

# Report to the Office of the Legislative Fiscal Analyst

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## Single Point of Entry for Long Term Care Services Eligibility

Prepared by

The Utah Department of Health and The Utah Department of Human Services

September 1, 2011



## **Background**

This report is submitted in response to the following intent language passed in Senate Bill 2 during the 2011 Legislative General Session:

“The Legislature intends the Department of Health and the Department of Human Services study the cost and benefits of having a single point of entry to determine eligibility for clients seeking any type of Medicaid long term care services. The Departments shall additionally report on the potential cost and benefits of using a non-State entity to provide the single point of entry services. The Departments shall report back recommendations for further action in one combined report to the Office of the Legislative Fiscal Analyst by September 1, 2011.”

Single Point of Entry Systems vary widely from state to state. Some states focus on providing access to a wide variety of long term care information, regardless of the funding source, while others focus on a specific segment of the population or a specific type of long term care service.

As the Utah Departments of Health and Human Services’ staff (Agency staff) conducted research for this report, it was evident that Maine’s system most closely resembled the study parameters identified in Senate Bill 2. Consequently, a significant segment of the report will focus on the method used in Maine.

In order to better understand the long term care eligibility determination process, the report discusses national Medicaid long term care eligibility criteria development, describes the systems currently used in Utah and Maine and compares general demographic and programmatic information. Questions about the potential benefits of a Single Point of Entry System are discussed and a cost analysis is presented.

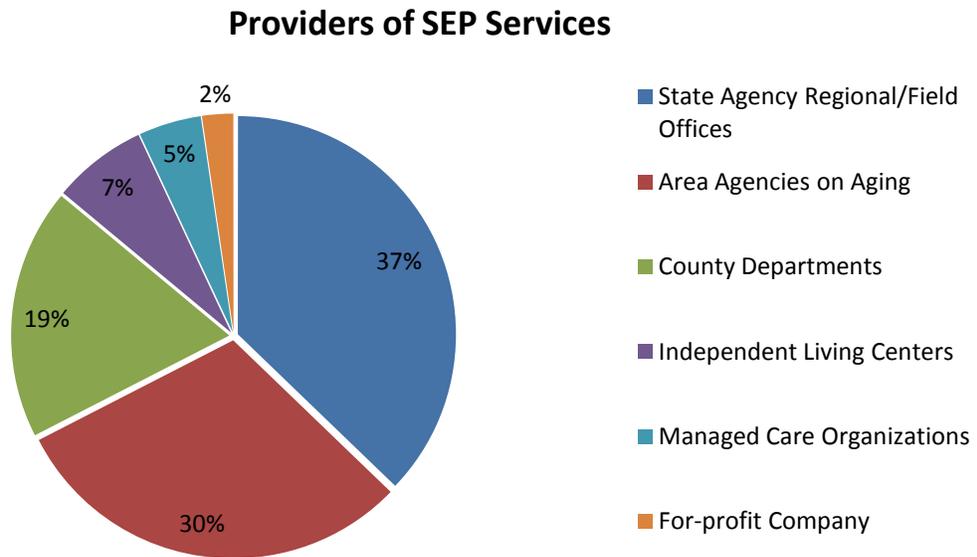
## **Introduction**

The Utah Departments of Health and Human Services appreciate the opportunity to study the single point of entry concept for determining long term care eligibility.

According to the *Single Entry Point Systems: State Survey Results*<sup>i</sup> (Survey) conducted by the National Academy of State Health Policy, August 2003, Single Entry Point (SEP) systems are defined as “a system that enables consumers to access long term and supportive services through one agency or organization. In their broadest forms, these organizations manage access to one or more funding sources and perform a range of activities that may include information and assistance, preliminary screening or triage, nursing facility preadmission screening, assessment of functional capacity and service needs, eligibility determination, care planning, service authorization, and reassessment.”

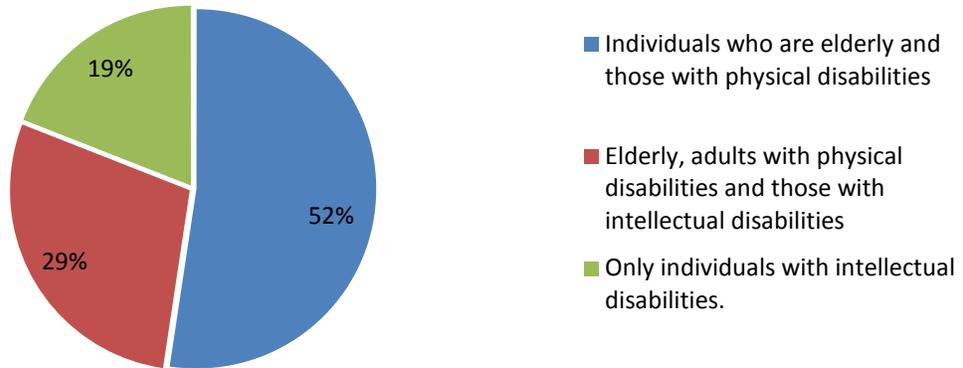
Individual states implement Single Entry Point Systems, also known as Single Points of Entry, in a variety of ways:

- *Who provides SEP services?* Of those responding to the Survey, thirty-two states and the District of Columbia reported that they utilize a total of 43 SEP's. Sixteen reported use of state agency regional/field offices, thirteen states use Area Agencies on Aging, eight states use county departments, three states use Independent Living Centers, two states use managed care organizations, and one state uses a for-profit company.



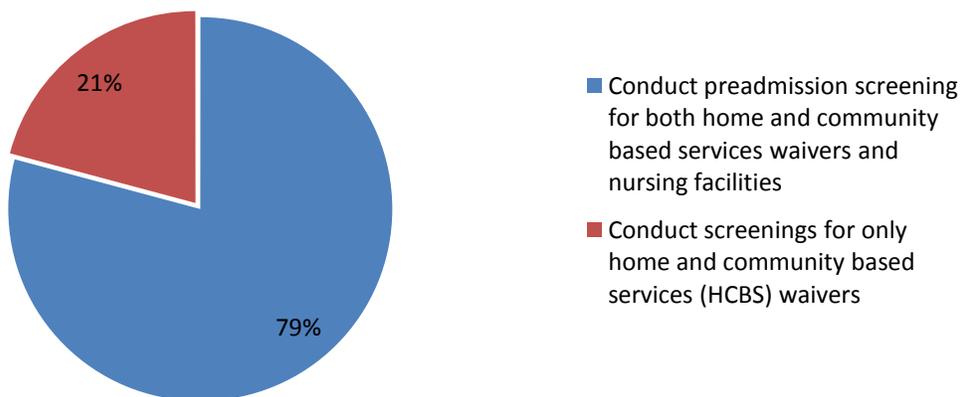
- *What populations are served in SEP Systems?* The majority of responding states, twenty-two, report serving only individuals who are elderly and those with physical disabilities, twelve states serve individuals who are elderly, adults with physical disabilities and those with intellectual disabilities, and eight states reported serving only those with intellectual disabilities.

### **Populations Served in SEP Systems**



- *How many states perform long term care preadmission screening as a component of SEP?* Twenty-four states reported conducting preadmission screenings. Of those states, nineteen reported conducting preadmission screening for both home and community based services waivers and nursing facilities and five states conduct screenings for only home and community based services (HCBS) waivers.

### **The Number of States that Perform Long Term Care Preadmission Screening as a Component of SEP**



Although Single Entry Point System methods vary across the nation, this report will focus on the following principles in order to follow the Legislative intent language:

- Only Medicaid long term care services will be considered;
- All potentially eligible populations will be considered, including: individuals who are aged, adults and children with physical disabilities, including brain injuries, and adults and children with intellectual disabilities;
- Activities related to nursing facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID)<sup>1</sup> and HCBS waiver pre-admission assessment and eligibility determination are the focal point of the analysis;
- Some states without Medicaid managed care plans include home health, private duty nursing, and personal care services when determining long term care eligibility. Because Utah's Medicaid program utilizes managed care, these services are not included in the analysis; and
- Medicaid long term care eligibility is different from Medicaid financial eligibility. Medicaid long term care eligibility, commonly referred to as *Level of Care* is a determination of medical necessity only. An applicant's financial eligibility is determined through a separate process completed by the Utah Department of Workforce Services and is not the subject of this report.

## **Medicaid Long Term Care Eligibility**

Agency staff reviewed other states' long term care criteria development processes and approaches to determining long term care eligibility.

Each state develops and implements its own Medicaid long term care eligibility (Level of Care) based on its interpretation of federal law. Medicaid long term care has two general Level of Care (LOC) categories: Nursing Facility and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID). There is no nationally accepted standard practice for either creating Medicaid LOC policy or for the process used to determine eligibility.

## **Criteria Development**

In a 2000 report completed for the Maryland Department of Health and Mental Hygiene<sup>ii</sup> three categories of State LOC criteria were identified:

- 17 states used eligibility criteria that were based on general definitions and guidelines (Utah's criteria falls into this category.)
- 19 states used eligibility criteria that required a minimum number of needs or impairments.
- 7 states required a threshold score based on an assessment that may have an added clinical review component.

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<sup>1</sup> Utah's use of the term ICF/ID has the same meaning as ICF/MR under Federal law.

## **Utah's Current Criteria and Process for Determining Eligibility for Long Term Care Services**

Medicaid long term care eligibility criteria are defined in Administrative Code *R414-502, Nursing Facility Levels of Care*. The criteria apply to both facility and HCBS based options.

### **Nursing Facility Based Eligibility**

Registered nurses (nurses or RNs) from the Utah Department of Health, Division of Family Health and Preparedness review individual cases to determine if an applicant meets nursing facility LOC. Individual case documentation is submitted by the nursing facility and includes, at a minimum, a comprehensive assessment that is required by the Centers for Medicare and Medicaid Services (CMS) called the *Minimum Data Set (MDS)*, a history and physical report completed by a physician, a screening for the presence of mental illness or intellectual disability called the *Pre-Admission Screening Resident Review (PASRR)* and physician's orders for medication and treatments. The documentation is reviewed against the LOC criteria and a determination is made. To assure ongoing eligibility, Department of Health (DOH) nurses conduct follow-up reviews ninety days after the initial determination and every six months thereafter.

### **ICF/ID Based Eligibility**

RNs from the Utah Department of Health, Division of Family Health and Preparedness review individual cases to determine if an applicant meets ICF/ID LOC. The individual case documentation is submitted by the ICF/ID. Required documentation includes assessment of functional limitations, documentation of intellectual disability or other related conditions, a social summary, any psychological assessments, medical assessments and physician's orders for medication and treatments. The documentation is reviewed against the LOC criteria and a determination is made. To assure ongoing eligibility, Department of Health (DOH) nurses conduct follow-up reviews ninety days after the initial determination date and every six months thereafter.

### **Home and Community Based Waiver Eligibility**

In addition to meeting LOC requirements, applicants must meet specific targeting criteria associated with each HCBS waiver. Utah has six HCBS waiver programs:

- Waiver for Individuals Aged 65 and Older
- Waiver for Individuals with Acquired Brain Injury
- Community Supports Waiver for Individuals with Intellectual Disabilities and Other Related Conditions
- New Choices Waiver
- Waiver for Individuals with Physical Disabilities
- Waiver for Individuals who are Technology Dependent

A description of the eligibility determination process for the each waiver is listed below:

***Waiver for Individuals Aged 65 and Older – Aging Waiver (AW)***

The Utah Department of Human Services, Division of Aging and Adult Services (DAAS) is the operating agency for this waiver. A referral (self or other) is made to a local Area Agency on Aging (AAA). Utah has twelve AAAs that administer the majority of the aging services in the state for their geographic regions. When a referral is received, an AAA staff person completes a *Demographic Intake and Risk Score* form for each applicant. Based on the applicant's score, if it appears the person will meet LOC and Medicaid financial eligibility, the form is submitted to DAAS.

When funding is available to support new waiver participants, DAAS staff identify the applicants with the highest risk score(s) and notify the appropriate AAA(s). At this point, a nurse from the AAA assesses the applicant to determine LOC. AAA nurses are trained by DAAS to determine LOC.

The nurse is sent to the applicant's home to conduct a comprehensive, face-to-face assessment. The assessment tool used is the *Minimum Data Set-Home Care* © (MDS-HC.) The MDS-HC is a derivative of the full MDS tool that is used to conduct facility based assessments. The assessment must be completed within 14 days of the AAA notification. Based on the results of the assessment the nurse makes the LOC determination. Once completed, the assessment, LOC determination, and care plan are sent to DAAS for approval. A nurse within DAAS reviews the submitted documentation to assure concurrence with the AAA's determination. If the DAAS nurse does not agree with the AAA's determination, the application is referred to the Utah Department of Health, Division of Medicaid and Health Financing (DMHF) for a final determination.

Once the eligibility process has been successfully completed, the participant is placed on the program and a care plan is developed. To assure ongoing eligibility, assessments and LOC determinations are completed annually or more frequently if the participant experiences a significant change in condition. These assessments and determinations follow the same steps as defined above.

***Waiver for Individuals with Acquired Brain Injury – Acquired Brain Injury Waiver (ABI)***

The Utah Department of Human Services, Division of Services for People with Disabilities (DSPD) is the operating agency for this waiver. An ABI intake is initiated either through an applicant's use of DSPD's toll free number or by contacting one of eight regional offices located throughout the State or the State office located in Salt Lake City. Application forms and instructions are given to the applicant through the mail or through an in-home or in-office meeting.

The following documentation is required to determine eligibility: an assessment of functional limitations, a documented diagnosis of an acquired brain injury, a *Comprehensive Brain Injury Assessment* (face-to-face assessment), a social summary, and physician's or other medical reports. The eligibility review process is completed by a certified, bachelor level DSPD staff person. Completion of the assessments requires specialist knowledge, experience and training.

Once the eligibility process has been successfully completed, the participant is placed on the program and an individual support plan is developed. To assure ongoing eligibility, certified DSPD staff complete a new assessment at least annually or more frequently with a significant change in condition. If there is a question about whether the client continues to meet LOC, the case is submitted to the DSPD Eligibility Review Committee for a more comprehensive evaluation and recommended course of action.

***Community Supports Waiver for Individuals with Intellectual Disabilities and other Related Conditions – (CSW)***

DSPD is the operating agency for this waiver. A CSW intake is initiated either through an applicant's use of DSPD's toll free number or by contacting one of eight regional offices located throughout the State or the State office located in Salt Lake City. Application forms and instructions are given to the applicant through the mail or through an in-home or in-office meeting.

The following documentation is required to determine eligibility: an assessment of functional limitations, a documented diagnosis of an intellectual disability or other related condition, a social summary, and psychological assessments. The eligibility review process is completed by a bachelor level DSPD staff person with specialist training and experience working with this population. Completion of the assessments requires specialist knowledge, experience and training. Once the eligibility process has been successfully completed, the participant is placed on the program and an individual support plan is developed.

To assure ongoing eligibility, qualified DSPD staff complete a re-determination of eligibility at least annually or more frequently with a significant change in condition. If there is a question about whether the client continues to meet LOC, the case is submitted to the DSPD Eligibility Review Committee for a more comprehensive evaluation and a recommended course of action.

***New Choices Waiver (NCW)***

Applications for the NCW are submitted to DMHF staff. A targeting criterion of the NCW requires that the applicant is a current resident in a nursing facility for 90 days or greater. Because the applicant has been a resident of facility based care, the applicant's eligibility has already been determined through the "Facility Based Eligibility" process described above. To assure ongoing eligibility, a nurse from the NCW case management agency completes a comprehensive, face-to-face assessment, the *Minimum Data Set- Home Care (MDS-HC.)*

Upon completion of the MDS-HC, if there is a question about whether the applicant continues to meet LOC, the case is submitted to the DOH nurses who complete the "Facility Based Eligibility" for further review. Once the eligibility process has been successfully completed, the participant is placed on the program and a care plan is developed. To assure ongoing eligibility, NCW case management nurses complete a new assessment at least annually or more frequently with a significant change in condition.

***Waiver for Individuals with Physical Disabilities – Physical Disabilities Waiver (PDW)***

DSPD is the operating agency for this waiver. A PDW intake is initiated either through an applicant's use of DSPD's toll free number or by contacting one of eight regional offices located

throughout the state or the State office located in Salt Lake City. Application forms and instructions are given to the applicant through the mail or through an in-home or in-office meeting.

The following documentation is required to determine eligibility: an assessment of functional limitations, documentation of a diagnosed physical disability, the *Minimum Data Set- Home Care (MDS-HC) assessment*, and pertinent medical records. The eligibility review process is completed by a DSPD Registered Nurse with specialist training and experience working with this population. Once the eligibility process has been successfully completed, the participant is placed on the program and a care plan is developed. To assure ongoing eligibility, DSPD Registered Nurses complete an eligibility determination at least annually or more frequently with a significant change in condition. If there is a question about whether the client continues to meet LOC, a consultation may be held with Utah Department of Health, DMHF staff.

***Waiver for Individuals who are Technology Dependent – Technology Dependent Waiver (TDW)***

A referral is made to the Department of Health, Division of Family Health and Preparedness (DFHP), which has responsibility for day-to-day waiver administrative activities. Most referrals come directly from Primary Children’s Medical Hospital or from a home health agency. Additional referrals come from state agencies, non-profit groups or the public. The nurse waiver coordinator completes a *Preliminary Level of Care Screening* form. This form provides basic demographic information, describes the type of technology upon which the applicant is dependent and scores the applicant based upon the required technology.

When funding is available to support new waiver participants, priority for admission to the waiver is given to the applicant with the highest numerical ranking. The nurse waiver coordinator will make a home visit with the applicant and their family. During this visit, the coordinator will complete a comprehensive assessment. The comprehensive assessment instrument for this waiver, known as the *Initial Comprehensive Assessment Form*, assists the coordinators to determine nursing facility LOC and eligibility based on TDW admission criteria. The coordinators are responsible for collecting the needed information and for making the initial LOC determinations.

The coordinators are trained by the Department of Health, DMHF staff regarding nursing facility LOC eligibility and specific waiver targeting criteria requirements. The waiver coordinator will then complete the *Initial and Annual Level of Care/Freedom of Choice Certification* form with the potential participant and a preliminary Plan of Care if it is determined that the potential participant meets all waiver criteria.

To assure ongoing eligibility LOC is reevaluated at least every 12 months. Reassessments are conducted by an RN waiver coordinator and completed during a reassessment home visit.

## **Maine’s Current Process for Determining Eligibility for Long Term Care Services:**

The State of Maine utilizes an approach that most closely illustrates the system described in the legislative intent language.

Since the 1990s, Maine has contracted with a non-state, for-profit company, Goold Health Systems, to be the single entry point for long term care eligibility determinations. Under this contract, Goold Health Systems (GHS) conducts preadmission screening for Medicaid long term care including: state plan home health, personal care and private duty nursing services, HCBS waivers and nursing facility services. Eligibility for ICFs/ID and HCBS waivers for individuals with intellectual disabilities are excluded from this contract. In addition, GHS conducts eligibility determinations for services funded by sources other than Medicaid.

The GHS website explains their long term care eligibility determination program as:

“GHS’ Community Assessment Program is comprised of 30+ nurses, who perform assessments in the field or provide support at GHS’ home office. Assessments are provided wherever the patient is located: hospitals, nursing facilities, individuals’ homes, and other health care facilities. Nurses in our office are available to support field nurses with their assessments. We also staff a toll-free help desk to receive referrals from medical providers and answer questions about existing or past cases.

We administer long-term care assessments for elderly and disabled people over 19 years of age, through a referral from a medical service provider. We also administer healthcare assessments to children under the age of 19 through the MaineCare Katie Beckett eligibility program.

Currently GHS processes 300 calls and 100 referrals every day. Our nurses conduct over 1500 onsite assessments monthly across the State of Maine. GHS is proud to administer Maine’s Community Assessment program, which leads the nation in innovation and efficiency.<sup>iii</sup>”

Agency staff contacted a representative from GHS who provided the following additional information:

- GHS performs assessments using the *Medical Eligibility Determination (MED)*,<sup>iv</sup> a tool that was developed by the State of Maine.
- Using the MED, GHS nurses assign the applicant to one of nine levels of care.
- GHS provides program eligibility information to the applicant. For example, if an applicant meets nursing facility LOC, the client would be eligible for any one of the HCBS waiver programs that require nursing facility LOC as long as the applicant also meets the waiver-specific targeting criteria. In Maine the relevant programs would be: Elderly HCB, Physical Disabilities HCB, Consumer Directed HCB, and Brain Injury HCB, etc.
- Applicants are free to choose the program in which they would like to enroll.

- GHS also develops the care plan, then forwards this information to one of two case management agencies for the ongoing oversight of the case once the applicant enters the waiver program.
- GHS does not perform Medicaid financial eligibility determinations.
- GHS staff complete assessments and reassessments at the following intervals:
  - For HCBS Programs
    - initial eligibility determinations;
    - a follow-up assessment ninety days after admission, then annually thereafter
  - Nursing Facility Services
    - initial assessments only<sup>2</sup>
- The typical cost of an assessment is \$172; the cost of a brain injury assessment is \$174.

### **General Demographic and Programmatic Comparisons**

In 2010, Maine's population was 1,328,361 and 314,000 (23.64%) residents were Medicaid recipients. During the same timeframe, Utah's Population was 2,763,885 and 338,130 (12.23%) residents were Medicaid recipients. The average annual Medicaid expenditure per client in Maine was \$8,019.05 while the average Utah Medicaid expenditure was \$4,818.43 per client.

### **Long Term Care Spending**

According to the Kaiser Family Foundation, State Health Facts, *Distribution of Medicaid Spending by Service, FY2009*, long term care spending accounted for 30.8% of Maine's overall Medicaid expenditures, ranking Maine 22<sup>nd</sup> in lowest percentage of spending on long term care services. In the same report, long term care spending accounted for 27.3% of Utah's overall Medicaid expenditures, ranking Utah 12<sup>th</sup> in lowest percentage of spending on long term care services.

According to the Kaiser Family Foundation, State Health Facts, *Distribution of Medicaid Spending on Long Term Care, FY 2009*, Maine spent 52.3% of its long term care budget on HCBS, ranking Maine 11<sup>th</sup> in highest percentage spent on HCBS. In the same report, Utah spent 49% of its long term care budget on HCBS, ranking Utah 13<sup>th</sup> in highest percentage spent on HCBS.

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<sup>2</sup> Previously, the nursing facility assessments occurred at more frequent intervals, but the regularity was reduced recently due to the State's budgetary constraints.

### 2009-2010 State Data Comparison Table<sup>v</sup>

	Utah	Maine
<b>State Population</b>	2,763,885	1,328,361
<b>Medicaid Recipients</b>	338,130	314,100
<b>Total Medicaid Expenditures</b>	\$1,629,254,870	\$2,517,981,111
<b>Percentage of Population Receiving Medicaid</b>	12.23%	23.64%
<b>Average Expenditure Per Recipient</b>	\$4,818.43	\$8,019.05
<b>Total Long Term Care Expenditures</b>	\$445,387,637	\$776,152,002
<b>Long Term Care Percentage of Total Expenditures</b>	27.30%	30.80%
<b>National Ranking in Long Term Care Service Spending</b>	12 <sup>th</sup> Lowest	22 <sup>nd</sup> Lowest
<b>Home and Community Based Services Percentage of Long Term Care Expenditures</b>	49%	52.30%
<b>National Ranking in Percentage of Long Term Care Expenditures Spent on Home and Community Based Services</b>	13 <sup>th</sup> Highest	11 <sup>th</sup> Highest
<b>Nursing Facility Occupancy Rate</b>	63.70%	91.70%
<b>Number of Nursing Facilities in the State</b>	97	107
<b>Number of People Residing in Nursing Facilities</b>	5,236	6,164
<b>Average Nursing Facility Private Pay Daily Rate</b>	\$151	\$233

### **Analysis of Using a Single Non-State Entity to Perform Medicaid LTC Eligibility**

*Would using a single, non-state entity provide greater consistency in long term care eligibility assessments results?*

#### ***Agency Response***

Although it is possible that use of a non-state entity could produce greater consistency in long term care eligibility assessment results, Utah has multiple controls in place to assure eligibility determinations are made in an objective and consistent way across all programs. These controls include:

- Routine training of individuals who complete assessments for both facility based and HCBS services;
- Agency staff routinely review eligibility assessments;
- Agency staff make all final eligibility determinations. Because Agency staff are responsible for serving individuals within each program's limited, established budgets,

there is a strong incentive to assure that people receiving services truly meet program eligibility criteria;

- Routine quality assurance reviews are performed using representative sampling to assure level of care determinations have been properly made;

There are no indications that Utah's long term care eligibility assessment results are inconsistent. On the contrary, indicators such as low nursing facility census and balanced Medicaid spending between facility based and HCBS services suggest that prudent and consistent long term care eligibility decisions are being routinely made.

***Would using a single assessment tool (such as Maine's MED) to determine Medicaid long term care eligibility result in increased consistency in eligibility determinations across programs?***

***Agency Response:***

Although Utah does not use one, exclusive tool for assessing eligibility for long term care services, the State uses the MDS, the MDS-HC, or a combination of the two as the basis for making level of care determinations in four of the six Medicaid long term care programs that require nursing facility LOC. The four programs that use these instruments are: nursing facility services and the New Choices, Aging and Physical Disabilities waivers. Both the MDS and the MDS-HC have undergone extensive validity and reliability testing. CMS mandates the use of the MDS for Medicare- and Medicaid-funded nursing facility care. By using these two instruments, there is a significant amount of consistency in determining eligibility for these four programs:

The two remaining programs: the ABI and Tech Dependent waivers have very distinctive characteristics that make the use of alternate assessment tools preferable. For example, Tech Dependent waiver applicants have highly complex medical issues such as ventilator or tracheostomy dependence. In these cases, there is little question that the applicant meets nursing facility LOC. The specialized assessment tool is used to determine nursing facility LOC and the client's needs simultaneously. Allowing this flexibility results in the efficient administration of the program and a reduction in the number of assessments required.

In addition, development of a tool such as Maine's MED is a substantial undertaking that requires significant financial and human resources to conduct research, development, validity and reliability testing.

***Would cost savings result from having a non-state entity perform long term care eligibility determinations?***

***Agency Response***

Agency staff asked GHS if any studies had been completed or objective data collected to demonstrate cost-effectiveness or cost-savings associated with this methodology. GHS staff indicated they were not aware of any specific studies. GHS recommended that Agency staff contact state agency officials in Maine to determine if any studies had been completed. Department staff attempted to contact Maine's Office of Elder Services to inquire about the

existence of any studies or reports of this nature. Utah staff did not receive a reply to this inquiry.

Appropriate, cost-effective, “gate-keeping functions” currently exist in Utah’s long term care system. For residents living in nursing facilities, DOH nurses monitor eligibility at the time of admission, ninety days after the initial determination, then every six months thereafter. For all HCBS programs, Agency staff reassess eligibility at least annually or more frequently if a significant change in condition occurs.

There are no indications that Utah’s long term care eligibility assessment processes results in inappropriate use or over-utilization of long term care services. On the contrary, indicators such as low nursing facility census, relatively low long term care services spending as a percentage of the State’s total Medicaid expenditures, and balanced Medicaid spending between facility based and HCBS services suggest that appropriate utilization of long term care services occurs.

Utah manages its long term care services programs in a very cost-effective manner. On average, the typical cost of a fiscal year 2010 assessment was \$60.13. A comparable assessment completed under the Maine system would typically cost \$172. The following information details the costs of completing long term care eligibility determinations in Utah’s programs and the projected comparison cost under the Maine system:

<b>Utah’s Total Number of Assessments Completed during 2010</b>	<b>Utah’s Cost Per Assessment</b>	<b>Utah’s Total Cost</b>	<b>Cost Per Assessment Under the Maine System</b>	<b>Projected Total Cost Under the Maine System</b>	<b>Cost Difference Between the Maine System and Utah’s Current System</b>
19,487	\$60.13	\$1,171,820	\$172	\$3,351,764	\$2,179,944

If the State adopted a system like the one that is currently operating in Maine and paid the same \$172 rate per assessment, the increased cost to the state would be approximately \$2,179,944 per year in administrative expenditures with little expectation that it would result in less costly placements on the program expenditure side.

## **Recommendations**

Although using a non-State entity to make long term care eligibility determinations has been implemented successfully in Maine, the information provided in this report shows that Utah's current system of determining long term care eligibility is very successful as well.

Agency staff measured success by comparing relevant indicators such as cost per assessment, utilization management indicators such as Medicaid long term care costs, distribution of long term care spending between facility and home and community based care, number of people living in nursing facilities, census in nursing facilities, etc. Based on the results of this evaluation, the recommendation is to not pursue a single entry point at this time.

## End Notes:

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<sup>i</sup> Mollica, Robert, Gillespie, Jennifer, Single Entry Point Systems: State Survey Results. National Academy of State Health Policy. August 2003. URL:  
[http://www.nashp.org/sites/default/files/CLE\\_single\\_entry\\_point.pdf](http://www.nashp.org/sites/default/files/CLE_single_entry_point.pdf)

<sup>ii</sup> Determining Medicaid Nursing Facility Level of Care Eligibility in Maryland. University of Maryland Baltimore County, Center for Health Promotion Development and Management. December 2000. URL:  
<http://www.hilltopinstitute.org/publications/DeterminingMedicaidNFLLevelOfCareEligibilityInMD-December2000.pdf>

<sup>iii</sup> *Clinical Assessment Programs: Long-term Care & Katie Beckett*. Goold Health Systems. URL:  
<http://www.ghsinc.com/clinical/assessments>

<sup>iv</sup> <http://www.maine.gov/dhhs/oes/medxx/medxx.htm>

<sup>v</sup> U.S. Census Bureau, State and County QuickFacts. URL:  
<http://quickfacts.census.gov/qfd/states/23000.html>

The Kaiser Family Foundation, statehealthfacts.org. Table: *Medicaid Spending, 2009*. URL:  
<http://www.statehealthfacts.org/profileind.jsp?cmprgn=21&cat=4&rgn=46&sub=47>

Maine Total Number of Medicaid Recipients, 2009 URL:  
<https://gateway.maine.gov/dhhs-apps/dashboard/>

Utah Total Number of Medicaid Recipients, 2009 URL:  
[http://www.health.utah.gov/medicaid/pdfs/annual\\_report2010.pdf](http://www.health.utah.gov/medicaid/pdfs/annual_report2010.pdf)

The Kaiser Family Foundation, statehealthfacts.org: *Distribution of Medicaid Spending by Service, FY2009*, URL:  
<http://www.statehealthfacts.org/comparetable.jsp?typ=2&ind=178&cat=4&sub=47&sortc=2&o=a>

The Kaiser Family Foundation, statehealthfacts.org: *Distribution of Medicaid Spending on Long Term Care, FY2009*, URL: <http://www.statehealthfacts.org/comparetable.jsp?typ=2&ind=180&cat=4&sub=47&sortc=4&o=a>

The Kaiser Family Foundation, statehealthfacts.org: *Certified Nursing Facility Occupancy Rate, 2009*, URL:  
<http://www.statehealthfacts.org/profileind.jsp?cmprgn=21&cat=8&rgn=46&sub=97>

The Kaiser Family Foundation, statehealthfacts.org: *Total Number of Certified Nursing Facilities, 2009*. URL:  
<http://www.statehealthfacts.org/profileind.jsp?ind=411&cat=8&rgn=46&cmprgn=21>

The Kaiser Family Foundation, statehealthfacts.org: *Total Number of Residents in Certified Nursing Facilities, 2009*. URL: <http://www.statehealthfacts.org/profileind.jsp?ind=408&cat=8&rgn=46&cmprgn=21&print=1>

*Utah Medicaid Nursing Home Rates, 2009*. URL:  
[http://health.utah.gov/medicaid/stplan/NursingHomes/Rates/NF/NH\\_RateModel\\_FY09\\_Q4%20vPostFinal.pdf](http://health.utah.gov/medicaid/stplan/NursingHomes/Rates/NF/NH_RateModel_FY09_Q4%20vPostFinal.pdf)

Long Term Care in Maine, December 2009, AARP URL:  
[http://assets.aarp.org/rgcenter/health/state\\_ltc\\_b\\_09\\_me.pdf](http://assets.aarp.org/rgcenter/health/state_ltc_b_09_me.pdf)