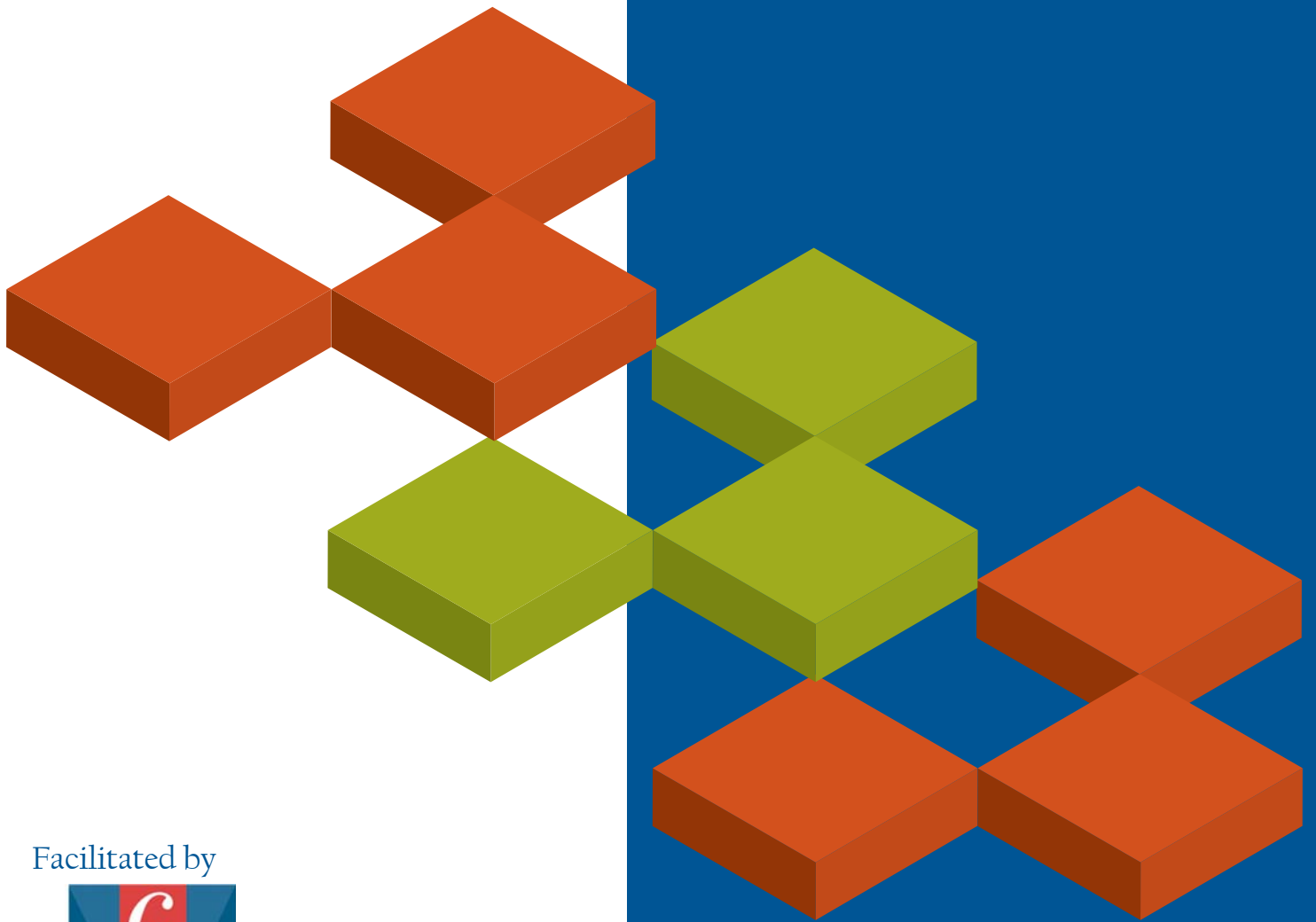


Senate Bill 173 Long-Term Care Advisory Committee

Final Report



Facilitated by



Long-Term Care Advisory Committee



July 1, 2006

Department of Health Care Policy and Financing

Governor's Office

Members of the Joint Budget Committee

Members of the Senate Health and Human Services Committee

Members of the House Health and Human Services Committee

The Senate Bill 05-173 Long-Term Care Advisory Committee is pleased to submit its final report to the Colorado Department of Health Care Policy and Financing pursuant to the reporting requirement specified in §26-4-425, C.R.S. This report presents our findings and recommendations for programs and program modifications that will help create a coordinated continuum of long-term care services and a unified LTC delivery system.

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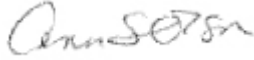
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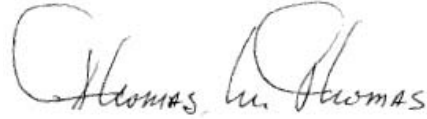
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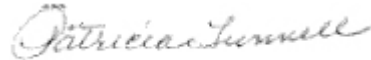
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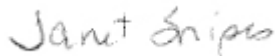
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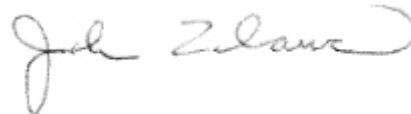
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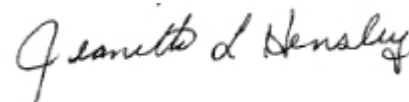
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EXECUTIVE SUMMARY

In 2005, the Colorado General Assembly passed Senate Bill 05-173 creating the Long-Term Care Advisory Committee. The Committee's charge was "to explore and recommend to the state department public policy that will enable the state's Medicaid program to act strategically as a client advocate and be an efficient and effective purchaser of services and service delivery." (SB 05-173, p. 2)

The Committee held nine meetings from August 2005 to June 2006. Early meetings focused on developing ground rules and a scope of activities, creating guiding principles and defining the target populations for the Committee's work. Several months into the Committee's deliberations, four workgroups were formed and each met three times to flesh out Committee recommendations in the areas of financing, quality, service options and program eligibility.

The Committee used a consensus based approach to ensure all members could support the recommendations contained in the final report. In a few cases, consensus was not reached and in these cases, committee members' concerns are noted in the body of the report.

In addition to recommending programs or program modifications, the Committee was charged with developing criteria by which the Colorado Department of Health Care Policy and Financing (HCPF) would evaluate coordinated care pilot programs pursuant to §26-4-426, C.R.S. A three-year coordinated care pilot program for community-based long-term care services was embedded in Senate Bill 05-173. The Committee's recommended criteria are included at the end of this report.

The Colorado Health Institute (CHI), with assistance from The Adams Group, was contracted by HCPF to provide analytical and facilitation support for the Committee. Progress reports were transmitted by CHI to the Joint Budget Committee of the General Assembly in December 2005 and April 2006. Information related to Committee activities can be found at the CHI Web site: http://www.coloradohealthinstitute.org/hot_issues/longtermcare.htm.

RECOMMENDATIONS FOR LTC SERVICE AND SYSTEM REFORM IN COLORADO

The Committee organized its 18 recommendations into the following four groupings:

- I. Person-centered service continuum;

2. Seamless care planning;
3. Eligibility and financing options that ensure access and value purchasing; and
4. Statewide leadership and accountability for LTC planning and program development.

The Committee views its recommendations as integral to meeting the policy goals set forth in SB 05-173 (See Appendix E). They represent a coherent package of program modifications and reforms that will achieve both the short-term and longer-term policy and program objectives specified in the legislation.

I. PERSON-CENTERED SERVICE CONTINUUM

RECOMMENDATION 1.1- Expand availability of alternative housing options

RECOMMENDATION 1.2 – Pilot alternative housing options

RECOMMENDATION 1.3 – Provide financial incentives to skilled nursing facilities to develop alternative uses of licensed beds that promote a ‘least restrictive’ home-like environment

RECOMMENDATION 1.4 – Add a personal care optional benefit to the Medicaid state plan

RECOMMENDATION 1.5 – Pool transportation funding

RECOMMENDATION 1.6 – Authorize a fully integrated primary care/LTC pilot

RECOMMENDATION 1.7 - Clarify eligibility for the Home Care Allowance Program

2. SEAMLESS CARE PLANNING

RECOMMENDATION 2.1- Clarify and strengthen the role of care managers

RECOMMENDATION 2.2 – Reduce care manager caseloads

RECOMMENDATION 2.3 – Fully automate the functional assessment and service allocation functions

RECOMMENDATION 2.4 – Include LTC data in the state’s emerging electronic health information exchange efforts

3. ELIGIBILITY AND FINANCING OPTIONS TO ENSURE ACCESS AND VALUE PURCHASING

RECOMMENDATION 3.1- Expedite financial eligibility determination

RECOMMENDATION 3.2 – Provide comprehensive training to hospital discharge planners with regard to the full continuum of LTC services

RECOMMENDATION 3.3 – Bundle transitional service planning services

RECOMMENDATION 3.4 – Institute rate-setting and financing reforms to achieve equity in reimbursement based on the scope of services provided in each setting

RECOMMENDATION 3.5 – Develop and implement an aggressive set of quality benchmarks and a fully automated monitoring system for all LTC services

4. STATEWIDE AND LOCAL LEADERSHIP AND ACCOUNTABILITY FOR SEAMLESS LTC PROGRAMS AND SERVICE DELIVERY

RECOMMENDATION 4.1- Consolidate the care planner/service broker function at the community level for all consumers of LTC services

RECOMMENDATION 4.2 – Ensure accountability for state level oversight and leadership

INTRODUCTION

Colorado enjoys a national reputation as an innovator in systems development for community-based long-term care (LTC) services. In a 2004 report issued by the AARP Public Policy Institute, Colorado ranked third in the country in the number of Medicaid recipients receiving services in their home or a community-based residential care setting, and fifth in the number of people in an aged/disabled Home and Community-Based Service (HCBS) waiver¹ as a percent of people residing in a nursing home.² Additional indicators of state leadership include having the second and sixth state HCBS waiver approved by the Health Care Financing Administration in the mid-1980s as well as being an early implementer of a single entry point system over a two-year period from 1993-95.

Despite Colorado's leadership role and recognized innovations in providing LTC services in the community, the Colorado General Assembly periodically has called for an assessment of the various components of the LTC continuum and the programs, services and residential care settings that comprise it. The most recent initiative to further improve Colorado's LTC service system is embodied in SB 05-173. This bill, signed into law in 2005, called for the creation of an advisory committee to recommend program and program modifications to improve the delivery of LTC services across the state. The urgency for this initiative is underscored by the demographic reality of an aging "baby boomer" generation. The Colorado Demography Office estimates that Colorado's 65+ population will grow more than 23 percent between 2005 and 2015.

The Long-Term Care Advisory Committee (hereafter "Committee") was appointed pursuant to SB 05-173 and took its charge from the bill's declaration:

"The General Assembly hereby finds that it is concerned that the community long-term care system is not prepared for the ensuing service demand that will be experienced as a result of the explosion of 'baby boomers' that will need services in the near future. The community long-term care system is antiquated, outdated and unable to respond efficiently and effectively to accommodate a range of services necessary to address the

¹ See Appendix B – Glossary for a definition of HCBS waivers.

² Gibson, MJ, S. Gregory, A. Houser and W. Fox-Grage. (2004). *Across the States: Profiles of Long-term Care*. AARP Public Policy Institute.

needs of this growing population. The state needs to provide effective and efficient delivery systems designed to provide better access, consumer choice, economy and congruence of a quality of life in the least restrictive setting to Medicaid recipients now and in the future. Finally, the state has an urgent need to create a community long-term care system prepared to address the needs of clients, provide the maximum service delivery and make the best use of public funds.”

Committee members were appointed based on specifications in the bill and represented major aging and disability stakeholder perspectives. They were supported by analytical, research and facilitation resources provided by the Colorado Health Institute with assistance from The Adams Group. Meetings began on August 15, 2005 and ended on June 14, 2006. Progress reports were issued to the Colorado General Assembly’s Joint Budget Committee in December 2005 and April 2006.

The Committee used a consensus-based approach to recommend program modifications and to ensure that critical stakeholders could support implementation of its recommendations. In some cases, consensus could not be achieved. In those instances, concerns have been noted.

SCOPE OF RECOMMENDATIONS

The bill explicitly identified aspects of the current LTC system that required close examination. The Committee was asked to identify programs and program modifications that would do the following:

- Create increased flexibility for clients and service providers along the full continuum of LTC services, including but not limited to: adult day programs, alternative care facilities, skilled nursing and therapies, personal care services (personal attendants and homemakers), assisted living residences, congregate and subsidized housing and skilled nursing facilities;
- Shift program and system focus from certification of providers and properties to the needs and preferences of consumers who receive services along the LTC service continuum;
- Ensure consumer choice in the least restrictive environment;
- Be research-driven, person-focused and ensure that Medicaid funds are utilized in the most cost-effective manner possible;

- Provide greater opportunities for consumers to direct the care and support they receive;
- Provide incentives for skilled nursing facilities to reduce the number of Medicaid-certified nursing home beds in pursuit of alternative models of care;
- Create an integrated continuum of LTC benefits and services, including but not limited to integrated funding streams for services provided in the community to Medicaid and non-Medicaid eligible consumers alike;
- Develop criteria for the state Department of Health Care Policy and Financing (HCPF) to use in evaluating and approving coordinated care pilot program proposals; and,
- Ensure accountability within state departments and participating community service providers that encourages efficiency and rewards those high-quality performers that improve consumer and program outcomes.

In examining the elements of the LTC system that suggest a fresh look, most notably those that could be held up to the scrutiny of evidence and promising practices from other states, the Committee focused on systems' re-design features that would provide better access to the full continuum of LTC services while promoting consumer choice, value-based purchasing and improve consumers' quality of life in the least restrictive setting. As specified in SB 05-173, the target population for these reform efforts is elders and adults with disabilities who are, or are at risk of becoming, eligible for Medicaid LTC services.

The Committee agreed that it was important to examine the interrelationships between Medicaid, Older Americans Act (OAA) funds and other sources of federal and state support available to current and potential users of LTC services. These additional sources include federal Housing and Urban Development (HUD) financing for subsidized housing, the state-funded Home Care Allowance (HCA) program, and the Old Age Pension (OAP) and Supplemental OAP health and medical program for individuals not eligible for Medicaid-funded health services. In addition, the revenue that derives from the private payments of consumers should be considered.

GUIDING PRINCIPLES ADOPTED BY THE SB 05-173 ADVISORY COMMITTEE

The Committee adopted the following principles to frame its policy and program recommendations. Program and structural modifications in the administration and financing of LTC services in Colorado will:

- Focus on consumer direction and choice in care planning and service delivery;
- Achieve a more appropriate balance between medical care and the social supportive services that maximize function and promote least restrictive care setting;
- Promote opportunities for program redesign, financing and service delivery that use interdisciplinary care teams;
- Achieve more seamless financing integration between Medicaid waivers, state plan services and other funding streams such as OAA funds, HUD housing programs that are targeted at elders and people with disabilities and transportation programs outside the purview of the Colorado Department of Human Services (DHS) and HCPF;
- Encourage the development of quality metrics that focus on consumer outcomes, including quality-of-life indicators as defined by consumers of LTC services;
- Be inclusive of all adult consumers of HCBS waivers, including elders and adults with dementia, physical and mental disabilities;
- Ensure that recommended program modifications focus on the consumer rather than the agency or organization providing services; and
- Promote alternative rate-setting methods for innovative residential care and community-based service combinations. Such innovations should reward programs that achieve optimal consumer outcomes such as maximizing function, promoting community integration and expanding consumer choice.

EFFECT OF THE DEFICIT REDUCTION ACT OF 2005

On February 1, 2005, the federal Deficit Reduction Act (DRA) was enacted. The DRA is relevant to the Committee's work because it contains several provisions that affect program modifications that were considered by the Committee. These provisions include:

- Effective February 1, 2007, states will be permitted to offer home and community-based (HCB) services as a Medicaid state plan option rather than exclusively through the waiver process.
- Effective January 1, 2007, LTC state plan options may be used to cover individuals up to 150 percent of the federal poverty level (FPL), with flexibility to set more generous income and resource limits.
- States will be allowed to establish functional eligibility criteria for HCB services that are less stringent than that used for institutional care. Additionally, states will be permitted to provide up to 60 days of presumptive eligibility for HCB services.

- As is currently the case under an approved waiver, states using a state plan option may cap the number of individuals who receive HCB services, establish waiting lists and will not be required to make optional services available statewide.
- A new state plan option for self-directed personal care services was added for elderly and disabled eligibility groups.
- A “money follows the person” demonstration that provides enhanced matching funds to states to move individuals from institutions to HCB settings was also included in the DRA.

Reference to these new state options will be noted at the appropriate place in the recommendations that follow.

RECOMMENDATIONS FOR LTC SERVICE AND SYSTEM REFORM IN COLORADO

The Committee organized its recommendations into the following four groupings:

1. Person-centered LTC service continuum;
2. Seamless care planning;
3. Eligibility and financing options that ensure access, integration and value purchasing; and
4. Statewide leadership and accountability for LTC planning and program development.

The Committee views its recommendations as integral to meeting the policy goals set forth in SB 05-173 (See Appendix E). The following recommendations present a coherent package of program modifications and reforms that will achieve both the short-term and longer-term policy and program objectives specified in the legislation.

[Appendix B provides a Glossary of definitions of terms used in the report, while Appendix C describes best-practice models implemented in other states and local communities.]

I. PERSON-CENTERED LTC SERVICE CONTINUUM

PROBLEM STATEMENT

From the perspective of the LTC consumer and his or her family, Colorado’s array of LTC services is characterized by fragmentation, redundancy and inconsistent and overlapping jurisdictions with regard to medical care providers, and skilled and unskilled health care and personal service providers and seemingly inequitable reimbursement policies. This situation is

due, in part, to restrictive rules and regulations and an inconsistent availability of services around the state.

Historically, the duration and scope of LTC services available to consumers has been based on a medical model that focuses eligibility on an underlying disease or chronic medical condition. In the alternative, “person-centered” supportive services focus on an individual’s overall *functional* needs, including social and personal care services that enable individuals to live as independently as possible in the least restrictive setting. The consumer and his or her legal representative is an integral part of the care planning and decisionmaking process in a person-centered LTC service delivery system.

The current array of HCB services available to elderly, blind and disabled waiver eligible consumers living in the community includes adult day care, personal care, homemaker-chore workers, skilled nursing care, alternative care facilities, home modifications and assistive devices, respite care, medical and non-medical transportation, in-home supportive services and other supports that help individuals remain in the community. As currently configured, these services often are provided by distinctly different agencies that are individually licensed, certified or otherwise monitored by the state to ensure service and fiscal accountability.

Specific problems noted by Committee members with regard to current LTC service availability include:

- The almost total disconnect between primary health care and HCB services which often results in unnecessary and preventable functional decline and compromised health status because consumers’ primary care providers are unaware of the signs of decline being monitored by HCB service providers.
- Transportation services are generally inadequate, with a lack of accessible statewide providers and funding. Coordination of the multiple transportation funding sources is non-existent. Rural communities in particular have few or no resources for non-emergency medical transportation.
- Supportive housing and service options for individuals with dementia, mental illness and brain injury are grossly inadequate or unavailable.
- Many adult day programs provide overnight respite care and assessment services, in response to family/caregiver needs. These services, however, are currently not reimbursable under Medicaid to adult day care service providers.

- The length of time it takes to secure authorization for HCB services often puts LTC consumers at risk for hospitalizations and other forms of institutional care.

RECOMMENDATION 1.1 – Expand the availability of alternative housing options

The state agencies responsible for licensing, certifying, program planning and setting reimbursement policies for HCB services should collaborate more effectively with federal, state and local agencies responsible for Section 8 and other HUD programs for elders and people with disabilities to maximize the benefits from these alternative housing options.

In July 2005, HCPF adopted a rule to expand the housing options available to individuals enrolled in the brain injury (BI) waiver including a newly certified housing option known as a Supported Living Program facility. This policy attention to an alternative housing option for LTC consumers with brain injuries should be expanded to include all HCBS-waiver consumers, particularly those living in areas of the state where the supply of licensed assisted living residences is limited or nonexistent. Better linking of housing options to consumer preferences across waiver recipients would result in a more person-centered continuum of housing options in the community.

RECOMMENDATION 1.2 – Pilot alternative housing options

Alternative housing options such as non-relative and relative adult foster care should be piloted and evaluated in at least one rural and urban county as components of the pilot program authorized by HCPF under the provisions of SB 05-173. If not authorized under the legislation's pilot provisions, alternative housing demonstrations could become part of a private initiative under the auspices of local philanthropy.

RECOMMENDATION 1.3 – Provide financial incentives to skilled nursing facilities to develop alternative uses of licensed beds that promote a “least restrictive” home-like environment

Skilled nursing facilities should be encouraged through financial incentives to develop, evaluate and refine innovative residential care options such as assisted living residences and adult day programs to provide consumers with more home-like housing and service options. These options should include bed conversions or, in the case of older facilities, modernization and/or closure of facilities in pursuit of more home-like environments.

RECOMMENDATION 1.4 – Add a personal care optional benefit to the Medicaid state plan

A personal care optional benefit under the Medicaid state plan should be developed in light of the SB 05-173 policy goal of assuring that Medicaid funds are used in the most cost-effective manner possible. This optional benefit would enable individuals with personal care needs who are not yet nursing home eligible, and therefore not eligible for a HCBS waiver slot, to receive limited personal care benefits and avoid or postpone the full costs associated with a HCBS waiver. As an optional state plan benefit, Medicaid recipients with a documented need based on a comprehensive functional assessment would be eligible for the benefit.

Currently, 26 states and the District of Columbia have a personal care optional state plan benefit. In the majority of states with this benefit, program costs are managed through limitations in the number of service hours that are authorized on a weekly, monthly or annual basis.³ The need for assistance with activities of daily living (ADLs) such as bathing, dressing, transferring in and out of bed, bladder and bowel control and eating is the criterion most often used to assess functional eligibility.

As allowed by the DRA, Colorado should explore the development of a separate functional assessment tool to determine consumers' functional eligibility for the personal care option. States that have added an optional personal care benefit under their state plan have either developed a second functional assessment tool or use a modified ADL threshold to establish eligibility.

The Colorado Department of Health Care Policy and Financing viewed recommendation 1.4 as an expansion of Medicaid and therefore could not support this recommendation because of its potential cost implications. Additionally, the Department could not support the development of a separate functional eligibility threshold for personal care or other HCB services for the same reason.

³ Summer, L. and E. Ihara (2005). *The Medicaid Personal Care Services Benefit: Practices in states that offer the optional state plan benefit*. Georgetown University Health Policy Institute. Paper can be found at: <http://www.aarp.org/ppi>.

RECOMMENDATION 1.5 – Pool transportation funding

Transportation funding streams available through Medicaid and Older Americans Act funds should be combined. In Medicaid specifically, waiver transportation services and the non-emergency medical transportation state plan benefit should be pooled. This pooling would make transportation funding more accessible, flexible, person-centered and seamless to both Medicaid consumers and people at risk of becoming eligible for Medicaid.

RECOMMENDATION 1.6 – Authorize a fully integrated primary care/LTC pilot

At least one pilot project should be authorized to pool, on a per capita basis, Medicaid acute and LTC funds utilizing a service delivery model such as Wisconsin Partnership, Wisconsin Family Care, Massachusetts Commonwealth Care Alliance or Minnesota’s Senior Health Options program. In several of the programs mentioned, Medicare funds also are included as part of the capitated rate; such a pilot in Colorado would require a federal waiver. The proposed pilot would begin by integrating Medicaid funding for primary, acute and long-term care into one capitation rate. A risk-sharing mechanism would test the cost-effectiveness and efficacy of such an approach from the perspectives of quality, efficiency and person-centeredness.

RECOMMENDATION 1.7 – Clarify eligibility for the Colorado Home Care Allowance Program (HCA)

Eligibility for HCA should be re-examined to ensure that the policy goal of reducing redundancy in the array of LTC services available to Medicaid and non-Medicaid LTC consumers is met. The HCA provides a special cash allowance to help low-income individuals with disabilities get the supportive services they need to remain in their homes. Qualified individuals should not be allowed to use both HCA and HCB services simultaneously, but rather HCA should be used as a pre-nursing home program for individuals not currently eligible for a HCBS waiver. The administration of this program was transferred from HCPF to the Department of Human Services on July 1, 2006.

2. SEAMLESS CARE PLANNING

PROBLEM STATEMENT

The recommendations in this section focus on the care management function. We have used the term “case manager” to refer to the current system as defined in regulation, while suggesting a

transition to the use of the term “care manager” which more appropriately describes the policy goal being pursued.

Consumers of Colorado’s LTC services are not benefiting from best of practice care planning and service brokering models. Although case managers in the state’s single entry point system are funded to be both care planners and service brokers, large caseloads and additional unfunded responsibilities result in their role being viewed by community-based organizations, service providers and consumers as largely administrative as opposed to face-to-face care planning and service monitoring with LTC consumers. The care planning function should include periodic functional re-assessments, service monitoring and an evaluation of consumers’ functional outcomes relative to the services they receive.

Furthermore, there is significant variation between Single Entry Point (SEP) regions in the care planning function and how hours and services get allocated and monitored, resulting in disparate service allocation between functionally comparable LTC consumers. Care managers have an important role to play in assuring that functional need is addressed while at the same time ensuring that over-utilization or unjustified service allocation does not occur. It is the delicate balance between administrative functions and care management that often gets off balance because of extremely large caseloads, resulting in perverse fiscal incentives for community agencies and their clients to either over- or underutilize supportive services.

Colorado’s assessment and care planning system is not fully automated from the consumer assessment function to service allocation to quality and outcomes monitoring. If it was to become fully automated, and the data compiled into a state-level database, the information could be used to more effectively monitor service quality and financial performance, and ultimately serve as a robust tool for policymakers to assure program accountability.

RECOMMENDATION 2.1– Clarify and strengthen the role of care managers

The role and functions of case managers employed by SEPs, Community Centered Boards (CCB) and the Aging and Disability Resource Center (ADRC) pilot program should be defined primarily by the core duties they perform. These core duties include functional assessment and care planning, service broker, and assessor of efficient high quality and appropriate supportive services, all built on a person-centered care plan. Because the term “care manager” best describes this set of duties, the Committee encourages its use.

To efficiently fulfill these duties, care managers should receive mandatory training and continuing education in person-centered care planning and be trained in the use of uniform statewide accountability standards based on consumer outcomes. Care decisions, to the extent feasible and efficient, should be made based on individual preferences.

RECOMMENDATION 2.2 – Reduce care manager caseloads

Currently in Colorado, the average caseload size for an SEP case manager is approximately 80 consumers. Reports from the field suggest that this caseload size makes it almost impossible for the care manager to function effectively as a care coordinator, service broker and prudent purchaser and monitor of services authorized. Every attempt should be made to achieve an optimal care manager/consumer caseload ratio. The literature suggests this ratio be no more than 50 consumers per care manager.

Concomitant with this recommendation is an acknowledgement that such a caseload adjustment will require an increased state appropriation, which the Committee believes can be recouped through more efficient care planning and service monitoring. Until the caseload issue is resolved, it is unrealistic to assume that the care manager role can be transformed into one that promotes person-centered care planning with fiscal accountability to the state and individuals receiving LTC services in the community.

RECOMMENDATION 2.3 – Fully automate the functional assessment and service allocation/monitoring functions

The functional assessment tool, and the degree to which it is automated, are significant factors in the overall efficiency and effectiveness of the care manager and service broker roles. A fully automated functional assessment, service allocation and monitoring system should be developed by HCPF in cooperation with care managers and single entry point agencies across the state. Consumer-level information collected by care managers should be electronically transmitted to a fully integrated state LTC database for quality monitoring and program accountability purposes.

RECOMMENDATION 2.4 – Include patient level LTC data in the state’s emerging electronic health information exchange efforts

The state agencies responsible for administering and financing LTC services should actively participate in the emerging Colorado Regional Health Information Organization (CORHIO), an evolving network of health care providers, payers and ancillary services that has formed to improve the quality and cost-effectiveness of health care through the electronic exchange of patient-level data across sites of care. Taking part in CORHIO will ensure that LTC user and utilization data become a part of a comprehensive health record at the patient level thereby improving quality as patients’ complete utilization history can be known at the time care is rendered.

3. ELIGIBILITY AND FINANCING OPTIONS THAT ENSURE ACCESS, SERVICE INTEGRATION AND VALUE-BASED PURCHASING

PROBLEM STATEMENT

In the current LTC system, case managers generally determine functional eligibility in an expeditious manner. Delays in determining Medicaid financial eligibility, however, create inappropriate delays in clients gaining access to needed long-term care services— both nursing home and community-based LTC care. A consequence of these delays is that individuals being discharged from an acute care facility often get placed in a more intensive level of care than needed as nursing homes have historically been more able than HCB providers to assume the financial risk of admitting a patient who may later be deemed ineligible for Medicaid. Recent experience suggests, however, that LTC providers (nursing homes and HCB services alike), experience significant delays in establishing Medicaid financial eligibility for LTC services, thus, putting them all at significant financial risk.

The federal DRA now allows states to provide 60 days of presumptive eligibility, giving Colorado a new option to correct this costly problem to the state and its network of LTC providers. As one committee member noted, it is more fiscally responsible to “spend more funds on less intensive services [in order] to spend less funds on more intensive services.”

Furthermore, reimbursement policies that govern payment to nursing facilities, home health agencies and other HCB service providers are inconsistent in the basis on which rates are set. Nursing facility rates are set in statute and generally use a cost-based reimbursement

methodology that adjusts facility rates based on patients' average acuity levels. This acuity adjustment is not currently used as a factor in setting HCB service provider rates.

The 2006-07 budget provided the first rate increases to HCB service providers since 2001. A total of \$5.1 million will be allocated across providers in the following manner:

- Assisted living facilities - 15.1%
- Adult day care services - 3.6%
- Skilled nursing visits provided by home health agencies, 7.2%
- Home health aides - 4.2%
- Physical therapy provided by home health agencies - 36.3%
- Speech therapy provided by home health agencies - 35.9%
- Occupational therapy provided by home health agencies - 29.2%
- Private duty registered nurse - 3.8%
- Private duty licensed practical nurse – 8.0%
- Personal care homemaker services – 10.0%
- All others - 2.57%

RECOMMENDATION 3.1– Expedite financial eligibility determination

Expedited financial eligibility determination for all LTC providers should be enacted legislatively to ensure appropriate and timely LTC service provision. Expedited eligibility can be accomplished through already tested programs such as Colorado Fast Track.⁴ Building on the experiences of the Fast Track Project at Denver Health, HCPF could authorize pilot projects that include expedited eligibility in at least one urban and one rural SEP region as a starting point for statewide implementation.

Included in the pilots could be alternative models for expediting financial eligibility determination with the policy goal of ensuring that LTC clients are assessed within 48 hours of a hospital discharge or upon an imminent institutional placement. The pilots should be evaluated by an independent evaluator with regard to risks to the state, funds needed to cover the expenses of consumers who do not qualify for Medicaid, and the cost savings achieved by avoiding more

⁴ Mollica, R.L. (2004). *Expediting Medicaid Financial Eligibility*. Community Living Exchange Collaborative: A National Technical Assistance Program, Rutgers Center for State Health Policy and National Academy for State Health Policy.

costly institutional placements. If expedited eligibility is not implemented by the department in a timely fashion, the legislature should consider enactment of the 60-day presumptive eligibility option provided for in the federal Deficit Reduction Act. HCPF has stated that it does not support any efforts to enact a policy of presumptive eligibility for LTC services in Colorado.

RECOMMENDATION 3.2 – Provide comprehensive training to hospital discharge planners

Comprehensive and ongoing training should be provided to hospital discharge planners to get patients back into the community as quickly as possible and improve coordination between discharge planners and SEP and CCB case managers. This training is an important element in ensuring discharged patients are placed in the most appropriate, cost-effective and person-centered post-hospital care setting. The curriculum development and training should be provided by an independent contractor with expertise in the full range of LTC service options available in Colorado.

Training options for discharge planners should include Web-based training opportunities and other technology-based media that can maximize the utility and accessibility of the curriculum. Hospital discharge planners should become better informed about home and community-based resources available to elders and people with chronic conditions and disabilities who are at risk of institutional care upon discharge from an acute hospitalization. HCPF should develop incentives, financial or otherwise, to recruit hospitals to participate in this training and the related cultural change necessary to promote and institutionalize person-centered discharge planning.

RECOMMENDATION 3.3 – Bundle transitional service planning services

Steps should be taken to increase awareness, authorization and use of transitional services, including home modifications and equipment as needed, prior to discharging patients from a skilled nursing facility such that a bundled expedited service package is available for at-risk non-Medicaid and Medicaid eligible individuals alike. This bundled approach would maximize Medicare's homebound home health agency benefit, ensure expedited eligibility for HCB services, and include needed home modifications or equipment to make patients' homes safe upon hospital or nursing home discharge. Funding for these bundled transitional care services should include Medicare, Medicaid, Older Americans Act and private funds, thereby avoiding more intensive Medicaid-reimbursed HCBS waiver services.

As of July 1, 2006, the transitional service planning function noted above was authorized in rules adopted by HCPF and is available for individuals transitioning from a nursing home to the community. The availability of this new service is not well known among nursing home discharge planners and community-based care managers and therefore training materials in the full range of post-nursing home care planning options should be developed and disseminated widely.

RECOMMENDATION 3.4 – Rate-setting and financing reforms should be instituted to achieve equity in reimbursement based on the scope of services provided in each care setting

A range of rate-setting and financing reforms should be instituted that promote person-centered and consumer-identified service outcomes. The principle of "money follows the person" should be implemented in all LTC rate-setting methodologies. Client outcomes should be based on quality of life measures such as person-centered care planning, consumer preferences for care setting and services delivered in the least restrictive care setting. From a provider perspective, outcome goals should include ensuring provider capacity and capabilities, that participant safeguards are in place, that consumer rights and responsibilities are respected, and that the system of services at the community level functions efficiently and effectively (see Centers for Medicare and Medicaid Services (CMS) HCBS Quality Framework at www.cms.hhs.gov/HCBS/downloads/qualityframework.pdf for a complete description of these quality metrics).

To accomplish these policy and equity-in-financing goals, the Committee recommends:

- An independent policy research entity with demonstrated expertise in LTC financing should be appointed to evaluate reimbursement models that pool existing federal and state funding streams for LTC consumers in different residential and/or service settings. The findings should focus on the quality and financial implications for Colorado's LTC budget. Although several Committee members felt that HCPF should conduct the study, the majority of the Committee felt that the study should be independent.
- A tiered reimbursement rate schedule for assisted living facilities and adult day care should be developed and piloted based on residents' acuity levels. Also, an independent study should estimate and model cost savings to be achieved by increasing reimbursement for HCB services provided in assisted living residences. Currently, reimbursement for these residences is approximately \$42.47 per day. Medicaid-funded dementia care in assisted living is almost non-existent because of these low reimbursement rates. New rate-setting methodologies should be explored that

encourage person-centered care for high-need patients in the least restrictive care setting.

- Rates for adult day centers and home health agencies should be adjusted to account for client severity. Currently, these providers receive a flat rate regardless of consumers' severity level or the degree of service intensity.
- HCPF should consider authorizing a pilot under the authority given in SB 05-173 that demonstrates and evaluates the degree to which efficiencies can be achieved and savings accrued from awarding a selective contract to an HCB service provider that serves a specific geographic area and cluster of LTC consumers.

RECOMMENDATION 3.5 – Develop and implement an aggressive set of quality benchmarks and a fully automated monitoring system for all LTC services

Comprehensive quality monitoring and accountability management, targeted at the continuum of LTC services (Medicaid and non-Medicaid) currently under the aegis of SEPs, CCBs, and the ADRC pilot should be developed and implemented. The focus should be on person-centeredness and outcomes-oriented measures (see the *CMS Quality Framework*). State agencies responsible for assuring quality across the full continuum of LTC services should contract with an independent, neutral entity to identify best practices in the following areas of quality improvement:

- Voluntary efforts for quality management and improvement that provide incentives for service agencies to participate, including but not limited to accreditation.
- In collaboration with the American Public Human Services Association, National Association of State Developmental Disabilities Services and the National Association of State Units on Aging, and using the CMS HCBS Quality Framework, the neutral entity should propose an HCBS quality assurance plan for Colorado that focuses on consumer-centered outcomes along the seven dimensions noted in the Framework document.

CMS is testing promising practices in quality improvement in other states where consumer outcomes serve as the standard for payment, often referred to as “pay-for-performance.” These experiments encourage LTC providers to bundle services in such a way as to maximize choice and autonomy, and improve person-centered outcomes. In these new service bundles, rates are based on client severity adjusters and related service needs. Accountability begins at the

consumer level with benchmarks for quality defined from a consumer outcome and service preference perspective.

Colorado state agencies responsible for LTC program financing, oversight and accountability should explore the additional flexibility in HCBS waivers and the new state plan options under the federal DRA to accomplish:

- Increased flexibility for HCBS consumers and provider agencies so that varying levels of services—including adult day centers, assisted living and services provided in a residential care setting are fungible and can be tailored to consumer needs at different points in time, especially for consumers with dementia.
- Financial incentives that encourage nursing facilities to develop innovative transition services such as assisted living, adult day centers, out-patient rehabilitation services and intergenerational care centers.

4. STATEWIDE AND LOCAL LEADERSHIP AND ACCOUNTABILITY FOR SEAMLESS LONG-TERM CARE PROGRAM PLANNING AND SERVICE DELIVERY

PROBLEM STATEMENT

Elderly and disabled consumers and their families face a dizzying array of agencies, organizations, rules and regulations, and financing requirements when seeking out LTC options. Delivery and oversight of quality LTC programs is represented by a complex maze that requires coordination of multiple service providers and funding streams to meet the unique circumstances of individual consumers, their families and informal support systems. Although Colorado's single entry point (SEP) agencies have made significant strides in pulling together under one roof many of the programs and services intended to support the long-term care needs of people with disabilities and the elderly, there remains significant fragmentation at the community level. This local fragmentation leaves consumers and their families facing a splintered array of agencies from which they receive information, follow-up referrals and services.

Too often in the current system, in spite of the existing SEP network, individuals needing community supports to maximize their independence become "lost" among county agencies, SEPs, Area Agencies on Aging (AAAs) and other community-based information and referral organizations. The "disconnect" between financial and functional eligibility and Medicaid and

non-Medicaid-funded LTC services is complex and unnecessarily fragmented from a consumer, care manager and service provider perspective.

Service providers face an array of state agencies with which they must negotiate on behalf of consumers and to which they are accountable for the various functions involved in providing care. These cross-agency functions include licensure and certification of services and facilities, eligibility determination and service authorization, delivery and reimbursement for the care planning function and services provided. Non-Medicaid services are reimbursed and regulated by different agencies, including those administered by the OAA, housing and transportation agencies, the Department of Human Services, the Department of Public Health and Environment and the Department of Local Affairs. In the current system, there is no one place where “the buck stops” from a consumer access perspective.

RECOMMENDATION 4.1– Consolidate the care planner/service broker function at the community level for all consumers of LTC services

The Committee recommends that the coordinative functions currently offered by SEPs and CCBs be expanded to include all of the following services:

- Intake and initial needs assessment;
- Information and referral;
- Medicaid financial eligibility assessment and determination;
- Functional assessment;
- Person-centered care planning and ongoing service monitoring;
- Allocation of services and supports using blended funding based on client eligibility for Medicaid, OAA funds, Home Care Allowance, and other state and federal funds that support elders and adults with disabilities in the least restrictive setting;
- Purchase of services, using the most appropriate funding sources; and
- Monitoring service utilization and assuring person-centered consumer outcomes are achieved.

The existing 25 SEPs, 16 AAAs, 20 CCBs for people with developmental disabilities, county offices where financial determination for Medicaid takes place and the ADRC pilots need to be better coordinated and supported in their performance of the functions identified above.

Regulatory changes are needed to provide needed flexibility and support services not currently offered by these community-based agencies. Stringent enforcement criteria should be established to hold local agencies accountable for fulfilling the outlined functions.

Implementation of this service and functional integration in pursuit of seamlessness from a consumer perspective could include the following two options:

- Implementation of a “virtual one-stop” system that relies on information technology such as Web sites and computer-assisted information and referral systems. This option would be based on a one-phone-call philosophy, and the intake and referral process transparent to the consumer and his/her family or other support system; and
- Electronic navigational tools that are linked to a live person who is available through telecommunication methods.

To ensure that any conflicts of interest between care planning, service allocation and service provision are not built into a newly configured single entry point system, an assessment of the extent to which SEPs and CCBs currently allocate and provide services should be completed and report on the extent to which conflicts of interest exist, and the report should include recommendations for eliminating identified conflicts. This study should take into account rural supply issues that may require special consideration in assessing conflicts of interest from both agency and consumer perspectives.

The Committee recommends the following changes be made to existing SEP and CCB practices to achieve a fully integrated single entry system:

- Expedite financial eligibility determination.
- Provide online access to the Colorado Benefits Management System (CBMS) to provide more timely information that can be used to expedite financial eligibility. This access could be read-only.
- Use of blended funding streams that include Medicaid (eligible clients only), HCA, OAP and OAA funds so that consumers not eligible for Medicaid LTC services can receive non-Medicaid care planning and supportive services as needed.
- Create a fully integrated electronic consumer record that includes the functional assessment, financial eligibility, care planning, service allocation and service monitoring, and outcomes functions. The outputs of this integrated consumer record would be used

to monitor service quality, consumer outcomes, fiscal management and appropriateness of services provided.

- Integrate all types of disabilities into the single entry point system (or virtual system), including adults with dementia, physical, developmental and mental disabilities.

In support of the above recommendations, the Committee also recommends that:

- Criteria are developed to evaluate the effectiveness of SEPs at meeting these new and expanded statutory responsibilities.
- A competitive bid process for SEP contract renewals should be developed to include compliance benchmarks with the criteria discussed above.
- LTC consumers, hospital discharge planners, care planners and service providers should be provided comprehensive training materials about consumer-centered planning and service provision. This training should include the full continuum of service options and financing mechanisms available. The curriculum should be developed and delivered by an independent contractor with expertise in the LTC service continuum and best practice models for person-centered care planning and service provision. A LTC service continuum tool kit should be developed that outlines issues related to maximizing Medicare payments for sub-acute care services before services are financed by Medicaid and OAA, HUD, and other federal and state sources.

The Department of Health Care Policy and Financing did not concur with all parts of Recommendation 4.1. Specifically, the Department has concerns about allowing SEPs to participate in the Medicaid financial eligibility function. These concerns relate to the implementation of the CBMS eligibility determination system under the purview of county human services agencies and the ability of HCPF to oversee additional entities having access to this system.

Further, a Committee member representing the nursing home industry expressed concern about a possible conflict of interest that might ensue by consolidating these functions under the single entry point agency.

RECOMMENDATION 4.2 – Ensure accountability for state level oversight and leadership

There is widespread recognition and agreement that statewide leadership is needed to pursue a transformative policy agenda in comprehensive LTC planning and service system development.

This “leadership factor” has been well-documented in national studies that have evaluated states with the most innovative and effective LTC systems. Although the Committee was not able to identify a single best practice from among systems implemented in other states, they agreed the next administration needs to address the issues of leadership, vision and coordination across agencies if Colorado is to be prepared for the future economic and social costs of its aging baby boomer population.

Other states have used a variety of mechanisms to address the leadership issue, including: 1) creation of a state oversight agency or executive-level position in the governor’s office; 2) incentive-based coordination between involved state departments; 3) creation of rigorous accountability and performance standards that hold individual agencies and departments accountable to constituents and taxpayers; and 4) adopting a set of measurable benchmarks tied to the accountability standards to which agencies and programs are held accountable.

The Committee recommends that a blue-ribbon commission be appointed, potentially the existing advisory committee, to oversee the development and implementation of a long-term care system transformation plan for Colorado based on the recommendations contained in this report.

PILOT PROGRAM EVALUATION AND APPROVAL CRITERIA

Statutorily required criteria for approved pilot proposals (26-4-426)

1. Three years duration;
2. At least two rural communities, three urban communities and specific populations designated by the Department of Health Care Policy and Financing;
3. Voluntary participant enrollment;
4. Voluntary provider participation;
5. Adequate provider network;
6. Contractual arrangements with organizations capable of coordinating care for Medicaid patients using a model that demonstrates cost savings; and
7. Evaluation of outcomes.

Additional criteria developed by the Long-term Care Advisory Committee:

1. Collaboration

Preference should be given to pilot proposals that provide evidence of collaboration between:

- Organizations responsible for information, referral, eligibility determination, case management, care coordination and quality assurance for people enrolled in or potentially eligible for community-based long-term care services (e.g., SEPs, AAAs, CCBs, etc.);
- Multiple services providers (e.g., home care agencies, adult day programs, assisted living residences, nursing facilities, primary care providers, etc.);
- Advocacy organizations (e.g., AARP, Colorado Cross-Disability Coalition, Alzheimer's Association, Brain Injury Association); and
- Diverse communities.

2. Piloting multiple recommendations

The Committee's final report includes 18 distinct recommendations in four areas – person-centered service continuum, seamless care planning, eligibility and financing, accountability and leadership. The Committee recommends preference is given to:

- Proposals that pilot multiple recommendations across more than one topic area;
- Pilots that coordinate Medicaid and non-Medicaid services;
- Approaches that are person-centered and consumer-directed; and

- Pilots that test and evaluate the integration of financing streams.

3. Strong evaluation plan

The Committee also recommends that preference be given to proposals with a sound evaluation design to be executed by an objective, independent evaluator.

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APPENDIX B – GLOSSARY OF TERMS

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| <p>Activities of Daily Living (ADL)</p> | <p>Personal care activities that individuals without functional limitations conduct independently. For individuals with functional limitations, they are ranked on a scale based on how much they depend on others to perform these activities. Activities of Daily Living include bathing, dressing, transferring in and out of bed or a chair, bladder and bowel control and eating. (Family Practice Notebook: www.familypracticenotebook.com/GERI1.htm, accessed 8/4/05)</p> |
| <p>Adult Day Services</p> | <p>Health and social services, individual therapeutic and psychological activities that provide wellness monitoring and respite for caregivers. Services are furnished on a regularly scheduled basis and offered in a specific location such as an adult day health center. Participants are people with disabilities and frail elders who commonly have Alzheimer’s, Parkinson’s, and are post stroke. Adult day services are targeted to those who are eligible for a skilled nursing facility but who are living in the community.</p> |
| <p>Aging and Disability Resource Center (ADRC)</p> | <p>A single, coordinated entry point into the long-term care system that includes information, referral, functional and financial assessments and access to long-term care providers for all individuals seeking long-term care supportive services. An ADRC serves individuals who need long-term support, their family caregivers and those planning for future long-term support needs, regardless of income. An ADRC also serves as a resource for health and long-term support professionals and others who provide services to the elderly and those with disabilities. (http://www.hcbs.org and www.aoa.gov/prof/aging_dis.asp, accessed 5/23/06)</p> |

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| <p>Alternative Care Facilities (ACF)</p> | <p>Private assisted-living residences that provide food, assistance with transportation, protective oversight, and social and recreational services to meet residents’ needs. Residents include Medicaid clients found who are eligible for home and community-based (HCB) services and who can be appropriately placed in an assisted-living residence. ACFs are licensed by the Colorado Department of Public Health and Environment.</p> <p>(http://www.chcpf.state.co.us/HCPF/Pdf_Bin/2002-10Doc4.pdf, accessed 5/25/06)</p> |
| <p>Area Agencies on Aging (AAA)</p> | <p>Established under the federal Older Americans Act (OAA), AAAs plan, coordinate and offer services that help older adults remain in their homes. By making a range of options available, AAAs make it possible for older individuals to choose the services and living arrangements that suit them best. (www.n4a.org/aboutaaas.cfm, accessed 5/53/06)</p> |
| <p>Assisted Living</p> | <p>A broad range of personal care and homemaker chore services that do not include skilled nursing care (a.k.a., assisted-living residences or alternative care facilities). Provides 24 hour oversight and assistance with activities of daily living.</p> |
| <p>Capitation</p> | <p>A global payment for a defined set of services on a per-person basis. (www.dictionary.com, accessed 5/31/06)</p> |
| <p>Case/care Management</p> | <p>A constellation of assessment and care coordination services whereby medical, social and other supportive services are coordinated by a professional care manager.</p> |
| <p>Case/care Manager</p> | <p>A professionally trained individual who coordinates, monitors and ensures that appropriate and timely services are provided to individuals with complex health and social needs.</p> |
| <p>Center for Medicare and Medicaid Services (CMS)</p> | <p>Formerly known as Health Care Financing Administration. The administrative agency within the federal Department of Health and Human Services that administers the Medicaid, Medicare and the State Child Health Insurance programs.</p> |

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| <p>Colorado Benefits Management System (CBMS)</p> | <p>A technology-based eligibility determination system developed to improve and expedite access to public assistance and medical benefits by providing a one-stop system for clients seeking public assistance. When fully operational, CBMS will permit faster eligibility determinations and increase the accuracy and consistency of the eligibility determination process on a statewide basis. Jointly developed by the Department of Human Services (DHS) and the Department of Health Care Policy and Financing (HCPF) to replace six older information and eligibility determination systems.</p> <p>(http://www.cbms.state.co.us, accessed 5/23/06)</p> |
| <p>Colorado Regional Health Information Organization (CORHIO)</p> | <p>A statewide coalition of interested individuals, health care providers, agencies, organizations and community leaders working to build and monitor an electronic health information network.</p> <p>(http://www.coloradohealthinstitute.org/Documents/corhio/charter-structure.doc, accessed 5/23/06)</p> |
| <p>Community Centered Board (CCB)</p> | <p>A private for-profit or nonprofit corporation that provides case management to people with developmental disabilities. CCBs are authorized to determine eligibility of such people within a specified geographical area. They serve as a single entry point (SEP) for people to receive support and services. Authorized services are distributed to people either directly or by purchasing such services and supports from services agencies.</p> <p>(http://www.state.co.us/gov_dir/leg_dir/olls/sl2003a/sl_308.htm accessed 5/26/06)</p> |
| <p>Consumer Direction</p> | <p>Consumer direction describes a service philosophy that offers maximum choice and control by people who use supportive services to assist them with ADLs and IADLs. In consumer-directed programs, people with disabilities choose to hire, manage and fire their support workers. Services are provided wherever the consumer lives. (www.consumerdirection.org, accessed 8/3/05)</p> |

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| <p>Deficit Reduction Act (DRA) of 2005</p> | <p>The 2005 Congressional Budget Resolution. The budget also contains legislative changes that reduce federal outlays and direct program changes. The DRA is the federal budget document that specifies federal spending for a fiscal year.</p> <p>(http://www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf, accessed 5/24/06)</p> |
| <p>Department of Health Care Policy and Financing (HCPF)</p> | <p>The Colorado state agency responsible for administering the Medicaid program, Child Health Plan Plus (CHP+) and the Colorado Indigent Care Program.</p> <p>(http://www.chcpf.state.co.us/default.asp, accessed 5/23/06)</p> |
| <p>Department of Health and Human Services (DHHS)</p> | <p>The U.S. government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. Federal programs administered by DHHS among many others include Medicare, Medicaid, health and social science research, disease prevention including immunization services, assuring food and drug safety, health information technology, financial assistance and services for low-income families, improving maternal and infant health, Head Start (preschool education and services), preventing child abuse and domestic violence, substance abuse treatment and prevention, and services for older Americans, including home-delivered meals.</p> <p>(http://www.hhs.gov/about/whatwedo.html , accessed 6/1/06)</p> |
| <p>Department of Human Services (DHS)</p> | <p>The Colorado state agency that provides social and human services including public assistance and child welfare services. DHS is responsible for the administration of the state's public mental health system, the system of services for people with developmental disabilities, the juvenile correctional system and all veteran nursing homes.</p> <p>(http://www.cdhs.state.co.us, accessed 6/1/06)</p> |

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| Federal Poverty Level (FPL) | <p>The FPL is an annual calculation used to determine financial eligibility for certain federal and state programs. Poverty level is measured by poverty thresholds and updated annually by the Census Bureau. In 2006, the poverty threshold for an individual is \$9,800, and for a family of four, \$20,000. For current FPL thresholds, see: http://aspe.hhs.gov/poverty/index.shtml.</p> |
| Functional Assessment | <p>An assessment that determines eligibility for Medicaid long-term care services based on functional limitations using ADL and IADL criteria.</p> |
| Home and Community-based (HCB) Services | <p>Long-term care supportive services that are provided in the community rather than an institutionalized setting such as a nursing home.</p> |
| Home and Community-based Service Waivers | <p>The federal Omnibus Budget Reconciliation Act of 1981 (OBRA-81) authorized home and community-based waivers under Medicaid, giving states more flexibility in how they provide long-term care services and home health services such as skilled nursing, physical therapy and occupational therapy. Waivers allow states to provide community-based services as an alternative to nursing home placements. In Colorado, six HCBS waivers serve adults with long-term care needs in the community. These six waivers include the following population groups: individuals with brain injuries (HCBS-BI); individuals with developmental disabilities (HCBS-DD); individuals who are elderly, blind or have a disability (HCBS-EBD); individuals with serious and persistent mental illness (HCBS-MI); people living with HIV/AIDS (HCBS-PLWA); and a targeted supportive-living waiver (HCBS-SLS).</p> |

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| <p>Home Care Allowance (HCA)</p> | <p>A special cash allowance in Colorado for the purpose of securing supportive service for low-income, functionally impaired individuals in their home. Eligible individuals may select any person over 18 years of age to provide needed services. People living in an adult foster care residence also may use this program. (Medicaid Service Board State rules: http://www.chcpf.state.co.us/HCPF/StateRules/indexT.asp, accessed 8/3/05)</p> |
| <p>Housing and Urban Development (HUD)</p> | <p>A federal agency created to increase home ownership for low-income individuals, support community development and increase access to affordable rental housing. (http://www.hud.gov/library/bookshelf18/hudmission.cfm, accessed 5/24/06)</p> |
| <p>In-Home Supportive Services (IHSS)</p> | <p>A service under the HCBS waiver that allows Medicaid clients who are eligible to direct, select and train their own attendants. Services include health maintenance activities, support for activities of daily living or instrumental activities of daily living and homemaker services. (http://www.chcpf.state.co.us/HCPF/Syschange/IHSS_Intro.asp, accessed 5/25/06)</p> |
| <p>Instrumental Activities of Daily Living (IADL)</p> | <p>Household activities a non-disabled individual can perform independently. A functional assessment scale is used to determine the level of dependence on others to perform these activities. IADLs include use of the telephone, traveling via car or public transportation, food or clothes shopping (regardless of transport), meal preparation, housework, medication use and money management. (Family Practice Notebook: www.familypracticenotebook.com/GERI1.htm, accessed 8/4/05)</p> |

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|---------------------------------|---|
| Long-Term Care (LTC) | A range of medical and/or social services designed to help people who have disabilities or chronic health care needs. Services may be provided in an individual's home, in a community-based agency or in a residential care facility (e.g., nursing homes or assisted-living facilities). (http://www.hcbs.org/glossary.php#L , accessed 6/1/06) |
| Medicaid | A federal/state partnership program that provides coverage for health and long-term care services to low-income eligible population groups. Medicaid, also known as the Medical Assistance Program, is authorized by Title XIX of the Social Security Act. |
| Old Age Pension (OAP) | A Colorado program that provides assistance and health care benefits for low-income people 60 years and older. (http://www.larimer.org/seniors/oap.htm , accessed 5/24/06) |
| Skilled Nursing Facility | A long-term care facility licensed under state law and certified by Medicare and Medicaid that provides 24-hour continuous skilled nursing care for individuals with significant functional, psychological and/or emotional limitations. |
| Single Entry Point (SEP) | An agency that provides information and referral, functional assessments for long-term care services, care management and the brokering of a wide variety of community supports for eligible individuals. The Colorado Single Entry Point system is composed of 25 public or private community agencies around the state. |
| Waiver | See Home and Community-based Service Waivers. |

APPENDIX C – STATE BEST PRACTICES

I. PERSON-CENTERED LTC SERVICE CONTINUUM

RECOMMENDATION 1.1 – Expand availability of alternative housing options

New Hampshire’s Care Options for People in Public Housing (Laconia, NH)

The Laconia Housing and Redevelopment Authority in New Hampshire created a program to assist residents at the Sunrise Towers, a public housing residence for the elderly. This program offers non-medical home-based services such as meals, personal assistance and other services that enable participants to stay in their homes. The housing authorities work closely with other care providers in the field, including the local hospital and public nursing home, to offer coordinated care to program participants. Other programs in the state focus more on home and community-based services (HCBS) for people in assisted-living facilities and other private, residential settings. The Laconia project fills a gap and expands the housing options for people who choose home and community-based services.

Source: Steigman, D. (2003). *Promising Practices in Home and Community Based Services: New Hampshire Care Options for People in Public Housing*. The Medstat Group: Cambridge, MA. (<http://www.hcbs.org/files/39/1909/NHLaconia.pdf>)

RECOMMENDATION 1.2 – Pilot alternative housing options

California Corporation for Supportive Housing (Oakland, CA)

The Corporation for Supportive Housing developed the Health, Housing and Integrated Services Network (HHISN) in Oakland, California. This pilot program expanded access to health and social services for formerly homeless people and low-income adults with chronic conditions. HHISN developed unique models for creating a network of public and private agencies to deliver and finance integrated housing, health care and social services. Through multidisciplinary care teams, more than 30 public and private nonprofit health care, mental health, social service and housing providers jointly funded and delivered affordable housing and integrated services to clients.

Source: Palmer, L. and S. Somers. (2005). *Integrating Long-Term Care: Lessons from Building Health Systems for People with Chronic Illnesses*. Center for Health Care Strategies: Hamilton, NJ. (<http://www.chcs.org>)

Massachusetts Supportive Housing Program

In 1999, Massachusetts developed the Supportive Housing Program (SHP) as a pilot program to strengthen coordination between public housing for elderly residents and service agencies. Massachusetts has an ample amount of public housing for its elderly population, but the community-based long term care services provided in this environment lacked coordination and quality control. As a result, the public housing often had high vacancy rates due to the lack of services and resources provided. SHP makes personal assistance available to each resident 24 hours a day, seven days a week, with an onsite care coordinator available to answer questions and coordinate services for public housing residents. This program decreased vacancy rates and premature admission to nursing facilities because it provides the needed assistance to help residents feel safe and remain in their own home.

Source: Mollica, R. and M. Morris. (2005). *Massachusetts Supportive Housing Program*. Rutgers Center for State Health Policy & National Academy for State Health Policy: Community Living Exchange: New Brunswick, NJ. (<http://www.cshp.rutgers.edu/>)

Wisconsin's Homecoming Project

Wisconsin's Homecoming Project made community housing available to people who wanted to leave nursing homes, but did not have resources. In 1999, Wisconsin received a \$500,000, one-year Nursing Home Transition Grant to fund the Homecoming Project. This pilot program helped consumers and their family members navigate the sometimes costly and stressful issues that arise when moving from a nursing facility to a community setting. The Homecoming Project offered independent living skills trainings, which covered a range of activities, including budgeting, shopping, food preparation and public transportation use. It also included peer support to help clients adapt to living in a community with a disability. Financial assistance included purchasing household items and paying for housing specialists who provided technical assistance with the process. In 1999, 150 people moved from a nursing facility into community housing. In addition, the project helped another 150 people begin the transition process, expanding availability of alternative housing to all nursing home residents.

Source: Eiken, S. et al. (2002). *The Homecoming Project: Wisconsin's Nursing Home Transition Demonstration*. The Medstat Group: Cambridge MA.

(<http://aspe.hhs.gov/daltcp/reports/WItrans.pdf>, accessed 6/01/06)

RECOMMENDATION 1.3 – Provide financial incentives to skilled nursing facilities to develop alternative uses of licensed beds that promote “least restrictive” home-like environment
[NOTE: *Although the Nebraska and Iowa used funds from Intergovernmental Transfer Programs to finance their nursing home conversion programs, it is important to note that funding from private foundations can be used to create similar programs.*]

Nebraska's Nursing Facility Conversion Program

In 1998, Nebraska's legislature passed a law that granted \$40 million to create the Nursing Facility Conversion Cash Fund. The Conversion Program provided grants to help nursing facility owners convert part of their facilities to assisted living or adult units. Funding for the grants came from the state Intergovernmental Transfer Program with the goals to decrease Medicaid spending and provide people living in low-density rural areas a variety of home and community-based service options. In 2001, an additional \$14 million was appropriated to the Conversion Program. Nebraska's Department of Health and Human Services conducted a series of meetings throughout the state, informing nursing facility owners and administrators of the application process and incentive benefits they could receive from the Conversion Program. The program assisted a total of 74 projects, creating 967 new assisted-living units and saving the state \$5.5 million.

Source: Milligan, C. (2005). *Money Follows the Person: Reducing Nursing Home Utilization and Expenditures to Expand Home and Community Based Services*. Rutgers Center for State Health Policy & National Academy for State Health Policy, Community Living Exchange: New Brunswick, NJ.

(<http://www.cshp.rutgers.edu/>)

Iowa's Senior Living Trust Fund

In March 2000, Iowa passed legislation that created the Senior Living Trust Fund with funding from the Intergovernmental Transfer Program. The Trust Fund provides roughly \$8 million per year to the Senior Living Program Grant Program that focuses on helping nursing facilities convert

part of the facility into assisted living. The program has three types of grants and the funding has gradually decreased since 2000. (1)The Conversion Grant is used to convert all or a portion of a licensed nursing facility to an affordable certified assisted-living program. (2)The Conversion Grant with Provision of Additional Services permits eligible programs to request \$50,000 if the facility also develops an added service such as adult day services. (3)The Long-Term Care Services Development Grant awards certain providers the opportunity to develop long-term care services covered under the Medicaid HCBS waiver. Grants are obtained through an application process and are evaluated by a Committee comprising representatives from multiple state departments.

Source: Milligan, C. (2005). *Money Follows the Person: Reducing Nursing Home Utilization and Expenditures to Expand Home and Community Based Services*. Rutgers Center for State Health Policy & National Academy for State Health Policy, Community Living Exchange: New Brunswick, NJ. (<http://www.cshp.rutgers.edu/>)

RECOMMENDATION 1.4 – Add a personal care optional benefit to the Medicaid State Plan

Twenty-six states and the District of Columbia offer optional state plan personal care services (PCS) to adults. Estimates of the cost per beneficiary range from \$10,000 in eight states to less than \$1,500 in Oregon and South Dakota. The need for assistance with activities of daily living is the criterion most used to assess functional eligibility. Three-quarters of the states that offer the benefit have functional eligibility criteria that are less restrictive for PCS than for nursing facility admission. Fifteen states limit the number of hours of service that can be provided. The major finding from a study of states that offer PCS as a state plan benefit is that a state's costs can be controlled by the benefit's design.

Source: Summer, L. and E. Ihara. (2005). *The Medicaid Personal Care Services Benefit: Practices in States that Offer the Optional State Plan Benefit*. AARP Public Policy Institute: Washington, D.C. (http://www.aarp.org/research/assistance/medicaid/2005_11_medicaid.html)

RECOMMENDATION 1.6 – Authorize a full integrated primary care/LTC pilot

Minnesota Senior Health Options Program

The Minnesota Senior Health Options (MSHO) program combines separate health programs and support systems into one health care package. It is for people ages 65 years and older who are eligible for Medical Assistance (MA) and enrolled in Medicare Parts A and B or who have MA only. People can choose to join MSHO or stay in their current MA program. MSHO enrollees are assigned a care coordinator who helps them get their health care and related support services. The coordinator works to bring the necessary medical and social services into a seamless system of care that is person-centered. MSHO is administered by the Minnesota Department of Human Services and nine health maintenance organizations. Services include doctor visits, emergency room care, hospitalization, dental care, lab and x-rays, durable medical equipment, prescription drugs, personal care attendant services, home health services, HCBS elderly waiver services, nursing home care, transportation, interpreter services and a care coordinator.

Source: Source: Palmer, L. and S. Somers. (2005). *Integrating Long-Term Care: Lessons from Building Health Systems for People with Chronic Illnesses*. Center for Health Care Strategies: Hamilton, NJ. (<http://www.chcs.org>)

Pennsylvania Albert Einstein's Health Care Network

In Philadelphia, the Albert Einstein Health Care Network developed an integrated acute long-term care demonstration program for chronically ill elderly individuals living in personal care homes. Because personal home care clients' needs were not being met, Albert Einstein, along with some other agencies, designed a new resident-centered model of integrated care. This model, the Personal Care Partnership, focuses on a multidisciplinary care team including a primary care physician, geriatric nurse practitioner and care manager. Its goals are to demonstrate cost savings, establish a pooled funding arrangement using Social Security Income, Medicare capitation and Medicaid waivers, and to present the personal care home as a viable and vital health care delivery site within the continuum of long-term care options.

Source: Palmer, L. and S. Somers. (2005). *Integrating Long-Term Care: Lessons from Building Health Systems for People with Chronic Illnesses*. Center for Health Care Strategies: Hamilton, NJ. (<http://www.einstein.edu/community/cuhpr/article9319.html>)

2. SEAMLESS CARE PLANNING

RECOMMENDATION 2.1 – Clarify and strengthen the role of care managers

South Carolina Care Management System

To improve the responsiveness of care managers, South Carolina integrated its electronic care plan development system and its functional assessment process. This integration guarantees a care manager will include in a client’s care plan all the needs identified in the functional assessment. The system sends automated reminders or “triggers” to care managers during the automated care plan development process when the assessment data indicates there is a problem in the service plan. Once a problem is identified, the care manager must indicate how to address the problem or document the unmet need. This type of computerized accountability strengthens care managers’ ability to implement person-centered planning.

Source: Medstat. (2004). *Promising Practices in Home and Community Based Services: South Carolina – Improving Responsiveness of Service Managers to Persons Needs*. The Medstat Group: Cambridge, MA. (http://www.hcbs.org/files/67/3322/South_Carolina_Improving_Responsiveness_Updated.pdf)

Vermont

Vermont has implemented specific policies that ensure care managers stay connected to their clients and that the consumers’ needs are being met and monitored effectively. In the HCBS waiver programs, care managers must contact each client at least once a month and make a face-to-face visit at least every 60 days. Care managers also conduct annual reassessments. In addition, Vermont requires care managers to uphold certification standards that include passing a state exam and participating in at least 20 hours of professional development annually.

Source: Justice, D. (2003). *Promising Practices in Long-Term Care Systems Reform: Vermont’s Home and Community Based Service System*. The Medstat Group: Washington, D.C. (<http://www.hcbs.org>)

Washington’s Care Manager Training

As part of their automated comprehensive assessment reporting evaluation, further discussed under recommendation 2.3, Washington’s care managers participate in four-day training seminars

that focus on developing interview skills to ensure they are responsive to client needs. Clients benefit from care managers knowing how to effectively assess their needs and then working with them to develop a care plan that provides the most appropriate services. State officials stress the importance of these trainings, and staff members regularly review a sample of care plans to ensure that care managers continually address and respond to all the clients' needs.

Source: Gillespie, J. and R. Mollica (2005). *Streamlining Access to Home and Community Based Services: Lessons from Washington*. Rutgers Center for State Health Policy & National Academy for State Health Policy, Community Living Exchange: New Brunswick, NJ
(http://www.hcbs.org/files/85/4209/full_report.pdf)

RECOMMENDATION 2.3 – Fully automate the functional assessment and service allocation/monitoring functions

Maine

In 1995, Maine adopted universal, statewide, preadmission screening for all long-term care placements, including private-pay individuals. The Department of Health and Human Services contracts with one agency to conduct assessments statewide. Nurses administer the Medical Eligibility Determination Tool, a fully automated assessment tool for individuals entering the long-term care system. The nurses meet with consumers, determine timely and objective functional eligibility decisions, educate consumers and families, and distribute a fair allocation of services statewide.

Source: Fox-Grage, W. et al. (2003). *Budgeting for Long-Term Care: Spending Limited Dollars Wisely*. National Conference of State Legislatures: Denver, CO. (<http://www.ncsl.org>)

Oregon

Single entry-point care managers use a single automated tool, the Consumer Assessment and Planning System, to assess function and the social environment, personal characteristics and preferences, and medical status; determine eligibility for Medicaid; and develop and authorize a service plan. In addition, all consumer-level information is transferred into a state database where monthly reports are generated to track the number of people receiving services in each covered service category and match the data with system performance measures.

Source: Justice, D. and A. Heestand. (2003). *Promising Practices in Long-Term Care Systems Reform: Oregon's Home and Community Based Service System*. The Medstat Group: Washington, D.C.
(<http://www.hcbs.org>)

Washington

The Comprehensive Assessment Reporting Evaluation (CARE), Washington's single automated system, assesses functional, health, behavioral and cognitive status, determines eligibility for LTC support services, develops care plans, and determines the maximum number of hours of service that may be authorized. Thirteen Area Agencies on Aging (AAAs) conduct the initial assessments for Medicaid services, functional eligibility and care plan development, as well as provide ongoing case management for HCBS clients. The regional offices of the Aging and Disability Services Administration (ADSA) provide ongoing case management for people in nursing facilities, adult family homes or assisted-living centers. The AAAs and regional offices of the ADSA use the same CARE database for applicant and consumer information, but a separate system for people with developmental disabilities. CARE combines assessment, eligibility and service authorization, and also links with Washington's payment system. The improved data integration and reduction in unnecessary contacts with consumers have improved Washington's ability to enroll clients and provide services in a timely way. The CARE system standardized the eligibility process to a one-month process.

Source: Gillespie, J. and R. Mollica.(2005). *Streamlining Access to Home and Community Based Services: Lessons from Washington*. Rutgers Center for State Health Policy & National Academy for State Health Policy, Community Living Exchange: New Brunswick, NJ
(http://www.hcbs.org/files/85/4209/full_report.pdf)

3. ELIGIBILITY AND FINANCING OPTIONS TO ENSURE ACCESS AND VALUE-BASED PURCHASING

RECOMMENDATION 3.1 – Expedite financial eligibility determination

Pennsylvania Community Choice Initiative

Community Choice is a pilot program in several Pennsylvania counties that expedites eligibility to HCBS in an effort to remove unnecessary barriers to services. It is not a “program,” but rather a process by which consumers can have more choices in a timeframe that meets their needs. With Community Choice, consumers have 24-hour access to assessments and eligibility determinations which are often initiated through a toll-free hotline. Referrals are triaged according to the need for an assessment in 24 hours, 72 hours or within a timeframe determined by the consumer. To prepare for Community Choice implementation, state agency staff reduced the financial eligibility application from 12 to four pages and the functional assessment form from 25 to five pages. Applicants may self-declare their income and asset status. Community Choice extends the asset limit to \$8,000 and exempts burial plots. The County Assistance Office presumes eligibility based on the information provided by the client and has 60 days to verify eligibility. In 2005, roughly four percent of those presumed eligible were later found ineligible.

Source: Mollica, R. and S. Reinhard. (2005). *Money Follows the Person Site Visit: Pennsylvania Community Choice Initiative*. Rutgers Center for State Health Policy & National Academy for State Health Policy, Community Living Exchange: New Brunswick, NJ (<http://www.cshp.rutgers.edu/>)

Washington

Washington conducts preadmission screening for everyone who seeks nursing facility services from the community, excluding private-pay clients. Consumers who are newly admitted to a nursing facility receive a face-to-face visit and assessment within seven days of admission. Because the financial eligibility assessors and functional eligibility assessors are both located in the Aging and Disability Services Administration, both assessments begin almost simultaneously.

Washington’s Fast Track allows social workers and nurses to authorize 90 days of essential HCBS before full eligibility is determined. Although Washington does not allow consumers to self-declare income and assets, those who are presumed eligible sign a Fast Track agreement and must apply for Medicaid within 10 days. Eligibility can be determined in as little as one day. Consumers

can submit applications by phone, fax, mail or during a home visit. Washington officials estimate that Fast Track clients save Medicaid roughly \$1,900 monthly by receiving services in the community rather than entering a nursing facility because services were delayed.

Source: Gillespie, J. and R. Mollica.(2005). *Streamlining Access to Home and Community Based Services: Lessons from Washington*. Rutgers Center for State Health Policy & National Academy for State Health Policy, Community Living Exchange: New Brunswick, NJ
(http://www.hcbs.org/files/85/4209/full_report.pdf)

Source: Mollica, R. (2004). *Expediting Medicaid Financial Eligibility*. Rutgers Center for State Health Policy & National Academy for State Health Policy, Community Living Exchange: New Brunswick, NJ.

RECOMMENDATION 3.2 – Provide comprehensive training to hospital discharge planners

Indiana, Nebraska and Pennsylvania’s training for discharge planners

To divert the high number of people entering nursing facilities, Indiana implemented a multidisciplinary team to determine patient care needs. Area Agency on Aging case managers now work with hospital discharge planners to better serve clients and provide information about all LTC options. In 2002, 316 people received home and community-based services because of the networking between case managers and discharge planners. In Pennsylvania, training sessions are held for discharge planners in 10 counties as part of the Community Choice Initiative. These trainings remind discharge planners that home and community-based services are a viable option that will not result in increased hospital admissions. In Nebraska, counselors from a pilot project called Choices work closely with discharge planners to inform them of alternative options for long-term care. The program places counselors in the hospitals.

Source: Summer, L. (2005). *Strategies to Keep Consumers Needing Long-Term Care in the Community and Out of Nursing Facilities*. Kaiser Commission on Medicaid and the Uninsured: Washington, D.C.

Crisp, S et al. (2003). *Money Follows the Person and Balancing Long-Term Care Systems: State Examples*. The Medstat Group: Washington, D.C.

4. STATEWIDE AND LOCAL LEADERSHIP AND ACCOUNTABILITY FOR SEAMLESS LONG-TERM CARE PROGRAM PLANNING AND SERVICE DELIVERY

RECOMMENDATION 4.1 – Consolidate the care planner/service broker function at the community level for all consumers of LTC services

Arizona and California

California and Arizona have implemented a user-friendly, Web-based system for connecting individuals and their families with a wide range of publicly funded health and social service programs. Known as “One-e-App” (one stop access to health care), the online application uses an interactive interview approach to simplify data collection and entry and electronic submission of applications to the county human services department for financial determination. One-e-App is easy to use and has been shown to improve the quality and completeness of applications. In Arizona, Deloitte Consulting, manager of the One-e-App process, has found that application errors were reduced by nearly 40 percent, the time between application submission and eligibility determination decreased by 21 percent, and 90 percent of applicants would rather apply online.

Source: <http://www.oneeapp.org/works/>

Oregon

Oregon’s single entry point system has evolved over time and “has truly become a ‘one-stop shop’ where older people and adults with physical disabilities can obtain information on a wide range of topics including community services, health care, financial assistance, housing, transportation, public benefits and other general resources useful to any person living in the community.”⁵ In Oregon, 90 percent of the state’s population lives in a region where the AAA is the SEP. In addition to comprehensive information and referral functions, the SEP offers: extensive outreach and public information; benefits counseling; determination of eligibility for Medicaid, food stamps, HCBS and nursing home care; functional assessment, care planning and service allocation; and crisis intervention.

⁵ Justice, D. and A. Heestand. (2003). Promising Practices in Long Term Care Systems Reform: Oregon’s Home and Community Based Services System. Medstat, Research and Policy Division. Washington, DC, June 18, p. 9

Source: Justice, D. and A. Heestand. (2003). *Promising Practices in Long-Term Care Systems Reform: Oregon's Home and Community Based Service System*. The Medstat Group: Washington, D.C. (<http://www.hcbs.org>)

Wisconsin

Under the Family Care Program, Aging and Disability Resource Centers serve as the single entry point agencies at the local level. They serve elders as well as people with physical and developmental disabilities. The services the ADRCs provide include information and assistance, long-term care options counseling, benefits counseling, emergency response for people in urgent situations, prevention and early intervention to help keep people healthy and independent, and access to the Family Care benefit for people who want to be considered for the Family Care Program.

Source: Fox-Grage, W. et al. (2003). *Budgeting for Long-Term Care: Spending Limited Dollars Wisely*. National Conference of State Legislatures: Denver, CO. (<http://www.dhfs.state.wi.us/LTCare/>)

RECOMMENDATION 4.2 – Establish accountability for state-level oversight and leadership

Although leadership can be an elusive element in state health policy reform, it is crucial to implementing comprehensive long-term care reform efforts in any state. Some entity, person or collaborative group of people must focus their attention on the reforms and the multitude of programs, populations, funding streams and political factors affected by any policy change. The “leadership factor” has been documented in a variety of analyses that study states with the most innovative LTC reforms.

In Maine, Minnesota, Oregon and Vermont the agency director or commissioner embraced the goals of their respective LTC initiatives and worked together with governors, legislators and a variety of stakeholders to move long-term care reforms forward. A vision was set and the state agencies took the lead with implementation. In Maine, Minnesota and Vermont, the impetus for reform was a budget crisis with the long-term care budget targeted for reductions. It is worth noting that all of these states consolidated their long-term care services into one overarching agency that handles all programs and funding streams. A new AARP report that analyzes systems with consolidated agencies states “...a consolidated agency can help develop consistent

policymaking and focus the systems on (consumers) rather than on program providers.” In interviews with state administrators, working with one agency among different divisions made the process easier because the leadership role was clear.

While Maine, Minnesota, Oregon and Vermont have long established single agency administrations, Texas, Michigan, New Mexico and Missouri are also developing consolidated agencies.

Source: Fox-Grage, W. (2006). *Pulling Together: Administrative and Budget Consolidation of State Long-Term Care Services*. AARP Public Policy Institute: Washington, D.C.

(http://www.aarp.org/research/longtermcare/programfunding/2006_05_state_ltc.html)

Minnesota and Vermont Setting Benchmarks for Accountability

When large numbers of reforms take place over the same period, it can be challenging for administrators to track progress and outcomes. Minnesota and Vermont both set specific benchmarks and budget goals to help the programs move forward and weave accountability into the reform implementation process. The agencies must also produce ongoing reports for their respective legislatures.

Source: Interviews with Minnesota and Vermont state administrators

Vermont Long-Term Care Coalitions

To assure stakeholders' participation and broaden the leadership roles across the state, Vermont established long-term care coalitions to help state administrators implement reforms. The coalitions were especially important in Vermont's early years of reform, because they gave feedback to administrators and offered a check-and-balances system as incremental change took place.

Source: Justice, D. (2003). *Promising Practices in Long-Term Care Systems Reform: Vermont's Home and Community Based Service System*. The Medstat Group: Washington, D.C.

(<http://www.hcbs.org>)

APPENDIX D – COLORADO LTC PROGRAM EXPENDITURES AND USER POPULATION CHARACTERISTICS

NURSING FACILITIES AND HCBS/EBD PROGRAM: SUMMARY OF SELECTED COST, ENROLLMENT AND SERVICE DATA

Summary of number of distinct clients, full time enrollee equivalents, and costs in nursing facilities versus EBD Waiver, FY 1999-00 through FY 2003-04.

| | FY '99-'00 | | FY '00-'01 | | FY '01-'02 | | FY '02-'03 | | FY '03-'04** | |
|--|------------|----------|------------|----------|------------|----------|------------|----------|--------------|----------|
| | NF | EBD | NF | EBD | NF | EBD | NF | EBD | NF | EBD |
| Number of distinct clients | 15,793 | 13,006 | 15,592 | 14,082 | 15,070 | 15,157 | 14,867 | 15,634 | 14,341 | 15,435 |
| Number of full time enrollee equivalents | 10,530 | 9,435 | 10,332 | 10,454 | 9,991 | 11,271 | 9,801 | 12,057 | 9,652 | 11,665 |
| Total Costs* | \$347,522 | \$65,204 | \$360,822 | \$72,256 | \$372,603 | \$86,793 | \$384,278 | \$93,169 | \$417,867 | \$92,569 |
| Costs per distinct client* | \$22 | \$5 | \$23 | \$5 | \$25 | \$ 6 | \$26 | \$6 | \$29 | \$6 |
| Cost per full time enrollee equivalents* | \$33 | \$7 | \$35 | \$7 | \$37 | \$8 | \$39 | \$8 | \$43 | \$8 |

* Costs in thousands of dollars

** Preliminary

Distinct client – An individual person who was enrolled in the program during the year regardless of the number of days enrolled.

Full time enrollee equivalent (FTEE) – One enrollee equivalent in the program for 365 days. For example, two distinct clients, one of whom was in the program for 300 days and the other of whom was in the program for 65 days would be counted as one full time enrollee equivalent.

Source: HCBS-EBD 372 reports

Number of distinct clients receiving specified HCBS/EBD services

| Type of Service | FY '99-'00 | FY '00-'01 | FY '01-'02 | FY '02-'03 | FY '03-'04 |
|----------------------------|------------|------------|------------|------------|------------|
| Adult Day Services | 787 | 833 | 911 | 943 | 960 |
| Non-medical transportation | 1,048 | 1,104 | 1,159 | 1,384 | 1,361 |
| Homemaker | 1,917 | 2,116 | 2,540 | 2,951 | 2,941 |
| Personal care | 7,735 | 8,119 | 8,741 | 9,226 | 9,166 |
| Home modifications | 387 | 451 | 566 | 546 | 435 |
| Home electronics | 6,508 | 7,005 | 7,665 | 7,982 | 7,572 |
| Alternative Care | 2,582 | 2,889 | 2,893 | 2,814 | 2,814 |
| Respite Care | 277 | 361 | 374 | 401 | 340 |

Adult Day Services – Health and social services, individual therapeutic and psychological activities furnished on a regularly scheduled basis in an adult day health center (ADHC). ADHC services are targeted at frail elders who would be eligible for a skilled nursing facility but who are living in the community.

Alternative Care-Assisted Living – A broad range of personal care and homemaker chore services that does not include skilled nursing care provided to people living in Assisted living facilities (a.k.a., assisted living residences or alternative care facilities).

Home electronics/electronic monitoring – The use of electronic devices to enable individuals to secure help in an emergency. It can also be used to provide the patient with reminders of medical appointments, treatments, or medication schedules.

Home modifications – Adaptations and improvements made to a home to accommodate a patient's needs based on medical conditions in order to increase independence and prevent institutionalization.

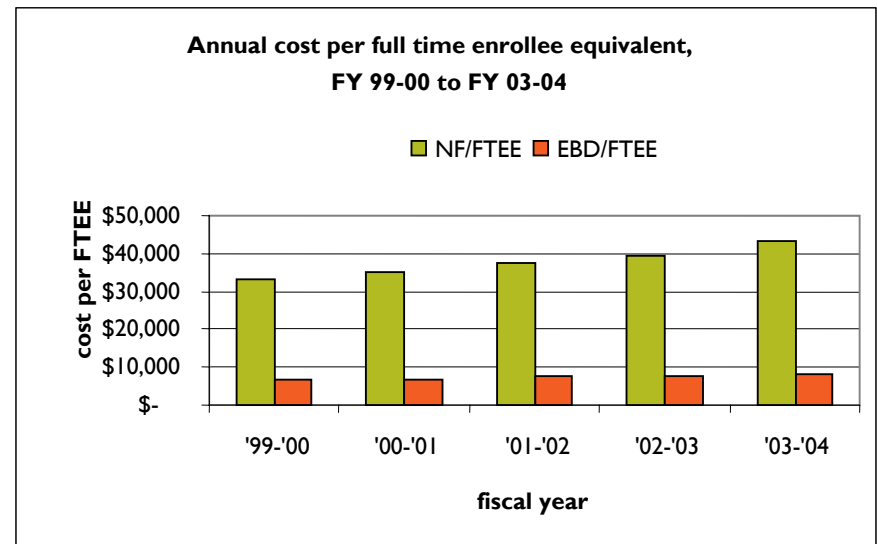
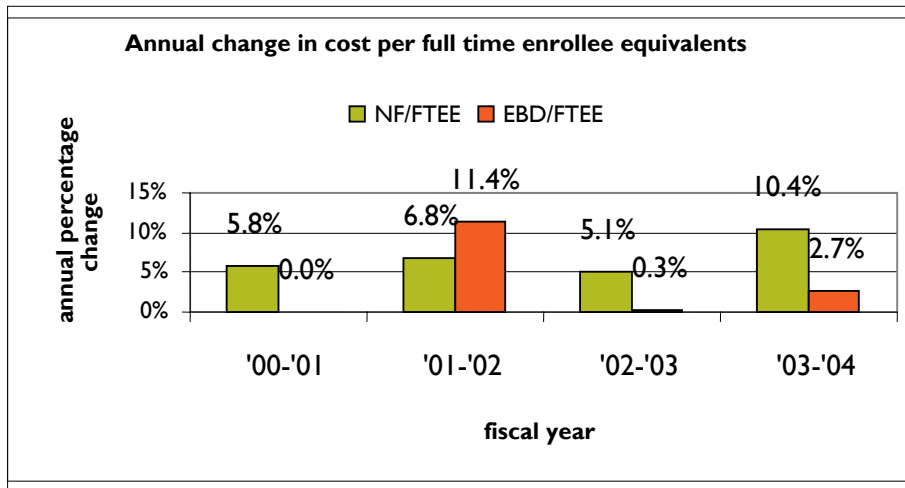
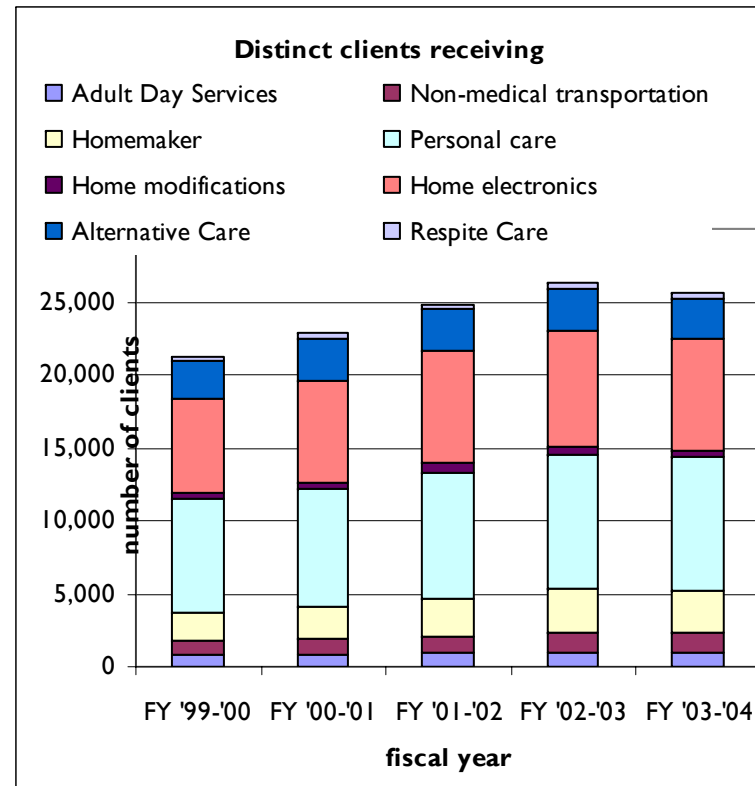
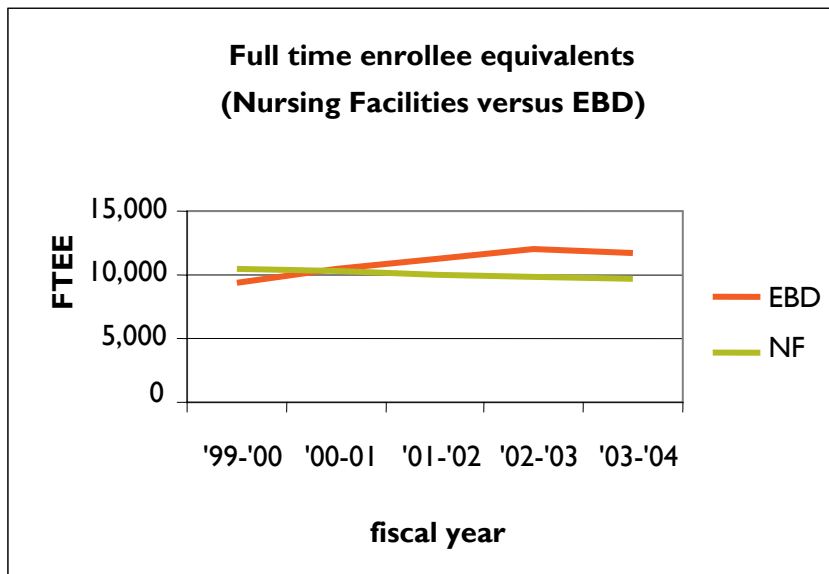
Homemaker – A service to provide assistance with general household activities such as routine cleaning, meal preparation, dishwashing, laundry, shopping, and others.

Non-medical transportation – Transportation which enables clients to gain personal physical access to non-medical community services and resources, as required by the care plan to prevent institutionalization.

Personal Care – Personal care services include physical care such as bathing, grooming, hygiene, and assistance with ambulation.

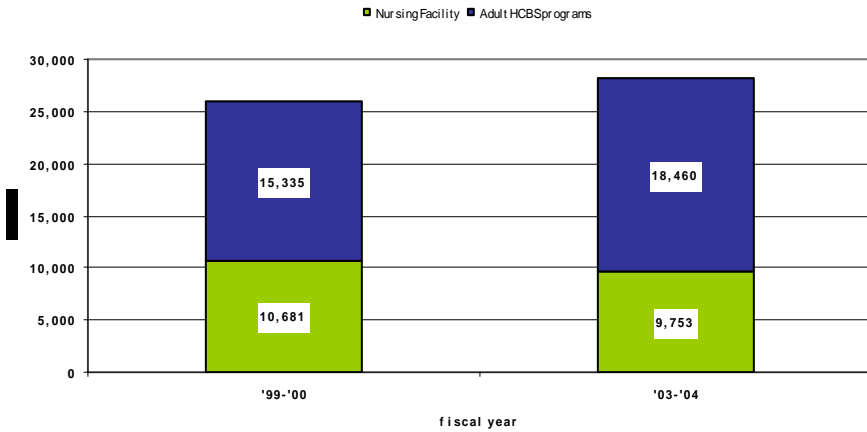
Respite Care – Services provided to an eligible client on a short-term basis because of the absence or need for relief of the primary caregiver.

Source: HCBS-EBD 372 reports

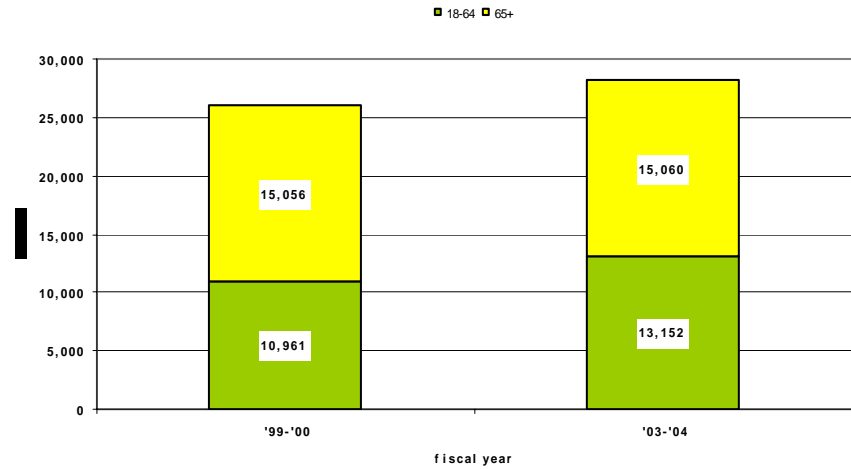


Source: HCBS-EBD 372 reports

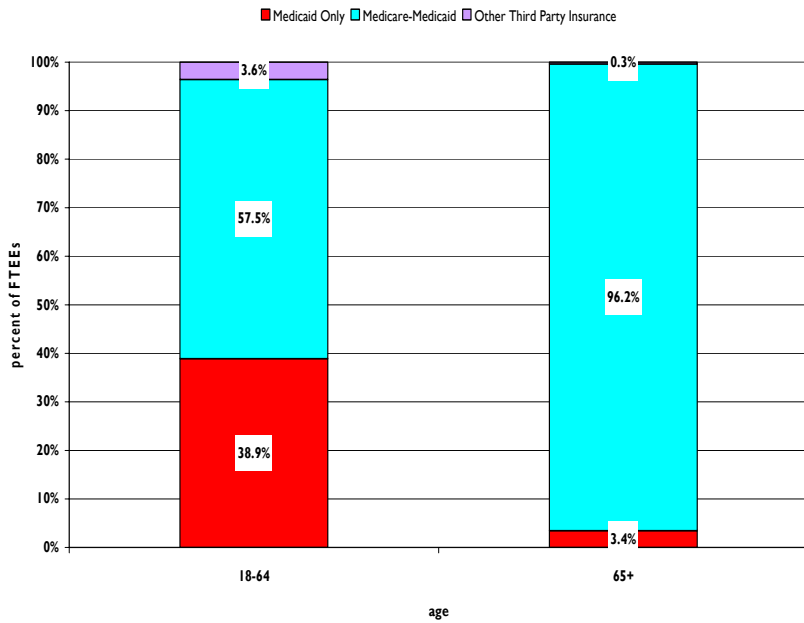
LTC adult full time enrollee equivalents in nursing facilities and adult HCBS programs, FY '99-'00 and FY '03-'04



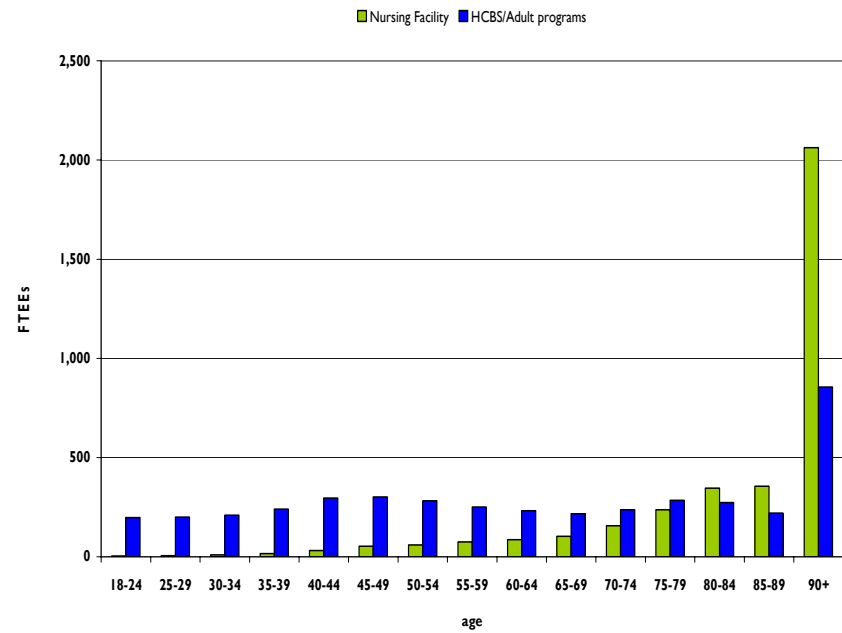
Elderly and non-elderly LTC full time enrollee equivalents, FY '99-'00 and FY '03-'04



Insurance status of adult LTC full time enrollee equivalents by age, FY '03-'04



Nursing facility and all HCBS full time enrollee equivalents by age group, FY '03-'04



Source: HCPF, MOelig files

APPENDIX E – SENATE BILL 05-173

NOTE: This bill has been prepared for the signature of the appropriate legislative officers and the Governor. To determine whether the Governor has signed the bill or taken other action on it, please consult the legislative status sheet, the legislative history, or the Session Laws.

An Act

SENATE BILL 05-173

BY SENATOR(S) Owen, Fitz-Gerald, Groff, Hanna, Kester, May R., Sandoval, Shaffer, Tapia, Taylor, Tochtrop, Williams, and Windels; also REPRESENTATIVE(S) Hall, Borodkin, Boyd, Green, Hoppe, Riesberg, and Todd.

CONCERNING LONG-TERM CARE SERVICES UNDER THE "COLORADO MEDICAL ASSISTANCE ACT".

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Part 4 of article 4 of title 26, Colorado Revised Statutes, is amended BY THE ADDITION OF THE FOLLOWING NEW SECTIONS to read:

26-4-425. Legislative declaration - advisory committee - long-term care - report - repeal. (1) **Legislative declaration.** (a) THE GENERAL ASSEMBLY HEREBY FINDS THAT:

(I) IT IS CONCERNED THAT THE COMMUNITY LONG-TERM CARE SYSTEM IS NOT PREPARED FOR THE ENSUING SERVICE DEMAND THAT WILL BE EXPERIENCED AS A RESULT OF THE EXPLOSION OF "BABY BOOMERS" THAT WILL NEED SERVICES IN THE NEAR FUTURE;

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

(II) THE COMMUNITY LONG-TERM CARE SYSTEM IS ANTIQUATED, OUTDATED, AND UNABLE TO RESPOND EFFICIENTLY AND EFFECTIVELY TO ACCOMMODATE A RANGE OF SERVICES NECESSARY TO ADDRESS THE NEEDS OF THIS GROWING POPULATION;

(III) THE STATE NEEDS TO PROVIDE EFFECTIVE AND EFFICIENT DELIVERY SYSTEMS DESIGNED TO PROVIDE BETTER ACCESS, CONSUMER CHOICE, ECONOMY, AND CONGRUENCE OF A QUALITY OF LIFE IN THE LEAST RESTRICTIVE SETTING TO MEDICAID RECIPIENTS NOW AND IN THE FUTURE; AND

(IV) THE STATE HAS AN URGENT NEED TO CREATE A COMMUNITY LONG-TERM CARE SYSTEM PREPARED TO ADDRESS THE NEEDS OF CLIENTS, PROVIDE THE MAXIMUM SERVICE DELIVERY AND MAKE THE BEST USE OF AVAILABLE PUBLIC FUNDS.

(b) THE GENERAL ASSEMBLY, THEREFORE, DECLARES THAT IT IS IN THE STATE'S BEST INTERESTS TO CREATE AN ADVISORY COMMITTEE TO EXPLORE AND RECOMMEND TO THE STATE DEPARTMENT PUBLIC POLICY THAT WILL ENABLE THE STATE'S MEDICAID PROGRAM TO ACT STRATEGICALLY AS A CLIENT ADVOCATE AND BE AN EFFICIENT AND EFFECTIVE PURCHASER OF SERVICES AND SERVICE DELIVERY.

(2) **Advisory committee.** CONTINGENT ON THE CONDITION SPECIFIED IN SUBSECTION (6) OF THIS SECTION, THE STATE DEPARTMENT SHALL CONVENE AN ADVISORY COMMITTEE NO LATER THAN AUGUST 15, 2005, TO ASSIST IN THE CREATION OF A COMMUNITY LONG-TERM CARE DELIVERY SYSTEM THAT WILL PROVIDE AN OPPORTUNITY FOR EXCELLENCE IN MANAGEMENT AND THAT FOSTERS A CONTINUUM OF COMMUNITY LONG-TERM CARE SERVICES AND SERVICE DELIVERY. THE STATE DEPARTMENT SHALL HIRE AN INDEPENDENT FACILITATOR TO ASSIST IN THE WORK OF THE ADVISORY COMMITTEE. THE ADVISORY COMMITTEE SHALL CONSIST OF TWENTY-TWO MEMBERS, AS FOLLOWS:

(a) THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT, OR THE EXECUTIVE DIRECTOR'S DESIGNEE;

(b) THE EXECUTIVE DIRECTOR OF THE STATE DEPARTMENT, OR THE EXECUTIVE DIRECTOR'S DESIGNEE;

(c) THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HUMAN

SERVICES, OR THE STATE DIRECTOR ON AGING SERVICES WITHIN THE DEPARTMENT OF HUMAN SERVICES;

(d) THE COLORADO STATE LONG-TERM CARE OMBUDSMAN OR THE OMBUDSMAN'S DESIGNEE;

(e) THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT SHALL APPOINT ONE MEMBER WHO IS A LICENSED PHYSICIAN, ONE MEMBER WHO IS A REGISTERED NURSE, AND ONE MEMBER WHO IS A LICENSED PSYCHIATRIST, ALL OF WHOM ARE FAMILIAR WITH THE NEEDS OF CLIENTS IN LONG-TERM CARE SETTINGS;

(f) ON OR BEFORE AUGUST 1, 2005, THE PRESIDENT OF THE SENATE SHALL APPOINT:

(I) THREE MEMBERS WHO ARE REPRESENTATIVES OF PROVIDERS OF COMMUNITY LONG-TERM CARE SERVICES:

(A) ONE OF WHOM IS A REPRESENTATIVE OF HOME- AND COMMUNITY-BASED SERVICES HOME CARE PROVIDERS AND ONE OF WHOM IS A CERTIFIED HOME HEALTH CARE PROVIDER, BOTH OF WHOM SHALL BE APPOINTED FROM A RECOMMENDATION OF AN ASSOCIATION REPRESENTING HOME CARE AGENCIES; AND

(B) ONE OF WHOM IS A REPRESENTATIVE OF ADULT DAY PROGRAMS.

(II) TWO MEMBERS WHO ARE REPRESENTATIVES OF ELDERLY AND DISABLED LONG-TERM CARE CONSUMERS FAMILIAR WITH THE NEEDS OF CLIENTS IN LONG-TERM CARE SETTINGS;

(III) ONE MEMBER WHO IS A REPRESENTATIVE OF THE HOME- AND COMMUNITY-BASED SERVICES PROVIDER COMMUNITY WITH EXPERIENCE IN MULTI-SERVICE COORDINATION;

(IV) ONE MEMBER WHO IS A REPRESENTATIVE OF THE PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY; AND

(V) ONE MEMBER WHO IS A SOCIAL WORKER WITH A MASTER'S DEGREE IN SOCIAL WORK.

(VI) OF THE ADVISORY COMMITTEE MEMBERS APPOINTED BY THE

PRESIDENT OF THE SENATE PURSUANT TO THIS PARAGRAPH (f), ONE MEMBER SHALL BE FROM A RURAL AREA OF COLORADO.

(g) ON OR BEFORE AUGUST 1, 2005, THE SPEAKER OF THE HOUSE OF REPRESENTATIVES SHALL APPOINT:

(I) ONE MEMBER WHO IS A REPRESENTATIVE OF THE AFFORDABLE HOUSING COMMUNITY;

(II) ONE MEMBER WHO IS A REPRESENTATIVE OF THE SINGLE ENTRY POINT SYSTEM;

(III) ONE MEMBER WHO IS A PHARMACIST WITH EXPERIENCE WITH CLIENTS IN LONG-TERM CARE SETTINGS;

(IV) TWO MEMBERS WHO ARE NURSING HOME ADMINISTRATORS LICENSED IN THE STATE OF COLORADO, ONE OF WHOM IS A REPRESENTATIVE OF A NONPROFIT NURSING HOME WHO SHALL BE APPOINTED FROM A RECOMMENDATION OF AN ASSOCIATION REPRESENTING NONPROFIT NURSING HOMES AND ONE OF WHOM IS A REPRESENTATIVE OF A FOR-PROFIT NURSING HOME WHO SHALL BE APPOINTED FROM A RECOMMENDATION OF AN ASSOCIATION REPRESENTING FOR-PROFIT NURSING HOMES;

(V) ONE MEMBER WHO IS AN EXECUTIVE DIRECTOR OF AN ASSISTED LIVING RESIDENCE IN COLORADO; AND

(VI) ONE MEMBER WHO IS A PRIMARY CARE PROVIDER FROM A FEDERALLY QUALIFIED HEALTH CENTER AND WHO HAS SIGNIFICANT EXPERIENCE SERVING PERSONS WITH DISABILITIES.

(VII) OF THE ADVISORY COMMITTEE MEMBERS APPOINTED BY THE SPEAKER OF THE HOUSE OF REPRESENTATIVES PURSUANT TO THIS PARAGRAPH (g), ONE MEMBER SHALL BE FROM A RURAL AREA OF COLORADO.

(3) THE ADVISORY COMMITTEE SHALL IDENTIFY PROGRAMS AND PROGRAM MODIFICATIONS THAT FURTHER THE INTENT OF THE LEGISLATIVE DECLARATION AND WILL:

(a) CREATE INCREASED FLEXIBILITY FOR CLIENTS AND SERVICE DELIVERY ALONG THE FULL CONTINUUM OF COMMUNITY LONG-TERM CARE, INCLUDING BUT NOT LIMITED TO: ADULT DAY PROGRAMS; INDEPENDENT

LIVING; ALTERNATE CARE FACILITIES; HOME CARE; ASSISTED LIVING RESIDENCES, CONGREGATE HOUSING, SUBSIDIZED HOUSING, AND SKILLED NURSING FACILITIES;

(b) EXPLORE A SHIFT FROM CERTIFIED PROVIDERS AND PROPERTIES TO ELIGIBLE CLIENTS AND SERVICES ALONG THE CONTINUUM;

(c) ALLOW CONSUMER CHOICE IN THE LEAST RESTRICTIVE ENVIRONMENT;

(d) BE RESEARCH-DRIVEN, CLIENT-FOCUSED, AND ENSURE MEDICAID FUNDS ARE UTILIZED IN THE MOST COST-EFFECTIVE MANNER POSSIBLE;

(e) PROVIDE GREATER OPPORTUNITIES ON THE PART OF CLIENTS TO DIRECT THE CARE AND SUPPORT THEY RECEIVE;

(f) PROVIDE INCENTIVES FOR SKILLED NURSING FACILITIES TO REDUCE THE NUMBER OF MEDICAID-CERTIFIED NURSING HOME BEDS IN PURSUIT OF ALTERNATE MODELS OF CARE;

(g) CREATE AN INTEGRATED CONTINUUM OF LONG-TERM CARE BENEFITS AND SERVICES, INCLUDING BUT NOT LIMITED TO AN INTEGRATED MODEL FOR REIMBURSEMENT FOR COMMUNITY- AND FACILITY-BASED, LONG-TERM CARE SETTINGS;

(h) EXPLORE OPTIONS AND MODELS FOR INTEGRATING ACUTE CARE AND LONG-TERM CARE INCLUDING BUT NOT LIMITED TO INTEGRATED FINANCING AND SERVICES;

(i) DEVELOP CRITERIA FOR THE STATE DEPARTMENT TO USE IN EVALUATING AND APPROVING COORDINATED CARE PILOT PROGRAM PROPOSALS PURSUANT TO SECTION 26-4-426;

(j) FACILITATE ACCOUNTABILITY BETWEEN THE STATE DEPARTMENT AND PARTICIPATING PROVIDERS IN ORDER FOR PROVIDERS TO BE EFFICIENT, HIGH-QUALITY PERFORMERS, DEDICATED TO IMPROVED CLIENT AND PROGRAM OUTCOMES.

(4) THE ADVISORY COMMITTEE SHALL MAKE RECOMMENDATIONS TO THE STATE DEPARTMENT ON OR BEFORE JULY 1, 2006, ON PROGRAMS OR PROGRAM MODIFICATIONS THAT WILL EFFECTUATE THE CREATION OF A

COORDINATED CONTINUUM OF LONG-TERM CARE SERVICES AND DELIVERY SYSTEMS, IMPROVED STRUCTURE AND QUALITY OF PROVIDER OPERATIONS AND PROCEDURES, AND ENHANCED QUALITY OF LIFE FOR PROGRAM PARTICIPANTS. PRIOR TO THE ADVISORY COMMITTEE SUBMITTING THE COMMITTEE'S RECOMMENDATIONS, THE ADVISORY COMMITTEE SHALL PRESENT THE COMMITTEE'S PROGRESS TO THE JOINT BUDGET COMMITTEE OF THE GENERAL ASSEMBLY IN DECEMBER 2005 AND APRIL 2006. ON OR BEFORE AUGUST 1, 2006, THE STATE DEPARTMENT SHALL FORWARD THE ADVISORY COMMITTEE'S RECOMMENDATIONS TO THE GOVERNOR'S OFFICE, THE JOINT BUDGET COMMITTEE OF THE GENERAL ASSEMBLY, AND THE HEALTH AND HUMAN SERVICES COMMITTEES OF THE SENATE AND THE HOUSE OF REPRESENTATIVES. THE RECOMMENDATIONS SHALL INCLUDE ANY LEGISLATION OR RULE CHANGES NECESSARY TO IMPLEMENT PROGRAMS AND PROGRAM MODIFICATIONS THAT WILL ENHANCE THE CURRENT CONTINUUM OF COMMUNITY LONG-TERM CARE SERVICES AND SERVICE DELIVERY SYSTEMS. ON OR BEFORE NOVEMBER 1, 2006, THE STATE DEPARTMENT SHALL REPORT TO THE JOINT BUDGET COMMITTEE OF THE GENERAL ASSEMBLY THE DEPARTMENT'S PROGRESS IN IMPLEMENTING THE RECOMMENDATIONS OF THE ADVISORY COMMITTEE.

(5) THE STATE DEPARTMENT MAY ACCEPT GIFTS, GRANTS, OR DONATIONS TO FACILITATE THE WORK OF THE ADVISORY COMMITTEE AND TO FACILITATE THE STATE'S PARTICIPATION IN PROPOSED OR EMERGING SERVICE DELIVERY MODELS OR RESEARCH. ANY MONEYS RECEIVED AS GIFTS, GRANTS, OR DONATIONS BY THE STATE DEPARTMENT SHALL BE DEPOSITED INTO THE STATE DEPARTMENT'S CASH FUND ESTABLISHED IN SECTION 25.5-1-109, C.R.S.

(6) (a) IF THE STATE DEPARTMENT RECEIVES SUFFICIENT GIFTS, GRANTS, OR DONATIONS, THE STATE DEPARTMENT SHALL CONVENE THE ADVISORY COMMITTEE AND HIRE THE INDEPENDENT FACILITATOR, AS REQUIRED UNDER SUBSECTION (2) OF THIS SECTION.

(b) TO AVOID ANY CONFLICT OF INTEREST, NEITHER THE INDEPENDENT FACILITATOR NOR THE ADVISORY COMMITTEE MEMBERS SHALL BE GIVEN INFORMATION BY THE STATE DEPARTMENT REGARDING THE SOURCE OF THE GIFTS, GRANTS, AND DONATIONS.

(7) MEMBERS OF THE ADVISORY COMMITTEE SHALL RECEIVE NO COMPENSATION BUT SHALL BE REIMBURSED FOR THEIR ACTUAL AND NECESSARY EXPENSES. ANY ACTUAL OR NECESSARY EXPENSES INCURRED BY

THE MEMBERS OF THE ADVISORY COMMITTEE SHALL BE PAID FOR THROUGH THE GIFTS, GRANTS, OR DONATIONS RECEIVED PURSUANT TO SUBSECTION (6) OF THIS SECTION.

(8) FOR PURPOSES OF THIS SECTION, "COMMUNITY LONG-TERM CARE SERVICES" INCLUDES, BUT IS NOT LIMITED TO: ADULT DAY PROGRAMS; INDEPENDENT LIVING; ALTERNATE CARE FACILITIES; HOME CARE; ASSISTED LIVING RESIDENCES; CONGREGATE HOUSING; SUBSIDIZED HOUSING; AND SKILLED NURSING FACILITIES.

(9) THIS SECTION IS REPEALED, EFFECTIVE JULY 1, 2007.

26-4-426. Community long-term care - coordinated care pilot program - federal authorization - rules - repeal. (1) NOTWITHSTANDING SECTION 26-4-113 (1.5) (b), THE STATE DEPARTMENT SHALL ACCEPT AND MAY APPROVE PROPOSALS FOR A THREE-YEAR COORDINATED CARE PILOT PROGRAM FOR COMMUNITY LONG-TERM CARE SERVICES, REFERRED TO IN THIS SECTION AS THE "PILOT PROGRAM". THE PILOT PROGRAM SHALL INCLUDE AT LEAST TWO RURAL COMMUNITIES, THREE URBAN COMMUNITIES, AND SPECIFIC POPULATIONS DESIGNATED BY THE STATE DEPARTMENT.

(2) ORGANIZATIONS MAY DEVELOP PROPOSALS FOR THE PILOT PROGRAM AND SUBMIT THE PROPOSALS TO THE STATE DEPARTMENT FOR APPROVAL. THE STATE DEPARTMENT SHALL OVERSEE ANY APPROVED PILOT PROGRAM. THE APPROVED PILOT PROGRAM SHALL INCLUDE, BUT NEED NOT BE LIMITED TO THE FOLLOWING COMPONENTS:

(a) VOLUNTARY RECIPIENT ENROLLMENT AND PARTICIPATION IN THE PILOT PROGRAM;

(b) VOLUNTARY PROVIDER PARTICIPATION IN THE COORDINATED CARE PILOT;

(c) PROVIDER NETWORK ADEQUACY;

(d) CONTRACTING WITH ORGANIZATIONS CAPABLE OF COORDINATING CARE FOR MEDICAID PATIENTS USING A MODEL THAT DEMONSTRATES COST SAVINGS, INCLUDING BUT NOT LIMITED TO, THE COORDINATION OF SERVICES AND MAINTENANCE OF AN ADEQUATE NETWORK OF PROVIDERS FOR COVERED SERVICES;

(e) AN EVALUATION OF THE PILOT PROGRAM'S OUTCOMES, INCLUDING BUT NOT LIMITED TO PROGRAM COSTS, THE BENEFITS TO THE RECIPIENT AND THE STATE, AND ANY NET FISCAL SAVINGS.

(3) NOTWITHSTANDING ANY PROVISION OF THIS ARTICLE TO THE CONTRARY, THE STATE DEPARTMENT SHALL HAVE FLEXIBILITY IN DETERMINING THE REIMBURSEMENT FOR ACUTE CARE PROVIDERS, LONG-TERM CARE COMMUNITY PROVIDERS, AND CLASS I NURSING FACILITIES WHEN IT IS NECESSARY TO SERVE A PILOT PROGRAM PARTICIPANT IN A MORE MEDICALLY APPROPRIATE AND COST-EFFECTIVE SETTING.

(4) THE STATE BOARD SHALL PROMULGATE ANY RULES NECESSARY FOR THE IMPLEMENTATION OF THIS SECTION.

(5) IT IS THE GENERAL ASSEMBLY'S INTENT THAT COORDINATING THE CARE OF MEDICAID PATIENTS UNDER THE PILOT PROGRAM WILL BE COST-EFFECTIVE FOR THE STATE'S MEDICAID PROGRAM. THE STATE DEPARTMENT, THEREFORE, IS AUTHORIZED TO USE SAVINGS IN THE MEDICAL SERVICES PREMIUMS APPROPRIATIONS TO FUND THE PILOT PROGRAM AUTHORIZED IN THIS SECTION.

(6) THE STATE DEPARTMENT SHALL SEEK ANY NECESSARY FEDERAL AUTHORIZATION FOR THE IMPLEMENTATION OF THIS SECTION AND CONTRACT WITH AN OUTSIDE ENTITY FOR SUCH PURPOSES, CONTINGENT ON THE RECEIPT OF SUFFICIENT GIFTS, GRANTS, OR DONATIONS.

(7) THIS SECTION IS REPEALED, EFFECTIVE JULY 1, 2010.

SECTION 2. Safety clause. The general assembly hereby finds,

determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Joan Fitz-Gerald
PRESIDENT OF
THE SENATE

Andrew Romanoff
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Karen Goldman
SECRETARY OF
THE SENATE

Marilyn Eddins
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

APPROVED _____

Bill Owens
GOVERNOR OF THE STATE OF COLORADO