



Medicaid Assessments for Long-Term Supports and Services (LTSS)

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Introduction

Long-term care needs assessments serve a vital role in Medicaid.¹ For individuals with disabilities and older adults, needs assessments are used to determine eligibility for both institutional and home and community-based services (HCBS). The assessment process establishes the type and extent of an individual's care needs, which inform the person-centered care planning process. Assessments also play important roles in rate setting, data reporting, and measuring quality of care.

States have significant latitude to establish the threshold needs-based criteria that determine eligibility for HCBS programs and waivers, for various types of institutional care, and for individual state plan HCBS, like personal care services. States also have flexibility to develop the instrument(s) used to collect functional needs data, the calculations that translate assessment results into recommendations for an individual's service needs, and the rules and protocols governing who conducts and administers assessments.² Consequently, state needs assessments vary considerably in structure, process, and outcomes. Despite this wide variation, trends have emerged across a number of assessment tools that reflect consensus "best practices" to promote reliability, validity, person-centered choice, transparency, and freedom from conflict-of-interest.

This paper reviews some federal assessment requirements and highlights select states with innovative comprehensive assessment tools.³ It also identifies potential potholes in

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² CMS reviews and approves a state's chosen criteria for different institutional and HCBS level of care (LOC) thresholds through the waiver and/or state plan amendment approval process. See, e.g., 42 C.F.R. § 441.715(a) for § 1915(i) state plan HCBS.

³ I greatly appreciate the various advocates who took time to consult with me and provided detailed accounts of the strengths and weaknesses of their state's assessment process. Not all

the application of assessment tools. Subsequent papers will focus on legal issues raised by states' use of assessment tools and other topics related to needs assessment.

Background: The Basics of Medicaid Needs Assessment

Needs assessment for Medicaid long-term care can be a single or multi-step process. Certain HCBS offered directly through the state plan, like personal care services, may be accessed through a single assessment to determine a beneficiary's need for that service. Eligibility for institutional care or HCBS programs and waivers requires at least two steps: a threshold assessment to establish eligibility and a more comprehensive secondary evaluation.⁴ The threshold assessment determines "functional eligibility" – whether the individual's support needs meet or surpass the state's Level of Care (LOC) criteria for a given institutional setting or HCBS program. The secondary comprehensive evaluation identifies the type and intensity of services and supports an individual needs and informs care planning. Some states use distinct screening tools for each part while others embed the functional eligibility screen in a longer, comprehensive assessment.⁵ Each approach has different benefits and raises different kinds of concerns.

Institutional Level of Care Assessment

States set needs-based functional eligibility criteria for individuals to qualify for Medicaid long-term coverage in HCBS programs and in various institutional settings, including hospitals, nursing facilities (NF), and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). This step is meant to determine the individual's health status and level of needs, not the amount, duration, and scope of services required. Beneficiaries must satisfy the relevant LOC criteria, in addition to meeting applicable financial and other categorical requirements for Medicaid eligibility, to qualify for coverage of these services. Most HCBS programs, including 1915(c) HCBS waivers and the 1915(k) Community First Choice state plan option, require an institutional LOC determination as a condition of eligibility.⁶ A few HCBS programs, such as the 1915(i) state plan option, require functional eligibility criteria that are less strict than an institutional LOC.⁷

the information could be included in this paper, but much will likely be incorporated in our future work on this topic.

⁴ Some states include additional "prescreening" steps. For example, as part of the functional eligibility assessment, Pennsylvania applicants must obtain a physician's certification that they have a long-term institutional care need. This extra step can create an eligibility barrier, especially because many physicians do not clearly understand how the different levels of care relate to Medicaid eligibility in Pennsylvania, nor the role the form plays in initiating the eligibility process.

⁵ Oregon, for example uses a combined tool. It reorganized its care tool to put questions related to functional eligibility first. This saves time in cases where it becomes clear that the individual's support needs will not satisfy the functional eligibility requirements. C. Shirk, HILLTOP INST., *Comprehensive Assessments in Home and Community-Based Services* 13 (2009), <http://www.hilltopinstitute.org/publications/ComprehensiveAssessmentInHomeAndCommunity-BasedServices-July2009.pdf>.

⁶ 42 C.F.R. § 441.301(b)(1)(iii); 42 C.F.R § 441.510.

⁷ 42 C.F.R. § 441.715(b).

The criteria used for determining functional eligibility typically include some combination of clinical needs, functional limitations, cognitive function, mental health, and behavioral issues. Almost all LOC assessments include some evaluation of the extent to which the individual requires assistance to complete various Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). ADLs are functions related to movement and care of the body, such as walking, eating, toileting, and bathing. IADLs are usually related to the everyday activities required for independent living, such as cooking meals, managing finances, cleaning, and shopping. In addition, an LOC screen may collect clinical data, such as diagnosed conditions or medications used, as well as information on cognitive function, mental health, and behavioral issues. Some states also take into account risk of institutionalization.

In setting their LOC criteria for HCBS and various institutional settings, states place different weight on the elements that make up the evaluation screens.⁸ For example, Pennsylvania's Level of Care Assessment screen focuses primarily on clinical factors, collecting information on an individual's diagnoses, clinical care needs, and medications and some data on ADL, IADLs, and fall risk.⁹ Pennsylvania also requires individuals to obtain a physician's signature attesting to their need for long-term NF care as part of the determination process. The state is piloting an algorithm that will automatically translate the data from the assessment into an LOC determination, but for now the assessor uses her judgment to determine if an individual is eligible for nursing home LOC.

Tennessee's Pre-Admission Evaluation for nursing facility care emphasizes ADLs and behavioral issues with only a few items related to clinical care needs.¹⁰ Tennessee's evaluation scores the intensity of need for various ADLs using a numerical scale and creates an overall "acuity score." Note that Tennessee's scale focuses on physical functioning (though some common ADLs, like bathing, are not measured at all.) Only 8 possible points relate even indirectly to mental health or cognitive well-being (4 for orientation, 3 for behavior, and one for communication). Advocates also point out that the screen scores "0" for individuals who require cueing to assist with certain behaviors like eating or taking medications, which can lead to a relatively strict interpretation of

⁸ Leslie Hendrickson & Gary Kyzr-Sheeley, RUTGERS CTR. FOR STATE HEALTH POLICY, *Determining Medicaid Nursing Home Eligibility: A Survey of State Level of Care Assessment* (Mar. 2008), <http://www.cshp.rutgers.edu/Downloads/7720.pdf>; see also Robert Mollica & Susan Reinhard, RUTGERS CTR. FOR STATE HEALTH POLICY, *Establishing "Nursing Home Level of Care:" How States Vary* (Oct. 2005), <http://www.cshp.rutgers.edu/Downloads/5910.pdf>.

⁹ Pennsylvania's Level of Care Assessment is used for older adults and individuals with physical disabilities, but not individuals with intellectual or developmental disabilities. Llasa Ray *et al.*, UCLA BORUN CTR., *Memorandum Comparing Four States' Comprehensive Assessment Systems*, 14 (May 9, 2013).

¹⁰ TennCare, *CHOICES Pre-Admission Evaluation (PAE)* (Updated 6/2014), <https://www.tn.gov/tenncare/forms/PAEFormActive.pdf>. Tennessee's CHOICES program covers the range of LTSS from nursing facilities to HCBS.

LOC need. An individual must score 9 out of a possible 21 overall points to establish an inpatient care need for a NF LOC (see chart).¹¹

TennCare Level of Care Acuity Scale¹²

Functional Measure	Condition	Always	Usually	Usually Not	Never	Maximum Individual Acuity Score	Max. Acuity Score for the Measure(s)
Transfer	Highest value of two measures	0	1	3	4	4	4
Mobility		0	1	2	3	3	
Eating		0	1	3	4	4	4
Toileting	Highest value of three questions for the toileting measure	0	0	1	2	2	3
Incontinence care		0	1	2	3	3	
Catheter/ostomy care		0	1	2	3	3	
Orientation		0	1	3	4	4	4
Expressive communication	Highest value of two questions for the communication measure	0	0	0	1	1	1
Receptive communication		0	0	0	1	1	
Self-administration of medication	First question only; excludes SS insulin	0	0	1	2	2	2
Behavior		3	2	1	0	3	3
Maximum possible AOL (or related) Total Acuity Score							21

Some states eschew a weighted scale like Tennessee and instead establish various pathways to reach an LOC threshold. For example, Minnesota has five pathways to a NF LOC, including:

- a need for assistance with 4 or more ADLs;
- a need for assistance that cannot be scheduled for toileting, transferring, or positioning;
- an ongoing condition that requires daily clinical monitoring;
- a cognitive impairment stemming from significant difficulties with memory, using information, daily decision-making, or behavioral needs that require at least occasional intervention; or
- a risk of institutionalization for individuals living alone including, among other factors, a recent fall that resulted in a fracture.¹³

¹¹ Individuals may also qualify for NF care or HCBS with a lower score if they demonstrate a safety risk. Bureau of TennCare Div. LTSS, *TennCare Long Term Services and Supports: A Guide to Pre Admission Evaluation Applications* 8 (2014).

¹² *Id.* at Attachment 8.

This last pathway is particularly important for HCBS functional eligibility as it allows individuals to qualify for HCBS to delay or prevent likely institutionalization even if they may not satisfy the other needs-based criteria. Tennessee's LOC assessment also expressly includes a pathway to HCBS for individuals at risk of institutionalization.¹⁴

Comprehensive Needs Assessment

The second part of a long-term care needs assessment involves a longer and more comprehensive assessment to determine the type and intensity of support the individual requires. The results from this assessment are critical to the person-centered care planning process. In many states, the comprehensive assessment looks slightly different based on whether the beneficiary resides in an institutional setting or receives care in the community.

Beneficiaries residing in institutional Medicaid settings must receive a comprehensive, periodic needs assessment after admission and at least once a year to help establish the resident's service needs.¹⁵ The Centers for Medicare & Medicaid Services' (CMS) standardized assessment tool for nursing facility care is the Resident Assessment Instrument (RAI). The RAI collects the Minimum Data Set (MDS), which establishes a core set of screening elements, including physical, medical, behavioral, and cognitive function, required for a comprehensive resident assessment.¹⁶ States can designate the CMS RAI as their evaluation tool for residents of nursing facilities, or they may use a CMS-approved alternative assessment tool so long as the alternative covers all the MDS and follows its utilization guidelines.¹⁷ Originally intended as a tool to promote better care planning, MDS's applications have expanded over time to also inform rate setting, quality control, and other facets of care.

In Medicare, CMS has put significant resources into designing and testing a new standardized assessment tool, called the Continuity Assessment Record and Evaluation (CARE) element set. It aims to deliver consistent and reliable assessment results across acute and post-acute care settings.¹⁸ Each CARE element is a specific question or test, such as asking an individual to rate their pain on a scale or to recall three words to measure memory. The CARE tool incorporates, updates, and standardizes the best and most thoroughly vetted elements from three other federal needs assessment tools: the MDS for nursing facilities, the Outcome and Assessment Information Set (OASIS)

¹³ *Modification of Nursing Facility Level of Care (NF LOC) Criteria*, Minn. Dept. Human Servs., http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_147891 (last visited Mar. 25, 2015).

¹⁴ Bureau of TennCare Div. LTSS, *supra* note 11, at 9.

¹⁵ 42 C.F.R. § 483.20(b)(2).

¹⁶ The detailed instruction manual for CMS's RAI is posted online. *MDS 3.0 RAI Manual*, CMS, <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html> (last visited Mar. 16, 2015).

¹⁷ 42 C.F.R. § 483.315.

¹⁸ *CARE Item Set and B-CARE*, CMS, <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/CARE-Item-Set-and-B-CARE.html> (last visited Mar. 19, 2015).

for home health agencies, and the Inpatient Rehab Facility Personal Assessment Instrument. CARE aims to improve data exchange and comparability of outcomes across post-acute institutional care settings by standardizing how the data is collected. Its focus is mainly clinical, but these efforts to standardize assessment of health, functional status, cognitive well-being, and social support in Medicare are also being adapted to apply in other long-term care settings, such as Medicaid HCBS.¹⁹

HCBS assessments grew out of the institutional assessment context. CMS's RAI serves as a model for standardization, but its institutional focus is not suitable to collect all the data necessary for comprehensive HCBS assessment. For example, it does not require states to assess an individual's potential care options in different community-based settings (aside from asking if the individual wants to leave the nursing facility) or evaluate the well-being, capabilities, and availability of informal caregivers.²⁰ To successfully develop an individualized care plan for individuals with disabilities and older adults living in the community, comprehensive assessments should collect such additional data.

As HCBS programs have proliferated to cover different populations with different service needs, HCBS comprehensive assessment tools have multiplied. Some tools are only appropriate for certain populations and should not be applied across programs. Some states use different assessment tools for each HCBS program. This can lead to redundant assessments and frequently puts case managers or intake staff in the role of predetermining the most appropriate program for an HCBS applicant.

States have recently been favoring approaches, with encouragement from CMS, that streamline assessment through the use of more uniform, automated, and comprehensive tools that apply across programs and populations. A number of organizations have developed standardized comprehensive assessments. InterRAI, an international consortium of researchers who design functional assessments for a variety of care settings, has adapted the MDS to address individuals receiving HCBS in the community. MDS-Home Care was originally launched in 1994 and most recently updated in 2007.²¹ MDS-Home Care forms the basis for HCBS functional assessments in Michigan, Oregon, and New Jersey, among other states. InterRAI has also developed a modular assessment tool, the Community Health Assessment, which New York selected and adapted for its recent HCBS assessment process redesign.²² The modular format includes trigger questions that lead to additional queries in certain areas, such as

¹⁹ States funded to test CARE elements in their Medicaid HCBS are: AZ, CT, GA, KY, LA, and MN. *Testing Experience and Functional Tools*, CMS, <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/grant-programs/teft-program.html> (last visited Apr. 1, 2015.)

²⁰ CMS, *Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0*, §§ E & Q (Oct. 2014).

²¹ *Home Care (HC)*, <http://www.interrai.org/home-care.html> (last visited Mar. 24, 2015).

²² Penny Black & Kathy Leitch, C.E. Reed & Assoc., *Analysis of State Approaches to Implementing Standardized Assessments* 13 (Apr. 2012), <http://www.thescanfoundation.org/ce-reed-and-associates-analysis-state-approaches-implementing-standardized-assessments>. For more on the InterRAI's CHA, see *Community Health Assessment (CHA)*, <http://www.interrai.org/community-health.html> (last visited Mar. 24, 2015).

mental health, if they are relevant to the individual's condition. This is intended to tailor the assessment to map each individual's needs without making it unnecessarily long.²³

The Supports Intensity Scale (SIS), developed by the non-profit American Association on Intellectual and Developmental Disabilities (AAIDD), is another widely used assessment tool for adults 16 and older with intellectual or developmental disabilities.²⁴ Over 20 states and a number of other countries use SIS to assess these populations.²⁵ A version of the SIS applicable to children is also in development. Like many other functional assessments, the SIS includes a scale to gauge the severity of an individual's need for support in each subpart of the assessment. The scoring is meant to determine the severity of particular needs, but cumulative scores have been used for other purposes, such as establishing functional eligibility, informing resource allocation, or prioritizing placement on an HCBS waiting list.²⁶

CMS has thus far avoided an overly prescriptive role in assessment design for Medicaid HCBS. Instead, CMS has compiled research and proffered funding that encourages states to apply some of the best practices from Medicare and leading states. One such initiative, the Testing Experience and Functional Tools (TEFT) Initiative has funded nine states up to \$500,000 to test specific elements from the CARE item set in community based settings, evaluate a beneficiary experience survey, and demonstrate new electronic records that incorporate LTSS.²⁷ Three relatively new optional Medicaid programs, the Balancing Incentive Program, the amended 1915(i) state plan HCBS benefit, and the 1915(k) Community First Choice program, require states to implement some of these "best practices" for LTSS comprehensive needs assessment. To date they represent the most detailed federal Medicaid blueprints for how states should structure their assessment tools.

Features of a Good HCBS Functional Assessment Tool

A number of recent reviews have highlighted common trends rising out of states' use of comprehensive assessments.²⁸ Though every assessment tool has strengths and

²³ The modular format can help tailor assessments to individual needs, but the trigger questions must be sensitive enough to capture all the individuals who might merit the additional probing in a given area.

²⁴ *Supports Intensity Scale*, <http://aaidd.org/sis> (last visited Mar. 24, 2015).

²⁵ *States/Provinces Using SIS in North America*, <http://aaidd.org/sis/sisonline/states-using-sis> (last visited Mar. 24, 2015.)

²⁶ Six states (CO, GA, OR, LA, NC, & WA) currently use the SIS for individual budget allocation. Several more, including NM, are in process. *SIS and Funding Models*, <http://aaidd.org/sis/product-information/funding-models> (last visited Apr. 2, 2015). Virginia has used the tool to prioritize its waiting lists.

²⁷ The nine states are: AZ, CO, CT, GA, KY, LA, MD, MN, and NH. *Testing Experience and Functional Tools (TEFT)*, *supra* note 19.

²⁸ C. Shirk, *supra* note 5; Karissa Hughes, SOUTHERN AREA CONSORTIUM OF HUMAN SERVS., *SACHS Research Summary: IHSS Functional Index and Alternative Assessment Tools* (2010), <http://theacademy.sdsu.edu/programs/SACHS/literature/SACHS-IHSS%20and%20Alternative%20Assessments%20May%202010.pdf>; Penny Black & Kathy

weaknesses, Washington's Comprehensive Assessment Reporting Evaluation (WA-CARE) and Minnesota's MNChoices tools are among the commonly cited examples of best practices for standardized assessments, though they also have weaknesses.²⁹ Both serve multiple purposes, including determining functional eligibility, assessing needs across a variety of areas, and informing care planning. The WA-CARE tool, originally modeled after Oregon's functional assessment, has been in use for over a decade and is known for its broad and in-depth range of topics.³⁰ The tool has been refined through experience and litigation, especially around its role in budget allocation. For example, the tool originally automatically reduced authorized HCBS hours for individuals who lived with an informal caregiver, but several lawsuits have forced the state to adjust the tool to instead investigate each individual's unique caregiver situation and evaluate any contribution by informal caregivers on a case-by-case basis.³¹

MNChoices, launched in late 2013 and still not fully implemented, also features a rich set of topics and is one of the few comprehensive functional assessment tools that applies across all Medicaid LTSS programs and state plan services, including all populations and ages.³² Notably, the MNChoices assessment begins with a semi-structured exploratory interview to identify an individual's goals and preferences and includes other topics on housing, employment situation, and self-direction of services.³³

Below is a summary identifying some of the (mostly) positive features of standardized needs assessments:

- **Face-to-Face Interviews.** Conducting an in-person assessment inside an individual's place of residence allows the interviewer to pick up subtle visual cues, watch the individual perform functional tests, and evaluate the setting for potential safety concerns or needed modifications.

Leitch, *supra* note 22; Mission Analytics Group & Human Servs. Research Inst. (for CMS), *The Balancing Incentive Program Implementation Manual*, App. G-73 (February 2013), <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/balancing/downloads/bip-manual.pdf>.

²⁹ See, e.g., Barbara Gage et al., Long-Term Quality Alliance, *Charting a Path Forward for Uniform Assessment of LTSS Needs* (June 2012), <http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images/LTQA-Charting-A-Path-Forward-Report-Final-Report-6-10-14-.pdf>.

³⁰ Mission Analytics Group & Human Servs. Research Inst., *supra* note 28, at App. G-79.

³¹ *Jenkins v. Dep't. of Soc. & Health Servs.*, 160 Wash.2d 287, 308, 157 P.3d 388 (2007); *Samantha A. v. Dep't. of Soc. & Health Servs.*, 171 Wash.2d 623, 256 P.3d 1138 (2011); see also *Samantha A. FAQ*, Disability Rights – Washington, <http://disabilityrightswa.org/advocacy-news/samantha-faqs> (last visited Apr. 1, 2015.); see generally Washington Administrative Code § 388-106-0130 (detailing current system for allocating informal supports in CARE tool).

³² Minn. Dept. of Human Servs., *MNChoices Initiative* (2015), <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6477-ENG>.

³³ Minn. Dept. of Human Servs., *MNChoices Content*, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_180264 (last visited Mar. 25, 2015.)

- **Greater automation.** Streamlining administration through electronic assessments should reduce duplication and improve data reporting and comparability. It can also speed up eligibility determinations and care planning. Some assessments, like Arizona’s, are web-based, while others rely on assessors entering data on a laptop during or after a face-to-face evaluation.
- **A broad set of core data.** BIP’s Core Data Set, described below, exemplifies most of the key elements, including functional abilities (ADLs and IADLs), mental health and cognitive function, medical needs, behavioral concerns, background information, and economic resources. HCBS assessments should also explore social resources, strengths, goals, and preferences of the individual with regard to their care and living situation.
- **A modular structure appropriate for multiple population groups.** Uniform comprehensive assessments collect the same core data for all applicants, but have extra modules that probe deeper on topics with an identified need. Different modules may also apply (or not) for different ages or populations. Modular assessments include mechanisms that “trigger” the extra questions. The triggers must be sensitive enough to capture all or nearly all individuals who merit deeper review in a given domain.
- **Validation to ensure proper application of assessment tool.** The assessment must be adequately tested and found appropriate for all populations to which it is applied.³⁴ For example, though it is now shifting to a new uniform tool, California has applied an assessment tool for its In Home Supports Services program that was not designed to measure individual needs or eligibility and has been misapplied for certain population. For example, the tool includes IADLs, such as cooking and shopping, that are not applicable to minors. Instead of disregarding these questions, children were scored with a single point on these elements, which artificially reduced their overall score on the assessment.³⁵
- **A no wrong door entry point that encourages choice.** Standardized assessment across programs, like MNChoices, can help match individuals with the HCBS program that best suits their assessed needs. This also reduces the redundancy of performing multiple assessments on the same individual for different programs or leaving the case manager to decide what program would be most appropriate for a given client. An individual’s options should not be shaped by how they accessed Medicaid. Rather, an individual should choose the most appropriate available program *after* being assessed for all his service needs, regardless of where he started the process.³⁶

³⁴ The SIS is an example of a tool that has been “normed” to apply to different ages and populations. *Most Frequently Asked Questions about SIS*, <http://aaidd.org/sis/product-information/faqs> (last visited Apr. 3, 2015).

³⁵ Karissa Hughes, *supra* note 28, at 3.

³⁶ Another best practice is to allow an individual to remain on a waitlist for a preferred option even as he accesses the most appropriate services available at the time.

- **Evaluation of available voluntary informal supports and a caregiver assessment.** The best assessments examine the role and well-being of an individual’s family and social network, including their capability and capacity to provide care. Caregiver assessments should be complementary to, but independent from the evaluation of an individual’s assessed needs, and an assessment tool may not coerce family members to stand in for professional caregivers to satisfy an individual’s needs.³⁷ Moreover, when an individual has a guardian or personal representative, that individual should be present for the face-to-face interview.
- **Minimization of conflicts-of-interest.** The best standardized assessment tool is still subjective and can easily be compromised if the interviewer has a vested interest in a particular outcome. The 1915(i) and 1915(k) state plan HCBS regulations offer the clearest federal guidance on conducting an independent assessment.³⁸ They generally prohibit individuals who are related to the beneficiary or the caregiver, or who have a financial interest in the beneficiary’s care, from conducting assessments unless they are the only available qualified assessor. In such cases regulations prescribe measures that must be taken to minimize the conflict-of-interest.
- **Training on use of the assessment tool.** A successful tool must deliver reliable and consistent results no matter who conducts the assessment. States should have a clearly defined, ongoing program to train assessors in the proper methods for using the tool. The training regimen should include a periodic inter-reliability test to ensure that all assessors are producing consistent results.
- **Increased transparency.** The assessment process is complex and often somewhat opaque. Beneficiaries should have easy access to their complete assessment results and the methods used to calculating those scores.

The Balancing Incentive Program (BIP): Standardizing Assessments

Many of the features described above have been built into BIP, an ACA-established HCBS program that allows states to expand the use of HCBS. BIP offers qualifying states enhanced federal matching rates for HCBS (2% for most states) but requires states to institute structural LTSS system reforms that promote HCBS care in the community. Specifically, states must:

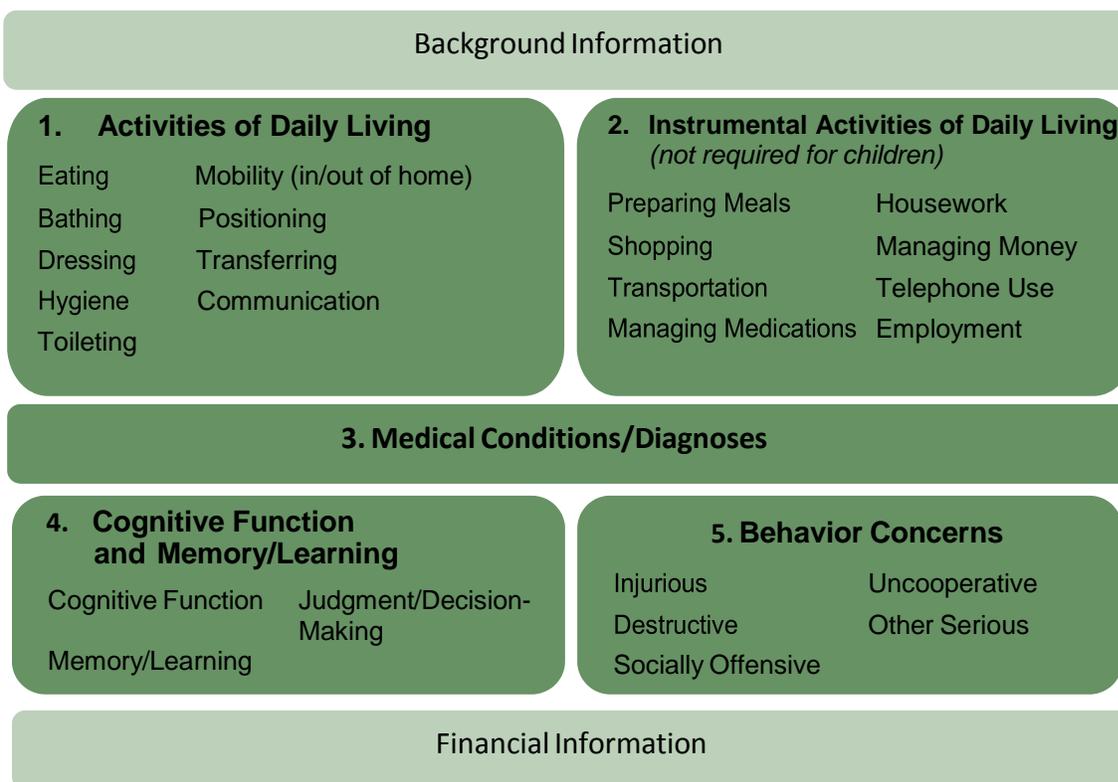
- establish a “no wrong door” system for LTSS access;
- provide conflict-free case management services; and
- create a core standardized assessment tool to determine HCBS eligibility.

³⁷ Family supports must be voluntary and may not be coerced. See 42 C.F.R. § 441.301(c)(2)(v), .540(b)(5), .725(b)(5). Decisions about informal caregivers role in providing services for an individual should be part of the care planning process.

³⁸ 42 C.F.R. § 441.730, .555(c).

The parameters for BIP’s standardized assessment reflect many of the characteristics of functional tools already in use in some leading states (e.g., Minnesota). The standardized assessment involves a two-part process with an initial screen, followed by a more comprehensive secondary evaluation of care and service needs. The assessment must collect a defined Core Data Set (CDS) across five domains for all HCBS programs and populations in the state (see chart below).³⁹ Each domain includes a set of subtopics that must be evaluated during the assessment. The data in the CDS must establish an individual’s LTSS eligibility, identify her care needs, and help inform the person-centered planning process.⁴⁰ States may elect to implement a single, standardized, state-wide assessment tool or adapt multiple existing tools. Regardless of the state’s decision, the state must ensure it collects the CDS across all HCBS programs and populations. CMS also encourages states to shift to web-based or otherwise automated data collection to help streamline administration and improve capacity to compile, analyze, and report on collected data.

BIP Core Dataset: Required Domains and Topics for a CSA⁴¹



While the BIP guidelines constitute one of the most detailed set of assessment protocols for an HCBS program, CMS still gives states wide latitude to determine the content and questions used for each subtopic, the criteria for establishing a level of care need, and

³⁹ The assessment must also collect information on individual’s background and financial status. Mission Analytics Group & Human Servs. Research Inst., *supra* note 28, at 23.

⁴⁰ *Id.* at 22.

⁴¹ *Id.* at 23.

the algorithms used to compile and weight the subtopic data. In an appendix to the BIP instruction manual, CMS provides sample questions and a crosswalk for a state to compare its current assessment tools with the required components of the CDS.⁴²

Who Administers the Assessment and How?

Even the best assessment tool is only as good as the individual who administers it. Training requirements and conflict-of-interest are the two biggest issues that surface with regard to assessors. As in other areas, states vary considerably in organizational structure and assessor qualification and training requirements. A 2009 comparison of 13 states with comprehensive assessments showed significant differences in these areas.⁴³ Maine contracted with a private vendor to conduct assessments using registered nurses. Washington used social workers employed by state regional field offices and Area Associations on Aging (AAA). Other states used managed care entities, local health departments, or case management agencies.

Even across states that use the same tool, different assessor protocols can dramatically affect the reliability of the assessment. A 2013 evaluation of Virginia's use of the SIS compared that state's training regimen against the requirements for administering the SIS in Oregon.⁴⁴ Oregon's model, considered a best practice for the SIS, deploys a small team of under ten highly-trained interviewers to conduct SIS interviews across the state. These individuals receive a three-day orientation to the tool followed by two months of practice interviews and an interviewer reliability qualifications review to show that the trainee's interviews produced evaluations consistent with other trained SIS evaluators.⁴⁵ Virginia, in contrast, required only two days of training, no explicit interview practice, and showed deficiency in the inter-reliability testing.⁴⁶ More significantly, the state used approximately 500 case managers to administer SIS interviews in a single year.⁴⁷ These interviewers were trained by Virginia state employees who had been certified to conduct orientations, but not to test assessor reliability.⁴⁸ Notably, in addition to greatly increasing the likelihood of variation due to evaluator differences, the evaluation warned that using case managers/support coordinators to assess the individuals they managed raises a potential conflict-of-interest.⁴⁹

⁴² *Id.* at 88.

⁴³ C. Shirk, *supra* note 5.

⁴⁴ Human Servs. Research Inst., *My Life, My Community! Re-designing Supports for Virginians with Intellectual and Developmental Disabilities Project Report* (Nov. 5, 2013).

⁴⁵ *Id.* at 12.

⁴⁶ *Id.*

⁴⁷ *Id.* at 13.

⁴⁸ *Id.* at 8.

⁴⁹ New regulations in 1915(i) and (k) generally prohibit agents who may have a financial interest in any entity that is paid to provide care to an individual from conducting the independent assessment, unless specific steps are taken to disclose and mitigate the conflict-of-interest. 42 C.F.R. § 441.730, .555(c). Other HCBS programs require states to set conflict-of-interest guidelines, but are not as specific about content. See, e.g., 42 C.F.R. § 441.301(c)(1)(v)-(vi) (requiring clear conflict-of-interest guidelines and protections in 1915(c) waiver programs).

Applying Assessments to Budgeting

HCBS assessment tools are generally designed to evaluate the scope of an individual's service needs to support care planning. Over time, states have expanded this purpose so assessments now inform Medicaid budgeting, rate-setting, and even prioritizing individuals on HCBS waiting lists. For example, AAIDD has posted several briefs outlining how to use the SIS for service allocation.⁵⁰

Other functional assessments are also closely tied to budget allocation. States may establish multiple LOC levels within an institutional category to differentiate individuals who require additional services (and different payment rates). For example, New Mexico distinguishes a "low" and "high" NF LOC based on an individual's anticipated needs, and pays more for beneficiaries with higher needs.⁵¹ Maine and Texas both include task and time guidelines as part of the assessment that closely relate to the allocation of service hours in the subsequent development of an individual care plan.⁵² Washington's CARE assessment includes an algorithm that links each assessed individual to 17 different levels, and these are used to set maximum payment rates for the beneficiary.⁵³

While assessments necessarily play a role in deciding the scope of an individual's services, the identification of needs is only part of the picture in terms of resource allocation. Other factors, including an individual's goals and priorities and the availability of voluntary and capable informal supports also factor into the person-centered plan. No budget determination should solely rely on the results from a functional assessment.⁵⁴

One key issue that often crops up in budgeting is the role of informal supports, such as family members, in meeting assessed HCBS needs. Experts agree that evaluation of available and capable informal, also known as natural, supports should be part of any functional assessment. But these supports should not be compelled by a state or

⁵⁰ AAIDD, *Resource Allocation and the Supports Intensity Scale: Four Papers on Issues and Approaches* (Robert L. Schalock, James R. Thompson & Marc J. Tasse eds., June 2008). <http://aaidd.org/docs/default-source/sis-docs/siswpresourceallocation.pdf?sfvrsn=0> (explaining how the SIS is used in several states and setting forth recommendations about how to use the SIS for resource allocation).

⁵¹ New Mex. Human Servs. Dept., *New Mexico Medicaid Nursing Facility (NF) Level of Care (LOC) Criteria and Instructions 2* (updated Nov. 1, 2014), http://www.hsd.state.nm.us/uploads/FileLinks/d87942c76e6841af970eca9b0d33e635/14_07_Nursing_Facility_Long_Term_Care_Guidelines_1.pdf.

⁵² C. Shirk, *supra* note 5, at 15; see also Tex. Dept. of Aging & Disability Servs., *Form 2060 Needs Assessment Questionnaire and Task/Hour Guide* (Jun. 2012), <http://www.dads.state.tx.us/forms/2060/>.

⁵³ Individuals who feel they require more services can they may request review from an Exceptions to the Rule committee, but only 2-3% of the beneficiary population has been granted such requests. Concerns remain that the tool may not allocate enough hours to meet all the beneficiaries' actual needs and that cuts to hours are budget driven and not sufficiently need-based. Llasa Ray et al., *supra* note 9, at 23.

⁵⁴ HHS, Section 2402(a) of the Affordable Care Act – Guidance for Implementing Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs 4 (June 6, 2014), <http://www.acl.gov/Programs/CDAP/OIP/docs/2402-a-Guidance.pdf>.

managed care entity. Regulations for 1915(c), (i), and (k) HCBS programs all clearly define natural supports as “unpaid supports that are provided voluntarily to the individual in lieu of state plan HCBS.”⁵⁵ Nonetheless, this problem persists in some states. Prior to litigation, Washington automatically reduced certain beneficiaries’ allocated hours if they lived with a potential caregiver.⁵⁶

Section 1915(i) & (k) State Plan HCBS Assessments

Section 1915(i) and (k) regulations specify several process-oriented requirements for the individual assessment that are more explicit than the federal requirements in other HCBS programs. The 1915(i) state plan option was established over a decade ago as a potential alternative to HCBS waivers. One of the advantages of 1915(i) programs for promoting community integration is that the needs-based eligibility criteria must be set below the institutional LOC in the state for the targeted population. This means a state can target the 1915(i) at populations that may be at high risk of institutionalization with the intent to allow those individuals to receive the services they need to keep living in the community. Section 1915(k), also known as Community First Choice, offers states a higher federal matching rate for certain HCBS provided the state implements certain administrative reforms and consumer protections. Assessments for both programs must be independent and face-to-face. Section 1915(i) also requires that individuals have the opportunity to identify other individuals (e.g., family members, other health professionals) to provide input during the independent assessment.

Section 1915(i) and 1915(k) provisions include the most detailed conflict-of-interest protections to date for Medicaid needs assessments. In January 2014, CMS finalized 1915(i) and (k) regulations that flesh out how assessors may establish their independence.⁵⁷ For example, assessors may not:

- be related by blood or marriage to the beneficiary or the beneficiary’s paid caregiver;
- be financially responsible to the beneficiary;
- be empowered to make financial or health-related decisions on behalf of the individual; or
- have a financial interest in any entity paid to provide care for the individual.⁵⁸

HCBS providers and other employees or individuals with an interest in such a provider may only conduct independent assessments if the state establishes that they are the only qualified and willing agents in the geographic area. In such cases, CMS may require states to create a “firewall” between the assessment and service provision functions of the entity.⁵⁹ In all cases, the state must also provide a clear and accessible

⁵⁵ 42 C.F.R. § 441.725(b)(5), .540(b)(5), .301(c)(2)(v).

⁵⁶ *Supra* note 31.

⁵⁷ 42 C.F.R. § 441.730. Nearly identical regulations finalized at the same time also apply to the 1915(k) state plan HCBS program. See 42 C.F.R. § 441.535, 555(c).

⁵⁸ 42 C.F.R. § 441.730(b).

⁵⁹ U.S. Dept. of Health & Human Servs., *Medicaid Program: State Plan Home and Community-Based Services*, 79 Fed. Reg. 2993 (Jan. 16, 2014).

alternative dispute resolution process to HCBS beneficiaries when it allows a service provider to conduct assessments.⁶⁰

This conflict-of-interest protection is more explicit than federal protections in 1915(c) waivers and other services covered directly through the state plan, and it represents a step forward in federal standards protecting individuals with Medicaid. For example, 1915(c) waiver regulations only require participating states to develop “clear conflict-of-interest” guidelines for the person-centered planning process (under which the functional assessment is subsumed), but no further guidance is provided.⁶¹

The 1915(i) regulations also provide more detail on the expected content for the assessment, indicating that it must evaluate:

the individual’s physical, cognitive, and behavioral health care and support needs, strengths and preferences, available service and housing options, and if unpaid caregivers will be relied upon to implement any elements of the person-centered service plan, a caregiver assessment.⁶²

Other HCBS programs, like 1915(c) waivers, do not specify this level of detail on either content or process of individual assessment, though they do include very similar requirements in the person-centered care plan.⁶³ Section 1915(c) waiver regulations call for initial evaluations to determine the necessary institutional level of care and periodic reevaluations thereafter.⁶⁴ The regulations also call for an individual assessment of functional need for the purposes of developing a person-centered plan, but the parameters for that assessment are primarily left to the state.⁶⁵

Assessments and Managed Care

Capitated managed LTSS, where a managed care organization (MCO) or similar entity receives a fixed per member, per month amount to manage all the LTSS needs for its enrollees, can complicate the assessment process. CMS guidance states that MCOs may not be involved in eligibility determinations or functional assessments prior to a beneficiary enrolling with that MCO.⁶⁶ However, once enrolled, MCOs in several states do conduct a secondary comprehensive assessment. Some states, like Texas, require all MCOs to use the state’s standardized assessment tool(s) to evaluate individuals’

⁶⁰ 42 C.F.R. §§ 441.730(b)(5), 555(c)(5).

⁶¹ 42 C.F.R. § 441.301(c)(1)(v)-(vi) (requiring conflict-of-interest protections). The person-centered service plan must reflect the needs identified through an assessment of functional needs. 42 C.F.R. § 301(c)(2).

⁶² 42 C.F.R. § 441.720.

⁶³ 42 C.F.R. § 441.301(c)(2)(ii), .535, .540(a).

⁶⁴ 42 C.F.R. § 441.302(c).

⁶⁵ 42 C.F.R. § 441.301(c)(2).

⁶⁶ CMS, *Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs* 10 (May 2013), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf>.

support needs.⁶⁷ Arizona has state employees conduct functional eligibility screens and requires Medicaid MCOs to use the state's comprehensive assessment tools, but also allows them to conduct their own additional elements if they so choose.⁶⁸ Other states, like Tennessee, allow MCOs to design and utilize their own comprehensive assessment tools, so long as those tools receive state approval and collect and transmit a core data set.⁶⁹ Allowing MCOs to conduct or design their own assessments can generate inconsistent results and raises conflict-of-interest concerns because capitated MCOs have a clear financial interest in controlling the type, intensity and frequency of services provided to enrollees.⁷⁰

Advocates can push other conflict-of-interest protections to reduce or mitigate the possible harm of conflict-of-interest for a capitated MCO, such as requiring the state to:

- Contract with a separate independent organization, such as an Aging and Disabilities Resource Center (ADRC) to conduct assessments;
- Include transparency requirements in MCO contracts for the assessment process, so the public has access to the tool and information on any scoring algorithms;
- If MCOs conduct assessments, require them to use the state's comprehensive assessment tool and ensure the contract creates a clear "firewall" that distinguishes the care planning and assessment unit from service provision and utilization review; and
- Define a clear alternative dispute resolution process, similar to the requirements in the 1915(i) regulations.⁷¹

⁶⁷ Carolyn Ingram, Alice Lind and Brianna Ensslin, Ctr. for Health Care Strategies, Inc., *Uniform Assessment Practices in Medicaid Managed Long-Term Services Supports Programs* 11 (Updated Sept. 2013), <http://www.chcs.org/resource/uniform-assessment-practices-in-medicaid-managed-long-term-services-and-supports-programs/>.

⁶⁸ *Id.*

⁶⁹ *Id.* at 11.

⁷⁰ Generally, MCO's financial incentive would be to cut a beneficiary's services to save money. However, in states where functional assessment results factor into rate setting the MCO may actually benefit from assessing an individual at higher acuity level, and thus triggering a higher pay rate. Unfortunately, in the 1915(i) context, CMS refused commenters' requests to include regulations barring MCOs from conducting independent assessments. It is unclear if the 1915(i) conflict-of-interest exception, with its requirement to establish administrative separation between assessment and service provisions, also applies to MCOs. Medicaid Program: State Plan Home and Community-Based Services, 79 Fed. Reg. 2948, 2992-3 (Jan. 16, 2014). Although CMS indicated it added § 441.301(c)(1)(vi) to address conflict-of-interest more directly and noted its importance to promote statutory objectives, it only specified the complete independence of the person(s) facilitating the planning process and providers generally. *Id.* at 3007, 3022.

⁷¹ 42 C.F.R. § 441.730(b)(5). States with managed LTSS programs must also make available an independent advocate or ombudsman to help enrollees understand their rights, navigate the system, and resolve problems between the beneficiary and the MCO. CMS, *supra* note 66, at 10.

Individual Service Caps and High HCBS Needs

HCBS waiver programs frequently include individual caps on services. Some states establish individual service caps as part of the budget neutrality component of their 1915(c) waivers. These caps affect individuals assessed with very high HCBS needs that approach or exceed the cost of institutional care. While such cases comprise a relatively small number of individuals, the restrictions on available HCBS due to the cap can make it impossible for such individuals to continue living in the community. In states that use assessments for resource allocation the caps may also factor into the budgeting algorithms, which indirectly affects many more individuals.

Generally, 1915(c) waivers must demonstrate that the waiver costs do not exceed the costs that the federal government would incur absent the waiver. Because waiver participants must meet an institutional LOC, cost-effectiveness is measured against the cost of institutional care (e.g., nursing facility or ICF). States may calculate cost neutrality in the aggregate or on a case-by-case basis.⁷² If the state chooses an aggregate calculation, it need not set an individual cap, as the excess cost of the few high needs individuals is offset by the generally large share of the HCBS population that is cheaper to care for in the community. But if the state chooses to calculate cost-neutrality on an individual level, then those individuals with more intensive service needs may trigger a “cost-effectiveness” screen. Should their assessed needs exceed the average cost of institutional care, they may not receive all the services they require to live in the community.⁷³

Arizona, for example, imposes an individual HCBS cap based on the average cost for institutional care for an individual with the same LOC needs.⁷⁴ The state does not require individuals who would exceed the cap to move into institutional care, but it limits coverage of HCBS to the cap. The policy manual suggests that any individuals with assessed needs in excess of the cap who choose to continue getting care in the community should sign a managed risk agreement to accept the risk for their well-being.⁷⁵ Practically, many providers may hesitate to serve individuals with such an agreement due to the fact that the individual is almost by definition not receiving the care she actually needs. Arizona allows exceptions for individuals who expect to only exceed institutional costs on a temporary basis, but this arrangement seems to structurally favor institutional care for high-cost individuals.

⁷² CMS, *Application for a § 1915(c) Home and Community-Based Waiver [Version 3.5]: Instructions, Technical Guide and Review Criteria 78* (January 2008).

⁷³ It may not always be clear how the state calculates the average cost of institutional care or whether that calculation reflects the projected cost of institutionalization for that particular individual.

⁷⁴ The cost-effectiveness study must include the projected added cost of any specialized care, such as extensive respiratory care, that individual might require in an institution. See Ariz. Healthcare Cost Containment System (“AHCCCS”), *AHCCCS Medical Policy Manual*, § 1620C-7 (Updated Mar. 1, 2013).

⁷⁵ *Id.* at 1620C-8.

Advocates in states that impose individual cost limits should know that states are not required to apply individual caps for 1915(c) cost-neutrality. Nor must those limits, if applied, be set equal to the cost of institutional care. Finally, states may establish criteria for an exceptions process to accommodate individuals who exceed the cap.⁷⁶

Trends and Recommendations

Clearly, the design and use of needs assessment tools is evolving. Not only are assessments a key component for Medicaid LTSS eligibility, but they represent a key data source to inform truly person-centered planning and ensure that an individual's needs are clearly identified. States vary widely in the criteria they evaluate, the tools used to collect needs-based data, and the entities charged with conducting assessments. Despite this variety, needs assessment is clearly trending toward more standardization and automation and a more person-centered approach. This includes evaluating individuals' preferences and goals, such as their options for living situation or employment opportunities, in the assessment process.

The assessment process also strongly influences whether individual's needs are properly met, both through identifying those needs (or not) and, in many cases, setting guidelines for subsequent service allocations. As states continue to shift toward standardized, comprehensive assessments, advocates should push states to:

- Develop a truly independent assessment process that minimizes conflicts-of-interest;
- Make sure tools are applied only to populations for whom they are intended and that they cover the full range of topics that comprise a comprehensive needs assessment;
- Ensure that assessors are well-trained and regularly tested for inter-reliability;
- Require transparency of assessment scores and an evidence-based justification for time & task guidelines or other algorithms used to translate assessed needs into recommended service allocations; and
- Develop consumer protections to prevent the state or other entities from coercing family caregivers and other informal supports into providing unpaid care.

⁷⁶ CMS, *supra* note 72, at 81.