Promising Practices in Long Term Care Systems Reform: Colorado's Single Entry Point System

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COLORADO'S SINGLE ENTRY POINT SYSTEM

As home and community-based support systems continue to grow and evolve, states are examining whether their current systems reflect fundamental participant and community values. A number of states are concluding that they need to put in place systemic reforms to ensure that their home and community-based support systems promote dignity, independence, individual responsibility, choice, and self-direction.

Systemic reforms are simultaneously addressing multiple aspects of community long term support systems in order to improve responsiveness to participants' needs and preferences. These initiatives are developing entirely new ways of designing, organizing, and managing community-based supports as a system rather than as a random collection of uncoordinated individual services. In some cases, this has required states to make fundamental changes to the administrative infrastructure of their home and community-based support programs.

Two design features in particular have repeatedly emerged as essential components of systemic reform initiatives:

- *Single Access Points* which provide people with a clearly identifiable place to get information, advice and access to a wide variety of community supports; and
- *Person-Centered Services*, which place participants, not services or providers, as the central focus of funding and service planning.

The Centers for Medicare and Medicaid Services contracted with Medstat to examine approaches nine states took to developing Single Access Points and Person-Centered Services to assist persons with disabilities to live productive and full lives in person-centered community settings. We conducted on-site interviews with state officials, advocacy organizations, and local program administrators, and extensively reviewed written documents on policy proposals, administrative rules, and program evaluations. The emphasis of the resulting nine case study reports is on identifying transferable models that can be adapted for replication in other states and communities across the country, while acknowledging that some aspects of state systems may be unique to each state's culture, history, and traditions.

Since most states have separate service systems for different populations, each case study will focus on a particular population. In Colorado, our focus is on long term supports for older persons and adults with physical disabilities.

Overview of Colorado's Home and Community Based Services System

Colorado is one of a few states that serve more people through Medicaid home and community-based alternatives to nursing facilities than in nursing facilities themselves. The state has long offered older people and people with physical disabilities a single access point for both institutional and community Medicaid supports. Colorado also has recently expanded its self-directed services options, including a unique program that allows people to

use an individual budget as a substitute for both state plan home health care and a Medicaid HCBS waiver.

The Long Term Benefits Division of the Department of Health Care Policy and Financing (HCPF), Colorado's Medicaid agency, sets Medicaid policy for both nursing facilities and home and community-based services. The division administers Medicaid-funded long term care and two state-funded community services programs. HCPF contracts with local Options for Long Term Care agencies, also called Single Entry Point (SEP) agencies, in 25 local districts. SEP agencies are a single place for people with physical disabilities and older people to go for publicly-funded long term supports. SEP agencies may be county departments of social service, county health departments, or private non-profit organizations.

The SEP agencies assess functional eligibility for

- Medicaid nursing facility services,
- Medicaid home health benefits provided for more than 60 days,
- Five Medicaid HCBS waivers that provide nursing home or hospital level of care,
- A Medicaid Research and Demonstration waiver providing self-directed services, and
- Two state-funded programs.

The agencies also provide case management for these supports, except for nursing facility services and a HCBS waiver for children under age 21. In addition, SEPs serve people who can privately pay for assessment and case management, and an SEP can offer services on a sliding fee scale if it raises funds to subsidize its services. The table below shows the number of people served and expenditures for both nursing facilities and the home and community based services programs with SEP case management.

Colorado Long Term Care Expenditures and Recipients: Seniors and Persons with Physical Disabilities, 2002

	Expenditures	Unduplicated Participants
Nursing Facilities	$360,822,890	15,592
HCBS Waiver for the Elderly, Blind and Disabled (HCBS-EBD)	$86,793,745	15,157
HCBS Waiver for People with Mental Illness (HCBS-MI)	$13,051,264	1,923
HCBS Waiver for People Living with AIDS (HCBS-PLWA)	$763,677	115
HCBS Waiver for People with Brain Injury (HCBS-BI)	$6,462,081	384
State Plan Home Health	$80,361,874	*6,652
Home Care Allowance	$15,330,215	5,642
Adult Foster Care	$234,547	87
Total	**$563,820,293**	

* 2000 data. Data for the number of participants in 2002 was not available.

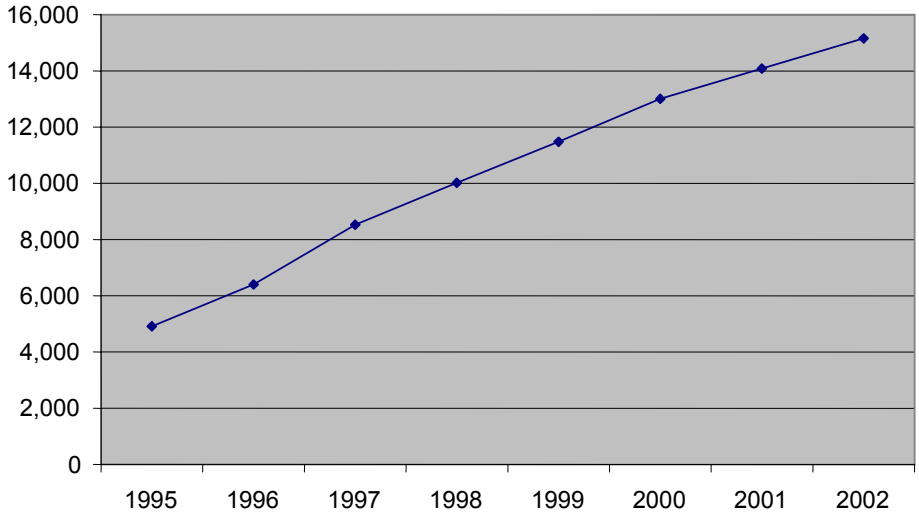
Sources:
Colorado Department of Health Care Policy and Financing
CMS Denver Regional Office
Burwell, Brian; Eiken, Steve; and Sredl, Kate. *Medicaid Long Term Care Expenditures in FY 2002*. Medstat, May 13, 2003.

Colorado served more people at the nursing facility level of care through Medicaid HCBS waivers than in nursing facilities in 2002. Nursing facilities served 15,592 participants in 2002. Three waivers – Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community Based Services for People with Mental Illness (HCBS-MI), and Home and Community Based Services for People Living with AIDS (HCBS-PLWA) – served almost 17,200 people eligible for nursing facility services.

The largest program SEP agencies administer is HCBS-EBD, which serves older people and people with physical disabilities. HCBS-EBD provides personal care, personal emergency response systems, assisted living, homemaker services, non-medical transportation, adult day care, home modifications, and respite. It also offers a self-directed service called in-home support services, which became available October 1, 2003. The largest service in the waiver is personal care, which served approximately 60 percent of waiver participants (8,741) and comprised 60 percent of waiver expenditures ($51.8 million) in 2002. Personal care agencies, including many home health agencies, provide this service.

As the chart below illustrates, the number of HCBS-EBD participants has tripled since 1995, when the waiver had 4,913 participants. Colorado has no wait list policy for HCBS-EBD. The state legislature has allowed the waiver to grow by appropriating funds for all people who qualify for home and community-based services.

Colorado's HCBS Waiver for the Elderly, Blind, and Disabled: Unduplicated Participants



SEP agencies administer three waivers in addition to HCBS-EBD: HCBS-MI, HCBS-PLWA, and a waiver for people with brain injuries (HCBS-BI). HCBS-PLWA serves people at both the hospital and nursing facility levels of care. Most participants use HCBS-PLWA as an alternative to nursing facility services. HCBS-PLWA offers personal care, personal emergency response systems, homemaker services, non-medical transportation, private duty

nursing, and adult day care. HCBS-MI provides assisted living, personal care, homemaker services, personal emergency response systems, adult day care, home modifications, and respite for people eligible for nursing facility admission. HCBS-BI serves people at the hospital level of care. Colorado has applied to CMS to offer this waiver at the nursing facility level of care as well. HCBS-BI offers transitional living services (to facilitate transition from institutionalization), adult day care, day treatment, behavioral management, personal care, assistive technology, non-medical transportation, home modifications, respite, independent living skills training, counseling, and substance abuse counseling.

The Consumer Directed Attendant Support program, a Medicaid Research and Demonstration waiver authorized under section 1115 of the Social Security Act, combines the estimated expenditures for a person's state plan home health care and HCBS-EBD personal care services into a single budget. Participants can use money in this budget to purchase in-home services from attendants they personally select, hire, and train, instead of receiving traditional services provided by home health or personal care agencies. This program started serving people in December 2002. As of April 2003, 24 people had enrolled, with total expenditures of $73,817 in that month. A maximum of 150 people can enroll in this five-year demonstration project.

In addition to Medicaid waivers, Colorado offers two programs that are primarily funded by state general revenues, although counties contribute five percent of expenditures. The largest of these programs, Home Care Allowance, directly pays low-income people with disabilities and older people to hire an in-home services provider. This program serves many people who do not qualify for Medicaid waivers due to their income or assets, but it supports waiver participants as well. Approximately one-third of participants are on a Medicaid HCBS waiver. Home Care Allowance served 5,642 unduplicated participants in 2002 and had $15.3 million in total expenditures. In 2002, participants received an average of $227 per month, with a maximum benefit of $403. Home Care Allowance was closed to new participants on July 1, 2002.

Colorado's Adult Foster Care program is a state and county-funded program that pays homes and facilities to support low-income people who require 24-hour non-medical supervision. Providers must serve 16 or fewer residents to qualify for Adult Foster Care, and must be licensed by the state. Adult Foster Care served 87 participants in 2002 with total expenditures of $234,547. The average monthly Adult Foster Care payment was $226, close to the average Home Care Allowance payment. The number of Adult Foster Care participants is decreasing as more people use assisted living, which receives more funding per person through the HCBS-EBD waiver.

On July 1, 2002, Colorado added prior authorization of long term Medicaid home health care to the SEP agencies' responsibilities. The state defines long term home health as home health services provided for a duration of more than 60 days. For people who received fee-for-service state plan services, before 2002 home health agencies sent care plans to the Medicaid fiscal agent for participants, who approved the care plan automatically. For people enrolled in Medicaid managed care plans, health plans authorized and funded state plan home health care for their enrollees. Colorado removed this responsibility from the health plans and the state

now pays for all long term home health care on a fee-for-service basis. The addition of home health prior authorization means SEP agencies provide assessment and case management for all Medicaid long term care for older people and adults with physical disabilities. The change provides a consistent contact person for providers and consumers who receive both home health and waiver services.

Evolution of Single Entry Point System

During the 1980s, people who used long term care and their family members reported a lack of information about both publicly and privately funded services to state staff and state legislators. When people did learn about supports, each program had different eligibility requirements and service options, creating confusion among program participants.

The programs were also administered in a fragmented manner. County departments of social services assessed participants' eligibility for nursing facility services, HCBS-EBD (then the only Medicaid HCBS waiver serving people at nursing facility level of care), and state-funded programs (Home Care Allowance and Adult Foster Care). However, most counties operated these options as three separate programs. State staff found that the services people received often depended on where the person requested assistance. For example, county social workers were likely to refer people to the Medicaid waiver while Medicaid financial eligibility technicians often referred people to Home Care Allowance, which started in the 1970s as an income maintenance program.

In 1988, the state department that included long term care, then the Department of Social Services, created a Long Term Care Policy Group to develop a plan to reform the long term care system. The policy group was an internal group that included management from the four divisions in the department that administered long term care programs. To inform the department's planning, the department's Executive Director appointed a Long Term Care Advisory Committee of providers, county staff, county elected officials, Area Agencies on Aging, and advocates.

The Long Term Care Policy Group released a long term care reform plan in 1989. The plan included the development of a single entry point system under which one agency in each region would provide coordinated management of the long term care system, including outreach, information and referral, assessment, case management, and resource development. The state would contract with these agencies and provide oversight and system evaluation. The basic structure of the SEP system was familiar to stakeholders and legislators because Colorado had been using the same service structure for people with developmental disabilities and people with mental illness.

The same year, Colorado's General Assembly established a two-year Long Term Health Care Task Force to study long term care reform, including a potential single entry point system. The task force included legislators, providers, and consumers. One of the highest priorities for this task force was to reorganize the service delivery system.

The legislative task force proposed 15 separate measures to change the long term support system. The legislature passed 14 of the bills, including a 1991 law to establish a SEP system. Other laws included creation of the Department of Health Care Policy and Financing (HCPF) and development of a single, standard assessment form for Medicaid and state-funded home and community-based services.

Colorado implemented the SEP system gradually. County Commissions were required to form the SEP districts in 1992. County Commissions in each district then jointly recommended SEP agencies to the state based on an application process. The state certified each agency's ability to fulfill the SEP requirements and contracted with the agencies. The Department of Social Services (and later HCPF, which became the waiver agency in 1993) was able to contract with another agency if the recommended agency did not meet certification standards for SEP agencies. HCPF certified the first two agencies in 1993, five more in 1994, and the last 18 in 1995.

Cooperation from county governments was critical to establishing the SEP system. County opposition was a potential challenge because counties previously administered home and community-based services. Under the SEP system, county departments of social services could become SEP agencies, but they faced the possibility of competing with other organizations. To encourage cooperation, the state implementation plan gave counties important roles in determining SEP agencies. Each county's commission, the county's elected governing board, determined which counties to join in a SEP district or whether to establish a single-county SEP district. Counties in each district recommended which agency would become the SEP agency, if that agency met state certification standards.

The state encouraged multi-county districts to be more efficient by achieving economies of scale. The state contracted with an economist to analyze the SEP system's potential income and costs. The economist calculated the minimum number of HCBS Waiver, Home Care Allowance, and Adult Foster Care participants necessary for a SEP to break even without increasing state payments for assessment and case management. The state required counties that did not have this minimum number of participants – 200 – to form multi-county districts.

The state did not establish a 200-participant minimum for multi-county districts for fear it would lead to very large rural and frontier districts that could present a geographic barrier to access. However, the state required multi-county districts to employ at least one full-time case manager, which ensures access to a case manager focused on community supports for older people and people with disabilities. Before the SEP system, many counties devoted case managers part-time to these programs. Thirteen counties had stopped providing case management for HCBS-EBD because they did not meet waiver provider requirements.

The state also provided a financial incentive for multi-county districts, paying $8,000 to districts for each county they include, but only if the district includes more than one county. These payments continue, and Colorado paid $456,000 to 57 counties in 2002. The remaining seven counties have their own SEP agencies.

Expansion of SEP Agency Responsibilities

In recent years, Colorado expanded SEP agencies' responsibilities in two ways. First, SEP agencies started providing functional eligibility determination for long term support services. Colorado has long required a licensed health professional (usually a registered nurse) to review the information collected in the assessment, which is typically conducted by a social worker or social service professional. The Colorado Foundation for Medical Care, Colorado's Medicaid Peer Review Organization, provided this service for more than a decade. Three SEP agencies started determining functional eligibility on a pilot basis on July 1, 2001. Within two years, the state expanded this responsibility to all SEP agencies.

Second, as described on page 4, SEP agencies started prior authorization of Medicaid state plan home health care provided for more than 60 days (long term home health) in July 2002. Colorado implemented the prior authorization requirement in response to rising home health costs. Between 1995 and 2000, total Medicaid home health expenditures increased at an average rate of 27 percent each year, from $20 million to $67 million, while the number of home health participants increased at an average rate of 4 percent each year, from 5,425 to 6,652. SEP agencies were well positioned to identify cost-effective alternatives for home health participants, such as personal care under a Medicaid HCBS waiver.

Stakeholder Involvement

The Long Term Care Advisory Committee – the group of providers, county staff, county elected officials, Area Agencies on Aging, and advocates that advised the state's Long Term Care Policy Group – informed the state's initial plan for SEP agencies and helped implement the concept. The state expanded the Long Term Care Advisory Committee in 1991 and involved its members in developing an implementation plan that guided the SEP agencies' establishment.

Soon after the SEP legislation passed, the advisory committee set up subcommittees of stakeholders and Department of Social Services staff to address several issues related to SEPs, including:

- Forming SEP districts and selecting a SEP agency in each district
- Improving participant access to services;
- Training SEP staff, especially case managers;
- Developing more resources for home and community-based services; and
- Financing SEP agencies.

Each subcommittee addressed one of these issues and developed recommendations. The advisory committee then revised and combined the recommendations into the implementation plan, which was completed four months after the SEP law passed. The Department of Social Services had ultimate approval for the implementation plan, and this plan became the basis for regulations regarding the SEP system.

The state continues to seek stakeholder input on an ongoing basis, primarily through an advisory committee of providers and consumers called the Medical Advisory Committee for Persons with Disabilities. Also, Colorado creates special committees of consumers and providers when considering major changes. These committees typically include advocacy groups and the state's home health and assisted living associations.

At the local level each SEP has a Community Advisory Committee that includes county commissioners, county staff, medical professionals, providers, consumers, and representatives from Area Agencies on Aging and the Long Term Care Ombudsman Program. This advisory committee appoints a Resource Development Committee to identify opportunities to increase the local support system's capacity. The Resource Development Committee prepares a resource development plan in coordination with the Area Agency on Aging that serves that area, and provides annual progress reports on the plan's implementation. Resource Development Committees survey consumers and providers to identify gaps in the service continuum.

Single Access Points: Facilitating Individuals' Access to Needed Supports

Most people learn about SEP agencies through referrals from people they encounter in the health and social service systems, including physicians, hospital discharge planners, and staff at county departments of social services and Area Agencies on Aging. Some people learn about SEP agencies through the agencies' own outreach efforts, which they are required to do under the state's contract with the agencies. These outreach efforts include participation in local fairs, symposiums, and other community gatherings.

When an SEP agency receives a referral, an intake case manager uses a basic screening tool to ask about the person's functional capacity and financial information. The intake case manager also asks questions regarding the urgency of the person's situation, so the most vulnerable people can receive services more quickly. If the person is not already a Medicaid participant, the intake case manager informs him or her that a Medicaid application is necessary before the SEP can assess functional eligibility for long term supports. The person must then submit a Medicaid application to the county department of social services, where Medicaid financial eligibility determination staff are located. The county notifies the SEP agency when they have received the Medicaid application.

Once the SEP is certain the person has applied for Medicaid, or is a Medicaid participant, an SEP case manager conducts an in-person assessment. The assessment collects information used to determine functional eligibility for services and to inform service planning once eligibility is determined. Colorado uses the same assessment tool for nursing facility services and all programs that Colorado funds as alternatives to nursing facility services, including: state plan long term home health care, Medicaid home and community-based services, and the Adult Foster Care program. The case manager then sends the assessment to a licensed health professional (usually a registered nurse) who determines functional eligibility based on the assessment information.

For adults eligible for home and community-based services, a SEP case manager works with the person to develop a care plan and set up services. The SEP has fifteen working days to complete the care plan for community services after functional and financial eligibility are determined. The SEP refers children under age 21 who are eligible for services to the local case management agency for the children's HCBS waiver.

The process is similar for people who receive long term home health services through Medicaid, except that a physician must prescribe home health. When a home health agency receives a prescription for long term home health care, the agency sends the SEP a care plan for the person. The SEP then conducts the in-person assessment used to assess eligibility for nursing facility and home and community-based services. After the assessment, the SEP informs the person of all available home and community-based services, and people can choose home health, a waiver, or the Adult Foster Care program if they are eligible for those services.

Person-Centered Services

This series of case studies on state long term supports initiatives focuses on two primary components of systemic reforms. The first, as described in the previous section of this report, is a single access point designed to provide an identifiable place where people can get information, objective advice, and access to a wide range of community supports. The other essential component is a system of person-centered services that places participants, not services or providers, at the center of funding and service planning.

Person-centered services systems, as presented in the following sections of this report, have two key features. First, by financing a wide range of support options, they enable persons to make meaningful choices about their living arrangements, the supports they receive, and the manner in which services are provided. Second, by designing person-centered quality management and information systems, the state enhances its ability to achieve intended participant outcomes and program goals.

Person-Centered Support Options

Currently, most people receive services from traditional provider agencies. In recent years, Colorado has implemented two initiatives that give people the opportunity to both hire their paid caregiver and choose supports that are not typically available: Consumer Directed Attendant Support (a Medicaid Research and Demonstration waiver) and In-Home Supported Services (a service in HCBS-EBD). The state is also planning to implement a third option, a new Medicaid HCBS waiver called Consumer Directed Care for the Elderly. This section first describes the case management process for Medicaid waiver services that ensures people can make meaningful choices among traditional and self-directed services. It then explains the state's options for self-directed services.

Case Management—The SEP agency staff who conduct assessments also provide case management. When a person is eligible for HCBS-EBD or another waiver, the case manager must give the person a list of all providers. During a care planning meeting, the case manager

advises the person regarding services the case manager believes are most appropriate and the participant chooses his or her services and providers. The SEP case manager then contacts the providers to arrange for services. Once the person receives services, the case manager contacts the person at least quarterly to identify any potential changes in the person's condition or any issues related to the person's services. The case manager must visit the participant face-to-face at least every six months to review the care plan. The person can also contact the case manager at any time.

Colorado pays the SEP agencies for assessment and case management based on the number of people who receive home and community-based services. HCPF pays SEPs approximately $800 per year for each participant in HCBS-EBD, HCBS-PLWA, HCBS-BI, HCBS-MI, the Consumer Directed Attendant Support waiver, Home Care Allowance, and Adult Foster Care. SEP agencies are not paid for assessments of people who enter nursing facilities, which provides an incentive to serve people in the community when possible. To prevent SEP agencies from manipulating the payment system, HCPF sets a maximum number of people for which an SEP can be paid each year, based on previous utilization.

Self-Directed Services—Colorado is expanding opportunities for Medicaid self-directed services with three initiatives. The first option, the Consumer Directed Attendant Support waiver, is a Research and Demonstration waiver that started serving people in December 2002. The second option, In-Home Support Services, is a service in the HCBS-EBD waiver which became available in October 2003. Finally, HCPF is preparing to implement the Consumer Directed Care for Elderly waiver, which will be a new Medicaid HCBS waiver. The table on the following page compares the three self-directed options.

Comparison of Colorado's Self-Direction Options
For Older People and Adults with Physical Disabilities

	CDAS	IHSS	CDCE
Effective date	December 1, 2002	October 1, 2003	Planned in 2004
Medicaid authority	Research and Demonstration Waiver (1115 Waiver)	Part of HCBS-EBD, a Medicaid HCBS Waiver (1915(c) Waiver)	New Medicaid HCBS Waiver (1915(c) Waiver)
Eligible population	People in stable health who have received at least one of four Medicaid services for at least 12 months: home health aide, home health nursing, personal care, or homemaker services.	HCBS-EBD participants.	People age 55 or older eligible for HCBS-EBD.
Authorized representative	Allowed only for financial management. A physician must certify the person can direct his or her services.	Participant may choose an authorized representative to direct their services.	Participant may choose an authorized representative to direct their services.
Budget management	Participant chooses supports within an individual budget determined by the person's previous expenditures.	No individual budget. Hourly cost of service determined by the state.	Participant chooses supports within an individual budget determined by the person's previous expenditures or by the estimated cost of services in a traditional care plan.
Providers exempt from Nurse Practice Act	Yes	Yes	No
Participant's employer responsibilities	Participant hires, trains, and supervises provider and negotiates the payment amount within individual budget.	Participant selects, trains, and supervises direct support worker. IHSS provider agency employs the worker.	Participant hires, trains, and supervises provider and negotiates the payment amount within individual budget.
Financial management services (FMS)	An Intermediary Service Organization (ISO) provides FMS.	IHSS provider agencies provide FMS for all participants.	An Intermediary Service Organization (ISO) provides FMS.
Participant training	Mandatory attendant management training by the state.	IHSS provider agencies provide mandatory attendant management training and optional independent living skills training.	Mandatory attendant management training by ISO.

Consumer Directed Attendant Support (CDAS) is a pilot program that allows up to 150 participants to hire their own attendants as a substitute for up to four state plan and HCBS waiver services:

- Medicaid state plan home health aide services;
- Medicaid state plan home health nursing;
- Medicaid HCBS waiver personal care; and
- Medicaid HCBS waiver homemaker services.

CDAS is available to people who received at least one of these services for at least 12 months. Each participant receives an annual individual budget equal to the amount Medicaid spent on the four services for that participant in the past year. The participant then develops a plan for his or her supports, with assistance from a SEP case manager.

Participants have flexibility in hiring their attendants. The state law that authorized CDAS exempted attendants from the state's Nurse Practice Act, so attendants can provide skilled services normally provided by a registered nurse, a licensed practical nurse, or a home health aide, including such tasks as medication administration, ventilator monitoring, and catheter irrigation. Participants also determine their attendants' hourly payment rate, as long as expenditures are within the individual budget. If the person saves money by negotiating a lower payment rate, the participant can use up to half of the cost savings to purchase equipment, supplies, or items that are not normally covered by Medicaid. The state keeps the other half of the cost savings.

CDAS is only available to participants who can direct their own care. A physician must certify the person's ability to direct his or her services and manage his or her health. Before using CDAS, participants must go to attendant management training held by the Department of Health Care Policy and Financing. Participants must also pass a test based on information in the training.

The state contracts with an intermediary service organization (ISO) to help participants manage many of their employer responsibilities. The ISO handles attendants' payroll, withholds taxes, obtains workers' compensation insurance, and conducts criminal background checks on attendants.

The SEP agencies' responsibilities are similar to their responsibilities under HCBS-EBD, Medicaid long term home health, and other services. SEP agencies must provide additional case management during a participant's first three months on CDAS; case managers contact participants twice a month to offer assistance with the change to self-directed services. Also, case managers provide a full reassessment of CDAS participants every six months, compared to annually for other home and community-based services participants.

As of April 2003, 24 participants were enrolled in CDAS. The state expects enrollment to increase, possibly to the maximum of 150 participants. Colorado will fund an evaluation of the pilot project that includes written participant satisfaction surveys and telephone interviews

to a sample of participants. The state will use these surveys to identify ways to improve CDAS as well as to measure the program's effectiveness.

In-Home Supportive Service (IHSS), a new service in HCBS-EBD and the HCBS waiver for children, became available in October, 2003. Like CDAS participants, IHSS participants select, train, and supervise their attendants. IHSS services are also exempt from Colorado's Nurse Practice Act, so participants can supervise skilled services normally provided or delegated by a registered nurse.

Under IHSS, attendants are employed by IHSS provider agencies rather than the participants themselves. In addition to employing IHSS attendants, IHSS provider agencies must offer four independent living services:

- Peer counseling,
- Information and referral,
- Independent living skills training, and
- Advocacy.

IHSS agencies must also employ or contract with a registered nurse or a physician to oversee attendant training, investigate complaints and critical incidents, and ensure health expertise is available when medical issues arise. IHSS agencies must also have back-up attendants available 24-hours a day in case a scheduled attendant is not available. Colorado anticipates that many of the IHSS provider agencies will be Centers for Independent Living (CILs), because federal law already requires CILs to offer the above independent living services. Other agencies also can be IHSS provider agencies if they meet the provider requirements. IHSS providers receive an hourly reimbursement rate set by the state.

A person can choose IHSS as part of the development of his or her plan of care under HCBS-EBD. The person can also select an authorized representative to direct his or her services. The participant chooses a provider agency, and the agency asks if the person knows who he or she wants to be their attendant. IHSS agencies are required to employ a participant's chosen attendant, although the attendant must pass a criminal background check. If the person does not have a preferred attendant, he or she can recruit one with assistance from the IHSS agency or choose an agency-employed attendant.

IHSS agencies provide initial training to both participants and attendants. Participants must attend an orientation to prepare them for managing their own attendant and to inform them of their rights and responsibilities. IHSS attendants receive basic training that includes information regarding typical attendant duties and tasks, first aid and emergency procedures, and infection control. The IHSS agency's health professional may waive training with completion of a written test or modify the training if the attendant already has some of the necessary knowledge and skills.

Consumer Directed Care for Elderly (CDCE) will be a new Medicaid HCBS waiver, scheduled to be available in 2004, for people age 55 and older who are eligible for HCBS-

EBD. Colorado's state legislature authorized CDCE in 2002. This waiver will be similar to CDAS, with a few important exceptions:

- People can enroll in CDCE even if they have not previously used Medicaid home and community-based services.
- Participants can enroll even if they are not able to direct their own supports, if they choose an authorized representative to direct their services.
- CDCE is not a substitute for Medicaid state plan home health services; it is only a substitute for Medicaid HCBS waiver services.
- CDCE providers will not be exempt from the state's Nurse Practice Act.

Person-Centered System Management

Moving from a county-based system to the SEP system increased Colorado's ability to manage the long term care system because the Department of Health Care Policy and Financing (HCPF) has a contractual relationship with each SEP agency, and can thus terminate the relationship or impose lesser penalties on the SEP agency if necessary. Colorado used its increased oversight ability to develop a quality measurement system for the SEP agencies. In addition to provider licensure and certification, this system provides a second level of quality assurance for long term supports in the community.

SEP Agency Quality Assurance—Each year, HCPF uses a participant satisfaction survey and an on-site monitoring review to measure SEP agencies' performance. The SEP agencies administer the participant satisfaction survey to participants in HCBS-EBD, HCBS-PLWA, HCBS-BI, the Consumer Directed Attendant Support waiver, Home Care Allowance, and Adult Foster Care. SEP agencies often use a contractor so an independent party interviews participants. The surveys are telephone interviews with a random sample of ten percent of the participants or ten participants, whichever is greater. The survey asks participants, or their proxies, questions regarding satisfaction with their services, including the quality of case management. SEP agencies send the survey results to HCPF. If the participant satisfaction survey identifies any problems, HCPF asks the SEP agency to address them.

The on-site monitoring review verifies that the SEP agency continues to meet state requirements. State staff review the SEP agency's progress in resource development and verify the agency meets standards for staff qualifications and ongoing staff training. Before visiting the agency, monitors review copies of a sample of participants' files to ensure the SEP meets timeliness standards for assessing participants, arranging the services participants choose, and periodically reviewing the care plan with the participant.

In addition, each year state staff focus their review on a "hot issue", an issue chosen by HCPF that is particularly important for the long term support system at that time. Hot issues from previous years have included providing adequate case manager salaries, maintaining a manageable average caseload, and identifying cost effective options for participants with the highest home health and Medicaid waiver expenditures. The review includes interviews with SEP staff, providers, and participants to learn more about how the SEP agency addresses the issue.

State monitors provide preliminary feedback to the SEP agency during an exit interview at the end of the visit. The state then reports findings to the SEP agency within 30 days, including any problems that the SEP must address to ensure that the system provides quality services and that participants can exercise their rights. For significant problems, the state requires the SEP agency to provide a corrective action plan within 60 days. The state conducts a follow up review to verify the remedial action took place. If necessary for participants' health and safety or for financial accountability, the state can terminate the contract with the SEP agency. The state can also take intermediate actions such as levying fines or withholding funds. The Aging and Adult Services division in the Department of Human Services (DHS) conducted these reviews until July 1, 2002, when Colorado transferred the two full-time employees who monitor SEP agencies from DHS to HCPF.

Service Provider Quality Assurance—Colorado's Department of Public Health and Environment, Division of Healthcare Facilities (DPHE) monitors the safety and quality of all Medicaid long term support providers. DPHE certifies home health agencies, personal care agencies, and providers of homemaker services, adult day care, and personal emergency response systems. DPHE licenses nursing facilities, assisted living facilities, home modification providers, and transportation providers. DPHE notifies HCPF when a provider is licensed or certified, and when DPHE determines a provider cannot be licensed or certified. For new providers, HCPF forwards the information to Colorado's Medicaid fiscal agent, which sends contracts to new providers. HCPF informs the provider directly if the provider does not meet licensure or certification requirements.

In recent years, DPHE has made the surveying process more rigorous for home health agencies and personal care agencies, the most common home and community-based services providers in Colorado. First, DPHE changed the survey protocol in 1998 to focus more on participant outcomes rather than process compliance. Since this change, DPHE staff review a sample of participants as part of each survey to evaluate whether they received the appropriate services and how the services influenced the individuals' independence. In 2001, DPHE developed a survey tool to standardize the surveys so staff review the same types of case management and service provision records. The survey tool added reviews of complaint data and, for home health agencies, data from the federally required Outcome and Assessment Information Set (OASIS). DPHE also set guidelines for the frequency of personal care provider surveys, which are conducted at least every two years.

Lessons Learned

Colorado's implementation of a system of Single Entry Point (SEP) agencies for Medicaid long term care increased the integration of home and community-based services. For example, the creation of a single assessment process for nursing facility services and for several home and community-based services programs for older people and people with disabilities ensured that case managers know about all programs and services and can pass along that knowledge to prospective participants.

The transition from a county-based long term care system to one with regional SEP agencies required broad involvement from the community in order to build political support. Colorado involved a variety of stakeholders early in the process, both through the state agency's advisory committee and through the legislative task force. The SEP system also established local advisory committees and resource development committees to ensure advocates, providers, and local governments have a voice in local long term care system development. .

Colorado further integrated services by increasing the duties of SEP agencies to include service authorization as well as assessment and case management. Since 2002, the SEP agencies have authorized long term home health services under the Medicaid state plan. SEP agencies also now determine functional eligibility for all Medicaid HCBS waiver and state-funded long term services for older adults and adults with physical disabilities. These additional responsibilities increase the degree to which SEP agencies can make home and community-based services more cost-efficient. For example, SEP agencies have the opportunity to inform home health participants about Medicaid HCBS waiver options, and people have the option to choose personal care or the new in-home supportive services option under the waiver instead of the more expensive home health aide services.

While Colorado has made significant progress in integrating services for older people and people with physical disabilities, some sources noted opportunities for further integration of home and community-based services. For example, some people reported service coordination challenges for people with multiple diagnoses who qualify for services from both the SEP system and the service system for either people with mental illness or people with developmental disabilities. Like residents in many states, Coloradoans who require services from multiple systems, such as people with physical disabilities and mental illness, could benefit from improved coordination across these systems.

Bibliography

Berens, Aggie. Personal Correspondence. May 30, 2003.

Burwell, Brian; Eiken, Steve; and Sredl, Kate. *Medicaid Long Term Care Expenditures in FY 2002*. Medstat, May 13, 2003.

Coffey, Todd. Personal Correspondence. May 14, 2003.

Colorado Department of Health Care Policy and Financing. "CMS 372 Report". Initial Report for Elderly, Blind and Disabled Waiver covering July 1, 2001 through June 30, 2002. November 25, 2002.

Colorado Department of Health Care Policy and Financing. *Assumptions and Calculations: Legislative Budget Request FY 04-05* November 3, 2003.

Colorado Department of Health Care Policy and Financing. *FY 04-05 Budget Request: Change Request for FY 04-05* November 3, 2003.

Colorado Department of Health Care Policy and Financing. *Staff Manual Volume 8 – Medical Assistance* Updated June 20, 2003.

Colorado Department of Health Care Policy and Financing. *Consumer Directed Attendant Support Application Packet* Updated June 24, 2003.

Colorado Department of Health Care Policy and Financing "Provider Bulletin: In-Home Support Services" October 1, 2003.

Colorado Department of Health Care Policy and Financing. *HCPF Consumer-Directed Programs: Key Feature Comparison Chart* undated.

Colorado Department of Public Health and Environment. "A Comparison of the Survey Process From 1993 to 2001" undated.

Colorado Department of Public Health and Environment. "Home and Community Based Services PCP/Homemaker Survey Cycle Guidelines" June 20, 2002.

Colorado Department of Social Services. *Long Term Care: New Dimensions for Colorado* September 1989.

Colorado Department of Social Services. *Improving Client Access to Long Term Care in Colorado: Report of a Study to Build a Long Term Care System* November 30, 1990.

Colorado Department of Social Services. *Single Entry Point System for Long Term Care: Detailed Implementation Plan* September 1, 1991.

Colorado Office of the State Auditor. *Home and Community Based Services and Home Health Services: Performance Audit* June 2001.

Kitchener, Martin; Ng, Terence; and Harrington, Charlene. *Medicaid Home and Community-Based Services Program Data, 1992-2001* Kaiser Commission on Medicaid and the Uninsured, June 2003.

Medstat. "Promising Practices in Home and Community-Based Services: Colorado – Increasing Persons' Control Over Personal Attendants" Published by the Center for Medicare and Medicaid Services, updated March 10, 2003.