado." In partnership with the Long Term Care Advisory Committee and a core team of stakeholders, the Department identified six key issues and strategies around community-based long-term care. These were to:

1. Make the financing of services in Colorado more sustainable, in part by re-examining reimbursement methodologies for providers;
2. Integrate policy decisions to improve access to community LTSS – that is, to look at programs and policies collectively, rather than in isolation;
3. To increase housing options for people with all types of disabilities;

4. To expand the current array of services, in part to diminish the gap between the services available to people in institutions and those available to people in the community, and in part to minimize cost shifting between systems, such as between the developmental disability system and the mental health system, as a result of services being available in one waiver but not in others;

5. To stabilize and grow the supply of direct service workers (DSWs), to reduce the kind of turnover in staffing that can increase the likelihood individuals will be placed in institutions; and

6. To better inform the community about the services available for people with disabilities.

In July 2012, Governor John W. Hickenlooper issued an Executive Order (2012-027) that accelerated the process of LTSS reform in Colorado. Echoing his predecessor's Executive Order, Governor Hickenlooper wrote:

The State of Colorado recognizes that confining disabled individuals to isolation without proper cause is a form of discrimination. In order to preserve the quality of life for individuals afflicted with disabilities, the state shall promote and advance the availability of autonomous and independent community-based treatment programs and facilities.

The Governor's Order established the Office of Community Living (OCL) within HCPF. It directed the Office and its Director to "redesign all aspects of the LTSS delivery system, including service models, payment structures and data systems to create efficient and person-centered community care." It further directed all relevant state agencies and divisions to coordinate with the Office. The guiding principles of the Office are to:

1. Provide services in a timely manner with respect and dignity;
2. Strengthen consumer choice in service provision;
3. Incorporate best practices in service delivery;
4. Encourage integrated home-and community-based service delivery;
5. Involve stakeholders in planning processes; and
6. Incorporate supportive housing.

The Order further mandated the creation of a Community Living Advisory Group (CLAG) with diverse membership and a mission to make legislative recommendations for 2013 and 2014, with final recommendations to the Governor by September 30, 2014. The CLAG has several working subcommittees, including a Waiver Simplification Subcommittee co-chaired by a staff person from HCPF and by the Executive Director of the Arc of Colorado.
Most recently, in May of 2013, the two Houses of the Colorado General Assembly issued a Joint Resolution (HJR 13-1028) creating a legislative committee to "study and analyze ways to redesign the system of long-term services and supports using the core values recommended by the Colorado Community Living Advisory Committee and others," with a written report to be issued by December 15, 2013. Notably, the Joint Resolution acknowledged that changes to the LTSS system must be based on recommendations by groups such as the CLAG and the Community First Choice (CFC) Council (to which we return in Section 3.7).

3.2 Adult Resources for Care and Help (ARCH)
Following the national model of Aging and Disability Resource Centers (ADRCs) established by the Administration on Aging (now the Administration for Community Living), Colorado has established the Adult Resources for Care and Help (ARCH) program. The mission of ARCH is to provide coordinated and streamlined access points to LTSS for adults aged 60 and over, or aged 18 and over living with a disability, and their caregivers. ARCH empowers older adults, adults with disabilities, and caregivers to navigate health and long term care options. Currently Colorado has 13 ARCH sites covering 52 of Colorado's 64 counties. ARCH sites are designed to streamline access to community LTSS for all individuals, not just those eligible for Medicaid. ARCH sites work collaboratively with community, state and federal programs to help people with disabilities and elders access supportive services that can enable them to live in the most integrated and independent setting possible.

3.3 Colorado Choice Transitions (CCT)
Colorado Choice Transitions (CCT), part of the federal Money Follows the Person (MFP) Rebalancing Demonstration, is a five-year grant program. Launched in March of 2013, CCT's primary goal is to facilitate the transition of Medicaid clients from nursing homes or other long-term care facilities to the community. CCT services are intended to promote independence, improve the transition process, and support individuals in the community. CCT participants have access to qualified waiver services as well as demonstration services. They will be enrolled in the program for up to 365 days, after which time they will enroll in one of five HCBS waivers so long as they remain Medicaid eligible.

3.4 PACE
Colorado has adopted the national Program of All-Inclusive Care for the Elderly (PACE), a Medicare/Medicaid managed care program that provides health care and support services to individuals 55 years of age and older. The goal of PACE is to help frail individuals to live in their communities as independently as possible by providing comprehensive services based upon their needs. Individuals must meet nursing facility level of care; must live in an area served by a PACE program; and must be able to live safely in a community setting. Available services include primary care physician services; specialty physician services; podiatry; medication;
durable medical equipment; rehabilitation therapies; adult day health; transportation to and
from the day center and medical appointments; home care services; respite; and mental health.

3.5 Family Caregiver Support Program
Colorado has also adopted the National Family Caregiver Support Program (NFCSP), which was
created by the reauthorization of the Older Americans Act in 2000. The goal of the NFCSP is to
provide services to caregivers who assist elderly adults, as well as grandparents over 60 raising
grandchildren aged birth to 18. Services provided through the NFCSP fall into five categories:
information to caregivers about available services; assistance to caregivers in gaining access to
supportive services; support for caregivers, including training and counseling; respite care, both
in-home and through adult day services; and services designed to supplement those provided
by caregivers, including home modifications and emergency response systems.

Priority is given to caregivers who are especially at-risk, including low-income and minority
individuals, and individuals providing support to persons with intellectual and developmental
disabilities.

3.6 Medicaid Buy-In
Since 2012, Colorado has offered two groups the option to "buy in" to Medicaid: working adults
with disabilities, and families with children who have disabilities. The groundwork for these two
options was laid by the federal Ticket to Work Incentives Improvement Act of 1999 (PL 106-170),
and by two state laws, the Medicaid Buy-in Act of 2008 (HB 08-1072) and the Colorado
Health Care Affordability Act of 2009 (HB 09-1293).

The Medicaid Adult Buy-In program launched on March 1, 2012. To be eligible for the program,
individuals must be between the ages of 16 and 64. All individuals are treated as a household of
one (i.e., eligibility does not depend on the income or assets of any other individuals). While
individuals must be working, there are no minimum wage or hour requirements. Individuals
must have a qualified disability using the criteria of the Social Security Administration, without
consideration of substantial gainful activity (SGA). In Colorado, working individuals with
disabilities can earn up to 450 percent of the federal poverty level (FPL), after certain
disregards. There are no resource limits, and premiums are set on a sliding scale based on
income. On December 1, 2012, the Buy-In program was extended to give individuals with
disabilities access to HCBS outside the State Plan. To receive additional HCBS benefits,
individuals must meet the eligibility criteria for the standard adult Buy-In program; be at least
18 years old; and meet the functional and targeting criteria of the EBD or CMHS waivers.
Colorado plans to explore the feasibility of expanding access to HCBS for all adults in the Buy-In
Program who have qualifying disabilities.
Launched on July 1, 2012, the Medicaid Buy-In Program for Children with Disabilities (Children’s Buy-In) provides Medicaid benefits for children with disabilities whose adjusted family income is at or below 300 percent of FPL. There are two ways to determine disability for the Children’s Buy-In: a disability determination through the Social Security Administration; or, if the child does not have such a determination, through the state's disability determination contractor.

Eligible families receive Medicaid benefits for their child with a qualifying disability by paying a monthly premium on a sliding scale based on their adjusted income. The Children’s Buy-In program does not have a level of care requirement.

Children on a waiver waitlist may qualify for the Children’s Buy-In program if they meet all eligibility criteria. Children on the waitlist for the CES or CWA waivers can remain on the waitlist and receive Medicaid benefits through Children’s Buy-In while awaiting waiver enrollment. Children on the waitlist for CHCBS must first enroll in the waiver before they can receive Medicaid benefits.

3.7 Community LTSS Reform Committees and Workgroups
The waiver simplification plan we describe in Section 4 has been informed by the work of several committees and subcommittees. These groups include:

- The Brain Injury Waiver Stakeholder Group;
- The Participant-Directed Programs Policy Collaborative, which has been meeting to review the CDASS and IHSS service delivery options (as described in Section 1.4);
- The Children's Disability Committee (also known as "Medicaid and Kids");
- The Consumer Direction Subcommittee of the CLAG, whose mission is to increase consumers' control over individual services and life circumstances by promoting person-centered culture change;
- The Waiver Simplification Subcommittee of the CLAG, whose mission is to draft formal recommendations for simplifying the state's waiver system and to define services to incorporate into new or modified waivers and into the State Plan;
- The Community First Choice Council, whose mission is to explore the feasibility of the state's adopting the CFC State Plan option.

If Colorado chooses to adopt CFC, many of the services that are currently delivered through waivers would become part of the State Plan. Personal assistance services would become available to all Medicaid recipients who meet institutional level of care. Individuals currently on wait lists would be able to receive at least some of the services they need. Moreover, recipients of CFC would be able to self-direct their PAS. While there is high-level support in the state for
adopting CFC (as noted in Section 3.1), and many individuals and families have advocated strongly for it, the state has not yet made a formal decision. Nonetheless, Colorado's exploration of CFC should be seen as part of its overall efforts to simplify its Medicaid-funded LTSS system.

Even if Colorado ultimately decides not to implement CFC, the work of the Council will inform the recommendations of the CLAG and its subcommittees as the state moves forward with its efforts to transform its community-based LTSS system.

4. Waiver Simplification Proposal

As described below, the state's waiver simplification proposal would ultimately reduce the total number of waivers from 12 to four (4), with related changes to the State Plan.

4.1 Adults

Figure 1 summarizes Colorado's proposal for simplifying its adult waiver system. Unfilled (white) boxes represent waivers that would be terminated. The light blue box represents a waiver that will be amended. Dark blue boxes represent the waivers that would operate once the simplification process is complete. Dotted lines represent tentative changes.

HCPF and DDD propose to create a new adult waiver for individuals with ID/DD that would ultimately replace the existing SLS and DD waivers. As noted in Section 2.1, individuals whose needs change over time (from more severe to less severe, or vice versa) may find that the waiver in which they are enrolled no longer meets their needs. Individuals enrolled in the DD waiver may develop independent living skills to the point of no longer needing DD services. However, because SLS has a wait list, they may remain on the much more costly DD waiver. The reverse could also happen for individuals in the SLS waiver if their needs become more acute; such individuals would continue to receive fewer, less intensive services than they need to live safe, fulfilling lives in the community. The new umbrella waiver for adults with ID/DD would combine services in the two existing waivers. It would thus allow individuals to receive services to meet their needs as they vary in acuity. For example, individuals could receive supported employment if they can live independently and hold down a job, or residential habilitation if their needs become more acute. There would be no need to move from one waiver into another, as the umbrella waiver would provide a continuum of needs-based care.

HCPF and DDD recognize that additional planning will be required to create this new waiver and phase out the existing waivers. The Division of Developmental Disabilities will soon form a workgroup to develop a proposal for this new waiver. The necessary collaborative work between DDD and HCPF will be made easier when the staff of DDD move to the newly created HCPF Division of Intellectual and Developmental Disabilities (see Section 2.2).
The PLWA waiver would be closed altogether. It serves a relatively small number of individuals whose needs can be met under the EBD waiver. The purpose of the SCI waiver was in part to determine if alternative therapies are cost effective. If this proves to be the case, the state will incorporate these services into other waivers and likely close SCI.

Individuals currently served under the BI waiver would move either to the EBD waiver or to the new adult DD waiver. Individuals who acquire their brain injuries between the ages of 18 and 21 could transition either to the adult DD waiver or to the EBD waiver, depending on age of onset, the individual's preferences, and whether the individual meets the criteria for having a developmental disability. Individuals who acquired their injuries after turning 22 would be able to transition only to the EBD waiver. Both the new DD waiver and the amended EBD waiver would have to include services and supports appropriate for the unique needs of individuals with brain injuries. Moreover, because these services are primarily rehabilitative, it will be essential to craft needs-based criteria so that services are targeted only to those who would truly need and benefit from them.

The timing of these transitions from one waiver to a new waiver program will depend critically on Colorado's plans to develop and deploy a new universal assessment tool and person-centered planning process throughout its community LTSS system. This system will have to be in place to ensure that individuals currently served by the SCI and BI waivers receive appropriate, individualized services under the EBD or DD waivers, as appropriate. (We return to the developmental of a new assessment and planning system in Section 6, when we discuss the state's anticipated timeline for simplifying its waivers.)

For now, the CMHS waiver would remain unchanged. Because the services offered under CMHS are similar to those offered under EBD, Colorado would prefer to combine the two waivers. Under a proposed rule published in 2011 (76 FR 21311), states will be able to create or amend 1915(c) waivers to serve multiple populations, with no restrictions. However, the state cannot pursue this option until CMS publishes the Final Rule.
4.2   Children

Figure 2 summarizes Colorado's proposal for simplifying its waiver system for children. As in Figure 1, unfilled (white) boxes represent waivers that will be terminated. The light blue box represents a waiver that will be amended. Dark blue boxes represent the HCBS systems that will remain when the simplification process is complete.

Under this proposal, CHRP would be terminated and folded into CES, with highly utilized CHRP-specific services added to an amended CES. The amendment to CES may also reflect decisions to eliminate certain services that may not make the most effective and efficient use of limited resources, thus freeing resources to provide services to more individuals, and to better monitor the quality of those services.

As noted earlier in Section 4.1, Colorado plans to combine the PLWA and BI waivers with the EBD waiver. The age ranges for these waivers are different: While EBD serves individuals aged 18 and older, PLWA serves individuals of all ages, and BI serves individuals aged 16 and older. In principle, then, some children with AIDS or with a brain injury could be denied necessary...
services. Both currently and in the recent past, no children between the ages of 16 and 18 have been served through the BI waiver. No children under the age of 18 have ever been served through the PLWA waiver. Moreover, the services currently available through PLWA are generally designed to serve adults living independently, rather than adolescents living with families or guardians.

Youth with brain injuries could be served either under an amended CES waiver or under the State Plan benefit for rehabilitative services. Colorado is working both internally and with stakeholders to determine the approach that best serves individuals and makes efficient use of Medicaid resources.

Colorado is working to determine the feasibility of closing the CLLI waiver and amending the State Plan to include palliative care for children to reflect the benefits currently offered through the waiver.

The state tentatively plans to close its CWA waiver. Colorado is working to determine the feasibility of offering behavioral therapy as a State Plan benefit. The CHCBS waiver would also be closed. If the state adopts Community First Choice, the self-directed model of personal attendant services would become available via the State Plan.

Colorado will work closely with CMS to determine how to modify the definitions of existing services in the State Plan or to introduce new State Plan services to replace the ones that are lost when waivers are terminated.
4.3 Advantages of Waiver Simplification
Simplifying Colorado’s waiver system would offer at least five important advantages for individuals and families:

1. It would create a more person-centered system by giving individuals and families access to a wider array of services. The current system creates a series of "service silos". Individuals and families must make difficult (and often confusing) choices about which silo to enter based on which services they most need. Once they enter a silo, they are cut off from services in other silos – even though they may need those other services as well. In the simplified, more individualized system, individuals and families would have access to more of the services they need.

2. It would be easier for individuals and families to understand the options available to them. The system as a whole would be easier to navigate.

3. A new adult DD waiver would accommodate a continuum of needs without requiring individuals to move from waiver to waiver as their needs change, or to remain in
waivers that do not meet their needs because more appropriate waivers have no open slots.

4. If Colorado adopts CFC, all individuals who qualify for personal assistance services would be able to receive them. As an uncapped entitlement for Medicaid recipients who meet institutional level of care, CFC would help to alleviate some of the burden created by long wait lists, especially for persons with ID/DD.

5. If Colorado adopts CFC, all eligible individuals would be able to self-direct their services. Self-direction would become a cornerstone of community LTSS in Colorado.

A simplified waiver system would offer at least two important administrative advantages for the state:

1. State staff would have fewer programs to administer. Resources could be redirected to expanding services and to monitoring the quality of services offered.

2. A simplified waiver system would bring with it a harmonized set of service definitions. It would be easier for the state to build and sustain a robust workforce of DSWs who can provide services to individuals with different diagnoses and different levels of need.

4.4 Challenges of Waiver Simplification

Under the Patient Protection and Affordable Care Act (ACA, PL 111-148), a state cannot adopt eligibility standards, methodologies, or procedures under its State Plan or waivers that are more restrictive than those in effect when the ACA was enacted. For adults, the Medicaid maintenance of effort (MOE) requirement in Section 1902(gg) of the SSA applies until the new health insurance exchanges are fully operational on January 1, 2014, and for children through September 30, 2019. (Because Colorado’s Children’s Health Insurance Program (CHIP) program was converted to a Medicaid expansion on January 1, 2013, provisions related to CHIP do not apply.) If a state does not comply with its MOE requirements, it puts at risk some or all of its Medicaid federal financial participation (FFP). Colorado’s waiver simplification proposal creates risks that the state may not meet its MOE obligations.

The targeting criteria for the BI waiver currently allow youth between the ages of 16 and 18 to receive services. The state must therefore amend these criteria before the end of 2013 to raise the minimum age of eligibility to 18; otherwise it will have to maintain the waiver in its current form until 2019. Because Colorado will have an operational health insurance exchange on January 1, 2014, the state can amend or terminate selected adult waivers after that date with no implications for MOE. Before it amends the BI waiver, Colorado will carefully consider how it would provide services for individuals with brain injuries aged 16 to 18, if individuals needing such services become known to the state before the changes described in Section 4.1 are in place.
Changes to the HCBS system for children potentially have more serious implications for MOE. In its provision of HCBS to children, the state wishes achieve several goals simultaneously:

1. To protect vulnerable families from the prospect of financial ruin from the high costs of providing community LTSS largely or entirely out-of-pocket;
2. To ensure that it does not violate its MOE eligibility obligations; and
3. To require more cost sharing by families, especially affluent families, so that limited state resources can be spent on individuals with the greatest needs.

The state proposes to terminate four waivers that serve children and move the relevant services into the State Plan. Importantly, children's waivers in Colorado do not consider parental income or resources. Therefore, moving children from waivers into the State Plan will cause many children to lose Medicaid eligibility. Because the Children's Buy-In program does not completely disregard family income, this change may interrupt coverage for children with family incomes above the Children’s Buy-In income limit of 300 percent FPL (after 33 percent of income is disregarded). Such a change could expose families to financial hardship. It could also leave Colorado in violation of the ACA’s MOE requirements.

Because the Children’s Buy-In was launched in July of 2012, there may in fact be no violation of MOE. According to a State Medicaid Director Letter issued in February of 2011 (SMDL #11-001): "States are not precluded from adopting premiums if they are applied to new coverage provided after July 1, 2008 for Medicaid and March 23, 2010 for CHIP, and the new coverage and premium amount is consistent with other provisions of law." It is unclear from this guidance whether Colorado’s plan would violate MOE for children whose waiver coverage began before July 1, 2008 or March 23, 2010. (The key date depends on whether CMS sees children enrolled in Colorado's expanded Medicaid program as having "come from" CHIP.) Colorado seeks guidance from CMS on this issue.

To preserve eligibility for vulnerable families, Colorado is actively exploring the adoption of a "Katie Beckett" State Plan option. Authorized by the Tax Equity and Financial Responsibility Act of 1982 (TEFRA), the option gives states the ability to cover children with disabilities in the community if the child would be eligible for Medicaid institutional services but can be cared for more cost effectively at home. Also called "institutional deeming," because the state determines eligibility as if the child were in an institution, this option allows states to disregard the income and assets of parents and consider only the income and assets of the child, which are typically minimal. If Colorado adopts the Katie Beckett option, children whose services are moved to the State Plan will continue to be eligible for Medicaid, thus protecting vulnerable families from financial catastrophe. Adopting the Katie Beckett option, however, does not help the state achieve its goal of requiring greater cost-sharing by affluent families.
To protect families and implement cost sharing, Colorado could pursue two options. The first is to adopt the Katie Beckett option and impose fees on a sliding scale. The second is to modify the Children's Medicaid Buy-In program so that all families with children who have disabilities can buy into the program, with premiums that accurately reflect their ability to pay. Colorado wishes to discuss with CMS its options for modifying the Children Buy-In program. Colorado seeks CMS's guidance on the feasibility of this approach.

As the state moves ahead both with its waiver simplification efforts and with the 2014 Medicaid expansion, Colorado must consider what private health insurance plans will now be required to cover. Families with children who have disabilities may carry private insurance plans that will soon pay for services that they typically have not covered in the past – for example, services for children with autism. Colorado will need to develop protocols for monitoring the services that are covered both by Medicaid and by private insurance, and for ensuring that private insurance is billed first (thus making Medicaid-only services a kind of "wraparound" for services not covered by private insurance).

In a related vein, the state will need to keep abreast of how private coverage compares to Medicaid coverage, in EPSDT or in an amended State Plan. For example, private plans may eventually offer coverage for autism-related services that is more extensive than the coverage that Colorado Medicaid offers. Colorado is committed to maintaining as much parity as possible between Medicaid and benchmark private plans, so that children in families covered only by Medicaid can receive services that are similar in amount, duration, and scope to those offered in private plans.

5. Public Input

As noted in Section 3, public input on the waiver simplification process began with the work that preceded the formal Olmstead report issued in July 2010. Public input has continued with meetings of the CLAG’s Waiver Simplification Subcommittee and the CFC Development and Implementation Council (which has been among the most active CFC Councils in the nation). Members of the Waiver Simplification Subcommittee regularly consult with the constituents they represent, providing feedback to the Subcommittee as a whole. Indeed, the Subcommittee's work has helped to shape the simplification proposal presented in this concept paper.

Once Colorado and CMS agree to a general plan for simplification, the state will seek additional stakeholder input, perhaps with town hall-style meetings or teleconferences that will help residents in rural parts of the state to participate. Colorado will consult with CMS and with stakeholders to develop an input plan that reflects the commitment that the state shares with CMS to involving individuals and their families as much as possible.
Once waivers have been amended, eliminated, or created, Colorado will keep individuals and families informed about the changes to the HCBS system. Again, the state will consult with both stakeholders and CMS to develop an outreach plan that makes individuals and their families aware of their new choices; facilitates transitions from one waiver to another (if such transitions are necessary); and highlights the benefits of the redesigned system.

6. Timeline and Key Dates

Colorado anticipates completing its waiver simplification process by the end of 2016. To help put its waiver simplification efforts on a firm foundation, Colorado plans to develop and deploy a new valid and reliable assessment instrument to be used across populations. As noted in Section 4.1, the BI waiver cannot be terminated until the new tool has been developed and individuals are confident that they will be assessed in an individualized, person-centered fashion and receive the services they uniquely need. It will take several years to develop, pilot, test, evaluate, modify, and deploy this new instrument.

Colorado will provide CMS with additional information about the timing of its simplification as they become clear. In the meantime, the state welcomes input from CMS on the proposal it has presented in this concept paper, and on the timing of the transformation efforts to which the state is committed.