HB 1374 Long-term Care Transitions Working Group

Final Report
[final edits as of 12/5/2007]

LETTER OF TRANSMITTAL AND ACKNOWLEDGMENTS

DATE: November 30, 2007

TO: Department of Health Care Policy and Financing

The House Bill 07-1374 Working Group is pleased to submit its final report to the Colorado Department of Health Care Policy and Financing pursuant to the reporting requirement specified in §25.5-6-104 (4) (a) (II).

HB 07-1374 WORKING GROUP MEMBERS

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EXECUTIVE SUMMARY

PROBLEM STATEMENT AND LEGISLATIVE CHARGE

The HB 1374 Working Group was authorized in the 2007 legislative session to tackle a number of problems that exist in the current Medicaid program that unnecessarily delay otherwise qualified individuals who need long-term care (LTC) Medicaid from receiving services in a timely fashion. The Working Group was charged with "study[ing] the eligibility process to facilitate a seamless transition from a hospital to an appropriate long-term care setting for an individual who is potentially eligible for long-term care" [25.5-6-104 (4) (a) (I)].

Over the past three months, the Working Group has identified a series of "bottlenecks" in the various eligibility determination processes for Medicaid long-term care and proposes three policy recommendations to rectify them. The group identified three additional areas where improvements are needed in the administration of LTC in Colorado— transparency of information including a clear, easily understood communications strategy for consumers and provider organizations about Colorado's LTC system; a strong and effective advocacy voice for LTC consumers; and high level state leadership in LTC programming, including interagency coordination.

The enabling legislation for the Working Group specifies that the group will provide recommendations that include federal funding opportunities and a timeframe for implementation of the group's recommendations. Because of the short time frame to complete the work of the group, these tasks remained undone. As a result, the Working Group respectfully requests that HCPF or its designee be tasked with completing these recommendation-related activities upon receipt of this final report.

RECOMMENDATIONS OF THE HB 1374 WORKING GROUP

Recommendation 1: Presumptive Eligibility

HCPF should implement a new federal option for establishing Medicaid presumptive eligibility for individuals being discharged from acute care hospitals to LTC services.

Recommendation 2: Issue an RFP to Contract out all LTC Medicaid Financial Eligibility Determinations

HCPF should issue a competitively bid Request for Proposal and contract with an entity to perform the financial eligibility determination process for all Medicaid LTC applicants.

Recommendation 3: Re-institute the Fast Track Program

HCPF should re-institute the Fast Track Program and make it available to hospitals on an optional statewide basis.

Recommendation 4: Develop Comprehensive Communication Plan

Develop strategies that improve communication among the agencies and community-based organizations that comprise the LTC system to provide consumers with accurate, timely, consistent and comprehensive information about LTC options in Colorado.

Recommendation 5: Enhance Advocacy efforts on behalf of LTC consumers

Create and/or empower an existing advocacy organization(s) that is/are independent of state government to assist consumers in resolving eligibility issues related to their participation in Medicaid LTC programs.

Recommendation 6: Establish Executive Level Leadership for Colorado's LTC Programs and Funding

Establish an executive cabinet-level position or Governor-appointed process that will elevate the visibility of programs that serve individuals with long-term care needs across state agencies and ensure that these services and their funding are coordinated across all affected state agencies.

TIMELINE OF SIGNIFICANT EVENTS IN COLORADO'S LTC POLICY DEVELOPMENT

Date	Event	Impact
1995	Establishment of Single Entry Point Agencies (SEPs) completed	All 25 SEP agency districts are fully operational. Individuals in need of LTC services have access to an SEP for a functional assessment and all individuals seeking community-based Medicaid support services must go through an SEP agency. SEPs develop care plans, arrange services and perform other ongoing case management functions. A statewide utilization review contractor (Colorado Foundation for Medical Care) reviews all assessments and approves HCBS or nursing facility care.
1996	Consumer Directed Attendant Support (CDAS) legislation passed	A specific demonstration waiver authorized in 1996 and implemented in 2001-02 establishing a consumer-directed attendant waiver program for participants with skilled home care needs. Enrollment, originally capped at 150, approaches 400 in 2007.
1997	Federal Balanced Budget Act of 1997	CMS implements Interim Payment System for Medicare home health agencies resulting in one-third of Colorado home health agencies going out of business.
1997	SB97-42 requires risk-adjusted payment for nursing facility care	This enables HCPF to pay nursing facilities according to patient resource requirements.
1999	*Olmstead* decision	The *Olmstead vs. L.C.* decision was a 1999 U.S. Supreme Court ruling that interpreted Title II of the Americans with Disabilities Act and its implementing regulations. *Olmstead* encourages states to administer long-term care programs "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." In response, the Bush Administration implements the New Freedom Initiative in 2001 which includes grant programs to facilitate *Olmstead* compliance. Colorado subsequently receives three Real Choices Systems Change grants, including a Nursing Facility Transition Grant.
2000	County-administered Med 9 process discontinued	Physician-authorized and county-approved disability determination deemed out of compliance with federal law. Applicants no longer able to qualify for Medicaid after 30-day stay in a facility. LTC providers begin not to accept patients.

Date	Event	Impact
2000	Disability determination contracted to Disability Determination Services (DDS)	Compliance with federal requirements narrows disability criteria and delays disability determination. Disconnect begins between financial and disability determination.
2000	50a task force established	Legislative charge: "The Department is requested to work with long-term care clients and providers, including home and community-based services, home health, and nursing facilities, to examine any issues of rate disparity and rate shortfalls within the long-term care continuum of care, to evaluate areas of greatest need affecting client services, and ways to control utilization and costs of these services and overall growth in the long-term care system."
2001	50a task force report released	The task force recommended rate increases ranging from 1.0 to 12.5 percent for home health and some HCBS services. The recommended increases were partly implemented in the FY 01-02 budget. The remainder of the recommended increases was implemented in the FY 06-07 and FY 07-08 budgets. The task force report also recommended additional study of nine other recommendations.
2001	State Auditor Report on operation of HCBS-EBD waiver and home health benefit	HCPF undertakes modification of rules and operations of HCBS and home health in response to audit recommendations and a footnote in the 2000 Long Bill indicating that the growth rate of home health expenditures needed to be slowed. Modifications include SEP authorization of long-term home health and review of budget neutrality statute (Statute required that budget neutrality be applied on an individual basis – i.e., LTC costs for each EBD participant had to be below average nursing facility cost. However, HCPF applied budget neutrality on a waiver-wide basis).
2001	Hospital providers close transitional care units (TCU) adjacent to hospitals	TCUs closed due to lack of reimbursement for care and need for inpatient acute beds. Less opportunity to place higher acuity patients. Emergency Medicaid for undocumented immigrants restricts payments to acute hospitals only.
2001	Fewer nursing facilities accepting Medicaid-pending patients	In response to TCU closures, hospitals become guarantors for care in post acute settings for those awaiting Medicaid approval.
2002	SEPs assume responsibility for authorizing LT home health care	SEPs better able to coordinate home health and waiver services.
2002	HB 02-1127 repeals individual cost containment for HCBS	HCBS waivers are deemed to meet budget neutrality standard if, in aggregate, they cost less than institutional care. This gives statutory authority to HCPF's long-standing practice of allowing some individuals whose home care costs exceed nursing facility costs to remain in HCBS.

Date	Event	Impact
2002	State fiscal constraints require each Department to put forward budget cut options. ADAPT leads protest of proposed home care rate cuts	In response to the ADAPT-led protest, HCPF negotiated budget reductions other than home care rate cuts and instituted a range of modifications of community-based long-term care programs including revision of the ULTC-100 assessment tool.
2003	SEPs assume responsibility for certifying functional eligibility for all long-term care services	Utilization review contract with Colorado Foundation for Medical Care terminated. Hospitals and nursing facilities no longer authorized to conduct functional assessments. This causes discharge delays for some hospital patients. Functional assessment, care planning and care management are centralized in SEPs. Involvement of SEPs improves patient awareness of community alternatives to nursing facility care.
2003	LTC assessment tool (ULTC-100.2) revised	New tool developed through an open process with input from clients, SEPs and LTC providers based on functional not medical criteria. The medical portion of the form has to be filled out by a licensed professional, resulting in additional work for hospital case management departments. SEPs have 72 hours to do the assessment which can delay transfers up to three days.
2003	CMS audits HCBS programs for people with developmental disabilities	CMS found numerous process violations. For example, consumers were getting waiver services that were not allowed under the waiver because they were available in state plan; Community Centered Boards (CCBs) were negotiating rates to get difficult clients served, making an unfair rate structure for providers; providers were not allowed to bill the state but all went through CCBs; and CCBs were operating as managed care systems without waiver authority. Required changes to DD system make it more like other waivers. Major administrative ripples included a new method of needs assessment, a new rate methodology, disruption of existing ways of administering the program and improved program transparency and accountability.
2003	Several New Freedom Initiative Systems Change grants awarded to HCPF for LTC reform efforts associated with the *Olmstead* decision	The Nursing Facility Transition Grant showed a savings of approximately $1,200 per month per consumer. The outlay for items such as first month rent, furniture, security deposits, etc. is usually less than $1,000 per client. JBC saw numbers and placed transition program in statute; full implementation not yet completed.
2003	Cost reports required of certain LTC providers	HCPF requires alternative care facilities (ACF) and home health agencies to submit cost reports as recommended by Footnote 50a Task Force. ACF requirement terminated in 2007.

Date	Event	Impact
2003	New contractor changes Pre-admission Screening and Resident Review (PASRR) process	All nursing facility placements required form to be filled out regardless of payer. SEPs complete PASRRs for Medicaid and Medicaid pending individuals which can be slower than prior procedure. This process is currently under review by HCPF.
2004	Implementation of Colorado Benefits Management System (CBMS) for Medicaid eligibility	Problems with determination of financial eligibility result in delays, postponements and inappropriate terminations for some LTC consumers. Hospital personnel could no longer work collaboratively with county technicians to review application status and assist with missing information. These problems continue to manifest themselves in 2007.
2004	Logisticare hired as transportation broker	Delays in approval for facility to facility transports. Not all counties covered by Logisticare, so multiple entities needed to be called and much confusion arose regarding which transportation vendors could be used.
2004	New Medicare payment system for nursing facilities implemented	Nursing facilities' Medicare income reduced. In response facilities are less likely to admit high acuity Medicaid patients. For example, nursing facilities are not accepting patients with Bariatric and extensive wound care needs. Hospitals unable to make supplementary payments to nursing facilities because of federal referral laws.
2004	State Services for Older Coloradans (DHS) Performance Audit	Report of the State Auditor found several quality of care and administrative concerns in services provided to older adults through the Area Agency on Aging network. New procedures for home care agencies contracting with Area Agencies on Aging instituted.
2005	Consumer direction authorized for all HCBS waivers	This is the state authorization only. Federal authorization has so far only been approved for 2 waivers, EBD and MI. HCPF will be requesting additional approvals. Consumer direction in EBD and MI will be effective 1/1/08. Many clients not yet aware that consumer direction is an option.
2005	SB 05-173 establishes the Long-term Care Reform Advisory Committee	Legislatively established committee meets monthly and produces report with 19 recommendations to improve the long-term care delivery system in Colorado.
ongoing	Nursing facilities not accepting "hospital pay" for Medicaid- pending patients because retrospective Medicaid reimbursement is too low for basic care needs	This makes it more difficult for hospitals to transition patients to nursing facilities.

Date	Event	Impact
2006	Federal Deficit Reduction Act and HB 06-1023 Special Session	Documentation requirements make it difficult or impossible for some applicants to demonstrate identity and legal residency.
2006	North Valley closed to any new referrals for Medicaid high-acuity patients	No LTAC (long-term acute care) provider will accept Medicaid, with the exception of Craig Hospital for SCI (spinal cord injury). Hospitals are unable to place patients who are medically complex, ventilator dependent or have severe head injuries with Medicaid pending. West Winds in Pueblo only known provider in CO accepting vent patients.
2006	Fewer nursing facilities accepting long-term patients (limiting their Medicaid beds)	Most developing short stay sub-acute units. Approved for transfer only when acuity and service level is low to mitigate loss on the case. Certain types of rehabilitative care severely limited, for example, physical therapy, occupational therapy and speech therapy.
2007	Licensed medical professional signatures are required for all HCBS waivers and nursing facilities.	Hospitals must have medical personnel fill out medical portion of ULTC 100.2. Previously this had been done by licensed clinical social workers in a discharge planning capacity. This is causing delays in hospital discharges.
2007	Hospital back-up program criteria narrow	Approval process for hospital back-up program is labor intensive and extremely confusing for hospital providers. Narrow criteria make it is extremely difficult to qualify patients. Currently, very few individuals are being served in this program. HCPF is reviewing the hospital back-up program.
2007	All SEPs required to report critical incidents, whether from home health or HCBS providers	Federal mandate for quality assurance that creates an additional reporting burden with unknown benefit.
2007	50a rate recommendations fully implemented	
2007	HB 07-1374 creates Working Group to study eligibility process	Working Group meets from August-November and prepares report with 6 recommendations regarding eligibility issues to facilitate "a seamless transition from a hospital to an appropriate long-term care setting for an individual who is potentially eligible for long-term care services."

SUCCESSES IN LTC POLICY DEVELOPMENT IN COLORADO

In the nearly four decades that Colorado has administered a Medicaid program, the program has offered a range of long-term care services to hundreds of thousands of low-income elders (individuals age 65 and older) and individuals with disabilities. While this report focuses on existing problems that these individuals face in gaining access to needed long-term care services, particularly as they relate to establishing eligibility in a timely fashion upon discharge from an acute care hospital, it is important to recognize that Colorado's LTC Medicaid program has fostered many successful innovations in care delivery and financing. As such, the program has been recognized as a national leader in providing community-based LTC options as a viable, safe and quality alternative to facility-based care. This section briefly summarizes four of these innovations:

- Successful development and implementation of several Home and Community-based Service (HCBS) waivers that provide a wide range of consumer-tailored services in community settings to diverse populations in need of skilled nursing level of care;
- Implementation of a statewide Single Entry Point (SEP) system for all individuals seeking supportive long-term care services;
- Multiple opportunities for consumer direction; and
- An innovative program to help nursing facility residents' transition to community-based services in their homes or other community settings.

HCBS Waivers

HCBS waivers are the primary vehicle available to states to provide nursing home level of care long-term care services to individuals with significant functional limitations in the community[1] as an alternative to an institutional setting such as a nursing home, intermediate care facility for mentally retarded individuals (ICF/MR) or a state hospital. With federal approval of the Elderly, Blind and Disabled (EBD) Waiver in the early 1980s, Colorado became one of the first states in the country to obtain an HCBS Waiver. Since that time, Colorado has established 10 other HCBS waivers for various targeted populations including persons living with AIDS, children with developmental disabilities and adults, persons with brain injury and, most recently, children with autism. In FY 06-07 over 30,000 individuals participated in these waivers, more than twice the number of individuals who received care in a nursing facility. Nevertheless, about three-quarters of all long-term care expenditures for elders and disabled Medicaid recipients are for nursing home care.

Each waiver has a specified list of covered services appropriate to the needs of the target population.[2] Individual care plans based on consumer need combine waiver services and,

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[1] A "community" residence can be a private home, a group home or an assisted living residence.
[2] For interesting details on each of the department's 11 HCBS waivers, see http://www.chcpf.state.co.us/HCPF/LTC/Waiver%20Chart%20_Feb%2017%202006_.pdf

where appropriate, home health services. More than half of all waiver participants in Colorado are in the EBD Waiver. Typical services include personal care for assistance with activities of daily living (ADLs) such as dressing, bathing and mobility, and homemaker services such as house cleaning and meal preparation. Colorado's HCBS waiver programs have continued to evolve with the recent addition of waivers for children with autism and several consumer-directed options discussed below.

Single Entry Point (SEP) System

The Colorado General Assembly enacted legislation that required a uniform long-term care client needs assessment process and instrument to be effective in July 1991. In order to facilitate an assessment tool that met the requirement of uniformity in process and approach, the single state Medicaid agency (then housed at the Department of Social Services) developed the concept of a Single Entry Point system that was originally piloted in three regions and was authorized for statewide expansion effective July 1, 1995.

At its creation, the responsibility of the SEP system was primarily focused on the uniform long-term care needs assessment process, coupled with development of a client care plan, ongoing case management and monitoring of the home and community-based waiver services authorized. Over the relatively short 12 years since statewide implementation, the responsibilities of the SEP system have continued to grow. In 2002 the Single Entry Points were asked to assume responsibility for authorizing long-term home health care, followed by assuming certification of functional eligibility in 2003. Both of these additions represent significantly increased importance of the SEP system in Medicaid-funded long-term care. Although the reimbursement methodology to SEP agencies has been modified over the years, the increases in responsibilities have not been commensurately reflected in the payment level.

Consumer Direction

Home and community-based services have traditionally relied on an agency model of service delivery. That is, a case manager would arrange for one or more agencies to provide the services needed for a waiver participant to live safely at home or other community setting. The agency, in turn, would assign one or more employees to provide authorized services to the waiver participant. Some waiver participants found this model of care delivery unsatisfactory. Caregiver turnover is a chronic problem and the unreliability of workers sometimes can lead to substandard care. When a satisfactory relationship with a caregiver is established, it still is true that a not insignificant portion of the Medicaid payment goes to agency overhead. Disability advocates argued that many waiver participants were fully capable of arranging for and directing their own care and the innovation that ensued came to be know as *consumer directed attendant support* (CDAS). Advocates successfully argued that the CDAS model of care would produce a higher quality of care with fiscal savings accruing to the state.

In 1996 the Colorado General Assembly directed the state's Medicaid agency (HCPF) to seek a federal waiver to implement a CDAS program. Implemented in 2002, the CDAS waiver enrolled individuals who had previously received home health and HCBS waiver

services purchased through the SEPs. After successfully completing training, CDAS enrollees hired and supervised personal attendants. Currently, there are approximately 400 participants in the CDAS waiver. The success of this pioneering program can be measured not only by enrollment growth but also by participant satisfaction and cost savings.

The initial success of the CDAS program led the legislature to expand opportunities for consumer direction in HCBS programs. In the 2003 session legislation was passed to establish a Consumer Directed Care for the Elderly waiver and add an In-Home Support Service option to the EDB waiver. In the 2005 legislative session, the department was directed to offer a consumer direction option in all HCBS waivers and to drop the requirement that participants must have 12 months of Medicaid-funded attendant support before participation in a consumer-directed option (HB 05-1243).

Nursing Facility Transition

The 1999 Supreme Court *Olmstead* decision established landmark parameters for federal and state long-term care policy. *Olmstead* encourages states to administer long-term care programs "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." In response to *Olmstead*, the Bush Administration implemented the New Freedom Initiative in 2001 which included a range of grant programs to help states comply with *Olmstead*. Colorado subsequently received three Real Choices Systems Change grants, including a Nursing Facility Transition Grant.

With the three-year transition grant, Colorado developed a program in which "navigators" from independent living centers helped nursing facility residents identify and secure the resources necessary to establish community-based residences. Funds were made available to purchase household items such as beds, utensils, linens and other essential furnishings. During the period of the grant, more than 800 individuals were informed of their right to choose community-based services and 111 individuals moved back into their communities. The initial success of this program in terms of consumer satisfaction and program savings resulted in HB 04-1219 which directed HCPF to add community transition services to the EBD waiver.[3] [See Betty's Story in Appendix B]

ISSUES, PROBLEM STATEMENTS AND RECOMMENDATIONS

Expedited eligibility determination

The HB 1374 Working Group has identified a series of "bottlenecks" in the eligibility determination processes for long-term care services and proposes three policy recommendations to address them. The bottlenecks often result in eligibility delays that exceed guidelines from the Centers for Medicare & Medicaid Services (CMS) and, in some cases, put individuals at risk of inappropriate long-term care placements, particularly following a hospitalization. The recommendations in this section include: establishing

[3] Colorado Department of Health Care Policy and Financing, FY 05-06 Budget Request, Strategic Plan

presumptive eligibility for LTC services; contracting out the financial eligibility determination process; and reinstituting the Fast Track program. While these recommendations differ in their specifics, they address a common problem described below. The recommendations are not presented in order of importance but rather are considered to be of equal importance in addressing the problems identified.

PROBLEM STATEMENT

Most often individual transitions from a hospitalization to an LTC setting are less than seamless due to delays in establishing eligibility for Medicaid-funded services. Eligibility delays can result in a range of adverse events including individuals being discharged to the community without sufficient supportive care in place, unnecessary extensions of a hospital stay and financial risks to a long-term care provider if the discharged individual doesn't qualify for Medicaid or is unable to gather all the paperwork necessary to establish eligibility prior to hospital discharge. For individuals with significant disabilities, a few days without supportive services can result in serious health consequences to the individual as well as adversely affect the state's financial exposure in the form of unnecessary acute care costs [See Mr. Jones' and Chrissy's stories in Appendix B].

An expedited eligibility determination would ensure that Colorado is in compliance with CMS standards,[4] prevent the likelihood of individuals developing secondary disabling disabilities, facilitate timely hospital discharges and ensure that Medicaid payments to LTC service providers result in the most appropriate supportive LTC services, allowing individuals to remain in their homes and communities in the least restrictive setting. [See Mary's story in Appendix B]

To qualify for Medicaid-funded LTC services, individuals must meet disability, financial and functional eligibility criteria that are specified in state and federal Medicaid and federal Social Security Administration (SSA) rules and regulations.[5] Currently, three different bureaucracies and/or agencies are responsible for establishing eligibility determination.

- To meet disability eligibility criteria, applicants to the Medicaid program under the age of 65 years must be deemed to be disabled as defined by SSA**.** Applicants must demonstrate that they are permanently disabled and not able to engage in

[4] CMS guidelines specify 45 days for financial and 90 days for disability determination to run concurrently, not consecutively.

[5] To be categorically eligible for Medicaid LTC as an elderly or disabled individual, one must be low income and 65 years of age or over or, if under age 65, determined to be disabled according to criteria established by the Social Security Administration. To be financially eligible for Medicaid-funded LTC, one must have an income below 300 percent of the Supplemental Security Income maximum grant, currently $1,869 per month. An income trust may be used to establish financial eligibility. Functional eligibility for Medicaid LTC is established through a functional assessment conducted by a Single Entry Point case manager using the state's functional assessment tool (the ULTC 100.2). This process is sometimes referred to as "level of care determination" because the applicant must have functional limitations that require a nursing facility level of care.

substantial gainful activity (SGA)[6] for at least 12 months in accordance with SSA criteria.

The Colorado Department of Health Care Policy and Financing (HCPF) contracts with Consultative Examinations, Ltd. (CEL), an Illinois-based firm, to pre-screen applicants for disability status according to the SSA criteria. Disability determination is necessary for individuals who previously have not had their disability status determined; those who are newly disabled, often upon a hospital discharge. CMS allows 90 days to complete the disability determination process. This timeframe is often exceeded by CEL, however, as a result of ongoing problems in the ways in which it processes applicant documentation paperwork. [See Mary's story in Appendix B]

Current practice is that county eligibility technicians are expected to start the process of disability determination by assisting applicants with filling out a rather complicated disability determination application form. In spite of this expectation, it has been reported that some county workers do not begin the process until other forms are completed or do so only after a significant lag time. If an applicant is currently appealing a disability decision from SSA, CEL will not complete its evaluation. The SSA appeals process is backed up 18-24 months in this region and therefore being in a state of appeal creates significant longer delays.

- Financial eligibility is currently determined by county social services departments or a Medical Assistance site. At the present time, Denver Health operates the only Medical Assistance site in Colorado that includes long term care financial eligibility. To be determined financially eligible for Medicaid LTC services, applicants must document that their monthly income is below 300 percent of the maximum monthly Supplemental Security Income (SSI) payment.[7] Applicants must also document that their resources are less than $2,000 if they are single; if married, they may follow special rules to protect the assets of the non-disabled spouse. Applicants with income above 300 percent of the maximum SSI monthly payment but below the local average cost of nursing home care can set up an income trust.[8]

  Some applicants for Medicaid LTC are already eligible for Medicaid acute care services because they receive SSI, a federal cash assistance program for low-income elders and people with disabilities. SSI financial eligibility requirements are stricter than those imposed by Medicaid, but once eligibility for SSI payments has

[6] In 2007, SGA for a non-blind individual was $900/month.
[7] $1,869 per month in 2007.
[8] An income trust allows a recipient of LTC Medicaid services to establish a trust, regulated by the Colorado Department of Regulatory Agencies, for the purposes of meeting the Medicaid financial eligibility requirements. The trust allows the recipient to retain up to 300 percent of the SSI maximum payment level per month to cover living expenses.

been established the recipient is also eligible for Medicaid acute care. SSI-eligible individuals are still required to go through the county-administered Medicaid financial eligibility determination process for LTC coverage.

Associated problems with the financial determination process include: the new federal requirement that individuals applying for Medicaid must produce proof of citizenship and proper identification documents, both of which are often hard for older adults or individuals with significant disabilities to produce; unnecessarily long delays in determining financial eligibility resulting from understaffed, ill-trained eligibility technicians (this is particularly true because of the high turnover rates in some counties among these positions); and currently eligible SSI recipients having to go through the Medicaid financial eligibility determination process all over again for the LTC benefit, in spite of already having been found eligible for Medicaid acute care benefits. [See Mr. Jones' story in Appendix B]

- Functional eligibility is determined by one of the state's 23 Single Entry Point (SEP) agencies. To qualify for Medicaid-financed long-term care services, an individual must need assistance with at least two activities of daily living (ADLs)[9] and may include protective oversight for individuals with cognitive limitations. In short, long-term care service needs are based on functional, not medical need criteria. An SEP case manager assesses the applicant's ability to perform six ADLs using the ULTC 100.2, a standardized assessment tool developed by the state. Functional eligibility for Medicaid LTC can be established if the applicant is found to need assistance in at least two ADL functional domains.

The following recommendations are designed to facilitate the "seamless transition from a hospital to an appropriate long-term care setting for an individual who is potentially eligible for long-term care" as called for in HB 07-1374.

1. Presumptive Eligibility

RECOMMENDATION

HCPF should institute a new federal option for establishing Medicaid presumptive eligibility for individuals being discharged from acute care hospitals to LTC services.

"Presumptive eligibility" is an option under federal law, specified in the Deficit Reduction Act of 2005, that allows a state Medicaid agency to establish rules and procedures to deem an applicant temporarily eligible for Medicaid services prior to final eligibility determination.

Presumptive eligibility can be granted if evidence is provided that an applicant will likely meet all of the criteria for disability and financial eligibility. Federal rules regarding presumptive eligibility allow up to 90 days of temporary eligibility status. During this time,

[9] ADLs include bathing, dressing, transferring in or out of bed or a chair, toileting, eating and walking.

an applicant or applicant's representative must provide the necessary documentation for a final determination of financial eligibility. If instituted, this interim eligibility period would provide applicants the needed time to get assistance with gathering needed documentation for their final eligibility determination. In the event that a presumed eligible applicant fails to establish eligibility, he or she would be terminated from Medicaid LTC at that time. Medicaid, however, would pay for services rendered between the determination of presumptive eligibility and termination. The state would be entitled to a federal match for all such expenditures. Experience with presumptive eligibility in other states with such a program suggests that greater than 90 percent of individuals are found to be eligible for Medicaid at the final determination of eligibility.

2. Contract out financial eligibility determination

RECOMMENDATION

HCPF should issue a competitively bid Request for Proposal and contract with an entity to perform the financial eligibility determination process for all Medicaid LTC applicants.

The Working Group concluded that Medicaid financial eligibility determinations and re-determinations currently conducted by county eligibility technicians for Medicaid LTC services are often unnecessarily delayed and that state rules and regulations are inconsistently applied across county jurisdictions. Among reasons cited by county workers for these delays are the challenges associated with implementation of the Colorado Benefits Management System (CBMS) and the complexity of the eligibility criteria governing Medicaid LTC applications. Although the majority of Medicaid applications and re-determinations are for low-income parents and their children, individuals applying for LTC Medicaid benefits face the most complicated eligibility process, and many counties do not have technicians that have been sufficiently trained to complete these applications in an expeditious way.

Both disability and functional eligibility determinations for LTC Medicaid are currently carried out by contractors (CEL and the SEP agencies). The Working Group recommends that the state should also contract out the financial determination process to facilitate this function being conducted by well-trained workers with sufficient knowledge to complete applications in a timely and consistent fashion. The new contractor, along with CEL and the SEPs, must be held accountable to robust performance standards, including financial sanctions for under-performance.

3. Re-institute the Fast Track Program

RECOMMENDATION

HCPF should re-institute the Fast Track Program and make it available to hospitals on an optional statewide basis.

Unlike the previous two recommendations, which would be implemented uniformly on a statewide basis, the re-establishment and expansion of the Fast Track program, which was

discontinued in 2003, should be an optional hospital-based solution. Initially funded by a grant secured by HCPF and then by local agencies, Fast Track consisted of a three-person team at Denver Health Medical Center that helped applicants establish eligibility for Medicaid LTC prior to hospital discharge by:

- Employing a "runner" to obtain the documents needed to establish financial eligibility;
- Using Denver Health on-site financial eligibility technicians to expedite the process;
- Having an SEP case manager complete a functional assessment (then approved by a utilization review contractor) and develop a care plan and arrange services for patients electing to receive their care in the community.[10]

A re-established and expanded Fast Track program has the potential to expedite eligibility determination since two of the three entities responsible for eligibility determination would be located at the hospital. Because the team is hospital-based, it would be in a better position to work with the individual, family members and representatives as well as the hospital discharge planner to determine the most appropriate setting for the individual to receive LTC services upon discharge from the hospital. This program would complement the goals of presumptive eligibility and outsourced financial eligibility and could be used in community hospitals with sufficient volume to warrant employing on-site resources.

Other issues and recommendations

To facilitate "seamless transition[s] from a hospital to an appropriate long-term care setting…" as well as access to LTC services more generally, the Working Group also identified three additional areas where improvements are needed. These recommendations include improved, user-friendly communication about LTC options, more effective advocacy for LTC-qualified individuals and coordinated leadership for LTC programs and services across several state agencies.

Communication/transparency

PROBLEM STATEMENT

The Working Group concluded that a lack of an identifiable, readily accessible source of clear information about Medicaid LTC programs and poor communication between hospital and nursing home discharge planners, SEP case managers, providers, and consumers and their representatives are barriers to individuals with long-term care needs getting timely access to care in the most appropriate setting after a hospitalization. On a statewide basis, there currently is no single place for individuals and families to get accurate information presented in a way that is culturally appropriate and easily understandable, regardless of education or cognitive limitations.

[10] From its beginning in 1997, the program evolved as funding opportunities changed and SEPs became responsible for level of care determination.

The Working Group identified the following factors that contribute to this problem:

- No single entity is responsible for knowing and understanding the range of resources available to individuals and their families at the point of discharge from an institutional setting.
- Miscommunication between agencies or inside agencies results from having no centralized, clear source of LTC eligibility and placement information.
- Fragmented funding streams create multiple, overlapping and sometimes conflicting regulations that govern the eligibility and services available to LTC consumers.
- Multiple case managers representing different points in the system, often with conflicting information, cause family and consumer confusion and frustration and result in gaps in care.
- Staff turnover at HCPF, county social services and other community organizations impedes the knowledge transfer necessary to conduct appropriate post-hospital placements.
- In some cases, county workers make decisions that are not based on the most current regulations and rules available. [See Rachel's Story in Appendix B]

RECOMMENDATION

Develop strategies that improve communication among the agencies and community-based organizations that comprise the LTC system to provide consumers with accurate, timely and consistent information about LTC options in Colorado.

The communications strategy should be informed by LTC consumers' needs and preferences and include the following features:

- Communication between state and local agencies and LTC consumers written in a language understandable to a broad range of consumers. Information formats should be tested on a broad range of consumers representing all types of disability, i.e., cognitive, developmental, behavioral and physical, before being implemented on a statewide basis;
- A system-level resource coordinator who is knowledgeable about the full range of LTC options, including eligibility requirements, application processes and community resources, available in each SEP region of the state, preferably housed in each SEP;
- An information clearinghouse, modeled after the Aging and Disability Resource Center, that would house comprehensive and up-to-date information and is readily accessible to all LTC consumers; and
- A Web site with FAQs that is interactive and operates on a real-time basis.
- Consumers who utilize LTC services involved at all stages of information development with input on both printed and Web-based materials before they are finalized.

Advocacy

PROBLEM STATEMENT

The Working Group found that consumers' full and appropriate participation in Medicaid LTC options is compromised by the complexity, fragmentation and multiplicity of programs and providers that comprise the LTC continuum of services. This complexity is underscored by the fact that there is no single person or entity empowered to resolve problems encountered by individual consumers. Even with greater transparency and improved channels of communication, consumers of Medicaid LTC services may still need an advocate to assist them in maneuvering through the maze of programs and program requirements. There currently exists a range of private sector advocacy organizations, some of which are condition or disability-specific, that may be available to consumers. There is no one place consumers can contact to find out what different advocacy organizations exist, however. [See Mary's and Chrissy's story in Appendix B]

RECOMMENDATION

Create and/or empower an existing advocacy organization(s) that is/are independent of state government to assist consumers in resolving eligibility issues related to their participation in Medicaid LTC programs.

This advocacy organization must be authorized by the state and empowered to assist in the resolution of issues that arise regarding LTC eligibility and program quality. It could take the form of a Consumer Resource Center that would be staffed by individuals who are fully versed in all relevant rules and regulations pertaining to LTC Medicaid. These advocates would provide a broad range of services to consumers including but not limited to assisting them with gathering needed documentation and completing application forms, and providing access to resources for getting to clinical evaluation appointments. These functions could potentially be performed by the financial eligibility contractor selected through a competitively bid process and held to high accountability standards that include responsiveness to consumers' needs for information and assistance with the eligibility determination process.

Leadership

PROBLEM STATEMENT

Individuals enrolled in or potentially eligible for Medicaid LTC have needs that are not met solely by Medicaid-funded services and extend far beyond Medicaid eligibility. Various state agencies are responsible for the supportive services that comprise the community-based LTC continuum, making it difficult for individual consumers and LTC organizations to coordinate care across the service continuum. For example:

- The Colorado Department of Public Health and Environment (CDPHE) is responsible for surveying, certifying and/or licensing LTC providers;

- The Department of Regulatory Agencies (DORA) licenses the majority of health care professionals that provide skilled LTC services;
- The Department of Human Services (DHS) administers LTC programs, some Medicaid funded and many others funded by the federal Older Americans Act, for individuals enrolled in or potentially eligible for LTC Medicaid at some time in the future;
- The Colorado Department of Local Affairs (DOLA) Division of Housing has responsibility for administering a range of federal Section 8 Housing programs including those for people with disabilities. Additionally, local housing authorities administer public housing programs and decide what percentage of units to set aside for people with disabilities. The Department of Human Services also operates a housing program for elders and people with disabilities.
- The Colorado Department of Labor and Employment (CDLE) addresses issues related to the LTC workforce; and
- The Colorado Department of Transportation (CDOT) provides grants for some human services transportation but each transit district is responsible for paratransit services. CDOT does pass through dollars for rural and frontier areas based on national DOT funding programs. Transit funding for larger entities such as Denver's Regional Transportation District is direct with no state agency pass through.

The Working Group has noted that health care for people with disabilities in need of LTC services has received little attention in the deliberations of the SB 208 Blue Ribbon Commission for Health Care Reform. This is the most recent indication of a broader problem of long-term care programs and services not receiving adequate attention in health reform discussions despite the large proportion of the Medicaid budget that is spent on Medicaid LTC.

At one time Colorado was considered a leader in the field of LTC policy in terms of program innovation and change in the incentive structures to promote community-based alternatives to institutional care. In the recent past, executive leadership has waned and Colorado has lost significant ground as a leader among states. Colorado has not produced an *Olmstead*/ADA implementation plan and missed an opportunity to receive federal dollars in 2006 for this purpose.

RECOMMENDATION

Establish an executive cabinet-level position or governor-appointed process that will elevate the visibility of programs that serve individuals with long-term care needs across state agencies and ensure that these services and their funding are coordinated across all affected state agencies.

Based on documented accountability failures in the current state system, the Working Group strongly recommends a cabinet-level position or governor-appointed process be created to coordinate the various state agency roles in the allocation of state and federal funds and to ensure program accountability for publicly funded LTC services in Colorado.

A cabinet-level position with the authority to coordinate affected agency policies and procedures that serve the interests of people with long-term care needs of all ages would ensure the appropriate level of accountability in the allocation and oversight of public dollars devoted to services along the LTC continuum. Additionally, an advisory group consisting of consumers, representatives, advocates, contractors and service providers should be formed to give voice to the needs of LTC consumers.

APPENDIX A

GLOSSARY OF TERMS

Activities of Daily Living (ADLs)	Personal care activities that individuals without functional limitations conduct independently. For individuals with functional limitations, ADLs are ranked on a scale based on how much the individuals depend on others to perform these activities. ADLs include bathing, dressing, transferring in and out of bed or a chair, bladder and bowel control, and eating. (Family Practice Notebook: www.familypracticenotebook.com/GER11.htm, accessed 8/4/05)
Adjudicated Claim	A claim that has reached final disposition such that it is either paid or denied.
Adult Day Services	Health and social services, individual therapeutic and psychological activities furnished on a regularly scheduled basis and provided in a specific location such as an adult day health center. Adult day services are targeted at frail elders and younger adults with disabilities who would be eligible for a skilled nursing facility but who are living in the community.
Aging and Disability Resource Center (ADRC)	A single, coordinated entry point into the long-term care system that includes information, referral, functional and financial assessment, and access to long-term care providers for all individuals seeking long-term care supportive services. An ADRC serves individuals who need long-term support, their family caregivers and those planning for future long-term support needs, regardless of income. An ADRC also serves as a resource for health and long-term support professionals and others who provide services to the elderly and those with disabilities. (http://www.hcbs.org and www.aoa.gov/prof/aging_dis.asp, accessed 5/23/06)
Alternative Care Facilities (ACF)	Private assisted living residences that provide food, assistance with transportation, protective oversight, and social and recreational services to meet residents' needs. Residents include Medicaid clients found to be eligible for home and community-based (HCB) services and who can be appropriately placed in an assisted-living residence. ACFs are licensed by the CO Department of Public Health and Environment. (http://www.chcpf.state.co.us/HCPF/Pdf_Bin/2002-10Doc4.pdf, accessed 5/25/06)
Area Agencies on Aging (AAA)	Established under the federal Older Americans Act (OAA), AAAs plan, coordinate and offer services that help older adults remain in their homes. By making a range of options available, AAAs make it possible for older individuals to choose the services and living arrangement that best suits their individual needs. (www.n4a.org/aboutaaas.cfm, accessed 5/53/06)
Assisted Living	A broad range of personal care and homemaker chore services that do not include skilled nursing care (a.k.a., assisted-living residences or alternative care facilities).
Bundled Payment	A single comprehensive payment for a group of related services.
Capitation	A global payment for a defined set of services on a per-person basis (www.dictionary.com, accessed 5/31/06).

Case/Care Management	A constellation of assessment and care coordination services whereby medical, social and other supportive services are coordinated by a professional care manager.
Case/Care Manager	A trained professional who coordinates, monitors and ensures that appropriate and timely services are provided to individuals with complex health and social needs.
Categorically Needy	Individuals eligible for Medicaid by virtue of being a member of a designated category such as low-income elders or people with disabilities. Unlike "medically needy," "categorically needy" individuals may not "spend down" their income to qualify for Medicaid.
Centers for Medicare & Medicaid Services (CMS)	Formerly known as Health Care Financing Administration. The administrative agency within the federal Department of Health and Human Services that administers the Medicaid, Medicare and the State Child Health Insurance programs.
Colorado Benefits Management System (CBMS)	A technology-based eligibility determination system that was developed to improve and expedite access to public assistance and medical benefits by providing a one-stop system for clients seeking public assistance. When fully operational, CBMS will permit faster eligibility determinations and increase the accuracy and consistency of the eligibility determination process on a statewide basis. Jointly developed by the Colorado Department of Human Services (DHS) and Department of Health Care Policy and Financing (HCPF) to replace six older information and eligibility determination systems. (http://www.cbms.state.co.us, accessed 5/23/06)
Colorado Regional Health Information Organization (CORHIO)	A statewide coalition of interested individuals, health care providers, agencies, organizations and community leaders working to build and monitor an electronic health information exchange network. (http://www.coloradohealthinstitute.org/Documents/corhio/charter-structure.doc, accessed 5/23/06)
Community-based Long-term Care (CBLTC)	A continuum of long-term care (LTC) services that combines housing and social supports for people who are unable to remain completely independent in their own homes. (http://www.ncsl.org/programs/health/forum/longtermcare.htm, accessed 5/23/06)
Community Centered Board (CCB)	A private for-profit or nonprofit corporation that provides case management to people with developmental disabilities. CCBs are authorized to determine eligibility of such people within a specified geographical area. They serve as a single entry point (SEP) for people to receive support and services. Authorized services are distributed to people either directly or by purchasing such services and supports from services agencies. (http://www.state.co.us/gov_dir/leg_dir/olls/sl2003a/sl_308.htm, accessed 5/26/06)
Consumer-Directed Attendant Support Program (CDAS)	A Colorado Medicaid optional program that pays for consumer-directed attendant care services to qualified clients. Consumers hire, fire and manage the terms of employment of their personal care worker.

Deficit Reduction Act (DRA) of 2005	The 2005 Congressional Budget Resolution Act. The act contains legislative changes that reduced federal outlays and directed program changes. (http://www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf, accessed 5/24/06)
Department of Health Care Policy and Financing (HCPF)	The Colorado single state agency responsible for administering the Medicaid program, Child Health Plan Plus (CHP+) and the Colorado Indigent Care Program. (http://www.chcpf.state.co.us/default.asp, accessed 5/23/06)
Department of Health and Human Services (DHHS)	The U.S. government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. Federal programs administered by DHHS include Medicare, Medicaid, health and social science research, disease prevention (including immunization services), assuring food and drug safety, health information technology, financial assistance and services for low-income families, improving maternal and infant health, Head Start (preschool education and services), prevention of child abuse and domestic violence, substance abuse treatment and services for older Americans, including home-delivered meals. (http://www.hhs.gov/about/whatwedo.html, accessed 6/1/06)
Department of Human Services (DHS)	The Colorado state agency that provides social and human services including public assistance and child welfare services. DHS is responsible for the administration of the state's public mental health system, the system of services for people with developmental disabilities (except Medicaid), the juvenile correctional system, older American Act programs and veteran's nursing homes. (http://www.cdhs.state.co.us, accessed 6/1/06)
Dual Eligible	A low-income Medicare beneficiary who is also eligible for Medicaid coverage.
Federal Poverty Level (FPL)	The FPL is an annual calculation used to determine financial eligibility for certain federal and state programs. Poverty level is measured by poverty thresholds and updated annually by the Census Bureau. In 2007, the poverty threshold for an individual is $10,210, and for a family of four, $20,650. For other year's FPL thresholds see: http://aspe.hhs.gov/poverty/index.shtml.
Functional Assessment	An assessment that determines eligibility for Medicaid long-term care services based on functional limitations using ADL criteria.
Home and Community-based Service Waivers	The federal Omnibus Budget Reconciliation Act of 1981 (OBRA-81) authorized home and community-based waivers under Medicaid, giving states more flexibility in how they provide long-term care services and to serve as an alternative to nursing home placements. In Colorado, six HCBS waivers serve adults with long-term care needs in the community. These six waivers include the following population groups: individuals with brain injuries (HCBS-BI); individuals with developmental disabilities (HCBS-DD); individuals who are elderly, blind or have a disability (HCBS-EBD); individuals with serious and persistent mental illness (HCBS-MI); people living with HIV/AIDS (HCBS-PLWA); a targeted supportive-living waiver (HCBS-SLS); and five children's waivers.

Health Maintenance Organization (HMO)	An integrated health care delivery system that provides the full range of health care services through a capitated reimbursement system.
Home Care Allowance (HCA)	A special cash allowance in Colorado for the purpose of securing supportive service for low-income, functionally impaired individuals in their home. Eligible individuals may select any person over 18 years of age to provide needed services. People living in an adult foster care residence also may use this program.
Home Care Agency	A long-term care provider certified by the state to provide health and supportive services in the home to Medicare beneficiaries and Medicaid recipients.
Housing and Urban Development (HUD)	A federal agency created to increase home ownership for low-income individuals, support community development and increase access to affordable rental housing. (http://www.hud.gov/library/bookshelf18/hudmission.cfm , accessed 5/24/06)
In-Home Support Services (IHSS)	A service under some HCBS waivers that allows Medicaid clients who are eligible to direct, select and train their own attendants under the supervision of a home health agency. Services include health maintenance activities, support for activities of daily living or instrumental activities of daily living and homemaker services. (http://www.chcpf.state.co.us/HCPF/Syschange/IHSS_Intro.asp, accessed 5/25/06)
Instrumental Activities of Daily Living (IADL)	Household activities a non-disabled individual can perform independently. A functional assessment scale is used to determine the level of dependence on others needed to perform these activities. IADLs include use of the telephone, traveling via car or public transportation, food or clothes shopping (regardless of transport), meal preparation, housework, medication use and money management. (Family Practice Notebook: www.familypracticenotebook.com/GER11.htm, accessed 8/4/05)
Intermediate Care Facility/Mental Retardation (ICF/MR)	A long-term care facility that provides medical care and supervision, nursing services, occupational and physical therapies, activity programs, educational and recreational services, and psychological services for people with a cognitive developmental disability. An ICF/MR also provides assistance with ADLs and IADLs, including meal preparation, housekeeping, personal care and medication management.
Individual Residential Services and Supports (IRSS)	Residences for people with developmental disabilities. These homes serve fewer than four people and provide habilitative services and supports as needed for living in the community, such as personal hygiene, money management, supervision services, cooking, shopping, community access, daily living activities and others.
Long-Term Care (LTC)	A range of medical and/or social services designed to help people of any age who have disabilities or chronic health care needs. Services may be provided in an individual's home, a community-based setting or in a residential care facility (e.g., nursing homes or assisted living facilities). (http://www.hcbs.org/glossary.php#L, accessed 6/1/06)
Managed Care	A comprehensive approach to the provision of health care services

	that combines clinical services and administration procedures within an integrated, capitated system. The approach is based on the philosophy that when care is managed, comprehensive and seamless better clinical outcomes are achieved.
Medicaid	A federal/state partnership program that provides coverage for health and long-term care services to low-income eligible population groups. Medicaid, also known as the Medical Assistance Program, is authorized by Title XIX of the Social Security Act.
Medicare Savings Program	An eligibility category within the Medicaid program in which the state pays monthly premiums to the federal government on behalf of eligible low-income Medicare beneficiaries for their Medicare Parts A and B premiums and cost-sharing obligations.
Minimum data set	The federal data collection system for assessing nursing home patients. The MDS is a comprehensive resident assessment instrument (RAI) that measures functional status, mental health status and behavioral status to identify chronic care patient needs and formalize a care plan in response to 18 Resident Assessment Protocols (RAP). Under federal regulation, assessments are conducted at the time of admission to a nursing facility, upon return from a 72-hour hospital admission or whenever there is a significant change in resident status.
Outcome and Assessment Information Set (OASIS)	The Outcome and Assessment Information Set (OASIS) is a group of data elements that represent core items of a comprehensive assessment for an adult home care patient and form the basis for measuring patient outcomes for purposes of outcome-based quality improvement (OBQI). The OASIS is a key component of Medicare's partnership with the home care industry to foster and monitor improved home health care outcomes and is proposed to be an integral part of the revised Conditions of Participation for Medicare-certified home health agencies (HHAs).
Old Age Pension (OAP)	A Colorado program that provides assistance and health care benefits for low-income people 60 years and older. (http://www.larimer.org/seniors/oap.htm, accessed 5/24/06)
***Olmstead* Decision**	In 1999, the U.S. Supreme Court ruled in *Olmstead vs. L.C.* that states cannot discriminate against people with disabilities by providing long-term care services only in institutions when certain individuals could be served in the community. The decision encourages states to reevaluate how they deliver long-term care services to people with disabilities. The decision affirms the state's duty to modify its policies, practices and procedures to provide services in the most integrated setting appropriate as long as such modification does not create a fundamental alteration in the program, service or benefit.
Program of All-Inclusive Care for the Elderly (PACE)	A fully capitated program that blends Medicare and Medicaid funds to provide a comprehensive array of primary, acute and long-term care services for frail elders who are eligible for a skilled nursing facility level of care. PACE was authorized as a state plan option in the Balanced Budget Act of 1997 and existed as a waiver prior to 1997.
Per diem	A form of payment for services in which the provider is paid a daily

	fee for specific services.
Personal Care	Personal care services include physical care such as bathing, grooming, hygiene and assistance with ambulation.
Skilled Nursing Facility	A long-term care facility licensed under state law and certified by Medicare and Medicaid that provides 24-hour continuous skilled nursing care for individuals with significant functional, psychological and/or emotional limitations.
Single Entry Point (SEP)	An agency that provides information and referral, functional assessments for long-term care services, care management and the brokering of a wide variety of community supports for eligible individuals. The Colorado Single Entry Point system includes 23 public or private community agencies around the state.
Supplemental Security Income (SSI)	A cash assistance program authorized under the federal Social Security Act that provides monthly cash payments to low-income elderly (age 65 years and older) and individuals with a permanent and significant disability. (http://www.ssa.gov/pubs/11000.html#part1, accessed 8/3/05)
Systems Change Grants	Since 2001, CMS has issued over $200 million in grants to all 50 states, the District of Columbia and two territories to "design and construct systems infrastructure that will result in effective and enduring improvements in community long-term support systems." These system change grants are designed to enable children and adults of any age who have a disability or long-term illness to live in the most integrated community setting appropriate to their individual support requirements and preferences; exercise meaningful choices about their living environment, the providers of services they receive, the types of supports they use and the manner by which services are provided; and obtain quality services in a manner as consistent as possible with their community living preferences and priorities. (*Medicaid Program: Real Choice Systems Change Grants* at: http://www.cms.hhs.gov/systemschange/2005rcsolicitation.pdf, accessed 8/3/05)
ULTC 100.2	A functional assessment tool based on ADL and IADL limitations to determine level of function and subsequently eligibility for long-term care programs and services in Colorado.

APPENDIX B
CONSUMER STORIES

BETTY'S STORY

For over 30 years, Atlantis Community has offered support, services and programs to facilitate community integration opportunities for people with disabilities to maintain and maximize their independence in the community.

The Rental Housing Access Modification Program (RHAMP) provides funding to eligible renters in the City and County of Denver to modify their homes as needed to remain in a community setting. Betty was referred to RHAMP by the Denver Commission for People with Disabilities and subsequently called to inquire about the program. Betty needed modifications for her home so that she could leave a nursing facility where she was currently residing. A meeting was set up to discuss the Community Transition Services (CTS) Program, of which RHAMP is a service offered.

At the meeting, Betty said she did not need transitional services because she would be going home the next day. She seemed puzzled when asked if she had a plan for moving and it soon it became apparent that before entering the nursing home she was utilizing a very supportive but strained informal support system. Staff at Atlantis Community immediately began to develop a transition strategy and plan which included helping Betty apply for the HCBS-EBD program and connecting her to the SEP for assessment and care planning.

MR. JONES'S STORY

Mr. Jones is an elderly man who was already enrolled in the Medicaid program. In early July, he was hospitalized. When his discharge was imminent, it was clear that he would need Medicaid long-term care services in order to return to living in a community setting. An SEP case manager completed his functional assessment within two business days. He was discharged to his daughter's home in another county in Colorado from his home county. Since he was now applying for LTC services in addition to regular acute care Medicaid, he needed to reapply to Medicaid to establish his financial eligibility for LTC in his home county. Once found eligible, he then had to apply for Medicaid financial eligibility in his daughter's county of residence and wait for the paperwork to be transferred from his county of residence to hers. From July until December, the SEP had 15 documented correspondences between the counties involved. During this time, Mr. Jones was re-hospitalized on two occasions. Mr. Jones died in December of that year, having never received the LTC services for which he applied because his financial eligibility for LTC services was caught between the counties and never approved.

MARY'S STORY

My name is Mary. I want to share with you my story about my recent experience applying for Colorado's Medicaid program. I write this with the help of a friend for you to understand the real-life consequences of a broken system and the impact to those of us

who require help after many years of paying taxes and making productive contributions to society. I am unable to put my thoughts down on paper by myself, nor type a letter. To know me is to understand I am (was) a very resilient and strong individual and have worked in the health care system for many years, until, due to my disease process, I was forced to retire.

I graduated nursing school in the mid-1980s and was also diagnosed with multiple sclerosis (MS). I worked in a Denver hospital as a bedside nurse for many years. I married and had two children. My illness progressed and began affecting my ability to walk and stand for long periods of time. As a result, I began my career in case management in the mid-1990s. Ironically, I was the lead case manager for the State of Colorado employee benefits program, acting as their advocate for health-related issues. To give you a sense of my work ethic, when my MS would flair up, I would go to work hooked to the IV steroids and go about my work day. It meant more to me to care for the state employees than to stay home since some of them had no one but me to assist them.

In 1996 my husband left work early to celebrate our anniversary and was killed by a drunk driver on his way home. I was now a widow, with MS and a 3- and 7-year old to support. I endured a lengthy trial and conviction of the person who killed my husband. The stress of the events caused an exacerbation of the MS and the emotional toll led to the diagnosis of bi-polar disorder. During this difficult time I still found the energy to participate in community activities that benefit others.

Eventually, I was unable to maintain a full work schedule and had to decrease my hours to part time. Five years ago, I retired from my job because I was unable to cognitively perform at a consistent level. I applied for Medicare and was approved for disability and started receiving SSDI benefits.

I made the decision to move from my home to a custom home where I was able to live for the rest of my life. I put all of my savings and equity of my previous home into my new home. The restitution payments for my sons ceased to come from the man who killed my husband since he had disappeared from the system and the courts could do nothing to assist.

In May of 2007 my son was admitted to the hospital for inpatient psychiatric care and was diagnosed as bi-polar. My 14-year-old son was covered under the Medicaid program, but his coverage lapsed due to a form not being filled out. I continue to battle paying these claims and my ability to obtain his necessary medications. I have had to call the EMS system on a number of occasions because of issues with his behavior.

By July 2007, I was unable to feed my children or pets and was advised to move from my dream home. I was down to 88 pounds because of the extreme stress and lack of an adequate diet. I was unable to walk more than a few feet at a time and used a wheelchair for basic mobility. My dream home went to foreclosure in September.

Cognitively I cannot understand complex information and my memory has diminished to the point where I need to write things down to remember tasks. If I happen to write these down and do not remember where I put the list, it goes unrecognized. I am disorganized because of this, and my priorities are driven on the crisis of the moment because I cannot remember the crisis of the day prior. Due to my lack of cognitive ability I cannot remember when or where I spend money or how to budget my income. I have a terrible credit rating at this point and it is difficult for me to arrange basic services such as phone and electric service. I owe tens of thousands of dollars and see no way out of this financial situation. My car was repossessed two weeks ago and I have trouble getting myself and my son to necessary doctor appointments.

My friend assisted me in applying for Medicaid, because I am no longer able to care for myself sufficiently and require assistance in the home. The application was submitted three months ago. I continued to deteriorate and was admitted to the hospital two months ago. While I was in the hospital a referral was also made to the Palliative Care Program at a hospice. The SEP opened my case and came to see me in my home. Unfortunately I cannot receive any services until my Medicaid is approved. To this day, I am still waiting for services and my Medicaid has not been approved. I just received a denial letter from the SEP and I do not understand why. I have called my Medicaid case manager and so has the social worker from the hospice to ask about the status of my application. If I am lucky enough to get a call back, I am told it is still being processed, three months later. I have a disability and I am broke. I thought that was the qualifying criteria.

I do not have any family in Colorado and those that are out of state are too overwhelmed with their own family situation to help me. I have a few friends that assist me on occasion, but they also lead very busy lives and help when they can. I have been taken advantage of from realtors, car salesman, banks and lending companies. It is demoralizing to be part of the health care system I once participated in with high standards. The need for advocates for people in my situation is a must. With help I believe neither my son nor I would have required hospitalization to stabilize our situation. We also would not have needed to access EMS and the police if there was sufficient infrastructure established. I would probably still have my home if my memory problems were recognized and the appropriate assistance provided to assure my bills were paid. I need help after so many years of helping others, and it just does not exist.

CHRISSY'S STORY

Chrissy is a disabled veteran living in a Colorado community along the Front Range. She has several disabilities, some service connected, some not. When her disabilities became worse she found herself in the hospital. The hospital social worker filled out a referral and completed a functional assessment, sending it to the local SEP in early February. Having not heard back, Chrissy went to the county office in mid-March; she did not get a response until mid-April. Chrissy continued to live in crisis and was forced to rely on a man who had been abusive to her in the past for care. Finally, the assessment conducted by the SEP was completed and she then had to fill out additional paperwork for the

county. The county subsequently sent a denial letter stating that she did not meet the level of care before the assessment was completed. When she presented the county with paperwork from the SEP that determined she did meet the level of care, the county maintained its claim of denial. Being resilient and persistent in seeking the care she needed, she called the county, the SEP and the HCPF customer service representative to make her case. Not until she contacted a private nonprofit disability rights organization that filed an appeal with an administrative law judge was her eligibility for LTC established. It was five months and one week after her initial hospital stay before her case was successfully adjudicated.

RACHEL'S STORY

Rachel has a rare and life-threatening illness. She was receiving services on an HCBS waiver when she had to be hospitalized. Because there are not any hospitals in Colorado that are able to adequately treat her specific condition, she sought treatment outside the state. She was hospitalized for approximately three months (some of the time in a sub-acute setting). During this time, she received personal care and medication monitoring by hospital and other facility staff. Rachel received a notice from her SEP that she was not using her HCBS services; however, that notice did not reach her in the hospital and therefore the county terminated her Medicaid without proper notification. Had they sent a notice directly to her, her mother could have appealed to keep her Medicaid active and changed it to institutional eligibility.

When she was discharged, Rachel was still fragile and was told she needed medical care, medications and in-home support services. The day she returned home, she had assistance with re-application and the SEP conducted an assessment that found her functionally eligible. The request for reinstatement was held by the county for more than 10 days before notifying her helper that she needed to resubmit a new Medicaid application. The helper made it clear that Rachel's life could be in danger if she did not get immediate access to medications and that she could not afford the medications. After the helper completed the application, the supervisor called days later and said she was going on vacation and it might take weeks before they could process Rachel's application. There was no question that Rachel was eligible and that it was a relatively simple process of entering her current financial information into a computer. Rachel was forced to change her medications to get samples after spending three months in a hospital where they found the right combination of medications. Her eligibility was reinstated only after advocates were able to reach a high-level person at the department.