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Sessions 1 & 2 Overview of Site Visit and Discussion of Assessment Structure

10.27.2014		In-person
Note taker	Andrew Cieslinski	
Attendees	Tim Cortez, Brittani Trujillo, Kelly Wilson, Lauren Stanislao, Chris Harbison, Jennifer Martinez, Colin Laughlin	

- *Tim will forward an offer to Julie Reiskin's assistant regarding a separate meeting to discuss the materials.*
- SIS- Language is being update, Exceptional behavioral medical will come first, and some other information for service planning will be added to inform service Planning. Brittani said that she has not been shown a draft of the updated information yet
- CFC will need to be looked at in implementing the SIS. Hasn't been talked about again, and may be interesting to see what Oregon has done to bring the two together.
- In the SIS they differentiate between individuals who have a job and don't, in that those who don't are asked "If you did have a job what type of support would you need?" Could potentially use non-SIS items in the assessment to guide the SIS discussion.
- The CO Planning Grant will be occurring over the next year, and Tim said that this will be when the role of the ADRC will be more clearly defined.
- Tim said that they have worked with eligibility in the past around improving time for financial determinations and expediting, and have found that it is very inconsistent. Tim said that he would like to have non-MAGI separate and have HCPF take it over themselves so that more attention can be paid to this population
    - Brittani said that they have talked about this, and also about presumptive eligibility. Tim said that they want the determination window to be very short, but right now there is not a financial incentive to do presumptive eligibility.
    - Steve suggested that under the pilot or other effort to collect data about who is going into NFs because they are waiting for financial eligibility.
- SEPs and CCBs do not have the ability to check individual's Medicaid eligibility. Tim said this is part of the future plans for the State.
- SEPs responsibility is to refer to county or use PEAK to do their Medicaid application. If it is HCBS strictly, they wait to do the 100.2 until there is a notification that financial eligibility has received, and for NFs and hospital discharges they do not wait and conduct 100.2 right away. This is more of a best practice than a written statue.
    - Tim said for the short term he agrees that the assessment protocols should wait until the notification of the financial eligibility determination to conduct the assessment.
    - Not all SEPs have PEAK assistance or are application assistance site. In the future would like all sites to provide this support
    - Financial eligibility screen and assistance protocol as part of initial screen.
- Brittani said that they are moving towards the conflict free module, where CCBs pick their role in either support planning/case management of providing services.
    - Envision doing an RFP for intake/support planning/CM that would be inclusive of all populations. Tim said that he would want responders to be required of serving all populations, but this is by no means a decision.
    - Entry point has not been a controversial thing for CCBs to give up, but they would like to maintain their CM function.
    - Envision having one entity per geographic area.
- Tim said that he is interested in having a conversation about re-doing the targeting criteria, because right now there are issues with the redeterminations in getting information from physicians; *would like to remove physician from the process.*
- PEAK generates a referral to the CM agency or SEP once a person has completed PEAK application to show that they have applied and to generate a referral for functional assessment. Case managers cannot go into PEAK, but staff working with PEAK can. *Would want the ability for staff working with the individual to see Medicaid eligibility.* Would also want the ability to send out notifications rather than making the CM/staff check the system.
- All except 3 have county based SEPs. Some are more siloed than others.
- Currently paying a flat rate and are capturing Medicaid match under an administrative component. CMS has not challenged this practice, though they might in the future and require some type of time study.
- The three private SEPs are getting paid for some functions outside of the flat assessment rate.
    - Children's waiver and MFP claim as a service under the waiver. Under the rest it is a monthly amount based on activity reports. On the non-admin side, they have been moving towards 15 minute increments, but on the admin side have not has this pressure from CMS.
    - Tim said they would like to look at actual costs when evaluating the rate that should be paid.
- Tim said they would like the system to also assist non-LTSS individuals, regardless of payer source.
    - As a result, may want to move some of the financial screen back so that they can claim on all individuals for functions of the assessment process.
    - Tim said that he has concerns that CM fees would significantly increase if claiming is billed as a service.

- SEPs currently have daily time sheets that they do 100% tracking with to see what programs the staff are working with. Don't break it out per-wavier; ACMI breaks it out by HCBS, children's HCBS, and home care allowance. Have had issues in rural areas around keeping track of funding streams and keeping things separate.
    - Have a quarterly tracking sheet that tracks activity over the last week to see which waivers are being worked on.

- Have a chart from the BUS that looks at eligibility process that looks at dates for the eligibility process. *Tim will send this out.*
    - **General Instructions:** To qualify for Medicaid long-term care services, the recipient/applicant must have deficits in 2 of 6 Activities of Daily Living, ADLs, (2+ score) or require at least moderate (2+ score) in Behaviors or Memory/Cognition under Supervision.
- Steve suggested that if there is a split for IDD and non-IDD, want to allow for program preference. Tim said that he agrees, and allows for more consumer choice.

TEFT

- Useful information will be yielded from round 2. In round 1, mailed out surveys were sent to clients.
- Tim said that he could envision working with a few counties to evaluate the workflow process, and this may also be tied into TEFT. Another related issue is time.
    - This could involve focus groups.
- Tim said that he also wanted to look at the consumer experience of the assessment.
- For the initial intake and eligibility screen pilot, want to make sure that there is a DD and non-DD sample.
- PACE, NF and LTHH all use 100.2, and most would come through SEPs but some LTHH may come through CCBs.
- Tim said that he would like to see what adding more specific items in the new tool would do to screen out individuals and how it differs from 100.2. Could look at specific items and which may be more appropriate to pull into the larger assessment.
    - Steve said that we will need to deconstruct the four parts of the 100.2 and figure out how to integrate.