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Single Entry Point Systems: State Survey Results

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NATIONAL ACADEMY for STATE HEALTH POLICY

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EXECUTIVE SUMMARY

The Rutgers Center for State Health Policy/NASHP Community Living Exchange Collaborative conducted a survey of the 50 states and the District of Columbia to identify states that operate single entry point (SEP) systems and to describe the characteristics of SEPs. A single entry point is defined as a system that enables consumers to access long term and supportive services through one agency or organization. In their broadest forms, these organizations manage access to one or more funding sources and perform a range of activities that may include information and assistance, preliminary screening or triage, nursing facility preadmission screening, assessment of functional capacity and service needs, eligibility determination, care planning, service authorization, monitoring, and reassessment.

Thirty-two states and the District of Columbia reported 43 SEPs. Nineteen states indicated that they do not operate SEPs. Among the survey findings:

- Twenty-four SEPs serve older adults, the population most commonly served by SEPs. Eleven of the eighteen SEPs that serve a single population serve people with MR/DD only. Twenty-five SEPs serve two or more populations.

- State agency field offices are the type of organization that most frequently acts as the SEP, followed by community-based nonprofits and Area Agencies on Aging.

- SEPs perform a range of functions. All SEPs develop care or individual service plans, and monitor service delivery. Most also complete assessments, authorize services, and complete periodic reassessments. Seventeen SEPs determine financial and functional eligibility. Twenty-four conduct nursing facility preadmission screening.

- All but one of the SEPs (42) provide access to Medicaid home and community-based services funded programs, 35 provide access to programs funded by state general revenues, and 26 manage Medicaid state plan services. Just over half (54 percent) of the SEPs serving older adults provide access to Older Americans Act funded services.

- Nearly half (47 percent) of SEPs take advantage of technology. Care managers use computerized assessments in 20 SEPs and another 4 percent are planning to implement computerized assessments. Care managers in 20 SEPs use laptops.

The survey identified some common elements across SEPs. Most SEPs serve two or more populations, control multiple funding sources, and require care managers to have a minimum of a bachelor's degree. The results also indicate that there is considerable variation among SEPs in the functions they perform, the populations they serve, and the organizations that function as the SEP. The survey findings also suggest that there is room for further progress by increasing the functions and funding sources managed by SEPs. Combining financial and functional eligibility determinations or improving coordination would expedite access to home and community-based services. Long term care systems might also ensure that applicants are aware of the full array of services, either through a preadmission screening or early contact once a person enters a nursing facility.

OVERVIEW

Twenty-five years ago, consumers needing long term and supportive services had few options. Since then, service options have expanded significantly. Medicaid pays for almost half of long term care expenditures — 38 percent in 1998 (Kaiser, 2001) — and therefore plays a major role in shaping access to and the quality of these services. Long term care (including nursing facility, Intermediate Care Facilities for persons with Mental Retardation (ICF-MR), personal care, home health, and home and community-based waiver services) is a significant part of the Medicaid program, accounting for 34 percent of all Medicaid expenditures in 2002. Even though the vast majority of Medicaid spending on long term care pays for institutional care — 70 percent in 2002 — the balance is shifting. Between 1990 and 2002, spending for community services increased 530 percent, from $3.9 billion to $25 billion, while institutional spending rose 124 percent, from $26 to $57 billion.[1]

Even though spending for community services is well below institutional spending, the array of service choices and funding options has grown, and progress to balance the system has been made. Expanding services can lead to fragmentation when each funding source has its own income and functional eligibility criteria. The more sources of funding available, the more complex the process for learning about what services are available and from whom. Medicaid state plan services may not be accessible to consumers living in the community whose income exceeds their state's eligibility levels, and those consumers may not qualify for waiver services. Consumers who do meet nursing facility level of care criteria may qualify for waiver services because they would qualify for Medicaid in an institution. Income and resource limits may vary for Medicaid, state general revenue programs, and Older Americans Act services, which have no income limits (means test) but only provides services to people age 60 and over.

Service choices now include personal care, self-directed care, homemaker, assistive devices, home adaptations, home delivered meals, chore services, respite services, transportation, assisted living, and many others. With choice sometimes comes confusion, if consumers have to contact each individual service provider to learn about the services they provide. This means that consumers themselves sometimes have to navigate a system that requires them to coordinate several disparate financing and delivery systems, making it more difficult to understand the full range of service choices and to make informed choices. Often consumers are referred to a service provider by a physician or other professional, and they may not explain what other services are available.

With the development of home and community-based services, states have changed the way services are organized and administered to reduce fragmentation, inform consumers about the range of service and program options available, and facilitate access to a coordinated array of long term and supportive services. Comprehensive single entry points (SEPs) streamline access to services. With one contact, a consumer receives information and assistance and, if appropriate, an assessment that identifies the person's functional capacity, health conditions,

[1] Based on analysis of CMS 64 data provided by Brian Burwell, Vice President, The MEDSTAT Group, Research and Policy Division.

supportive service needs, preferences, and the services available. Working with the SEP, the consumer can then develop a care plan based on her needs and preferences. Of course, access to a SEP depends on how well known it is among the consumers, family members, and professionals they are likely to contact. Unless the SEP is well known, consumers may find the system fragmented and difficult to negotiate.

In 2001, the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) began awarding Systems Change Grants for Community Living. Among these grants the *Real Choice Systems Change* grants provide funding to help states design and implement enduring improvements in community long term care support systems to enable people with disabilities to live and participate in community life. CMS also funded two technical assistance initiatives to help grantees met their goals. The Rutgers Center for State Health Policy (CSHP) and the National Academy for State Health Policy (NASHP) are leading one of these initiatives. Under this technical assistance contract the Rutgers/NASHP Community Living Exchange Collaborative conducted a survey of the 50 states and the District of Columbia designed to identify states with SEPs, the structure of the systems through which consumers access services, and the populations served. There is substantial variation among states that are considered to operate single entry point systems, and defining the term is difficult. This report describes the scope and variation among what states consider to be single entry systems. The survey did not seek extensive details about the operations of SEPs. Real Choice grantees can use the information presented to identify states that can be contacted for further details.

The main findings in this report address the populations served by SEPs, the organizations that have been designated by states as SEPs, their functions, and the sources of financing managed. The narrative also presents data on the structure of the service management or care management functions, and the requirements for service managers.

DEFINITION

The term single entry point has several connotations. For some, it is readily accessible information for anyone searching for long term support services that needs assistance for daily living tasks. Several web-based information and assistance systems use the term. SEP also refers to a pathway or place to gain information about, access to, and coordination of services. For the purposes of this report, a single entry point is defined as a system that enables consumers to access long term and supportive services through one agency or organization. In their broadest form, SEPs perform a range of activities that may include information and assistance, referral, initial screening, nursing facility preadmission screening, assessment of functional capacity and service needs, care planning, service authorization, monitoring, and periodic reassessments. SEPs may also provide protective services.

One or more sources of financing, typically Medicaid, state general revenues, Older Americans Act, Social Services Block Grant, county funds, or fee charged to consumers may be used to pay for services. SEPs also coordinate service delivery with other community organizations and programs that might be available outside the SEP's control. SEPs may utilize Internet websites to provide information or screening tools that help consumers and family members understand

their needs and the resources available to them. Organizations that only provide information and referral do not fall under this operational definition.

In most cases, a particular agency or organization, like the local Area Agency on Aging, performs all the SEP functions. In other cases, functions are split between agencies. For example, in Washington, the state agency (for older adults and people with physical disabilities) completes the assessment, determines financial and functional eligibility, and authorizes services. Area Agencies on Aging implement the consumer's care plan and provide ongoing case management. Other states, such as Wisconsin, may separate the information and screening functions from the authorization and care management activities. SEPs in a particular state may facilitate access to one or more, but not necessarily all, funding sources or programs.

Use of Terms

The survey asked states which of the following functions were performed by SEPs:

- Information and referral includes assistance provided by phone, sending written materials, and communicating via a website. It includes the provision of follow-up assistance to help consumers access services.
- Screening, sometimes called triage, refers to the brief assessment conducted by phone to help the SEP to understand the type of information and assistance needed.
- A nursing facility preadmission assessment screening (PAS) is completed to record information about a person's health, environment, social/cognitive/psychological state, and functional status. Information obtained on the assessment is used to determine whether a person may be eligible for admission to a nursing facility or for Medicaid home and community-based services.
- A similar process, ICF/MR preadmission screening, is used for people with mental retardation/developmental disabilities.
- The assessment function is similar to the PAS but is used to assess capacity and service needs that lead to a care or individual service plan. SEPs may combine assessment and PAS into one assessment tool to serve both purposes.
- Financial eligibility determination is the process for determining whether a person meets the income and resource requirements, if any, for the program providing services.
- Functional eligibility determination is the process for determining whether a person meets the functional requirements, if any, for the program providing services. Measures of functional status are typically defined in terms of every day activities an individual is unable to perform without assistance, called Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).
- The care plan is built on findings from the assessment process and lists the services that may be selected by the consumer.
- Once a care plan is developed, the SEP then authorizes services that may be provided by outside agencies or arranged by the consumer.
- SEPs also monitor service delivery from providers of services to make sure the care plan is being implemented.

- Reassessment is the process for redetermining the person's functional eligibility for the program and whether any changes have occurred that require modification of the care plan.
- Protective services protect vulnerable adults by investigating allegations of abuse, neglect, abandonment, and financial exploitation.

SURVEY FINDINGS

The survey was mailed to the directors of each state's Medicaid, Aging, and Mental Retardation/Developmental Disability (MR/DD) agency. Survey responses were received from at least one agency in each state and the District of Columbia. Responses were received from 40 state aging agencies, 28 MR/DD agencies, and 25 Medicaid agencies (see Table 1). A total of 42 SEPs were identified in 31 states and the District of Columbia. Fifty agencies (representing 19 states) responded that they were not operating SEPs.

Table 1 Responses by agency

Agency	Number
Aging	40
MR/DD	28
Medicaid	25
Total	93

Five states expressed interest in or are developing a SEP. The Alaska Division of Senior Services, the Arkansas Division of Aging and Adult Services, and the District of Columbia Medical Assistance Administration are considering SEPs. Texas and Hawaii have received CMS Real Systems Change grants to develop SEPs. The efforts in Texas and Hawaii are subtly different from the definition of a SEP framing this study. Rather than establishing one location for the consumer to gain access to services, the Texas and Hawaii initiatives emphasize streamlining the functions of a SEP so the consumer can access services wherever they enter the system.

The Texas Health and Human Services Commission is working with local groups to improve coordination for consumers of all ages with disabilities and children with disabilities and/or special health care needs. Under the CMS Real Choice Systems Change grant, two Texas communities will implement models that include common intake, referral, assessment, and follow-up protocols. In one model, services are accessed through a single access point. The other model will provide access to services through multiple but highly coordinated access points, referred to as a "no wrong door approach."

The Hawaii Department of Human Services is developing a cross-agency multi-population web-based single entry point that will provide consumers with information on all their available options, including those offered by private as well as public agencies. This website will provide an interactive assessment process to help consumers identify services for which they are eligible

and to identify available providers of all long term care services offered by the state, counties, and private organizations in their region. The Hawaii Executive Office on Aging described the state's approach as a "multiple agency consumer friendly accessible system" rather than a single entry system.

Populations

The survey asked states if they operated systems that they considered to be a SEP for any of the following groups: older adults (65+), people with disabilities, people with mental retardation or developmental disabilities (MR/DD), people with traumatic brain injury (TBI), children with special needs, people with HIV/AIDS, people with mental health needs, or other populations. States with SEPs and the populations served are presented in Appendix A. Older adults are served by the most (24) SEPs, followed by people with disabilities (22), and people with MR/DD (20), as seen in Table 2.

Table 2 Number of SEPs serving each population

Population	States
Older adults	24
People with disabilities	22
People with MR/DD	20
Traumatic brain injury	13
Children with special needs	7
HIV/AIDS	6
Mental health	6
Other	3

SEPs may serve a single group, such as older adults, or people with MR/DD, or multiple groups. Eighteen SEPs serve a single population, and 25 serve two or more groups. Eleven SEPs serve only people with MR/DD and five serve only older adults. Two serve people with mental health needs exclusively. Table 3 shows the 19 different combinations of populations that are included in this survey.

Design

States have designated a range of organizations to function as the SEP, and these organizations vary across states and populations served. The SEP may be a state agency field office, Area Agency on Aging (AAAs), county department (health or social service, which in some states are designated as AAAs), home health agency, Center for Independent Living, community-based nonprofit, other organization, or some combination of the above. A state agency field office is the type of organization that most frequently acts as the SEP, followed by community-based nonprofits, and Area Agencies on Aging. Table 4 shows the number of SEPs by each type of organization.

Table 3 SEP and populations served

Populations served	Number of SEPs
MR/DD only	11
Older adults and PWD	8
Older adults only	5
Older adults, PWD, and TBI	2
MH only	2
Older adults, PWD, MR/DD, and TBI	1
Older adults, PWD, MR/DD, TBI, CSN, HIV/AIDS, and MH	2
Older adults, PWD, MR/DD, TBI, CSN, and HIV/AIDS	1
Older adults, PWD, and other	1
Older adults, PWD, TBI, CSN, and HIV/AIDS	1
PWD and TBI	1
MR/DD and MH	1
Older adults, PWD, and CSN	1
PWD, MR/DD, TBI, and MH	1
Older adults, PWD, MR/DD, and HIV/AIDS	1
PWD, TBI, and other	1
Older adults, PWD, MR/DD, TBI, and HIV/AIDS	1
MR/DD and TBI	1
MR/DD and CSN	1
Total Number of SEPs	43

PWD=people with disabilities, MH=mental health, CSN=children with special needs

Table 4 SEP organizations

Organization	Number
State regional/field offices	16
Community-based organizations	13
Area Agencies on Aging	13
Other	10
County departments	8
Centers for Independent Living	3
Home health agencies	1

States sometimes operate parallel SEPs for different populations. In Pennsylvania, for example, the AAAs are the SEP for older adults, county departments service people with MR/DD, and community resource centers serve adults with physical disabilities, traumatic brain injuries, and people who are technology dependent. Alternatively, in Wisconsin, county departments serve as the SEP for older adults, people with physical disabilities, MR/DD, and people with traumatic brain injuries. Appendix B presents the type of organizations acting as the SEP in each state.

In most cases, one SEP serves a specified geographic area. In five states (Arizona, Connecticut, Hawaii, Kansas, and Montana), there may be more than one SEP in an area. In Arizona, for

example, there is a choice of three managed care organizations in the state's largest county, Maricopa (Phoenix metropolitan area) and one in each of the remaining counties**.**

Functions

SEPs offer consumers one point of contact to learn about the services available and their eligibility for specific services as well as for support in selecting the preferred services. SEPs must perform a range of functions to carry out this mission. First, they must have information about the services and settings available in their community — in-home, community, residential, and institutional — and assist people in gaining access to available programs and services. The information should be available to consumers, family members, professionals, providers, and other community organizations, over the Internet, by phone, and in writing. Second, SEPs must be well known in the community so that consumers or professionals contacted will know where to call.

Third, SEPs implement an initial screening process to determine which services may be available based on individual and family circumstances and preferences. Some SEPs may complete the assessment and determine functional eligibility for HCBS programs. Comprehensive SEPs conduct a preadmission screening (PAS) to determine eligibility for admission to a nursing facility as well as HCBS programs. The PAS may be completed for current Medicaid beneficiaries, people who are likely to become Medicaid beneficiaries within six months, or private pay applicants.

Fourth, the SEP conducts a full assessment to determine functional eligibility and to build a care plan or individualized service plan with the consumer, their family members, or their support system. The full assessment is often part of the PAS. SEPs may also provide assistance in obtaining accessible and affordable housing. Fifth, once a care plan is developed, the SEP has the ability to authorize and arrange services. The authorization function allows services to be paid by the programs for which the consumer is eligible. Care plans are monitored and modified as the consumer's needs and supports change over time.

The survey listed 14 possible functions of a SEP, including: information and assistance (web, phone, written), initial screening, nursing facility preadmission screening, ICF/MR preadmission screening, assessment, determination of financial or functional eligibility, care plan development, service authorization, service delivery monitoring, periodic reassessment, and protective services. Appendix C presents the functions performed by each SEP. Seven states (Arizona, Connecticut, Georgia, Maine, Michigan, Washington and Wisconsin) have split the SEP functions among organizations; those results are presented in Appendix D.

The SEP in Massachusetts and Minnesota perform all 14 functions, and SEPs in Arizona, South Dakota, and Washington (older adults and people with physical disabilities) perform 13 functions. The Maryland SEP performs six functions, the lowest number of functions performed by any SEP. The number of functions performed by each SEP is included in Appendices C and D.

All of the SEPs develop care or individualized service plans and monitor service delivery, as shown in Table 5.[2] Nearly all of the SEPs also provide telephone information and referral, complete assessments, authorize services, and complete periodic reassessments. Less than half (19) of the SEPs provide web-based information and referral, and nine SEPs provide protective services.

Coordination of the financial and functional eligibility determination processes can be a barrier to serving people in the community. People often seek services during a crisis. Following a hospital admission, discharge arrangements are often made quickly. Community services are more difficult to arrange and coordinate than placement in a nursing facility. If the person is not already a Medicaid beneficiary, the application and eligibility process places community provider agencies at risk for nonpayment if the person is found ineligible after a service plan has been implemented. Nursing facilities, on the other hand, have a greater ability to accept the risk and expect that they will be paid either by the person, their family, or Medicaid. SEPs that have the authority to determine financial and functional eligibility may be able to expedite the process and initiate community services more quickly. The process may be expedited when both determinations are made by the same organization or the process is coordinated. Seventeen SEPs indicated that the SEP performs both the financial and functional eligibility determinations.

Table 5 Functions performed by SEPs

Function	Number
1. Develop care plan	43
2. Monitor service delivery	43
3. Telephone information and referral	42
4. Complete assessment	41
5. Authorize services	41
6. Complete reassessment	41
7. Written information and referral	40
8. Initial screening	38
9. Determine functional eligibility	38
10. Nursing facility preadmission screening	24
11. Web based information and referral	19
12. ICF/MR preadmission screening	17
13. Determine financial eligibility	17
14. Protective services	9

Consumers and family members are typically referred to a SEP or call seeking information about service options. Once they determine that they want to receive services, a comprehensive assessment is conducted to identify functional capacity, determine the areas in which assistance is needed or requested, and identify formal and informal resources available to meet those needs. The assessment may be conducted for consumers seeking admission to a nursing home or only for those interested in HCBS programs.

[2] We consider Wisconsin a split system; however, the state does not consider the functions of their care management organizations to be part of the SEP.

Nineteen SEPs conduct an assessment to determine eligibility to enter a nursing facility. Medicaid beneficiaries may not enter a nursing facility without an assessment and level of care determination by the SEP in 22 SEPs and people who are likely to become Medicaid beneficiaries must receive the assessment in 17 SEPs. Private pay applicants must be screened in eight SEPs and may voluntarily do so in seven SEPs. All but one (Pennsylvania MR/DD) of the SEPs that conducts PAS also determines functional eligibility (see Appendix E).

A few states have addressed the barrier to community placement by allowing case managers to "presume" eligibility when an initial review of the person's circumstance indicate the person is likely to be eligible. Services can be initiated and authorized for up to 90 days while the Medicaid application is completed and a determination is made. If the person is found to be ineligible, federal Medicaid reimbursement is not available. Nebraska, Oregon, and Washington allow case managers to presume eligibility. The President's proposed budget for fiscal year 2004 includes a presumptive eligibility provision that would allow states to receive federal reimbursement for services that were provided for up to 90 days to people being discharged to home from a hospital who were later found ineligible for Medicaid.

Financing

One significant area of potential fragmentation addressed by SEPs is the financing of long term and support services. The major sources of funding are Medicaid HCBS waiver programs, Medicaid state plan services, the Older Americans Act, Social Services Block Grant, state general revenues, county funds, and fees from people who are not eligible for subsidized programs. SEPs create a structure to simplify access and reduce fragmentation. However, the ways in which programs are financed shape a state's ability to rebalance its system by shifting funds from institutional to community services. The CMS Disabled and Elderly Health Program Group has described several examples of how states are rebalancing financing of long term care services. Examples from Texas, Vermont, and Wisconsin can be found among the list of promising practices.[3] Oregon and Washington (SEP for older adults and people with physical disabilities) pool funding for all long term care services, which facilitates shifting funds between nursing facility and HCBS programs.

SEPs that control multiple funding sources can provide seamless access to programs and services. SEPs serving older adults and people with physical disabilities in New Hampshire manage six funding sources. Five funding sources are managed by the SEPs in Georgia (older adults and physical disabilities), Kansas (MR/DD and Children with Special Needs), Minnesota, New Jersey, Ohio (MR/DD), Pennsylvania (older adults), and South Dakota (see Appendix F). SEPs in Maryland, Missouri, and Nebraska only manage one funding source.

All of the SEPs, except for the Missouri SEP for mental health services, manage access to Medicaid HCBS funded services. Medicaid general revenue services are accessed through 35 of the SEPs (see Table 6). Twenty-six SEPs authorize some state plan services. The state plan services most commonly authorized by SEPs are nursing facility (14), ICF-MR (13), and

[3] See www.cms.hhs.gov/promisingpractices.

personal care (12) (see Appendix G). In addition, the cost of eligibility determination is eligible for Medicaid administrative match.

Table 6 Funding source

Source	Number
Medicaid HCBS	42
State general revenue	35
Medicaid state plan	26
SSBG	15
Older Americans Act	13
County	9
Others	4

The sources of funding accessed through the SEPs vary by the population served, as shown in Table 7.

Table 7 Number of SEPs by source of funding and population served

Source	Older Adults	PWD	MR/DD	TBI	CSN	HIV/AIDS	MH	Other
Medicaid HCBS	24	21	20	11	6	6	5	2
Medicaid State Plan	14	12	12	5	4	3	4	1
OAA	13	--	--	--	--	--	--	--
SSBG	8	7	8	3	2	1	1	1
State General Revenue	19	15	15	7	3	3	5	2
County	4	3	6	1	2	1	2	1
Other	3	2	2	2	2	2	1	1

PW=People with Disabilities, CSN=Children with Special Needs, MH=Mental Health, OAA=Older Americans Act, SSBG=Social Services Block Grant

Charts 1-3 present the number of SEPs that provide access to Medicaid HCBS, General Revenue, and Medicaid State Plan-funded services by population as a percentage of the SEPs serving each population. For example, all (100 percent) of the SEPs serving older adults and people with HIV/AIDS provide access to Medicaid HCBS-funded services. About half (54 percent) of the SEPs serving older adults provide access to Older Americans Act funds.

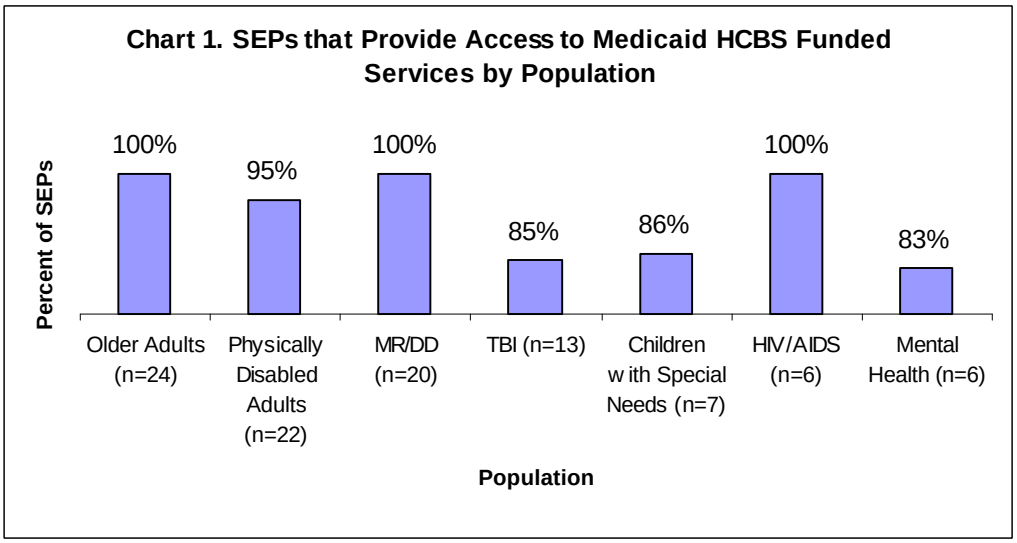
Chart 1. SEPs that Provide Access to Medicaid HCBS Funded Services by Population
Percent of SEPs
100%
95%
100%
85%
86%
100%
83%
Older Adults (n=24)
Physically Disabled Adults (n=22)
MR/DD (n=20)
TBI (n=13)
Children w ith Special Needs (n=7)
HIV/AIDS (n=6)
Mental Health (n=6)
Population

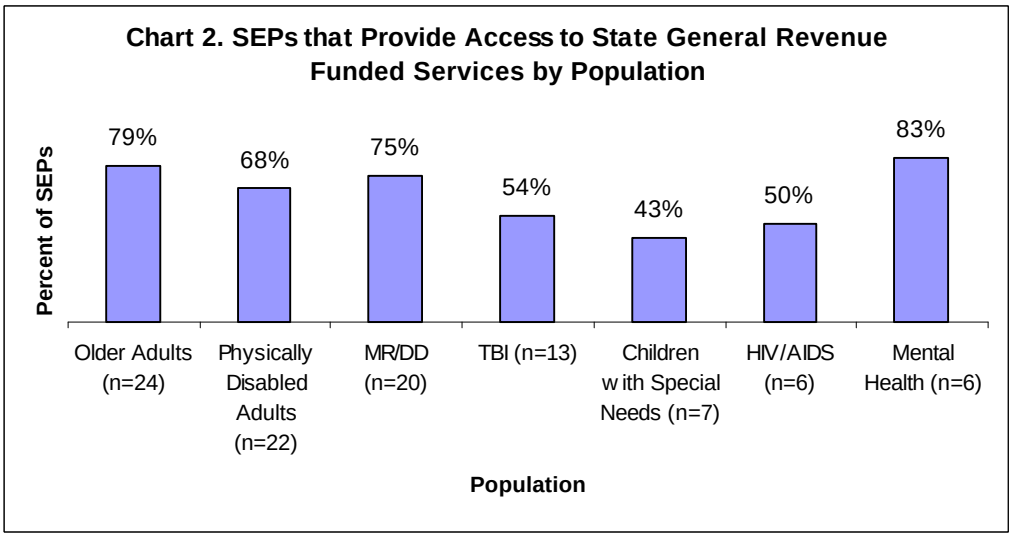
Chart 2. SEPs that Provide Access to State General Revenue Funded Services by Population
Percent of SEPs
79%
68%
75%
54%
43%
50%
83%
Older Adults (n=24)
Physically Disabled Adults (n=22)
MR/DD (n=20)
TBI (n=13)
Children w ith Special Needs (n=7)
HIV/AIDS (n=6)
Mental Health (n=6)
Population

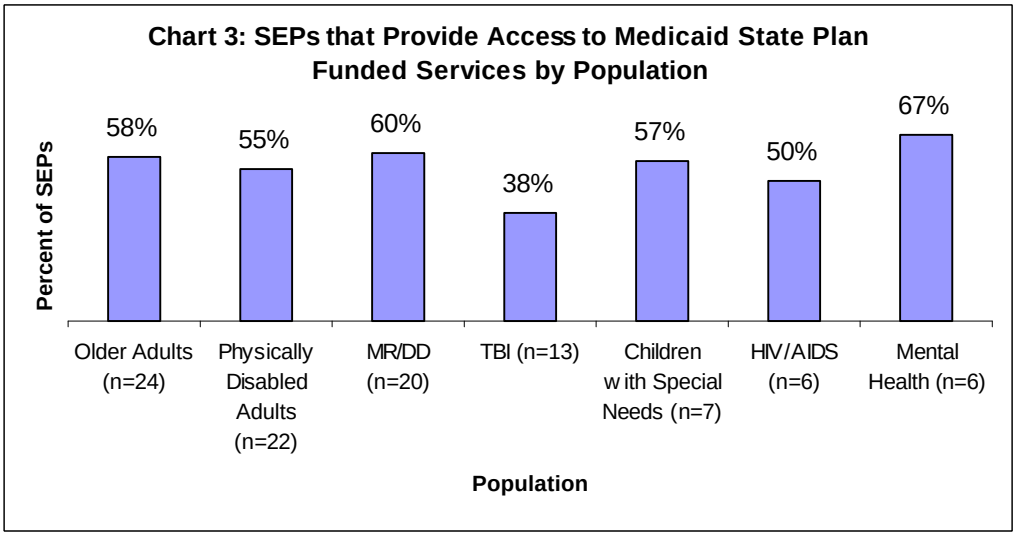
Chart 3: SEPs that Provide Access to Medicaid State Plan Funded Services by Population
Percent of SEPs
58%
55%
60%
38%
57%
50%
67%
Older Adults (n=24)
Physically Disabled Adults (n=22)
MR/DD (n=20)
TBI (n=13)
Children w ith Special Needs (n=7)
HIV/AIDS (n=6)
Mental Health (n=6)
Population

Service Delivery

SEPs emerged in part from a concern that provider agencies have an incentive to offer consumers the services that those agencies deliver and may not inform consumers about, or refer them to, other providers for services that may be appropriate and available. To promote access and choice, SEPs in some states are not allowed to deliver services. Exceptions are sometimes made when there are no providers of a particular service.

Sixteen SEPs are allowed to deliver services that they authorize and 19 SEPs are prohibited from delivering services they authorize. Five SEPs are allowed to deliver services they authorize if other providers are not available in that area, if the SEP can provide the service at a lower cost, or the services are funded by Title III of the Older Americans Act.

Service Management

States use different terms for the role of staff that work with consumers and their family members. Case or care manager, used by 24 SEPs, is the most commonly used term. Support or service coordinator is used in 8 SEPs and is commonly associated with SEPs that serve people with physical disabilities or MR/DD. Other terms include call center representative, home services facilitator, resource center specialist, and single portal coordinator.

Care management activities performed outside a state agency are usually funded on a fee-for-service basis (17 SEPs). Eight of the states negotiate the care management with the SEP, seven provide a monthly capitation payment, and two use a combination of methods.

Care management teams and assessment

Early SEP models assigned a case manager to each consumer. Policymakers have designed more sophisticated care management processes. In some systems, registered nurses (RNs) serve as consultants to the case manager, advising about risk factors and health conditions that might warrant a referral to a home health agency or contact with the physician. Other states formed teams of social workers and registered nurses. Nurses may conduct the assessment and develop the care plan when there are unstable medical conditions or conditions that require skilled monitoring or observation. Either the social worker/care manager or an RN completes the assessment in 26 SEPs. In 11, only the case manager completes the assessment and only the RN completes the assessment in 2 SEPs.

Twenty of the SEPs form teams whose members vary depending on the needs of the consumer. Team members may include: the consumer, provider agencies, RN consultants, assessors, the case manager's supervisor, physician consultants, psychologists, psychiatrists, family members, friends, or others selected by the consumer. In Maine, hospital discharge planners are considered part of the case management team, when appropriate. In New Jersey, for example, most counties have a mix of social workers and RNs providing case management. In some counties, they work

as a team and in others, they may work individually and exchange information in case conferences.

Educational requirements

A high school diploma or experience was often the minimum requirement for care coordinator positions when these programs were implemented in the 1970s and 1980s. Education requirements for care managers have changed over time. Most SEPs (28) require a minimum of a bachelor's degree (this includes SEPs that require either a bachelor's degree, Registered Nurse or a Master in Social Work [MSW]). Three SEPs require an RN or an MSW, two require an MSW, and one requires a high school diploma. Experience with the population served can often be substituted for education and, in some cases, an individual without the stated educational requirements may work under supervision. Minimum educational requirements are shown in Table 8.

Table 8 Minimum educational requirements of care managers

Education	Number of SEPs
Bachelor's degree	28
RN or MSW	2
MSW	2
High school diploma	1
No specific requirements	3
Missing	7
Total	43

Housing

SEPs may assist consumers in finding accessible and affordable housing and coordinate with conventional elderly housing sites. Many residents in conventional elderly housing sites receive home and community-based services to maintain their independence. Case managers are assigned to residents as they seek services. As the number of residents receiving services rises, multiple case managers and service providers may serve building residents. Several SEPs have revised their approaches. Ten SEPs reported that they assign case managers to specific buildings to serve all residents who need supportive services — Connecticut (two SEPs), Illinois, Kansas (older adults), Minnesota, Missouri, Maryland, New Hampshire, Oregon, and Washington (older adults and people with physical disabilities).

Another six SEPs in Arizona, Pennsylvania (older adults), Colorado (older adults, people with physical disabilities, and people with TBI or HIV/AIDS), New Jersey, Tennessee, and Wisconsin indicated that it depends on the local SEP. For example, Tennessee reported that there is no state policy on coordinating case management assignments based on housing settings. Local offices make decisions about geographic assignment. In Arizona, Managed Care Organizations generally like to assign people living in one setting to as few case managers as possible. As a

result, it is very common to have only one case manager assigned to an assisted living home, an apartment complex, or a nursing facility.

Use of technology

Assessment has always been a paper intensive process. Technology has become an important part of state home and community-based service systems to support the assessment and care planning process. Twenty SEPs use computerized assessments and another four indicated that they are planning to implement computerized assessments. Programs contain sophisticated prompts, reminders, drop down screens, and help menus to guide assessors through the process. The programs prepare, document, and print service plans; authorize service hours and set payment rates; and enable program administrators to track and compare consumers across care settings and time.

Case managers in 20 SEPs use laptops. Among states indicating that case managers use laptops, usage ranges from 5-100 percent of the case managers. In three states (Indiana, Maine, and South Carolina), all case managers use laptops to complete the assessment process. Laptops could be linked to Medicaid Management Information Systems (MMIS) to check what services are prior authorized. Tennessee is developing software to enable case managers to use personal digital assistants (PDAs) to complete assessments.

Frequency of reassessment

Health and functional capacity varies among consumers and changes over time. Some consumers may have stable health conditions, predictable service needs, and considerable support from family caregivers. Contact with case managers is more routine and less frequent. Others may be unstable and subject to frequent episodes that require monitoring and changes to the service plan.

HCBS waiver programs and state policies generally include requirements for the frequency of contact with consumers. Twenty-eight SEPs conduct reassessments at least annually. Another seven SEPs require a reassessment bi-annually, five reassess quarterly, and one SEP reported that frequency of reassessment varies (see Table 9). Regardless of the minimum requirements, all states provide for reassessment when there is a significant change in the consumer's condition, and they adjust the service plan accordingly.

Table 9 Reassessment requirements

Frequency	Number
Annual	28
Bi-annual (180 days)	7
Quarterly (90 days)	5
Varies	1
Missing	2
Total	43

Coordination

Primary care physicians

Approximately half (23) of the SEPs have provisions for coordination with the beneficiary's Primary Care Physician (PCP). Physician involvement is based on formal and informal arrangements, ranging from signing the care plan to coordination related to medication management. Coordination varies greatly within states and is determined locally rather than by an established statewide standard.

Collaboration with hospitals and nursing facilities

A high percentage of consumers are admitted to a nursing facility following a hospital stay. Collaboration between hospital discharge planners and case managers has been explored as a means of diverting people back to the community by intervening soon after admission and developing a service plan prior to discharge. Thirteen of the SEPs indicated that they locate case managers in hospitals to collaborate with discharge planners. This practice may vary within each state; for example, in Colorado, only two of the SEPs locate case managers in hospitals.

Some states, such as Vermont, that do not require SEPs to place case managers in hospitals indicated that they collaborate with discharge planners in other unspecified ways. In Wisconsin, SEPs are not required to locate case managers in hospitals, but the state requires each local SEP to have a process in place to facilitate coordination between case managers and hospital discharge planners.

As hospital stays have declined, more consumers enter nursing facilities for short-term rehabilitation, and locating case managers in hospitals may be less effective than assigning them to nursing facilities. Twenty-two SEPs assign case managers to work with a nursing facility and ICF/MR residents to provide crisis management and facilitate relocation to community settings.

CONCLUSION

This survey identified some common elements across SEPs; most serve older adults and people with physical disabilities, control multiple funding sources, and require care managers to have a minimum of a bachelor's degree. There is also considerable variation among SEPs, in the functions they perform and in the organizations that function as the SEP. Based on the degree of integration of populations served, functions performed, and funding streams accessed, SEPs can be arrayed along a continuum. The survey findings suggest that there is room for further progress by increasing the populations, functions, and funding sources managed by SEPs.

Populations: SEPs that serve multiple populations may achieve economies of scale and streamline SEP/provider agency relationships. The survey identified multiple examples of SEPs serving older adults and adults with physical disabilities, however only a few of those included services for people with mental retardation and developmental disabilities or other populations.

SEPs for people with mental retardation and developmental disabilities tend to serve these populations exclusively.

Functions: Combining financial and functional eligibility determinations or improving coordination would expedite access to home and community-based services. Yet, only 16 of the SEPs identified in this survey determine both financial and functional eligibility. The recent joint Administration on Aging (AoA) and CMS Aging and Disability Resource Centers demonstration program will support integration of financial and functional eligibility by providing nearly $14 million for SEPs in the 16 states that perform both functions. Long-term care systems might also ensure that applicants are aware of the full array of services, either through a preadmission screening or early contact once a person enters a nursing facility.

Financing: SEPs that coordinate funding from Medicaid state plan, HCBS waiver, and state general revenue programs have more flexibility to respond to varying individual needs than programs that only manage HCBS waiver funds. Of course, during a period of declining revenues, states operating programs with general revenues may be seeking ways to maximize revenue and cost effectiveness by shifting services to programs that are financed with federal funds. The AoA and CMS-supported Aging and Disability Resource Centers will coordinate all Medicaid-funded long term support services, which includes both Medicaid state plan and HCBS waiver services, as well as Older Americans Act funded services.

The results of this survey provide a starting point for further study to understand the actual operation and ability of SEPs to offer seamless access to services based on income, functional capacity, and service needs.

SOURCES

Centers for Medicare and Medicaid Services (2002). *Compendium of the Systems Change Grants for Community Living*.

Centers for Medicare and Medicaid Services (2003). *Systems Change Grants for Community Living, Compendium, Second Edition.*

Kaiser Commission on Medicaid and the Uninsured, (2001). *Facts.* Washington, DC. Mar 2001.

DATA TABLES

Appendix A. Populations Served in SEPs by State

State	Older adults (65+)	Adults with Disabilities	MR/DD	TBI	Children with Special Needs	HIV/AIDS	Mental Health	Other	None reported
AL									x
AK									x
AZ	x	x	x	x	x	x	x		
AR									x
CA			x						
CO	x	x	x	x		x			
CT	x	x	x	x			x		
DE	x	x	x	x	x	x			
DC			x						
FL*			x						
GA*	x	x	x						
HI			x						
ID									x
IL*	x								
IN	x	x		x					
IA									x
KS*	x	x	x	x	x		x		
KY									x
LA									x
ME	x	x		x					
MD*	x	x							
MA*	x								
MI			x				x		
MN	x	x	x	x	x	x	x	x	
MS									x
MO							x		
MT	x	x		x	x	x			
NE	x	x	x	x	x	x			
NV									x
NH	x	x							
NJ*	x	x						x	
NM									x
NY									x
NC			x	x					
ND			x						
OH	x	x	x		x				
OR	x	x							
OK									x
PA*	x	x	x	x				x	
RI									x
SC	x	x							
SD*	x	x							
TN	x	x							
TX									x
UT									x
VA									x
VT			x						
WA	x	x	x						
WV									x
WI	x	x	x	x					
WY									x
Total	24	22	20	13	7	6	6	3	18

*FL: Adults and children with developmental disabilities only, not mental retardation

*GA, IL, KS, MA, SD: Older adults 60+

*MD: Older adults 60+ and adults with disabilities 50+

*NJ: Other = caregivers

*PA: Implementation of SEP for adults with disabilities, TBI, and technology dependent postponed indefinitely

Appendix B. Type of Organizations Acting as SEP by State and Population

State	State agency field offices	AAAs	County Departments	Home Health Agencies	CILS	Community-based Nonprofits	Other
Arizona	1,2,3,4,5,6,7		1,2,4,5,6,7				Managed care organizations 1,2,4,5,6,7
California						3	
Colorado		1,2,4,6	1,2,4,6			1,2,4,6	
Colorado						3	
Connecticut	2,3,4,7						
Connecticut	1					1	
Delaware	1,2,3,4,6						
District of Columbia	3						
Florida	3						
Georgia		1,2				1,2	
*Georgia							TBD, 3
Hawaii	3						
Illinois			1			1	
Indiana		1,2,4					
Kansas		1					
Kansas			3,5			3,5	
Kansas				2,4	2,4		
Kansas							Community Mental Health Centers, 7
Maine						1,2,4	For-profit companies, 1,2,4
Maryland		1,2					
Massachusetts						1	
Michigan	3,7						Managed care organizations 3,7
Minnesota		1,2,3	1,2,3,4,5,6,7		2,3,4,5		State agency, 6
Missouri						7	
Montana		1				1,2,4,5,6	
Nebraska	3,5	1			2,4,6	5	Schools and hospitals, 5
New Hampshire	1,2						
New Jersey		1,2					
North Carolina							Local Mental Health Authorities, 3,4
North Dakota	3						
Ohio							Case management contractors, 1,2,5
Ohio			3				
Oregon	1,2	1,2					
Pennsylvania*							Community Resource Centers 2,4,8
Pennsylvania		1					
Pennsylvania			3				
South Carolina	1,2						
South Dakota	1,2						
Tennessee		1,2					
Vermont						3	
Washington	1,2	1,2					
Washington	3						
Wisconsin*			1,2,3,4				
Total	16	13	8	1	3	13	10

1=Older Adults, 2=Adults with Physical Disabilities, 3=MR/DD, 4=TBI, 5=Children with Special Needs, 6=HIV/AIDS, 7=Mental Health, 8=Other

*PA: Community Resource Centers vary by county and include CILs, county MH/MR departments, former service providers, and vocational rehabilitation agencies.

*WI: In the 9 counties with Family Care demonstrations, including Milwaukee, the SEPs are Aging and Disability Resource Centers. In Milwaukee, the SEP is operated by the Milwaukee County Department on Aging, which serves as the AAA , the SEP and the CMO.

* GA: TBD = To be determined

Appendix C. SEP Functions Performed by State and Population

State	Information and referral			Screening	NF preadmission screening	ICF/MR preadmission screening	Complete the assessment	Determine financial eligibility	Determine functional eligibility	Develop care plan	Authorize services	Monitor service delivery	Complete reassessment	Protective services	Other	Number of Functions
	Web based	By telephone	Written materials													
California*	3	3	3	3	3	3	3		3	3	3	3	3		Resource dev. and advocacy, 3	12
Colorado	1,2,4,6	1,2,4,6	1,2,4,6	1,2,4,6	1,2,4,6		1,2,4,6			1,2,4,6	1,2,4,6	1,2,4,6	1,2,4,6			10
Colorado	3	3	3	3			3	3	3	3		3	3			10
Connecticut		2,3,4,7	2,3,4,7	2,3,4,7			2,3,4,7	2,3,4,7	2,3,4,7	2,3,4,7	2,3,4,7	2,3,4,7	2,3,4,7			10
Delaware*		1,2,3,4,6			1,2,3,4		1,2,3,4,6		1,2,3,4,6	1,2,3,4,6	1,2,3,4,6	1,2,3,4,6	1,2,3,4,6	1,2,3,4,6		9
District of Columbia		3	3			3			3	3	3	3	3			8
Florida		3	3	3		3	3	3	3	3	3	3	3			11
Georgia		3	3	3		3	3	3	3	3	3	3	3		Tracking waiting lists, 3	11
Hawaii		3	3	3		3	3		3	3	3	3	3			10
Illinois*		1	1	1	1		1	1	1	1	1	1	1			11
Indiana	1,2,4	1,2,4	1,2,4	1,2,4	1,2,4	1,2,4	1,2,4		1,2,4	1,2,4	1,2,4	1,2,4	1,2,4			12
Kansas	3,5	3,5	3,5	3,5	3,5	3,5	3,5		3,5	3,5	3,5	3,5	3,5			12
Kansas		2,4	2,4	2,4	2,4		2,4		2,4	2,4		2,4	2,4			9
Kansas	1	1	1	1	1		1		1	1	1	1	1			11
Kansas	7	7	7	7	7		7		7	7	7	7				10
Maryland	1, 2	1,2	1,2							1,2	1,2	1,2				6
Massachusetts	1	1	1	1	1	1	1	1*	1	1	1	1	1	1		14
Minnesota	1,2,3,4,5,6,7	1,2,3,4,5,6,7	1,2,3,4,5,6,7	1,2,3,4,5,6,7	1,2,3,4,5,6,7	1,2,3,4,5,6,7	1,2,3,4,5,6,7	1,2,3,4,5,6,7	1,2,3,4,5,6,7	1,2,3,4,5,6,7	1,2,3,4,5,6,7	1,2,3,4,5,6,7	1,2,3,4,5,6,7	1,2,3,4,5,6,7		14
Missouri		7	7	7			7	7	7	7	7	7	7			10
Montana		1,2,4,5,6	1,2,4,5,6				1,2,4,5,6		1,2,4,5,6	1,2,4,5,6	1,2,4,5,6	1,2,4,5,6	1,2,4,5,6			8
Nebraska		1,2,3,4,5,6	1,2,3,4,5,6	1,2,3,4,5,6	1		1,2,3,4,5,6	1,2,3,4,5,6	1,2,3,4,5,6	1,2,3,4,5,6	1,2,3,4,5,6	1,2,3,4,5,6	1,2,3,4,5,6	1,2,3,4,5,6		12
New Hampshire	1,2	1,2	1,2	1,2	1,2		1,2		1,2	1,2	1,2	1,2	1,2	1,2		12
New Jersey*		1,2,8	1,2,8	1,2,8	1,2,8		1,2,8		1,2,8*	1,2,8	1,2,8	1,2,8	1,2,8			10
North Carolina		3,4	3,4	3,4		3	3,4		3,4	3,4	3,4	3,4	3,4			10
North Dakota		3	3	3		3	3		3	3	3	3	3			10
Ohio	1,2,5	1,2,5		1,2,5			1,2,5		1,2,5	1,2,5	1,2,5	1,2,5	1,2,5			9
Ohio		3	3	3			3		3	3	3	3	3			9
Oregon		1,2	1,2	1,2	1,2		1,2	1,2	1,2	1,2	1,2	1,2	1,2	1,2		12
Pennsylvania		2,4,8	2,4,8	2,4,8			2,4,8			2,4,8	2,4,8	2,4,8	2,4,8			8
Pennsylvania	3		3	3	3	3	3			3	3	3	3	3	3	11
Pennsylvania		1	1	1	1		1		1	1	1	1	1	1		11
South Carolina	1,2	1,2		1,2	1,2		1,2		1,2	1,2	1,2	1,2	1,2			10
South Dakota	1,2	1,2	1,2	1,2	1,2		1,2	1,2	1,2	1,2	1,2	1,2	1,2	1,2	Ombudsman, 1	13
Tennessee		1,2	1,2	1,2			1,2			1,2	1,2	1,2	1,2			8
Vermont	3	3	3	3		3	3	3	3	3	3	3	3			12
Washington	3	3	3			3	3		3	3	3	3	3			10

1=Older Adults, 2=Adults with Physical Disabilities, 3=MR/DD, 4=TBI, 5=Children with Special Needs, 6=HIV/AIDS, 7=Mental Health, 8=Other

* DE: Mental Health services are managed care. SEP conducts nursing home PAS and determination of functional eligibility for HCBS applicants only

* MA: Determination of financial eligibility is for state funded services only

* NJ: Nursing home preadmission screening and determination of functional eligibility conducted by AAA (SEP) for state funded services and SAFOs for Medicaid state plan and HCBS

* IL: SEP determines financial eligibility for HCBS only

* IN: financial eligibility determination for OAA, SSBG, and state funds only

Appendix D. SEP Functions Performed by Split Single Entry Systems

State	Population	Information and referral			Screening	Nursing facility preadmission screening	ICF-MR	Complete Assessment	Determine financial eligibility	Determine functional eligibility	Develop care plan	Authorize services	Monitor service delivery	Complete reassessment	Number of functions
		Web based	By telephone	Written materials											
Arizona*	1,2,3,4,5,6,7	SAFO	SAFO	SAFO	SAFO	SAFO	SAFO	SAFO	SAFO	SAFO	MCO	MCO	MCO	SAFO	13
Connecticut	1		SAFO	SAFO	SAFO	SAFO		CBN	SAFO	SAFO	CBN	CBN	CBN	CBN	11
Georgia	1,2		AAA	AAA	AAA			CBN	AAA	AAA	CBN	CBN	CBN	CBN	10
Maine	1,2,4		FPC	FPC	FPC	FPC		FPC		FPC	FPC	CBN	CBN	CBN	10
Michigan	3,7		MCO	MCO	MCO			MCO	SAFO	MCO	MCO	MCO	MCO	MCO	10
Washington*	1,2	SAFO	SAFO	SAFO	SAFO	SAFO	SAFO	SAFO	SAFO	SAFO	SAFO	SAFO/AAA	AAA	AAA	13
Wisconsin*	1,2,3,4		County	County	County	County	County	CMO		County	CMO	CMO	CMO	CMO	11

1=Older Adults, 2=Adults with Physical Disabilities, 3=MR/DD, 4=TBI, 5=Children with Special Needs, 6=HIV/AIDS, 7=Mental Health, 8=Other

SAFO = State Agency Field Offices, MCO = Managed Care Organization, CBN = Community Based Nonprofits, FPC = For-profit Companies, AAA = Area Agency on Aging, CMO = Care Management Organizations

*AZ: MCOs develop care plans, authorize services, and monitor service delivery for all populations except DD, which is conducted by the State Department of Economic Security

*WA: AAAs provide services for in-home clients only. Clients in assisted living and other residential facilities receive all services from SAFO. The initial authorization is done by SAFO and reauthorization by AAAs

* WI: CMOs are currently mostly county departments and only operate in the Family Care demonstration sites. PAS is WI is "long-term care options counseling." County does not determine functional eligibility for nursing facility placement

Appendix E. Preadmission Screening*

State	HCBS Applicants Only	Nursing Facility and HCBS Applicants	Recipients of Preadmission Screening							
			Beneficiaries		Potential Beneficiaries			Private Pay		
			Mandatory	Voluntary	Mandatory	Voluntary	No	Mandatory	Voluntary	No
Arizona		x	x			x			x	
California*										
Colorado		x	x		x					x
Connecticut (1)		x	x		x					x
Delaware	x		x		x					x
Illinois		x	x		x			x		
Indiana		x	x		x				x	
Kansas (2,4)		x	x		x			x		
Kansas (3,5)		x	x		x			x		
Kansas (1)		x	x		x			x		
Kansas (7)		x	x		x			x		
Maine		x	x		x			x		
Massachusetts		x	x		x					x
Minnesota	x	x	x		x			x		
Nebraska	x		x		x					x
New Hampshire		x	x			x			x	
New Jersey*	x		x		x					x
Oregon		x	x		x				x	
Pennsylvania (1)	x		x			x			x	
Pennsylvania (3)		x	x			x			x	
South Carolina		x	x				x			x
South Dakota		x	x		x			x		
Washington(1,2)*		x	x		x					x
Wisconsin*		x		x		x			x	
Total	5	19	22	1	17	5	1	8	7	8

1=Older Adults, 2=Adults with Physical Disabilities, 3=MR/DD, 4=TBI, 5=Children with Special Needs, 6=HIV/AIDS, 7=Mental Health, 8=Other

* Preadmission screening does not include PAS for ICF/MR
* CA: did not respond to these questions
* CO: Nursing facility beginning 7/1/03, long-term home health only
* KS: adult day care only, not day health
* NJ: PAS for state funded HCBS only
* WA: day health only, not adult day care
* WI: PAS in WI is "long-term care options counseling". County does not determine functional eligibility for fee-for-service nursing facility placement

Appendix F. Sources of Funding for Services Accessed through SEPs by Population

State	Medicaid state plan	Medicaid HCBS	State general revenue	SSBG	Older Americans Act	County	Others
Arizona	1,2,3,4,5,6,7	1,2,3,4,5,6,7	1,2,3,4,5,6,7				
California	3	3	3	3			
Colorado	1,2,4,6	1,2,4,6	1,2,4,6				
Colorado*		3	3			3	Private Foundations Fed IDEA Part and Title IV E Child Welfare, 3
Connecticut		2,3,4,7	3				
Connecticut	1	1	1				
Delaware		1,2,3,4,6	1,2	1,2	1		
District of Columbia	3	3					
Florida		3	3	3			
Georgia		1,2	1,2	1,2	1	1,2	
Georgia		3	3	3			
Hawaii		3	3				
Illinois	1	1	1		1		
Indiana		1,2,4	1,2,4	1,2,4	1		
Kansas*	1	1	1		1	1	
Kansas*	2,4	2,4					
Kansas*	3,5	3,5	3,5	3,5		3,5	
Kansas*	7	7	7				
Maine	1,2,4	1,2,4	1,2,4				
Maryland		1,2					
Massachusetts		1	1		1		
Minnesota	1,2,3,4,5,6,7	1,2,3,4,5,6,7	1,2,3,4,5,6,7	1,2,3,4,5,6,7		1,2,3,4,5,6,7	1,2,3,4,5,6,7
Missouri			7				
Michigan	3,7	3,7	3,7			3,7	
Montana		1,2,4,5,6					1,2,4,5,6
Nebraska		1,2,3,4,5,6					
New Hampshire	1,2	1,2	1,2	1,2	1	1,2	
New Jersey	1,2	1,2	1,2	1,2	1		
North Carolina	3,4	3	3,4	3,4			
North Dakota	3	3	3				
Ohio	1,2,5	1,2,5					
Ohio	3	3	3	3		3	
Oregon	1,2	1,2	1,2		1		
Pennsylvania	3	3				3	
Pennsylvania		2,4,8	2,4,8				
Pennsylvania		1	1	1	1		Lottery and Tobacco funds 1
South Carolina	1,2	1,2					
South Dakota	1,2	1	1,2	1,2	1		
Tennessee		1,2	1,2		1		
Vermont*	3	3	3	3			
Washington*	1,2	1,2	1,2		1		
Washington*	3	3	3				
Wisconsin		1,2,3	1,2,3				
Total	26	42	35	15	13	9	4

1=Older Adults, 2=Adults with Physical Disabilities, 3=MR/DD, 4=TBI, 5=Children with Special Needs, 6=HIV/AIDS, 7=Mental Health, 8=Other

*CO: County taxes are accessed through some of the SEP contractors

*KS: HCBS/Frail elderly managed by Kansas Department of Aging. Medicaid State Plan funds are targeted case management providers

*VT: Medicaid state plan funding for DD services only

Appendix G. Type of State Plan Services Authorized by SEPs

State	Nursing Facility	ICF-MR	Home health services	Private duty nursing	Personal Care	Adult day care/day health	Other
Arizona	x	x	x	x	x	x	
California*							
Colorado	x		x				
Connecticut (1)			x				
District of Columbia		x					
Illinois	x						
Kansas (2,4)	x	x			x	x	
Kansas (3,5)	x	x		x	x	x	
Kansas (1)							targeted case management
Kansas (7)	x	x			x	x	
Maine	x		x	x	x		
Michigan		x					
Minnesota	x	x	x		x		
New Hampshire			x			x	transportation and OP/PT/ST
New Jersey*			x	x	x	x	
North Carolina							case management
North Dakota (3)		x					
Ohio (1,2,5)	x		x	x	x		
Ohio (3)		x	x	x			OT/PT/ST
Oregon	x				x		
Pennsylvania (3)	x	x					
South Carolina	x						
South Dakota					x		transportation
Vermont		x					
Washington (3)	x	x	x	x	x	x	
Washington (1,2)*	x	x	x	x	x	x	
Total	14	13	11	8	12	8	5

1=Older Adults, 2=Adults with Physical Disabilities, 3=MR/DD, 4=TBI, 5=Children with Special Needs, 6=HIV/AIDS, 7=Mental Health, 8=Other

* CA: did not respond to these questions
* CO: home health services includes long-term home health only. Nursing facility services will be including beginning 7/1/03
* KS: adult day care only, not day health
* NJ: PAS for state funded hcbs only
* WA: day health only, not adult day care