



COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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

August 2012

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

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

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

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

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

Sincerely,

A handwritten signature in blue ink, appearing to read "Suzanne Brennan", is written over a faint, stylized graphic of a plant or tree.

Suzanne Brennan
Medicaid Director

sb/jrb

LONG-TERM SERVICES AND SUPPORTS STRATEGIC PLANNING REPORT



**Colorado Department of Health Care Policy
and Financing**

July 2012



Consultants in Healthcare and Housing Innovation

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

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

1. **Medicaid Entry and Eligibility:** This initiative will include a complete review of the single entry point function and system (SEP, CCB, ARCH) and an evaluation and possible restructuring of the process for Medicaid eligibility and determination of service need. It was also decided that the issue of presumptive eligibility would be explored by the LTCAC through this Subcommittee. Given the challenges around entry into the Medicaid system, it would be premature to suggest implementing presumptive eligibility without first fixing those changes, particularly those that focus on the length of time it takes to be deemed eligible. This Subcommittee will initially focus on presumptive eligibility best practices from other states and their applicability to the Colorado system.
2. **Waiver Modernization:** Colorado's home and community-based waiver programs (11) need a complete review and possible consolidation. This will include a process to determine which waivers might be consolidated, a review of the regulatory structure governing each of the waivers, an integration of waivers focused on seniors with waivers focused on persons with disabilities, and standardization of reimbursement rates and assessments.
3. **Care Coordination:** This initiative will review the care coordination process with a focus on training for care coordinators, case load, independence of care coordinators, flexibility of care planning and care coordination in transitional situations. The care

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

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

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

1. **Quality Assurance:** The integration of DHS and HCPF provides a unique opportunity to review the quality assurance processes and create a consolidated, person-centered, outcome-based quality assurance system. There appear to be significant opportunities for efficiencies by a consolidation of these systems.
2. **Mapping and Streamlining the Continuum of Care:** The integration of DHS and HCPF provides an opportunity to create a more coordinated continuum of care, provides opportunities to focus on prevention rather than intervention and presents opportunities to more creatively use the funding streams of each organization to support seniors and persons with disabilities. The LTCAC will be asked to contribute to the work of this group as well.

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

Next Steps

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

1. **Staff and LTCAC Buy-In:** Neither staff nor the LTCAC has had a chance to review this report and its recommendations. There should be a process where staff and the LTCAC can buy-into these recommendations and perhaps suggest “minor” changes.
2. **Teams:** Teams that include staff and relevant stakeholders (LTCAC and others) need to be created for each initiative. There should be one staff member and one stakeholder designated as the co-leaders to be responsible for ensuring that the process moves forward in a timely manner and that the work of the Team is disseminated to relevant stakeholders to achieve buy-in throughout the process.

3. **Work Plans and Timelines:** Each Team needs to initially create both a work plan and timeline. There should be clear deliverables within clearly stated time frames.
4. **Resources:** As is evident from the report, these initiatives will require resource allocations both in terms of staff and outside consultants. Teams need to clearly define those resources and get buy-in from management that the resources will be provided.

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

Introduction

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

The following were the recommendations from that report:

Recommendation #1 – Restructure the management team in the Long Term Benefits Division and provide that team with the resources necessary to turn the Division into a high-functioning, motivated team.

Recommendation #2: Evaluate the current staff and provide them with the necessary tools, leadership, training and support that allow them to perform at a high level and be visionary in their work.

Recommendation #3: Prior to the process of consolidation of the waivers, begin a thorough review of the waivers and make structural, operational, financial and quality improvements.

Recommendation #4: Create accountability mechanisms within the Division to ensure that each of the waivers has checks and balances to prevent both manipulation and fraud.

Recommendation #5: As the availability of data is crucial for decision-making within the Division, begin the process for aligning the data systems with the needs of staff for relevant data. For at least the next 12 months, ensure that the Division has priority for any data needs (changes, fixes, etc.) within the Department.

Recommendation #6: As stakeholders are crucial to the success of many of HCPF's initiatives, create a process that acknowledges their role, successfully manages their input, gains their trust and ensures that they enjoy a collaborative relationship with the Division and the Department.

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

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

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

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

Planning

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

DHS's mission is to design and deliver quality human services that improve the safety and independence of the people of Colorado. The Department is committed to the improvement of individual and family outcomes, cross-system integration, and community partnerships.

DHS's vision is to promote safety, health, well-being and independence for all Coloradans through leadership, innovation, and accountability to human services programs throughout Colorado.

HCPF's mission is to improve access to cost-effective, quality health care services for Coloradans.

HCPF's vision for Colorado balances the three primary goals of increasing access to health care, improving health outcomes and containing health care costs.

While the mission and vision for the two organizations are similar, there are important differences with DHS's mission and vision being more focused on those concepts that are so important to the disability community – person-centered care, partnerships, choice and

independence. This difference may be a factor as the two organizations began efforts to merge. One comment from the planning process for the LTCAC highlights that difference:

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

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

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

Process Mapping

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

Medicaid

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

Single Entry Points (SEPs)

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

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

CCBs

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

Care Management

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

Service Utilization

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

Data

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

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

State Unit on Aging (SUA)

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

Waivers

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

Reimbursement

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

General Comments

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

Federal Issues

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

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

As part of the process, staff selected five high-level strategic initiatives to focus on (see below). It was felt that it would be challenging to take on more than five major issues. While a number of the comments fit within these five issues, there were a number of other issues that were also deemed important. In order of importance², these are:

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

² Priority was determined by staff voting.

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

High-Level Strategic Initiatives

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

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

At the consolidated staff meeting (HCPF and DHS) on March 6th, there were concerns that these five initiatives did not fairly represent the thinking of staff from DHS, as the February meeting did not include many of the line staff from DHS. In an effort to better understand the concerns

of DHS staff, the agenda was changed to include time for DHS staff to talk through what they considered crucial areas for change. The following areas were highlighted by DHS staff:

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

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

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

1. Single Entry Point(s)

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

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

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

Challenges and issues:

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

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

The Challenge:

Colorado has at least three “single” points into the system. In each of these systems, there are case management functions and, while the three entry points are meant to focus on differing

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

Next Steps:

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

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

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

Step #3: Based on the information provided in steps one and two, management needs to determine the importance of and the process for a complete system change. Is this an incremental, “small steps” process where changes to the system occur over a long period of

time so as to avoid destabilizing provider networks (SEPs, CCBs, and ARCHs), or are there another mechanisms that provide positive changes on a broad scale, while strengthening provider networks and services to consumers at the same time?

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

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

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

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

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

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

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

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

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

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

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

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

Challenges and Issues:

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

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

Staff determined that the new tool needs to be:

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

Staff highlighted the following steps in this process:

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

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

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

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

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

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

Step #7: Train staff.

Step #8: Roll out new system.

Step #9: Conduct ongoing quality assessments.

Staff identified the following “users” who would need to be involved in the process: providers, clients (populations/age groups/educators for children’s groups), advocacy organizations, program specialists, and internal IT staff. Staff suggested that the following resources would be needed: an all-inclusive budget allocation, ability to do data testing, better understanding of

how rate structures would work, team training, time from the communications department, engagement of vendors and clarifications around rules, legislation and definitions.

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

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

3. Data Systems

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

The following are systems currently in use throughout the State:

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

Challenges and Issues:

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

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

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

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

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

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

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

4. Waiver Modernization

With 11 home and community-based waivers, there seems to be universal agreement within HCPF that the number of waivers needs to be reduced through a process of consolidation. It has become increasingly difficult for staff to manage and report on the waivers. Most of the waivers have overlapping services that make for reasonable consolidation. While the process of waiver modernization makes fiscal, operational, management and oversight sense, the process of waiver modernization may be challenging requiring extensive stakeholder involvement and support and also legislative changes. Some of the waivers are "broken" having inconsistencies, some have the structural potential for fraud and/or conflict of interest, others lack

accountability and, for many, the regulations are out of date. It may be difficult to roll out CCT and the ACC without first addressing many of the challenges presented by the waivers.

Challenges and Issues:

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

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

Staff chose the following objectives for this initiative:

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

4. Create new waiver applications and state plan amendments

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

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

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

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

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

5. Quality Assurance

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

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

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

Challenges and Issues

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

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

The Challenges:

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

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

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

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

Staff suggested the following objectives from this process:

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

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

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

Next Steps:

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

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

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

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

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

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

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

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

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

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

Staff identified the following barriers to this work:

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

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

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

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

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

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

Next Steps

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

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

Long Term Care Advisory Committee

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

1. **Medicaid (Entry Point and Eligibility):** There were challenges to many of the aspects of entry into and eligibility for Medicaid beginning with the bifurcation of the SEP/County processes. The LTCAC suggested mapping the entire process to better understand where challenges exist, and then dividing the work into those areas that could be immediately remedied versus those areas that would take time, collaboration with multiple entities and perhaps some regulatory changes. Timing, appeals, role of SEPs and CCBs, common applications and processes, complexities of the system, assessment tools, differing understanding of eligibility, presumptive eligibility, reapplication and redetermination were among a host of issues to be addressed. This initiative has a substantial number of sub-issues and could easily be divided among several subcommittees, each focused on a different challenge. Some of the specific comments were:
 - a. The process to apply for Medicaid is bifurcated – the county does the financial assessment and the SEP/CCB does the functional. These groups don't communicate well with each other.
 - b. The time for an appeal is too short.
 - c. While the time for process is supposed to be 45 days, some cases take up to 9 months and, while one entity process their paperwork in a timely manner, the other entity may not.
 - d. The application process (done by parents) needs to be filled out as if the child is doing the application – that isn't realistic.
 - e. Eligibility should be consistent, but local capacity is not.

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

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

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

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

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

community planning, should be contracted by the state to entities with responsibility for reasonably sized and manageable geographic areas.

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

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

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

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

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

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

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

- Blending of funding streams

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

Conclusions

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

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

Challenges

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

Colorado Choice Transitions - Money Follows the Person

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

Appendices

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

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

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

MEMORANDUM

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

FROM: David Nolan, Chi Partners

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

DATE: March 17, 2012

LTCAC Members Present:

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

Ex Officio Members Present:

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

Guests and Staff Present:

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

Creating a Relationship of Trust – How We Work Together

Charter

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

Guiding Principles

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

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

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

March 6th Meeting – Summary and Goal

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

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

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

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

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

1. **Housing:** Reports highlighted the need for affordable, accessible housing for persons with all types of disabilities and the need to expand alternative housing options through demonstrations. The ability to move people from nursing homes to the community through the MFP program is dependent on the availability of affordable, accessible housing throughout the State. Currently, demand outweighs need in most areas.
2. **Single entry points and case management:** The role of single entry points and case management agencies was a consistent theme. Reducing case load, clarifying roles, strengthening case management and streamlining access to LTC services and supports were all themes in this category.
3. **Expansion of services:** Reports highlighted the need to look at the array of services and expand that array as funding permits with the hope that services received in the community would match services provided in institutions and thus prevent unnecessary institutionalization.
4. **Communication:** While Colorado delivers an impressive array of HCBS services, many in the community are either not aware of these services or confused about issues like eligibility. Additionally, communication between and among the many community-based organizations, agencies, providers and state departments could benefit from a comprehensive communications strategy.
5. **Eligibility:** The challenges posed by the process for financial eligibility is a consistent theme from the reports with exploration of presumptive eligibility for transition from acute care to LTC being one solution.
6. **Reimbursement:** Reports suggested that the methodologies used for rate-setting be examined to maximize the use of scarce federal and state resources and to achieve equity in reimbursement.

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

Process

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

High-Level Strategic Initiatives

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

- **Medicaid:** There were challenges to many of the aspects of entry into and eligibility for Medicaid beginning with the bifurcation of the SEP/County processes. The LTCAC suggested mapping the entire process to better understand where challenges exist, and then dividing the work into those areas that could be immediately remedied versus those areas that would take time, collaboration with multiple entities and perhaps some regulatory changes. Timing, appeals, role of SEPs and CCBs, common applications and processes, complexities of the system, assessment tools, differing understanding of eligibility, presumptive eligibility, reapplication and redetermination were among a host of issues to be addressed. This initiative has a substantial number of sub-issues and could easily be divided among several subcommittees, each focused on a different challenge. Some of the specific comments were:
 - The process to apply for Medicaid is bifurcated – the county does the financial assessment and the SEP/CCB does the functional. These groups don't communicate well with each other.
 - The time for an appeal is too short.
 - While the time for process is supposed to be 45 days, some cases take up to 9 months and, while one entity process their paperwork in a timely manner, the other entity may not.
 - The application process (done by parents) needs to be filled out as if the child is doing the application – that isn't realistic.
 - Eligibility should be consistent, but local capacity is not.
 - Map the system and that process should demonstrate where there are complexities and easy fixes.
 - When the Medicaid application goes into the County, there should be an automatic way to tell the SEP that they received the application.
 - Need to insure that Medicaid rules (such as the Medicaid Buy-In program) and waivers (such as HCBS) do not pose disincentives for employment.

- Department should seek to create a "Medicaid 101" standardized training for all who work in the system. The training should discuss the variety of services and supports from State Plan to specific waivers.
 - When Medicaid application is submitted to the County, notification should be given to County so they can schedule assessment visit. Sometimes it takes weeks for this communication to occur. Then once it is received by SEP, it takes another 10 working days for appointment.
 - Duplicative qualifying oversight (60 day reviews/annual reviews) by different agencies once a person is already qualified for long-term support.
- **Waiver Modernization:** The number of waivers, the complexity of the waiver system, waiver regulations that were deemed outdated, and long waiting lists to get on waivers (particularly DD waivers) were all issues for the LTCAC. As there will be a process for waiver modernization beginning soon, it would be important to articulate a process by which a subcommittee of the LTCAC would have input into the modernization process. Some of the specific comments were:
 - There are four waivers for children each with differing level of care requirements. The children's waivers need to be modernized.
 - Need for waiver programs to be more consistent among populations.
 - The DD waivers are too complicated and have long waiting lists pushing some people to go on the EBD waivers. Some would rather just have EBD and not DD.
 - It is perceived that the waivers are a disincentive to employment.
 - Strategic Plan should include a commitment to keep rules, policies and procedures updated and easily accessible.
 - **Care Coordination:** There were many issues targeted around care coordination including case load, care coordinator training, independence of care coordinators from service provision, multiple entry points to the system, multiple care coordinators, flexibility of care planning, and lack of care coordination in transitional situations for children. Some of the specific comments were:
 - Suggest a holistic approach to care coordination. Instead of looking at the **disability or the frailty, consider the whole person – a more comprehensive approach.**
 - Case managers are overburdened.
 - Service planning, service coordination, provider selection, plan monitoring, "trouble shooting" of plan implementation, development of local providers and community planning, should be contracted by the state to entities with responsibility for reasonably sized and manageable geographic areas.
 - Consideration should be given to needs and conditions of urban, rural and frontier communities.

- Governance and financial direction of case management agencies should be independent from agencies responsible for eligibility determination and/or service providers. Consideration of the needs and conditions of rural and frontier areas would be required.
- **Presumptive Eligibility:** While this is covered under the strategic initiative for Medicaid, it was high on the list of strategic initiatives. It was suggested that legislation had been passed that would allow this to happen in Colorado and that the next step(s) might be to look at “lessons learned” from other states. Some of the specific comments were:
 - Presumptive eligibility – a number of states have created presumptive eligibility and had good success with it. CO should examine the lessons from those states to better understand the issue. Apparently, the legislation is in place to allow this. This would also depend on the ability to fast-track eligibility.
- **Data Systems:** The availability of good data for decision-making and the efficiency of data systems that were integrated (talked to each other) and, as such, created cost efficiencies for care coordinators and the Department(s) was deemed an important issue by the LTCAC. Once again, this is an area where the Department is interested and planning for change and might welcome the feedback from the LTCAC. Some of the specific comments were:
 - State’s data systems are simply out of date and not adequate.
 - There should be a single form, a single set of documents that is universal throughout the State that works for all the funding streams within and outside of the Department(s).
 - Staff has applied for a federal grant that would upgrade many of the data systems. LTCAC wanted to know how they would be involved in providing feedback on systems changes.
 - Information needs to flow seamlessly between clients and caregivers.
- **Consumer Direction:** Current issues with self-direction and CDASS, as well as expansion of self-direction programs were flagged as issues for exploration.

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

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

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

Next Steps in the LTCAC Strategic Planning Process

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

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

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

Quick Fixes

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

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

Appendix B: LTCAC Strategic Planning - Email Comments from Stakeholders

MEMORANDUM

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

FROM: David Nolan, Chi Partners

RE: LTCAC Strategic Planning
Email Comments from Stakeholders

DATE: March 17, 2012

The Issues

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

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

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

people -- people in different parts of the state seem to get different things in same situations.

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

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

- The child transition cliff – when children age out of the program with little transition from one set of systems and services to another. Schools aren't savvy about helping with this.
- There are four waivers for children, each with differing level of care requirements. The children's waivers need to be modernized.
- There should be some acknowledgement of parental wisdom and value.
- Ideally, I'd like for us to develop a system that is based on abundance instead of scarcity. Parents shouldn't feel like they have to fight and be angry ALL the TIME, just to get the needs met for their child and family. It is an unhealthy way to live - we can do better. No service should be "place specific". Services should be provided wherever the person is - home, school, community, on-the-job.
- Parents want things simple. They want it based on the actual need of their child - not an interpretation, and they want to be a part of the solution, a part of the team--bring parents and people with disabilities in first, not as an afterthought. We can help.
- EPSDT - how do we protect the extraordinary benefits if this program moves to DHS? Confusion amongst parents, providers when children move into that 18-21 year old range about EPSDT and the differences in what is covered there versus state plan adult Medicaid and what is covered under the waivers.
- **Medicaid application and process:**
 - As there are 64 counties in CO, the process, timing and response rate for these counties differs markedly. Shouldn't all of this be standardized? In the same vein, Nonprofit Organizations (NPOs) vary in their capacity and knowledge of the larger system and resources.
 - Shouldn't there be a "navigator's manual" to help both Providers and stakeholders navigate the application process and, more generally, the Medicaid system?
 - Difficulty navigating the system gives rise to paid navigators. The system shouldn't be so difficult that you have to pay someone to help you navigate that system.
 - Need to get Medicaid benefits suspended for persons in jail or state psych hospitals who are placed for over 30 days rather than terminated as per law.
 - Provide redetermination date and indicate type of Medicaid: LTC, Medicare Savings, SSI, Family, etc.
 - The complexity of having to fill out virtually duplicate paperwork for waivers through SEP and then fill out more through County to actually access the Medicaid, this after applying for SSI. Medicaid should be all in one office with ONE FORM.
 - Medicaid beneficiaries who are eligible for Home Health benefits need to have their personal care (assistance with eating, personal hygiene, etc.) needs

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

- **Waivers and waiver modernization/consolidation:**

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

- **SEPs:**

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

- **Data Systems and Information Needs:**

- Commitment to improvements in use of technology and electronic databases for increasing efficiency and providing quality data reporting. MMIS, BUS, ACS, CBMS ... would one new system be more efficient?
- Changes to the BUS – 1) A place for a Release of Information, so we would know by looking at the system whom we could share information with. Typically, that information is kept in the client file and not easily accessible. 2) Add a place for a disaster plan – who to contact, special accommodations, etc. 3) Go green. Add required forms to BUS so that signatures can be done electronically and do away with paper files.
- **Quality:**
 - Can the strategic plan include priorities for new commitments to quality oversight, outcome monitoring and ongoing technical assistance throughout the Medicaid system?
- **Assessment Tool:**
 - Current system is based on diagnosis, should be based on functional need.
 - Focus on engagement, not the disability.
- **Home Health:**
 - Ensure long-term program sustainability through strategic cost containment.
 - Cost containment efforts should favor reasonable utilization management over new provider rate cuts.
 - Cost containment will benefit from seeking new service delivery model efficiencies, including being open to additional Nurse Practice Act waivers in cases where appropriately trained and supervised non-RN staff can safely perform certain tasks that generally require an RN today (e.g., taking vital signs, performing feeding tube feedings, applying pressure stockings).
 - Provide clarification on the issue of relative personal care providers performing homemaking services.
 - HCPF should issue new interpretative guidance to all impacted constituents including acknowledgement of conflicting rules and conflicting guidance provided by HCPF, DPHE, and SEPs in the past.
 - New interpretative guidance needs to address: Specifically what is/isn't allowed under HCBS? Specifically what is/isn't allowed under IHSS? Specifically what is/isn't allowed under CDASS?
 - Need to ensure that HCPF, DPHE, SEPs, and HCAs are all on the same page.
 - Medicaid beneficiaries who are eligible for Home Health benefits need to have their personal care (assistance with eating, personal hygiene, etc.) needs

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

- **Reimbursement:**

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

- **Homeless:**

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

- **Transitions:**

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

- **Developmental Disabilities:**

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

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

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

- Clear standards so that providers are held accountable for individual person-centered outcomes such as better quality of life; client control over services and supports; protection of rights; competitive employment options in addition to quality assessment and performance measures focused on acute and chronic care
 - Cost-effectiveness and efficiency
 - Plans for supporting people who are on waiting lists
 - Plans for ensuring transitions from public education, NHs and institutions.
 - Re-examine the chronic care model, including self-management and patient education programs, drug and behavior management strategies and appraisals, as well as physician and medical practitioner training in best practices for treating patients with DD and chronic co-morbid conditions.
- **Autism:**
 - The CO LTSS Transformation Council needs to specifically include representation of people on the autism spectrum to be a voice against discrimination of Medicaid benefits for people with an autism diagnostic label. I recommend the representation be through the Autism Society of Colorado personnel who are the most cognizant of the access and care coordination problems for this vulnerable population.
 - The Senior Management staff recommended to be on the CO LTSS Transformational Council in this document should be true decision-makers for their Departments. Since a short timeline is needed, the CO LTSS Transformational Council cannot be plagued by organizational “bottlenecks” for decision-making.
 - A recent statistic on chronic diseases recognizes some 44 percent of Americans experience at least one chronic condition. Many (two-thirds over age 64) have multiple or co-morbid conditions. The LTSS population is Colorado’s most expensive population in terms of health care. Although, in America, we have pretty good systems in place for acute conditions, we are poorly situated to manage long-term illnesses or chronic DD conditions. One overt reason is our lack of attention to and lack of training for primary care and medical home resources to manage and coordinate care, particularly in DD. Jumping from doctor to doctor in specialty care as well as, (as pointed out below), Colorado’s conflicting definitions and confusing lack of coordination and barriers to access, adds to our rising health care costs.
 - Recommend the full report and appendix of the 10-year Strategic Plan for Autism in Colorado, adopted by the Governor and General Assembly in 2010, as mandatory reading for the CO LTSS Transformation Council. This recommendation should not be in statute, but belongs in the recommended list of documentation to study by the Council provided in the below recommendations.

- Recommend a review of the Core Values from the Division for Developmental Disabilities by the CO LTSS for potential recommendation by the Council for adoption by HCPF for the benefit of all the LTC beneficiaries. Again, this recommendation is not necessarily for inclusion in the process statute, but it is important and I want to include it in my list of recommendations for consideration.
- Recommend the CO LTSS Transformation Council study consideration of a potential “small” respite benefit for people with DD on the wait list for services. Researchers at the University of Pennsylvania discovered an 8 percent drop in the odds of hospitalization for every \$1,000 states spent on respite services in the previous 60 days.
- Create the CO LTSS Transformation Council to review recent audits, studies, proposals, and other contemporary policy discussions to frame a longer term plan for system re-design. The LTSS Transformation Council will identify common themes and recommend priorities and goals for system transformation. The Council will report to the Joint Budget Committee in November, 2012. The Transformation Council will develop plans to integrate the Division for Developmental Disabilities, the State Unit on Aging, and the Children’s Habilitation Residential Program in the CO Department of Healthcare Policy and Financing. The LTSS Transformation Council will begin the process to recommend to the Legislature and the Executive branch changes required to ensure responsiveness, flexibility, accountability, and individualized services for all eligible persons.
- The Children with Autism Waiver (CAW): The legislature passed the bill in 2000 with 90 out of 100 votes, but vetoed by the Governor. The statute was passed and signed into law in 2004, but the first child was not served until mid-year 2007. The delay of implementation was simply that HCPF didn’t want to implement it. When it was finally implemented, it was poorly managed.
- Health care practitioners are not familiar with resources for persons with disabilities.
- Rural communities have fewer support systems, fewer providers, and often must provide a multitude of services out of a single site. The strategic plan should set some goals for increasing providers in rural areas; particularly transportation providers and Home Modification providers.
- One issue we have in northern Colorado is that Larimer County is forcing Medicaid LTC (home) patients to choose either them or hospice. They believe hospice is a duplication of services even though their services are unskilled and ours are entirely skilled. It puts families in a terrible position and most of the time, they choose hospice because they want/need symptom management.

- There is a difference in Mission, Vision and, at the heart of the matter, Core Values between DDD and HCPF. DDD's mission statement is about the quality of life of the individuals served and HCPF's mission statement is largely about access to quality medical care. It may be true that the mission and vision of DDD remains the same under HCPF as it is under CDHS, but it is the core values of the individuals and management of HCPF that guides the priorities and choices that must be made on every level of operation and service to clients. This refers to the principles that guide internal priorities and choices as well as the relationship of HCPF to the external world.
- Mistreatment, Abuse, Neglect or Exploitation (MANE) investigations should be conducted by an unbiased entity via a state or contracted independent agency unknown to either the service provider or the consumer.
- HCPF has refused to participate in the Coordinated System of Payment for Early Intervention statute. Every other funding resource is in compliance, especially DDD, except for HCPF. HCPF has not been willing to discuss their lack of compliance with this 2007 statute.
- There needs to be ombudsperson services available for all Medicaid beneficiaries.
- The Department's strategic plan should address when / where the local level will be prioritized in reform efforts and where regional or statewide management must be used. It seems that the ACC effort tries to draw this balance but perhaps the strategic plan can state that reform will continue to include both local-level management of services and supports as well as regional / statewide management of utilization and costs.
- Will the strategic plan set a standard for leadership among HCPF staff? Can the goals be clear enough, concrete enough that everyone in the Department knows how to work toward those goals?
- Decrease potential for fraud.
- Address whether community-based care can and should provide 24/7 care.
- Address the tough question of paying families to provide care.
- Is it time to re-examine the supports and services needed by the brain-injured population AND to do targeting resource development?
- Some organizations are so focused on protecting their turf that they fail to see how this hurts the clients that they serve.

- Each effort to receive input from stakeholders should include the "big picture" framework for the particular item / project / change. In particular, the "map" of all the current change efforts / reforms would be helpful. The map should show how each particular effort links to the big picture; i.e. CCT, ACCOs, Dual Eligibles, etc.
- Aren't there "best practices" that we can gather from across the country as to how these LTSS challenges have been met in other states?
- Why is there no focus on wellness? If you help me in small ways now (early), perhaps I won't need more expensive help later on.
- How do we incentivize doing the "right thing" and continually making the "process" better?
- Need to establish community mental health centers as patient-centered homes and have that status with the RCCOs.
- Need to figure out what needs to be different in the CO Choice Transitions grant program to successfully transition persons with a serious and persistent mental illness (SPMI), where there has been a problem in transition efforts for people with SPMI in other states, with resulting low rates of success.