COLORADO CROSS-DISABILITY COALITION

TO: Medical Services Board

FROM: Julie Reiskin, LCSW, Colorado Cross-Disability Coalition

RE: MSB 23-03-13-A Case Management

Dear Board Members:

Please accept these written comments as well as verbal comments at your meeting.

The Colorado Cross-Disability Coalition is the largest statewide disability led disability rights organization in Colorado. Most of our leadership are members in HCBS program as are many of our members. We have deep expertise with HCBS programs. We also participated in all Department meetings and committees related to the drafting of these rules and supported the case management redesign legislation.

We appreciate the many hours HCPF spent meeting with us and that they made some of the recommended changes. The “listening log” that outlined what changes they did and did not make was very hard to follow and often the response was not relevant to the comment or question. For example, someone might have asked a question, and their response was “resolved”. As of our last meeting many of the important items had notations that the matter would be addressed later. Because the log was so unwieldy and hard to follow, we cannot say for sure what may or may not have been updated.

We do appreciate the intent of case management redesign. We support conflict free case management. We support some of the improvements in this rule. We also found a few items that are style and readability related and will identify these as well. Our comments are divided into three areas: 1) Major substantive issues.

2) Readability.

3) Clarification-which are areas where we think there is agreement, but the language is not clear.

Major Substantive Items:

1) **8.7102.2 Level of Care Letter H:** Says the cost of HCBS waiver services shall not be greater than the cost of placement in an institution and the individual's safety and health can be assured in the community. This does not make sense and violates federal law and *Olmstead v. United States*, 277 U.S. 438 (1928). The cost of care is aggregate not individual. "States must show that the average Medicaid expenditures for the services provided under the waiver are equal to or less than what ***average*** expenditures would be if that same population were to be served in an institutional setting." US Government Accountability Office Report, GAO-18-628. *See also* 42 U.S.C. § 1396n(c)(2)(D). This is restated at 8.7103.2 (CES) Item C using slightly different and confusing language, and children are not subject to rigid limits or caps because of EPSDT. This appears in 8.7514.17 Case Management Functions C. 3 as well.
2) **8.7205.3 Community Advisory Committee C 3 items a-c.** The number of people is too small to ensure adequate client/member representation and have other community members involved.
3) **8.7206.3 Nursing Facility Admission and Discharge:**
   a. A1: WE LOVE that options counseling will be provided alerting people about community support or additional support before admission.
   b. B (3)c: This is one of the issues that the Department of Justice is talking about in the lawsuit against HCPF. If someone gets a one-year certification in a nursing facility they should not have less than that if they want to leave. The setting should not matter. This requirement discourages people from trying to leave because clients are told they will not "pass" and will lose their Medicaid. This is a particular issue for people with chronic illnesses and brain injuries who may look like they need less in an institutional setting. Letter E seems to contradict this and says what we think it should say, which is that the original

length of stay should be used. It seems to say that one only gets that if they are using transition services. People should not have to use transition services if they do not need or want them (even though they are usually a good idea).

4) **8.7206.19 Support RE: Dispute Resolution: A:** The items outlined here are appealable items, members need to be given formal notices and appeal rights (according to 10 CCR §2505-10 8.057). Having a way to talk in hopes of resolving the appeal is fine, but this makes it seem as if this "dispute process" in lieu of appeals which is completely inappropriate. Same issue is in 8.748 item 7.
5) The same section must include that the cost of mediation will be borne entirely by the CMA and that the mediator shall be mutually agreed upon.
6) **8.7416 Psychotropic medications.** The requirement to never be allowed to do PRN, especially for family caregivers or with guardian approval is leading to a lot of emergency room visits, need for crisis services, and law enforcement interaction. We agree there needs to be some guardrails to make sure people are not being drugged or having medications used for behavior, but the prohibition is a problem, particularly given the lack of behavioral health services for people with IDD.
7) **8.7522.03 Health Maintenance:** There are a number of places here where HCPF is suggesting eliminating member inability to direct or assist with the task as a criteria for skilled services. They did add some language saying that the Department can determine something is skilled even if the other criteria are not met but this means more figuring out the magic language and lack of equity for those who do not have someone that can advocate for them. If someone cannot direct or assist with tasks like dressing, positioning, bathing, they need a skilled person to assist because judgement is required. The main differentiation between skilled and "unskilled" is that some judgement is used. There is no task where a client cannot assist or direct at all where there is no judgement required. We strongly object to this language. We understand that there are some provider agencies abusing this but managing the abusive providers is what is needed, not taking away a level of care from vulnerable individuals. This will cause decreases in services from people who are already

barely hanging on in consumer direction and will put people in an untenable situation as personal care providers are not allowed to help people who require this level of judgement. This is a significant decrease in service and will cause widespread chaos and appeals on top of the chaos that is already in our system. We ask that the board require that this language not be removed from the rule.

8) **In both personal care and homemaker (8.7526.04.A.6 and 8.7526.06.A.2) definitions it says they cannot be reimbursed for travel time.** This is a labor law violation. If they do errands as part of their work, they must be paid for this time. If they are working for an agency and going from point A to point B they also must be paid. 7 CCR 1101-1.9.2.

Readability:

1) Please identify all acronyms at the beginning of the section where they are used frequently. This includes items that may be spelled out elsewhere such as PASSR. We found a few areas that do not have acronyms spelled out.
2) Language about cost containment is confusing. We appreciate that some of it was removed, but what was replaced is just fuzzy and hard to read.
3) **8.7205.3 Community Advisory Committee C 2 (i)(a)**: We appreciate the sentiment but using the term “self-advocates” is a euphemism for client or person with disability or disabled person. Disability is not a bad word. If someone is only advocating for themselves, they should not be on a committee. Disabled people can be great advocates for the whole client community. Please use our words, euphemisms are not culturally competent.
4) **8.7206.7 Waitlist Management G:** We suggest you break up number 2 into two different numbers and have people leaving institutions be one number and CLLI/CES/CHRP be another number making a total of 4 subcategories.
5) **Same section H: Number 1:** 30 days to accept or decline: This should be clear that this is to say yes or no, not to find a placement.

Clarifications:

1) **Member Rights Section 8.7004**
   a. **C.3**: Retaliation protections should include people who have someone else advocating for them, for example no retaliation against a client due to advocacy by a family member or professional advocate. We believe this is the intention of the Department but would like it be noted.
   b. **A.5-A.9:** Please include both the Legally Authorized representatives and LTSS Representative in items 5-9. Many people who do not have a legally authorized representative such as a guardian will have an advocate that they want included. The "person centered plan" says clients have this right. *See* 8.7004.E.1. Please clarify this here.
   c. **Preservation of members' rights (8.7004 B)**: makes it appear as if the enforcement is completely up to members and that the Department is not responsible for enforcement. We do not believe this is the intent of HCPF as the single state agency.
2) **8.7102.2 Level of Care**
   a. **Letter B:** the state prescribed tool should mention executive function as this was heavily discussed in the new tool and is a major reason for institutional care.
   b. **Letter E:** The PMIP does not cause a medical professional to say that the person needs an institutional level of care. It simply identifies diagnoses and notes if there is a TBI, MI, or IDD.
3) **8.7205.4 Complaint Process Letter B:** should include guardians and any communication-related accommodation issues. For example, if someone is unable to speak and they communicate through another person this should be noted in all records and on the landing page of the CCM record for that client and this person should be notified of all complaint procedures. This is not always a legal representative.
4) **8.7205.8 Recordkeeping: Letter D:** Same comment, all communication accommodations should be noted. We had specifically and repeatedly asked that this be on the dashboard or front page of the client record on the CCM and apparently that

suggestion was either rejected without communication, ignored, or not shared with developers as it does not appear to be there. This means case managers often do not know about these critical issues. This lack of knowledge leads to immediate miscommunication.

5) **8.7205.9.A**: Releases should not all have to be redone if there is a change in provider. I think the intent is that only the release for THAT provider would be eliminated. Please clarify.
6) **8.7205.12 Incident Reporting:** We discussed that this needs to be more nuanced. Case managers will be flooded if someone reports every time a client goes to the hospital or has any injury. This should include language that says something like "and the event is not expected as a normal event regarding their disability". Also, if in a nonresidential setting who is required to report and where do they report? Most clients do not know who the case manager is. If this is going to become a serious requirement for clients a significant educational campaign is needed because clients do not currently do this. They call if there is a new need for service.
7) **8.7206.10 Person Centered Support Coordination Letter I:** This needs clarification. It says to ask permission if the case manager can observe a residence but then says shall be compelled to permit observation (sentence is written strangely). If this is required say it and clarify how often. Is this only once a year? Do not ask permission if it is mandatory. Also, say how much intrusion is required. Do they get to look in every room or just come in. Do they get to go through drawers, the refrigerator, etc.? Is the level of inspection based on anything such as vulnerability of the client or identification of clear concerns?
8) **Same section Letter M:** having a list but saying including but not limited to is not a great idea in rule. We suggest not having a list and saying instead that case managers must follow all operational guidance and policies.

9) **8.7206.21 Continuous Quality Improvement: Letter E:** The may should be shall. I do not think the Department intends to select which performance reviews it makes public and keep some private.
10) **8.7405 Documentation items 7 and 8:** This seems excessive for family caregiver situations.

11) **8.7414 Room and Board:** Please identify who pays for medically necessary OTC that are not covered by Medicaid. We have repeatedly asked for this clarification.

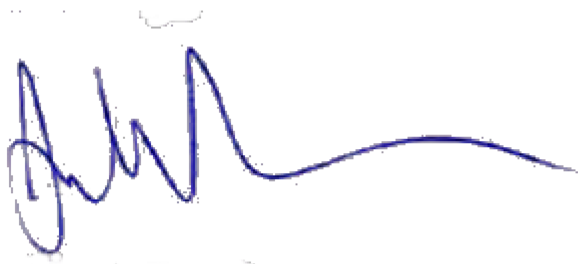
12) **8.7514.05 CDASS Exclusions and Limitations:** CDASS should not be provided in a nursing facility or hospital generally. There should be exceptions for hospitals for when it is necessary for health and safety. We have been meeting with HCPF for months on this issue. HCPF does grant exceptions based on reasonable modifications under the ADA and this should be noted. Also, to comply with DOJ limited services for training and transition should be available in nursing facilities.

13) **8.7524.04 Home Accessibility Modifications: Letter G:** not covered are walk in tubs. Is this different from a roll in shower? Those are common accessibility modifications. Also, sometimes air conditioning and duct cleaning can be a health need.

14) **8.7536.04 Personal Care Exclusions, A 4:** Says family members cannot be paid for homemaking. I believe the rule is that this is the case when they share a home, not in all cases. A relative that does not live with the client should be able to be paid for homemaking.

Thank you for your time and attention to this important and extensive rule set. We did raise all these issues with staff during the many months of review.

Sincerely



Julie Reiskin, LCSW

Co-Executive Director