



Olmstead: Recommendations and Policy Options for Colorado

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Lead agency: Colorado Department of Health Care Policy & Financing

"The mission of the Department of Health Care Policy & Financing is to improve access to cost-effective, quality health care services for Coloradans"

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OLMSTEAD: Recommendations and Policy Options for Colorado

EXECUTIVE SUMMARY

As part of Colorado's on-going commitment to providing the most progressive services to people with all types of disabilities as well as elders, Governor Bill Ritter, Jr. issued an Executive Order D 011 09, "Directing the Development of a Strategic Plan to Promote Community Based Alternatives for the Disabled Citizens of Colorado," on June 22, 2009. Many states have similar strategic plans, commonly known as *Olmstead* Plans, to address providing services for people with disabilities in integrated community settings. *Olmstead* refers to a Supreme Court decision issued in 1999 that recognizes that unnecessary segregation of individuals with disabilities in institutions is a form of discrimination based on disability per Title II of the *Americans with Disabilities Act*¹. The principle defendant, a woman with a developmental disability treated in a psychiatric ward, desired to be discharged from the institution where she was living into a more integrated community based setting. Her care providers agreed that, with the proper supports, she could live successfully in a community based setting. At the time, the state she was living in did not have the appropriate supportive services available, so the defendant had to remain in her institutional setting. The Supreme Court's decision gives states the ultimate responsibility of providing the reasonable accommodations needed to support individuals with disabilities who qualify for living in less restrictive settings.

Colorado has historically been a leader among states providing supportive services to people with all types of disabilities enabling them to live in the least restrictive settings possible. Currently, Colorado has an extensive infrastructure of home and community based services designed specifically for people with disabilities and the elderly to live in the least restrictive settings possible. However, there are still barriers to transitioning for some individuals who wish to and are qualified for living in less restrictive settings, and who currently live in an institution or nursing facility. The policy options and recommendations herein address those barriers.

The Long Term Care Advisory (LTC Advisory) committee, in partnership with staff at the Department of Health Care Policy and Financing worked with a core team of stakeholders including people receiving services, case management and service providers, mental health professionals, home health providers, academics, state staff and advocacy organizations to develop recommendations and policy options to further promote community based long term care (CBLTC) services. In spring, 2010 the draft was circulated statewide to additional stakeholder groups for a thirty-day public comment period. After stakeholder input was incorporated, the final recommendations and policy options document was submitted to the Governor in July, 2010 to coincide with the 20th anniversary of the *Americans with Disabilities Act*.

The *Olmstead* core team identified the following six key issues and strategies to address each:

SUSTAINABLE FINANCING - While there is a strong infrastructure of home and community based services available in Colorado, reimbursement methodologies for these service providers should be examined in order to maximize the availability of these services.

Strategy - Identify current and future potential funding sources and reimbursement methodologies.

¹ *Olmstead v. L.C.*, (98-536) 527 U.S. 581 (1999), the complete court brief can be found here: <http://www4.law.cornell.edu/supct/html/98-536.ZS.html>; Accessed May 5, 2010.

POLICY INTEGRATION - The process of developing policy recommendations related to CBLTC generates an opportunity to examine current state regulations and policies to determine if they complicate access to home and community based services. Additionally, there is an opportunity to develop policy or regulations that may enhance access to services.

Strategy - Identify areas where current policies related to long term care need to be adapted to support the *Olmstead* decision and the actions in this document. Additionally, create a policy that prompts systematic, on-going review of progress in implementing these recommendations as well as identification of any needed changes.

INCREASE HOUSING OPTIONS AVAILABLE FOR PEOPLE WITH ALL TYPES OF DISABILITIES - There is a shortage of options for integrated, supportive housing for people with disabilities and others with long term care needs. Ideal supportive housing for people with long term care needs is located in rural, suburban and urban areas; adaptable to the clients' needs throughout the lifespan; allows for client interaction in the community and is affordable. While there are some housing options in Colorado that meet these expectations, demand far outweighs capacity at this time.

Strategy - Improve access to affordable housing that is adaptable for people with physical and intellectual disabilities as well as people with severe persistent mental illness by eliminating barriers to accessing affordable housing, informing the community of existing housing options and increasing the number of affordable and accessible housing units through a number of funding strategies.

EXPAND THE CURRENT ARRAY OF SERVICES - Failure to provide an adequate array of services and adaptive technologies can contribute to the unnecessary institutionalization of people with disabilities and the elderly. There is a gap between the services available to people in institutions and those available to people in the community that can contribute to unnecessary institutionalization. Currently, cost shifting occurs between systems, such as between the developmental disability system and the mental health system, as a result of services available in one waiver, but not in others.

Strategy – After appropriate financial analysis, work toward making many of the current HCBS waiver services available to all individuals using HCBS waiver services and expand the array of services as funding permits.

STABILIZE AND GROW THE DIRECT SERVICE WORKFORCE - Direct service workers (DSWs) are people who help individuals with disabilities perform activities of daily living, such as personal hygiene, dressing, etc. Historically, there is frequent turnover in the direct service workforce and workers often need additional training. An unstable direct service workforce contributes to reduced access to services and more individuals who could otherwise live in the community may be forced to live in more restrictive settings.

Strategy - Identify barriers and opportunities to improve retention and improve recruitment of direct service workers. Identify and implement a method for training and credentialing of direct service workers.

BETTER INFORM THE COMMUNITY ABOUT THE SERVICES AVAILABLE FOR PEOPLE WITH DISABILITIES - While there are many existing options for long term care services outside of institutional settings, most people do not fully know about these options for themselves or family members which can result in reduced access to these services.

Strategy - Identify best practices to encourage informed choice for individuals in need of long term care services. Develop informational tools to disseminate to the public about available home and community based services and resources.

The policy recommendations in this document give Colorado’s state agencies the opportunity to partner with community stakeholders to build a strategy towards improving upon the existing infrastructure of services for people with disabilities. It is a priority for the State to optimize the health and functioning of all Coloradans and enabling people with disabilities and the elderly to live in the least restrictive settings possible is one way to achieve that goal.

Edited by: Lesley W. Reeder, RN, BSN
Performance Management
Medicaid & CHP+ Program Administration Office
Colorado Department of Health Care Policy & Financing

For further information, please contact Lesley Reeder at lesley.reeder@state.co.us or 303-866-5879

OLMSTEAD: Recommendations and Policy Options for Colorado

TABLE OF CONTENTS

Common Acronyms	8
Introduction	9
Who is Most Affected by These Policy Recommendations?	10
Why Develop Policy Recommendations?	10
An Overview of the <i>Olmstead</i> Decision	11
Identifying the Most Integrated Setting	13
The Stakeholder-Driven Process	13
Setting Priorities.....	14
Diagram of Prioritization of Key Issues	16
Current Environment in Home and Community Based Services	16
Brief Description of HCBS Waiver Programs	16
Systems Supporting People with Mental Illness.....	17
Systems Supporting People with Developmental Disabilities.....	18
Systems Supporting Elders.....	19
Systems Supporting Children with Special Health Care Needs.....	20
Systems Supporting Others at Risk for Institutionalization	20
State Medicaid Long Term Care Budget and Caseload	21
Current Opportunities for Transfer from Facility to Integrated Settings	23
Federal Support for Community Based Services	27
Colorado <i>Olmstead</i> Key Issues and Policy Recommendations	28
Conclusion	31
Appendices	32
Appendix A: Detailed Key Issues and Policy Recommendations	
Appendix B: Executive Order D01109, “Directing the Development of a Strategic Plan to Promote Community based Alternative of the Disabled Citizens of Colorado”	
Appendix C: Core <i>Olmstead</i> Team	
Appendix D: HCBS 1915 (c) Medicaid and CDHS Waiver Chart	

OLMSTEAD: Recommendations and Policy Options for Colorado

COMMON ACRONYMS

ADA	Americans with Disabilities Act	HUD	Housing and Urban Development
CBLTC	Community Based Long Term Care	ICF/MR	Intermediate Care Facilities for Persons with Mental Retardation
BHO	Behavioral Health Organizations	JBC	Colorado Joint Budget Committee
CCB	Community Centered Board	LTC	Long Term Care
CDHS	Colorado Department of Human Services	MHI	Mental Health Institute
CDASS	Consumer Directed Attendant Support Services	MI	Mental Illness
CES	Children’s Extensive Support	OCR	Office of Civil Rights
CHRP	Children’s Habilitation Residential Program	OLTC	Options for Long Term Care
CLASS Act	Community Living Assistance Services and Supports Act	PACE	Program for All-Inclusive Care for the Elderly
CMHC	Community Mental Health Center	PAR	Prior Authorization Request
CMHI	Colorado Mental Health Institutes	PASRR	Pre Admission Screen and Resident Review
CMHIFL	CMHI at Ft. Logan	OBHH	CDHS Office of Behavioral Health & Housing
CMHIP	CMHI at Pueblo	RC	Regional Center
CMHS	Center for Mental Health Services (federal)	RCCF	Residential Child Care Facility
CMS	Centers for Medicare and Medicaid Services	RFP	Request for Proposals
DBH	Division of Behavioral Health	SCRC	Systems Change for Real Choices grant
DCWS	Division of Child Welfare Services	SED	Serious Emotional Disturbances
DD	Developmental Disability	SEP	Single Entry Point
DDD	Division for Developmental Disabilities	SHHP	Division of Supportive Housing and Homeless Programs
DHHS	U.S. Department of Health and Human Services	SLS	Supportive Living Services
EBD	Elderly, Blind, and Disabled	SMI	Serious Mental Illness
HCBS	Home and Community based Services	SNF	Skilled Nursing Facility
HCBS-DD	Home and Community based Services for Persons with Developmental Disabilities	SPMI	Serious and Persistent Mental Illness
HCPF	Colorado Department of Health Care Policy and Financing	SSDI	Social Security Disability Insurance
		SSI	Supplemental Security Income
		TRCCF	Therapeutic Residential Child Care Facilities
		ULTC-100.2	Uniform Long Term Care Form

OLMSTEAD: Recommendations and Policy Options for Colorado

Introduction

On June 22, 1999, the United States Supreme Court found in *Olmstead v. L.C.* that unnecessary segregation of individuals with disabilities in institutions is a form of discrimination based on disability². Referring to the *Americans with Disabilities Act* (ADA)³, the *Olmstead* decision holds states accountable for providing community based care whenever appropriate, rather than placing individuals with disabilities in institutional settings. The decision reinforces the premise that, with adequate resources, many individuals with disabling conditions can successfully live in the community. The *Olmstead* decision was reinforced on June 18, 2001, when President Bush signed an Executive Order requiring states to provide community based alternatives for individuals with disabilities in compliance with the terms of the *Olmstead* decision.

In June, 2009, Colorado Governor Bill Ritter signed Executive Order D01109, “Directing the Development of a Strategic Plan to Promote Community Based Alternatives for the Disabled Citizens of Colorado.” The Executive Order directs the Long Term Care Advisory (LTC Advisory) committee, housed in the Colorado Department of Health Care Policy and Financing (HCPF), its delegates, and other relevant community stakeholders to develop long-term policy recommendations to ensure the continued development and improvement of systems designed to support people with disabilities and others at risk for living in institutional settings.

The LTC Advisory and HCPF collaborated with relevant community stakeholders and state agency representatives to create the following policy recommendations. For the purposes of this document, “institutional settings” include, but are not limited to, the Colorado Mental Health Institutes at Pueblo and Fort Logan, skilled nursing facilities (SNFs), Regional Center campus settings and Intermediate Care Facilities for the Mentally Retarded (ICF-MR). Addressing the needs of these populations, this report recommends policies and actions that will:

- Inform clients and family members, advocates, and providers about community based housing alternatives/options available for people with physical, intellectual, or mental health disabilities and the elderly.
- Address barriers to community based settings and implement recommended solutions to enable persons to live in the most integrated settings appropriate to their needs.
- Acknowledge that persons with physical and/or mental health disabilities and their families desire to make choices for themselves, have positive and rewarding relationships, maintain physical and mental well-being and independence, and live in stable and safe environments.
- Set out recommendations to guide the state of Colorado to provide reasonable modifications of policy, practice and procedure when necessary to provide services in the most integrated setting.

² *Olmstead v. L.C.*, (98-536) 527 U.S. 581 (1999)

³ Americans with Disabilities Act of 1990, 104 Stat.337, 42 U.S.C. Section 12132

Who is Most Affected by these Policy Recommendations?

All Coloradans will benefit from increased knowledge and improved access to home and community based living options. While these recommendations represent statewide initiatives on behalf of all Coloradans, the people most affected will be people eligible for Medicaid long term care services. Thus, the data and programs described in this document are largely Medicaid and other state agency data and programs, specifically the Home and Community Based Services (HCBS) waiver program.

HCBS waivers, also known as 1915 (c) waivers, refer to the array of Medicaid-funded long-term health and non-medical supportive services that are provided in a non-institutional setting (e.g., outside of a nursing facility, IFC-MR or other institutional setting). Such services may include assistance with activities of daily living—bathing or showering, dressing, getting in or out of bed or a chair, walking, using the toilet, and eating. Services can also include assistance with preparing meals, managing money, shopping for groceries or personal items, and performing housework. Individuals may require home and community based services on a regular or occasional basis, for a few months, or for a lifetime⁴. The people receiving HCBS services are determined to be at an institutional level of care and the medical and non-medical services provided by HCBS allow clients to reside in a community based setting, thereby enabling greater freedom of movement and supported self-sufficiency.

Colorado has eleven different HCBS waiver programs that serve a variety of vulnerable populations including; children with disabilities, children with autism, children and adults with developmental disabilities, individuals with acquired brain injury, adults with mental illness and adults who are elderly, blind or disabled. HCPF contracts with CDHS to administer four HCBS waivers that serve children and adults with developmental disabilities and children in foster care with special needs. HCPF has ultimate oversight of each of the eleven waivers and administers seven waivers within the agency, the rest being administered by the CDHS Division for Developmental Disabilities and the Division of Child Welfare Services. Clients access HCBS waiver services predominantly via three types of entry point agencies, Community Centered Boards (CCB), Single Entry Point (SEP) agencies and County Departments of Human or Social Services. In a few cases, private case management agencies serve children with disabilities, historically because neither the SEP or the CCB in that geographic region was able.

Why Develop Policy Recommendations?

While currently Colorado provides a broad infrastructure of services that enable people to live in the least restrictive and most integrative settings possible, barriers to accessing CBLTC still exist.

The *Olmstead* decision implies that, as appropriate, individuals should have the freedom to choose the living situation that optimizes their independence and contributes to the best quality of life possible. Yet many people have had that right compromised; the safety-net system does not always adequately support elders or individuals with physical, intellectual or mental health conditions. While the committee focused on a few key issues thought to best enable more people to choose supportive community based

⁴ Source: Access to Medicaid Home and Community based Long-Term Care Services Department of Health Care Policy and Financing Performance Audit, January 2009

housing and supportive services, other factors can obstruct an individual's choice to live in a community based setting. These factors can include but are not limited to:

- Lack of coordinated physical and mental health care for individuals receiving home and community based services;
- A fragmented system of home and community based services, making it difficult to navigate for consumers and their families;
- Insufficient funding and flexibility of funding for available services;
- Lack of coordinated and comprehensive transition planning to maximize success for individuals who wish to transition into community based settings from an institutional setting; and
- Use of the corrections system for people who may be more appropriately served in a supportive, community based environment.

While Colorado has been a leader among states in developing infrastructure to serve individuals with disabilities in community based settings, the current HCBS system can be difficult to navigate for clients and families and opportunities for improvement to better serve current clients as well as plan for future clients exist. Issues related to access to services, availability of appropriate services, waiting lists, and program administration need to be addressed in order to best serve current and future clients.

This report is divided into several sections. The first section summarizes the *Olmstead* Supreme Court decision and discussion related to understanding the term, "most integrated setting..." This is followed by a description of the process the team used to develop and prioritize policy recommendations to promote CBLTC. The report then describes current systems in place to support individuals receiving long term care services in a home or community based setting. Analysis of data tells the story of who is served and costs of service. Finally, the document recommends a prioritized list of actions and timelines for each of the six key issues to promote a continued commitment to serving individuals with long term care needs in the least restrictive settings possible.

An Overview of the *Olmstead* Decision

The Supreme Court's 1999 *Olmstead* decision directs states to move individuals with disabilities in institutions to more integrated settings when the individuals are qualified and desire such transitions. The Court held that states are required to provide community based services for people with disabilities who would otherwise be entitled to institutional services when: (a) treatment professionals reasonably determine that such placement is appropriate; (b) the affected person does not oppose such treatment; and (c) the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of other individuals with disabilities⁵.

⁵ From: <http://www.hhs.gov/ocr/civilrights/understanding/disability/serviceolmstead/> accessed May 1, 2010.

The federal Department of Health and Human Services (HHS), Office of Civil Rights (OCR) and the Centers for Medicare and Medicaid Services (CMS) offer on-going guidance and resources to states to enable compliance with the *Olmstead* decision. CMS has offered several grant funded demonstration programs, like the Money Follows the Person demonstration, aimed to increase the number of qualified individuals who choose to transfer from institutional settings into community based settings as well as to re-balance funding away from institutional settings and into less restrictive home and community based settings. Nationally, the OCR is responsible for investigating complaints under Title II of the ADA and overseeing *Olmstead* enforcement.⁶ The OCR shares emerging themes regarding complaints with state policy specialists, decision-makers and stakeholders so that recurring concerns can be adequately and promptly addressed. It is noteworthy that in a number of states, there is litigation tied to issues related to compliance with the *Olmstead* decision.

In its progress report titled, “Still Waiting; the Unfulfilled Promise of *Olmstead*,” the Bazelon Center for Mental Health Law suggests that states’ compliance with the *Olmstead* decision will be helped by states continuing to re-balance funds toward supportive home and community based services, collecting and acting upon data regarding the number of individuals who qualify and desire to move into a less restrictive setting and improving the quality and availability of supportive services to reduce the incidence of individuals returning to institutional settings⁷.

The Supreme Court decision points out that the ADA does not suggest that individuals should be moved from institutional settings if unable to handle or benefit from community settings, or if the integrated setting is inappropriate to their needs. Rather, states are obliged to “make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.”⁸ Fundamental alteration of a program takes into account three factors:

1. The cost of providing services to the individual in the most integrated setting appropriate;
2. The resources available to the state; and
3. The ability of the state to meet the needs of others with disabilities⁹.

In the end, the onus is on states to provide access to an appropriate range of supportive services to enable qualified individuals to live in the least restrictive settings possible. For individuals eligible for Medicaid long term care services, this is largely accomplished via 1915(c) waivers, also known as Home and Community Based Services (HCBS) waivers. The waiver allows a Medicaid agency to pay for non-medical supportive services to enable individuals to live in the least restrictive setting possible. The waiver services are in addition to and complement the array of medical services that are available to Medicaid waiver participants through the Medicaid State Plan. While Colorado has long been a leader in delivering services via 1915(c) waivers to individuals at risk for

⁶ See, 28 C.F.R. Section 35.130(b)(7)(1998) , *General prohibitions against discrimination*.

⁷ June, 2009. “Still Waiting, the Unfulfilled Promise of *Olmstead*.” The Bazelon Center for Mental Health Law

⁸ See, 28 C.F.R. Section 35.190(b)(1998), *General prohibitions against discrimination*.

⁹ *Ibid*.

institutionalization, Colorado is using this opportunity to develop policy recommendations to improve upon existing infrastructure to ensure on-going compliance with the *Olmstead* decision.

Identifying the Most Integrated Setting

The US Department of Justice (DOJ) developed regulations and guidance for states to comply with the *Olmstead* decision and Title II of the Americans with Disabilities Act. The DOJ defines the “most integrated setting” to mean: “...a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible...”¹⁰ This regulation addresses what has long been clear to individuals with disabilities, advocates and family members: housing that segregates residents from the society at large is not the most integrated setting.

Many times, housing for people with disabilities or mental illness is developed as a congregate model. Congregate living is a common housing model where people with physical, intellectual, or mental health disabilities are grouped together. In these settings, people with intellectual disabilities are often grouped together for planned activities, leaving few opportunities for individual choice or interaction with non-disabled people. During care planning the individual receiving services should be encouraged to make choices about their living situation. However, oftentimes the client may not be given a full array of choices. As a result, individuals may not know they could have other options allowing for greater integration into society.

Sometimes, even well-intentioned service and care management providers may assume individuals are not able to make their own decisions, are not able to participate in community life or live with the consequences of poor decisions. Inhibiting individuals’ decision-making can hinder their overall ability to recover previous higher functioning status or can keep them from functioning at the peak of their abilities. Community based living options should serve to encourage individuals to live at their highest potential.

The Stakeholder – Driven Process

Colorado has responded to the *Olmstead* decision and the Governor’s Executive Order by establishing a unified set of policy recommendations to continue to support transitioning individuals to a community based service system as appropriate, as well as to inform those at risk of living in more restrictive settings of available home and community based options. The recommendations in this report are consistent with Colorado’s progressive efforts to ensure that persons with disabilities and the elderly live in the most appropriate integrated settings possible.

¹⁰ Allen, Michael (2004) Fact Sheet: Just Like Where You and I Live – Integrated Housing Options for People with Mental Illness.” From <http://www.bazelon.org/issues/housing/infosheets/integratedhousing.htm>. Accessed April 4, 2010.

Colorado initially developed recommendations aligned with the *Olmstead* decision in 2002 using a committee of state agency representatives, service providers, and advocates. The 2002 recommendations were comprehensive and addressed priority areas with great specificity and thoroughness. Although the sitting Governor did not sign it, the 2002 recommendations and process became the foundation for current recommendations in terms of both content and structure.

The Executive Order states that the Long Term Care Advisory committee (LTC Advisory) housed in HCPF, is the primary entity in charge of managing the development of policy recommendations that align with the *Olmstead* decision. The current effort began with a public forum in October 2009. Participants shared their interpretation of the *Olmstead* decision and indicated what core issues should be emphasized throughout the development process. Following the public forum, state staff formed a collaborative core team of community advocates, consumers, other state department representatives, and other interested parties which was approved by the LTC Advisory. Participants from the public forum were encouraged to join the core team and to recommend others. A list of core team members is provided in Appendix C. Several of the core team members are also members of the Long Term Care Advisory committee, thereby enabling cross-communication and better tracking of the process by the LTC Advisory.

The *Olmstead* Core Team began meeting in November, 2009, and met nearly every other week through July, 2010. Subject matter experts from across the state provided information and insight as priority issues were identified and action plans were developed.

The Core Team identified current issues and barriers and created a problem statement focused on broad issues that inhibit or prevent individuals from living in community based environments. The team's efforts focused on six key issues that would create the best opportunities for supporting disabled individuals who wish to live in community based settings. Sub-groups were formed to develop policy recommendations addressing each of the key issues.

The Long Term Care Advisory committee and the Core Team released the document to a broad range of stakeholders for review and public comment in the spring of 2010. With continued support from the agencies involved, successful implementation of these policy recommendations will be an ongoing, dynamic process with successful implementation requiring continued systematic revisions and reviews of progress.

The final report was presented to the Governor in July, 2010, to coincide with the 20th anniversary of the Americans with Disabilities Act.

Setting Priorities

It became apparent early in the process of developing these policy recommendations that the number of potential activities and policies designed to promote CBLTC services are nearly unlimited. Many believe that the ability to independently choose the most integrated and least restrictive living arrangements possible is hindered due to a general lack of knowledge of supportive services currently available and inadequate resources in terms of funding, housing options and workforce shortages. Some believe that there is a need for a change in how individuals think about LTC services for these issues to be

resolved. For instance, early in the 20th century, there was little question that an individual with disabilities would be best served in an institutional setting. In the past 30 years, a shift in this thinking is evident based on relatively recent policies like requiring public schools to mainstream children with disabilities and the increased availability of Early Intervention services for children under three years of age with disabilities. However, even today, many families automatically turn to a SNF when making decisions on behalf of an elderly family member needing extra medical or household support when there are supportive services currently available that may enable them to live in a household setting. The natural conclusion is that, while great progress has been made, there are still many steps needed to fully engender a culture of individuals and families never feeling as though a facility or institutional setting is the only option for care.

Therefore, the team was compelled to begin the process of supporting additional advances in promoting CBLTC by identifying and prioritizing six key issues. Next, the team prioritized policy recommendations and activities for each of the key issues. Key issues and the associated recommended policies and activities were prioritized based on a number of factors:

- Alignment with the Governor's Executive Order that prompts this document
- Alignment with stakeholder priorities
- Alignment with optimizing the health, functioning and self-sufficiency of Coloradans receiving CBLTC services
- Strength of the link between the key issue or policy recommendation and direct CBLTC services
- Maximizing resources; including funding, staff and infrastructure

The six key issues are as follows:

- ✓ Funding
- ✓ Integrating Principles into Current Policy
- ✓ Housing
- ✓ Appropriate Array of Services
- ✓ Direct Service Workforce
- ✓ Informing the Community

The Core Team prioritized the issues as follows: ensuring sustainable funding and integrating principles into current policies are on-going activities that are recommended to take place as other key issues are being addressed. The issues of housing and appropriate array of services were considered to be very high priority and equal in importance. Addressing the direct service workforce was next in importance followed by informing the community of the supports and services available. This is illustrated in the diagram below:

Diagram of Prioritization of Key Issues



Appendix A contains detailed policy recommendations for each of the key issues with associated estimations of resource needs and timelines.

Current Environment in Home and Community Based Services

Colorado has demonstrated national leadership in striving to serve persons with disabilities, the elderly and their families within the most integrated settings possible as evidenced by current infrastructure as well as data analyses related to trends in the number of individuals placed in home and community based settings and financial data. While the Colorado Departments of Human Services and Health Care Policy and Financing currently administer an extensive infrastructure for home and community based services, data reveals that there may be opportunities for some individuals who live in more restrictive settings to safely transition into less restrictive community environments.

Brief Description of HCBS Waiver Programs

As mentioned, Colorado currently has an extensive system of HCBS waivers enabling qualified individuals to live in an integrated and supported community setting. Appendix D has a chart that gives basic information on each of Colorado's eleven HCBS Waivers.

To receive HCBS waiver services, an individual must meet income and eligibility category criteria for regular Medicaid services and meet other eligibility criteria specific to some of the children's waivers or other disability-specific criteria. Then, the individual must meet additional criteria to receive HCBS, most importantly concerning whether the individual has needs that meet an institutional level of care. Single Entry Point (SEP) agencies that contract with HCPF determine eligibility for long term care services and they administer an assessment tool called the ULTC 100.2. This is a functional assessment tool used to determine if a client meets the appropriate level of care. The trained SEP case manager further evaluates the individual to determine which of the HCBS waivers is the best fit for their needs. There are 23 SEPs in Colorado, managed by HCPF through a process of certification and contract, covering all geographic areas within the state. For adults and children with developmental disabilities, the Community Centered Board (CCB) serves as the SEP and determines eligibility and administers the

ULTC 100.2 assessment. The County Department of Human/Social Services is responsible for completing the ULTC 100.2 assessment for children with a developmental disability and placed outside of the home, in a foster or group home care setting, for example. Each HCBS waiver has an enrollment cap and some waivers, like the waiver for Adults with Developmental Disabilities, have a continuous waiting list as the demand for the waiver exceeds the enrollment cap.

A general description of the HCBS system is incomplete without acknowledging Colorado's current wait lists for the waivers serving people with disabilities. The two adult waivers for people with developmental disabilities and the waiver for children with developmental disabilities all have waiting lists. The waiting lists are organized based on a first come, first serve basis, however people with the greatest need for services can be moved to the top of the list. Some individuals can bypass the waiting list if they qualify for another HCBS waiver that has the appropriate services. As the recommendations in this report are implemented, specifically the recommendations related to developing the direct service workforce and increasing the amount of appropriate housing for people with special needs, it is expected that the waiting lists may be reduced. Any plans for future comprehensive reforms of the HCBS system will necessarily address the need to reduce or eliminate waiting lists.

Systems Supporting People with Mental Illness¹¹

Colorado's public mental health system provides statewide services for persons of all ages with mental illness and serious emotional disorders. The system is composed of a number of interlinked components described below:

Community Mental Health Centers (CMHCs) and Clinics: Community mental health services are primarily delivered through contracts with 7 specialty clinics and 17 not-for-profit community mental health centers. The state is divided into geographic service areas, and each CMHC is responsible for providing a comprehensive array of services for the residents of its assigned area. Each specialty clinic serves a defined special population (such as members of an ethnic minority group) and may provide a narrower range of services than a CMHC. The roles and functions of both CMHCs and clinics are statutorily defined in C.R.S. 27-1-201 *et seq.*, *Purchase of Community Mental Health Services*.

Behavioral Health Organizations: There are five regional Behavioral Health Organizations (BHOs) responsible for implementing the Medicaid Mental Health Program through contracts with HCPF. The BHOs operate managed care programs serving all of Colorado's 64 counties. Each BHO manages the delivery of mental health services to Medicaid-eligible individuals in its assigned geographic service area.

Designated Facilities: Under the provisions of C.R.S. 27-65-101, *Care and Treatment of the Mentally Ill, et seq.*, involuntary mental health services are provided by over 50 public and private facilities located statewide, including all CMHCs and both Mental Health Institutes. These entities are designated and monitored by the Division of Behavioral Health. The Division of Behavioral Health is also responsible for certifying

¹¹ Accessed from: http://www.cdhs.state.co.us/dmh/system_description.htm on April 4, 2010.

and monitoring residential facilities that provide mental health services to children (e.g., Therapeutic Residential Child Care Facilities) and adults (e.g. acute treatment units).

Colorado Mental Health Institutes: Inpatient psychiatric hospitalization for Colorado citizens with serious mental illness or emotional disorders is provided in two state-operated Mental Health Institutes—Colorado Mental Health Institute at Pueblo (CMHIP) and Colorado Mental Health Institute at Fort Logan (CMHIFL). The CDHS Office of Behavioral Health and Housing (OBHH) provides policy oversight for the Institutes, which function as part of the integrated public mental health system.

Single Entry Points: The Single Entry Point (SEP) agencies provide individuals access to the HCBS-MI waiver under the oversight of HCPF. Trained case managers assess applicants, determine eligibility, develop service plans and prior authorize services, as well as provide on-going case management for people on the program. SEP case managers coordinate with the Community Mental Health Centers for the provision of mental health services.

People with serious mental illnesses are particularly vulnerable to inappropriate institutionalization due to a shortage of supportive services appropriate for management and treatment of serious mental illness in most communities. People with a diagnosed major mental illness who are eligible for Medicaid and qualify for services may obtain services through the HCBS Mental Illness (MI) waiver which is administered by HCPF and accessed via the local SEP agency.

Systems Supporting People with Developmental Disabilities

In Colorado, DHS and HCPF partner with county agencies and other community based organizations to administer programs for people with developmental disabilities. Individuals with developmental disabilities who are eligible can obtain services from any of the waivers for which they meet the eligibility criteria. There are four HCBS waivers that are specifically designed to address the needs of people with developmental disabilities: the Children’s Extensive Support waiver, the Children’s Habilitation Residential Program waiver, the Supportive Living Services waiver for adults with developmental disabilities and HCBS waiver for adults with Developmental Disabilities which provides comprehensive residential services. CBLTC supportive services for people with developmental disabilities are obtained through Community Centered Boards (CCB) or county departments of human/social services. CCBs are private non-profit organizations designated in statute as the single entry point into the long-term service and support system for persons with developmental disabilities. CCBs provide trained case managers who assess applicants, determine eligibility, develop service plans and prior authorize services, as well as provide on-going case management for people on the program. Additionally, CCBs can provide services, contract for services and coordinate with independent providers for service delivery. Each CCB has a non-overlapping geographic service region of one to ten counties.¹² The County Departments of Human/Social Services are responsible to perform case management including intake, eligibility determination, assessing needs, service plan development, arrangement for

¹² Accessed from http://www.cdhs.state.co.us/ddd/CCB_Main.htm on April 4, 2010.

services, delivery of services, monitoring, and many other functions for children placed in out-of-home care.

Individuals with developmental disabilities who are not eligible for Medicaid can also turn to CCBs for services, including state-funded programs for adults and families and early intervention services for infants and toddlers. Early Intervention Services can be purchased with State funds, Part C of the federal Individuals with Disabilities Education Act (IDEA) funds, private health insurance, the individual's family or another third-party source. Individuals may also be able to obtain supportive resources from community based organizations. In 2009, the Colorado legislature passed the Colorado Health Care Affordability Act (C.R.S. Section 25.5-4-402.3). One provision of the Act is to provide a Disabled Buy-in option for individuals who are disabled but not financially eligible for Medicaid, and do not have medical insurance from another party. This option will be available to disabled Coloradans by the summer of 2011.

Systems Supporting Elders

Older individuals are also at risk for inappropriate admission into a nursing facility and can be at risk for lengthy or indefinite stays. Many elders and their families may not realize supportive services are available that will allow them to live in their home or another community based setting.

The DHS State Unit on Aging is responsible for administering programs and services funded by the federal Older Americans Act and state Older Coloradans Act. All Coloradans over age 60 can benefit from these services, not just individuals enrolled in Medicaid. The following services are available through the Older Americans Act and Older Coloradans Act programs and obtained through Area Agencies on Aging (AAA):

Caregiver Program - Provides information, access to services, counseling, caregiver time-off, and other services.

Long Term Care Ombudsman Program - An ombudsman is a resource for long-term care residents, through whom they may obtain resolution to complaints or issues affecting their health, safety, welfare, and rights. Additionally, the ombudsman program is a resource to the community regarding long-term care information and referral.

Nutrition Program - Provides group meals in senior centers and other community rooms, home delivered meals, nutrition counseling and nutrition education.

Supportive Services - Includes transportation, personal care, homemaking, legal assistance, adult day programs, chore services, and material aid with items such as eye glasses, dentures, and medical equipment.

The State Unit on Aging also links people to other organizations that provide services to optimize the quality of life and functional independence of older Coloradans. For individuals eligible for Medicaid and HCBS services, elders can obtain supportive services through the Elderly, Blind, and Disabled HCBS (HCBS-EBD) waiver, which is accessed via the local SEP agency.

A key component to accessing appropriate services for elders is acknowledging that in the United States a nursing home is often the first and only option considered for

supportive care needs. The Nursing Facility Culture Change Accountability Board (NFCCAB) was charged with identifying areas of culture change to promote resident-centered care including substantial, lasting and replicable improvements to the quality of life of nursing facility residents. NFCCAB grants a portion of Civil Monetary Penalties (CMP) funds to entities that promote culture change in Nursing Facilities including educating individuals about available community based living options for which the individual may qualify.

In addition to the programs listed above, Colorado provides assistance to older and disabled adults through two state-only programs, Home Care Allowance and Adult Foster Care, which provide support to low-income individuals who need assistance but not at the nursing home level of care. These programs are also accessed through the SEPs, under the oversight of CDHS.

Systems Supporting Children with Special Health Care Needs

Children with special health care needs (CWSHCN) who are at risk for living in an institutional setting benefit from a wide array of services from CDHS, HCPF, CDPHE and the Department of Education. The comprehensiveness of the services available to profoundly disabled children and their caregivers have produced positive results –very few children in Colorado live in institutional settings for more than a limited amount of time. Many of these services are available to all children who qualify in Colorado, not just children receiving Medicaid benefits. Services for children include the Early Intervention program, the waiver for children with developmental disabilities and education plans designed to integrate and support CWSHCN into public schools.

Systems Supporting Others at Risk for Institutionalization

There are additional waivers not mentioned above that serve individuals with conditions that fall outside of the mental illness, developmental disabilities and elder categories. These include individuals with acquired immune deficiency syndrome and people with acquired brain injury, among others. These waivers are also accessed through the SEPs with HCPF oversight.

Please see Appendix D for a brief description of all of the 1915(c) HCBS waivers administered by HCPF and CDHS.

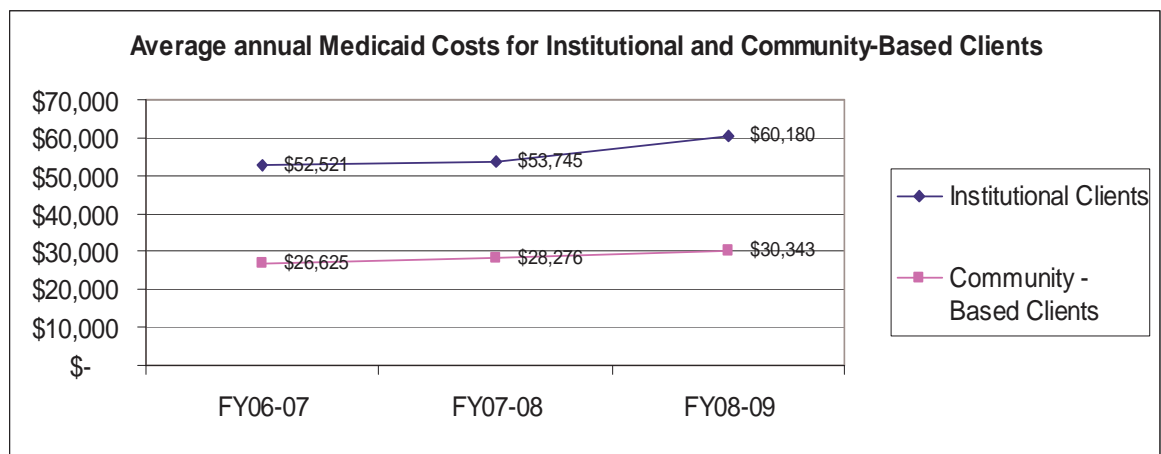
State Medicaid Long Term Care Budget and Caseload

The following analysis uses data from the Medicaid claims system to give the reader a current picture of the complete costs related to caring for clients in home and community based settings as well as the cost of care for individuals living in institutional settings. For this report, institutional settings include skilled nursing facilities (SNFs), state Mental Health Institutes and ICFs-MR, including those at state operated Regional Centers. Individuals living in HCBS waiver-funded group homes on Regional Center campuses are counted in the non-institutional population. Home and community based services includes the cost of HCBS services as well as other costs of care including home health services and medical services. Institutional costs include the cost of the institution as well as medical services and other costs associated with the care for these individuals.

Additionally, a trended analysis of the number of LTC clients living in institutional settings as well as those served in home and community based settings is presented. Both of the analyses include *all* clients served by waivers administered by HCPF, DDD and DCWS.

In 2009, the average annual cost per client on Medicaid for 12 months in a row who was living in an institutional setting was \$60,180. For the same time period, the annual cost for an average client on Medicaid for 12 months in a row who was using HCBS waiver services was \$30,343; nearly half the cost of care for an individual in an institutional setting. The costs represented include the institutional or waiver services plus other costs including but not limited to non-emergent transportation, children’s preventive medical care and treatment, home health care costs, medical supplies, doctor’s visits, hospitalizations and pharmacy charges. In the vast majority of cases, nursing facility care costs more per person than supportive care in a community based setting. It is important to remember that nursing facilities have costs related to items like building maintenance; 24 hour skilled staff and provision of basic needs, e.g. food, linens and activity and social services staff. Additionally, individuals residing in a nursing home or other facility-type setting may have greater or more extensive medical needs than an individual living in a community based setting. Figure 1 illustrates the difference described above in annual cost per client in each setting.

Figure 1



Figures 2 and 3 show how the number of clients living in an institutional setting has trended downward over the past three fiscal years while the number of clients living in community based settings has trended upward during the same time period.

Figure 2

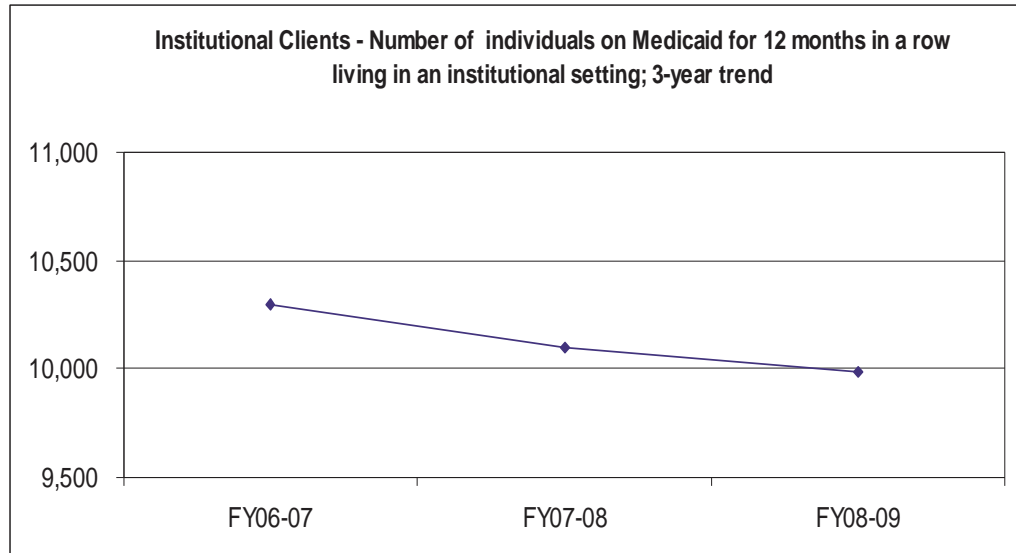
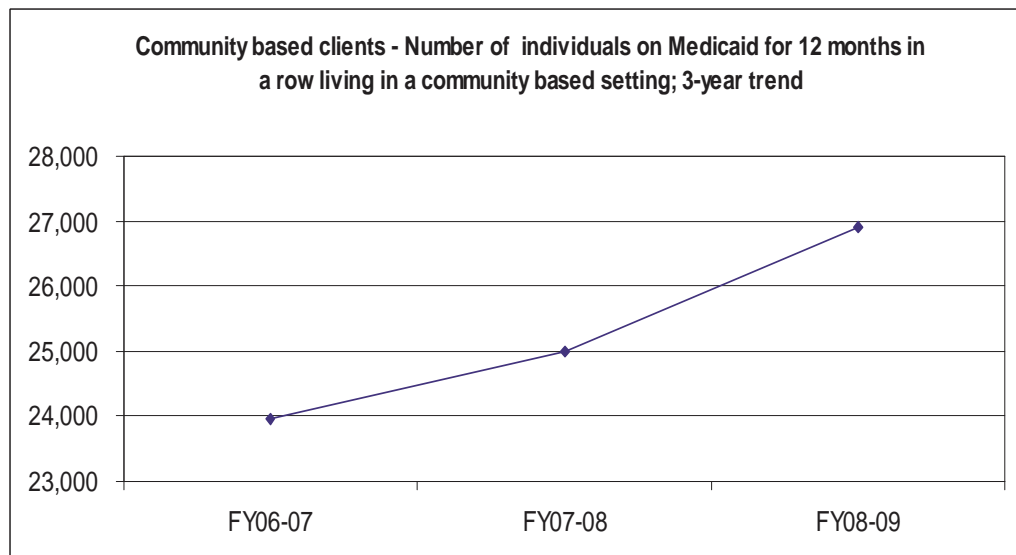


Figure 3



Overall, the number of individuals living in an institutional setting decreased by about 10% while the number of individuals living in a community setting increased by about 11% between fiscal year 06-07 and fiscal year 08-09.

Analyses such as these will have limitations that should be considered when interpreting the data. For instance, it is difficult to determine from claims data which clients have

highly acute needs as opposed to those who may not need as much care. A client with high needs may be more likely to live in a SNF thereby skewing the cost of care for clients in SNFs. Additionally; these data only pertain to Coloradans enrolled in Medicaid. There are many Coloradans with long term care needs that do not have Medicaid and they are not represented in these analyses. While the analysis will attempt to account for all costs of care and all clients in each setting, due to the complexity of the analysis, there is a possibility that some costs and/or clients will be missed. Finally, there are similar published analyses such as cost and client number data reported in the HCPF budget request, the CDHS budget request and federal reporting. It is important to note that each of these analyses use a different method for mining the databases used, therefore discrepancies in the numbers will occur.

Current Opportunities for Transfer from Institutional to Integrated Settings

Each type of institutional setting serves individuals with very different needs. In order to best identify individuals who may be interested and would qualify for discharge from their institutional setting to a CBLTC setting, it is important to recognize the unique features of each institutional setting.

Identifying opportunities for appropriate discharge from Skilled Nursing Facilities

Prior to Medicaid approval for a nursing home admission, a trained Single Entry Point (SEP) case manager will assess the individual's needs and level of care. The ULTC 100.2 is utilized to determine whether the individual meets the nursing home level of care and the options an individual has for where they are able to receive services, in a nursing home, in their own home or in an alternative care facility. If the individual chooses nursing home placement, the case manager will determine the approved length of stay based on the needs of the person. If the individual chooses HCBS, the case manager will approve the appropriate community based services, in the person's home or in an alternative care facility, depending on the individual's needs and desires. The SEP will provide on-going case management which includes referral to providers, development of a service plan and prior authorization of services. Services are monitored for quality and needs are reassessed annually or more frequently, depending on changes in condition or circumstances.

Upon admission to a nursing home, two screenings are used by trained case managers to assess the individual's needs and level of care. One screening is the Pre-admission Screening and Resident Review (PASRR). This federally-mandated screening tool is used to identify whether the individual has needs related to intellectual disability or severe and persistent mental illness (SPMI). Because severe mental health needs and needs related to supporting people with developmental disabilities require specialized services and supports that are not always available in nursing facility settings, it is important to proactively identify and appropriately screen these individuals in the nursing home admission process in order to provide appropriate services or divert them into more appropriate settings as needed. Colorado is currently revising its PASRR survey tool to more accurately identify mental health care needs and to provide a reliable baseline for follow-up to ensure individuals' needs related to SPMI or developmental disability are being met.

A second tool, the Minimum Data Set (MDS) is a federally-mandated clinical assessment used to evaluate an individual's functional status and clinical needs in order to formulate the appropriate treatment plan upon admission to a SNF. One section (section Q) in the MDS relates to discharge planning and assesses whether the individual plans or wishes to return to their home or another integrated living arrangement, as well as whether the individual has social or family support that can support them in transitioning out of the nursing facility. The section Q questions are a key component of an overall assessment of an individual's ability to qualify for transition to a less restrictive community based setting. Other elements to qualify for CBLTC include a clinician's assessment of health needs and whether reasonable accommodations can be made in a community based setting.

Both the MDS and PASRR tools provide an opportunity to identify whether an individual may be more appropriately served in an integrated community based setting. If the PASRR screen indicates special needs related to SPMI or developmental disability, it is possible that the array of services available in one or more of the HCBS waivers would be more suitable. If, in the MDS section Q, an individual indicates a plan or desire to discharge from the nursing home then an opportunity for transition is evident. Another potential indicator of an opportunity to appropriately transition an individual to a less restrictive setting is the individual's age. Individuals with SPMI who are aged 64 or younger may be especially vulnerable to inappropriate institutionalization.

Colorado PASRR data for fiscal year 08–09 shows the following¹³:

- 1,742 nursing facility residents have a major mental illness diagnosis;
- 275 nursing facility residents have a developmental disability diagnosis;
- 38 nursing facility residents are diagnosed with both a major mental illness and a developmental disability;
- Of the 2,055 individuals mentioned above, the large majority are served by Medicaid and 689 of the 2,055(33 percent) are 65 years old or younger.

Colorado MDS data for calendar year 2008 shows the following¹⁴:

- The total number of individuals assessed upon admission to a nursing facility in Colorado was 27,110; of those 21,691 (80 percent) expressed a plan or desire to return to the community;
- Upon annual assessment, the number of individuals assessed was vastly reduced to 9,459, indicating that nearly 65 percent of those originally assessed were discharged or died;
- However, of the 9,459 annual assessments conducted, 6,461 (68 percent) indicated that they plan or desire to discharge to the community.

¹³ These data represent the total number of assessments; if an individual was admitted to a nursing facility on two or more different occasions in the same year, they would appear in this count more than once. Additionally, these data are inclusive of all payment sources, not just clients covered by Medicaid.

¹⁴ Ibid.

These statistics indicate there may be a number of opportunities for a qualified individual currently living in a nursing facility to transition to an appropriate community setting.

Identifying opportunities for appropriate discharge from Regional Centers

Regional Centers serve adults (18 or older) in a number of settings, including: short- or long-term admissions to community based HCBS group homes and the ICF-MR. Regional Centers typically serve people who are a danger to themselves or others and/or need a combination of services and supports so extensive as to preclude community placement within available appropriated resources. These individuals typically do not have a community placement available and require a highly structured setting with readily available access to professional psychological, nursing or therapy services. Opportunities for transfer to community based settings for individuals admitted to a Regional Center include: the individual expressing interest in transferring, which would then trigger a process for the care team to convene and determine if the individual is qualified; the individual meeting assessment criteria upon re-assessment and/or the individual's care team initiating a decision to transfer to CBLTC.

Relatively few individuals live in the Regional Center setting as they are reserved for the most hard-to-serve people with disabilities. Typically, these individuals have a history of unsuccessful placements in community based settings and/or no provider is available to provide the necessary services for the individual. In addition, a person admitted into an ICF-MR at the Regional Center must meet special criteria specific to this type of institutional setting. Examples of an individual meeting these criteria can include:

- The person exhibits behavior that is highly dangerous to self or others if immediate, sometimes restrictive emergency intervention does not occur.
- The person demonstrates consistent and extreme aggression toward others (physical, verbal, sexual).
- The person is involved in other significant socially unacceptable behavior that violates the law or is not compatible with more community integrated living
- The person is referred as an alternative to correctional placement.

Some people admitted into a Regional Center are short term individuals who may not have an extensive history of dangerous behavior, but rather need stabilization and treatment in order to move back into the community. All residents are assessed on a periodic and regular basis to determine if they are suitable for a successful discharge.

Recently, the Grand Junction Regional Center Skilled Nursing Facility (SNF) serving 32 medically fragile individuals was closed and all but three individuals were transitioned to a Medicaid HCBS waiver living situation in the greater community. The recent closure and subsequent transition of individuals to community based settings from the Grand Junction Regional Center SNF indicates that some qualified individuals served in the other Regional Centers may be appropriately transitioned into community based settings.

Identifying opportunities for appropriate discharge from Mental Health Institutes

As of Spring, 2010 The Mental Health Institutes operate 568 inpatient beds (454 beds in Pueblo and 114 beds in Denver) to provide comprehensive inpatient psychiatric, psychological, rehabilitation and therapeutic care to indigent and Medicaid-eligible individuals with a serious mental illness and to also serve individuals referred by the courts with pending criminal charges or a criminal commitment. Of these 568 beds, 310 beds at the Colorado Mental Health Institute at Pueblo (CMHIP) provide services to individuals referred from the county jails requiring evaluation of competency to stand trial, restoration to competency, and individuals found to be not guilty by reason of insanity. These “forensic” individuals are typically discharged back to jail to stand trial, or treated at CMHIP and progressed as appropriate back to the community with appropriate community resources and case management supervision provided by CMHIP and community mental health center staff. Progression of these forensic individuals into the community requires court approval.

One way to increase appropriate discharge of individuals in an MHI to the community includes access to affordable housing and independent living resources appropriate for individuals with a history of court system involvement, i.e. forensic status. In addition, the Institute continues to work with the judicial system to drop criminal charges against individuals that are assessed to be permanently incompetent to proceed to trial in an effort to allow these individuals to transition to an appropriate community placement.

The remaining 258 beds operated by the Institutes include 158 beds allocated to the state’s community mental health centers for hospitalization of individuals with a serious mental illness who are deemed to be a danger to themselves or others and who are in need of treatment and stabilization. Many individuals who are admitted to the Institutes are short term patients who may not have an extensive history of dangerous behavior, but rather need stabilization and treatment in order to move back into the community. A significant number of admissions are dually diagnosed with both a mental illness and a substance abuse diagnosis. These individuals ability to successfully live in the community would be enhanced by an expanded array of services and housing alternatives.

In addition, the Institutes operate 40 beds for elderly individuals, 20 beds for adolescents, 20 beds for individuals with a serious mental illness and a major substance abuse disorder and 20 Therapeutic Residential Child Care Facility beds for adolescents. The Institutes work collaboratively with the community mental health centers, county departments of social services, and other referring agencies to assess the appropriateness for admission, coordinate benefits and payment sources, prepare a discharge plan for the individual and secure placement in the community once inpatient psychiatric care is no longer needed.

Opportunities for improving appropriate discharge of civilly committed individuals to the community include the development of partnerships and resource sharing agreements between community providers to place individuals with specific challenges and resource needs and the availability of resources to meet the housing and community based services needs of individuals that have been hospitalized at the MHIs. Institute and community mental health center staff members meet regularly to review individual dispositions and discharge needs and work to place individuals with challenging community resource needs.

Federal Support for Community Based Services

On March 24, 2010, President Obama signed the Health Care and Education Affordability Reconciliation Act of 2010. There are several elements in the bill that demonstrate continued federal government support for home and community based services. The highlights:

Community First Choice Option – allows states the option to incorporate home and community based services programs into their Medicaid State Plans along with the other medical Medicaid services. This would remove the limits on waiver enrollment as well as require states to offer all of the services statewide and to any Medicaid client that is eligible for a nursing home level of care. Under the 1915 (c) HCBS waivers in Colorado, there are eligibility criteria for the waivers that are in addition to the criteria for Medicaid eligibility.

Money Follows the Person Demonstration – extends a current demonstration program offered by CMS that helps fund home and community based services for individuals discharging from a facility to CBLTC.

State Balancing Incentive Payments Program – will in the future offer an increased match of federal funds to states that meet certain structural requirements creating 1) “No Wrong Door” -- single entry points for a statewide system of access points for long term services and supports, 2) conflict free case management and 3) application of core standardized assessment instruments used throughout a state to determine eligibility for long term services and supports so as to expand community based services and supports.

Training Opportunities for Direct Service Workers – directs Health and Human Services to offer grants to support training for Direct Service Workers.

Individuals with Disabilities Training – supports existing training programs and development of new training programs for health professionals in working with people with disabilities.

Demonstration Project to Address Health Professions Workforce Needs – extended to several health profession types, but specifically dictates a Demonstration project for up to six states to receive funding for developing core training competencies and certification programs for personal or home care aides.

Community Living Assistance Services and Supports Act (CLASS Act) – establishes a voluntary insurance program to pay for community based services for an individual’s future needs due to age or acquired disability or current needs related to a sustained disability. This addresses institutional bias towards nursing facilities by providing a financing mechanism that supports choice and community based living arrangements.

Expansion of Spousal Impoverishment Protections—requires states, beginning in 2004, to extend Medicaid’s spousal impoverishment protections to spouses of all Medicaid HCBS waiver recipients and state plan benefits. This will allow more people to live at home with spousal caregivers.

The elements in the health care reform bill noted above are in addition to the supportive work the federal government has done for states since the *Olmstead* decision was first issued in 1999. These on-going efforts by several federal government departments and agencies are now being coordinated by the Department of Health and Human Services (HHS) under the Community Living Initiative announced by Secretary Sebelius in May,

2010. Some highlights of on-going federal government assistance to states in support of CBLTC include:

Availability of Technical Assistance – to support states in maximizing current Medicaid rules and regulations, for on-going quality improvement planning and implementation and for implementing increasingly reliable PASRR assessments.

Advancing Access to Affordable Housing –HHS and the Department of Housing and Urban Development have partnered to increase the availability of housing vouchers for non-elderly persons with disabilities.

Aging and Disability Resource Centers (ADRCs) – In Colorado, referred to as the Adult Resources for Care and Help (ARCH), are programs to streamline access to long-term care services and supports for all individuals, not just those eligible for Medicaid. ADRCs work collaboratively with community, state and federal programs to help people with disabilities and elders access supportive services that can enable them to live in the most integrated and independent setting possible. The Agency on Aging and CMS are strategizing to expand current ADRC programs to additional communities.

SNF Discharge Planning – in October, 2010, HHS will release a new version of the MDS which will ask if nursing home residents would like more information about CBLTC options and requires the SNF to make appropriate referrals for resources for the SNF resident that indicates they would like information.

Colorado Olmstead Key Issues & Policy Recommendations

The vision for long term care in Colorado is a future where individuals with all types of disability and the elderly can access services that optimize their health and functional status. Optimal services will meet individualized needs in the least restrictive and most integrated settings possible. In most cases, this will be in home and community based settings. As documented, CDHS and HCPF have extensive experience in creating integrated service alternatives. CDHS and HCPF will use these recommendations to guide state policy to further promote home and community based care for qualified individuals with long term care needs. To this end, the six key issues that emerged from extensive stakeholder input and CDHS and HCPF review are below.

- ✓ Funding
- ✓ Integrating Recommendations into Current Policy
- ✓ Housing
- ✓ Appropriate Array of Services
- ✓ Direct Service Workforce
- ✓ Informing the Community

The Core Team determined that, while integrating the activities and policy recommendations as needed into state policies and pursuing funding are on-going activities, access to affordable housing and looking into adjusting the current array of services were the most important key issues to address. The team understood that resource concerns would also have a hand in

determining which of the recommendations can be addressed first. To that end, here is a list of the highest priority policy recommendations and their status as of Spring, 2010.

✓ Funding

- Pursue all funding opportunities that support the elements in this report, including supporting the development of the Direct Service Workforce, informing the community of CBLTC services as well as other relevant funding opportunities offered through the federal Health Care Reform legislation as well as other federal programs as they arise.
 - Current status: In April, 2010 Governor Ritter signed an Executive Order creating the Interagency Health Reform Implementation Board. This board will coordinate efforts by affected state agencies to implement elements of the federal Health Care Reform legislation. Each state Department has a breakdown of the relevant portion(s) of the legislation and will analyze for directives and funding opportunities.
- Examine reimbursement methodologies in other Colorado Medicaid services and identify ways that these methods could be applied to community based services. Also examine other reimbursement methodologies from other states to appropriately encourage capacity building.
 - Current status: this project started in January, 2010 and is housed in the HCPF Rates section. Additional resources are needed to retain a consultant to help with data gathering, modeling, researching other states' reimbursement methodologies, etc. Unknown timeframe for completion.
- Seek grant funding to support one-time-only expenses as needed to support selected activities and policy recommendations in this document.
 - Current status: task will begin as priorities are refined and funding opportunities arise.

✓ Integrating Recommendations into Current Policy

- Develop a policy by which the progress and content of this policy recommendation document is reviewed on an annual basis and changes are made as needed.
 - Current status: annual report will be given to the LTC Advisory for review on July 31, 2011 and each year thereafter.
- Review all current Code of Colorado Regulations (CCR), in particular, 2 CCR 503-1, section 16.100 and 10 CCR 2505-10, section 8.400 related to long term care services, as well as current state statutory mandates for compatibility with the *Olmstead* decision and the ADA.
 - Current status: must designate state staff time from both HCPF and CDHS; estimated timeframe is six months with added time for any rule changes needed.

✓ Housing

- Develop policies for transition out of institutions that specifically address the individual's risk for homelessness upon discharge with the understanding that the state is not obligated to provide housing but should have a part in enabling individuals to avoid homelessness upon discharge.
 - Current status: Task has been started by the Colorado Community & Interagency Council on Homelessness (CCICH); unknown timeframe.
- Improve the ability of individuals with long term care needs to have necessary identification and documentation to improve access to existing affordable housing opportunities.
 - Current status: Early work with relevant stakeholders has started; must designate staff time from both HCPF and CDHS; estimated timeframe for policy development and execution for all elements is one year.
- Pursue funding for expanded housing options in federal healthcare reform
 - Current Status: In April, 2010 Governor Ritter signed an Executive Order creating the Interagency Health Reform Implementation Board. This board will coordinate efforts by affected state agencies to implement elements of the federal Health Care Reform legislation. Each state Department has a breakdown of the relevant portion(s) of the legislation and will analyze for directives and funding opportunities.

✓ Appropriate Array of Services

- Explore and identify a mechanism to allow all HCBS clients access to all currently available services on any of the waivers as well as any future expansion of HCBS services.
 - Current status: Must designate staff time from HCPF and DHS as well as seek funding for research, facilitation of stakeholder meetings and investigation of costs associated with proposal.

✓ Direct Service Workforce

- Pursue opportunities for funding and supporting the development and recruitment of the Direct Service Workforce in Federal Health Care Reform legislation, specifically, nominating a qualified Coloradan for the new federal Personal Care Attendants Workforce Advisory Panel under the CLASS Act
 - Nomination submitted to the US Department of Health and Human Services representative June 18, 2010.
- Create a formal Direct Service Worker Taskforce within state government.

- Current status: Must determine which state agency will be the lead, designate staff time from HCPF and DHS as well as seek funding for research. Open-ended timeframe.

✓ Informing the Community

- Pursue funding for community outreach via the “Implementing the Affordable Care Act: Making it Easier for Individuals to Navigate their Health and Long-Term Care through Person-Centered Systems of Information, Counseling and Access” grant offered by the federal Department of Health and Human Services.
 - Current status: In contact with the State Unit on Aging to coordinate efforts. Proposal is due on July 30, 2010.

Conclusion

Coloradans have access to a wide array of options for community based long term care. However, we recognize that significant barriers to accessing integrated community based living options that optimize independence still exist. The policy recommendations and recommended activities found in this report illustrate a vision and strategy to build upon Colorado’s current infrastructure of services and housing options for individuals at risk for institutionalization with the goal of maximizing independence, functional status and health status. The State of Colorado looks towards a future where all individuals with long term care needs are able to make choices that best suit their wishes and needs.

Appendices

Appendix A – Detailed Key Issues and Policy Recommendations

Key Issue - Direct Service Workforce				
<i>Expectation</i>	People who choose to live in a home or community based environment require a stable, reliable direct service workforce.			
<i>Problem/Issue</i>	Direct service workers (DSWs) are people who help individuals with disabilities perform activities of daily living, such as personal hygiene, dressing, etc. Historically, there is frequent turnover in the direct service workforce and workers are often in need of better training. An unstable direct service workforce contributes to reduced access to services and more individuals who could otherwise live in the community may be forced to live in more restrictive settings.			
<i>Strategy</i>	Identify barriers and opportunities to improve retention and improve recruitment of direct service workers. Identify and implement a method for training and credentialing of direct service workers.			
<i>Measurable outcomes</i>	(1) The number of direct services workers available to individuals will increase. (2) The length of time the same direct service worker remains with an individual will increase. (3) The length of time a direct service worker remains in their field will increase. (4) There will be standards for training and credentialing of direct service workers			
POLICY RECOMMENDATIONS AND ACTION STEPS (in order of priority)		TIMEFRAME	RESPONSIBLE LEAD AGENCY/CIES	COSTS
1a. Create a formal Direct Service Worker Taskforce within state government. ACTIONS 1a1. Assign a lead agency within state government through an Executive Order through the Governor’s Office to be responsible for developing the necessary workforce called the Interagency and Stakeholder Taskforce to Develop the LTC Direct Service Workforce (DSW Taskforce), capitalizing on the above stakeholder analysis. 1a2. Use the DSW Taskforce to identify the factors that inhibit and support long-term employment of DSWs and make recommendations to state government for actions to increase the number of high quality DSWs available to individuals. The Taskforce should specifically address the following: recruitment, retention, training and credentialing of DSWs. 1a3. Review the research into high staff turnover in long term care service provider agencies and best practices for retaining a quality workforce.		TBD	Governor’s Office Other agencies include: HCPF, CDHS, Child Welfare Services, and community based organizations	Costs related to travel reimbursement for participants; Estimated FTE time/costs TBD
1b. Local DSW stakeholders will have a voice in indentifying ways to improve recruitment, retention and training of the DSW. ACTIONS 1b1. Perform a thorough environmental scan identifying all relevant stakeholders, funding sources and decision makers. Seek input from non-traditional sources, including private insurance companies,		TBD	HCPF LTC HCBS waivers section in partnership with DDD and community based organizations	Estimated FTE time/costs TBD

<p>major pharmaceutical firms, and other major players in the health industry who have long term public relations and financial interests.</p> <p>1b2. Communicate with identified stakeholders regarding recruitment and retention of the direct service workforce, cooperation in implementing workable solutions and addressing the challenges of implementing workable solutions.</p> <p>1b3. The DSW Taskforce should address the following:</p> <ul style="list-style-type: none"> ▪ Identify and analyze barriers to achieving long-term employment. ▪ Obtain baseline data on the number of direct services workers currently in the field, identify the number of DSWs required to meet the current and anticipated need and devise a method for on-going data collection and analysis to identify fluctuations in the workforce. ▪ Identify short- and <i>long-term</i> benefits and costs including, for example, the <i>costs</i> associated with high staff turnover and benefits of retention to the employer, to the individuals receiving services, to the community at large and to the taxpayer. ▪ Identify any barriers, constraints, and other legislation, rules, policies, procedures, etc., at the federal, state, and local level that may inhibit retention and training of the DSW, whether real or perceived. ▪ Develop and propose a strategic plan to relevant state departments that includes changes, programs, processes, etc., to address and ameliorate any barriers and identify needs for improving working conditions, recruitment and retention. 			
<p>1c. Develop and institute standards for training and credentialing DSWs.</p> <p>ACTIONS</p> <p>1c1. Identify best practice or promising practice models in other states for training and/or credentialing direct service workers.</p> <p>1c2. Identify efforts in Colorado that demonstrate intent to promote best practices in training and credentialing.</p> <p>1c3. Develop targeted training and education programs to provide professional certification through the Colorado Department of Public Health & Environment (CDPHE) or the Colorado Department of Regulatory Agencies (DORA) based on identified evidence and best practices. Capitalize on federal technical assistance for training design.</p> <p>1c4. Establish rule/legislation to enforce training and credentialing guidelines recommended in 1c3.</p>	<p>TBD</p>	<p>HCPF LTC Division DHS DDD Community based organizations</p>	<p>Costs related to travel reimburse ment for participant s; Estimated FTE time/costs TBD</p>

Key Issue - Housing				
<i>Expectation</i>	Delivery of existing affordable housing resources to individuals with long term care needs at risk for living in restrictive settings needs to be improved. The number of affordable, integrated housing resources should be increased. Access to affordable, integrated housing is a key component for assisting long-term care individuals to remain in or transition to community based settings.			
<i>Problem/Issue</i>	There are few options for integrated supportive housing for people with disabilities or others with long term care needs. This is even more the case for people with mental illness. Ideal supportive housing for people with long term care needs is located in rural, suburban and urban areas; adaptable to the individuals' needs throughout the lifespan; allows for individual interaction in the community and is affordable. While there are some housing options in Colorado that meet these expectations, demand far outweighs capacity at this time.			
<i>Strategy</i>	Improve access to affordable housing that is adaptable for people with physical and intellectual disabilities as well as people with severe persistent mental illness by eliminating barriers to accessing affordable housing, informing the community of existing housing options and increasing the number of affordable and accessible housing units through a number of funding strategies.			
<i>Measurable outcomes</i>	(1) The percentage of affordable housing subsidies used by long-term care individuals will increase. (2) The number of affordable housing units will increase. (3) The number of persons transitioned from nursing facilities and other settings into affordable housing will increase.			
OVERARCHING GOALS AND ACTION STEPS (in order of priority)		TIMEFRAME	RESPONSIBLE LEAD AGENCY/CIES	COSTS
2a. Develop policies for transition out of institutions that specifically address the individual's risk for homelessness upon discharge with the understanding that the state is not obligated to provide housing but should have a part in enabling individuals to avoid homelessness upon discharge. ACTION 2a1. Convene a work group that addresses the following: <ul style="list-style-type: none"> ▪ CDHS will evaluate policy for institutions CDHS has authority over regarding individuals at risk for homelessness upon discharge. ▪ CDHS will work with key stakeholders from nursing homes and other facility settings to develop policy on their transition and discharge process which includes assessment of what services and supports each person needs to successfully integrate into least restrictive settings. The transition plan should be standardized and completed in full partnership with the individual served. Any current barriers to community integration should be fully documented in the transition plan. ▪ CDHS will work with key stakeholders from nursing homes and other facility settings to develop informational resources for individuals who are living in facility settings and are at risk for homelessness upon discharge. 		TBD	Colorado Community Interagency Council on Homelessness, housed in the Governor's office	Estimated FTE time/costs TBD
2b. Improve the ability of individuals with long term care needs to have necessary identification and documentation to improve access to existing affordable housing opportunities.		TBD	HCPF LTC Division	Estimated FTE time/costs

<p>ACTIONS</p> <p>2b1. Require nursing homes and other long-term care residential providers to, within HIPAA guidelines, keep and maintain a resident’s original identification documents unless the resident or legal representative refuses, in which case the provider must keep a certified copy of the original identification document; or help residents get valid documents.</p> <ul style="list-style-type: none"> ▪ Publish Dear Administrator Letter (DAL) instructing long term care residential providers of requirement. ▪ Work to date: To improve individuals’ access to identification documents, we are starting with implementing a protocol for nursing facilities to make copies of the necessary document and record the original’s location in the individual’s case file. <p>2b2. Educate long-term care case management agencies about assistance opportunities including the Colorado Legal Services grant-funded project to assist individuals gain documents. Publish DAL providing information to case management agencies including Single Entry Point (SEP) agencies, and Community Centered Boards (CCBs)</p> <p>2b3. Explore conditions or criteria under which certain groups of long-term care individuals may be exempted justifiably from certain documentation requirements.</p> <ul style="list-style-type: none"> ▪ Research whether any other state or Housing and Urban Development (HUD) Region has successfully addressed. <p>2b4. Raise the identification issue to federal attention through organizations such as National Governors’ Association (NGA), National Association of State Medicaid Directors (NASMD), National Association of State Directors of Developmental Disabilities Services (NASDDDS), and National Association of State Mental Health Program Directors (NASMHPD).</p> <p>2b5. Develop strategies to increase the use of services, such as Community Transition Services (CTS), to assist long-term care individuals in obtaining valid documents.</p> <ul style="list-style-type: none"> ▪ Develop and implement training on CTS to case management agencies. ▪ Review program rules to determine if changes are needed to expand number or type of agencies that are qualified to enroll. ▪ Recruit and enroll additional CTS providers. 			TBD
<p>2c. Fund development of Housing First programs and other programs aimed at serving chronically homeless individuals with mental health and/or substance abuse disorders.</p> <p>ACTION</p> <p>2c1. Fund six new regional Housing First pilot programs throughout Colorado.</p>	TBD	Department of Local Affairs, Division of Housing	Bonds have been secured; Estimated FTE time/costs TBD

<p>2d. Improve information to consumers by creating internet links between local housing resources websites and long-term care services agency websites.</p> <p>ACTIONS</p> <p>2d1. Develop strategy to recruit long term care services agencies to participate</p> <p>2d2. Publish Dear Administrator Letter (DAL) to Medicaid case management agencies suggesting they create website links to local housing resources.</p> <p>2d3. Provide information about links to local housing resources to interested long-term care services agencies.</p> <p>2d4. Foster relationship building and cross training between local housing resources and case management agencies at the community level. - Identify best practices for community collaboration for dissemination to local case management agencies.</p>	TBD	HCPF LTC Division and CDHS DDD	<p>Costs related to website improvements TBD</p> <p>Estimated FTE time/costs TBD</p>
<p>2e. Adapt existing housing resource websites to the needs of people with disabilities by including options for accessible housing and streamlining the search process.</p> <p>ACTIONS</p> <p>2e1. Encourage long-term care services individuals and advocates to review and comment on housing resources websites</p> <p>2e2. Identify ways to provide incentives to property owners and managers to list their properties, including sufficient pertinent vacancy information, on a single website. ▪ Research best practices in other states. ▪ Seek resources to support such a website.</p>	TBD	ADAPT to solicit comments on housing websites, compile, and reach out to housing website operators and property managers/owners	Estimated FTE time/costs TBD
<p>2f. Cross -educate the housing community and the long term care services community about affordable housing resources and available long-term care services.</p> <p>ACTIONS</p> <p>2f1. Develop and distribute a guide to long-term care services for distribution to housing resource provider such as housing authorities, landlords, and property management companies.</p> <p>2f2. Provide information about links to long-term care services agencies to Colorado Housing Finance Authority for inclusion on their website.</p> <p>2f3. Foster relationship building and cross training between case management agencies and housing resource providers at the community level. ▪ Identify best practices for community collaboration for dissemination to local housing resources.</p> <p>2f4. Develop a guide to income restricted/subsidized housing resources and distribute guide to case management agencies and long-term care services agencies.</p> <p>2f5. Notify case management agencies for long term care services about assistance available in finding housing through: ▪ Colorado Housing and Finance Authority's http://www.ColoradoHousingSearch.com</p>	TBD	HCPF LTC Division with support from DDD, State Unit on Aging Supportive Housing and community housing stakeholders.	<p>Estimated costs for printing and distributing for 2 full color informational guides; Costs related to website improvements TBD</p> <p>Estimated FTE time/costs TBD</p>
<p>2g. Require homeless shelters and housing programs to make reasonable modifications of their policies, practices and procedures in order to meet, to the extent possible, the requirements of the Federal Fair Housing Act Amendments of 1988 and the American's with Disabilities Act of 1990 (amended in 2009), the Colorado Anti Discrimination Act, and if applicable, section 504 of the 1973 Rehabilitation Act.</p>	TBD	Colorado Department of Local Affairs, Division of Housing as well as the local city or	Funding for a third party organization to develop

<p>(Note: these laws rely on federal standards for brick and mortar access—the date of construction (or major rehabilitation projects) will dictate what the architectural requirements are and the need for modification of the structure is assessed against the difficulty of the needed remodeling and the resources of the entity.) If the shelter does not receive state or federal money, Department of Local Affairs is unable to enforce.</p> <p>ACTIONS</p> <p>2g1. Survey the environment for compliance. Engage community groups to develop and circulate check lists to shelter and housing providers; and to provide them technical assistance with regard to making reasonable modifications of policy, practice or procedure, when necessary to avoid discrimination.</p> <p>2g2. Follow up with any shelters and housing providers found to not be in compliance with federal and state statute and work with them to correct the concerns.</p>		<p>county office</p>	<p>survey tool, conduct survey and report results, TBD</p> <p>Estimated FTE time/costs TBD</p>
<p>2h. Encourage housing authorities to develop local preference for long-term care individuals by setting aside a certain percentage of designated affordable housing for people with long term care needs.</p> <p>ACTION</p> <p>2h1. Identify and convene community stakeholders to participate in local housing plan meetings.</p> <ul style="list-style-type: none"> ▪ Inform local housing authorities about the need for and best practices of set-asides. ▪ Create incentives to stimulate implementation of recommendation. ▪ Collaborate with regional councils of government 	<p>TBD</p>	<p>Department of Local Affairs, Division of Housing</p>	<p>Estimated FTE time/costs TBD</p>
<p>2i. Ensure Low Income Housing Tax Credit Qualified Allocation Plan (LIHTC) prioritizes housing projects serving special needs populations.</p> <p>ACTIONS</p> <p>2i1. Prioritize the allocation of tax credits to projects that primarily serve the lowest income households for the longest period of time.</p> <p>2i2. Further prioritize projects providing supportive housing for the lowest income households with adequate supportive services, including housing for special needs households throughout the state.</p>	<p>TBD</p>	<p>Department of Local Affairs, Division of Housing in partnership with CHFA</p>	<p>Estimated FTE time/costs TBD</p>
<p>2j. Streamline and simplify the application process for affordable housing, including forms, lottery and waiting lists.</p> <p>ACTION</p> <p>2j1. Recommend local housing authorities streamline their application processes and materials with individual input.</p> <ul style="list-style-type: none"> ▪ Develop champions among the local housing authorities <p>2j2. Investigate the resources needed to create a centralized database of waiting lists, openings, applications processes and lotteries.</p>	<p>TBD</p>	<p>HCPF LTC Division</p>	<p>Estimated FTE time/costs TBD</p>
<p>2k. Strongly support the ongoing efforts to create a statewide Housing Investment Fund funded from a specified source to expand the affordable housing resources serving long-term car individuals. Establish a state housing investment fund to expand the capacity to produce and preserve affordable housing for those in greatest need.</p> <p>ACTIONS</p> <p>2k1.</p> <ul style="list-style-type: none"> ▪ Develop partnership with Housing Colorado to pursue legislative change. ▪ Develop support from stakeholders ▪ Educate potential legislative sponsors 	<p>TBD</p>	<p>HCPF LTC Division; Department of Local Affairs, Division of Housing</p>	<p>Estimated FTE time/costs TBD</p>

2k2. Increase state general funding (Division of Housing) for the development of affordable housing with targeting to those that provide housing to special needs populations.			
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Key Issue - Appropriate Array of Services				
<i>Expectation</i>	It is necessary to have an appropriate array of supportive services available to HCBS waiver clients to optimize their independence and functional status.			
<i>Problem/Issue</i>	Failure to provide an adequate array of services can contribute to the unnecessary institutionalization of people with disabilities. There is a gap between the services available to people in institutions and those available to people in the community that can contribute to unnecessary institutionalization. Currently, cost shifting occurs between systems such as between the developmental disability system and the mental health system as a result of services available in one waiver, but not in others.			
<i>Strategy</i>	After appropriate financial analysis, work toward making many of the current HCBS waiver services available to all individuals using HCBS waiver services and expand the array of services as funding permits.			
<i>Measurable outcomes</i>	(1) Stakeholder group convened to address the appropriate array of HCBS waiver services by 1/31/2011 (2) Consultant hired to work with stakeholders on cost estimate and budget request to finance an expanded array of services by 7/1/11. (3) Legislation introduced to codify and finance expanded array of services for 2012 session by 12/01/2011 (4) Rule-making and any state plan amendments completed to establish expanded array of HCBS waiver services by 07/2013.			
OVERARCHING GOALS AND ACTION STEPS (in order of priority)		TIMEFRAME	RESPONSIBLE LEAD AGENCY/CIES	COSTS
3a. Explore and identify a mechanism to allow all HCBS clients access to all currently available services on any of the waivers as well as any future expansion of HCBS services. ACTIONS 3a1. Research the costs associated with making all HCBS services available to all clients as well as alignment with CMS regulations and state rule and statute.		TBD	HCPF LTC HCBS waivers section in partnership with CDHS DDD and CDHS DCWS	Estimated FTE time/costs TBD
3b. Develop and finance an expanded array of services appropriate for HCBS users' needs and those people living in institutions ACTIONS 3b1. Identify key stakeholders to develop a comprehensive list of appropriate services available to all HCBS users (see recommended array of services following this action plan). 3b2. Hire a consultant to research and determine the costs associated with expansion of services and develop supplemental budget request. Consultant will work with stakeholder group as needed. 3b3. Implement rule change or legislative change as needed		TBD	HCPF LTC Division with CDHS DDD and CDHS DCWS	Costs associated with hiring a consultant to perform financial analysis x 1 year Estimated FTE time/costs TBD

Recommended Comprehensive Array of Services		
<p>Note: This list contains a suggested comprehensive array of services developed by consumers, providers and other key stakeholders and implicitly includes all services currently available in the eleven HCBS waivers. <i>The group acknowledges that another larger group of key stakeholders will convene to review this list and adjust as appropriate and intend to make the process of establishing the services available through HCBS as transparent as possible.</i> Benefits acknowledged as a “current service” may be available on one of the 11 HCBS waivers, but are not available on all of the waivers.</p>		
Name	Description	Current Service?
Adult Foster Care	Residential care to persons who are unable to perform some activities of daily living and who need 24-hour supervision in a non-medical residential facility	Yes
Alternative Care Facilities	Assisted Living residence to provide alternative care services and protective oversight to Medicaid clients.	Yes
Companion Care Services	A paid roommate who becomes the principal care provider for an individual. For people who require 24-hour support.	No
Habilitation Services – Residential	<p>Provides comprehensive level of service addressing full spectrum of individuals need (non-medical, personal care, transportation, home living activities, community living, ADLS, socialization, training/support, etc.)</p> <p><u>Two Types of Environments in Residential Services:</u></p> <p><u>Individual Residential Services and Supports (IRSS)</u></p> <p>Three or fewer persons receiving services may live in a single residential setting or Host Home. Need for 24 hour supervision or 24 hours accessible supervision.</p> <p><u>Group Residential Services and Supports (GRSS)</u></p> <p>Four to Eight persons receiving services may live in this setting which is licensed by state. Need for 24 hour supervision.</p>	Yes
Permanent Supportive Housing (scattered site)	Permanent Supportive Housing (PSH) refers to integrated permanent housing (typically scattered site rental apartments) linked with flexible community based mental health services that are available to tenants/consumers when they need them, but are not mandated as a condition of	No

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Name	Description	Current Service?
	occupancy.	
Adult Day Services	Health and social services, individual therapeutic and psychological activities furnished on a regularly scheduled basis in an adult day services center, as an alternative to long-term nursing facility care.	Yes
Assertive Community Treatment	A service delivery model providing comprehensive, individualized, locally-based treatment to individuals with serious mental illness. ACT services should be provided by a multi-disciplinary treatment team and should be available twenty-four (24) hours a day, seven (7) days a week, 365 days a year.	Yes (in certain geographical areas under BHO contracts)
Assistive Technology	<p>Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants.</p> <p>Assistive technology devices and services when the cost is above and beyond that of typical expenses and are not available through the Medicaid State Plan or third party resource.</p> <p>Home accessibility adaptations, vehicle modifications, and assistive technology to ensure the health, welfare and safety of the participant.</p>	Yes
Behavioral Health Services	<p>Behavioral services identified in the Service Plan including individual and/or group counseling, behavioral interventions, diagnostic evaluations or consultations related to the individual's and are needed for the individual to acquire or maintain appropriate interactions with others.</p> <p>If an individual has a defined covered mental health diagnosis and is in need of covered mental health services, then those services must be accessed through the</p>	Yes

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Name	Description	Current Service?
	Medicaid State Plan.	
Case management	Services that assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is granted.	No, Yes in CHRP waiver
Cognitive Services	Cognitive services means working with the waiver participant to better understand and comprehend cause and effect and the correlation between behaviors and consequences. It may also take the form of repetitive directions, staying on task, levels of receptive language capabilities, and retention of information.	Yes – CHRP waiver
Communication Services	Communication Services means assistance with additional concepts and materials to enhance communication.	Yes – CHRP waiver
Community Transition Services	Activities essential to move a individual from an institutional setting to a community –based residence.	Yes
Consumer Directed Attendant Support Services	Consumer Directed Attendant Support Services (CDASS) is a benefit that allows clients to manage their attendant services. In CDASS, you and/or your authorized representative can: Hire attendants, even friends and family, based on qualifications that you set. Train, supervise and fire your attendants. Decide when and where you receive services. Set wages for your attendants, within your monthly budget. Choose someone you trust, like a family member or friend (an authorized representative), to help you manage the program.	Yes
Dental	These services are provided only when the services are not provided thru the Medicaid state plan. This includes dental costs for dental problems that may lead to generalized disease.	Yes

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Name	Description	Current Service?
Electronic Monitoring	This includes electronic medication boxes.	Yes
Emergency Assistance	Emergency Assistance means safety planning, fire and disaster drills, and crisis intervention.	Yes – CHRP waiver
Habilitation Services – Adult Day	Day Habilitation includes assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant’s private residence or other residential living arrangement, except when due to medical and/or safety needs.	Yes
Homemaker Services - Basic	Services that consist of the performance of basic household tasks within the participant’s primary residence (i.e., cleaning, laundry, or household care) including maintenance which are related to the participant’s disability and provided by a qualified homemaker, when the parent or primary caretaker is unable to manage the home and care for the participant in the home.	Yes
Homemaker Services - Enhanced	Services provided by a qualified homemaker that consist of the same household tasks as described under Basic homemaker services with the addition of either habilitation or extraordinary cleaning.	Yes
Home Accessibility Adaptations	<p>Those physical adaptations to the primary residence of the participant’s family, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home.</p> <p>Excluded are those adaptations or improvements to the home that are of general utility (e.g., carpeting, roof repair, central air conditioning, etc.) and are not of direct medical or remedial benefit to the participant.</p>	Yes

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Name	Description	Current Service?
Home Modifications	<p>Specific Modification, adoptions or improvements in an eligible individual's existing home setting, which, based on the individual's medical condition:</p> <ol style="list-style-type: none"> 1. Are necessary to ensure the health, welfare and safety of the individual 2. Enable the individual to function with greater independence in the home 3. Are required because of the individual's illness, impairment or disability 4. Prevents institutionalization of the individual. 	Yes
Independent Living Core Services and Skills Training	Services designed and directed at the development and maintenance of the program participant's ability to independently sustain himself/herself physically, emotionally and economically in the community. Skills training can be provided in the individual's residence, in the community or in a group living situation.	Yes
In Home Support/ Personal Care and Homemaker Services	Services that include Health maintenance activities and support for activities for daily living which include homemaker and personal care services.	Yes
In Home Support/ Services by an Attendant	Services that are provided by an attendant and include Health Maintenance Activities and support for activities for daily living which include homemaker and personal care services.	Yes
Mentorship	Service provided to participants to promote self-advocacy through methods such as instruction, providing experiences, modeling and advising. This service may also include training in child and infant care for parent(s).	Yes
Pre-employment Skills Training	Training that prepares individuals to pursue an employment goal including resume writing, interview skills, setting goals,	Yes

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Name	Description	Current Service?
	decision making, conflict resolution etc.	
Personal Assistance, foster care	Personal Assistance means a range of assistance to enable waiver participants to accomplish tasks for themselves. This assistance may take the form of hands-on assistance (actually performing the task for the person) or cueing to prompt the participant to perform a task. Personal Assistance services may be provided on an episodic or on a continuing basis and may include performance and/or guidance of assisted daily living skills such as toileting, bathing, dressing, transferring, and mobility. Personal Assistance also includes performance and/or guidance in the instrumental activities of daily living skills to include hygiene, medication management, transportation, money management, shopping, meal preparation, laundry, accessing resources (e.g. using the telephone, making appointments), and housework.	Yes – CHRP waiver
Personal Emergency Response System (PERS)	PERS is an electronic device that enables waiver participants to secure help in an emergency.	Yes
Personal Care	A range of assistance to enable participants to accomplish tasks that they would normally do for themselves (i.e. hygiene, bathing, eating, dressing, grooming, bowel and bladder care, menstrual care, transferring, money management, grocery shopping), if they did not have a developmental disability. When Personal Care and health-related services are needed, they may be covered to the extent the Medicaid State Plan, third party Resource or other waiver service is not responsible.	Yes
Professional Services	Professional services include Hippo-therapy, Movement Therapy and Massage. The identified “Professional service” cannot be available under the regular Medicaid	Yes

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Name	Description	Current Service?
	State Plan or from a third party source.	
Respite Care	Services provided to participants that are furnished on a short-term basis, because of the absence or need for relief of those persons who normally provide care for the participant.	Yes
Self Help, Socialization, Adaptive Skills Training/Support	Includes assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant’s private residence or other residential living arrangement, except when due to medical and/or safety needs. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice.	No
Self-advocacy Training – foster care	Self-Advocacy training and support includes assistance and teaching of appropriate and effective ways to make individual choices, accessing needed services, asking for help, recognizing abuse, neglect, mistreatment, and/or exploitation of self, responsibility for one’s own actions, and participation in all meetings.	Yes – CHRP waiver
Specialized Medical Equipment and Supplies	<ol style="list-style-type: none"> 1) Devices, controls, or appliances, specified in the Service Plan, that enable participant to increase their ability to perform activities of daily living. 2) Kitchen equipment required for the preparation of special diets. 3) Specially designed clothing. 4) Maintenance and upkeep of the equipment. 	Yes
Supervision Services	Supervision means the level of supervision necessary to keep the waiver participant safe in the home and in the community. Levels of supervision would include line-of-sight, one-on-one, room-to-room, and within sight distance (yard). Behavioral needs would include, but not limited to, the	Yes – CHRP waiver

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Name	Description	Current Service?
	<p>waiver participants physical and verbal aggressiveness, sexual inappropriateness, victimization, property destruction, self-harm, suicidal, stealing. Medically fragile waiver participants could require, in addition to the behavioral needs, monitoring of medical equipment, feeding tubes, seizures, and other life threatening medical issues if not being provided by the State plan</p>	
Supported Community Connection	<p>Supported Community Connection (SCC) supports the abilities and skills necessary to enable the individual to access typical activities and functions of community life such as those chosen by the general population, including community education or training, retirement and volunteer activities. Supported Community Connection provides a wide variety of opportunities to facilitate and build relationships and natural supports in the community, while utilizing the community as a learning environment to provide services and supports as identified in a person’s Service Plan. These activities are conducted in a variety of settings in which participants interact with non-disabled individuals, other than those individuals who are providing services to the participant. These types of services may include socialization, adaptive skills and personnel to accompany and support the individual in community settings, resources necessary for participation in activities and supplies related to skill acquisition, retention or improvement.</p> <p>Supported Community Connections may be provided in a group setting (or groups traveling together into the community) and/or may be provided on a one-to-one basis as a learning environment to provide instruction when identified in the Service Plan.</p>	Yes

Recommended Comprehensive Array of Services

Note: This list contains a suggested comprehensive array of services developed by consumers, providers and other key stakeholders and implicitly includes all services currently available in the eleven HCBS waivers. *The group acknowledges that another larger group of key stakeholders will convene to review this list and adjust as appropriate and intend to make the process of establishing the services available through HCBS as transparent as possible.* Benefits acknowledged as a “current service” may be available on one of the 11 HCBS waivers, but are not available on all of the waivers.

Name	Description	Current Service?
Supported Community Connections (Foster Care)	Services are provided one-on-one to deliver instruction for documented severe behavior problems that are being demonstrated by the waiver participant while in the community, i.e. physically or sexually aggressive to others and/or exposing themselves. These activities are conducted in a setting in which participants interact with non-disabled individuals (other than the individual that is providing the service to the participant). Supported Community Connections is an additional service provided by a Medicaid provider to work with the child one-on-one in the community for no more than five (5) hours per week. The child will receive the Supported Community Connections service by the same individual during the service span in order to provide consistency. The targeted behavior, measurable goal(s), and work plan must be clearly articulated in the Service Plan.	Yes – CHRP waiver
Supported Employment	Supported Employment services consists of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting.	Yes
Substance Abuse Counseling	Planned treatment as identified by an assessment and listed in the treatment plan. The intended outcome is the management, reduction, or resolution of the identified problem. Planned counseling session rendered to a consumer by a clinician to target substance abuse issues.	No
Transition Case Management	Exclusive activities essential to move a individual from an institutional setting and establish a community based residence.	Yes – EBD waiver only
Transportation from Home to Habilitation Sites	Refers to non-emergent transportation	Yes

Recommended Comprehensive Array of Services

Note: This list contains a suggested comprehensive array of services developed by consumers, providers and other key stakeholders and implicitly includes all services currently available in the eleven HCBS waivers. *The group acknowledges that another larger group of key stakeholders will convene to review this list and adjust as appropriate and intend to make the process of establishing the services available through HCBS as transparent as possible.* Benefits acknowledged as a “current service” may be available on one of the 11 HCBS waivers, but are not available on all of the waivers.

Name	Description	Current Service?
Transportation to Non-Medical Community Resources/ Services	Service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources.	Yes
Vehicle Modifications	Adaptations or alterations to an automobile or van that is the participant’s primary means of transportation in order to accommodate the special needs of the participant.	Yes – DDD waivers
Vision	These services are provided only when the services are not available through the Medicaid State Plan due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules.	Yes

Key Issue – Informing the Community of Available Long Term Care Options				
<i>Expectation</i>	It is necessary for Coloradans, including people in the allied health professions as well as other professionals that come into contact with individuals needing long term care, to know and understand the array of options available for long term care services as well as appropriate avenues for resolving concerns or problems.			
<i>Problem/Issue</i>	While there are many existing options for long term care services outside of institutional settings, many people do not fully know about these options for themselves or family members which can result in reduced access to these services.			
<i>Strategy</i>	Identify best practices from other states to encourage informed choice for individuals in need of long term care services. Develop informational tools to disseminate to the public and to professionals about available home and community based services and resources.			
<i>Measurable outcomes</i>	<p>(1) Persons needing long term care services, their allies and professionals in frequent contact with those who use or are in need of long term care services will be able to demonstrate knowledge of the variety of options available for long term care.</p> <p>(2) People with all types of disabilities, their allies and people in frequent contact with those who use or are in need of long term care services will be able to demonstrate awareness of avenues for resolving concerns or problems.</p> <p>(3) Complaints to the state LTC Ombudsman related to individuals being given inadequate information about home and community based options will be reduced.</p>			
OVERARCHING GOALS AND ACTION STEPS (in order of priority)		TIMEFRAME	RESPONSIBLE LEAD AGENCY/CIES	COSTS
<p>4a. Best practices from other states and in-state resources related to informing professionals and the public of home and community based long term care services should be used as part of comprehensive information dissemination and outreach.</p> <p>ACTIONS</p> <p>4a1. Research how other states have reduced the number of persons with disabilities in SNFs and other institutional settings via transitioning individuals to community based settings including methods related to outreach, education and policy change. In cooperation with the disability community and allied health professionals develop a plan and timeline to implement best practices used in other similarly situated states.</p> <p>4a2. Find opportunities to leverage Aging & Disability Resources Center funding in Colorado and technical assistance from CMS & AOA to raise public awareness and improve information and referral systems.</p> <p>4a3. Research how other states have streamlined application processes and eligibility determination for both Medicaid and non-Medicaid home and community based long term care services.</p>		TBD	LTC Advisory; HCPF, CDHS & CDPHE with key community Stakeholders	Estimated FTE time/costs TBD Costs related to implement ation TBD
<p>4b. Allied health professionals and professionals in frequent contact with those who use or are in need of long term care services, including state workers, will be informed about available options for home and community based services as well as appropriate avenues for resolving concerns or problems.</p> <p>ACTIONS</p> <p>4b1. Create materials and informational resources geared towards allied health professionals and other professionals in frequent contact with those who use or are in need of long term care services based on the information gathered in 4a. Investigate the following avenues for</p>		TBD	HCPF LTC Division & CDHS DDD and DCWS; key community stakeholders; Governor’s OIT office	Cost analysis needed to develop training materials Estimated FTE time/costs TBD

<p>disseminating resources and information:</p> <ul style="list-style-type: none"> - Development of a comprehensive, user friendly website - Investigate if DORA could do an insert with LTC options & resources when doing licensure renewals for allied health professionals 			
<p>4c. Coloradans who use or are in need of long term care services will be informed about available options for home and community based services as well as appropriate avenues for resolving concerns or problems.</p> <p>ACTIONS</p> <p>4c1. Establish a multidisciplinary committee to identify current resources, investigate the costs, identify needed features of the campaign, identify appropriate and accessible methods for disseminating the information and identify a methodology for determining the effectiveness of a statewide Public Awareness (PA) outreach campaign about available home and community based long term care services.</p>	<p>TBD</p>	<p>HCPF LTC Division & CDHS DDD and DCWS; key community stakeholders; Governor’s OIT office</p>	<p>Estimated FTE time/costs TBD</p>

Key Issue - Funding				
<i>Expectation</i>	Sustainable funding for Home and Community Based Services is essential to support the principles inherent in the <i>Olmstead</i> decision			
<i>Problem/Issue</i>	While there is a strong infrastructure of home and community based services available in Colorado, reimbursement methodologies for these service providers should be examined in order to maximize the availability of these services.			
<i>Strategy</i>	Identify current and future potential funding sources			
<i>Measurable outcomes</i>	(1) Spending on HCBS benefits will trend upward over time while spending on SNFs and other institutional settings will decrease over the same time period (2) One-time-only funds will be made available either from the state budget or awarded grant funds for elements in this document.			
OVERARCHING GOALS AND ACTION STEPS (in order of priority)		TIMEFRAME	RESPONSIBLE LEAD AGENCY/CIES	COSTS
5a.	<p>Examine reimbursement methodologies in other Colorado Medicaid services and identify ways that these methods could be applied to community based services. Also examine other reimbursement methodologies from other states to appropriately encourage capacity building and maximize flexibility in funding.</p> <p>ACTIONS</p> <p>5a1. Investigate costs or returns associated with rate changes & identify opportunities in the Medicaid LTC Budget to accommodate rate changes.</p> <p>5a2. Adjust rates to encourage HCBS provider enrollment, thereby increasing access to HCBS services for individuals based on findings from 5a1; incorporate in State Plan and rule as needed.</p> <p>5a3. Explore applying for the next round of the CMS Money Follows the Person demonstration.</p> <p>5a4. Explore the costs of retaining a consultant to help with data gathering, modeling, researching other states' reimbursement methodologies, etc.</p>	TBD	HCPF LTC and Rates Divisions	TBD costs related to hiring a consultant Estimated FTE time/costs TBD
5b.	<p>Relevant state Departments will seek grant funding to support one-time-only expenses needed to support selected activities in this document.</p> <p>ACTIONS</p> <p>5b1. Determine which prioritized elements in this document will require one-time-only funds</p> <p>5b2. Approach local and national funding sources for grant funding. Work with lead agencies and grants manager to apply for funds.</p> <p>5b3. Work with the State Unit on Aging (SUA) to apply for federal funds to enable planning for capacity building within the ARDC model.</p>	TBD – ADRC application due July 31, 2010	HCPF LTC Division & Office of Client & Community Relations and CDHS DDD and DCWS and SUA	Estimated FTE time/costs TBD

<p>5c. Examine the recommendations arising from the Senate Bill 05-173 and House Bill 07-1374 Advisory committees as well as the analysis from Auerbach Consulting to address integrating long term care funding streams.</p> <p>ACTION</p> <p>5c1. Utilize the LTC Advisory to review the recommendations and their applicability to this plan.</p>		<p>HCPF LTC Advisory</p>	
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Key Issue –Integrating Recommendations into Current Policy				
Expectation	In order to ensure that Colorado remains <i>Olmstead</i> compliant and to ensure that the recommendations in this document are supported based on available resources, it is necessary to integrate current policy with the principles of the recommendations as well as develop new policies to review progress and support accountability to on-going promotion of home and community based long term care services.			
Problem/Issue	Development of these policy recommendations generates an opportunity to examine current state regulations and policies to determine if they align with promoting access to home and community based long term care services, as well as develop policy or regulations as needed that may enhance access to services.			
Strategy	Identify areas where current policies related to long term care need to be adapted to support access to CBLTC and the actions in this document. Additionally, create a policy that prompts systematic, on-going review of progress in implementing these recommendations, as well as identification of any needed changes to the recommendations.			
Measurable outcomes	<p>(1) All appropriate CCR sections are reviewed for ADA and <i>Olmstead</i> compatibility and any needed amendments are made and passed by the appropriate governing board(s).</p> <p>(2) A question related to whether a proposed rule for the CCR is compliant with the <i>Olmstead</i> decision is inserted in the regulatory analysis section of the form used to submit the proposed rule to the Office of the Secretary of the State.</p> <p>(3) An annual review and report on progress on implementing these policy recommendations will be submitted to the Long Term Care Advisory committee on July 30, 2011 and annually thereafter.</p> <p>(4) BHO, CCB, SEP, SNF and MCE contracts will include a clause to align with the ADA as well as promotion of CBLTC services as appropriate.</p> <p>(5) Number of individual CBLTC service plans aligning with services rendered will increase as measured year over year.</p>			
OVERARCHING GOALS AND ACTION STEPS (in order of priority)		TIMEFRAME	RESPONSIBLE LEAD AGENCY/CIES	COSTS
6a.	The committee recommends that the state have a dedicated Director of <i>Olmstead</i> Policy & Implementation ACTIONS 6a1. Job responsibilities would include monitoring the progress of implementation of the recommendations in this report, receiving <i>Olmstead</i> related grievances, and reporting to the LTC Advisory and other related committees on the report and implementation.	TBD	Any State-based agency	Estimated FTE
6b.	Review all current Code of Colorado Regulations (CCR), in particular, 2 CCR 503-1, section 16.100 and 10 CCR 2505-10, section 8.400 related to long term care services, as well as current state statutory mandates for compatibility with the <i>Olmstead</i> decision. ACTIONS 6b1. Review and indentify any discrepancies 6b2. Make recommendations for changes & proceed through the state rule making process	TBD	HCPF LTC Division and CDHS DDD and DCWS and the AGs office	Estimated FTE time/costs TBD
6c.	Ensure that all rules proposed for future inclusion in the CCR are compliant with the <i>Olmstead</i> decision by instituting a question in the regulatory analysis section of the OP form used to submit the proposed rule to the Office of the Secretary of the State. 6c1. HCPF contacts Secretary of State’s Office to make this addition.	TBD	HCPF LTC Division	Estimated FTE time/costs TBD

<p>6d. Make an ADA request form available online for all meetings hosted by the Department.</p> <p>ACTION</p> <p>6d1. Model after form used by the Colorado State Judicial Branch for people called to jury duty.</p>	TBD		Estimated FTE time/costs TBD
<p>6e. Review and update clinical and case management criteria embedded in contracts with Behavioral Health Organizations (BHO), Community Centered Boards (CCB), Single Entry Points (SEP), skilled nursing facilities (SNF) and physical health managed care entities (MCE) to align with the promotion of CBLTC as appropriate.</p> <p>ACTIONS</p> <p>6e1. Notify relevant contract managers at HCPF and DHS of these policy recommendations and how they may affect contracts.</p> <p>6e2. Designate staff at HCPF and DHS as consultants to contract managers regarding alignment with these policy recommendations.</p> <p>6e3. Explore adding clause to “Vanilla” Contract template that aligns with title II of the ADA and the principles of these policy recommendations.</p>	TBD	HCPF LTC Division	Estimated FTE time/costs TBD
<p>6f. Institute policies to ensure that all LTC, BHO, county and MCE case managers and/or care coordinators review the individual’s care plan on a periodic basis to assure that all recommended HCBS services are being provided and any discrepancies between service plans and services received are addressed in a timely manner.</p> <p>ACTIONS</p> <p>6f1. Add appropriate language to all BHO, MCE, SEP, CCB and SNF contracts</p> <p>6f2. Notify all relevant contract managers to add said language and to monitor contractors for compliance</p> <p>6f3. Designate staff at HCPF and DHS to periodically and randomly audit service plans to ensure compliance</p>	TBD	HCPF LTC Division; CDHS DDD and DCWS and CDHS Division of State Veteran’s Nursing Homes	Estimated FTE time/costs TBD
<p>6g. Stay informed regarding federal guidance for the “Community First Choice” option for states to incorporate HCBS waiver benefits into the State Plan and move forward with a state analysis of this option once federal guidance is received.</p>	TBD	HCPF LTC Division, Reform Unit	
<p>6h. Explore strategies to simplify the current HCBS waiver system to enable better access to services, a person-focused system, ease of navigation and streamlined administration of the program</p> <p>6h1. Continue the process of addressing potential conflict of interest issues inherent in the structure of the current CCB system.</p> <p>6h2. Strategies to explore for HCBS waiver modernization include consolidation of waivers, making all benefits available to all waiver recipients, utilizing the Money Follows the Person model as well as other options.</p>	In progress; estimated multiple year timeline	HCPF & CDHS	

<p>6i. Bring together a standing HCPF stakeholder committee or choose an existing committee charged with similar work to address policy barriers to deinstitutionalization for action.</p> <p>ACTIONS</p> <p>6i1. Stakeholder committee provides a place where individuals, advocates, and or providers can bring policy barriers to deinstitutionalization for action.</p> <p>6i2. Said stakeholder group shall make a yearly report to the Governor on issues received, actions recommended, and what action was actually taken.</p>	TBD	HCPF	
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Appendix B: Executive Order D01109, “Directing the Development of a Strategic Plan to Promote Community based Alternative of the Disabled Citizens of Colorado”

D 011 09 EXECUTIVE ORDER

Directing the Development of a Strategic Plan to Promote Community based Alternatives for the Disabled Citizens of Colorado

Pursuant to the authority vested in the Governor of the State of Colorado, I, Bill Ritter, Jr., Governor of the State of Colorado, hereby issue this Executive Order directing the development of a strategic plan to promote the placement of qualified individuals with disabilities in community based treatment programs and facilities.

I. Background and Purpose

On June 22, 1999, the United States Supreme Court handed down its landmark decision *Olmstead v. L.C.*, 527 U.S. 581 (1999) which required the states under certain circumstances to place individuals with disabilities in community based treatment programs. The decision interpreted Title II of the Americans with Disabilities Act of 1990 (ADA) (42 U.S.C. § 12101 *et. seq.*) as forbidding the segregation of disabled individuals in institutions without proper justification.

The State of Colorado rejects the institutionalization of individuals with disabilities when such institutionalization is not justified and has continued to serve as a national leader in providing service programs that expand and improve community based alternatives for people with disabilities. Yet, 10 years after the Court’s disposition in *Olmstead*, barriers still exist that impede the ability of people with disabilities to live and receive treatment in less restrictive environments.

This Executive Order directs the development of a strategic plan that will promote the policies laid out in *Olmstead* by guarding against unjustifiable isolation and enhancing Colorado’s ability to provide community based treatment programs and facilities for people with disabilities.

II. Mission and Scope

This Executive Order directs the Long-Term Care Advisory Committee or its delegates within the Department of Health Care Policy and Financing to review relevant state policies and bring together key stakeholders in order to develop a long-term strategy for improving access to community based treatment programs and facilities for qualified individuals with disabilities.

III. Directives

A. The State of Colorado shall comply in full with the holding, legal interpretations, and policies set forth in *Olmstead v. L.C.*, 527 U.S. 581 (1990) such that any state entity will respect the ability of individuals with disabilities to live and seek treatment in community based settings.

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

C. The Long-Term Care Advisory Committee (hereafter the “Committee”) shall develop a strategic plan to promote the placement of qualified disabled individuals in less restrictive, community based treatment programs and facilities.

D. The Committee must review the policies that are relevant to the purposes of this Executive Order within the following agencies: the Department of Human Services, the Department of Health Care Policy and Financing, the Colorado Department of Public Health and Environment, the Department of Transportation, and the Department of Local Affairs.

E. When conducting the review, the Committee shall ensure the involvement and input of relevant stakeholders, including but not limited to, consumers and families, providers, agency representatives, and organizations representing individuals with disabilities.

F. Upon completion of the review, the Committee shall establish a plan focusing on identifying and removing barriers that impede the opportunities of individuals with disabilities to live and seek treatment in community based settings.

G. In formulating such a plan, the Committee shall develop a long-term strategy that outlines policy and program recommendations aimed at addressing barriers to the improvement and expansion of community based alternatives. The long-term strategy shall address, at a minimum, the following: (1) a statewide vision and roadmap; (2) guiding principles; (3) building community based capacity, including accessible and affordable housing; (4) optimizing health, functioning and self-sufficiency; and (5) rate reform to appropriately encourage capacity-building.

H. The Committee shall complete both its review and the subsequent plan by July 1, 2010 and deliver it to the Office of the Governor as well as each of the executive directors of the aforementioned agencies.

I. The Committee shall be free to solicit, accept, and expend gifts, grants, and donations for the purpose of defraying the associated costs of conducting the plan development.

IV. Duration

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

GIVEN under my hand and the
Executive Seal of the State of
Colorado this 22nd day of
June, 2009.
Bill Ritter Jr., Governor

Appendix C: Core *Olmstead* Team

	Name	Affiliation	Contact information
1	Andy Oliver	HHS, Office for Civil Rights	Andrea.oliver@hhs.gov
2	Barbara Prehmus	HCPF Division Director, Long Term Care	Barbara.prehmus@state.co.us
3	Barbara Ramsey	Department of Human Services (DHS), Division of Developmental Disabilities	Barbara.ramsey@state.co.us
4	BJ Iacino	Colorado Coalition for the Homeless	biacino@coloradocoalition.org
5	Chad Morris	Division of Behavioral Health, Behavioral Health & Wellness Program, University of Colorado	Chad.Morris@ucdenver.edu
6	Carol Bouchard	Accent on Independence	csb@accentoni.com
7	Dale Reid	Atlantis/ADAPT	dale@atlantiscommunityinc.com
8	Dawn Russell	Atlantis/ADAPT	dawn@atlantiscommunityinc.com
9	Debbie Lapp	Foothills Gateway, inc., a Community Centered Board in Larimer County	debbiel@foothillsgateway.org
10	Grace Walsh	Citizens for Fort Logan	gracewalsh@msn.com
11	Grant Gilliland	Rainbow Center	ggilliland@bhiinc.org
12	Jayla Sanchez- Warren	Area Agency on Aging/ DRCOG	jswarren@drcog.org
13	Jen Malloy	Behavioral Health Inc.	jmalloy@bhiinc.org
14	Joscelyn Gay	DHS, Office of Behavioral Health and Housing	Joscelyn.gay@state.co.us
15	Julie Reiskin	Colorado Cross Disability Coalition	jreiskin@ccdonline.org
16	Judy Hughes	Colorado Dept. of Public Health & Environment, Health Facilities & Emergency Medical Services Division	Judy.hughes@state.co.us
17	Lacey Beruman	Nat'l Alliance on Mental Illness	lberumen@nami.org
18	Lesley Reeder	HCPF, Performance Management	Lesley.reeder@state.co.us
19	Liz Fuselier	The Legal Center for People with Disabilities and Older People	Fuselier@thelegalcenter.org
20	Marijo Rymer	Arc of Colorado	mrymer@thearcofco.org
21	Nora Brahe	Dept of Health Care Policy & Financing (HCPF), Nursing Facilities	Nora.brahe@state.co.us
22	Pam Rios-Menter	Colorado Health Care Association	Prios-menter@pinonmgt.com

23	Robert Bremer	Colorado Access behavioral health organization (BHO)	Robert.bremer@coaccess.com
24	Ruth Long	Larimer County Dept of Human Services, single entry point (SEP) agency	rlong@larimer.org
25	Shelley Hitt	State Long Term Care (LTC) Ombudsman	skhitt@thelegalcenter.org
26	Sylvia Labrucherie	Colorado Dept of Transportation	Sylvia.Labrucherie@dot.state.co.us
27	Val Corzine	The Legal Center for People with Disabilities and Older People	vcorzine@thelegalcenter.org
28	Viki Manley	DHS, State & Veterans Nsg Homes	Viki.manley@state.co.us

Each waiver has an enrollment limit. There may be a waiting list for any particular waiver. Applicants may apply for more than one services through one waiver at a time. Anyone who is denied Medicaid eligibility for any reason has a right to appeal. Talk to Social/Human Services if you wish to exercise your right to appeal.

This chart was produced by the Community Based Long Term Care Section, Colorado Department of Health Care Policy and Financing

NAME OF WAIVER	CHILDREN'S HCBS WAIVER (CHILDREN'S HCBS)	HCBS – CHILDREN WITH AUTISM WAIVER (HCBS-CWA)*	CHILDREN'S EXTENSIVE SUPPORT WAIVER (HCBS-CES)	CHILDREN'S HABILITATION RESIDENTIAL PROGRAM WAIVER (HCBS-CHRP)	HCBS WAIVER for PERSONS with BRAIN INJURY (HCBS-BI)	HCBS WAIVER for PERSONS with MENTAL ILLNESS (HCBS-MI)	HCBS WAIVER for PERSONS LIVING WITH AIDS (HCBS-PLWA)	HCBS WAIVER for PERSONS who are ELDERLY, BLIND, AND DISABLED (HCBS-EBD)	HCBS WAIVER for PERSONS who are ELDERLY, BLIND, AND DISABLED (HCBS-EBD)
What is the primary purpose of this waiver?	To provide Medicaid benefits in the home or community for disabled children who would otherwise be ineligible for Medicaid due to excess parental income and/or resources. Children must be at risk of nursing facility or hospital placement.	To provide Medicaid benefits in the home or community for children with a medical diagnosis of Autism who are most in need due to the severity of their disability. Children must meet additional targeted criteria.	To provide Medicaid benefits in the home or community for children with developmental disabilities or delays, that are most in need due to the severity of their disability. Children must meet additional targeted criteria.	To provide habilitative services for children and youth in foster care who have a developmental disability and extraordinary needs. Children must meet additional targeted criteria.	To provide a home or community based alternative to hospital or specialized nursing facility care for persons with brain injury.	To provide a home or community based alternative to nursing facility care for persons with major mental illness.	To provide a home or community based alternative to hospital or nursing facility care for persons living with HIV/AIDS.	To provide a home or community based alternative to nursing facility care for elderly, blind, and disabled persons.	To provide a home or community based alternative to nursing facility care for elderly, blind, and disabled persons.
What ages are served?	Birth through age 17	Birth through age 5	Birth through age 17	Birth through 20 years of age	Age 16 through 64	Age 18 and older	All ages	Age 18 and older	Age 18 and older
Who is served?	Disabled children in the home at risk of nursing facility or hospital placement.	Children medically diagnosed with Autism with intensive behavioral needs who are at risk of institutionalization.	Children with intensive behavioral or medical needs who are at risk of institutionalization. Children, birth through age 4, must have a developmental delay. Children, 5 through 17, must have a developmental disability.	Children from birth through 20 years of age who are placed through a County Department of Human/Social Services, have a developmental disability and extraordinary service needs, and for whom services cannot be provided at the county negotiated rate.	Persons with brain injury as defined in the Colorado Code of Regulations with specific diagnostic codes.	Persons with a diagnosis of major mental illness.	Persons with a diagnosis of HIV/AIDS.	Elderly persons with a functional impairment (aged 65+) or blind or physically disabled persons (aged 18-64).	Elderly persons with a functional impairment (aged 65+) or blind or physically disabled persons (aged 18-64).
What is the active enrollment cap on the program?	1,308 children	75 children	375 children	Year one at 160, increasing by 10 over the five year span.	500 persons	2,883 persons	110 persons	19,981 persons	200 persons
Where to apply?	County Department of Social or Human Services, Options For Long Term Care - also known as Single Entry Point Agencies (SEP), or Community Centered Boards	Community Centered Boards	Community Centered Boards	County Department of Human Social Services for children and youth in out-of-home placement	Single Entry Point (SEP) Agencies	Single Entry Point (SEP) Agencies	Single Entry Point (SEP) Agencies	Single Entry Point (SEP) Agencies	Single Entry Point (SEP) Agencies
Is there a waiting list?	Yes	Yes	Yes	No	Yes, for nursing facility level of care in the Supported Living Program	No	No	No	No
What are the medical criteria?	Nursing facility or hospital level of care.	<ul style="list-style-type: none"> Diagnosed with Autism Under 6 years of age 	Intermediate care facility for the mentally retarded level of care.	Intermediate care facility for the mentally retarded level of care.	Hospital or nursing facility level of care.	Nursing facility level of care.	Nursing facility or hospital level of care.	Nursing facility level of care.	Hospital or nursing facility level of care.
Who determines the eligible persons needs?	<ul style="list-style-type: none"> Case manager Family Primary physician 	<ul style="list-style-type: none"> Case Manager 	<ul style="list-style-type: none"> Client Case manager Family or legal guardian 	<ul style="list-style-type: none"> County Department of Human Social Services 	<ul style="list-style-type: none"> Client Case manager Family or legal guardian Inpatient interdisciplinary team 	<ul style="list-style-type: none"> Client Case manager Family or legal guardian 	<ul style="list-style-type: none"> Client Case manager Family or legal guardian 	<ul style="list-style-type: none"> Client Case manager Family or legal guardian 	<ul style="list-style-type: none"> Client Case manager Family or legal guardian

					Living Skills Training					
Who selects the service providers?	• Family	• Family	• Family	• County Department of Human Social Services	• Client	• Client	• Client	• Client	• Client	• F • C
What type of plan is used?	Individualized care plan	Individualized care plan	Individualized care plan	Individualized care plan	Long-term care plan	Long-term care plan	Long-term care plan	Long-term care plan	Long-term care plan	Ind plan
Who provides case management?	<ul style="list-style-type: none"> • Approved Case Management Agencies • Approved Community Centered Boards 	• Community Centered Boards	• Community Centered Boards	• County Department of Human Social Services	• Single Entry Point (SEP) Agencies	• Single Entry Point (SEP) Agencies	• Single Entry Point (SEP) Agencies	• Single Entry Point (SEP) Agencies	• Single Entry Point (SEP) Agencies	• S (S)
What state/federal organizations administer this program?	Department of Health Care Policy and Financing; Centers for Medicare and Medicaid Services	Department of Health Care Policy and Financing; Centers for Medicare and Medicaid Services	Department of Human Services, Developmental Disabilities Services; Department of Health Care Policy and Financing; Centers for Medicare and Medicaid Services	Department of Human Services, Division of Child Welfare Services Department of Health Care Policy and Financing; Centers for Medicare and Medicaid Services	Department of Health Care Policy and Financing; Centers for Medicare and Medicaid Services	Department of Health Care Policy and Financing; Centers for Medicare and Medicaid Services	Department of Health Care Policy and Financing; Centers for Medicare and Medicaid Services	Department of Health Care Policy and Financing; Centers for Medicare and Medicaid Services	Department of Health Care Policy and Financing; Centers for Medicare and Medicaid Services	Dep Car Fin Me Me
What laws and regulations govern the program?	C.R.S. 25.5-6-901, as amended; 42 C.F.R. 441.300 – 310; Department of Health Care Policy and Financing, 10.C.C.R. 2505-10, Section 8.506	C.R.S. 25.5-6-801–805, as amended Department of Health Care Policy and Financing, 10.C.C.R. 2505-10, Section 8.519	C.R.S. 27-10.5-401, as amended; C.R.S. 25.5-6-401-411, as amended; 42 C.F.R. 441.300-310 Department of Human Services, Developmental Disabilities Services, 2 CCR 503-1; Department of Health Care Policy and Financing, 10.C.C.R. 2505-10, Section 8.503	C.R.S. 25.5-5-306(1) (1995 Supp); C.R.S. 27-10.5-102(11) (1995 Supp) Department of Human Services, Child Welfare Services, 10.C.C.R. 2505-10, Section 8.508	C.R.S. 25.5-6-701-706, as amended; 42 C.F.R. 441.300 - 310 Department of Health Care Policy and Financing, 10.C.C.R. 2505-10, Section 8.515	C.R.S. 25.5-6-601-607, as amended; 42 C.F.R. 441.300 – 310 Department of Health Care Policy and Financing, 10.C.C.R. 2505-10, Section 8.509	C.R.S. 25.5-6-501-508, as amended; 42 C.F.R. 441.300 – 310 Department of Health Care Policy and Financing, 10.C.C.R. 2505-10, Section 8.496	C.R.S. 25.5-6-301-313, as amended; 42 C.F.R. 441.300 – 310 Department of Health Care Policy and Financing, 10.C.C.R. 2505-10, Section 8.485	C.R.S. 25.5-6-301-313, as amended; 42 C.F.R. 441.300 – 310 Department of Health Care Policy and Financing, 10.C.C.R. 2505-10, Section 8.485	C.R. am Dep Car Fin 250

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