STATE OF COLORADO

Colorado Department Health Care Policy and Financing
Susan E. Birch, MBA, BSN, RN, Executive Director

Colorado Department of Human Services
Reggie Bicha, Executive Director

John W. Hickenlooper
Governor

October 17, 2012

The Honorable Cheri Gerou
Chair, Joint Budget Committee
Legislative Services Building, 3rd Floor
200 East 14th Avenue
Denver, Colorado 80203

Dear Representative Gerou:

The Colorado Department of Human Services and the Department of Health Care Policy and Financing, in response to the Long Bill fiscal year FY 2012-13 Request for Information #5 (RFI #5), respectfully submit the attached report and corresponding appendices. RFI #5 requests the Departments "submit to the Joint Budget Committee by October 15, 2012, a report on the high-level outline of the initial steps required to modify the Colorado long-term care system into a new model of service delivery. This report is requested to include the following information: summary of the information gathered through community forums including participants of the forums; the status and results of the fiscal and programmatic analysis done of the existing waivers, including what methods were explored for streamlining existing waivers while maintaining waiver expenditures at current levels; and the status of the nation-wide search of best practice service delivery models and the advantages and disadvantages of implementation of the alternative models."

The Department of Health Care Policy and Financing is conducting a follow-up analysis that will provide additional detail of Developmental Disabilities' expenditures stemming from the Community Centered Boards. The follow-up report, titled *Division for Developmental Disabilities: Analysis of Community Centered Boards,* is anticipated to be completed and submitted to the Joint Budget Committee within the next month.

If you have any questions, please contact Joscelyn Gay, Director, Office of Long Term Care at 303-866-2806.

Sincerely,

Susan E. Birch, MBA, BSN, RN
Executive Director

Reggie Bicha
Executive Director

cc:

Senator Mary Hodge, Vice-Chair, Joint Budget Committee
Representative Jon Becker, Joint Budget Committee
Representative Claire Levy, Joint Budget Committee
Senator Pat Steadman, Joint Budget Committee
Senator Kent Lambert, Joint Budget Committee
Mr. John Ziegler, Staff Director, Joint Budget Committee
Ms. Megan Davisson, Joint Budget Committee Staff
Mr. Henry Sobanet, Director, Office of State Planning & Budgeting
Ms. Melodie Beck, Office of State Planning & Budgeting
Ms. Bettina Schneider, Office of State Planning & Budgeting
Ms. Nikki Hatch, Deputy Executive Director of Operations
Ms. Dee Martinez, Deputy Executive Director of Enterprise Partnerships
Mr. Jay Morein, Director, Office of Performance and Strategic Outcomes
Mr. Will Kugel, Budget Director, Colorado Department of Human Services
Ms. Joscelyn Gay, Director, Office of Long-Term Care
Ms. Barbara Ramsey, Acting Director, Division of Developmental Disabilities
Ms. Sarah Sills, CDHS Legislative Liaison
Ms. Suzanne Brennan, Deputy Executive Director, Health Programs Office
Mr. Jed Ziegenhagen, Deputy Medicaid Director, Long Term Services and Supports
Ms. Sarah Roberts, Operations Division Director, Long Term Services and Supports
Mr. John Bartholomew, Deputy Executive Director, Finance Office
Ms. Carrie Cortiglio, HCPF Legislative Liaison

Legislative Request for Information

Department of Health Care Policy and Financing and the Department of Human Services,
Services for People with Disabilities

FY 2012-13 #5

> *The report is requested to include the following information: summary of the information gathered through community forums including participants of the forums, the status and results of the fiscal and programmatic analysis done of the existing waivers, including what methods were explored for streamlining existing waivers while maintaining waiver expenditures at current levels, and the status of the nationwide search of best practice service delivery models and the advantages and disadvantages of implementation of the alternative models.*

Background Information:

In September 2011 the Long-term Care Advisory Committee (LTCAC) was reconstituted by Sue Birch, Executive Director of the Department of Health Care Policy and Financing (HCPF), to be the primary planning and implementation channel for long-term services and supports (LTSS) redesign. The LTCAC was reconstituted to include members from all segments of the LTSS system to begin crafting a roadmap for the redesign of the LTSS system. Beginning in November 2011 and continuing through April 2012, both Sue Birch and Reggie Bicha, Executive Director of the Department of Human Services (CDHS), led a series of community forums and meetings to gather stakeholder input on streamlining the administration of the two departments to reduce duplicate efforts with regard to rules, planning, and other administrative functions.

By April 2012, the LTCAC had conducted a strategic planning session, which included review and consideration of the recommendations found in Senate Bill 05-173 (2005), House Bill 07-1374 (2007), and the Olmstead Report (2010). The strategic planning session resulted in the identification of four strategic priorities and the development of four subcommittees of stakeholders and staff to work on those priorities. These four strategic priorities are Medicaid Entry and Eligibility, Waiver Modernization, Care Coordination, and Consumer Direction (See Appendix A, LTSS Strategic Planning Report 2012). The subcommittees met for the first time on August 3, 2012.

Out of the multiple sessions held by Directors Birch and Bicha, the Directors along with the Governor's Office, decided that an executive level visioning and planning process was needed to assist the work of the Long-term Care Advisory Committee. On July 5, 2012 Governor Hickenlooper signed an Executive Order establishing The Office of Community Living within the Department of Health Care Policy and Financing and the Community Living Advisory Group to oversee this work and help Colorado meet the growing need for long-term services and supports by people with disabilities and aging adults. The Community Living Advisory Group will serve as the steering committee to provide oversight for community living efforts occurring in Colorado to ensure alignment. (See Appendix B, Office of Community Living Executive Order 2012). The first Community Living Advisory group meeting was held on August 28, 2012. (See the timeline of events related to the Long-Term Services and Supports redesign in Appendix C, LTSS Timeline.)

As the steering committee for long term services and supports redesign, the Community Living Advisory Group will assure the alignment of high-level policy development and direction across the diverse interests and activities throughout the system. The LTCAC serves as the operational arm of the Community Living Advisory Group and will research, develop and test assessment tools, models of service delivery, models of payment, etc., to improve the client experience with the LTSS system by making it more effective and efficient. The LTCAC's findings and recommendations will be provided to the Community Living Advisory Group for vetting and approval to move forward for implementation.

Section 1: Summary of the information gathered through community forums including participants of the forums;

Directors Birch and Bicha led community forums to discuss the redesign of the Long-term Supports and Services system (See Appendix D, LTSS Community Forums) including the potential relocation of the Division for Developmental Disabilities, the State Unit on Aging, and the Children's Residential Habilitation Program from the Department of Human Services to the Department of Health Care Policy and Financing. With the relocation, the departments planned to streamline the state's Long-term Services and Supports system by reducing department level fragmentation, to leverage federal health care reform dollars, and to improve services to clients.

More than 200 stakeholders and partners were invited to attend these forums to provide their invaluable input on the proposal. The community forums were held in Pueblo on January 24, 2012, Grand Junction on January 30, 2012, Frisco on February 3, 2012, and Westminster on March 19, 2012.

In addition to the forums, 12 stakeholder meetings, totaling approximately 60 people in all, were held in the months of February and March (See Appendix E, LTSS Stakeholder Meetings). The groups who attended these meetings included the Mile High Down Syndrome, the Legal Center for People with Disabilities and Older Persons, the Colorado Interagency Coordinating Council, the Autism Society, Family Voices, JFK Partners, Area Agencies on Aging, Colorado Hands and Voices, Arc of Colorado, the Colorado Commission on Aging, Colorado Chapters of the Arc, Colorado Cross Disabilities Coalition, AARP, Parents of Adults with Disabilities in Colorado, DDRC Board of Directors, and Shalom Denver. A small group (12) of stakeholders representing the Community Centered Boards, advocates and representatives from the Colorado Commission on Aging met with the Department and the Governor's Office throughout the months of February – April, 2012 to determine whether the group could reach consensus on a bill to streamline administrative functions across the two departments.

Information gathered at these various community meetings included:

- Concerns that the process was happening too fast;
- Stakeholders wanted to create planning sessions to discuss the proposed relocation of programs;
- Concerns about unintended consequences;
- Need for easier navigation of the developmental disabilities system;
- Streamlining of the multiple developmental disabilities waivers to increase clarity;
- Streamlining of administrative functions associated with the management and oversight of the developmental disabilities programs between the two departments; and
- Inclusion of the community in the development and implementation of relocating programs from the Department of Human Services to the Department of Health Care Policy and Financing.

These issues were discussed at standard monthly meetings, such as the Advocacy Communication meeting held for family members and advocates and meetings with the Community Centered Boards (See Appendix F, Community Centered Board Meetings). Additionally, Joscelyn Gay and Barbara Ramsey presented at the 2012 Alliance Summit: Focus on the Future conference on the progress of the LTCAC and next steps for LTSS redesign (See Appendix G, Alliance: Focus on the Future).

A complete list of meetings related to the long-term services and supports system including forums, stakeholder meetings, Community Center Board meetings, advocate meetings, and conferences are included in the appendices section of this document.

Section 2: The status and results of the fiscal and programmatic analysis done of the existing waivers;

The departments have completed an analysis of the costs of each Home and Community Based Services (HCBS) waiver and facility option within the LTSS system, including the additional cost associated with State Plan services (See Appendices H, Long-term Benefits Databook and I, DDD Analysis of Expenditure Drivers 2012). Appendix H was submitted in March 2012 as an update to the November 2011 Legislative Request for Information. Appendix I examines the recent increases in the cost of the waivers for persons with developmental disabilities. The Department of Health Care Policy and Financing will be submitting a follow up to this report, which will examine costs by CCB. This follow up report will be submitted in the next month and is an update to March 2012 report. This information will be used by the departments and the LTCAC to inform their recommendations regarding system modifications.

Fiscal analysis for the consolidation of existing waivers is just getting started, and will be completed within the next six to nine months. This is a complicated process of assessing, determining and selecting the best waiver option for the types of services Colorado wants to provide. Each waiver option has a number of considerations and constraints with regard to the level of services provided, the population allowed to receive the service, and the cost of the provision of those services. The Long-term Care Advisory Committee is engaged in this assessment process through its Waiver Modernization subcommittee. Any recommendations developed will be submitted to the Community Living Advisory Group for vetting and approval before moving forward to the Department of Health Care Policy and Financing or the General Assembly for consideration for implementation. As this information becomes available, the Department will provide an update to the Joint Budget Committee.

Section 3: Methods explored for streamlining existing waivers while maintaining waiver expenditures at current levels;

The LTCAC Waiver Modernization subcommittee is in the process of creating six-, 12-, and 18-month work plans to review and possibly combine existing waivers to improve services for clients. In its current state, waiver programs are difficult for clients to understand and agencies to manage. Within this subcommittee, members will form recommendations concerning which waivers can be combined, review the regulatory structure governing the waivers, integrate the waivers focused on seniors, children, and persons with disabilities, and standardize reimbursement rates and assessments. By doing so, the LTCAC's goal is to create a model for an efficient waiver system that reduces fragmentation, is easier for clients to navigate, and is better suited for proper management and fiscal integrity. The subcommittee met September 11, 2012 and began the initial development of the work plans.

This subcommittee is considering the possibility of combining the adult developmental disabilities waivers and consolidating the children's waivers as one of the first steps of waiver consolidation. Again, these recommendations will be vetted by the Community Living Advisory Group, which will review and develop the appropriate strategy for implementation. Those recommendations will then be forwarded to the Department, Governor's Office and Legislature for consideration and approval.

Section 4 and Section 5 combined: The status of the nationwide search of best practice service delivery models and the advantages and disadvantages of implementation of the alternative models;

The LTCAC subcommittees will work to identify and assess the best practices and alternative models of other states throughout the country that have the potential to be applied to Colorado. The Community Living Advisory Group will vet the models proposed and determine the necessary strategy for implementation.

High level identification of possible models in other states has already been completed by the Department of Health Care Policy and Financing. This information will be discussed in the subcommittees of the LTCAC and evaluated in more depth as recommendations are developed. Preliminary scans have been completed for each of the priority areas included below. Each work group within the LTCAC will bring models forward for review by the Community Living Advisory Ggroup.

Single Entry Point/Case Management Design – The Centers for Medicare and Medicaid Services (CMS) through the Affordable Care Act has incentivized states to create more efficient, person-centered single entry point systems. States that are eligible for these incentives must invest less than 50 percent of their total tong-term care expenditures in HCBS services. While Colorado is not eligible for these incentives, it can use the manual created by CMS that outlines best practices for assessment and service planning processes, expectations for conflict-free case management and a suggested framework for entry point design. The entry point design work is based on the Aging and Disability Resource Center (ADRC) initiative that CMS and the Administration on Community Living have been promoting nationally over the last decade. The intent of this initiative is to streamline access to long-term services and supports regardless of payer. The ADRC initiative has generated multiple documents on best practices by state, and defines the functions of an entry point system (See Appendix J, Aging and Disability Resource Center Initiatives).

As the LTCAC defines its recommendation for the appropriate role and responsibilities for the single entry points, the Community Living Advisory Group will review and approve the model to be recommended to the Department of Health Care Policy and Financing.

Care Coordination – Wisconsin and Massachusetts have generally been considered leaders in care coordination/case management for HCBS clients and particularly for individuals who are dual eligible for Medicare and Medicaid (i.e. the Duals). The AARP Policy Institute has published several reports on best practices in case management, which can be used as reference material as we redesign our case management infrastructure. HCPF has convened a DHS/HCPF workgroup examining care coordination to map the various entities doing case management/care coordination in the state for our Medicaid population. Based on this analysis, the Department of Health Care Policy and Financing will be working to identify areas where we can consolidate certain functions and areas where we can create more efficient hand-offs.

The LTCAC will use HCPF's information to develop recommendations for a standard set of activities for care coordination. The ultimate goal is a clearly defined standard for care coordination. The Community Living Advisory Group will evaluate and approve the model and develop the implementation strategy for HCPF's consideration.

Waiver Modernization – To improve how we serve clients and reduce the overall administrative burden and inefficiencies by having 12 waivers, HCPF is examining how we can modernize our waivers by consolidating the number of waivers at the same time that we expand the choice of services. As part of this process we will be examining how we can create efficiencies in our assessment and service planning processes and improve the allocation of services so that clients only receive the services they need when they need them. This specific work will be informed by the CMS manual mentioned earlier, which discusses best practices in assessment and service planning processes. It also lists all of the tools currently in use to assess the functional capacity of clients. States who have been leaders in waiver consolidation include Pennsylvania, Nebraska and Delaware. We are in the process of securing a contractor who will research these states and others to examine lessons learned and the success of the consolidation efforts. We anticipate the selection of a contractor in October 2012. In addition, the Department is in close contact with CMS to discuss the tools, timing and any technical assistance resources they may be able to provide as new waivers are submitted for federal approval.

The LTCAC will oversee the cost analysis of any waiver consolidation options and propose a recommendation to the Community Living Advisory Group for thorough vetting and approval to recommend to HCPF for adoption and implementation.

Consumer Direction – Both departments are committed to improving the client's experience when contact is necessary with government systems. This means that services are developed to provide the right services at the right time in the right amount. One strategy for getting the right services at the right time is to maximize consumer choice and direction in the provision of services. The Department of Health Care Policy and Financing is currently engaged in a number of projects related to consumer direction, such as the development of the Community First Choice Council, the Participant Director Policy and Procedures Committee and now the Consumer Direction subcommittee of the LTCAC. These groups will be working closely together to expand consumer directed options in all aspects of the LTSS system.

The LTCAC is examining models in other states and has identified Massachusetts as a recognized leader in providing consumer-directed options. The National Resource Center for Participant-Directed Services is in Massachusetts and provides a wealth of information on designing such services. There is also a National Clearing House for HCBS, which centralizes various reports, tools and other documents from states and consulting firms that identify best practices and policies to improve various aspects of HCBS delivery. Both of the web-based resources can provide a wealth of information to Colorado in terms of creating a more efficient delivery system for HCBS services.

As with the other subcommittees, the Consumer Direction subcommittee will develop recommendations for promoting consumer direction throughout HCPF's activities and will work with the Community First Choice (CFC). These proposals will be reviewed by the LTCAC and approved by the Community Living Advisory Group to be submitted to HCPF for consideration for implementation.

Conclusion

The Community Living Advisory Group has begun its work to set the high-level policy and direction for the improvement of Colorado's long-term services and supports system. The Community Living Advisory Group includes legislators, county commissioners, agency directors, consumers and other representatives from across the long-term services and supports system. In this way, the General Assembly and the Joint Budget Committee will have a trusted vehicle for ensuring that varied perspectives have contributed to a balanced approach for shaping the long-term services and supports system in Colorado. The Community Living Advisory Group conducts open meetings and its work will be tracked and reported along with the Long-term Care Advisory Committee through semi-annual reports available on the Long-term Care Advisory Committee website:
http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1251627784788.

The departments will keep the Joint Budget Committee informed of the Community Living Advisory Group's efforts and work in partnership to develop legislation and other necessary activities to make person focused and community involved long-term services and supports redesign a reality in Colorado.

Appendix

A. LTSS Strategic Planning Report 2012
B. Office of Community Living Executive Order 2012
C. LTSS Timeline
D. Executive Director Stakeholder Community Forums
E. Executive Director Stakeholder Meetings
F. Community Centered Boards Meetings
G. 2012 Alliance June Summit: Focus on the Future
H. Long-term Benefits Databook
I. Division for Developmental Disabilities An Analysis of Expenditure Drivers 2012
J. The Aging and Disability Resource Center (ADRC) Demonstration Grant Initiative: Interim Outcomes Report

Appendix A

COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax

John W. Hickenlooper, Governor • Susan E. Birch MBA, BSN, RN, Executive Director

August 2012

Dear Long-Term Services and Supports (LTSS) Stakeholders:

I'm excited to share with you the attached "Long-Term Services and Supports Strategic Planning Report." In the first half of 2012, we conducted strategic planning with our Long Term Care Advisory Committee (LTCAC), our Long Term Benefits Division, the Department of Human Services / Division for Developmental Disabilities and the State Unit on Aging. I want to thank all of these dedicated people for their hard, thoughtful work in this process.

The result of this work is the attached integrated strategic plan, developed by Chi Partners, consultants in health care. This plan is a living document, which will evolve over time as the LTCAC and our staff work to make LTSS more person-centered, make progress on the strategic initiatives identified in the report, and identify new opportunities to modernize and streamline LTSS.

LTSS is central to our work to improve the quality of life for our clients, including people living with disabilities and the aging population. Executive Director Birch and I strongly support a robust continuum of options and services that supports people living in the community or a setting of their choice. We are committed to improving LTSS programs to meet the needs of our clients. We need your input and support to identify and implement these improvements.

The LTCAC has created subcommittees to commence work in August on the strategic initiatives outlined in this report. You have the opportunity to learn about and participate in this important work. I look forward to hearing your comments or responses to the report. For more information about the work of the LTCAC, or to comment on this report, please contact John Barry at John.R.Barry@state.co.us or 303-866-3173, or visit our LTCAC Web site.

Sincerely,

Suzanne Brennan
Medicaid Director

sb/jrb

"The mission of the Department of Health Care Policy & Financing is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources."

Appendix A

LONG-TERM SERVICES AND SUPPORTS

STRATEGIC PLANNING REPORT

Colorado Department of Health Care Policy and Financing

July 2012

Appendix A

chi▲partners™
Consultants in Healthcare and Housing Innovation

Strategic Planning
Staff and Long Term Care Advisory Committee
Consolidated Plan
Executive Summary

This executive summary brings together the planning processes for both staff of the Department of Human Services (DHS) and the Department of Health Care Policy and Financing (HCPF), and the Long Term Care Advisory Committee (LTCAC) into a consolidated process for moving forward. Each group selected a limited number of strategic initiatives to focus on. While the two strategic planning processes were conducted separately, the outcomes were similar and overlapping. As such, the process for moving forward will involve staff from both departments and members of the LTCAC for each of the strategic initiatives. Those initiatives are:

1. **Medicaid Entry and Eligibility:** This initiative will include a complete review of the single entry point function and system (SEP, CCB, ARCH) and an evaluation and possible restructuring of the process for Medicaid eligibility and determination of service need. It was also decided that the issue of presumptive eligibility would be explored by the LTCAC through this Subcommittee. Given the challenges around entry into the Medicaid system, it would be premature to suggest implementing presumptive eligibility without first fixing those changes, particularly those that focus on the length of time it takes to be deemed eligible. This Subcommittee will initially focus on presumptive eligibility best practices from other states and their applicability to the Colorado system.

2. **Waiver Modernization:** Colorado's home and community-based waiver programs (11) need a complete review and possible consolidation. This will include a process to determine which waivers might be consolidated, a review of the regulatory structure governing each of the waivers, an integration of waivers focused on seniors with waivers focused on persons with disabilities, and standardization of reimbursement rates and assessments.

3. **Care Coordination:** This initiative will review the care coordination process with a focus on training for care coordinators, case load, independence of care coordinators, flexibility of care planning and care coordination in transitional situations. The care

coordination initiative will have some overlap with the Entry/Eligibility initiative, so there should be a process for these to work in concert.

4. **Consumer Direction:** While there is currently a stakeholder/staff group working on improvements to the CDASS program, this process will be expanded to include evaluation of the Community First Choice option, evaluation of the In-Home Support Services (IHSS) program and the potential for consumer direction in other waiver programs.

In addition to the previous four initiatives that would be undertaken by joint staff/stakeholder work groups, the following two initiatives would be led by staff:

1. **Quality Assurance:** The integration of DHS and HCPF provides a unique opportunity to review the quality assurance processes and create a consolidated, person-centered, outcome-based quality assurance system. There appear to be significant opportunities for efficiencies by a consolidation of these systems.

2. **Mapping and Streamlining the Continuum of Care:** The integration of DHS and HCPF provides an opportunity to create a more coordinated continuum of care, provides opportunities to focus on prevention rather than intervention and presents opportunities to more creatively use the funding streams of each organization to support seniors and persons with disabilities. The LTCAC will be asked to contribute to the work of this group as well.

These initiatives have strong correlations to one another and to other initiatives within HCPF. Continuous, robust collaboration will be essential to prevent duplication of responsibility and to maximize opportunities to leverage staff, funding and political capital to bring about system changes.

Next Steps

The following next steps are recommended for moving these initiatives forward:

1. **Staff and LTCAC Buy-In:** Neither staff nor the LTCAC has had a chance to review this report and its recommendations. There should be a process where staff and the LTCAC can buy-into these recommendations and perhaps suggest "minor" changes.

2. **Teams:** Teams that include staff and relevant stakeholders (LTCAC and others) need to be created for each initiative. There should be one staff member and one stakeholder designated as the co-leaders to be responsible for ensuring that the process moves forward in a timely manner and that the work of the Team is disseminated to relevant stakeholders to achieve buy-in throughout the process.

3. **Work Plans and Timelines:** Each Team needs to initially create both a work plan and timeline. There should be clear deliverables within clearly stated time frames.

4. **Resources:** As is evident from the report, these initiatives will require resource allocations both in terms of staff and outside consultants. Teams need to clearly define those resources and get buy-in from management that the resources will be provided.

Appendix A

Outcome of the Strategic Planning Process
Health Care Policy and Financing
Department of Human Services
April 21, 2012

Introduction

In June of 2011, Chi Partners, LLC contracted with Colorado Health Care Policy and Financing (HCPF) to conduct a series of interviews, both internal (HCPF) and external (stakeholders, advocates, etc.), to review available documents (historical and current) and suggest strategic changes that would assist the Long Term Benefits Division (Division) of HCPF to become a more efficient and effective division.

The following were the recommendations from that report:

> *Recommendation #1 – Restructure the management team in the Long Term Benefits Division and provide that team with the resources necessary to turn the Division into a high-functioning, motivated team.*
>
> *Recommendation #2: Evaluate the current staff and provide them with the necessary tools, leadership, training and support that allow them to perform at a high level and be visionary in their work.*
>
> *Recommendation #3: Prior to the process of consolidation of the waivers, begin a thorough review of the waivers and make structural, operational, financial and quality improvements.*
>
> *Recommendation #4: Create accountability mechanisms within the Division to ensure that each of the waivers has checks and balances to prevent both manipulation and fraud.*
>
> *Recommendation #5: As the availability of data is crucial for decision-making within the Division, begin the process for aligning the data systems with the needs of staff for relevant data. For at least the next 12 months, ensure that the Division has priority for any data needs (changes, fixes, etc.) within the Department.*
>
> *Recommendation #6: As stakeholders are crucial to the success of many of HCPF's initiatives, create a process that acknowledges their role, successfully manages their input, gains their trust and ensures that they enjoy a collaborative relationship with the Division and the Department.*

In a meeting on October 11th, managers and staff provided feedback to the report and, based on that feedback, the report was updated.

Appendix A

Following the report, Chi Partners was selected to update the strategic planning work with the Long Term Benefits staff. By this point, HCPF and the Colorado Department of Human Services (CDHS) were discussing a proposal to move CDHS long term care programs to HCPF. The strategic planning effort was modified to include staff from CDHS.

1. In addition, HCPF was in the process of reconstituting its LTCAC, and so again, the strategic planning process was modified to include this stakeholder group. Ultimately, Chi Partners was asked to conduct two staff sessions, and one kick off session with the LTCAC: Consolidated planning with the Department of Human Services and the Department of Health Care Policy and Financing; and
2. Planning with the newly reconstituted LTCAC.

Though the two planning efforts were separate, it was hoped that elements of the plans would coalesce and that the task forces (HCPF/DHS) and subcommittees (LTCAC) would work in concert on those initiatives that were similar. If the two efforts contained significantly different outcomes, this would also be helpful information for HCPF to be aware of as they move forward with health care reform.

Planning

The first meeting of the consolidated planning efforts with DHS (Division for Developmental Disabilities, State Unit on Aging, and the Children's Habilitation Residential Program) and HCPF (Long-Term Benefits Division) was held on February 6, 2012. Because of logistical issues, that meeting was limited to LTB staff and only the management staff from DHS. The meeting began with a discussion of the mission and vision for each department:

> *DHS's mission is to design and deliver quality human services that improve the safety and independence of the people of Colorado. The Department is committed to the improvement of individual and family outcomes, cross-system integration, and community partnerships.*
>
> *DHS's vision is to promote safety, health, well-being and independence for all Coloradans through leadership, innovation, and accountability to human services programs throughout Colorado.*
>
> *HCPF's mission is to improve access to cost-effective, quality health care services for Coloradans.*
>
> *HCPF's vision for Colorado balances the three primary goals of increasing access to health care, improving health outcomes and containing health care costs.*

While the mission and vision for the two organizations are similar, there are important differences with DHS's mission and vision being more focused on those concepts that are so important to the disability community – person-centered care, partnerships, choice and independence. This difference may be a factor as the two organizations began efforts to merge. One comment from the planning process for the LTCAC highlights that difference:

> *There is a difference in Mission, Vision and, at the heart of the matter, Core Values between DDD and HCPF. DDD's mission statement is about the quality of life of the individuals served and HCPF's mission statement is largely about access to quality medical care. It may be true that the mission and vision of DDD remains the same under HCPF as it is under CDHS, but it is the core values of the individuals and management of HCPF that guides the priorities and choices that must be made on every level of operation and service to clients. This refers to the principles that guide internal priorities and choices as well as the relationship of HCPF to the external world.*

There was unanimous support for the concept of the triple aim:

> *Improving the U.S. health care system requires simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Preconditions for this include the enrollment of an identified population, a commitment to universality for its members, and the existence of an organization (an "integrator") that accepts responsibility for all three aims for that population. The integrator's role includes at least five components: partnership with individuals and families, redesign of primary care, population health management, financial management, and macro system integration.*[1]

Process Mapping

At this meeting, staff engaged in "process mapping" to understand the challenges encountered by clients as they both enter and engage the DHS and HCPF systems. The key issues that came out of that process are summarized in the following:

Medicaid

- The asset qualification issue is difficult to navigate and takes months to work through.
- It takes in excess of 45 days to get qualified for Medicaid (90 days for those applications that involve disability determinations).
- Medicaid pending clients are almost always not accepted by SNFs as they historically have lost money on these clients.
- Presumptive eligibility would help.
- Disconnect between Social Security and the County.
- Many counties struggle to find and retain staff backing up the Medicaid application process. Turnover of staff creates training issues.

Single Entry Points (SEPs)

---

[1] Donald Berwick, Thomas Nolan, and John Whittington: "At the Intersection of Health, Health Care and Policy"

Appendix A

- SEPs (and Community-Centered Boards [CCBs]) need access to information.
- There is no continuity in the assessment process.
- SEPs are good at getting people into the system, not good at care management.
- Assessment tool is subjective and has too much variability.
- SEPs have a heart and want to help people get on the system and get services, as such they may "bend the data" to help the client.
- There is no correlation between acuity and spending.
- Care management is confusing given the number of SEPs and confusing given the roles of other care management agencies.

CCBs

- CCBs vary in their capacity.
- Long waiting lists (DD) because of a cap on the waivers causing some clients to move to the EBD waiver.
- Kids must be severe to get into the system. Once in the system, you're good.
- CCBs control the front door and the back door. There are no checks and balances (same with some other programs like brain injury).
- In rural areas, the CCBs may be the only game in town, so have to determine and deliver services.
- No RFPs for CCB services, no competition around cost, quality, etc.
- DD determination is made on the basis of the ULTC 100.2 and SIS.
- CCBs keeping up to 40 percent of the money for administrative overhead.
- Services are paid in 15 minute increments.
- There is creep in the CCB allotment of time.

Care Management

- Need more flexible care management.
- Need more consistent training.
- Care managers need to be qualified to assess for a wide range of disability – not an easy thing to do.

Service Utilization

- No way to know that the service was actually delivered.
- No way to know that the billed hours are correct.
- How to know if the care plan is accurately reflects needs of the client.
- No way to tell if the services are actually effective.
- Need to pay for outcomes not service delivery.
- DD focused on outcomes.

Data

- Systems don't talk to each other.
- Fixes take years.
- Can't aggregate client data.

- Maintenance is slow and often takes the systems off line.
- Lots of break downs, crashes, data loss, etc.

State Unit on Aging (SUA)

- SAMS (their system) is outside of the data system so potential for sharing data is nil.
- There should be greater collaboration between SUA and LTB
- Possible to leverage funding (Older Americans Act), create a more complete service delivery system and provide preventive services.

Waivers

- Across the waivers, there is variability in the service packages.
- Regulations – Inconsistent across the departments and waivers.
- Regulations are outdated.
- Some programs are over regulated, others are under regulated.
- For some programs, there is a lack of regulations.
- Regulations are sometimes out of compliance with statutes.

Reimbursement

- SNF reimbursement is in statute, as such, hard to adjust.
- ACFs reimbursement is low and doesn't allow them to take "heavy" care clients or those with dementia.
- HBU reimbursement not based on acuity.
- Disproportionate funding across the waivers.
- Tiers – no reimbursement based on acuity. No checks and balances.

General Comments

- Survey Process – Surveys overlap and are inefficient – how could these be collaborative (DHS/HCPF/CDPHE)?
- HCPF – not enough focus on quality of care.
- Despite waivers, there is still an institutional bias.
- Lack of housing for those trying to get out of SNFs. This will impact Colorado Choice Transitions (MFP).
- How do you create a 911 system for ADRCs/SEPs/CCBs?
- Colorado's focus on local control creates issues (quality, capacity, etc.) at the county level. Some counties have capacity, some don't.

Appendix A

Federal Issues

There were several challenges cited that were outside of the purview of the State to resolve, focusing mostly on federal issues:

- Preventive care: Funding for prevention and chronic disease management is lacking.
- Asset examination for Medicaid: While this has proven to be a challenging and time-consuming endeavor for the State, it has very little control over the criteria. It does have control over how quickly the process moves forward.
- Older Americans Act: These funds are limited and provide crucial services for many communities, yet they are not means-tested, allowing those with assets and income to access scarce funding.
- Nursing home eligibility: The criteria for most HCBS programs targeted to seniors and persons with disabilities is that those seniors and persons with disabilities must be otherwise eligible to be cared for in a nursing home. Staff felt that there should be a pre-nursing home eligible program that would intervene before people became too frail to prevent further health deterioration.
- Private pay: PACE has helped to keep dual eligibles out of both hospitals and nursing homes, yet it has not been able to reach the private pay/Medicare market, nor has it reached the pre-PACE market.

As part of the process, staff selected five high-level strategic initiatives to focus on (see below). It was felt that it would be challenging to take on more than five major issues. While a number of the comments fit within these five issues, there were a number of other issues that were also deemed important. In order of importance[2], these are:

- Regulatory overhaul: Many of the regulations guiding the waiver programs are out of date. It was thought that a regulatory overhaul would be part of waiver modernization.
- Sharing information across entities: There were a number of issues around data systems, but the fact that the current systems don't allow providers, clients and the State to share information was highlighted as important. Currently SEPs, ADRCs and CCBs have limited or no access to data from certain systems. From a care coordination perspective, this can be challenging.
- Streamline the survey and certification process: There is an exceptional amount of inefficiency in this process that is currently handled by HCPF, CDPHE and DHS. Given the merger of certain units from DHS and HCPF, it was felt that progress could be made on this issue.
- Prevention: Prevention, disease management, wrap-around services and early intervention were cited as ways to get out in front of frailty, but there is little funding or attention paid to these areas.

---

[2] Priority was determined by staff voting.

- Care coordination: While this may be part of the initiative around SEPs, there was considerable discussion at all three meetings (both staff meetings and the LTCAC meeting) about care coordination. With the coming of the ACC and the Duals initiatives, this will take on some urgency.
- Reimbursement: Staff wished to look at new methodologies for reimbursement including a tiered payment system based on frailty and value-based outcomes.
- Assessment: There was considerable discussion about assessments and, while "selecting a new assessment tool" was cited as a high-level initiative, staff also had concerns about subjectivity of those doing the assessment and the lack of a clinical component in the assessment. Staff suggested that this could possibly come from a public health nurse.
- Additional Issues:
    - Creating a true continuum of care,
    - Does the system in Colorado really allow people to age in place?
    - Lack of accessible, affordable housing (without waiting lists) – particularly important for Colorado Choice Transitions (MFP),
    - Transportation – too many systems that don't work in concert with each other,
    - Workforce issues including training and scarcity of qualified workforce,
    - End of life issues – person-centered care,
    - LTC health insurance,
    - HCBS Medicaid Coding,
    - Improve the transition process - moving from SNF to HCBS can take months for the Medicaid approvals, and
    - State Plan versus HCBS – apparently need to access HCBS services once per month to continue to access state plan services.

High-Level Strategic Initiatives

At the February staff strategic planning session there were five high-level strategic initiatives that were highlighted for further study:

- Single Entry Points
- Establish a Comprehensive Long-Term Services and Supports Assessment Tool to replace or improve the ULTC 100.2
- Data Systems
- Waiver Modernization
- Quality Assurance

At the consolidated staff meeting (HCPF and DHS) on March 6th, there were concerns that these five initiatives did not fairly represent the thinking of staff from DHS, as the February meeting did not include many of the line staff from DHS. In an effort to better understand the concerns of DHS staff, the agenda was changed to include time for DHS staff to talk through what they considered crucial areas for change. The following areas were highlighted by DHS staff:

- Information sharing: While there has been some focus on greater sharing of information (providers, clients, HCPF, etc.), there is also the issue of information sharing between departments and divisions within those departments. As DHS and HCPF (and CDPHE) look to make changes to the data systems, they should consider what type of inter-departmental information sharing needs to take place and for what purposes.
- Prevention: Much of the work of the SUA is focused on preventive services including transportation, legal services, outreach to special populations, in-home/respite services, health promotion, mental health, family caregiver support, information and referral, Ombudsman program and nutrition services. A focus on prevention and non-medical services has the potential to save Medicaid funds in the future, provides for a better quality life and creates a fuller continuum of service options for those who are not Medicaid-eligible.
- DHS/HCPF merger: There was considerable discussion about the potential merger of HCPF and certain units of DHS, what this would mean to staff and how it would impact the work of each organization.
- Continuum of care: Given the potential merger of the two organizations with differing but complementary service packages, it was suggested that staff focus on how this might affect/enhance the continuum of care in communities through the State. There would need to be efforts made to coordinate/integrate services across these departments. This is a complex process that involves multiple providers across the State.

Based on this discussion, it was decided that the initiative around "data" would be pulled from consideration at this point. The State has requested a grant to enhance their data systems and, when that grant gets approved, the State would coordinate a staff and stakeholder working group to provide input. As a substitute, staff wanted to examine "enhanced system coordination and service integration" across the continuum as the final strategic initiative.

Staff then broke into self-determined groups to focus on each of these five strategic initiatives. They were tasked with defining the challenge that the strategic initiative posed, suggesting steps to solve those challenges (not necessarily solutions, but how to get to solutions), suggesting resources that might be needed (both funding and technical assistance) to work through each initiative and defining which departments (HCPF and DHS), providers, stakeholders and organizations would need to be involved with creating solutions. While some of the groups were able to get through each of those tasks, others were challenged to complete this process in the limited time frame. As such, more work needs to be done to create a more complete plan for change.

1. Single Entry Point(s)

Appendix A

Clients access home and community-based waiver services predominantly via three agencies: Community Centered Boards (CCBs), Single Entry Point (SEP) agencies and County Departments of Human or Social Services (CDH/SS). In addition, the Area Agencies on Aging and the Adult Resources for Care and Help (ARCH) Aging and Disabilities Resource Centers (ADRCs) program provides information, assistance and referrals.

SEP agencies determine functional eligibility for community-based long-term care programs, provide care planning and case management for clients who need long-term care services including personal care or homemaker services, nonemergency medical transportation, home access modifications, electronic monitoring, assisted living (Alternative Care Facility), adult day programs, and respite care. SEPs also make referrals to other resources. SEP agencies serve clients by county of residence.

Both CCBs and CDH/SS are entry point agencies supporting people with developmental disabilities. CCBs are private nonprofit organizations that serve as the SEP responsible for assessing applicants, determining functional eligibility (counties determine financial eligibility), developing service plans, providing prior-authorization and on-going case management for individuals with developmental disabilities. Services are delivered by public and private agencies including CCBs themselves. Each CCB has a non-overlapping geographic service region of one to ten counties.

Challenges and issues:

- There is a need to separate case management from eligibility and from service delivery (SEPs and CCBs). There are inherent conflicts of interest when the same entity both determines eligibility and breadth of services and then provides those services. There are no checks and balances.
- Eligibility and determination of service need is not uniform across all agencies. This is a result of turnover in staff (SEPs), lack of consistent training for new and existing staff and an assessment tool that lacks reliability and consistency.
- The rules/statutes that govern entry point agencies need to be reviewed with a focus on updating, consistency and possible consolidation of units with the departments.
- While the term "single entry point" is used in CO, there are several single entry points. Is it possible to truly create one single entry point?
- CCBs in rural areas may be the only providers, so separating service provision from eligibility in these areas is challenging.

Next Steps from the March 7, 2012 Strategic Planning Meeting (DHS and HCPF)

The Challenge:

Colorado has at least three "single" points into the system. In each of these systems, there are case management functions and, while the three entry points are meant to focus on differing populations, there is overlap leading to no clear, single case manager who follows a client through all phases of their life. This creates a fragmented system that can be confusing for clients and families. Staff suggested that the system should be refined so that there is only one true single entry point. As Colorado looks to modernize its waiver system and break down the silos between the disability community and the senior community, it needs to evaluate how it will also break down the single entry point silos between these same communities. To access services in a coordinated system, a client would fill out one application and have one assessment to determine eligibility and needs. The results would be available electronically to all providers who needed further information about the client. That application and assessment would gather information on all medical, social and personal care services needed by the client. The client would then be assigned a "resource coordinator" (RC), whose responsibilities would expand beyond the usual care coordination role. That RC would follow the client throughout the system (hospital, home, school, etc.). The RC would assist with housing needs, help to develop the service plan, monitor the client's service needs and delivery, follow the client through transition points (school to adulthood, hospital to home, etc.) and assist with provider selection and ongoing evaluations and assessments.

Next Steps:

Colorado has a highly entrenched system of single entry points whose members are politically connected and whose structure would have to be changed through legislation.

Step #1: Clarify the challenges to the system. While this plan outlines some basic challenges created by this tri-furcated system, it would be important to be much more specific about what is dysfunctional about this system. This would require an evaluation of each of the single entry point agencies, their functions, their funding, their assets, and their liabilities. How do these match up with what was envisioned for this system when it was created? It would also be important to create some type of financial analysis – a cost-benefit analysis for each of the systems. What are the costs to deliver a unit of service for each of the systems? Management needs a complete picture before it begins to suggest wholesale changes to the system. This step should include a representative stakeholder input process, which requires direct outreach from the departments to clients, as well as through the single entry point agencies which serve them.

Step #2: Define the components of a true single entry point system for Colorado. Once again, this plan begins to talk about a holistic system that is a true single entry point with a resource coordinator who has larger role in system entry. In order for management to make some determination about moving forward, it must have some framework for the new system. This allows management to make some determination as to whether the benefits of the new system outweigh the challenges of putting it in place.

Step #3: Based on the information provided in steps one and two, management needs to determine the importance of and the process for a complete system change. Is this an incremental, "small steps" process where changes to the system occur over a long period of time so as to avoid destabilizing provider networks (SEPs, CCBs, and ARCHs), or are there another mechanisms that provide positive changes on a broad scale, while strengthening provider networks and services to consumers at the same time?

Step #4: Based on the breadth of change discussed on this topic and, as both single entry points and care coordination were dominant issues for the LTCAC, management should create a joint HCPF/DHS/Stakeholder task force to begin the process of change.

Staff identified the following individuals/groups as needing to be involved in the discussion in some form: SEPs, CCBs, AAAs, ARCHs, senior resource centers, MA (medical assistance) sites, schools, providers, The Legal Center, HCPF and DHS staff, nursing and alternative care facilities, BHOs, and consumers. Staff also identified the following resources that were needed: an inventory of what is currently in place, an evaluation of all the training programs that relate to this area and a needs identification tool (assessment tool?). This is an example of the integral nature of these initiatives: assessment tools will play a role in discussions on entry points and eligibility, waiver modernization and care coordination. Decisions need to be made by management or the LTCAC regarding which group will take the lead, what is the scope, etc.

As with many of these strategic initiatives, implementation of Colorado Choice Transitions (MFP) will have a significant effect on this initiative.

The LTCAC also highlighted single entry points and care coordination as important strategic initiatives. It will be important to integrate these two processes (staff and LTCAC) into one initiative. The following are comments from the LTCAC regarding care coordination:

> *There were many issues targeted around care coordination including case load, care coordinator training, independence of care coordinators from service provision, multiple entry points to the system, multiple care coordinators, flexibility of care planning, and lack of care coordination in transitional situations for children. Some of the specific comments were:*
>
> - *Suggest a holistic approach to care coordination. Instead of looking at the disability or the frailty, consider the whole person – a more comprehensive approach.*
> - *Case managers are overburdened.*
> - *Service planning, service coordination, provider selection, plan monitoring, "trouble shooting" of plan implementation, development of local providers and community planning, should be contracted by the state to entities with responsibility for reasonably sized and manageable geographic areas.*
> - *Consideration should be given to needs and conditions of urban, rural and frontier communities.*
> - *Governance and financial direction of case management agencies should be independent from agencies responsible for eligibility determination and/or*

> *service providers. Consideration of the needs and conditions of rural and frontier areas would be required.*

Additionally, many of the concerns expressed in the "Medicaid Entry and Eligibility" strategic initiative from the LTCAC were SEP-focused including:

> *There were challenges to many of the aspects of entry into and eligibility for Medicaid beginning with the bifurcation of the SEP/County processes. The LTCAC suggested mapping the entire process to better understand where challenges exist, and then dividing the work into those areas that could be immediately remedied versus those areas that would take time, collaboration with multiple entities and perhaps some regulatory changes. Timing, appeals, role of SEPs and CCBs, common applications and processes, complexities of the system, assessment tools, differing understanding of eligibility, presumptive eligibility, reapplication and redetermination were among a host of issues to be addressed.*

The comments from the LTCAC mirror in most respects comments from Staff.

2. Establish a Comprehensive Long-Term Services and Supports Assessment Tool to Replace or Improve the ULTC 100.2

In addition to meeting asset and income eligibility criteria, a Medicaid applicant must also be functionally eligible. In other words, he or she must be impaired enough to require a certain level of care (eligible to be placed in a nursing facility). This criterion is determined by a functional assessment performed when an application is submitted. The functional assessment tool for Colorado is the ULTC 100.2. The Department contracts out this assessment to SEPs and CCBs. Staff feels that the current assessment tool needs to be replaced.

Challenges and Issues:

- The current assessment tool lacks reliability and does not provide a comprehensive medical, mental and functional review that assesses need to drive service planning. There appears to be no correlation between acuity and spending.
- There are various assessment tools serving different purposes, but none are complete, comprehensive and reliable enough to drive and monitor service planning. For example, the ULTC 100.2 provides for functional eligibility, but does not determine service needs. The Supports Intensity Scale used in addition to the ULTC 100.2 in the developmental disabilities system does not adequately capture natural supports.
- The tool should auto-populate the service plan and integrate with other data systems in use by the State.
- There is currently in no way to verify service utilization.
- There appears to be some amount of "tier creep" in the CCB SIS assessments that is not related to increasing need and/or frailty.

Appendix A

Next Steps from the March 7, 2012 Strategic Planning Meeting (DHS and HCPF)

Staff determined that the new tool needs to be:

- Comprehensive
- Objective
- Age-appropriate
- Flexible
- Able to be used across waivers and programs.
- "Robust" – like MDS 3.0 used in nursing facilities.
- Able to assess the whole person – ADL functionality, medical needs and social supports.
- Relevant across care systems, the care continuum and the life span of the client.
- Able to provide the "determination of need" based on reliable inputs. It should not be subject to any form of manipulation.
- Capable of providing information for tiered payments (exists in SIS, but not in the ULTC 100.2).

Staff highlighted the following steps in this process:

Step #1: Gather input from stakeholders including medical providers (, CM, and clients and their advocates.

Step #2: Seek private funding (foundations) for all aspects of research and implementation.

Step #3: Rather than spending the money to create a new tool, research existing tools currently being used in other states and assess their functionality for Colorado.

Step #4: Seek a policy decision on tiered payment structures.

Step #5: Determine the assessment tools to be tested.

Step #6: Test assessment tools, score outcomes and purchase a tool.

Step #7: Train staff.

Step #8: Roll out new system.

Step #9: Conduct ongoing quality assessments.

Staff identified the following "users" who would need to be involved in the process: providers, clients (populations/age groups/educators for children's groups), advocacy organizations, program specialists, and internal IT staff. Staff suggested that the following resources would be needed: an all-inclusive budget allocation, ability to do data testing, better understanding of how rate structures would work, team training, time from the communications department, engagement of vendors and clarifications around rules, legislation and definitions.

There were only two comments about the assessment tool at the meeting of the LTCAC:

- *Current system (assessment) is based on diagnosis, should be based on functional need.*
- *The assessment tool should focus on engagement, not the disability.*

3. Data Systems

The State has myriad database systems that assist staff to do claims processing, manage client information, verify eligibility, track service delivery, manage contracts between providers and the State and numerous other crucial tasks. While many, if not most, of the systems need improvement and/or upgrades, the State's biggest priority is completing system changes to the Medicaid Management Information System (MMIS), the Colorado Benefits Management System (CBMS) and Benefits Utilization System (BUS - case management software) in order to successfully implement Colorado Choice Transitions (CCT, formerly MFP). These information system changes are necessary to identify CCT Demonstration Program participants, monitor their progress, and track their expenditures according to CCT program requirements. As staff identified "data systems" as one of the key challenges to their efficiency, it makes sense to take a more holistic perspective on changes to the data systems.

The following are systems currently in use throughout the State:

- BUS – Benefit Utilization System
- MMIS - Medicaid Management Information System
- CCMS – Community Contracts Management System
- CBMS – Colorado Benefits Management System
- SAMS – Social Asset Management System
- TRAILS – Child Welfare database
- ILCs – Another system for the Independent Living Centers
- COFRS – Colorado's payment system
- ASPEN and OASIS – Federal databases

Challenges and Issues:

- Systems don't "talk" to each other. They can't aggregate client data.
- Getting changes and/or fixes to the systems takes an inordinate amount of time. Maintenance of the systems requires them to be "off-line" and that maintenance seems slow.
- SAMS (State Units on Aging system) is outside of the other data system. As such, there is no way to compare data across systems.

- The BUS in particular has significant challenges including crashes, lost data, and slow response time.
- Systems don't necessarily provide useful reports allowing Staff to be more efficient in their work.
- Systems don't necessarily provide data that facilitate or incent positive outcomes for clients.
- Staff also recommended that information be shared across agencies (SEPs, CCBs, AAA, etc.) for better care coordination.

Next Steps from the March 7, 2012 Strategic Planning Meeting (DHS and HCPF)

Staff did not choose to work on "data systems" at the March 6, 2012 planning retreat. The LTCAC did choose data systems as a strategic initiative with the following comments:

The availability of good data for decision-making and the efficiency of data systems that were integrated (talked to each other) and, as such, created cost efficiencies for care coordinators and the Department(s) was deemed an important issue by the LTCAC. Once again, this is an area where the Department is interested and planning for change and might welcome the feedback from the LTCAC. Some of the specific comments were:

- *State's data systems are simply out of date and not adequate.*
- *There should be a single form, a single set of documents that is universal throughout the State that works for all the funding streams within and outside of the Department(s).*
- *Staff has applied for a federal grant that would upgrade many of the data systems. LTCAC wanted to know how they would be involved in providing feedback on systems changes.*
- *Information needs to flow seamlessly between clients and caregivers.*

Once again, moving forward on this initiative will be tied to receiving a substantial matching grant from the federal government for a complete overhaul of Colorado's data systems.

4. Waiver Modernization

With 11 home and community-based waivers, there seems to be universal agreement within HCPF that the number of waivers needs to be reduced through a process of consolidation. It has become increasingly difficult for staff to manage and report on the waivers. Most of the waivers have overlapping services that make for reasonable consolidation. While the process of waiver modernization makes fiscal, operational, management and oversight sense, the process of waiver modernization may be challenging requiring extensive stakeholder involvement and support and also legislative changes. Some of the waivers are "broken" having inconsistencies, some have the structural potential for fraud and/or conflict of interest, others lack accountability and, for many, the regulations are out of date. It may be difficult to roll out CCT and the ACC without first addressing many of the challenges presented by the waivers.

Challenges and Issues:

- The 11 waivers represent a significant number of divergent stakeholder groups. Management of the stakeholder involvement process will be daunting.
- One of the areas highlighted by staff was regulatory overhaul. That overhaul could/should be accomplished within or prior to the modernization process. The regulations are inconsistent across waivers. Some areas are over-regulated and others are under-regulated. Some regulations are out of compliance with the statutes
- Would consolidation help to eliminate the current waiver waiting lists?
- Payment reform, tiers of reimbursement, value-based reimbursement and standardization of reimbursement rates were all staff concerns and could be part of the modernization process.

Next Steps from the March 7, 2012 Strategic Planning Meeting (DHS and HCPF)

Staff chose the following objectives for this initiative:

1. Staff would conduct fundamental research including:
    a. Review all waiver rules and regulations – federal and state statues
    b. Conduct a waiver inventory
        i. Targeting criteria
        ii. Eligibility
        iii. Levels of care
        iv. Services
        v. CMS renewal dates
    c. Examine third party or natural supports
    d. Inventory the needs of the population(s) served, not served and under-served
    e. Reimbursement models from other states
    f. Outcome of the waiver consolidation in other states
    g. LTSS integration (managed care) in other states
    h. Consumer direction and paid family caregiver experiences nationally
    i. Explore state plan options – Community First Choice (CFC)

2. Design benefit package
    a. State plan
    b. Waiver benefits
    c. Feasibility study

3. Research necessary legislation

4. Create new waiver applications and state plan amendments

The task force for this initiative would include: CCT staff, behavioral health, parents, advocates, waiver administrators, consumer advocates from waiver populations, auditors, CMAs, providers, rates department, and LTCAC. The task force would need to develop a communications plan to reach out to stakeholders.

The task force would need the following resources: research from other states (best practices); contractor for facilitation, technical assistance and research, a new assessment tool, solutions to the SEP issues, an updated database, all workgroups in place, and an all-inclusive budget.

The LTCAC also chose "waiver modernization" as one of their high-level strategic initiatives and had the following observations:

> *The number of waivers, the complexity of the waiver system, waiver regulations that were deemed outdated, and long waiting lists to get on waivers (particularly DD waivers) were all issues for the LTCAC. As there will be a process for waiver modernization beginning soon, it would be important to articulate a process by which a subcommittee of the LTCAC would have input into the modernization process. Some of the specific comments were:*
>
> - *There are four waivers for children each with differing level of care requirements. The children's waivers need to modernized.*
> - *Need for waiver programs to be more consistent among populations.*
> - *The DD waivers are too complicated and have long waiting lists pushing some people to go on the EBD waivers. Some would rather just have EBD and not DD.*
> - *It is perceived that the waivers are a disincentive to employment.*
> - *Strategic Plan should include a commitment to keep rules, policies and procedures updated and easily accessible.*

5. Quality Assurance

While Section B.8 of the CCT grant application defines a process for continuous quality assurance and improvement, staff were concerned that the current quality assurance mechanisms were fragmented and that the Department(s) needed a global quality assurance process. The following "requirements of Colorado's QIS" seems to be a good starting point:

Appendix A

Service Dimensions	Quality Activities	Desired Outcomes
Participant Access	Performance improvement projects as determined by prioritization table	-Individuals have access to home and community-based services and supports in their communities. -Improve outcomes
Participant Centered Service Planning and Delivery	· Department on-site visits to SEP/CCB agencies. · Department comparison of service plan to billed services · SEP/CCB agency designation process · Performance improvement projects as determined by prioritization table	-Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community. -Assure participants receive the service plan services -Assure the SEP/CCB agency has providers to provide all services Improve outcomes
Provider Capacity and Capabilities	· Provider licensure or certification verified upon initial application and then as identified in the approved waiver · Mandatory training of all providers · Performance improvement projects as determined by prioritization table	· There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants. · Minimum standard for all providers applied · Minimum knowledge base is established for all providers · Improve outcomes
Participant Safeguards	· Instances of abuse, neglect and exploitation are identified and acted upon. · Monitoring use of restraints and seclusion · Performance improvement projects as determined by prioritization table	· Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices. · Eliminate instances of abuse, neglect and exploitation. · Assure appropriate safeguards are implemented · Improve outcomes
Participants Rights and Responsibilities	· Performance improvement projects as determined by prioritization table	· Participants receive support to exercise their rights and in accepting personal responsibilities. · Improve outcomes
Participant Outcomes and Satisfaction	· Participant complaint reporting · Performance improvement	· Participants are satisfied with their services and achieve desired outcomes.

Appendix A

	projects as determined by prioritization table · Client satisfaction survey	· Improve outcomes · Identify potential areas for improvement
System Performance	· Performance improvement projects as determined by prioritization table	· The system supports participants efficiently and effectively and constantly strives to improve quality. · Improve outcomes

Challenges and Issues

- Creating a "universal quality assurance system" that spans all program and all waivers.
- How do you measure quality across programs?
- Consolidating processes among HCPF, DHS and CDPHE.

Appendix A

Next Steps from the March 7, 2012 Strategic Planning Meeting (DHS and HCPF)

The Challenges:

The quality assurance system is rife with duplication and multiple methodologies for similar tasks. As stated at the first staff meeting, there is no holistic approach to quality assurance across the waivers. Some of the challenges seem to be a result of the data systems and an inability to gather relevant data on quality that is, once again, uniform across waivers. The system is very silo focused with no one person, no one department having a good understanding of all of the pieces. Staff was in agreement that there needs to be uniformity – processes and requirements – throughout the system. There are differences in terminology between and among the QA systems and multiple sets of rules and regulations governing QA depending on the setting and waiver. Staff defined that there are six HCPF staff, two SUA staff, 12 DDD staff and an unknown number of Colorado Department of Public Health and Environment (CDPHE) staff focused on quality assurance.

Staff then created a list of quality assurance processes, functions and settings. This list would lead into a more complete inventory of the QA processes throughout the State.

- "Licensing and Occurrences" through CDPHE (NF and AL)
- Retrospective and post-payment reviews – billing, TCM
- QIS reviews
- Investigations
- 372s and discovery – remediation
- Administrative reviews (SEPs and CCBs), program tool, IRR
- Definition Review
- Client satisfaction surveys
- Desk audits (AAA)
- Onsite reviews (AAA)
- Utilization reviews
- Personal needs (PN)
- Critical Incident Response System (CIRS)
- Fiscal and financial reviews
- Survey and monitoring
- Complaint review and follow-up
- Program approval and certification

Providers involved with quality assurance process: Nursing Homes, CCBs (20), SEPs (23), AAAs (16), PASAs (214), CMAs (46), Providers (SUA) and ACFs.

Staff suggested the following objectives from this process:

- A consolidated, integrated and improved system that would also result in better staff retention and support.
- It would be important to maintain a person-centered, outcome-based QA system.
- Internal staff training, external training of agencies and technical assistance would be key components of this improved system.
- It would be important to create a common QA language that was consistent across all settings, waivers and providers.
- This process would seek to eliminate duplication and create efficiencies within the system.
- The QA system would be consistent throughout the state.
- Because the QA language and systems were consistent, staff would understand all of the parts of that system across departments, providers, settings, etc.
- The rules and regulations would be common/uniform throughout the QA system.
- There would be stakeholder input throughout the process.
- The new system would be a data-driven outcome system.
- The process of change would be integrated with the waiver modernization process.
- There would be measureable performance measures.
- The process for change would begin with identification of the QA gaps.

Staff identified the following organizations as crucial partners in this process: Ombudsman manager; CDPHE, DHS, HCPF – PQ and PI; Stakeholders including providers, SEPs, and advocates; IT and investigation component.

Staff identified the following resources as necessary to this process: funding, tools and technology including IPads, training, leadership, assistance from internal IT, staffing, and time.

Next Steps:

Step #1: Conduct a complete inventory of the QA systems in place throughout the State. This process will create a context for understanding the complexities of change that is needed and help identify those who need to be involved in the process.

Step #2: Convene a meeting of internal stakeholders (HCPF, DHS, and CDPHE) to get buy-in to both the process and suggest a potential structure.

Step #3: Determine the characteristics of a "global quality assurance process". It has been suggested that the matrix in Colorado's CCT program would be a good starting point (see above) as it has the approval of CMS at the federal level.

Step #4: Work with CMS Region VIII to get their buy-in to both the process for this change and for the matrix that will be used.

Step #5: Research the Colorado legislation as it relates to QA in order to understand what legislative changes would be necessary.

Step #6: Management should create a joint HCPF/DHS/CDPHE/Stakeholder task force to begin the process of change.

It should be noted that there was only one comment from the LTCAC regarding quality assurance:

> *Can the strategic plan include priorities for new commitments to quality oversight, outcome monitoring and ongoing technical assistance throughout the Medicaid system?*

6. Enhanced System Coordination and Service Integration (from the March 7, 2012 meeting)

Long-term care integration is defined as the integration of home and community-based long term care services with the delivery of primary and acute care services, and institutional long term care services, for older adults and adults with disabilities. Long-term care systems in CO and in most states are bifurcated between Medicare and Medicaid with acute, hospitalization and pharmacy paid through Medicare and nursing home (custodial) and community-based services paid through Medicaid. These systems do not coordinate care with one another, have separate case management systems, and separate, and sometimes competing, regulatory structures and payment methodologies. It is a system of silos defined by regulation and reimbursement. Additionally, there is the integration and coordination of those services funded through Medicaid with services funded through the Older Americans Act and other programs administered by DHS. While this type of service merger hasn't been considered in most states, the merger of DHS and HCPF presents the opportunity to look at a true continuum of care and a breaking down of many of the funding and regulatory silos. While much work will be done in the coming years around coordination of Medicare and Medicaid in Colorado's Duals Project, system coordination is an area where the State could achieve some efficiency in both funding and operations.

Staff identified the following barriers to this work:

- Funding and eligibility: The funders (Medicaid, Medicare, OAA, etc.) each have criteria around populations they will serve, income levels they will target, and they have defined regulations governing administration and service delivery of each program. These systems were not created to work in collaboration with each other and, as such, have competing regulatory structures and reimbursement methodologies.
- Perceptions of the systems: Communication around service systems is not holistic. The SUA focuses on communicating information about its programs. Medicaid focuses on communicating information about its programs. There is not one organization that takes a holistic approach to services (and communication around those services) for seniors and persons with disabilities. Even the SEPs, CCBs and ARCHs each focus on communicating only that information that is directly related to their program.

Appendix A

- Entry points: As has been discussed earlier in this report, there are multiple single entry points creating a level of confusion among clients and providers.
- Care management: With multiple entry points come multiple care management organizations. Additionally, care management duties and personnel are often scattered between home, school, hospital, community, etc. The quality of training for these care managers varies in intensity and quality.

Staff suggested the following as a starting place for discussions around possible solutions:

- Needs of the person: All interventions should be designed around the strengths and needs of the recipient, in other words be "person-centered". Interventions should be determined based on the outcomes that the recipient wants to achieve. Recipients should be able to choose from a menu of services.
- Assessment and training: The assessment process and the assessment tool need to be "fixed". There should be one lead agency that manages the assessment and that agency should have a consistent and well-tested training curriculum. There should be an ongoing technical assistance program for those conducting the assessments to keep them up-to-date on changes and enhancements.
- Prevention: A merging of units from DHS and HCPF provides an exceptional opportunity to begin to provide a menu of prevention services to clients who are often focused on intervention.
- Reimbursement: Evaluate reimbursement methodologies to better understand how they might be refined, coordinated and adapted to better match up with service needs and frailty. There needs to be some clarification about the "payor of last resort".
- Single entry points: Examine Colorado's single entry point systems as there is not currently one entry point, but many entry points and they are not necessarily coordinated.
- Efficiency: Staff saw the merger of units from DHS and HCPF as an exceptional opportunity to examine administrative processes and begin to reduce duplication and create efficiencies (quality assurance, communication, etc.).

Staff suggested that stakeholders, budget division, rates team and a cross-functional team from HCPF and DHS need to be involved in exploring this initiative.

Staff also suggested the possibility that this initiative might function and be approached as a cross-cutting part of the work of other initiatives, similar to an approach to the need to improve Data Systems.

Appendix A

Next Steps

Since this was an initial discussion of this topic at a staff meeting (unlike the other staff initiatives in this list), this group was not specific about next steps other than to highlight the following areas as a starting point:

- Identify all systems and programs relative to these populations without regard to payor source, regulatory requirements, or department oversight.
- Identify contact staff member involved in each of those programs as resource for information and possible inclusion in the task force.

Long Term Care Advisory Committee

On March 6, 2012, the LTCAC held a day-long strategic planning retreat to consider their agenda for the coming year. They engaged in a process similar to that of HCPF/DHS staff. At the conclusion of the strategic planning sessions, the LTCAC members were asked to prioritize their key strategic initiatives. While the initiatives of the LTCAC differed somewhat from those of the Staff, there were many similarities. The following are those initiatives in order of importance (as determined by the LTCAC).

1. **Medicaid (Entry Point and Eligibility):** There were challenges to many of the aspects of entry into and eligibility for Medicaid beginning with the bifurcation of the SEP/County processes. The LTCAC suggested mapping the entire process to better understand where challenges exist, and then dividing the work into those areas that could be immediately remedied versus those areas that would take time, collaboration with multiple entities and perhaps some regulatory changes. Timing, appeals, role of SEPs and CCBs, common applications and processes, complexities of the system, assessment tools, differing understanding of eligibility, presumptive eligibility, reapplication and redetermination were among a host of issues to be addressed. This initiative has a substantial number of sub-issues and could easily be divided among several subcommittees, each focused on a different challenge. Some of the specific comments were:

    a. The process to apply for Medicaid is bifurcated – the county does the financial assessment and the SEP/CCB does the functional. These groups don't communicate well with each other.
    b. The time for an appeal is too short.
    c. While the time for process is supposed to be 45 days, some cases take up to 9 months and, while one entity process their paperwork in a timely manner, the other entity may not.
    d. The application process (done by parents) needs to be filled out as if the child is doing the application – that isn't realistic.
    e. Eligibility should be consistent, but local capacity is not.

f. Map the system and that process should demonstrate where there are complexities and easy fixes.
g. When the Medicaid application goes into the County, there should be an automatic way to tell the SEP that they received the application.
h. Need to insure that Medicaid rules (such as the Medicaid Buy-In program) and waivers (such as HCBS) do not pose disincentives for employment.
i. Department should seek to create a "Medicaid 101" standardized training for all who work in the system. The training should discuss the variety of services and supports from State Plan to specific waivers.
j. When Medicaid application is submitted to the County, notification should be given to County so they can schedule assessment visit. Sometimes it takes weeks for this communication to occur. Then once it is received by SEP, it takes another 10 working days for appointment.
k. Duplicative qualifying oversight (60 day reviews/annual reviews) by different agencies once a person is already qualified for long-term support.

2. **Waiver Modernization**: The number of waivers, the complexity of the waiver system, waiver regulations that were deemed outdated, and long waiting lists to get on waivers (particularly DD waivers) were all issues for the LTCAC. As there will be a process for waiver modernization beginning soon, it would be important to articulate a process by which a subcommittee of the LTCAC would have input into the modernization process. Some of the specific comments were:

    a. There are four waivers for children each with differing level of care requirements. The children's waivers need to modernized.
    b. Need for waiver programs to be more consistent among populations.
    c. The DD waivers are too complicated and have long waiting lists pushing some people to go on the EBD waivers. Some would rather just have EBD and not DD.
    d. It is perceived that the waivers are a disincentive to employment.
    e. Strategic Plan should include a commitment to keep rules, policies and procedures updated and easily accessible.

3. **Care Coordination**: There were many issues targeted around care coordination including case load, care coordinator training, independence of care coordinators from service provision, multiple entry points to the system, multiple care coordinators, flexibility of care planning, and lack of care coordination in transitional situations for children. Some of the specific comments were:

    a. Suggest a holistic approach to care coordination. Instead of looking at the disability or the frailty, consider the whole person – a more comprehensive approach.
    b. Case managers are overburdened.
    c. Service planning, service coordination, provider selection, plan monitoring, "trouble shooting" of plan implementation, development of local providers and

   community planning, should be contracted by the state to entities with responsibility for reasonably sized and manageable geographic areas.
   d. Consideration should be given to needs and conditions of urban, rural and frontier communities.
   e. Governance and financial direction of case management agencies should be independent from agencies responsible for eligibility determination and/or service providers. Consideration of the needs and conditions of rural and frontier areas would be required.

4. **Presumptive Eligibility:** While this is covered under the strategic initiative for Medicaid, it was high on the list of strategic initiatives. It was suggested that legislation had been passed that would allow this to happen in Colorado and that the next step(s) might be to look at "lessons learned" from other states. Some of the specific comments were:

   a. Presumptive eligibility – a number of states have created presumptive eligibility and had good success with it. CO should examine the lessons from those states to better understand the issue. Apparently, the legislation is in place to allow this. This would also depend on the ability to fast-track eligibility.

5. **Data Systems:** The availability of good data for decision-making and the efficiency of data systems that were integrated (talked to each other) and, as such, created cost efficiencies for care coordinators and the Department(s) was deemed an important issue by the LTCAC. Once again, this is an area where the Department is interested and planning for change and might welcome the feedback from the LTCAC. Some of the specific comments were:

   a. State's data systems are simply out of date and not adequate.
   b. There should be a single form, a single set of documents that is universal throughout the State that works for all the funding streams within and outside of the Department(s).
   c. Staff has applied for a federal grant that would upgrade many of the data systems. LTCAC wanted to know how they would be involved in providing feedback on systems changes.
   d. Information needs to flow seamlessly between clients and caregivers.

6. Consumer Direction: Current issues with self-direction and CDASS, as well as expansion of self-direction programs were flagged as issues for exploration.

The following areas were also mentioned in the final determination of strategic initiatives:

- Blending of funding streams

- County regionalization – counties working together to create a more stable, responsive system
- Mapping the DHS/HCPF systems to look for areas of efficiency
- Guidance on how the "system" works with a focus on Medicaid
- Cost savings and cost sharing based on a three-way partnership among the Client, Provider and Department

Conclusions

At the conclusion of the second staff meeting on March 7th, staff suggested the following next steps:

- Mission, vision and values: HCPF and DHS have differing missions, visions and values. Staff suggested that a small group representing both organizations come up with a draft consolidated statement of mission, vision and values.
- Stakeholders: Staff wanted a better understanding of the stakeholder community and, as such, asked for a comprehensive list of stakeholders and who they represent.
- Integration: Staff was concerned that the two plans (LTCAC and HCPF/DHS) be integrated and that there would be integrated task forces for each plan.
- Data systems: Staff acknowledges that this is a long-term project, but wanted to know if there is any way to create key "fixes" now. They were hoping for creation of an internal IT position to manage these fixes.
- Lessons learned: Staff felt that many of the high level strategic initiatives represented issues that other states may have encountered. They suggested management first look at lessons learned in other states before beginning changes in Colorado.

Challenges

This document suggests a formidable body of work for both HCPF and DHS management and staff. Because the nature of this contract and the planning time with staff was limited, it would be important to talk about how this information and these initiatives move from the conceptual stage they are in to a more detailed format. Task forces need to be formed for each strategic initiative. While staff has suggested some "next steps", there needs to be a larger conversation about the timeline for this work. Some of the work groups worked on initiatives that were complex and, as such, they did not have enough time to truly explore the nature of the work, the resources needed to successfully complete that work and/or envision the timing of these projects, some of which will be years in implementation. There is exceptional overlap on many of these initiatives and some thought needs to be given about how they will work in concert. The task forces (DHS and HCPF) need to create very detailed work plans and timelines that have the approval and support of senior management. At the same time, the subcommittees of the LTCAC need to also create very detailed work plans and timelines and then merge those with the work of staff.

Colorado Choice Transitions - Money Follows the Person

Colorado's MFP program is very much dependent on changes suggested by these high level strategic initiatives. Additionally, efforts to modernize Colorado's waivers are also very dependent on the outcome of these strategic initiatives (beyond the initiative that specifically deals with waiver modernization). As such, these initiatives can't be conceptualized and implemented separately. Thought needs to be given as to how these will work together and how they will be coordinated.

Appendices

In order that this report be as complete as possible, I have attached the outcomes from the LTCAC work as well:

- Appendix A: LTCAC Strategic Planning - Outcome of the Retreat held on March 6, 2012
- Appendix B: LTCAC Strategic Planning - Email Comments from Stakeholders

Appendix A

Appendix A: LTCAC Strategic Planning - Outcome of the Retreat held on March 6, 2012

MEMORANDUM

TO: Long-Term Care Advisory Council (LTCAC)
HCPF and DHS Senior Management

FROM: David Nolan, Chi Partners

RE: LTCAC Strategic Planning
Outcome of the Retreat held on March 6, 2012

DATE: March 17, 2012

LTCAC Members Present:

Barbara Wilkins Crowder, Adult Care Management, Inc.
Barry Rosenberg, Personal Assistance Services of CO
Dave Norman, Area Agency on Aging of NW CO
Dawn Russell, Atlantis Community, Inc.
Donna Zwierzynski, Evangelical Lutheran Good Samaritan Society
Dustin Dodson, Grand River Hospital District
John Zabawa, Seniors' Resource Center
Julie Farrar, CO Developmental Disabilities Planning Council
Julie Geiser, Alamosa County Public Health
Kathy Martin, Denver Options, Inc.
Kevin Smith, Accent on Independence
Marijo Rymer, The ARC of CO
Nick Scheidegger, City and County of Denver
Penny Cook, CO Culture Change Coalition, Inc.
Shelley Hitt, The Legal Center for People
Susan Langley, The Denver Hospice
Vicki Rodgers, Jefferson Center for Mental Health
Vivian Stovall, Colorado Commission on the Aging
Renee Boyes Walbert, Parent to Parent of Colorado

Ex Officio Members Present:

Patrick Coyle, Department of Local Affairs
Todd Coffey, Department of Human Services
John Barry, Department of Health Care Policy and Financing

Guests and Staff Present:

Appendix A

Susan Birch, Department of Health Care Policy and Financing
Suzanne Brennan, Department of Health Care Policy and Financing
Sarah Roberts, Department of Health Care Policy and Financing
Joscelyn Gay, Department of Human Services
Tim Cortez, Department of Health Care Policy and Financing
Carol Meredith, The Arc of Arapahoe and Douglas Counties
Casey Ryan, Long Term Care Options
Chris Roe, Department of Local Affairs
Gabrielle Steckman, Public Partnerships of Colorado
John Weslar, Philips LifeLine
Kathleen Negri, Elder Law Attorney
Marci Eads, Department of Health Care Policy and Financing

Creating a Relationship of Trust – How We Work Together

Charter

The Long Term Care Advisory Committee (LTCAC) has been formed to discuss, research and advise the Department on recommended policies and processes. Members are appointed by the Executive Director for a two- or three-year term to engage in comprehensive policy discussion on innovations and issues in the delivery of long-term services and supports (LTSS), to review proposals and work products from reporting groups, and to make recommendations to the Department for consideration. The LTCAC actively participates in plans for new initiatives or programs affecting persons who utilize LTSS. The committee provides input on Department policy with anticipated areas of focus to include Colorado's Choice Transitions (Money Follows the Person) initiative, the Affordable Care Act, waiver modernization, delivery system capacity and models, accountability and responsiveness, and LTSS eligibility reform.

Guiding Principles

1. **Person-centered:** Committed to ensuring that LTSS programs meet the individual's needs, provide opportunities for self-direction, offer choice, and improve personal experience.
2. **Independent Living**: Committed to ensuring that clients live in the most appropriate setting with appropriate supports in alignment with Colorado's Olmstead Recommendations.
3. **Coordinated Care**: Committed to ensuring integration between all systems and programs and to facilitating transitions between care settings.
4. **Streamlined Access**: Committed to ensuring timely, transparent, and person-centered access to care.
5. **Sustainable Financing**: Committed to ensuring sustainable costs and funding.

Appendix A

While the LTCAC has both a charter and guiding principles, the strategic planning session began with the creation/acceptance of some basic guidelines suggesting how the members would work together to build trust and create an atmosphere of respect within the LTCAC and with the Department(s). Those guidelines are:

1. **Today is the first day of our working relationship.** While it is important to have a historical perspective, it is more important that the LTCAC begin its work with a clean slate seeking to create a new level of trust and new working relationships based on the current membership and the current leadership within the Departments.
2. **We are solution-focused.** It is important to articulate the challenges, but progress will come from a focus on how to solve those problems.
3. **Step up and step back.** The members of the LTCAC were chosen because they represent specific constituencies throughout the State. As such, it is important that each member of the LTCAC have the opportunity to express their thoughts. This guideline suggests that members express their thought and then allow others to do the same.
4. **Say it once** and **receive acknowledgement that your voice has been heard.** Time is short and there is a substantial body of work in front of the LTCAC. As such, it is important to be succinct and not repetitive. It is equally important that the Ex Officio Members acknowledge that they hear and understand what has been said.
5. **Person-centered.** As expressed in the guiding principles, we are "committed to ensuring that LTSS programs meet the individual's needs, provides opportunities for self-direction, offers choice, and improves personal experience", that they are person-centered.
6. **Collaboration is crucial.** If we are to succeed, we must be able to collaborate. We must be able to both give and take.
7. **Language is important.** Language often defines who we are and how people view us, so it is important that we use language that acknowledges how we want to be defined and seen.
8. **Listen.** How do we respond if we don't hear the other person? How do we understand if we don't listen to the other person?
9. **Process is important.** Stakeholders (LTCAC) need to understand and have input into the decision-making process. This requires that the Department(s) clearly articulate that "process" and abide by it.
10. **Discuss the un-discussable.** If there is an "elephant in the room", we should acknowledge that.

March 6th Meeting – Summary and Goal

On March 6th, the LTCAC met for an all-day strategic planning session. The purpose of the meeting was to:

- Surface major challenges in Colorado's long-term care delivery system for seniors and persons with disabilities,

- Engage the LTCAC in an exploration of those issues, and
- Select up to five high level strategic initiatives from those issues for further work.

The LTCAC would explore those strategic initiatives in concert with staff from both HCPF and DHS and would then make recommendations for improving the long-term care delivery system.

As a prelude to the work of the day, LTCAC members provided a historical perspective from other stakeholder efforts in Colorado including Senate Bill 173, House bill 1374 and the Olmstead Report. The following were consistent themes from those three presentations:

1. **Housing:** Reports highlighted the need for affordable, accessible housing for persons with all types of disabilities and the need to expand alternative housing options through demonstrations. The ability to move people from nursing homes to the community through the MFP program is dependent on the availability of affordable, accessible housing throughout the State. Currently, demand outweighs need in most areas.

2. **Single entry points and case management:** The role of single entry points and case management agencies was a consistent theme. Reducing case load, clarifying roles, strengthening case management and streamlining access to LTC services and supports were all themes in this category.

3. **Expansion of services:** Reports highlighted the need to look at the array of services and expand that array as funding permits with the hope that services received in the community would match services provided in institutions and thus prevent unnecessary institutionalization.

4. **Communication:** While Colorado delivers an impressive array of HCBS services, many in the community are either not aware of these services or confused about issues like eligibility. Additionally, communication between and among the many community-based organizations, agencies, providers and state departments could benefit from a comprehensive communications strategy.

5. **Eligibility:** The challenges posed by the process for financial eligibility is a consistent theme from the reports with exploration of presumptive eligibility for transition from acute care to LTC being one solution.

6. **Reimbursement:** Reports suggested that the methodologies used for rate-setting be examined to maximize the use of scare federal and state resources and to achieve equity in reimbursement.

Tim Cortez from HCPF also provided a synopsis of Colorado Choice Transitions, a Money Follows the Person Demonstration.

Process

Appendix A

The LTCAC was asked to walk through the process by which clients enter the long-term care system in CO in order to highlight challenges in the process. They were then asked to identify the challenges that clients encounter while they are in the system.

High-Level Strategic Initiatives

At the conclusion of the strategic planning sessions, the LTCAC members were asked to prioritize their key strategic initiatives. The following are those initiatives in order of importance (as determined by the LTCAC). These need to be revisited by the LTCAC in light of the large number of comments that were submitted via email both before and after the strategic planning session. Those comments have not been integrated into this document and so have not been used to change the LTCAC's voting on high-level strategic initiatives.

- **Medicaid**: There were challenges to many of the aspects of entry into and eligibility for Medicaid beginning with the bifurcation of the SEP/County processes. The LTCAC suggested mapping the entire process to better understand where challenges exist, and then dividing the work into those areas that could be immediately remedied versus those areas that would take time, collaboration with multiple entities and perhaps some regulatory changes. Timing, appeals, role of SEPs and CCBs, common applications and processes, complexities of the system, assessment tools, differing understanding of eligibility, presumptive eligibility, reapplication and redetermination were among a host of issues to be addressed. This initiative has a substantial number of sub-issues and could easily be divided among several subcommittees, each focused on a different challenge. Some of the specific comments were:

    - The process to apply for Medicaid is bifurcated – the county does the financial assessment and the SEP/CCB does the functional. These groups don't communicate well with each other.
    - The time for an appeal is too short.
    - While the time for process is supposed to be 45 days, some cases take up to 9 months and, while one entity process their paperwork in a timely manner, the other entity may not.
    - The application process (done by parents) needs to be filled out as if the child is doing the application – that isn't realistic.
    - Eligibility should be consistent, but local capacity is not.
    - Map the system and that process should demonstrate where there are complexities and easy fixes.
    - When the Medicaid application goes into the County, there should be an automatic way to tell the SEP that they received the application.
    - Need to insure that Medicaid rules (such as the Medicaid Buy-In program) and waivers (such as HCBS) do not pose disincentives for employment.

  - Department should seek to create a "Medicaid 101" standardized training for all who work in the system. The training should discuss the variety of services and supports from State Plan to specific waivers.
  - When Medicaid application is submitted to the County, notification should be given to County so they can schedule assessment visit. Sometimes it takes weeks for this communication to occur. Then once it is received by SEP, it takes another 10 working days for appointment.
  - Duplicative qualifying oversight (60 day reviews/annual reviews) by different agencies once a person is already qualified for long-term support.

- **Waiver Modernization**: The number of waivers, the complexity of the waiver system, waiver regulations that were deemed outdated, and long waiting lists to get on waivers (particularly DD waivers) were all issues for the LTCAC. As there will be a process for waiver modernization beginning soon, it would be important to articulate a process by which a subcommittee of the LTCAC would have input into the modernization process. Some of the specific comments were:

  - There are four waivers for children each with differing level of care requirements. The children's waivers need to modernized.
  - Need for waiver programs to be more consistent among populations.
  - The DD waivers are too complicated and have long waiting lists pushing some people to go on the EBD waivers. Some would rather just have EBD and not DD.
  - It is perceived that the waivers are a disincentive to employment.
  - Strategic Plan should include a commitment to keep rules, policies and procedures updated and easily accessible.

- **Care Coordination:** There were many issues targeted around care coordination including case load, care coordinator training, independence of care coordinators from service provision, multiple entry points to the system, multiple care coordinators, flexibility of care planning, and lack of care coordination in transitional situations for children. Some of the specific comments were:

  - Suggest a holistic approach to care coordination. Instead of looking at the **disability or the frailty, consider the whole person – a more comprehensive approach.**
  - Case managers are overburdened.
  - Service planning, service coordination, provider selection, plan monitoring, "trouble shooting" of plan implementation, development of local providers and community planning, should be contracted by the state to entities with responsibility for reasonably sized and manageable geographic areas.
  - Consideration should be given to needs and conditions of urban, rural and frontier communities.

  - Governance and financial direction of case management agencies should be independent from agencies responsible for eligibility determination and/or service providers. Consideration of the needs and conditions of rural and frontier areas would be required.

- **Presumptive Eligibility:** While this is covered under the strategic initiative for Medicaid, it was high on the list of strategic initiatives. It was suggested that legislation had been passed that would allow this to happen in Colorado and that the next step(s) might be to look at "lessons learned" from other states. Some of the specific comments were:

  - Presumptive eligibility – a number of states have created presumptive eligibility and had good success with it. CO should examine the lessons from those states to better understand the issue. Apparently, the legislation is in place to allow this. This would also depend on the ability to fast-track eligibility.

- **Data Systems:** The availability of good data for decision-making and the efficiency of data systems that were integrated (talked to each other) and, as such, created cost efficiencies for care coordinators and the Department(s) was deemed an important issue by the LTCAC. Once again, this is an area where the Department is interested and planning for change and might welcome the feedback from the LTCAC. Some of the specific comments were:

  - State's data systems are simply out of date and not adequate.
  - There should be a single form, a single set of documents that is universal throughout the State that works for all the funding streams within and outside of the Department(s).
  - Staff has applied for a federal grant that would upgrade many of the data systems. LTCAC wanted to know how they would be involved in providing feedback on systems changes.
  - Information needs to flow seamlessly between clients and caregivers.

- **Consumer Direction:** Current issues with self-direction and CDASS, as well as expansion of self-direction programs were flagged as issues for exploration.

The following areas were also mentioned in the final determination of strategic initiatives:

- Blending of funding streams
- County regionalization – counties working together to create a more stable, responsive system
- Mapping the DHS/HCPF systems to look for areas of efficiency
- Guidance on how the "system" works with a focus on Medicaid

- Cost savings and cost sharing based on a three-way partnership among the Client, Provider and Department

Next Steps in the LTCAC Strategic Planning Process

Many of the comments submitted and included above, were solicited by the members of the LTCAC. Other comments came to the Department through its publicizing the LTCAC strategic planning process through email and on the Department website. These comments should be reviewed as a whole, by the LTCAC and by interested members of the public.

This document will be distributed to LTCAC members, emailed to the Department's LTSS stakeholder list, sent to DHS/DDD for distribution to its stakeholders, and will be posted on the Department website.

The LTCAC meets again on Tuesday, April 3, 2012. At that time, the LTCAC will discuss this report of its March 6th meeting, will report any subsequent public comments, hear from members of the public who participate in the meeting, prioritize high-level LTSS strategic initiatives, and will establish LTCAC Subcommittees to move forward with implementation of these initiatives.

Quick Fixes

There were several issues that were flagged as needing some attention, but that did not rise to the level of study by a subcommittee. They are:

- Map the system and that process should demonstrate where there are complexities and easy fixes. There were examples given where one person hand-filled in a form that another person then entered into the computer system.
- The children's waivers need to modernized and consolidated.
- When the Medicaid application goes into the County, there should be an automatic way to tell the SEP that the County received the application.
- Service authorization – CM fills out a form that goes to some else to key in. Not an efficient process.
- Family members commented on the amount of notices they receive in the mail. (Most of these comments came from Medicaid recipients). Could this be an immediate cost savings? Can this information be online and alleviate the need to mail as many notifications?
- Most of the information family members received about LTC options were from family and friends. They would like the State to host a clearinghouse for information that is easily accessible and in terms they can understand. Options other than LTC were not always presented.

Appendix A

Appendix A

Appendix B: LTCAC Strategic Planning - Email Comments from Stakeholders

MEMORANDUM

TO: Long Term Care Advisory Committee (LTCAC)
HCPF and DHS Senior Management

FROM: David Nolan, Chi Partners

RE: LTCAC Strategic Planning
Email Comments from Stakeholders

DATE: March 17, 2012

The Issues

The following is a list of challenges/issues that were submitted by email to members of the LTCAC. Some of these challenges/issues were mentioned and incorporated in the memorandum to the LTCAC titled "Outcome of the Retreat held on March 6, 2012".

- **Care Coordination:**
    - What is the vision and plan relating to case management and single points of entry? The ARCH program replicates the original vision of the SEPs and the Community-Centered Boards (CCBs) now refer to themselves as SEPs. Is there a vision / plan for creating one entry point for long-term care services or will different populations continue to access supports and services through different entry points?
    - Might the strategic plan name the value of case management in reform efforts AND create a strategy for credentialing or certifying care managers via web-based training and testing?
    - People should be able to choose their care coordinator.
    - What about a coaching model of care coordination?
    - The notices family members receive from the case worker are sometimes confusing. Sometimes they are uncertain as to what information/ documentation the case worker is requesting. Someone suggested a checklist as to the documentation to submit. This comment came from several family members specifically during the recertification process.
- **Communication:**

- There needs to be clearer communication between the aging community and the LTC Benefits Division.
- Need for HCPF to get stakeholder input before making changes that affect populations over the long term.
- The strategic plan should set some guiding principles for all communication processes to, from, within, and with the Department. Examples of values/principles: 1) Reactivity, suspicion and hidden agendas all subvert creative, strategic, thoughtful communication and problem-solving. Therefore all department staff and stakeholders will make every effort to be clear about the goals of a policy, program, and changes. 2) Each participant in a feedback circle / planning process brings multiple perspectives. Whenever possible, the priority perspective should be made clear. 3) Speaking about any individual in a public meeting when they are not present, whether the person is department staff, advocate, client, provider, politician or other participant in the system should be discouraged unless directly authorized to represent him/her. 4) We are all equal participants in the "system"; we are all responsible for considering equal access, fiduciary responsibility, quality outcomes and the unique needs of those who receive services. Examples of guidelines: 1) Ask permission before sharing one-to-one conversations. 2) Ask permission before "publishing" email communications. 3) Dialogue with one or a few that impacts the many will be communicated to the many as quickly and clearly as possible.
- The Department should set a strategic goal of increasing efficiency and effectiveness throughout the system. Efforts to save money are often processed in a way that creates more bureaucracy, more inefficiency, more confusion and more rules. Every proposed change should include an analysis of the "hidden" costs it creates.
- Family members commented on the amount of notices they receive in the mail. (Most of these comments came from Medicaid recipients.) Could this be an immediate cost savings? Can this information be placed online to alleviate the need to mail as many notifications?
- Most of the information family members received about long-term care (LTC) options was from family and friends. They would like the State to host a clearinghouse for information that is easily accessible and in terms they can understand. Options other than LTC were not always presented. This may have been because most of the family members with whom I was able to speak are from the Alzheimer's/Dementia population.
- Family members believe the State could do a better job assisting families to assess long-term care options. They would like more resource information when making this important decision as this not only will affect the loved one but the spouse and family.
- Eligibility issues for HCBS services - shifting interpretations of various waiver eligibility rules, lack of consistency, being told different things by different

  people -- people in different parts of the state seem to get different things in same situations.
  - Colorado's conflicting definitions and confusing lack of coordination and barriers to access, adds to our rising health care costs.
  - No consistency in what families are told by CCB's, Providers, insurers--including Medicaid

- **Skilled Nursing, Alternative Care Facilities (ACFs) and Housing**

  - The moratorium on skilled nursing should be lifted for two models: culture change (person-centered care) and small home models like Green House.
  - Some stakeholders perceive that there is an overarching movement and mindset that there is motivation to eliminate Nursing Facilities (NFs) in the post-acute continuum of care due to the perception of being the most expensive delivery of care. Stakeholders would like The Department to recognize that NF's have a significant role in the post-acute delivery of care and instead of being perceived as 'the safety net', or the setting 'by default', to partner with the NF providers and hospital providers to develop a matrix of when NFs are the best solution to post-acute care. There are many instances when Home and Community-Based (HCBS) programs end up being more costly to the health system as opposed to NF-based care. With NF providers embracing person- centered care models many clients actually prefer to be in a NF due to the safety and security of quality health care, increased socialization, care provided based on physical, emotional, mental, spiritual, and strength-based care.
  - Respite Care - Medicaid does not reimburse a NF when a Medicaid client needs respite care in a NF and their length of stay is less than 30 days. This puts a burden on family members / caregivers who may need to be away from the person in need as well as a burden of emotional / financial stress on the client. When respite care is needed, a stay in the NF may actually result in a longer / improved quality condition in the HCBS program. While at the NF the client will be seen by a physician, have their medical and psychosocial needs, advanced directives, spiritual and living arrangements assessed and possibly improved on prior to return to their home. This will result in a better quality of life for the client, equip the caregiver with services at home and provide the client with preventive/wellness healthcare interventions. Patients with dementia are stuck in hospitals as there are no beds in ACFs or Skilled Nursing Facilities (SNFs) for them – these providers don't want them and reimbursement doesn't match up with care needs. In rural communities, patients with dementia must go to SNFs as there are no other options. Same issue of those with mental and behavioral issues.
  - There is still an institutional bias; it is simpler for the discharge planner to use the nursing home.

  - Need to develop/implement person-centered standards for Nursing Homes (NHs.)
  - Need to develop housing alternatives for persons who need housing somewhere between independent and nursing homes, but with high levels of support and security.
  - Name the strategic steps that will be needed to support continued deinstitutionalization.
  - When we talk about a resident wanting to transition from a NH to the community or an ACF, the current system of eligibility often ties them up. So, you may have an organization like Atlantis or any independent living setting up a transition out, they have located a new home, but are unable to secure services as the resident has to go back through financial eligibility. As you know, this process can take over 6 months, meanwhile the available housing is now gone, or the ACF would not take them as there was no guarantee of payment. This takes away a person's hope for a different life, leaving them to feel living their days out in a NH or an Assisted Living Residence (ALR) is the only life they may ever know.
  - Seeing as how there are so few regulations for ALR's there are actually some pretty decent ACF "rules" that very much promote person-centered care. It would be good for HCPF to take action on an ACF's certification when they are not meeting these very basic rules. The Health Department doesn't feel they can really write tags surrounding many of these rules, as they are too subjective. It would appear that the only way HCPF will take any action on a Medicaid certification if there are written deficiencies from CDPHE. I would like to see HCPF be more proactive than this, and use some of the muscle they have to enforce some of these really important rules.
  - Many family members feel that the State is inaccessible during yearly facility inspections. This comment came from three people that have had family members in the system and have never been approached by State inspectors during the annual visit. State workers left early and were not available at night or weekends when more family members were at the facility. Some family members do not know who to go to when issues are unresolved at the facility. They would like to have more visibility as to whom they can report issues with and to know their concerns are being addressed by the State.

- **Children:**

  - Transition issue - there is a clear disconnect between and among the systems that serve children with home, hospital and school not talking to each other and not coordinating with each other. There is not one single case manager who navigates all of these venues.

  - The child transition cliff – when children age out of the program with little transition from one set of systems and services to another. Schools aren't savvy about helping with this.
  - There are four waivers for children, each with differing level of care requirements. The children's waivers need to modernized.
  - There should be some acknowledgement of parental wisdom and value.
  - Ideally, I'd like for us to develop a system that is based on abundance instead of scarcity. Parents shouldn't feel like they have to fight and be angry ALL the TIME, just to get the needs met for their child and family. It is an unhealthy way to live - we can do better. No service should be "place specific". Services should be provided wherever the person is - home, school, community, on-the-job.
  - Parent's want things simple. They want it based on the actual need of their child--not an interpretation, and they want to be a part of the solution, a part of the team--bring parents and people with disabilities in first, not as an afterthought. We can help.
  - EPSDT - how do we protect the extraordinary benefits if this program moves to DHS? Confusion amongst parents, providers when children move into that 18-21 year old range about EPSDT and the differences in what is covered there versus state plan adult Medicaid and what is covered under the waivers.

- **Medicaid application and process:**

  - As there are 64 counties in CO, the process, timing and response rate for these counties differs markedly. Shouldn't all of this be standardized? In the same vein, Nonprofit Organizations (NPOs) vary in their capacity and knowledge of the larger system and resources.
  - Shouldn't there be a "navigator's manual" to help both Providers and stakeholders navigate the application process and, more generally, the Medicaid system?
  - Difficulty navigating the system gives rise to paid navigators. The system shouldn't be so difficult that you have to pay someone to help you navigate that system.
  - Need to get Medicaid benefits suspended for persons in jail or state psych hospitals who are placed for over 30 days rather than terminated as per law.
  - Provide redetermination date and indicate type of Medicaid: LTC, Medicare Savings, SSI, Family, etc.
  - The complexity of having to fill out virtually duplicate paperwork for waivers through SEP and then fill out more through County to actually access the Medicaid, this after applying for SSI. Medicaid should be all in one office with ONE FORM.
  - Medicaid beneficiaries who are eligible for Home Health benefits need to have their personal care (assistance with eating, personal hygiene, etc.) needs

provided when they are in the community, in order to support their employment, volunteerism or health-improving community connectivity.

- **Waivers and waiver modernization/consolidation:**
  - Waivers have limited choices, need to be able to choose based on need.
  - Will the strategic plan name a goal of developing and implementing a Super Waiver for Colorado? If not, the boundaries around waivers (target definitions) need to be reexamined and clarified.
  - Simplifying waivers - I'd love to see all the services available on all the waivers - then you access based on need.

- **SEPs:**
  - Would like CDASS to be available to high-needs children, and would like to limit the criteria for adults to be more specific to high needs that cannot otherwise be accommodated through an agency.
  - Would like HCPF to let SEP agencies know what is coming down, rather than clients or client advocates knowing about policy changes before we do.
  - Would like HCPF staff to know what it is like to be a case manager, new HCPF hires may shadow a case manager for a while.
  - Would like to see more video conferencing and webinars vs. teleconferences.
  - Need a training manual that is standardized and updated regularly. Vol. 8 is nice, but it doesn't cover specific examples and leaves a lot for interpretation. The Vol. 8 is cumbersome and hard to navigate on the website.
  - Updates to who's who at HCPF once a month, on the website, would be helpful.
  - Would also like to submit PARs electronically
  - Wait List administration be managed by the appropriate state agency—not by individual case management agencies
  - Eligibility determination and responsibility for initial information and referral for all LTSS be contracted to either existing single access point entities (e.g. SEPs) or another contracting agency to provide initial eligibility determination and information for persons wishing to access any of the state's Medicaid waivers or other Medicaid services.
  - The state should have the final authority to approve eligibility determinations. Once eligibility is determined, the individual is referred to the appropriate case management agency.
  - Governance and financial direction of entities that provide entry level information and referral and/or eligibility determination must be independent from that of any service provider or case management entity.

- **Data Systems and Information Needs:**

  - Commitment to improvements in use of technology and electronic databases for increasing efficiency and providing quality data reporting. MMIS, BUS, ACS, CBMS … would one new system be more efficient?
  - Changes to the BUS – 1) A place for a Release of Information, so we would know by looking at the system whom we could share information with. Typically, that information is kept in the client file and not easily accessible. 2) Add a place for a disaster plan – who to contact, special accommodations, etc. 3) Go green. Add required forms to BUS so that signatures can be done electronically and do away with paper files.

- **Quality:**

  - Can the strategic plan include priorities for new commitments to quality oversight, outcome monitoring and ongoing technical assistance throughout the Medicaid system?

- **Assessment Tool:**

  - Current system is based on diagnosis, should be based on functional need.
  - Focus on engagement, not the disability.

- **Home Health:**
  - Ensure long-term program sustainability through strategic cost containment.
    - Cost containment efforts should favor reasonable utilization management over new provider rate cuts.
    - Cost containment will benefit from seeking new service delivery model efficiencies, including being open to additional Nurse Practice Act waivers in cases where appropriately trained and supervised non-RN staff can safely perform certain tasks that generally require an RN today (e.g., taking vital signs, performing feeding tube feedings, applying pressure stockings).
  - Provide clarification on the issue of relative personal care providers performing homemaking services.
    - HCPF should issue new interpretative guidance to all impacted constituents including acknowledgement of conflicting rules and conflicting guidance provided by HCPF, DPHE, and SEPs in the past.
    - New interpretative guidance needs to address: Specifically what is/isn't allowed under HCBS? Specifically what is/isn't allowed under IHSS? Specifically what is/isn't allowed under CDASS?
    - Need to ensure that HCPF, DPHE, SEPs, and HCAs are all on the same page.
  - Medicaid beneficiaries who are eligible for Home Health benefits need to have their personal care (assistance with eating, personal hygiene, etc.) needs

provided when they are in the community, in order to support their employment, volunteerism or health-improving community connectivity.

- **Reimbursement:**
  - Payment for services is not incremental. The rate simply does not go far enough.
  - There is a pie (total amount of reimbursement available) and that pie is divided by the number of SEPs. This is neither a logical nor an efficient process and doesn't acknowledge the differences among the SEPs and the fact that clients are not all equal in need.
  - Describe the rates in terms of a logic model – do they make sense?
  - There needs to be transparency in the rates – where does the money go, how much goes to direct services, how much goes to the provider, how much goes to the SEP/CCB?
  - There should be incentives built into the system to create efficiency and save the State money and, likewise, disincentives for those who are inefficient.
  - How do we better take multiple funding streams and direct them more efficiently to deliver services? Transportation is a key issue here – too many systems with differing rules.
  - There should be an effort to access all other resources before going after Medicaid.
  - Tiered reimbursement for ACFs is needed.

- **Homeless:**
  - Do you focus on the acute health situation first or the housing situation first?
  - What about the re-occurrence of homelessness?
  - How do we work with property managers?
  - Is there a SEP for homeless?

- **Transitions:**
  - There is a general theme of "transitions". Hospital to home, hospital to NH, back to hospital, children moving from childhood to adulthood, transitions for children from school to home to hospital, etc. There isn't an entity that brings all of these transition points together.
  - The strategic plan should set a priority that the Department will increase funding for, support for (i.e. HIPAA issues) and use of collaborative teams in planning for and monitoring care transitions for consumers.

- **Developmental Disabilities:**

- Implement an unbiased, foundation-funded, non-political, legislative selected **external** structural study of the entire Developmental Disability (DD) delivery system. How do we know if the DD/Community-Centered Board structure, established "as is" 50 years ago, is the "best" system unless we measure and evaluate the structure? Does our current system structure provide us with singular cost-effective administrative processes, utilizing the most modern technologies and efficiencies for financial and other controls? How do we compare with other states and their very different systems? We need to meet the needs of our individuals with developmental disabilities and their families utilizing highly efficient organizational management.
- Develop ways of electronically structuring methods for families, individuals, organizations and groups who cannot attend numerous meetings or respond to requests for feedback to provide input on an interactive, publicly viewable basis. Many folks are providing extensive care for their children and family members and/or work full-time and simply cannot make these meetings. Input needs to be interactive and viewable. Google and other internet programs may have some solutions for interactive input. Has anyone ever calculated the amount of parent and consumer time requested for input into seemingly endless changes in rules and regulations, waiver changes, advisory meetings, etc.?
- Since 2007, there have been continuous cuts in programs that were originally developed to support parents and family members in best performing these duties for their children with disabilities.
- The state, utilizing the "Supports Intensity Scale" (SIS) developed "Levels" to further categorize and measure (and ultimately further reduce) supports to individuals. However, the SIS failed miserably in measuring the natural supports available to a family, meaning that to meet critical needs, a family with few or no natural supports received the same amount of funding as a family with many natural supports. Results were inconsistent between evaluators (both employees of CCBs and DDD and contractors), causing marked differences in funding even though individual needs were similar.
- Cutbacks in program: Capitation was implemented resulting in limitations of supports to many individuals. Hourly rates for providers were cut in half, with the result that qualified providers could not be hired. SPAL's (State Plan Authorization Limits) reduced a number of folks from Level 7 (the highest) to Level 6, further reducing supports, with no allowances for geographical differences in cost of living. Behavioral supports for individuals with critical behavioral needs were reduced and eliminated. Day program services were changed from 40 hours to 24 hours for those on the DD waiver. Major changes in the system resulted in limitations in group hours in a single activity. Recreation passes were eliminated, so that individuals with DD could no longer participate in social, health and recreational benefits in the community. Transportation was cut terribly, tremendously reducing independence and opportunity for community involvement for those able to independently use

transportation services. These and other cuts and changes in the SLS waiver and rate levels means that individuals with profound disabilities critically needing one-on-one support were reduced to one-in-three support; and some individuals are no longer able to participate in the community, forced into inappropriate "disability groups".

- The state has made it increasingly difficult to gain state reviews of the SIS, even in the evidence of marked changes in an individual's physical condition, and parent-requested reviews by the captive Administrative Law Judges are considered a waste of time by parents.
- It is increasingly common for professionals and policy makers in the disabilities field to tout "Natural Supports" in place of paid assistance to provide services to those with disabilities, in a hope of reducing expenditures. Their belief is that there are neighbors, relatives, family members, churches, community organizations and the like just waiting to help individuals with disabilities. A national survey, "Final Results of the National Natural Support Survey" http://ourwebs.info/naturalsupportmain.htm, with 491 respondents, completed in April, 2011, shows this belief to be an invalid assumption. As natural supports are neither consistent nor guaranteed, using "natural supports" as a care model or adjunct care model is not appropriate except in the most unusual situations.
- Having an open meeting where Medicaid (and/or DD) beneficiaries (or those on Waiting Lists) at least quarterly can show up (free parking, convenient time such as a Saturday afternoon), phone in or participate interactively by computer, to express their concerns including policy issues. Staff needs to record the specific issue and respond satisfactorily by at least the next meeting. This communication group meeting and the resulting responses need to be widely publicized. This kind of meeting is currently modeled by the CDASS participant policy group, and needs to be replicated especially for the DD constituency with the impending move of DDD to HCPF.
- Medicaid does not allow the hospital to bill for both mental health and physical health services to the same patient on the same day. It is not uncommon for people with DD to need both mental and medical health services at the same time. This billing situation presents a serious problem.
- Timelines and processes for responding to emergency need for community-based services should be clarified.
- Assessments and plans that are person-centered; services delivered in accordance with the plan; services designed to meet the outcomes desired by the individual, meet the individuals' needs and are modified as needs change; and assure that people are free of abuse, neglect, discrimination and exploitation.
- Options for beneficiaries to oversee their own direct services and supports, control over budgets, and training and support to perform required functions
- Information, counseling, training and support for families who provide direct support and include provisions for family caregivers to be paid.

- Clear standards so that providers are held accountable for individual person-centered outcomes such as better quality of life; client control over services and supports; protection of rights; competitive employment options in addition to quality assessment and performance measures focused on acute and chronic care
- Cost-effectiveness and efficiency
- Plans for supporting people who are on waiting lists
- Plans for ensuring transitions from public education, NHs and institutions.
- Re-examine the chronic care model, including self-management and patient education programs, drug and behavior management strategies and appraisals, as well as physician and medical practitioner training in best practices for treating patients with DD and chronic co-morbid conditions.

- **Autism:**

  - The CO LTSS Transformation Council needs to specifically include representation of people on the autism spectrum to be a voice against discrimination of Medicaid benefits for people with an autism diagnostic label. I recommend the representation be through the Autism Society of Colorado personnel who are the most cognizant of the access and care coordination problems for this vulnerable population.
  - The Senior Management staff recommended to be on the CO LTSS Transformational Council in this document should be true decision-makers for their Departments. Since a short timeline is needed, the CO LTSS Transformational Council cannot be plagued by organizational "bottlenecks" for decision-making.
  - A recent statistic on chronic diseases recognizes some 44 percent of Americans experience at least one chronic condition. Many (two-thirds over age 64) have multiple or co-morbid conditions. The LTSS population is Colorado's most expensive population in terms of health care. Although, in America, we have pretty good systems in place for acute conditions, we are poorly situated to manage long-term illnesses or chronic DD conditions. One overt reason is our lack of attention to and lack of training for primary care and medical home resources to manage and coordinate care, particularly in DD. Jumping from doctor to doctor in specialty care as well as, (as pointed out below), Colorado's conflicting definitions and confusing lack of coordination and barriers to access, adds to our rising health care costs.
  - Recommend the full report and appendix of the 10-year Strategic Plan for Autism in Colorado, adopted by the Governor and General Assembly in 2010, as mandatory reading for the CO LTSS Transformation Council. This recommendation should not be in statute, but belongs in the recommended list of documentation to study by the Council provided in the below recommendations.

  - Recommend a review of the Core Values from the Division for Developmental Disabilities by the CO LTSS for potential recommendation by the Council for adoption by HCPF for the benefit of all the LTC beneficiaries. Again, this recommendation is not necessarily for inclusion in the process statute, but it is important and I want to include it in my list of recommendations for consideration.
  - Recommend the CO LTSS Transformation Council study consideration of a potential "small" respite benefit for people with DD on the wait list for services. Researchers at the University of Pennsylvania discovered an 8 percent drop in the odds of hospitalization for every $1,000 states spent on respite services in the previous 60 days.
  - Create the CO LTSS Transformation Council to review recent audits, studies, proposals, and other contemporary policy discussions to frame a longer term plan for system re-design. The LTSS Transformation Council will identify common themes and recommend priorities and goals for system transformation. The Council will report to the Joint Budget Committee in November, 2012. The Transformation Council will develop plans to integrate the Division for Developmental Disabilities, the State Unit on Aging, and the Children's Habilitation Residential Program in the CO Department of Healthcare Policy and Financing. The LTSS Transformation Council will begin the process to recommend to the Legislature and the Executive branch changes required to ensure responsiveness, flexibility, accountability, and individualized services for all eligible persons.
  - The Children with Autism Waiver (CAW): The legislature passed the bill in 2000 with 90 out of 100 votes, but vetoed by the Governor. The statute was passed and signed into law in 2004, but the first child was not served until mid-year 2007. The delay of implementation was simply that HCPF didn't want to implement it. When it was finally implemented, it was poorly managed.

- Health care practitioners are not familiar with resources for persons with disabilities.

- Rural communities have fewer support systems, fewer providers, and often must provide a multitude of services out of a single site. The strategic plan should set some goals for increasing providers in rural areas; particularly transportation providers and Home Modification providers.

- One issue we have in northern Colorado is that Larimer County is forcing Medicaid LTC (home) patients to choose either them or hospice. They believe hospice is a duplication of services even though their services are unskilled and ours are entirely skilled. It puts families in a terrible position and most of the time, they choose hospice because they want/need symptom management.

Appendix A

- There is a difference in Mission, Vision and, at the heart of the matter, Core Values between DDD and HCPF. DDD's mission statement is about the quality of life of the individuals served and HCPF's mission statement is largely about access to quality medical care. It may be true that the mission and vision of DDD remains the same under HCPF as it is under CDHS, but it is the core values of the individuals and management of HCPF that guides the priorities and choices that must be made on every level of operation and service to clients. This refers to the principles that guide internal priorities and choices as well as the relationship of HCPF to the external world.

- Mistreatment, Abuse, Neglect or Exploitation (MANE) investigations should be conducted by an unbiased entity via a state or contracted independent agency unknown to either the service provider or the consumer.

- HCPF has refused to participate in the Coordinated System of Payment for Early Intervention statute. Every other funding resource is in compliance, especially DDD, except for HCPF. HCPF has not been willing to discuss their lack of compliance with this 2007 statute.

- There needs to be ombudsperson services available for all Medicaid beneficiaries.

- The Department's strategic plan should address when / where the local level will be prioritized in reform efforts and where regional or statewide management must be used. It seems that the ACC effort tries to draw this balance but perhaps the strategic plan can state that reform will continue to include both local-level management of services and supports as well as regional / statewide management of utilization and costs.

- Will the strategic plan set a standard for leadership among HCPF staff? Can the goals be clear enough, concrete enough that everyone in the Department knows how to work toward those goals?

- Decrease potential for fraud.

- Address whether community-based care can and should provide 24/7 care.

- Address the tough question of paying families to provide care.

- Is it time to re-examine the supports and services needed by the brain-injured population AND to do targeting resource development?

- Some organizations are so focused on protecting their turf that they fail to see how this hurts the clients that they serve.

Appendix A

- Each effort to receive input from stakeholders should include the "big picture" framework for the particular item / project / change. In particular, the "map" of all the current change efforts / reforms would be helpful. The map should show how each particular effort links to the big picture; i.e. CCT, ACCOs, Dual Eligibles, etc.

- Aren't there "best practices" that we can gather from across the country as to how these LTSS challenges have been met in other states?

- Why is there no focus on wellness? If you help me in small ways now (early), perhaps I won't need more expensive help later on.

- How do we incentivize doing the "right thing" and continually making the "process" better?

- Need to establish community mental health centers as patient-centered homes and have that status with the RCCOs.

- Need to figure out what needs to be different in the CO Choice Transitions grant program to successfully transition persons with a serious and persistent mental illness (SPMI), where there has been a problem in transition efforts for people with SPMI in other states, with resulting low rates of success.

Appendix B

STATE OF COLORADO

OFFICE OF THE GOVERNOR

136 State Capitol Building
Denver, Colorado 80203
Phone (303) 866 - 2471
Fax (303) 866 - 2003

John W. Hickenlooper
Governor

D 2012-027

EXECUTIVE ORDER

Establishing The Office of Community Living

Pursuant to Article IV, Section 2 of the Colorado Constitution and the authority vested in the Office of the Governor, I, John W. Hickenlooper, Governor of the State of Colorado, hereby issue this Executive Order establishing the Office of Community Living in the Department of Health Care Policy and Financing.

I. Background and Purpose

The State has long been committed to helping all Coloradans, including people with disabilities and aging, live at home with the supports they need and participate in communities that value their contributions. In Colorado, we are fortunate to have providers and advocates working hard to connect people to the right services at the right time. However, there is a need for the State to better align services and supports so that people with long-term services and supports needs, and their families, do not have to navigate a complicated and fragmented system. This fragmentation prolongs the amount of time it takes for people to gain access to support, and prevents people from gaining access to the right services at the right time.

We need to prepare our long-term services and supports system for the coming 'wave of wisdom', when the nation's population age 65 and older is projected to double. By 2021, the number of older adults in Colorado is expected to increase by 54 percent.

The need for services is growing in other areas as well. Colorado needs to use its limited funds efficiently to better serve more people:

- As of March 2012, approximately 2,000 adults and 500 children with developmental disabilities were waiting to receive services through Medicaid waiver programs. Another 5,500 families are waiting to receive Family Support Services, which assist with the costs of caring for children with developmental disabilities.
- Waiting lists also exist for other home- and community-based waiver services. Approximately 425,000 people nationwide sustain moderate to severe traumatic brain injuries (TBIs) each year. Adults age 75 and over sustain the highest rates of hospitalization associated with TBI.

- Autism is the fastest growing developmental disability. The costs for lifelong care for a child with autism can be reduced by 66% with early diagnosis and intervention services.

Therefore, Colorado needs an effective system of services and supports to enable aging Coloradans and those with developmental, mental and physical disabilities to live in the community. This includes the full spectrum of supports from prevention and intervention services to skilled nursing care. It requires a strategic vision that will improve outcomes, recognize limited resources, break down silos, and promote self-direction and person-centered care.

All Coloradans – including people with disabilities and aging adults– should be able to live in the home of their choosing with the supports they need and participate in communities that value their contributions. To help meet these needs, we are creating an Office of Community Living within the Department of Health Care Policy and Financing with the goal of increasing access to community-based supports for long-term care services that will focus attention and resources on the unique needs of aging Coloradans and people with disabilities.

Establishing an Office of Community Living with active participation of the impacted consumers, families, advocates, providers, communities, and agencies is the most effective way to ensure that necessary coordination and administration is achieved.

II. Directives, Mission, and Scope

A. The Office of Community Living

In order to meet the growing needs of the people of Colorado, the Office of Community Living ("Office") will be established within the Colorado Department of Health Care Policy and Financing ("Department"). The Department shall establish a Director of the Office of Community Living who shall be a part of the Department's Executive Leadership Team and report to the Executive Director. The goal of the Office is to redesign all aspects of the long-term services and supports delivery system, including service models, payment structures and data systems to create efficient and person-centered community-based care. All State agencies and divisions engaged in activities concerning Community Living shall coordinate with the Office on their activities, including, but not limited to, the Division of Housing, the Department of Public Health and Environment, and the Department of Human Services. Moreover, State agencies and divisions shall provide information to the Office and shall involve the Office in strategic decisions regarding Community Living.

To ensure appropriate services are provided to clients, guiding principles of the Office shall be to:

- Provide services in a timely manner with respect and dignity;
- Strengthen consumer choice in service provision;

- Incorporate best practices in service delivery;
- Encourage integrated home- and community-based service delivery;
- Involve stakeholders in planning and processes; and
- Incorporate supportive housing.

In furtherance of these guiding principles, the Office shall:

1. Create an advisory group, the Community Living Advisory Group, that shall consider and recommend necessary changes to the system to ensure responsiveness, flexibility, accountability, and self-directed long-term services and supports for all eligible persons that are beneficial to the citizens of Colorado. In addition, the advisory group shall:
    - Be comprised of two members each of the House and Senate; members of impacted agencies and divisions; one member representing the Commission on Aging; two members representing the Area Agencies on Aging (AAAs); two members representing the Community Centered Boards (CCBs); two members representing providers of care to aging and people with disabilities; two members representing Colorado Counties Incorporated; one member representing Single Entry Point providers; one member representing a nursing home or home health agency; and 12 members representing consumers or consumer advocates with aging or disability community expertise.
    - Conduct open, public, and transparent meetings;
    - Coordinate and integrate with the existing work of the Long-term Care Advisory Committee, the Colorado Commission on Aging, and other planning groups to ensure a cohesive planning process for Colorado;
    - Recommend legislative changes for 2013 and 2014;
    - Sunset September 30, 2014, with final recommendations made to the Governor and Executive Directors of the State Departments of Health Care Policy and Financing, and Human Services.

2. Consider co-location of staff among impacted Departments as is financially and programmatically feasible; and

3. Provide oversight of Community Living efforts for the State of Colorado.

III. Resources

The Office may enter into memoranda of understanding and other agreements with federal, state, and local agencies as necessary to accomplish the mission and purpose delegated to it by this Executive Order. Furthermore, the Office shall have the power to accept money, grants, and in-kind contributions from public and private agencies and entities. The Office shall have the power to hire consultants in compliance with Colorado law as deemed necessary and appropriate by the Director. To the fullest extent permitted by law, the Office shall be authorized to enter into contracts, receive and expend funds, purchase goods and services, and lease space.

IV. Duration

This Executive Order shall remain in effect until modified or rescinded by future Executive Order of the Governor.

GIVEN under my hand and the
Executive Seal of the State of
Colorado this fifth day of
July, 2012.

John W. Hickenlooper
Governor

Appendix C

LTSS Timeline

LONG-TERM SERVICES AND SUPPORTS IN COLORADO

July 2006
Senate Bill 173 report issued

November 2007
House Bill 1374 report issued

July 2010
Olmstead Recommendations report issued

April 2011
LTCAC is appointed steering committee for Money Follows the Person Grant

July 2011
Sue Birch and Reggie Bicha work closely together on LTSS redesign

September 2011
LTCAC reconstituted by Sue Birch to be the primary planning and implementation vehicle for LTSS Redesign

November 2011 – April 2012
Sue Birch and Reggie Bicha conduct meetings throughout the state on the need for redesign of LTSS System

February 2012 – March 2012
LTSS Strategic Planning with David Nolan

April 2012
LTCAC approves four strategic initiatives and authorized subcommittees

July 2012
Governor Hickenlooper signs the Community Living Executive Order

August 2012
LTCAC Subcommittees begin work

August 2012
Community Living Advisory Group initial meeting

Appendix D

Executive Director Stakeholder Community Forums

Date	Location	Number of Stake holders Invited	Number of Stakeholders in Attendance
January 24, 2012	Pueblo	207	21
January 30, 2012	Grand Junction	207	26
February 3, 2012	Frisco	207	19
March 19, 2012	Westminster	207	28

Appendix E

Executive Director Stakeholder Meetings

Date	Stakeholder Groups	Number of Stakeholders Invited
February 2, 2012	Mile High Down Syndrome	3
February 2, 2012	Legal Center for People with Disabilities and Older Persons	3
February 2, 2012	1. CICC 2. Autism Society 3. Family Voices 4. JFK Partners 5. Area Agencies on Aging 6. Colorado Hands and Voices	26
February 2, 2012	The Arc of Colorado	1
February 7, 2012	Colorado Commission on Aging	1
February 7, 2012	Colorado Chapters of the Arc	11 ARCs
February 7, 2012	Colorado Cross Disabilities Coalition	10
February 17, 2012	AARP	2
February 21, 2012	Area Agencies on Aging	10
February 21, 2012	Parents of Adults with Disabilities in Colorado	2
February 22, 2012	DDRC Board of Directors	17
March 22, 2012	Shalom Denver	4

Appendix F

Community Centered Boards Meetings

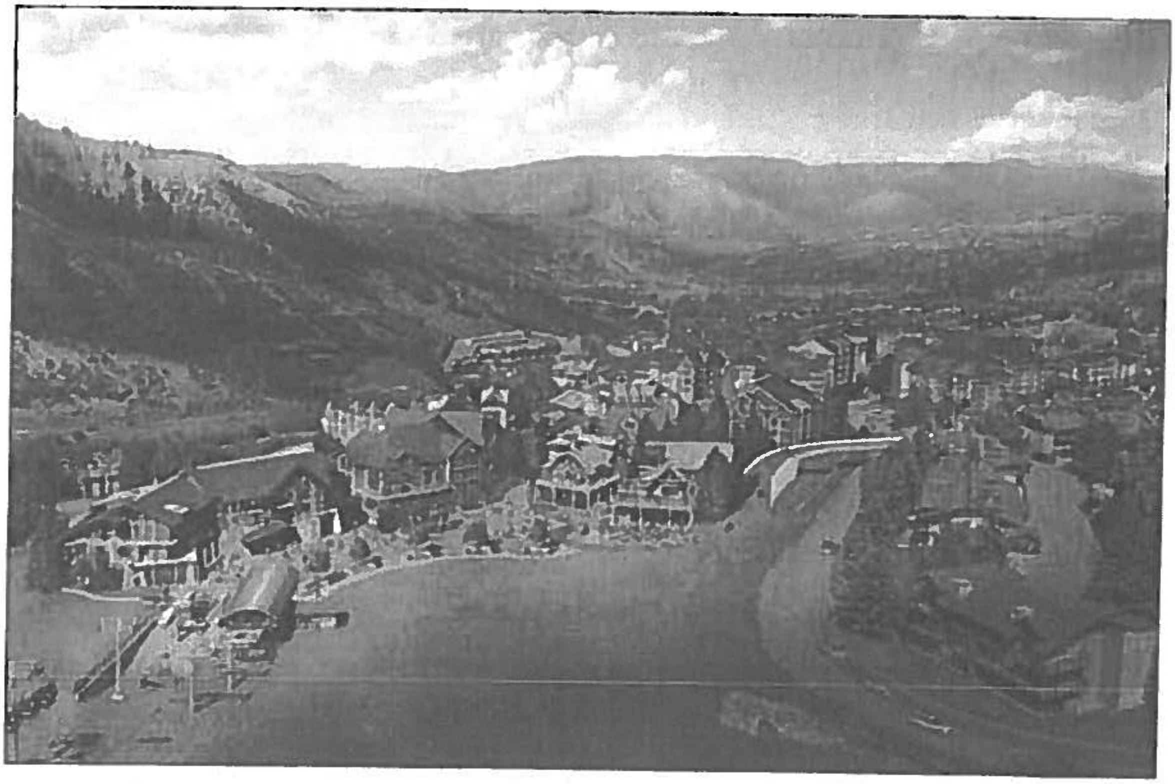
Date	Community Centered Boards and Regional Centers Invited
January 11, 2012	1. Alliance
February 8, 2012	2. Blue Peaks Developmental Services, Inc.
March 14, 2012	3. Colorado Bluesky Enterprises, Inc.
April 11, 2012	4. Community Connections, Inc.
May – N/A	5. Community Options, Inc.
June 13, 2012	6. DD Resource Center
July 22, 2012	7. Denver Options, Inc.
August 8, 2012	8. Developmental Pathways, Inc.
September 12, 2012	9. Eastern Specialized Services
October 10, 2012	10. Envision
November 14, 2012	11. Foothills-Gateway, Inc.
December 12, 2012	12. Grand Junction Regional Center
	13. Imagine!
	14. Inspiration Field
	15. Mesa Developmental Services
	16. Mountain Valley Developmental Services, Inc.
	17. North Metro Community Services, Inc.
	18. Pueblo Regional Center
	19. South Eastern Developmental Services, Inc.
	20. Southern Colorado Developmental Disability Services, Inc.
	21. Starpoint
	22. The Resource Exchange, Inc.
	23. Wheat Ridge Regional Center

Appendix G

Alliance

Colorado Communities United for People
with Developmental Disabilities

2012 ALLIANCE JUNE SUMMIT:
FOCUS ON THE FUTURE



Featuring speakers and resources for
Colorado CCBs and SPOs

June 20th – 22nd, 2012
Viceroy Snowmass
130 Wood Road
Snowmass Village, CO

Appendix G

Alliance

Colorado Communities United for People
with Developmental Disabilities

2012 Alliance June Summit: FOCUS ON THE FUTURE
Schedule of Events

Viceroy Snowmass, Snowmass Village, CO
June 20th – 22nd, 2012

Wednesday June 20th

Registration from **10:00am to 1:00pm and 4:30pm to 5:00pm**– Pre-Function Area, 1st Floor

Time	Event	Location
1:00pm-1:10pm	Welcome Alliance President, Mike Atlas-Acuña	Salon 1 & 2
1:10pm – 2:10pm	Alliance Focus on the Future Workgroup Presentation, See page 12-14	Salon 1 & 2
2:10pm – 3:25pm	David Leslie, C.E.O. & Founder, ZippSlip, Inc., *"Outside Learning In - Perspectives of an Acting CEO"*, See page 16	Salon 1 & 2
3:25pm – 3:35pm	**Break**	
3:35pm – 4:45pm	Capt. Zachary Taylor, MD, Regional Administrator, Office of the Assistant Secretary for Health - Region VIII, *"U.S. Department of Health and Human Services—Affordable Care Act Update on the New HHS Agency, the Administration for Community Living"*, See page 16-17	Salon 1 & 2
5:00pm-7:00pm	Welcome reception with hors d'oeuvres and cash bar	Nest Lounge and Café/ Pool area

Appendix G

Thursday June 21st

Time	Event	Location
7:00am-8:00am	Breakfast Buffet	Salon 1 & 2
8:05am – 9:05am	Barb Brent, M.S., Director of State Policy, NASDDDS. *"The Changing Landscape in Developmental Disability Systems- Federal Policy, State Realities, Discovering Possibilities Together"*, See page 17	Salon 1 & 2
9:05am-10:05am	Annette Downey, Executive Director, Community Living Services of Oakland County & John Toppi, Owner, Toppi's Creative Cards and Crafts, *"Self-Directed Supports: A Look at How Michigan Operationalizes Self-Determination"*, See page 17-18	Salon 1 & 2
10:05am – 10:15am	**Break**	
10:15am–11:45am	Dr. David Braddock, Ph.D., Coleman Institute for Cognitive Disabilities, *"The State of the States in Developmental Disabilities: 2012"*, See page 19-20	Salon 1 & 2
12:00pm-1:15pm	Recognition Luncheon	Salon 1 & 2
1:15pm- 2:45pm	Teri Bolinger, Leslie Weems, April Abrahamson, & Lesley Reeder, *"Colorado's Demonstration to Integrate Care for Dual Eligible Individuals"*, See page 20-21	Salon 1 & 2
	Breakout Sessions:	
2:50pm - 3:50pm	Teri Bolinger & Leslie Weems, April Abrahamson, & Lesley Reeder, *"The Dual Eligible Demonstration – Connecting the Dots"*, See page 21-22	Salon 3
	Beth Mathis, *"Quality of Life: Measurement, Management, and Improvement"*, See page 22	Salon 4
	Barb Brent, *"State Initiatives & Efforts – Similarities and Differences to Colorado's Focus on the Future"*, See page 23	Summit 1
	Susan Hepburn, *"Intervening with Families Through Videoconferencing: Lessons Learned from the TeleCopes Project"*, See page 23-24	Summit 2
	Annette Downey, *"Everything You Ever Wanted to Know About Self-Directed Supports"*, See page 24	Snowmass
3:55pm - 4:55pm	Teri Bolinger & Leslie Weems, April Abrahamson, & Lesley Reeder, See page 21-22	Salon 3
	Beth Mathis, *"Quality of Life: Measurement, Management, and Improvement"*, See page 22	Salon 4
	Barb Brent, *"State Initiatives & Efforts – Similarities and Differences to Colorado's Focus on the Future"*, See page 23	Summit 1
	Connie McWilliams, *"Quality Management: Program Standards according to CO Licensure Regulations"*, page 24-25	Summit 2
	Anna Keith, *"Improving System Access Via Technology"*, 25	Snowmass
	Diana Holland & Candie Dalton, *"Expanding Employment Opportunities for People with I/DD"*, page 25-26	Salon 1
	Carol Meredith and Corry Robinson, *"Colorado Collaborative on Autism and Neurodevelopmental Disabilities Options (CANDO)"*, See page 26-27	Salon 2
5:30pm–8:30pm	Event/dinner offsite – (Not included in Registration cost, will be billed back) **Please sign in at your arrival, SEE PAGE 5 FOR MORE INFORMATION**	Hickory House, Aspen CO

Appendix G

Hickory House
730 West Main Street
Aspen, CO 81611
Thursday June 21st, 5:30pm – 8:30pm

Transportation Options:

- Take the free Roaring Fork Transportation Authority (RFTA) Bus.
    - Buses depart every thirty minutes at :15 and :45 past the hour from the Snowmass Mall and Rubey Park in Aspen until 2:15am. Detailed Aspen maps are at the Concierge desk and they would love to explain this all in detail if you prefer.
    - The bus stop is very close to the hotel, and the Viceroy Valet team (970-923-8000) will happily drive you down to the bus stop, otherwise it is less than a five minute walk to The Base Village Parking Garage where the bus terminals are.
    - Terminal C is the pickup point for Aspen at the Snowmass Base Village Parking Garage. The bus comes back to Snowmass from Aspen on the same schedule.
    - In Aspen, you will get off at the Eighth Street stop, it just after the second bridge as you are entering Aspen city. You should mention to the driver which stop you want to get off at so you do not miss it. They do call out most of the stops on the intercom system; however they do not call out Eighth Street. That is the closest but should you miss the stop, you will enter the main road and see Hickory House on your left-hand side and the next stop is about two blocks away.
    - The bus stop going back to Snowmass Village is on the other side of the road a few yards higher up the road from the Eighth Street stop you get off at.
- Carpool with other attendees!

Friday June 22nd

Time	**Event**	**Location**
7:30am-8:30am	Breakfast Buffet	Salon 1 & 2
8:30am – 10:00am	**CFO Meeting** (roundtable)	Salon 1 & 2
8:30am – 10:00am	**Case Managers Meeting** (roundtable)	Salon 1 & 2
8:30am – 10:00am	**Early Intervention/FSSP Meeting** (roundtable)	Salon 1 & 2
8:30am – 10:00am	**Public Relations Meeting** (roundtable)	Salon 1 & 2
8:30am – 10:00am	**Adult Services Meeting** (roundtable)	Salon 1 & 2
8:30am – 10:00am	**Human Resources Meeting** (Presentation by Pinnacol Assurance) (roundtable)	Salon 1 & 2
10:00am – 10:10am	**Break**	
10:10am–12:00pm	Government Relations Report: • Year in Review / Committee Recognition Awards • Elections • Budget • Interim Activities • Connecting with your local legislators • What to expect next year	Salon 1 & 2
12:00pm	Summit Concludes	

COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

Appendix H

Long Term Benefits Databook

October 15, 2012

Appendix H

LONG TERM BENEFITS DATABOOK

TOTAL MEDICAID COST OF CARING FOR CLIENTS RECEIVING LONG TERM BENEFITS FOR FISCAL YEARS 2007 - 2011

FISCAL YEAR	LONG TERM BENEFIT COSTS	STATE PLAN COSTS	TOTAL COSTS	ANNUALIZED CLIENT COUNT	AVERAGE PER CAPITA
2006-07	$982,414,934	$368,000,573	$1,350,415,507	35,621	$48,190
2007-08	$1,031,067,376	$410,783,109	$1,441,850,485	36,545	$67,577
2008-09	$1,176,010,227	$476,980,763	$1,652,990,990	38,082	$65,100
2009-10	$1,175,438,992	$484,772,444	$1,660,211,436	39,655	$62,832
2010-11	$1,190,856,846	$487,794,052	$1,678,650,898	40,883	$63,489

Total Medicaid Cost

Appendix H

LONG TERM BENEFITS ACRONYMS

BI	Brain Injury
CDASS	Consumer Directed Attendant Support Services
CES	Children's Extensive Support
CHCBS	Children's Home & Community Based Services
CHRP	Children's Habilitation Residential Program
CWA	Children with Autism
DD	Developmentally Disabled
EBD	Elderly, Blind & Disabled
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
LTB	Long term benefit (for example nursing facility or waiver costs
MI	Mental Illness
NF	Nursing Facilities
PACE	Program of all Inclusive Care for the Elderly
PHW	Pediatric Hospice Waiver
PLWA	Persons Living With AIDS
SLS	Supported Living Services
SP	State Plan (all non-long term benefit Medicaid costs)

Appendix H

Long Term Benefit & State Plan Costs with Growth Rate and Per Capita

CLASS I NURSING FACILITY

FISCAL YEAR	DISTINCT CLIENT COUNT	ANNUALIZED CLIENT COUNT (FTE)	NF LTB COSTS	STATE PLAN COSTS FOR NF CLIENTS	TOTAL COSTS	PER CAPITA COST	PER CAPITA COST GROWTH RATE
2006-07	14,722	10,461	$487,760,591	$77,903,386	$565,663,977	$54,074	**N/A**
2007-08	14,545	10,236	$487,004,903	$84,898,031	$571,902,934	$55,872	**3.33%**
2008-09	14,242	10,138	$540,320,160	$103,636,902	$643,957,062	$63,519	**13.69%**
2009-10	14,331	10,184	$504,552,238	$86,692,832	$591,245,070	$58,056	**-8.60%**
2010-11	14,439	10,222	$495,249,732	$89,974,655	$585,224,387	$57,251	**-1.39%**

ICF/IID

FISCAL YEAR	DISTINCT CLIENT COUNT	ANNUALIZED CLIENT COUNT (FTE)	ICFMR LTB COSTS	STATE PLAN COSTS FOR ICFMR CLIENTS	TOTAL COSTS	PER CAPITA COST	PER CAPITA COST GROWTH RATE
2006-07	144	140	$21,461,225	$2,300,420	$23,761,646	$169,726	**N/A**
2007-08	139	133	$22,383,735	$1,515,420	$23,899,154	$179,693	**5.87%**
2008-09	137	133	$23,129,956	$1,757,198	$24,887,155	$187,121	**4.13%**
2009-10	192	187	$25,746,399	$8,571,572	$34,317,971	$183,519	**-1.93%**
2010-11	194	188	$34,035,121	$2,096,909	$36,132,029	$192,192	**4.73%**

PACE

FISCAL YEAR	DISTINCT CLIENT COUNT	ANNUALIZED CLIENT COUNT (FTE)	PACE CAPITATION COSTS		TOTAL COSTS	PER CAPITA COST	PER CAPITA COST GROWTH RATE
2006-07	1,391	1,123	$45,055,483	ALL PACE COSTS ARE CONTAINED WITHIN CAPITATION COSTS	$45,055,483	$40,121	**N/A**
2007-08	1,535	1,236	$49,497,887		$49,497,887	$40,047	**-0.18%**
2008-09	1,821	1,415	$61,788,787		$61,788,787	$43,667	**9.04%**
2009-10	2,070	1,633	$69,524,317		$69,524,317	$42,575	**-2.50%**
2010-11	2,294	1,848	$78,405,432		$78,405,432	$42,427	**-0.35%**

Appendix H

WAIVER PROGRAMS

HCBS-BRAIN INJURY

FISCAL YEAR	DISTINCT CLIENT COUNT	ANNUALIZED CLIENT COUNT (FTE)	WAIVER COSTS	STATE PLAN COSTS	TOTAL COSTS	PER CAPITA COST	PER CAPITA COST GROWTH RATE
2006-07	313	237	$10,996,076	$4,387,875	$15,383,951	$64,911	**N/A**
2007-08	278	234	$10,695,752	$3,550,586	$14,246,338	$60,882	**-6.21%**
2008-09	273	228	$12,030,010	$4,397,422	$16,427,431	$72,050	**18.34%**
2009-10	262	219	$11,718,000	$3,656,899	$15,374,899	$70,205	**-2.56%**
2010-11	257	225	$12,218,757	$3,370,248	$15,589,005	$69,284	**-1.3%**

HCBS-CHILDREN'S HOME AND COMMUNITY BASED SERVICES

FISCAL YEAR	DISTINCT CLIENT COUNT	ANNUALIZED CLIENT COUNT (FTE)	WAIVER COSTS	STATE PLAN COSTS	TOTAL COSTS	PER CAPITA COST	PER CAPITA COST GROWTH RATE
2006-07	1,297	1,062	$955,505	$28,582,981	$29,538,486	$27,814	**N/A**
2007-08	1,379	1,222	$1,373,655	$37,505,547	$38,879,202	$31,816	**14.39%**
2008-09	1,384	1,210	$1,729,626	$44,061,995	$45,791,621	$37,844	**18.95%**
2009-10	1,417	1,194	$1,873,078	$44,517,904	$46,390,982	$38,853	**2.67%**
2010-11	1,352	1,126	$1,907,503	$43,660,035	$45,567,538	$40,469	**4.16%**

HCBS-CHILDREN'S HABILITATION RESIDENTIAL PROGRAM

FISCAL YEAR	DISTINCT CLIENT COUNT	ANNUALIZED CLIENT COUNT (FTE)	WAIVER COSTS	STATE PLAN COSTS	TOTAL COSTS	PER CAPITA COST	PER CAPITA COST GROWTH RATE
2006-07	171	137	$5,392,112	$4,308,546	$9,700,658	$70,808	**N/A**
2007-08	157	119	$5,242,003	$4,585,764	$9,827,766	$82,586	**16.63%**
2008-09	162	126	$5,819,775	$5,052,143	$10,871,919	$86,285	**4.48%**
2009-10	171	136	$6,216,965	$5,314,765	$11,531,730	$84,792	**-1.73%**
2010-11	151	94	$5,740,987	$4,816,889	$10,557,877	$112,318	**32.46%**

HCBS-CHILDREN WITH AUTISM

FISCAL YEAR	DISTINCT CLIENT COUNT	ANNUALIZED CLIENT COUNT (FTE)	WAIVER COSTS	STATE PLAN COSTS	TOTAL COSTS	PER CAPITA COST	PER CAPITA COST GROWTH RATE
2006-07	18	3	$36,729	$67,982	$104,711	$34,904	**N/A**
2007-08	73	38	$711,646	$330,331	$1,041,977	$27,420	**-27.29%**
2008-09	90	65	$1,177,937	$933,284	$2,111,221	$32,480	**15.58%**
2009-10	116	65	$1,510,297	$1,524,746	$3,035,043	$46,693	**30.44%**
2010-11	115	59	$1,265,712	$1,109,729	$2,375,440	$40,262	**-15.97%**

HCBS-ELDERLY BLIND AND DISABLED

FISCAL YEAR	DISTINCT CLIENT COUNT	ANNUALIZED CLIENT COUNT (FTE)	WAIVER COSTS	STATE PLAN COSTS	TOTAL COSTS	PER CAPITA COST	PER CAPITA COST GROWTH RATE
2006-07	17,341	13,592	$123,858,405	$166,652,558	$290,510,964	$21,374	**N/A**
2007-08	18,200	14,147	$141,269,548	$182,802,259	$324,071,807	$22,907	**7.18%**
2008-09	19,364	15,161	$177,910,502	$205,572,499	$383,483,002	$25,294	**10.42%**
2009-10	20,335	16,051	$193,060,403	$208,066,478	$401,126,881	$24,991	**-1.20%**
2010-11	21,096	16,960	$208,285,746	$216,531,860	$424,817,606	$25,048	**0.23%**

HCBS-MENTAL ILLNESS CLIENT SERVICES

FISCAL YEAR	DISTINCT CLIENT COUNT	ANNUALIZED CLIENT COUNT (FTE)	WAIVER COSTS	STATE PLAN COSTS	TOTAL COSTS	PER CAPITA COST	PER CAPITA COST GROWTH RATE
2006-07	2,232	1,720	$17,438,690	$18,857,953	$36,296,643	$21,103	**N/A**
2007-08	2,399	1,878	$20,371,327	$22,331,617	$42,702,944	$22,739	**7.75%**
2008-09	2,581	2,066	$23,170,474	$25,200,777	$48,371,251	$23,413	**2.97%**
2009-10	2,743	2,191	$23,267,856	$27,535,648	$50,803,504	$23,187	**-0.96%**
2010-11	2,898	2,312	$24,384,239	$33,043,553	$57,427,792	$24,839	**7.12%**

Appendix H

HCBS-PEDIATRIC HOSPICE WAIVER

FISCAL YEAR	DISTINCT CLIENT COUNT	ANNUALIZED CLIENT COUNT (FTE)	WAIVER COSTS	STATE PLAN COSTS	TOTAL COSTS	PER CAPITA COST	PER CAPITA COST GROWTH RATE
2006-07	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2007-08	2	0	$350	$62,233	$62,583	$250,332	N/A
2008-09	57	26	$40,032	$3,853,473	$3,893,505	$149,750	-40.18%
2009-10	91	58	$101,498	$6,304,514	$6,406,012	$110,448	-26.24%
2010-11	124	83	$143,628	$8,216,663	$8,360,291	$100,726	-8.80%

HCBS-PERSONS LIVING WITH AIDS

FISCAL YEAR	DISTINCT CLIENT COUNT	ANNUALIZED CLIENT COUNT (FTE)	WAIVER COSTS	STATE PLAN COSTS	TOTAL COSTS	PER CAPITA COST	PER CAPITA COST GROWTH RATE
2006-07	68	52	$513,614	$759,957	$1,273,571	$24,492	N/A
2007-08	72	60	$587,168	$759,290	$1,346,458	$22,441	-8.37%
2008-09	71	58	$592,243	$773,765	$1,366,007	$23,552	4.95%
2009-10	68	59	$604,877	$971,110	$1,575,987	$26,712	13.42%
2010-11	63	51	$547,179	$711,566	$1,258,745	$19,980	-25.20%

HCBS-CHILDREN'S EXTENSIVE SUPPORT

FISCAL YEAR	DISTINCT CLIENT COUNT	ANNUALIZED CLIENT COUNT (FTE)	WAIVER COSTS	STATE PLAN COSTS	TOTAL COSTS	PER CAPITA COST	PER CAPITA COST GROWTH RATE
2006-07	395	346	$4,752,313	$15,904,188	$20,656,500	$59,773	N/A
2007-08	435	376	$5,888,918	$19,580,627	$25,469,545	$58,551	-2.04%
2008-09	434	388	$6,933,711	$22,186,534	$29,120,245	$67,097	14.60%
2009-10	433	392	$7,053,807	$23,349,385	$30,403,192	$70,215	4.65%
2010-11	436	376	$7,358,606	$22,478,689	$29,837,295	$68,434	-2.54%

Appendix H

HCBS-DEVELOPMENTALLY DISABLED

FISCAL YEAR	DISTINCT CLIENT COUNT	ANNUALIZED CLIENT COUNT (FTE)	WAIVER COSTS	STATE PLAN COSTS	TOTAL COSTS	PER CAPITA COST	PER CAPITA COST GROWTH RATE
2006-07	4,198	3,925	$227,594,166	$25,075,057	$252,669,222	$64,374	**N/A**
2007-08	4,283	4,029	$246,404,421	$28,537,380	$274,941,801	$68,241	**6.01%**
2008-09	4,437	4,145	$275,560,017	$31,700,624	$307,260,641	$74,128	**8.63%**
2009-10	4,535	4,284	$294,453,215	$39,917,012	$334,370,227	$78,051	**5.29%**
2010-11	4,465	4,284	$286,372,193	$30,833,555	$317,205,748	$74,044	**-5.13%**

HCBS-SUPPORTED LIVING SERVICES

FISCAL YEAR	DISTINCT CLIENT COUNT	ANNUALIZED CLIENT COUNT (FTE)	WAIVER COSTS	STATE PLAN COSTS	TOTAL COSTS	PER CAPITA COST	PER CAPITA COST GROWTH RATE
2006-07	3,070	2,823	$36,600,025	$23,199,670	$59,799,695	$21,183	**N/A**
2007-08	3,095	2,837	$39,636,064	$24,324,024	$63,960,088	$22,545	**6.43%**
2008-09	3,337	2,923	$45,806,997	$27,854,145	$73,661,142	$25,201	**11.78%**
2009-10	3,334	3,002	$35,756,043	$28,349,579	$64,105,622	$21,354	**-15.26%**
2010-11	3,303	3,055	$34,942,012	$30,949,702	$65,891,714	$21,568	**1.00%**

Appendix H

CDASS

FISCAL YEAR	DISTINCT CLIENT COUNT	ANNUALIZED CLIENT COUNT (FTE)	CDASS COSTS	STATE PLAN COSTS FOR CDASS CLIENTS	PER CAPITA COST	PER CAPITA COST GROWTH RATE
2006-07	0	0	0	0	N/A	N/A
2007-08	452	330	$5,453,473.73	$5,729,794.07	$33,888.69	N/A
2008-09	862	821	$26,992,113.60	$9,432,789.51	$44,357.50	30.89%
2009-10	1,159	1,115	$36,760,708.50	$10,780,571.79	$42,644.29	-3.86%
2010-11	1,757	1,659	$47,279,636.77	$15,615,360.96	$37,909.49	-11.10%

CDASS TABLE

Appendix H

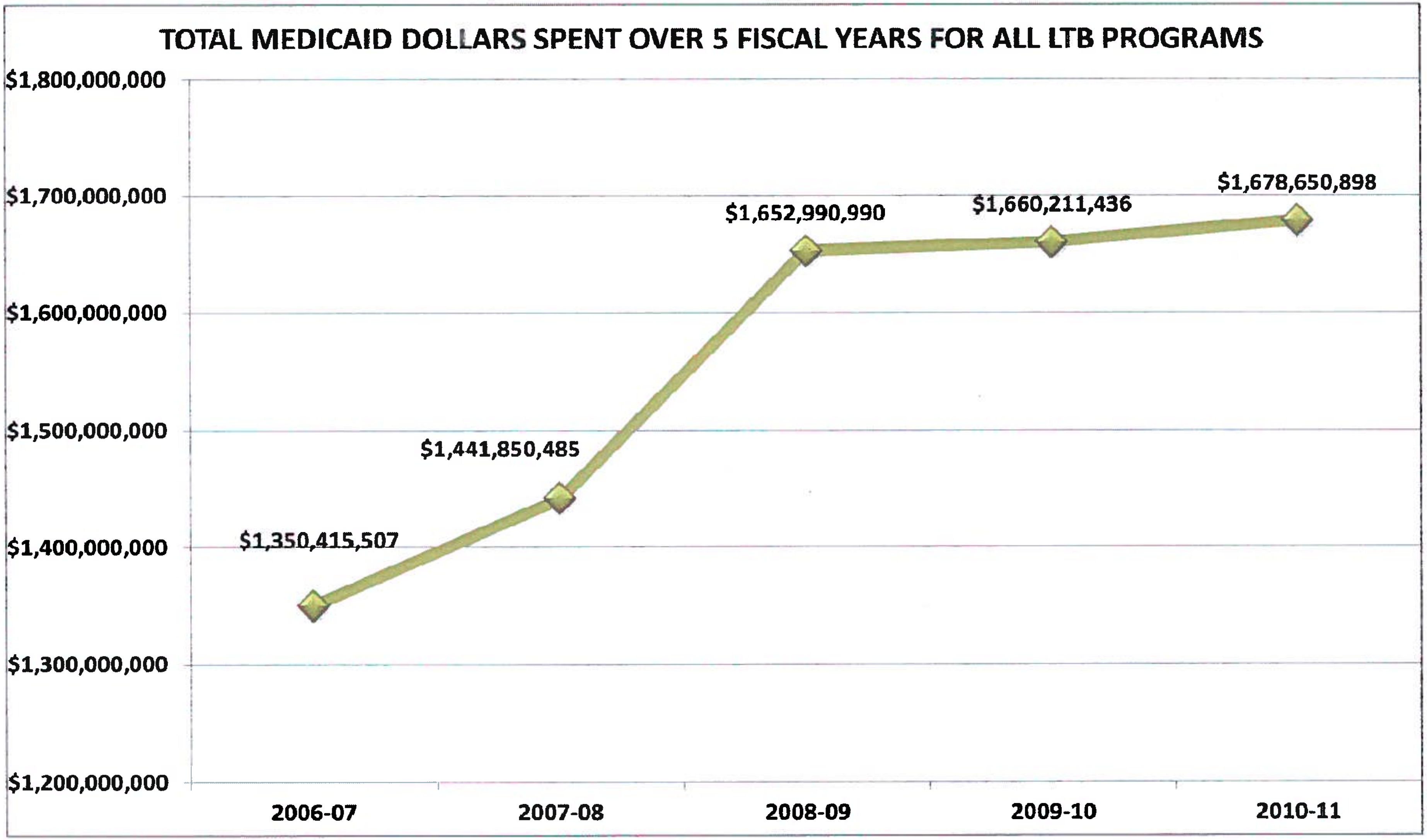


CHART 1

Appendix H

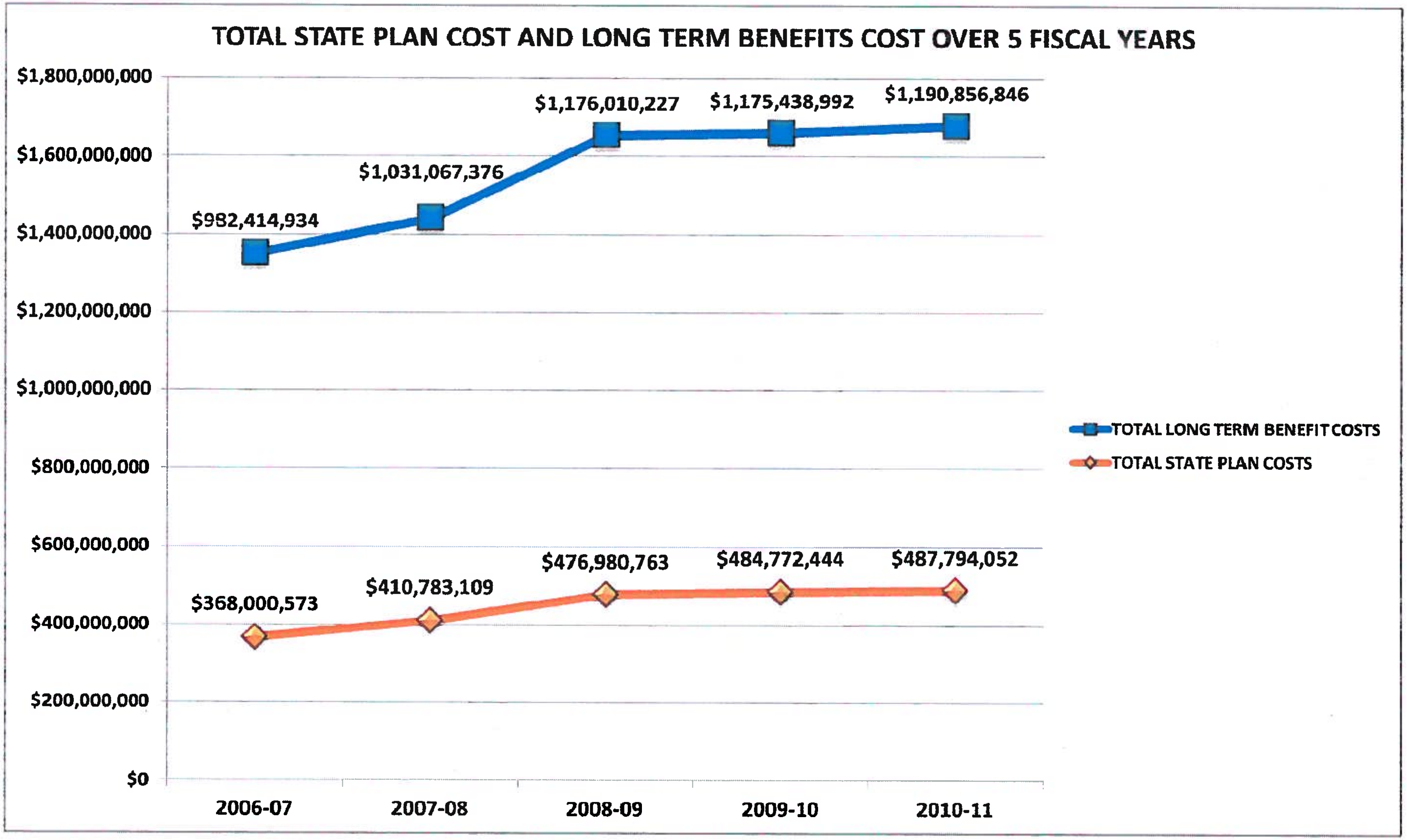


CHART 2

Appendix H

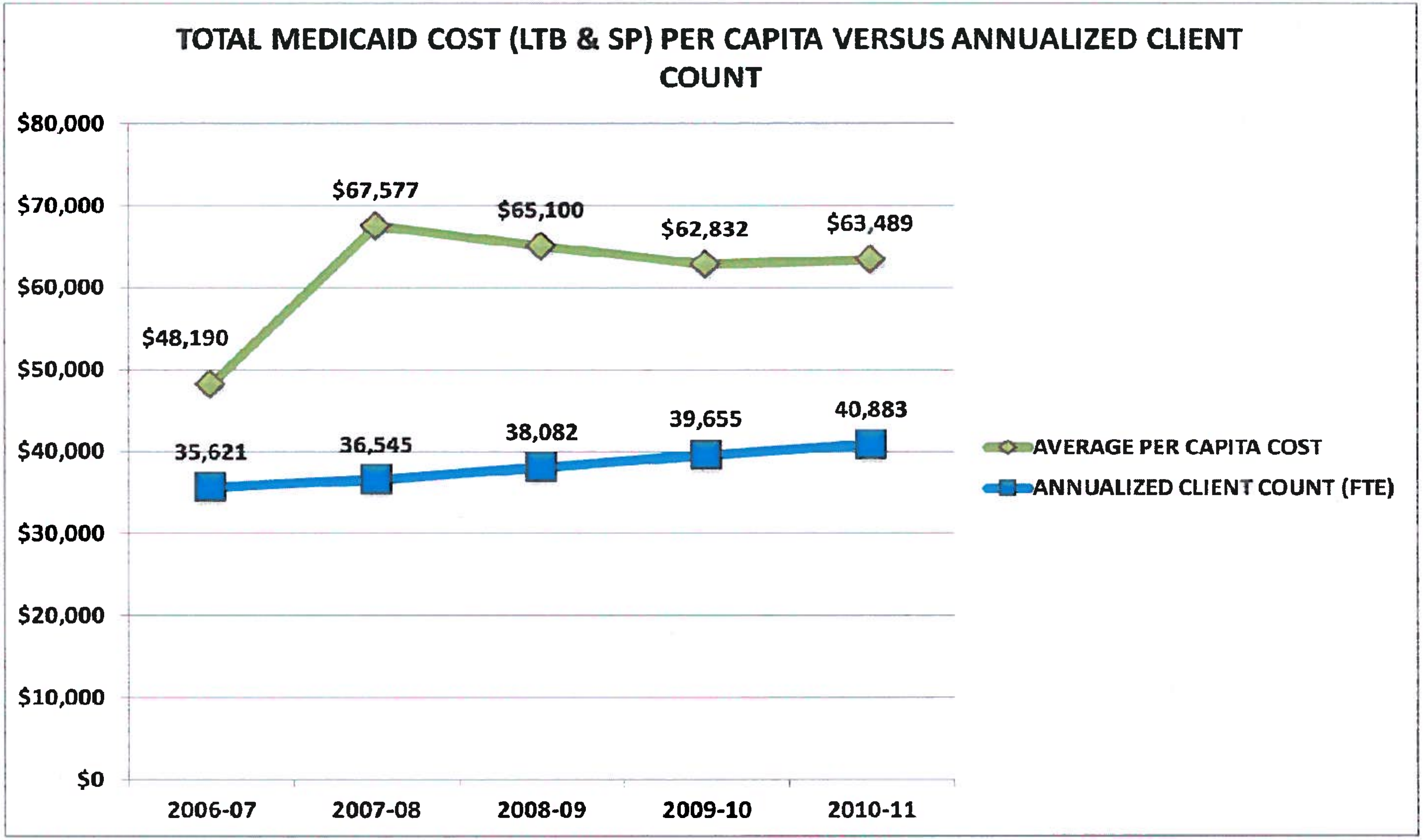


CHART 3

Appendix H

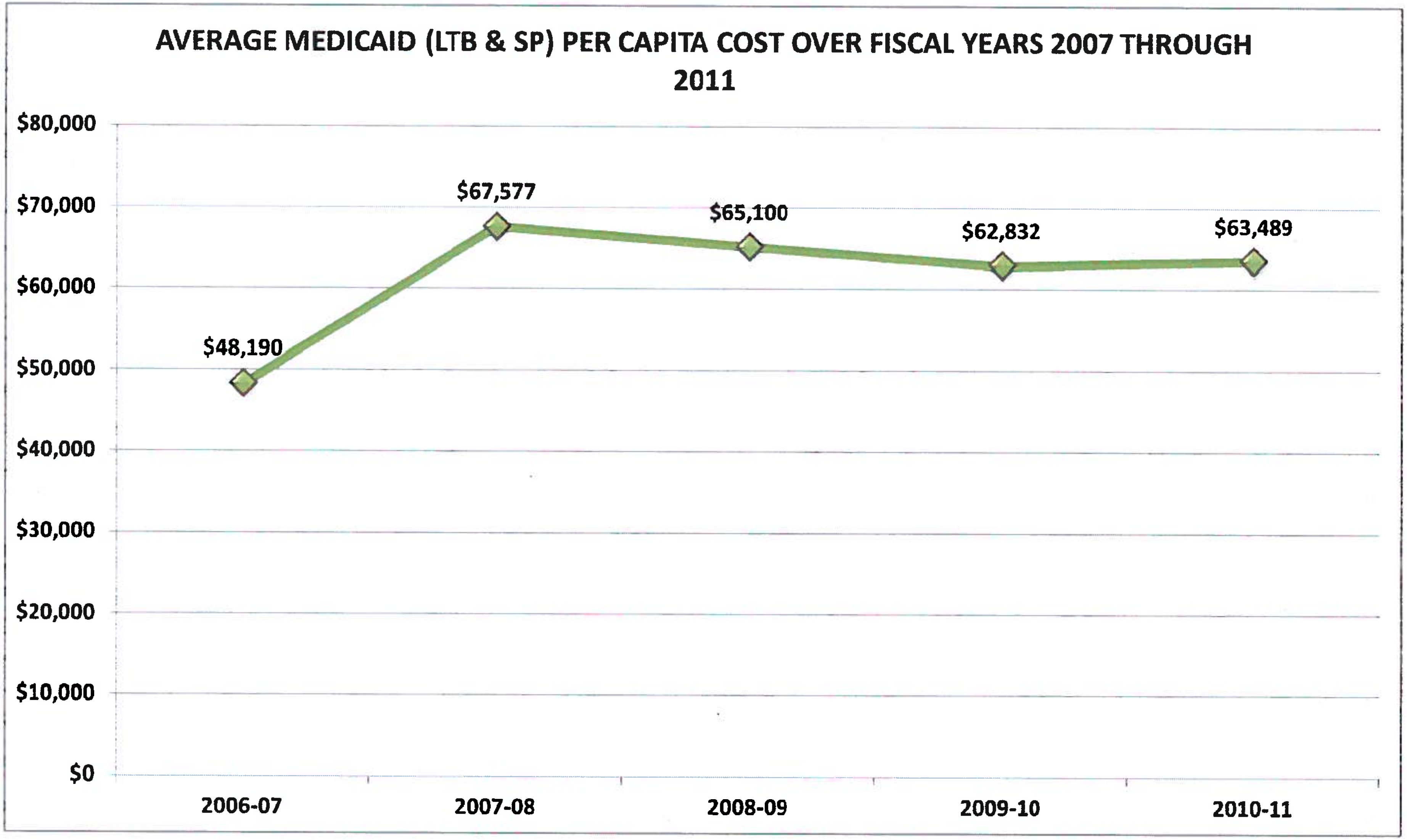
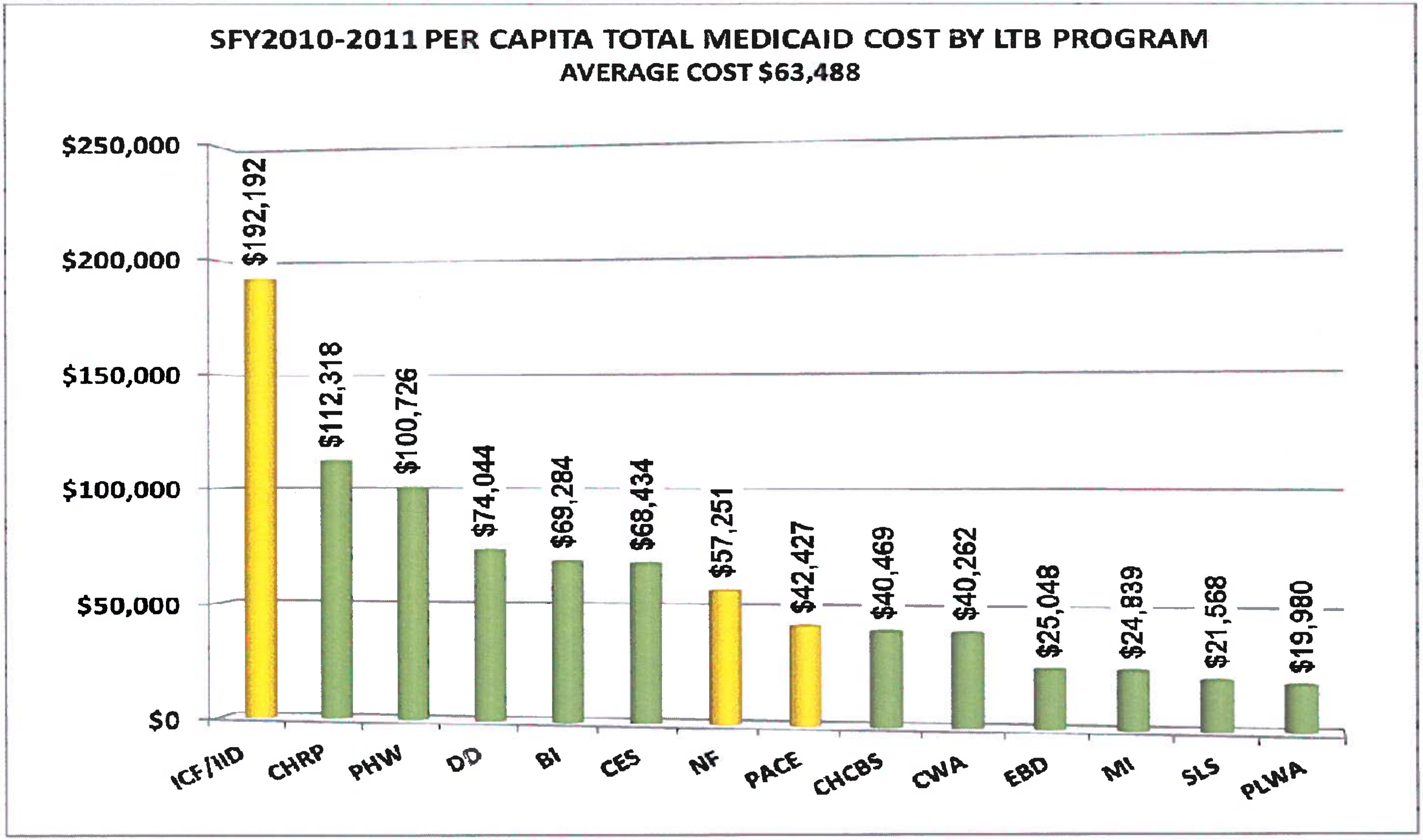


CHART 4

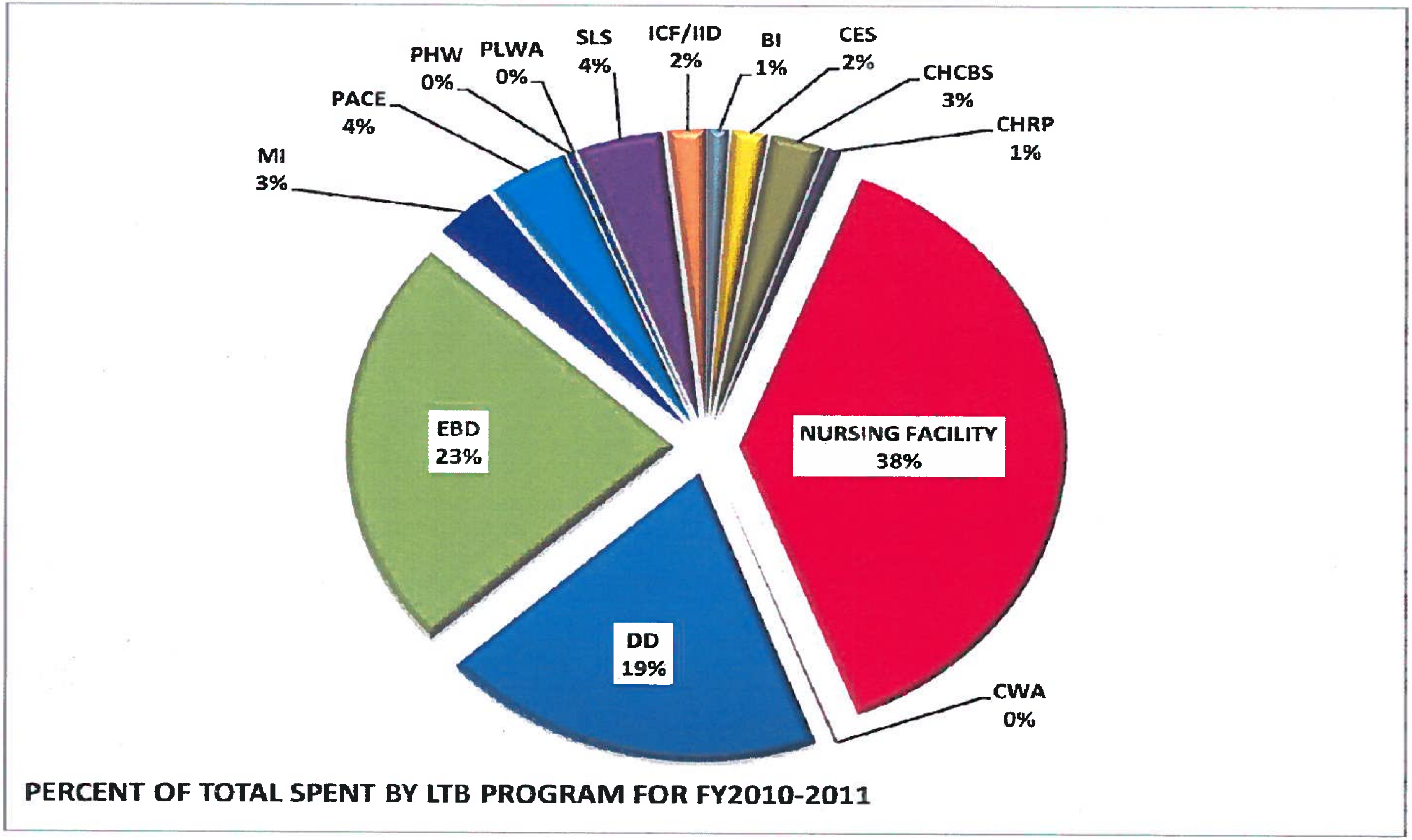
Appendix H



SFY2010-2011 PER CAPITA TOTAL MEDICAID COST BY LTB PROGRAM
AVERAGE COST $63,488

CHART 5

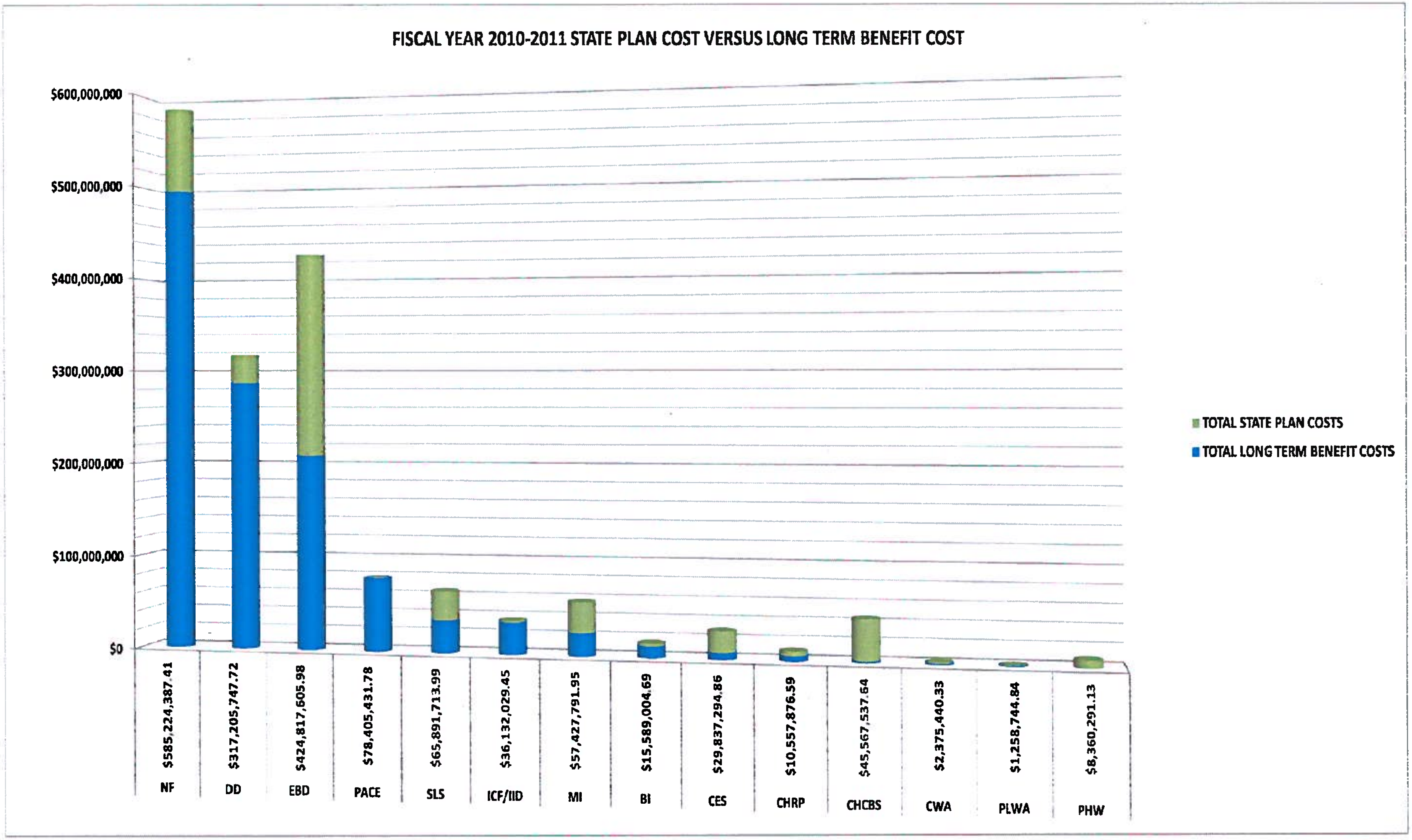
Appendix H



PERCENT OF TOTAL SPENT BY LTB PROGRAM FOR FY2010-2011

CHART 6

Appendix H



FISCAL YEAR 2010-2011 STATE PLAN COST VERSUS LONG TERM BENEFIT COST

CHART 7

Appendix H

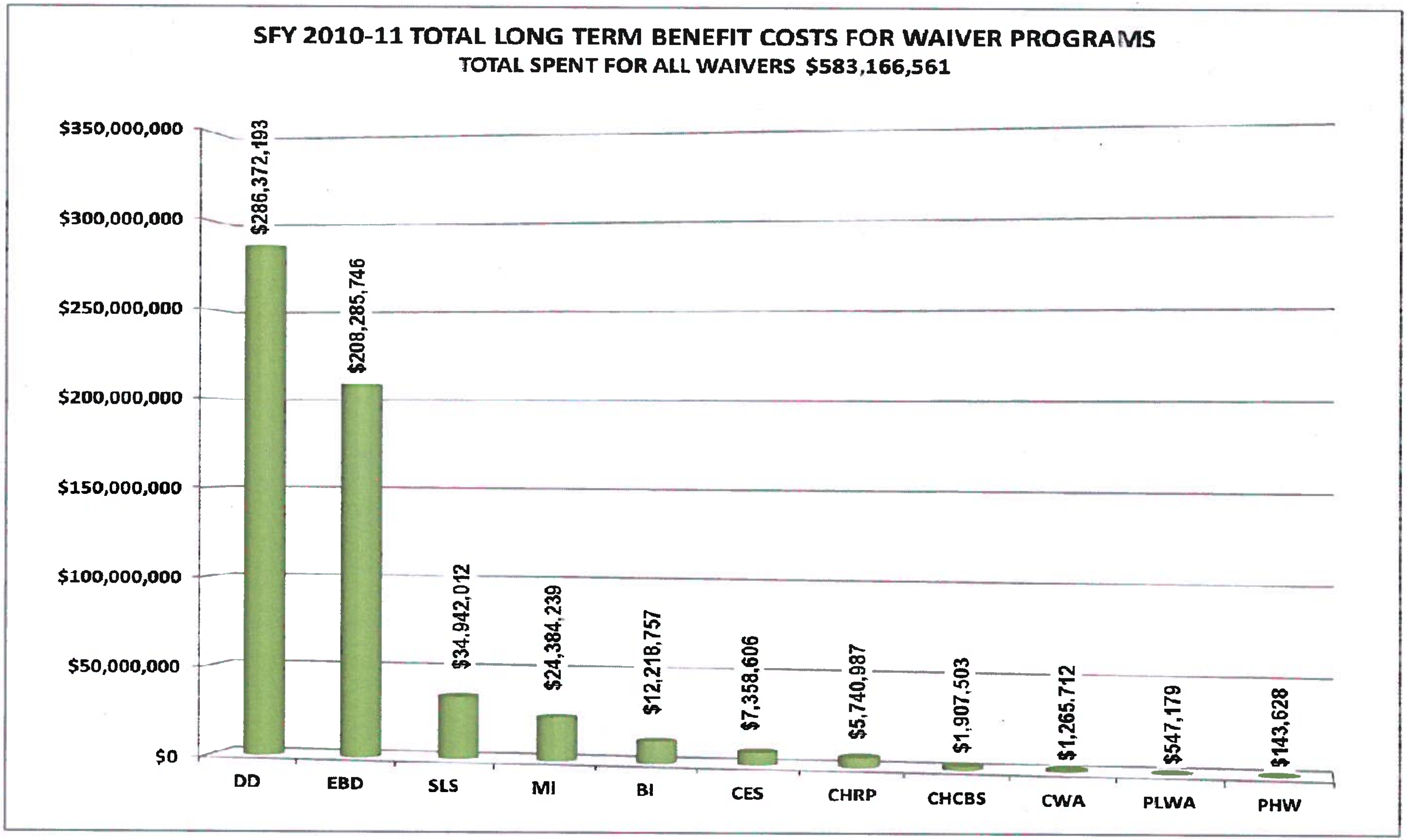
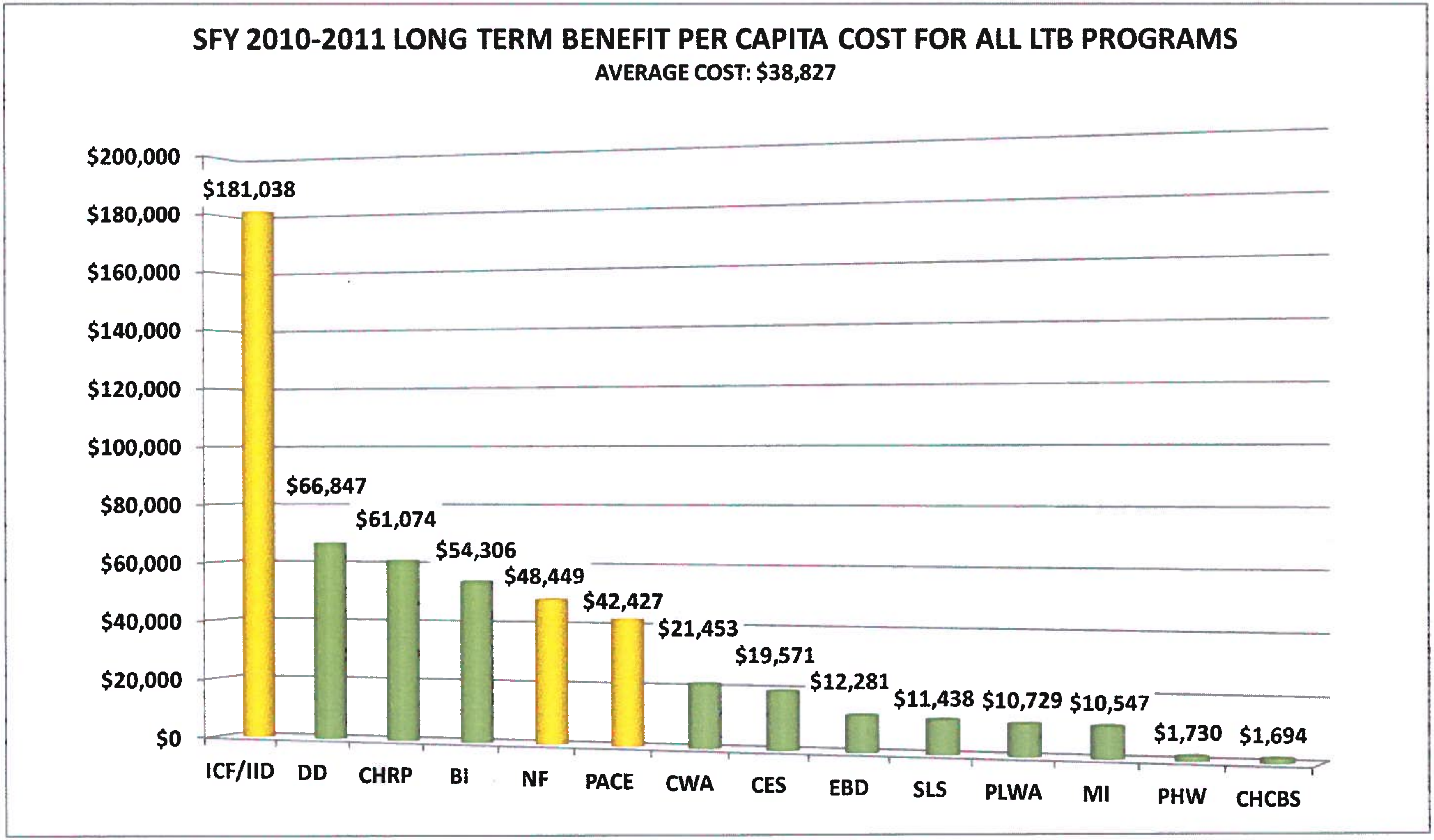


CHART 8

Appendix H


SFY 2010-2011 LONG TERM BENEFIT PER CAPITA COST FOR ALL LTB PROGRAMS

AVERAGE COST: $38,827

Chart 9

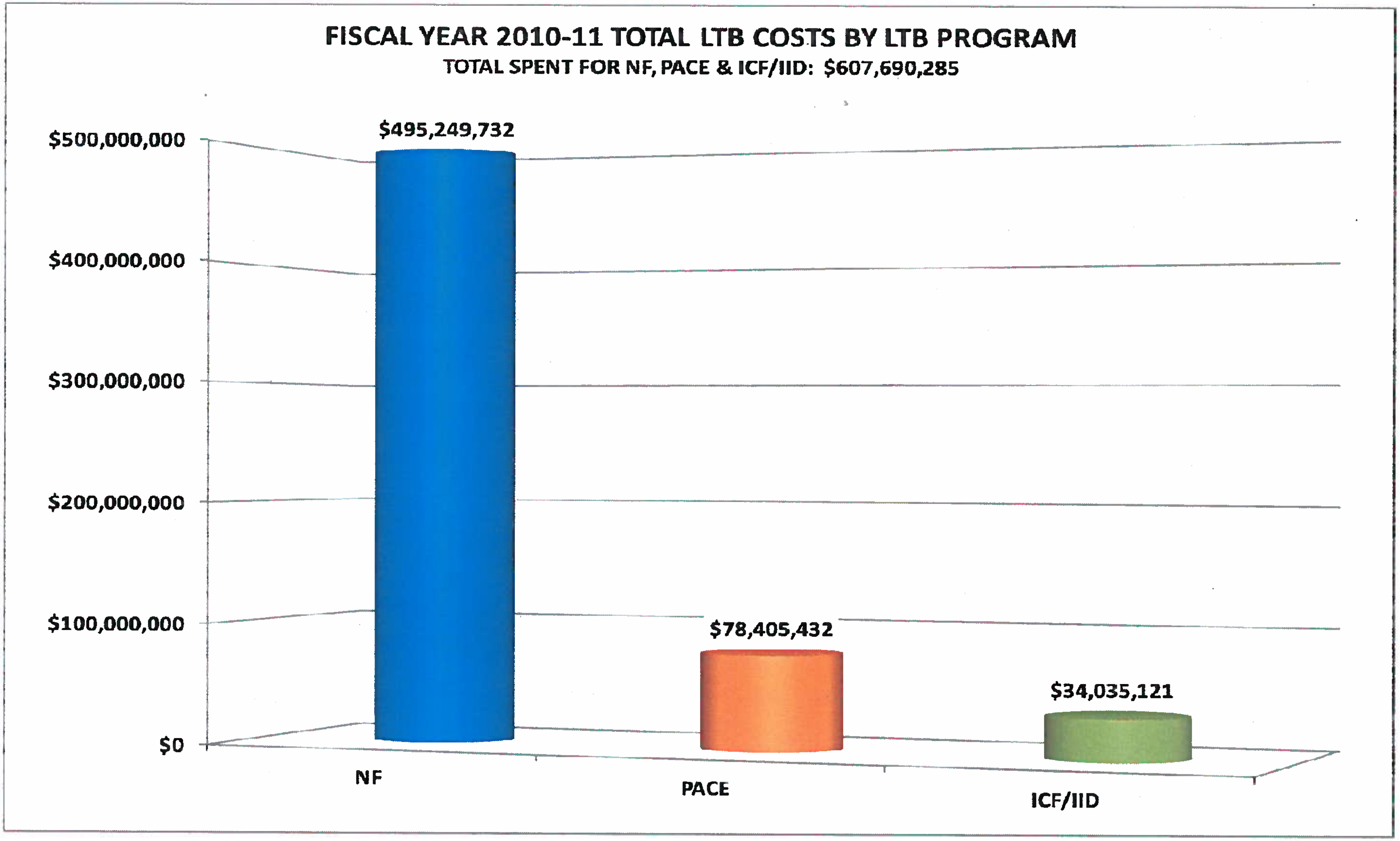

FISCAL YEAR 2010-11 TOTAL LTB COSTS BY LTB PROGRAM
TOTAL SPENT FOR NF, PACE & ICF/IID: $607,690,285
$500,000,000
$400,000,000
$300,000,000
$200,000,000
$100,000,000
$0
$495,249,732
$78,405,432
$34,035,121
NF
PACE
ICF/IID

CHART 10

Appendix H

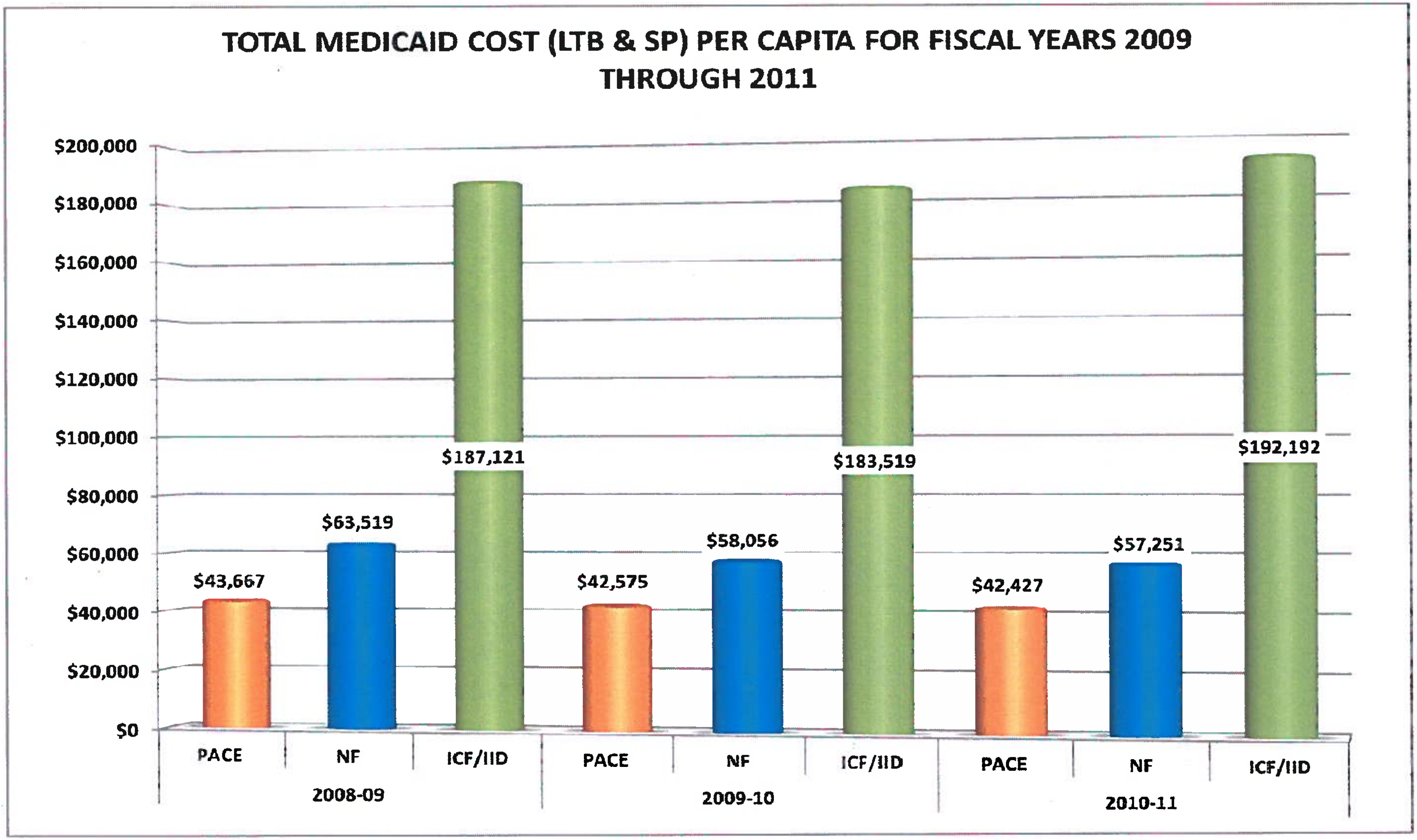

TOTAL MEDICAID COST (LTB & SP) PER CAPITA FOR FISCAL YEARS 2009 THROUGH 2011

CHART 11

Appendix H

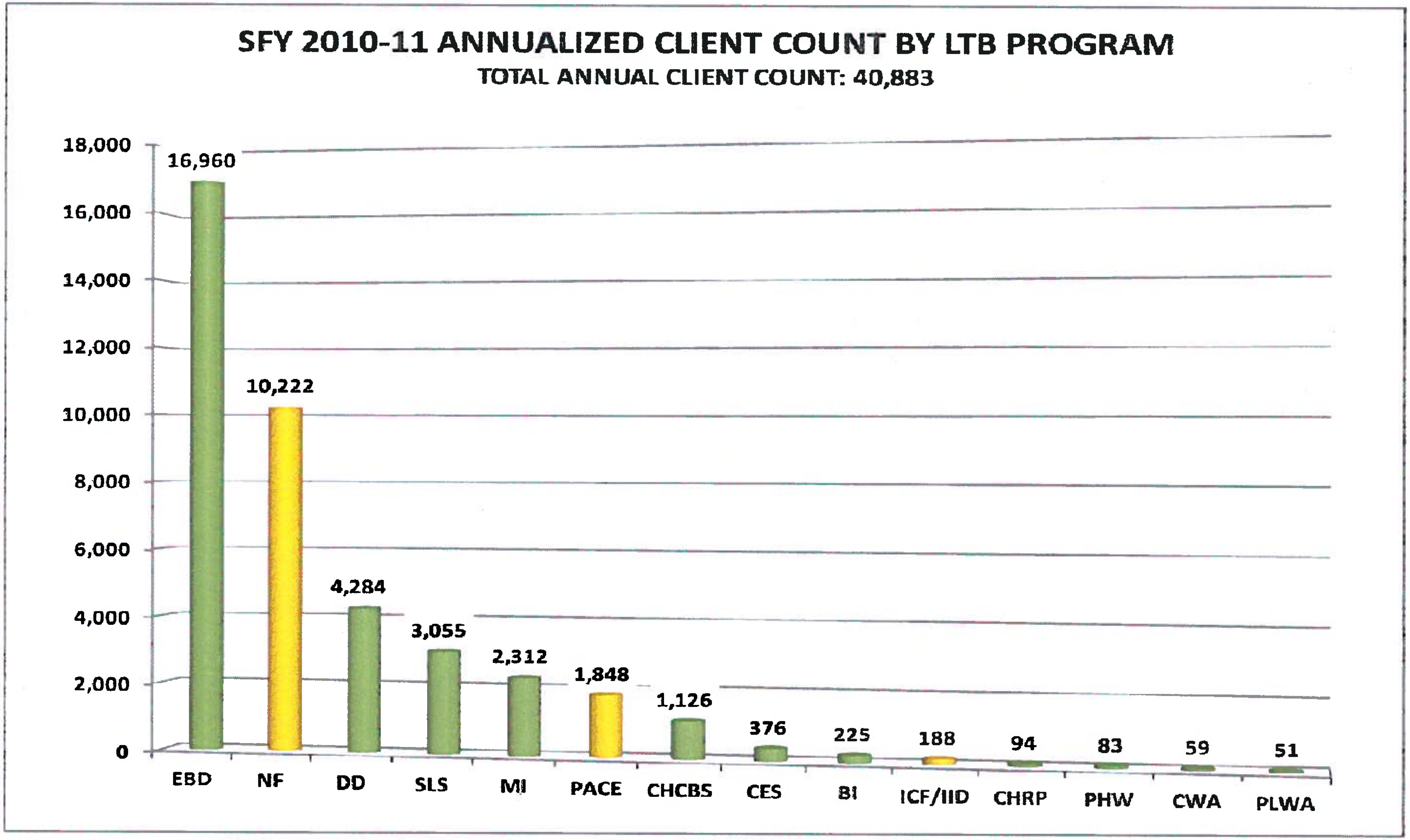
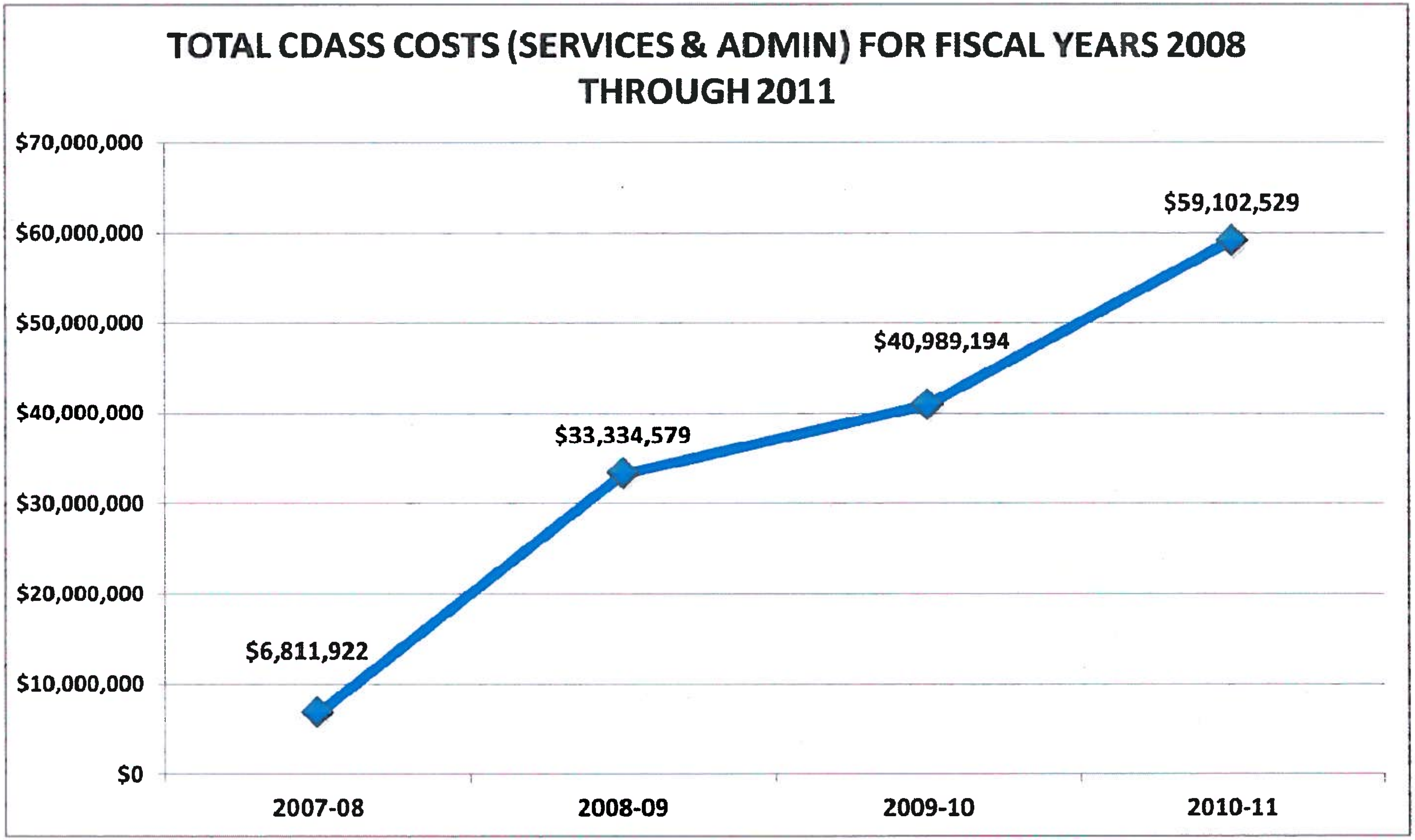


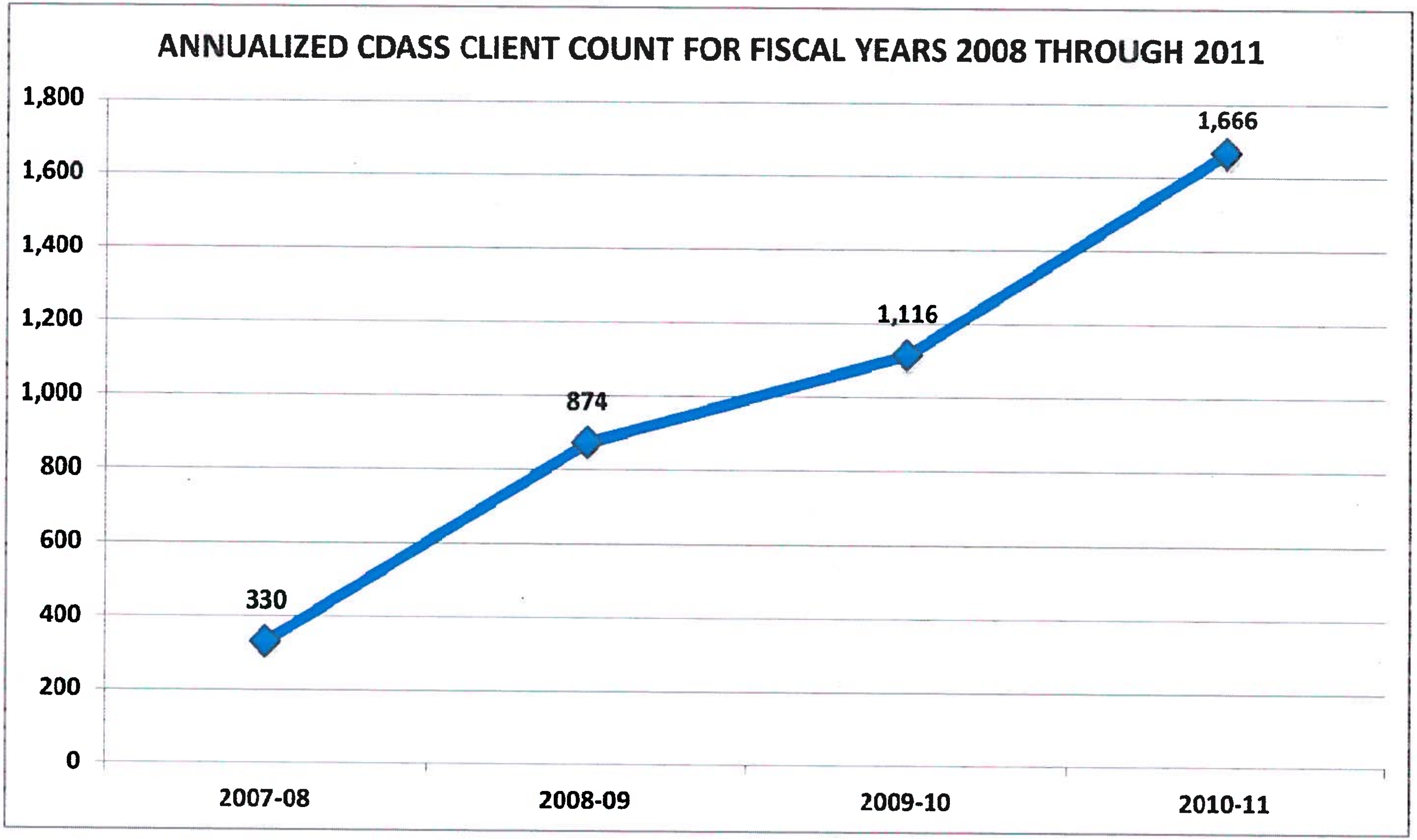
CHART 12

Appendix H

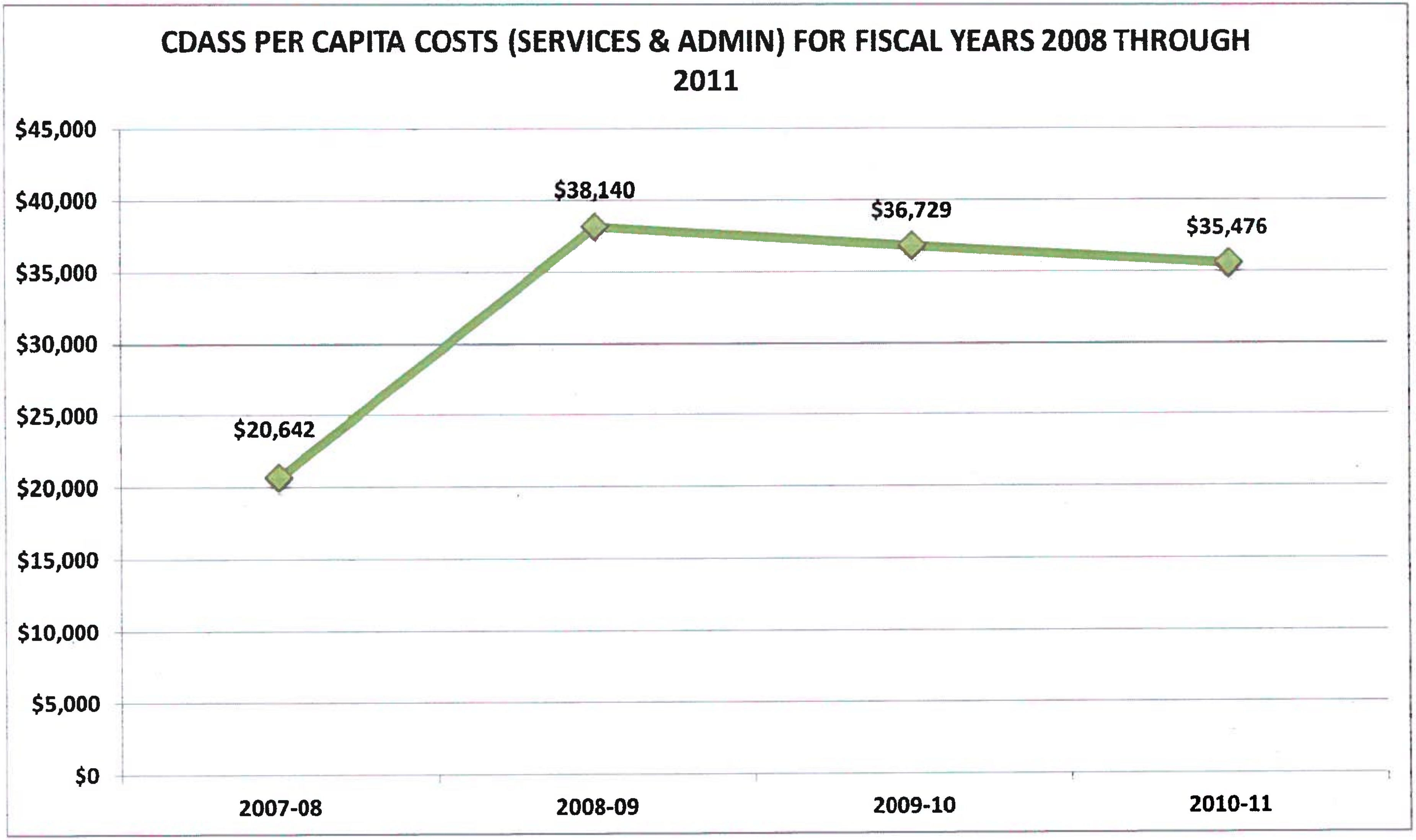


TOTAL CDASS COSTS (SERVICES & ADMIN) FOR FISCAL YEARS 2008 THROUGH 2011

Appendix H


ANNUALIZED CDASS CLIENT COUNT FOR FISCAL YEARS 2008 THROUGH 2011

Appendix H


CDASS PER CAPITA COSTS (SERVICES & ADMIN) FOR FISCAL YEARS 2008 THROUGH 2011
$45,000
$40,000
$35,000
$30,000
$25,000
$20,000
$15,000
$10,000
$5,000
$0
$20,642
$38,140
$36,729
$35,476
2007-08
2008-09
2009-10
2010-11

Appendix I

Colorado Department of Health Care Policy and Financing
and
Colorado Department of Human Services

Division for Developmental Disabilities

An Analysis of Expenditure Drivers

March 9, 2012

Table of Contents

Executive Summary

The following work represents the inaugural effort by the Department of Health Care Policy and Financing (HCPF) and the Department of Human Services (DHS) to provide a joint report to the General Assembly pertaining to expenditure and usage analysis of the Division for Developmental Disabilities (DDD). The work is the result of a highly collaborative effort between the two departments and has the primary goal of providing a transparent assessment to the Legislature, Executive Branch, stakeholders, and the citizens of Colorado. While the following report represents an initial effort by the departments, the departments acknowledge that it is also a less than perfect assessment. To that end, the departments are committed to the annual production of similar reports and to constantly improving reporting outputs.

The DHS Division for Developmental Disabilities manages the Department of Health Care Policy and Financing's (HCPF) Home and Community-Based Services (HCBS) Waivers (DD Waivers) serving people with developmental disabilities. Those waivers are: the HCBS waiver for individuals with Developmental Disabilities (HCBS-DD), HCBS Supported Living Services (HCBS-SLS), and HCBS Children's Extensive Services (HCBS-CES). There is also a State Plan component associated with these waivers known as Targeted Case Management (TCM), as well as administrative functions for single point of entry activities, utilization review and quality assurance.

Overall, DD Waiver Medicaid expenditures have increased by 30.69% since FY 2006-07 while the number of FTE clients served has only increased 10.15%. Expenditures are growing at greater than three times caseload growth. The total amount of services consumed in FY 2010-11 for the three waivers was approximately $325M and, taking into account all enrollments within the waivers, just over $43,000 per person. (The amount per person varies significantly by waiver.) HCBS-DD Waiver expenditures account for approximately 80% of the appropriations and approximately 90% of expenditure increases since FY 2006-07.

Clients in HCBS-DD and HCBS-SLS are assigned a Support Level[1] ranging from one to seven. Clients in higher Support Levels have higher intensity of need. Generally, the

---

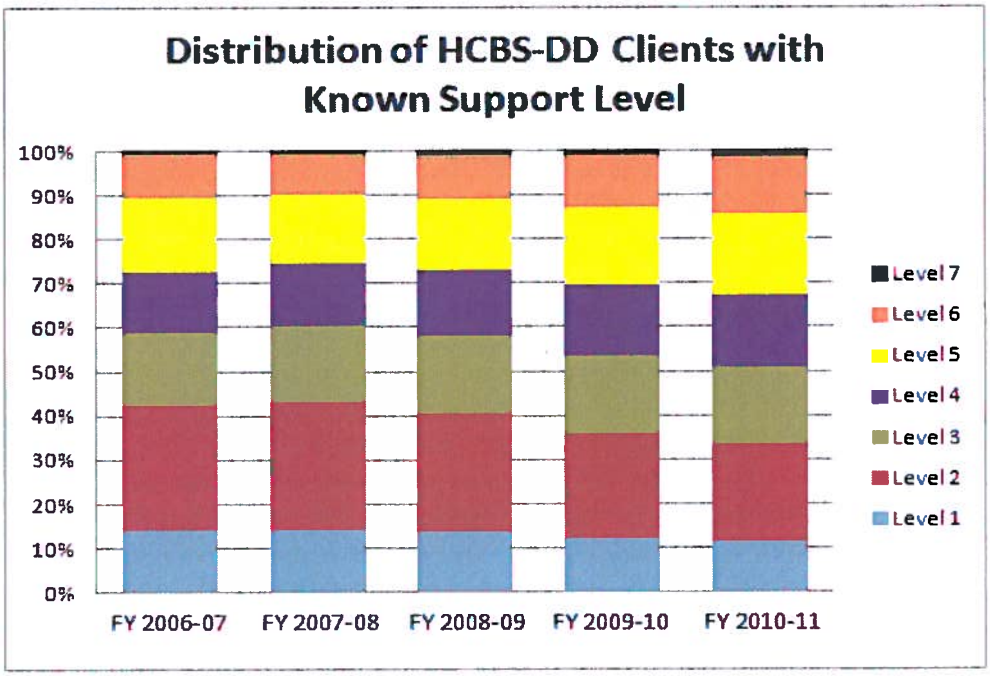
[1] "Support Level" is recognized as a formal assessed level of need for HCBS-DD and HCBS-SLS waiver clients. The departments note that "Support Level" is not technically correct terminology for years prior to FY 2009-10. For textual consistency, the term "Support Level" is used across all years analyzed in this report. Detailed explanation of Support Level history and utilization is contained on pages 8-10 of the report and in Appendix A.

higher the support level, the higher the reimbursement rate for a unit of service. Personalized services and supports are identified in individual Service Plans. Case managers at Community Centered Boards (CCB) assist clients to develop their Service Plans, refer clients to service providers, help coordinate the client's services and monitor that service is delivered according to the Service Plan.

The data suggests four primary factors are driving costs: Number of Clients Served, Average Support Level, Reimbursement Rates, and Service Consumption.

The number of enrollments approved by the General Assembly as shown in the Long Bill has increased by more than 12% since FY 2006-07. Taken in combination with the factors discussed below, the number and distribution of individuals served becomes central to the larger issue of increasing expenditure trends.

Implementation of a Support Level determination algorithm[2] in FY 2008-09 led to an upward shift in support level distribution among clients from an average of 3.2 in FY 2007-08[3] to 3.5 in FY 2010-11. Although this may not appear significant, the data shows the upward shift in distribution has had a compounding effect on per-capita expenditures. The shift has resulted in more clients consuming greater amounts of services and at higher reimbursement rates.



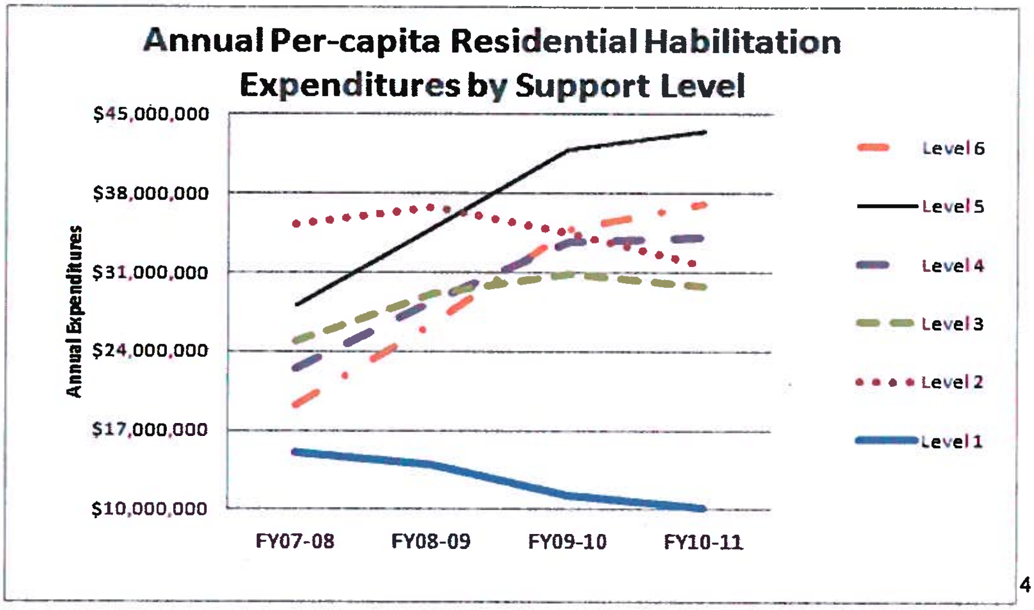
---

[2] "Support Level" means a numeric value determined using an algorithm that places clients into groups with other clients who have similar overall support needs. The algorithm is a calculation that weights various factors from the Supports Intensity Scale assessment tool, along with two additional factors not contained in the tool: Community Safety Risk, and Danger to Self. The output from the algorithm determines an individual's Support Level.

[3] Prior to FY 2007-08, not all HCBS-DD clients had been assigned a support level. For this reason, FY 2007-08 is often used in this report as a baseline year for comparison.

Appendix I

Reimbursement rates for services have changed several times since FY 2006-07. While some rates have gone down over time, rates for other services have gone up. Rates for Residential Habilitation, specifically, have increased over the past several years. The data shows that this one service accounts for approximately 75% of total HCBS-DD expenditures and over 60% of total expenditure increases.


Annual Per-capita Residential Habilitation Expenditures by Support Level[4]

Residential Habilitation is the primary waiver service and most clients must utilize it every day year-round. The fundamental need for the service significantly constrains the ability to adjust the number of units of service consumed.

The tables below show the combined changes in per-capita utilization since FY 2007-08 for all services other than Residential Habilitation. Unlike Residential Habilitation, these services allow for far greater flexibility to adjust the number of units of utilization consumed. The data shows that per-capita units consumed have increased significantly since FY 2007-08. Utilization increases have resulted in higher expenditures per-capita across all Support Levels except Support Level 1.

The effective cost per unit[5] in the top table is calculated by dividing the total expenditures for services consumed in a given Support Level by the total number of units consumed in that Support Level. The top table shows how unit costs have generally declined in lower Support Level services, but increased in higher Support Levels. Overall, the impact of rate changes has been less than 1%. The middle table illustrates change in the number

---

[4] Support Level 7 enrollments account for about 2% of HCBS-DD expenditures and less than 1.5% of individual count. This subgroup is not included on the Annual Per-capita Residential Habilitation Expenditures by Support Level graph.

[5] Effective Cost per Unit is calculated by dividing the annual total amount spent for services by the total number of units utilized.

of units consumed per person across Support Levels. The increase has been significant and also fairly consistent across Support Levels. Overall, average consumption of services has increased by over 20%. The combined impact of these two changes is shown in the bottom table, which shows non-Residential Habilitation per-capita expenditures across Support Levels. The data shows a laddered rate of growth in expenditures across Support Levels. This is illustrated in the percentage change in growth of per-capita expenditures across Support Levels.

HCBS-DD Effective Unit Cost (Expenditure) Excluding Residential Habilitation									
Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	$3.28	$3.12	$3.24	$3.51	$3.90	$4.30	$4.92	$3.78	$3.48
FY 2010-11	$2.57	$2.74	$3.01	$3.41	$4.06	$5.32	$5.53	$3.56	$3.51
Four Year % Growth	-21.84%	-12.09%	-7.01%	-2.96%	4.10%	23.72%	12.27%	-5.81%	0.94%

Per-Capita HCBS-DD Units of Service Consumed Excluding Residential Habilitation									
Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	3,088	4,174	4,300	4,204	4,219	3,794	3,218	3,596	3,984
FY 2010-11	3,839	4,831	5,069	5,168	5,166	4,787	4,334	2,735	4,865
Four Year % Growth	24.33%	15.74%	17.89%	22.93%	22.44%	26.17%	34.69%	-23.94%	22.12%

Per-capita HCBS-DD Expenditures Excluding Residential Habilitation									
Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	$10,140	$13,014	$13,939	$14,776	$16,453	$16,313	$15,848	$13,590	$13,858
FY 2010-11	$9,854	$13,241	$15,281	$17,626	$20,973	$25,466	$23,965	$9,736	$17,083
Four Year % Growth	-2.82%	1.74%	9.63%	19.29%	27.47%	56.11%	51.21%	-28.36%	23.27%

To summarize the primary factors driving DD Waiver Medicaid expenditure increases:

- The number of clients being served is increasing;
- more units of service are being consumed per client;
- clients are more likely to be in a higher support level;
- and the cost per unit has gone up at an accelerating pace in correlation to higher support level.

The tables above illustrate how rate changes and service consumption increases have impacted per-capita expenditures. This, in combination with the upward support level redistribution of clients largely explains the overall increases in expenditures in the HCBS-DD waiver.

Other Cost Driver/Trend Observations

- Expenditures for Targeted Case Management have been increasing rapidly.
- Expenditures for HCBS Children's Extensive Services are up by 50% over the past five years.
- Expenditures for HCBS Supported Living Services are down, but stabilizing.

The Departments recognize the multitude of dynamics involved in the administration of services to individuals with developmental disabilities. The Departments acknowledge the role of service providers, the concerns of family members, personal caregivers, and loved ones, and the contributions by the tax-paying citizens of Colorado. The Departments believe that these interests must be balanced with the fundamental needs of the waiver clients themselves to receive essential services and the need to provide those services within a finite budget.

DHS and HCPF are implementing the following changes that will result in reduced expenditures in FY 2011-12 and subsequent years. The changes have recently initiated implementation after receiving CMS approval of the relevant Medicaid HCBS waiver amendments.

- Implement Service Limits
- Assess the Supports Intensity Scale administration and Audit Targeted Case Management
- Implement Enhanced Single Entry Point (SEP)/CCB training
- Consolidate Waiver Programs
- Assess Overall Programmatic Structure, Quality, and Controls
- Report to the General Assembly
- Organizational Approach: Combining DDD and HCPF

The report represents an initial effort by the departments to provide detailed service-related data and analysis to the General Assembly. The departments will continue to strive to provide relevant and accurate data to the best of their ability. The departments intend to submit annual reports and also intend to begin producing reports examining expenditure drivers for individual CCBs in the fall of 2012.

Appendix I

Division for Developmental Disabilities

An Analysis of Expenditure Drivers

Overview/History

The Department of Human Services (DHS) Division for Developmental Disabilities (DDD) manages the Department of Health Care Policy and Financing's (HCPF) Home and Community-Based Services (HCBS) Waivers (DD Waivers) serving people with developmental disabilities. Those waivers are: the HCBS waiver for individuals with Developmental Disabilities (HCBS-DD), HCBS Supported Living Services (HCBS-SLS), and HCBS Children's Extensive Services (HCBS-CES). There is also a State Plan component associated with these waivers known as Targeted Case Management (TCM), as well as administrative functions for single point of entry activities, utilization review and quality assurance.

HCBS-DD services are for adults who require extensive supports to live safely (including access to 24-hour supervision) and who do not have other sources for meeting those needs.

HCBS-SLS services supplement already available supports for adults who either can live semi-independently with limited supports or who, if they need extensive support, are getting that support from other sources, such as their family.

HCBS-CES provides enhanced in-home supports for children considered to be most in need due to the child's disability.

TCM is provided to all adults and children enrolled in HCBS waiver services and all Medicaid-eligible infants and toddlers enrolled in Early Intervention services from the point of referral and includes planning, locating and facilitating access to services; coordinating and reviewing all aspects of needed services, supports and resources in cooperation with the person with a developmental disability, the person's family as appropriate, and involved agencies; and monitoring and evaluation of all services and supports.

Since FY 2006-07, the first year included in this analysis, expenditures have consistently increased year over year. Overall, DD Waiver Medicaid expenditures have increased by 30.69% since FY 2006-07 while the number of FTE clients served has only increased 10.15%. Expenditures are growing at greater than three times caseload growth. The total amount of services consumed in FY 2010-11 for the three waivers was just shy of $325M and, taking into account all enrollments within the waivers, just over $43,000 per person. (The amount per person varies significantly by waiver.) Please refer to the table below (DD Waiver Client Counts by Fiscal Year), and on the following page (Total Annual Expenditures by Waiver and Date of Service), for more detailed information. The Departments continue their ongoing assessment and evaluation as to what is driving costs.

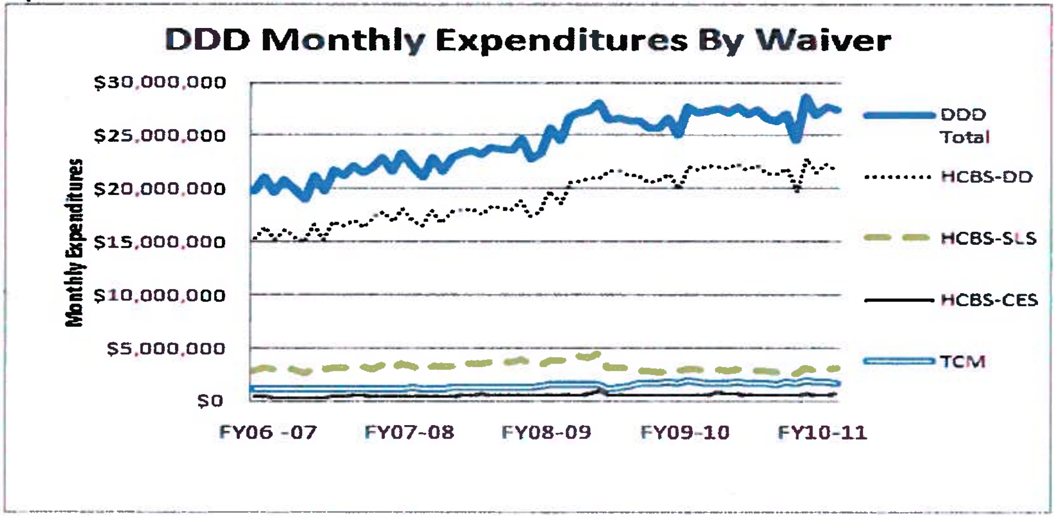
DD Waiver FTE Counts by Fiscal Year

	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
HCBS-CES	343.4	374.3	378.4	384.8	372.2
HCBS-SLS	2808.6	2817.8	2891.0	2953.3	3006.8
HCBS-DD	3694.7	3771.5	3903.5	4098.6	4162.8
Total	6846.7	6963.6	7172.9	7436.6	7541.7

To date, the data suggests four primary factors are driving costs: Number of Clients Served, Average Support Level, Reimbursement Rates, and Service Consumption.

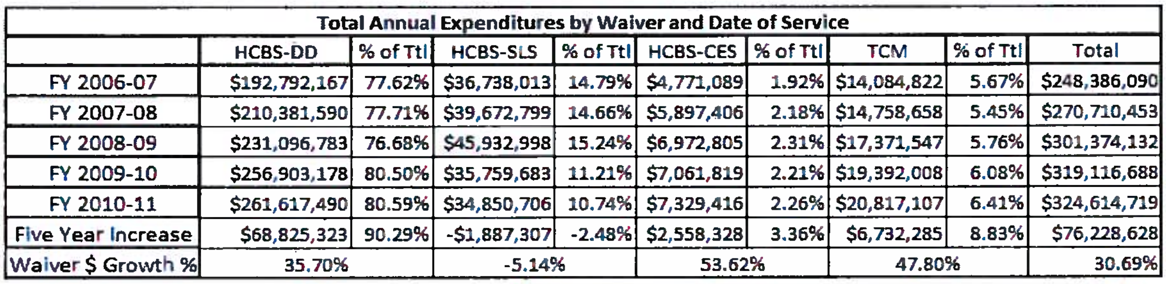
The current reimbursement structure for DDD Program financial administration uses a fee-for-service model. The model is based on a rate per unit of service provided and reimburses on an escalating scale based upon the intensity of support need as reflected by the support level. Clients in HCBS-DD and HCBS-SLS are assigned a support level ranging from one to seven. Clients in higher support levels have higher intensity of need. Generally, the higher the support level, the higher the reimbursement rate for a unit of service. Personalized services and supports are identified in individual Service Plans (SP). Case managers at Community Centered Boards (CCB) assist clients to develop their Service Plans, refer clients to service providers, help coordinate the client's services and monitor that service is delivered according to the Service Plan.

HCBS-DD Waiver expenditures comprise the bulk of the three DD waiver appropriations, as well as the bulk of the expenditure increases in those appropriations.



Appendix I

HCBS-DD Waiver expenditures account for approximately 80% of the appropriations and approximately 90% of expenditure increases since FY 2006-07.



Total Annual Expenditures by Waiver and Date of Service

	HCBS-DD	% of Ttl	HCBS-SLS	% of Ttl	HCBS-CES	% of Ttl	TCM	% of Ttl	Total
FY 2006-07	$192,792,167	77.62%	$36,738,013	14.79%	$4,771,089	1.92%	$14,084,822	5.67%	$248,386,090
FY 2007-08	$210,381,590	77.71%	$39,672,799	14.66%	$5,897,406	2.18%	$14,758,658	5.45%	$270,710,453
FY 2008-09	$231,096,783	76.68%	$45,932,998	15.24%	$6,972,805	2.31%	$17,371,547	5.76%	$301,374,132
FY 2009-10	$256,903,178	80.50%	$35,759,683	11.21%	$7,061,819	2.21%	$19,392,008	6.08%	$319,116,688
FY 2010-11	$261,617,490	80.59%	$34,850,706	10.74%	$7,329,416	2.26%	$20,817,107	6.41%	$324,614,719
Five Year Increase	$68,825,323	90.29%	-$1,887,307	-2.48%	$2,558,328	3.36%	$6,732,285	8.83%	$76,228,628
Waiver $ Growth %	35.70%		-5.14%		53.62%		47.80%		30.69%

Current Efforts

The Departments recognize the multitude of dynamics involved in the administration of services to individuals with developmental disabilities. The Departments acknowledge the role of service providers, the concerns of family members and loved ones, personal caregivers, and the contributions by the tax-paying citizens of Colorado. The Departments believe that these interests must be balanced with the fundamental needs of the waiver clients themselves to receive essential services and the need to provide those services within a finite budget.

DHS and HCPF are implementing the following changes that will result in reduced expenditures in FY 2011-12 and subsequent years. These changes represent actions that the departments are undertaking in order to reduce projected expenditures for DD programs and bring them in line with the amount of funds appropriated through the FY 2011-12 Long Bill. Because of this, these changes do not represent savings that can be immediately captured in the state budget process. The changes have recently been implemented after receiving CMS approval of the relevant Medicaid HCBS waiver amendments.

Implement Service Limits – After an extensive stakeholder engagement process conducted throughout 2011 to explore implementing upper usage limits for the following services, DDD implemented:

- Behavioral Health: Limits the number of units of Behavioral Services for assessments, consultation and counseling;
- Dental Services: Limits Dental Services per plan year for basic services and per five-year waiver period for major services;
- Day Habilitation Services: Limits the number of units of Day Habilitation services per year; and
- Targeted Case Management: Limits the number of units available for TCM services, or reduce the rate per unit.

The departments are pursuing other changes such as implementing thresholds on some services and requiring providers to obtain prior approval for service delivery to a client over the threshold.

Assess the Supports Intensity Scale and Audit Targeted Case Management – The DHS/DDD has implemented an audit of the Support Intensity Scale (SIS) assessments and the development of Support Levels for individuals meeting Public Safety Risk criteria. The DHS/DDD is continuing this audit and will verify that each client is accurately assessed through the Supports Intensity Scale. In addition, the DHS/DDD is conducting a quality assurance audit of Targeted Case Management services to ensure the appropriate use and delivery of these services for clients.

Implement enhanced SEP/CCB training – The departments are developing enhanced training for Single Entry Point agencies (SEP) and CCBs. This training will increase the consistency and appropriateness of functional assessments of clients and subsequent individual Service Plan development.

Consolidate waiver programs – HCPF and DHS are assessing all of the Medicaid waiver programs to determine how to structure the programs in order to better serve clients, reduce administrative overhead, and improve program operations. This assessment includes an examination of managed care waivers and other health care reform models such as the Accountable Care Collaborative, as a means of providing the right services to consumers, within a comprehensive cost containment structure. This effort involves significant stakeholder and client input.

Assess overall programmatic structure, quality, and controls – The departments are analyzing the current case management structure and will be developing recommendations for a more cohesive, consistent, quality, and streamlined approach. The departments intend to strengthen quality assessment, auditing, fraud identification and remediation functions to ensure that the program and the SEP/CCB structure is operating consistently and according to CMS and state regulations. The departments are conducting ongoing financial and utilization analysis to understand the net impact of changes to the waivers and variability in client usage and allocation of services.

Reporting to the General Assembly – The plan described above contains many components of varying size and complexity, from setting limits for individual services within the waivers to a review of overall system structure and design. The departments will provide periodic updates on the efforts described above to the General Assembly, through the Joint Budget Committee. Similarly, as analysis of the causes of over-expenditures progress, the departments will provide as much detail as is available describing the exact causes of the over expenditures and plans for cost containment within the developmental disabilities service system. The departments understand the over expenditures of the past year cannot continue and require full attention and remediation. The departments are committed to bringing expenditures in line with the FY 2011-12 appropriations and establishing sufficient controls to ensure improved program integrity in the developmental disabilities system. In addition, the departments are committed to assessing the most effective organizational and programmatic structure to ensure that clients are receiving quality services in the most cost effective manner. In addition to the above-referenced periodic update, which the departments intend to submit annually, the departments also intend to begin producing reports examining expenditure drivers for individual CCBs in the fall of 2012.

Organizational Approach: Combining DDD and HCPF – DHS and HCPF are working together to create recommendations and a plan for combining the Division for Developmental Disabilities with HCPF. This includes an examination of the Children's Residential Habilitation Program (CHRP) and other Long Term Care programs, including the state's aging programs, for relocation to HCPF. The Departments believe program operations and fiscal integrity of the waivers can be improved by combining the Division of Developmental Disabilities and potentially other Long Term Care programs with HCPF and more effectively leveraging staff expertise. Combining DDD within HCPF could result in the following benefits: reduced fragmentation and increased consistency of program operations and administration; consistent application of rate development processes and changes; coordination and standardization of waiver development and management; consistency in payment methodologies; greater consistency in stakeholder communications; and standardized policies and procedures.

Below, is an outline of the work the departments are doing to accomplish this relocation and estimated timelines for completion.

1. *Hold Community Forums:* Gather stakeholder and community input on outcomes and benefits they would like to see out of a combined department and programs (November 2011-July 2012).
2. *Analyze Organizational Structure & Staffing:* Review HCPF Long Term Care Benefits Division and DHS/DDD organizational charts and staffing. Analyze functions and skills sets to determine how to best combine the groups and deploy individuals to provide fiscal and programmatic oversight of the waivers. Create an implementation plan to align both organizations and create a cohesive organization structure (November 2011 - July 2012).
3. *Assess the Need for Legislation:* As part of the organizational and programmatic assessments described above, the departments are also evaluating the timing and implementation of such a move through legislation. Implementation of such a change will require careful consideration to ensure continuity of care for clients and providers within the system. The departments are very interested in such a move being successful and so, at this point, additional planning and stakeholder input is being undertaken (November 2011 - March 2012).
4. *Implement Re-organization:* HCPF and CDHS will begin combining DDD staff and functions within HCPF. This will of course depend upon receiving the appropriate approvals and direction from the Legislature (Target Date: July 2012).

Possible Future Measures – Given the findings contained in this report, the departments intend to consider and explore modifications to support level assessment systems, reimbursement rates, and service unit utilization limits. The departments will continue to assess these issues and will consider possible adjustments in order to effectively manage and control expenditures while expecting appropriate provision of services for individuals served within the waivers. The departments acknowledge that issues currently unrecognized or nonexistent may arise in the future. The departments are committed to addressing issues proactively when possible and reactively when necessary.

Guiding Principles

The departments are using the principles outlined below to guide this project:

- Ensure that appropriate and necessary services are provided to clients.
- Ensure that services are provided safely, in a timely manner and with respect and dignity.
- Strengthen consumer choice in service provision.
- Incentivize best practice in service delivery.
- Incentivize less restrictive settings for service delivery.
- Ensure that taxpayer dollars are used efficiently and effectively.
- Involve all stakeholders in the design and development of this project, including individuals receiving services and their families, service providers, advocates, the Legislature, and the Governor's Office.

Analytical Methodology for Data Collection and Assessment

The data analyzed was collected from individual client level claims paid through the Medicaid Management Information System (MMIS) from July 1, 2006 through August 31, 2011 for services received between July 1, 2006 and June 30, 2011. Support level data was provided by the Department of Human Services.

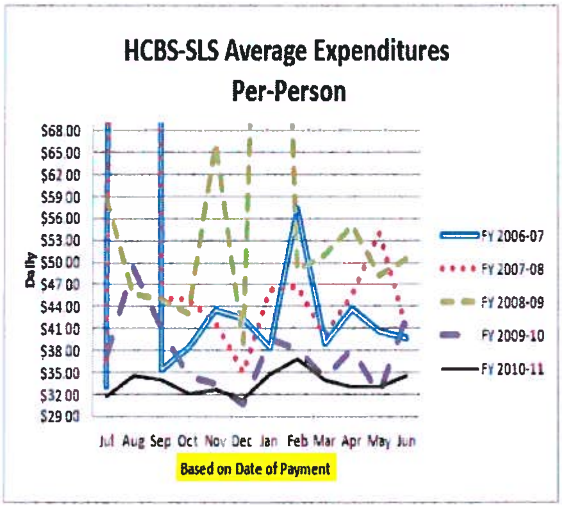
This same data served as the source for the analysis presented in the Departments' response to the 2011 Legislative Request for Information pertaining to the potential transfer of the Division for Developmental Disabilities between Departments. The analysis contained in this report uses the full and complete data available. The data has not been edited, altered, nor materially manipulated in any way that would impact its integrity.

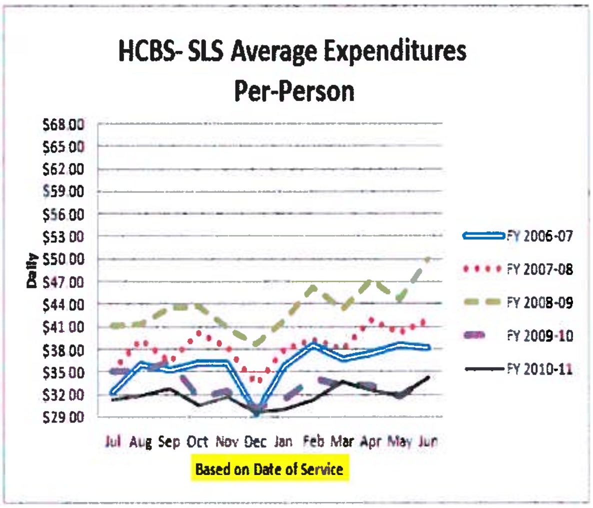
When analyzing claims data, two methods may be used. "Date-of-Payment" organizes data by the date a claim is paid by HCPF. This methodology is useful for analyzing expenditures paid out in a specific period of time, (e.g. fiscal year) and ties to annual expenditures reported through the Colorado Financial Reporting System (COFRS). "Date-of-Service" organizes data by the date services were provided, regardless of when those services were paid. This methodology is useful for analyzing consumption patterns. Date-of-Service analyses will not tie to annual expenditures reported through COFRS.

The departments used the Date-of-Payment methodology in the LRFI submitted in November of 2011. The Date-of-Payment methodology was used at that time as the departments wanted to connect to historical fiscal year expenditures as reported through COFRS, as well as to run parallel with Long Bill appropriations. This report uses the Date-of-Service methodology and therefore will not reconcile to expenditures reported in the LRFI or to COFRS annual expenditures.

Appendix I

Date-of-Service better captures client service utilization trends. These trends then inform overall program expenditures. For this reason, the analysis in this report looks at data based upon the date services were received by clients as opposed to the date those services were paid. A visual comparison between Date-of-Payment and Date-of-Service methodologies for each waiver can be found in Appendix D, pages 2-5. A sample using SLS is provided below to illustrate the differences between the two methodologies.





The axes of the charts are set to scale with each other. Although some points of data in the Date-of-Payment graph on the left appear to be missing, this is only because they fall outside the range on the vertical axis.

This report contains the following appendices: Each Appendix is preceded by a descriptive narrative.

- Appendix A – Graphs illustrating support level trends in the HCBS-DD waiver and HCBS-SLS
- Appendix B – Graphs illustrating trends in per-capita expenditures in each of the waivers and TCM
- Appendix C – Tables containing compiled data for the various waivers, as well as selected specific services
- Appendix D – Graphs comparing Date-of-Payment and Date-of-Service tracking methodologies
- Appendix E – Service Descriptions and Rates Tables for services in each of the DD waivers
- Appendix F – Wait List Data and brief overview of miscellaneous points

Cost Driver/Trend Summary

While there is a great deal of complexity in the data, the Departments believe the data suggests four primary factors are driving costs: Number of Clients Served, Average Support Level, Reimbursement Rates, and Service Consumption.

Number of Clients Served - The number of enrollments (clients served) approved by the General Assembly has increased by more than 12% since FY 2006-07. Requests for additional enrollments are necessary to continue services for individuals who, due to age, are transitioning from another Home and Community Based waiver, or the Child Welfare system and to address specific needs of individuals on the waiting list, such as emergencies or high risk situations.

New enrollments are necessary for a variety of reasons. Once children in the HCBS-CES reach age 18 or foster care or HCBS-CHRP waiver reach age 21, they can no longer be served within that waiver. Frequently, these children who are aging out continue to need services through an adult developmental disability waiver. This can necessitate a transition into either the HCBS-SLS or HCBS-DD waiver and typically new enrollments are requested to ensure this transition.

Individuals on the waiting list for HCBS-DD, who meet the definition of an emergency, are exceptions to the waiting list order of selection. Individuals may meet this definition when they become homeless or lose a caregiver. These individuals may be receiving HCBS-SLS or may be individuals on the wait list who are not being served under any DD waiver who may experience an emergency necessitating urgent enrollment in a waiver.

At the discretion of the General Assembly, increased funding may be and has been made available to increase the number of waiver slots that are not emergency-based. These newly created slots are filled by individuals on the waiting list based on the amount of time those individuals have been on the list or to meet a target group such as those who have aging caregivers.

In the HCBS-DD waiver, on average, 100-120 enrollments become available after vacancies occur when clients discontinue participation in the program. Additionally, the General Assembly has approved an additional 30 enrollments to enroll individuals who are in an emergency situation and roughly 60 individuals per year who transition from foster care or HCBS-CHRP. In the HCBS-SLS waiver, approximately 250 enrollments become available after vacancies occur when clients discontinue participation in the program. Additionally, the General Assembly approves 30-40 enrollments for children in HCBS-CES who will transition to HCBS-SLS due to their age. Recent DHS budget requests indicate that a primary driver of the need for emergency placements is the aging and/or ailing of caregivers. (Source: Department of Human Services Annual Budget Requests - FY 2009-10: DI-3, FY 2011-12: DI-6, FY 2012-13: R-1.)

Additional information on the wait list can be found on page 15 and in Appendix F.

Taken in combination with the following factors, the number and distribution of individuals served becomes central to the larger issue of increasing expenditure trends.

Increasing Average Support Levels – While the SIS tool came into use in 2006, this represented only the first phase of implementation of this client assessment model. In the middle part of the last decade, CMS directed that a comprehensive new rate methodology be implemented. The transition took several years. This included implementing a needs assessment tool, setting rates for services, and determining expected service utilization based on need. The first phase included the establishment of tier levels that were based on the amount of funds being spent at that time on each client. Following the identification of tiers, the Departments implemented beta testing a new tool (SIS) with a representative sample of waiver clients to establish need level categories, then evaluating service utilization by those individuals, and then applying a rate structure for those services. The rate structure was temporary until a permanent rate structure went into effect in 2009.

Finally, beginning in FY 2008-09, an algorithm[6] was incorporated for determining Support Level. The algorithm weighted three sections from the SIS tool, and added two additional factors: Danger to Self, and Community Safety Risk. These two factors significantly impacted Support Level assignments. An affirmative response to Community Safety Risk automatically places an individual into a minimum Support Level 5 or 6 regardless of all other factors. Going back to October of 2007, 249 individuals in HCBS-DD (6.7% of the waiver population) were determined to pose a community safety risk. The number rose to over 400 individuals in 2009 and 2010 (greater than 10% of the waiver population). The number has since dropped and the December 2011 data indicates 320 individuals (7.6% of the waiver population) as posing a community safety risk.

An affirmative response to Danger to Self automatically moves an individual up by one to two Support Levels regardless of all other factors. Once phase two was implemented, first priority was given to assessing DD Adult Comp waiver clients. This process was largely complete by June of 2009, at which time HCBS-SLS client assessments using the algorithm were then prioritized. The one algorithmic exception is that HCBS-SLS clients do not include Community Safety Risk/non-convicted or Danger to Self factors.

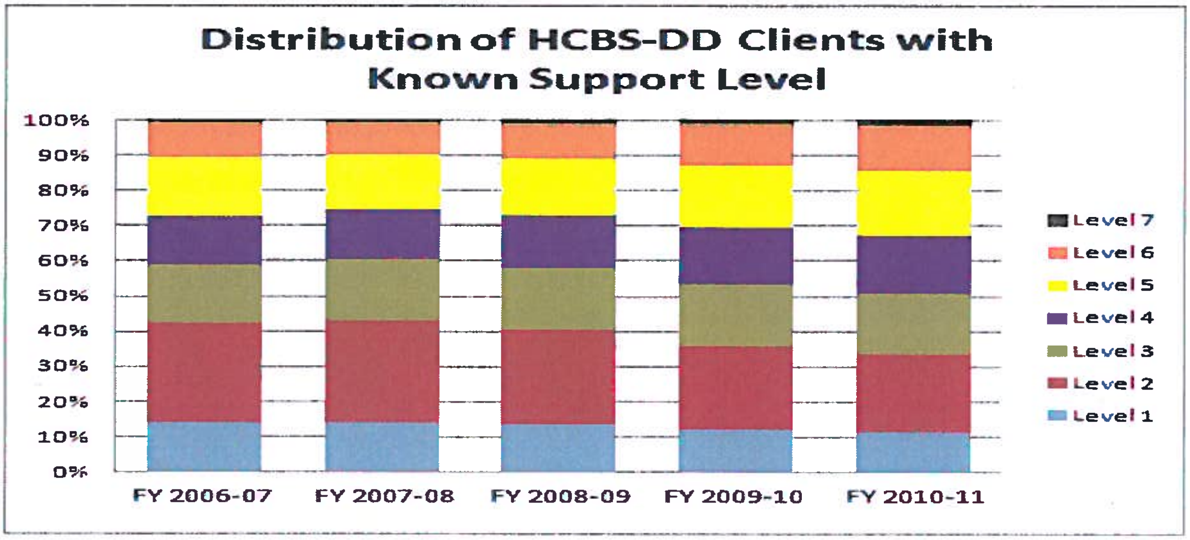
Implementation of the Support Level determination algorithm in FY 2008-09 displayed a different Support Level distribution than the tier level distribution among clients from an average of 3.2 in FY 2007-08[7] to 3.5 in FY 2010-11. Although this may not appear significant, the data shows the upward shift in distribution has had a compounding effect on per-capita expenditures. The shift has resulted in more clients consuming greater amounts of services and at higher reimbursement rates. Prior to implementation of the algorithm, approximately 40% of clients were estimated to be at tier 4, 5, or 6 while about 60% were estimated to be at tier 1, 2, or 3. This estimate was based on historical service delivery utilization data. By FY 2010-11, after the implementation of the Support Level determination process, the actual data showed the distribution had shifted to approximately a 50-50 even split. Appendix A discusses this topic in detail and contains

---

[6] The algorithm is a calculation that weights various factors from the Supports Intensity Scale assessment tool, along with two additional factors not contained in the tool: Community Safety Risk and Danger to Self. The output from the algorithm determines an individual's Support Level. The HCBS-SLS algorithm does not include the two additional factors.

[7] Prior to FY 2007-08, HCBS-DD clients had been assigned a tier level during the development of the Support Level methodology. For this reason, FY 2007-08 is often used in this report as a baseline year for comparison.

graphs that illustrate the impact the algorithm has had on the distribution of clients by support level. The comparative bar graphs below illustrate the shift in Support Level (or tier) distribution in the period from FY 2006-07 through FY 2010-11. The data shows a shift away from Support Level 2 followed by consistent and proportionally significant growth in Support Levels 4, 5, and 6. Data for HCBS-DD Client counts used for creating the chart below can be found in Appendix C on page C.3.

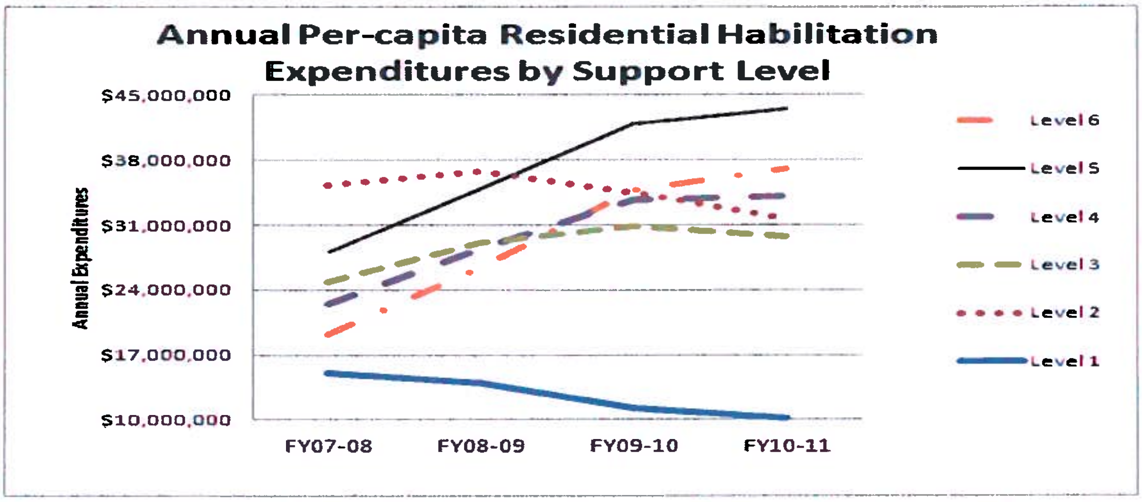


Reimbursement Rates – The departments acknowledge reimbursement rates as a core component related to expenditures. The departments continue to assess reimbursement rates and will consider adjustments as an available option to effectively manage and control expenditures.

Residential Habilitation is the primary waiver service and most clients must utilize it every day year-round. Residential Habilitation is provided in Group Home, Host Home, and Personal Care Alternative (PCA) settings and is designed to ensure the health, safety and welfare of the participant, and to assist in the acquisition, retention and/or improvement in skills necessary to support the participant to live and participate successfully in their community.

Residential Habilitation is the general name given to three specific types of living settings (Group Home, PCA, and Host Home) where 24 hour professional care is provided to DD Adult Comp waiver clients. Reimbursement rates for services have changed several times since FY 2006-07. While some rates have gone down over time, rates for other services have gone up. Rates for Residential Habilitation, specifically, have increased over the past several years.

The daily need for the service significantly constrains the ability to adjust the number of units of service consumed. The data shows that this one service accounts for approximately 75% of total HCBS-DD expenditures and over 60% of total expenditure increases; growing from $158 million expended in FY 2007-08 to over $190 million in FY 2010-11 and over 9% per person. This is important, as HCBS-DD Waiver expenditures account for approximately 80% of the appropriations and approximately 90% of expenditure increases since FY 2006-07. Residential Habilitation is reimbursed on a per-diem basis and almost all HCBS-DD waiver clients are permanent residents who receive this service almost every day of the year. Residential Habilitation expenditures are increasing due to upward trends in mean support levels, driving an increase in rate reimbursement for a given unit of service. Average per-diem Residential Habilitation unit costs have increased since FY 2007-08. Since FY 2007-08, per-diem unit costs for Support Levels 1 and 2 have dropped, but costs for all other levels have gone up. Simultaneously, an increase in average client Support Level has also gone up resulting in a lower proportion of the population in Support Levels where unit costs have decreased and a higher proportion in the levels where costs have increased. Appendix C page C.5 contains data showing trends in per-capita Residential Habilitation expenditures by fiscal year and Support Level. Page C.10 shows total annual expenditures by Support Level.



[8]

Service Consumption - The tables on the next page show the combined changes in per-capita utilization since FY 2007-08 for all services other than Residential Habilitation. Unlike Residential Habilitation, these services allow for far greater flexibility to adjust the number of units of utilization consumed. The data shows that per-capita units consumed have increased significantly since FY 2007-08. Utilization increases have resulted in higher expenditures per-capita across all Support Levels except support level 1.

The effective cost per unit in the Effective Unit Cost (top) table is calculated by dividing the total expenditures for services consumed in a given support level by the total number of units consumed in that support level. The Effective Unit Cost table shows how unit costs have generally declined in lower Support Level services, but increased in higher Support Levels. Overall, the impact of rate changes has been less than 1%. The Per-Capita Units Consumed table (middle) illustrates change in the number of units consumed per person across Support Levels. The increase has been significant and

---

[8] Support Level 7 enrollments account for about 2% of HCBS-DD expenditures and less than 1.5% of individual count. This subgroup is not included on the Annual Per-capita Residential Habilitation Expenditures by Support Level graph.

also fairly consistent across Support Levels. Overall, average consumption of services has increased by over 20%. The combined impact of these two changes is shown in the Per-Capita Expenditures (bottom) table, which shows non-Residential Habilitation per-capita expenditures across Support Levels. The data shows a laddered rate of growth in expenditures across Support Levels. This is illustrated in the percentage change in growth of per-capita expenditures across Support Levels.

HCBS-DD Effective Unit Cost (Expenditure) Excluding Residential Habilitation

Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	$3.28	$3.12	$3.24	$3.51	$3.90	$4.30	$4.92	$3.78	$3.48
FY 2010-11	$2.57	$2.74	$3.01	$3.41	$4.06	$5.32	$5.53	$3.56	$3.51
Four Year % Growth	-21.84%	-12.09%	-7.01%	-2.96%	4.10%	23.72%	12.27%	-5.81%	0.94%

Per-Capita HCBS-DD Units of Service Consumed Excluding Residential Habilitation

Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	3,088	4,174	4,300	4,204	4,219	3,794	3,218	3,596	3,984
FY 2010-11	3,839	4,831	5,069	5,168	5,166	4,787	4,334	2,735	4,865
Four Year % Growth	24.33%	15.74%	17.89%	22.93%	22.44%	26.17%	34.69%	-23.94%	22.12%

Per-capita HCBS-DD Expenditures Excluding Residential Habilitation

Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	$10,140	$13,014	$13,939	$14,776	$16,453	$16,313	$15,848	$13,590	$13,858
FY 2010-11	$9,854	$13,241	$15,281	$17,626	$20,973	$25,466	$23,965	$9,736	$17,083
Four Year % Growth	-2.82%	1.74%	9.63%	19.29%	27.47%	56.11%	51.21%	-28.36%	23.27%

The tables above illustrate how rate changes and service consumption increases have impacted per-capita expenditures. This, in combination with the upward Support Level redistribution of clients largely explains the overall increases in expenditures in the HCBS-DD waiver.

In cases where the service utilization allows for flexibility, increases in unit costs over time and/or increases in units consumed affect expenditures. The Effective Cost/Unit tables on the next page show how unit costs have changed over the past few years for the three largest services other than Residential Habilitation. The data for Supported Employment and Day Habilitation[9] shows that unit costs have decreased for lower Support Levels and increased for higher Support Levels. As the Support Level distribution among clients adjusts to higher Support Levels, more people are receiving services at higher unit costs and in a dynamic where those units' costs are also increasing over time. Appendix C pages C.6-11 contain data on Supported Employment, Day habilitation, and Non-emergency Transportation[10].

---

[9] Day Habilitation includes assistance with self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement, except when due to medical and/or safety needs. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice.

[10] Non-emergency Transportation refers to the purchase or provision of transportation for individuals receiving day program under comprehensive services which enables them to gain access to programs and other community services and resources required by their Individualized Plan/Plan of Care.

Appendix I

Effective Cost (Expenditure)/Unit (e.g. 15 minutes)

Supported Employment

Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	$4.78	$4.30	$4.40	$4.29	$4.55	$4.12	$4.50	$4.40	$4.46
FY 2010-11	$3.93	$3.75	$4.17	$4.87	$5.95	$6.75	$4.55	N/A	$4.42
Four Year % Growth	-17.71%	-12.85%	-5.08%	13.49%	30.93%	63.81%	1.14%	N/A	-0.89%

Day Habilitation

Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	$2.86	$2.80	$3.02	$3.28	$3.63	$4.11	$4.35	$3.56	$3.21
FY 2010-11	$2.36	$2.59	$2.94	$3.42	$4.13	$5.67	$6.20	$3.88	$3.57
Four Year % Growth	-17.51%	-7.25%	-2.66%	4.40%	13.76%	37.93%	42.36%	9.14%	11.01%

Non-emergency Transportation

Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	$9.53	$10.43	$10.28	$10.06	$10.38	$10.03	$11.87	$9.97	$10.20
FY 2010-11	$7.08	$7.64	$7.52	$7.40	$7.60	$7.49	$8.19	$5.34	$7.51
Four Year % Growth	-25.67%	-26.73%	-26.90%	-26.42%	-26.86%	-25.35%	-30.98%	-46.44%	-26.36%

Non-emergency Transportation unit costs, unlike the costs for Supported Employment and Day Habilitation, have decreased significantly in recent years across all Support Levels. However, real expenditures for Non-emergency Transportation Services have gone up over that same time. The data below shows that the reason for this is because units consumed have gone up at a rate that negates expected savings from unit cost reductions. The data suggests that unit cost changes must be targeted strategically since the impact of such reductions could be negated by increases in utilization. Appendix C pages C.6, and 9-11 contain data on Supported Employment, Day Habilitation, and Non-emergency Transportation.

Per-Capita Non-emergency Transportation Units of Service

Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	127	158	158	160	155	143	132	134	1,167
FY 2010-11	186	261	272	277	285	264	145	41	1,731
Four Year % Growth	46.42%	65.34%	71.90%	72.47%	84.28%	84.98%	10.07%	-69.22%	48.37%

Non-emergency Transportation Total Expenditures

Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	$604,125	$1,670,638	$1,000,300	$797,478	$891,446	$460,005	$40,899	$330,866	$5,795,758
FY 2010-11	$611,021	$1,853,635	$1,477,722	$1,395,965	$1,673,560	$1,054,254	$69,162	$459	$8,135,778
Four Year % Growth	1.14%	10.95%	47.73%	75.05%	87.74%	129.18%	69.10%	-99.86%	40.37%

To summarize the primary factors driving DD Waiver Medicaid expenditure increases: The number of clients being served is increasing; more units of service are being consumed per client; clients are more likely to be in a higher Support Level; and the cost per unit has gone up at an accelerating pace in correlation to higher Support Level.

Other Cost Driver/Trend Observations

Children's Extensive Services (HCBS-CES) – Expenditures for HCBS-CES are up by 50% over the past five years, although CES expenditures account for only slightly more than 2% of overall DDD Medicaid expenditures. Data for HCBS-CES in Appendix

C on page C.14 shows the significant increase in expenditures over the past several years.

Supported Living Services (HCBS-SLS) – Expenditures for HCBS-SLS are down, but stabilizing. Since implementation of the algorithm, expenditures have decreased. However, those in FY 2010-11 were generally the same as FY 2009-10. Data for HCBS-SLS in Appendix C on pages C.12-13 shows the expenditures over the past several years.

Targeted Case Management (TCM) – TCM Expenditures have risen dramatically over the past several years. There appear to be three primary contributing factors. Case management is not only for waiver clients, but also includes children in DHS' Early Intervention (EI) program who are Medicaid eligible. Early Intervention State General Funded and Federal Part C funded service and includes some children who are Medicaid eligible. Historically, approximately 50% of EI clients fit into this category and this has impacted TCM client counts. As a result of SB 07-004, the number of children receiving EI services increased significantly. Medicaid Caseload during the recent recession has increased significantly. The data indicates that the unduplicated count of children being served has increased by 979 since FY 2008-09 and that 948 of those children have been Medicaid eligible. As of FY 2010-11, over 5,600 EI children are Medicaid eligible. This has impacted EI related TCM expenditures.

Early Intervention Enrolled and Medicaid Eligible

Year	Total Enrolled Unduplicated Count	Medicaid Eligible Unduplicated Count	Percent
2008-09	10,011	4,703	47%
2009-10	10,739	5,292	49%
2010-11	10,990	5,651	51%
Three Year Change	979	948	97%

Targeted Case Management Expenditures by Support Level

Total Annual Expenditures

Support Level	1	2	3	4	5	6	7	Unk	Total	$ Increase vs. Prior Year	% Increase vs. Prior Year
FY 2008-09	$3,564,353	$3,748,516	$1,942,689	$1,587,227	$1,725,623	$1,238,247	$520,718	$3,044,173	$17,371,547	$2,612,889	17.70%
FY 2009-10	$3,659,418	$3,846,550	$2,274,585	$2,079,613	$2,311,804	$1,704,373	$441,850	$3,073,815	$19,392,008	$2,020,462	11.63%
FY 2010-11	$3,713,065	$3,894,915	$2,407,937	$2,277,549	$2,642,187	$2,012,035	$398,331	$3,471,088	$20,817,107	$1,425,098	7.35%
Three Year Growth %	4.17%	3.91%	23.95%	43.49%	53.11%	62.49%	-23.50%	14.02%	19.83%		

Clients Served (FTE)

Support Level	1	2	3	4	5	6	7	Unk	Total	Increase vs. Prior Year	% Increase vs. Prior Year
FY 2008-09	1672.1	1759.4	911.1	743.5	809.2	579.8	242.8	1443.8	8161.7	913	12.59%
FY 2009-10	1664.8	1781.4	983.1	835.2	953.6	681.8	209.8	2023.0	9132.7	971	11.90%
FY 2010-11	1600.8	1723.3	982.4	881.1	1033.7	745.4	167.7	2204.6	9338.9	206	2.26%
Three Year Growth %	-4.26%	-2.06%	7.83%	18.50%	27.74%	28.56%	-30.95%	52.69%	14.42%		

Rates for TCM have also risen significantly in recent years. Effective July 1, 2009 the TCM rate was $12.60 per unit. In November 2009, a retroactive rate change was implemented. This was based on an adjustment to the productivity factor and resulted in an increased rate. Additionally, DDD applied a 2.5% rate reduction to all rates for HCBS and TCM at that same time. The final TCM rate was $14.93 per unit effective October 1, 2009. This represents a rate increase of more than 18%.

Additionally, units of service billed has increased year over year and there may be a correlation between this increase and client support level. Data for TCM in Appendix C on pages C.15-16 shows the significant increase in the number of FTE for whom TCM has been administered over the past several years.

Service Rates – The development of the Support Level assessment methodology brought a necessary standardization of service rates. Implementation of the new rate structure took several years and included restructuring certain services and resetting rates for virtually all services. Service Rates have also changed due to budget constraints and the need to reduce costs. The Division for Developmental Disabilities acknowledges reimbursement rates as a core component related to expenditures. The Division continues to assess reimbursement rates and will consider adjustments as an available option to effectively manage and control expenditures. A table of service rates for the various DD waiver programs can be found in Appendix E on pages E3 through E11.

Relationship Between HCBS-SLS and HCBS-DD – Of its nature, the HCBS-SLS waiver is structured for higher functioning clients, presumably with less intensive needs than individuals in the HCBS-DD waiver. Occasionally, a change will occur with an HCBS-SLS client that results in a need for emergency placement into the HCBS-DD waiver program. This has a dual effect. It drives a need for more slots in the HCBS-DD waiver, and in doing so, it redistributes average per-person per-diem expenditures because of the significantly higher per-person per-diem expenditure in the HCBS-DD waiver.

The Wait-List – The three waivers (HCBS-CES, HCBS-SLS, and HCBS-DD) are structured to serve an approved number of clients (enrollments). This number is approved each year by the General Assembly and is noted in the Long Bill. In addition to those who receive services through the waivers, DHS maintains a list of individuals who are deemed eligible, yet are not able to be served within a waiver because of a lack of available vacant slots. The wait list is not static and the number of individuals on it changes regularly. However, the number of individuals on the wait list generally increases over time. The three primary drivers for this are 1) population growth, 2) the increasing number of individuals who are Medicaid eligible, and 3) aging baby-boomer caregivers who are becoming unable to care for the developmentally disabled individual driving a need for alternative care solutions. A table containing Wait List data as of June 30, 2011 can be found in Appendix F on pages F2 and F3.

Appendix A
Support Level Trends
An Overview

The data and graphs on the following pages show the client counts for each service support level in the HCBS-DD waiver since incorporation of the Supports Intensity Scale (SIS) tool.

SIS and Support Levels:

In the middle part of the last decade, CMS directed that a comprehensive new rate methodology be implemented. The transition took several years. This included implementing a needs assessment tool, setting rates for services, and determining expected service utilization based on need.

While the SIS tool first came into use in 2006, this represented only the first phase of implementation of this client assessment model. Full implementation of Support Level methodology was a two phase process.

The first phase included beta testing a new tool (SIS) with a representative sample of waiver clients to establish need level categories, evaluating service utilization by those individuals, and applying a rate structure for those services. The need levels were first called "tiers" and became the progenitors of the "Support Levels." This also helped determine intensity of service need in terms of units of utilization, as well as the associated costs for providing that particular service to a person with a particular level of need. The rate structure was temporary until a permanent rate structure went into effect in 2009.

Phase two was implemented effective January of 2009 and used a Support Level determination algorithm (the algorithm)[1] to determine Support Level. The algorithm applies weights to certain factors measured by the SIS tool and then adds two external factors – 1) Community Safety Risk, and 2) Danger to Self. Each of these two factors has the capacity to significantly increase the support level assignment. As clients originally assigned a tier using the SIS tool between 2006 through 2008 underwent reassessment incorporating the algorithm with the two external factors, the number of clients with lower Support Levels began to decline as they were reassessed at higher Support Levels. Additionally, new clients entering the waiver are being assessed at higher levels because of the implementation of the algorithm.

In addition, overall client counts have gone up as additional enrollments have been granted by the General Assembly. The combination of these new enrollments with the incorporation of the algorithm means that new clients entering the system are typically assigned a higher initial support level. Additionally, as vacancies occur, they are filled

---

[1] The algorithm is a calculation that weights various factors from the Supports Intensity Scale tool, along with two additional factors not contained in the tool: Community Safety Risk, and Danger to Self. The output from the algorithm sets an individual's Support Level. The HCBS-SLS algorithm does not include the two additional factors.

first based on emergency need. It is reasonable to assume that clients entering the waiver based upon emergency need likewise have a higher level of need translating into a higher Support Level. The combination of these various components has altered the Support Level distribution of clients upward. This, in turn, has had a significant impact on expenditures.

The graph on page A.3 illustrates the steady decline in the number of HCBS-DD waiver clients in Support Levels 1 and 2 contrasted against the simultaneous steady increase in the number of clients in Support Levels 4, 5, and 6. The graph on page A.4 shows the distribution of clients in specific Support Levels (or tiers) by fiscal year. The graph illustrates a shift in the distribution of clients between fiscal years 2006-07 through 2007-08 before the algorithm came into use versus the distribution afterward in fiscal years 2008-09 through 2010-11. The data shows two distinct changes – 1) Support Level 1 and 2 clients comprised a smaller portion of the distribution, and 2) Support Levels 4, 5, and 6 began comprising more of the distribution. The third bar graph chart shows the breakdown of clients by Support Level and actual client count. There are three noteworthy observations. The data shows a very high number of clients in FY 2006-07 not assigned to a Support Level. The data also shows an increase in overall client counts from one fiscal year to the next. The data also shows a shift beginning in FY 2008-09 when the algorithm came into use where the number of clients in Support Levels 1, 2, and 3 began declining while the number of clients in Support Levels 4, 5, or 6 began increasing.

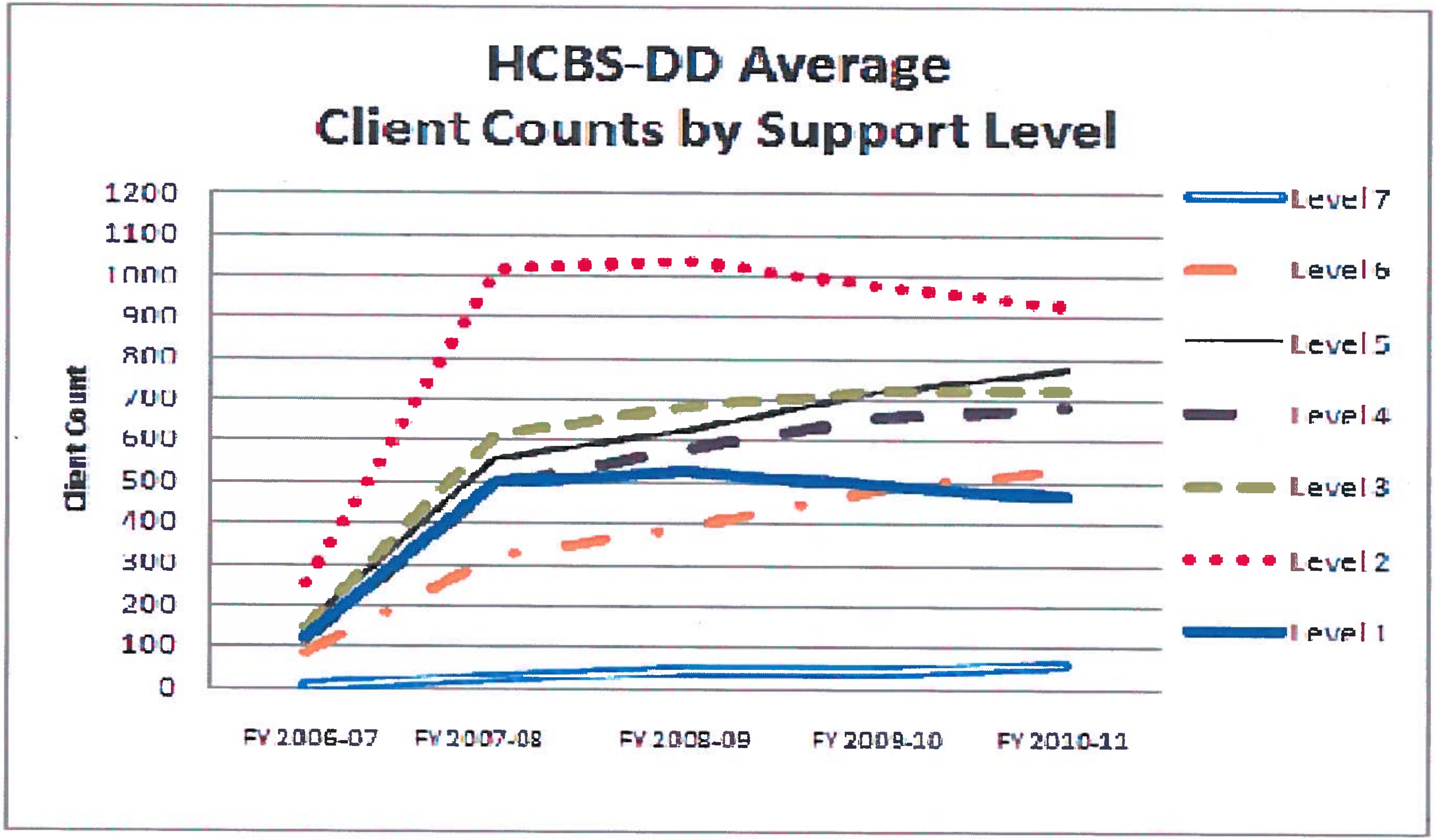
Overall, the data shows a simultaneous upward shift in the real number of clients to higher Support Levels while also shifting the proportional distribution upward as well.

The data used to create these graphs can be found in Appendix C on page C.3.

Similar graphs are presented on pages A.6-8 for the Supported Living Services (HCBS-SLS) clients. In contrast to what the data related to HCBS-DD shows, HCBS-SLS shows a very steady and consistent distribution across years and Support Levels. One item of note is that client counts are trending upward.

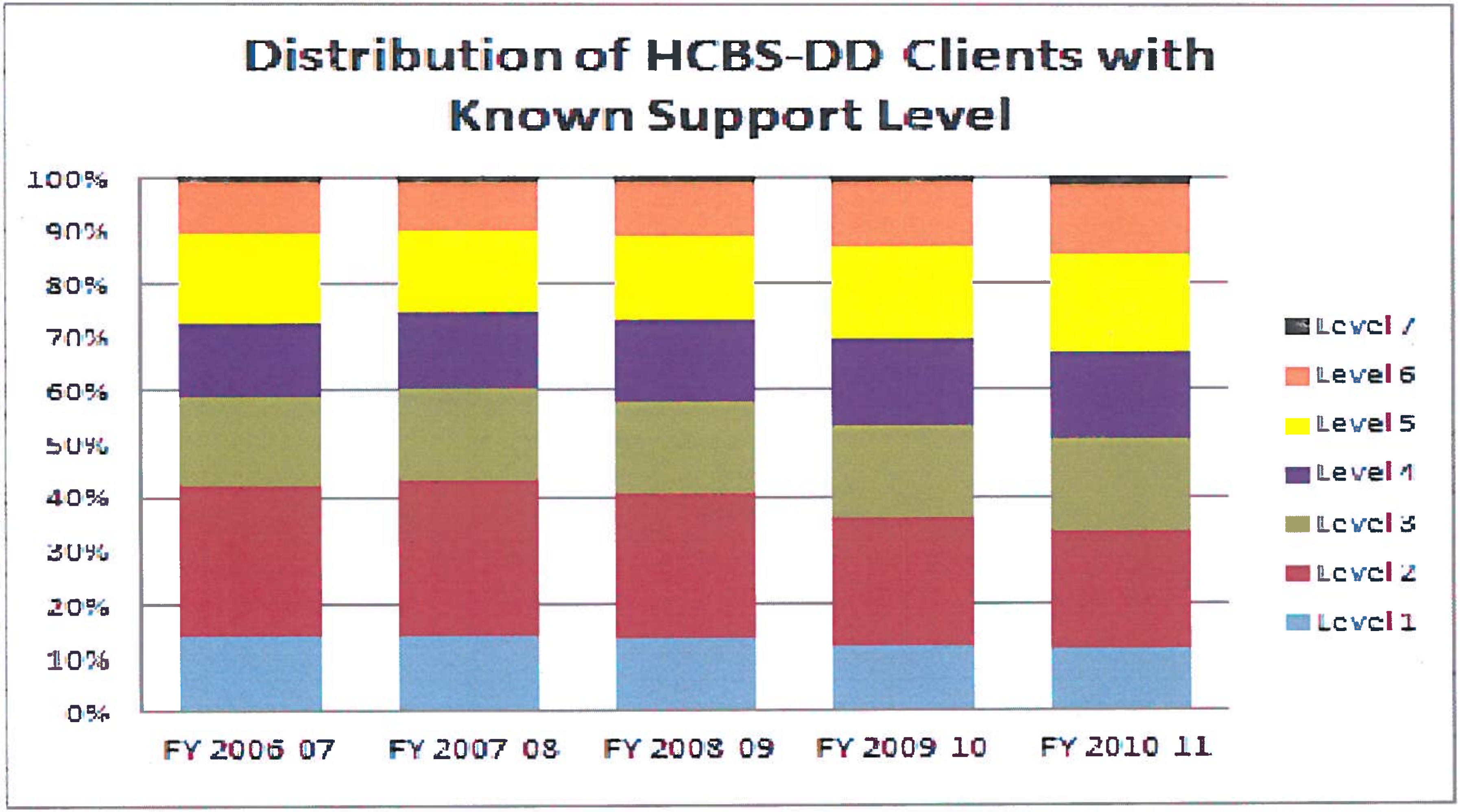
The data used to create these graphs can be found in Appendix C on page C.13.

Appendix I



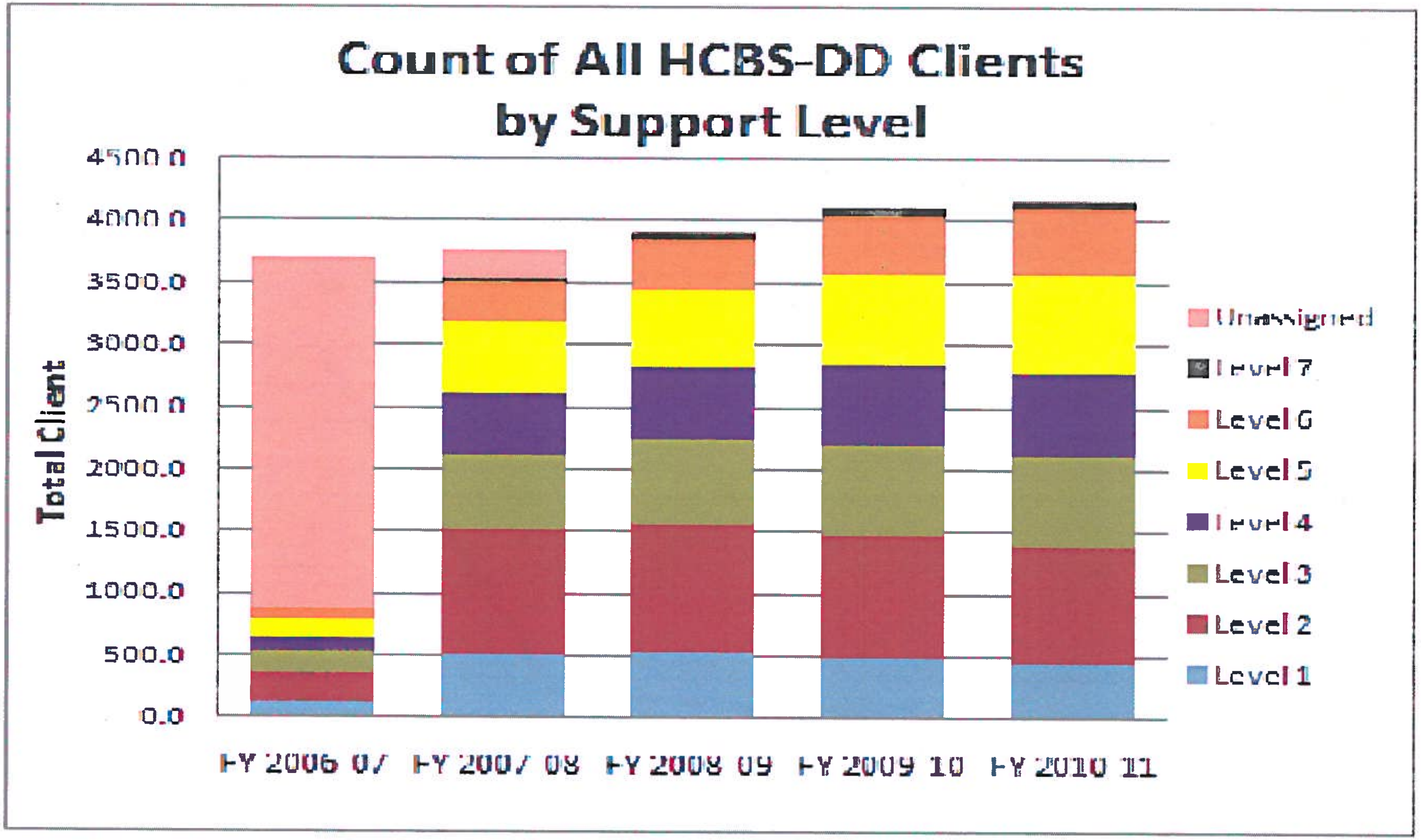
The graph above uses Supports Intensity Scale tool (SIS) data as well as Support Levels as determined by the algorithm that became effective in late calendar year 2008. Clients assessed before the implementation of the algorithm were assigned tiers as measured by the SIS assessment, which first came into use in 2006. By late 2007, most HCBS-DD clients had been assessed using this tool. The Support Level Determination algorithm was instituted beginning in late 2008. Clients previously assigned a tier using only the SIS were, over time, reassessed using the algorithm and assigned to a Support Level. The SIS and the algorithm measure on a 7-tier system. The data used to produce this chart can be found in Appendix C on page C.3.

Appendix I



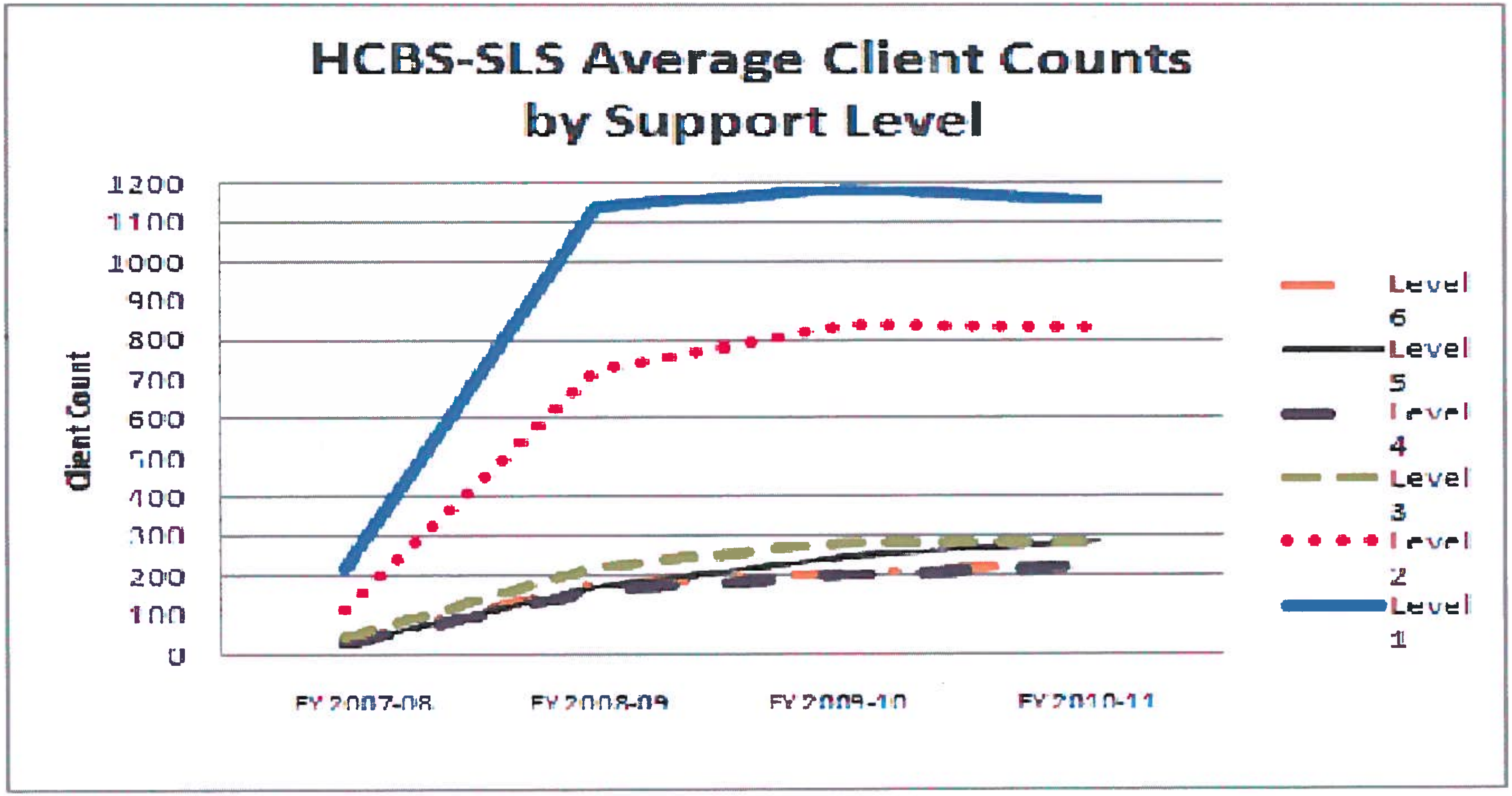
The bar graphs above show the percentile distribution of clients, by Support Level and fiscal year. There were a high number of clients in FY 2006-07 with no assessment score and these clients are not included in the FY 2006-07 graph. By December of 2008, all clients had been assessed. The Support Level Determination Algorithm came into use in FY 2008-09. These two factors appear to have contributed to gradual redistribution on the proportion of clients in the various Support Levels. The data used to produce this chart can be found in Appendix C on page C.3.

Appendix I



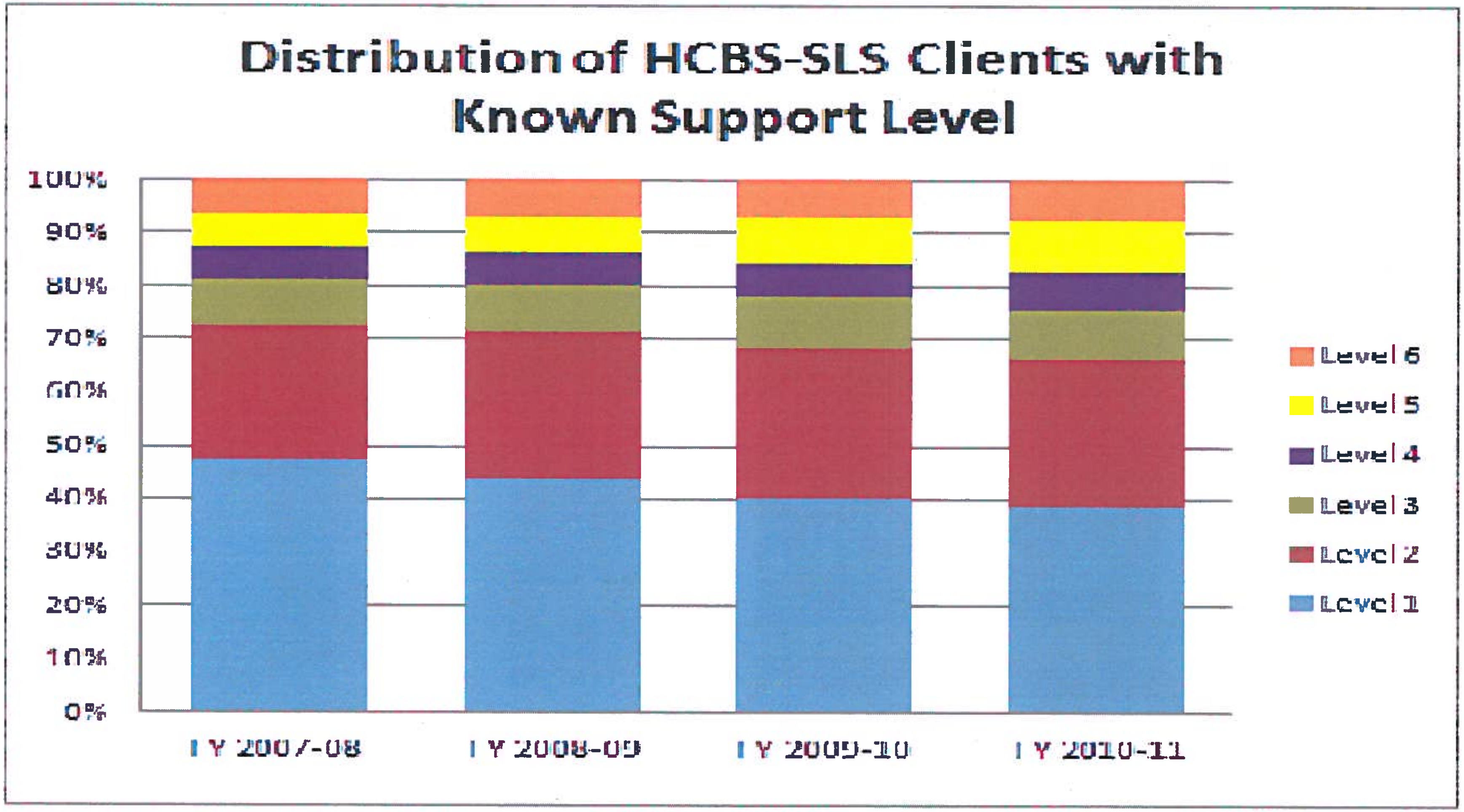
The bar graphs above show the average annual client count distribution by Support Level and fiscal year. There were a high number of clients in FY 2006-07 with no assessment score and these clients are shown as Unassigned. By December of 2008, all clients had been assessed. The Support Level Determination Algorithm came into use in FY 2008-09. These two factors appear to have contributed to the redistribution on the proportion of clients in the various Support Levels. The data used to produce this chart can be found in Appendix C on page C.3.

Appendix I

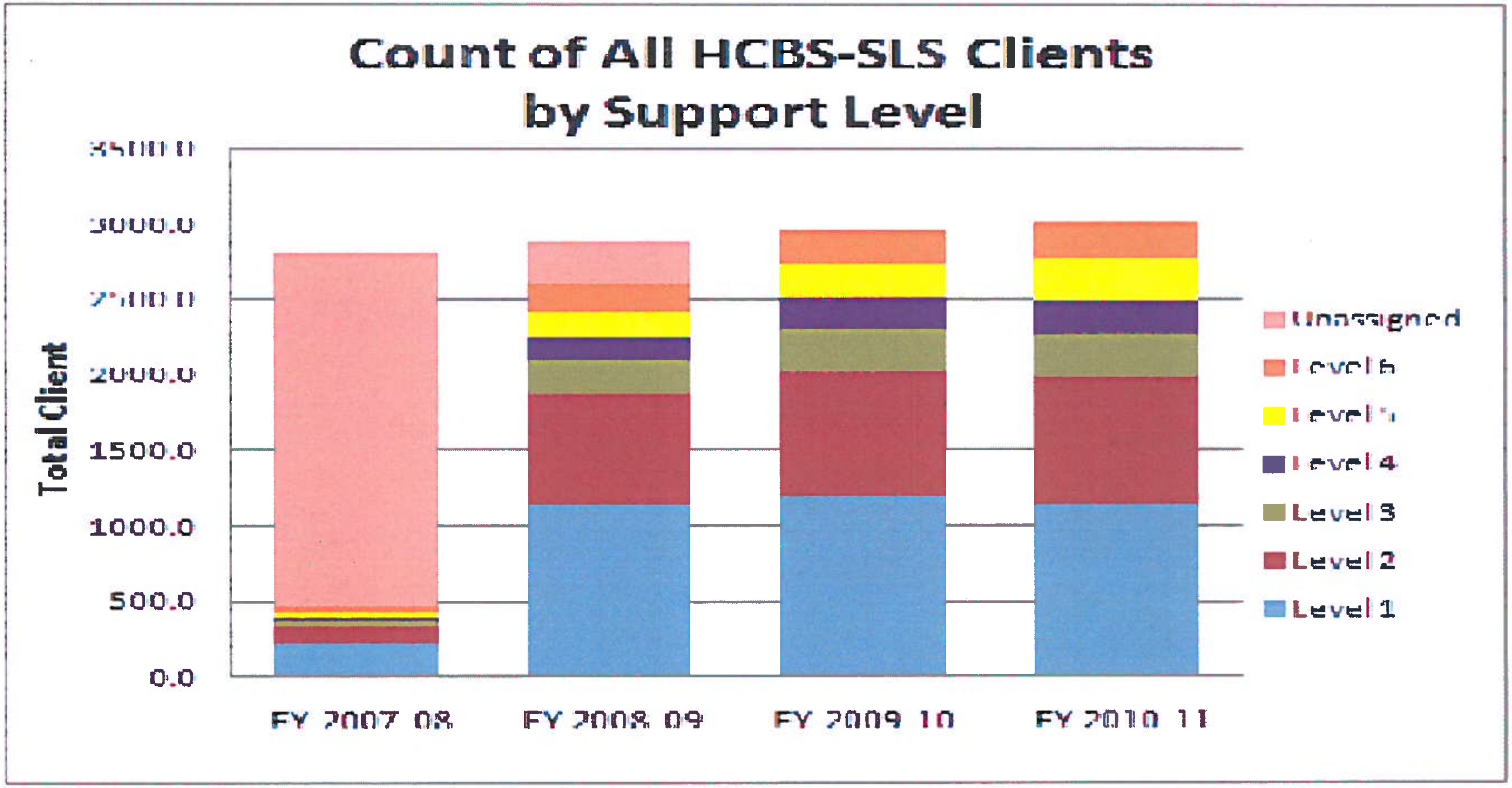


The graph above uses Supports Intensity Scale tool (SIS) data as well as Support Levels as determined by the algorithm that became effective in late calendar year 2008. Clients assessed before the implementation of the algorithm were assigned tiers as measured by the SIS assessment, which first came into use in 2006. Very few HCBS-SLS clients were evaluated using the SIS tool prior to FY 2007-08. The Support Level Determination algorithm was instituted beginning in late calendar year 2008 and most HCBS-SLS clients had been assessed using the algorithm by the end of FY 2008-09. The SIS and the algorithm measure on a 7-tier system. SLS clients are almost never assigned to Support Level 7 and this chart tracks only Support Levels 1 through 6 clients. The data used to produce this chart can be found in Appendix C on page C.13.

Appendix I



The bar graphs above show the percentile distribution of clients by Support Level and fiscal year. Very few HCBS-SLS clients had been evaluated using the Supports Intensity Scale (SIS) tool by the end of FY 2007-08 and only clients with SIS scores are included in the FY 2007-08 bar. The Support Level Determination Algorithm came into use in late calendar year 2008. By June of 2009, virtually all clients had been assessed. The data used to produce this chart can be found in Appendix C on page C.13.



The bar graphs above show the distribution of clients by Support Level and fiscal year. There were a high number of clients in FY 2007-08 with no assessment score and these clients are shown as unassigned. By June of 2009 virtually all clients had been assessed. The Support Level Determination Algorithm came into use in 2009 for HCBS-SLS clients. The data used to produce this chart can be found in Appendix C on page C.13.

Appendix B
Average Expenditures Based on Date-of-Service
An Overview

The data and graphs on the following pages show per-capita expenditures for various waivers. The graphs on pages B.4 through B.6 are illustrated by waiver (with a separate graph for Targeted Case Management on B.7). The data from which per-capita expenditures is calculated is shown on page B.8. The data was collected from individual client level claims paid through the Medicaid Management Information System (MMIS) from July 1, 2006 through August 31, 2011 for services received between July 1, 2006 and June 30, 2011. Support level data was provided by the Department of Human Services. The graphs on pages B.2 and B.3 show annual total expenditures for each waiver side by side. The graph on page B.2 shows total annual expenditures and the graph on B.3 shows total annual expenditures per-capita.

HCBS-DD

The data shows a consistent pattern of daily average expenditures throughout the year (e.g. December expenditures routinely lower than other months). The data also shows a consistent upward trend in average daily expenditures year over year. Expenditures have stabilized, however, since the end of FY 2008-09. See graph on page B.4.

Supported Living Services (HCBS-SLS)

The data shows per-capita expenditures rising steadily from FY 2006-07 through FY 2008-09. In FY 2009-10, per-capita expenditures dropped significantly. The level of expenditures then stayed relatively stable at this decreased level through FY 2010-11. Several concerns reside below the surface of the data. Support Level methodology using the algorithm was implemented for HCBS-SLS clients in July of 2009. While the data indicates a decrease in per-capita expenditures since peaking in FY 2008-09 (possibly as a result of the implementation of the Support Level methodology), expenditures appear to have now bottomed. See graph on page B.5.

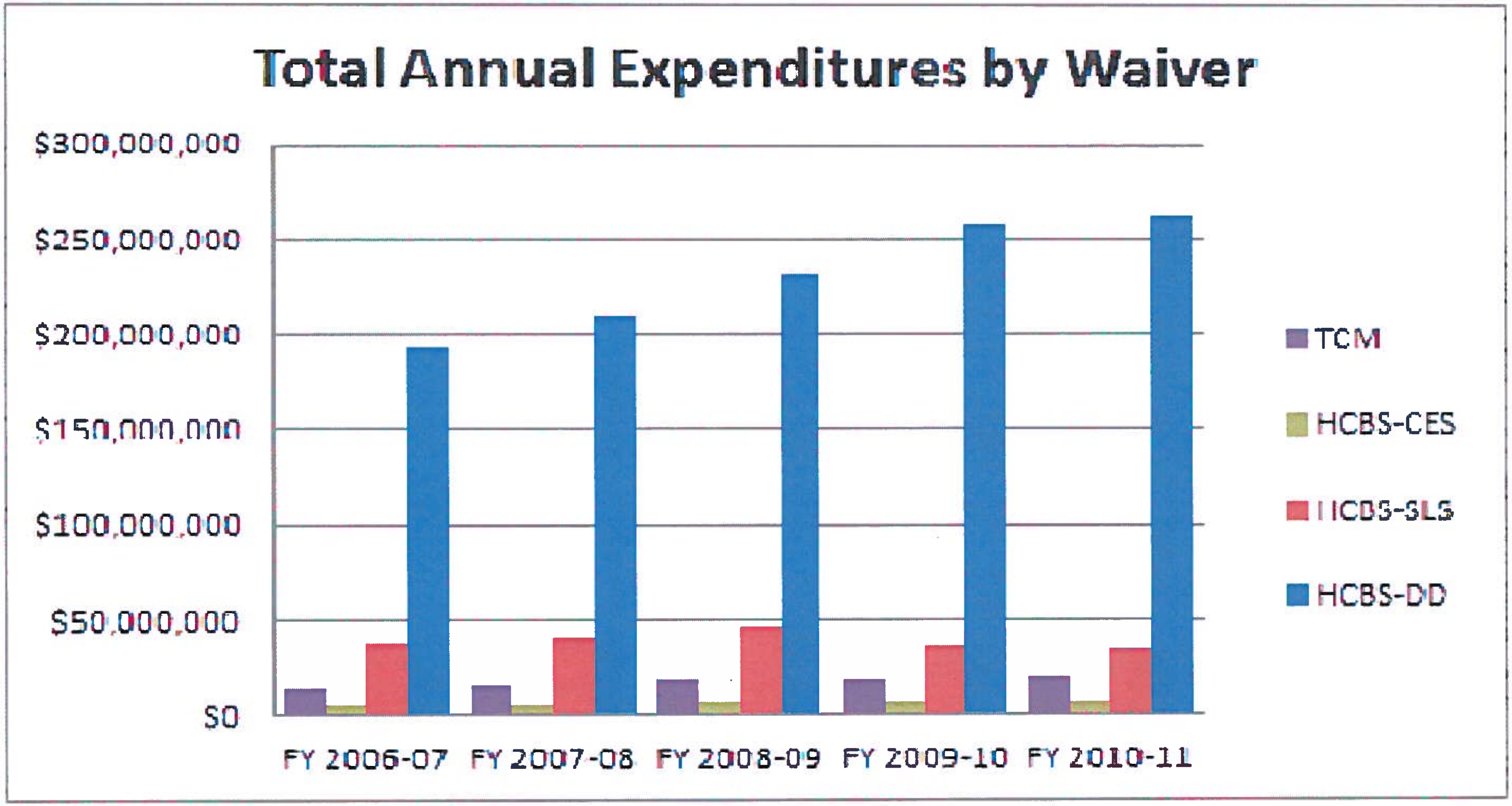
Children's Extensive Services (HCBS-CES)

The CES expenditure data shows consistent increases in per-capita per-diem expenditures over time. Overall CES expenditures have increased by over 50% over the past five years. While this is noteworthy, it is also important to note that HCBS-CES still accounts for only about 2% of total DD-related expenditures between the three waivers plus Targeted Case Management. See graph on page B.6.

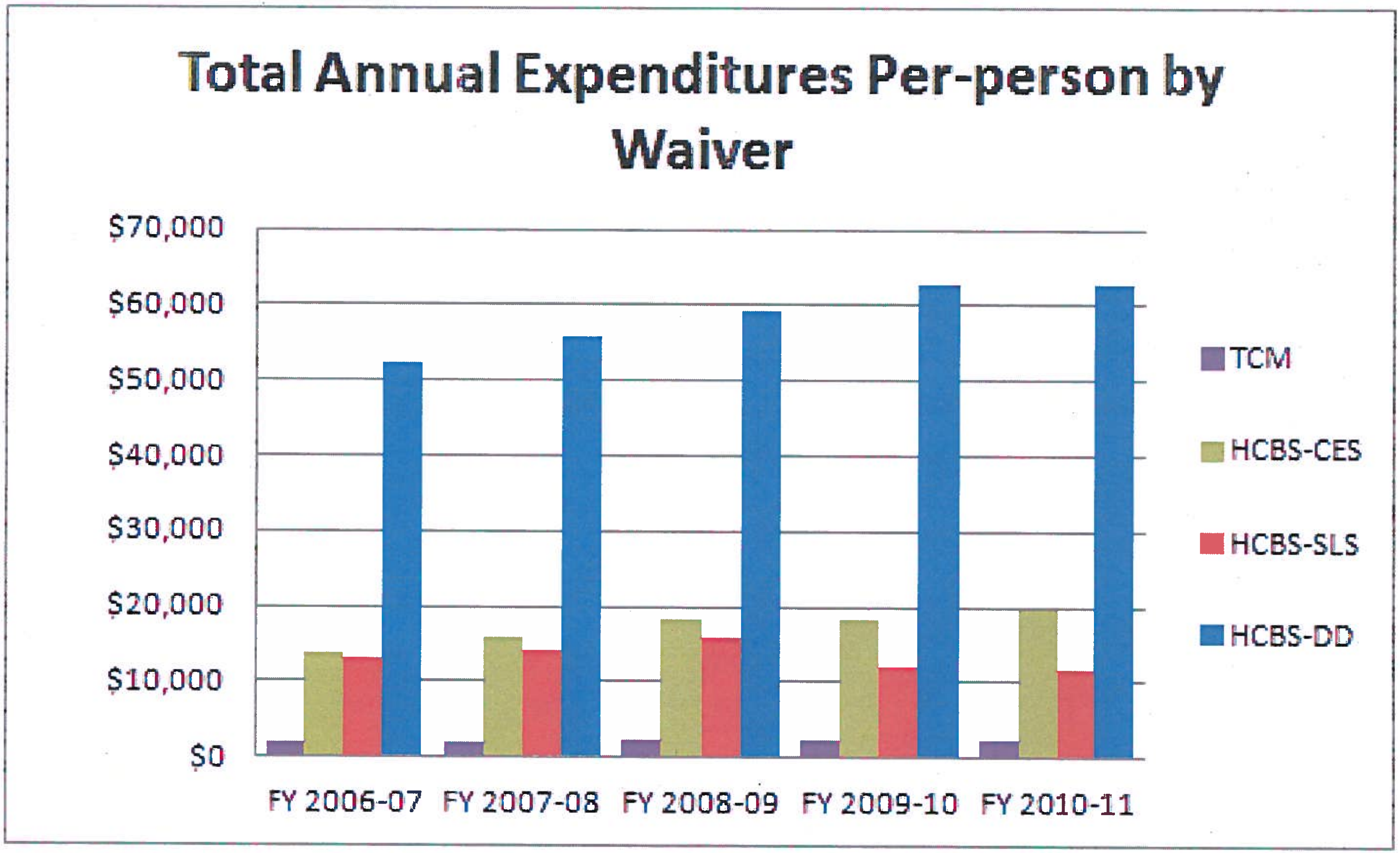
Targeted Case Management (TCM)

TCM expenditures are generally associated with the administrative functions related to client management. TCM is overseen by the various Community Centered Boards (CCB). TCM used to be paid based upon a flat per-capita contracted rate. With the implementation of fee-for-service, the rate was transitioned in a two phase process to a fifteen minute rate. The initial phase provided a one-time per-capita rate bump that took place in January 2009. Beginning in July 2009, the second phase moving to the fifteen minute rate was implemented. TCM Expenditures have consistently increased each year and, since moving to the 15 minute increment, the pace of expenditure increases has risen even faster. See graph on page B.7.

Appendix I

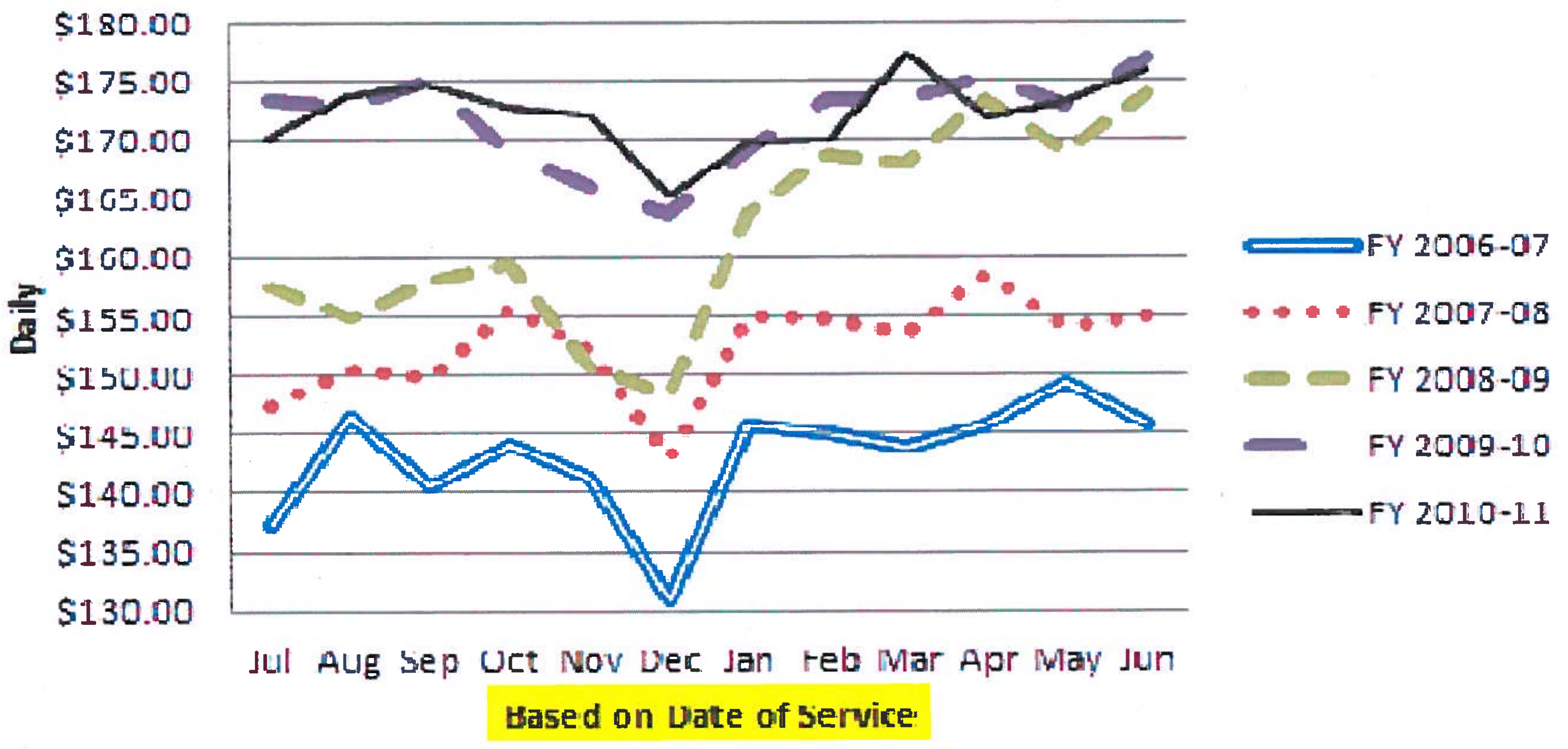

Total Annual Expenditures by Waiver

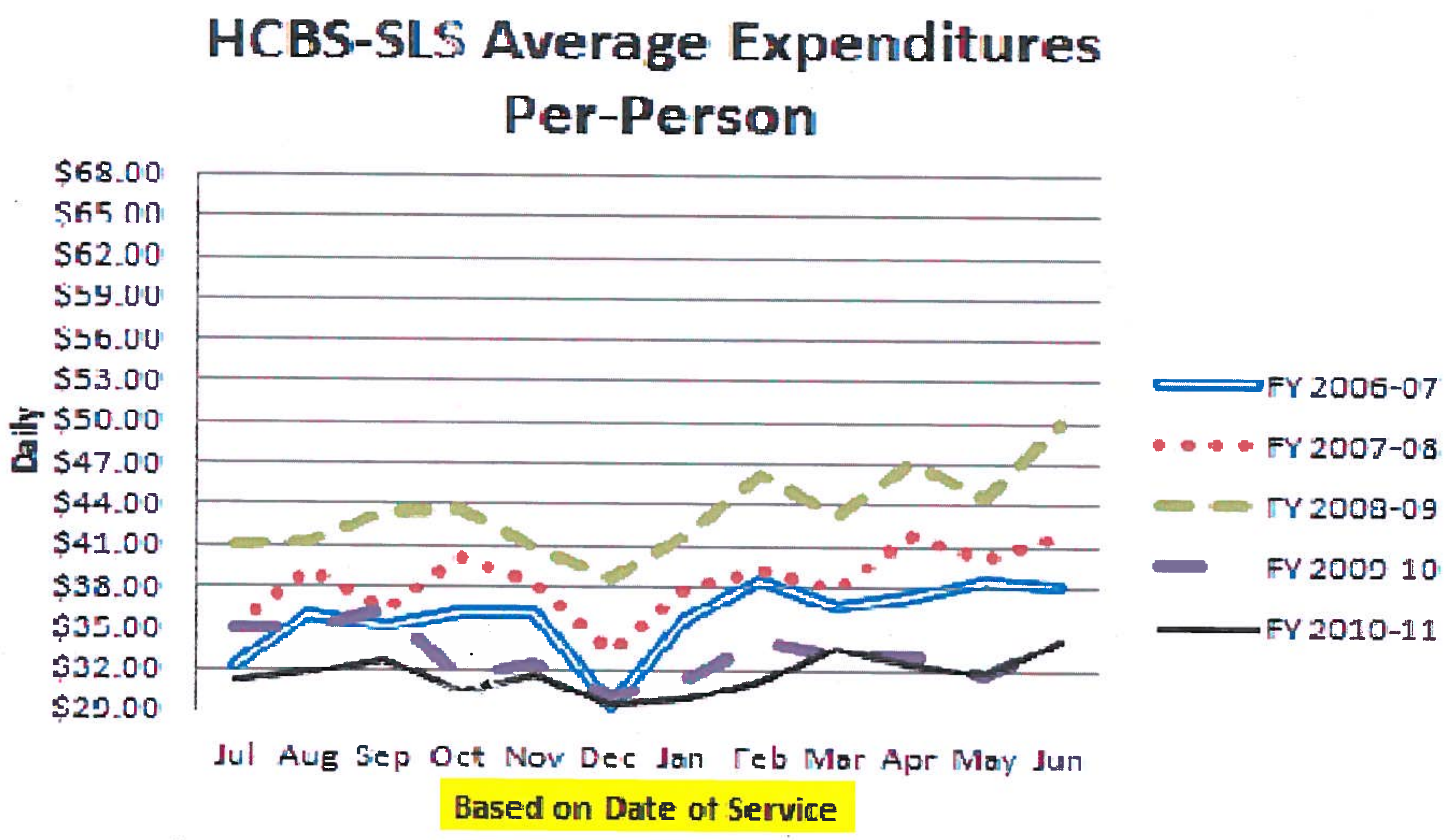
Appendix I



Total Annual Expenditures Per-person by Waiver

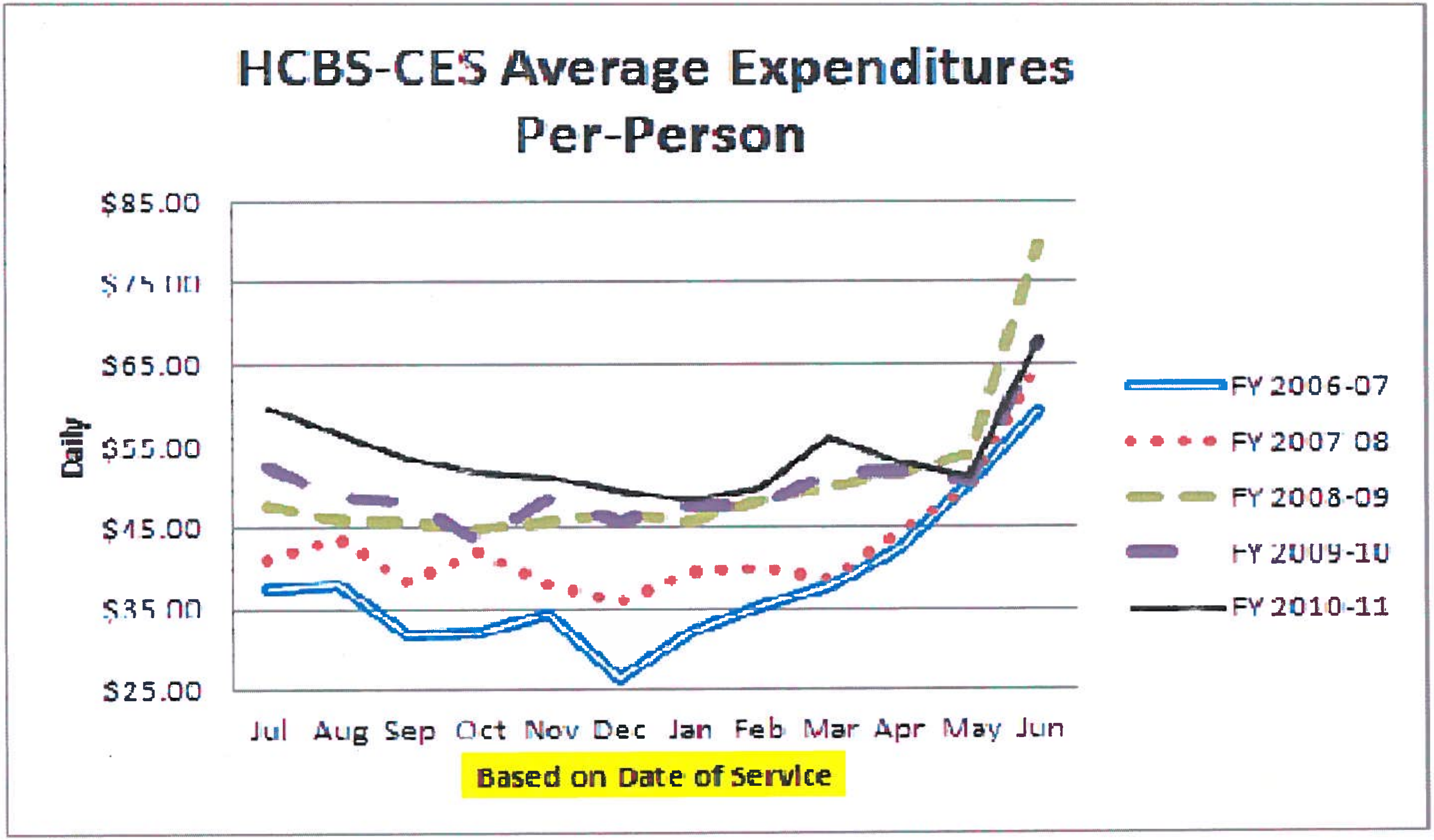
HCBS-DD Average Expenditures Per-Person



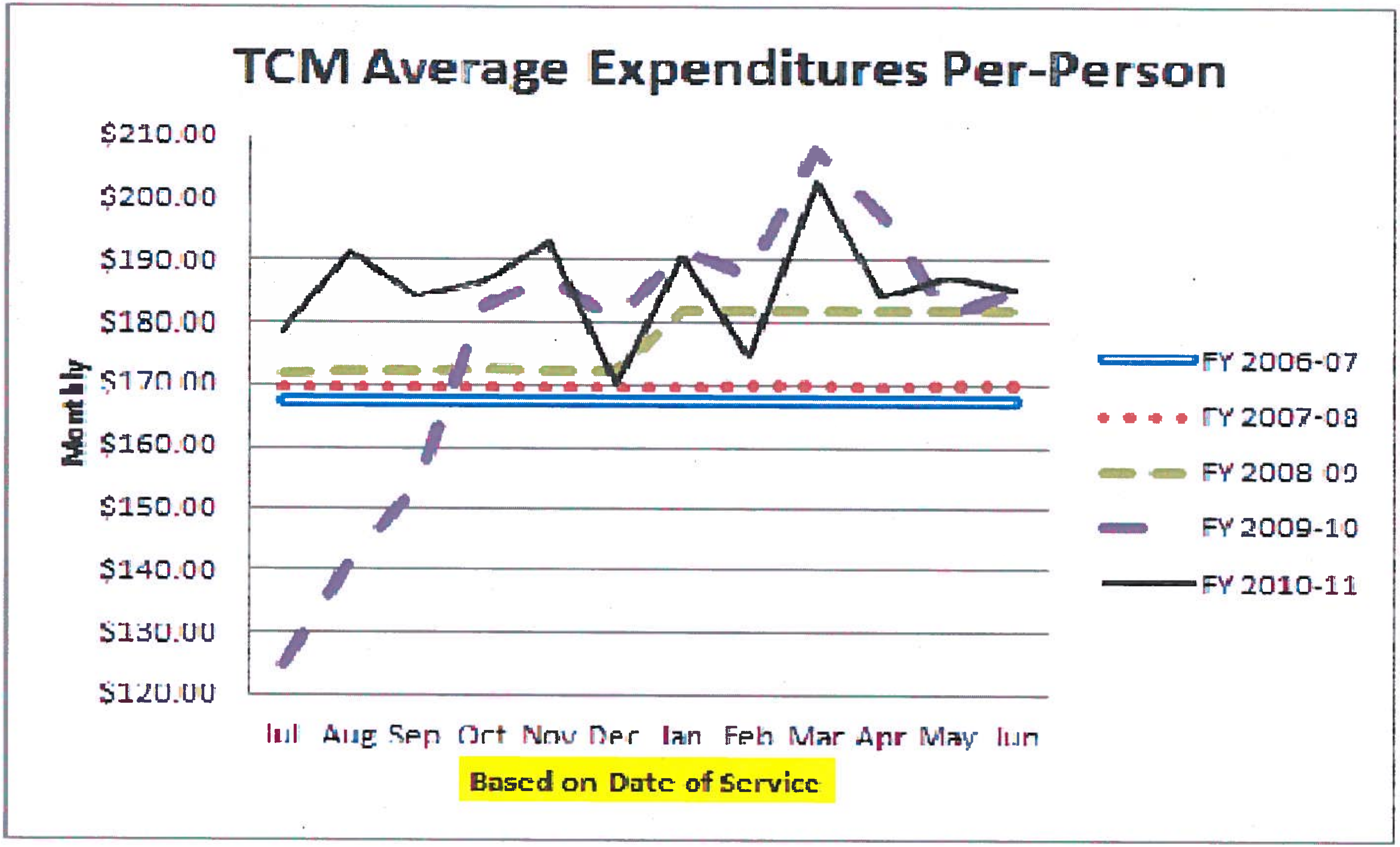


Based on Date of Service

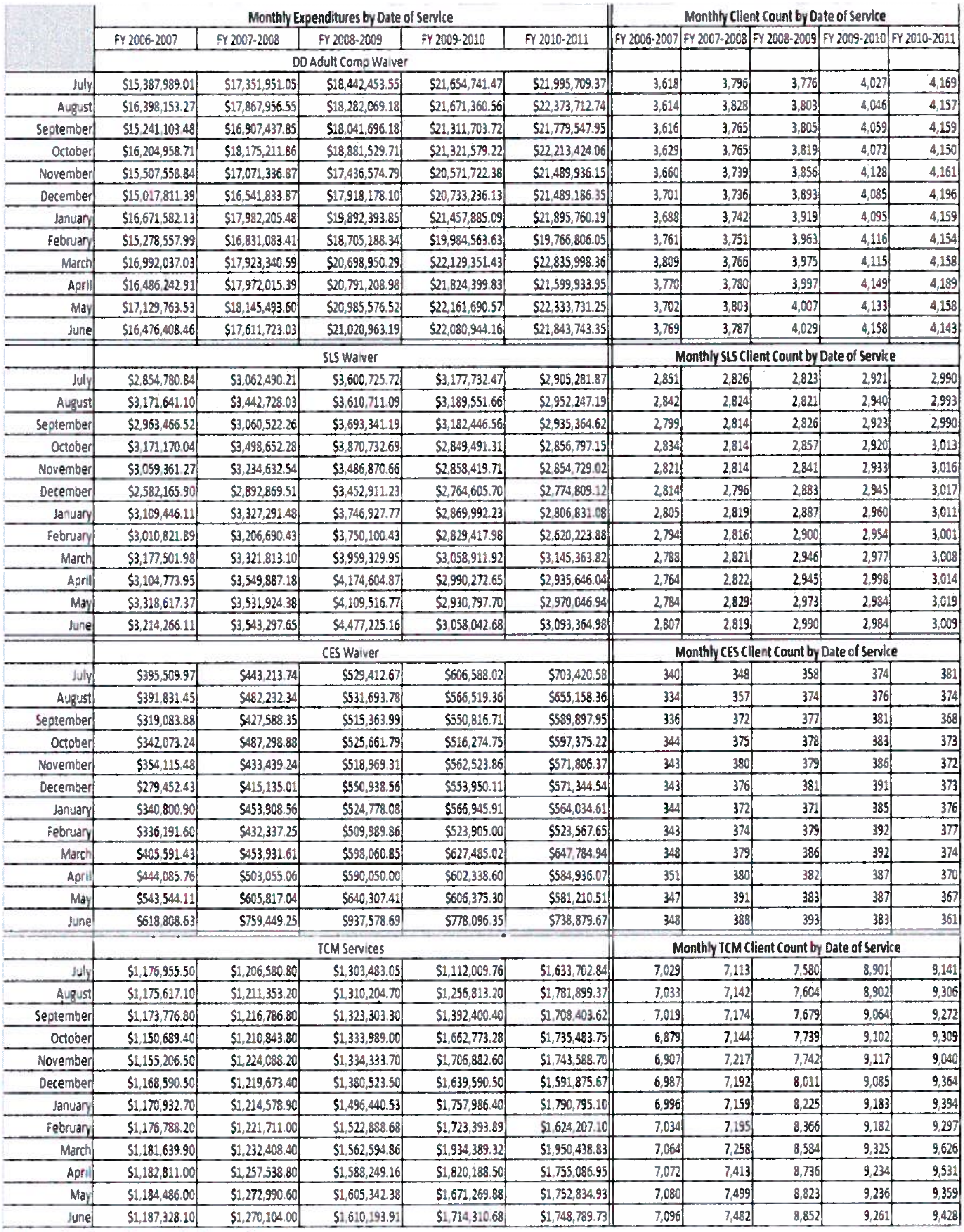
Appendix I


HCBS-CES Average Expenditures Per-Person
Daily
$85.00
$75.00
$65.00
$55.00
$45.00
$35.00
$25.00
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Based on Date of Service
FY 2006-07
FY 2007 08
FY 2008-09
FY 2009-10
FY 2010-11

Appendix I


TCM Average Expenditures Per-Person
Monthly
$210.00
$200.00
$190.00
$180.00
$170.00
$160.00
$150.00
$140.00
$130.00
$120.00
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
FY 2006-07
FY 2007-08
FY 2008 09
FY 2009-10
FY 2010-11
Based on Date of Service

Appendix I



	Monthly Expenditures by Date of Service					Monthly Client Count by Date of Service				
	FY 2006-2007	FY 2007-2008	FY 2008-2009	FY 2009-2010	FY 2010-2011	FY 2006-2007	FY 2007-2008	FY 2008-2009	FY 2009-2010	FY 2010-2011
	DD Adult Comp Waiver									
July	$15,387,989.01	$17,351,951.05	$18,442,453.55	$21,654,741.47	$21,995,709.37	3,618	3,796	3,776	4,027	4,169
August	$16,398,153.27	$17,867,956.55	$18,282,069.18	$21,671,360.56	$22,373,712.74	3,614	3,828	3,803	4,046	4,157
September	$15,241,103.48	$16,907,437.85	$18,041,696.18	$21,311,703.72	$21,779,547.95	3,616	3,765	3,805	4,059	4,159
October	$16,204,958.71	$18,175,211.86	$18,881,529.71	$21,321,579.22	$22,213,424.06	3,629	3,765	3,819	4,072	4,150
November	$15,507,558.84	$17,071,336.87	$17,436,574.79	$20,571,722.38	$21,489,936.15	3,660	3,739	3,856	4,128	4,161
December	$15,017,811.39	$16,541,833.87	$17,918,178.10	$20,733,236.13	$21,489,186.35	3,701	3,736	3,893	4,085	4,196
January	$16,671,582.13	$17,982,205.48	$19,892,393.85	$21,457,885.09	$21,895,760.19	3,688	3,742	3,919	4,095	4,159
February	$15,278,557.99	$16,831,083.41	$18,705,188.34	$19,984,563.63	$19,766,806.05	3,761	3,751	3,963	4,116	4,154
March	$16,992,037.03	$17,923,340.59	$20,698,950.29	$22,129,351.43	$22,835,998.36	3,809	3,766	3,975	4,115	4,158
April	$16,486,242.91	$17,972,015.39	$20,791,208.98	$21,824,399.83	$21,599,933.95	3,770	3,780	3,997	4,149	4,189
May	$17,129,763.53	$18,145,493.60	$20,985,576.52	$22,161,690.57	$22,333,731.25	3,702	3,803	4,007	4,133	4,158
June	$16,476,408.46	$17,611,723.03	$21,020,963.19	$22,080,944.16	$21,843,743.35	3,769	3,787	4,029	4,158	4,143
	SLS Waiver					Monthly SLS Client Count by Date of Service				
July	$2,854,780.84	$3,062,490.21	$3,600,725.72	$3,177,732.47	$2,905,281.87	2,851	2,826	2,823	2,921	2,990
August	$3,171,641.10	$3,442,728.03	$3,610,711.09	$3,189,551.66	$2,952,247.19	2,842	2,824	2,821	2,940	2,993
September	$2,963,466.52	$3,060,522.26	$3,693,341.19	$3,182,446.56	$2,935,364.62	2,799	2,814	2,826	2,923	2,990
October	$3,171,170.04	$3,498,652.28	$3,870,732.69	$2,849,491.31	$2,856,797.15	2,834	2,814	2,857	2,920	3,013
November	$3,059,361.27	$3,234,632.54	$3,486,870.66	$2,858,419.71	$2,854,729.02	2,821	2,814	2,841	2,933	3,016
December	$2,582,165.90	$2,892,869.51	$3,452,911.23	$2,764,605.70	$2,774,809.12	2,814	2,796	2,883	2,945	3,017
January	$3,109,446.11	$3,327,291.48	$3,746,927.77	$2,869,992.23	$2,806,831.08	2,805	2,819	2,887	2,960	3,011
February	$3,010,821.89	$3,206,690.43	$3,750,100.43	$2,829,417.98	$2,620,223.88	2,794	2,816	2,900	2,954	3,001
March	$3,177,501.98	$3,321,813.10	$3,959,329.95	$3,058,911.92	$3,145,363.82	2,788	2,821	2,946	2,977	3,008
April	$3,104,773.95	$3,549,887.18	$4,174,604.87	$2,990,272.65	$2,935,646.04	2,764	2,822	2,945	2,998	3,014
May	$3,318,617.37	$3,531,924.38	$4,109,516.77	$2,930,797.70	$2,970,046.94	2,784	2,829	2,973	2,984	3,019
June	$3,214,266.11	$3,543,297.65	$4,477,225.16	$3,058,042.68	$3,093,364.98	2,807	2,819	2,990	2,984	3,009
	CES Waiver					Monthly CES Client Count by Date of Service				
July	$395,509.97	$443,213.74	$529,412.67	$606,588.02	$703,420.58	340	348	358	374	381
August	$391,831.45	$482,232.34	$531,693.78	$566,519.36	$655,158.36	334	357	374	376	374
September	$319,083.88	$427,588.35	$515,363.99	$550,816.71	$589,897.95	336	372	377	381	368
October	$342,073.24	$487,298.88	$525,661.79	$516,274.75	$597,375.22	344	375	378	383	373
November	$354,115.48	$433,439.24	$518,969.31	$562,523.86	$571,806.37	343	380	379	386	372
December	$279,452.43	$415,135.01	$550,938.56	$553,950.11	$571,344.54	343	376	381	391	373
January	$340,800.90	$453,908.56	$524,778.08	$566,945.91	$564,034.61	344	372	371	385	376
February	$336,191.60	$432,337.25	$509,989.86	$523,905.00	$523,567.65	343	374	379	392	377
March	$405,591.43	$453,931.61	$598,060.85	$627,485.02	$647,784.94	348	379	386	392	374
April	$444,085.76	$503,055.06	$590,050.00	$602,338.60	$584,936.07	351	380	382	387	370
May	$543,544.11	$605,817.04	$640,307.41	$606,375.30	$581,210.51	347	391	383	387	367
June	$618,808.63	$759,449.25	$937,578.69	$778,096.35	$738,879.67	348	388	393	383	361
	TCM Services					Monthly TCM Client Count by Date of Service				
July	$1,176,955.50	$1,206,580.80	$1,303,483.05	$1,112,009.76	$1,633,702.84	7,029	7,113	7,580	8,901	9,141
August	$1,175,617.10	$1,211,353.20	$1,310,204.70	$1,256,813.20	$1,781,899.37	7,033	7,142	7,604	8,902	9,306
September	$1,173,776.80	$1,216,786.80	$1,323,303.30	$1,392,400.40	$1,708,403.62	7,019	7,174	7,679	9,064	9,272
October	$1,150,689.40	$1,210,843.80	$1,333,989.00	$1,662,773.28	$1,735,483.75	6,879	7,144	7,739	9,102	9,309
November	$1,155,206.50	$1,224,088.20	$1,334,333.70	$1,706,882.60	$1,743,588.70	6,907	7,217	7,742	9,117	9,040
December	$1,168,590.50	$1,219,673.40	$1,380,523.50	$1,639,590.50	$1,591,875.67	6,987	7,192	8,011	9,085	9,364
January	$1,170,932.70	$1,214,578.90	$1,496,440.53	$1,757,986.40	$1,790,795.10	6,996	7,159	8,225	9,183	9,394
February	$1,176,788.20	$1,221,711.00	$1,522,888.68	$1,723,393.89	$1,624,207.10	7,034	7,195	8,366	9,182	9,297
March	$1,181,639.90	$1,232,408.40	$1,562,594.86	$1,934,389.32	$1,950,438.83	7,064	7,258	8,584	9,325	9,626
April	$1,182,811.00	$1,257,538.80	$1,588,249.16	$1,820,188.50	$1,755,086.95	7,072	7,413	8,736	9,234	9,531
May	$1,184,486.00	$1,272,990.60	$1,605,342.38	$1,671,269.88	$1,752,834.93	7,080	7,499	8,823	9,236	9,359
June	$1,187,328.10	$1,270,104.00	$1,610,193.91	$1,714,310.68	$1,748,789.73	7,096	7,482	8,852	9,261	9,428

Data Compiled from Individual MMIS Claims Data

Appendix C
Waiver Utilization Data
Overview

The following data was collected from individual client level claims paid through the Medicaid Management Information System (MMIS) from July 1, 2006 through August 31, 2011 for services received between July 1, 2006 and June 30, 2011. Support level data was provided by the Department of Human Services.

The tables include data for each waiver and are generally organized by fiscal year and Support Level. Generally, the data is all-inclusive for a given waiver. HCBS-DD, however, also includes data on four specific services because the data suggests these to be significant contributors to overall expenditures in that waiver. The data uses expenditure data and client counts to produce the following:

- Total expenditures
- Total units of service consumed
- Per-capita expenditures
- Per-capita units of service consumed
- Percentage change over time

HCBS-DD Waiver related tables: Pages C.2-11
HCBS-SLS Waiver related tables: Pages C.12-13
HCBS-CES Waiver related tables: Page C.14
TCM Waiver related tables: Pages C.15-16

Note: Calculating Number of Clients Served: The number of clients served needs to be as accurate as possible in order to get a clear picture of service consumption per client. Since some clients begin or terminate services under waivers at various times through the year, while others receive services for all 12 months, using an unduplicated count does not accurately represent consumption per client. Therefore, Clients Served is calculated in this report as a full time equivalent (FTE). For purposes here, each client receiving a service in a given month is considered 1/12 FTE. The total is then summed and divided by 12. This gives a highly accurate FTE assessment.

Appendix I

The Developmentally Disabled Comprehensive waiver (HCBS-DD) is primarily designed to serve adults with developmental disabilities who may be capable of living in the community, yet within a 24 hour care model.

The Support Level is a scale ranging from one to seven, representing an escalating level of disability need. The Support Level is based upon an algorithim calculated based upon an evaluation (Supports Intensity Scale, or SIS) along with other unique factors such as extreme danger to self and community safety.

The SIS is an evaluative tool used by Case Managers in one-to-one settings to assess the needs of an individual waiver client. This tool is comprised of approximately 40 questions covering a wide range of issues related to developmental disability needs determination. The Support Level is a numerical representation of the services and support a given client requires, as well as the rate structure associated with the reimbursement for those services. Support level 1 represents the lowest support needs and support level 7 represents the highest.

The SIS was first implemented as the designated scoring tool in 2006. As a result, many clients did not have scores at the outset, as the assessment tool required person-to-person interaction.

HCBS-DD Waiver Utilization by Support Level

Total Annual Expenditures

Support Level	1	2	3	4	5	6	7	Unk	Total	$ Increase vs. Prior Year	% Increase vs. Prior
FY 2006-07	$4,626,773	$11,366,268	$7,354,424	$6,810,197	$9,476,695	$6,321,495	$530,743	$146,305,572	$192,792,167	NA	NA
FY 2007-08	$20,066,263	$48,568,312	$33,437,567	$29,731,803	$37,234,874	$24,451,231	$2,700,614	$14,190,926	$210,381,590	$17,589,423	9.12%
FY 2008-09	$19,031,351	$50,475,856	$38,942,164	$37,787,216	$46,595,396	$34,322,132	$3,038,556	$904,111	$231,096,783	$20,715,193	9.85%
FY 2009-10	$15,894,732	$47,370,741	$41,495,863	$44,963,534	$56,489,546	$46,468,883	$3,976,625	$243,254	$256,903,178	$25,806,396	11.17%
FY 2010-11	$14,731,736	$43,910,686	$40,853,187	$46,135,920	$59,707,703	$50,582,725	$5,576,306	$119,228	$261,617,490	$4,714,312	1.84%
Four Year Growth %	-26.58%	-9.59%	22.18%	55.17%	60.35%	106.87%	106.48%	-99.16%	24.35%		

Annualized Expenditures per Person

Support Level	1	2	3	4	5	6	7	Unk	Total	$ Increase vs. Prior Year	% Increase vs. Prior
FY 2006-07	$37,565	$45,074	$50,002	$56,831	$63,073	$71,497	$93,660	$52,100	$52,180	NA	NA
FY 2007-08	$40,133	$47,910	$54,422	$60,166	$67,191	$76,073	$103,208	$57,356	$55,780	$3,600	6.90%
FY 2008-09	$36,067	$48,616	$56,733	$65,272	$74,216	$88,137	$74,111	$64,579	$59,202	$3,422	6.13%
FY 2009-10	$32,268	$48,346	$57,653	$68,603	$78,530	$96,475	$87,881	$51,211	$62,679	$3,477	5.87%
FY 2010-11	$31,704	$47,296	$56,557	$67,681	$77,350	$94,828	$95,731	$57,229	$62,847	$167	0.27%
Four Year Growth %	-21.00%	-1.28%	3.92%	12.49%	15.12%	24.65%	-7.25%	-0.22%	12.67%		

Appendix I

Clients Served (FTE)

Support Level	1	2	3	4	5	6	7	Unk	Total	Increase vs. Prior Year	% Increase vs. Prior
FY 2006-07	123.2	252.2	147.1	119.8	150.3	88.4	5.7	2808.2	3694.7	NA	NA
FY 2007-08	500.0	1013.8	614.4	494.2	554.2	321.4	26.2	247.4	3771.5	77	2.08%
FY 2008-09	527.7	1038.3	686.4	578.9	627.8	389.4	41.0	14.0	3903.5	132	3.50%
FY 2009-10	492.6	979.8	719.8	655.4	719.3	481.7	45.3	4.8	4098.6	195	5.00%
FY 2010-11	464.7	928.4	722.3	681.7	771.9	533.4	58.3	2.1	4162.8	64	1.57%
Four Year Growth %	-7.07%	-8.42%	17.56%	37.94%	39.29%	65.96%	122.61%	-99.16%	10.37%		

Clients in Support Level as Percentage of All Clients with Known Levels

Support Level	1	2	3	4	5	6	7		Total
FY 2006-07	13.89%	28.44%	16.59%	13.52%	16.95%	9.97%	0.64%		100.00%
FY 2007-08	14.19%	28.77%	17.43%	14.02%	15.73%	9.12%	0.74%		100.00%
FY 2008-09	13.57%	26.69%	17.65%	14.88%	16.14%	10.01%	1.05%		100.00%
FY 2009-10	12.03%	23.93%	17.58%	16.01%	17.57%	11.77%	1.11%		100.00%
FY 2010-11	11.17%	22.31%	17.36%	16.38%	18.55%	12.82%	1.40%		100.00%
Four Year Growth %	-21.29%	-22.43%	-0.42%	16.84%	17.98%	40.57%	88.55%		

FOOTNOTES: Data does not include clients receiving services through Regional Centers billing for services through the HCBS-DD Waiver Program

Client counts are annualized based upon unique clients served per month.

The data presented is based upon the date services were provided (as opposed to payment date)

SPECIAL NOTES:

The Supports Intensity Scale for determining Support Levels of service was introduced in 2006. Many clients in FY 2006-07 were not assessed until later, thereby creating a high percentage of "Unknowns" in that year, both for expenditures and FTE client counts. For this reason, the Growth % shown beneath each chart compares FY 2010-11 against FY 2007-08.

The Budget Division notes a potential anomoly in the Support Level 7 Column of the Annualized Expenditures per Person table. The Division does not believe the data obtained to be faulty. Budget Staff will take a deeper look at this particular subset of data to determine what, if anything, may be responsible for any irregularity.

Beginning at the start of FY 2006-07 the reimbursement methodology began a transition from a block-grant quasi-managed care model to a fee-for-service model. Implementation took approximately two and a half years. SIS began in earnest in FY 2006-07, and also took approximately roughly one year to fully implement for clients under the HCBS-DD waiver, as these were considered high priority based on need.

Selected Per-Capita Services Utilization within HCBS-DD

Of the twelve services available in the HCBS-DD Waiver, four account for over 97% of the total expenditures. The information herein is based on client date of service within a given fiscal year for the following services:

- Residential Habilitation
- Non-emergency Transportation
- Supported Employment
- Day Habilitation

The charts show per-capita expenditures and service utilization (in terms of "units used"). The chart below represents the grand totals for the entire HCBS-DD Waiver. The four primary services are illustrated on the following pages.

In FY 2006-07, a transition began with the implementation of a new rate structure. For that reason, when comparing growth rates overall, this analysis begins with FY 2007-08.

HCBS-DD Waiver - Per-Capita Grand Total Expenditures

Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	$40,133	$47,910	$54,422	$60,166	$67,191	$76,073	$103,208	$57,356	$55,780
FY 2008-09	$36,067	$48,616	$56,733	$65,272	$74,216	$88,137	$74,111	$64,579	$59,202
FY 2009-10	$32,268	$48,346	$57,653	$68,603	$78,530	$96,475	$87,881	$51,211	$62,679
FY 2010-11	$31,704	$47,296	$56,557	$67,681	$77,350	$94,828	$95,731	$57,229	$62,847
Four Year % Growth	-21.00%	-1.28%	3.92%	12.49%	15.12%	24.65%	-7.25%	-0.22%	12.67%

Per-Capita HCBS-DD - Grand Total Units of Service

Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	3,442	4,530	4,656	4,559	4,575	4,148	3,565	3,943	4,339
FY 2008-09	3,740	4,965	5,036	4,953	4,982	4,479	3,437	4,432	4,746
FY 2009-10	3,874	5,020	5,162	5,176	5,197	4,894	3,822	3,387	4,933
FY 2010-11	4,193	5,187	5,424	5,526	5,523	5,143	4,602	3,098	5,220
Four Year % Growth	21.80%	14.51%	16.50%	21.20%	20.72%	23.97%	29.10%	-21.42%	20.31%

Appendix I

Residential Habilitation - Per-Capita Expenditures									
Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	$29,993	$34,896	$40,483	$45,389	$50,737	$59,760	$87,360	$43,767	$41,922
FY 2008-09	$26,362	$35,498	$42,328	$49,159	$55,547	$67,700	$61,339	$49,785	$44,250
FY 2009-10	$22,986	$35,159	$42,776	$51,402	$58,273	$72,195	$68,489	$40,108	$46,413
FY 2010-11	$21,850	$34,056	$41,277	$50,055	$56,377	$69,362	$71,766	$47,493	$45,763
Four Year % Growth	-27.15%	-2.41%	1.96%	10.28%	11.12%	16.07%	-17.85%	8.51%	9.16%

Per-Capita Residential Habilitation									
Support Level	1	2	3	4	5	6	7		Total
FY 2007-08	355	356	357	356	356	355	347	347	355
FY 2008-09	349	352	354	353	353	353	234	340	351
FY 2009-10	353	354	354	354	356	355	254	335	353
FY 2010-11	354	356	356	358	357	356	268	363	355
Four Year % Growth	-0.26%	0.07%	-0.27%	0.72%	0.22%	0.42%	-22.74%	4.63%	-0.01%

Residential Habilitation Services and Supports (RHSS) are designed to ensure the health, safety and welfare of the participant, and to assist in the acquisition, retention and/or improvement in skills necessary to support the participant to live and participate successfully in their community.

These services are individually planned and coordinated through the participant's Service Plan. The frequency, duration and scope of these services are determined by the participants needs identified in the Service Plan. These services may include a combination of lifelong - or extended duration - supervision, training and/or support which are essential to daily community living, including assessment and evaluation and the cost of training materials, transportation, fees and supplies.

Individual Residential Services and Supports (IRSS) in which three (3) or fewer participants receiving services may live in a single residential setting or in a host home setting. Group Residential Services and Supports (GRSS) encompass group living environments of four (4) to eight (8) participants receiving services who may live in a single residential setting which is licensed by the State as a Residential Care Facility/Residential Community Home.

Appendix I

Non-emergency Transportation - Per-Capita Expenditures

Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	$1,208	$1,648	$1,628	$1,614	$1,609	$1,431	$1,563	$1,337	$1,537
FY 2008-09	$1,028	$1,568	$1,584	$1,664	$1,715	$1,498	$943	$1,216	$1,521
FY 2009-10	$1,236	$2,065	$2,057	$2,127	$2,175	$1,931	$1,254	$625	$1,967
FY 2010-11	$1,315	$1,997	$2,046	$2,048	$2,168	$1,976	$1,187	$220	$1,954
Four Year % Growth	8.83%	21.15%	25.66%	26.90%	34.78%	38.10%	-24.04%	-83.52%	27.18%

Per-Capita Non-emergency Transportation

Support Level	1	2	3	4	5	6	7		Total
FY 2007-08	127	158	158	160	155	143	132	134	151
FY 2008-09	170	237	239	262	261	232	124	159	234
FY 2009-10	171	257	263	281	279	255	150	101	254
FY 2010-11	186	261	272	277	285	264	145	41	260
Four Year % Growth	46.42%	65.34%	71.90%	72.47%	84.28%	84.98%	10.07%	-69.22%	72.72%

Non-Emergency Transportation Services (N-et) are services offered in order to enable waiver participants to gain access to day habilitation and supported employment services as specified by the Service Plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them.

Transportation services under the waiver are offered in accordance with the participant's Service Plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge are utilized.

Appendix I

Supported Employment - Per-Capita Expenditures

Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	$2,522	$1,525	$702	$566	$720	$684	$759	$1,013	$1,168
FY 2008-09	$2,498	$1,551	$796	$639	$742	$802	$290	$589	$1,189
FY 2009-10	$2,302	$1,519	$830	$772	$798	$1,067	$177	$218	$1,177
FY 2010-11	$2,469	$1,568	$1,008	$799	$787	$1,276	$180	$0	$1,243
Four Year % Growth	-2.13%	2.86%	43.57%	41.26%	9.36%	86.47%	-76.33%	-100.00%	6.39%

Per-Capita Supported Employment

Support Level	1	2	3	4	5	6	7		Total
FY 2007-08	528	355	160	132	158	166	169	230	262
FY 2008-09	536	373	175	129	142	134	56	94	259
FY 2009-10	541	390	193	147	129	154	21	67	257
FY 2010-11	628	418	242	164	132	189	39	0	282
Four Year % Growth	18.94%	18.03%	51.24%	24.47%	-16.47%	13.83%	-76.60%	-100.00%	7.34%

Supported Employment services consists of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. Supported employment is conducted in a variety of settings in which participants interact with non-disabled individuals (other than those individuals who are providing services to the participant) to the same extent that individuals employed in comparable positions would interact. Persons must be involved in work outside of a base site. Included are persons in community jobs, in enclaves, and on mobile crews. Supported employment includes activities needed to sustain paid work by participants, including supervision and training.

Appendix I

Day Habilitation - Per-Capita Expenditures

Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	$5,131	$8,722	$10,458	$11,163	$12,540	$12,054	$9,922	$9,839	$9,775
FY 2008-09	$4,759	$8,616	$10,688	$12,214	$14,472	$15,699	$7,838	$10,641	$10,640
FY 2009-10	$4,491	$8,389	$10,696	$12,818	$15,684	$18,623	$14,457	$8,176	$11,583
FY 2010-11	$4,739	$8,394	$10,780	$12,883	$16,234	$19,793	$19,272	$7,388	$12,201
Four Year % Growth	-7.64%	-3.77%	3.08%	15.41%	29.46%	64.20%	94.23%	-24.91%	24.82%

Per-Capita Day Habilitation

Support Level	1	2	3	4	5	6	7		Total
FY 2007-08	1,795	3,121	3,463	3,407	3,456	2,935	2,278	2,768	3,043
FY 2008-09	1,746	3,067	3,433	3,459	3,530	3,026	1,549	2,583	3,063
FY 2009-10	1,824	3,128	3,504	3,616	3,695	3,226	2,386	2,173	3,217
FY 2010-11	2,010	3,238	3,668	3,766	3,933	3,494	3,109	1,904	3,421
Four Year % Growth	11.96%	3.76%	5.89%	10.54%	13.80%	19.04%	36.44%	-31.20%	12.44%

Day Habilitation includes assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. These services are individually coordinated through the person's Service Plan.

- Specialized Habilitation (SH) services focus on enabling the participant to attain his or her maximum functional level, or to be supported in such a manner, which allows the person to gain an increased level of self-sufficiency. Such services include assistance with self-feeding, toileting, self-care, sensory stimulation and integration, self-sufficiency, maintenance skills, and supervision.

- Supported Community Connection supports the abilities and skills necessary to enable the participant to access typical activities and functions of community life such as those chosen by the general population, including community education or training, retirement and volunteer activities. These types of services may include socialization, adaptive skills and personnel to accompany and support the participant in community settings, resources necessary for participation in activities and supplies related to skill acquisition, retention or improvement.

Appendix I

Total Units of Service Data

Residential Habilitation

Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	177,357	360,545	219,168	175,706	197,183	113,993	9,069	85,810	1,338,831
FY 2008-09	184,367	365,953	242,754	204,328	221,717	137,554	9,602	4,764	1,371,039
FY 2009-10	173,848	346,892	254,954	232,182	256,286	171,201	11,502	1,591	1,448,456
FY 2010-11	164,395	330,441	256,964	244,116	275,267	189,976	15,597	756	1,477,512
Four Year % Growth	-7.31%	-8.35%	17.25%	38.93%	39.60%	66.66%	71.98%	-99.12%	10.36%

Non-emergency Transportation

Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	63,406	160,158	97,259	79,310	85,840	45,842	3,445	33,187	568,447
FY 2008-09	89,465	246,144	164,319	151,691	163,829	90,474	5,090	2,229	913,241
FY 2009-10	84,446	251,473	189,636	184,193	200,860	122,586	6,790	479	1,040,463
FY 2010-11	86,281	242,522	196,554	188,688	220,345	140,731	8,441	86	1,083,648
Four Year % Growth	36.08%	51.43%	102.09%	137.91%	156.69%	206.99%	145.02%	-99.74%	90.63%

Supported Employment

Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	263,906	359,435	98,184	65,204	87,717	53,362	4,410	56,991	989,209
FY 2008-09	282,966	387,552	120,010	74,601	89,452	52,174	2,277	1,319	1,010,351
FY 2009-10	266,616	381,934	138,640	96,082	92,499	74,316	930	317	1,051,334
FY 2010-11	291,707	388,530	174,578	111,955	102,056	100,808	2,297	0	1,171,931
Four Year % Growth	10.53%	8.09%	77.81%	71.70%	16.35%	88.91%	-47.91%	-100.00%	18.47%

Day Habilitation

Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	897,446	3,163,572	2,128,020	1,683,684	1,915,131	943,341	59,620	684,727	11,475,541
FY 2008-09	921,241	3,183,852	2,356,339	2,002,488	2,216,304	1,178,253	63,520	36,160	11,958,157
FY 2009-10	898,518	3,065,004	2,521,921	2,370,164	2,657,906	1,554,097	107,966	10,323	13,185,899
FY 2010-11	933,769	3,006,282	2,649,252	2,567,419	3,035,839	1,863,685	181,078	3,967	14,241,291
Four Year % Growth	4.05%	-4.97%	24.49%	52.49%	58.52%	97.56%	203.72%	-99.42%	24.10%

Appendix I

Total Expenditure Data

HCBS-DD Waiver - Total Expenditures

Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	$20,066,263	$48,568,312	$33,437,567	$29,731,803	$37,234,874	$24,451,231	$2,700,614	$14,190,926	$210,381,590
FY 2008-09	$19,031,351	$50,475,856	$38,942,164	$37,787,216	$46,595,396	$34,322,132	$3,038,556	$904,111	$231,096,783
FY 2009-10	$15,894,732	$47,370,741	$41,495,863	$44,963,534	$56,489,546	$46,468,883	$3,976,625	$243,254	$256,903,178
FY 2010-11	$14,731,736	$43,910,686	$40,853,187	$46,135,920	$59,707,703	$50,582,725	$5,576,306	$119,228	$261,617,490
Four Year % Growth	-26.58%	-9.59%	22.18%	55.17%	60.35%	106.87%	106.48%	-99.16%	24.35%

Residential Habilitation

Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	$14,996,474	$35,375,553	$24,873,247	$22,429,798	$28,116,896	$19,207,943	$2,285,916	$10,828,574	$158,114,401
FY 2008-09	$13,910,535	$36,855,340	$29,054,305	$28,458,853	$34,874,505	$26,363,568	$2,514,914	$696,993	$172,729,013
FY 2009-10	$11,322,567	$34,449,564	$30,788,243	$33,689,902	$41,918,022	$34,773,739	$3,099,135	$190,511	$190,231,683
FY 2010-11	$10,153,109	$31,617,885	$29,815,470	$34,120,584	$43,518,668	$36,998,831	$4,180,343	$98,944	$190,503,834
Four Year % Growth	-32.30%	-10.62%	19.87%	52.12%	54.78%	92.62%	82.87%	-99.09%	20.48%

Non-emergency Transportation

Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	$604,125	$1,670,638	$1,000,300	$797,478	$891,446	$460,005	$40,899	$330,866	$5,795,758
FY 2008-09	$542,191	$1,627,649	$1,086,972	$963,085	$1,076,447	$583,290	$38,645	$17,026	$5,935,305
FY 2009-10	$608,687	$2,023,170	$1,480,840	$1,394,050	$1,564,381	$930,105	$56,743	$2,971	$8,060,948
FY 2010-11	$611,021	$1,853,635	$1,477,722	$1,395,965	$1,673,560	$1,054,254	$69,162	$459	$8,135,778
Four Year % Growth	1.14%	10.95%	47.73%	75.05%	87.74%	129.18%	69.10%	-99.86%	40.37%

Supported Employment

Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	$1,261,140	$1,545,658	$431,552	$279,577	$398,770	$219,892	$19,859	$250,527	$4,406,974
FY 2008-09	$1,318,307	$1,610,662	$546,252	$369,673	$465,723	$312,236	$11,908	$8,248	$4,643,009
FY 2009-10	$1,134,072	$1,488,406	$597,645	$506,147	$574,303	$513,758	$8,013	$1,033	$4,823,378
FY 2010-11	$1,147,102	$1,456,051	$728,383	$544,783	$607,473	$680,470	$10,462	$0	$5,174,723
Four Year % Growth	-9.04%	-5.80%	68.78%	94.86%	52.34%	209.46%	-47.32%	-100.00%	17.42%

Day Habilitation

Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	$2,565,407	$8,842,241	$6,425,817	$5,516,163	$6,949,252	$3,874,512	$259,634	$2,434,328	$36,867,354
FY 2008-09	$2,510,955	$8,945,863	$7,336,305	$7,070,657	$9,086,040	$6,113,503	$321,357	$148,979	$41,533,659
FY 2009-10	$2,212,236	$8,219,476	$7,698,686	$8,401,313	$11,281,717	$8,970,143	$654,172	$38,837	$47,476,578
FY 2010-11	$2,201,900	$7,793,046	$7,787,064	$8,781,817	$12,531,105	$10,558,170	$1,122,600	$15,392	$50,791,094
Four Year % Growth	-14.17%	-11.87%	21.18%	59.20%	80.32%	172.50%	332.38%	-99.37%	37.77%

Appendix I

Effective Cost (Expenditure)/Unit (e.g. Day, 15 minutes, etc.)

Residential Habilitation

Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	$84.56	$98.12	$113.49	$127.66	$142.59	$168.50	$252.06	$126.19	$118.10
FY 2008-09	$75.45	$100.71	$119.69	$139.28	$157.29	$191.66	$261.92	$146.30	$125.98
FY 2009-10	$65.13	$99.31	$120.76	$145.10	$163.56	$203.12	$269.44	$119.74	$131.33
FY 2010-11	$61.76	$95.68	$116.03	$139.77	$158.10	$194.76	$268.02	$130.88	$128.94
Four Year % Growth	-26.96%	-2.48%	2.24%	9.49%	10.87%	15.58%	6.33%	3.71%	9.18%

Non-emergency Transportation

Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	$9.53	$10.43	$10.28	$10.06	$10.38	$10.03	$11.87	$9.97	$10.20
FY 2008-09	$6.06	$6.61	$6.62	$6.35	$6.57	$6.45	$7.59	$7.64	$6.50
FY 2009-10	$7.21	$8.05	$7.81	$7.57	$7.79	$7.59	$8.36	$6.20	$7.75
FY 2010-11	$7.08	$7.64	$7.52	$7.40	$7.60	$7.49	$8.19	$5.34	$7.51
Four Year % Growth	-25.67%	-26.73%	-26.90%	-26.42%	-26.86%	-25.35%	-30.98%	-46.44%	-26.36%

Supported Employment

Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	$4.78	$4.30	$4.40	$4.29	$4.55	$4.12	$4.50	$4.40	$4.46
FY 2008-09	$4.66	$4.16	$4.55	$4.96	$5.21	$5.98	$5.23	$6.25	$4.60
FY 2009-10	$4.25	$3.90	$4.31	$5.27	$6.21	$6.91	$8.62	$3.26	$4.59
FY 2010-11	$3.93	$3.75	$4.17	$4.87	$5.95	$6.75	$4.55	N/A	$4.42
Four Year % Growth	-17.71%	-12.85%	-5.08%	13.49%	30.93%	63.81%	1.14%	N/A	-0.89%

Day Habilitation

Support Level	1	2	3	4	5	6	7	Unassigned	Total
FY 2007-08	$2.86	$2.80	$3.02	$3.28	$3.63	$4.11	$4.35	$3.56	$3.21
FY 2008-09	$2.73	$2.81	$3.11	$3.53	$4.10	$5.19	$5.06	$4.12	$3.47
FY 2009-10	$2.46	$2.68	$3.05	$3.54	$4.24	$5.77	$6.06	$3.76	$3.60
FY 2010-11	$2.36	$2.59	$2.94	$3.42	$4.13	$5.67	$6.20	$3.88	$3.57
Four Year % Growth	-17.51%	-7.25%	-2.66%	4.40%	13.76%	37.93%	42.36%	9.14%	11.01%

Appendix I

The Supported Living Services waiver (HCBS-SLS) is primarily designed to serve adults with developmental disabilities who are capable of living in the community with some support.

The Support Level is a scale ranging from one to seven, representing an escalating level of disability need. The Support Level is based upon an algorithim calculated based upon an evaluation (Supports Intensity Scale, or SIS) along with other unique factors such as extreme danger to self and community safety.

The SIS is an evaluative tool used by Case Managers in one-to-one settings to assess the needs of an individual waiver client. This tool is comprised of approximately 40 questions covering a wide range of issues related to developmental disability needs determination. The Support Level is a numerical representation of the services and support a given client requires, as well as the rate structure associated with the reimbursement for those services. Support level 1 represents the lowest support needs and support level 7 represents the highest.

The SIS was first implemented as the designated scoring tool in 2006. As a result, many clients did not have scores at the outset, as the assessment tool required person-to-person interaction.

HCBS-SLS Waiver Utilization by Support Level

Total Annual Expenditures

Support Level	1	2	3	4	5	6	7	Unk	Total	$ Increase vs. Prior Year	% Increase vs. Prior
FY 2006-07	$68	$15,945	$0	$0	$15,908	$0	$0	$36,706,092	$36,738,013	NA	NA
FY 2007-08	$2,589,436	$1,839,211	$797,433	$509,022	$601,237	$576,411	$0	$32,760,049	$39,672,799	$2,934,786	7.99%
FY 2008-09	$14,148,247	$12,406,121	$4,538,664	$3,223,283	$3,864,046	$3,683,337	$0	$4,069,299	$45,932,998	$6,260,198	15.78%
FY 2009-10	$9,510,960	$9,779,421	$4,189,591	$3,013,830	$4,810,334	$4,437,600	$0	$17,948	$35,759,683	-$10,173,315	-22.15%
FY 2010-11	$8,966,306	$9,054,397	$3,720,232	$3,117,707	$5,278,075	$4,699,239	$13,840	$909	$34,850,706	-$908,977	-2.54%
Three Year Growth %	-36.63%	-27.02%	-18.03%	-3.28%	36.59%	27.58%		-99.98%	-24.13%		

Annualized Expenditures per Person

Support Level	1	2	3	4	5	6	7	Unk	Total	$ Increase vs. Prior Year	% Increase vs. Prior
FY 2006-07	$818	$17,394	$0	$0	$31,816	$0	$0	$13,076	$13,081	NA	NA
FY 2007-08	$11,905	$16,005	$18,911	$18,795	$21,346	$19,539	$0	$13,890	$14,079	$999	7.63%
FY 2008-09	$12,420	$17,177	$20,194	$19,887	$22,389	$20,378	$0	$14,060	$15,888	$1,809	12.85%
FY 2009-10	$8,031	$11,717	$14,949	$15,228	$19,299	$21,664	$0	$8,615	$12,109	-$3,780	-23.79%
FY 2010-11	$7,766	$10,891	$13,115	$14,081	$18,503	$20,461	$20,761	$5,454	$11,591	-$518	-4.28%
Three Year Growth %	-37.47%	-36.59%	-35.06%	-29.19%	-17.36%	0.41%		-61.21%	-27.05%		

Appendix I

Clients Served (FTE)

Support Level	1	2	3	4	5	6	7	Unk	Total	Increase vs. Prior Year	% Increase vs. Prior
FY 2006-07	0.1	0.9	0.0	0.0	0.5	0.0	0.0	2807.1	2808.6	NA	NA
FY 2007-08	217.5	114.9	42.2	27.1	28.2	29.5	0.0	2358.5	2817.8	9	0.33%
FY 2008-09	1139.2	722.3	224.8	162.1	172.6	180.8	0.0	289.4	2891.0	73	2.60%
FY 2009-10	1184.3	834.7	280.3	197.9	249.3	204.8	0.0	2.1	2953.3	62	2.15%
FY 2010-11	1154.6	831.3	283.7	221.4	285.3	229.7	0.7	0.2	3006.8	53	1.81%
Three Year Growth %	1.35%	15.10%	26.21%	36.61%	65.28%	27.06%		-99.94%	4.00%		

Clients in Support Level as Percentage of All Clients with Known Levels

Support Level	1	2	3	4	5	6	7		Total
FY 2006-07	5.56%	61.11%	0.00%	0.00%	33.33%	0.00%	0.00%		100.00%
FY 2007-08	47.35%	25.02%	9.18%	5.90%	6.13%	6.42%	0.00%		100.00%
FY 2008-09	43.79%	27.76%	8.64%	6.23%	6.63%	6.95%	0.00%		100.00%
FY 2009-10	40.13%	28.28%	9.50%	6.71%	8.45%	6.94%	0.00%		100.00%
FY 2010-11	38.40%	27.65%	9.43%	7.36%	9.49%	7.64%	0.02%		100.00%
Three Year Growth %	-12.30%	-0.40%	9.21%	18.21%	43.02%	9.95%			

FOOTNOTES: Client counts are annualized based upon unique clients served per month.

The data presented is based upon the date services were provided (as opposed to payment date)

SPECIAL NOTES:

The Supports Intensity Scale for determining Support Levels of service was introduced in 2006. Many clients in FY 2006-07 were not assessed until later, thereby creating a high percentage of "Unknowns" for the first two years of implementation, both for expenditures and FTE client counts. For this reason, the Growth % shown beneath each chart compares FY 2010-11 against FY 2008-09.

Beginning at the start of FY 2006-07 the reimbursement methodology began a transition from a block-grant quasi-managed care model to a fee-for-service model. Implementation took approximately two and a half years. SIS began in earnest in FY 2006-07, and also took approximately two years to fully implement, as clients under the HCBS-DD waiver were considered higher priority based on need.

Appendix I

The Children's Extensive Service waiver (HCBS-CES) provides various services for children who require nearly 24-hour supervision.

Clients under the HCBS-CES Waiver do not utilize SIS for assessing needs levels.

The data presented is based upon the date services were provided (as opposed to payment date)

HCBS-CES Waiver Utilization

Total Annual Expenditures

	Total	$ Increase vs. Prior Year	% Increase vs. Prior Year
FY 2006-07	$4,771,089	NA	NA
FY 2007-08	$5,897,406	$1,126,317	23.61%
FY 2008-09	$6,972,805	$1,075,399	18.24%
FY 2009-10	$7,061,819	$89,014	1.28%
FY 2010-11	$7,329,416	$267,597	3.79%
Five Year Growth %	53.62%		

Annualized Expenditures per Person

Support Level	Total	$ Increase vs. Prior Year	% Increase vs. Prior Year
FY 2006-07	$13,893	NA	NA
FY 2007-08	$15,754	$1,861	13.40%
FY 2008-09	$18,426	$2,672	16.96%
FY 2009-10	$18,354	-$72	-0.39%
FY 2010-11	$19,694	$1,340	7.30%
Five Year Growth %	41.75%		

Clients Served (FTE)

Support Level	Total	$ Increase vs. Prior Year	% Increase vs. Prior Year
FY 2006-07	343.4	NA	NA
FY 2007-08	374.3	31	9.00%
FY 2008-09	378.4	4	1.09%
FY 2009-10	384.8	6	1.67%
FY 2010-11	372.2	-13	-3.27%
Five Year Growth %	8.37%		

FOOTNOTES: Client counts are annualized based upon unique clients served per month.

Beginning at the start of FY 2006-07 the reimbursement methodology began a transition from a block-grant quasi-managed care model to a fee-for-service model. Implementation took approximately two and a half years.

Appendix I

Targeted Case Management (TCM) is primarily designed to serve adults with developmental disabilities who are capable of living in the community with some support.

The Support Level is a scale ranging from one to seven, representing an escalating level of disability need. The Support Level is based upon an algorithim calculated based upon an evaluation (Supports Intensity Scale, or SIS) along with other unique factors such as extreme danger to self and community safety.

The SIS is an evaluative tool used by Case Managers in one-to-one settings to assess the needs of an individual waiver client. This tool is comprised of approximately 40 questions covering a wide range of issues related to developmental disability needs determination. The Support Level is a numerical representation of the services and support a given client requires, as well as the rate structure associated with the reimbursement for those services. Support level 1 represents the lowest support needs and support level 7 represents the highest.

The SIS was first implemented as the designated scoring tool in 2006. As a result, many clients did not have scores at the outset, as the assessment tool required person-to-person interaction.

Targeted Case Management Expenditures by Support Level

Total Annual Expenditures

Support Level	1	2	3	4	5	6	7	Unk	Total	$ Increase vs. Prior Year	% Increase vs. Prior
FY 2006-07	$233,049	$471,284	$276,045	$229,034	$286,585	$167,969	$10,707	$12,410,149	$14,084,822	NA	NA
FY 2007-08	$1,436,508	$2,273,111	$1,321,212	$1,046,306	$1,172,297	$712,990	$141,274	$6,654,960	$14,758,658	$673,836	4.78%
FY 2008-09	$3,564,353	$3,748,516	$1,942,689	$1,587,227	$1,725,623	$1,238,247	$520,718	$3,044,173	$17,371,547	$2,612,889	17.70%
FY 2009-10	$3,659,418	$3,846,550	$2,274,585	$2,079,613	$2,311,804	$1,704,373	$441,850	$3,073,815	$19,392,008	$2,020,462	11.63%
FY 2010-11	$3,713,065	$3,894,915	$2,407,937	$2,277,549	$2,642,187	$2,012,035	$398,331	$3,471,088	$20,817,107	$1,425,098	7.35%
Three Year Growth %	4.17%	3.91%	23.95%	43.49%	53.11%	62.49%	-23.50%	14.02%	19.83%		

Annualized Expenditures per Person

Support Level	1	2	3	4	5	6	7	Unk	Total	$ Increase vs. Prior Year	% Increase vs. Prior
FY 2006-07	$2,006	$2,008	$2,006	$2,008	$2,008	$2,008	$2,008	$2,007	$2,007	NA	NA
FY 2007-08	$2,037	$2,038	$2,038	$2,038	$2,038	$2,036	$2,033	$2,034	$2,036	$29	1.42%
FY 2008-09	$2,132	$2,131	$2,132	$2,135	$2,133	$2,136	$2,144	$2,108	$2,128	$92	4.54%
FY 2009-10	$2,198	$2,159	$2,314	$2,490	$2,424	$2,500	$2,106	$1,519	$2,123	-$5	-0.24%
FY 2010-11	$2,319	$2,260	$2,451	$2,585	$2,556	$2,699	$2,376	$1,574	$2,229	$106	4.98%
Three Year Growth %	8.81%	6.09%	14.95%	21.09%	19.86%	26.40%	10.79%	-25.32%	4.73%		

Appendix I

Clients Served (FTE)

Support Level	1	2	3	4	5	6	7	Unk	Total	Increase vs. Prior Year	% Increase vs. Prior
FY 2006-07	116.2	234.7	137.6	114.1	142.8	83.7	5.3	6182.1	7016.3	NA	NA
FY 2007-08	705.3	1115.5	648.4	513.5	575.2	350.3	69.5	3271.4	7249.0	233	3.32%
FY 2008-09	1672.1	1759.4	911.1	743.5	809.2	579.8	242.8	1443.8	8161.7	913	12.59%
FY 2009-10	1664.8	1781.4	983.1	835.2	953.6	681.8	209.8	2023.0	9132.7	971	11.90%
FY 2010-11	1600.8	1723.3	982.4	881.1	1033.7	745.4	167.7	2204.6	9338.9	206	2.26%
Three Year Growth %	-4.26%	-2.06%	7.83%	18.50%	27.74%	28.56%	-30.95%	52.69%	14.42%		

Clients in Support Level as Percentage of All Clients with Known Levels

Support Level	1	2	3	4	5	6	7		Total
FY 2006-07	13.92%	28.13%	16.49%	13.67%	17.11%	10.03%	0.64%		100.00%
FY 2007-08	17.73%	28.04%	16.30%	12.91%	14.46%	8.81%	1.75%		100.00%
FY 2008-09	24.89%	26.19%	13.56%	11.07%	12.04%	8.63%	3.61%		100.00%
FY 2009-10	23.42%	25.06%	13.83%	11.75%	13.41%	9.59%	2.95%		100.00%
FY 2010-11	22.44%	24.15%	13.77%	12.35%	14.49%	10.45%	2.35%		100.00%
Three Year Growth %	-9.85%	-7.77%	1.54%	11.59%	20.29%	21.05%	-34.98%		

FOOTNOTES: Client counts are annualized based upon unique clients served per month.

The data presented is based upon the date services were provided (as opposed to payment date)

SPECIAL NOTES: The Supports Intensity Scale for determining Support Levels of service was introduced in 2006. Many clients in FY 2006-07 were not assessed until later, thereby creating a high percentage of "Unknowns" for the first two years of implementation, both for expenditures and FTE client counts. For this reason, the Growth % shown beneath each chart compares FY 2010-11 against FY 2008-09.

Beginning at the start of FY 2006-07 the reimbursement methodology began a transition from a block-grant quasi-managed care model to a fee-for-service model. Implementation took approximately two and a half years. SIS began in earnest in FY 2006-07, and also took approximately two years to fully implement, as clients under the DD waiver were considered higher priority based on need.

The number of "unknowns" in early years of the data can be attributed in large part to the number of waiver clients who had not yet received SIS assessments. However, included in these unknowns is also the subset of Early Intervention (EI) children who are medicaid eligible. As the number of medicaid eligible children has increased in more recent years, due in part to implementation of the Early Intervention Services Trust in 2008 (SB 07-004), so has the number of "unknowns" in TCM.

Appendix D
Date-of-Payment versus Date-of-Service
An Overview

The charts on the following pages compare expenditures across fiscal years. The top chart on each page shows expenditures based on Date-of-Payment and the bottom chart uses a Date-of-Service methodology.

The data shows a much more logical pattern across fiscal years on the Date-of-Service graphs (bottom graph). As a helpful point of reference to illustrate the value of the Date-of-Service methodology, one only need look at expenditure patterns in the month of December where the pattern of services provided shows a clear and consistent reduction as providers closed operations during the holiday season. By contrast, one would be somewhat more hard-pressed to find as clear a pattern in the corresponding Date-of-Payment graph.

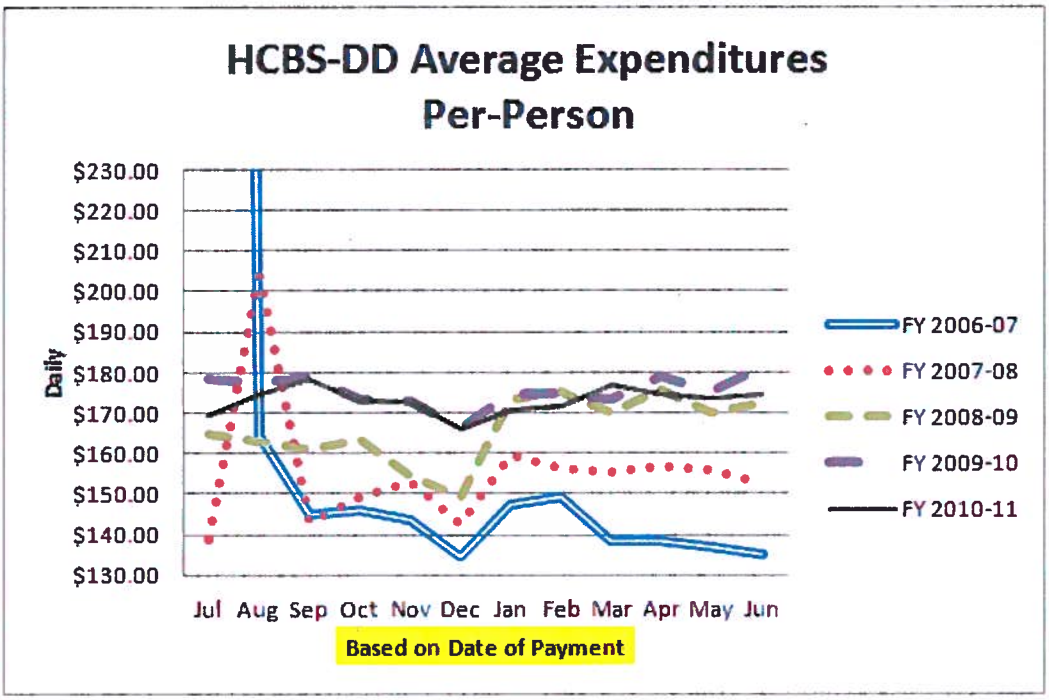
As a miscellaneous note – Targeted Case Management (Appendix D.5) was a flat rate before the second phase of implementation of the Support Level based fee-for-service reimbursement model went into effect in FY 2009-10. There was a one-time rate bump in January of 2009 (green line) that lasted for the remainder of the fiscal year. Beginning in FY 2009-10, a permanent rate structure based on 15 minute units of service went into effect. The graph clearly shows the impact this reimbursement methodology had on average monthly expenditures per person.

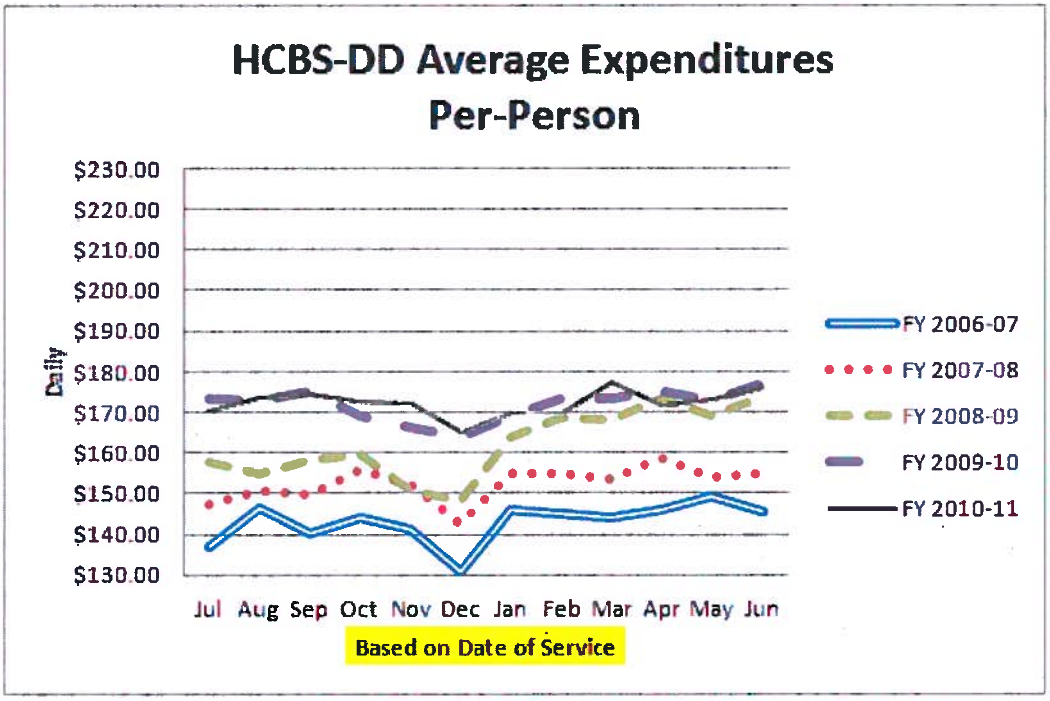
Delays in billing (see Date-of-Payment graphs) can distort the client service need and utilization data that, by contrast, can be seen in the Date-of-Service data. The limitations of Date-of-Payment are primarily twofold:

- Anomalies can occur frequently, yet are unique and are therefore incidental to assessing fundamental and valid cost drivers. Two recent specific examples are – a one-time adjustment to billing processes by a single service provider, which also shifted several million dollars, and the FY 2009-10 two-week payment delay which shifted several million dollars of expenditures into the next fiscal year. Although issues such as these impact fiscal expenditures, they are also matters of timing as opposed to utilization.
- Service Providers have 120 days to submit Medicaid claims. Claims are submitted by providers and paid by HCPF over a range of time that can easily span several months after the service was actually rendered. Business accounting procedures may be constructed in such a way as cause reimbursements to shift across business years, smooth reimbursements over several months, or for other purposes. While such strategies impact fiscal expenditures, they mask the underlying core driver – Client Service Utilization.

Appendix I

HCBS-DD
Date-of-Payment versus Date-of-Service Methodology

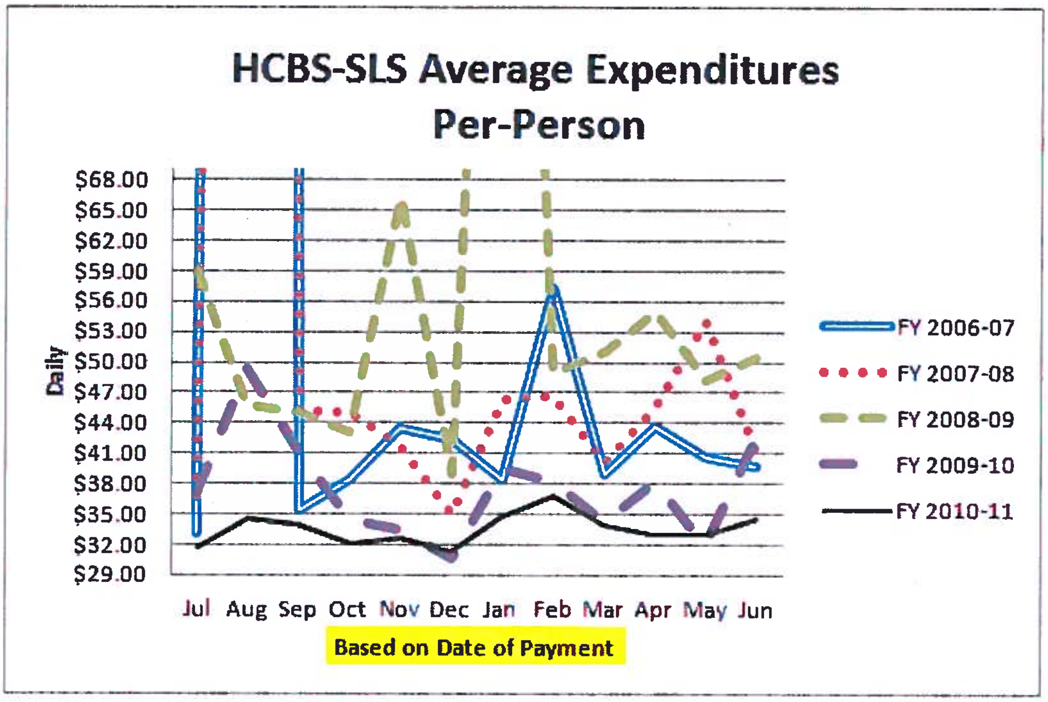


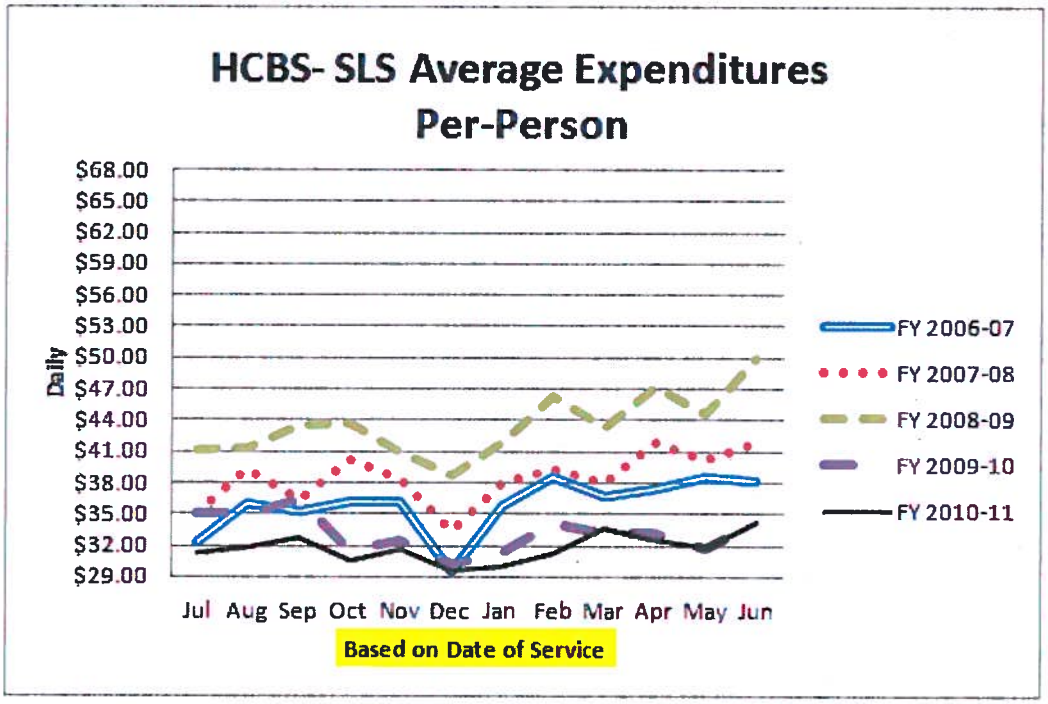


The graphs above are uniformly structured along the vertical and horizontal axis range for visual parity. While the top graph may occasionally appear to be missing data points, this is because those particular points are above the range of the chart axis range.

Appendix I

Supported Living Services (HCBS-SLS)
Date-of-Payment versus Date-of-Service Methodology

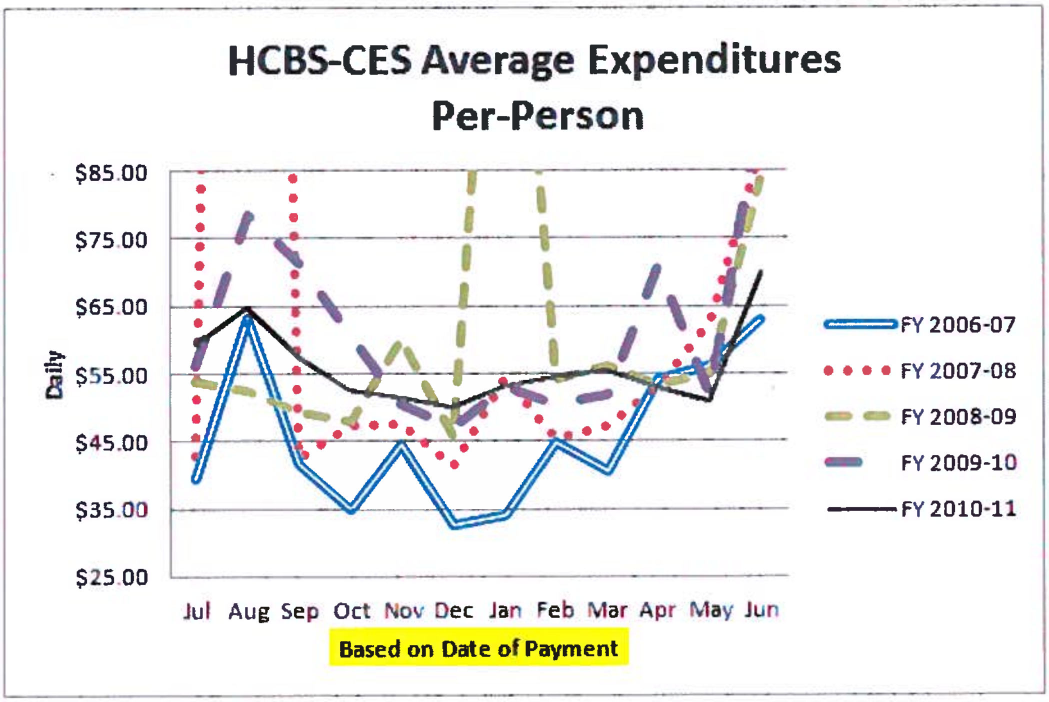


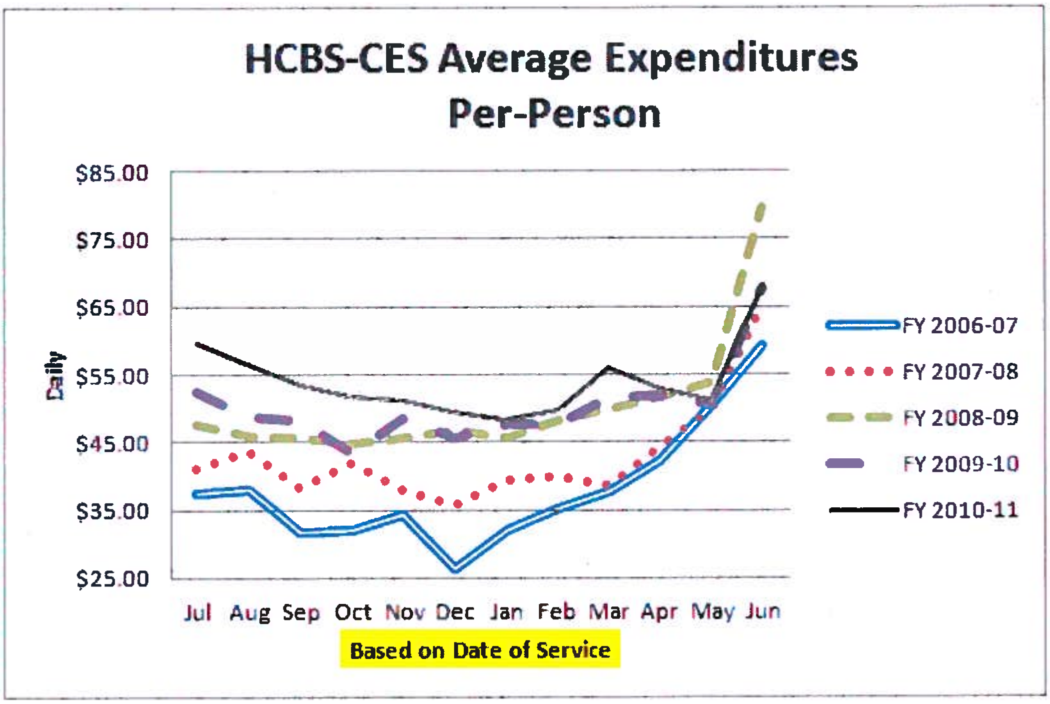


The graphs above are uniformly structured along the vertical and horizontal axis range for visual parity. While the top graph may occasionally appear to be missing data points, this is because those particular points are above the range of the chart axis range.

Appendix I

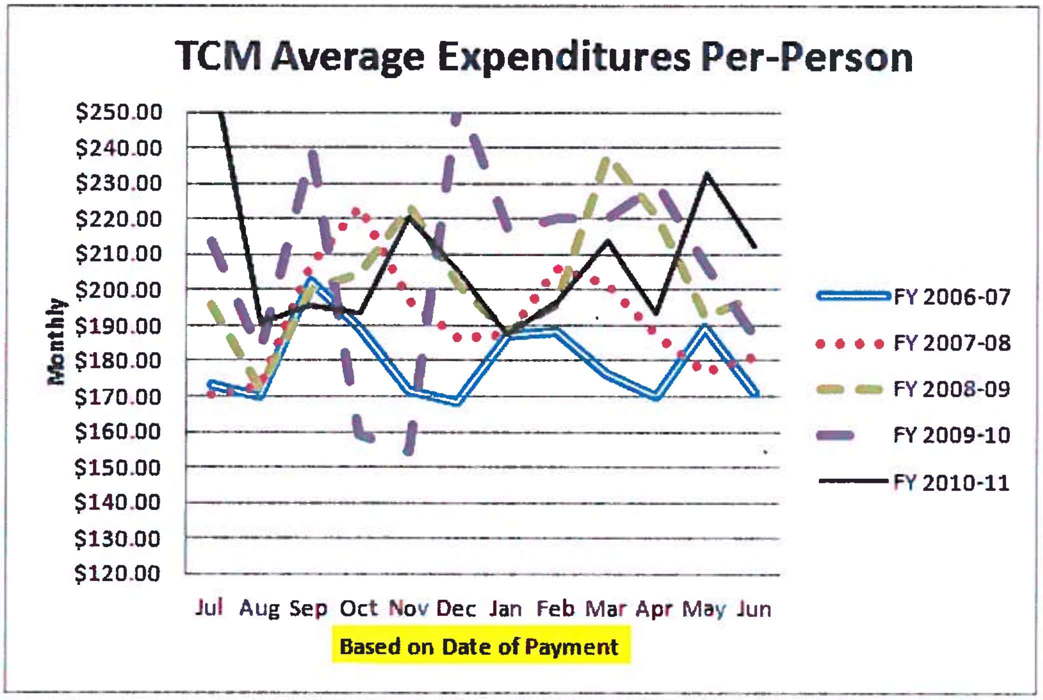
Children's Extensive Services (HCBS-CES) Date-of-Payment versus Date-of-Service Methodology

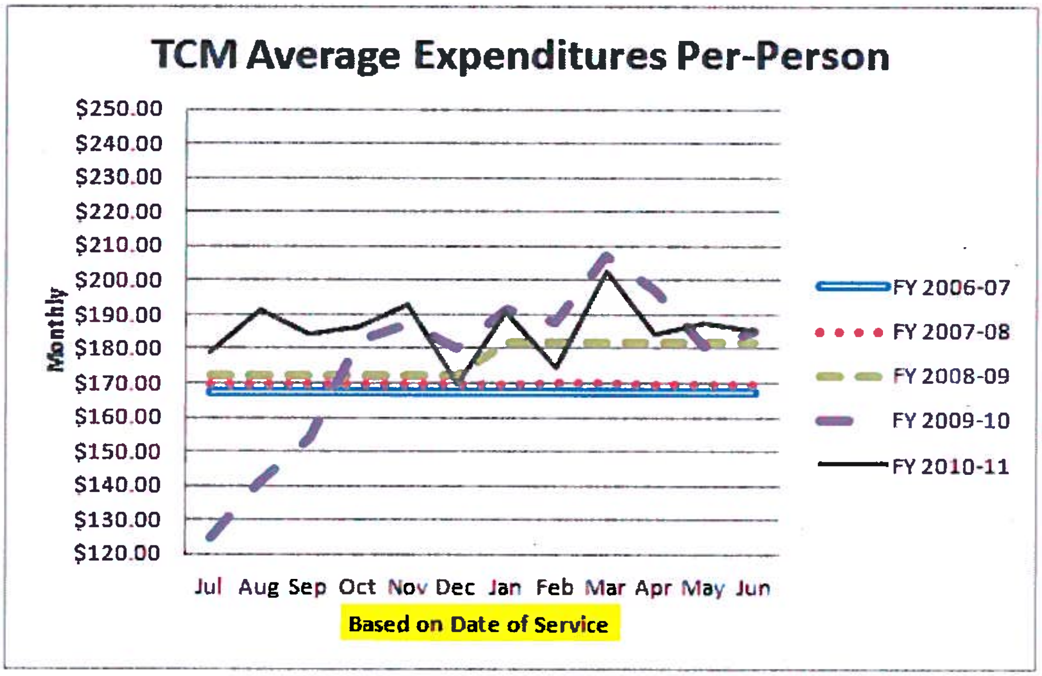




The graphs above are uniformly structured along the vertical and horizontal axis range for visual parity. While the top graph may occasionally appear to be missing data points, this is because those particular points are above the range of the chart axis range.

Targeted Case Management
Date-of-Payment versus Date-of-Service Methodology





The graphs above are uniformly structured along the vertical and horizontal axis range for visual parity. While the top graph may occasionally appear to be missing data points, this is because those particular points are above the range of the chart axis range.

<u>**Appendix I**</u>

Appendix E
Explanation of Waiver Services
Rate Information

The data and graphs on the following pages show the client counts for each service support level in the HCBS-DD waiver since incorporation of the Supports Intensity Scale (SIS) tool.

HCBS-DD – Services are aimed at adults who require extensive supports to live safely (including access to 24-hour supervision) and who do not have other sources for meeting those needs.

HCBS-DD Services

<u>Residential Habilitation Services and Supports:</u> Residential Habilitation Services and Supports (RHSS) are designed to ensure the health, safety and welfare of the participant, and to assist in the acquisition, retention and/or improvement in skills necessary to support the participant to live and participate successfully in their community. These services are individually planned and coordinated through the participants Service Plan. The frequency, duration and scope of these services are determined by the participants needs identified in the Service Plan. These services may include a combination of lifelong - or extended duration - supervision, training and/or support (i.e. support is any task performed for the participant, where learning is secondary or incidental to the task itself, or an adaptation is provided) which are essential to daily community living, including assessment and evaluation and the cost of training materials, transportation, fees and supplies. Reimbursement for RHSS does not include the cost of normal facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of participants or to meet the requirements of the applicable life safety code. Under Residential Habilitation Services and Supports the responsibility for the living environment rests with the service agency and encompasses two types of living environments:

- Individual Residential Services and Supports (IRSS) in which three (3) or fewer participants receiving services may live in a single residential setting or in a host home setting. The living environment does not require state licensure. However, the Division for Developmental Disabilities (DDD) must approve the service agencies to provide such services. Monitoring of IRSS services to individuals is the responsibility of CCB Case Managers and the monitoring of IRSS provider agencies is a DHS/DDD responsibility.
- Group Residential Services and Supports (GRSS) encompass group living environments of four (4) to eight (8) participants receiving services who may live in a single residential setting which is licensed by the State as a Residential Care Facility/Residential Community Home. All IRSS and GRSS settings are required to have staff available to meet the needs of the participant as defined in the Service Plan.

The following activities are performed by RHSS staff and are designed to assist participants. [illegible] reside as independently as possible in the community. 1. Self-advocacy training may include training to assist in expressing personal preferences, self-representation, self-protection from and reporting of abuse, neglect and exploitation, individual rights and to make increasingly responsible choices. 2. Independent living training may include personal care, household services, infant and childcare (for parents who have a developmental disability), and communication skills such as using the telephone. 3. Cognitive services may include training involving money management and personal finances, planning and decision making. 4. Implementation of recommended follow-up counseling, behavioral or other therapeutic interventions by residential staff, under the direction of a professional. Services are aimed at increasing the overall effective functioning of the participant. 5. Medical and health care services that are integral to meeting the daily needs of participants (e.g., routine administration of medications or tending to the needs of participants who are ill or require attention to their medical needs on an ongoing basis). 6. Emergency assistance training includes developing responses in case of emergencies; prevention planning and training in the use of equipment or technologies used to access emergency response systems. 7. Community access services that explore community services available to all people, natural supports available to the participant, and develop methods to access additional services/supports/activities needed by the participant. 8. Travel services may include providing, arranging, transporting, or accompanying the participant to services and supports identified in the Service Plan. 9. Supervision services which ensure the health and welfare of the participant and/or utilizing technology for the same purpose. All direct case staff not otherwise licensed to administer medications must complete a training class approved by the Colorado Department of Public Health and Environment, pass a written test and a practical/competency test.

Behavioral Services: Behavioral services identified in the Service Plan including individual and/or group counseling, behavioral interventions, diagnostic evaluations or consultations related to the individual's developmental disability and are needed for the individual to acquire or maintain appropriate interactions with others. Intervention modalities shall relate to an identified challenging behavior need of the person and specific criteria for remediation of the behavior must be established. The provider(s) will be identified in the Service Plan and will be at the minimum qualification level necessary to achieve the specific criteria for remediation. If an individual has a covered mental health diagnosis and is in need of covered mental health services, then those services must be accessed through the Medicaid State Plan. It is possible for people with co-occurring diagnoses of Developmental Disabilities and Covered Mental Health conditions to have identified needs that the Developmental Disabilities system can provide and identified needs that the Mental Health system provides.

Day Habilitation - Specialized Habilitation: Day Habilitation includes assistance with acquisition, retention or improvement in self help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement, except when due to medical and/or safety needs. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. These services are individually coordinated through the person's Service Plan. Specialized Habilitation (SH): services focus on enabling the participant to attain his or her maximum functional level, or to be supported in such a manner, which allows the person to gain an increased level of self-sufficiency. These services are generally provided in non-integrated settings where a majority of the persons have a disability, such as program sites and supervised work settings. Such services include assistance with self-feeding, toileting, self-care, sensory stimulation and integration, self-sufficiency, maintenance skills, and supervision. Specialized habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings and, where appropriate, are coordinated with any physical, occupational, or speech therapies listed in the Service Plan.

Day Habilitation – Supported Community Connection: Day Habilitation includes assistance with acquisition, retention or improvement in self help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement, except when due to medical and/or safety needs. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. These services are individually coordinated through the person's Service Plan. Supported Community Connection: supports the abilities and skills necessary to enable the participant to access typical activities and functions of community life such as those chosen by the general population, including community education or training, retirement and volunteer activities. Supported Community Connection provides a wide variety of opportunities to facilitate and build relationships and natural supports in the community, while utilizing the community as a learning environment to provide services and supports as identified in a participant's Service Plan. These activities are conducted in a variety of settings in which participants interact with non-disabled individuals (other than those individuals who are providing services to the participant). These types of services may include socialization, adaptive skills and personnel to accompany and support the participant in community settings, resources necessary for participation in activities and supplies related to skill acquisition, retention or improvement. Supported Community Connections may be provided in a group setting (or groups traveling together into the community) and/or may be provided on a one-to one basis as a learning environment to provide instruction when identified in the Service Plan.

Supported Employment: Supported Employment services consists of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. Supported employment may include assessment and identification of vocational interests and capabilities in preparation for job development, assisting the participant to locate a job or job development on behalf of the participant. Supported employment is conducted in a variety of settings in which participants interact with non-disabled individuals (other than those individuals who are providing services to the participant) to the same extent that individuals employed in comparable positions would interact. Persons must be involved in work outside of a base site. Included are persons in community jobs, in enclaves, and on mobile crews. Group employment (e.g. mobile crews and enclaves) shall not exceed eight persons. Supported employment includes activities needed to sustain paid work by participants, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities. This does not include payment for the supervisory activities rendered as a normal part of the business setting.

Transportation Services: Service offered in order to enable waiver participants to gain access to day habilitation and supported employment services as specified by the Service Plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's Service Plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge are utilized.

Specialized Medical Equipment and Supplies: 1. Devices, controls, or appliances that enable participants to increase their ability to perform activities of daily living. 2. Devices, controls, or appliances that enable the participant to perceive, control or communicate with the environment in which they live. 3. Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items. 4. Such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations; and, 5. Necessary medical supplies in excess of state plan limitation or not available under the State plan. Specialized Medical Equipment and Supplies are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

Dental: These services are provided only when the services are not available through the Medicaid State Plan due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at 8.011.11 or available through a third party resource. Dental services include periodic examination and diagnosis; radiographs when indicated; detection of all manifestations of systemic disease; elimination of infection or life threatening oral conditions, disease of bone and soft tissue of the oral cavity, oral cancer, or cellulites; treatment of injuries; restoration of decayed or fractured teeth; retention or recovery of space between teeth when indicated; and payment dental insurance. The cost of anesthesiology for dental procedures is not covered under the waiver. Dental services under the waiver are limited to the most cost effective and efficient means to alleviate or rectify the dental issues associated with the person.

Vision: These services are provided only when the services are not available through the Medicaid State Plan due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at 8.011.11 or available through a third party resource. Vision services are provided by a licensed Optometrist or physician and include eye exams and diagnosis, glasses, contacts, and other medically necessary methods used to improve specific dysfunctions of the vision systems. Lasik and other similar types of procedures are only prior approved and allowable when the procedure is necessary due to documented specific behavioral complexities (i.e. constant destruction of eye glasses) associated with the participant that make other more traditional remedies impractical.

Support Services for Adults – Services supplement already available supports for adults who either can live semi-independently with limited supports or who, if they need extensive support, are getting that support from other sources, such as their family.

HCBS-SLS Services

Home Accessibility Adaptations: Those physical adaptations to the primary residence of the participant's family, required by the participant's Service Plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. All adaptations shall be the most cost effective means to meet the identified need. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are of general utility (e.g., carpeting, roof repair, central air conditioning, etc.) and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Prior authorization is required for any adaptation adding square footage to a home. All devices and adaptations shall be provided in accordance with applicable State or local building codes and/or applicable standards of manufacturing, design and installation. Medicaid State Plan or third party resources shall be utilized prior to accessing waiver funds.

Homemaker – Basic: Services that consist of the performance of basic household tasks within the participant's primary residence (i.e., cleaning, laundry, or household care) including maintenance which are related to the participant's disability and provided by a qualified homemaker, when the parent or primary caretaker is unable to manage the home and care for the participant in the home. This assistance must be due to the participant's disability that results in additional household tasks and increases the parent/caregiver's ability to provide care needed by the participant. This assistance may take the form of hands-on assistance (actually performing a task for the participant) or cuing to prompt the participant to perform a task.

Homemaker – Enhanced: Services provided by a qualified homemaker that consist of the same household tasks as described under Basic Homemaker services with the addition of either habilitation or extraordinary cleaning. Habilitation includes direct training and instruction to the participant, which is more than basic cuing to prompt the participant to perform a task. Habilitation shall include a training program with specific objectives and anticipated outcomes. There may be some amount of incidental basic homemaker services that is provided in combination with enhanced

homemaker services; however, the primary intent must be to provide habilitative services to increase independence of the participant.
Habilitation may include some hands-on assistance (actually performing a task for the participant) or cuing to prompt the participant to perform a task, only when such support is incidental to the habilitative services being provided and the primary duties must be to provide habilitative services to increase independence of the participant. Enhanced Homemaker services also include the need for extraordinary cleaning as a result of the participant's behavioral or medical needs.

Behavioral Services: Behavioral services identified in the Service Plan including individual and/or group counseling, behavioral interventions, diagnostic evaluations or consultations related to the individual's developmental disability and are needed for the individual to acquire or maintain appropriate interactions with others. Intervention modalities shall relate to an identified challenging behavior need of the person and specific criteria for remediation of the behavior must be established. The provider(s) will be identified in the Service Plan and will be at the minimum qualification level necessary to achieve the specific criteria for remediation. If an individual has a covered mental health diagnosis and is in need of covered mental health services, then those services must be accessed through the Medicaid State Plan. It is possible for people with co-occurring diagnoses of Developmental Disabilities and Covered Mental Health conditions to have identified needs that the Developmental Disabilities system can provide and identified needs that the Mental Health system provides.

Day Habilitation- Specialized Habilitation: Day Habilitation includes assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement, except when due to medical and/or safety needs. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. These services are individually coordinated through the person's Service Plan. Specialized habilitation (SH) services focus on enabling the participant to attain his or her maximum functional level, or to be supported in such a manner, which allows the person to gain an increased level of self-sufficiency. These services are generally provided in non-integrated settings where a majority of the persons have a disability, such as program sites and supervised work settings. Such services include assistance with self-feeding, toileting, self-care, sensory stimulation and integration, self-sufficiency, maintenance skills, and supervision. Specialized habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings and, where appropriate, are coordinated with any physical, occupational, or speech therapies listed in the Service Plan.

Day Habilitation – Supported Community Connection: Day Habilitation includes assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement, except when due to medical and/or safety needs. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. These services are individually coordinated through the person's Service Plan. Supported Community Connection supports the abilities and skills necessary to enable the participant to access typical activities and functions of community life such as those chosen by the general population, including community education or training, retirement and volunteer activities. Supported Community Connection provides a wide variety of opportunities to facilitate and build relationships and natural supports in the community, while utilizing the community as a learning environment to provide services and supports as identified in a participant's Service Plan. These activities are conducted in a variety of settings in which participants interact with non-disabled individuals (other than those individuals who are providing services to the participant). These types of services may include socialization, adaptive skills and personnel to accompany and support the participant in community settings, resources necessary for participation in activities and supplies related to skill acquisition, retention or improvement. Supported Community Connections may be provided in a group setting (or groups traveling together into the community) and/or may be provided on a one-to-one basis as a learning environment to provide instruction when identified in the Service Plan.

Supported Employment: Supported Employment services consists of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. Supported employment may include assessment and identification of vocational interests and capabilities in preparation for job development, assisting the participant to locate a job or job development on behalf of the participant. Supported employment is conducted in a variety of settings in which participants interact with non-disabled individuals (other than those individuals who are providing services to the participant) to the same extent that individuals employed in comparable positions would interact. Persons must be involved in work outside of a base site. Included are persons in community jobs, in enclaves, and on mobile crews. Group employment (e.g. mobile crews and enclaves) shall not exceed eight persons. Supported employment includes activities needed to sustain paid work by participants, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities. This does not include payment for the supervisory activities rendered as a normal part of the business setting.

Mentorship: Service provided to participants to promote self-advocacy through methods such as instructing, providing experiences, modeling and advising. This service includes assistance in interviewing potential providers, understanding complicated health and safety issues, and assistance with participation on private and public boards, advisory groups and commissions. This service may also include training in child and infant care for parent(s) who themselves have a developmental disability. This service does not duplicate case management or waiver services such as Day Habilitation. Mentorship is limited to 192 units (48 hours) per year. Units to provide training to participants for child and infant care may be authorized beyond the 192 units per year.

Non-Medical Transportation Services: Service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the Service Plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's Service Plan. Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge, are utilized. Transportation to and from day program shall be reimbursed based on the applicable transportation band. Transportation in addition to day program is limited to 4 trips per week reimbursed at transportation band one.

Vehicle Modifications: Adaptations or alterations to an automobile or van that is the participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the Service Plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. The following are specifically excluded: 1) Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the participant; 2) Purchase or lease of a vehicle; and 3) Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.
The total cost of home accessibility adaptations, vehicle modifications, and assistive technology may not exceed $10,000 over the life of the waiver except that on a case by case basis the DHS/DDD may approve a higher amount, to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis.

Personal Care: A range of assistance to enable participants to accomplish tasks that they would normally do for themselves (i.e. hygiene, bathing, eating, dressing, grooming, bowel and bladder care, menstrual care, transferring, money management, grocery shopping), if they did not have a developmental disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Personal Care services may be provided on an episodic, emergency or on a continuing basis. When Personal Care and health-related services are needed, they may be covered to the extent the Medicaid State Plan, Third Party Resource or another waiver service is not responsible.

Personal Emergency Response System (PERS): PERS is an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. The participant and their case manager develop a protocol for identifying who is to be contacted if/when the system is activated.

Appendix I

Professional Services: Professional services include Hippo-therapy, Movement Therapy and Massage. These services can be funded only when the provider is licensed, certified, registered and/or accredited by an appropriate national accreditation association in that profession and the intervention is related to an identified medical or behavioral need. The service must be an identified need in the Service Plan. In addition, the service must be an identified need by a licensed Medicaid State Plan therapist/physician and that therapist/physician has identified a goal for the treatment and shall monitor the progress of that goal at least quarterly. The identified "Professional Service" cannot be available under the regular Medicaid State Plan or from a third party source. Passes to community recreation centers when used to access professional services is allowed. Recreational passes shall be purchased in the most cost effective manner (i.e. day passes or monthly passes.) Hippotherapy: A therapeutic treatment strategy that uses the movement of the horse to assist in the development/enhancement of skills: gross motor, sensory integration, attention, cognitive, social, behavioral, and communication. Movement Therapy: The use of music and/or dance as a therapeutic tool for the habilitation, rehabilitation and maintenance of behavioral, developmental, physical, social, communication, pain management, cognition and gross motor skills. Massage: The physical manipulation of muscles to ease muscle contractures, spasms, extension, muscle relaxation and muscle tension including Watsu.

Respite: Respite Services provided to participants that are furnished on a short-term basis, because of the absence or need for relief of those persons who normally provide care for the participant. Respite may be provided in the participant's home/private place of residence or the private residence of a respite care provider. Federal financial participation is not to be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite shall be billed according to a unit rate or daily rate whichever is less. The total amount of respite provided in one plan year may not exceed 30 days and 1,880 additional units when the service period is less than a day. A full day is 10 hours (15 minute units x 4 x 10) or greater within a twenty-four (24) service period. DHS/DDD may approve a higher amount based on a documented increase in medical or behavioral needs as reflected in the behavior plan for behavioral needs or in the medical records for medical needs.

Specialized Medical Equipment and Supplies: Specialized Medical Equipment and supplies include: 1. Devices, controls, or appliances, specified in the Service Plan, that enable participant to increase their ability to perform activities of daily living; 2. Kitchen equipment required for the preparation of special diets if this results in a cost saving over prepared foods. 3. General care items such as distilled water for saline solutions, supplies such as specialized eating utensils, etc., required by a participant with a developmental disability and related to the disability. 4. Specially designed clothing (e.g. velcro) for participant if the cost is over and above the costs generally incurred for a participant's clothing. 5. Maintenance and upkeep of the equipment Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

Appendix I

Assistive Technology: Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes: 1. The evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant; 2. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; 3. Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and 4. Devices that help the participant to communicate such as electronic communication devices (excluding cell phones, pagers, and internet access unless prior authorized by the state); skill acquisition devices which are proven to be a cost effective and efficient means to meet the need and which make learning easier, such as adaptations to computers, or computer software related to the person's disability.

Assistive technology devices and services are only available when the cost is above and beyond that of typical expenses and are not available through the Medicaid State Plan or third party resource.

The total cost of home accessibility adaptations, vehicle modifications, and assistive technology may not exceed $10,000 over the life of the waiver except that on a case by case basis the DHS/DDD may approve a higher amount, to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis.

Dental: These services are provided only when the services are not available through the Medicaid State Plan due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at 8.011.11 or available through a third party resource. Dental services include periodic examination and diagnosis; radiographs when indicated; detection of all manifestations of systemic disease; elimination of infection or life threatening oral conditions, disease of bone and soft tissue of the oral cavity, oral cancer, or cellulites; treatment of injuries; restoration of decayed or fractured teeth; retention or recovery of space between teeth when indicated; and payment for dental insurance. The cost of anesthesiology for dental procedures is not covered under the waiver. Dental services under the waiver are limited to the most cost effective and efficient means to alleviate or rectify the dental issues associated with the person.

Vision: These services are provided only when the services are not available through the Medicaid State Plan due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at 8.011.11 or available through a third party resource. Vision services are provided by a licensed Optometrist or physician and include eye exams and diagnosis, glasses, contacts, and other medically necessary methods used to improve specific dysfunctions of the vision systems. Lasik and other similar types of procedures are only prior approved and allowable when the procedure is necessary due to documented specific behavioral complexities (i.e. constant destruction of eye glasses) associated with the participant that make other more traditional remedies impractical.

Children's Extensive Services (HCBS-CES) – Enhanced in-home supports for children considered to be most in need due to the child's disability.

HCBS-CES Services

Home Accessibility Adaptations: Those physical adaptations to the primary residence of the participant's family, required by the participant's Service Plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. All adaptations shall be the most cost effective means to meet the identified need. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are of general utility (e.g., carpeting, roof repair, central air conditioning, etc.) and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Prior authorization is required for any adaptation adding square footage to a home. All devices and adaptations shall be provided in accordance with applicable State or local building codes and/or applicable standards of manufacturing, design and installation. Medicaid State Plan or third party resources shall be utilized prior to accessing waiver funds. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology may not exceed $10,000 over the life of the waiver except that on a case by case basis the DHS/DDD may approve a higher amount, to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis.

Homemaker -- Basic: Services that consist of the performance of basic household tasks within the participant's primary residence (i.e., cleaning, laundry, or household care) including maintenance which are related to the participant's disability and provided by a qualified homemaker, when the parent or primary caretaker is unable to manage the home and care for the participant in the home. This assistance must be due to the participant's disability that results in additional household tasks and increases the parent/caregiver's ability to provide care needed by the participant. This assistance may take the form of hands on assistance (actually performing a task for the participant) or cuing to prompt the participant to perform a task.

Homemaker – Enhanced: Services provided by a qualified homemaker that consist of the same household tasks as described under Basic Homemaker services with the addition of either habilitation or extraordinary cleaning. Habilitation includes direct training and instruction to the participant, which is more than basic cuing to prompt the participant to perform a task. Habilitation shall include a training program with specific objectives and anticipated outcomes. There may be some amount of incidental basic homemaker services that is provided in combination with enhanced homemaker services; however, the primary intent must be to provide habilitative services to increase independence of the participant. Habilitation may include some hands-on assistance (actually performing a task for the participant) or cuing to prompt the participant to perform a task, only when such support is incidental to the habilitative services being provided and the primary duties must be to provide habilitative services to increase independence of the participant. Enhanced Homemaker services also include the need for extraordinary cleaning as a result of the participant's behavioral or medical needs. Services provided by a qualified homemaker that consist of the same household tasks as described under Basic Homemaker services with the addition of either habilitation or extraordinary cleaning. Habilitation includes direct training and instruction to the participant, which is more than basic cuing to prompt the participant to perform a task. Habilitation shall include a training program with specific objectives and anticipated outcomes. There may be some amount of incidental basic homemaker services that is provided in combination with enhanced homemaker services; however, the primary intent must be to provide habilitative services to increase independence of the participant. Habilitation may include some hands-on assistance (actually performing a task for the participant) or cuing to prompt the participant to perform a task, only when such support is incidental to the habilitative services being provided and the primary duties must be to provide habilitative services to increase independence of the participant. Enhanced Homemaker services also include the need for extraordinary cleaning as a result of the participant's behavioral or medical needs.

Personal Care: A range of assistance to enable participants to accomplish tasks. A range of assistance to enable participants to accomplish tasks that they would normally do for themselves (i.e. hygiene, bathing, eating, dressing, grooming, bowel and bladder care, menstrual care, transferring, money management, grocery shopping), if they did not have a developmental disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Personal Care services may be provided on an episodic, emergency or on a continuing basis. When Personal Care and health-related services are needed, they may be covered to the extent the Medicaid State Plan, Third Party Resource or another waiver service is not responsible.

Parent Education: Consultation and direct service costs for training parents and other care providers in techniques to assist in caring for the participant's needs, including sign language training. Acquisition of information, specific to the participant's disability, for family members from support organizations and special resource materials, cost of registration for parents/caregivers to attend conferences/educational workshops that are specific to the participant's disability, cost of membership to parent support/information organizations and publications designed for parents of children with disabilities. The maximum annual allowance for Parent Education is $1,000.00 per year.

Appendix I

Respite: Services provided to participants that are furnished on a short-term basis, because of the absence or need for relief of those persons who normally provide care for the participant. Respite may be provided in the participant's home/private place of residence or the private residence of a respite care provider. Federal financial participation is not to be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite shall be billed according to a unit rate or daily rate whichever is less. The total amount of respite provided in one plan year may not exceed 30 days and 1,880 additional units when the service period is less than a day. A full day is 10 hours (15 minute units x 4 x 10) or greater within a twenty-four (24) service period. DHS/DDD may approve a higher amount based on a documented increase in medical or behavioral needs as reflected in the behavior plan for behavioral needs or in the medical records for medical needs.

Behavioral Services: Behavioral services identified in the Service Plan including individual and/or group counseling, behavioral interventions, diagnostic evaluations or consultations related to the individual's developmental disability and are needed for the individual to acquire or maintain appropriate interactions with others. Intervention modalities shall relate to an identified challenging behavior need of the person and specific criteria for remediation of the behavior must be established. The provider(s) will be identified in the Service Plan and will be at the minimum qualification level necessary to achieve the specific criteria for remediation. If an individual has a covered mental health diagnosis and is in need of covered mental health services, then those services must be accessed through the Medicaid State Plan. It is possible for people with co-occurring diagnoses of Developmental Disabilities and Covered Mental Health conditions to have identified needs that the Developmental Disabilities system can provide and identified needs that the Mental Health system provides.

Community Connector: Supports the abilities and skills necessary to enable the individual to access typical activities and functions of community life such as those chosen by the general population, including community education or training, and volunteer activities. Supported Community connections provides a wide variety of opportunities to facilitate and build relationships and natural supports in the community while utilizing the community as a learning environment to provide services and supports as identified in the participant's service plan. These activities are conducted in a variety of settings in which participants interact with non-disabled individuals (other than those individuals who are providing services to the participant). These types of services may include socialization, adaptive skills, and personnel to accompany and support the individual in community settings, resources necessary for participation in activities and supplies related to skill acquisition, retention, or improvement. Community Connections are provided on a one-to-one basis as a learning environment to provide instruction when identified in the Service Plan.

Adaptive Therapeutic Recreational Equipment and Fees: Recreational equipment that is adapted specific to the participant's disability and not those items that a typical age peer would commonly need as a recreation item, the cost of recreation shall be above and beyond what is typically expected for recreation and recommended by a doctor or therapist; adaptive bicycle, adaptive stroller, adaptive toys, floatation collar for swimming, various types of balls with internal auditory devices and other types of adapted equipment appropriate for the recreational needs of a child with a developmental disability. Recreational activities including passes to community recreation centers when used to access professional services. Water Safety Training is allowed. Recreational passes shall be purchased in the most cost effective manner (i.e. day passes or monthly passes.) Specifically excluded are tickets for zoos, museums, butterfly pavilion, movie, theater, concerts, professional and minor league sporting events and typical indoor/outdoor play structures. The maximum annual allowance for recreational items/services is $1,000.00 per plan year.

Vehicle Modifications: Adaptations or alterations to an automobile or van that is the participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the Service Plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. The following are specifically excluded: 1) Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the participant; 2) Purchase or lease of a vehicle; and 3) Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology may not exceed $10,000 over the life of the waiver except that on a case by case basis the DHS/DDD may approve a higher amount, to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis.

Assistive Technology: Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes: 1) The evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant; 2) Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; 3) Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and 4) Devices that help the participant to communicate such as electronic communication devices (excluding cell phones, pagers, and internet access unless prior authorized by the state); skill acquisition devices which are proven to be a cost effective and efficient means to meet the need and which make learning easier, such as adaptations to computers, or computer software related to the person's disability.

Assistive technology devices and services are only available when the cost is above and beyond that of typical expenses and are not available through the Medicaid State Plan or third party resource. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology may not exceed $10,000 over the life of the waiver except that on a case by case basis the DHS/DDD may approve a higher amount, to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis.

Professional Services: Professional services include Hippo-therapy, Movement Therapy and Massage. These services can be funded only when the provider is licensed, certified, registered and/or accredited by an appropriate national accreditation association in that profession and the intervention is related to an identified medical or behavioral need. The service must be an identified need in the Service Plan. In addition, the service must be an identified need by a licensed Medicaid State Plan therapist/physician and that therapist/physician has identified a goal for the treatment and shall monitor the progress of that goal at least quarterly. The identified "Professional Service" cannot be available under the regular Medicaid State Plan or from a third party source. Passes to community recreation centers when used to access professional services is allowed. Recreational passes shall be purchased in the most cost effective manner (i.e. day passes or monthly passes.) Hippotherapy: A therapeutic treatment strategy that uses the movement of the horse to assist in the development/ enhancement of skills: gross motor, sensory integration, attention, cognitive, social, behavioral, and communication. Movement Therapy: The use of music and/or dance as a therapeutic tool for the habilitation, rehabilitation and maintenance of behavioral, developmental, physical, social, communication, pain management, cognition and gross motor skills. Massage: The physical manipulation of muscles to ease muscle contractures, spasms, extension, muscle relaxation and muscle tension including Watsu.

Specialized Medical Equipment and Supplies: Specialized Medical Equipment and supplies include: 1. Devices, controls, or appliances, specified in the Service Plan, that enable participant to increase their ability to perform activities of daily living; 2. Kitchen equipment required for the preparation of special diets if this results in a cost saving over prepared foods. 3. General care items such as distilled water for saline solutions, supplies such as specialized eating utensils, etc., required by a participant with a developmental disability and related to the disability. 4. Specially designed clothing (e.g. velcro) for participant if the cost is over and above the costs generally incurred for a participant's clothing. 5. Maintenance and upkeep of the equipment Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

Vision: Vision therapy is provided only when the services are not available through the Medicaid State Plan or EPSDT due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at 8.011.11 or available through a third party resource. Vision therapy is a sequence of activities individually prescribed and monitored by a doctor of optometry or ophthalmology to develop efficient visual skills and processing. It is based on the results of standardized tests, the needs of the participant and the participant's signs and symptoms. It is used to treat eye movement disorders, inefficient eye teaming, misalignment of the eyes, poorly developed vision, focusing problems and visual information processing disorders to enhance visual skills and performing visual tasks.

Case Management/Service Coordination – is provided to all adults and children enrolled in services and all infants and toddlers from the point of referral, and includes eligibility determination; planning, locating and facilitating access to services; coordinating and reviewing all aspects of needed services, supports and resources in cooperation with the person with a developmental disability, the person's family as appropriate, and involved agencies; and monitoring and evaluation of all services and supports.

TCM Services

Determination of developmental disability Long Term Care eligibility
- Development of an Individualized (Service) Plan
- Advocating for and facilitating access to services and supports
- Coordination of services and supports
- Monitoring of services and supports
- Reviewing services and supports provided to determine if they are meeting the person's needs
- Advocating for individual's rights
- Information and referral services

Appendix I

HCBS-DD Waiver Rates

Service Name	Proc	Modifiers/0411	Date 7/2006 Unit	Date 7/2006 Rate	Date 1/2007 Unit	Date 1/2007 Rate	Date 7/2007 Unit	Date 7/2007 Rate	Date 7/2008 Unit	Date 7/2008 Rate	Date 1/2009 Unit	Date 1/2009 Rate	Date 7/2009 Unit	Date 7/2009 Rate	Date 10/2009 Unit	Date 10/2009 Rate	Date 7/2010 Unit	Date 7/2010 Rate
Grp Home Level 1	T2016	U3 HQ	day	$50 71	day	$52 36	day	$53 15	day	$53 95	day	$85 21	day	$85 21	day	$83 08	day	$81 42
Grp Home Level 2	T2016	U3 22 HQ	day	$73 17	day	$75 55	day	$76 68	day	$77 83	day	$112 16	day	$112 16	day	$109 36	day	$107 17
Grp Home Level 3	T2016	U3 TF HQ	day	$105 78	day	$109 22	day	$110 86	day	$112 52	day	$132 13	day	$132 13	day	$128 83	day	$126 25
Grp Home Level 4	T2016	U3 TF 22 HQ	day	$131 87	day	$136 16	day	$138.20	day	$140 27	day	$156 09	day	$156 09	day	$152 19	day	$149 15
Grp Home Level 5	T2016	U3 TG HQ	day	$159 33	day	$164 51	day	$166 98	day	$169 48	day	$172 43	day	$172 43	day	$168 12	day	$164 76
Grp Home Level 6	T2016	U3 TG 22 HQ	day	$187 16	day	$193 24	day	$196 14	day	$199 08	day	$204 04	day	$204 04	day	$198 94	day	$194 96
Grp Home	T2016	U3 SC HQ	day	individual	day	individual	day	individual	day	individual	day	individual	day	individual	day	individual	day	
PCA Level 1	T2016	U3	day	$50 71	day	$52 36	day	$53 15	day	$53 95	day	$62 65	day	$62 65	day	$61 08	day	$59 86
PCA Level 2	T2016	U3 22	day	$73 17	day	$75 55	day	$76 68	day	$77 83	day	$101.23	day	$101 23	day	$98 70	day	$96.73
PCA Level 3	T2016	U3 TF	day	$105 78	day	$109.22	day	$110 86	day	$112 52	day	$123 68	day	$123 68	day	$120 59	day	$118 18
PCA Level 4	T2016	U3 TF 22	day	$131 87	day	$136 16	day	$138 20	day	$140 27	day	$150 58	day	$150 58	day	$146 82	day	$143 88
PCA Level 5	T2016	U3 TG	day	$159 33	day	$164 51	day	$166 98	day	$169 48	day	$173 04	day	$173 04	day	$168 71	day	$165 34
PCA Level 6	T2016	U3 TG 22	day	$187 16	day	$193 24	day	$196 14	day	$199 08	day	$217 47	day	$217 47	day	$212 03	day	$207 79
PCA	T2016	U3 SC	day	individual	day	individual	day	individual	day	individual	day	individual	day	individual	day	individual	day	
Host Home level 1	T2016	U3 TT	day	$50 71	day	$52 36	day	$53 15	day	$53 95	day	$58 10	day	$58 10	day	$56 65	day	$55 52
Host Home level 2	T2016	U3 22 TT	day	$73 17	day	$75 55	day	$76 68	day	$77 83	day	$93 88	day	$93 88	day	$91 53	day	$89 70
Host Home level 3	T2016	U3 TF TT	day	$105 78	day	$109 22	day	$110 86	day	$112 52	day	$114 70	day	$114 70	day	$111 83	day	$109 59
Host Home level 4	T2016	U3 TF 22 TT	day	$131 87	day	$136 16	day	$138 20	day	$140.27	day	$139 65	day	$139 65	day	$136 16	day	$133 44
Host Home level 5	T2016	U3 TG TT	day	$159 33	day	$164.51	day	$166 98	day	$169 48	day	$160 47	day	$160.47	day	$156 46	day	$153 33
Host Home level 6	T2016	U3 TG 22 TT	day	$187 16	day	$193 24	day	$196 14	day	$199 08	day	$201 69	day	$201 69	day	$196 65	day	$192 72
Host Home	T2016	U3 SC TT	day	individual	day	individual	day	individual	day	individual	day	individual	day	individual	day	individual	day	
Skilled Nursing	T1003		15 minutes	$15 62	15 minutes	$15 62	15 minutes	$15.85	15 minutes	$16 09	15 minutes	SN included in						
Specialized Habilitation Level 1	T2021	U3 HQ	15 minutes	$1 99	15 minutes	$2 05	15 minutes	2 08	15 minutes	$2 11	15 minutes	$2 28	15 minutes	$2 28	15 minutes	$2 22	15 minutes	$2 18
Specialized Habilitation Level 2	T2021	U3 22 HQ	15 minutes	$2 96	15 minutes	$3 06	15 minutes	3 11	15 minutes	$3 16	15 minutes	$2 50	15 minutes	$2 50	15 minutes	$2 44	15 minutes	$2 39
Specialized Habilitation Level 3	T2021	U3 TF HQ	15 minutes	$3 87	15 minutes	$4 00	15 minutes	4 06	15 minutes	$4 12	15 minutes	$2 78	15 minutes	$2 78	15 minutes	$2 71	15 minutes	$2 66
Specialized Habilitation Level 4	T2021	U3 TF 22 HQ	15 minutes	$4 61	15 minutes	$4 76	15 minutes	4 83	15 minutes	$4 90	15 minutes	$3 27	15 minutes	$3 27	15 minutes	$3 19	15 minutes	$3 13
Specialized Habilitation Level 5	T2021	U3 TG HQ	15 minutes	$5 55	15 minutes	$5 73	15 minutes	5 82	15 minutes	$5 91	15 minutes	$4 06	15 minutes	$4 06	15 minutes	$3 96	15 minutes	$3 88
Specialized Habilitation Level 6	T2021	U3 TG 22 HQ	15 minutes	$7 14	15 minutes	$7 37	15 minutes	7 48	15 minutes	$7 59	15 minutes	$5 84	15 minutes	$5 84	15 minutes	$5.69	15 minutes	$5 58
Specialized Habilitation Level 7	T2021	U3 SC HQ	15 minutes	$8 64	15 minutes	$8 92	15 minutes	9 05	15 minutes	$9 19	15 minutes	$9 19	15 minutes	$9 19	15 minutes	$8 96	15 minutes	$8 78
Supported Community Connections Level 1	T2021	U3	15 minutes	$1 99	16 minutes	$2 05	15 minutes	2 08	15 minutes	$2 11	15 minutes	$2 77	15 minutes	$2 77	15 minutes	$2 70	15 minutes	$ 2 85
Supported Community Connections Level 2	T2021	U3 22	15 minutes	$2 96	15 minutes	$3 06	15 minutes	3 11	15 minutes	$3 16	15 minutes	$3 04	15 minutes	$3 04	15 minutes	$2.96	15 minutes	$ 2 90
Supported Community Connections Level 3	T2021	U3 TF	15 minutes	$3 87	15 minutes	$4 00	15 minutes	4 06	15 minutes	$4 12	15 minutes	$3 42	15 minutes	$3 42	15 minutes	$3 33	15 minutes	$ 3 26
Supported Community Connections Level 4	T2021	U3 TF 22	15 minutes	$4 61	15 minutes	$4 76	15 minutes	4 83	15 minutes	$4 90	15 minutes	$3 93	15 minutes	$3 93	15 minutes	$3 83	15 minutes	$ 3 75
Supported Community Connections Level 5	T2021	U3 TG	15 minutes	$5 55	15 minutes	$5 73	15 minutes	5 82	15 minutes	$5 91	15 minutes	$4 73	15 minutes	$4 73	15 minutes	$4 61	15 minutes	$ 4 52
Supported Community Connections Level 6	T2021	U3 TG 22	15 minutes	$7 14	15 minutes	$7 37	15 minutes	7 48	15 minutes	$7 59	15 minutes	$6 22	15 minutes	$6 22	15 minutes	$6 06	15 minutes	$ 5 94
Supported Community Connections Level 7	T2021	U3 SC	15 minutes	$8 64	15 minutes	$8 92	15 minutes	9 05	15 minutes	$9 19	15 minutes	$9 19	15 minutes	$9 19	15 minutes	$8 96	15 minutes	$ 8 78

Note * Denotes required fields (Begin Date, End Date and New Rate are not required for "Hospital Rates")

Appendix I

HCBS-DD Waiver Rates

Supported Employment Group Level 1	T2019	U3 HQ	15 minutes	$3.65	15 minutes	$3.77	15 minutes	3.83	15 minutes	3.89	15 minutes	$3.06	15 minutes	$3.06	15 minutes	$2.98	15 minutes	$2.92
Supported Employment Group Level 2	T2019	U3 22 HQ	15 minutes	$3.65	15 minutes	$3.77	15 minutes	3.83	15 minutes	3.89	15 minutes	$3.34	15 minutes	$3.34	15 minutes	$3.26	15 minutes	$3.19
Supported Employment Group Level 3	T2019	U3 TF HQ	15 minutes	$3.65	15 minutes	$3.77	15 minutes	3.83	15 minutes	3.89	15 minutes	$3.72	15 minutes	$3.72	15 minutes	$3.63	15 minutes	$3.56
Supported Employment Group Level 4	T2019	U3 TF 22 HQ	15 minutes	$3.65	15 minutes	$3.77	15 minutes	3.83	15 minutes	3.89	15 minutes	$4.30	15 minutes	$4.30	15 minutes	$4.19	15 minutes	$4.11
Supported Employment Group Level 5	T2019	U3 TG HQ	15 minutes	$3.65	15 minutes	$3.77	15 minutes	3.83	15 minutes	3.89	15 minutes	$5.14	15 minutes	$5.14	15 minutes	$5.01	15 minutes	$4.91
Supported Employment Group Level 6	T2019	U3 TG 22 HQ	15 minutes	$3.65	15 minutes	$3.77	15 minutes	3.83	15 minutes	3.89	15 minutes	$6.70	15 minutes	$6.70	15 minutes	$6.53	15 minutes	$6.40
Supported Employment Individual	T2019	U3 SC	15 minutes	$10.77	15 minutes	$11.12	15 minutes	11.29	15 minutes	11.46	15 minutes	$12.56	15 minutes	$12.56	15 minutes	$12.25	15 minutes	$12.01
SE - DVR																		
SE-Group Job Development	H2023	U3 HQ									15 minutes/max 100 units	$4.01	15 minutes/max 100 units	$4.01	15 minutes	$3.91	15 minutes	$3.83
SE-Ind Job Development SIS Lvl 1-2	H2023	U3									15 minutes/max 80 units	$12.56	15 minutes/max 80 units	$12.56	15 minutes	$12.25	15 minutes	$12.01
SE-Ind Job Development SIS Lvl 3-4	H2023	U3 22									15 minutes/max 100 units	$12.56	15 minutes/max 100 units	$12.56	15 minutes	$12.25	15 minutes	$12.01
SE-Ind Job Development SIS Lvl 5-6	H2023	U3 TF									15 minutes/max 120 units	$12.56	15 minutes/max 120 units	$12.56	15 minutes	$12.25	15 minutes	$12.01
SE-Group Job Placement	T2038	U3 HQ									max 400 units	$1.00	max 400 units	$1.00	1/1/2009	$1.00	max 400 units	$1.00
SE-Individual Job Placement	T2038	U3									max 1000 units	$1.00	max 1000 units	$1.00	1/1/2009	$1.00	max 1000 units	$1.00
Bus Pass	T2025	U3									Cost	$1.00	Cost	$1.00	1/1/2009	$1.00	Cost	$1.00
Transportation Milage Level 1	T2002 T2003	U3	day	$8.36	day	$8.63	day	$8.76	day	$8.90	Trip max 2 per day	$5.59	Trip max 2 per day	$5.59	10/1/2009	$5.45	10/1/2009	$5.34
Transportation Milage Level 2	T2002 T2003	U3 22	day	$35.02	day	$36.16	day	$36.70	day	$37.26	Trip max 2 per day	$11.71	Trip max 2 per day	$11.71	10/1/2009	$11.42	10/1/2009	$11.19
Transportation Milage Level 3	T2003	U3 TF									Trip max 2 per day	$17.84	Trip max 2 per day	$17.84	10/1/2009	$17.39	10/1/2009	$17.04
Behavioral Line Staff	H2019	U3	15 minutes	$3.75	15 minutes	$3.87	15 minutes	$3.93	15 minutes	$3.99	15 minutes	$6.40	15 minutes	$6.40	10/1/2009	$6.24	10/1/2009	$6.12
Behavioral Plan Specialist	H2019	U3 22	15 minutes								15 minutes	$12.14	15 minutes	$12.14	10/1/2009	$11.84	10/1/2009	$11.60
Senior Therapist	H2019	U3 TF	15 minutes	$15.00	15 minutes	$15.49	15 minutes	$15.72	15 minutes	$15.96	15 minutes	$24.24	15 minutes	$24.24	10/1/2009	$23.63	10/1/2009	$23.16
Lead Therapist	H2019	U3 TF 22	15 minutes	$22.50	15 minutes	$23.23	15 minutes	$23.58	15 minutes	$23.93	15 minutes	$30.71	15 minutes	$30.71	10/1/2009	$29.94	10/1/2009	$29.34
Behavioral Plan Assesement	T2024	U3									Cost	$1.00	Cost	$1.00	1/1/2009	$1.00	1/1/2009	$1.00
Targeted Case Management	T2023	U4	Monthly	$167.30			Monthly	169.8	Monthly	$172.35	Monthly	$184.77	Monthly	$184.77				
Targeted Case Management	T1017	U4											15 minutes	$12.60	15 minutes	$14.93	15 minutes	$14.63
Specialized Medical Supplies - Disposable	T2028	U3	Cost	$1.00	Cost	$1.00	Cost	$1.00	Cost	$1.00	Cost	$1.00	Cost	$1.00	1/1/2009	$1.00	1/1/2009	$1.00
Specialized Medical Equipment	T2029	U3	Cost	$1.00	Cost	$1.00	Cost	$1.00	Cost	$1.00	Cost	$1.00	Cost	$1.00	1/1/2009	$1.00	1/1/2009	$1.00
Dental Services	D0999 D2999	U3	Cost	$1.00	Cost	$1.00	Cost	$1.00	Cost	$1.00	Cost	$1.00	Cost	$1.00	1/1/2009	$1.00	1/1/2009	$1.00
Vision Services	V2799	U3	Cost	$1.00	Cost	$1.00	Cost	$1.00	Cost	$1.00	Cost	$1.00	Cost	$1.00	1/1/2009	$1.00	1/1/2009	$1.00

Note * Denotes required fields (Begin Date, End Date and New Rate are not required for "Hospital Rates")

Appendix I

HCBS-SLS Waiver Rates July 1, 2006 to June 30 2009

Service Name	Proc.	Date 7/2006 Unit	Date 7/2006 Max Rate	Date 7/2007 Unit	Date 7/2007 Max Rate	Date 7/2008 Unit	Date 7/2008 Max Rate
Personal Assistance	T1019	15 Minutes	$12.00	15 Minutes	$14.60	15 Minutes	$14.60
Professional Services	97530	15 Minutes	$32.50	15 Minutes	$32.50	15 Minutes	$32.50
Day Habilitation	T2021	15 Minutes	$10.00	15 Minutes	$12.00	15 Minutes	$12.00
Supported Employment	T2019	15 Minutes	$15.00	15 Minutes	$16.00	15 Minutes	$16.00
Prevocational Services	T2015	Hour	$40.00	Hour	$40.00	Hour	$40.00
Transportation Services	T2002	Day	$50.00	Day	$50.00	Day	$50.00
Dental Treatment	D2999	Cost	$1.00	Cost	$1.00	Cost	$1.00
Dental Diagnostic	D0999	Cost	$1.00	Cost	$1.00	Cost	$1.00
Vision Services	V2799	Cost	$1.00	Cost	$1.00	Cost	$1.00
Specialized Medical Equip	T2029	Cost	$1.00	Cost	$1.00	Cost	$1.00
Environmental Engineering	S5165	Cost	$1.00	Cost	$1.00	Cost	$1.00
Personal Care Item	S5199	Cost	$1.00	Cost	$1.00	Cost	$1.00
Service Assessment	T2024	Cost	$1.00	Cost	$1.00	Cost	$1.00
Waiver Serv not Specified	T2025	Cost	$1.00	Cost	$1.00	Cost	$1.00

Note: The above rates represent standard caps. One CCB had a higher rate for one service due to a special circumstance.

Appendix I

HCBS-SLS Waiver Rates, Beginning July 1, 2009

Service Name	Proc.	Modifiers/0411	Unit	Date 7/2009 Rate	Unit	Date 10/2009 Rate	Unit	Date 7/2010 Rate
Personal Care	T1019	U8	15 minutes	$4.78	15 minutes	$4.66	15 minutes	$ 4.57
Respite Care								
Individual	S5150	U8	15 minutes	$4.78	15 minutes	$4.66	15 minutes	$ 4.57
Individual	S5151	U8	Day	$191.06	Day	$186.28	Day	$ 182.55
Group	S5151	U8, HQ		$1.00		$1.00		$ 1.00
Camp	T2036	U8		$1.00		$1.00		$ 1.00
Homemaker								
Basic	S5130	U8	15 minutes	$3.63	15 minutes	$3.57	15 minutes	$ 3.50
Enhanced	S5130	U8, 22	15 minutes	$5.92	15 minutes	$5.77	15 minutes	$ 5.65
Mentorship	H2021	U8	15 minutes	$9.65	15 minutes	$9.41	15 minutes	$ 9.22
Day Habilitation								
Specialized Habilitation Level 1	T2021	U8, HQ	15 minutes	$2.28	15 minutes	$2.22	15 minutes	$ 2.18
Specialized Habilitation Level 2	T2021	U8, 22, HQ	15 minutes	$2.50	15 minutes	$2.44	15 minutes	$ 2.39
Specialized Habilitation Level 3	T2021	U8, TF, HQ	15 minutes	$2.78	15 minutes	$2.71	15 minutes	$ 2.66
Specialized Habilitation Level 4	T2021	U8, TF, 22, HQ	15 minutes	$3.27	15 minutes	$3.19	15 minutes	$ 3.13
Specialized Habilitation Level 5	T2021	U8, TG, HQ	15 minutes	$4.06	15 minutes	$3.96	15 minutes	$ 3.88
Specialized Habilitation Level 6	T2021	U8, TG, 22, HQ	15 minutes	$5.84	15 minutes	$5.69	15 minutes	$ 5.58
Supported Community Connections Level 1	T2021	U8	15 minutes	$2.77	15 minutes	$2.70	15 minutes	$ 2.65
Supported Community Connections Level 2	T2021	U8, 22	15 minutes	$3.04	15 minutes	$2.96	15 minutes	$ 2.90
Supported Community Connections Level 3	T2021	U8, TF	15 minutes	$3.42	15 minutes	$3.33	15 minutes	$ 3.26
Supported Community Connections Level 4	T2021	U8, TF, 22	15 minutes	$3.93	15 minutes	$3.83	15 minutes	$ 3.75
Supported Community Connections Level 5	T2021	U8, TG	15 minutes	$4.73	15 minutes	$4.61	15 minutes	$ 4.52
Supported Community Connections Level 6	T2021	U8, TG, 22	15 minutes	$6.22	15 minutes	$6.06	15 minutes	$ 5.94

Appendix I

HCBS-SLS Waiver Rates, Beginning July 1, 2009

Supported Employment

Group Level 1	T2019	U8, HQ	15 minutes	$3.06	15 minutes	$2.98	15 minutes	$ 2.92
Group Level 2	T2019	U8, 22, HQ	15 minutes	$3.34	15 minutes	$3.26	15 minutes	$ 3.19
Group Level 3	T2019	U8, TF, HQ	15 minutes	$3.72	15 minutes	$3.63	15 minutes	$ 3.56
Group Level 4	T2019	U8, TF, 22, HQ	15 minutes	$4.30	15 minutes	$4.19	15 minutes	$ 4.11
Group Level 5	T2019	U8, TG, HQ	15 minutes	$5.14	15 minutes	$5.01	15 minutes	$ 4.91
Group Level 6	T2019	U8, TG, 22, HQ	15 minutes	$6.70	15 minutes	$6.53	15 minutes	$ 6.40
Individual	T2019	U8, SC	15 minutes	$12.56	15 minutes	$12.25	15 minutes	$ 12.01

SE - DVR

Job Development Group	H2023	U8, HQ	15 minutes	$4.01	15 minutes	$3.91	15 minutes	$ 3.83
Job Development Individual SIS Level 1-2	H2023	U8	15 minutes	$12.56	15 minutes	$12.25	15 minutes	$ 12.01
Job Development Individual SIS Level 3-4	H2023	U8, 22	15 minutes	$12.56	15 minutes	$12.25	15 minutes	$ 12.01
Job Development Individual SIS Level 5-6	H2023	U8, TF	15 minutes	$12.56	15 minutes	$12.25	15 minutes	$ 12.01
Job Placement Group	T2038	U8, HQ	400	$1.00	400	$1.00	400	$ 1.00
Job Placement Individual	T2038	U8	1000	$1.00	1000	$1.00	1000	$ 1.00

Transportation

Mileage Day Program Level 1	T2003	U8	Trip	$5.59	Trip	$5.45	Trip	$ 5.34
Mileage Day Program Level 2	T2003	U8, 22	Trip	$11.71	Trip	$11.42	Trip	$ 11.19
Mileage Day Program Level 3	T2003	U8, TF	Trip	$17.84	Trip	$17.39	Trip	$ 17.04
Mileage Not Day Program	T2003	U8	Trip	$5.59	Trip	$5.45	Trip	$ 5.34
Bus Pass	T2025	U8	cost	$1.00	cost	$1.00	cost	$ 1.00

HCBS-SLS Waiver Rates, Beginning July 1, 2009

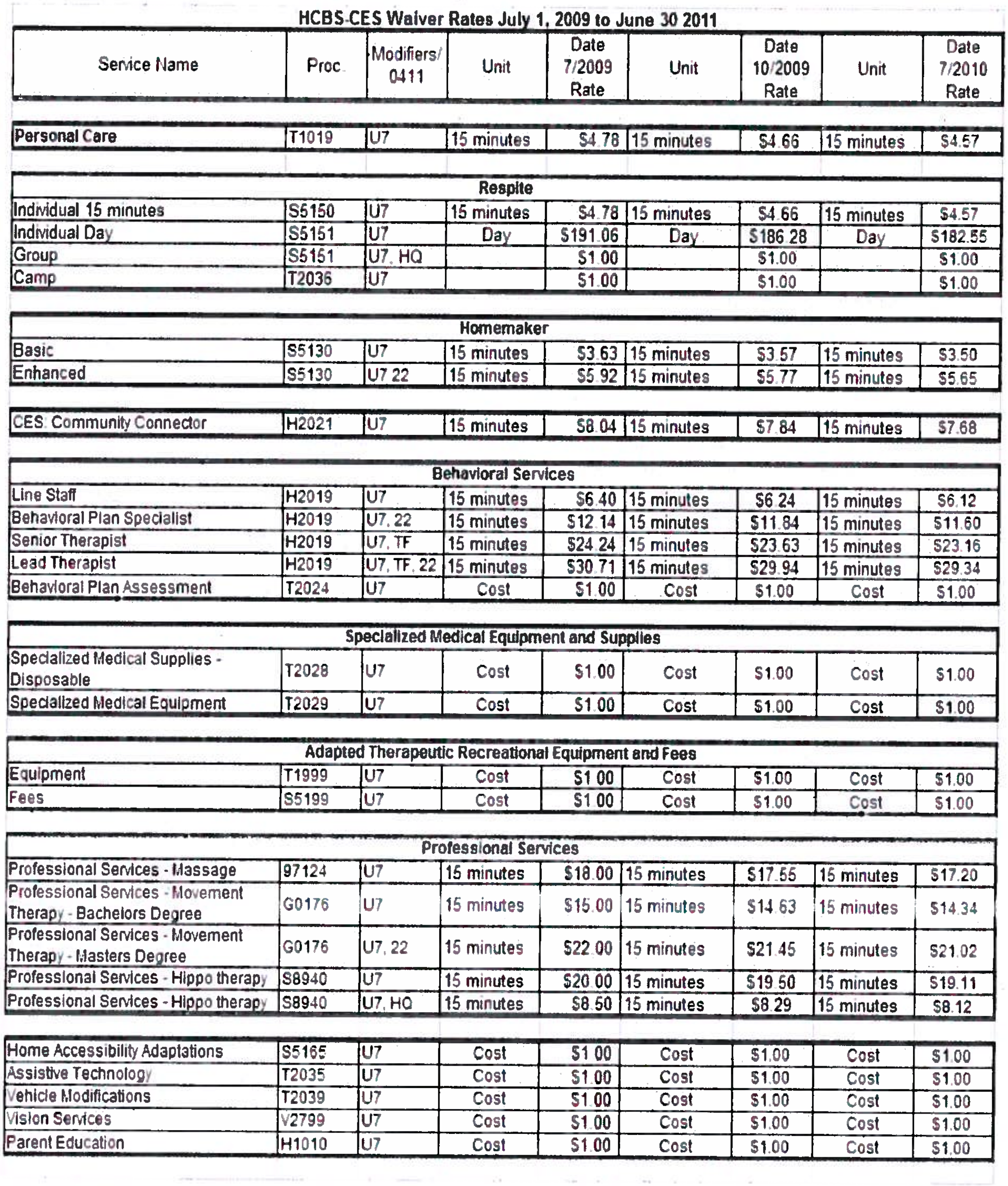
Behavioral Services								
Line Staff	H2019	U8	15 minutes	$6.40	15 minutes	$6.24	15 minutes	$ 6.12
Behavioral Plan Specialist	H2019	U8, 22	15 minutes	$12.14	15 minutes	$11.84	15 minutes	$ 11.60
Senior Therapist	H2019	U8, TF	15 minutes	$24.24	15 minutes	$23.63	15 minutes	$ 23.16
Lead Therapist	H2019	U8, TF, 22	15 minutes	$30.71	15 minutes	$29.94	15 minutes	$ 29.34
Behavioral Plan Assessment	T2024	U8	cost	$1.00	cost	$1.00	cost	$ 1.00
Specialized Medical Supplies - Disposable	T2028	U8	cost	$1.00	cost	$1.00	cost	$ 1.00
Specialized Medical Equipment	T2029	U8	cost	$1.00	cost	$1.00	cost	$ 1.00
Professional Services								
Massage	97214	U8	15 minutes	$18.00	15 minutes	$17.55	15 minutes	$ 17.20
Movement Therapy Bachelors	G0176	U8	15 minutes	$15.00	15 minutes	$14.63	15 minutes	$ 14.34
Movement Therapy Masters	G0176	U8, 22	15 minutes	$22.00	15 minutes	$21.45	15 minutes	$ 21.02
Hippo Therapy Individual	S8940	U8	15 minutes	$20.00	15 minutes	$19.50	15 minutes	$ 19.11
Hippo Therapy Group	S8940	U8, HQ	15 minutes	$8.50	15 minutes	$8.29	15 minutes	$ 8.12
Rec Pass	S5199	U8	cost	$1.00	cost	$1.00	cost	$ 1.00
Personal Emergency Response Systems	S5161	U8	cost	$1.00	cost	$1.00	cost	$ 1.00
Home Modifications	S5165	U8	cost	$1.00	cost	$1.00	cost	$ 1.00
Assistive Technology	S2035	U8	cost	$1.00	cost	$1.00	cost	$ 1.00
Vehicle Modifications	T2039	U8	cost	$1.00	cost	$1.00	cost	$ 1.00
Dental Services	D2999	U8	cost	$1.00	cost	$1.00	cost	$ 1.00
Vision Services	V2799	U8	cost	$1.00	cost	$1.00	cost	$ 1.00

Appendix I

HCBS-CES Waiver Rates July 1, 2006 to June 30 2009

Service Name	Proc.	Date 7/2006 Unit	Date 7/2006 Max Rate	Date 7/2007 Unit	Date 7/2007 Max Rate	Date 7/2008 Unit	Date 7/2008 Max Rate
Personal Assistance	T1019	15 Minutes	$10.30	15 Minutes	$10.30	15 Minutes	$14.60
Professional Services	97530	15 Minutes	$36.80	15 Minutes	$36.80	15 Minutes	$36.80
Assistive Tech	T2029	Cost	$1.00	Cost	$1.00	Cost	$1.00
Home Modification	S5165	Cost	$1.00	Cost	$1.00	Cost	$1.00
Community Connections	H2021	15 Minutes	$10.30	15 Minutes	$10.30	15 Minutes	$14.60
Specialized Medical Equip	T2028	Cost	$1.00	Cost	$1.00	Cost	$1.00
Behavioral Services	H2019	15 Minutes	$36.80	15 Minutes	$36.80	15 Minutes	$36.80
Item for Prof/Behavioral Svc	T2024	Cost	$1.00	Cost	$1.00	Cost	$1.00
Personal Care Item	S5199	Cost	$1.00	Cost	$1.00	Cost	$1.00
Waiver Serv not Specified	T2025	Cost	$1.00	Cost	$1.00	Cost	$1.00

Appendix I



HCBS-CES Waiver Rates July 1, 2009 to June 30 2011

Service Name	Proc	Modifiers/ 0411	Unit	Date 7/2009 Rate	Unit	Date 10/2009 Rate	Unit	Date 7/2010 Rate
Personal Care	T1019	U7	15 minutes	$4.78	15 minutes	$4.66	15 minutes	$4.57
Respite								
Individual 15 minutes	S5150	U7	15 minutes	$4.78	15 minutes	$4.66	15 minutes	$4.57
Individual Day	S5151	U7	Day	$191.06	Day	$186.28	Day	$182.55
Group	S5151	U7, HQ		$1.00		$1.00		$1.00
Camp	T2036	U7		$1.00		$1.00		$1.00
Homemaker								
Basic	S5130	U7	15 minutes	$3.63	15 minutes	$3.57	15 minutes	$3.50
Enhanced	S5130	U7 22	15 minutes	$5.92	15 minutes	$5.77	15 minutes	$5.65
CES: Community Connector	H2021	U7	15 minutes	$8.04	15 minutes	$7.84	15 minutes	$7.68
Behavioral Services								
Line Staff	H2019	U7	15 minutes	$6.40	15 minutes	$6.24	15 minutes	$6.12
Behavioral Plan Specialist	H2019	U7, 22	15 minutes	$12.14	15 minutes	$11.84	15 minutes	$11.60
Senior Therapist	H2019	U7, TF	15 minutes	$24.24	15 minutes	$23.63	15 minutes	$23.16
Lead Therapist	H2019	U7, TF, 22	15 minutes	$30.71	15 minutes	$29.94	15 minutes	$29.34
Behavioral Plan Assessment	T2024	U7	Cost	$1.00	Cost	$1.00	Cost	$1.00
Specialized Medical Equipment and Supplies								
Specialized Medical Supplies - Disposable	T2028	U7	Cost	$1.00	Cost	$1.00	Cost	$1.00
Specialized Medical Equipment	T2029	U7	Cost	$1.00	Cost	$1.00	Cost	$1.00
Adapted Therapeutic Recreational Equipment and Fees								
Equipment	T1999	U7	Cost	$1.00	Cost	$1.00	Cost	$1.00
Fees	S5199	U7	Cost	$1.00	Cost	$1.00	Cost	$1.00
Professional Services								
Professional Services - Massage	97124	U7	15 minutes	$18.00	15 minutes	$17.55	15 minutes	$17.20
Professional Services - Movement Therapy - Bachelors Degree	G0176	U7	15 minutes	$15.00	15 minutes	$14.63	15 minutes	$14.34
Professional Services - Movement Therapy - Masters Degree	G0176	U7, 22	15 minutes	$22.00	15 minutes	$21.45	15 minutes	$21.02
Professional Services - Hippo therapy	S8940	U7	15 minutes	$20.00	15 minutes	$19.50	15 minutes	$19.11
Professional Services - Hippo therapy	S8940	U7, HQ	15 minutes	$8.50	15 minutes	$8.29	15 minutes	$8.12
Home Accessibility Adaptations	S5165	U7	Cost	$1.00	Cost	$1.00	Cost	$1.00
Assistive Technology	T2035	U7	Cost	$1.00	Cost	$1.00	Cost	$1.00
Vehicle Modifications	T2039	U7	Cost	$1.00	Cost	$1.00	Cost	$1.00
Vision Services	V2799	U7	Cost	$1.00	Cost	$1.00	Cost	$1.00
Parent Education	H1010	U7	Cost	$1.00	Cost	$1.00	Cost	$1.00

Appendix I

Appendix F
The Wait List

A wait list is maintained for each HCBS waiver and contains the list people with developmental disabilities who are not currently being served through that particular waiver, but are waiting for an enrollment. The list is basically structured in terms of waiver program the individual desires or is best suited to enter, and by date placed on the list. While emergency situations are always placed at the front of the list, if an enrollment becomes available and no emergency cases are waiting, the enrollment may be authorized to an individual based upon how long an individual has been waiting on the list.

Below are some general points, facts, and observations related to the HCBS-DD and HCBS-SLS wait lists.

HCBS-DD Waiver Turnover

- Caseload turnover is the result of many moving parts.
- There is an average of 9 vacancies created per month in the DD Comp Waiver, or approximately 108 per year.
- When a vacancy occurs, enrollments are authorized to individuals on the waiting list.
    - Emergency placements always take top priority and move to the top of the wait list. In DD Comp, the average is around 45-50 emergencies/year.
    - The next highest priority is the placement of CHRP youth who age out of that Waiver.
    - Third in order of priority are deinstitutionalized clients (could come from a mental health facility, a regional center, a nursing home, etc.).
    - Finally, slots are filled by using the standing wait list. These are individuals who may, for example, be residing with family for the time being.
-

HCBS-SLS Waiver Turnover

- The HCBS-SLS caseload does not have "Emergency Placements" per-se. HCBS-SLS high-priority cases are termed "High Risk". The HCBS-SLS Waiver enrollments are authorized in a manner similar to the prioritization methodology used for HCBS-DD. The primary difference is that HCBS-CES youth (as opposed to CHRP youth) transition to HCBS-SLS.
- DHS did not have ready access to average vacancy-per-month rates.
- Individuals can be receiving services through a waiver and still be on a wait list for a different waiver. This is most common for individuals receiving HCBS-SLS services and waiting for a HCBS-DD enrollment.
- As a result of the many factors above, the turnover is greater in the HCBS-SLS waiver.

Appendix I

Department of Human Services, Office of Long Term Care
Division for Developmental Disabilities
Waiting List Report
June 30, 2011

Waiting List Details (Current & Budget Period)
Unduplicated Count (unless otherwise specified)

		Adult Services Waiting List						Children & Family Services Waiting List		
		No Current Adult Services								
		Would Accept Only HCBS-DD	Would Accept SLS or HCBS-DD	Currently in SLS Waiting for HCBS-DD	Total Waiting List for HCBS-DD	Total Waiting List for SLS	Unduplicated Adult Services Total	HCBS-CES	Family Support Services Program	Unduplicated Children & Family Services Total
Requested Date of Enrollment	ASAA	199	982	455	1,484	1,361	2,845	373	5,172	5,545
	FY12	54	115	4	166	156	322		17	17
	FY13	32	129	3	150	131	281		9	9
Estimated Funding	Medicaid	285	1,125	462	1,800	1,251	3,051	373		373
	State		101			397	397		5,198	5,198
Age Group	Birth 2.9							17	1,541	1,558
	3-13.9							310	2,616	2,926
	14-15.9							30	148	178
	16-17.9	16	251		242	262	504	16	165	181
	18-20.9	106	397	35	507	462	969		262	262
	21-39.9	90	463	332	810	732	1,542		410	410
	40-54.9	40	73	66	156	128	284		35	35
	55 Older	31	37	29	79	63	142		9	9
	*Missing	2	5		6	1	7		12	12
Current Residence (Duplicate Count)	Parent/Relative	103	1,042	368	1,400	1,381	2,781	366	5,181	5,547
	Indep Home	18	48	56	106	158	264		7	7
	Other Res Setting	164	136	38	294	109	403	7	10	17
Total		285	1,226	462	1,800	1,648	3,448	373	5,198	5,571

High Risk Total	117	293	154	527	313	840		
Avg by Category of Time on Waiting List	3.8	2.8	3.7	3.1	2.9		8.5	2.4
Total Average Years						2.9		

* Age Group/ Missing data is due to no date of birth in Community Contract and Management System (CCMS) record.

Footnotes for Division for Developmental Disabilities Waiting List Report

1) The grayed boxes indicate that there is no data possible due to the individual's age or funding type.

2) The Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) Adult Waiting List includes those age 16 and older who are requesting services within two years and are not currently in a publicly funded residential service (DDD Residential, Nursing Home, ICF/MR, Regional Center, Social Services Children's Home).

3) HCBS-DD WL - No Current Adult Services - Would accept HCBS-DD or Supported Living Services (SLS). - indicates that the person is waiting for both HCBS-DD & SLS and would accept SLS while they wait for HCBS-DD. It DOES NOT mean that SLS would entirely meet the person's needs. It is unlikely that providing SLS would remove the person from the HCBS-DD WL. It would just remove them from the SLS WL and move where they are counted on the HCBS-DD WL from 'No Current Service' to 'In Current Service'.

4) HCBS-DD WL - In Current Adult Service - this indicates that an individual is receiving SLS while waiting for HCBS-DD services.

5) The SLS Adult Waiting List includes those age 16 and older who are not in an adult service and are requesting SLS within 2 years, although they could be receiving a family support service or HCBS- Children's Extensive Supports (HCBS-CES).

6) The Requesting Only Supported Living Services Waiting List column includes the HCBS-SLS and State SLS Waiting List within 2 years with any duplication across HCBS-DD and HCBS-SLS and State SLS removed. When duplication across HCBS-DD and HCBS-SLS and State SLS Waiting Lists occurs (i.e., person is on both lists), then the count is put in HCBS-DD before HCBS-SLS and State SLS. The Requesting Only Supported Living Services waiting list is derived by subtracting the Unduplicated Adult Services Total number from the Unduplicated HCBS-DD Total Waiting List number.

7) Children & Family Services Waiting List includes all who need HCBS-CES or FSSP but are not currently receiving that service or an Adult Service. Children in foster care placements and waiting for HCBS-CES are included (i.e., enrollment into HCBS-CES may facilitate the child's return to family), however, children in foster care placements who will need HCBS-DD services at age 21 are not included in this waiting list report. The demand for those services are tracked separately for budgetary purposes. When duplication across Children and Family Services occurs (i.e., the child is on more than one list), then the count is put in HCBS-CES before FSSP.

8) High Risk factors available for this report are limited to the following indicators currently on CCMS. Individuals who are 40 years or older and are living with parent or relative (on the assumption that these caregivers are elderly)., and/or individuals who have one or more of the following disabilities: Mental Illness (MI), Maladaptive Behavior (MB), Non-Mobile (NM), Medically Fragile (MF) and/or has an overall function level of Profound (PF). It is recognized that there may be additional individuals with high risk factors that are not identifiable through information currently contained on the CCMS system. Therefore, this should be considered an estimate only.

9) This waiting list report is primarily for budgetary purposes for those requesting services within 2 years does not include 14 & 15 year olds because they would be outside of the budgetary period.

10) Under federal requirements, Early Intervention Services is not permitted to have a waiting list.

Appendix J

Aging & Disability ResourceCenter
An Initiative of the U.S. Department of Health and Human Services
TECHNICAL ASSISTANCE EXCHANGE

The Aging and Disability Resource Center (ADRC) Demonstration Grant Initiative

Interim Outcomes Report

Prepared for:

U.S. Department of Health and Human Services

Prepared by:

The Lewin Group

November 2006

Appendix J

Table of Contents

APPENDIX A: ACRONYMS AND GLOSSARY

APPENDIX B: TECHNICAL APPENDIX

APPENDIX C: EXAMPLES OF PROGRAM RESOURCES

Appendix J

EXECUTIVE SUMMARY

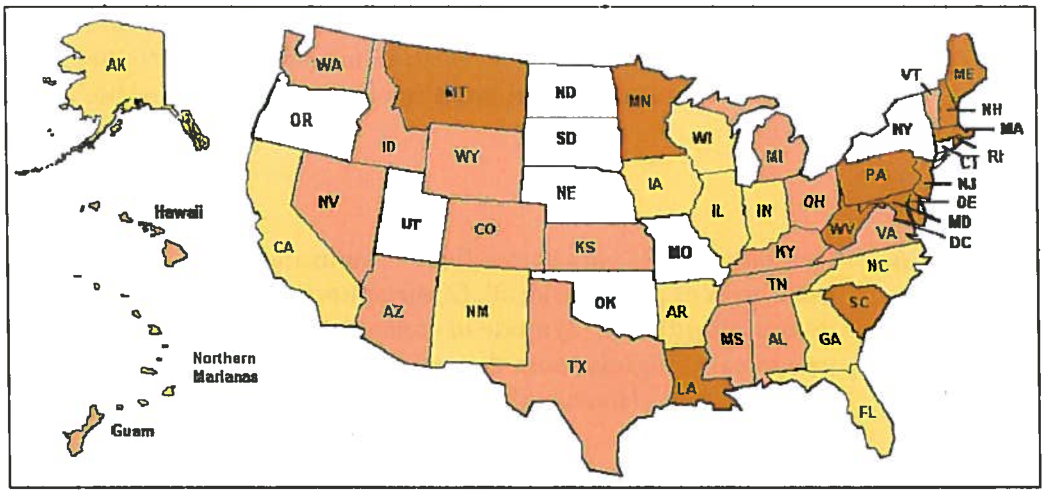
Background

The Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) launched the Aging and Disability Resource Center (ADRC) initiative in 2003. The ADRC initiative is part of a nationwide effort to restructure services and supports for older adults and younger persons with disabilities and it complements other long term care system change activities designed to enhance access to community living.

ADRCs serve as integrated points of entry into the long-term care system, commonly referred to as a "one stop shops," and are designed to address many of the frustrations consumers and their families experience when trying to access needed information, services, and supports. Integrated points of entry strive to create community-wide service systems that reduce consumer confusion and build consumer trust and respect by enhancing individual choice and informed decision-making. This strategy can also help to break down barriers to community-based living by giving consumers information about the complete spectrum of long-term care options.

Forty-three states and territories have received three-year competitive grants since the program was launched: 12 in 2003, 12 in 2004, and 19 in 2005. ADRC grantees must meet a broad set of requirements including the provision of three main ADRC functions—information and awareness, assistance and access. Major requirements include creating visible and trusted places in the community, streamlining access to long term supports, establishing information technology systems to support the functions of the ADRC, and sustaining the program beyond the life of the grant. The federal sponsoring agencies and technical assistance team encourage grantees to design ADRC programs that build on community strengths to address their unique needs.

ADRC Grantees Across the U.S., 2006



Appendix J

Service Populations

As of August 2006, 63 Aging and Disability Resource Centers (ADRCs) operated in 25 states.[1] Over 38 million U.S. residents in 467 counties across the country live in an ADRC service area. Approximately 46 additional pilot sites are expected to open by the end of 2006. When all the planned pilot sites as of October 2006 open, ADRCs will serve 613 counties with a combined population of 61 million, almost 22 percent of the U.S. population.

Target Populations	No. of Pilot Sites (2003, 2004 grantees)
Adults Aged 60 and Older	51 (100%) in 24 states
People with Physical Disabilities	45 (88%) in 19 states
People with MR/DD/ID	28 (55%) in 13 states
People with Mental Illness	27 (53%) in 12 states
All Disabilities	20 (39%) in 10 states

Grantees are required to serve adults 60 years of age and older and at least one other target population of younger individuals with disabilities in at least one community of all income levels. Almost 90 percent of all sites chose to serve people with physical disabilities and nearly 40 percent serve people with all types of disabilities.

Program Budgets

...ADRC funds represent only 25% of annual pilot budgets.

The grant offers up to $800,000 for 3 years per grantee, but grant funds represent only 25 percent of annual pilot site budgets. Most of the average annual ADRC pilot site operating budget ($1.4 million in rural areas and $5.5 million urban/suburban areas) come from Older Americans Act (OAA), Medicaid, state and local revenue, and other grants. Many grantees budgeted a significant portion of their grant funds, and in some cases, additional sources of funding to integrate existing services, improve service system infrastructure, such as management information systems (MIS), and to support marketing and outreach activities ($312,000 on average, median of $110,000). Some grantees budgeted for new staff at the state and local levels to coordinate grant activities, but only a small percentage of grant funds support direct ADRC services.

Model Structures

...Slightly more than 60% of all ADRC pilot sites have state-driven management and centralized structures.

Program models vary across three organizational dimensions: (1) management (state vs. local), (2) structure (centralized vs. decentralized), and (3) mode of consumer access (physical setting vs. virtual). Slightly more than 60 percent of all ADRC pilot sites fall at the state-driven end of the management structure and

---

[1] This figure includes Wisconsin's nine original ADRCs and three open pilot sites in Virginia (2005 grantee).

centralize their organizational structure. The state-driven and centralized cohort divides fairly evenly between physical and virtual models. The next largest group of grantees lies at the locally-driven end of the management scale, but are also centralized in their structure and divided along the consumer access dimension. While decentralized models constitute the minority, some grantees have developed successful decentralized models and more of the recent grantees appear to be adopting decentralized designs.

Distribution of Pilot Sites across Model Types, FY 2003 and 2004 Grantees (n = 24 States)

Management		Structure		Consumer Access		# of Pilot Sites	% of Pilots
State	Local	Centralized	Decentralized	Physical	Virtual		
√		√		√		17	33%
√		√			√	14	27%
√			√	√		2	4%
√			√		√	3	5%
	√	√		√		8	16%
	√	√			√	5	10%
	√		√	√		1	2%
	√		√		√	1	2%
73%	27%	86%	14%	53%	47%	51	99%*

* = Total does not sum to 100% because the results were rounded

Interim Findings

ADRCs began to establish themselves as visible and trusted places in the community and served increasing numbers of individuals

- Consumers and providers made more than 750,000 contacts to ADRCs between March 2004 and March 2006, and the average number of contacts per month per site increased by over 200 percent across all sites and 60 percent for sites reporting in both periods.
- One-third to one-half of ADRC contacts involved the provision of non-LTC information, in part because ADRCs played a vital role in providing the Medicare Part D prescription drug benefit information and enrollment support.
- Consumers constitute 71 percent of contacts, while caregivers represent 17 percent and professionals 12 percent. A slight majority of all contacts came from new consumers, but the substantial number of repeat contacts indicates that ADRCs have begun to establish themselves as a trusted source of information.

...the substantial number of repeat contacts indicates that ADRCs have begun to establish themselves as a trusted source of information.

- For most ADRC pilot sites, younger adults with disabilities represented a new and growing service population (20 percent of contacts for October 2005 through March 2006).
- Grantees and pilot sites strategically marketed the ADRCs using names and messages that were consistent with their model types. Most ADRCs (70 percent) marketed and publicized the ADRC as a new entity, but several grantees implementing decentralized models used their marketing resources to raise visibility and awareness in the community about the enhanced services newly available through existing networks of trusted service organizations.

Strategic partnerships play a key role in establishing ADRCs

- Partnership development among diverse constituencies at both the state and local levels proved critical to successful expansion of the project. Partnering activities ranged from information sharing to co-location of staff.
- ADRCs must foster a strong relationship with Medicaid at the state and local level, which has been a challenge for some. Several grantees reported difficulty partnering with Medicaid, although the input and involvement of Medicaid is necessary to moving forward with plans to streamline access.
- Some grantees encountered difficulty with establishing relationships between aging and disability entities, because of differences in service philosophy and historic divisions between the two service systems at both the state and local levels.

Partnership Activities	State Level (n=211 partnerships in 24 States)	Pilot Site Level (n=288 partnerships in 51 Pilots)
Formal Protocols/MOUs	29%	28%
Co-location of Staff	13%	16%
Information Sharing	42%	44%
Joint Training	19%	25%
Joint Sponsorship of Programs	18%	23%

- Grantees made a special effort to partner with "critical pathway" providers – i.e., common pathways for consumers to the long-term care system, both community-based and institutional, such as hospitals and discharge planners, doctors' offices, rehabilitation nursing homes, and intake agencies for home and community-based services (HCBS). These types of organizations together accounted for 55 percent of all referrals to ADRCs, suggesting that ADRCs are playing a key role in the process of making consumers aware of available options and assisting consumers make informed decisions (options counseling).

ADRCs built and enhanced the information technology infrastructure for information, referral, assistance, and eligibility

- Seventy-five percent of the 2003 and 2004 grantees are moving toward developing and implementing web-based, centralized data management systems to provide

…75% of the 2003 and 2004 grantees are moving toward web-based, centralized data management systems.

access to information, expedite application and eligibility determinations and facilitate updating, sharing and tracking of consumer information.

- In selected sites, progress has also been made in establishing IT/MIS systems that support self- assessments, client intake, needs assessments, client tracking, case management, service utilization levels and costs.
- The establishment of comprehensive resource databases and the ability to efficiently share information among agencies to make the most effective referrals through enhanced IT/MIS and formal partnerships represents a different way of delivering I&R/A than "business as usual."
- Grantees found the process of implementing the IT/MIS refinements more time consuming and costly than originally planned and IT/MIS delays were the most commonly reported reason for delays in streamlining access.

Grantees made significant progress in streamlining access to services

Over the course of the three-year grant period, the 2003 grantees undertook at least three of 14 different types of activities to increase the ease with which consumers access information and services and improve the efficiency or timeliness of the process.

Major Activities Undertaken by Grantees to Streamline Access to Long Term Support Services, 2003 grantees (26 pilot sites)

Consumer Ease	Efficiency/Timeliness
Develop Web-based resource database *(66%, 16 pilots)*	Collect preliminary financial information as part of initial screen *(80%, 21 pilots)*
Provide online access to programmatic or financial applications or forms *(75%, 18 pilots)*	Shorten forms *(33%, 8 pilots)*
Allow electronic submission of applications or forms *(69%, 18 pilots)*	Reduce duplication (e.g. pre-population of forms with consumer information) *(42%, 10 pilots)*
Offer online decision support tools *(12.5%, 3 pilots)*	Integrate forms or develop universal assessment *(42%, 10 pilots)*
Shorten time from intake to eligibility determination *(58%, 15 pilots)*	Co-location of staff *(61%, 16 pilots)*
Reduce number of interactions for the consumer *(54%, 13 pilots)*	Institute presumptive eligibility or self-declaration of financial resources *(16.6%, 4 pilots)*
Reduce number of entities involved in the process *(21%, 5 pilots)*	Integrate MIS/ share information across agencies/ track clients system-wide *(66%, 16 pilots)*

- Streamlining access often involved establishing standard screening and intake processes across organizations.

- Facilitators for streamlining access include having a strong partnership between the ADRC and the Medicaid agency and pursuing a largely state-driven initiative (planned and managed across all sites at the state level).
- For eight pilot sites in five states that reported consistent data about average monthly enrollment in HCBS, institutional settings and other LTC programs, since instituting an ADRC, these pilot sites experienced a 10.2 percent increase in HCBS enrollment and a 11.8 percent decline in institutional placements.

Grantees faced challenges in realigning systems and building relationships and learned valuable lessons to address these challenges

- All 24 of the 2003 and 2004 grantees reported at least one substantial challenge to planning and implementing their ADRC grant. They reported IT/MIS challenges most frequently. Other frequently reported challenges related to leadership, staffing and turnover, forming and maintaining partnerships with other agencies, streamlining access, and engaging consumers.
- ADRC grantees developed strategies to address these challenges in a variety of ways, some of which included investing time in building partnerships, cross-training staff from partnering organizations, establishing a systematic process for determining IT/MIS user specifications, and effectively managing changes in the political environment, such as changes in administration.

Challenges and Facilitators (24 grantees)

Challenges	Facilitators/ Lessons Learned
IT/MIS ***(16 of 24, 67%)***	
• Insufficient staff time/resources set aside for IT/MIS issues • Technical issues linking systems from different agencies • Difficulty procuring IT/MIS vendor • Delays due to other agencies' activities/issues/concerns • Other	• Allowing adequate time and resources for determining IT/MIS needs and procuring a vendor. • Establishing systematic process for determining user specifications. • Tools to facilitate the re-engineering process, such as mobile input devices.
Staffing and Leadership ***(15 of 24, 63%)***	
• Administration and leadership changes/agency reorganizations • Delays in hiring key staff due to hiring freezes, budget delays • Turnover of key staff during grant period • Insufficient staff capacity	• Establishing relationships with new leaders early and educating them about the purpose of the ADRC. • Appointing a dedicated project manager. • Cross-training staff from partnering organizations.
Partnerships with Other Agencies ***(13 of 24, 54%)***	
• Partnerships between aging and disability agencies • Partnerships with state and county Medicaid agencies	• Involving partners early in the planning process. • Identifying champions in partnering organizations.

Challenges	Facilitators/ Lessons Learned
• Partnerships with other agencies	• Setting clear and realistic expectations for partners. • Remaining flexible in determining partner roles. • Selecting pilot sites that already have strong partnerships with key agencies.
Streamlining Access Activities (11 of 24, 45%)	
• Integrating ADRC with other Medicaid system reform efforts/initiatives • Fragmentation of eligibility determination processes • Privacy concerns related to data sharing between agencies	• Coordinating closely with other system reform initiatives and grant programs • Taking incremental steps toward streamlining • Implementing policies to protect consumer privacy and facilitate data sharing
Consumer Involvement *(9 of 24, 38%)*	
• Recruiting consumers from target populations to participate • Maintaining active involvement of consumer participants	• Involving consumers in meaningful ways, such as direct involvement in marketing and outreach activities • Establishing links with existing advisory committees. • Creating a separate board for consumers.

Conclusion

The ADRC grantees have begun to create integrated points of entry into long-term care systems; to empower individuals to make consumer-directed, informed choices about long-term care options; and to serve as highly visible and trusted places that people of all ages can rely on for a full range of information and supports regarding long-term care, utilizing four overarching strategies:

1) Streamlining access to long-term care information, services and supports;
2) Building upon strategic partnerships and consumer empowerment to achieve project goals;
3) Establishing and operating replicable models of service delivery consistent with the ADRC philosophy and mission and program objectives; and
4) Creating programs that demonstrate the feasibility, effectiveness and value of rebalancing long-term care service systems.

Several characteristics differentiate ADRCs from other long-term care organizations and establish them as leaders in rebalancing systems of care historically oriented toward institutional care. These include:

- Delivery of efficient, simplified access to a wide range of information and supports about community-based options for an array of consumer groups seeking information or access into the long-term care system through diverse entry points.

- Commitment to developing consumer-centric systems based on values of consumer direction, person-centered planning, and individual choice and autonomy.
- Capacity to facilitate effective linkages at multiple junctures involving diverse stakeholders along the long-term care continuum.
- Ability to prevent unnecessary institutional placement by maximizing access to comprehensive, updated and credible information about alternate resources in the community, including access to Medicaid HCBS waiver services.

The ADRC program is a collaborative effort mobilizing both public and private sector resources. It provides states with creative opportunities to effectively deliver long term support resources for providers and consumers in a single coordinated serviced delivery system consistent with the goals of long-term care rebalancing initiatives taking place at all levels. In addition to their role as change agents in producing enduring systems change, the initial experience of the initiative also shows that ADRCs provide the community and state levels capable of playing a critical role in implementing national programs, such as Medicare Part D, and assisting consumers in times of crises, such as responding to the devastation of Hurricanes Katrina and Rita.

The outcomes that ADRCs have achieved over the past three years have had significant impact at the individual, program, community and state levels. The benefits, successes and lessons learned through ADRC experiences have energized and informed policymaking and program development at all levels in the long-term care arena. ADRCs have shown, as demonstrated in the findings in this report, that it is possible to develop more efficient and effective access to information and supports and that these initiatives are widely endorsed by diverse stakeholders involved in the rebalancing enterprise. They have demonstrated that it is possible to achieve economies of scale through decreasing duplication of effort, maximizing existing resources and building new, more effective partnerships.

I. INTRODUCTION

In Fiscal Year (FY) 2003, the Administration on Aging (AoA) and the Centers for Medicare & Medicaid Services (CMS) formed a historic partnership to launch the Aging and Disability Resource Center (ADRC) demonstration grant initiative. The ADRC initiative is part of a nationwide effort to restructure services and supports for people with disabilities, building on the *Olmstead Decision*[2], a 1999 Supreme Court ruling directing states to provide services in the most integrated setting appropriate to the needs of qualified individuals with disabilities, and the *New Freedom Initiative* (NFI)[3], a 2001 presidential initiative aimed at increasing access to an array of supports and promoting participation in daily community life for persons with disabilities. States have largely responded to *Olmstead* and NFI by expanding their use of home and community based services (HCBS) Medicaid waivers and implementing Real Choice Systems Change[4] projects, another key component of NFI.

Two shortcomings of the current long-term care system that are often cited by consumers, advocates, and policymakers are the confusion and frustration that consumers and their families often experience in trying to access needed information and support, and the over-reliance on institutional care. Consumers may have to take many steps before becoming eligible for a program or service and, in the process, interact with multiple entities, often "telling their story" and providing the same information multiple times. Sometimes consumers get bounced around within an agency or between different organizations with no systematic follow-up and tracking to determine if the consumers' needs were met. Furthermore, lack of awareness about long-term support options and the difficulty of accessing home and community-based services result in unnecessary institutionalization for some consumers.

An integrated point of entry into the long-term supports and services system commonly referred to as a "one stop shop," can address many of these problems. Integrated points of entry have the potential to create community-wide systems of services that reduce consumer confusion and build consumer trust and respect by enhancing individual choice and informed decision making. This strategy can also break down barriers to community-based living by offering consumers information about the complete spectrum of long-term care options.

ADRCs were derived from this integrated point of entry concept. The ADRC program seeks to empower individuals to make informed choices about long-term support options and to streamline access for consumers to long-term support services. The federal vision is that there will be ADRCs in every community serving as highly visible and trusted places where people of all ages can turn for information on the full range of long-term support options and for a single point of entry to publicly-funded long-term support programs and benefits. By coordinating and integrating access to all publicly-

---

[2] OLMSTEAD V. L. C. (98-536) 527 U.S. 581 (1999)

[3] U.S. DHHS, New Freedom Initiative, http://www.hhs.gov/newfreedom/init.html

[4] Information about the Centers for Medicare and Medicaid Services' Real Choice Systems Change Grants can be found online at: http://www.hcbs.org/

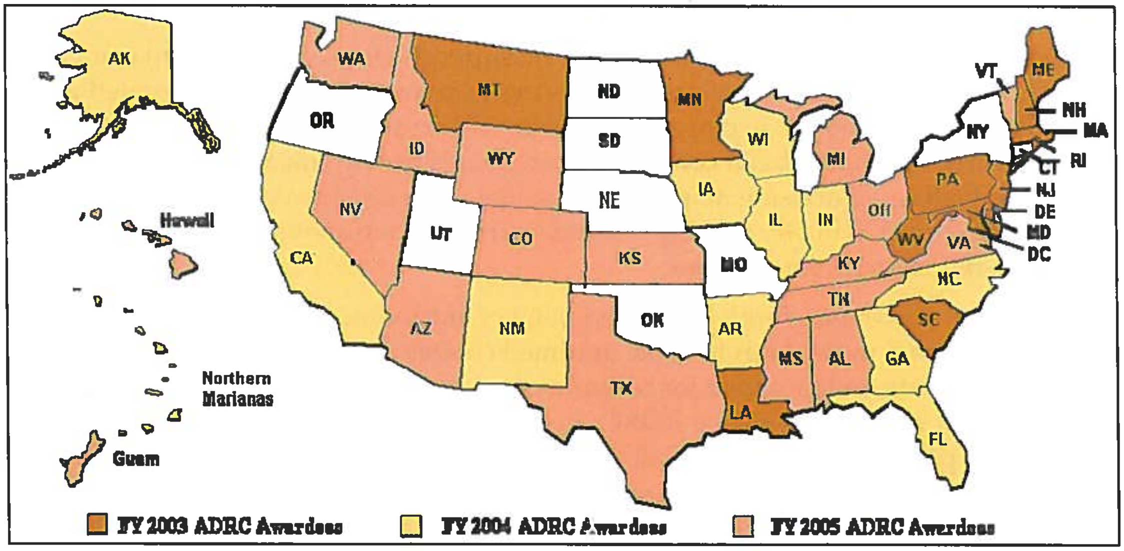
supported long-term care programs, ADRCs should improve the efficiency of government programs and reduce the frustration and confusion that consumers often face when trying to learn about and access the long-term care system.

ADRCs serve as a resource for individuals of all income levels and a range of populations -- older adults, younger individuals with disabilities, family caregivers, as well as persons planning for future long-term support needs. ADRCs also offer resources to health and long-term support professionals and others who provide services to older adults and to persons with disabilities. Since the program launched in 2003, 43 states and territories have received three-year competitive grants from AoA and CMS to design and implement ADRC demonstrations serving the elderly and at least one other target population of adults with disabilities in at least one community.

Twelve states were awarded grants in 2003, 12 states in 2004, and 19 additional states were funded in 2005 to develop ADRC programs (***Exhibit 1***). Currently, many grantees plan to expand the number of ADRC sites in pursuit of operating ADRCs statewide. By the end of 2006, these grantees will operate 109 pilot sites across the country covering almost 22 percent of the U.S. population.

The grantees are supported by the ADRC Technical Assistance Exchange (ADRC-TAE), which is funded by AoA and operates in partnership with CMS via its technical assistance center for the Real Choice grantees. The ADRC-TAE partnership includes The Lewin Group, Rutgers University Center for State Health Policy, the National Academy for State Health Policy, and the National Association of State Units on Aging.

Exhibit 1: ADRC Grantees across the U.S., 2006



Overview

This report presents findings at the state level and the pilot site level on the outcomes, accomplishments, and contributions of the ADRC program over the grant period. It emphasizes the activities of FY 2003 and FY 2004 grantees in the greatest detail. While it is too soon to report impacts of the program, this interim report details more immediate results related to key consumer and program outcomes. It also documents lessons learned and program and policy implications at the pilot, state and national level.

Grantees must serve older adults and at least one other disability target population and meet a broad set of requirements (***Exhibit*** 2), including the provision of three main ADRC functions - information & awareness, assistance and access to long-term support services. In addition, federal expectations include: creating a seamless system for consumers; streamlined eligibility; meaningful involvement of consumers and other stakeholders; partnership among aging networks, disability networks and Medicaid agencies; investment in management information systems that support the goals of the ADRC; performance measurement; and sustainability.[5]

The sponsoring federal agencies gave the grantees flexibility to develop ADRC models that best meet their specific needs, as long as these models align with the federal vision. The federal project officers and the ADRC-TAE support team encourage grantees to design and implement programs by leveraging existing resources they employ, either in-house or through partnerships, rather than duplicating or creating new services. As this report highlights, the variability across grantees in terms of political and environmental climates, state and local vision of the program, and existing capacity yielded a range of program models capable of achieving the goals of ADRCs.

---

[5] ADRC 2005 Grant Cooperative Agreement available online at: http://www.adrc-tae.org/tiki-index.php?page=ADRCGrantInfoPublic and ADRC 2005 Grant Initiative Solicitation online at: http://aoa.gov/prof/aging_dis/ADRC2005solicitation percent20- percent20final percent20revised percent20- percent204-05.pdf

Exhibit 2: Summary of Grant Requirements

Required Functions of an ADRC

Awareness & Information

- Public Education
- Information on Options

Assistance

- Options Counseling
- Benefits Counseling
- Employment Options Counseling
- Referral
- Crisis Intervention

Access

- Eligibility Screening
- Private Pay Services
- Comprehensive Assessment
- Programmatic Eligibility Determination
- Medicaid Financial Eligibility Determination
- One-Stop Access to All Public Programs
- Planning for Future Needs

Target Populations

- Must serve the population aged 60 and over and at least one disability population under age 60 – i.e., physically disabled, severe mental illness, developmental disability
- Must include the private pay population

Research Questions

This report addresses the following research questions related to the initial experience of the ADRC initiative:

1. What is the range of program activity and what progress have grantees made toward:
    - Serving their target populations?
    - Promoting informed decision making about long-term support options?
    - Streamlining access to services and supports?
    - Conducting outreach to critical pathways?
    - Achieving visibility and public awareness/trust?
    - Creating IT/MIS infrastructure to support ADRC functions?
    - Achieving sustainability?

2. What ADRC program models have emerged and which models or model components are related to better outcomes?
3. What makes an ADRC an ADRC? What is their capacity for replication?
4. What role does the ADRC program play in the broader context of long-term support systems reform?

Data Sources and Methods

Data Collection

Findings presented in this report are from six primary data sources:

- **Semi-annual Reports (SART).** Every six months, ADRC grantees submit a progress report through a Web-based instrument called the "Semi-annual Reporting Tool" or SART. The SART contains fields for both state and local level program data and includes narrative sections for the authors to further explain approaches taken, and successes and challenges encountered. This report addresses information from three reporting periods: April 2005, October 2005 and April 2006. Data from the most recent reporting period (April 2006) are emphasized.
- **Sustainability Site Visits.** During the winter and spring of 2006, the ADRC-TAE conducted site visits to Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, and South Carolina, which represented half of the states receiving ADRC grants in 2003. Grantees were selected for site visits because they were among the first to receive ADRC grants and were in the final year of their three-year grants when they were likely to be focusing on sustainability issues. The particular study states were chosen because they exhibited different model types and represented a range of service delivery strategies and initiatives as well as economic and programmatic settings.

  Structured interviews were conducted with project leaders, staff, advisory board members, evaluators, volunteers, and other project partners in the six states, at nine pilot sites and at four ADRC Access Points (in Minnesota). Topics covered in the fieldwork included: (1) *Elements* of the ADRC initiative that are most likely to be sustained and/or replicated; (2) *Strategies* used to achieve sustainability; and (3) *Conditions, features or characteristics* of the different states and ADRC programs that facilitate sustainability. Findings from the site visits are incorporated into the "Achieving Sustainability" section of this report.
- **Grants Monitoring Database.** AoA and CMS conduct calls every six months (off-cycle from the Semi-annual Reports) with each grantee to monitor grant compliance and program development. Grantees report successes and any significant challenges they have experienced. Project officers input notes from these calls into a Web-based database which is shared with the technical assistance team. Data from Grants Monitoring calls for all grantees were analyzed for this report.
- National Meeting Proceedings. Grantees attend two national meetings each year focused on the ADRC initiative. The meetings present an opportunity to learn about grantees' experiences with program design and development, including approaches

taken and lessons learned, at both the grantee and pilot levels. The ADRC-TAE team at Lewin abstracts and synthesizes common themes and posts the proceedings on the ADRC Technical Assistance Exchange (TAE) website.

- **Grantee Teleconferences**. The ADRC-TAE arranges a variety of ADRC-specific teleconferences, including: (1) standing topic-oriented monthly grantee calls (e.g., Options Counseling), (2) peer workgroup calls with themes suggested by grantees (i.e., pilot sites workgroup, evaluation workgroup), (3) individualized teleconferences between the grantee and the ADRC-TAE. Data from these sources were examined and used for the illustrative examples included in this report.
- **TA Tracker and Website resources**. AoA sponsors the ADRC-TAE website, where resources, information about grantees, and numerous examples of grantee materials such as work plans, budgets, intake forms, advisory board minutes, formal agreements, marketing materials, and streamlining access flow charts are found. In addition, the TAE team uses a Web-based tool to track grantee requests for technical assistance and the provided response. Requests for assistance are coded by themes that allow the team to look across grantees for common challenges, which informed several sections of this report. In particular, for the visibility and public awareness subsection of this report, we analyzed marketing materials and tag lines to determine if ADRCs at the pilot level branded themselves as a new entity or an enhanced entity. Likewise, ADRC names were examined to determine if the ADRCs branded themselves as a network/affiliation or a physical center.

Data Analysis

Initially, SART program data pertaining to implementation and outcomes from three reporting periods were coded and analyzed at both the state level (i.e., "grantee") and local level (i.e., "pilot site"). Data from the Grants Monitoring database and TAE events (i.e., grantee teleconference, national meetings, and TA Tracker) were triangulated to abstract common themes. Finally, data from the site visits were used to vet the secondary data analysis and to inform the findings pertaining to sustainability, best practices and lessons learned.

To analyze grantees marketing and outreach activities (under ADRC Visibility and Marketing), the research team constructed variables that indicate whether the ADRC is being marketed as a (1) New Entity or (2) Existing/ Enhanced Entity based on analysis of their marketing materials.

To analyze the relationship between existing capacity, program model and grantee outcomes pertaining to streamlined access to public programs, the research team constructed variables representing:

- *Existing capacity at the start of the grant* – (1) Partnership between Grantee and Medicaid (less mature, more mature) based on integration and partnership prior to grant, (2) IT/MIS infrastructure (less mature, more mature) based on integration of MIS and use of specialized IT systems.
- *HCBS Spending* – (1) percent of state long-term care spending on home and community based services

- *Different program models based on three dimensions* – (1) Management (State-driven, Locally-driven), (2) Structure (Centralized, Decentralized), and (3) Mode of Consumer Access (Physical, Virtual)
- *Streamlined access*– (1) activities designed to improve Consumer Ease of Access, (2) activities designed to improve Efficiency/Timeliness of process, (3) Post-ADRC Grantee and Medicaid Partnership (less mature, more mature)

Data Limitations

Analysis limited to 2003 and 2004 grantees. Almost all of the analysis in this report is based on the experience of and data reported by the 24 FY2003 and FY2004 grantees only. The findings in this report do not represent the experience of all 43 ADRC grantees. As they complete the first year of their grant period, most of the FY2005 grantees are in the planning and design stages of their projects, do not have fully developed models and have not yet reported outcomes.

Analyzing self-reported data. The primary data used in this report are self-reported by the grantees and pilot sites. Grantees have discretion over the types of information they report in their Semi-annual Reporting Tool (SART) and the depth and detail of the narrative sections of the report varies considerably across grantees. In some cases, grantees are engaged in activities that are not reported on in the SART. Supplementing the SART data with other data sources such as Grant Monitoring calls and grantee teleconference has helped provide a more complete picture, but this report cannot account for all grantee activity.

Differences in capacity for collection and reporting across grantees. The grantees' capacity for collecting and reporting the minimum data set requested varies considerably. The extent to which grantees have been able to report baseline and outcomes data related to service volume, consumer demographics, types of assistance provided, sources of referrals, and long-term outcomes varies according to the data elements their IT systems allow them to collect, their client tracking systems, staff time, and training. Furthermore, differences in data collection processes and definitions of terms across grantees sometimes result in data that are not comparable, which must be excluded from the analysis. The sample sizes ("n" values) for many of the data elements and figures in this report are smaller than the total number of grantees or pilot sites because data were drawn from sub-sets of grantees that were able to report these data elements consistently.

Difficulty comparing consumer satisfaction data across grantees. Although the majority of grantees are conducting surveys of consumers satisfaction, there was no required or standardized survey instrument or data collection routine. Consequently, consumer satisfaction data varies widely across the grantees. Eighteen grantees reported at least some outcome data from their consumer satisfaction surveys. While some grantees submitted the full results of their consumer satisfaction surveys, others reported only a few indicators. It is difficult to compare results as some grantees used Likert scale measures and others multiple choice or yes or no responses. Response rates varied from 5.2 percent to 100 percent, and level of response was not related to the survey method.

Analyzing predictors of program outcomes. The analysis of the relationship between program model type, existing capacity, and streamlined access to long-term support services is based on the early experiences of the first round of ADRC grantees and is an assessment of program performance at a "point in time." It is too early to measure the extent to which the program can be sustained over time and the true evidence of change; therefore, rather than drawing conclusions about which factors result in streamlined access and other successful outcomes, this report emphasizes the major trends from the data analyses and what the trends may suggest regarding program performance.

Organization of the Report

The remainder of this report is divided into four sections and three appendices as follows:

- **Section II: Grantee Program Models and Characteristics** describes the range of ADRC program models that emerged from the FY 2003 and FY 2004 grantees and reports select characteristics of these programs such as the target populations being served, geographic coverage, program budgets, and staffing composition and training.
- **Section III: Findings** describes the major findings of the ADRC initiative in terms of accomplishments and outcomes, subdivided by consumer and program levels.
- **Section IV: Promising Practices/ Lessons Learned** highlights emerging promising practices related to planning, infrastructure, and access to long-term support and describes key facilitators and barriers to program planning and implementation as reported by the grantees.
- **Section V: Conclusion** synthesizes the major contributions of the ADRC program and reports key program policy implications of the findings for the grantee and federal levels related to future ADRC development and its role within broader long-term care systems reform. This includes discussion implications for replication, challenges and future direction of the program.
- **Appendix A – "Acronyms and Glossary:"** provides a list of commonly used acronyms and definitions of key terms used in the report.
- **Appendix B – "Exhibits:"** provides a chart of all the tables and graphs included in this report with page references.
- **Appendix C – "Examples of Program Resources:"** includes several resources related to ADRC websites, cross-training, partnership development, marketing, and streamlined access developed by grantees.

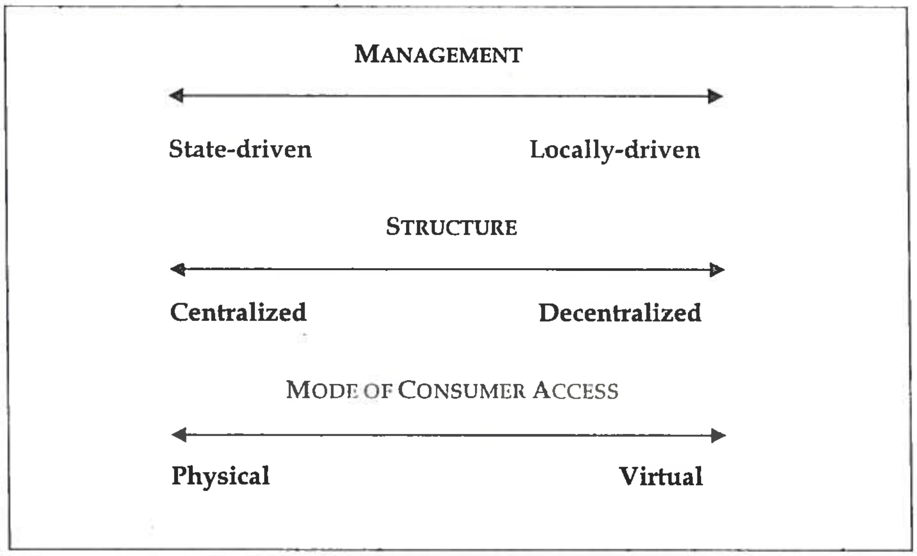
II. GRANTEE PROGRAM MODELS & CHARACTERISTICS

ADRC Program Models

A key intent of the ADRC concept is the development of proactive and responsive systems of information and support that meet the range of needs consumers have regarding home and community-based services and supports. Over the first three years of the ADRC grant initiative, participating states and pilot sites responded to this consumer-centered systems approach by developing and implementing models designed to achieve the goals of the program, while balancing and leveraging factors unique to each grantee, including socio-economic and political contexts, existing infrastructure and capacity, and needs expressed by key stakeholders and consumers. As a result, a range of ADRC models have evolved over the course of implementation. In general, the ADRC models (*Exhibit* 3) vary across three organizational dimensions: (1) management (state vs. local), (2) structure (centralized vs. decentralized), and (3) mode of consumer access (physical setting vs. virtual). One ideal model for delivering ADRC services has not emerged. Indeed, programs with notably different designs have made similar progress in realizing the ADRC vision.

In terms of management, states vary in the extent to which grant planning, design and administrative responsibilities reside at the state or local levels and the extent to which pilot sites have discretion in the implementation of the grant. The second dimension, organizational structure, varied at the pilot site level from centralized to decentralized in terms of how many organizations share responsibility for providing ADRC functions and the extent to which these organizations partner with others in the community. The third dimension, consumer access, pertains to how consumers interface with the ADRC to access information and services in which some pilot sites focus more heavily on physical means of access and other focus more on virtual means.

Exhibit 3: ADRC Model Dimensions



To describe where the grantees fall within the dimensions, four categories were applied to each dimension. The percentage of the pilot sites that fit into each of these four categories and the criteria used to define each category are outlined below.

Management

About three-quarters of the 2003 and 2004 grantee pilot sites are managed primarily at the state level (*Exhibit* 4). This category includes ADRCs that offer services statewide, which are often operated by state level staff. Others in this category are states that developed an overall policy vision and project design at the state level, to be implemented across multiple pilot sites. Pilot sites in these states may benefit from innovative directors and skilled staffs, as well as strong local partners and advisory boards, but major decisions about ADRC policies are made primarily at the state level. Just over one quarter of pilot sites fall toward the locally-driven end of the spectrum. In these cases, the state provides support and technical assistance but otherwise allows pilot sites a great level of discretion to develop and implement the ADRC program. In some cases, states chose pilot sites that had been operating programs with ADRC-like components prior to the grant award and encouraged them to develop their ADRC initiatives locally. Locally-driven projects have demonstrated that ADRC pilot sites can succeed when they have the flexibility to develop programs that meet the needs of their communities, as well as support and guidance from the state.

Exhibit 4: Management: State-driven to Locally-driven
(n = 51 Pilot Sites)[6]

27.5% (14)	45.1% (23)	11.7% (6)	15.7% (8)
State-Driven: One or more state agencies have primary responsibility for planning and oversight, with limited input from pilot sites/local level organizations.	**State/Local:** One or more state agencies share responsibility for planning and oversight, with significant input from pilot sites.	**Local/State:** Local level organizations have flexibility in ADRC planning and implementation, with significant state involvement.	**Locally-driven :** Local level organizations have primary responsibility for pilot site planning and implementation, with limited state involvement.

Structure

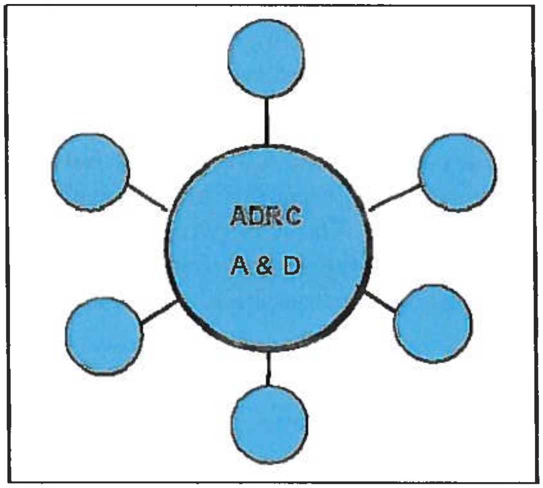
In centralized models, one organization takes primary responsibility for providing all ADRC functions and serving all target populations, similar to Wisconsin's original

---

[6] The 51 pilot sites are those opened by 2003 and 2004 grantees. It does not include the 2005 grantees' pilot sites or Wisconsin's original nine sites, which are not considered pilots in the national initiative.

ADRCs and other single point of entry systems.[7] However, centralized models still rely heavily on other partnering organizations in the community to serve on advisory boards, help with marketing and outreach, refer clients to the ADRC, and provide direct services for ADRC clients. In decentralized models, two or more organizations partner to provide ADRC services, offering consumers multiple entry points into the long-term care system. Through the coordination of referrals, standardized intake procedures, and data sharing between these primary partnering organizations, consumers can enter into any one of these organizations and receive the same standard set of ADRC services. Decentralized models have a core group of primary partners, organizations that are responsible for offering ADRC services, as well as peripheral partners that play more limited roles, such as assisting with outreach and referring clients to one of the multiple access points. There is variation in how decentralized ADRC models are organized. In some, all of the primary operating organizations serve all the ADRC target populations. In other decentralized models, one partner takes the lead on serving the aging population while another focuses its outreach and services to disability populations. In both centralized and decentralized models, grantees work to simplify the process of accessing services and to impose consistency and uniformity across the intake and eligibility determination processes for long-term care programs. *Exhibits 5, 6* and *7* below illustrate the differences between a centralized model and two different kinds of decentralized ADRC models.

Exhibit 5: Centralized ADRC with one operating organization that serves older adults and younger people with disabilities, with support of Partnering Organizations



---

[7] Wisconsin opened Aging and Disability Resource Centers in nine counties as part of the state's Family Care initiative in 1999. More information about the Wisconsin ADRCs and Family Care is available online at: http://dhfs.wisconsin.gov/LTCare/Generalinfo/RCs.htm

Exhibit 6: Decentralized ADRC with multiple operating organizations that serve both older adults and younger people with disabilities, with support of Partnering Organizations

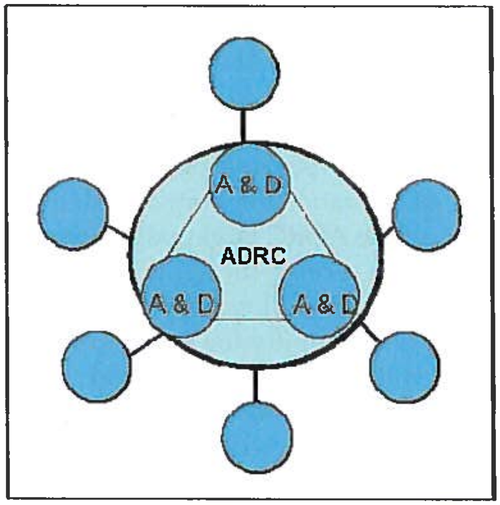
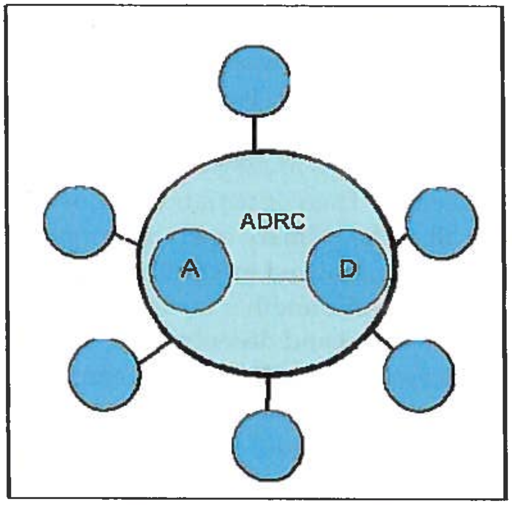


Exhibit 7: Decentralized ADRC with multiple or Disability populations, with support of Partnering operating organizations that focus on either Aging Organizations



Most ADRC pilot sites are working to implement a highly centralized structure, where ADRC functions will be offered by one organization (***Exhibit** 8*). Integrating all the ADRC functions into one organization often represents a major change in how these services were offered at the local level. Some highly centralized sites have achieved complete integration, through co-location of entire organizations or hosting staff from other organizations, on a full-time or part-time basis. Other centralized sites are still working to bring all the functions together.

About 20 percent of pilot sites are implementing "somewhat centralized" models, where some ADRC functions remain the responsibility of an outside organization but are closely coordinated with the ADRC. About 14 percent of sites have decentralized structures. These sites are notable in the extent to which they have streamlined access to public and private services through partnerships, coordination, and data sharing.

Exhibit 8: Structure: Centralized to Decentralized (n = 51 Pilot Sites)

64.7% (33)	21.6% (11)	5.9% (3)	7.8% (4)
Highly Centralized: One primary organization offers all ADRC functions; partners play a limited role, referring clients to the ADRC and receiving referrals back for direct services.	**Somewhat Centralized:** One primary organization offers most ADRC functions, but relies on partners for some functions; partners play a significant role; client information may be shared between ADRC and partners.	**Somewhat Decentralized:** Two primary organizations offer all ADRC functions; client information is shared between primary partners; other partners play a limited role, referring clients to the ADRC and receiving referrals back for direct services.	**Decentralized :** Two or more primary organizations partner to offer ADRC functions; many organizations play significant roles; client information is shared among primary partners and peripheral partners.

Mode of Consumer Access

In physical models, consumers' primary means of accessing information and services is by contacting the ADRC by telephone or in-person. Most of the pilot sites that are designated below as having highly physical modes of access sites also host websites to provide basic information about services and how to connect with them. However, these sites are not a primary mode of consumer access; rather they supplement and direct consumers to access the ADRC in other ways. About half of the 2003 and 2004 pilot sites offer more virtual mechanisms as primary modes of access (*Exhibit 9*). In virtual models, consumers access the ADRC primarily by telephone or by using Web-based searchable databases to access information and resources. Many of these sites operate statewide call centers and websites that connect consumers to local services. Once an initial contact has been made through a virtual mechanism, an in-person appointment for counseling or assessment may be scheduled. In highly virtual models, consumers can use online tools to help them assess their own needs, electronically submit personal information to the ADRC to begin the service process, or complete and submit applications for Medicaid and other public programs.

Exhibit 9: Mode of Consumer Access: Physical to Virtual (n = 51 Pilot Sites)

33.3% (17)	19.6% (10)	19.6% (10)	27.5% (14)
Highly Physical: Consumers access the ADRC mainly by walking in or by calling.	**Mostly Physical:** Consumers access the ADRC mainly by walking in or by calling; they may find basic (static) information about ADRC and services on a website.	**Somewhat Virtual:** Consumers access the ADRC mainly by walking in or by calling; they may also use a Web-based searchable resource database; they may be able to download and mail in applications for Medicaid and/or other public programs.	**Virtual :** Consumers access the ADRC mainly by calling or a using Web-based searchable resource database; they can electronically submit personal information and/or application forms to begin eligibility process for Medicaid and/or other public programs.

Eight Model Types

When the four categories of each dimension are collapsed into two dichotomous classifications (e.g., State-driven versus Locally-driven) and examined across all three dimensions, the grantees fall into eight different model types. ***Exhibit 10*** shows the distribution of pilot sites across these eight types. Slightly more than 60 percent of the ADRC pilot sites fall at the state-driven end of the management structure and are centralized in their organizational structure. The state-driven and centralized cohort is fairly evenly divided between physical and virtual models. The next largest group of grantees lies at the locally-driven end of the management scale, but are also centralized in structure and divided along the consumer access dimension.

Exhibit 10: Distribution of Pilot Sites across Model Types, FY 2003 and 2004 Grantees (n = 24 States)

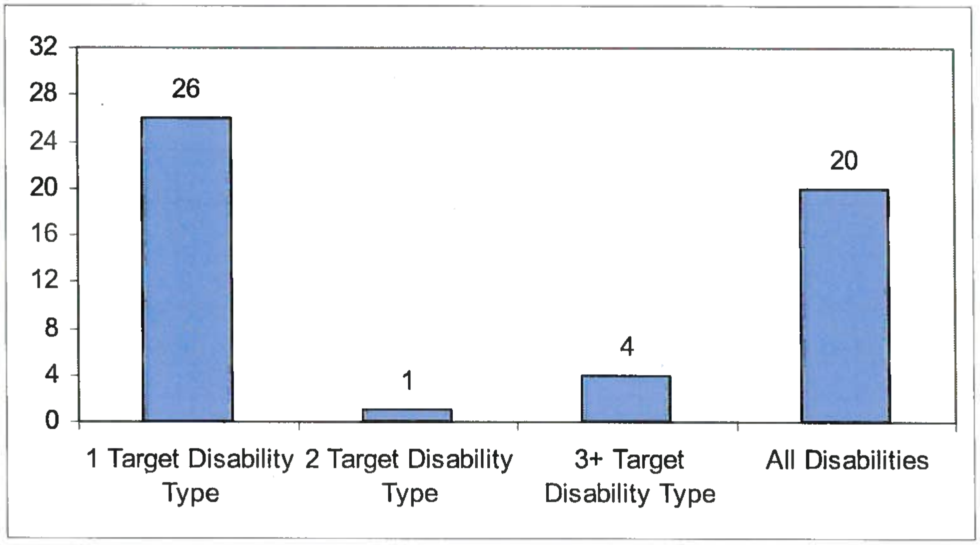
Management		Structure		Consumer Access		# of Pilot Sites	% of Pilots
State	Local	Centralized	Decentralized	Physical	Virtual		
√		√		√		17	33%
√		√			√	14	27%
√			√	√		2	4%
√			√		√	3	5%
	√	√		√		8	16%
	√	√			√	5	10%
	√		√	√		1	2%
	√		√		√	1	2%
73%	27%	86%	14%	53%	47%	51	99%*

* = Total does not sum to 100 percent because the results were rounded.

Target Populations

ADRC pilot sites must serve adults over the age of 60, as well as younger individuals in at least one target disability group. As shown in *Exhibit 11*, nearly half of the pilot sites began by serving one target disability group, such as people with physical disabilities, mental retardation or developmental disabilities, or mental illness. Just less than 40 percent of these pilot sites serve people with all types of disabilities. Most sites serve adults only, while roughly one-third serve people of all ages.

Exhibit 11: Number of Pilot Sites Targeting One or More Disability Type (n = 51 Pilot Sites)[8]



About 88 percent of all sites serve people with physical disabilities as one of their target populations, with 24 pilot sites in 13 states choosing to target this population specifically and another 21 sites serving people with all disability types (*Exhibit 12*). Approximately 55 percent of pilot sites have chosen to include people with mental retardation/developmental disabilities/intellectual disabilities in their target population. While sites in only two states have chosen target individuals with mental illness exclusively as their one disability group, 53 percent of all sites serve individuals with mental illness.

Exhibit 12: Number of Pilot Sites Serving Different Target Populations, 2006 (n = 51 Pilot Sites)

Target Population	No. of Pilots Sites
Physical Disabilities	45 (88%) in 19 states
Mental Retardation/Developmental Disabilities/Intellectual Disabilities	28 (55%) in 13 states
Mental Illness	27 (53%) in 12 states
All Disabilities	21 (41%) in 10 states

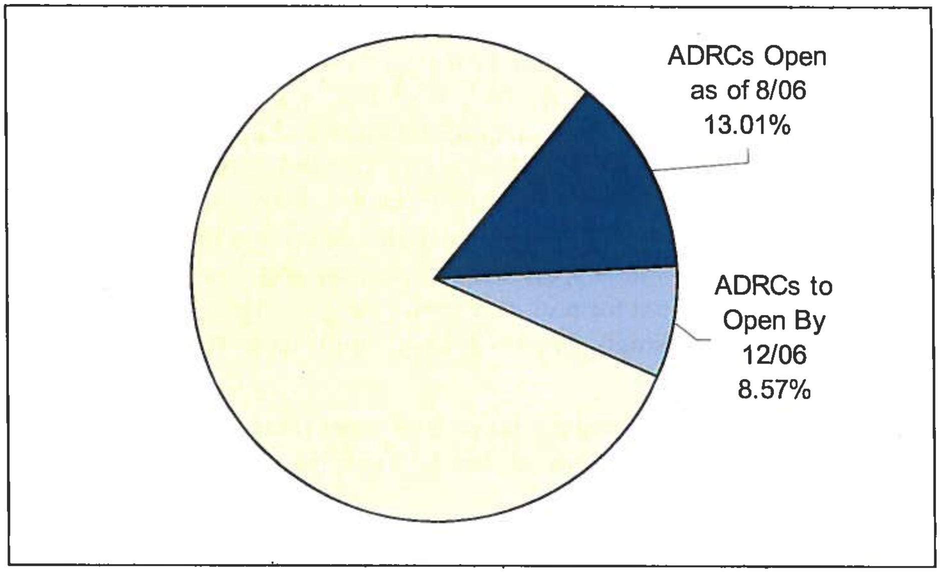
---

[8] The 51 pilot sites are those opened by 2003 and 2004 grantees. It does not include the 2005 grantees' pilot sites or Wisconsin's original nine sites, which are not considered pilots in the national initiative.

Geographic Coverage

As of August 2006, there are 63 pilot sites operating in 25 states.[9] Over 38 million U.S. residents in 467 counties across the country live in an ADRC service area (***Exhibit 13***). Approximately 46 additional pilot sites are expected to open by the end of 2006. When all the planned pilot sites to date open, ADRCs will serve 613 counties with a combined population of 61 million, almost 22 percent of the U.S. population.

Exhibit 13: Percent of U.S. Population Living in ADRC Service Areas, August 2006



Most states pilot the ADRC initiative in one to three sites, with grantees opening multiple pilot sites choosing at least one urban/suburban location and one rural location. Iowa, Minnesota, New Mexico, and Rhode Island began their ADRCs as statewide initiatives.[10] The District of Columbia, Guam, and the Northern Mariana Islands are piloting district-wide or territory-wide.[11] Among the 59 ADRCs that operate within specific regions of the state, their service areas range from one to 13 counties. The resident population ranges from just over 10,000 for one rural pilot to nearly 3.5 million for one urban pilot. ***Exhibit 14*** shows the range in pilot site service area populations.

---

[9] This figure includes Wisconsin's nine original ADRCs and three open pilot sites in Virginia. (2005 grantee).

[10] Key ADRC functions such as I&R/A are offered statewide; Minnesota and New Mexico are piloting other ADRC functions in Hennepin County and Santa Fe, respectively.

[11] The District of Columbia, with a population of 550,521, is categorized as an Urban/Suburban site. Guam and the Northern Mariana Islands, with populations of 154,000 and 69,221 respectively, are categorized as Rural sites.

Exhibit 14: ADRC Service Areas by Urban/Rural, 2006 (n = 63 Pilot Sites)

	Rural	Urban/Suburban	Statewide
Avg. Pop. in Service Area	138,306	1,111,502	2,736,863
No. of Pilot Sites, Open and Planned	20 (31% of all Pilots)	39 (61% of all Pilots)	4 (6% of all Pilots)

Note: 63 sites include the original Wisconsin sites and three open pilot sites in Virginia (FY 2005 grantee).

Program Budgets

Grantees received up to $800,000 in federal funding to design and implement the ADRC initiative over the course of three years. Since the ADRC grant initiative is intended to help states reorganize and streamline existing processes and service delivery, many grantees allocated a significant portion of their grant funds to improve service system infrastructure, such as management information systems (MIS), and to support marketing and outreach activities. On average, grantees planned to spend $312,000 (from grant funds and other sources) on MIS enhancements over the course of three years. Some grantees budgeted for new staff at the state and local levels to coordinate grant activities. A relatively small percentage of grant funds were budgeted to provide direct ADRC services.

The average annual ADRC pilot site operating budget in rural areas was approximately $1.4 million and in urban/suburban areas was $5.5 million (*Exhibit 15*).

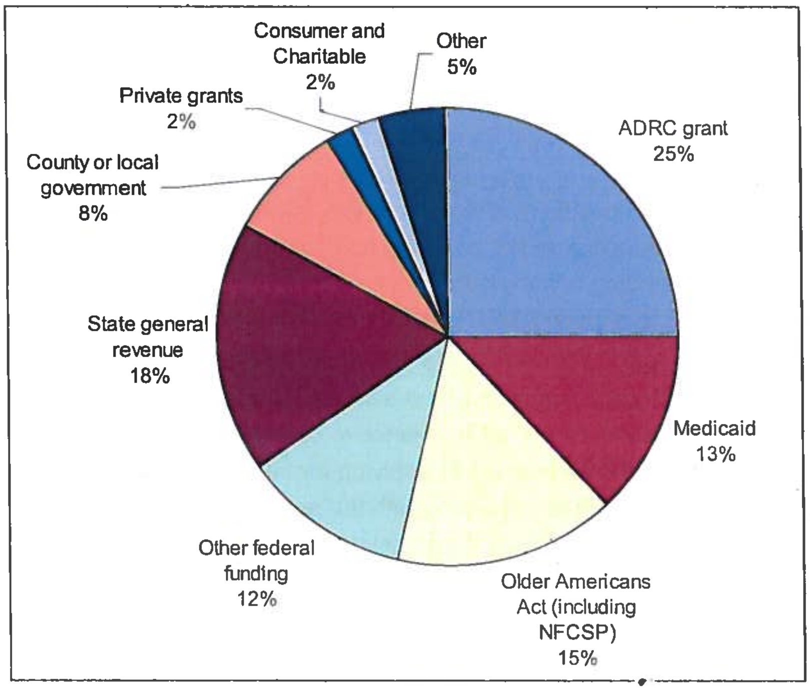
Exhibit 15: Staff Levels and Operating Budgets in Rural and Urban/Suburban Pilot Sites, April 2006

	Rural	Urban/Suburban
Avg. Annual ADRC Pilot Site Operating Budget	$1,399,129	$5,542,481
Annual Dollar Amount Budgeted per Resident in Service Area	$9.77	$5.14
Avg. Total Full Time Equivalent (FTE)	8.75 FTE	18.96 FTE

Annual operating budgets and staff levels reported by ADRC pilot sites vary considerably, in large part based on how the ADRC defines itself. In some states, when an organization such as an Area Agency on Aging is designated as an ADRC pilot site, the whole organization *becomes* the ADRC. In these cases, the annual operating budget is more reflective of the entire organization's budget. In other cases, pilot site organizations will designate a few staff members, or a smaller division within the larger organization, to serve as the ADRC and the annual operating budget will reflect the amount budgeted for the ADRC division only. Budgets and staffing levels in rural and urban/suburban sites also vary considerably from one another, due in large part to differences in staff size. Urban pilot site budgets are more than three times the size as rural site budgets; however, rural sites budgeted 90 percent more per capita than urban/suburban sites, reflecting a level of fixed costs associated with ADRC activities.

Given the size of the average ADRC operating budget, it is clear that pilot sites draw from funding sources other than federal grant dollars. In fact, ADRC pilot sites reported that 75 percent of their annual budgets come from sources other than the ADRC grant, such as the Older Americans Act (OAA), Medicaid, state and local revenue, and other grants. *Exhibit 16* illustrates the average proportion of total annual budgets across different revenue sources for the ADRC pilot sites.

Exhibit 16: Proportion of ADRC Pilot Site Budgets from Different Revenue Sources, April 2006 (n = 37 pilot sites)



Staffing Composition and Qualifications

Staff positions and job roles are defined differently across ADRC pilot sites. For the purposes of grant reporting, grantees were asked to use the following job categories based on key functions (*Exhibit 17*). However, in many cases one staff person performed cross-functional work and therefore devoted time to more than one position.

Exhibit 17: ADRC Staff Positions and Job Functions

Position	Key Job Functions
I&R/A Specialists	• Answering telephones and meeting with in-person visitors • Offering initial information, referral and assistance on a variety of topics (caregiver support, home care, adult day care, employment, housing, transportation, financial counseling, prevention and wellness programs, etc.) • Triaging emergency situations • Determining if a home visit or an appointment for options counseling, or referral to case worker is necessary • Assisting with populating and maintaining resource database
Case Workers (Nurses and Other)	• Providing clinical consultation and/or health promotion services (for Nurse Case Workers) • Performing assessments • Determining LTC level of care (LOC) • Conducting LTC options counseling via phone or in person • Interacting with Medicaid eligibility workers • Confirming eligibility approval
Training and Outreach Staff	• Training and providing outreach to workers along critical pathways to LTC (e.g., hospital discharge planners, physicians, community "gatekeepers") • Developing and/or selecting training materials and training ADRC staff • Attending health and promotional fairs • Implementing ADRC outreach and marketing plans • Assisting with identifying community resources for resource database
Benefits Counselors	• Offering information about available benefits • Providing technical assistance to consumers about how to access benefits • Assisting consumers in applying for benefits • Advocating for/ assisting with the appeal process for benefits denial • Consulting with legal counsel when appropriate
Financial Eligibility Workers	• Making financial eligibility determinations for publicly funded programs, such as Medicaid • Assisting consumers through the financial eligibility determination process • Providing technical assistance to consumers with gathering financial information and filling out eligibility forms
IT/ MIS Staff	• Developing and/or maintaining Management Information Systems • Developing and/or maintaining ADRC website • Managing network systems, hardware and software used by ADRC • Training ADRC staff on the use of data systems and trouble shooting • Assisting with program reporting • Assisting with populating and maintaining resource database
Administrative Support Staff	Providing administrative assistance for all functions of the ADRC

Position	Key Job Functions
Management	• Managing ADRC grant requirements • Coordinating reporting requirements • Assembling and coordinating advisory committees • Hiring, scheduling and supervising clinical and administrative staff • Developing and managing policies and procedures for ADRC • Overseeing all ADRC activities
Consultants	These individuals may provide consultation on an as-needed basis regarding medical, psychological, behavioral, public policy or other issues.
Others	Examples of other positions within ADRCs are LTC Ombudsman, Caregiver Advocate, and Behavior Health Specialist.

Exhibit 18 shows the number of pilot sites reporting any full-time equivalent staff (FTEs) devoted to these positions and the average number of FTEs across pilot sites, classified by urban/suburban or rural. Over 90 percent of ADRC pilot sites had at least one I&R/A Specialist on staff and the average number of full-time equivalent (FTE) I&R/A Specialists across all sites was three. Those sites that did not report having an I&R/A Specialist on staff did report staff in the Case Worker or Benefits Counselor categories and therefore some of these staff members may be performing I&R/A functions.

Exhibit 18: Pilot Site Staffing Averages, April 2006
(n = 49 Pilot Sites)

Staff Position	Percent of Pilot Sites Reporting Any FTE	Avg. No. FTE Across Rural Sites	Avg. No. FTE Across Urban/ Suburban Sites	Avg. No. FTE Across All Grantees
I&R/A Specialists	92%	2.7	4.1	3.0
Nurse Case Worker	33%	1.6	3.9	2.7
Case Workers	47%	4.6	6.6	5.8
Training and Outreach Staff	49%	1.1	3.8	2.5
Benefits Counselors	51%	2.2	3.1	2.6
Financial Eligibility Workers	24%	0.2	3.4	1.8
IT/ MIS Staff	55%	0.5	1.4	1.0
Administrative Support Staff	80%	1.4	2.2	1.6
Management	86%	1.3	2.6	1.8
Consultants	22%	1.5	0.9	1.0
Others	22%	2.5	1.5	2.3
Total	49	Average: 8.6 (Range: 1 – 22)	Average: 19.0 (Range: 1 – 122)	Average: 12.7

Note: 49 of 51 pilot sites from FY 2003 and FY 2004 grantees reporting.

Many ADRCs required minimum qualifications for certain staff positions (***Exhibit 19***). For example, almost half of pilot sites required I&R/A Specialists to hold Bachelors degrees at a minimum; nearly seven percent require a Masters degree for this position. In addition, thirteen of these sites (representing five states) required I&R/A Specialists to be certified through the Alliance of Information and Referral Systems (AIRS).

Exhibit 19: Minimum Qualifications Required for ADRC Staff Positions, April 2006

Pilot Site Staff Positions	% of Pilot Sites Reporting Any Min. Requirement	% of Pilot Sites Requiring Bachelors Degree	% of Pilot Sites Requiring Masters Degree
I&R/A Specialists	63.3%	48.3%	6.7%
Case Workers	23.3%	20.0%	1.7%
Training and Outreach Staff	35.0%	21.7%	6.7%
Benefits Counselors	20.0%	16.7%	1.7%
Financial Eligibility Workers	25.0%	20.0%	3.3%
IT/ MIS Staff	26.7%	25.0%	1.7%
Administrative Support Staff	33.3%	20.0%	3.3%
Management	56.7%	35.0%	21.7%
Consultants	26.7%	15.0%	8.3%
Other	20.0%	11.7%	8.3%

Note: 49 of 51 pilot sites from FY 2003 and FY 2004 grantees reporting

III. FINDINGS

Consumer-level Accomplishments & Outcomes

This section of the report describes the accomplishments and results of the ADRC initiative in relation to immediate consumer outcomes. It addresses the following areas:

- Demographics of the populations served by ADRC Programs
- Consumer satisfaction and access to long-term support
- The receipt of information, assistance, and informed decision making about long-term support options
- Prevention and health promotion opportunities for consumers

Demographics of Populations Served by ADRC Programs

ADRCs provided information and long-term support to more than 750,000 contacts between March 2004 and March 2006 and the average number of contacts per month increased by over 200 percent during this period. Between March 2004 and March 2006, grantees reported responding to a total of 752,789 contacts.[12] During this same period, the average number of contacts per month per pilot site grew from 401 to 1,315 (*Exhibit 20*).

Exhibit 20: Total ADRC Contacts March 2004 to March 2006 (n = 49 Pilot Sites)

Reporting Time Period	No. of Pilot Sites Reporting	Total No. of Contacts	Total No. of Contacts Per Month	Total No. of Contacts Per Month Per Site
March 2004-March 2005 (13 months)	22	114,759	8,828	401
April 2005-September 2005 (6 months)	37	251,324	41,887	1,132
September 2005-March 2006 (6 months)	49	386,706	64,451	1,315

It is important to note that for reporting purposes, grantees have been asked to distinguish between the number of times they were called and or had a consumer walk in and the number of individuals they served. It is not always necessary or appropriate for I&R/A providers to ask callers for identifying or demographic information, so they may not know the actual number of unduplicated individuals served or very much information about the individuals they serve. The "contact" was chosen as the primary unit of service about which ADRCs report, because it provides a more realistic picture of

---

[12] Across 49 pilot sites that reported contacts for at least one period.

overall service volume. When a contact comes from an individual who needs more comprehensive services, such as short-term case management or intake for public programs, ADRC staff will collect more detailed information, which can then be reported.

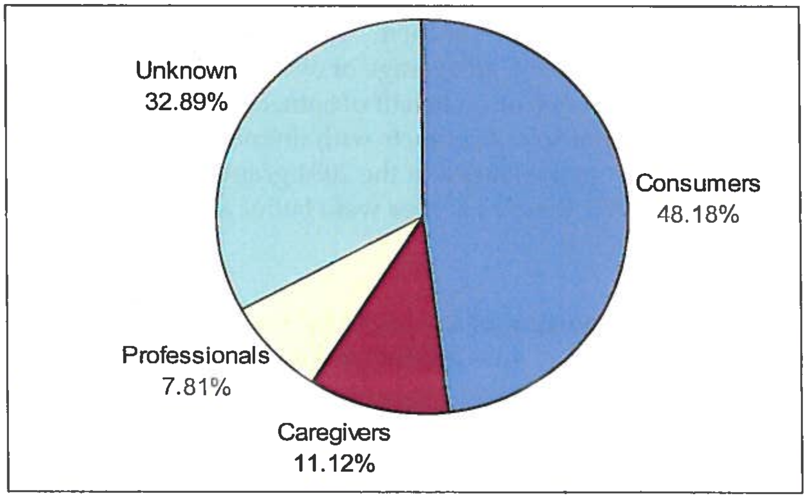
The sites reporting verifiable contact information for all three periods showed a significant increase in contact volume over a two year period; the average number of contacts the grantees received per month increased by over 60 percent (*Exhibit 21*). Seventeen pilot sites in 12 states were able to report verifiable contact information in all three reporting periods and these sites experienced a significant increase in contact volume over a two year period.

Exhibit 21: Change in Contact Volume for Grantees Reporting Over Three Periods (n = 17 Pilot Sites in 12 States)

Reporting Time Period	Total No. Contacts Per Month	Total No. Contacts per Month Per 1,000 Residents in Service Area
March 2004-March 2005 (13 months)	1,501	2.34
April 2005-September 2005 (6 months)	1,692	2.89
September 2005-March 2006 (6 months)	2,426	3.99

Consumers contact ADRCs more frequently than caregivers and professionals. On average, grantees collected information about caller type for about two-two thirds of the contacts made to the ADRC. Many ADRC contacts involve the provision of basic information and because the calls are brief, staff do not collect this information (33 percent). For the contacts about which these data were collected, consumers constitute 71 percent, while caregivers represent 17 percent and professionals 12 percent (*Exhibit* 22).

Exhibit 22: Percent of All Contacts by Consumers, Caregivers, Professionals and Unknown, April 2006 (n = 33 Pilot Sites)



Note: The "unknown" contacts include contacts involving provision of basic information, where staff may not ask the caller about themselves.

New customers represent a slim majority of ADRC contacts. Grantees were asked to track the number of contacts from first-time callers and the number from repeat consumers. This measure is intended to demonstrate the extent to which ADRCs are attracting new consumers and the extent to which they are responding to the same consumers over time. For those grantees that have the data collection capacity to track new and repeat callers, it also serves as a rough estimate of how many contacts are provided with in-depth services, in which enough identifying information is collected to determine if the consumer has contacted the ADRC before.

As seen in *Exhibit* 23, during the most recent reporting period, over half of ADRC contacts were with new individuals and roughly 30 percent were with repeat customers. This ratio of new to repeat contacts may result from the newness of the initiative and the increased marketing activity that pilot sites have undertaken with the grant. As time goes on, it will be important for ADRCs to maintain a steady stream of repeat customers. Repeat contacts demonstrate consumers' trust and consumers' willingness to contact the ADRC again as their needs change over time.

Exhibit 23: New and Repeat Contacts, April 2006 (n = 32 Pilot Sites)

	Percent New Contacts	Percent Repeat Contacts	Percent Unknown Contacts
All Contacts **(October 2005-March 2006)** **n = 32 pilots**	55.7%	33.0%	11.3%

Note: Guidance provided to grantees on how to report New and Repeat Contacts changed in April 2006; data from prior reporting periods are not incomparable.

The proportion of all ADRC consumers who report they are under the age of 60 or calling on behalf of someone under the age of 60 increased slightly since initial launch. More than half of all ADRC pilot sites focused primarily on serving the aging population prior to becoming an ADRC and younger adults with disabilities represented a new service population for them. During the last reporting period (October 2005 through March 2006), an average of over 20 percent of all contacts came from someone under the age of 60 or on behalf of someone under the age of 60 (*Exhibit 24*). The increase in the proportion of contacts with unknown age from the first to second period is due in part to the launch of the 2004 grantee pilot sites in the second half of 2005. By October 2005, these new sites were better able to collect and report this information.

Exhibit 24: Proportion of Contacts by Age Group over Time (n = 30 Pilot Sites)

	Number of Pilot Sites Reporting	Consumers 60+	Consumers ≤ 60	Age Unknown
All Contacts (March 2004-March 2005)	18	72.90%	13.12%	13.98%
All Contacts (March 2005-September 2005)	20	60.38%	8.80%	30.82 %
All Contacts (October 2005-March 2006)	30	66.48%	21.11%	12.41%

Grantees have had difficulties collecting and reporting data about contacts by disability type, sometimes because individuals who call do not identify themselves as someone with a disability or do not explain what type of disability they have. The grantees that have been able to collect and report these data found that between 8 and 15 percent of their contacts come from their primary disability target population under age 60. Most grantees report that they frequently serve individuals with all types of disabilities, even those outside their primary target populations. For example, South Carolina's first pilot site reported an increase in the number of contacts from people with disabilities under age 60 of over 100 percent between April 2005 and April 2006. This pilot site's primary target population is people with physical disabilities but this increase in contacts includes individuals with MR/DD, mental illness, and other disabilities. They also served a significant number of individuals over age 60 with physical disabilities. Some grantees have been able to capture information about their consumers through consumer satisfaction surveys. For example, Maryland found that about half of their survey respondents had contacted them about either a disability-related or a disability-related and aging-related issue.

Maryland Access Point Consumer Satisfaction Survey
March 2005-February 2006
260 completed surveys

Maryland's two pilot sites focused primarily on serving the aging population prior to the ADRC grant. However, they report that 27 percent of their calls come from individuals 64 or younger. Their consumer survey found that 16 percent of respondents had called the ADRC to ask for help with something "disability-related" as opposed to aging-related. The survey question and response rates are outlined below:

Question: Are you asking for help for disability services, aging services, or both?

Response:

Aging-related services	36%
Both disability and aging-related services	35%
Disability-related services	16%
No response given	14%

Consumer Satisfaction and Access to Long-term Support

Grantees were required to establish measurable performance goals related to consumers' interface with the ADRC program as well as indicators to track progress. The federal expectation was that, at a minimum, grantees be able to assess the following elements of consumer satisfaction: (a) *Trust* on the part of the public in the objectivity, reliability, and comprehensiveness of the information and assistance available at the ADRC, (b) *Ease of Access* (e.g., reduction in the amount of time and level of frustration and confusion individuals and their families experience in trying to access long-term support), and (c) *Responsiveness* to the needs, preferences, unique circumstances, and feedback of individuals as it relates to the functions performed by the ADRC. This section focuses on grantees' approaches to assess trust, responsiveness and ease of access and reports preliminary results pertaining to consumer satisfaction.

The most common technique for assessing consumer satisfaction was the use of a consumer satisfaction survey. All twenty-four 2003 and 2004 grantees conducted some form of consumer satisfaction survey, using either telephone or mailed surveys or a combination of these methods. While the content and administration of the instruments varied considerably, in general, the surveys captured data in three main areas in addition to basic demographic information:

Appendix J

- Customer Service
    - Clarity and usefulness of information
    - Wait time
    - Quality of interaction with staff
- Application for Services
    - Subsequent application for services
    - Ease of application
    - Timeliness of services
- General Experience/Overall Satisfaction
    - Quality of interaction with the ADRC
    - If consumer would recommend the ADRC to others

Examples of Approaches to Assess Consumer Satisfaction

Maryland. Between March 2005 and February 2006, Maryland mailed 1,088 surveys to consumers from both its pilot sites. The Maryland Access Point Consumer Satisfaction Survey fielded nine questions, including whether the consumer was able to speak with a staff member within one business day of first contact, and whether the information and help the consumer received from Maryland Access Point helped that consumer make a decision and/or find appropriate services.

New Mexico. New Mexico implemented a telephone survey of consumers who spoke with a Resource Center counselor, collecting information on access ("Was your telephone call answered quickly?;" Was your telephone transfer to a counselor completed smoothly?;" "Are our hours of operation sufficient to allow you to call us conveniently?"); trust (" Do you feel your counselor listened to what you wanted?;" "Was your counselor courteous to you?") and satisfaction ("How would you rate your overall experience with the Resource Center?;" " Will you recommend the Resource Center to others who may need this kind of assistance?"). The survey is conducted immediately after the consumer has spoken with a resource counselor. New Mexico plans to conduct this survey one month per quarter in order to compare responses over time and make ongoing quality improvements.

North Carolina. In Forsyth County, the ADRC fielded questions with consumers about overall satisfaction and quality of service in a written survey. The survey included additional questions about call outcome ("Did the information you received from [agency name] help you make a decision or find the service you needed?") and operational processes ("Were you told to go to, or to call, any other place for a service or for more information?;" "If you contacted [agency name] for services, are you receiving the service that you were seeking?") in order to measure the effect of streamlining in the transition to an ADRC model.

There were eighteen survey instruments available to examine for this report. Of the 18 instruments, 16 fielded questions about the consumer's general experience, 15 about customer service, and nine included at least one question about subsequent application for services. Many grantees expanded or revised existing consumer satisfaction surveys for the ADRC grant initiative. The text box above highlights several examples of grantees' efforts to assess consumer satisfaction.

Grantees reported high levels of consumer satisfaction. While it is difficult to compare survey results due to the variability of instruments in terms of methods, metrics, and measurement scales, grantees reported overwhelmingly positive feedback from individuals who had contacted the ADRC on measures such as: whether the information was clear and understandable; whether the information helped them with the issue they contacted the ADRC about; and whether the staff listened carefully, was courteous and respectful, and took into account the callers' wants and needs. The most consistently reported measure of overall satisfaction was whether callers would recommend the ADRC to others (***Exhibit*** 25). Seventy-five percent of ADRCs who asked this question reported that over 90 percent of respondents would recommend the ADRC to others.

Exhibit 25: Percent of Consumers Who Would Recommend ADRC (n = 22 Pilot Sites)

Percentage of Respondents Who Would Recommend the ADRC to Others	Percentage of Grantees with this Level of Positive Responses
90-100%	75%
80-90%	13%
70-80%	6%
60-70%	6%

Consumers gave high praise for ADRC programs, such as:

> *"I was surprised at the wealth of information offered to me. This is a wonderful service."*
>
> *"In this day and age, it is a wonderful resource to have all information in one central place. It certainly made my quest easier."*
>
> *"I was very pleased with the person who assisted me. She offered to send information that would help us make decisions and it arrived quickly."*
>
> *"I feel the counselor will do everything she can for me."*
>
> *"I like to get answers and this is where I know I can come for them."*
>
> *"I got information I would not have otherwise known about."*

Some consumers expressed levels of dissatisfaction, which underscores the need to continue to refine the system to improve consumers' experiences:

> *"I initially called and waited fifteen minutes on hold, then called back and got right through."*
>
> *"After many calls they finally got back to us and then after one month sent someone to our home to ask a lot of questions to two very sick people and to say they don't have enough funds to help us."*
>
> *"Basically the woman I talked to said she'd send me a book that would have all the information I needed – she didn't seem interested in providing information over the phone. I waited a few days for the book. When it arrived all it contained was a list of programs with very brief descriptions and phone numbers. If the purpose of [the ADRC program] is to serve as a single point of contact to assist citizens…. in identifying appropriate services and facilitate their securing services, then the program has failed in my case."*
>
> *"Hopefully we will receive some assistance eventually. It takes time to work through the [unreadable] system."*

Grantees' assessment of consumer satisfaction focused largely on evaluating the quality of consumers' experience at initial contact and how easily consumers could contact the ADRC, less so on measures of streamlined access to services. Most surveys assess consumers' front-end experience in gaining long-term support information and assistance, and very few assess consumers' experience with going through the system including eligibility determination and access to public programs (***Exhibit 26***).

However some grantees, such as North Carolina, did use consumer satisfaction surveys to track consumers' experience as it relates to streamlined access to services and supports by including queries about whether the consumer is receiving services, whether those services are useful, and whether the services were received in a timely manner. Eleven grantees asked at least one question about access to services and supports beyond the initial contact with the ADRC. Arkansas and Pennsylvania included questions about how long it took a consumer to receive services from the time when the consumer first contacted the ADRC. Ten states included questions about whether the consumer was receiving services, whether those services were appropriate to their needs, and whether those services were useful in increasing or maintaining independence.

Exhibit 26: Consumer Satisfaction Survey Questions by Type of Question

Question	No. of Grantee Surveys (n=22)
Quality of Information:	
Was the information you received from *organization name* clear?	10
Will the information you received from *organization name* be helpful in dealing with the issue you called or came to our offices to talk about?	19
Response Time:	
If you called, how quickly was your call answered?	18
If you left a message, when did the person call you back?	10
General Experience:	
Were you told to go to or call any other places for a service or more information?	12
If you came to our offices, how long did you wait to see someone?	8
Overall, did the person you talked with listen carefully to what you wanted?	12
Did you feel they took into account your wants and needs?	11
Were there any problems with the service provided by *organization name*?	11
What could we do differently to make it better?	11
Would you tell a friend or relative to call *organization name*?	22
Information About Responder:	
Did you call or come to our offices for yourself or someone else?	18
Are you or the person you called about aged 60 or over? Do you or the person you called about have a disability?	11
Race/ethnicity	8
Male or Female	9
Age	8
Home zip code	6
Household Income	1
Streamlining Access to Services:	
Did you apply for apply for services?	7
The steps to apply for services were easier than I expected/about what I expected/harder than I expected.	2
If you needed help, did the people who work at organization name help you with your paperwork?	3
Did the person you spoke with explain the steps clearly?	7
If you were approved for services, how long did it take to receive services from when you first contacted organization name?	3
Timeliness	3
Appropriateness	4
Services received/useful	9

Information, Assistance and Informed Decision Making about Long-term Support Options

Grant requirements included designing an ADRC that engaged in "Awareness and Information" and "Assistance" to empower consumers to make informed decisions about their long-term support options. For most grantees, this meant coordinating or integrating with other community agencies to offer a range of functions, from public education and information on long-term support options to community referrals and crisis intervention (see text box below). This section describes grantees' accomplishments in providing information, referral and assistance (I&R/A), identifying what makes the delivery of I&R/A through ADRCs different than "business as usual." It also addresses the extent to which ADRCs are empowering consumers to make informed decisions.

Awareness and Information & Assistance Functions of an ADRC

Awareness and Information

- Public education
- Information on long-term support options

Assistance

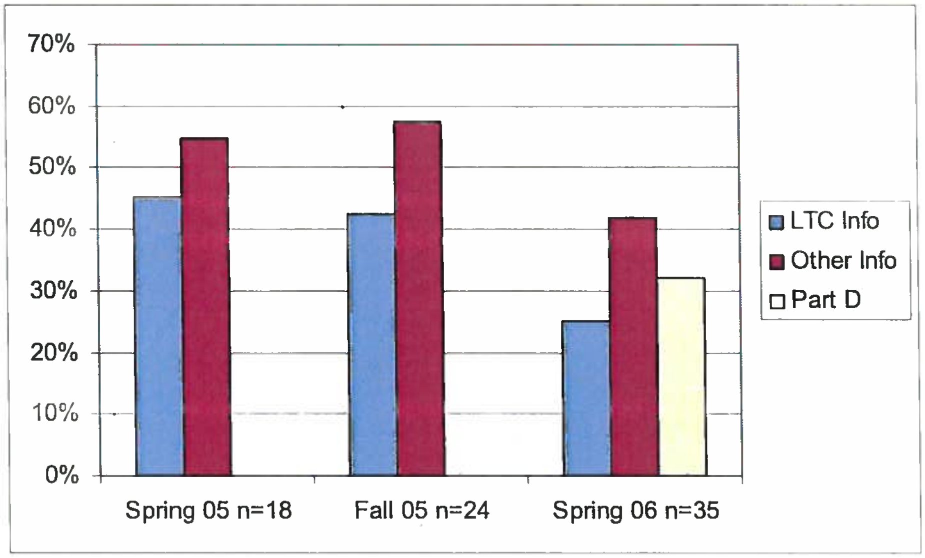
- Long-term support options counseling
- Benefits counseling
- Employment options counseling for people who are interested in or may be interested in such counseling; Grantees would be expected to coordinate with other sources funding employment counseling in their state, such as the Social Security Administration and/or the Department of Labor, to ensure access and prevent duplication
- Referral to other programs and benefits that can help people remain in the community, including programs that can assist a person in obtaining and sustaining paid employment
- Crisis intervention
- Helping people to plan for their future long-term support needs

The highest proportion of contacts with the ADRC involved the provision of non-LTC information and ADRCs played a vital role in providing the Medicare Part D prescription drug benefit information and enrollment support. As seen in *Exhibit* 27, the majority of ADRC contacts involved the provision of non-LTC related information. Non-LTC related information includes information about other services or resources such as Low-Income Home Energy Assistance Program (LIHEAP), county tax relief, local libraries, food stamps, or other kinds of public assistance. The proportion of non-LTC related information provision compared to LTC related information increased each reporting period.

Information related to Medicare Part D impacted a significant portion of ADRC activity from October 2005 to April 2006. The massive initial enrollment process in the new program meant that, in addition to the 1-800-MEDICARE line and the CMS funded State Health Insurance Assistance Program (SHIP) which focuses on assisting Medicare beneficiaries with health insurance issues, nearly all other agencies providing information and assistance felt the impact. Of the 35 pilot sites that were able to report contact figures for the most recent SART, on average, 32 percent of contacts were provided information about Part D. In fact, during the peak of enrollment period, pilot sites reported limited capacity to engage in other ADRC planning and implementation activities. By offering objective information and beneficiary enrollment support, ADRCs clearly played a vital role in the successful roll-out of Medicare Part D.

ADRCs played a large role in the Part D enrollment efforts, in part, because grantees proactively coordinated and collaborated with their respective SHIPs to meet consumers' needs prior to the launch of Part D. The majority of pilot sites (64 percent) co-locate with SHIP. In 17 states, the ADRC and the SHIP program reside in the same agency at the state level. In the remaining seven states, ADRCs and SHIPS partner at either the state or local levels. In Pennsylvania, for example, ADRC and SHIP are part of the same agency at the state level, but are not co-located at the local level. In this instance, the Cumberland County, PA pilot site reported that the state SHIP identified partners at the local level and provided education and information. In Iowa, the ADRC and SHIP reside in separate agencies and the State Unit on Aging, Area Agencies on Aging, and Social Security Administration all coordinated with SHIP to offer Medicare Part D outreach and education activities.

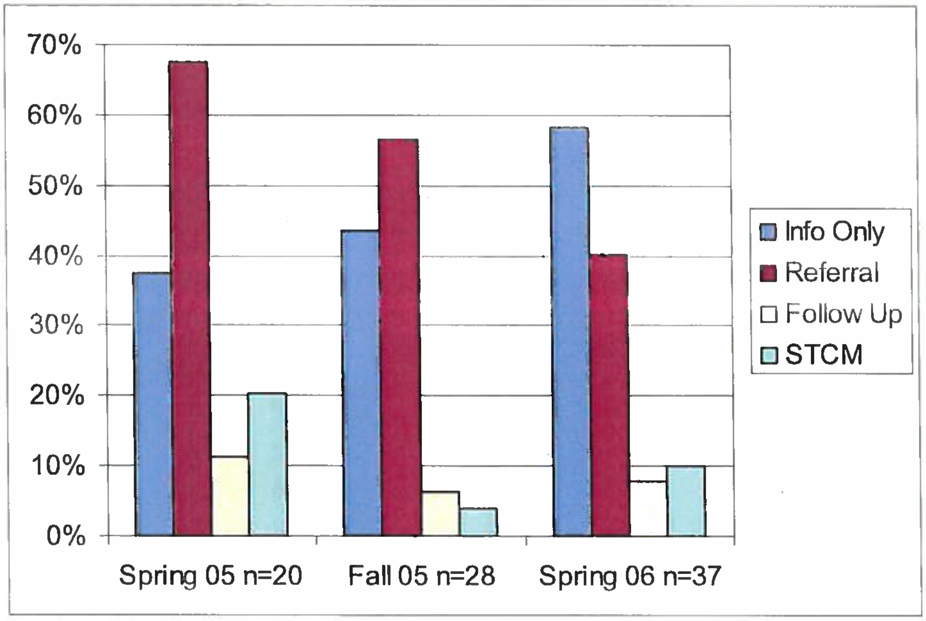
Exhibit 27: Average Percent of Contacts by Type of Information Provided – Related to LTC, Other than LTC and Medicare Part D



The establishment of comprehensive resource databases and the ability to efficiently share information among agencies to make the most effective referrals through enhanced IT/MIS and formal partnerships represented a different way of delivering I&R/A than "business as usual." Most ADRCs established comprehensive Web-based resource databases for use by consumers, community providers and program staff (see IT/MIS section of the report for more detail). In this effort, many ADRCs also broadened their scope of I&R/A to include more information geared to the private pay population and persons with disabilities than the network traditionally offers. Many pilot sites also worked with key partners to cross-train and establish protocols for referrals and information-sharing (see Partnership section) which reduced the likelihood of "empty referrals" in which consumers bounce from agency to agency with no accountability for whether the individual receives the necessary information or assistance. In addition to being better equipped to make appropriate referrals, ADRCs increased their in-house capacity to provide comprehensive information, thereby reducing a lot of back-and-forth.

As *Exhibit 28* displays, the average percentage of information-only contacts increased from 37 percent in the first reporting period to 59 percent in the spring of 2006, while the average percentage of referrals decreased from 68 percent to 41 percent. The lower percentage of referrals is consistent with the experience of well-established ADRCs in Wisconsin in which the majority of contacts require basic long-term care information and assistance rather than program access.

Exhibit 28: Average Percent of Contacts by Type of Assistance Provided – Information Only, Referral, Follow Up, and Short Term Case Management



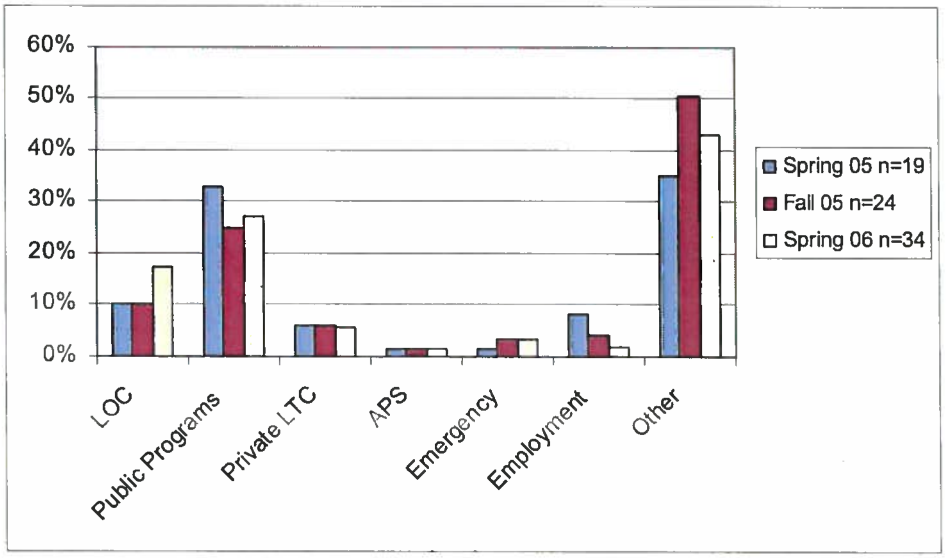
Note: STCM stands for Short-term case management

In addition to providing information and making a referral on behalf of consumers, ADRCs engaged in: 1) short-term case management (STCM), characterized as intensive assistance to stabilize a consumer's situation to enable the individual to remain in the community and 2) follow up to ensure that consumers' needs were met. Short-term case management often serves as a bridge connecting an individual with formal or informal long-term case management. It can be provided at different junctures or settings, such as in the home, upon hospital discharge, or in nursing facilities to assist individuals transitioning to the community. In La Crosse County, Wisconsin, for example, ADRC staff provide short-term case management until the particular situation has been stabilized. Once the situation is stabilized, the worker checks in with the consumer via telephone and maintains basic case management notes to track activity. If the individual needs long-term case management and does not qualify for state or Medicaid funded long-term case management, the ADRC may recommend that he or she privately purchase case management. Often a family member will assume general coordination of services and then call the ADRC when an issue or problem arises. In this case, consumers use the services of the ADRC numerous times along a continuum of service need.

Grantees also developed methods to ensure consumers' needs were met in making referrals. For example, South Carolina incorporated a simple case management design in their database system that allows an individual case manager to track consumer goals and that features a tickler that reminds the case manager when to complete the necessary tasks by a certain date.

As seen in ***Exhibit 29***, the most common type of referral reported by pilots during all three reporting periods, aside from the "other" classification was "applications to public programs." Level of Care (LOC) referrals accounted for the next largest category of referrals and actually spiked in the third period which may indicate that pilot sites made progress in streamlining access. Other major types of referrals included employment, privately purchased LTC, emergency services, and Adult Protective Services (APS). The proportion of referrals for private LTC (roughly five percent of referrals) remained at the same level over time; the proportion of referrals for employment decreased each reporting period which may be indicative of some of the challenges pilot sites faced in connecting the aging and disability communities.

Exhibit 29: Average Percent of Contacts by Type of Referrals Made by Pilot Sites



ADRCs emerged as critical components of state and local communications networks that will invariably be accessed during emergencies and disasters. The early experience of ADRCs demonstrated that they are a ready infrastructure to provide essential information about the availability and location of life-saving resources such as food, shelter, and medical care for vulnerable populations. ADRCs played a critical role in supporting their communities as a result of the devastation of Hurricanes Katrina and Rita. When Hurricane Katrina hit Louisiana, the pilot ADRC was serving eight parishes in the south central region of the state, which did not include New Orleans. Nevertheless, state and local officials chose to use the ADRC toll-free number as the central resource in the state for information about evacuees, victims, and their families. As a result, the ADRC program expanded to cover 42 parishes in southern Louisiana. Between August and September 2005 during Hurricane Katrina and its aftermath, contacts to the Louisiana ADRC jumped from 107 to 486. Of those calls, 221 were identified as having come from evacuees and it is likely that the remaining 261 contacts were from individuals impacted by the hurricane. ADRCs in other states assisted in serving evacuees. For example, the ADRC pilot site in Atlanta, Georgia area contracted with Jewish Family and Career Services to provide case management services for individuals affected by Hurricane Katrina who located either temporarily or permanently to the metro Atlanta area.

Grantees are in the early stages of establishing systematic processes for empowering consumers and their families to make informed decisions about long-term support options. Much of the role of the ADRC involves information and referrals, but a significant goal of the ADRC initiative extends beyond traditional assistance to support individuals and families with informed decision making about long-term support options, or "options counseling." Most grantees offer aspects of options counseling, often through follow-up or short term case management activities.

Assessing grantees' accomplishments with providing options counseling presents a challenge. A survey of ADRC grantees conducted by the ADRC-TAE (Lewin and NASUA) in 2005 demonstrates that grantees interpret the term "options counseling" in a variety of ways. *Exhibit 30* represents the responses of 25 ADRC respondents at either the state or local level when asked the question, "What activities are included in Options Counseling?" While all respondents reported that options counseling constituted information and referral activities, only 60 percent reported that it constituted assessing an individual's needs.

Exhibit 30: Activities Included in Options Counseling (ADRC-TAE Options Counseling Survey, Fall 2005)

Activities Included in Options Counseling	Percent of Respondents
Information Giving	100%
Referral Giving	100%
Explaining Documentation for Applications	96%
Assistance Contacting Agency	92%
Advocating	92%
Making a Home Visit	76%
Providing Short-Term Case Management	68%
Conducting Functional Needs Assessment	60%
Conducting Consumer Reassessments	52%
Providing Long-Term Case Management	20%

Similarly, grantees provided a variety of responses when asked, "What distinguishes options counseling from other ADRC services?" However, as displayed in *Exhibit 31*, a majority of grantees reported similar topics discussed during options counseling, such as the range of long-term care settings (i.e., nursing homes, adult family care homes, assisted living facilities, board and care facilities). *Exhibit* 32 shows the different kinds of topics that grantees reported discussing during options counseling. Other resources discussed with consumers included: senior centers, food stamps, drug discount programs, Medicaid eligibility agencies, support groups, and companion visits. Most grantees also mentioned that they linked with other agencies in their communities to provide options counseling. For example, grantees partnered with SHIP, Ombudsmen, legal programs, estate planning attorneys, school systems, independent living centers, and protection and advocacy programs to offer specialized options counseling.

Exhibit 31: Topics Discussed During Options Counseling (ADRC-TAE Options Counseling Survey, Fall 2005)

Topics	Percent of Respondents
Home Health	96%
Personal Care	92%
Assisted Living	88%
Adult Day Care	88%
Homemaker	88%
Chore	88%
Nursing Home	84%
Adult Family Care Homes	60%
Escort	56%
Board & Care Facilities	52%
Other	56%

Exhibit 32: Supported Services for In-home Long-term Care Services (ADRC-TAE Options Counseling Survey, Fall 2005)

Supported Services for In-home Long-term Care Services	Percent of Respondents
Transportation	96%
Nutrition Services	88%
Nutrition Counseling	56%
Special Diets	40%
Other	40%

A few grantees began to establish formal processes to refine and deliver options counseling through ADRCs. This activity often resulted from a state-driven initiative. Wisconsin used part of their ADRC grant money to develop an options counseling tool kit including a video which details the process of options counseling from both the consumer and staff perspective. New Hampshire created the position of Long-term Supports Counselors at the ADRC to provide pre-screening for eligibility as well as provide comprehensive options counseling to individuals who are looking for long-term supports, regardless of funding source or an individual's financial situation.

Despite the variability in the organization and delivery of options counseling, most grantees reported that supporting consumers in long-term support decision making is an on-going *process* which requires relationship development. Pilot sites reported that providing consumers with information may not be enough to help people come to important decisions on long-term care. Rather, it takes time, trust, and relationship building for people to work through the concomitant issues associated with LTC planning and obtaining resources. Over time, grantees will be able to assess their efforts in offering objective, reliable, and comprehensive information and supporting consumer decision making. A few grantees have begun to measure these objectives through consumer satisfaction surveys.

ADRCs also provide assistance to individuals and families with planning for future LTC needs. Some of the 2003 and 2004 grantees hope to use ADRC supplemental funding to continue to implement some future planning initiatives. Some grantee states have received funding from HHS/AoA's Own Your Own Future Campaign to target individuals with a letter from the Governor encouraging LTC planning.[13] ADRCs can play a critical role in this effort, providing information and support to those interested in planning for their future long-term care needs.

For many organizations involved in ADRCs, a focus on consumers who can privately finance services requires both procedural and cultural changes. Prior to ADRCs, many information and referral systems only included services provided by government and non-profit organizations. As a result, many ADRCs needed to develop defensible criteria for including for-profit providers in their databases, which may be more likely to serve consumers with higher incomes. Expanding beyond publicly financed consumers also requires ADRC staff to re-orient their approach to advising individuals about their options often necessitating changes in organizational culture.

Wisconsin Options Counseling Toolkit

Wisconsin has created an options counseling toolkit to continue to educate new and current ADRC pilots about the details of providing options counseling. The toolkit contains introductory material, a DVD, a series of recorded web casts, and discussion questions to support training new ADRC staff and provide opportunities to re-visit key aspects of the provision of this service.

A state-wide Information and Assistance workgroup developed, filmed, and produced a 37 minute DVD featuring an overview of the options counseling process. The DVD details discussions of why Information and Assistance is a central function of the ADRC and of how the process works through scenarios featuring county representatives and clients.

Currently available web casts cover legal decision making tools, residential/housing options, benefits for people with disabilities, etc. The web casts pair presentations by experts in subject matter important to long-term care options counseling with materials to retain for ongoing reference.

The toolkit will also be included as part of the materials provided for the next phase of statewide managed care expansion, currently in progress.

Wisconsin describes the options counseling in the following way:

---

[13] ADRC grantees that received Own Your Own Future funding include: AR, ID, NV, NJ, VA, KS, MD, RI, WA, GA, MA, MI, and TX.

> "The Relationship between I&A and Long-Term Care Options Counseling:
>
> Long-term care options counseling is an extension of the I&A process. This service is focused on consumer education and is often provided when an individual is planning for or currently experiencing a life change. These life changes may include surviving a traumatic event such as a car accident, a medical event such as a stroke, or the transition from school-based services to programs for adults with disabilities. To be effective in providing this service, it is important to take the time needed to fully understand each individual's strengths as well as needs. In order to ensure continuity in service delivery, options counseling can be provided by the same I&A Specialist that began the process with the individual."
>
> Source: Planning for Information and Assistance (I&A) Service. Aging and Disability Resource Center Development Technical Assistance: Wisconsin Department of Health and Family Services, Division of Disability and Elder Services. August 1, 2006.

Prevention and Health Promotion

Although not a grant requirement, the solicitation encouraged grantees to incorporate health promotion and disease prevention activities into the ADRC initiative. The emphasis on health promotion and disease prevention is to assist consumers in enhancing and sustaining a higher quality of life, reduce acute and long-term care crises, and lessen the burden of costly medical care. There are a number of terms related to health promotion and disease prevention that are commonly used to describe these types of activities, such as disease management, chronic disease self management, behavior change intervention, geriatric care management, and health management.

ADRCs' role as community gateways to information, education and assistance position them well to offer health promotion and disease prevention. By identifying and linking consumers with individualized resources and tracking consumers over time, ADRCs have the ability to provide optimal support at the right time which may assist in preventing unnecessary institutionalization, chronic disability due to disease, and acute crises resulting in emergency room visits or hospitalization. In addition, partnerships with community health providers offer greater opportunity to collaborate on health promotion activities. This section describes the health promotion and disease prevention activities that grantees pursued during the three-year grant period.

Grantees have started to consider health promotion and disease prevention, but many grantees remain in the planning stages for such initiatives. As shown in ***Exhibit 33***, a few grantees articulated prevention/health promotion goals in project work plans, evaluation plans, and/or Semi-annual Reports. Many grantees remain in the beginning stages of these initiatives. However, the first generation ADRCs in Wisconsin continue to engage in special prevention projects, such as fall prevention, nutrition screening, and preventative health care which are detailed in ***Appendix C***.

The range of health promotion and disease prevention activities spans from partnering with health and wellness agencies, to engaging in specific ADRC initiatives, to participating in larger community-based initiatives such as the Chronic Care Management program in North Carolina. Several grantees made concerted efforts to include representatives from the Department of Public Health on the ADRC advisory boards.

Exhibit 33: Examples ADRC Health Promotion/ Disease Prevention Activities

State	Goal	Type of Model	Progress/Outcomes
New Jersey ***State-level***	Evaluation plan goal: "Become the gateway to programs that connect consumers to basic human need resources: *work/volunteer opportunities, insurance programs, financial support services, health promotion/disease prevention, crisis intervention* (county)"	Health Promotion	"A directory of disability services, telephone access programs, Social Security disability, as well as some disease specific materials have been added to the center's collection of resource material." April 2006 SART
California ***Pilot-level***	"Develop a module on Falls Prevention to be housed on the ADRC website[14] to be tested with consumers, caregivers, physicians and other health and social service providers. Fall Prevention will be used as an initial focus to support effective community, client and provider education around effective problem identification and solution. " SART April 2006	Disease Prevention	"Based on findings, learning strategy will be expanded to the broader array of chronic care conditions/problems faced by older and disabled adults." April 2006 SART
Maine ***Pilot-level***	ADRC partners with the Healthy Community Coalition (HCC), Franklin County	Health Promotion	HCC acts as the Coalition leader, providing staffing, dissemination of materials, and partnering in designing and delivering ADRC activities with Coalition partners.
Maryland ***Pilot-level***	Grant to Howard County Office on Aging from Horizon Foundation (ADRC is intake point)	Chronic Disease Self Management	"Howard County is running the CDSM using the ADRC as the intake point. Consumers sign up for the prevention program and can be assessed for other programs and services. The ADRC is screening and attracting consumers by conducting community outreach around the program. As part of their outreach efforts, the ADRC collects information about needs that area consumers identify and informs them about both I&R and evidence-based programs. Maryland has invested in a video as well".

---

[14] Available at http://sandiego.networkofcare.org/aging/library/articleList.cfm?cat=180 Accessed August 17, 2006.

State	Goal	Type of Model	Progress/Outcomes
North Carolina ***State and pilot-levels***	The ADRC participates with the Chronic Care Management Steering Committee to help to ensure that I&R is part of the CCM model which brings together local health departments, hospitals, and social service agencies to better manage the care of 650,598 Medicaid enrollees.	Disease Management/ Chronic Care Self Management	The ADRC has presented, to the eight Community Care Networks, on the strengths of the aging network, Home and Community Block Grant Planning Committees and the role of I&A in chronic care management and self management. One of the Networks (Surry County) overlaps with the ADRC site and will be closely linked. Cumberland County, another CCM site, overlaps with the NC Carelink pilot and has a strong Aging I&A system. The State will be working directly with these two sites to support emerging models/partnerships related specifically to I&A and the aging network.
Massachusetts ***(state or pilot)***	Massachusetts is involved with the Chronic Disease Consortium, which is a group of service providers who are trying to start a program based on the CDSM model.	Chronic Disease Self Management	The Consortium has had some trouble finding group leaders and getting them qualified as trainers, ADRC suggested reaching out to the disability community. There are around 40 people who come to Consortium meetings.

Some grantees use health promotion and disease prevention language to market ADRC services. A few grantees market health promotion and disease prevention to portray the focus of ADRCs in a more positive light. For example, in New Jersey, the term "healthy living" is used as opposed to "long-term care" in reference to ADRC offerings. In Maryland, the tagline is "Your Link to Health and Support Services."

Grantees also report that showcasing health promotion/disease prevention to market the ADRC can attract consumers into the system who may benefit from other services the ADRC has to offer. For example, an ADRC in Wisconsin partnered with the local health department to purchase a bone scan machine. They offered free screenings and reported that the machine offered a mechanism for people to feel comfortable beginning a conversation with ADRC staff. Thus, many contacts began by discussing bone density and then moved into long-term care options counseling and/or futures planning.

Program-level Accomplishments & Outcomes

This section of the report describes the accomplishments and results of the ADRC initiative in relation to immediate program outcomes. It addresses the following areas:

- Strategic Partnerships
- ADRC Visibility and Public Awareness
- Outreach to Critical Pathways
- IT/MIS Infrastructure to Support ADRC Functions
- Streamlined Access
- Sustainability

Strategic Partnerships

As described earlier in this report, the ADRC grant requires that grantees serve the elderly population and at least one population from the disability community, and that access to all publicly-funded long-term care programs serving aged and disabled populations, including OAA, state-funded, and Medicaid programs, be integrated or closely coordinated across the organizations involved. Serving individuals across populations and integrating or coordinating such a broad set of services requires substantial cooperation and contribution from state and local organizations.

This section describes grantee accomplishments and outcomes in developing strategic partnerships to fulfill the information, assistance, and access functions of ADRCs in general, and analyzes partnership at three levels: (1) Partnership among core entities – i.e., the state's main Aging, Disability, and Medicaid entities; (2) Partnership with community-based organizations, including providers, advocacy organizations and public/private partnerships; and (3) Partnership between the ADRC state grantee and the ADRC pilot.

Grantees invested significant time and energy in strengthening and building partnerships with a broad spectrum of agencies and providers. As of April 2006, there were a total of 211 partners across the twenty-four 2003 and 2004 grantees at the state level, and 282 partners across the 51 pilot sites at the local level (*Exhibit 34*). The states with the highest number of partners were Pennsylvania with 60, California with 55, and New Jersey and West Virginia with more than 30 partners each. Overall, ADRCs averaged 20 partners per grantee.

Exhibit 34: State and Local Partnerships
FY 2003 and 2004 Grantees, April 2006

	State Level N=24	Pilot Site Level N=51
Total No. of Partnerships	211	282
Avg. No. of Partners	8.8	5.5
Range of Partners	1-23	1-27

Grantees reported that rather than approaching partnership building as one step or a single grant activity, they needed to involve stakeholders from initial planning through implementation. Most grantees began ADRC program development by assessing which stakeholders were critical to involve in the design of the ADRC and inviting them to partner. At the state level, grantees worked to develop or strengthen partnerships between the State Unit on Aging, State Medicaid Office, and agencies that operate disability services programs (e.g., State Independent Living Council). Most pilot sites developed several local level partnerships and some benefited from the partnerships developed at the state level that extended to them.

Partnership manifested differently across the grantees, with data sharing and formal protocols/MOUs as the most common components of partnership. Of the different activities, data sharing was the most common activity of ADRC partnerships (42 percent of partnerships at the state level, 44 percent at the local level) and co-location of staff was the least common activity (13 percent of partnerships at the state level, 16 percent of partnerships at the local level). ADRC partnerships also involved developing formal written agreements for working with a partner (29 percent at state level, 28 percent at local level); conducting joint training activities (19 percent state, 25 percent local); and jointly hosting or sponsoring events or programs for consumers (18 percent state, 23 percent local). *Exhibit 35* displays partnership activities reported by grantees in the SART.

Exhibit 35: Proportion of Partners with Formal Agreements and Other Components of Partnership, April 2006

	State Level (n=211 partnerships in 24 States)	Pilot Site Level (n=288 partnerships in 51 Pilots)
Formal Protocols/MOUs	29%	28%
Co-location of Staff at Local Level	13%	16%
Information Sharing	42%	44%
Joint Training	19%	25%
Joint Sponsorship of Programs	18%	23%

In general, the most commonly reported benefits of strategic partnership were being able to reach different and broader audiences, support sustainability, and offer a stronger network of services than existed without partnerships in place. Partners also serve on ADRC advisory committees, assist ADRCs in developing and implementing outreach and marketing strategies, and refer their own clients and constituents to the ADRC. Some grantees also involved partners in program evaluation activities.

Grantees reported that, in some cases, partnerships led to unexpected and positive outcomes. For example, one South Carolina pilot site was approached by a faith-based organization interested in starting a medication assistance program (MAP) in the community to help consumers access discounted prescription drugs from private pharmaceutical companies. The pilot site invited the MAP to share office space with the ADRC. The MAP has reportedly been enormously successful at recruiting volunteers, who are now familiar with the ADRC and its services and who regularly refer the consumers they serve to the ADRC. The MAP has also built strong connections with physicians' offices in the community by assisting their patients in accessing their prescribed medications, raising the visibility of the ADRC along this critical pathway in the process.

Aging and Disability Organization Partnerships

The capacity and focus areas of the grantees and pilot sites prior to receiving the grant influenced the types of partnerships developed to implement the ADRC program. While over 90 percent of the 2003 and 2004 grants were awarded to State Units on Aging, only a slight majority of their pilot sites (53 percent) focused exclusively on serving the aging population prior to becoming an ADRC pilot (*Exhibit 36*). In Alaska, Centers for Independent Living operate the pilot sites. Almost 10 percent of pilot sites used more than one organization to develop the ADRC partnership, characterized as joint efforts involving both an aging-focused and a disability-focused organization. For example, a partnership between the Atlanta Regional Commission (an AAA) and the Atlanta Alliance on Developmental Disabilities operate Atlanta's ADRC and Massachusetts' ADRC is based on a partnership between an Independent Living Center (ILC) and an Aging Services Access Point. Another 25 percent of pilot sites are operated by a single organization that already served both aging and disability populations prior to receiving the grant.

Exhibit 36: Pilot Site Population Focus Prior to Grant and Aging and Disability Partnerships after Grant, FY 2003 and 2004 Grantees (N = 51 Pilots)

Pilot Site Population Focus Prior to ADRC Grant	No. of Pilot Sites	At Least One Aging Partner Reported	Formal Agreement with Aging Partner	At Least One Disability Partner Reported	Formal Agreement with Disability Partner
Aging Focused (AAA or other Aging Organization)	27	19	9	17	15
Disability Focused (ILC or other Disability Organization)	5	5	5	5	5

Pilot Site Population Focus Prior to ADRC Grant	No. of Pilot Sites	At Least One Aging Partner Reported	Formal Agreement with Aging Partner	At Least One Disability Partner Reported	Formal Agreement with Disability Partner
Focused on Aging and Disability Populations Through Two Separate Organizations (now partnering to operate ADRC)	6	6	1	6	2
One Organization Focused on Aging and Disability	13	10	1	13	6
Total	51	40	16	41	28

Given that so many pilot sites are operated by aging-focused organizations, it is not surprising then that over 80 percent of pilot sites reported at least one disability-focused partner, such as a Center for Independent Living, disability council or task force, or advocacy organization, at either the state or local level.[15] Over 78 percent of pilot sites also reported at least one outside aging-focused partner at either the state or local level such as an AAA, senior center, AARP, or other advocacy group.[16] Of those that reported having at least one disability partner, 68 percent had a formal agreement with a disability partner, compared to 40 percent of those with aging partners.

Many grantees experienced challenges building strong partnerships between the aging and disability networks because of differences in service philosophy and historic divisions between the two service systems at both the state and local level. One of the most commonly reported barriers was developing a working partnership between the main aging entity and main disability entity. Grantees reported that it takes commitment and patience on the part of both aging and disability organizations to overcome cultural and organizational differences and to work together productively.

---

[15] Among those with at least one disability-focused partner, the median number of disability-focused partners is three.

[16] Among those with at least one aging-focused partner, the median number of aging-focused partners is three.

Appendix J

Examples of Aging and Disability Networks Working Together

Massachusetts Disability and Aging Cross Training. Massachusetts' ADRC model is based on an equal partnership between an Independent Living Center and an Aging Services organization. The two organizations maintain their own identities but through membership in the consortium, they partner to increase and streamline access to services for older adults and people with disabilities in the community. Staff in both organizations have been cross-trained about the different service philosophies of the aging network and disability network, the needs and values of the different populations, and the different resources available to them. Staff in both organizations report that through this partnership, they have developed a new understanding and appreciation for the different populations, as well the two service systems and their philosophies has been achieved in both partner organizations. The partnership has created a safe learning environment in which staff from both organizations can exchange ideas, make mistakes, be forgiven, and keep working toward common goals.

Maine's Partnership with Independent Living Center. Based on ADRC connections, the Eastern Area Agency on Aging's Executive Director developed a partnership with Alpha One (an Independent Living Center) to provide financial assistance for at-home installation services for wheelchair ramps for elders with physical disabilities. Alpha One had been pursuing banks and other financial entities for support, but through an ADRC presentation learned of opportunities for people with physical disabilities to qualify for small grants that need not be repaid. At least three consumers have been served through these grants since late February 2006, meaning easier and direct access and shorter time in securing such assistance.

North Carolina's Partnership with Family Support 360 Grant. Family Support 360 (FS 360) is a grant initiative of the U.S. DHHS Administration of Children and Families and Administration on Developmental Disabilities, designed to create one-stop centers that assist families of individuals with developmental disabilities. In North Carolina, the Family Support Network recently transferred their pilot site from eastern North Carolina to Forsyth County (also an ADRC pilot site county). ADRC staff at the state and local levels have attended FS 360 grant collaborative team meetings, and the evaluators of the ADRC and FS 360 grant have met to determine commonalities and to learn from each other. The state ADRC team and the Family Support Network plan to meet jointly with their pilot sites to more fully develop collaborative activities. They have already made plans to partner on serving grandparents raising grandchildren and providing I&R.

Despite the challenges they faced in coordinating program development activities, grantees' experience showed that there are many opportunities when aging and disability networks partner and that the different resources, skills, and strengths that each network brings can be leveraged to provide better access and better services for consumers. Several examples of successful aging and disability partnerships are highlighted in the text box above.

Medicaid

As part of the overall federal vision, ADRCs are to provide the following functions to enhance access to long-term support: (a) one-stop access to all publicly funded programs for community and institutional long-term support services administered by the state under Medicaid; (b) programmatic Eligibility Determination (level of care determination) for publicly funded long-term support services; and (c) Medicaid Financial Eligibility Determination that is either integrated or so closely coordinated with the Resource Center that each individual applicant experiences a seamless interaction. Achieving these goals requires strong partnerships between the grantee and Medicaid at the state and local levels.

The structure of state government and the type of Medicaid functions that were being **performed at the pilot level prior to the grant influenced the way grantees approached their partnerships with Medicaid and role that Medicaid played in the ADRC initiative.** As shown in *Exhibit 37*, all 24 grantees partnered with Medicaid to some extent, at the state or local levels or both. Overall, 13 grantees have formal agreements with Medicaid at either the state or local level. For 10 grantees, the Medicaid agency and the grantee agency are in the same umbrella department at the state level. In these states, Medicaid staff played an active role in grant planning and implementation, often without the need for a formal agreement.

Exhibit 37: Integration of Grantee Agency with Medicaid Agency Prior to ADRC Grant and Partnership Post-ADRC (n = 24 States)

			Post-ADRC Partnership					
Level of Integration Prior to ADRC	No.	State	Formal Agreement at State Level	Formal Agreement at Pilot Level	Formal Agreement at Either Level	Co-location at Pilot Level	Info Sharing	Joint Training
Different Departments at State Level and No Integration at Pilot Level	8	AK, FL, IA, LA, NM, NC, SC, WV	4	2	4	1	6	3
Same Department at State Level but No Integration at Pilot Level	3	ME, NH, CNMI	2	0	2	1	3	1
Different Departments at State Level but Co-located at Pilot Level	6	CA (1 Pilot), PA, NJ, IL, MD, GA	3	3	4	6	4	1

Appendix J

			Post-ADRC Partnership					
Level of Integration Prior to ADRC	**No.**	**State**	**Formal Agreement at State Level**	**Formal Agreement at Pilot Level**	**Formal Agreement at Either Level**	**Co-location at Pilot Level**	**Info Sharing**	**Joint Training**
Same Department at State Level and Integration at Pilot Level	7	IN, MT, WI, MA, MN, AR, RI	3	1	3	7	6	0
Total	24		11	6	13	14	19	5

States where the grantee agency and Medicaid are in separate departments typically experienced challenges engaging Medicaid leadership and staff in grant activities, at least in the initial phases of planning and implementation. However, at least eight of the grantees that are not in the same department as their Medicaid agencies have enjoyed a high degree of involvement from Medicaid facilitated by a formal agreement. For example, New Jersey's Medicaid Director regularly attends ADRC state management meetings and Medicaid staff play leading roles in designing new assessment and eligibility determination processes. The Pennsylvania grantee coordinates closely with Medicaid Agency staff to align the ADRC grant with other state rebalancing efforts. The Florida grantee established formal agreements with Medicaid that facilitated co-location of Medicaid staff in one pilot site and data sharing across all sites.

Some grantees strategically selected ADRC pilot sites that had prior experience with Medicaid programs and eligibility processes. Nine grantees chose pilot sites that were already performing case management for Elderly and/or Disabled Medicaid waivers. Six states had already implemented "single points of entry" at their pilot sites for at least one Medicaid waiver program. However, for eight grantees, the grantee agency and the Medicaid Agency are in different departments at the state level and no Medicaid functions had been performed at the pilot site level prior to the grant. Of these eight grantees, four have since established formal relationships with Medicaid at either the state or pilot site level, one has co-located eligibility workers at the pilot site, six are now sharing client information with Medicaid, and three are conducting joint trainings. In addition, in many cases, the ADRC grant has assisted states in expanding on or continuing long-term care reform initiatives that started in the Medicaid agency, such as Real Choice Systems Change initiatives.

Partnerships with Other Community-based Providers

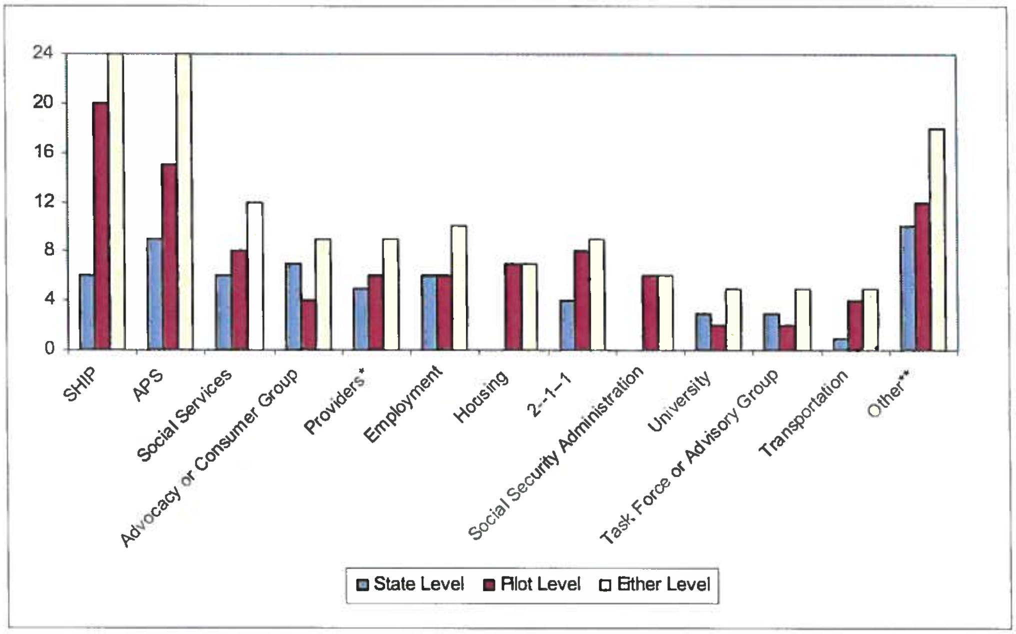
Throughout the first three years of the ADRC grant program, grantees strategically partnered with an array of provider and community-based organizations, with State Health Insurance Assistance Program (SHIP) and Adult Protective Services (APS) being the most common type of partner. Aging-focused, disability-focused, SHIP and APS partners combined represented over half of all ADRC partners. The grant announcement specifically encouraged grantees to partner with SHIP. The majority of pilot sites (64 percent) are co-located with SHIP. In 17 states, the

ADRC and the SHIP program are in the same agency at the state level. In the remaining seven states, ADRCs and SHIPS are partnering at either the state or local levels. Co-location and partnership with SHIP has been particularly important in the last year, when ADRCs and SHIP collaborated closely to provide assistance with Medicare Part D.

ADRCs are required to be able to link consumers to emergency services, including APS. Of the 24 grantees, 16 are in the same department at the state level as the APS program. Representatives from APS serve on grantee Advisory Committees, and ADRCs refer consumers to APS services as needed. Of the 51 pilot sites, 23 are co-located with APS and the remainder are partnering with APS at either the state or pilot level. In some cases, states worked out formal referral protocols with APS and worked to train staff on correct APS procedures. For example, New Hampshire and Wisconsin provided training to ADRC staff on recognizing and handling emergency cases appropriately.

In addition, grantees partnered with employment, housing, and transportation service providers and other social and human service organizations, including local and state health boards, rural services, community centers, and community assistance networks (***Exhibit** 38*).

Exhibit 38: Number of Grantees Partnering with Different Types of Partners at State and Local Levels

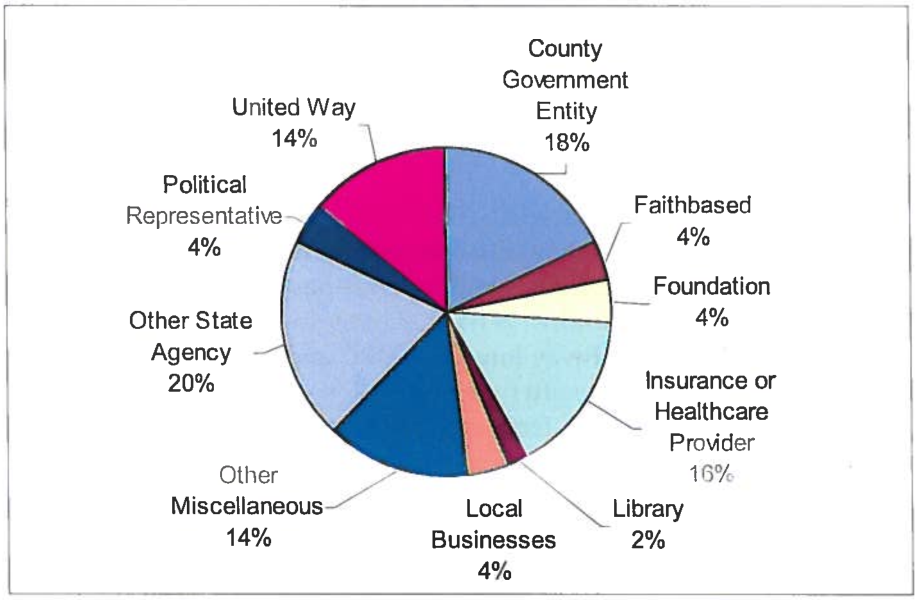


Note: Providers include hospitals, home health agencies, nursing facilities, and provider associations. "Other" includes United Ways, County Health Departments, Faith-based organizations, and others.

- **Critical pathway providers.** Grantees made a special effort to partner with "critical pathway" providers – common pathways for consumers to the long-term care system, both community-based and institutional. Examples of critical pathway providers include hospitals and discharge planners, doctors' offices, rehabilitation nursing homes, and intake agencies for home and community-based services. Grantee outreach approaches to critical pathway providers are described in more detail in the "Outreach to Critical Pathways" section of this report.

- **Non-profit and for-profit sector**. ADRCs also involved a variety of non-profit and for-profit private sector partners to strengthen their activities (*Exhibit* 39).

Exhibit 39: Breakdown of Types of Partners Included in "Other" Category



Private sector partners often served on the ADRC advisory board and were reportedly a valuable asset to the ADRC. For instance, some private partners operate entities where individuals with long-term care support needs are likely to come on a regular basis, such as grocery stores, banks, and libraries; ADRCs leave marketing materials and brochures in these locations for individuals to take home. In some states, ADRCs placed electronic Internet kiosks in public places where consumers can search the Resource Directory to find services and health information (see IT/MIS section of the report for more detail).

Non-profit agencies assisted with in-kind support or sharing costs for certain activities. For example, Minnesota, New Mexico, and North Carolina partnered with AARP to recruit volunteers who can assist with ADRC counseling. Illinois partnered with AARP tax preparation volunteers who help ADRC consumers file taxes. For-profit businesses were also strategic partners for a minority of grantees and have been particularly valuable in helping to disseminate information to privately paying consumers.

For-profit businesses also contributed financially to ADRC programs. In Virginia (FY 2005 grantee), ADRC pilots are operated using a public-private partnership model that incorporates local multi-disciplinary coalitions of public-private service providers. Each pilot site community receives in-kind public relations expertise from the Dominion Power (a Virginia power company) corporate public relations office. Dominion is also providing a $50,000 cash match for the project. ADRCs have also received grants United Ways, banks, hospitals, and local health systems. At least one grantee has made a particular effort to include foundation representatives on their local Advisory Committees.

At least nine pilot sites developed partnerships with local 2-1-1 operators, an Information and Referral service that connects people with health and human services in their communities. Where there is both a 2-1-1 and an ADRC operating in the same region, the ADRC typically maintains a separate telephone number and the two entities make referrals to one another. At least five ADRCs have formal agreements with the local 2-1-1 that outline how each entity will share resource databases and/or make mutual referrals. A few pilot sites have made arrangements for 2-1-1 to answer after-hours and weekend calls. In this case, consumers who call the ADRC number after business hours are routed directly to 2-1-1. ADRCs reported that 2-1-1 staff have been pleased to refer callers that need more detailed information about aging and disability services. See text box below for specific examples of partnerships with 2-1-1.

Some grantees report that there has been some concern in their states that the ADRC and 2-1-1 offer duplicative services and might potentially compete for limited resources. However, for the most part, states where 2-1-1 and ADRCs both operate have reported that the two entities play very different roles in the community. 2-1-1 is an easy-to-remember number for consumers, and another potential pathway into the ADRC and long-term care system. While 2-1-1 differs across the country (i.e., some offer general I&R, some are crisis responders, some offer both) they do not specialize in long-term care. ADRCs are positioned to go much more in depth with callers and have expertise in aging and disability services. In addition to basic I&R, ADRCs often provide supplemental information given the caller's circumstances that may not be directly asked for, make preliminary assessments on the phone, offer referrals, conduct long-term support options and benefits counseling, and provide follow-up and short-term case-management.

Appendix J

Examples of Partnership with 2-1-1

New Jersey's Atlantic County pilot site (2003 grantee) operates both the 2-1-1 and the ADRC. In addition, the grantee and NJ 2-1-1 have partnered at the state level to conduct orientation sessions for the two pilot counties about both initiatives as well as for the other counties that are served by NJ 2-1-1 call centers.

Iowa (2004 grantee) is building a virtual ADRC based on the existing I&R capacity of 2-1-1, the aging network and the disability network. In Iowa, 2-1-1 is statewide and offers information tailored toward the general public, while the aging and disability I&R systems maintain the specific information about programs and agencies that provide services to their populations. All the systems have some overlap but each has their own unique set of data. Iowa is establishing MOUs between all the I&R services to assure that referrals are made to the appropriate I&R. This type of relationship helps to eliminate duplication because the clients are directed to the appropriate source versus each source answering the same question. They plan for the ADRC Website to allow web users to access all three databases.

In **Idaho** (2005 grantee), the 211 CareLine functions as the single point of entry to long-term care services. The CareLine is a toll-free, bilingual service available to link consumers with health or human service providers and programs. Consumers will be connected to an Integrated Access Team consisting of four full time staff persons serving all three communities. A Community Resource Team, composed of volunteers from local agencies, will be established in each of three pilot communities, to provide information and assistance to the Integrated Access Team and consumer as needed.

ADRC Visibility and Public Awareness

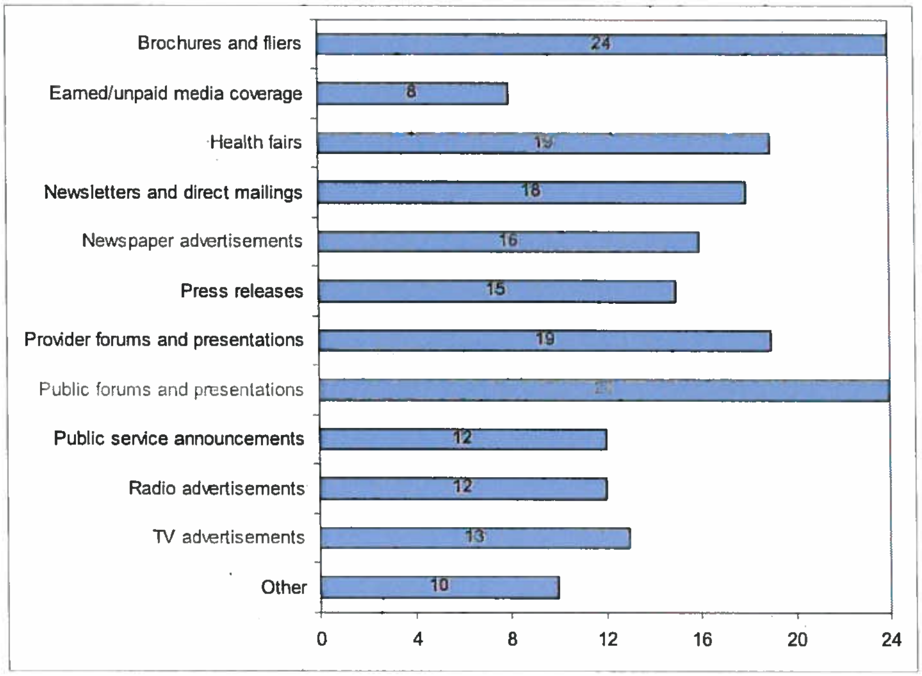
The federal vision is to have ADRCs in every community serving as *highly visible and trusted* places. Visibility can be defined as the extent to which the public is aware of the existence and functions of the Resource Center. Grantees are required to establish measurable performance goals for their programs, including the goal of *visibility*. In addition, public awareness is a component of the "Information and Awareness" function of an ADRC that all grantees are required to implement.

Increasing the visibility and awareness of the ADRC can be achieved through a variety of marketing strategies and activities, such as developing outreach materials, logos, and taglines; launching or enhancing a Web-based resource directory that includes both non-profit and for-profit providers; or developing a marketing plan. Successful branding and marketing may assist grantees in promoting ADRCs as a trusted source of information and assistance, where consumers can receive a full range of long-term support options and information to public long-term support programs and benefits.

This section describes the range of methods and strategies grantees employed to market the ADRC to different populations and includes an analysis of the relationship between the program model and how the ADRC was branded.

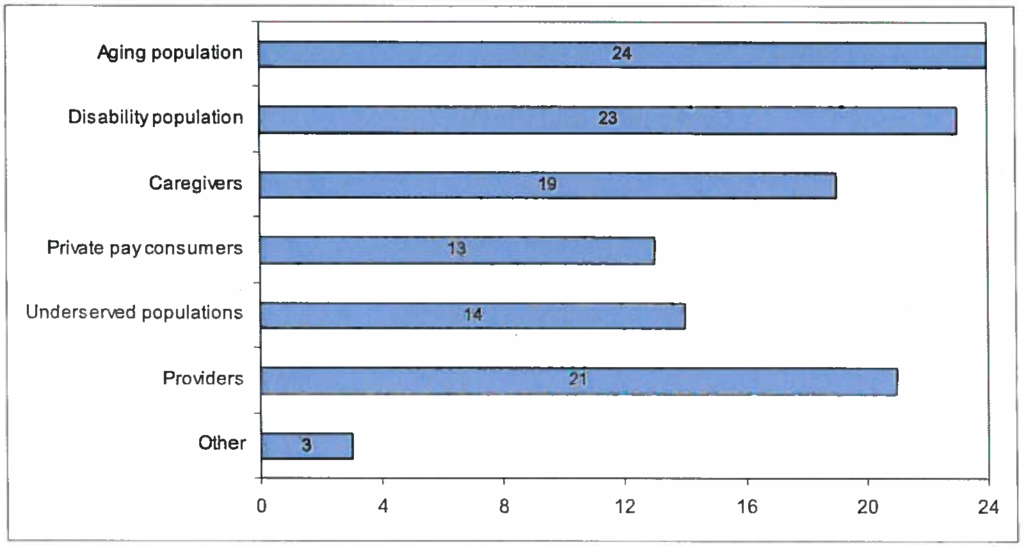
Grantees and their pilot sites employed a variety of strategies to successfully market ADRCs. Grantees reported using between three and twelve different marketing methods each, with most grantees using a combination of eight. Pilot sites, in particular, were actively engaged in marketing activities. ***Exhibit 40*** presents the frequency of marketing methods as reported at the state level. In addition to the specific methods grantees were prompted to report about, 40 percent used "other" marketing activities and strategies to promote and brand the ADRC—other activities included advertising on billboards and posters, disseminating promotional souvenirs (e.g., cups, magnets, pens, business cards, etc.), and developing CDs and DVDs for distribution.

Exhibit 40: Number of Grantees Using Different Marketing and Outreach Activities (N=24 Grantees)



Grantees tailored some of their marketing activities for particular audiences, with aging, disability and provider populations as the most commonly targeted audiences. Nearly all grantees developed marketing materials specifically for aging and disability populations. Providers along critical pathways were specifically targeted by 87 percent of grantees (21), and caregivers by 80 percent of grantees (19) (***Exhibit 41***). In addition, several states chose to design marketing materials and activities to reach historically underserved populations as well as consumers with the ability to pay privately for services. "Other" audiences that grantees specifically reached out to included advocacy organizations, minority groups, and state legislators.

Exhibit 41: Number of Grantees Tailoring Marketing Strategies to Specific Populations (N = 24 Grantees)



The extensive effort grantees made to market the ADRC to providers was important for reaching "critical pathway" providers as evidenced by the number of referrals these providers made to the ADRC. The most common sources of referrals to ADRCs, accounting for an average of 55 percent of all referrals across reporting pilot sites, were along critical pathways, including HCBS or social services organizations, doctors or health professionals, hospitals, nursing facilities, ICFs/MR, Senior Centers, ILCs, and alternative residential centers (see *Outreach to Critical Pathways* section of the report for more detail).

Friends and neighbors referred more than a quarter of all ADRC consumers. Overall, marketing materials and efforts such as brochures, websites, and radio, television and newspaper ads account for approximately 17 percent of all referral sources. Sources of referrals identified as 'other' by grantees include libraries, AARP, disaster response agencies, government agencies, first responders, telephone books, and public utilities who serve as gatekeepers.

Overall, 60 percent of the 2003 and 2004 grantees are using a name other than "Aging and Disability Resource Center" for their ADRCs. Twelve grantees chose and branded unique names for their ADRCs, and three grantees created new names by modifying existing brand names in their states. For example, New Hampshire built on their existing I&R system called *ServiceLink* to create *ServiceLink Resource Centers*. Several grantees, including Iowa, Maryland, Louisiana and Rhode Island, hired marketing consultants and conducted stakeholder surveys to assist them with the process of choosing program names and tag lines that would resonate and appeal to consumers in their communities. Rather than using the term *center*, three states chose the term *point* and two chose *station*. Two grantees replaced the term *resource* with *information*. Several grantees departed from the concept of a *center* by using terms like *network*, *connection*, and *coalition*. Six grantees incorporated the term *link* into their program's name or tag line. In all cases where a new name was chosen, states use the same basic name for all their pilot sites. See ***Exhibit 42*** for a list of the ADRC names and "tag lines".

Appendix J

Exhibit 42: ADRC Names and Tag Lines

State	No. of Pilot Sites	ADRC Public Name	Tag Lines
Alaska	**5**	Aging and Disability Resource Center (all 5 pilot sites)	Information for Alaskans
Arkansas	**1**	Aging and Disability Resource Center	
California	**2**	Aging and Disability Resource Center	
Florida	**3**	Aging and Disability Resource Center of (County name)	Pointing You in the Right Direction!
Georgia	**2**	Georgia's Aging and Disability Resource Connection	
Illinois	**2**	Starting Point	Your Aging and Disability Resource Center
Indiana	**2**	Link-Age	Aging Resource Connection - the Point for All the Answers
Iowa	**1**	LifeLongLinks	Connecting You to Iowa's Aging and Disability Resources
Louisiana	**5**	Aging and Disability Information Station	Louisiana Answers
Maine	**1**	DASH Network (Disability and Aging Hotline)	Getting You Connected to Services
Maryland	**2**	Maryland Access Point (MAP) (County name)	Your Link to Health and Support Services
Massachusetts	**2**	Aging & Disability Resource Consortium of Northeastern Massachusetts Partnering orgs: Elder Services of Merrimack Valley and Northeast Independent Living Program continue to use these names publicly.	
Minnesota	**1**	Minnesota Help Network (Senior Linkage Line, Disability Linkage Line, and MinnesotaHelp.info)	Connecting Minnesotans to Community Resources
Montana	**1**	Yellowstone County Council on Aging Resource Center	
New Hampshire	**5**	Service Link Resource Center of (County name)	Connections for Independent Living and Healthy Aging
New Jersey	**2**	New Jersey EASE Aging and Disability Resource Connection	Your Doorway to Information and Assistance
New Mexico	**1**	Aging and Disability Resource Center	
North Carolina	**2**	(County name) Aging and Disability Resource Connection	

Appendix J

State	No. of Pilot Sites	ADRC Public Name	Tag Lines
Northern Mariana Islands	1	Aging and Disability Resource Center	
Pennsylvania	2	(County name) Link to Aging and Disability Resources	
Rhode Island	1	The POINT	Rhode Island's Resource Place for Seniors and Adults with Disabilities
South Carolina	2	Aging and Disability Information Center	SC Access - A Program of The Lower Savannah Council of Governments
West Virginia	2	ADRC of (County name)	
Wisconsin	3 (new and open)	Aging and Disability Resource Center of (County name)[17]	

Grantees selected names reflective of the chosen ADRC program structure and design. Every one of the pilot sites with decentralized structures named their ADRCs using words like *connection, network or link*, whereas centralized models more frequently chose names with words such as *center*, *point* or *station* (***Exhibit** 43*). It is important to note that these words were chosen for different reasons and have meanings that are unique to the grantees' environmental context. For example, Maryland chose Maryland Access Point, which connotes a physical place. However, they deliberately chose this name and use the acronym MAP to communicate that the ADRC can help consumers get where they want to go. This message is enforced by their logo that includes an image of a bridge.

Similarly, for Pennsylvania's two pilot sites that are somewhat centralized (as opposed to completely centralized), choosing the word *Link* for their name reflects their strong commitment to partnership building at the local level. In fact, their two sites have more formal partnerships in place with different organizations in the community than any of the other ADRC pilot sites. Interestingly, the percentage of virtual and physical models was fairly evenly mixed in comparing the terms used to represent their initiatives.

---

[17] Some of Wisconsin's original nine ADRC sites do not use this naming convention.

Exhibit 43: Key Words Chosen by Structure Type

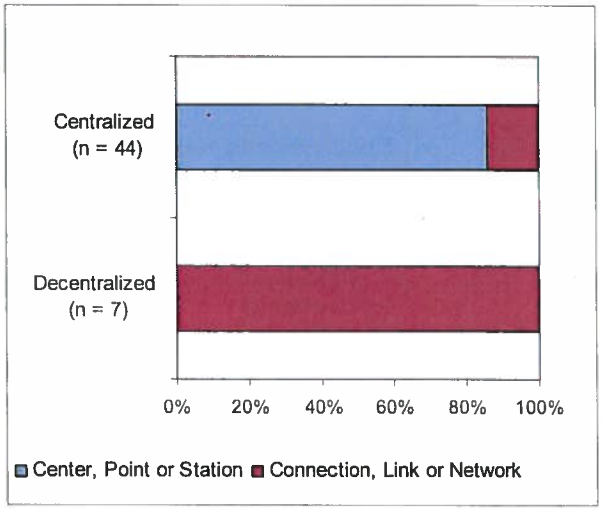
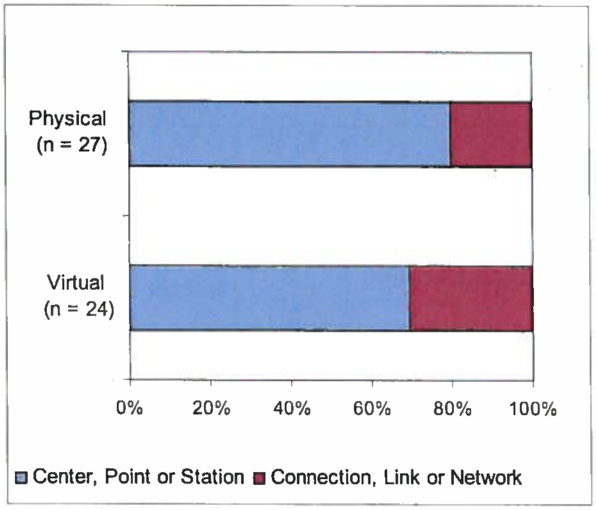


Exhibit 44: Key Words Chosen by Access Type



Most grantees marketed and publicized the ADRC as a brand new entity. While most grantees were building pilot sites within pre-existing organizations, such as Area Agencies on Aging, county government entities, and Centers for Independent Living, 17 of the 24 grantees (70 percent) decided to publicize their ADRC initiative as a new entity with its own name and identity. Five grantees chose not to market the ADRC as a new entity, but to advertise the ADRC initiative as an *enhancement* to existing entities. For example, Massachusetts decided that the two lead organizations piloting the ADRC were so well-known and well-trusted in the community that changing their names would not make sense. Rather, their marketing materials emphasize that enhanced services are available through a new partnership between these well-established organizations.

Those grantees that chose words implying a physical place, such as *center*, *point* or *station*, tended to market their initiatives as new entities, while almost half of those who used words like *connection* or *network* marketed their ADRCs as enhancements to existing organizations. Two grantees chose not to advertise the ADRC initiative and instead expanded and increased their marketing efforts to raise the visibility of existing entities.

Exhibit 45: Marketing New or Enhanced Entities by Key Words Chosen (n = 24 States)

Key Words in Name	New	Enhanced	Total
Center, Point or Station	12	1	13
Connection, Link or Network	5	4	9
No Unique Branding	0	2	2
Total	**17**	**7**	**24**

Grantees and pilot sites collaborated on marketing efforts. While many states took the lead on branding the initiative statewide, pilot sites were closely involved in planning and implementing marketing activities.

Examples of Marketing Strategies at the Grantee and Pilot Levels

Maryland – Maryland Access Point. At the state level, the grantee was responsible for developing a marketing campaign to rename the project, selecting two website addresses, determine a target audience, and issuing a request for proposal for a marketing and outreach contractor. A marketing firm assisted the Maryland Access Point (MAP) in developing a logo and tagline appropriate and reflective of the program. Additionally, it developed a statewide marketing and outreach plan that was comprehensive to educate the public, targeted populations and internal stakeholders about MAP. The grantee also organized and conducted consumer focus groups and surveys in order to gather input from pilot sites and key stakeholders to assist in renaming the initial name of the ADRC program. At the pilot site level, pilots were responsible for outreach activities. These activities included attending health fairs; presenting at long-term care facilities; creating flyers and brochures; direct mailings to hospitals, physician's offices; and advertisements in local newspapers and newsletters, among other activities. Maryland's most successful marketing activities were reportedly presentations to HCBS and senior centers, which accounted for 20 percent and 14 percent of referrals made to the pilot sites respectively.

Louisiana – Information Station. Louisiana had a unique marketing approach which included developing a tagline and organizing a campaign to promote the opening of Louisiana's ADRC. The campaign involved outreach and mailed invitations to local elected officials and advisory committee members. Louisiana also ran advertisements through the local media. Specifically, ads were placed in local newspapers, a string of radio public service announcements were broadcasted, and a paid TV PSA was aired during the day of opening. They coordinated demonstrations and presentations of the new ADRC website to key stakeholders and long-term care agencies. Louisiana's most successful marketing activities included public and private presentations to HCBS organizations and senior centers, TV PSA, the Internet, and activities marked as 'other.' On average, pilot sites reported receiving 27 percent and 12 percent of referrals from HCBS organizations and senior centers. The internet and TV PSA accounted for 18 percent and 16 percent of referrals.

Georgia – The Aging and Disability Resource Connection. Georgia, at the pilot site level, was responsible for developing a marketing plan and branding the ADRC, with the assistance of a marketing consulting firm. The marketing plans goal was to push the awareness and use of the ADRC through existing channels, including professional referral networks, business referral sources, and consumers and caregivers who are currently in the system. The pilot site developed flyers and brochures, and incorporated the use of CD's and DVD's to distribute to providers, board members, and consumers. Marketing and outreach activities also focused on individuals with brain and spinal cord injuries. The pilot site is also building partnerships with local TV stations to expand its outreach. Georgia's marketing strategy has enabled to ADRC to reach groups outside its target population, such as grandparents raising children, caregiver groups, hospitals, school transition teams and consumer groups. On average, the pilot site reported receiving 45 percent and 17 percent of their referrals from HCBS organizations and family members.

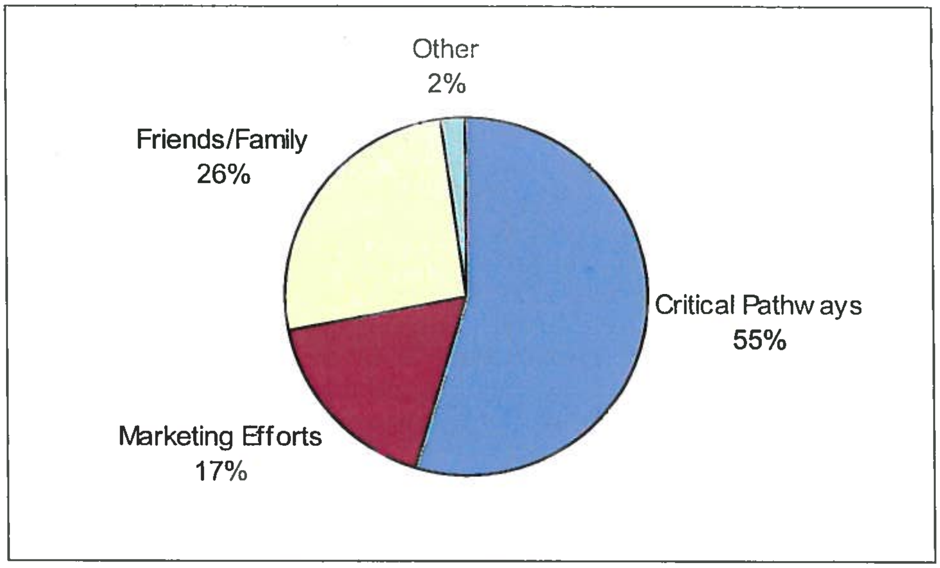
Outreach to Critical Pathways

In an effort to steer consumers to the right information or service at the right time and to prevent or delay unnecessary institutionalization, ADRCs are expected to form linkages with "critical pathways"—i.e., providers that serve as the major pathways to long-term care, such as hospital discharge planners, rehabilitation facilities and health clinics. Critical pathways provide information to individuals at a key decision making juncture. Outreach to critical pathways generally involves increasing providers' knowledge about services that are available through the ADRC and promoting appropriate referrals to the ADRC. The participation of critical pathways in referring individuals to ADRCs is thought to be vital for advancing the goals of consumer empowerment through informed decision making and serving as the entry point to all publicly-administered long-term supports.

Outreach to critical pathways is especially purposeful for identifying and intervening with individuals at-risk of institutional placement. All too often, individuals enter the long-term care system at a point of crisis when they face limited options and when assistance is time-intensive and care is costly. Therefore, in addition to assisting individuals with urgent needs, a long-term objective of performing outreach to "critical pathways" is to identify and assist individuals earlier on before they reach a point of crisis. This section describes grantees' approaches to performing outreach to various critical pathways and the extent to which critical pathways are referring individuals to ADRCs.

"Critical pathway" providers play an important role in connecting individuals to the ADRCs. HCBS or social services organizations, doctors or health professionals, hospitals, nursing facilities, ICFs/MR, Senior Centers, ILCs, and alternative residential centers together accounted for 55 percent of all referrals to ADRCs (***Exhibit 46***).

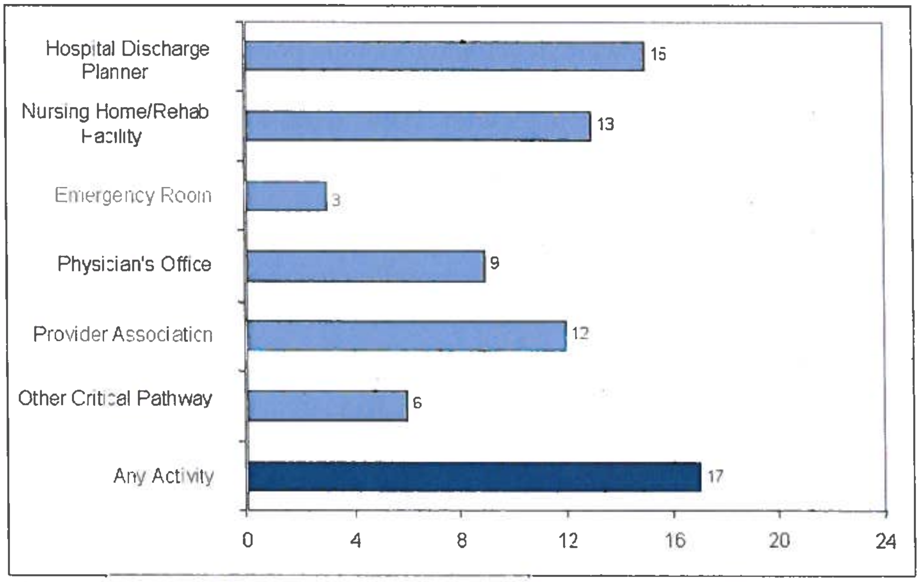
Exhibit 46: Average Percent of Referrals from Different Sources, April 2006 (n =35 Pilot Sites)



As providers of critical pathways become more familiar with the services of an ADRC, they will likely play an increased role in providing information about resources and referring individuals in need of long-term care to ADRCs. Further, as grantees' IT/MIS infrastructure matures, grantees will be better positioned to track the effectiveness of outreach activities and the relationship between referrals and consumer outcomes.

Grantees conducted outreach to a variety of critical pathways, with hospital discharge planners representing the most common type. As shown in *Exhibit 47*, grantees performed outreach to different types of critical pathways with the majority of grantees reporting activities with hospital discharge planners, provider associations and nursing and rehabilitation facilities. Also, nearly half of the grantees conducted outreach with physician offices and a few grantees linked with emergency room providers. Other pathways included pharmacies, senior centers, elder law attorneys, libraries, and employers.

Exhibit 47: Outreach to Critical Pathways by Provider Type, April 2006
(n = 24 Grantees)



Grantees engaged in a number of marketing, training, and educational activities targeted to different types of critical pathways. In general, ADRCs offered training on the availability of community long-term support and the ability of ADRC staff to help link individuals to these services. Although some training was conducted in a group setting, ADRCs more commonly provided training and education on a one-on-one basis. ADRCs also provided an array of written materials (e.g. brochures, business cards, magnets, ADRC newsletters) about the ADRC to critical pathway providers that were then disseminated to consumers. Specific activities by provider type are described below:

- **Hospital Discharge Planners.** Acute hospital stays represent times of crises in which patients and their families may have an urgent need for information about available options. Critical decisions at the time of discharge can have a significant impact on an individual's ability to remain in the community. For nearly half of the grantees, hospital representatives served on the ADRC advisory board or stakeholder coalition. A few grantees, such as Indiana and the District of Colombia, assigned ADRC staff to specific hospitals as a strategy to develop relationships with those providers. Others, such as Georgia, reached out to the statewide hospital association. Two states reported mandatory referrals from hospital providers to the ADRC for persons of the designated ADRC target population who are in need of long-term care (Illinois and New Hampshire). Wisconsin currently practices mandatory referrals from long-term care facilities to the ADRC, but discontinued mandatory referrals from hospitals because of the overwhelming volume of inappropriate referrals.18 Despite these efforts, a fairly small percentage of referrals came from hospitals (grantees reported an average of less than three percent).

  In general, ADRCs located in rural areas or small service regions, such as Alaska and Arkansas, reported an easier time developing relationships with discharge planners than ADRCs serving larger metropolitan areas. The main challenges grantees faced in conducting outreach to discharge planners were developing a single point of contact at hospitals due to high hospital staff turnover and, given the hurried pace at the hospital, limited availability of the hospital discharge planner to meet with ADRC representatives.

- **Nursing or Rehabilitation Facilities**. Another critical time for decision making occurs when individuals are completing therapy at nursing or rehabilitation facilities and must determine a discharge plan and next steps. This transitional period offers an opportunity for the ADRC to provide individualized information and counseling to consumers about their options for long-term support. Additionally, ADRCs have an opportunity to target some individuals residing in institutional settings who wish to return to the community and who may be unaware of their options. This cohort could benefit from learning about home and community-based support options, although affordable housing can pose a significant barrier.

  A majority of ADRCs involved nursing facility representatives on their advisory boards, leadership teams, or coalitions. Some grantees, such as New Mexico, worked with the nursing home ombudsman. Other strategies included assigning ADRC staff to specific facilities (Indiana) accounting for 10 percent of referrals in one pilot, offering options counseling to nursing facility residents (Indiana), assessing nursing facility residents for possible return to the community (Maryland) accounting for 6 percent of referrals. However, grantees have reported that reaching out to this group of provider can be a slow and time-intensive process, often requiring an ongoing effort. One of Illinois' pilot sites (Macon County) serves as the county Case Coordination Unit and has responsibility for conducting all nursing home prescreen assessments for individuals over age 18 in the county. They also conduct de-institutional screens when someone is preparing to leave a nursing facility, interim assessments and conversion screenings when a nursing home resident transitions onto Medicaid. Having responsibility for these functions gives this

---

[18] Hospital discharge planners reportedly referred everyone for fear of the financial penalty associated with failure to refer.

ADRC a direct link to nursing facilities, in addition to having administrators and discharge supervisors serve on their local advisory board. It also helps to create a seamless experience for the consumer from their initial assessment to when the ADRC helps to find them appropriate services in the community when they discharge.

- **Emergency Rooms.** Only four grantees reported any activity during the most recent reporting period in performing outreach to emergency room providers. Examples of approaches included providing sensitivity training to emergency room staff on working with older adults (Florida) and education about prescription plans (South Carolina).
- **Physicians**. Physicians tend to have great influence on consumer decision making and many medical providers are unaware of the full range of long-term support options for their patients, including home and community-based support. Although some grantees reported that physicians' busy schedules presented a challenge for the ADRC in making connections, many have been able to reach out through a variety of approaches. Some approaches included distributing ADRC brochures, mailing letters, and conducting educational presentations to physicians and their office staff. Maine and Illinois reported that meaningful involvement of physicians through ADRC-related coalitions and networks. Three innovative practices are described in the box below.

Examples of Outreach to Physician Offices

Florida. "In one pilot site, a geographical database of physicians was created to target those serving indigent and multi-cultural populations. As a result, over 950 letters were mailed with information about the ADRC and long-term care resources for older persons. An offer to attend a staff meeting was included. Of the physician offices identified, over 350 were targeted for high priority follow-up due to their location in rural, poverty-stricken and underserved areas. To date, 139 offices received follow-up calls and 23 offices have been visited with resource materials distributed. Another pilot site has established a working relationship with a multi-disciplinary team composed of nurses, physicians and other medical professionals. This team staffs geriatric assessment clinics in the community and has provided an opportunity to increase awareness of the ADRC in the local medical network." *Florida SART April 2005 (reporting 19.38 percent of all referrals from physicians)*

Tennessee. "The First Tennessee pilot site has developed a prescription pad type info sheet to distribute to physicians. The physician can give a patient needing in-home services a page from the prescription pad that tells how to get in touch with the AAAD. This concept was developed by the First Tennessee ADRC Advisory Committee. " *Tennessee SART April 2006*

Illinois. "Rockford: The ADRC has a number of linkages with local physician offices including local medical clinics, which refer clients to the ADRC for assistance. We have had good coordination with the Federally Subsidized Health Clinic in our area, Crusader Clinic, which serves low-income clients and those who are uninsured. Crusader offers a Memory Diagnostic Center. The director attends monthly network meetings at the ADRC. ADRC staff communicate with Crusader's pharmacy staff to help clients who have difficulty paying for their medications. We coordinate with three local audiologists to help low-income clients obtain free hearing aides through the HEAR NOW program." *Illinois SART April 2006*

- **Provider Associations.** Outreach to provider associations offers an opportunity for ADRCs to educate a base of individuals who have links to many critical pathways within the state. Nearly two-thirds of grantees reported outreach to provider associations during the most recent reporting period. In general, ADRCs provided education to provider associations about services offered by the ADRC and a few ADRCs provided specialized education concerning Medicare Part D.

  Reportedly, a major benefit of outreach to provider associations was that it offered an avenue to the privately paying population and better access to special provider types, such as those serving persons with mental health needs and developmental disabilities. Some of the main challenges included managing contacts for a large rural state and provider perception of competition between their services and the services provided by the ADRC. In addition, grantees connected with the local housing authority or the state chapter of the Association of Homes and Services for Aging. One grantee also worked with the state trooper association.

Grantees leveraged or enhanced existing outreach efforts that were part of other grants, particularly the state's Real Choice Systems Change grant activities. Many grantees reported that outreach to hospital discharge planners was an agenda for the state prior to implementing their ADRC program. Some grantees, such as Maine, Minnesota, North Carolina and Rhode Island, reported targeting discharge planners through additional grant funds such as Alzheimer's Disease Demonstration Grants and Nursing Home Transition Grants.

New Jersey implemented a hospital Pre-Admission Screening (PAS) program as part of a larger system-wide transformation in three counties (two of which had ADRCs). The program enables hospital staff to assess level of care for individuals entering a nursing facility or a Medicaid waiver program, which is then authorized by a Community Choice counselor. The purpose of the preadmission screening pilot was to coordinate processes between the hospital discharge planners, nursing homes, Community Choice counselors and Boards of Social Services (State regional Medicaid offices). ADRC staff facilitated the planning process trained hospital discharge planners and provided the state screening tool. A major goal of training hospital discharge staff was to free ADRC staff to focus more on options counseling (see *Information, Assistance and Informed Decision Making about Long-term Support Options* section of this report).

The Nursing Home Transition grants, part of President Bush's New Freedom Initiative, were awarded by CMS to states to assist in helping individuals move from nursing facilities into community-based residences. In several states, connections with nursing and rehabilitation facilities were borne out of these already existing Nursing Home Transition programs. For example, in Wisconsin, the grant funded the Homecoming Project, in which Wisconsin's Department of Health and Family Services (DHFS) contracted with Independent Living Centers (ILCs) to transition nursing home residents in their service area to community settings. During the duration of the program, 150 people transitioned from nursing facilities to community-based settings and an additional 150 people began the transition process. This preexisting relationship between DHFS, the ILCs and the nursing facilities provided the foundation for ADRC relationships with nursing facilities.

In New Jersey, Nursing Home Transition grant staff developed a "Round Table/ Interdisciplinary Team" model, which is a consumer-driven forum, coordinated by the state's Office of Community Choice Options and nursing home discharge planners. ADRC staff have adopted this model for developing comprehensive service plans that identify housing options, formal and informal services, frequency of services, special needs and cultural preferences. The Round Table/Interdisciplinary Team also includes family members, health care professionals, a care management organization, and community service providers who are instrumental in carrying out and monitoring the service plan.

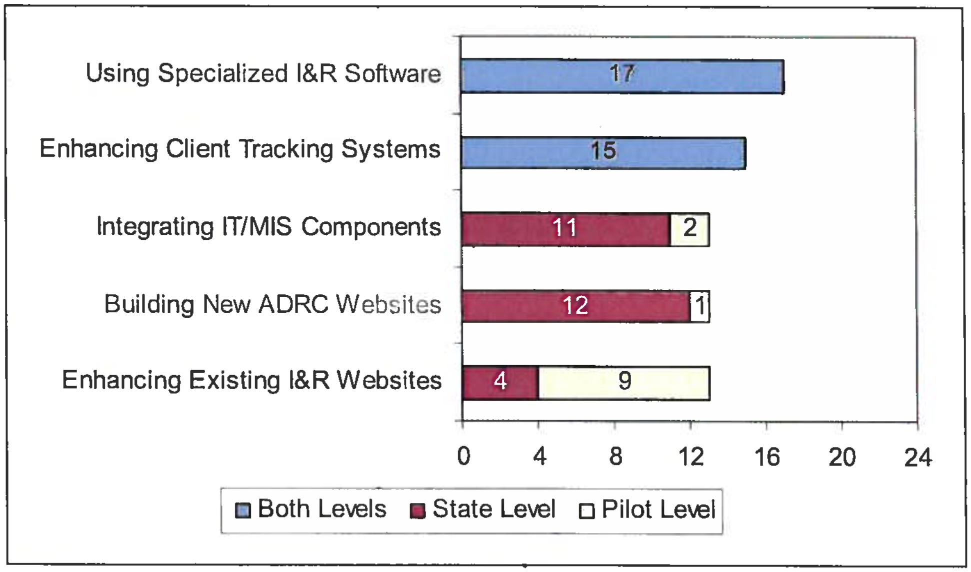
Louisiana's ADRC team has collaborated with several other grant initiatives. The state received a Real Choices Systems Transformation Grant in 2005 and one of the goals of this grant is to explore technology that will allow data sharing between separate agencies. They hope that this technology will allow client information to be shared between Medicaid and the ADRCs to coordinate service delivery. Their Alzheimer's Disease Demonstration Grant has provided funding to expand their web-based resource database, LouisianaAnswers.com, beyond the original pilot site area.

IT/MIS Infrastructure to Support ADRC Functions

A key program element for an ADRC is an information technology and management information system (IT/MIS) that supports the functions of the program, including client intake, needs assessment, care plans, tracking, utilization and costs. Information technology can support ADRC functions in a range of ways, from increasing public awareness and providing information through public websites, to streamlining access to services through online applications and electronic data-sharing between partner agencies. Traditionally, many health and human service organizations have used information technology primarily to collect, monitor, and report program data. The ADRC initiative brings many opportunities, as well as a host of challenges, for these agencies to refine and expand the use of technology. This section describes the variety of ways that grantees enhanced their IT/MIS infrastructure to support the functions of the ADRC and addresses the role that IT/MIS played in improving access to long-term support and other program activities.

Grantees focused on enhancing information technology capacity in four major areas: information and referral, client tracking, development of public websites, and IT integration. Grantees assessed their pre-existing infrastructure and worked to identify and fill the gaps in their data systems. Several grantees used ADRC funding to purchase specialized I&R software to help them better manage their resource databases and keep track of I&R calls, and 17 of 24 grantees now use specialized I&R software. Most grantees already had some kind of client tracking system in place for intake, care planning and services tracking activities when the grant began and have used the grant to integrate their client tracking with a specialized I&R package. Building new websites or enhancing existing websites has been a major activity at both the state and local levels with 22 of 24 grantees building new or enhancing existing websites.

Exhibit 48: MIS Activities and Enhancements, Implemented or Planned (N=24 Grantees)



IT/MIS decision making predominantly takes place at the state level for the majority of **ADRC grantees, often in coordination with other state agencies and local partners.** Decisions about IT/MIS tend to be locally-driven in states' long-term care systems. With the ADRC initiative, IT/MIS has become elevated such that states are thinking more strategically about the role of IT/MIS in long-term care reform and how to coordinate IT/MIS between state and local systems. For 21 of the 24 grantees who received ADRC awards in FY 2003 and 2004, the state took the lead role in IT/MIS design and implementation in conjunction with partners at the state and local level. Louisiana, for example, contracted with a vendor to build a statewide website and searchable I&R resource database for all their pilot sites to use. In Alaska, the State Centers for Independent Living coordinate with the Division of Senior and Disability Services and the Senior Housing Alliance to adapt its current IT/MIS system for ADRC requirements. Rhode Island and South Carolina enhanced statewide client tracking and I&R systems that were originally developed through Real Choice Systems Change grants.

Half of the 24 grantees built or purchased new management information systems, and just fewer than half pursued enhancements or improvements to their existing data systems. A number of factors determined whether an ADRC chose to use an "off the shelf" software package or created or customized a system, including: available resources, intra-agency IT/MIS compatibility, and whether a commercially available software package could meet the organization's ADRC-specific needs. In addition to building systems, another major area of focus for grantees was MIS integration. At least 14 grantees worked to integrate different MIS or implement electronic data sharing between systems.

The majority of grantees chose to use or purchase commercial software, but customized (or are in the planning stages to customize) the software for ADRC use. Iowa, for example, is building on the data storage and exchange protocols set up under the "Seamless Project" which created a software package to streamline elder case management. The same vendor is also building the

Iowa ADRC's web portal which creates greater coordination of resources.

Under the ADRC initiative, South Carolina enhanced an existing Web-based information and assistance system, SC Access, by building an electronic bridge to link its system to other databases, including the Medicaid Waiver Case Management system, the Office on Aging Family Caregiver system, and the Aging Information Management system. Maryland developed a Request for Proposal for a statewide MIS infrastructure that will link its existing aging and disability information systems and create an integrated application and tracking tool.

Eighteen of the 2003 and 2004 grantees (75 percent) chose Web-based systems for either professional or consumer use or both. In web-based systems, data are centralized and can be accessed and updated by multiple agencies, allowing for greater integration both within the ADRC and across partners. Georgia and Illinois, for example, use Elder Services Program (ESP) software, but are converting from a Microsoft Access version of the software to a Web-based version. Montana modified an existing Web-based Information and Assistance MIS program for ADRC program purposes. Montana also plans to make the resource database portion of its system accessible to the public in 2007.

Web-accessed systems have several advantages for ADRCs including ease of updating the application and the ability to provide access to multiple users. The grantees' experience shows the value of Web-based MIS systems in facilitating electronic data sharing and advancing efforts to streamline access to long-term care services. One of the grantees' primary strategies to streamline access was the development and use of online applications for benefits and programs. Sixteen of the 24 grantee states (67 percent) have Medicaid application forms posted online, but the majority must be printed out, filled in, and mailed or delivered to the local Medicaid agency (***Exhibit** 49*). Three states, Florida, Pennsylvania, and South Carolina, allow consumers to fill out and submit applications online, including an electronic signature function. North Carolina is piloting online submission of its Medicaid application, however, consumers in the pilot area must still print out and mail in the signature page. In addition to consumer-accessible online Medicaid application forms, seven grantees implemented online application forms that are accessible only to staff. Staff in both Iowa and Wisconsin, for example, can fill out and submit functional assessments for the HCBS waiver or other long-term care programs electronically. Grantees' experience also showed that their ability to streamline access depended in large part on the participation and cooperation of the State Medicaid agency.

Exhibit 49: On-line Medicaid Application Systems in ADRC Grantee States

State	Medicaid Application Available Online	Submission Method
Alaska	Form is online for download.	Mail or in-person.
Arkansas	Form is online but must be printed and mailed or dropped off.	Mail or in-person.
California	Form is online but must be printed and submitted.	Mail or in-person.
Florida	Form is online through ACCESS Florida.	Online using electronic signature, mail or in-person.

Appendix J

State	Medicaid Application Available Online	Submission Method
Georgia	Using supplemental funding to put Georgia's Medicaid form 700 online, with public access. Form 700 is the instrument used to determine initial financial eligibility for all aged, blind and disabled categories of Medicaid. This form will be a consumer-friendly interactive tool that can be filled out by consumers, caregivers, professionals or other representatives and will be located on several easy access public sites. Currently, the Medicaid application is online for download. The website indicates applicants can apply by email, but there is no signature information.	Mail, fax, phone, or in-person.
Illinois	Rockford: Using Real Benefits, a computer program which takes client information and puts this information directly onto an application form for Medicaid, Food Stamps, LIHEAP, and soon, Circuit Breaker. Macon County: The ADRC has the ability to complete Medicaid applications for clients but can't determine eligibility. The application and documentation can be mailed to the local office to determine eligibility without the client going into the Medicaid office. Medicaid forms can be downloaded, but must be printed and mailed or dropped off.	Mail or in-person.
Indiana	An "Eligibility Modernization" Request for Proposal (RFP), which includes online Medicaid applications, was officially released February 9, and vendors have responded with proposals to rehabilitate the current system. Form is currently online. Applicants can enter information into the online form but cannot save it.	Mail or in-person.
Iowa	The Iowa Department of Human Services (DHS) continues to test and refine a combination application for several social service programs, including Medicaid. The combination application would be available both through the enhanced Iowa COMPASS website and through the Seamless application for all HCBS waiver clients. Case managers can currently electronically send level of care information to the Iowa Foundation for Medical Care for the level of care determination, but determining financial eligibility is still a paper-based system. Form is online for download.	Mail or in-person.
Louisiana	Forms are online for download. Cannot save information in form.	Mail or in-person.
Maine	The pilot and the other Coalitions continue to advocate for publicly-funded services applications to be offered online. Much discussion has also centered on the need for face-to-face assistance given the complexity of some application processes. MaineCare application online for download.	Mail or in-person.
Maryland	An on-line application work group has met twice and has begun compiling spreadsheets for all applications for all publicly-subsidized programs providing long-term support services. Work on the application was delayed until DHR participation could be developed. Forms are not currently online.	In-person only.

State	Medicaid Application Available Online	Submission Method
Massachusetts	The Virtual Gateway is being used to facilitate online financial eligibility determinations. Virtual Gateway is available only to health care providers. Forms are available online that can be filled out online or downloaded.	Mail or in-person.
Minnesota	Online form may be filled out online and downloaded.	Mail or in-person.
Montana	No online forms.	In-person only.
New Hampshire	Forms online for download.	Mail or in-person.
New Jersey	No online forms for long-term care programs.	In-person only.
New Mexico	No online forms for long-term care programs.	In-person only.
North Carolina	Form online for download for Medicaid waiver. Forsyth County DSS reports an increase in the number of mail-in applications received since implementation began in October 2005.	Mail or in-person.
CNMI	No online forms.	
Pennsylvania	Medicaid application online with e-sign. Users can also print and send in signature page.	Online using electronic signature or mail.
Rhode Island	No online forms for long-term care programs.	In-person only.
South Carolina	Form that can be filled out and submitted online is available in pilot site service area.	Online. Must mail signature page.
West Virginia	Online screening for LTC programs but no online application forms. Forms must be picked up at DHHR office.	Mail or in-person.
Wisconsin	The system's online eligibility calculator is now used as virtual application option for some consumers who apply for public benefits. Forms are online for download.	Mail or in-person.

In addition to focusing on Web-based IT/MIS infrastructure, ADRC grantees are also using the Internet to increase public awareness and provide access to resources through websites. Twenty-two grantees built or plan to build public websites; grantees' activities in this area ranged from making minor changes to existing organization websites and adding some additional information about the ADRC (Alaska) to building new websites with interactive searchable resource databases (Iowa, Louisiana and Indiana) to making major enhancements to existing interactive websites (Minnesota and South Carolina). For a complete list of ADRC websites with descriptions of features, see ***Appendix C.***

In addition to public websites, grantees pursued other consumer accessed Web-based applications and data integration. Minnesota's ADRC model, for example, is a combination of a virtual and human network, the "MinnesotaHelp Information Network" — a network of information and assistance access points, known as ADRC Access Points (**see text box**). Two other grantees, New Mexico and Michigan, also plan to use public Internet kiosks to make ADRC services more accessible to consumers.

Several ADRC grantees use the capability offered by Web-based network systems to adopt mobile technology and offer consumer assessments and other services in the home setting. Arkansas, for example, uses a Web-based case management system that includes a comprehensive database, an Information and Referral Contact Record and a Consumer Assessment Referral and Enrollment (CARE) tool (**see text box**).

Examples of Web-based Applications to Improve Consumer Access

Minnesota's ADRC model is a combination virtual and human network, the MinnesotaHelp Information Network, a network of information and assistance access points, known as ADRC Access Points, which include an interactive online resource database for consumers and providers (www.MinnesotaHelp.info), written materials, toll free telephone assistance through the Linkage Lines, and referrals for long-term care consultation with a social worker or public health nurse. Access to the Network is available in places where people currently seek and receive information such as health clinics, community agencies, hospitals, pharmacies, libraries, senior centers, faith communities, social service and public health offices, and places where they work, in addition to the Web or the telephone. One of the Hennepin County Access Points is located in the Brookdale Library. Four computer terminals have been configured to feature aging and disability resources and the ADRC has trained librarians to access long-term care information through MinnesotaHelp and the Linkage Lines. The critical component to the resource center is the availability of a new web based tool that helps users complete an informal assessment of long-term care needs. Once the user has entered information, a community resource plan can be developed and then saved or printed at the resource center allowing the user to then seek further assistance in implementing the plan either by self directing access to the services, or seeking the services of a long-term care consultant.

Arkansas' Web-based case management system includes a comprehensive database, an Information and Referral Contact Record and a Consumer Assessment Referral and Enrollment (CARE) tool. The Contact Record enables I&R staff to record consumer contact and demographic information, referral requests, referral outcomes and follow-up summaries. The CARE Tool, which functions as a single entry point for LTC services, enables multiple agencies to enroll clients and record and track client information using the single system. Case managers are using laptops in the field to fill out and submit level of care assessment forms. They are also using portable printers with scanner capability to copy financial documents for eligibility determinations so that clients no longer have to entrust the originals of their personal documents to a third party for copying. However, in a 12-county rural area of Southwest Arkansas, where Arkansas' first pilot site operates, Internet access is not always available. This is especially true in areas case managers travel to for home visits. To meet this technological challenge, this grantee's IT contractor created PC versions of the online applications to enable case managers to enter data while in the field. The data can later be uploaded into the online system. The application of mobile technology, such as cell phones, notebook computers, and portable printers/scanners has reportedly enhanced communications between case managers and provider agencies, saved time and travel expense, and sped up the eligibility process for clients.

The process of refining IT/MIS is time-intensive and was the most commonly reported reason for delays in streamlining access. For many grantees, the process of refining IT/MIS involved assessing existing IT/MIS capacity, meeting with partners, establishing goals, determining compatibility and interoperability issues, developing specifications, addressing any data sharing privacy requirements, selecting and meeting with vendors, and testing and monitoring the implementation of software applications. The grantees' experience showed that IT/MIS infrastructure development is an inherently time-intensive process, and that participants often underestimate both the time and resources necessary to achieve their goals. Eight grantees have reported delays in meeting their IT/MIS goals, including the contracting and procurement processes (4 grantees), having to wait for the state or other agencies to make decisions (3 grantees), and the sheer complexity of the issues involved (5 grantees.) As described in the following section of the report, IT/MIS played a major role in grantees' efforts to streamline access to long-term care services and support and therefore IT/MIS delays experienced by grantees contributed significantly to grantees' progress in streamlining access.

Streamlined Access to Services and Support

A major focus of the ADRC initiative is to create a seamless experience for consumers and their families in accessing needed long-term care support. The federal vision is for ADRCs to provide one-stop access in the community to all publicly-funded long-term support programs and benefits such as Medicaid, state-funded, OAA, and other home and community-based services (HCBS). Therefore, the aim is to streamline the process to access services to long-term care services and support in which eligibility screening, comprehensive assessment, programmatic and financial eligibility determination, and entry into programs are either integrated or so closely coordinated that entry into programs for consumers and their families is as simple and efficient as possible.

By the end of the third year, ADRC pilot sites are expected to perform all the "Access" functions of an ADRC, which include screening and determining eligibility for public programs.[19] As mentioned above, in addition to serving individuals eligible for publicly funded services, ADRCs are intended to serve individuals who can pay privately by linking them with available support in the community. This section describes grantees' progress toward streamlining access and illustrates how some ADRCs were positioned to *integrate* several of these screening and eligibility functions across programs, with Medicaid and other entities, while others were more apt to streamline the process by *closely coordinating* with their partners.

Grantees pursued several different strategies designed to accomplish at least two major goals: 1) improving the ease with which consumers initially access services and support and, 2)

---

[19] Eligibility screening, providing assistance in gaining access to long-term support service that may be paid with private funds, performing comprehensive assessment of long-term support needs and care planning, conducting programmatic eligibility determination for long-term support services, Medicaid Financial Eligibility Determination that is either integrated or so closely coordinated with the Resource Center that each individual applicant experiences a seamless interaction, One-Stop Access to all public programs for community and institutional long-term support services administered by the state under Medicaid, and those portions of Older Americans Act programs that the state has determined will be devoted to long-term support services and any other publicly funded services which the state determines should be accessed through the Resource Center.

improving the administrative efficiency and timeliness of the process. *Exhibit 50* outlines the major activities that grantees completed or are planning to implement for each of these goals. These steps to streamline access centered on the use of IT/MIS and collaborative relationships among the Aging and Disability Networks and Medicaid.

Exhibit 50: Major Activities Undertaken by Grantees to Streamline Access to Long-term Support Services

Consumer Ease of Access	Efficiency/Timeliness
Develop Web-based resource database	Collect preliminary financial information as part of initial screen
Provide online access to programmatic or financial applications or forms	Shorten forms
Allow electronic submission of applications or forms	Reduce duplication (e.g. pre-population of forms with consumer information)
Offer online decision support tools	Integrate forms or develop universal assessment
Shorten time from intake to eligibility determination	Co-location of staff
Reduce number of interactions for the consumer	Institute presumptive eligibility or self-declaration of financial resources
Reduce number of entities involved in the process	Integrate MIS/ share information across agencies/ track clients system-wide

FY 2003 grantees made progress in streamlining access, completing six activities on average, **ranging from three to ten. All together, grantees completed more activities related to improving administrative efficiency and timeliness than activities related to improving consumer ease of access.** See *Exhibits 51* and 52 below for more detail on streamlining activities. In working toward greater ease of access for consumers, over half of the pilot sites (15 of 26) have already shortened the time it takes between initial intake and eligibility determination. Eventually, 69 percent (18 of 26) will offer online access to program applications. Towards improving the efficiency and timeliness of the eligibility determination process, 80 percent (21 of 26) have begun collecting preliminary financial information from consumers at the beginning of the intake process to help determine whether a full financial eligibility determination is appropriate as well as to quicken the determination process. Sixteen pilot sites (61 percent) have functional or financial eligibility staff co-located with the ADRC.

Exhibit 51: Completed and Planned Activities Designed to Improve Consumer Ease of Access (2003 Grantees Only, n=26 Pilot Sites)

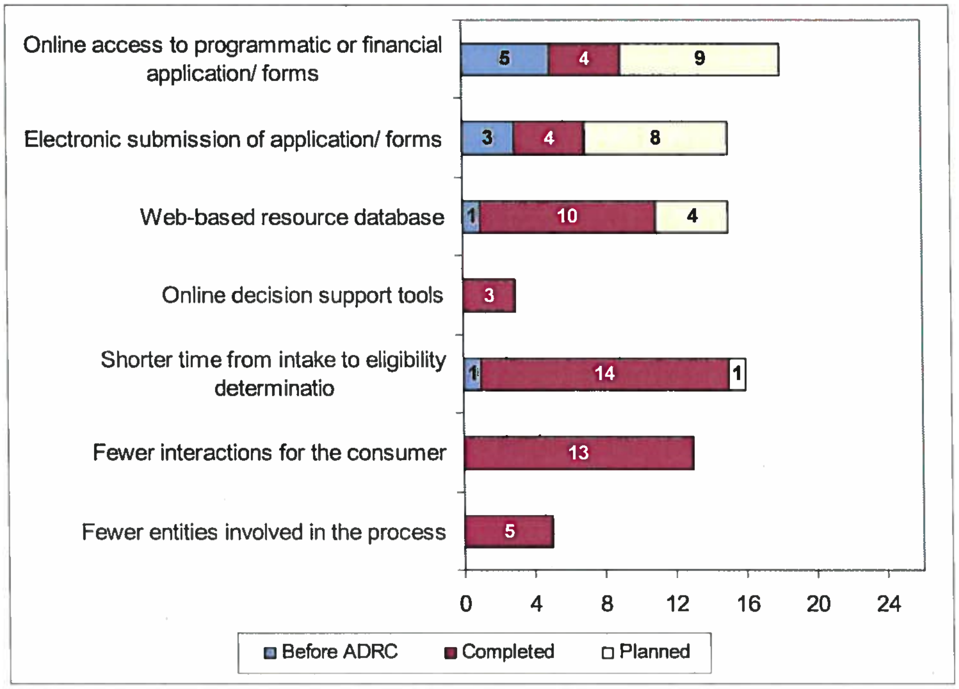
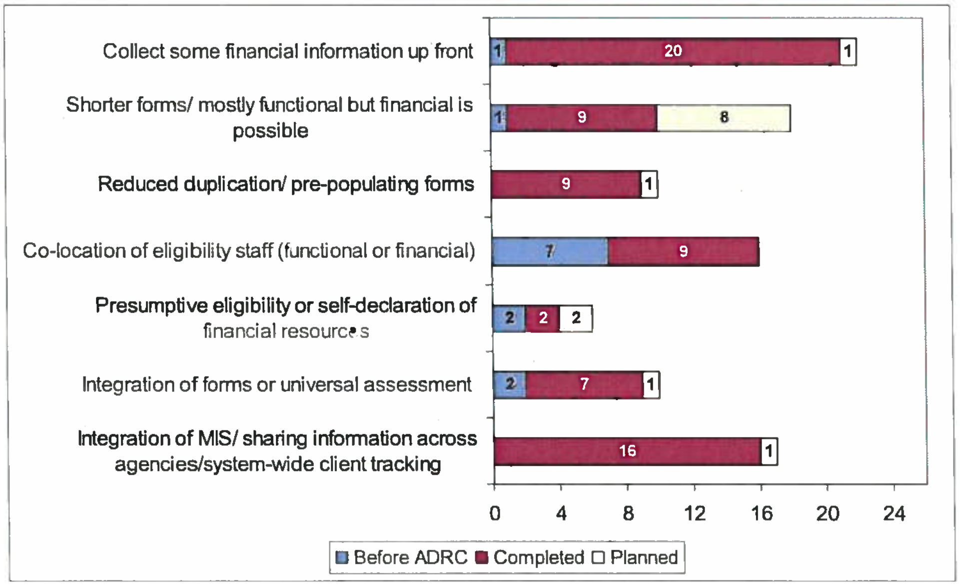


Exhibit 52: Completed and Planned Activities Designed to Improve Efficiency and Timeliness (2003 Grantees Only, n=26 Pilot Sites)



The strength of the partnership between the ADRC grantee and the Medicaid agency is closely correlated with streamlining access. While it is too soon to determine which factors result in streamlined access, early analyses suggest that having a strong partnership between the ADRC and the Medicaid agency is an advantage to achieving streamlined access. Our analyses show that pre-existing capacity is positively correlated with the achievement of streamlining activities.[20] It was determined that eight states had substantial pre-existing ties with Medicaid. Similarly, the strength of the relationship that developed during program development and implementation is positively correlated to streamlining outcomes.[21] Our analysis of the post-ADRC relationship found seven grantees to have a strong working partnership with Medicaid and that this variable has a statistically significant influence on the achievement of streamlining outcomes (five of the original eight with pre-existing capacity and two that had minimal pre-existing capacity).

The current division of responsibilities for eligibility determination makes achieving the streamlining access goal more difficult. By law, different staff can be assigned to perform financial and functional eligibility determinations.[22] Some grantees perform financial and functional screens for publicly-funded programs within their ADRCs. For others, eligibility determinations are handled by an ADRC partner organization (e.g., agency handing nursing home pre-admission screenings, HCBS Medicaid waiver services). One grantee reported that programmatic eligibility for waivers services and LOC determinations are performed by the local waiver staff, but that ADRC staff are able to coordinate the application process for consumers electronically. However, some grantees report that large waiting lists for services still remain, thereby prolonging the time between application and enrollment.

In general, ADRC model type moderately influences the implementation of streamlining activities; the management dimension has the strongest correlation with streamlined outcomes. When examining the three different dimensions of model type (State-driven vs. Locally-driven Management, Centralized vs. Decentralized Structure, and Virtual vs. Physical mode of access) and controlling for the strength of the partnership with Medicaid, the

---

[20] To measure grantees' existing capacity or *potential* for a strong partnership with Medicaid, we considered whether the grantee agency is situated in the same department as Medicaid at the state and local levels and whether the pilot sites were already performing some Medicaid functions prior to the ADRC grant period.

[21] In considering the strength of the *post-ADRC* relationship with Medicaid, we first looked at the level of Medicaid staff involvement in ADRC planning and management activities. If grantees report a high degree of participation and active involvement in ADRC planning and management activities by Medicaid staff, we considered this a strong partnership. In the absence of a high degree of Medicaid participation in planning and management, we considered whether there was a formal agreement in place between the grantee and Medicaid, whether information about consumers is shared, and whether joint trainings have been conducted.

[22] Section 1905(a) of the Social Security Act and regulations at 42 CFR 431.10(c), stipulates that the final determination of Medicaid eligibility shall be made by the State or local agency administering the State plan, the agency administering the supplemental security income (SSI) program, or the agency administering the State plan approved under part A of title IV. If ADRC staff are not part of the same agency as the Medicaid single state agency, then Medicaid agency staff must approve their determinations of eligibility. If they are part of the same department, they may be able to establish procedures to meet the Medicaid agency requirements and be permitted to make the determinations. Specifically, unless otherwise delegated by regulations at 42 CFR 431.10(e)(3), employees of the State Agencies other than the State Medicaid Agency can only perform initial processing activities. As stated in regulations on the use of outstation locations to process Medicaid applications, at 42 CFR 435.904 (e)(3)(ii), non-Medicaid agency employees at the outstation location can only perform "initial processing" functions.

dimension with the greatest correlation to streamlined access is Management. On average, grantees with initiatives that have been largely state-driven (planned and managed across all sites at the state level) have pursued and completed a greater number of streamlining activities. This may be partly due to during the initial phase of ADRC implementation, locally-driven sites faced more challenges planning and implementing streamlined processes given the limited control or influence over state Medicaid policy by pilot site staff.

When examining the effect of ADRC model type on the two major groupings of streamlining activities (consumer ease and efficiency), having a decentralized structure is positively related to the completion of streamlining activities designed to improve *consumer ease* of access, of small scale. While there are centralized models that have made great progress toward improving consumer ease, decentralized models may offer more options and/or familiarity in where and how to access services.

Whether the initiative is state-driven or locally-driven had a significant influence on achieving *efficiency*. State-driven initiatives were more likely to complete activities to improve the efficiency and timeliness of the process than locally-driven initiatives. In addition, we analyzed what effect a state's annual home and community-based spending as a percentage of Medicaid LTC spending had on achieving streamlined access and found that having a higher proportion of HCBS spending was a slight advantage for grantees. It is important to understand that we cannot draw conclusions from these early analyses about which models are most successful and what are the necessary components to have in place especially given the small sample size and the lack of trend data available to determine sustainability and true evidence of change.

Eight pilot sites in five states reported consistent data about average monthly enrollment in HCBS, institutional settings and other LTC programs. Over time, these pilot sites experienced a 10 percent increase in HCBS enrollment (Medicaid and other state funded programs). These grantees experienced a similar reduction in institutional enrollment between Fall 2005 and Spring 2006 in their service areas (*Exhibit* 53). Enrollment in other programs such as state-funded or OAA programs has also increased by 50 percent. In order to measure the impact of streamlining access to Medicaid and other public LTC programs, grantees are asked to report data about average monthly enrollment in HCBS, institutional settings, and in other LTC programs. At this time, however, few consumer-level outcomes in this area have been reported. It is either too early for grantees to report these outcomes or they do not yet have the capacity to track individual clients this far through the system. However, eight pilot sites in five states have been able to report consistent data and show an increase in HCBS enrollment and a decrease in institutional enrollment. It is important to note that these grantees reported overall enrollment in these programs, not enrollment specifically of ADRC consumers. Also the trend toward HCBS may reflect current trends in these states rather than the ADRC initiative, although the national annual average decline in Medicaid nursing facility residents was only 1.1 percent compared to 11.8 percent for the ADRCs able to report.[23]

---

[23] The Lewin Group analysis of Annual Nursing Home Statistics Yearbooks for 1994 and 2005.

Exhibit 53: Average Monthly Enrollment in HCBS, Institutional Care, and Other LTC Program per 1000 Residents in Service Area (n=8 Pilot Sites in 5 States)

	Fall 2005	Spring 2006	Percent Change
HCBS	1.37	1.51	10.22%
Institutional	4.57	4.03	-11.82%
Other Program	8.77	13.23	50.86%

Note: Numbers based on enrollment per 1,000 residents in the pilot site area.

Achieving Sustainability

Achieving sustainability is an important activity for ADRCs since grantees are expected to implement systems change goals that improve the delivery of long-term care services that: involve multiple stakeholders, are dependent upon diverse partnerships, and impact state and local systems in both the public and private sectors. This section describes progress that ADRCs have made in ensuring sustainability of project initiatives after funding has ended.

Sustainability has been defined as "ensuring that the values, ideas and processes of the effort are widely shared and deeply felt; that important relationships are nurtured and remain strong; that policy and practice innovations are institutionalized and become the norm; and that needed financial and human resources are secured for the long term."[24] Characteristics contributing to sustainability may differ among funded organizations but typically include:

- Availability of resources;
- Flexibility in response to change or in meeting challenges;
- Commitment to the project's vision and mission by staff at all levels of the organization;
- Identification of a program or project "champion";
- Institutional or organizational "fit" of the project within the mission of the grantee organization and/or in the broader environment;
- Measurable perception of the benefits of the program by staff, stakeholders and the broader community; and
- Support and "buy in" by related stakeholders.[25]

---

[24] Ira Cutler. (2002). "End Games: The Challenge of Sustainability." The Annie E. Casey Foundation, MD.

[25] Scheirer, M.A. (2005). "Is Sustainability Possible? A Review and Commentary on Empirical Studies of Program Sustainability. American Journal of Evaluation, Vol. 26, No. 3, pp. 320-347.

ADRCs have focused their efforts to achieve sustainability on: 1) maximizing resources; 2) **developing sustainable programmatic infrastructures to ensure sustainability; and 3) identifying and addressing future challenges to sustainability in their long-range plans.** In addition, they have embedded many of the aforementioned characteristics in their programs' operational infrastructure and have used a various strategies to achieve sustainability and ensure long-term program impact.

Maximizing Resources to Achieve Sustainability. ADRCs reported using three key approaches to increasing the availability of resources to augment and sustain project activities. These included: seeking public-sector financial resources; developing partnerships with other organizations, thereby leveraging the capacity of staff to provide services as well as to obtain space and equipment for their operations; and exploring other venues for program sustainability (*Exhibit 54*). Along with sustainability strategies, ADRCs also identified implementation challenges in each of these areas. To meet these challenges some ADRCs have established Sustainability Committees to focus on identifying potential resources, to pursue funding opportunities in both the public and private sectors, and to strategize new approaches for leveraging resources involving creative partnerships, in-kind resources.

Exhibit 54: ADRC Sustainability Strategies

Activity	Strategies	No. of ADRCs (n=24)	Challenges
Seeking Public Sector Financial Resources			
Securing Medicaid reimbursement	• Seek Medicaid match for ADRC functions (i.e., waiver services, case management, assessment, counseling, quality initiatives, managed care processes and client tracking through eligibility processes) • Pursue Medicaid Federal Financial Participation (FFP) • Collaborate with Systems Transformation Grant and incorporate/partner with other state and federally funded programs (i.e., medication management, transportation, mental health services) • Pursue state funds for ADRC initiatives	19	• Working around Medicaid priorities • State budget constraints • Fixed number of waiver slots • Time intensive to develop policies • May be difficult to establish alignment of ADRC core functions within state government structure
Pursuing/ implementing cost-sharing	• Pilot cost sharing • Incorporate in new waivers • Pilot sliding scale fee system • Partner with ILCs that have cost sharing in place • Request voluntary donations	8	• Introducing new concept to providers and consumers • Developing equitable policies for diverse consumer groups

Appendix J

Activity	Strategies	No. of ADRCs (n=24)	Challenges
Developing Partnerships			
Building Private-Sector Partnerships	• Enhance volunteer involvement with business sector and community groups • Engage in outreach strategies to the business community – for funding and volunteers • Involve other agencies and organizations in joint activities	9	• Staff resources limited for recruiting and training volunteers • Concerns about conflict of interest
Exploring Other Venues for Funding/ Supporting Program Sustainability			
Engaging in sustainability-specific strategic planning	• Develop sustainable interagency infrastructure • Form Sustainability Committee • Pursue legislation to codify ADRC activities and mission	9	• Time- and staff-intensive • Long-term commitments uncertain
Seeking Private Sector Investment Opportunities	• Seek funding/grants from private foundations with similar goals • Maximize use of community volunteers • Share resources with organizations and businesses in the community	9	• Time and staff intensive • Private foundations may have their own priorities, may not fit precisely with ADRC goals

Notes: Chart lists the most-commonly cited sustainability strategies and concerns of the 24 2003 & 2004 grantees. Not all ADRCs reported on sustainability initiatives; numbers represent ADRCs that indicated they were planning to or had implemented sustainability strategies; individual ADRCs may have utilized several strategies and may be represented in multiple categories.

Developing Sustainable Programmatic Infrastructure: Case Studies. In the winter and spring of 2006, ADRC-TAE team-members conducted site visits to six 2003 Aging and Disability Resource Center grantees to discuss site-specific program elements and project activities related to sustainability of project outcomes beyond the funding period.[26] Grantees discussed the following topics related to sustainability: (1) Elements of the ADRC initiative that are most likely to be sustained and/or replicated; (2) Strategies used to achieve sustainability; and (3) Conditions, features or characteristics of the different states and ADRC programs that facilitate sustainability. A summary of the findings from each site-visited state in each of these areas is provided in *Exhibit 55*.

Challenges to Sustainability. ADRCs reported that their most critical area of concern in ensuring project sustainability was obtaining funding and resources. Other primary challenges

---

[26] Study states included: Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, and South Carolina which represented half of the states receiving ADRC grants in 2003. Structured interviews were conducted with project leaders, staff, advisory board members, evaluators, volunteers, and other project partners in the six states, at nine pilot sites and at four Access Point sites (in Minnesota).

to sustainability, reported by many of the ADRCs, included:

- Continuing operations
- Maintaining services already in place and provide ongoing training for staff
- Improving existing infrastructure, especially in the area of IT/MIS
- Developing and expanding effective partnerships
- Ensuring quality in the services and supports they provide
- Supporting expansion and replication of project activities to all areas of the state

Of the twenty-four 2003 and 2004 ADRC grantees, three grantees had to significantly modify or eliminate a pilot site. In two states, decisions were made not to continue pilot site operations in specific localities and one state relocated an ADRC pilot site in order to reduce overall project costs. Strategic, funding and/or consumer service concerns were the primary reasons for altering expansion plans at these ADRCs. Lessons learned from the experience of these three states underscore the critical importance of program monitoring and proactive assessment of successful model elements for replication and statewide expansion.

Exhibit 55: Sustainability Site Visits Summary of Findings

State & ADRC Name	Elements Most Likely to be Sustained	Strategies Used to Ensure Sustainability	Facilitators of Sustainability
New Hampshire ***Service Link Resource Centers***	- Uniform statewide standards - IT/MIS improvements - Streamlined access through staff co-location - Statewide network of *ServiceLinks*	- Integrate project with broader systems reform - Involve diverse stakeholders in project activities - Educate policymakers and demonstrate beneficial outcomes	- Develop ADRC as integral component of ongoing systems change - Maximize ADRC relationships within state government structure - Strike balance between state oversight and local flexibility
Massachusetts ***Aging and Disability Resource Consortium***	- Decentralized approach to LTC service delivery - Joint/Collaborative management - Alignment of service philosophies among different service systems - Collaborative development of tools and resources	- Build on existing infrastructure - Heed lessons learned from other systems change initiatives - Establish trust between aging and disability partners - Identify shared values	- Engage partners in strategic planning at outset of project - Promote "give and take" among project collaborators - View partnership-building as a project goal
New Jersey ***Aging and Disability Resource Connection***	- Standardized screening and eligibility determination processes - Commitment to consumer-centered policies and programs - Commitment to quality monitoring and improvement	- Engage large and diverse workgroups in planning project activities - Leverage expertise of external consultants - Strive for consensus among stakeholders - Expand responsibility for project success across stakeholder groups and agencies	- View ADRC as an ongoing activity within the state - Develop a "can do" attitude in working around challenges and managing change - Implement policy directives from the "top down" while recognizing local needs
South Carolina ***Aging and Disability Information Center***	- Improved consumer access to streamlined services - Close coordination between ADIC and CLTC Medicaid waiver program - Visibility and focus on consumer and provider education - Strengthened state and local-level partnerships	- Build upon prior initiatives - Find a niche for the ADRC - Improve utilization of scarce resources through collaboration - Leverage the potential of partnerships and clout of "project champion"	- Demonstrate and practice visionary leadership - Remain open to developing creative partnerships - Establish clear expectations of staff roles; maintain staff capacity and morale

Appendix J

State & ADRC Name	Elements Most Likely to be Sustained	Strategies Used to Ensure Sustainability	Facilitators of Sustainability
Maryland *Maryland Access Point*	- Streamlined access to services through co-location and/or coordination - Commitment to consumer-centered policies and programs - IT and MIS improvements - Interagency partnerships	- Earn support of diverse stakeholders - Enter into formal partnership agreements with collaborating agencies and organizations - Develop a cohesive marketing strategy to raise awareness of ADRC activities - Track and document programmatic outcomes	- Recognize opportunity for ADRC project to shape state's broader long-term care reform agenda - View the ADRC as a catalyst for positive systems change - Cultivate participation of "natural" as well as unexpected partners in project activities - Integrate ongoing staff training into project activities as a component of quality services
Minnesota *MinnesotaHelp Information Network*	- Multiple approaches for consumers to access streamlined services - ADRC Access Points established in diverse community locations for easy access to services and information - Consumer Decision Tools which are easy to use and readily accessible - Close working relationships that have increased coordination between state and local service delivery systems	- Engage in strategic planning as a critical "first step" in project implementation - Use flexible "give and take" management strategies to foster collaboration - Develop products and resources that have multiple applications and can be used in different settings - Prepare to adapt to policy and political changes ongoing in the state.	- Staying "on message" and focused on the ADRC initiative - Leverage commitment and expertise of "project champions" at the state and local levels - Utilize staff expertise in overcoming bureaucratic barriers to project implementation

Appendix J

IV. PROMISING PRACTICES/ LESSONS LEARNED

This section describes the most commonly reported challenges the ADRC grantees encountered during planning and implementation phases, as well as facilitators that have supported the ADRCs in overcoming challenges and achieving their goals.

Key Challenges

During the planning and implementation of the ADRC grants, grantees encountered a number of challenges that affected the implementation of their programs. *Exhibit 56* lists the most frequently reported barriers that ADRCs have encountered. All 24 of the 2003 and 2004 grantees reported that they encountered at least one substantial challenge to planning and implementing their ADRC grant.

Exhibit 56: Challenges to Planning and Implementing ADRC Grants (n = 24 grantees)

Challenges	No. of Grantees	Percent of Grantees
IT/MIS challenges	**16**	**67%**
Insufficient staff time/resources set aside for IT/MIS issues	7	29%
Technical issues sharing data and/or linking different systems	7	29%
Difficulty procuring IT/MIS vendor	4	17%
Delays due to other agencies' priorities/issues/concerns	3	13%
Other	**3**	**13%**
Staffing and leadership challenges	**15**	**63%**
Administration and leadership changes	9	38%
Delays in hiring key staff due to hiring freezes, budget delays	8	33%
Turnover of key staff during grant period	5	21%
Insufficient staff capacity	2	8%
Difficulty forming and maintaining partnerships with other agencies	**13**	**54%**
Partnerships between aging and disability agencies	8	33%
Partnerships with state and county Medicaid agencies	7	29%
Partnerships with other agencies	4	17%
Streamlining access challenges	**11**	**46%**
Integrating ADRC with other Medicaid system reform efforts/initiatives	8	33%
Fragmentation of eligibility determination processes across agencies	4	17%
Privacy concerns related to data sharing between agencies	4	17%
Difficulty maintaining consumer involvement	**9**	**38%**
Total Grantees Reporting Any Significant Challenge	**24**	**100%**

IT/MIS Issues

Many of the grantees have plans to improve current IT/MIS technologies or adopt new technologies to facilitate better sharing of information across agencies and reduce duplication of effort in collecting and entering consumer information. However, this often requires collaboration across several agencies that have different information needs and different systems. Sixteen (67percent) grantees reported challenges to updating and integrating IT/MIS technologies. Of these, seven (29 percent) of the grantees reported that they had not allocated sufficient staff time or resources to coordinating a process to identify the information needs of all stakeholders and determining the specifications for the IT/MIS system, researching software options, and either developing a solution or procuring a software vendor.

Another seven (29 percent) grantees reported running into technical problems integrating IT/MIS systems across agencies. In several cases, data fields had to be restructured, functions reprogrammed, and/or information "re-keyed" before two systems could be successfully linked. Three (13 percent) of the grantees reported that their efforts to procure an IT/MIS vendor resulted in significant delays in implementing their IT/MIS plans. Also at the state level, three (13 percent) of the grantees reported that they needed to delay ADRC-related IT/MIS decisions and improvements in order to coordinate with other efforts in their states to streamline IT/MIS systems. Three grantees (13 percent) reported other IT/MIS challenges, including identifying appropriate IT/MIS software packages, functionality of selected software and other delays in selecting an IT/MIS vendor.

Staffing and Leadership

Over the course of the ADRC grant, several grantees experienced changes in administration at the state level and leadership changes at the state and local levels. In a few cases, the grants spanned a change in governor, which required grantees to re-establish relationships with and support from their administrations. In other cases, key leaders within the administration have retired or moved onto other positions. In total, eight (33 percent) of the 2003 and 2004 grantees reported changes in administration or leadership that presented substantial challenges to planning and implementation of the ADRC grant. When the commissioner of aging in one state left her position, the grantee reported that they had "lost their champion at the state level" and that they would have to find a new state champion to build support for the ADRC within the administration and with external stakeholders. In the case of another 2003 grantee, the retirement of the state's Independent Living Center (ILC) director was a challenge because the grantee had invested significant time establishing a relationship with the director and they were in the process of developing an MOU. One of the 2004 grantees encountered a setback when the state's Medicaid director resigned because the director had been a great supporter of the ADRC. With the departure of the director, the ADRC lost both a powerful advocate for the grant and someone who could help secure the Medicaid agency's collaboration with streamlining efforts.

One half (12) of the 2003 and 2004 grantees have experienced barriers and challenges related to staffing issues. Most commonly, grantees reported that at the state level, hiring freezes or budget delays resulted in significant delays in hiring key staff, especially project managers and coordinators. According to these grantees, this resulted in delays in planning and implementation of the grant, including delays in selecting sites, transferring funds to sites, establishing coalitions and partnerships, developing interagency MOUs, and selecting and hiring independent contractors for marketing and evaluation of the ADRC. Unsuccessful attempts to hire a full-time project coordinator prompted one 2003 grantee to subcontract project management to a local university.

Turnover in key staff posed another staffing issue for grantees. Five (21 percent) of the grantees reported that during the first one or two years of the grant, they lost key staff, including project managers and directors, due to retirements and agency reorganizations. Grantees reported that this resulted in some loss of institutional memory, delays in project planning and implementation, and setbacks in the areas of partnership and coalition building because relationships needed to be reestablished with new staff. Additionally, at the state level, two (8 percent) grantees reported that they had allocated insufficient staff to plan and implement the ADRC grant and that the workloads of their grant staff were too high. Specifically, they reported that they had not anticipated how much work would be required to build coalitions and to coordinate across agencies around streamlining access and IT/MIS issues.

Difficulty Forming and Maintaining Partnerships with Other Agencies

Successful implementation of the ADRC grants requires collaboration among multiple agencies at the state and local levels. Thirteen (54 percent) of the 2003 and 2004 grantees have reported substantial challenges in forming and maintaining partnerships with key agencies. Most commonly, grantees reported challenges establishing relationships between aging and disability agencies. At either the state or the local level, eight (33 percent) grantees have experienced resistance to partnership between aging and disability agencies. Many of the grantees attributed this to a history of mistrust between the agencies. Another source of tension between the agencies at the state level cited by one 2003 grantee is the substantial difference between the aging and disability agencies in terms of budget and staff.

Seven (29 percent) of the grantees reported significant challenges partnering with their Medicaid agencies at the state or local levels. In the case of several grantees, they have found it difficult to engage the Medicaid agencies, reporting that they do not attend meetings on the ADRC or do not support or prioritize ADRC activities. This has been most difficult to grantees around the issues of streamlining access to Medicaid, specifically with reducing duplication of effort to collect data from consumers and reducing steps in the Medicaid eligibility processes. In addition, four (17 percent) of the 2003 and 2004 grantees reported challenges establishing partnerships with other key partners, including a state 2-1-1 agency, which delayed linking ADRC and 2-1-1 databases, and with a state office on long-term care, which was resistant to streamlining access activities.

Streamlining Access Activities

One of the most challenging aspects of the ADRC program involves streamlining consumer access to services and supports. Grantees cannot accomplish this goal without considerable support and participation of state and local Medicaid partners. In addition to the partnership challenges outlined above, 11 (46 percent) of grantees faced other barriers to the process of streamlining access. Eight (33 percent) grantees reported challenges related to coordinating their ADRC activities with other systems change efforts and grant programs. In some cases, ADRCs had to put their activities on hold while other systems change initiatives were implemented. In other cases, grantees found that their streamlining plans conflicted with or duplicated the effort of other programs or initiatives and needed to be redesigned. Four (17 percent) grantees reported that the fragmentation of eligibility requirements and determination processes across various state departments and programs for ADRC populations has posed challenges to their streamlining activities. Overcoming this fragmentation is an inherent challenge of the ADRC initiative; it often involves mapping the system, identifying all the entities involved, coming to a consensus, and then coordinating change with all the entities. In addition, four (13 percent) grantees reported challenges around protecting consumer privacy while sharing consumer data across agencies.

Difficulty Engaging Consumers

ADRCs are required to involve consumers in their activities and many ADRCs have consumer representatives on their advisory committees. Consumer board members help the ADRC staff review outreach materials, identify service providers and help the ADRC in collaborating with other advocacy groups. However, nine (38 percent) of the 2003 and 2004 grantees reported that they experienced substantial challenges with involving consumers in the development of their ADRC programs. Two of the 2003 grantees reported that at the state level, they had a core group of active consumers on their advisory boards, but that the remainder of the boards appeared to be "drifting by." At the state and the local levels, other grantees have had difficulty recruiting and maintaining certain types of consumer populations, particularly individuals with disabilities, to participate in their advisory boards.

Facilitators and Lessons Learned

While grantees encountered a number of barriers to successful implementation of their ADRC programs, they also established a variety of practices to facilitate their efforts to provide streamlined access to long-term care services. These include investing time in building partnerships and effectively managing changes in the political environment, such as changes in administration. The most frequently reported facilitators are listed in *Exhibit 57* below.

Exhibit 57: Facilitators and Lessons Learned About Planning and Implementing ADRC Grants

Barriers	Facilitators/Lessons Learned
IT/MIS	Allowing adequate time and resources for determining IT/MIS needs and procuring a vendor
	Establishing systematic process for determining user specifications
	Involving end users early in selection/development process
Staffing and Leadership	Establishing relationships with new leaders early and educating them about the
	Appointing a dedicated project manager
	Cross-training staff from partnering organizations
	Monitoring impact of ADRC on case loads
	Co-locating staff from partnering agencies
Partnerships with Other Agencies	Involving partners early in the planning process
	Identifying champions in partnering organizations
	Setting clear and realistic expectations for partners
	Remaining flexible in determining partner roles
	Selecting pilot sites that already have strong partnerships with key agencies
Streamlining Access	Coordinating closely with other system reform initiatives and grant programs
	Taking incremental steps toward streamlining
	Implementing policies to protect consumer privacy and facilitate data sharing
Consumer Involvement	Involving consumers in meaningful ways
	Establishing links with existing advisory committees
	Creating a separate board for consumers

IT/MIS

- **Allowing adequate time and resources for determining IT/MIS needs and developing systems.** One of the primary lessons learned about implementing the ADRC grant for many of the 2003 and 2004 grantees has been planning for significant time and resources to be spent on determining IT/MIS needs and developing systems or procuring vendors. One 2003 grantee advised other grantees to "estimate the time that you think it will take for IT and multiply that by three."
- **Establishing systematic process for determining IT/MIS needs.** One 2003 grantee engaged a diverse group of stakeholders to assist with the process of determining IT/MIS needs and designing a system, which reduced the burden on the core ADRC project staff responsible for overseeing all grant activities. The group developed a form for soliciting the IT/MIS needs of all users and used the results to develop the specifications for its system.

- **Involving end users early in selection/development process.** One strategy to ensure that the final product purchased or developed will be accepted, accessible, and used by those who are intended to use it is to involve users in the planning, development and selection of the software. At least three grantees conducted focus groups with professional and consumers prior to selecting an IT/MIS vendor and used this feedback to help guide their IT/MIS decisions.

Staffing and Leadership

- **Establishing relationships with new leaders early and educating them about the purpose of the ADRC.** Over the course of the grant, many of the ADRCs have experienced changes in administration at the state level and/or changes in the leadership of their agency. Because the purpose of the ADRC program is to streamline and improve existing systems, leadership commitment to the ADRC goals is critical to the success of the grants and a change in leadership is a potential barrier. One of the lessons learned from the 2003 and 2004 grantees is that when there is a change in leadership or administration, it is important for the grant staff to reach out to the new leadership early, establish a relationship with them and educate them about the goals of the ADRC program and how the ADRC initiative fits with other system reform efforts.
- **Appointing a dedicated project manager.** At the state level, it is very helpful to have a dedicated project manager to oversee planning and implementation of the ADRC grant. One of the critical roles at the state level is establishing partnerships between the lead agency and other agencies and stakeholders. Several of the grantees have reported that having a dedicated project manager in this role has been critical to the success of their programs. However, some grantees have also observed that this will be one of the most difficult components of the ADRC program to sustain beyond the grant period.
- **Cross-training staff from partnering organizations.** Several of the 2003 and 2004 grantees are helping the staff from their agencies and other agencies enhance their knowledge and skills in serving multiple populations by facilitating cross-training of staff from multiple agencies. Cross-training helps aging and disability staff better understand the needs and values of both populations and enables them to serve both populations more effectively. Typically, the grantees' cross-training practices are ongoing.
- **Monitoring impact of ADRC on case loads.** Another lesson learned from the 2003 and 2004 grantees is the importance of monitoring the impact of the ADRC on calls and case loads and adjusting staff configurations as needed. Many of the grantees have found that call and caseload volumes have increased over time and have had to adjust how they staff the ADRCs accordingly.
- **Co-locating staff from partnering agencies.** Grantees reported that co-location (physical or virtual) of staff responsible for determining eligibility for public assistance programs (e.g., Medicaid, Food Stamps, and Temporary Cash Assistance) within the ADRC, has been helpful in streamlining access to services and presenting a seamless process for consumers. Similar to financial eligibility determinations,

grantees reported that the physical and/or virtual co-location of the ADRC with organizations (e.g., Waiver Units) that determine functional eligibility for nursing home admission and home and community-based services has been helpful in streamlining access. Where physical co-location of staff is a new feature, one ADRC reports that it is important to intentionally and carefully cultivate new staff so that they feel like part of the overall team.

Partnerships

- **Involving partners early in the planning process.** The ADRC grant program has provided an opportunity for aging and disability agencies and networks to overcome historic differences and work together to streamline access to long-term care services to both populations. Several of the grantees based in state aging agencies have found that involving their colleagues in the disability agencies early on in the planning process for the ADRC has helped them establish trust with the disability agencies. In fact, involving all the key stakeholders in developing a shared vision for the ADRC grant can help secure their buy-in and ongoing support for the program. One grantee organized a retreat for key stakeholders at the beginning of the grant and brought in external experts to facilitate the meeting. This put the lead agency on a more equal footing with other meeting participants and helped the group come to consensus on a no wrong door approach for the ADRC grant. Grantees also streamlined processes through restructuring and/or creating new state-level executive teams or state agency units such as Central Enrollment Units, or the Division on Aging (designated as the State Unit on Aging).
- **Identifying champions in partnering organizations.** Another strategy that grantees have found effective in building effective partnerships with other agencies is identifying and cultivating relationships with champions for the ADRC program within those agencies. For example, several agencies that have reported difficulty engaging state Medicaid agencies around streamlining access to Medicaid have found that identifying a champion in either a leadership or other key position in the agency facilitates securing the agency's commitment to the goals of the grant. Champions may be in key leadership or program staff positions. At the leadership level, champions can be effective in securing their agencies' commitment to the ADRC program and in influencing programmatic and policy changes in support of the ADRC goals. Champions at the staff level can also be very valuable because they are often the program experts and best able to facilitate their agencies' role in the ADRC.
- **Setting clear and realistic expectations for partners.** Several grantees found that a key to successful partnering is being realistic about expectations for ADRC partners and being flexible about the partners' roles in the ADRC initiative. Several of the 2003 and 2004 grantees that have established work groups or advisory boards in which partners play a role have provided very clear guidance for the partners about expectations at the outset of the process. One 2004 grantee, for example, created a job description for individuals serving on its advisory board. In that grantee's assessment, establishing clear expectations at the outset was critical to the success of the advisory board.

- **Remaining flexible in determining partner roles.** As several of the 2003 and 2004 grantees have discovered, potential partnering organizations operate under their own financial, staff, structural and political constraints; these constraints often change over time, which can impact the extent to which partners can assist with key ADRC activities. State Medicaid agencies, for example, are critical partners for key ADRC activities, particularly around streamlining access to care, and often operate with multiple competing priorities and in complex environments. Several grantees strengthened their partnerships with Medicaid by offering to assist understaffed Medicaid offices with some of the steps involved in determining eligibility, such as working with consumers to locate and submit complete financial documentation.
- **Selecting pilot sites that are already working to integrate disability, aging and Medicaid functions.** Several of the 2003 and 2004 grantees carefully selected pilot sites that were more ready to function as an ADRC than other potential sites. For instance, a number of the sites that were selected as ADRC pilot sites already integrated some disability, aging and Medicaid functions or demonstrated strong partnerships across the three groups prior to the grant.

Streamlining Access Activities

- **Coordinating closely with other system reform initiatives and grant programs.** In most states, the ADRC initiative is happening along side several other systems change and Medicaid reform efforts. Grantees have worked to make sure the ADRC is not duplicating another effort or designing processes that will conflict with other changes in the works, by coordinating closely with other grant initiatives. Several states strategically designed their ADRC projects to continue activities started with earlier Real Choice Systems Change grants, or have built their ADRC Advisory Boards using existing systems change advisory boards or task forces. Several grantees have reported that regular communication among the various grant partners is essential to stay informed about other initiatives and to keep ADRC partners informed, so that the ADRC is fully integrated into all the state's long-term care activities.
- **Taking incremental steps towards streamlining application process.** Making substantial changes to the eligibility determination process for public programs requires the time, attention and cooperation of several state and local agencies. Several grantees determined early on in their grants that their state Medicaid agencies might not be able to make major changes to the functional or financial eligibility processes during the grant period. However, ADRCs found that in the meantime, they could take other important steps toward streamlining the application process and making it simpler and less time-consuming for consumers. For example, grantees have worked to standardize the initial screening process. Some have standardized screening tools used for all their long-term care programs to improve consistency in how they are used across counties. Some ADRCs pre-populate and submit applications on the behalf of consumers to eliminate the need for consumers to go to multiple agencies to apply for benefits. Many ADRCs assist consumers in gathering all the required documentation needed for financial applications. Additionally, some grantees use portable equipment such as scanners

and printers to copy consumers' financial information. This limits the need for consumers to travel to the ADRC or eligibility determination office, reduces the number of trips the staff must make to gather all required application documentation.

- **Implementing policies to protect consumer privacy and facilitate data sharing.** Grantees used different strategies to implement data sharing between partner agencies to reduce duplication and the number of times consumers have to tell their story. At least two grantees established their ADRC pilot sites as Business Associates under the Health Insurance Portability and Accountability Act (HIPAA) to facilitate the electronic exchange of client information.[27] Several grantees purchased or developed software applications that offer multiple security levels to control access by staff in some agencies to certain data elements. Two grantees developed electronic referral processes that do not involve electronic transfer of personal data, but alert partnering agencies to log-in to a secure web-based system for client updates. One grantee worked with their Medicaid agency to add a question to the Medicaid application asking consumers to consent to having their data shared with the ADRC.

Consumer Involvement

- **Involving consumers in meaningful ways.** ADRCs are required to involve consumers in the planning and implementation of their grant and many of the 2003 and 2004 grantees have identified strategies for engaging consumers in meaningful ways. Several of the 2003 grantees have invited consumers to participate in focus groups to review marketing messages, materials, and even the name of the ADRC. One 2003 grantee also conducted focus groups on two online resource directory systems that it was considering. Another 2003 grantee conducted consumer focus groups on a new online Medicaid application and another 2003 grantee tested its website with consumers. Inviting consumers to review and comment on materials and tools can provide grantees with valuable feedback on how they could be improved to better meet the needs of the target audience. Another way to engage consumers is through advisory boards. All grantees have consumer representation on their ADRC advisory boards, which provides consumers a voice in shaping the ADRC grants to best meet the needs of elders and people with disabilities. Consumers serving on advisory board can also be an effective sounding board for program staff. One ADRC actually created a separate Consumer Board, composed solely of consumers.
- **Establishing a link to existing advisory committees.** Some ADRCs have built upon advisory boards established under the Real Choice Systems Change Program to overcome the challenge that many of them face in identifying certain groups of consumers to serve on their committees. In some cases, they this existing advisory board serves as the ADRC Advisory Committee. Some ADRCs have also chosen to

---

[27] Health Insurance Portability and Accountability Act, 1996, Public Law 104-191. For more information see ADRC-TAE Issue Brief: ADRCs and HIPAA online at:: http://www.adrc-tae.org/tiki-index.php?page=TAEIssueBriefs#hipaa

ask the Real Choice Systems Change board to advise the ADRC Committee, rather than to be involved in routine decision-making. Engaging the Real Choice board in conjunction with the ADRC Advisory Committee allows the grantees the opportunity to potentially streamline administrative support for several grants and helps ensure coordination among them.

- **Creating a separate Consumer Advisory Board.** One 2003 grantee established a separate board comprised entirely of consumers to advise them on ADRC planning and activities. The consumers are given orientation training as well as a stipend and reimbursement for expenses related to participation. The board has played a key role in reviewing project materials and getting the word out to the community about the ADRC.

V. CONCLUSION

Over the past three years, ADRCs have made significant progress in implementing the vision set forth by AoA and CMS to create integrated points of entry into long-term care systems; to empower individuals to make consumer-directed, informed choices about long-term care options; and to serve as highly visible and trusted places that people of all ages can rely on for a full range of information and supports regarding long-term care.

ADRCs are defined by their ability to provide integrated and seamless access to long-term care information, assistance and services. Whether it is called a "one stop" center, "no wrong door," or a "single point of entry," the ultimate goal of the ADRC initiative is to create consumer-driven, consumer-friendly systems that simplify access to needed services and support. ADRCs achieve this through enhancing or realigning existing intake, application and eligibility processes, and tracking procedures such that the process to access support is transparent to the consumer. Integrated service systems have the added benefit of streamlining data collection and reporting in order to improve quality of care and monitor costs.

Findings in this report clearly demonstrate that millions of U.S. citizens in communities across the country have access to and are benefiting from ADRC services, whether they are provided in physical locations or through web-based communications systems. ADRCs are unique in the services they provide and the target populations they serve. They provide comprehensive access to long-term care information, services and supports; they serve both publicly supported and privately paying individuals; their target populations include older adults as well as people of all ages with all types of disabilities; and their services are available for consumers, family members, care providers, agency staff, informal caregivers and individuals planning for future long-term care needs. ADRCs provide education, awareness and training for the public as well as for professionals involved in long-term care. They have informed public policy and raised the awareness of decision-makers at the local, state and national level about the diverse and complex needs of people who require long-term care services as well as the possibilities and opportunities for providing services that are comprehensive, efficient and effective.

ADRCs have accomplished these goals, underscored by the findings presented in this Interim Report, utilizing four overarching strategies: 1) Streamlining access to long-term care information, services and supports; 2) Building upon strategic partnerships and consumer empowerment to achieve project goals; 3) Establishing and operating replicable models of service delivery consistent with the ADRC philosophy and mission and program objectives; and 4) Creating programs that demonstrate the feasibility, effectiveness and value of rebalancing long-term care service systems.

ADRCs Have Effectively Utilized IT/MIS as a Vehicle for Establishing Streamlined Access to Services and Supports

A major goal of the ADRC project is to develop IT/MIS infrastructure that allows for integrated points of entry into the long-term care system. Consistent with the AoA/CMS vision, ADRCs developed or plan to develop IT/MIS systems that enhance streamlined access to information and programs, allow for client tracking and a more unified case management system, support program monitoring and evaluation, and provide information for continuous improvement in program services and functions.

ADRCs used different strategies to build IT/MIS systems that serve multiple target populations. Progress has been made in developing IT/MIS systems that support client intake, assessment, eligibility determination, client tracking, case management, as well as tracking of service utilization levels and costs. In many cases, grantees did not build these systems "from scratch" but improved on, realigned or integrated existing systems. These strategies facilitate access to a comprehensive array of information and supportive services that represent a different and more effective way to serve consumers, both now and in the future. Moreover, the IT/MIS systems developed under the ADRC program have allowed grantees to better partner with related systems of care such as family services, health care, housing, employment, APS, and others.

ADRCs used web-based strategies to make information and services more accessible to more users. Seventy-five percent of the 2003 and 2004 grantees are moving toward developing and implementing web-based, centralized data management systems to provide access to information, expedite application and eligibility determinations and facilitate updating, sharing and tracking of consumer information. The web and internet-based information and assistance resources that ADRCs created promote information sharing and serve consumers, family members, professional care providers and decision makers at the national, state and individual community levels. Nearly all of the 2003 and 2004 grantees are using the Internet to raise public awareness of long-term care services and to provide web-based access to a comprehensive range of long-term care information via interactive sites and searchable databases. Some ADRCs have physically located their technology-based information systems in the community -- at user-friendly ADRC access points such as libraries, community centers or faith-based organizations, or in kiosks -- to expedite consumer access to long-term care information, services and care and future planning tools.

Challenges and Future Direction

Obtaining funding for ongoing investments in IT/MIS. IT/MIS investments are costly and new sources are continually needed to fund and support IT/MIS functions.

IT/MIS activities taking longer than expected. It is often a challenge to coordinate the work schedules of multiple partners when deadlines change due to delays or when unexpected barriers occur.

Maintaining IT/MIS partnerships as ADRCs expand. ADRCs will need to sustain the momentum of the partnerships that were formed in the initial phases of program development and implementation as the projects expand and new applications for the technology are developed.

Using IT/MIS applications effectively requires ongoing investments in staff training and learning to use new systems of information management is highly staff intensive. ADRCs have developed ongoing training programs for project staff as well as for staff of partnering organizations but are often challenged by the need to resources, both in terms of money, hardware and people to maintain adequate levels of continuing education.

ADRCs Have Developed Strategic Partnerships and Strengthened Consumer Empowerment to Make Informed Decisions

Strategic partnerships are a key ingredient contributing to the success of ADRCs. Strategic partnerships, whether formal or informal, provide the supporting framework for all other aspects of ADRC projects. The need to develop strong strategic partnerships among these groups was recognized early on as an important factor in ADRC success. Local sites that were selected by the state lead agency to pilot the ADRC initiative tended to be those sites that exhibited some existing capacity either in the area of strong local partnerships and/or solid IT/MIS.

An impressive feature of a number of ADRC programs is the presence of an extensive network of partners. It is likely that a great deal of the capacity that pilot sites have to leverage resources for ADRC activities is due to their close community connections and partners in the community. Through these partners, ADRCs broadened their scope of services and outreach activities to include multiple populations, including individuals with the ability to privately pay for services, people with disabilities, including those with mental illness and to individuals of all ages.

Developing partnerships greatly expands ADRC resources. Data in this report indicate that 75 percent of the annual budget of pilot sites was from sources other than the ADRC grant and included primarily OAA, Medicaid and state funds, local revenues and other grants such as from consumer and charitable grants. These partnerships provide new opportunities to leverage resources of diverse resources and they underscore the role of ADRCs as significant contributors to the health, well-being and strength of local communities.

Grantees are in the early stages of establishing processes for empowering consumers and their families to make informed, consumer-directed decisions about long-term support options. A significant goal of the ADRC is to extend beyond providing traditional assistance to support individuals and family members with informed decision-making about long-term care options. This is being provided through options counseling services that are unique to ADRCs. In addition, ADRCs report being involved in providing information and assistance to individuals who are beginning to plan for long-term care and for families needing advice for helping with futures planning for loved ones.

Challenges and Future Direction

While building strategic partnerships is one of the most critical components of ADRC success, it appeared to be one of the most challenging aspects of program development. This is not surprising since many of the elements that comprise long-term care services are located in diverse agencies and organizations and affect individuals in groups based on age or a medical diagnosis rather than on needs or shared values. The ADRC target populations and their natural strategic partners historically have not interacted with each other, shared information or leveraged resources in collaborative partnerships.

ADRC projects must strengthen and maintain their partnerships with Medicaid at the state and local levels. While AoA and CMS have a formal partnership at the federal level and co-funded the grants, fostering strong partnerships with Medicaid at the state and local levels was challenging for some grantees. Several grantees reported difficulties getting Medicaid to take an active role in the project, although the input and involvement of Medicaid is necessary to move forward with plans to streamline access, integrate IT/MIS systems, and implement systems for sharing data.

Several grantees reported that developing partnerships with Medicaid entities at the local levels, in addition to the state level, was critical to successful streamlining. States can play a role in promoting strong local partnerships, by providing templates for local level MOUs, initiating policy changes that will facilitate access at the local level, supporting the development of IT/MIS infrastructure to facilitate data sharing between partners at the local level, and setting an example with state level partnerships.

The aging and disability communities need to strengthen their working relationships. Over the past three years, ADRCs have reported challenges in developing partnerships between the aging and disability communities. For example, it was particularly difficult for some pilots to develop aging and disability partnerships when no state-level partnership existed. In addition, states in which Independent Living Centers (ILC) and Area Agencies on Aging (AAA) cover different planning and service areas will need to determine how best to coordinate with one another and define potential benefits gained from partnering, such as enhanced service access.

Furthermore, since many of the ADRCs are operated by AAAs, and these organizations generally seek personnel who have experience working predominantly with older adults, there tends to be less in-house in-depth experience with the disability community, particularly as it relates to accessibility. Disability agencies, in contrast, tend to have greater expertise in issues related to accessibility, family-centered care planning and employment. For an ADRC to be successful, it is important that partners from both networks be actively involved and share their expertise with each other. Individual champions can have a significant impact on progress in creating bridges between the two communities.

To ensure that ADRCs are successful in serving consumers of all types of disabilities, stronger partnerships are needed at the federal level with the Administration for Children and Families' Administration on Developmental Disabilities, the National Council on Disability, and the DHHS Office on Disabilities, as well as their respective associations.

ADRCs Have Established Replicable Models for More Efficient and Effective Delivery of Long-Term Care Services

ADRCs have evolved into an array of program models based on three key characteristics: management, structure and mode of consumer access. ADRCs differ by management (those that are state-driven to those that are locally-driven); structure (those with highly centralized management to those that are managed predominantly by local organizations and partnerships); and mode of consumer access (those with a high level of virtual access to those where services are accessed primarily at physical locations through face-to-face interactions with staff). Elements contributing to the evolution of these various ADRC typologies include political climate, available resources, historical partnerships, community infrastructure and state organization. These factors are highly variable and posed considerable challenges in implementing and expanding the ADRC program nationwide. Experiences over the past three years have shown that ADRCs have the capacity to adapt to differing environments and to effectively utilize environmental differences to maximize and leverage project outcomes and achieve overall success.

As ADRCs expand, it is likely that they will retain fidelity to the original philosophy, goals and activities envisioned by AoA and CMS for the ADRC program. The past three years of experience with ADRCs have demonstrated that embedding clear goals into project expectations at the outset, of monitoring the projects and providing feedback at all stages of implementation are major contributors to ADRC success and long-term sustainability. The identification of clear ADRC typologies will help new ADRCs achieve fidelity to the program model, even in diverse state and local environments. Typologies will assist ADRC program managers to more effectively deal with future challenges that may arise and apply "lessons learned" to new challenges they encounter, without having to reinvent new implementation strategies from the ground up.

ADRCs Have Contributed Significantly to Rebalancing Long-Term Care Systems

Several characteristics differentiate ADRCs from other long-term care organizations and establish them as leaders in rebalancing systems of care historically oriented toward institutional care. These include:

- Delivery of efficient, simplified access to a wide range of information and supports about community-based options for an array of consumer groups seeking information or access into the long-term care system through diverse entry points;
- Commitment to providing resources based on the values of consumer direction, person-centered planning, and individual choice and autonomy, particularly through options counseling;
- Capacity to facilitate effective linkages at multiple junctures involving diverse stakeholders along the long-term care continuum; and
- Ability to prevent institutional placement by maximizing access to comprehensive, updated and credible information about alternate resources in the community including access to HCBS waiver services.

The ADRC program is a collaborative effort mobilizing both public and private sector resources. The program's initiatives provides states with creative opportunities to effectively maximize and use their long-term support resources for providers and consumers in a single coordinated serviced delivery system consistent with the goals of long-term care rebalancing initiatives taking place at all levels.

ADRCs demonstrated their value in helping to shape long-term systems reform through various leadership initiatives. Many ADRCs facilitated the roll-out of Medicare Part D by working with AAAs, CMS, SHIPS, ILCs and other organizations to provide services to thousands of individuals the provision of information and, in some instances, Part D enrollment. Many ADRCs have served as catalysts at the state and local levels for other long-term reform efforts through their partnerships with Systems Transformation Grants, Family 360 Grants, the Own Your Own Future campaigns and other initiatives. As the work of the ADRCs continue, ongoing beneficial outcomes are expected as these programs begin to proactively address the information and service needs of consumers seeking to improve their health status and opportunities for independence by maximizing community living opportunities and delaying or preventing dependence on institutional care.

Challenges and Emerging Roles for ADRCs

The Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) encourage ADRC grantees to further incorporate health promotion and disease prevention into their programs. Health promotion and disease prevention will continue to be a priority at the federal level as evidenced by the AoA Choices for Independence proposal which includes an evidence-based health promotion/disease prevention component that specifically builds on the lessons learned from AoA funded initiatives that enable older people to make behavioral changes that will reduce their risk of disease, disability, and injury.

ADRCs should consider disease prevention and health promotion as one of the functions of an ADRC. The prevention of acute and long-term care crises and chronic disease and disability enables individuals to sustain a high quality of life. Healthy individuals incur less medical expenditures. ADRCs can promote health by offering information, assistance and resources to individuals and families to enable informed decision-making before crises ensue. ADRCs offer other opportunities to educate individuals about health and wellness, begin special evidence-based programs, and collaborate with key health agencies in the community.

The outcomes that ADRCs have achieved over the past three years have had significant impact at the individual, program, community and state levels. The benefits, successes and lessons learned through ADRC experiences have energized and informed policymaking and program development at all levels in the long-term care arena. ADRCs have shown, as demonstrated in the findings in this report, that it is possible to develop more efficient and effective access to information and supports and that these initiatives are widely endorsed by diverse stakeholders involved in the rebalancing enterprise. They have demonstrated that it is possible to achieve economies of scale through decreasing duplication of effort, maximizing existing resources and building new, more effective partnerships.

APPENDIX A:
ACRONYMS & GLOSSARY

Appendix J

GUIDE TO ACRONYMS

AAA	Area Agency on Aging
ADRC	Aging and Disability Resource Center
AOA	Administration on Aging
APS	Adult Protective Services
CMS	Centers for Medicare & Medicaid Services
DHHS	U.S. Department of Health and Human Services
DHS	Department of Human Services
DSS	Department of Social Services
FTE	Full Time Equivalent
FY	Federal Fiscal Year
FFP	Federal Financial Participation
FPL	Federal Poverty Level
HCBS	Home and Community Based Services
I&R/A	Information and Referral/ Assistance
ILC	Independent Living Center
IT/MIS	Information Technology/ Management Information Systems
LIHEAP	Low Income Home Energy Assistance Program
MOU/A	Memorandum of Understanding/ Agreement
NFI	New Freedom Initiative
OAA	Older Americans Act
PAS	Pre-Admission Screening
SART	Semi-annual Reporting Tool
SHIP	State Health Insurance Assistance Program
SILC	State Independent Living Council
SSA	Social Security Administration
SSBG	Social Services Block Grant
SSI/SSDI	Supplemental Security Income/Social Security Disability Insurance
SUA	State Unit on Aging
TAE	Technical Assistance Exchange

GLOSSARY OF TERMS

2-1-1:

2-1-1 provides callers with information about and referrals to human services for every day needs and in times of crisis. Services that are offered through 2-1-1 vary from community to community. There are currently 209 2-1-1s operating in all or part of 41 states.

Adult Protective Services (APS):

A program that is typically state-administered and which involves the investigation of allegations of abuse, neglect, and exploitation of anyone over age 18 and provides protective services to those who are found to be maltreated.

Aging Network:

A highly complex and differentiated system of federal, state and local agencies, organizations, institutions, and advocates, which serve and/or represent the needs of older people.

Area Agencies on Aging (AAAs):

Public or private non-profit organizations designated by the state to develop and administer the area plan on aging within sub-state geographic planning and service areas.

Caregiver:

A generic term referring to a person either paid or voluntary, sometimes a family member or friend, who provides long-term care and support to a person in need of assistance.

Consumer:

A generic term for an individual who might be served by an ADRC.

Cost-sharing:

The practice of requesting that service recipients contribute a portion of the cost of a service provided.

Independent Living Center (ILC):

A consumer-controlled, community-based, cross-disability, non-residential non-profit agency that (1) is designed and operated within a local community by individuals with disabilities; and (2) provides an array of independent living services.

Disability network:

A highly complex and differentiated system of federal, state and local agencies, organizations, institutions, and advocates, which serve and/or represent the needs of people with disabilities.

Eligibility:

Financial eligibility: Financial eligibility requirements for Medicaid and other public long-term care programs vary from state to state, but generally include limits on the amount of income and the amount of assets an individual is allowed to have in order to qualify for publicly-funded services.

Functional or programmatic eligibility: Medical, functional and/or programmatic eligibility requirements for Medicaid and other public long-term care programs vary from state to state and by type of program (e.g. Medicaid state plan personal care services, home and community based services waiver), but generally include a requirement that an individual undergo a Level of Care or needs assessment and be determined to meet a certain threshold of need for assistance.

Federal Financial Participation (FFP):

Federal reimbursement to the state for a percentage of their allowable expenditures for Medicaid services or administrative costs

Home and Community-Based Services (HCBS):

A variety of supportive services delivered in community or home settings designed to help individuals in need of long term support remain living at home and avoid institutionalization.

Information & Referral/Assistance (I&R/A):

Information Specialists provide assistance and linkage to available services and resources. Information and assistance/referral may be provided via Internet, in person, or over the phone.

Long-term care (LTC) supports and services:

A set of health, personal care, and social services delivered over a sustained period of time to persons who have lost or never acquired some degree of functional capacity—either mental or physical. Services can be provided in an institution, the home, or the community, and include informal services provided by family or friends as well as formal services provided by professionals or agencies.

Low-income individuals:

Individuals with an annual household income that falls below the official poverty measure as established in the federal register by the U.S. Department of Health and Human Services.

Medicaid Agency:

The state agency that administers the federal and state-funded Medicaid program, which provides a broad array of medical and long-term care services to eligible individuals.

Medicaid HCBS waiver:

Funding for home and community-based services provided under the Medicaid program. States can receive waivers from certain Medicaid requirements in order to provide targeted assistance to different populations in non-institutional settings.

Mental Illness (MI):

MI includes such disorders as schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, autism and pervasive developmental disorders, attention deficit/hyperactivity disorder, borderline personality disorder, and other severe and persistent mental illnesses that affect the brain.

Mental Retardation/Developmental Disability:

Diagnostic criteria for mental retardation usually include significantly sub-average intellectual functioning, concurrent deficits or impairments in present adaptive functioning in areas of major life activity, and onset before age 18. The Federal Developmental Disabilities Act defines Developmental Disability as a severe, chronic disability that is attributable to mental or physical impairment or a combination of impairments, is manifested before the person attains age 22, is likely to continue indefinitely, results in substantial functional limitation in three or more areas of major life activity usually arising before adulthood as a result of congenital causes, but sometimes due to brain injury, and characterized by any of various cognitive deficiencies, including impaired learning, social, and vocational ability.

National Family Caregiver Support Program (NFCSP):

Established by the Older Americans Act Amendments of 2000 to assist the aging network to develop a multi-faceted system of supports for caregivers.

Older Americans Act (OAA):

Federal law enacted in 1965 to provide money for programs and direction for a multitude of services designed to improve and enrich the lives of senior citizens.

Older adults:

Most ADRC grantees serve adults aged 60 and over, but in some cases the term older adults may include individuals aged 55 and over.

Options counseling:

Options counseling is a required function of an ADRC and refers to assisting consumers with making informed decisions about their long term support options. Options counseling is defined differently by different grantees. It may include some combination over time of the following activities: provision of information, making referrals, counseling, deliberating, assisting with applications, advocating, home visits, short-term case management, and conducting needs assessments and reassessments.

Personal care:

Assistance with activities of daily living, such as bathing, as well as with self-administration of medications and preparing special diets.

Physical Disability (PD):

A physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment that results from injury, disease or congenital disorder and that significantly interferes with or significantly limits at least one major life activity of a person.

Single Point of Entry (SPE):

A system that enables consumers to access long term supports and services through one agency or organization.

State Health Insurance Assistance Program (SHIP):

A national program that offers one-on-one counseling and assistance about Medicare to recipients and their families. Through grants directed to states, SHIPs provide free counseling and assistance via telephone and face-to-face interactive sessions.

State Units on Aging (SUA):

SUAs are located in every state and U.S. territory. In addition to funding critical nutrition and supportive services, AoA funds are awarded to the SUA for elder rights programs, including the long-term care ombudsman program, legal services, outreach, and elder abuse prevention efforts.

Short-term case management (STCM):

STCM is used to stabilize individuals and their families in times of immediate need before they have been connected to ongoing support and services. It often involves more than one follow up contact.

Waiver: see **Medicaid HCBS waiver**

APPENDIX B:
LIST OF EXHIBITS

LIST OF EXHIBITS

To use hyperlinks, use control key when mouse is over page number.

I INTRODUCTION

II. GRANTEE PROGRAM MODELS & CHARACTERISTICS

III. FINDINGS

Consumer-level Accomplishments & Outcomes

Program-level Accomplishments & Outcomes

IV. PROMISING PRACTICES/LESSONS LEARNED

APPENDIX C: EXAMPLES OF PROGRAM RESOURCES

APPENDIX C:
EXAMPLES OF PROGRAM RESOURCES

Appendix J

Exhibit C-1: Wisconsin ADRC Prevention Projects

Five Wisconsin ADRCs received funding from the Wisconsin Department of Health and Family Services to implement prevention projects. The projects are summarized in the chart below. Many partnered with the local university to add a research component.

County and Topic	Funding Source/ Amount/ Timeframe	Evidence-based Model	Activity in Grant Period	Evaluation Design/ Results	Descriptive Information/ Partnerships
Jackson **Falls Prevention**	2000/2001	NA	1. Evaluated 59 adults ages 75 and over for balance, muscle strength, and walking speed. Western Dairyland EOC did home assessments for all and 40 homes had safety modifications. High school students trained to help older adults complete in-home daily exercise to increase leg strength and overall stability. 2. Started community-based weekly exercise and safety education program (92 active adults 55 and older).	Pre- and post-tests for fall risk for 20 participants	Intergenerational effort – Collaboration with high-school, hospital rehab, Western Dairyland Economic Opportunity Council (EOC), Inc., and the physical therapy department at UW La Crosse.
Kenosha **Falls Prevention**	$243,191 (2000/2001) $265,782 (2001/2002)	Multifactor causes for falls. American Geriatric Society (2001)[28]	1. Enrolled 346 participants in control or intervention group. 2. Offered intervention plans to intervention group including in home assessment by RN or PT and monthly follow-up. Plans included referrals to PT and recommendations to participant's physicians.	Control and intervention groups. Participants reported falls on monthly basis.	Partnered with Dr. Gene Mahoney, UW Madison and Dr. Terry Shay, PT
Marathon **In-Home Preventive Health Care**	$356,612 (2000/2001) $381,928 (2001/2002)	Replicated a model which reduced disability rates and nursing facility use Stuck (2000)[29]	1. In-home assessments by geriatric nurse practitioner for individuals -75 and older living at home; -no significant physical/ cognitive impairment; and -not terminally ill. 2. Telephone monitoring. 3. Linkage to RC services. Expect 430 participants over 3 years	Control and intervention groups	North Central Health Care, Dr. Mark Sager, and UW Madison Medical School

Appendix J

County and Topic	Funding Source/ Amount/ Timeframe	Evidence-based Model	Activity in Grant Period	Evaluation Design/ Results	Descriptive Information/ Partnerships
Milwaukee **Changing Health Related Behaviors**	$241,261 (2000/2001) $237,790 (2001/2002)	NA	Targeted minorities (African American, Hispanic, Native American, Southeast Asian) over 60 and all seniors over 70. Three interventions: 1. Computer-based health risk assessment and internet-based health and fitness education. 2. Individual fitness assessments by exercise physiologist and assess to equipment and structured workout time. 3. Print information (pamphlets, booklets, and newsletters.)	Control and intervention groups Measured actual change in fitness and feeling about fitness (i.e. what motivates individuals to change health behaviors)	Collaboration with UW Milwaukee
Trempealeau **Nutrition Risk Identification and Intervention**	2000/2001	NA	Identified high or moderate nutritional risk individuals and provide: 1. Nutritional Counseling. 2. Personal health planning. 3. Volunteer assistance such as friendly visitor, transportation, and meal preparation. Also used funds to purchase strength training equipment for senior centers.	Measured nutritional health of participants and also benefits for volunteers	Collaboration with United Volunteer Caregivers, Inc.

Exhibit C-2: New and Enhanced Public Websites (Implemented and Planned)

State	Grant Yr.	Pilot Site	Website URL	Features	Planning or Implemented / New or Enhanced Site
AK	2004	All 5 Pilot Sites	www.alaskasilc.org	Information only.	Implemented Enhancements to Existing Site
AR	2004	Aging and Disability Resource Center Southwest Arkansas	http://www.sa-hello.org/	Interactive statewide resource directory, 156 local providers.	Implemented Enhancements to Existing Site
CA	2004	Aging and Independent Services of San Diego	http://sandiego.networkofcare.org/	Interactive resource directory, featuring "My Record" system where consumers to enter and update personal information.	Implemented Enhancements to Existing Site
		Del Norte InfoCenter	http://www.a1aa.org/dninfocenter	Interactive resource directory.	Implemented Enhancements to Existing Site
FL	2004		Statewide website is planned.		Planning New Site
GA	2004	Atlanta	Atlanta Regional Commission (ARC) **http://www.agingatlanta.com/search.asp** Atlanta Alliance for Developmental Disabilities: http://www.aadd.org/	Interactive resource directory through ARC's AgeLine	Implemented Enhancements to Existing Site
		Central Savannah River Area:	http://www.csrardc.org	Information only.	Implemented Enhancements to Existing Site
IL	2004	Rockford	www.nwilaaa.org	Information only.	Implemented Enhancements to Existing Site

Appendix J

State	Grant Yr.	Pilot Site	Website URL	Features	Planning or Implemented / New or Enhanced Site
		Decatur	http://www.maconcountyhealth.org		Implemented Enhancements to Existing Site
IN	2004	Both Pilot Sites	http://www.link-age.org	Interactive resource directory.	Implemented New Site
IA	2004	Statewide	http://www.LifeLongLinks.org	Links to several interactive resource directories.	Implemented New Site
LA	2003	All 5 Pilot Sites	http://www.LouisianaAnswers.com	Interactive resource directory.	Implemented New Site
ME	2003	Bangor	State planning ADRC website	Information only.	Planning New Site
MD	2003	Howard County and Worcester County	New statewide website is planned. MAP of Howard County currently uses: http://www.horizonhelp.org	Interactive resource directory. Benefits Check-up.	Planning New Site
MA	2004	Merrimack Valley and North Shore	Statewide "Virtual Gateway" website at pilot stage.	Interactive resource directory planned.	Planning New Site
MN	2003	Hennepin County	http://www.minnesotahelp.info	Interactive resource directory.	Implemented Enhancements to Existing Site
MT	2003	Yellowstone County	http://www.yccoa.org	Information only.	Implemented Enhancements to Existing Site
NH	2003	All 5 Pilot Sites	http://www.servicelink.org	Information only.	Implemented Enhancements to Existing Site
NJ	2003	Atlantic County and Warren County	http://www.state.nj.us/adrcnj	Interactive resource directory.	Implemented New Site

Appendix J

State	Grant Yr.	Pilot Site	Website URL	Features	Planning or Implemented / New or Enhanced Site
NM	**2004**	Santa Fe and Statewide	Statewide Social Services Resource Directory website planned.	Information only.	Planning New Site
NC	**2004**	Forsyth County and Surrey County	Contract in place to create a statewide interactive resource database website, "NC Carelink."	Interactive resource directory.	Planning New Site
RI	**2003**	Statewide	www.ThePointRI.org	Information only. Interactive resource directory planned.	Implemented New Site
SC	**2003**	Aiken and Santee Lynches	www.scaccesshelp.org	Interactive resource directory. Online Medicaid application.	Implemented Enhancements to Existing Site
WV	**2003**	Ohio County	www.familyservice-uov.com	Information only.	Implemented Enhancements to Existing Site
		Marion County	www.marionseniors.org	Information only.	Implemented Enhancements to Existing Site
WI	**2004**	All 9 Established Sites and 9 New Pilot Sites	State planning virtual Resource Center.	Interactive resource directory.	Planning New Site