Attachment B

Colorado
Cross-Disability
Coalition
Nothing about us, without us.

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The Colorado Cross-Disability Coalition STRONGLY SUPPORTS HB 09-1103 which will enable the Department of Health Care Policy and Financing (Medicaid) to pursue federal authority to establish PRESUMPTIVE ELIGIBLITY for Medicaid Long Term Care:

What is Presumptive Eligibility? Often called PE for short, this is a program where under special circumstances the Medicaid agency is allowed to begin services immediately, and give the client/applicant time to gather the documentation. If the client is found to not be eligible the federal government lets the state keep the match money and the providers still get paid. If the client is eligible, the status just changes from PE to permanent or regular eligibility.

What is Medicaid Long Term Care?: This is a special eligibility category for people who are so disabled that they need assistance from another human being on most days. Long term care is provided either in a nursing home or in the community under Home and Community Based Services (HCBS) waiver programs. Colorado is a national leaders in promoting HCBS as an alternative for our disabled and elderly citizens. To get long term care one must meet "nursing home level of care". This does not mean the person has to go to a nursing home, it is just the term to make sure only those who are the most severely disabled are receiving this care. Long term care has a few extra services like personal care and non medical transportation and also allows people a slightly higher income level than regular Medicaid that you get with SSI.

How Does One Get Medicaid Long Term Care? One must prove three different kinds of eligibility. If someone is not on Social Security Disability or SSI they need to go through a state level process to make sure that the person is "really" disabled. This can take up to 90 days, sometimes longer. Then the person has to be assessed by a single entry point agency (SEP) to make sure that they meet a high enough level of care. This usually happens pretty quickly. Finally, they need to fill out dozens of pages of financial paperwork at the county level. This is supposed to take no more than 45 days but often takes months.

Why do we need PE?

1) Sometimes people cannot qualify because they need the in home care that they would get through Medicaid long term care to get the documents together that they need to prove eligibility. They cannot get the care until they do this so it becomes a vicious circle.
2) Even if one can comply with the numerous complicated requirements people often get much more disabled while waiting for all of this to happen. To be eligible you have already proven that you need help with BASIC activities of daily living—for example help with eating, bathing, dressing and moving. Then we ask them to wait months for this help. People often fall, break bones, get skin breakdowns and end up in the hospital while waiting.
3) When someone is in the hospital and cannot go home because there is no help at home they can end up living in the hospital until the eligibility all gets processes. It is not cost effective and is very bad quality of life to have a disabled person live in a hospital for weeks or months.
4) A few nursing homes will take clients "Medicaid pending" but no HCBS providers will take clients under this status. This is because they will not backdate HCBS. If someone is desperate they end up going into a nursing home when they could be served for less money in the community. Once someone goes into a nursing home they often lose their home. Then to get them out they will need significant services. Many never come out. The average cost per client excess for living in a nursing home was estimated at $1200 per client per month in 2005.
5) Data from other states and our own anecdotal evidence shows that most hospital discharge social workers, independent living specialists, advocates and others who deal with this population and predict with very high accuracy who is and is not eligible. The delay is not because there are many grey areas, but because the documentation requirements are so extensive. If we get eligible clients in the system and begin serving them at the appropriate level we keep them as healthy as possible. If we delay care, the clients do get in the system eventually but often at a much higher cost and at a permanently higher level of care.