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Analysis of State Approaches to Implementing Standardized Assessments

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EXECUTIVE SUMMARY

States have long had processes in place to determine programmatic eligibility for state and federally-funded long-term services and supports (LTSS). These processes vary from state to state and included manual as well as automated assessments. A standardized automated assessment is a tool that is available on a computer (e.g., laptop or tablet) that is used to collect and document client information in a uniform and consistent manner during a face-to-face interview. Unlike the Medicare/Medicaid nursing facility program, which mandates the use of the same automated assessment for all residents, no such requirement exists for Medicaid-funded or other state-funded home and community-based services (HCBS) programs. Each state designed its own assessment system and in many cases states developed separate assessment tools for each program option available.

Recognizing the inefficiency of having multiple assessments, many states revised their assessment processes and designed, or are in the process of designing, automated standardized assessment tools that are used for multiple populations and programs. These standardized automated assessment tools are designed to be more person-centered by evaluating individual need and using that information to develop a care plan to address the individual's strengths, deficits, and preferences. States have recognized that standardized automated assessments also allow for more equitable resource allocation and the collection of standardized data for use in program planning, budgeting, quality monitoring, reporting and rate setting.

This paper examines the evolution of assessment for LTSS and how the new requirements from the Affordable Care Act (ACA) impact assessment systems. In addition, the paper highlights the main issues addressed by four states (Washington, Minnesota, Arkansas, and New York) that have either developed and implemented or are in the process of developing and implementing new automated standardized assessments. The thematic summary and in-depth case studies provide information about the extent and type of stakeholder engagement, as well as considerations for states interested in pursuing standardized assessment.

Many states are in the process of developing Medicaid managed/integrated service delivery systems for the provision of both medical services and LTSS. States that are pursuing managed/integrated service delivery systems should require health plans to implement a standardized automated assessment that collects common data elements (both clinical and functional) that address consumer protections, develop risk adjustment methods and rate setting for managed care plans, manage expenditures and measure services and support quality outcomes. If a state does not require a uniform standardized automated assessment for the managed/integrated plans, it will need to prescribe and define the data elements all plans need to collect and the format and frequency for reporting to the state.

A standardized automated assessment system can also provide information to state/local management entities that compares acuity of consumers served by different plans and identifies the range of LTSS provided by each plan. The data collected in an automated assessment system can be helpful in establishing or revising rates based on acuity or setting. Standardized assessments can be used to transition institutionalized populations to community settings and make referrals to programs for effective chronic care management. The assessment information collected can be used for quality monitoring and improvement.

Addressing data needs from these integrated programs allows the state to have more comprehensive and standardized information for all contracted plans.

Issues states should consider when developing and implementing a standardized automated assessment system are detailed in this policy brief starting on page 16. They take into account the significant budget challenges states face.

To expedite the process, states should define the scope of the automated assessment project, which populations and programs it will cover; review existing national or state automated tools available that can be modified to address a state's specific needs rather than designing from the ground up; and assure that the state uses automation to its maximum benefit by creating a system that determines consumer eligibility for LTSS and authorizes home care hours, residential rates and/or individual budgets. States should create a stakeholder process that includes consumers and users of the system to assure the system will meet consumer and assessor needs. Stakeholders and end users should be involved in testing the system. States should assign adequate administrative staff and/or contractor resources to select a tool, staff the stakeholder process, and communicate the progress to stakeholders. Furthermore, states will need to review policies that are critical to the development of algorithms based on assessment data to support care planning and hours authorization/individual budgets. Finally, states will need dedicated staff to support the development of reports the system needs to generate, develop the request for proposal process when vendors will be used, test the system, and provide appropriate training and a well-thought out rollout schedule to implement the system.

Background: Standardized Automated Assessment

A standardized automated assessment is a tool that is available on a computer (e.g., laptop or tablet) that is used to collect and document client information in a uniform and consistent manner during a face-to-face interview. An automated system takes advantage of the power of technology to integrate eligibility, assessment findings, authorized hours (where applicable), and the care plan. When the assessment is completed, the information can be uploaded into a central consolidated database. The central database serves as a central depository for all client and assessment data. This data can be used to produce standard reports; respond to customized queries; and used to monitor quality and outcomes of care.

Automated standardized assessments serve a variety of purposes including: 1) the ability to create individualized, person centered assessment which helps inform care planning; 2) provide information to providers for the delivery of services and supports, allowing them to compare the acuity of the populations they serve and the types of supports they need; 3) provide data for planning/resource allocation at the local and state level; 4) create reports from the system that can assist state agencies as well as legislators understand the needs of the populations served and how their needs vary across programs; and 5) provide the data and reports that are necessary to comply with federal quality assurance requirements. The automated standardized assessments can also be used for refining case mix adjustment methodologies where applicable.

An automated assessment system will:

- Create detailed, compatible data across programs for the purpose of program and budget development;
- Create budget accountability by ensuring that eligibility is correctly and consistently determined;
- Improve inter-rater reliability[*] and promote accurate assessments and service plans;
- Allow for the creation of tools within the assessment to help assessors complete their assessments, such as policy manuals, cognitive functional assessments (e.g., mini-mental status exam, etc.), and other clinical and functional scales;
- Create management reports to aid in managing the programs and staff;
- Manage client liability related to potential lawsuits and protect vulnerable adults by assessing/identifying risk indicators; and
- Automatically determine client eligibility through the creation of mathematical algorithms that run based on the data entered into the assessment.

The Minimum Data Set and Development of the Standardized Automated Assessment

The Federal Nursing Home Reform Act, part of the Omnibus Budget Reconciliation Act of 1987 (OBRA ’87) created a set of national minimum standards for care and rights for people living in

[*] Inter-rater reliability refers to the capacity of the assessment to produce the same results by different assessors for the same client. A well-designed assessment will ensure accuracy and consistency across case managers, providers, geography, and time.

certified nursing facilities. This landmark federal legislation brought precedent setting changes to nursing facility care and included:

- Emphasis on quality of life as well as quality of care;
- New expectations that resident's abilities will be maintained;
- The requirement of a resident assessment process that would lead to an individualized plan of care; and
- Identification of resident's rights to remain in a nursing facility, maintain personal funds, return to a nursing facility after a hospitalization, choose a physician and access to medical records, participate in resident councils, be free of inappropriate restraints, etc.

OBRA-87 changed the way care is provided and monitored in nursing facilities and set the stage for the changes and innovations that we see today in community based long-term services and supports (LTSS).

The result of the call for a resident assessment process was the development of the Minimum Data Set (MDS). The MDS was developed to create a standardized automated assessment that is consistent and accurate. It was initially designed as a three part process: 1) evaluation of an individual based on a comprehensive assessment; 2) identification of specific needs based on information in the assessment (based on algorithms called resident assessment protocols (RAPs)); and 3) care planning based on the identification of needs. Prior to the MDS, assessments were done manually. Every state or nursing home had a different process with no consistent way to develop a plan of care from a person's assessed needs nor were states or the federal government able to use data to compare resident acuity or care across facilities. The implementation of the MDS required facilities to develop systems and submit automated assessment data to state/federal partners.

Use of the MDS for payment purposes came later in 1998 with development of the Resource Utilization Groups (RUGs), the case-mix system used to classify residents based on acuity and need. Besides being used for Medicare reimbursement, a large number of states use the RUGs methodology in their Medicaid nursing home case mix reimbursement methodology.

State Developments

As states developed home- and community-based services (HCBS) options to meet consumer LTSS needs, they developed assessments to determine programmatic eligibility for state and federal services and supports. These processes vary from state to state and can include manual as well as automated assessments. In many states, each program has its own distinct assessment. A different assessment for each program determines whether the person is eligible for a particular program rather than looking at the different options that can meet a person's needs. Multiple assessments can also be lengthy and duplicative, causing burden for the consumer as well as inefficient use of assessment staff resources.

Some states revised their assessment processes and designed, or are in the process of designing, assessment tools that are used for multiple programs and populations. A standardized automated assessment used across multiple programs and populations can promote choices for consumers, reduces administrative burdens, promotes equity, and captures standardized data.[1] A standardized

tool helps minimize different outcomes among assessors and prevents unnecessary institutionalization.[2] Standardized assessments can also be a tool for measuring and monitoring quality, serve as the basis for reimbursement, and create a more person-centered system of care. In addition, states use standardized assessments to develop individualized plans of care, set rates, and support federal and state reporting.

Several recent publications from national organizations emphasize the importance of a standardized assessment as one of the necessary features in a balanced system of LTSS. The AARP Public Policy Institute publication *A Balancing Act: State Long-Term Care Reform* of July, 2008 listed twelve components of a high performing LTSS system which included standardized assessment. The publication stated that "some states use a single tool to assess functional eligibility and service needs and then develop a person-centered plan of services and supports…Such a tool can be used to collect consistent data, leading to better system management.[3]

A Hilltop Institute publication acknowledged that comprehensive assessments play an important role as states seek to provide more LTSS in HCBS settings rather than in institutions. A well-designed instrument identifies the full range of a consumer's service needs so that they can be addressed when possible, thus preventing or delaying the need for institutionalization.[4]

In a recent policy brief prepared by The SCAN Foundation, one of the five principles for transforming California's system of LTSS was a need for universal assessment. The assessment recommendation suggested establishing a core set of questions that all programs would use in an assessment process to determine eligibility and level of need. This will enable the needs of individuals who receive services from different programs to be evaluated in a uniform way. "Analysis of this information will shed light on both the functional levels of individuals across programs and population-level understanding of service use to monitor quality and support planning."[5]

Assessment and Managed Long-Term Services and Supports

Whether a state is expanding its LTSS options, developing a Medicaid managed LTSS program, or designing an integrated health and LTSS program, the data available in a comprehensive assessment is necessary for several purposes. These include determination of programmatic eligibility, authorization of home care hours or service units, development of an individualized budget, determination of community residential rates, and identification of high risk consumers for additional intervention including more frequent visits by case managers and/or referral to chronic care management programs. The data in a comprehensive standardized assessment provides information that is useful for developing capitation rates, for producing reports for managing programs, as well as compliance with the Centers for Medicare and Medicaid Services (CMS) quality assurance protocols for HCBS waivers.

In December 2009, CMS published *Providing Long-Term Services and Supports in a Managed Care Delivery System*.[6] Besides providing technical assistance on the different Medicaid authorities a state could consider in developing an integrated/managed LTSS program, the document also discussed quality assurance requirements. It emphasized that CMS would expect states to address the quality assurances that are fundamental to Medicaid HCBS programs,

including level of care, service plan development, provider qualifications, health and welfare, and financial and administrative accountability.

An automated assessment system helps provide the data necessary to address these assurances and develop quality improvement processes. To have the data necessary to report to CMS, a state should consider requiring health plans that will be performing HCBS assessments to use a common tool or the state should be very prescriptive about all the domains and data elements that are needed in order to submit required reports to the state on a specified frequency. Without specific requirements, a state could lack the data necessary for planning, rate setting, quality monitoring and improvement, as well as being unable to comply with CMS quality assurance requirements.

The Patient Protection and Affordable Care Act (ACA)

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148) includes provisions to improve care management for persons with complex medical conditions. The Medicare-Medicaid Coordination Office (MMCO), established in the ACA, was created to better align Medicare and Medicaid for those who are dually eligible for both programs. One of its initiatives is to support state efforts to integrate Medicare and Medicaid benefits for dual eligibles.

The ACA provides states an opportunity to qualify for enhanced federal matching to expand HCBS options under the 1915(k) Community First Option and the State Balancing Incentives Program (BIP). For the Community First Option, the ACA requires that states conduct an assessment of individuals' functional needs on which to base the person-centered service plan. The assessment will determine if the individual requires assistance with activities of daily living, instrumental activities of daily living or health-related tasks.

For the BIP, a state must submit a plan to the Department of Health and Human Services which 1) outlines its plans to expand Medicaid and 2) describes its approach to making three major structural changes in its LTSS delivery systems. The three reforms are: 1) the establishment of a single entry point; 2) implementation of conflict-free case management and; 3) development of standardized assessment for determining eligibility for non-institutional services and supports used in a uniform manner throughout the state. States must also collect data on service utilization, core quality measures and client outcome measures.

In addition to the requirements of the ACA, moving to automated assessments is necessary for effective service planning and management. As identified in the Center for Health Care Strategies, Inc. (CHCS) publication *Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services*, "(o)ne of the hallmarks of having a successful long-term care program is the implementation of a needs assessment system…this increases the likelihood that consumers are being assessed objectively and that services are being provided to meet consumer needs rather than provider revenue needs."[7]

CHCS has produced a technical assistance brief entitled *From the Beneficiary Perspective: Core Elements to Guide Integrated Care for Dual Eligibles*[8] that summarizes nine key elements for consumer protections:

1. Comprehensive assessment to determine needs
2. Personalized plan of care
3. Multidisciplinary care teams
4. Family caregiver involvement
5. Comprehensive provider network
6. Strong HCBS options
7. Adequate consumer protections
8. Robust data sharing and communication systems
9. Financial incentives aligned with integrated quality care

These elements and the activities occurring under the ACA are seen as essential for integrated care programs to adequately address the needs of consumers while providing data to adequately inform system design and development.

Current National Uniform Assessments

Several assessment instruments already exist at the national and state level but not every state has adopted a standardized assessment for the HCBS they offer. National assessment tools have been designed that are used across multiple populations or programs, improve processes and functions and are automated or have the capacity for automation. The national tools include:

- Minimum Data Set (MDS): The MDS is a Centers for Medicare and Medicaid Services (CMS) mandated assessment of all residents in Medicare or Medicaid certified nursing homes, assessing each individual's functional capabilities, and helping nursing home staff to identify health problems.
- Minimum Data Set-Home Care (MDS-HC): The MDS-HC is a validated assessment tool created by interRAI Corporation that was modeled after the MDS. It was developed to assist agencies in identifying the needs, preferences, and strengths of elderly clients living in the community, although it may also be used for adults with disabilities. Several states are using this instrument for HCBS services.
- Inventory for Client and Agency Planning (ICAP): The ICAP is a standardized assessment instrument that measures adaptive and maladaptive behavior. It can be used for both children and adults.
- Continuity Assessment Record and Evaluation (CARE): The CARE Tool was designed for implementation with Medicare populations, primarily those who are aging and /or have physical disabilities. It was developed for use in acute and post-acute-care (PAC) settings participating in the PAC Payment Reform Demonstration.
- Outcome and Assessment Information Set (OASIS): The OASIS tool collects data that can be gathered across home health agencies in a standardized manner, to improve the quality of services using outcomes-based quality improvement methods.

- Supports Intensity Scale (SIS): The SIS is a validated and normed tool developed by the American Association on Intellectual and Developmental Disabilities. The tool is designed for use with adults (16 and over) with developmental disabilities. Several states are using this tool for planning purposes and for resource allocation.

After the passage of the ACA, additional federal guidance on standardized assessment was issued for states who are applying for the BIP. As stated in the 2011 Balancing Incentive Program Implementation Manual:

> "Core Standardized Assessment (CSA) requirement in Section 10202 reflects a current trend nationwide toward the use of universal assessments. A well designed assessment tool…can promote choice for consumers, reduce administrative burdens, promote equity, capture standardized data, and automate data systems to indicate programs for which an individual is likely to be eligible. Universal assessment information and data systems can also support State efforts to project future service, support and budget needs, prioritize individuals for services when waitlists are present or budgets are limited."[9]

BIP requires that the standardized assessment(s) be used across the state and across populations to determine eligibility, identify support needs, and inform service planning. The assessment must contain a core data set (CDS) of five domains:

1. Activities of Daily Living
2. Instrumental Activities of Daily Living
3. Medical Conditions
4. Cognitive Function and Memory/Learning Difficulties
5. Behavior Difficulties

Other States' Use of Standardized Assessments

A recent survey of states about their assessment process for most of their LTSS programs showed that 22 states reportedly use a uniform assessment.[10] However this report does not identify if the assessments are automated nor does the report identify whether states use one standardized automated assessment for all programs or whether they use multiple uniform assessments for their HCBS programs.

State specific tools that were analyzed in the BIP Implementation Manual included Colorado, Maine, Massachusetts, Minnesota, Virginia, Washington, and Wisconsin. Each of the national and state tools was reviewed to determine how the assessments address six broad content domains including: background information; financial assessment; health; functional assessment; cognitive, social, emotional, behavioral assessment; and other. States who choose to apply for BIP will need to determine whether their assessment processes identify the domains/topics required by CMS or need to be modified to meet the requirements.

Methodology Used to Select States for Interviews

The states profiled in this paper all chose to adopt and either implemented, or are in the process of implementing, automated standardized assessment systems to aid in rebalancing their LTSS systems and controlling costs.

The four states selected for in-depth interviews represent the diverse regions of the United States: West (Washington), Midwest (Minnesota), South (Arkansas), and East (New York). Three of the states are in the final process of programming their new assessment systems (Minnesota, New York and Arkansas). Training and implementation plans are being designed to rollout these systems in 2012 and 2013. Washington has the most mature system as it has been in place since 2003. The remaining states are in different stages in the development or implementation of their assessment systems. The selected states were also diverse relative to the utilization and maturity of their HCBS systems.

Both Minnesota and New York have county based/local district systems and use mainly local employees/providers to perform assessments. Washington uses state employees for initial assessments and Area Agency on Aging contractors for the reassessment of consumers living in their own homes, while Arkansas uses state employees to perform assessments/reassessments.

Minnesota and Washington ranked nationally first and second, respectively overall for LTSS system performance in the September 2011 State LTSS Scorecard.[11] There is believed to be a link between system performance and a state having a standardized automated assessment system. New York and Arkansas are both in the process of implementing LTSS reforms that will rebalance their systems to increase their use of HCBS options.

A standard set of questions was used to gather information from the states through telephone interviews and review of state websites. The questions were designed to determine what motivated states to develop/procure an automated standardized assessment, what the process was for selection of the tool for each state, the components of the tool, stakeholder engagement, training and implementation plans, assessor education/experience requirements, cost of the initial system, reports that can be produced from the system and how the adoption of the automated system has or will change the way a state does business. Each in-depth state interview is included in the appendices to this report.

KEY THEMES IN INTERVIEWS WITH THE SELECTED STATES

Why These States Chose to Adopt an Automated Standardized Assessment

Each of the states interviewed presented similar reasons as to why they chose to adopt a standardized automated assessment system for HCBS. These included efficiencies, consistency between assessors (i.e., inter-rater reliability), accuracy of assessments and plans of care, assuring consumers have information about the array of options available to meet their individual needs, and the need for data for decision support, program planning, reporting, budget development and the ability to automatically generate information for CMS quality assurance reports.

Three of the states had multiple assessments (New York, Arkansas, and Minnesota) for the variety of programs they offered, which created redundancy and inefficiencies. The standardized assessment would help to create efficiencies in part by eliminating multiple assessments for

multiple programs. The remaining state (Washington) had an automated form but no system to collect data.

The need to adopt a system that promotes inter-rater reliability was listed by all states to ensure consistency between assessors. The states all desired to produce a tool that automatically determined eligibility for services/programs. In those states that employed the MDS or interRAI assessments (AR, NY), this was achieved by creating algorithms that run on a mathematical formula that determines eligibility and Resource Utilization Group (RUG) levels when identified data elements are entered into the assessment. RUGs are a way in which clients that have similar clinical characteristics and needs for care are grouped into relative resource utilization groups. Washington and Minnesota have also created RUG-like algorithms that produce the same information about resource utilization. The states were all interested in improving care planning by having a system that would trigger client specific health and supportive needs issues that would require care planning upon their identification. Additionally, the states wanted the capacity to identify client specific risk factors that would trigger care management activities and referrals that could support the management of chronic conditions.

When a state has multiple assessments for multiple programs, it usually requires the assessor to speculate which program will meet the consumers' needs and use that program's assessment. In this process there is no assurance that the consumers/consumer advocates know the entire range of options that are available in a state to meet their needs. With an automated comprehensive assessment system the consumer and/or the consumer's family is only required to know that they need some type of LTSS. The assessment is comprehensive and will guide the consumer and the assessor to an array of options that can then be discussed with the consumer for service plan development.

Each of the states recognized the need for data beyond just claims information for effective program management. Each of them had little or no automated clinical or functional data about the LTSS consumers. In an era where decisions are increasingly data driven, the states wanted data to:

- Manage their programs, including workloads;
- Determine timeliness of assessments/reassessments;
- Quantify authorization of services, including home care hours authorization;
- Establish equitable and appropriate rates for residential settings;
- Set individual client budgets;
- Create management reports for program planning, quality assurance, budget development, staff accountability, comparison of consumers' acuity/ needs within a program and across settings;
- CMS waiver quality assurance reports;
- Determine client outcomes and identify risks; and
- Interface to the health care claims information in the state Medicaid Management Information System to help identify high utilizers of both health and LTSS.

Two states (New York and Washington) specifically mentioned the value of an automated standardized assessment to provide the data necessary about consumers as they develop plans for capitation and move to develop an integrated health/LTSS delivery system. The data would be used for reviewing case mix, rate setting methodologies, and identifying clients who would benefit from additional interventions to improve their health outcomes and maintain their ability to live in their homes for as long as possible.

Currently, more states are moving to a web-based approach to automating assessments because of the evolution of technology. A more important consideration for states is to require the use of laptops at the place of face-to-face assessment. This avoids the redundancy of converting hand written notes at the place of assessment into a computer at the office. After assessors schedule appointments for the day or the week, they should be able to check-out and download a number of clients from the main database and complete assessments in the field. Ideally, they complete the assessments in a disconnected mode and then return to the office to upload the completed assessments to the main database.

The Selection of the Assessment Systems

Table 1 below summarizes the types of assessments, populations served and programs the assessments are used for in each of the four states interviewed.

Washington State spent considerable staff and stakeholder time determining elements to be included in a tool and what the tool should accomplish. It was eventually decided that designing an original tool would take too much time and the cost and time would be prohibitive. The state reviewed the work being completed in Oregon, in which a tool was developed based on the Minimum Data Set for Home Care (MDS-HC) assessment. Washington officials contracted with the same contractor that Oregon used (Deloitte Consulting) and modified the tool for the Comprehensive Automated Resource Evaluation (CARE) tool. By adopting the assessment used in Oregon and employing the same contractor that Oregon used, Washington was able to implement an automated system in a shorter period of time. The state implemented the tool in 2003. Since that time, it has been modified to include the Supports Intensity Scale to assess the needs and preferences of individuals with intellectual/developmental disabilities.

Arkansas took the approach of determining whether existing tools had the potential to meet their needs for an automated assessment. The state used outside contractors to provide expert technical assistance in identifying the “off the shelf tools” that would meet Arkansas’s needs. Several on-site demonstrations were provided to the Arkansas Department of Human Services and the Division of Aging and Adult Services (DAAS) staff which resulted in the decision to use the interRAI-Home Care tool (a later iteration of the MDS-HC) with modifications to meet the DAAS programmatic requirements. This included developing a systematic acuity-based method to determine the cash allowance and/or service hour allocations for in-home services and using the automated system to determine level of care for nursing home/waiver eligibility, and other program eligibility (algorithms).

Minnesota reviewed other state assessments but eventually decided that the state would design its own assessment. The state wanted an assessment that would include all populations, all ages, and cover an extensive list of federally- and state-funded programs. The state wanted a person-centered interview process that included a quality of life domain. The state selected an

independent contractor in 2004 to facilitate the stakeholder process and the assessment content development which was completed in 2007.

New York selected the interRAI Community Health Assessment (CHA) with Functional and Mental Health Supplements as well as designing New York modifications. This automated system will be used for Medicaid HCBS. It will not be used by persons with intellectual disabilities. State staff did an extensive analysis and review of literature and recommended this tool. An independent party validated the staff work and the selection of the tool to be used.

Arkansas, Minnesota and New York plan to start using their respective assessment tools in 2012-2013.

Table 1. Summary of State Assessment and System Characteristics

State	Name of Assessment	Assessment Selected	Populations Served	Programs Included
Arkansas	ArPath	Minimum Data Set-Home Care (MDS-HC) (Arkansas modifications)	Older adults, people with physical disabilities age 18 plus	Medicaid Home and Community Based Services Waivers
Minnesota	MnCHOICES	Designing own system	All ages, people with physical and/or intellectual disabilities	Medicaid Personal Care, Home and Community Based Waivers, alternative care, home health, private duty nursing, traumatic brain injury, nursing facilities, intermediate care facility for persons with developmental disabilities, health plans offering long term services and supports, state funded family support and community services
New York	Uniform Assessment System-New York (UAS-NY)	interRAI Community Health Assessment (CHA) with Functional and Mental Health Supplements (NY modifications)	Older adults, people with physical disabilities age 18 plus	Medicaid Personal Care (including consumer directed personal assistance program), Medicaid Home and Community Based Waivers, assisted living, adult day health, managed long term care
Washington	Comprehensive Automated Resource Evaluation (CARE)	Used Oregon ACCESS which included interRAI-Home Care features w/Washington modifications; Supports Intensity Scale module used for intellectual disabilities, all ages	Older adults, people with physical disabilities age18 plus, people with intellectual disabilities, all ages	Medicaid Personal Care, Medicaid Home and Community Based Waivers, nursing facility case management, adult day health, PACE, managed health/long term care program, private duty nursing, state and veterans funded home care, non-Medicaid case management

Stakeholder Engagement

As part of their LTSS reform processes, the four states interviewed included considerable stakeholder involvement to identify issues that needed to be addressed to improve their LTSS systems and offer adequate HCBS options that are individualized and person-centered. Each state had already decided through earlier stakeholder processes that they needed to develop a standardized automated system. Consequently, each of the states designed stakeholder processes to meet the identified requirements of their specific political and advocacy environments.

In Minnesota, the decision to design an automated assessment that would include a wide variety of populations (children and adults with intellectual disabilities, as well as adults with physical disabilities and older adults) covering state as well as federally funded programs resulted in the need for an extensive stakeholder process. The goal of this stakeholder process was to be inclusive of the populations, programs and local entities that would be impacted by the new assessment process. The initial three-year long process benefited from the involvement of an independent contractor to help assure that all concerns were heard and considered in the content development. The process included formal workgroups and subgroups to cover all the topics necessary (e.g., children's workgroup, cultural competency workgroup, support planning workgroup, and mental health workgroup). The contractor, as an independent party, provided valuable testimony during legislative consideration of the agency funding request.

After the legislature approved funding in 2009, the stakeholder process continued with the Project Steering Committee and included four new workgroups: 1) Intensive Policy Workgroup; 2) Experienced Assessor Workgroup; 3) First Implementers Workgroup; and 4) Technology Committee. These groups included consumers/consumer advocates for older people, people with disabilities including mental health, traumatic brain injury, developmental disabilities, assessment/case management staff (such as Area Agency on Aging staff), lead agencies (counties and tribes), managed care organizations as well as direct service providers. The First Implementers Workgroup continues to be actively involved as the state tests the system.

States who may be considering developing an assessment process as broad as Minnesota's could benefit from analyzing the assessment product that Minnesota implements and consider using as much content as possible for their state's needs. In the current budget climate, most states would not be able to sponsor as extensive and lengthy a stakeholder process as occurred in Minnesota.

In New York, significant stakeholder work went into the state's LTSS system reform efforts. Through that process they identified a need for a standardized assessment. The New York State Medicaid Redesign Team approved going forward with implementation of an automated comprehensive assessment for LTSS programs. To keep the scope of this effort at a manageable level, it was decided to use the new assessment initially for Medicaid HCBS, replacing existing assessment processes for eight LTSS programs. The Office of Long Term Care, located in the Department of Health, developed the legislative proposal for the project and led the stakeholder process.

New York's goal was to use the stakeholder process to help them understand the consumer and business needs related to shifting to a standardized assessment system. The state wanted to hear about how this would affect consumers and agencies at the local level. Stakeholders included consumer advocacy groups and consumers, users of the system, including providers and local districts. The state used an advisory group as well which was made up of consumer advocates, consumers, providers, and other state agencies.

Like Minnesota, testing of the New York system will include local entities that will actually be using the system. There are thirty organizations that have agreed to be involved in testing the functionality of the tool. An important part of this stakeholder process will include; reviewing system stability, developing the statewide rollout strategy, determining the impact on the testing site business practices and identifying the impact on assessed individuals. After this phase of testing is complete, a pilot is also planned which will involve testing the impact of the system and making adjustments as necessary.

In Arkansas, the goal of the stakeholder process was to help select the automated tool to be used. Leadership for this process was confined primarily to the DAAS and the Department of Human Services staff. The Division convened an Eligibility, Access, and Application Workgroup to identify all of the elements required in the tool to meet waiver and eligibility requirements and discuss policy questions that needed to be considered as the tool was developed. Arkansas will also involve field staff in the testing of the tool.

In Washington, the stakeholder process sought to define the data elements that should be included in the design of a new tool and review other national or state tools that could be considered. A community stakeholder group was formed and included the Area Agencies on Aging, direct service providers, AARP, the State Council on Aging, and the State Long-Term Care Ombudsman as well as state subject matter experts. During the process, the state realized that it needed to reduce the amount of time it would take to create a totally new tool and reduce the projected expenditures for the project. After review and selection of the Oregon tool, the agency created a Joint Review and Planning Committee (JRP) of field experts to provide clinical advice and testing of the software. The JRP included assessors from the Area Agencies on Aging as they too would be using the newly developed tool to reassess clients after initial assessments and authorizations were completed by state employees.

Implementation Time, Costs, and Anticipated Efficiencies

The total cost to design, modify, program and implement these systems varied from $1.4 to $4.8 million. These figures represent the amount paid to contractors and/or included in the state budgets for the projects. States received approval, or were applying for approval, from CMS for a federal Medicaid match to pay for some of the cost of the assessment projects. Complete fiscal information on the cost of state resources used for the projects including management, technical, stakeholder processes and field involvement especially for testing was not available. These resources, dedicated to the project, however, are essential to the success of the projects.

Once a contractor is selected, modifications to the tool are made, the tool is programmed, the product is tested, the staff is trained, and the rollout and full implementation takes, on average, two years. More time is spent upfront by states in selecting a system, developing the Request for Proposal, and content development if the state designs its own system.

Although not quantified, the three states still in their implementation phase reported that they expected to achieve savings through efficiencies after implementing an automated standardized assessment system. Some of the efficiencies include the elimination of multiple forms and assessments for HCBS, the ability to obtain automated data for CMS waiver quality assurance reporting, automated and consistent client eligibility determinations, reductions in “Exception to Rule” authorizations.

Washington is the only state interviewed that has had experience with the use and impact of their automated standardized assessment tool. They related increases in clients served not to implementation of the assessment tool but rather to other rebalancing initiatives. They report the effective use of data to compare costs, clients and acuity across programs and have used this information to make program adjustments and refine rates. They also use data to identify and better manage client chronic conditions and risk factors. They also report a significant reduction in "Exception to Rule" authorizations. Exceptions to rule are authorizations of hours/levels above the amount determined by the assessment. They are usually the result of an appeal to management and are often not regulated by a policy framework.

Considerations for States When Moving to Develop and Implement an Automated Standardized Assessment System

The following are considerations for states that are considering adopting a standardized automated assessment system within a shortened timeframe and at a reasonable cost. The recommendations include and address "lessons learned" by the states interviewed.

Policy Decisions to be Made Prior to Moving Forward with a Standardized Automated Assessment Project

- Identify the maximum amount of hours/dollars that may be authorized for an in-home care plan. Twenty-four hour in-home care may be difficult for a state to afford.
- Determine if there is a population that cannot be safely served in an in-home setting. For example, the state may decide that clients with significant dementia cannot be authorized for in-home care unless there is daily involvement by family members or other informal caregivers.
- Review the rates that you currently pay for all care settings. Consider a tiered rate structure to provide incentives to providers to take heavier care or clinically complex clients.
- Randomly sample the current caseload, reassess the sampled caseload using the draft of the new tool and determine how the new assessment will impact the current caseload and the impact on future consumers. Preferably the sample should be reassessed using unbiased assessors. Analyze the sample and determine if your new assessment and algorithm impacts eligibility which may require an adjustment to an algorithm.
- Communicate to stakeholders the anticipated impact of the assessment. For example, when implementing a more comprehensive and consistent automated assessment, it is expected that that levels of care or hours authorized may change. Some clients will receive more hours of care, some less. It is important that stakeholders understand this before the system is implemented.
- If it is anticipated that a percentage of clients will no longer be eligible, decide whether to continue serving those clients or whether to terminate their participation.
- Establish a structured appeals process, staffed by clinicians experienced in using the standardized automated assessment.
- Consider the amount of time the new assessment/reassessment will take in relation to the current number of assessors.

Scope of an Assessment Project

- Decide on the purpose and scope of the project in order to keep it manageable and within budget and on time. The assessment should be developed in a way that allows for expansion in the future for new programs and/or populations. Time and money can be saved if the selected tool is part of a suite of assessments, as is the case with the interRAI assessment tools.
- The state should seriously consider being broadly inclusive of all LTSS programs in the assessment project including waivers, state plan services, and other pertinent state- or federal-funded programs, such as Veterans' Home Care programs. The standardized automated assessment system will provide better data for program development, rate setting, quality assurance, and other key processes if all programs, waivers and populations served are part of one system.

Selection of the Tool and Funding

- Given the current budget situation in most states and the reduction of administrative staff, states can manage the scope of their assessment projects by using an existing and validated state or national tool and make state specific modifications rather design a unique system.
- Survey the existing assessment tools available nationwide to assist in the selection of an off-the-shelf tool that can be modified for state use. Validation and reliability of these tools should be analyzed, preferably by a conflict-free entity (an entity that has no fiduciary interest in any of the assessment tools or systems being considered). The survey should also include any automated assessments used in the state or at the local level that could be revised or need to be incorporated into the project.
- Secure high-level support for the project and develop a work plan, budget proposal and funding commitment for the project. Clear leadership and guidance should come from the director of the agency where the LTSS system resides. If the Medicaid agency is in a separate organization, the state's Governor or Secretary/Commissioner (if appropriate) should provide direction to the agencies impacted. State legislators should be conversant regarding the policy initiatives necessary for rebalancing the LTSS system. Money Follows the Person administrative dollars and an approved Advance Planning Document (APD) from CMS has the potential for claiming some federal financing for the project.

Stakeholder Involvement

- Identify the stakeholders (internal staff, consumers, advocacy groups, case management staff/assessors) and develop a plan and parameters for their involvement in the development and implementation of the assessment. Set specific timeframes in the work plan for the stakeholder process.
- Convene stakeholders to develop a set of guiding principles regarding the populations and programs the assessment will cover. The guiding principles could be used by state staff as they review national and other state tools for use in their state.

- Secure commitments from, and procedures for communicating with, interagency interests and programs. Communication should occur on a regularly scheduled basis and require a formal record for reference.
- Involve stakeholders in testing the system as the state nears implementation. The stakeholders should include all entities that will be performing assessments including state employees, county employees, aging network staff, etc.
- Develop a communication plan for the stakeholder process that makes the process transparent and provides information on a timely basis.

Assessment/Case Management Staff

- Determine who will be assessing consumers under the new system, for example, state employees, county or lead agency employees, health plans, others. Assessors/case management staff should be conflict-free (not have an interest in providing the services that may be authorized). If a health plan is providing services, preferably other entities such as state or local employees would complete the assessment to assure no conflict of interest. This may not be achievable with some health plans but careful monitoring of their processes should occur for consumer protection.
- Eliminate conflict of interest by assuring that direct service providers will not assess, develop initial care plans, or reassess consumers who might be recipients of their services in order to comply with federal requirements.
- Determine the educational/experience/certification requirements for the assessors/case management staff. All of the states interviewed require at least a bachelor's degree in Social Work or a bachelor's degree in Nursing.
- Determine prior experience with laptops to complete assessments. Experience in the use of a laptop is useful otherwise the state will have to provide laptop training.
- Develop a training plan that includes application as well as policy training. The training plan should include group training with assessment exercises. The training team should include management and supervisory staff to enhance support and buy-in from the staff that will be implementing the new system. There should be enough training staff at training events to ensure that trainers can identify assessment staff who might be struggling with the new tool/application. Training should also be available on-line for refreshers after implementation.

Staffing Necessary for the Standardized Automated Assessment Project

- Identify staff that can be dedicated to the project and/or include staffing needed in the budget proposal developed for the project. In addition to the project manager, subject matter experts and business analysts dedicated to the development and implementation are important to the success of the project.
- Identify and budget the state technical staff that will be necessary to support the assessment system once it is in place. Support will include maintenance of the system, administering changes as required by program budget increases and decreases, changes identified as necessary by program managers, and special program queries identified as necessary by program managers to address program and legislative questions.

Technical Review and Requirements

- Survey impacts of the new system on existing systems and identify additional equipment requirements such as servers and laptops.
- Identify additional data system integration requirements such as the Medicaid Management Information System (MMIS), Older Americans Act data systems, etc.
- Determine the platform that can be accommodated in your state, identify the number of servers and laptops needed and plan for replacing equipment at least every three years.

Request for Proposal

- Develop a detailed request for proposal for programming any changes to the assessment tool that is selected and for the algorithms that the state needs for eligibility determination, home care hours authorization, residential rate determination, individual budgets and/or resource utilization groups.
- Determine and limit the parameters for customization of the tool. For example, if purchasing an off-the-shelf tool limit the amount of changes that can be made to the tool to manage scope of the project.

Development of the Application

- Identify who will develop the algorithms.
- Sample the existing population served and identify how that population will be impacted by the new tool. If the new tool allows too many new clients in or eliminates participation of too many existing clients, the state may need to adjust the algorithm.

Implementation

- Assign staff and ample time to the process of implementation including testing, feedback, and training of staff.
- Stage roll-out by geographic area, allowing time between the first area implementation and the subsequent areas in order to identify problems and make corrections before rolling out to the remaining areas of the state.

Evaluation of Standardized Automated Assessment Implementation

- Further study or evaluation would be useful analyzing the implementation of standardized automated assessment systems used by several states. The evaluation should address how the system impacts populations served, cost of administration, quality impacts and return on investment.

Standardized automated assessment is key in creating an accurate person-centered care plan for consumers that addresses consumer goals and protections while providing client information to providers and data to a state for program development and design. Without a reliable way of measuring client acuity and costs, a state agency cannot be accountable to state executives and

legislators especially in tight budget times. To move towards a balanced LTSS system, states must begin coordinating and automating their client assessment systems.

APPENDICES

Appendix A – Definitions of Terms Used Related to Standardized Assessment Tools

- **Minimum Data Set (MDS):** Implemented in 1990 as a component of the Resident Assessment Instrument. The RAI is a federally mandated tool used to assess the needs of LTSS clients in nursing facilities.
- **Inter-Rater Reliability:** When two assessors using the same tool on the same or similar clients come to similar outcomes when the assessment is completed.
- **interRAI:** Is a non-profit organization of clinicians, researchers, policymakers whose interests are to in research, assessment instrument development and implementation. InterRAI holds the copyright to a number of assessment instruments including the interRAI Home Care and interRAI Community Health Assessment (CHA).
- **interRAI Home Care Assessment Tool:** A home care assessment tool developed by an international panel of experts on geriatrics, gerontology, assessment and health services. The tool has been tested and validated to be appropriate and effective in establishing reliable Resource Utilization Groups for home care.
- **CARE Tool:** Is an assessment tool cross walking MDS and MDS Home Care items with data elements and algorithms specific to the needs of Washington's LTSS system.
- **Resources Utilization Groups (RUGs):** Case mix groupings that classify health care recipients according to similar levels of resource use.
- **Clinical Assessment Protocols (CAPs):** Identify individuals with key issues that pose risk; protocols for guidance or practice recommendations are triggered by answers to certain items.
- **Algorithm:** Is a mathematical formula programmed within assessment tools to establish eligibility, classification groups and payment levels usually based on need for assistance with activities of daily living (ADLs), cognitive performance, behaviors or moods and clinical complexity.
- **Disconnected Mode:** Assessors take their laptops to where the consumer is and assess the consumer at that location and then return to the office and connect to the main system and upload data collected.
- **Linear Regression Model:** In statistics, linear regression is an approach to modeling between variable ***y*** and one or more explanatory variables denoted as ***x***. Most commonly used when attempting predictions or forecasting.
- **Exception to Rule/Extension of Benefits:** The former used in Washington, the latter in Arkansas, to denote when services are authorized above what the assessment determines as appropriate.

Appendix B – State Interviews

Washington's approach to LTSS and assessment

Washington has long been recognized nationally for its leadership in developing a publicly funded LTSS system that has optimized consumer choice, quality of care and Medicaid cost control. However an automated assessment tool was not implemented until April 2003. Prior to 2003 Aging and Adult Services (now Aging and Disability Services Administration) used a tool entitled the Comprehensive Assessment (CA).

What motivated Washington to develop an automated assessment?

In 1998 and 2000, two reports, one written by an outside consultant group and the other by the Joint Legislative and Executive Task Force on Long Term Care, noted that the CA did not take full advantage of the power of computerization to integrate eligibility, assessment findings, authorized hours and the care plan. Other findings of these reports noted that the CA lacked the necessary elements to classify clients according to impairment levels. The reports recommended the development of an assessment tool that contained more detail on complex medical needs, cognitive impairment and behavioral problems. Additionally the reports urged the State to improve "inter-rater reliability" to provide more consistent evaluations and authorization levels between assessors.

During this same period, the Health Care Financing Administration (HCFA), now the Centers for Medicare and Medicaid Services (CMS), conducted an audit of Washington's programs to ensure that care was being delivered to clients who were truly eligible for the services that they were receiving. The auditors found errors where eligibility and payments were authorized that were not in accordance with Medicaid rules. They also found that there was significant variation in the amount of services authorized between clients with similar clinical characteristics. In response to these factors ADSA undertook the development of a new automated assessment tool that would determine functional eligibility as well as payment levels for authorized services.

What was Washington hoping to achieve?

One goal of the new assessment tool was to create a method in which clients that had similar clinical characteristics and care needs would be grouped into relative resource groups. This process is similar to the RUG-III system used to group residents in nursing facilities. This ability to group clients allows the state to compare resource utilization across service settings and use this information to make program decisions. To achieve this, ADSA undertook a time study to determine the relative resource needs of clients served across the community based LTSS settings in the state.

ADSA wanted and needed cost information in order to develop defensible budget projections and to build reasonable rates related to acuity and setting. They wanted to improve inter-rater reliability, correctly identify the involvement of informal supports, and produce management reports by individual assessor, unit and county for the purpose of better managing distribution of work and staff performance. Washington also wanted to assure compliance with CMS protocols, and state and federal laws.

Additionally ADSA operated several HCBS waiver programs and state plan services. It was impossible to compare clients between these programs and settings without a common

assessment tool. The CARE tool was designed to assess all clients served in all LTSS programs and settings.

A later goal was to produce data to begin to build the foundation for outcome-based care planning and risk/medical interventions to avoid unnecessary hospitalizations.

ADSA feels that they achieved their goals, but the state continues to make adjustments to many elements of the assessment tool.

How was Washington organized?

ADSA is an administration within the Department of Social and Health Services (DSHS). The administration includes Home and Community Services (all waivers, Medicaid Personal Care and Older American's Act programs for the over 18 disabled population), Residential Care Services (all complaint, licensing, regulation and sanctioning of boarding home, nursing facilities and adult family homes), Developmental Disabilities (including institutions) and Management Services (rate setting, budgeting, and information services for all of the above).

DSHS was the Medicaid Agency and included two administrations that used Medicaid financing: 1) Health and Recovery Services Administration (health and recovery services for low income populations), and 2) Aging and Disability Services Administration (LTSS).

ADSA's field operation is located in 42 field offices in communities across the state. The field offices are comprised of social workers, nurses and financial eligibility workers and their supporting staff.

ADSA designated and contracted with 13 Area Agencies on Aging (AAAs) to do planning and program development for Older Americans Act (OAA) programs as well as provide standardized case management for OAA, HCBS waiver and Medicaid state plan Personal Care (MPC) program participants. AAAs provides case management to Medicaid clients receiving in-home services.

When ADSA began working on a new assessment tool, the AAAs became major stakeholders in the development and implementation of the tool.

In 1995, it was decided that state employees (social workers and nurses) would do the initial assessment of clients, authorization of services and development of the service plan. Responsibility for care plan monitoring, changes and annual reauthorizations for in-home cases would is then transferred to the AAAs. State employees were responsible for the all activities in adult family homes, boarding homes, assisted living facilities and for relocation/transition activities in nursing facilities.

What was the process?

In Washington, there was considerable stakeholder involvement in the early discussions of what the tool would do and what elements it would contain. The Association of Area Agencies on Aging was involved from the outset since they performed the ongoing case management of clients in in-home settings. Client advocate groups such as home care and home health agencies, AARP, State Council on Aging, Volunteer Ombudsman, Adult Family Home Association, Nursing Facility Association, and Boarding Home Association etc. were all involved in the early discussions regarding the new tool. Advocates eventually agreed to become members of a community stakeholder group that met frequently with ADSA staff to define the data elements to be included in the tool. The community stakeholder group, comprised of representatives of

providers and provider organizations as well as consumer advocates from the State Council on Aging, met monthly to review elements that ADSA staff were identifying as potential components of the tool and to review possible "off-the-shelf" tools. The AAA Association was involved both on the Data Elements Workgroup and through their monthly meetings with ADSA. ADSA staff reviewed existing assessment and standardized screening tools to build an expert knowledge base and facilitated the discussions of the Data Elements Workgroup. In addition to the Data Elements Workgroup, a Clinical Resource Workgroup was created to review the results of linear regression models developed and define clinically meaningful characteristics to be used in the classification model. This group was comprised of ADSA staff (program experts and technical staff) and clinical experts from community programs and the University of Washington.

While the work groups were meeting, ADSA contracted for a time study in boarding homes, adult family homes and in in-home settings to establish the foundations of relative resource utilization.

The time study included the collection of two types of data from a sample of clients served within the community based care system. The first set of data was clinical characteristics. This was collected in a paper format using a subset of data fields, MDS elements and other standardized screening tools that would later be included in the CARE tool. The second set of data tracked the amount of time a client received care over a 72 hour period from any type of caregiver, formal or informal (paid or unpaid). The two sets of data were then merged to group similar client's characteristics and resource needs.[12]

The outcome of the study provided ADSA with the main predictors of resource use. The predictors are:

- Need for assistance with Activities of Daily Living (ADLs)
- Cognitive Performance
- Behaviors/Mood
- Clinical Complexity

This information allowed ADSA to develop algorithms that were programmed into CARE to establish groupings and payment levels.

A great deal of time was spent gathering information to determine the construct of the tool. At this juncture, ADSA realized that they could not afford, both in terms of time and budget, to create a tool from the ground up. ADSA was aware of work being completed in Oregon on an assessment tool called Access Oregon. ADSA staff visited Oregon and reported that the tool being developed there would essentially meet the needs of the Washington program. ADSA contracted with Deloitte Consulting (the contractor used in Oregon) to program what was to become the CARE tool. ADSA, to this point, had committed approximately three years to the project. Pressures from outside the agency dictated that the tool needed to be completed and implement more quickly. The contract specified 18 months to roll out. The tool to be programmed by Deloitte was to cross walk with the MDS so that comparisons could be made between clients in nursing facilities and home and community service systems. ADSA created a "Joint Review and Planning Committee" of field experts to provide clinical advice and testing of the software. This group also performed extensive testing of the tool to determine if the segments of the tool operated as intended. The Joint Review and Planning Committee field experts were

AAA and ADSA assessors who had been identified as “experts” at using a laptop and assessing potential clients.

How is CARE constructed?

CARE is not a web based application; it was designed to work on disconnected laptops in the “home” environment then later sync to a centralized database. In the disconnected mode, three different types of operation are available:

1. View and edit pre-determined data set
2. Only view data and
3. View data with additional capability of creating new narrative records and appending them to existing records

When connected to the central database, a worker can perform the following functions:

- Person search and create a new person
- Log in
- Transfer case
- Assign worker
- View reports

The central database is Microsoft SQL, which serves as the central holding database for all clients and assessment data.

CARE is used to assess potential clients for all Medicaid state plan LTSS services, all HCBS waivers for the age 18 and over population, and Older Americans Act case management services. A separate suite was later developed and added for assessment of persons with intellectual/developmental disabilities.

What is the reporting capacity of CARE?

The CARE data base allows managers to create queries to produce grouped data on client acuity, costs by acuity and setting, demographic distributions of the clients served, comparisons of clients by waiver and other program type. Additionally, the reporting system creates management reports by:

- Total number of assessments completed
- Assessment versus payment authorizations
- Participant classifications, settings and rates/hours
- Participant transfers
- Clinical scores
- Pilot programs inactive cases
- Intake
- Nursing facility/hospital assessments

- Nursing/medical referrals
- Relative providers
- Service delivery overviews
- Ticklers
- Response time activity reports

These reports can be produced by worker, unit, office, region, and statewide.

How long did all this take?

After a five-year period of design and testing and returning to the drawing board, ADSA implemented the CARE tool (April 2003).

How much did this cost?

Without taking into consideration the involvement of ADSA Program Management, Technical and Field Testing staff time commitment, the contract with Deloitte Consulting totaled $3 million, $1.5 million from the state and $1.5 million from the federal government.[13] ADSA staff commitment in management, technical, and field staff testing time was considerable but was not quantified. With a project of this complexity and size, ADSA feels the commitment was necessary and ultimately worth the investment.

The project consisted of three core teams:[14] the executive steering committee (Project Sponsor, Project Director, IT Management and the Project Manager), the core team (Project Manager, Project Director, IT Management, Quality Assurance Manager, and Technical Leads) and the Technical Team, (Project Manager, Technical Leads, IT Management).

Testing was provided by field staff identified as laptop and assessment experts; 6 were state employees from each region of the state and approximately 10 from the AAAs. Test scripts were developed to test every requirement of the tool.

What are the components of the tool?

The foundation of the assessment tool is the Minimum Data Set (MDS). The MDS was implemented in 1990 as a component of the Resident Assessment Instrument (RAI). The RAI is a federally mandated tool used to assess the needs of LTSS clients in nursing facility settings. The MDS provides a core set of data elements that have proven over time to be reliable and valid in assessing and screening for the medical, functional and psychosocial needs of clients. It includes standardized definitions and coding categories that are used to produce accurate and uniform assessments. Although the original purpose of the MDS was as an assessment tool to identify care needs to be addressed in an individualized client care plan, its role has expanded greatly over the years. MDS based data is now used for the Medicare reimbursement system as well as many State Medicaid reimbursement systems, including Washington State.

In addition to the MDS, ADSA utilized a number of proven standardized screening tools to increase the accuracy and reliability of the clinical assessments. These tools include the Mini-Mental Status Exam, the CESD-Iowa Depression Scale, (Washington later replaced the CESD with the PHQ-9) the Cognitive Performance Scale, the Zarit Burden Scale, Alcohol/Substance Abuse screening tools. Protocols were developed which provide guidelines and individualized care planning for clients who have problematic conditions. Identification of these problematic

conditions is “triggered” by particular CARE items. The protocols consist of the following domains:

- Pressure ulcers
- Medication issues
- Referral to nursing services
- Depression referral

As outlined in the state's “Assessor’s Manual”, the CARE tool assists assessors to gather information on a client’s strengths and needs, which are then addressed in an individualized care plan. The tool aids staff to evaluate goal achievement and revise service plans accordingly by providing tracking mechanisms of changes in the client’s status. As the process of problem identification is integrated with clinical interventions, the service plan becomes each client’s unique path toward achieving or maintaining the highest level of functioning.

The classification system and the resulting payment system are algorithms programmed into the CARE tool, which established the classification group, eligibility, and payment levels. The algorithms have been refined over time either to better measure the needs and thus the classification of clients or to adjust eligibility thresholds to meet budget restrictions.

To complete an initial assessment and create a service plan it takes an assessor about 4.5 hours and the annual reassessment takes about 2 hours.

What technical support did ADSA provide?

ADSA agreed to provide technical staff to participate in the validation of the transfer requirements and the design of the system and agreed to conduct user acceptance testing in order to confirm that the finished product met the approved transfer requirements.

Because there was an aggressive time line for completion of the project, ADSA had to assure commitment and dedication of ADSA project management, the business requirements team and other resources.

The project management team included:[15]

- Project Sponsor
- Project Advisors from the contractor
- Two Project Managers, one from ADSA and one from the contractor
- Two Application Manager, one from ADSA and one from the contractor

The contractor technical team included:

- Technical Lead
- Two Technical Architects
- Two Database Administrators, one from ADSA and one from the contractor

The contractor development team included:

- Development Team Lead

- Four contractor Developers

Once the project was completed, ADSA identified resources to continue to technically support the project. They do three enhancement cycles a year to include new functionality in the system. They also anticipate an additional change cycle each year to address legislative requirements/changes and legal challenges. The CARE architecture and development takes about three full time positions a year to accomplish these tasks at about $98,000 per year (includes a range in salary and benefits). Maintenance issues related to server and patch maintenance require about another two full time positions, (there are also 21 FTE in the field where a portion of their time is spent on supporting CARE) so total cost to maintain the system is about $750,000 per year.[16]

AAAs are each responsible for maintaining their servers and providing application support to their users.

How long did it take to rollout/implement the new tool?

There were six geographic regions in Washington and ADSA planned to train 48 people per week for a total of 19 weeks, training approximately 1,091 people. Policy training was 2 days in length for 24 people and application training was 1 day for 12 people. The groups who attend policy training were divided in half to attend one of two 1 day application trainings. There were 2 policy trainers and 2 application trainers. One region was designated as a pilot. After the training, there was a two week break to iron out bugs and problems.

The trainings occurred in local offices where staff worked. ADSA was responsible for working with regional technical staff to ensure that the application training facilities were configured with a local area network and work stations. The facilities were assured to have the capacity to accommodate the anticipated number of attendees. The training was both lecture and hands-on instruction.

ADSA transported the necessary equipment and did the set up for each training, as well as, tested all of the computer equipment and systems to ensure that it was working properly. ADSA staff also installed the working application on each of the laptops.

The trainers were all ADSA staff, either policy or technical. All trainers had a solid understanding of CARE policy, business rules, and the application. The lead trainer (policy or application) was from ADSA headquarters, the co-trainer was an identified “expert” user from the local office and a local office technical staff member. The local office co-trainers were expected to provide support to local office staff once the training events were completed.

During the training events, trainers watched for staff (or staff could self-identify) who seemed to be struggling with either policy or the application those staff were accompanied into the field. Trainers then assisted them in completing their assessments until they felt competent in using the system. The training and roll out occurred according to the anticipated schedule.

What certifications/educational/experience were required of assessors?

Washington does not require certifications but does require Bachelor of Science degree for nursing staff.

The education requirements of case managers are:

- Master's degree in behavioral or health sciences and one year of paid on-the-job social services experience or;
- Bachelor's degree in behavioral or health sciences and two years of paid on-the-job social services experience or;
- Bachelors' degree and four years of paid on-the-job social services experience.

The Quality Assurance requirements of new and established staff are:

1) Supervisory monitoring of new and established staff:
2) New staff without CARE experience
    a) Review of first five assessments
        (1) 1. The goal is to provide training on correct assessment techniques without having to create another assessment
        (2) 2. Review must occur in a timely manner to meet the 30 day response time
    b) After the first five, review 50% of assessments for the next 3 months
    c) After three months, additional reviews are done at the supervisor's discretion based on performance

How did the implementation of this system change the way Washington did business?

Many changes occurred at the time of implementation of CARE, some as a direct result of CARE and some were the result of policy changes that were happening simultaneous to the development of CARE.

Given that CARE would place clients in levels/classifications or RUGs ADSA decided to review the rates paid to community settings. This decision precipitated the time study and ultimately resulted in increasing rates and building tiers related to acuity. This change provided an incentive for providers to accept higher acuity care clients.

Prior to the development of CARE, Washington had begun to re-balance its LTSS system by expanding waivers and developing a nursing facility relocation program. From approximately 1990 to 2011, the nursing facility caseload dropped from 18,500 clients to below 10,000 clients. The CARE tool was critical to developing person centered care plans that addressed the risk factors and care needs of clients either coming out of nursing facilities or diverting clients that might have gone into nursing facilities. ADSA also wanted to be able to collect data on where the high acuity nursing facility clients ended up receiving service and at what cost so that they could identify savings related to relocation.

The goal of implementing the CARE tool was not to save the state money. The purpose of the tool was to correctly assess and address the needs of individual clients and serve them in the least restrictive setting of their choice. ADSA Administrators wanted the implementation of the tool to be budget neutral while recognizing that some existing clients' authorizations would increase (appropriately) and some authorizations would go down and new clients coming in to the program would truly be eligible. This expectation basically played out in this fashion. Another outcome that did result in savings was the reduction of "Exceptions to Rule (ETR)." These were client care plans that were authorized outside of the "normal" parameters of the programs based typically on outside influences.

Prior to CARE approximately 20% of the caseload was an ETR at a level of 184 hours per month, to date the ETRs have been reduced to 1% of the caseload. Washington cannot say for sure whether the centralization of ETRs resulted in a budget savings. The primary intent was to ensure consistency and to review the results of the new classification and payment system.

Washington can now produce a number of client-level management reports to assist in program management, budget forecasts, and federal reporting.

In late 2002, shortly before the CARE tool was finalized for use in LTSS programs, the LTSS and developmental disabilities programs were merged under one administration within DSHS. Prior to this re-organization, the Division of Developmental Disabilities (DDD) program was the focus of several very critical reviews by the state's legislative auditor, a $26 million federal Medicaid disallowance, and a number of lawsuits related to program consistency. By 2009, the CARE tool was modified to focus on the specific needs of individuals with developmental disabilities. This helped to respond to state legislative, federal, and consumer concerns that the DDD program could not ensure that similar services were authorized for persons with similar needs. It also supported a major revision to the DDD case management program.

Trends in the number of Medicaid LTSS cases and costs per case changed significantly after the implementation of the CARE tool. Washington does not claim that these changes are a direct result of the tool. However, in the seven years prior to implementation of the CARE tool in state fiscal year 2003 (SFY 03) the Medicaid in-home caseload went up 45% and the caseload increased 30% in seven years after SFY 03. The Medicaid residential caseload increased 131% in the seven years prior to SFY 03, but only 29% in the seven years after SFY 03. Nursing home caseloads dropped 18.6% and 18% respectively in the seven years before and after SFY 03. The Medicaid program is complex and has many moving parts which contributed to these caseload changes. However, it is safe to say that implementation of the CARE assessment tool did not cause home and community caseloads to increase faster than growth historically experienced nor did it cause a slowing in the decrease of the nursing home caseload.

Changes in state cost per Medicaid case also varied before and after implementation of the CARE tool in SFY 03. The average home and community cost increased by 31.3% from FY98 to FY03 and by 52.4% from FY 03 to FY 08. It should be noted that during this time a state voter initiative to unionize home care workers was passed. Nursing home costs per case, which are not impacted by the CARE assessment, saw similar increases, rising 12.7% from FY 98 to FY 03 and by 29% from FY 03 to FY 08.

Arkansas's approach to LTSS and assessment

Arkansas made substantial progress in the 1980s and 1990s to increase use of HCBS for seniors and people with physical disabilities and is considered a national leader in policy and program development in LTSS, especially so among rural and/or southern states. They have had success in rebalancing utilization towards HCBS but rebalancing nursing home expenditures has not been achieved. Arkansas continues to serve low acuity clients at a high level in nursing facilities.

With the support of the Governor and the legislature, Arkansas identified a strong vision of community integration and consumer choice. Arkansas pioneered the National Cash and Counseling Demonstration and eventually made this program, Independent Choices, permanent where consumers may elect cash benefits rather than personal care services under the State Medicaid Plan. However there have been obstacles to rebalancing in Arkansas including:

> "fiscal constraints; strong lobby groups for nursing homes ….and difficulty in creating a single-entry case-managed system given the historical evolution of the Area Agencies on Aging, home health agencies, and developmental disability organizations."[17]

It should be noted that Arkansas is still in the process of developing the automated assessment system.

What motivated Arkansas to begin to develop an automated assessment?

Arkansas has recognized for a long time that they could not provide information and data about their programs and who they served. In 2001, Arkansas received a CMS Real Choice Systems Change Grant, a part of which was to be used to improve access to information for consumers and providers. Under that grant, Arkansas piloted a uniform assessment in Southwest Arkansas as well as a web-based tool for consumers. These efforts were not brought to scale; the various programs in the Division of Aging and Adult Services (DAAS) continued to use separate paper and web-based tools to assess clients and provide information about their programs to providers and decision makers.

In 2009, as part of a CMS State LTSS Profile Grant, DAAS convened outside experts in LTSS systems reform to make recommendations regarding actions for Arkansas to pursue in order to balance the LTSS system. This group included CE Reed and Associates; Carol O'Shaughnessy, a nationally recognized expert in LTSS policy; Lisa Alecxih of The Lewin Group; and Ray Scott, a human services expert from within the state of Arkansas.

The group produced a report entitled, "Recommendations to Balance Arkansas's Long-Term Care System." The report recommended, among other things, that Arkansas develop a single, standardized, automated assessment, service plan and authorization tool that would build upon information collected as part of the intake and eligibility process and would classify consumers according to acuity. Part of the purpose of the assessment tool would be to develop data and report production to inform day-to-day program management and to provide information for decision makers' long range planning. The report found that in the absence of standardized assessment, it is impossible to collect data needed to manage and control increasing demand for services. Additionally consumers do not receive consistent eligibility determinations and program authorizations due to the lack of a standardized system for completing authorizations.

In 2010, the Affordable Care Act passed which provided incentive payments for states that work towards rebalancing their Long-Term Services and Supports (LTSS). Arkansas is interested in

applying for BIP, which requires development of a standardized assessment instrument to determine eligibility for HCBS and develop individual care plans.

Taking all of these circumstances together, Arkansas decided to move forward in developing an automated assessment system.

What was Arkansas hoping to achieve?

Much like Washington, DAAS wanted to create a method in which clients, in all programs, with similar clinical characteristics and needs for care, would be grouped into relative resource groups. The resource groups would be related to acuity and would result in identification of in-home hours needed to meet client care needs as well as levels for placement into residential community settings.

DAAS wants a standardized assessment that would:

- Screen clients for potential eligibility
- Allow assessment face-to-face
- Support collection of information from other sources in order to understand the specific needs of clients
- Ensure that clients at risk of nursing facility placement are aware of all potential service options
- Document the client's needs, strengths, limitations, resources, preferences and level of care requirements
- Document current and potential care contributions from community resources and the client's informal supports
- Develop a care plan that:
    1. Incorporates elements of client choice
    2. Documents how these needs are currently being met or will be met
    3. Document who is currently or will be meeting these needs
    4. Help providers be aware of the client's needs so the provider can determine if they can meet the client's needs

DAAS goals further were/are to:

- Create data compatible across all programs for the purpose of program and budget development
- Create budget accountability by ensuring that correct eligibility determinations are consistently determined
- Standardize inter-rater reliability and promote accurate assessments
- Manage client liability and protect vulnerable adults by assessing/identifying risk indicators

How is Arkansas organized?

DAAS is a division within the Department of Human Services. The Division Director for DAAS reports to one of two Deputy Directors who report to the Director of the Department of Human Services. The Division of Medicaid Services Director reports to the other Deputy Director. Also within that chain of command are the county offices where financial eligibility is determined and the Nursing Facility Survey staff.

Responsibility for budget development is in the Office of Finance and Administration and that director reports directly to the Director of the Department of Human Services.

What was the process?

Arkansas's development process was confined primarily to DAAS and Department of Human Services (DHS) stakeholders. DAAS convened a workgroup called the Eligibility, Access and Application Workgroup whose composition evolved as new policy issues were identified. The group was charged with the responsibility of identifying all of the elements required in the tool to meet waiver and eligibility specifications. They were later called upon to discuss policy issues that needed to be changed or considered as the tool developed.

DAAS contracted with Penny Black of CE Reed and Associates and the University of Michigan to provide expert technical assistance in identifying the type of "off the shelf" tools that meet Arkansas's needs. The University of Michigan (UM) was also contracted to develop the algorithm to be used in the tool.

After several on-site demonstrations of potential tools, DHS and DAAS decided to use the interRAI Home Care tool with modifications to meet the programmatic requirement of DAAS.

Over a 19 month period, the UM assisted DAAS to:

- Design, test, and validate a systematic acuity based method to determine the cash allowance and/or service hour allocation that could be paid for in-home service
- Provide analyses to assist DHS to understand the functional, cognitive and medical status of nursing facility clients
- Determine current nursing facility Level of Care (LOC) algorithm from existing DAAS policy (and any eligibility criteria for other programs that might differ from NF LOC) and create an algorithm to enable automated determination of LOC decisions

While UM was working on the algorithm(s), DAAS began developing a Request for Proposals for a potential contractor for development of the software. After a public process, a contractor (CH Mack) was selected to begin work on developing the software and reporting capabilities needed by DAAS.

The interRAI home care assessment was developed by an international panel of experts on geriatrics, gerontology, assessment and health services. The tool has been tested and validated to be appropriate and effective in establishing reliable Resource Utilization Groups for home care.[18] The tool assesses ADLs, cognition, pain, depression, communication, establishes CAP triggers for interventions, supports care planning and sharing of information across care providers.

How is ArPath constructed?

ArPath is a web based application. The application was built for use on laptops in a disconnected mode. In the disconnect mode, three types of operation will be available: 1) view and edit pre-determined data set; 2) only view data; and 3) view data with additional capability of creating new narrative records and appending them to existing records.

While connected to the central database, the worker will be able to perform the following activities: person search and create a new person, log in, transfer case, assign workers to a case and roles to a worker and view reports. The remainder of the functionality will be enabled in the disconnected mode after the person data and the associated case assessments are checked out. Log-in functionality will be provided in the disconnected mode to maintain data security.

The central database will be Microsoft SQL and will serve as a central holding database for all clients and assessment data. Independent of the application, the central consolidated database will be able to be accessed by the database administrator.

What is the reporting capacity of ArPath?

One of DAAS's goals for implementing an automated standardized assessment tool is to enhance DAAS's ability to monitor and analyze data for program adjustments as knowledge and experience expands. Monitoring the impacts of participant outcomes and costs are expected to provide information to impact decisions on service delivery methods and resource allocations.

DAAS expects to have the capability of standardized reports as well as the ability to create ad hoc reports using "report writer." DAAS administrators will have the ability to configure data sets and reporting formats for use by end users while maintaining the ability to define larger data sets that can be filtered for additional reporting flexibility and functionality.

DAAS also expects to be able to create new reports using preconfigured datasets in the reporting database and upload these reports into the DAAS system.

The following data presentations will be available:

- Assessor by program by client approved/denied
- Assessments completed by date, geographic area, program, assessor or unit
- Assessment/reassessment completed and referrals made
- Assessment and payment authorization made
- Care plan and classification levels
- Nursing facility/hospital assessments
- Relative providers
- Intake totals by workers
- Response times
- Inactive cases
- Clinical scores
- Nursing/medical referrals

- Fair hearings
- Case Management
- Complaints

How long did all this take?

DAAS began constructing the Request for Proposal in March of 2010 and in May the bid was awarded to CH Mack to build the software for ArPath. The new assessment is expected to rollout at the beginning of January 2013. This is a very aggressive timeline, and there is concern about completion of all of the requirements and testing by that target date.

How much did this cost?

Without taking into consideration the involvement of DAAS Program Management, Technical and ultimately Field Testing staff time commitment, the contract with CH Mack is $1,435,000 for the first year to rollout of the tool.

The project consists of an executive steering committee (Project Sponsor, Project Manager, IT Management and Program Experts) and experts from the contract entity.

What are the components of the tool?

The interRAI HC Assessment tool is a MDS screening tool that enables an assessor to assess multiple key domains of function, health, social support, and service use. Particular interRAI items also identify persons who can benefit from further evaluation of specific problems or risks for functional decline. These items are known as “triggers” and link the interRAI HC to a series of problem-oriented Clinical Assessment Protocols (CAPs).

The CAPs contain general guidelines for further assessment and individualized care and services. There are 30 CAPs in multiple domains (e.g. clinical, mental health, psychosocial, physical function). On average, a person receiving home care services triggers about 10 of the 30 CAPs.

The interRAI system provides a variety of support materials these include: standardized scoring schema for creating summary indicators for measures such as ADLs, cognition, communication, pain and mood; a screening system; a case mix system that places persons into distinct service-use/intensity categories (RUG-III/HC); translations of the interRAI into several languages and; a variety of software systems to facilitate data entry and triggering of the CAPs.

The classification system and the resulting payment system are/will be algorithms programmed into the ArPath tool, which establishes the classification group, eligibility and payment levels. The algorithms have been developed by UM and can be adjusted over time as eligibility levels change to meet budget restrictions.

To complete an initial assessment and create a service plan takes an assessor approximately 2.5 to 3 hours. The annual reassessment is projected to take 1.5 to 2 hours.

What technical support did/will DAAS provide?

DAAS agreed to provide technical staff to participate in validation of the transfer requirements and the design of the system and agreed to conduct user acceptance testing in order to confirm that the finished product meets the approved transfer requirements.

The project management team includes:

- Project Sponsor
- Project Advisors from the contractor
- One Project Manager from the contractor and one Project Manager from DAAS
- One Application Manager from DAAS and one form the contractor

The contractor technical team includes:

- Project Manager
- Business Analyst Product Lead
- Business Analyst Integration
- Quality Analyst Lead
- Technical Lead
- Training Lead

Once the project is completed, DAAS has identified resources to provide ongoing technical support for the project. They are anticipating one part time lead and two full time positions to provide maintenance related to the server and equipment. The two technical positions will also provide technical support to staff.

How long is rollout expected to take?

Again DAAS is on an aggressive timeline. They anticipate the software development to be completed by the end of April 2012 and training to occur in May 2012. Training will be provided to DAAS Program Managers and field Supervisors by the contractors. The Managers and Supervisors will in turn provide training to the nurses in the field.

What certifications/educational/experience are required of assessors?

Currently the assessors are all state employees and are required to be Registered Nurses. The nurses are located in field offices in counties throughout the state. DAAS has not developed or decided how ongoing case management will occur or whether the case managers will complete the annual reassessment or changes in assessments.

Minnesota's approach to LTSS and assessment

In 2011, Minnesota was recognized nationally for their leadership in the development of a comprehensive system of support for older people and people with disabilities. Minnesota received the top ranking in the AARP, Commonwealth Fund, and SCAN Foundation report entitled "Raising Expectations, A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities and Family Caregivers." The report includes four dimensions and Minnesota ranked #4 in Affordability and Access, #3 in Choice of Setting and Provider, #4 in Quality of Life and Quality of Care, #4 for Support for Family Caregivers.

What motivated Minnesota to develop an automated assessment?

The Department of Human Services (DHS), Continuing Care Administration, currently uses a variety of paper screening and assessment documents to determine if persons are eligible for LTSS. The current screening and assessment process was considered challenging and time consuming for both consumers and lead agencies who determine eligibility.

Several issues with the current process included:

- Duplication in the questions asked and paperwork required
- Multiple forms were confusing and cumbersome for clients, families and some lead agencies
- The current Long-Term Care Consultation (LTCC) assessment is too focused on aging concerns
- The current Developmental Disabilities process does not satisfactorily screen for level of complexity and intensity of the needs of the DD population
- Two screening tools, one for DD and one for LTCC, create a separation at the county level of service units
- Consumers did not feel the current design captured their true needs and makes it difficult for staff to be responsive to their actual needs
- Not enough relevant detail collected to direct planning and fiscal accountability.
- Difficult for lead agencies to meet assessment timeframes
- Lack of automation makes it very difficult to complete required CMS reports for waiver quality assurance purposes

In 2004, a previous division director in the Disability Services Division and the Assistant Commissioner of the Continuing Care Administration of the Department of Human Services supported moving forward to develop an automated process to replace the multiple paper assessments being completed for clients served by the administration.

In 2012, the DHS will begin using the web-based MnCHOICES tool to assess the needs of children, adults, and older adults. The MnCHOICES tool will replace all LTSS assessment tools.

What was Minnesota hoping to achieve?

Through use of the automated MnCHOICES, the Department of Human Services would achieve the following goals:

- Implement a single framework for access to and assessment of coverage and service options through combining LTSS assessment processes

- Ensure greater consistency across lead agencies (counties, health plans, and tribes) by simplifying and standardizing face-to-face assessments and certifying assessors
- Make decisions that are responsive to persons with disabilities and older Minnesotans. Allow for timely consideration of support options beyond what is reimbursed through Medical Assistance LTSS programs
- Distribute available resources in a fair and timely manner.
- Provide additional data to evaluate outcomes

In addition, the state expects to be able to obtain consistent and accurate data that can be used for budget development and rate setting decisions, information and reports at the lead agency and assessor level, data on the acuity levels of clients, automate LTSS eligibility, determine hours for personal assistance services and compliance with the Centers for Medicare and Medicaid Services (CMS) waiver quality assurance protocols.

How is Minnesota organized?

The Continuing Care Administration is one of the program areas within the Department of Human Services (DHS). The administration includes four divisions-Aging and Adult Services; Deaf and Hard of Hearing Services; Disability Services; and Nursing Facility Rates and Policy. The other administrations within DHS include Chemical and Mental Health Services; Children and Family Services; Health Care; Operations; Health Policy and Reform, and Minnesota Sex Offender Program.

The Department of Human Services is the designated State Medicaid Agency. The state has 87 counties who perform financial and programmatic eligibility for LTSS programs. In addition, Minnesota has a robust managed care program that requires all older Minnesotan's who are on Medical Assistance to receive their health care and LTSS through health plans. There are 8 health plans that manage the LTSS system for older Minnesotan's although some of them contract back with counties to do assessments and case management. There are also 5 tribal nations in Minnesota that manage the LTSS system to varying degrees. These lead agencies provide social workers, nurses and financial eligibility staff to perform the necessary LTSS functions.

What was the process?

The changes were expected to be significant—in the future the assessment process will not assume what program someone will enroll in before the assessment is initiated. The assessment is envisioned to address the person's needs, complete a support plan, and then look at the funding sources that are available to meet the needs rather than the reverse. It is a major philosophical shift and multiple assessments and processes need to be incorporated into one process.

Because of the significance of the change, it was decided that the stakeholder process would be extensive. An RFP was issued in 2004. An outside contractor, HCBS Strategies, Inc., was selected to facilitate the stakeholder process including committees, workgroups and focus groups that would help develop new processes.

A project steering committee was formed that included advocates for older persons, people with disabilities including mental health, brain injury, and developmental disabilities, Area Agencies on Aging, counties, managed care organizations, developmental disabilities providers, aging providers, home care agencies and consumers.

In addition other work groups were formed: a children's work group, cultural competency work group, support planning work group, a mental health work group and various other subgroups to design the content of the assessment. All of these work groups included various advocate groups, counties, tribes, health plans, and consumers.

From 2004 through 2007 these groups along with HCBS Strategies, Inc. designed the content of the assessment and developed the framework for the new processes to be implemented.

In designing MnCHOICES, other state assessments were reviewed including the Washington CARE, the New Jersey EASE, and the interRAI. The state wanted a person centered approach to the assessment process and worked with Michael Smull and Dr. Beth Mount to design questions for a person-centered interview (now called the quality of life domain). In addition, building on the work of the Medicaid Infrastructure Grant that the state received in 2001, the state wanted to focus attention on employment as part of the plan. The assumption is that persons ages 14-64 could work. For people age 65 and older, community involvement including volunteering is considered.

When the funding was approved in the 2009 legislature the project steering committee was reformed and new work groups were formed including an intensive policy work group, an experienced assessor work group; technology committee and a first implementer work group. Once again, these groups included advocates, counties, managed care organizations, tribes, providers and consumers.

The MnCHOICES tool would be used across all the Medical Assistance State Plan LTSS, HCBS waivers, and state funded programs. These included:

- Alternative Care Program
- Community Alternative Care Waiver
- Community Alternatives for Disabled Individuals Waiver
- Developmental Disability Waiver
- Elderly Waiver
- Home health agency services
- Intermediate care facility for persons with developmental disabilities
- Nursing facilities
- Personal care assistance
- Private duty nursing
- Traumatic brain injury
- Community Support Grant (state funded)
- State grant (Semi-independent living services)
- Family Support grant (administered by counties)

MnCHOICES will take the place of all current LTSS assessments including:

- Personal care assistance
- Developmental screening
- Long-Term Care Consultation (LTCC)
- Private Duty Nursing Assessment

How is MnCHOICES constructed?

The assessment is constructed using Microsoft Silverlight to accommodate users connected to the internet and offline users. Connected users access the application through the county based Social Services Information System (SSIS) platform or directly through a web browser. Offline users install the application on their laptop, complete the assessment, and synchronized with the centralized application when online.

Policy and regulatory rules for determining eligibility are encapsulated with the IBM ILOG rules engine. The eligibility rules can be executed in both connected and offline modes.

Initially there will be limited integration with SSIS, which will be enhanced in the future.

Currently DHS relies on the Screening Document subsystems to capture and edit assessment information that is relevant to service and program eligibility and budgets. In a future phase, MnCHOICES will:

- Apply business rules with the MnCHOICES application
- Capture the information and edit it
- Interface with rate-setting and service authorization tools
- Populate MMIS with only the information it needs, which is the conclusion about eligibility and budgets, not all of the information that resulted in the decision

What is the reporting capacity of MnCHOICES?

The discussion about what reports management and the users (counties, tribes, and health plans) want the system to generate will occur in the spring of 2012 after beta testing is completed. Currently since the system is not automated only hard copies of information are available at the county level. Some limited information is entered into the MMIS for eligibility and service authorization purposes.

Some preliminary thoughts about what reports will be available include:

- MnCHOICES will be able to generate reports that will enable the agency to provide the information necessary to comply with CMS waiver quality assurance protocols
- The state wants the system to be able to provide reports that allow comparison of HCBS consumer characteristics with the MDS nursing home resident data
- The system will make data accessible to lead agencies (counties, tribes, and health plans). It is expected that the Health Risk Assessment and data from chronic care management questions will be available in an early release of the application
- The implementation of the system will allow the agency to collect data in order to design a program that allows for an individual budget for consumers

In addition to the set of reports they decide will be regularly generated from the system, they want to be able to allow queries that produce custom reports. They will engage state staff, counties, tribes, and health plans about the kind of queries they want. They also will be talking to users to determine who will have access to the data and are thinking initially starting with the supervisory level and not all assessors.

How long did all this take?

The assessment content and stakeholder work began in 2004 and was completed in 2007. Due to overall state budget constraints, the project was put on hold after this phase. An agency budget

proposal was funded by the legislature for the 2009-11 biennium and rollout of the assessment is projected for late 2012.

How much did this cost?

The legislature provided $3.5 million for MnCHOICES implementation in total funds and the Department is preparing an Advance Planning Document for CMS to obtain federal reimbursement. The original 3-year contract with HCBS, Inc. was for $425,000 and the subsequent 2009 contract was for $490,000. These figures do not include state staff time in the Continuing Care Administration which was substantial but necessary to complete this complex project.

What are the components of the tool?

MnCHOICES is designed as an automated modular tool that only prompts for information that is relevant to a particular individual. There are three phases: 1) the initial contact screening call that captures the reason for referral, the urgency of the person's needs and whether a full assessment is needed 2) the assessment of preferences, strengths, and needs and 3) the development of the support plan. The assessment sections include:

- Intake
- Quality of Life
- Activities of Daily Living
- Instrumental Activities of Daily Living
- Decision Making
- Employment
- Health (Children)
- Health (Adult)
- Housing and Environment
- Memory and Cognition
- Safety/Self Preservation
- Sensory and Communication
- Social Communication and Friendships
- Health Care Access
- Caregiver Assessment
- Assessor Conclusions

The tool will include screening tools such as Geriatric Depression Screening, Pediatric symptom checklist, T-CARE screening (Rhonda Montgomery), and a mental status exam.

The assessment needs will populate the support plan. The Department is currently working on how the needs will flow to the support plan. In order to promote consistency they intend for the rules in the system to drive similar services for similar needs.

Algorithms planned for the system include level of care eligibility and personal care assistance hours. The state rate for services will be included in the system. They are also in the process of developing a rate setting methodology on a separate track that will link with assessment data mainly for residential services.

During beta testing, the department will be analyzing how long it takes to complete an initial assessment and expect the reassessment time to be shorter than the current process.

What technical support did DHS provide?

DHS contracted with business analysts and programmers to develop the web-based application. They are in the process of testing with some counties, the second round of alpha testing will be completed December 11, 2012 and involved the First Implementers Workgroup. Beta testing is scheduled to commence in late spring, early summer.

Conversations have started about on-going technical support from their partners in the DHS SSIS system including technical assistance and help desk functions. An agreement may be developed in the future.

How long did it take to rollout/implement the new tool?

The schedule for rollout/implementation is being developed. The training provided to assessors will be across populations/across programs. This will result in assessors being cross-trained and able to assess any person regardless of age, diagnosis, functional ability or assistance requested, etc. The training will be a 3-step process-overview, assessment (both of these will be on-line) and application training (this might be an on-line webinar). The volume of people to be trained necessitates an on-line process.

What certification/educational/experience were required of assessors?

Assessors educational/experience requirements are a Public Health Nurse or Social workers with 1 year experience in HCBS, a Registered Nurse with a 2 or 3 year degree and 2 years of experience in HCBS, or a person in a related field (special education, mental health) and 1 year of experience in HCBS.

With the rollout/implementation of the tool, a certification requirement will be necessary in addition to the current education/experience. Recertification will occur every 3 years.

How does the implementation of this system change the way Minnesota does business?

Minnesota did not anticipate savings because of the implementation of the system but efficiencies will occur due to the elimination of multiple assessments, creation of standardized protocols for all ages and disabilities, cross-training of staff to address all age groups, clarification of certified assessor and case management roles to eliminate duplication of activity and billing, elimination of multiple DHS and agency specific paper forms and manual processes, and helping support efficient and effective communication among staff.

Develops consistency so that consumers with similar needs receive similar services. Consumers have input into receiving the right supports at the right time.

Private duty nursing assessments will no longer be completed by a home care provider and will become the responsibility of the certified assessor.

The state will be able to comply with the CMS quality assurance protocols for waivers and not be dependent on paper processes.

Decision-making for program policy, program development, budget planning, program monitoring can be data driven. Management can monitor staff and contractor performance.

New York's approach to LTSS and assessment

New York has many screening and assessment tools in use today that are not standard across programs and create significant redundancy. After extensive research the state identified a replacement instrument, the interRAI Community Health Assessment. The state, at this phase, in order to keep the scope of the project manageable, plans to use the new assessment for Medicaid HCBS. The new assessment will be used initially by 8 LTSS programs, assisted living, personal care services, adult day health care, long-term home health care, nursing home transition and diversion, traumatic brain injury waiver, care at home I and II waivers, and managed LTSS. Programs designed solely for individuals with developmental disabilities (DD) are not specifically included in the scope of work of this project but due to the nature of the interRAI suite of the population could be added later with additional resources.

What motivated New York to develop an automated assessment?

In 2007 the Office of Long Term Care was created within the Department of Health with a specific directive to implement reforms in the LTSS system. Information systems changes were seen as a very necessary part of LTSS reform.

The Department of Health currently operates an extensive Medicaid reform effort. The New York State Medicaid Redesign Team approved going forward with recommendation #69 - implementation of an automated comprehensive assessment for LTSS programs.

Staff work done internally to determine if there were tools that could be used included extensive analysis and review of literature. A third party validated the staff work and selection of the tool to be used, the interRAI Community Health Assessment. There was support from the Division of Budget and the Legislature that provided funding for the development of the system.

The Office of Long Term Care has little clinical or functional data about individuals they serve. The current centralized data is Medicaid billing information. Other functional or clinical data is often in paper forms at program sites or included in program systems. The implementation of the system will provide information to understand the population being served including the opportunity to use the data for risk assessment and rate setting.

Long-term services and supports reform in New York includes moving from a fee for service system to managed LTSS and the automated comprehensive assessment is seen as essential to that initiative. In addition the Affordable Care Act initiatives – Balancing Incentive Payment Program and the Community First state plan option – require a state to improve their infrastructure through the development of a standardized assessment.

What was New York hoping to achieve?

As part of the Medicaid Redesign effort in New York State, the Office of Long Term Care wanted to create a system to facilitate uniform assessments for HCBS programs in New York State. Prior to the effort to redesign the Medicaid system, clients accessed the large and complex system by way of many assessment methods and tools. The tools in use lack standardization across programs and many have not been tested for reliability or validity. As in the other states profiled, care plans, referrals and authorizations can be subjective.

The Uniform Assessment System-New York (UAS-NY) is expected to facilitate access to programs and services, eliminate duplicative assessment data, and improve consistency in the assessment process. New York is hoping to reduce fragmentation in the delivery of LTSS

services by implementing the standardized assessment of functional and other client needs through an empirically tested and validated tool.

The objectives of the UAS-NY are to:

- Assess a client's functional needs and abilities through an empirically tested and validated means
- Provide accurate data to develop individualized plans of care that are consumer-driven, build on consumer strengths and offer consumer choice
- Identify level of care
- Assist with care planning and oversight
- Reduce redundancy
- Improve the quality, consistency, and accuracy of assessment and care plans
- Enhance the state's capacity for program development and policy decisions that are data driven
- Increase access to data by multiple providers via electronic means
- Provide compatibility with other data sets and align with existing standards to the extent that it's possible

How is New York organized?

The Department of Health is the designated state Medicaid agency. The Department of Health has Memoranda of Understanding (MOUs) with separate state agencies such as the Office of Mental Health and the Office for People with Developmental Disabilities. Within the Department of Health there is an Office of Health Insurance, which includes divisions responsible for various Medicaid activities such as LTSS, managed care, quality, rate setting, etc.

At the local level, there are designated local districts of social services under the governance of the counties and the City of New York. The state delegates to these local entities Medicaid eligibility and some programmatic assessments, for example, personal care and two of New York's 1915(c) HCBS waivers. The assessment project will require these entities to use the statewide tool. There are 58 local districts, 9 other regional authorities, and approximately 1000 assessing providers.

What was the process?

The Department of Health, Office of Long Term Care developed the budget proposal for the project and led the stakeholder process. Stakeholders included consumer advocacy groups and consumers, users of the system including providers and local districts, and an advisory group made up of consumer advocates, consumers, providers, and other state agencies. These representatives have helped with understanding consumer and business needs related to a shift to a uniform assessment system. The state emphasizes to stakeholders the end vision, the ability to share data, and the functionality that would be included in the system.

Thirty organizations have agreed to be involved in beta testing in the spring. The decision to participate in the beta testing is at the discretion of the organizations. The areas being reviewed within the beta are: system stability, statewide rollout strategy, impact on beta site business practices, and impact on assessed individuals. After beta testing a pilot is planned for the summer which will involve participating in the live system.

How is the UAS-NY constructed?

The UAS-NY is a web based application. The State is developing a configurable system that will allow adaptions of the system.

The UAS-NY will include the following interRAI instruments, algorithms, clinical assessment protocols, and risk triggers as the core functionality of the tool:

- interRAI Community Health Assessment
- interRAI Functional Supplement
- interRAI Community Health Supplement
- Scales related interRAI formats
- Triggers for Functional Supplement and Mental Health Supplement
- New York State “Level of Care” algorithm
- Resource Utilization Group (RUG) III Home Care

Assessment data will migrate to a central data base.

New York has required that the following data requirements be addressed:

- Assessment data be aligned with national standards for Health Information Exchange
- The system align with state and national data sets
- Capture user information
- Account for unique client identifier to avoid duplication in the system
- Assign unique assessment identifiers related to clients identified
- Correctly incorporate the use of ICD-9 and 10 data sets

While connected to the central database, the assessor/tool will: be restricted from providing data that is not valid for the specific item of the assessment, auto-populate information when appropriate, default values by the data specification, display messages after data is entered for a given item to alert the assessor of data problems (e.g., data out of range or inconsistent with other information), and allow the assessor to immediately modify the data, perform edits and validations and will not provide the assessor with the option to skip data validation edits, provide the assessor with the option of accepting, where appropriate, the data as provided despite edit validation failures, allow assessors to enter notes at the end of each domain.

What is the reporting capacity of UAS-NY?

The DOH will include the capacity to produce and print a variety of reports from assessment information entered into the UAS-NY. Some reports are statistical in nature; provide insight into daily, monthly, and yearly workload volumes. Other reports will be program-specific to support service planning and adjustments. Monitoring the impacts of client outcomes and costs are also anticipated to provide information that impact on service delivery methods,

1. The UAS-NY will provide reports including but not limited to:
    - List of client needs
    - Clinical Assessment Protocols (CAPs)for care planning and review
    - Case mix groups
    - Summary reports of recipient assessment profiles over time
    - Production reports by user
    - Ad-hoc reporting request

- Interactive assessment scales, triggers and CAPs (real-time)
- Work flow between settings/users

2. Personal Health Summary report
3. Program specific reports for service planning
4. Standard assessment reports that allow managers to view summary and detailed assessment data
5. Reports based on user selection criteria such as date range, assessment status, local districts and other selection criteria

How long did all this take?
The Governor and the legislature provided support for the development of a universal assessment tool in the budget for the state fiscal year 2008-2009.

The project timeline has been and is as follows:

- 2007-2008: uniform data set development, research and tool identification
- 2008-2009: licensing agreement and development of IT RFP
- 2009-2010: approval and completion of RFP
- 2010-2011: selection of a vendor and initiation of the project
- 2012-2013: beta testing, piloting and implementation of the project

How much did this cost?

At this point in the project, the estimated development and implementation costs are expected to reach approximately $8.6 million over the state fiscal years 11/12 and 12/13. An Advance Planning Document (APD) has been approved by CMS for 50% of $4.806 million (or $2.403 million) for the project management plan, development and implementation of the uniform assessment system for LTSS. New York will be seeking additional cost sharing with CMS for maintenance costs and completion of development of the system.

The vendor was required to provide the following types of staff to the project related to the IT build:

- Project Manager
- Technical Lead
- DBA/Database Designer
- Quality Assurance Lead
- Business Analyst
- Security Lead
- Training Lead

The project consists of an executive steering committee (Project Sponsor, Project Management, IT Management and Program Experts) and experts from the contract entity.

The Office of Long Term Care contributed 2 FTEs to do research, planning and development through the contract execution. The 2 FTEs coordinated the efforts of approximately 30 staff from program, quality and IT areas, consultants and executive staff support.

What are the components of the tool?

The interRAI HC Assessment tool is a MDS screening tool that enables an assessor to assess multiple key domains of function, health, social support, and service use. Particular interRAI items also identify persons who can benefit from further evaluation of specific problems or risks for functional decline. These items are known as “triggers” and link the interRAI HC to a series of problem-oriented CAPs.

The Clinical Assessment Protocols (CAPs) contain general guidelines for further assessment and individualized care and services. There are 30 CAPs in multiple domains (e.g. clinical, mental health, psychosocial, ADL).

The interRAI system provides a variety of support materials, these include: standardized scoring schema for creating summary indicators for measures such as ADLs, cognition, communication, pain and mood; a screening system; a case mix system that places persons into distinct service-use/intensity categories (RUG-III/HC); translations of the interRAI into several languages and a variety of software systems to facilitate data entry and triggering of CAPs.

What technical support did/will the Office of Long Term Care provide?

Research, planning and development through contract execution involved 2 FTEs coordinating approximately 30 people from Program, Quality, and IT areas, consultants, and executive staff support. The process was orchestrated by the Deputy Director and directed by the Deputy Commissioner of the Office of Long Term Care.

Two staff members are expected to support the training and technical help lines after implementation. The cost of this effort will be dependent upon the level of support and the salary structure for the staff involved.

How long did it take to rollout/implement the new tool?

The state is paying for the system and the training. During beta testing, the state plans to include users who have a low level of computer readiness.

What certifications/education/experience were required of assessors?

Generally the assessors will be nurses, social workers, occupational therapists, physical therapists and speech therapists. All assessors must complete the assessment training developed for the UAS-NY.

How will the implementation of this system change the way New York does business?

New York anticipates that the UAS-NY will provide the capacity to allocate resources equitably, reduce duplication, and streamline processes for those providing services and being served by the LTSS programs. The anticipated cost and quality improvements will be identified with the data analysis of the actual assessment data.

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EndNotes

[1] Engelhardt, Tim and Julie Guill. "Universal Assessments and Streamlining Access to Long Term Care." The Lewin Group. October 2009.

[2] AARP Public Policy Institute. Kassner, Enid, et al. A Balancing Act: State Long-Term Care Reform. July 2008.

[3] AARP Public Policy Institute. Kassner, Enid, et al. A Balancing Act: State Long-Term Care Reform. July 2008.

[4] Shirk, Cynthia. Comprehensive Assessments in Home and Community-Based Services. The Hilltop Institute, UMBC. July 2009.

[5] The SCAN Foundation: Transforming California's System of Care for Older Adults and People with Disabilities a Look at the State's Administrative and Fiscal Organization. May 2011.

[6] Centers for Medicare and Medicaid Services, Providing Long-Term Services and Supports in a Managed Care Delivery System. December 2009.

[7] Lind, Alice, Suzanne Gore, Lindsay Barnette, Stephen Somers. Center for Health Care Strategies. Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services. The SCAN Foundation. November 2010.

[8] Lind, Alice and Suzanne Gore. Center for Health Care Strategies. From the Beneficiary Perspective: Core Elements to Guide Integrated Care for Dual Eligibles" The Commonwealth Fund. December 2010.

[9] Mission Analytics Group. The Balancing Incentive Program: Implementation Manual. Acumen, Human Services Research Institute. October 2011.

[10] Reinhard, Susan et al. Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers. AARP, The Commonwealth Fund, The SCAN Foundation. September 2011.

[11] Reinhard, Susan et al. Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities and Family Caregivers. AARP, The Commonwealth Fund, and The SCAN Foundation. September 2011.

[12] Bea Rector 2004.

[13] AASA/Deloitte Phase I and II Project Management Plan 2002.

[14] AASA/Deloitte Phase I and II Project Management Plan 2002.

[15] AASA/Deloitte Phase I and II Project Management Plan 2002.

[16] Information provided by ADSA Technical Management staff.

[17] Ribar, Mary Beth. "Rebalancing Long-Term Care Systems in Arkansas." 2005.

[18] Lippincott, Williams and Wilkins. "Validation of Resource Utilization Groups Version III for Home Care." 2008.