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The First Step

Fixing Colorado's System of Long-Term Services and Supports

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Informing Policy. Advancing Health.

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Table of Contents

4 Introduction

5 The Next Steps

6 Understanding the Nuts and Bolts

7 Why Now? The "Silver Tsunami"

8 Future of LTSS in Colorado

9 Investing in LTSS

10 Colorado's LTSS Puzzle

12 What the Puzzle Shows

14 Minnesota's LTSS Entry Point and Eligibility System

16 Long-Term Services and Supports: A Timeline

18 LTSS Puzzle Definitions

Introduction

Picture a house that has been remodeled a number of times over the years. Some owners added bedrooms to accommodate growing families. Some updated the kitchen and bathrooms. Different architects were brought in. Different materials were used. And the work was often done under punishing deadlines.

This is how Colorado's long-term services and supports (LTSS) system evolved. When a service, waiver or population was added to the mix, the system expanded. Immediate needs were addressed as they arose, always with the best of intentions, but often at the expense of a cohesive, efficient system with an overarching structure.

Today, the system operates with little communication between organizations. In many cases, agencies serving the same client do not have computers that talk with each other. Some entities determine whether people are financially eligible while others determine whether their care needs make them functionally eligible. And within each category, different organizations serve different populations.

While Colorado has long been a leader in providing LTSS services, today's system is often confusing and unpredictable.

Understanding how daunting the system has become is the first step toward fixing it.

Work is underway in many corners of Colorado – and across the nation – to better use LTSS to serve seniors and those with disabilities, making their care more efficient and more effective.

This paper focuses on Colorado's LTSS Puzzle, detailing the complicated system that has been built piecemeal over the years, looking closely at how people access the system and pointing out changes that could streamline access and make it work better at a lower cost.

Definitions

- **Long-Term Services and Supports**
A broad range of supportive services needed by people who have limitations in their ability to perform daily activities because of a physical, cognitive, or mental disability or condition.

- **Activities of Daily Living (ADLs)**
Personal assistance, such as help with bathing, dressing, toileting and eating.

- **Instrumental Activities of Daily Living (IADLs)**
Shopping, housekeeping, paying bills.

- **Additional Assistance**
Monitoring physical health, mental health, social well-being, safety and personal security of environmental surroundings; nutrition counseling; physical therapy.

- **Waivers**
The mechanisms allowing Colorado Medicaid to provide supportive services to people with disabilities in the least restrictive settings possible, such as at home instead of a nursing facility. Some waivers have an enrollment limit, and there may be a waiting list for particular waiver.

The Next Steps

The Colorado Health Institute (CHI) first presented its visualization of the state's LTSS Puzzle at the Aging and Disability Summit in late 2012 in Colorado Springs. CHI asked participants from across the state's LTSS community to study the puzzle and use it as the basis to create their ideal system.

The results were illuminating. All of the work groups essentially came up with similar recommendations. And each of their recommended systems was much simpler than the current one.

The system proposed by the summit participants, at its most basic, would feature:

- One entry point, which could mean either regional brick-and-mortar buildings or a statewide connected data system.
- A connected data system that would assess both financial and functional eligibility.
- Case management agencies that would be solely responsible for helping people navigate the system and connect to services.

Guiding principles would include:

- A person-centered system in which clients would be assessed individually for needs, instead of being placed in eligibility categories with pre-defined service packages.
- A flexible service determination system to allow clients access to a broader array of services instead of funneling clients through 12 waiver programs.
- A truly no-wrong door entry point system. A central entry point would assess both functional and financial eligibility, with a connected data and information-sharing system. This entry point would not be co-located with case management organizations.

Other important ideas and principles identified by the participants, some short-term and some longer-term, include providing:

- Service brokers for clients who need one or two services and case managers for clients with more complex needs.
- Easier-to-understand written information and communication.
- An expanded eligibility assessment that would include all social services, such as food stamps, housing and transportation.
- More convenient entry points, such as a retail store, where information could be provided through an initial screening interview.
- Separate systems for adults and children.
- Integrated primary care and preventive, acute and behavioral health services within the LTSS system.
- A swipe card with LTSS information that follows the client.

These ideas offer a number of options as Colorado works on creating the most efficient and useful LTSS system possible.

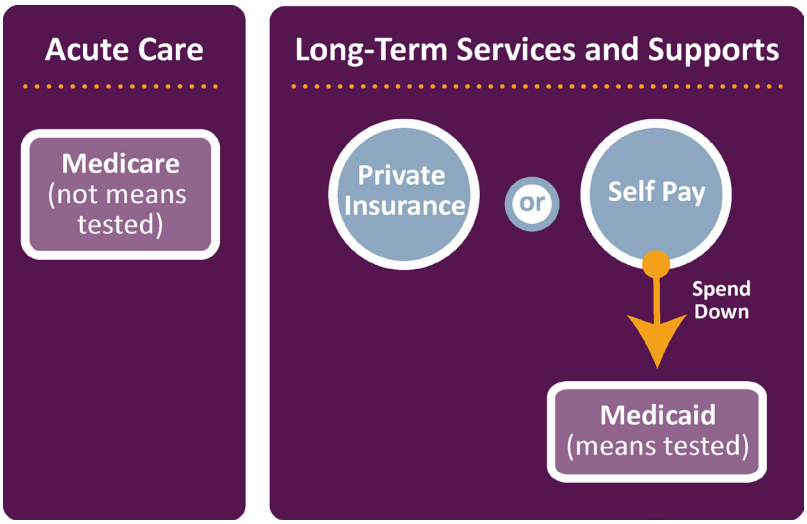
Understanding the Nuts and Bolts

A key feature of LTSS – better known until recently as long-term care – is providing ongoing assistance rather than intermittent medical attention. Nursing facilities are perhaps the most well-known LTSS service providers, but LTSS care is increasingly being offered in the home or in a community setting such as an assisted-living center.

Often, those who need LTSS have limited incomes and turn to Medicaid – the federal-state public health insurance program – to help fund their care. To qualify for Medicaid LTSS services, a person must have a low income, limited assets and require assistance with the Activities of Daily Living (ADLs), which cover the majority of needs, or Instrumental Activities of Daily Living (IADLs). These levels of need are measured by a **functional eligibility** test.

Some seniors are able to pay for their LTSS care, whether it's in their home or in a nursing facility, without the help of Medicaid. And nationally about 10 percent of people over the age of 50 have private long-term care insurance. Others, though, use most of their savings – called "spending down" – and then must rely on other funding sources for their continued care (see Illustration 1).

Illustration 1. Spending Down: Medicare and Medicaid



An analysis released in 2013 by RTI International found that, over the course of 10 years, nearly 10 percent of people ages 50 and over who were not covered by Medicaid ended up spending down their resources and becoming eligible for the federal insurance program.

As a result, Medicaid is responsible for just under half of all LTSS expenditures in the United States, making it the nation's biggest payer of LTSS.[1]

A **financial eligibility** test determines whether a person qualifies for Medicaid LTSS. Generally, those with annual incomes below 222 percent of the federal poverty level (FPL) are financially eligible. This was $25,560 for an individual in 2013. Assets are limited to $2,000 for an individual, or $4,000 for a couple if both are applying for Medicaid LTSS.[2] In addition, there are complicated rules related to home and car ownership that apply.

Meanwhile, Medicare, the federal public health insurance program for seniors and those with disabilities regardless of income, pays for basic acute care services such as doctor visits and preventive check-ups. When it comes to LTSS, Medicare coverage is limited. For example, Medicare pays for 20 days of nursing facility care and a portion of the next 80 days following a hospitalization. Medicare also reimburses some home health care services if clients are homebound, need skilled care and are under a physician's care.

Why Now? The "Silver Tsunami"

Seniors are predictable users of LTSS, and their numbers are growing. About 70 percent of seniors over the age of 65 will need LTSS at some point in their lives. Colorado's 65-and-older population is expected to more than triple to 1.4 million in 2040 from about 419,000 in 2000 – a growth rate that will outpace that of the nation, at least in part due to an influx of Baby Boomers to Colorado during the 1980s and 1990s.[3]

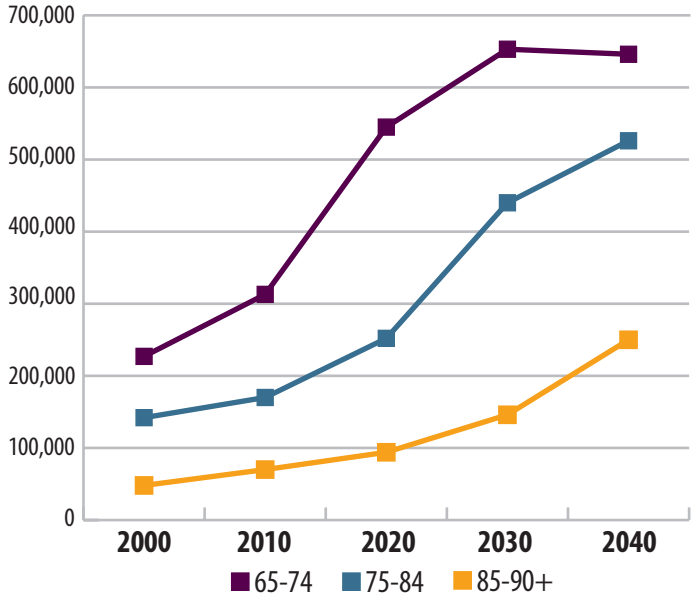
The proportion of seniors relative to the working-age population is expected to increase as well. In 2013, Colorado has 591,000 seniors over the age of 65 compared to 3.2 million working-age adults. This translates to about 5.4 working-age adults for each senior. However by 2040, Colorado will be home to 1.4 million seniors and 4.3 million working-age adults. This translates to 3.1 working-age adults for every senior. This large demographic shift will put more pressure on public spending, including public insurance programs supported by the taxes of the working-age population.[4]

The state of Colorado spent about $1.4 billion in fiscal year (FY) 2011-12 on LTSS services. With this in mind, the state is examining LTSS expenditures with an eye to the future.[5]

Seniors 65 and older along with Coloradans with disabilities make up 17 percent of the state's Medicaid enrollees, but account for more than 60 percent of Medicaid expenditures. This disparity (see Graph 2) results from the more expensive needs of these populations.[6]

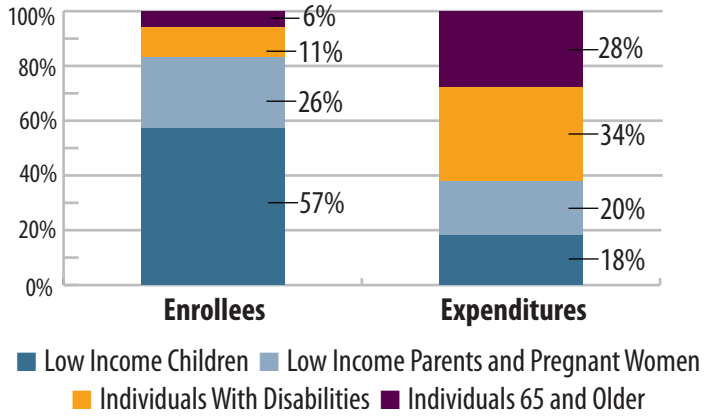
Colorado has historically been a leader in providing care to seniors and those with disabilities through home and community-based services (HCBS) waivers, which essentially set aside the federal requirement that people who need LTSS must move to a nursing facility. There are many reasons to do this. People usually prefer to stay in their home or in their community.

Graph 1. 65+ Age Distribution in Colorado, 2000-2040



Source: Colorado State Demography Office

Graph 2. Medicaid Enrollees and Expenditures, Colorado FY 2012-2013



Source: Colorado Department of Health Care Policy and Financing

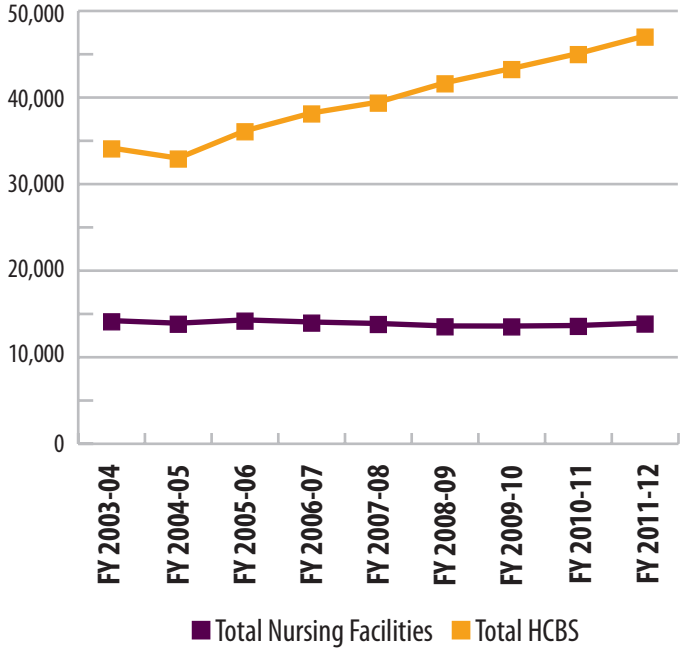
The 1999 U.S. Supreme Court's Olmstead decision requires caring for people in the least restrictive environment possible. And it generally costs less compared with a nursing facility.

For example, in FY 2010-2011 Medicaid paid about $9,600 for an individual in the Elderly, Blind and Disabled waiver for LTSS in the

community compared to about $51,000 in a nursing facility. This spending isn't directly comparable because a person who is able to stay in their home or community often has less complex needs than someone who must be cared for in a nursing facility and the cost does not account for things like housing. Still, the potential for cost savings is an incentive to keep more seniors in their homes or community as long as reasonable.

Graph 3 shows the growth in home and community based services (HCBS) in Colorado over time. While enrollment in nursing facilities remained relatively stable, there has been almost a 40 percent increase in HCBS over the last nine years.

Graph 3. Medicaid Enrollment, HCBS vs. Nursing Facility, Colorado



Source: Colorado Department of Health Care Policy and Financing

Future of LTSS in Colorado

About 64,000 Coloradans received Medicaid LTSS services in FY 2011-12, nearly 30 percent more than in FY 2003-04. As the population ages, this number will continue to grow.

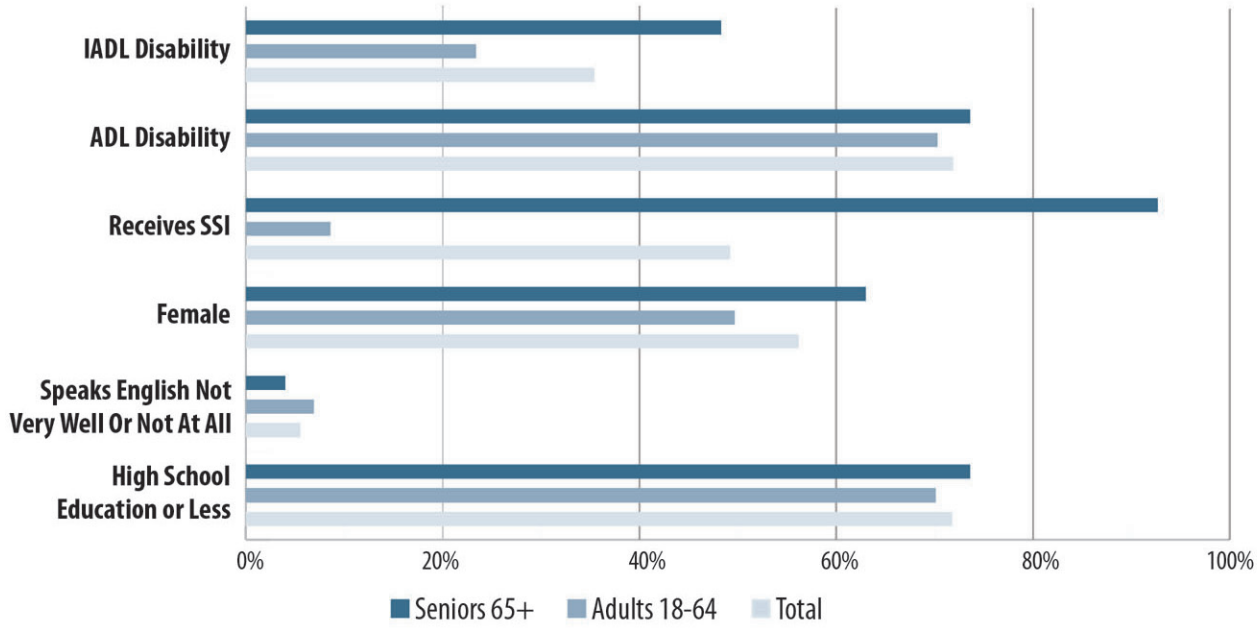
At the same time, an estimated 78,100 Coloradans with incomes of less than $25,560 - the threshold for Medicaid LTSS eligibility - and a self-reported disability were not enrolled in Medicaid, according to the 2011 American Community Survey (ACS).[7]

There are many reasons these people may not have enrolled. Some might not be eligible because they have too many assets or their disability is not be severe enough to qualify. Still others may not know they are eligible or they have decided they just don't want to use Medicaid benefits. It is important to note the potential impact of this unenrolled population on Medicaid. As their conditions become more acute or they spend down their assets, they could qualify for Medicaid in the future.

Limited education can be a major barrier for people trying to access and navigate the LTSS system (see Graph 4). Nearly three of four (72 percent) in the population who are not enrolled in Medicaid and are low-income and report a disability, have a high school degree or less.

Knowing that limited education represents a barrier to LTSS benefits may hold lessons for outreach and communication strategies.

Graph 4. Characteristics of Low-Income Coloradans With Self-Reported Disability Who Are Not Enrolled in Medicaid



Source: CHI analysis of the 2011 American Community Survey

Investing in LTSS

In some cases, the effort to care for more people at home or in the community is requiring investments to improve the HCBS system.

Colorado, for example, passed a law in 2013 (SB 13-127) to increase funding for Area Agencies on Aging (AAAs) by $4 million annually from the current $8 million until it reaches $20 million. Non-Medicaid services provided by the AAAs, such as meal delivery, transportation and in-home assistance, can be a difference in keeping people in their homes.

Colorado Choice Transitions (CCT), funded by a five-year, $22 million federal Money Follows the Person (MFP) grant, is designed to move eligible nursing facility residents to a less restrictive environment such as a home or community-based setting.

Colorado was awarded the CCT grant money in April 2011 and officially launched the program in March 2013. But as of August 30, 2013, CCT has yet to move any enrollees from a nursing facility.

There are many challenges. Often, when a person has moved to a nursing facility, they give up their home, so it's no longer available when it comes time to find housing. A challenge is overcoming a shortage of affordable housing.

Colorado is also pursuing the Community First Choice option, a federal Medicaid rule which makes it easier for people to receive care in their communities.

The federal government has also been helping states get more people into home and community-based care through the Balancing Incentives Program. This program provides funding and technical assistance for states that serve fewer than 50 percent of their LTSS clients in HCBS settings to create more streamlined access to HCBS. Colorado serves more than 50 percent of LTSS clients in HCBS settings, so it doesn't qualify. But it is looking to solutions from other states that might apply in Colorado.

Colorado's LTSS Puzzle

Much work is underway in Colorado to redesign the LTSS system. The Colorado Department of Health Care Policy and Financing (HCPF), the state's Medicaid agency, along with advocates and leading policymakers are engaged in ongoing discussions.

Governor John Hickenlooper issued an executive order in July 2012 creating the Office of Community Living. At the same time, the Community Living Advisory Group (CLAG) was created and charged, along with partners such as the Long Term Care Advisory Committee and the Colorado Commission on Aging, with recommending changes. The process has resulted in a consensus that reforming the LTSS entry and eligibility systems are important steps in redesigning Colorado's LTSS system.

To help inform that process, CHI conducted research to depict a system-wide view, the LTSS Puzzle, of the entry point and eligibility processes in Colorado.

While most within the LTSS community recognize organizational problems, the knowledge often is limited to particular areas. The LTSS Puzzle, unveiled at the 2012 Aging and Disability Summit in Colorado Springs, has served to create a broader shared understanding and to launch discussions about how to improve Colorado's LTSS entry point and eligibility systems.

CHI conducted key informant interviews with Colorado experts as well as workers on the LTSS front lines in order to create the puzzle. Each

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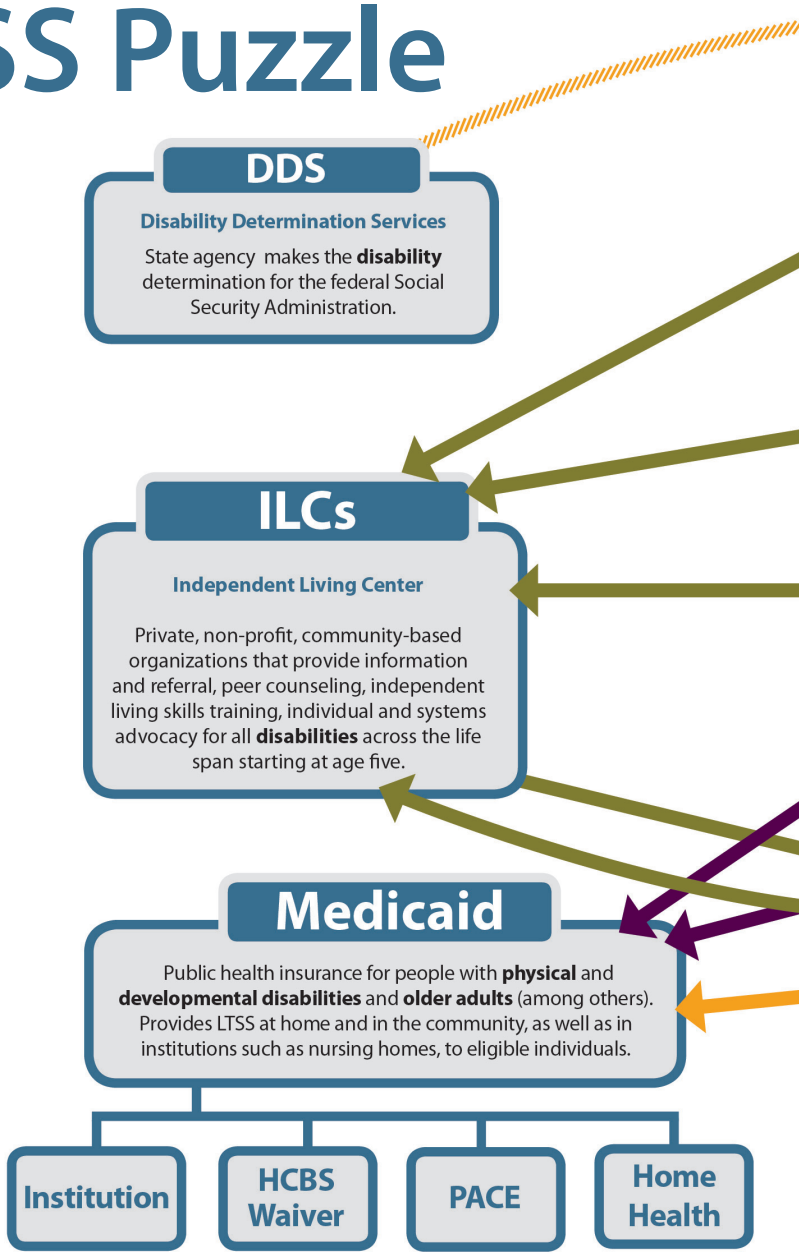


Understanding the Puzzle

This is how to read and understand CHI's LTSS Puzzle:

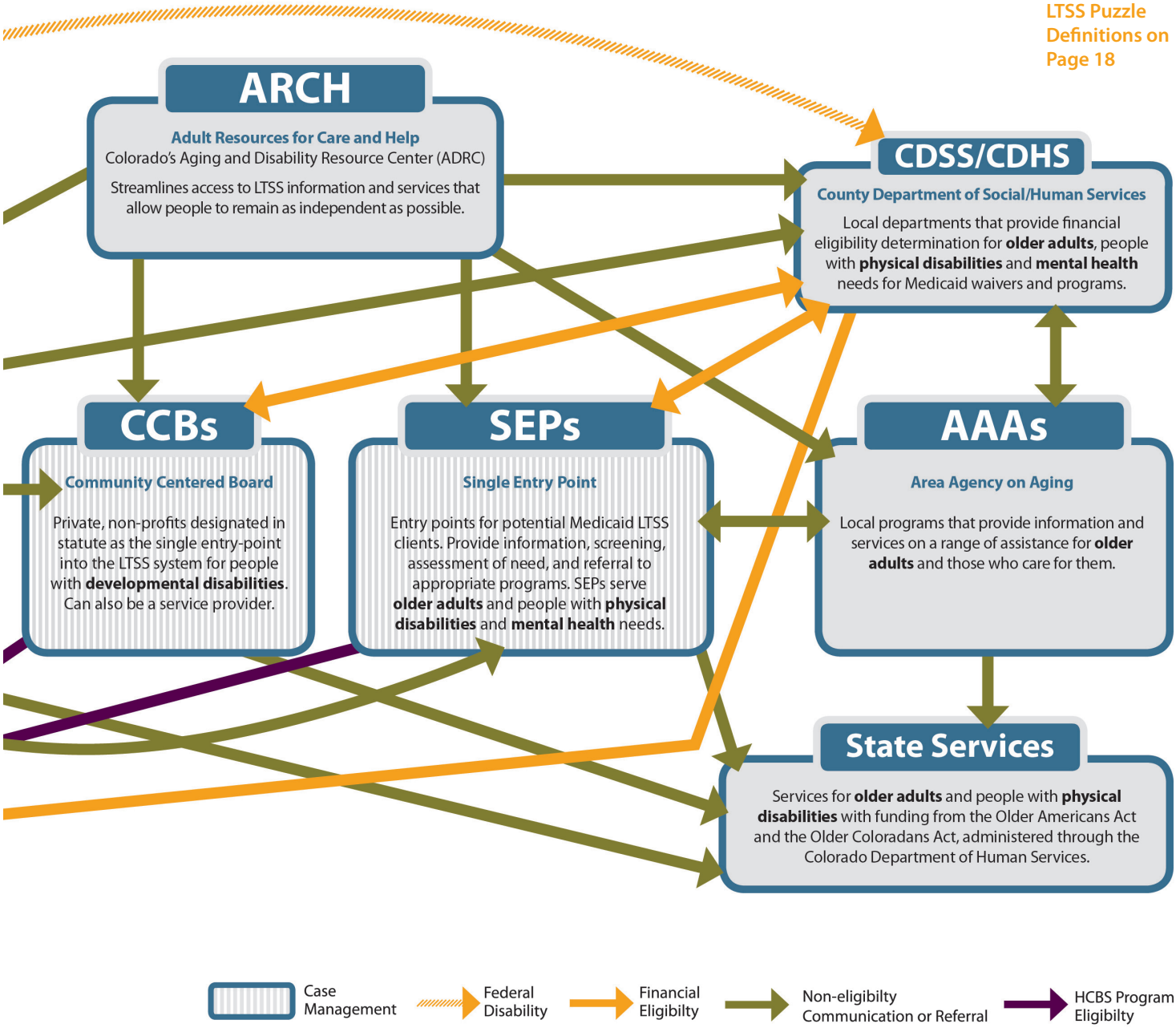
Boxes represent entry points and/or eligibility determination points.

- The **gray lined boxes** are entry points that also provide formal case management services.
- The **gray boxes** are entry points that provide information, referrals, options counseling, and short-term or less formal case management services.

Arrows show how clients move through the system.

- **Green arrows** are non-eligibility communication or referral pathways. People moving along these arrows are not going through a formal process. The arrows trace a client's path as he or she is referred from one entry point to another to find the programs and services that best fit unique situations. Clients are often referred to many places throughout the process, making this the most complex set of arrows. But while complicated, the green arrows represent the idea of a "no wrong door" entry point system. Clients can enter the system through any of these places, but they are then referred to the correct entry point depending on the services they need.
- **Green arrows with points on both ends** illustrate areas in which the client may be sent back and forth for referrals or paperwork.
- **Yellow arrows** are financial eligibility pathways. They trace the process to determine financial eligiblity for

LTSS Puzzle Definitions on Page 18



Medicaid programs, including Programs of All-Inclusive Care for the Elderly (PACE) and Home and Community Based Services (HCBS) waivers.

- **Hashed yellow lines** represent federal disability determination, which is done by the Disability Determination Services (DDS) state agency. It decides if a client qualifies for supplemental security income (SSI) or social security disability insurance (SSDI).

Disability Determination Services (DDS) only communicate with the county departments when someone is applying for Medicaid eligibility. The Community Centered Boards (CCBs) and Single Entry Points (SEPs) communicate with the county departments of human or social services to make sure clients are financially eligible for Medicaid before moving ahead with assessing their functional eligibility for Medicaid LTSS. The county departments can send clients directly to Medicaid if they don't need home and community based services (HCBS).

- **Purple arrows** are functional eligibility pathways. They show the process to determine if a client is eligible for home and community based services (HCBS). The Single Entry Points (SEPs) and Community Centered Boards (CCBs) are the only entry points that assess functionally eligibility for Medicaid LTSS. Single Entry Points (SEPs) are for seniors and people with physical disabilities and mental health needs, while the Community Centered Boards (CCBs) are solely for those with developmental disabilities. These two organizations serve as the case managers for those eligible for Medicaid. And Community Centered Boards (CCBs) can provide services as well.

One look at the puzzle, with the criss-crossing arrows and multitude of boxes, makes it clear just how complex the system is.

From Page 10

interviewee provided a unique look into the various silos that comprise the system.

The puzzle represents a wide array of perspectives, from Single Entry Points (SEPs) to Independent Living Centers (ILCs) to Area Agencies on Aging (AAAs) to Community Centered Boards (CCBs).

Simply entering the system can be daunting for many consumers. The puzzle provides a broad overview of the LTSS entry point and eligibility system from the perspective of a consumer.

Pieces of the puzzle, including acute and behavioral health care, veterans' services, housing and workforce, are intentionally absent in order to better highlight the sticking points in simply accessing LTSS. The puzzle also omits details about service delivery to maintain the focus on understanding the foundation of Colorado's LTSS system.

It is important to recognize that regional and local flavors of LTSS are strong in Colorado. While the puzzle represents a general roadmap of the pieces and how they fit together, each county and region may look slightly different. CHI has written a companion report titled "Long-Term Services and Supports in Larimer County, Colorado: A Case Study," which walks through the system at the county level.

What the Puzzle Shows

Studying the LTSS Puzzle reveals important findings:

- **Case Management:** Such a complex system relies on effective case management. But case managers are often overloaded and can't dedicate enough time to adequately guide clients through the system. Meanwhile, the system creates the potential for a conflict of interest in case management. SEPs and CCBs conduct the functional assessment for Medicaid eligibility and also serve as case managers, creating care plans for clients. CCBs also provide services to persons with developmental disabilities and may have an incentive to create more robust care plans – essentially calling for more services - for clients because they are the getting paid to provide services.
- **Assessment Tool:** The ULTC 100.2 is used to determine the level of a client's need - the functional eligibility for Medicaid. But many observers feel that the tool could be updated and improved, making it more objective and resulting in a clearly delineated care plan. The tool forces case managers to create care plans with little guidance.
- **Administration:** Administering LTSS is spread across a number of state departments, increasing the potential for fragmentation. Two state departments, the Colorado Department of Human Services (DHS) and HCPF, oversee service administration for LTSS. The Colorado Department of Public Health and Environment (CDPHE) oversees regulation of nursing facilities and the Department of Regulatory Agencies (DORA) licenses health care professionals.
- **Data Systems:** There are multiple data systems used to track people throughout the system, and most of them do not connect with each other. For example, SEPs do not always have access to the data system used to determine financial eligibility by the county departments. That lack of communication can lead to long wait times for clients. Information is not automatically shared between entry

Mary's Story: An LTSS Case Study

Mary has lived in Colorado all of her 73 years. She and her husband, Will, worked hard to save money, but went through their nest egg when Will got cancer. He died two years ago, and Mary now depends on her monthly Social Security check.

A couple months ago, Mary fell. She was rushed to the hospital and underwent emergency surgery for a broken hip. This was when she entered Colorado's long-term services and supports (LTSS) system.

Mary's story – developed by the Colorado Health Institute based on an analysis of data as well as key informant interviews - illustrates how difficult it can be to navigate a complex system, particularly by seniors or those with disabilities who encounter it when they are at their most fragile.

After leaving the hospital, Mary moved to a nursing home for six weeks of rehabilitation. Medicare covered her hospital stay, minus a deductible, but only the first 20 days at the nursing home. Then, Mary's doctor told her that she would need daily help when she went home.

With help from a neighbor and her two out-of-state daughters, Mary filled out paperwork to find out if she was financially eligible for Medicaid. She applied for various waivers and home-based programs, many of which required more paperwork to determine if she was physically eligible. She was directed to several agencies and had two case managers, each from a different organization. She told her story over and over. She encountered several delays along the way.

Mary still hadn't heard about her Medicaid application when she was discharged from the nursing home. Her daughters flew home for a week to get her settled, and Mary's neighbor pitched in, visiting each day to help her get dressed and shop for groceries.

Finally, three months later, Mary received a letter confirming her eligibility for an Elderly, Blind and Disabled waiver, which meant she could receive Medicaid-funded services and stay in her home. She had managed, with much difficulty, to traverse Colorado's system. Many aren't that lucky.

points, lengthening the entry process, which can be from 45 days to nine months.

Recognizing these limitations, HCPF released a strategic planning document in August 2012 that includes recommendations to:

- Streamline access, including studying how clients get into the system and making it easier to navigate.
- Separate the functional eligibility assessment from the case management services.
- Update the assessment tool so that it is more objective, more rigorous and more person-centered
- Integrate the data system so that case managers can work more efficiently by sharing information across entry points, which should reduce wait times.
- Assume presumptive eligibility to reduce enrollment wait times. This would allow clients to start getting services on the day they apply while they await an eligibility determination. Often, clients are not able to wait months to receive critical LTSS services.

BEST PRACTICES

Minnesota's LTSS Entry Point and Eligibility System

Minnesota is a leader in LTSS innovation. It won the highest ranking for LTSS in a scorecard prepared in 2011 by AARP's Public Policy Institute, The Commonwealth Fund, and The SCAN Foundation. It was also named No. 1 for the ability of people to access LTSS, either through an aging and disability resource center (ADRC) or a single entry point (SEP).[8]

Minnesota operates a coordinated system of entry points. People looking for help can contact long-term care consultation teams through their local social services or public health offices. They can also contact the Senior LinkAge Line® or the Disability Linkage Line® either in person or over the phone. The lines, which are part of Minnesota's aging and disability resource center (ADRC) provide comprehensive information and links to the local long-term care consultation (LTCC) teams. The local LTCC teams then provide more comprehensive in-person assessments and community support planning. Both the LinkAge Lines and the LTCC are available to all Minnesotans, regardless of income or level of need.

The LinkAge Lines work hard to have many highly visible points of contact and are well-connected with all services in Minnesota, allowing for comprehensive information.

Because of its integrated system, Minnesota is able to collect, and respond to, a great deal of information. For example, the needs of caregivers are assessed in addition to the client. This ensures that Minnesota is supporting both the client and the caregiver. In addition, the LinkAge Lines have access to the data system that houses all LTSS provider information for Minnesota, allowing for more organized care planning.

Lessons From Minnesota

- Unified aging and disability services
- Unified assessment form and data system
- Integrated financial and functional eligibility determination system
- Interdisciplinary teams to assess need
- Caregiver support

Consultation services are available in every county, as well as through tribes and managed care organizations under contract with the Minnesota Department of Human Services. The consultation is not means-tested, meaning this service available to anyone regardless of income or disability status. The consultation services are provided by multiple lead agencies, so they are able to reach more people than if they were just provided by the county departments.

Social workers, public health nurses or other nurses with home care experience serve as the long-term care consultants, and each agency has a team consisting of these providers. Team members will interview people in their health care facilities or communities if they are unable to travel to an office. The consultants perform the functional assessment required for waiver eligibility determination, and coordinate with county-based financial teams, which determine financial eligibility.

- An **Early Intervention Visit** providing information and support regarding an applicant's needs and options.
- A **Community Assessment** determining the needed level of care, any risks to the applicants health and safety, the applicant's goals and preferences, plan implications and a determination of eligibility for HCBS waivers and programs.
- **Developing a Support Plan** that identifies needed services and that reflects the person's choices about where to live and other decisions. The support plan reflects an evaluation of risk and the strategies to address that risk, including personal risk management. Support for informal caregivers is included.
- **Pre-Admission Screening** for any person seeking admission to a certified nursing facility determines the needed level of care, screens for mental illness and developmental disabilities, and ensures that specialized services are provided for those with mental illness or developmental disabilities. This screening is linked to efforts to assist people transitioning back to the community.
- **Transition Assistance** is provided by both the long term care consultants and LinkAge Lines staff members, who identify and offer assistance to people who are moving from facility-based care to their home or community.

The coordination between the LinkAge Lines and the long-term care consultation services is fundamental to Minnesota's system, as is a strong technology component. Data is collected at each encounter point, with access granted to both LTCC consultants and the LinkAge Lines.

A web-based assessment tool called "MnCHOICES" is a major systems improvement for both individuals and the lead agencies responsible for completing not only LTCC assessments but three other assessments. LTCC and other assessors will be "certified" by the department. MNChoices goals include eliminating multiple assessments for different services and programs, ensuring a broad competency in assessment, a more objective care planning process and maintaining local connections to resources while ensuring equity across the system.

Other innovations in Minnesota are creating a more person-centered and streamlined system. New legislation requires any person who wishes to transition from the community to a nursing facility to receive counseling to ensure that all community-based options have been explored. Other legislation passed will further integrate the LinkAge Lines into the LTSS system by shifting from the current pre-admission screening process to "First Contact" through Senior LinkAge Line®.

The integration and coordination between the LinkAge Lines and LTCC services will continue to create broader access to information, assistance and support for Minnesotans. As communication technology improves, the role of the LinkAge Lines as "First Contact" will increasingly streamline where health care professional can seek assistance in transition and discharge planning.

The LinkAge Lines will continue to play their role at the local level, understanding available resources and fostering community, providing assistance for people who can't access supports through public programs.

Long-Term Services and Supports: A Timeline

1934

Social Security Act becomes law. It includes old-age pension and disability insurance.

1945

Social Security Administration adds disability program, recognizing the need for medical rehabilitation.

1965

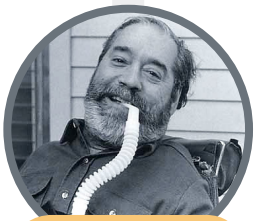
Medicare and Medicaid approved under President Lyndon B. Johnson, above.

1972

Medicare extends benefits to those under 65 with long term disability or end stage renal disease.

1975

Education for all Handicapped Children Act (now Individuals with Disabilities Education Act) requires public schools to offer free and appropriate education in the least restrictive environment to all children with disabilities.



1972

Ed Roberts, above, starts first Center for Independent Living (CIL) in Berkeley, Calif.

1980

Medicare broadens home health service coverage.

1981

Home- and community-based service (HCBS) waivers established in Medicaid.

1983

Colorado implements first HCBS waiver.

1985

Colorado implements Elderly, Blind and Disabled waiver.

1987

Omnibus Budget Reconciliation Act strengthens protections for nursing home residents.

1990

Americans with Disabilities Act (ADA) passes.

1990

Medicaid begins to pay Medicare premiums for those between 100 percent and 120 percent of the Federal Poverty Level (FPL).

1990

Colorado implements Children's HCBS waiver.

1991

Total Longterm Care is founded in Denver, Colorado as one of the first Programs of All-Inclusive Care for the Elderly (PACE) to receive Medicare and Medicaid funding.

1991

Colorado opens doors to first Single Entry Points (SEPs).

1994

Colorado implements Persons Living with AIDS waiver.

1995

Colorado implements Persons with Brain Injury waiver.

1996

Colorado implements Support Living Services waiver.

1996

Colorado implements Children's Extensive Support waiver.

1996

Colorado implements Children's Habilitation Residential Program waiver.

1997

State Children's Health Insurance Program (CHIP) created.

1997

PACE model established as a permanently recognized provider type under both Medicare and Medicaid programs.

1999

The U.S. Supreme Court's Olmstead decision says that people should remain in communities when possible. Undue institutionalization is considered discrimination under the ADA.

2002

Colorado implements HCBS for Community Mental Health Supports waiver.

2006

Colorado implements HCBS Children with Autism waiver.

2007

Colorado implements Children Living with Limiting Illness waiver.

LTSS Puzzle Definitions

ARCH

Adult Resources for Care and Help

Overview: Colorado's Aging and Disability Resource Center (ADRC). Counselors discuss long-term services and supports (LTSS) options, assist and track applications, make service referrals, provide short-term case management. Funded through Colorado Department of Human Services (DHS) with grants from federal Administration on Community Living, based on joint funding from Centers for Medicare & Medicaid Services (CMS) and Older Americans Act (OAA).

Population Served: 60 and older; 18 and older with a disability. 94.6 percent of state population; 66 percent geographically.

Area Served: 12 regional ARCHs in 46 counties.

Eligibility Determination: None. ARCHs must complete the options counseling assessment tool for State Unit on Aging (SUA). Data not tracked uniformly.

Department: DHS

Connection with Entry Points: Often co-located with Area Agencies on Aging (AAAs), and sometimes with county Department of Human Services and/or Single Entry Points (SEPs).

Data Systems: Varies.

AAA

Area Agencies on Aging

Overview: Local programs provide information and services for older adults, plus community and program planning and development. SUA issues regulations for programs authorized by OAA and Older Coloradans Act (OCA), including nutrition, transportation, in-home, community-based, information and referral services. Administers Long-Term Care Ombudsman Program.

Population Served: 60 and older

Area Served: 16 regional AAAs statewide.

Eligibility Determination: Some state programs, no Medicaid.

Departments: DHS, SUA

Connection with Entry Points: Often co-located with ARCHs, sometimes with county Department of Human Services and/or SEPS.

Data Systems: Social Assistance Management System (SAMS)

CCB

Community Centered Boards

Overview: Private, non-profits designated in statute as single entry-point for people with developmental disabilities. Provides case management, including intake, functional eligibility determination, service plan development, coordination, delivery and monitoring. Services Medicaid waivers administered by DHS. Assess community service needs, develop service plans.

Population Served: Those with developmental disabilities, all ages

Area served: 20 regional CCBs statewide.

Eligibility Determination: Functional eligibility for Medicaid/HCBS waivers using ULTC 100.2 and Supports Intensity Scale (SIS).

Department: DHS Office of Long-Term Care, Division for Developmental Disabilities (DDD)

Connection with Entry Points: None

Data Systems: Benefits Utilization System (BUS), Colorado Benefits Management System (CMBS), Medicaid Management Information System (MMIS), Community Contract and Management System (CCMS)

CDHS/CDSS

County Departments of Human/Social Services

Overview: Provides assistance, protective and prevention services to all populations, case management for Children's Habilitation Residential Program Waiver.

Population Served: Low-income

Area Served: Statewide

Eligibility Determination: Financial eligibility for Medicaid.

Department: DHS

Connection with Entry Points: Sometimes co-located with AAAs, ARCHs and/or SEPs.

Data Systems: CMBS

DDS

Disability Determination Services

Overview: State agency makes disability decisions for federal Social Security Administration (SSA), which provides funding. Not involved with application process, other eligibility determinations or benefit calculations.

Population Served: Those with physical and developmental disabilities, all ages

Area Served: One office statewide

Eligibility Determination: Decisions for Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). SSI is based on disability and financial need and results in Medicaid eligibility. In order to be eligible for Medicaid with SSDI (disability insurance for those who have paid into Social Security through employment) individuals must have incomes at or below of 300% of the SSI limit and be determined functionally eligible for long-term care benefits.

Department: DHS

Connection with Entry Points: None

Medicaid

Overview: Federal-state health insurance program for low-income seniors and people with disabilities, among others, operated by Department of Health Care Policy and Financing (HCPF) and DHS. Requires financial and functional eligibility. CCBs and SEPs determine functional eligibility with ULTC 100.2. Must meet nursing home, intermediate care facilities (ICF) or hospital level of care for LTSS coverage. Colorado has 12 home and community-based waivers (HCBS) that allow for services at home or in the community.

Population Served: About 32,000 in HCBS waivers and about 13,000 in nursing facilities in FY 2009-10 statewide.

Area Served: State

Departments: HCPF administers eight waivers - Children's HCBS , Children with Autism, Children with a Life-Limiting Illness, Persons with Brain Injury, Community Mental Health Supports, Persons Living with AIDS, Persons who are Elderly, Blind and Disabled, and Persons with Spinal

Cord Injury. DHS administers four waivers - Children's Extensive Support, Supported Living Services, Children's Habilitation Residential Program, and Persons with Developmental Disabilities.

Data System: BUS, CMBS, MMIS

PACE

Program for All-Inclusive Care for the Elderly

Overview: Medicaid-Medicare program that provides LTSS and physical health care. Most enrollees remain home. Must meet nursing facility level of care, determined with ULTC 100.2. Managed care model coordinated by interdisciplinary health care teams.

Population Served: 55 and older

Area Served: Must live in one of three PACE areas - Mesa and Delta counties, El Paso County or metro Denver and Pueblo.

Departments: HCPF and CMS

SEP

Single Entry Point

Overview: Entry points for Medicaid LTSS. Provides care planning and case management, makes referrals. Services HCBS waivers for HCPF.

Population Served: Older adults, children, adults with physical disabilities and mental health needs

Area Served: 23 regional SEPs statewide

Eligibility Determination: Functional eligibility for Medicaid and HCBS waivers with ULTC 100.2.

Department Involved: HCPF

Connection with Entry Points: Sometimes co-located with AAAs, ARCHs and/or county Departments of Human/Social Services.

Data Systems: BUS, CMBS, MMIS

State services

Overview: Services for older adults and individuals with disabilities not covered by Medicaid, including nutrition, transportation, in-home, community-based care, caregiver support and legal assistance. Financial assistance provided by state programs such as Aid to the Needy Disabled (AND), Aid to the Blind (AB) and Old Age Pension (OAP). Some services require financial eligibility while others available to all older adults and individuals with disabilities. Funded by OAA, OCA and Colorado state general funds. Also provides Adult Foster Care (AFC) and Home Care Allowance (HCA). HCA lets those who are financially eligible but not at nursing home level of care to pay for home care.

Population Served: Specific programs for specific populations. For example, OAP is for low-income individuals ages 60 and older. HCA serves about 3,000

Area Served: Statewide

Department Involved: DHS

ILC

Independent Living Center

Overview: Independent Living Centers work with a cross-disability population to achieve their independent living goals through information and referral, peer counseling, independent living skills, and individual and systems advocacy. Three of the ten centers also provide home health services. Receive state general funds and federal funds through the Rehabilitation Act, among other sources.

Population served: Those with significant disabilities (defined by the Americans with Disabilities Act (ADA)), all ages

Area Served: 10 regional ILCs statewide

Eligibility Determination: None

Department Involved: DHS, Division of Vocational Rehabilitation (DVR).

Endnotes

[1] "Medicaid Spend Down: New Estimates and Implications for LTSS Financing Reform." The SCAN Foundation and RTI International. March 2013. Accessed at: http://www.thescanfoundation.org/sites/thescanfoundation.org/files/rti_medicaid-spend-down_3-20-13_1.pdf.

[2] Medicaid Long Term Care Eligibility, http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1205745755264.

[3] Colorado State Demography Office.

[4] Colorado State Demography Office.

[5] "FY 2011-2012 Expenditures for Selected Long-term Care Categories." Colorado Department of Health Care Policy and Financing, Department Description, FY 13-14 Budget Request. Accessed at: http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251832730725&ssbinary=true.

[6] "Exhibit E - Summary of Total Requested Expenditure by Service Group." Colorado Department of Health Care Policy and Financing, FY 13-14 Budget Request. Accessed at: http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251832962151&ssbinary=true.

[7] This data reflects those respondents of the American Community survey who have a yearly income of less than $25,560 (or 300% of SSI) and answered "Yes" to the following disabilities: "Deaf or has serious difficulty hearing"; "Blind or has a serious difficulty seeing even when wearing glasses"; "Difficulty concentrating, remembering or making decisions because of a physical, mental or emotional condition"; "Difficulty walking or climbing stairs"; "Difficulty dressing or bathing"; "Difficulty doing errands alone such as visiting a doctor's office or shopping because of a physical, mental or emotional condition".

[8] "Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers." AARP, The Commonwealth Fund, and The SCAN Foundation. 2011. Accessed at: http://www.longtermscorecard.org/.

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