GATEWAY TO GLOBAL AGING DATA

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Gateway Policy Explorer: Long-Term Care Series

Colorado, USA

Long-Term Care In-Kind Benefit Plan Details

1992-2024

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Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

Background — *Gateway Policy Explorer: Long-Term Care Series*

The *Gateway Policy Explorer* (http://g2aging.org/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Long-Term Care Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

Why are we tracking past policy? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Long-Term Care Series* are country and time. In the United States, policy is reported at the state level. We prioritize data collection for each country or state based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country or state and each broad category of policies covered in the *Gateway Policy Explorer: Long-Term Care Series*.

Colorado, USA

In-Kind Benefits

Plan details 1992-2024 * †

Public long-term care (LTC) benefits in Colorado are primarily provided by Medicaid, a public health insurance program for low-income individuals. Enrollment in Medicaid is voluntary.

In Colorado, LTC services are primarily provided as in-kind benefits. LTC benefits vary by program, with separate programs for home-based care, community care, residential care, and some that cover a variety of care. Programs vary in eligibility criteria.

Since 1992, Colorado's Medicaid LTC system has been subject to one major policy reform: the expansion of Medicaid eligibility to cover adults with incomes up to 138% of the federal poverty level under the Affordable Care Act in 2014.

Key Dates

First law: 1965

Major changes since 1992: 2014

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† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Chapter 1: Policy enacted 1992-2013

Overview

Long-term care (LTC) benefits in Colorado are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Colorado is administered at the state level by the Colorado Department of Healthcare Policy and Financing (HCPF).

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Colorado are mostly provided through Medicaid state plan benefit programs (Long-Term Home Health Services - LTHH, Nursing Facility Care) or through federally approved home-and community-based services (HCBS) LTC programs (HCBS Elderly, Blind and Disabled Program - HCBS-EBD, Program of All-Inclusive Care for the Elderly - PACE).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. LTHH provides home care for beneficiaries that have established medical necessity while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by HCBS-EBD are also able to receive a variety of LTC benefits if deemed medically eligible, such as In Home Support Services (IHSS) and Consumer Directed Attendant Support Services (CDASS). Those applying for the HCBS-EBD program are not immediately guaranteed care, as the program has an enrollment limit. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available.

All LTC benefit programs in Colorado require applicants to meet a nursing facility level of care (NFLOC) based on a comprehensive assessment prior to admission.

Policy changes during this period:

- (1996) The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 restricted most legal immigrants entering the United States after August 22, 1996 from receiving federally funded Medicaid (and some other public assistance) for at least five years after immigration (U.S. Congress, 1996).
- (1997) The Adult Day Health Care program was implemented as a community-based long term care benefit (ASPE, 2005).
- (2003) Colorado temporarily repealed Medicaid coverage for legal immigrants in 2003, but reinstated Medicaid eligibility for this group in 2006 (Colo. Gen. Assemb., 2003; Colo. Gen. Assemb., 2005).
- (2004) Colorado implemented new participant-directed care delivery systems for long term care under HCBS-EBD —IHSS and CDASS (Colo. Gen. Assemb., 2002).
- (2006) For individuals qualifying for Medicaid by being eligible for the Supplemental Security Income program (eligibility track 1a.) or through institutional rules for people receiving LTC (eligibility track 2a.), Colorado increased the look back period for asset transfers from 36 months (60 months for a trust) to 60 months for all assets (CCR § 8.100.7.F, 2024b).
- (2011) Colorado home equity limits for Medicaid eligibility begin increasing annually with inflation (CCR § 8.100.7.M, 2024b).

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2024c)

Colorado Law for Medicaid

- Code of Colorado Regulations (CCR), 2505- Department of Healthcare Policy and Financing (CCR, 2000)
- Colorado Revised Statutes (C.R.S), Title 25.5 - Department of Healthcare Policy and Financing (C.R.S., 2023)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Colorado Medicaid spending on beneficiaries in fiscal year 1992 was 54.79%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending. The match rate for most administrative functions is 50%, although some functions are matched at a higher rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Colorado Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Colorado.

Eligibility for Medicaid in Colorado for people needing LTC services is primarily attained by satisfying at least one of 2 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 1992, the monthly federal benefit amount was $422 for an individual and $633 for a couple (SSA, 2024a). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989 (U.S. Senate, 1996; KFF, 1999).
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[2]
    - Home equity limit: From 2006, the equity interest in the individual's home may not exceed $500,000, or else they will be ineligible for LTC services. From 2011, this figure increases annually with inflation (CCR § 8.100.5.M, 2024b). See Table 3 for historical home equity limits.
  - Citizenship/immigration requirements (SSA, 1998): The applicant must be a Colorado resident and a U.S. citizen or non-citizen who meets additional eligibility requirements.[3] After 1996, the applicant must be a Colorado resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2024b) for additional information. Colorado temporarily repealed Medicaid coverage for legal immigrants in 2003, but reinstated Medicaid eligibility for this group in 2006 (Colo. Gen. Assemb., 2003; Colo. Gen. Assemb., 2005).
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC [5]
  - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount (KFF, 1999). In 1992, this was $1,266 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist when a person is institutionalized, receiving HCBS (as of 1999), or participating in PACE (as of 1997) and has a spouse residing in the community (CCR § 8.112, 2000).[6] See Table 4 for historical monthly spousal disregards.

- ◇ Asset requirements: Resources may not exceed $2,000 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents (CMS, 2021). Additional asset disregards exist when a person is institutionalized, receiving HCBS (as of 1999), or participating in PACE (as of 1997) and has a spouse residing in the community.[7] See Table 4 for historical monthly spousal disregards.
  - Asset transfer & home equity limit: Same as eligibility track 1a.
- ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
- ◇ Other requirements
  - The applicant must be receiving Medicaid Nursing Facility Care for at least 30 consecutive days or be enrolled in the HCBS-EBD or PACE programs.

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. These tracks are omitted because they are more rarely used or do not cover older adults.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Long-term Home Health (LTHH), Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit Eligibility* section of this policy period).

HCBS-EBD

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65, or between age 18-64 and blind or disabled. If the program has reached capacity, eligible applicants will be placed on a waiting list. [8]

Program of All-Inclusive Care for the Elderly (PACE)

Beyond meeting the minimum level of dependence, individuals must be at least age 55 and community-dwelling. If an individual does not meet the financial eligibility requirements for the Medicaid state plan, they may pay privately for PACE services (HCPF, 2024a).

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Spinal Cord Injury program (HCBS-SCI) —from 2012
- Private Duty Nursing
- Colorado Indigent Care Program
- Hospital Back-Up

Benefit

Home care benefit

Home care benefits vary by LTC health benefit program. The details of the four largest programs are summarized below.

LTHH

LTHH provides the following nursing services (CCR § 8.523.11, 2000; CCR § 8.520.4.C.2, 2024e):

- Skilled nursing services: intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse (RN) or licensed practical nurse (LPN)
- Home health aide services: Semi-skilled care such as simple wound care, vital monitoring, and personal care

Colorado Medicaid offers an acute home health services benefit that covers the first 60 days of services without prior authorization. Individuals requiring home health services for more than 60 days are covered through the LTHH benefit. LTHH requires prior authorization and recipients must meet a nursing facility level of care (NFLOC).

Nursing Facility Care

Nursing facility care does not provide home care.

HCBS-EBD

The HCBS-EBD program provides the following home care services —from 2004:

- In-Home Support Services (IHSS), [9] which include (Colo. Gen. Assemb., 2002):
  - Homemaker Services: Assistance with instrumental activities of daily living (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
  - Health Maintenance Services: Assistance with skilled health-related activities such as wound care or medication management
  - Personal Care Services: Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Consumer-Directed Attendant Support Services (CDASS): [9] Personal care services provided by an attendant that the beneficiary chooses, manages, and directs (beneficiaries who choose this option cannot receive LTHH, only acute home care, which is provided on a short term basis) (CCR § 8.551.2, 2000; CCR § 8.510, 2024e)

Services provided under IHSS and CDASS are participant-directed.

HCBS-EBD services can be received in an alternative care facility (ACF) (CCR § 8.7505, 2024f).

PACE

The PACE program provides home health services, personal care services, and private duty nursing. Private duty nursing includes skilled nursing care for those who are technology dependent (HCPF, 2024a).

Community care

Community care benefits vary by LTC health benefit program. The details of the four largest programs are summarized below.

LTHH, Nursing Facility Care

These programs do not provide community care.

HCBS-EBD, PACE

These programs provide (CCR § 8.491, 2000):

- Adult Day Health Care (ADHC): Centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting —from 1997 (ASPE, 2005)
- Specialized centers for adults living with specific diagnoses or chronic conditions
- Transportation to and from day care services

Residential care

Residential care benefits vary by LTC health benefit program. The details of the four largest programs are summarized below.

LTHH, HCBS-EBD, PACE

These programs do not provide residential care.

Nursing Facility Care

Colorado Medicaid covers residential care in a nursing facility. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (CFR, 1992a; CCR § 8.408, 2024d). Services may include the following:

- Physician services
- Room and board
- All general nursing services and routine personal hygiene services
- Medical supplies, equipment, and over-the-counter (OTC) medication
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Other care benefits vary by LTC health benefit program. Below we detail other benefits provided by the Medicaid state plan, followed by Colorado's two largest home and community-based services (HCBS) programs.

Colorado Medicaid provides additional benefits related to LTC (CCR § 8.680, 2000; CFR § 440.170(a)(4), 2024c; CCR § 8.590, 2024d):

- Durable medical equipment and supplies: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Long-Term Home Health Services

- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

HCBS-EBD

From 2007, HCBS-EBD provides the following services in addition to those offered under the state plan, unless otherwise noted (CCR § 8.496, 2000):

- Electronic monitoring: Electronic equipment or adaptations that are necessary due to an individual's disability or are required to ensure that the individual remains in the community
- Home-delivered meals: Planning, preparation and delivery of meals to homes of beneficiaries who are unable to prepare their own meals or have dietary restrictions and lack outside assistance
- Non-medical transportation: Provides beneficiaries with access to non-medical community services and supports like adult day services, shopping, and counseling
- Respite care: Services provided to participants unable to care for themselves on a short-term basis at home or in a nursing facility because of the absence of or need of relief for those persons normally providing care for the participant
- Home modification: Special modifications or improvements to a beneficiary's home for to promote independence, prevent institutionalization, and ensure the individual's heath and safety
- Life skills training: Individualized training provided in a beneficiary's home or community to develop and maintain physical, emotional, social and economic sustainability in the community
- Peer mentorship: Support and advising from peers to promote self-advocacy and encourage community living
- Transition setup: Assistance with the logistics and expenses associated with transitioning out of a nursing facility or other congregate facility into the community

PACE

The PACE program provides the following services in addition to those offered under the state plan, unless otherwise noted (CMS, 2011; HCPF, 2024a):

- Meals: Preparation and provision of nutritious meals meeting dietary restrictions of participants, nutritional support including tube feeding, total parenteral nutrition or peripheral parenteral nutrition
- Non-medical transportation: Provides beneficiaries with access to non-medical community services and supports like adult day services, shopping, and counseling
- Respite care: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Social Services [10]
- Therapy: Occupational, physical, and recreational

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Colorado Department of Health Care Policy and Financing (HCPF). Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

LTHH

Long-term Home Health is provided by a Medicaid-certified Home Health Agency. Skilled nursing services are provided by a registered nurse (RN) or a licensed practical nurse (LPN) under direction of an RN (CCR § 8.525, 2000; CCR § 8.520, 2024e). Homemaking, skilled, and unskilled personal care services are provided by home health aides.

Nursing Facility Care

Care is provided by RNs, LPNs, and other auxiliary staff including dieticians employed by a state registered nursing facility (CCR § 8.408.4, 2000; 2024d).

HCBS-EBD, PACE

The provision of care for program services will vary by authorized service.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence for the four largest programs are summarized below.

LTHH, Nursing Facility Care, HCBS-EBD, PACE

To qualify for all LTC services, applicants must meet a nursing facility level of care (NFLOC) (CCR § 8.401, 2024d).

An NFLOC is defined as the individual requiring one of the following (CCR § 8.401.1, 2000):

- Moderate assistance with at least 2 activities of daily living (ADLs)
- At least moderate supervision due to certain behaviors (wandering, disruptive, self-injurious, resistive to care, self-neglect) or memory/cognitive deficits

To receive care in a nursing facility or through LTHH, a physician licensed in the state of Colorado must deem skilled nursing care to be medically necessary (CCR § 8.406.1, 2000; CCR § 8.406, 2024d).

Duration of benefit

Reassessments of eligibility differ by program and service type. Below we detail reassessments for Medicaid, followed by reassessments for the four largest programs (CCR § 8.393.25, 2000).

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months.

LTHH

Colorado Medicaid offers an acute home health services benefit that covers the first 60 days of services without prior authorization. Individuals requiring home health services for more than 60 days are covered through the LTHH benefit. LTHH requires prior authorization and recipients must meet a nursing facility level of care (NFLOC). This prior authorization request must be renewed every 12 months (CCR § 8.527, 2000; CCR § 8.520.8.C., 2024e).

Nursing Facility Care

An individual's medical need for skilled nursing care must be reassessed monthly by a physician. Level of care reassessment will occur if there is a significant change in a resident's physical or medical status, if the case manager sets an end-date for eligibility, or if requested by the individual (CCR § 8.408.63, 2000; 2024d).

HCBS-EBD

Level of care for the HCBS-EBD program is reassessed annually by a case manager or more frequently if there are significant changes that may affect the beneficiary's eligibility for the program (CCR § 8.393.25, 2000; CCR § 8.486.200, 2024d).

PACE

Individuals must undergo an annual level of care recertification. If a participant continues to meet the level of care during their first annual reassessment they may be permanently waived from the annual requirement (CCR § 8.390, 2000; CCR § 8.497.11.F., 2024d).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by age requirements for the four largest programs.

Medicaid

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid (CCR § 8.100.5, 2000; CCR § 8.100.3, 2024b).

LTHH, Nursing Facility Care

There is no age requirement.

HCBS-EBD
The individual must be at least age 65, or between age 18-64 and blind or disabled.

PACE
Individuals must be at least age 55.

Care needs assessment

Definition of dependence

Definitions of dependence vary slightly depending on the health benefit program. The details are summarized below for the four largest programs.

LTHH
LTHH services are provided if they are medically necessary for a period longer than 60 days. Medically necessary home health services means that services are clinically appropriate to treat, diagnose, prevent, or cure a physical or mental illness, condition, injury or disability. Medicaid coverage for LTHH requires a prior authorization (CCR § 8.523.2, 2000; CCR § 8.076.8, 2024a; CCR § 8.520, 2024e).

Additionally, applicants must meet a nursing facility level of care (NFLOC). An NFLOC is defined as the individual requiring one of the following (CCR § 8.401, 2000):

- Moderate assistance with at least 2 activities of daily living (ADLs)
- At least moderate supervision due to certain behaviors (wandering, disruptive, self-injurious, resistive to care, self-neglect) or memory/cognitive deficits

Nursing Facility Care
To qualify for placement in a nursing facility, the applicant must require skilled nursing care that is certified as medically necessary by a licensed physician and meet an NFLOC. An NFLOC is determined using the same criteria described above under LTHH.

HCBS-EBD, PACE
Applicants must meet an NFLOC to be eligible. An NFLOC is determined using the same criteria defined above under LTHH.

Applicants to the HCBS-EBD program are not immediately guaranteed care, as the program has an enrollment limit. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available. [8]

Evaluation of dependence

Evaluations of dependence vary depending on the health benefit program. The details of the four largest programs are summarized below.

LTHH
Applicants must obtain a prior authorization for LTHH services and meet a nursing facility level of care (NFLOC). An NFLOC is determined using a level of care assessment (CCR § 8.527.11, 2000; CCR § 8.401.16, 2024d).

Colorado uses the Uniform Long-Term Care (ULTC 100.2) assessment to determine level of care. Applicants are scored based on their ability to complete 6 ADLs (mobility, bathing, dressing, eating, toileting, transferring) and their need for supervision. Individuals are scored from 0 to 3 on each activity, with a score of 0 indicating total independence, and a score of 3 indicating total dependence. To meet an NFLOC, applicants must have one of the following:

- A deficit (score of 2 or higher) in at least 2 ADLs
- Require at least moderate supervision (score of 2 or higher) in the subcategories of Behaviors or Memory/Cognition

See Table 5 for ADL scoring and Table 6 for Behaviors, Memory, and Cognition scoring.

Nursing Facility Care
Applicants must have a need for skilled nursing care as certified by a licensed physician and meet an NFLOC. An NFLOC is determined using the same criteria described above under LTHH.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). The PASRR screening helps the state determine whether an incoming nursing facility resident is likely to have a developmental disability or mental illness. Results of the PASRR Level I screening will indicate whether an individual requires PASRR Level II screening to determine if specialized mental health or developmental disability services are needed. A physician licensed to practice in Colorado must certify that nursing facility care is medically necessary and must draft a plan of treatment before an individual is admitted (CCR § 8.401.18, 2000). See Box 1 for more information on the PASRR, and Box 2 for the MDS.

HCBS-EBD, PACE

Applicants must meet an NFLOC in order to be eligible for these programs. An NFLOC is determined using the same criteria described above under LTHH. Additionally, some services may require a prior authorization (CCR § 8.401, 2000; 2024d).

Applicants to the HCBS-EBD program are not immediately guaranteed care, as the program has an enrollment limit. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available. [8]

Evaluators

Evaluators vary by health benefit program. The details of the four largest programs are summarized below.

LTHH, HCBS-EBD, PACE

Level of care assessments are administered by case managers from Case Management Agencies (CMAs) within the single-entry point (SEP) system (CCR § 8.393.25, 2000; 2024c).

Nursing Facility Care

Nursing facility eligibility must be certified as medically necessary by a licensed physician (CCR § 8.408.6, 2000; CCR § 8.076.8, 2024a). Case managers administer the level of care assessment and PASRR evaluation prior to resident admission.

Benefit limitations

Can you mix LTC benefits?

All Colorado Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other public benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the four largest programs.

Medicaid

As required by federal law, Colorado enforces Estate Recovery. The acceptance of Medicaid in Colorado creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age (C.R.S. § 25.5-4-302, 2023). Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. The state agency may only recover assets from beneficiaries who received services in an institutionalized setting or if they were aged 55 or older when services were received (CCR § 8.063, 2000; Health First Colorado, 2016; CCR § 8.100.5.D., 2024b). The debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (Colorado Gerontological Society, 2023; Hammond Law, 2024).

LTHH

LTHH does not require a copayment from Medicaid beneficiaries (Health First Colorado, 2024).

Nursing Facility Care

Beneficiaries are expected to contribute all their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. See Table 4 for historical spousal impoverishment standards . In 1992, the PNA was $34 per month. In 1999, this amount increased to $50 per month (Colo. General Assembly, 1999). See Table 7 for historical PNA amounts in Colorado.

HCBS-EBD

HCBS-EBD does not require a copayment (CCR § 8.754, 2000).

PACE

PACE does not require a copayment and PACE organizations in Colorado are prohibited from charging Medicaid beneficiaries a monthly premium for services rendered (HCPF, 2024a).

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 2: Policy enacted 2014-2024

Policy change in 2014
In 2014, Colorado adopted Medicaid expansion following passage of the Affordable Care Act (ACA), creating a new eligibility track covering adults age 19-64 with incomes up to 138% of the federal poverty level (FPL), referred to here as eligibility track 2c (ACA expansion adults).

Other policy changes during this period:

- (2014) Colorado Medicaid allows a beneficiary's spouse to be classified as an attendant for in-home support services (Colo. Gen. Assemb., 2014).
- (2015) Colorado increased the PNA from $50 per month to $77.25 per month. This amount increased annually thereafter with inflation (HCPF, 2014).
- (2016) Colorado renamed their Medicaid program to Health First Colorado. For simplicity, we will refer to Health First Colorado as Medicaid throughout this policy period (chapter).
- (2017) Colorado approved coverage of home health services in the community, meaning beneficiaries were no longer restricted to receiving home health services in their residence. Some community settings where LTHH coverage was expanded included alternative care facilities, hotels (in temporary situations like travel), telehealth, or anywhere that normal life activities take place (CCR, 2024e).
- (2023) Colorado implemented a new level of care assessment tool called the Colorado Single Assessment Level of Care (CSA LOC) Screen to replace the ULTC 100.2. Both the ULTC 100.2 assessment and the CSA LOC Screen are used by CMAs when determining applicant eligibility until the CSA LOC Screen has been fully implemented throughout the state.
- (2023) Passed in 2023 but effective July 1, 2025, Colorado will expand long term care (LTC) services by adding the Community First Choice Option (CFCO) to the state plan (Colo. Gen. Assemb., 2023). The implementation of this program will transfer many LTC services from the existing Home- and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) program to CFCO. Applicants for this program must be eligible for Medicaid, be in an eligibility group that includes nursing facility care, or, in the case that this does not apply, must have an income that is less than or equal to 150% of the FPL. Additionally, individuals must be at least age 65 and meet an NFLOC.

Overview

Long-term care (LTC) benefits in Colorado are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Colorado is administered at the state level by the Colorado Department of Healthcare Policy and Financing (HCPF).

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Colorado are mostly provided through Medicaid state plan benefit programs (Long-Term Home Health Services - LTHH, Nursing Facility Care) or through federally approved home-and community-based services (HCBS) LTC programs (HCBS Elderly, Blind and Disabled Program - HCBS-EBD, Program of All-Inclusive Care for the Elderly - PACE).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. LTHH provides home care for beneficiaries that have established medical necessity while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by HCBS-EBD are also able to receive a variety of LTC benefits if deemed medically eligible, such as In Home Support Services (IHSS) and Consumer Directed Attendant Support Services (CDASS). Those applying for the HCBS-EBD program are not immediately guaranteed care, as the program has an enrollment limit. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available.

All LTC benefit programs in Colorado require applicants to meet a nursing facility level of care (NFLOC) based on a comprehensive assessment prior to admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2024c)

Colorado Law for Medicaid

- Code of Colorado Regulations (CCR), 2505- Department of Healthcare Policy and Financing (CCR, 2000)

- Colorado Revised Statutes (C.R.S), Title 25.5 - Department of Healthcare Policy and Financing (C.R.S., 2023)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Colorado Medicaid spending on beneficiaries in fiscal year 2014 was 50%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending. The match rate for most administrative functions is 50%, although some functions are matched at a higher rate.[11]

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Colorado Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Colorado.

Eligibility for Medicaid in Colorado for people needing LTC services is primarily attained by satisfying at least one of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount. In 2014, the monthly federal benefit amount was $721 for an individual and $1,082 for a couple (SSA, 2024a). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989 (U.S. Senate, 1996; KFF, 1999).
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[12]
    - Home equity limit: The equity interest in the individual's home may not exceed $543,000 or else they will be ineligible for LTC services. This figure increases annually with inflation (CCR § 8.100.5.M, 2024b). See Table 3 for historical home equity limits.
  - Citizenship/immigration requirements: The applicant must be a Colorado resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals that entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2024b) for additional information.

    - Other requirements
        - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC
    - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount (KFF, 1999). In 2014, this was $2,163 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist when a person is institutionalized or participating in an HCBS program and has a spouse residing in the community (CCR § 8.100.7, 2024b).[13] See Table 4 for historical monthly spousal disregards.
    - Asset requirements: Resources may not exceed $2,000 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents (CMS, 2021). Additional asset disregards exist when a person is institutionalized or participating in an HCBS program and has a spouse residing in the community (CCR § 8.112, 2024b).[14] See Table 4 for historical monthly spousal disregards.
        - Asset transfer & home equity limit: Same as eligibility track 1a.
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - Other requirements
        - The applicant must be receiving Medicaid Nursing Facility Care for at least 30 consecutive days or be enrolled in the HCBS-EBD or PACE programs (CCR § 8.100.7, 2024b).
- 2c. Affordable Care Act (ACA) expansion adults
    - Income requirements: Monthly income may not exceed 138% of the FPL. In 2014, this was $1,342 for an individual and $1,809 for a household of two. See Table 2 for historical income limits.
    - Asset requirements: There is no asset test for this population (KFF, 2018).
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - Other requirements
        - Applicants must be age 19-64, ineligible for Medicare, and ineligible for other Medicaid eligibility tracks.

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. These tracks are omitted because they are more rarely used or do not cover older adults.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Long-term Home Health (LTHH), Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit eligibility* section of this policy period).

HCBS-EBD

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65, or between age 18-64 and blind or disabled (CMS, 2024a). If the program has reached capacity, eligible individuals are placed on a waiting list. Though regulations exist detailing prioritization of waiting list applicants, sources indicate that this program no longer puts a cap on enrollment and therefore has not had a waiting list since at least 2017 (Colorado Center for Aging, 2017; CMS, 2024a).[8]

Program of All-Inclusive Care for the Elderly (PACE)

Beyond meeting the minimum level of dependence, individuals must be at least age 55 and community-dwelling. If an individual does not meet the financial eligibility requirements for the Medicaid state plan, they may pay privately for PACE services (HCPF, 2024a).

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Community First Choice Option —from 2025
- Complementary and Integrative Health program (previously Spinal Cord Injury program)
- Private Duty Nursing
- Colorado Indigent Care Program

- Hospital Back-Up

Benefit

Home care benefit

Home care benefits vary by LTC health benefit program. The details of the four largest programs are summarized below.

LTHH

LTHH provides the following nursing services (CCR § 8.523.11, 2000; CCR § 8.520.4.C.2, 2024e):

- Skilled nursing services: intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse (RN) or licensed practical nurse (LPN)
- Home health aide services: Semi-skilled care such as simple wound care, vital monitoring, and personal care

Colorado Medicaid offers an acute home health services benefit that covers the first 60 days of services without prior authorization. Individuals requiring home health services for more than 60 days are covered through the LTHH benefit. LTHH requires prior authorization and recipients must meet a nursing facility level of care (NFLOC).

Nursing Facility Care

Nursing facility care does not provide home care.

HCBS-EBD

The HCBS-EBD program provides the following home care services:

- In-Home Support Services (IHSS), [9] which include (Colo. Gen. Assemb., 2002):
  - Homemaker Services: Assistance with instrumental activities of daily living (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
  - Health Maintenance Services: Assistance with skilled health-related activities such as wound care or medication management
  - Personal Care Services: Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Consumer-Directed Attendant Support Services (CDASS): [9] Personal care services provided by an attendant that the beneficiary chooses, manages, and directs (beneficiaries who choose this option cannot receive LTHH, only acute home care, which is provided on a short term basis) (CCR § 8.551.2, 2000; CCR § 8.510, 2024e)

Services provided under IHSS and CDASS are participant-directed. From March 2015, the spouse of a beneficiary is permitted to serve as the beneficiary's attendent providing IHSS (Colo. Gen. Assemb., 2014).

HCBS-EBD services can be received in an alternative care facility (ACF) (CCR § 8.7505, 2024f).

PACE

The PACE program provides home health services, personal care services, and private duty nursing. Private duty nursing includes skilled nursing care for those who are technology dependent (HCPF, 2024a).

Community care

Community care benefits vary by LTC health benefit program. The details of the four largest programs are summarized below.

LTHH, Nursing Facility Care

These programs do not provide community care.

HCBS-EBD, PACE

These programs provide (CCR § 8.491, 2000):

- Adult Day Health Care (ADHC): Centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (ASPE, 2005)
- Specialized centers for adults living with specific diagnoses or chronic conditions
- Transportation to and from day care services

From 2021, adult day services can be provided on-site or virtually via Telehealth (HCPF, 2024c).

Residential care

Residential care benefits vary by LTC health benefit program. The details of the four largest programs are summarized below.

LTHH, HCBS-EBD, PACE

These programs do not provide residential care.

Nursing Facility Care

Colorado Medicaid covers residential care in a nursing facility. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (CFR, 1992a; CCR § 8.408, 2024d). Services may include the following:

- Physician services
- Room and board
- All general nursing services and routine personal hygiene services
- Medical supplies, equipment, and over-the-counter (OTC) medication
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Other care benefits vary by LTC health benefit program. Below we detail other benefits provided by the Medicaid state plan, followed by Colorado's two largest home and community-based services (HCBS) programs.

Colorado Medicaid provides additional benefits related to LTC (CCR § 8.680, 2000; CFR § 440.170(a)(4), 2024c; CCR § 8.590, 2024d):

- Durable medical equipment and supplies: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Long-Term Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy
- Telehealth: Services can be provided virtually to beneficiaries with specific chronic conditions who need ongoing monitoring. Prior authorization for telehealth services is required (CCR § 8.520.5.D, 2024e)

HCBS-EBD

HCBS-EBD provides the following services in addition to those offered under the state plan, unless otherwise noted (CCR § 8.496, 2000):

- Electronic monitoring: Electronic equipment or adaptations that are necessary due to an individual's disability or are required to ensure that the individual remains in the community
- Home-delivered meals: Planning, preparation and delivery of meals to homes of beneficiaries who are unable to prepare their own meals or have dietary restrictions and lack outside assistance
- Non-medical transportation: Provides beneficiaries with access to non-medical community services and supports like adult day services, shopping, and counseling
- Respite care: Services provided to participants unable to care for themselves on a short-term basis at home or in a nursing facility because of the absence of or need of relief for those persons normally providing care for the participant
- Home modification: Special modifications or improvements to a beneficiary's home for to promote independence, prevent institutionalization, and ensure the individual's heath and safety
- Life skills training: Individualized training provided in a beneficiary's home or community to develop and maintain physical, emotional, social and economic sustainability in the community
- Peer mentorship: Support and advising from peers to promote self-advocacy and encourage community living
- Transition setup: Assistance with the logistics and expenses associated with transitioning out of a nursing facility or other congregate facility into the community

PACE

The PACE program provides the following services in addition to those offered under the state plan, unless otherwise noted (CMS, 2011; HCPF, 2024a):

- Meals: Preparation and provision of nutritious meals meeting dietary restrictions of participants, nutritional support including tube feeding, total parenteral nutrition or peripheral parenteral nutrition
- Non-medical transportation: Provides beneficiaries with access to non-medical community services and supports like adult day services, shopping, and counseling
- Respite care: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant

- Social Services [10]
- Therapy: Occupational, physical, and recreational

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Colorado Department of Health Care Policy and Financing (HCPF). Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

LTHH

Long-term Home Health is provided by a Medicaid-certified Home Health Agency. Skilled nursing services are provided by a registered nurse (RN) or a licensed practical nurse (LPN) under direction of an RN (CCR § 8.525, 2000; CCR § 8.520, 2024e). Homemaking, skilled, and unskilled personal care services are provided by home health aides.

Nursing Facility Care

Care is provided by RNs, LPNs, and other auxiliary staff including dieticians employed by a state registered nursing facility (CCR § 8.408.4, 2000; 2024d).

HCBS-EBD, PACE

The provision of care for program services will vary by authorized service.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence for the four largest programs are summarized below.

LTHH, Nursing Facility Care, HCBS-EBD, PACE

To qualify for all LTC services, applicants must meet a nursing facility level of care (NFLOC) (CCR § 8.401, 2024d).

An NFLOC is defined as the individual requiring one of the following (CCR § 8.401.1, 2000):

- Moderate assistance with at least 2 activities of daily living (ADLs)
- At least moderate supervision due to certain behaviors (wandering, disruptive, self-injurious, resistive to care, self-neglect) or memory/cognitive deficits

To receive care in a nursing facility or through LTHH, a physician licensed in the state of Colorado must deem skilled nursing care to be medically necessary (CCR § 8.406.1, 2000; CCR § 8.406, 2024d).

Duration of benefit

Reassessments of eligibility differ by program and service type. Below we detail reassessments for Medicaid, followed by reassessments for the four largest programs (CCR § 8.393.25, 2000).

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months.

LTHH

Colorado Medicaid offers an acute home health services benefit that covers the first 60 days of services without prior authorization. Individuals requiring home health services for more than 60 days are covered through the LTHH benefit. LTHH requires prior authorization and recipients must meet a nursing facility level of care (NFLOC). This prior authorization request must be renewed every 12 months (CCR § 8.527, 2000; CCR § 8.520.8.C., 2024e).

Nursing Facility Care

An individual's medical need for skilled nursing care must be reassessed monthly by a physician. Level of care reassessment will occur if there is a significant change in a resident's physical or medical status, if the case manager sets an end-date for eligibility, or if requested by the individual (CCR § 8.408.63, 2000; 2024d).

HCBS-EBD

Level of care for the HCBS-EBD program is reassessed annually by a case manager or more frequently if there are significant changes that may affect the beneficiary's eligibility for the program (CCR § 8.393.25, 2000; CCR § 8.486.200, 2024d).

PACE

Individuals must undergo an annual level of care recertification. If a participant continues to meet the level of care during their first annual reassessment they may be permanently waived from the annual requirement (CCR § 8.390, 2000; CCR § 8.497.11.F., 2024d).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by age requirements for the four largest programs.

Medicaid

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid (CCR § 8.100.5, 2000; CCR § 8.100.3, 2024b).

LTHH, Nursing Facility Care

There is no age requirement.

HCBS-EBD

The individual must be at least age 65, or between age 18-64 and blind or disabled.

PACE

Individuals must be at least age 55.

Care needs assessment

Definition of dependence

Definitions of dependence vary slightly depending on the health benefit program. The details are summarized below for the four largest programs.

LTHH

LTHH services are provided if they are medically necessary for a period longer than 60 days. Medically necessary home health services means that services are clinically appropriate to treat, diagnose, prevent, or cure a physical or mental illness, condition, injury or disability. Medicaid coverage for LTHH requires a prior authorization (CCR § 8.523.2, 2000; CCR § 8.076.8, 2024a; CCR § 8.520, 2024e).

Additionally, applicants must meet a nursing facility level of care (NFLOC). Using the current level of care assessment tool, an NFLOC is defined as the individual requiring one of the following (CCR § 8.401, 2000):

- Moderate assistance with at least 2 activities of daily living (ADLs)
- At least moderate supervision due to certain behaviors (wandering, disruptive, self-injurious, resistive to care, self-neglect) or memory/cognitive deficits

In 2023, Colorado introduced a new level of care assessment that will replace the current instrument following a gradual rollout period. To meet an NFLOC under the new system, applicants must meet at least one of the following eligibility criteria:

1. Meet one or more ADL and health condition criteria thresholds in at least 2 areas including ADLs (mobility, transferring, bathing, dressing, toileting, eating) or health condition (diagnosis of paralysis or a missing limb)
2. Meet one or more Behavioral thresholds
3. Meet one or more Memory and Cognition threshold
4. Meet Sensory and Communication threshold

Nursing Facility Care

To qualify for placement in a nursing facility, the applicant must require skilled nursing care that is certified as medically necessary by a licensed physician and meet an NFLOC. An NFLOC is determined using the same criteria described above under LTHH.

From 2023, nursing facilities implemented a new level of care assessment over a gradual transition period. NFLOC criteria under this new system is determined using the same criteria described above under LTHH.

HCBS-EBD, PACE

Applicants must meet an NFLOC to be eligible. An NFLOC is determined using the same criteria described above under LTHH.

From 2023, HCBS-EBD and PACE implemented a new level of care assessment over a gradual transition period. NFLOC criteria under this new system is determined using the same criteria described above under LTHH.

Applicants to the HCBS-EBD program are not immediately guaranteed care, as the program has an enrollment limit. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available. [8]

Evaluation of dependence

Evaluations of dependence vary depending on the health benefit program. The details of the four largest programs are summarized below.

LTHH

Applicants must obtain a prior authorization for LTHH services and meet a nursing facility level of care (NFLOC). An NFLOC is determined using a level of care assessment (CCR § 8.527.11, 2000; CCR § 8.401.16, 2024d).

Colorado uses the Uniform Long-Term Care (ULTC 100.2) assessment to determine level of care. Applicants are scored based on their ability to complete 6 ADLs (mobility, bathing, dressing, eating, toileting, transferring) and their need for supervision. Individuals are scored from 0 to 3 on each activity, with a score of 0 indicating total independence, and a score of 3 indicating total dependence. To meet an NFLOC, applicants must have one of the following:

- A deficit (score of 2 or higher) in at least 2 ADLs
- Require at least moderate supervision (score of 2 or higher) in the subcategories of Behaviors or Memory/Cognition

See Table 5 for ADL scoring and Table 6 for Behaviors, Memory, and Cognition scoring.

From 2023, Colorado implemented a new assessment instrument called the Colorado Single Assessment Level of Care (CSA LOC) Screen, which will replace the ULTC 100.2 as the primary screening tool after a gradual statewide rollout. During the transition period, both assessments are used to determine eligibility for LTC services (Colorado Medical Services Board, 2023; CCR § 8.401.16.B., 2024d).

Using the CSA LOC Screen, dependence is measured based on performance thresholds, rather than a point score. Applicants are evaluated on measures of Memory and Cognition, Sensory and Communication, Behavior, and ADLs. To meet an NFLOC, applicants must meet at least one of the following eligibility criteria:

1. Meet one or more ADL and health condition criteria thresholds in at least 2 areas including ADLs (mobility, transferring, bathing, dressing, toileting, eating) or health condition (diagnosis of paralysis or a missing limb)
2. Meet one or more Behavioral thresholds
3. Meet one or more Memory and Cognition threshold
4. Meet Sensory and Communication threshold

See Box 3 for ADL criteria thresholds and Box 4 for Behavioral, Memory and Cognition, and Sensory and Communication criteria thresholds (CCR § 8.401.16.B., 2024d).

Nursing Facility Care

Applicants must have a need for skilled nursing care as certified by a licensed physician and meet an NFLOC. An NFLOC is determined using the same criteria for the ULTC 100.2 described above under LTHH.

From 2023, an NFLOC may be determined using the same criteria for the CSA LOC Screen described above under LTHH.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). The PASRR screening helps the state determine whether an incoming nursing facility resident is likely to have a developmental disability or mental illness. Results of the PASRR Level I screening will indicate whether an individual requires PASRR Level II screening to determine if specialized mental health or developmental disability

services are needed. A physician licensed to practice in Colorado must certify that nursing facility care is medically necessary and must draft a plan of treatment before an individual is admitted (CCR § 8.401.18, 2000). See Box 1 for more information on the PASRR, and Box 2 for the MDS.

HCBS-EBD, PACE

Applicants must meet an NFLOC in order to be eligible for these programs. An NFLOC is determined using the same criteria for the ULTC 100.2 described above under LTHH. Additionally, some services may require a prior authorization (CCR § 8.401, 2000; 2024d).

From 2023, an NFLOC may be determined using the same criteria for the CSA LOC Screen described above under LTHH.

Applicants to the HCBS-EBD program are not immediately guaranteed care, as the program has an enrollment limit. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available. [8]

Evaluators

Evaluators vary by health benefit program. The details of the four largest programs are summarized below.

LTHH, HCBS-EBD, PACE

Level of care assessments are administered by case managers from Case Management Agencies (CMAs) within the single-entry point (SEP) system (CCR § 8.393.25, 2000; 2024c).

Nursing Facility Care

Nursing facility eligibility must be certified as medically necessary by a licensed physician (CCR § 8.408.6, 2000; CCR § 8.076.8, 2024a). Case managers administer the level of care assessment and PASRR evaluation prior to resident admission.

Benefit limitations

Can you mix LTC benefits?

All Colorado Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other public benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the four largest programs.

Medicaid

As required by federal law, Colorado enforces Estate Recovery. The acceptance of Medicaid in Colorado creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age (C.R.S. § 25.5-4-302, 2023). Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. The state agency may only recover assets from beneficiaries who received services in an institutionalized setting or if they were aged 55 or older when services were received (CCR § 8.063, 2000; Health First Colorado, 2016; CCR § 8.100.5.D., 2024b). The debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (Colorado Gerontological Society, 2023; Hammond Law, 2024).

LTHH

LTHH does not require a copayment from Medicaid beneficiaries (Health First Colorado, 2024).

Nursing Facility Care

Beneficiaries are expected to contribute all their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. See Table 4 for historical spousal impoverishment standards. In 2014, the PNA was $50 per month. This amount increased to $77.25 per month in 2015 and then increased annually thereafter with inflation (HCPF, 2014). See Table 7 for historical PNA amounts in Colorado.

HCBS-EBD

HCBS-EBD does not require a copayment (CCR § 8.754, 2000).

PACE

PACE does not require a copayment and PACE organizations in Colorado are prohibited from charging Medicaid beneficiaries a monthly premium for services rendered (HCPF, 2024a).

Taxation of benefits

In-kind benefits are not subject to taxation.

Tables and Formulas

Table 1: Colorado Federal Medical Assistance Percentage (FMAP) for Medicaid

Fiscal Year	FMAP
1992	54.79%
1993	54.42
1994	54.30
1995	53.10
1996	52.44
1997	52.32
1998	51.97
1999	50.59
2000	50.00
2001	50.00
2002	50.00
2003	51.48
2004	52.21
2005	50.00
2006	50.00
2007	50.00
2008	50.00
2009	60.19
2010	61.59
2011	56.81
2012	50.00
2013	50.00
2014	50.00
2015	51.01
2016	50.72
2017	50.02
2018	50.00
2019	50.00
2020	54.65
2021[1]	56.20
2022	56.20
2023	54.98
2024	50.38

Source: Congress.gov (2020), Colo. Gen. Assemb. (2021), U.S. DHHS (2023)

Notes: FMAPs displayed here apply to the federal fiscal year indicated unless otherwise noted, which runs from October 1 through September 30. For example, FY 2022 refers to the period from October 1, 2021 through September 30, 2022. FY 2020, FY 2021, FY 2022, and FY 2023 FMAPs reflect higher federal matching funding (6.2 percent increase in FMAP rates for all states) made available through the Families First Coronavirus Response Act for the duration of the public health emergency period. [1] Colorado additionally leveraged a benefit from the American Rescue Plan Act that provided a temporary 10% increase in FMAP from 2021-2025 to support HCBS programs in the state.

Table 2: Colorado Medicaid Income Limits (1992 - 2024)

Year	SSI (Individual)	SSI (Couple)	300% SSI (Individual)	300% SSI (Couple)	138% FPL (Individual)	138% FPL (Couple)
1992	$422.00	$633.00	$1,266.00	$1,899.00		
1993	434.00	652.00	1,302.00	1,956.00		
1994	446.00	669.00	1,338.00	2,007.00		
1995	458.00	687.00	1,374.00	2,061.00		
1996	470.00	705.00	1,410.00	2,115.00		
1997	484.00	726.00	1,452.00	2,178.00		
1998	494.00	741.00	1,482.00	2,223.00		
1999	500.00	751.00	1,500.00	2,253.00		
2000	513.00	769.00	1,539.00	2,307.00		
2001	531.00	796.00	1,593.00	2,388.00		
2002	545.00	817.00	1,635.00	2,451.00		
2003	552.00	829.00	1,656.00	2,487.00		
2004	564.00	846.00	1,692.00	2,538.00		
2005	579.00	869.00	1,737.00	2,607.00		
2006	603.00	904.00	1,809.00	2,712.00		
2007	623.00	934.00	1,869.00	2,802.00		
2008	637.00	956.00	1,911.00	2,868.00		
2009	674.00	1,011.00	2,022.00	3,033.00		
2010	674.00	1,011.00	2,022.00	3,033.00		
2011	674.00	1,011.00	2,022.00	3,033.00		
2012	698.00	1,048.00	2,094.00	3,144.00		
2013	710.00	1,066.00	2,130.00	3,198.00		
2014	721.00	1,082.00	2,163.00	3,246.00	$1,342.00	$1,809.00
2015	733.00	1,100.00	2,199.00	3,300.00	1,354.00	1,832.00
2016	733.00	1,100.00	2,199.00	3,300.00	1,367.00	1,843.00
2017	735.00	1,103.00	2,205.00	3,309.00	1,387.00	1,868.00
2018	750.00	1,125.00	2,250.00	3,375.00	1,397.00	1,893.00
2019	771.00	1,157.00	2,313.00	3,471.00	1,437.00	1,945.00
2020	783.00	1,175.00	2,349.00	3,525.00	1,468.00	1,983.00
2021	794.00	1,191.00	2,382.00	3,573.00	1,482.00	2,004.00
2022	841.00	1,261.00	2,523.00	3,783.00	1,564.00	2,106.00
2023	914.00	1,371.00	2,742.00	4,113.00	1,677.00	2,268.00
2024	943.00	1,415.00	2,829.00	4,245.00	1,732.00	2,352.00

Source: CCR (2000), CMS (2024), HHS (2024), SSA (2024b)

Notes: Income limits for individuals and couples are monthly. Income limits at 138% of the FPL begin in 2014, corresponding to Colorado's implementation of this track. Authors have not yet identified when track 2a. Institutional Rules for People Receiving LTC was implemented but it is confirmed to have existed from at least 1996.

Table 3: Colorado Home Equity Limits (2006 -2024)

Year	Home equity limit
2006	$500,000
2007	500,000
2008	500,000
2009	500,000
2010	500,000
2011	518,000
2012	525,000
2013	536,000
2014	543,000
2015	552,000
2016	552,000
2017	560,000
2018	572,000
2019	585,000
2020	595,000
2021	906,000
2022	955,000
2023	1,033,000
2024	1,071,000

Source: HCPF (2018), CCR (2024), HCPF (2024c), SSA (2024e)

Notes: The limit was $500,000 from January 2006 to December 2010, after which the equity limit began increasing annually with inflation. The Colorado Department of Health Care Policy and Financing (HCPF) releases operational memos and agency letters annually documenting these limit increases. Home equity limits are calculated using Social Security Cost-of-Living Adjustments (COLAs) and are validated by state and federal sources.

Table 4: Colorado Spousal Impoverishment Standards (1992 - 2024)

Year	Minimum MMNA	Maximum MMNA	Minimum CSRA	Maximum CSRA
1992	$984.20	$1,718.00	$13,740.00	$68,700.00
1993	1,148.75	1,769.00	14,148.00	70,740.00
1994	1,178.75	1,817.00	14,532.00	72,660.00
1995	1,230.00	1,871.00	14,964.00	74,820.00
1996	1,253.75	1,919.00	15,348.00	76,740.00
1997	1,295.00	1,976.00	15,804.00	79,020.00
1998	1,326.25	2,019.00	16,152.00	80,760.00
1999	1,356.25	2,049.00	16,392.00	81,960.00
2000	1,382.50	2,103.00	16,824.00	84,120.00
2001	1,406.25	2,175.00	17,400.00	87,000.00
2002	1,451.25	2,232.00	17,856.00	89,280.00
2003	1,492.50	2,266.50	18,132.00	90,660.00
2004	1,515.00	2,319.00	18,552.00	92,760.00
2005	1,561.25	2,377.50	19,020.00	95,100.00
2006	1,603.75	2,488.50	19,908.00	99,540.00
2007	1,650.00	2,541.00	20,328.00	101,640.00
2008	1,711.25	2,610.00	20,880.00	104,400.00
2009	1,750.00	2,739.00	21,912.00	109,560.00
2010	1,821.25	2,739.00	21,912.00	109,560.00
2011	1,839.00	2,739.00	21,912.00	109,560.00
2012	1,892.00	2,841.00	22,728.00	113,640.00
2013	1,939.00	2,898.00	23,184.00	115,920.00
2014	1,967.00	2,931.00	23,448.00	117,240.00
2015	1,992.00	2,981.00	23,844.00	119,220.00
2016	2,003.00	2,981.00	23,844.00	119,220.00
2017	2,030.00	3,023.00	24,180.00	120,900.00
2018	2,058.00	3,090.00	24,720.00	123,600.00
2019	2,114.00	3,160.50	25,284.00	126,420.00
2020	2155.00	3,216.00	25,728.00	128,640.00
2021	2,177.50	3,259.50	26,076.00	130,380.00
2022	2,288.75	3,435.00	27,480.00	137,400.00
2023	2,465.00	3,715.50	29,724.00	148,620.00
2024	2,555.00	3,853.50	30,828.00	154,140.00

Source: CMS (2024), HCPF (2018), HCPF (2024c)

Notes: State sources were not found for years prior to 2012, but they are subject to the federal minimum and maximum standards. Federal law requires states to set the minimum monthly maintenance needs allowance (MMNA) standard at 150% of the federal poverty level (FPL) for a couple, increasing each year with inflation, except for FY 1992, which was set at 133% of the FPL. MMNAs are calculated using FPLs for each year and are validated by state and federal sources. Some states round to the dollar, which may lead to minor variations between the calculated federal amounts and state-specific standards. For Community Spouse Resource Allowances (CSRAs), the minimum was set at $12,000 and the maximum at $60,000 as of September 30, 1989, increasing each year with inflation. CSRAs are calculated using the Consumer Price Index for urban consumers (CPI-U).

Table 5: Uniform Long-Term Care (ULTC 100.2) Functional Assessment Scoring —ADLs

ADL	Score	Description
All	0	The applicant is independent in completing the activity safely.
Bathing		
	1	The applicant requires oversight help or reminding; can bathe safely without assistance or supervision, but may not be able to get into and out of the tub alone.
	2	The applicant requires hands on help or line of sight standby assistance throughout bathing activities in order to maintain safety, adequate hygiene and skin integrity.
	3	The applicant is dependent on others to provide a complete bath.
Dressing		
	1	The applicant can dress and undress, with or without assistive devices, but may need to be reminded or supervised to do so on some days.
	2	The applicant needs significant verbal or physical assistance to complete dressing or undressing, within a reasonable amount of time.
	3	The applicant is totally dependent on others for dressing and undressing.
Toileting		
	1	The applicant may need minimal assistance, assistive device, or cueing with parts of the task for safety, such as clothing adjustment, changing protective garment, washing hands, wiping and cleansing.
	2	The applicant may need minimal assistance, assistive device, or cueing with parts of the task for safety, such as clothing adjustment, changing protective garment, washing hands, wiping and cleansing.
	3	The applicant is unable to use the toilet. The applicant is dependent on continual observation, total cleansing, and changing of garments and linens. This may include total care of catheter or ostomy. The applicant may or may not be aware of own needs.
Mobility		
	1	The applicant is mobile in their own home but may need assistance outside the home.
	2	The applicant is not safe to ambulate or move between locations alone; needs regular cueing, stand-by assistance, or hands on assistance for safety both in the home and outside the home.
	3	The applicant is dependent on others for all mobility.
Transferring		
	1	The applicant transfers safely without assistance most of the time, but may need standby assistance for cueing or balance; occasional hands on assistance needed.
	2	The applicant transfer requires standby or hands on assistance for safety; applicant may bear some weight.
	3	The applicant requires total assistance for transfers and/or positioning with or without equipment.
Eating		
	1	The applicant can feed self, chew and swallow foods but may need reminding to maintain adequate intake; may need food cut up; can feed self if food brought to them, with or without adaptive feeding equipment.
	2	The applicant can feed self but needs line of sight standby assistance for frequent gagging, choking, swallowing difficulty; or aspiration resulting in the need for medical intervention. The applicant needs reminder/assistance with adaptive feeding equipment; or must be fed some or all food by mouth by another person.
	3	The applicant must be totally fed by another person; must be fed by another person by stomach tube or venous access.

Source: CCR (2000), CCR (2024d), HCPF (2023)

Notes: Individuals applying for all Medicaid LTC services in Colorado are evaluated using the ULTC 100.2. Applicants are scored based on their ability to perform the following 6 activities of daily living (ADLs): bathing, dressing, toileting, mobility, transferring, eating and their need for supervision in 2 categories behaviors and memory/cognition. Scoring differs slightly for each ADL.

Table 6: Uniform Long Term Care (ULTC 100.2) Functional Assessment Scoring —Supervision

Category	Score	Description
Behaviors		
	0	The applicant demonstrates appropriate behavior; there is no concern.
	1	The applicant exhibits some inappropriate behaviors but not resulting in injury to self, others and/or property. The applicant may require redirection. Minimal intervention is needed.
	2	The applicant exhibits inappropriate behaviors that put self, others or property at risk. The applicant requires more than verbal redirection to interrupt inappropriate behaviors. The applicant needs medication assistance, monitoring, supervision or is unable to make safe decisions.
	3	The applicant exhibits behaviors resulting in physical harm for self or others. The applicant requires extensive supervision to prevent physical harm to self or others.
Memory/Cognition Deficit		
	0	Independent no concern.
	1	The applicant can make safe decisiosns in familiar/routine situations, but needs some help with decision making support when faced with new tasks, consistent with individual's values and goals.
	2	The applicant requires consistent and ongoing reminding and assistance with planning, or requires regular assistance with adjusting to both new and familiar routines, including medication assistance and monitoring or requires ongoing supervision or is unable to make safe decisions, or cannot make his/her basic needs known.
	3	The applicant needs help most or all of time. Medications must be administered for the applicant.

Source: CCR (2000), CCR (2024d), HCPF (2023)
Notes: Individuals applying for long-term home health services, nursing facility care or home and community-based services programs are evaluated using the Uniform Long Term Care (ULTC 100.2) evaluation. Applicants are scored based on their ability to perform the following 6 activities of daily living (ADLs): bathing, dressing, toileting, mobility, transferring, eating, and their need for supervision in 2 categories: behaviors (including wandering, disruptive, self-injurious, resistive to care, self neglect) and memory/cognition.

Box 1: Preadmission Screening and Resident Review (PASRR)

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR). The purpose of PASRR is to prevent individuals with mental illness, intellectual disability, developmental disability, or a related condition from inappropriate admission to a nursing facility. The process consists of a Level I screen, Level II evaluation (depending on the outcome of the Level 1 screening), and a final determination. All applicants of Medicaid certified nursing facilities receive a Level I screen to identify possible conditions. These screens generally consist of forms completed by hospital discharge planners, community health nurses, or others as defined by the state. Individuals who do or may have a mental condition as described above are referred for a Level II PASRR evaluation.

PASRRs were required on an annual basis until 1996, when the annual requirement was removed. Some states continue to conduct PASRRs on an annual basis.

Source: 42 CFR 483.100-138, HCPF (2024b)

Box 2: Minimum Data Set (MDS)

Nursing facilities are required by federal law to periodically assess each resident. The Minimum Data Set (MDS) is the uniform instrument used nationally to assess resident condition. The MDS collects resident data for a variety of purposes, such as to inform care plans or assess a resident's ongoing need for nursing home care. Assessments are performed every 3 months or more often depending on the resident's health condition.

The first MDS was implemented nationally in 1991. There have been two new versions of the MDS since then —one in 1995 (MDS 2.0), and another in 2010 (MDS 3.0). However, all versions generally assess the following domains: functional and cognitive status, behavioral symptoms, diagnoses and medications, geriatric syndromes, and psychosocial functioning.

Source: Mass.gov (1999), UCSF (2023)

Table 7: Colorado Personal Needs Allowances (PNA) (1992 - 2024)

Year	PNA (monthly)
1992	$34
1993	34
1994	34
1995	34
1996	34
1997	34
1998	34
1999	34
2000	50
2001	50
2002	50
2003	50
2004	50
2005	50
2006	50
2007	50
2008	50
2009	50
2010	50
2011	50
2012	50
2013	50
2014	50
2015	77.25
2016	79.57
2017	81.95
2018	84.41
2019	86.95
2020	89.55
2021	91.35
2022	93.17
2023	95.97
2024	105.56

Source: Colorado General Assembly (1999), CGA (2003), LTC Ombudsman (2010), HCPF (2018), HCPF (2024c)
Notes: Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA). Authors have not yet verifed the PNAs for Fiscal Years (FYs) 1992-1999, but sources indicate that Colorado increased the PNA from $34 to $50 in 1999. Sources also indicated that in 2015 the Colorado base PNA amount increased from $50 to $75. However due to an immediate Social Security Cost-of-Living Adjustment (COLA), the recognized PNA in 2015 was $77.25. From 2015, this amount increases annually with inflation. The Colorado Department of Health Care Policy and Financing (HCPF) releases operational memos annually detailing changes to the PNA.

Box 3: Colorado Single Assessment Level of Care Screen Eligibility Thresholds (ADLs)

To qualify for LTC, applicants must meet 1 of the following criteria thresholds in at least 2 ADLS:

Bathing
- Participant requires, at minimum, partial/moderate assistance for the ability to shower/bathe self in shower or tub, including washing, rinsing, and drying self (does not include transferring in/out of tub/shower)

Dressing
- Participant requires, at minimum, partial/moderate assistance with upper body dressing
- Participant requires, at minimum, partial/moderate assistance with lower body dressing
- Participant requires, at minimum, partial/moderate assistance with putting on/taking off footwear

Toileting
- Participant requires, at minimum, partial/moderate assistance with toilet hygiene
- Participant requires, at minimum, partial/moderate assistance with toilet transfers
- Participant requires, at minimum, partial/moderate assistance with menses care
- Participant requires assistance with managing equipment related to bladder incontinence
- Participant is currently using a bladder program to manage participant's bladder continence
- Participant requires assistance with managing equipment related to bowel incontinence
- Participant is currently using a bowel program to manage the participant's bowel continence

Mobility
- Participant does not walk but walking is indicated in the future or participant does not walk and walking is not indicated in the future
- Participant requires a cane or walker during all mobility activities
- Participant uses a wheelchair or scooter as their primary mechanism for mobility
- Participant requires, at minimum, partial moderate assistance to walk (once standing) 10 feet indoors
- Participant requires, at minimum, supervision or touching assistance to walk (once standing) 150 feet indoors
- Participant requires, at minimum, supervision or touching assistance to walk 10 feet outside of the home
- Participant requires, at minimum, supervision or touching assistance to walk 150 feet outside of the home

Transferring
- Participant requires use of a cane or walker during all transfer activities
- Participant requires, at minimum, partial/moderate assistance for the ability to roll left and right: from lying on back to left and right side, and return to lying on back on the bed
- Participant requires, at minimum, partial/moderate assistance for the ability to complete a sit to stand transfer: safely come to a standing position from sitting in a chair or on the side of the bed

Eating
- Participant requires, at minimum, partial/moderate assistance for eating
- Participant requires, at minimum, partial/moderate assistance for tube feeding

Source: CCR (2024d)

Notes: From 2023, individuals applying for long-term home health services, nursing facility care or home and community-based services programs are evaluated using the Colorado Single Assessment Level of Care (CSA LOC) screen. This screening instrument will phase out the Uniform Long Term Care (ULTC 100.2) evaluation after a gradual rollout. Using the CSA LOC screen, applicants are evaluated using performance thresholds rather than a scoring system. Applicants are tested on their ability to perform the following 6 activities of daily living (ADLs): bathing, dressing, toileting, mobility, transferring and eating. They are also assessed on behaviors, memory and cognition, and sensory and communication.

Box 4: Colorado Single Assessment Level of Care Screen Eligibility Thresholds (Behaviors, Memory and Cognition, Sensory and Communication)

Applicants are assessed on behaviors, memory and cognition, and sensory and communication. To qualify for LTC, applicants must meet at least 1 threshold in either of the 3 categories detailed below:

Behavior

1. To meet the behavior area 1 criteria threshold, participant's behavior status previously or currently requires interventions or presents symptoms for injury to self, physical aggression or property destruction. Additionally, one or more of the following are met:
    - Cueing frequency, at minimum, is required more than once per month and up to weekly
    - Physical intervention frequency, at minimum, is required more than once per month up to weekly
    - Planned intervention frequency, at minimum, is required less than monthly up to once per month
2. To meet the behavior area 2 criteria threshold, participant's behavior status for verbal aggression currently requires interventions or presents symptoms for this behavior and participant presents threats to own or other's safety. Additionally, one or more of the following are met:
    - Cueing frequency, at minimum, is required more than once per month and up to weekly
    - Physical intervention frequency, at minimum, is required more than once per month up to weekly
    - Planned intervention frequency, at minimum, is required less than monthly up to once per month
3. To meet the behavior area 3 critera threshold, one or more of the following are met:
    - Injurious to self, property destruction, physical aggression, or verbal aggression behavior status currently requires intervention and/or displays symptoms
    - Likelihood behavior would occur and/or escalate if HCBS services were withdrawn is likely or highly likely

Memory and Cognition (meet one of the following criteria thresholds)

- Participant has a Level of Impairment of moderately or higher in at least one area (Memory, Attention, Problem Solving, Planning, or Judgment)
- Participant has a level of impairment of mildly or high in at least two areas (Problem Solving, Planning, Judgement)

Sensory and Communication (meet one of the following criteria thresholds)

- Participant frequently exhibits difficulty expressing needs and/or ideas with individuals they are familiar with
- Participant rarely or never expresses themself or is very difficult to understand

Source: CCR (2024d)

Notes: From 2023, individuals applying for long-term home health services, nursing facility care or home and community-based services programs are evaluated using the Colorado Single Assessment Level of Care (CSA LOC) screen. This screening instrument will phase out the Uniform Long Term Care (ULTC 100.2) evaluation after a gradual rollout. Using the CSA LOC screen, applicants are evaluated using performance thresholds rather than a scoring system. Applicants are tested on their ability to perform the following 6 activities of daily living (ADLs): bathing, dressing, toileting, mobility, transferring and eating. They are also assessed on behaviors, memory and cognition, and sensory and communication.

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Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Activities of Daily Living (ADLs): Tasks performed on a daily basis that are considered necessary to live independently, including bathing or showering, dressing, toileting, eating, and transferring (mobility).

Acute Home Care: Home care benefit provided to Colorado Medicaid beneficiaries for treatment of acute medical conditions for a period of 60 days or less or until the acute medical condition is resolved, whichever comes first. These services do not require prior authorization. See CCR (2024e) for more information.

Adult Day Health Care (ADHC): A community-based long-term care benefit that provides comprehensive health care services in a congregate day setting or virtually via telehealth. Services include nursing, case management, clinical management, medical, diagnostic, social, rehabilitative, recreational and personal care services on a routine or daily basis. Services are provided according to the assessed needs of the beneficiary. In Colorado, this service is referred to as "Adult Day Services (ADS)." Beneficiaries can access Adult Day Services through the PACE program and HCBS-EBD. Specialized Adult Day Service centers serve adults living with specific diagnoses or chronic conditions. Adult day services were availiable to beneficiaries beginning in 1997. See ASPE (2005) for more information.

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act (ACA) made a number of changes to Medicaid, most notably is the expansion of eligibility to adults with incomes up to 133 percent of the federal poverty level (FPL). Originally a requirement, the June 2012 Supreme Court ruling in National Federation of Independent Business v. Sebelius effectively made the Medicaid expansion an option. To date, over three-quarters of states have opted to expand.

Alternative Care Facility (ACF): A group residence that provides consistent care to older adults that do not require the type of care provided in a nursing facility. Services may include homemaker and personal care services including assistance with ADLs, personal hygiene, and protective oversight. See CCR (2024f) for more information.

Case Management Agency (CMA): A public or private for-profit or non-profit organization authorized by the state of Colorado to provide case management services/activities for Medicaid beneficiaries

Colorado Department of Health Care Policy and Financing (HCPF): HCPF is Colorado's single state agency that administers the state Medicaid program.

Colorado Indigent Care Program (CICP): Colorado offers the Indigent Care Program (CICP), which provides discounted healthcare services to applicants within 250% of the FPL. This program is not health insurance but serves as a safety net for Coloradans who do not qualify for coverage under the Medicaid state plan.

Colorado Single Assessment Level of Care (CSA LOC) Screen: Functional assessment used to determine whether a beneficiary meets the minimum level of care (NFLOC) for receiving long-term care services. This tool was introduced in 2023 and will replace the UTLC 100.2 assessment following completion of a gradual rollout period. Applicants are assessed by case managers to determine whether they meet a set of criteria thresholds for multiple categories including ADLs (mobility, transferring, bathing, dressingm toileting, eating), health conditions, behaviors, memory and cognition, and sensory and communication.

Complementary and Integrative Health program (CIH): HCBS program available to LTC beneficiaries in Colorado beginning in 2012. Originally called the Spinal Cord Injury (HCBS-SCI) program, it only served individuals with spinal cord injuries. In 2022, this program was renamed the Complementary and Integrative Health Program (HCBS-CIH) and expanded eligibility for the program to include individuals with traumatic or nontraumatic spinal cord injury, multiple sclerosis, brain injury, spina bifida, muscular distrophy, and cerebral palsy. See HCPF (2022) for more information.

Community First Choice Option (CFCO): Colorado state plan home and community-based services program for disabled or older adults that meet a nursing facility level of care. CFCO enrollees have a variety of services available to them, such as case management. This program will not be available in Colorado until 2025. Once it is implemented, most services from the HCBS-EBD program will be transferred to CFCO.

Community Spouse Resource Allowance (CSRA): Amount of countable assets a spouse residing in the community can retain if their spouse is institutionalized or requires home and community-based long-term care.

Consumer-Directed Attendant Support Services (CDASS): Personal care services provided by an aide that is hired and managed by the recipient.

Eligibility Track 1a. Supplemental Security Income (SSI) Recipients: Mandatory coverage group under Medicaid that generally automatically results in Medicaid coverage for individuals that receive SSI, a federal cash assistance benefit for aged, blind, and disabled individuals with low income and assets.

Eligibility Track 2a. Institutional Rules for People Receiving LTC: Optional coverage group under Medicaid that allows for expanded income limits, up to 300% of the federal poverty level, for individuals that are in an institution or who medically qualify for placement in an institution and are instead receiving home and community-based services (HCBS). Federal terminology separates the institutional and HCBS populations into two coverage groups: Individuals receiving HCBS under Institutional Rules, and Institutional Individuals Eligible under a Special Income Level. This is because some states do not extend this income limit to both coverage groups. For ease, we have combined the two groups under a single track, as regardless of whether it applies only to institutional care or extends to HCBS, the eligibility track uses institutional standards, e.g., institutional income/asset limits including spousal impoverishment disregards, as well as dependence requirements (NFLOC). It will be clearly noted in policy documents when a state does not extend this income limit to both populations.

Eligibility Track 2c. Affordable Care Act (ACA) Expansion Adults: Optional coverage group under Medicaid that allows for expanded income and asset limits for individuals ages 19-64 who are ineligible for Medicaid through any other group. States that choose to cover this group may cover adults up to 138 percent of the federal poverty level. There is no asset test for this population.

Eligibility Tracks: Requirements for an individual to qualify for Medicaid and start receiving long-term care benefits. An individual must satisfy only one eligibility track to qualify for Medicaid.

Estate Recovery: State Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. For individuals age 55 or older, states are required to seek recovery of payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age. Colorado does not limit recovery to the federally required minimum services and seeks recovery of payments for all medical assistance received.

Federal Medical Assistance Percentage (FMAP): The percentage of Medicaid payments that the federal government pays as a share of both federal and state government payments for Medicaid services. The FMAP is computed from a formula that takes into account the average per capita income for each State relative to the national average. The minimum FMAP is 50 percent. The standard FMAP applies to most Medicaid spending on benefits, while the administrative rate nationwide is 50 percent with exceptions for some administrative activities such as training and compensation of skilled professionals (75 percent) and preadmission screening and resident review (75 percent).

Federal Poverty Level (FPL): Poverty threshold established by the Department of Health and Human Services (HHS) for administrative

purposes, such as determining financial eligibility for federal programs. The Federal Poverty Level (FPL) is determined annually for different household sizes and financial eligibility for a program is generally a percentage of the FPL (e.g., 100 percent of the FPL), meaning households with annual/monthly income at or below 100% of the FPL would qualify based on financial eligibility.

Health Maintenance Services: In-home support service available to eligible Medicaid beneficiaries that provides assistance with skilled health-related activities. Services are typically provided by a CNA, LPN, or RN, but beneficiaries also have the ability to hire and train staff that do not have these certifications or licensure.

Home-and Community-Based Services (HCBS): Services designed to assist individuals in a home or community setting, such as an adult day center. HCBS are often designed to enable people to stay in their homes in lieu of nursing home admission.

Home-and Community-Based Services for the Elderly, Blind, and Disabled (HCBS-EBD): Medicaid 1915(c) long-term care program designed to assist individuals who are 65 or older, blind, or disabled with a demonstrated need for a nursing facility level of care to continue living in the community. Some services include adult day health care, in-home support services like homemaker and personal care services, and some respite care services. Beginning July 1, 2025, some services offered under this program will be shifted to the Community First Choice (CFCO) plan in Colorado.

Home Health Agency: Main provider of long-term home health services including skilled nursing services from registered nurses (RN) or licensed practical nurses (LPN), homemaking and personal care services provided by home health aides, and physical or occupational therapy provided by therapists.

Home Health Aide Services: Home health aides assist with personal care as well as some semi-skilled tasks, such as observing vital signs, administering medication under the direction of a nurse, and more. In Colorado, these services, as well as assistance with ADLs, are performed by a certified nurse aid (CNA) and are referred to as "CNA Services".

Homemaker Services: In-home support service available to eligible Medicaid beneficiaries that provides assistance with general household activities like meal preparation, laundry, and housekeeping.

Hospital Back-Up: Statewide program for Medicaid long-term care beneficiaries in Colorado that allows skilled nursing facilities to provide hospital level care to residents who need 24-hour monitoring following acute care in a hospital. Nursing facilities must be hospital back-up (HBU) approved to provide these services.

Hospital Level of Care: Level of care with a dependence threshold higher than that of a nursing facility level of care (NFLOC). Individuals who meet an NFLOC and require substantial additional assistance completing ADLs are classified as meeting a hospital level of care. Meeting a hospital level of care is an additional pathway by which individuals can qualify for HCBS-EBD. See CCR (2024d) for more information on dependence thresholds.

In-home Support Services (IHSS): Long-term home care benefit that provides homemaker, health maintenance, and personal care services to beneficiaries in their home or community.

Instrumental Activities of Daily Living (IADLs): Tasks related to independent living including preparing meals, managing money, shopping for groceries, performing housework, and using a telephone.

Long-Term Home Health Services: Medicaid health benefit program that provides services in the patient's home to promote, maintain, or restore health or lessen the effects of illness and disability. Services may include part-time or intermittent nursing care, speech, physical and occupational therapies, and home health aide services (personal care and semi-skilled tasks such as ostomy care). This service also includes medical equipment and supplies if medically necessary. In Colorado, the standard Medicaid home health services benefit is separated into two categories: long-term home health (LTHH) and acute home health. This document only covers long-term home health because acute home health is only provided on a short-term basis.

Mandatory Categorically Needy: An eligibility track that states are required to cover under Medicaid. This track encompasses several categorical groups, including individuals receiving SSI, pregnant women, and some children.

Medicaid State Plan: Every state has a Medicaid State Plan, a comprehensive document that outlines the amount, scope, and duration of all services offered under the State's standard benefit package. All beneficiaries may receive all services in the standard benefit package (e.g., personal care, home health), however, benefit programs may have varying eligibility criteria (e.g., level of dependence). If eligible, some beneficiaries may enroll in an HCBS program. HCBS program enrollees may receive all state plan benefits as well as additional services under the program. If a beneficiary is enrolled in managed care, they may receive all state plan benefits through

their managed care plan and may receive additional benefits as available.

Medical necessity: As defined by the U.S. Department of Health and Human Services, medically necessary services are health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. This is usually the dependence threshold that must be met to receive a Medicaid benefit. However, the exact dependence characteristics needed to meet this threshold vary by state, although it usually is met through a physician's order for services.

Minimum Data Set (MDS): A federally mandated tool for implementing standardized assessment and for facilitating care management in nursing homes.

Monthly Maintenance Needs Allowance (MMNA): Amount of countable income for a beneficiary's spouse residing in the community if the beneficiary is institutionalized or requires home and community-based long-term care.

Nursing facility care: Residential care that typically provides skilled nursing or medical care and related services, rehabilitation needed due to injury, disability, or illness, and health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition.

Nursing facility level of care (NFLOC): Level of care comparable to what an individual would receive in a nursing facility. This is often the minimum level of dependence required for long-term care programs.

Optional Categorically Needy: An eligibility track that states may opt in to cover. This track encompasses several groups, including aged and disabled individuals not receiving SSI, some individuals receiving long-term care, and more.

Other populations: The Gateway Policy Explorer Long-Term Care Series is primarily focused on individuals most likely to require long-term care, such as older adults or disabled individuals. There are additional eligibility tracks one may use to qualify for Medicaid that are out-of-scope for this Series. Some of these include pregnant women, children, and families with children.

Participant-directed: Care delivery option that allow Colorado long-term care beneficiaries to choose, manage, and direct attendants of their choice to provide health maintenance, homemaker, and personal care services under the IHSS and CDASS programs.

Personal Care Services: Medicaid optional state plan benefit that provides in-home assistance to recipients with housekeeping and personal care needs, such as bathing, dressing, eating, and mobility.

Personal Needs Allowance: Income that is exempt from contribution to nursing home cost that may be spent on any personal item by institutionalized beneficiaries.

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996: Federal legislation that restricted most legal immigrants entering the United States after August 22, 1996, from receiving federally funded Medicaid or Supplemental Security Income (SSI) for at least five years after immigration or until they attain citizenship.

Preadmission Screening and Resident Review (PASRR): A federally required assessment for nursing facility applicants to ensure that individuals are not inappropriately placed in nursing homes for long term care. The initial Level I assessment screens for mental illnesses or other related conditions. If the Level I assessment indicates that the applicant has a mental illness or related condition, they will be directed to a Level II assessment and alternative residential care.

Prior authorization: An approval that is sometimes required before a service may be provided. Specifically, prior authorization is a determination by a utilization review entity that a covered service has been reviewed and, based on the information provided, satisfies the utilization review entity's requirements for medical necessity and appropriateness and that payment will be made for that health care service.

Private Duty Nursing: Home Care benefit provided to Colorado LTC beneficiaries that provides up to 23 hours per day of skilled nursing services for individuals 21 years or older who are technology dependent and meet medical necessity for skilled nursing services. Provided services do not include non-skilled tasks like assistance with ADLs. Individuals who are eligible for both long-term home health and private duty nursing must choose one of the two services. Private duty nursing requires prior authorization. See CCR (2024e) for more information.

Program of All-inclusive Care for the Elderly (PACE): PACE provides comprehensive medical and social services to some older adults living in the community. Most of the participants who are in PACE are dually eligible for both Medicare and Medicaid. Enrollment in

PACE programs is typically capped at a relatively low number of participants. In Colorado, PACE is offered in specific counties across the state, referred to as "service areas." These counties include: Adams, Arapahoe, Boulder, Broomfield, Delta, Denver, El Paso, Jefferson, Larimer, Mesa, Montrose, Pueblo, Weld (southwest).

PRUCOL: An immigration status where Immigration and Naturalization Services knows of and permits the individual's presence in the country and does not contemplate enforcing their departure. Oftentimes, this status is for refugees or parolees.

Single Entry Point (SEP) system: A collection of agencies statewide that provide case management, service navigation, and care planning services for Colorado Medicaid beneficiaries.

Skilled Nursing Services: Skilled nursing care consists of those services that must, under State law, be performed by or under the supervision of a licensed or certified nurse. These services include injections, tube feedings, catheter changes, observation and assessment of a patient's conditions, and more.

Social Security Administration (SSA): United States government agency that administers public assistance programs covering disability, retirement, and survivors' benefits. The SSA administers Supplemental Security Income (SSI) payments.

Supplemental Nutritional Assistance Program (SNAP): Federal nutrition assistance program that provides benefits to eligible low-income individuals and families via an Electronic Benefits Transfer card. This card can be used like a debit card to purchase eligible food in authorized retail food stores.

Supplemental Security Income (SSI): The U.S. cash assistance program for aged, blind, and disabled persons of limited means.

Technology Dependent: An individual who is technology dependent must use medical devices or other procedures to maintain a bodily function. Without use of these devices, adverse health outcomes may occur, including further disability, hospitalization or death.

Uniform Long Term Care Assessment (ULTC 100.2): Functional assessment used to determine whether an applicant meets the minimum level of care required (NFLOC) for accessing long-term care services in Colorado. The assessment measures levels of dependence when completing 6 ADLs (mobility, bathing, dressing, eating, toiletting, and transferring) and levels of supervision for certain behaviors or memory/cognition. This test is administered by case managers within the single entry point (SEP) system in Colorado. As of October 2024, the ULTC 100.2 is in the process of being phased out by a new assessment, the Colorado Single Assessment Level of Care (CSA LOC) Screen.

Notes

This section reports notes from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

1. Some SSI recipients may receive a State Supplementary Payment (SSP). SSP amounts vary by living arrangement. Receipt of this payment will marginally increase the income limit under this track. See SSA (2011) for more information.
2. The look back period is 36 months prior to the date of application, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application. From 2006, Colorado increased the look back period for asset transfers from 36 months (60 months for a trust) to 60 months for all assets.
3. Lawfully permanent residents and PRUCOL (i.e., Immigration and Naturalization Services knows of and permits their presence in the country and does not contemplate enforcing their departure, oftentimes refugees or parolees).
4. Applicants must meet strict requirements established by the Social Security Administration in order to qualify for SSI through a disability or blindness. See SSA (2024d) for more information on these requirements.
5. Authors have not yet verified the year that eligibility track 2a (Institutional Rules for People Receiving LTC) was implemented for both nursing facility applicants and individuals enrolled in home and community-based services (HCBS) programs. Sources indicate that this track was implemented at least by 1996. See KFF (1999).
6. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home), receiving HCBS (as of 1999), or participating in PACE (as of 1997) and their spouse resides in the community, there are spousal impoverishment laws

that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep a Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 1992, the minimum MMNA in Colorado was $984.20 per month, and the maximum was $1,718. This standard increases annually with inflation. See Table 3 for historical MMNAs.

7. Spousal considerations for assets: The community spouse is also able to keep 50% of the couple's countable assets with a minimum of $13,740 and a maximum of $68,700 in 1992. This is referred to as the Community Spouse Resource Allowance (CSRA). Countable assets/property are real and personal property that are counted to determine eligibility. See Table 3 for historical CSRAs.

8. Individuals are placed onto the waiting list for HCBS-EBD based on their initial date of determined eligibility for the program. As spots open up in the program, the following priorities are considered: (a) applicants being discharged from a nursing facility, (b) applicants being discharged from a hospital who would have to be discharged to a nursing facility without HCBS-EBD services, (c) applicants receiving LTHH who could be served at a lesser cost to Medicaid, and (d) applicants with high scores on the ULTC 100.2 functional assessment who are at risk of nursing facility placement. See CCR (2000) for more information.

9. Colorado implemented new delivery systems for receiving in-home support that were participant-directed: In-Home Support Services (IHSS) and Consumer-Directed Attendant Support Services (CDASS). IHSS and CDASS benefits include personal care, health maintenance, and homemaker services for those receiving long-term care under the HCBS-EBD program, effective 2004. Home health benefits under IHSS include acute and long-term home health and private duty nursing, while CDASS only includes acute home health. See HCPF (2016) to compare benefits within each delivery system.

10. A description of this service specific to Colorado's PACE program could not be found, however sources from other states indicate that this service may include case management, counseling, care coordination, and connection to community resources. See CMS (2011) for more information.

11. The Affordable Care Act (ACA) provides 100% matching funds for newly eligible adults with incomes up to 138% of the Federal Poverty Level between 2014-2016, gradually declining to 90% in 2020 where it remains indefinitely (ASPE, 2014).

12. The look back period is 60 months prior to the date of application for all assets.

13. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) or enrolled in HCBS programs and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep a Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 2014, the minimum MMNA in Colorado was $1,967 per month, and the maximum was $2,931. This standard increases annually with inflation. See Table 3 for historical MMNAs.

14. Spousal considerations for assets: The community spouse is also able to keep 50% of the couple's countable assets with a minimum of $23,448 and a maximum of $117,240 in 2014. This is referred to as the Community Spouse Resource Allowance (CSRA). Countable assets/property are real and personal property that are counted to determine eligibility. See Table 3 for historical CSRAs.

Version information

Current Version: 1.0 (December 2024)

Version History

- 1.0 (December 2024): First version.