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THE BALANCING INCENTIVE PROGRAM: IMPLEMENTATION MANUAL

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FOREWORD

The Centers for Medicare and Medicaid Services (CMS) is dedicated to helping States provide quality care to individuals in the most appropriate, least restrictive settings. Against this backdrop, CMS is pleased to offer its State partners new opportunities under the Balancing Incentive Payments Program (referred to as the Balancing Incentive Program).

Authorized by Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), the Balancing Incentive Program provides enhanced Federal Medical Assistance Percentages (FMAP) to States that spend less than 50 percent of long-term care dollars on care provided in home and community-based settings. To qualify for these funds, States must implement three structural changes in their systems of community-based long-term services and supports (LTSS): a No Wrong Door/Single Entry Point (NWD/SEP) eligibility determination and enrollment system; Core Standardized Assessment Instruments; and conflict-free case management.

CMS has produced this Manual to provide guidance to States in implementing these structural changes. In developing this guidance, CMS has attempted to reduce the burden on States as much as possible, while still ensuring that participating States comply with the letter and spirit of the legislation. Many States will find that they have already implemented the required structural changes, or are close to doing so. For many States, achieving the requirements of the Balancing Incentive Program is eminently realistic.

CMS stands ready to provide States with technical assistance on several fronts. Six months after submitting an application for the Balancing Incentive Program, States must submit a Work Plan describing the milestones they will meet as they implement these changes. CMS will work closely with States to ensure that the goals laid out in the Work Plan are appropriate and realistic. For the first year of the Program, a team of consultants will supplement the assistance that CMS provides. These consultants will help States to draft the Work Plan, to identify the funds necessary to make structural changes, and to implement those changes. In addition, CMS plans to disseminate information on best practices and lessons learned, helping States learn from each other about the successes and challenges of implementing the Balancing Incentive Program.

States should not view the Balancing Incentive Program strictly as a set of administrative requirements necessary to obtain enhanced Federal funding. Rather, States should view the Program as a way to help more individuals live healthy, independent, fulfilled lives in the community. The Balancing Incentive Program should be seen as one component of a comprehensive approach to systems balancing.

CMS hopes that its State partners will embrace the opportunities that the Balancing Incentive Program provides, to create a future in which more individuals with long-term care needs live in the communities of their choice, among friends and family, with control over their own lives and futures.

1. INTRODUCTION

Section 10202 of the Patient Protection and Affordable Care Act (Pub. L. 111-148), titled the State Balancing Incentive Payments Program (hereafter referred to as the Balancing Incentive Program), provides financial incentives to States to increase access to non-institutionally based long-term services and supports (LTSS) (referred to as community LTSS in this Manual). This provision of the Affordable Care Act will assist States in transforming their long-term care systems by lowering costs through improved systems performance and efficiency, creating tools to facilitate person-centered assessment and care-planning, and improving quality measurement and oversight. In addition, the Balancing Incentive Program provides new opportunities to serve more individuals in home and community-based settings, adding to the available tools for States to administer services and activities in the most integrated settings, as required by the Supreme Court's 1999 *Olmstead* decision.

The following discussion provides a more detailed description of the benefits and requirements of the Balancing Incentive Program, as well as the organizational structure of this Manual, the purpose of which is to help States implement the Balancing Incentive Program's required structural changes.

1.1. BENEFITS AND REQUIREMENTS OF THE PROGRAM

The Balancing Incentive Program provides financial incentives to States to offer community LTSS as an alternative to institutional care. Specifically, States that spend less than 50 percent of their long-term care dollars on community LTSS receive a two percent increase in their Federal Medical Assistance Percentages (FMAP), while States that spend less than 25 percent receive a five percent increase. In order to access these funds, States must ensure their systems include, or will include, the following structural features as described by the legislation:

- **NO WRONG DOOR—SINGLE ENTRY POINT SYSTEM:** Development of a Statewide system to enable consumers to access all long-term services and supports through an agency, organization, coordinated network, or portal, in accordance with such standards as the State shall establish and that shall provide information regarding the availability of such services, how to apply for such services, referral services for services and supports otherwise available in the community, and determinations of financial and functional eligibility for such services and supports, or assistance with assessment processes for financial and functional eligibility.
- **CONFLICT-FREE CASE MANAGEMENT SERVICES:** Conflict-free case management services to develop a service plan, arrange for services and supports, support the beneficiary (and, if appropriate, the beneficiary's caregivers) in directing the provision of services and supports for the beneficiary, and conduct ongoing monitoring to assure that services and supports are delivered to meet the beneficiary's needs and achieve intended outcomes.
- **CORE STANDARDIZED ASSESSMENT INSTRUMENTS:** Development of core standardized assessment instruments for determining eligibility for noninstitutionally-based long-term services and supports described in subsection (f)(1)(B), which shall be used in a uniform manner throughout the State, to determine a beneficiary's needs for training, support services, medical care, transportation, and other services, and develop an individual service plan to address such needs.

The full legislation can be found in [Appendix A](#).

Within six months of applying for Program funds, States must submit a Work Plan to CMS describing the timeline and activities involved in implementing the structural changes required by the Balancing Incentive Program. [Appendix E](#) contains guidance for creating and submitting the Work Plan and its related deliverables.

The legislation also requires States to meet certain target levels of community LTSS spending by October 1, 2015. States that spend less than 25 percent of their long-term care dollars on community LTSS should hit the 25 percent target, while States below 50 percent should reach the 50 percent target. Throughout the course of the grant, States should demonstrate to CMS that they are making reasonable progress toward these targets in quarterly financial reports (described in Chapter 7).

[Appendix D](#) of the Manual is a checklist of Balancing Incentive Program requirements to help States track progress.

1.2. SERVICES AFFECTED BY THE PROGRAM

CMS defines non-institutionally-based Medicaid LTSS as services provided only in integrated settings that are home and community-based and therefore not provided in institutions.¹ Many population groups can receive these services, including the elderly and individuals with mental illness,

Medicaid Program Authorities with Community LTSS

- HCBS under 1915 (c) or (d) or under an 1115 Waiver
- State plan home health
- State plan personal care services
- State plan optional rehabilitation services
- The Program of All-Inclusive Care for the Elderly (PACE)
- Home and community care services defined under Section 1929(a)
- Self-directed personal assistance services in 1915 (j)
- Services provided under 1915(i)
- Private duty nursing authorized under Section 1905 (a)(8) (provided in home and community-based settings only)
- Affordable Care Act, Section 2703, State Option to Provide Health Homes for Enrollees with Chronic Conditions
- Affordable Care Act, Section 2401, 1915(k) - Community First Choice (CFC) Option

developmental disabilities, physical disabilities such as traumatic brain injury, and other conditions that warrant community LTSS such as Alzheimer's disease.

A State's eligibility for the Balancing Incentive Program will be determined by the share of total LTSS dollars spent on community LTSS. However, CMS does not have access to all of these service data, including managed care. In addition, States may propose additional types of community LTSS. Therefore, States may present CMS their own data sources and calculations for determining eligibility.

¹ Institutions include nursing facilities, Intermediate Care Facilities for the Mentally Retarded (ICF-MR), Institutions for Mental Diseases (IMD) for people under age 21 or age 65 or older, long-term care hospitals as defined for the Medicare program (i.e., those with an average length of stay of 25 or more days), and psychiatric hospitals that are not IMDs.

1.3. ORGANIZATIONAL STRUCTURE OF THE MANUAL

The purpose of this Implementation Manual is to provide States with guidance on the implementation of the structural changes required by the Balancing Incentive Program. The Manual is structured as follows:

- **Chapter 2** of the Manual provides a background to the Balancing Incentive Program legislation, including previous efforts to balance LTSS toward home and community-based settings.
- **Chapters 3, 4, and 5** address each of the structural changes required by CMS: the No Wrong Door/Single Entry Point (NWD/SEP) system, Core Standardized Assessment (CSA), and Conflict-Free Case Management. These chapters will help States implement structural changes that meet the Balancing Incentive Program requirements and exceed these requirements where possible. Each chapter ends with a table summarizing the structural change's requirements and recommendations.
- **Chapter 6** provides guidance to States related to the automation of NWD/SEP systems. Although not a requirement of the Balancing Incentive Program, Electronic Information Exchanges (EIEs) can greatly help States streamline and coordinate the eligibility determination process.
- **Chapter 7** provides a summary of data collection and reporting requirements.
- **Chapter 8** addresses funding sources that States can potentially access to implement the structural changes the Program requires.

The [Appendices](#) provide additional tools and resources for operationalizing the structural changes and completing the Work Plan, including:

- Official documents describing the Balancing Incentive Program, including the legislation, State Medicaid Director Letter, and application form.
- A checklist of Balancing Incentive Program requirements to help States track their progress.
- Instructions for completing the Work Plan, including a table of subtasks, deliverables, and due dates.
- Information to help States coordinate efforts across multiple and diverse entities, including an example Memorandum of Understanding (MOU).
- Implementation guidance for the CSA, including descriptions of State and national practices and tools to help States evaluate their current assessment instruments and identify topics and domains that must be included to meet Balancing Incentive Program requirements.
- Suggested Medicaid Adult Health Quality Measures recommended to help States meet the data collection requirements.
- Information to help States share data securely and build websites accessible to people with physical and developmental disabilities.
- Glossary of acronyms, references, and website resources.

2. BACKGROUND

State Medicaid programs are under increasing pressure to balance their long-term care systems. Because it contributes so substantially to rising health care costs and because the population of the United States is growing progressively older, long-term care has become an essential component of health care policy. Long-term services and supports (LTSS) consume nearly one-third of State Medicaid budgets on average, with the majority of this spending going towards costly institutional care: 58 percent of overall spending is used for institutional care, with 70 percent of these funds going to older adults and younger individuals with disabilities (The Lewin Group, 2005).

One way to reduce LTSS costs while improving quality of care is to divert people away from institutions and into home and community-based settings. However, due to reimbursement incentives and the difficulty in navigating community LTSS eligibility and enrollment systems, the Medicaid population has historically relied on nursing homes for care. Recent legislative efforts have helped mitigate this trend by introducing legal mechanisms that allow States to provide community LTSS and support an environment for more effective enrollment procedures. Some of these efforts are described below.

2.1. IMPROVING FINANCIAL INCENTIVES FOR COMMUNITY LTSS

Under Title XIX of the Social Security Act (SSA), States are required to provide nursing home care as a benefit to all eligible individuals. In contrast, reimbursement for community LTSS via the basic State Plan is limited to one required service – home health – and one optional service – personal assistance services (PAS).

Over the last several decades, the SSA has been amended to help reduce the institutional bias in Medicaid long-term care:

- Under **Section 1915(c)** of the SSA, States can ask the Secretary of Health and Human Services (HHS) – via CMS – to waive certain statutory requirements of the SSA, including the requirement to provide the same services to everyone whose needs and income make them eligible ("comparability") and the requirement to provide the same services throughout the State ("Statewideness").
- The 2005 Deficit Reduction Act (DRA) created **Section 1915(i)**, which allows States to amend their Medicaid plans to provide community LTSS based on needs-based criteria (rather than diagnosis) and to individuals whose needs do not necessarily rise to institutional level of care. The DRA allowed States to cap enrollment in 1915(i) services.
- The DRA also created **Section 1915(j)**, under which States can amend their plans to give individuals the power to self-direct their PAS.
- Finally, under **Section 1115**, States can create demonstration programs to deliver community-based care in innovative ways.

The 2010 Affordable Care Act established new vehicles and amended existing vehicles for improved financing of Medicaid-funded community LTSS. New vehicles include the Community First Choice Option (CFCO), a State plan option for community LTSS that provides an increased Federal Medical Assistance Percentage (FMAP) of six percent for program costs. The Health Homes provision, which provides 90 percent FMAP for health home services for two years, was also established for individuals with chronic conditions. The Act also created the Balancing Incentive Program, which targets those

States that have not moved as quickly with balancing, offering support in the form of enhanced FMAP for community LTSS. Finally, the Affordable Care Act amended Section 1915(i), allowing multiple benefits targeted to specific populations, but requiring that benefits not be capped.

2.2. IMPROVING ACCESS TO COMMUNITY LTSS THROUGH STREAMLINED ENROLLMENT

Another cause of institutional bias in long-term care costs is the difficulty in navigating community LTSS eligibility and enrollment systems. Community LTSS are provided through multiple programs, funding streams, and entities. Eligibility criteria vary among programs and may include both functional and financial status. Often, different programs have different eligibility assessment processes and instruments, even among programs administered by the same entities. As a result, individuals may not be aware of the full range of community LTSS options for which they might be eligible or how to apply for them. Once the enrollment process has started, an individual may have to communicate with multiple, uncoordinated entities, having to "tell their story" multiple times, which can lead to confusion, and delayed eligibility determinations and access to services. Delayed access to needed services may result in institutionalization of an individual who could have been served in the community.

The Affordable Care Act established several measures for addressing barriers to enrollment and improving access to community LTSS. The Act extended the Money Follows the Person (MFP) demonstration program until September 30, 2016 and continued funding for the Aging and Disability Resource Center (ADRC) program, co-sponsored by the Administration on Aging (AoA) and CMS. Through coordinated information, options counseling, eligibility determination and case management systems, ADRCs provide a model for streamlining access to care and increasing the person-centered aspect of LTSS. In addition, the Balancing Incentive Program includes an important requirement for States to access the enhanced FMAP. States must implement a streamlined enrollment process that ensures everyone has the same access to information and resources on community LTSS, regardless of their first point of entry into the enrollment system. Under this framework, individuals should be assessed only once with a single instrument for the entire range of services and programs for which they might be eligible. By facilitating streamlined access to community LTSS, the Balancing Incentive Program aims to reduce reliance on nursing homes and improve access to community-based care.

3. STRUCTURAL CHANGE 1: NO WRONG DOOR/SINGLE ENTRY POINT SYSTEM

This section describes the first structural change required by the Balancing Incentive Program – a No Wrong Door/Single Entry Point (NWD/SEP) system. Within the Program, this structural change is defined as the:

“development of a Statewide system to enable consumers to access all long-term services and supports through an agency, organization, coordinated network, or portal, in accordance with such standards as the State shall establish and that shall provide information regarding the availability of such services, how to apply for such services, referral services for services and supports otherwise available in the community, and determinations of financial and functional eligibility for such services and supports, or assistance with assessment processes for financial and functional eligibility.”

States should keep in mind three interlinked principles when approaching and implementing a NWD/SEP system. First, changes to existing systems should increase the accessibility of community long-term care services and support (LTSS) by making it easier for individuals to learn about and be linked to services. Second, the structural change should create a community LTSS enrollment system with increased uniformity across the State in terms of how individuals are evaluated for services and how these services are accessed. Third, the structural change should result in a more streamlined system from the perspective of an individual’s experience and the manner in which information is collected and exchanged between relevant actors in the NWD/SEP system.

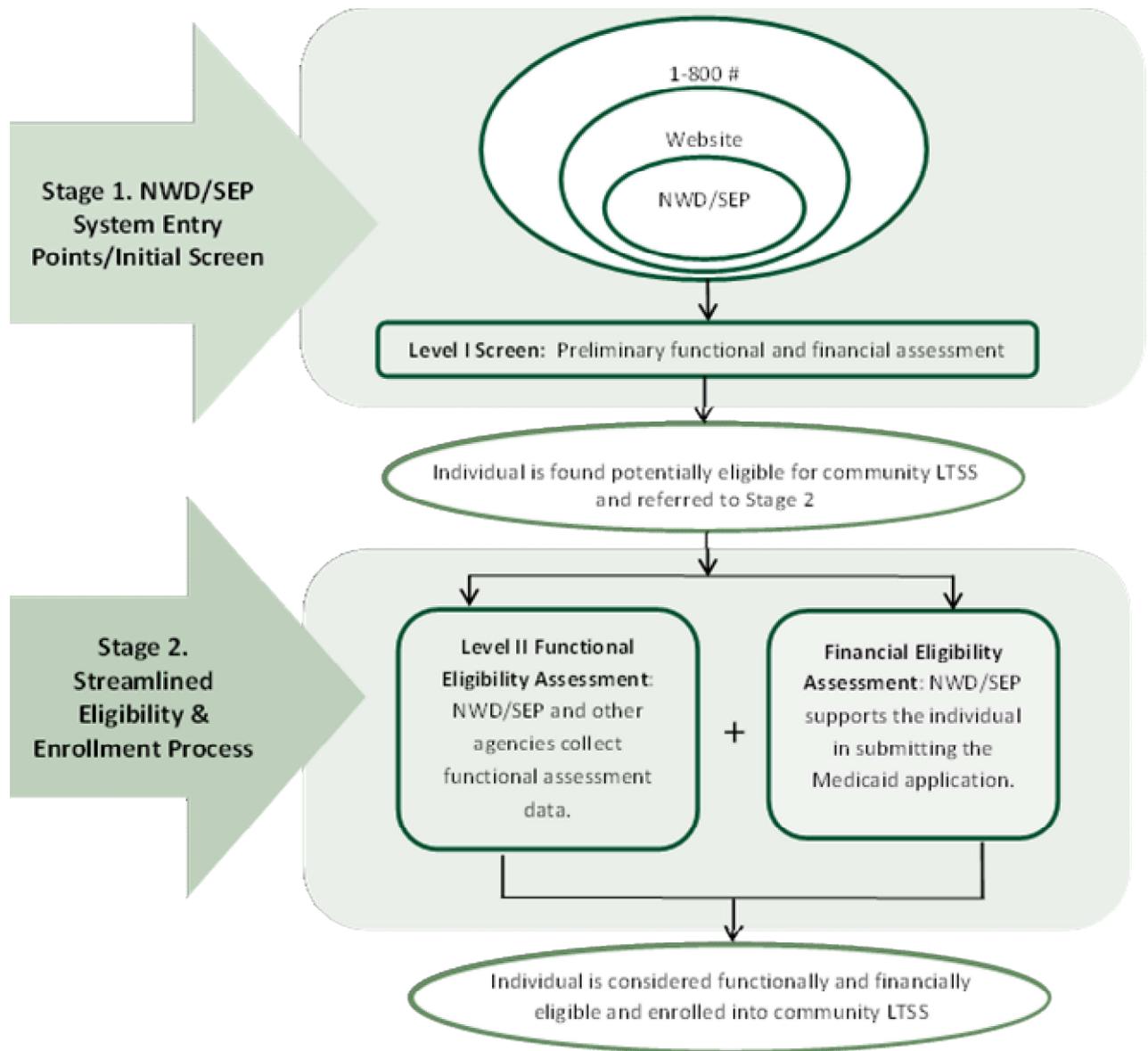
3.1. OVERVIEW OF CONCEPT

The NWD/SEP system aims to provide individuals with information on community LTSS, determine eligibility, and enroll eligible individuals in appropriate services. NWD/SEP systems can take many different forms depending on how they are defined and their program context. The figure and description below presents a potential NWD/SEP system from the perspective of an individual moving through the system, from the starting point of gaining initial information about the services available to the end point of becoming enrolled in appropriate services. This view of the NWD/SEP system is referred to as the “person flow.”

The NWD/SEP system presented in the figure and described in the following discussion is a two-stage process. Within Stage 1, individuals making inquiries about community LTSS go through an initial screen (Level I), which collects preliminary financial and functional data and points to potential needs and program eligibility. This screen may be completed online or conducted over the phone or in person by trained, designated NWD/SEP staff. Only those applicants who are considered potentially eligible at the Level I screen will receive the comprehensive Level II assessment during Stage 2. Although the Balancing Incentive Program enhanced Federal Medical Assistance Percentage (FMAP) is provided for Medicaid beneficiaries, States should ideally construct their NWD/SEP systems so that they also help serve individuals who are not Medicaid eligible.

Within Stage 2, the Level II assessment provides a more complete picture of an individual’s abilities and needs. The assessment must be completed in person by designated personnel who have received standardized training. If individuals are not considered eligible at this point, they are referred to non-Medicaid services, ideally with the support of the NWD/SEP system. The following sections describe these stages in more detail.

Figure 3-1: Person-Flow through the NWD/SEP System



3.2. STAGE 1: ENTRY POINT AND INITIAL ASSESSMENT

The entry points to a NWD/SEP system are the channels by which individuals enter the system and are routed to information, assessments, and ultimately, eligibility determinations. An important component of the NWD/SEP system is that it is Statewide. A true Statewide system ensures that individuals can access the system entry points from any location within the State, and that all individuals accessing the system experience the same processes and receive the same information about community LTSS options.

To be Statewide, a NWD/SEP system must include the following three components, depicted in Figure 3-1:

- A set of designated NWD/SEPs
- An informative website about community LTSS options in the State
- A Statewide 1-800 number that connects individuals to the NWD/SEP or their partners

Each component and how it may route an individual to Stage 2 of the NWD/SEP system – streamlined eligibility and enrollment – is described below.

NWD/SEPs

A network of NWD/SEPs will form the core of the NWD/SEP system in each State. The NWD/SEP network is the “face” of the NWD/SEP system, providing access points for individuals to inquire about community LTSS and receive comprehensive information, eligibility determinations, community LTSS program options counseling, and enrollment assistance. The NWD/SEPs will develop and implement standardized processes for providing information and eligibility assessments, ensuring a consistent experience for individuals accessing the system.

The Medicaid Agency must be the NWD/SEP Oversight Agency; it must have ultimate authority over and responsibility for the NWD/SEP network. However, the Medicaid Agency may delegate an Operating Agency. This Operating Agency should oversee the activities of the NWD/SEP network, the content of the community LTSS website, and the operation of the 1-800 number in order to ensure consistency in information and processes. The NWD/SEP system should build on established community LTSS networks to the greatest extent possible. Therefore, States should coordinate with local entities such as Centers for Independent Living (CILs), Area Agencies on Aging (AAAs), and Aging and Disability Resource Centers (ADRCs) that have been functioning as entry points to community LTSS in the State. See [Appendix F](#) for more information on how to coordinate efforts across multiple and diverse agencies.

When designing their NWD/SEP system, States should consider how physical NWD/SEPs are distributed relative to the individuals they are likely serve. The geographic area served by a physical NWD/SEP is referred to as its “service shed.” It is recommended that the combined service sheds of the NWD/SEPs serve a large share of a State’s population. Ideally, all individuals would be able to travel to a physical NWD/SEP by car or public transit and return home within a single day. This includes accessibility considerations for older adults and individuals with disabilities. However, CMS recognizes that this is not universally realistic, particularly for rural areas. In these cases, States should consider making other arrangements for enhancing access to NWD/SEPs. For example, NWD/SEPs could contract with vendors or home health agencies to dispatch staff to an individual’s home or to a central location (such as a nearby hospital).

Path from NWD/SEP to Stage 2: Individuals first accessing the NWD/SEP system through a NWD/SEP will receive a Level I screen at the NWD/SEP. If an individual is considered potentially eligible for community LTSS, the NWD/SEP will then conduct or schedule a comprehensive Level II assessment.



Informative Community LTSS Website

Another key component of a Statewide NWD/SEP system is an informative website about community LTSS options in the State. It should provide broad access to standardized information about community LTSS and contact information for NWD/SEPs and the 1-800 number where individuals can get more information or complete an assessment. Websites must be 508 compliant and accessible for individuals with disabilities. Attention should also be paid towards designing a website accessible to a wide-range of users with varying functional and health literacy skills. For more information on making websites accessible to a diverse user group, see [Appendix K](#).

CMS strongly encourages States to incorporate an online Level I self-screen into their informational website. A recent national inventory conducted by Mission Analytics Group, Inc. as background research for this Manual found that eight States currently have an informational website with a Level I screen (Johansson et al., 2011). These online self-screens require an individual to enter basic demographic, financial, and functional information. The information is used to generate a list of LTSS programs and services for which the individual or members of their household may be eligible. (Often these lists of services also include resources and social services outside of Medicaid community LTSS, such as food stamps or low-income heating assistance). Results may be tailored for the county where an applicant lives. Some websites allow an applicant to download and save the list of recommended entities and resources and convert it into a printer-friendly format.

Community LTSS 1-800 Number

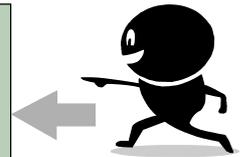
A 1-800 number provides the widest access to the NWD/SEP system. A Statewide 1-800 number can be accessed by all individuals, regardless of how far they are from the nearest NWD/SEP. These numbers provide a particularly important link to information for individuals who are more comfortable talking to a “real person” rather than searching for information on a website. And of course, 1-800 numbers offer a link to information and referral services for those without internet access. To ensure accessibility, these numbers should provide translation services for non-English speakers and TTY services.

Path from Website to Stage 2: The path from an informational website to Stage 2 can occur in a number of ways:



- The most basic community LTSS websites would not contain an online Level I self-screening. Individuals would find out about the range of community LTSS available in the State by reviewing the website content; they may choose to pursue community LTSS by contacting a NWD/SEP.
- Websites that include an online Level I self-screen would provide individually tailored information to those who complete the Level I screen; still, these individuals would generally be responsible for following up with the NWD/SEP after receiving the results of their Level I screen.
- The most sophisticated websites would allow Level I data to be saved and passed on to a NWD/SEP. NWD/SEPs could then contact individuals who are considered potentially eligible at Level I to schedule an appointment.

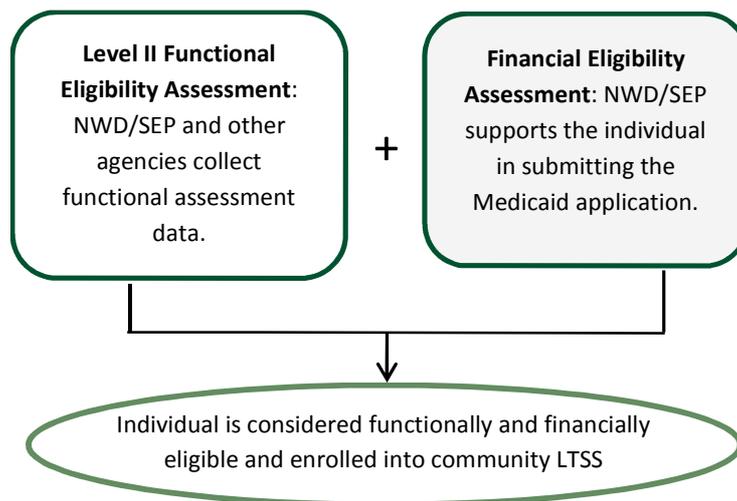
Path from 1-800 Number to Stage 2: CMS encourages States to set up systems by which individuals are able to have a Level I screen completed via the 1-800 number. A 1-800 number can create a “person-to-person hand off” to the next step towards receiving services. An individual may call a 1-800 number, receive an initial screening of needs and eligibility for community LTSS, and make an appointment over the phone for the next step in the application process.



3.3. STAGE 2: STREAMLINED ELIGIBILITY AND ENROLLMENT PROCESS

After the initial eligibility determination, individuals potentially eligible for Medicaid-funded community LTSS move to Stage 2: the streamlined eligibility and enrollment process. The figure below displays the components of the eligibility determination process. Note that functional and financial eligibility assessments may occur simultaneously or in a linear fashion. Note also that the figure and discussion below do not incorporate the role of waitlists.²

Figure 3-2: Overview of the Community LTSS Eligibility Determination Process



The NWD/SEP will be the key player in the streamlined eligibility and enrollment process, coordinating all components of the process including eligibility determination and enrollment in programs and services. Within the NWD/SEP, a single eligibility coordinator, case management system, or otherwise coordinated process should guide the individual through the entire assessment and eligibility determination process. This support should ensure that:

² Because services are not necessarily immediately available to anyone who is eligible, States may consider various ways of structuring and managing a waitlist system. Two common approaches for structuring a waitlist include: (1) immediately determining interested individuals’ eligibility status and putting them on a waitlist thereafter and (2) immediately placing interested individuals on a waitlist and undertaking the eligibility determination process as services become available. Regardless of approach, in the spirit of the Balancing Incentive Program legislation, States should also provide individuals who are waitlisted or non-Medicaid eligible with referrals for supports and services during the interim.

1. Individuals are assessed once for the range of Medicaid-funded community LTSS for which they may be eligible, and therefore only have to tell their story once.
2. The eligibility determination, options counseling, and enrollment process proceeds in as streamlined and timely a manner as possible.
3. Individuals can easily find out the status of the eligibility determination and next steps.

For States to fulfill these criteria, NWD/SEPs should carry out the following functions.

- ***Coordinate the Completion of the Functional Assessment:*** Arguably the most important function of the NWD/SEP is to initiate and coordinate collection of the Level II functional assessment. Each NWD/SEP will have at least one staff member trained to initiate the assessment. In some cases, these staff members will be able to complete the assessment; in other cases, other differently qualified individuals may be required to complete specific portions of the Level II assessment coordinated by the NWD/SEP.
- ***Coordinate the Financial Eligibility Assessment:*** The NWD/SEP will also coordinate the Medicaid financial eligibility determination. The financial eligibility determination process should be as automated as possible; where feasible, financial eligibility data should be pulled from existing data sources (e.g., IRS, Social Security). Admittedly, much of the financial data required for community LTSS eligibility data (e.g., asset testing and look back periods on asset transfers) cannot be pulled from existing data sources. States should consider creating systems that will streamline the financial eligibility process to the extent possible given these constraints.
- ***Coordinate Final Eligibility Determinations:*** Another key role of a NWD/SEP is to coordinate an applicant's financial and functional data. Many States currently struggle to coordinate functional and financial eligibility determinations in order to expedite eligibility determinations and service activation. Delayed eligibility processes are a barrier to community LTSS and may lead to unnecessary institutionalization. Ideally, States will have systems in which financial and functional data systems are integrated or "talk to each other," and NWD/SEP staff are able to both input data into these systems and extract data necessary for making eligibility determinations. Data considerations related to the coordination of functional and financial data are discussed in more detail in Chapter 6. Finally, States should consider co-locating functional and financial eligibility determination staff, as this would help expedite eligibility determinations.
- ***Coordinate the Enrollment in Services:*** After determinations are made, NWD/SEPs will help individuals choose among programs for which they are eligible and then support them through the process of enrolling in services and setting up supports. Note that while the functional assessment should *inform* an individual's plan of care, it should not be the only source of information. The State should bring in additional sources of information or analyses to develop a more person-centered plan. Individuals considered ineligible by the Level I screen or Level II assessment should be referred to other services. States can decide whether to continue supporting these individuals through the NWD/SEP system with case management services, as appropriate.

3.4. SUMMARY OF REQUIREMENTS AND RECOMMENDATIONS

The following table summarizes the required and recommended elements of the NWD/SEP system described above.

Requirements and Recommendations
The Balancing Incentive Program Structural Change 1: NWD/SEP System
<u>General NWD/SEP Structure</u>
<i>Requirements:</i>
<ul style="list-style-type: none">• Individuals accessing the system experience the same process and receive the same information about Medicaid-funded community LTSS options wherever they enter the system.• A single eligibility coordinator, “case management system,” or otherwise coordinated process guides the individual through the entire assessment and eligibility determination process, such that:<ol style="list-style-type: none">1. Individuals are assessed once for the range of community LTSS for which they may be eligible, and therefore only have to tell their story once.2. The eligibility determination, options counseling, and enrollment processes proceed in as streamlined and timely a manner possible.3. Individuals can easily find out eligibility status and next steps.• State advertises the NWD/SEP system to help establish it as the “go to system” for community LTSS.

Requirements and Recommendations

The Balancing Incentive Program Structural Change 1: NWD/SEP System

NWD/SEP

Requirements:

- *NWD/SEP network:* State has a system of NWD/SEPs that form the core of the NWD/SEP system: the NWD/SEP network. The Medicaid Agency is the Oversight Agency and may delegate the operation of the NWD/SEP system to a separate Operating Agency.
- *Coordinating with existing community LTSS counseling entities and initiatives:* The NWD/SEP network includes or coordinates with Centers for Independent Living (CILs), Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), and/or other entities that have been functioning as entry points to community LTSS in the State.
- *Full service access points:* NWD/SEPs have access points where individuals can inquire about community LTSS and receive comprehensive information, eligibility determinations, community LTSS program options counseling, and enrollment assistance. Physical locations must be accessible to older adults, individuals with disabilities, and users of public transportation.
- *Ensuring a consistent experience and core set of information:* NWD/SEPs design and follow standardized processes for providing information, referrals, and eligibility determinations so that individuals accessing the system at different NWD/SEPs experience a similar process and are provided a consistent core set of information about community LTSS options in the State.
- *Coordinated eligibility and enrollment process:* The NWD/SEP coordinates both the functional and financial assessment and eligibility determination process from start to finish, helping the individual choose among services and programs for which they are qualified after eligibility determination.

Strongly Recommended:

- States establish physical NWD/SEPs that are universally accessible.
- Beneficiary is assigned an eligibility coordinator who serves as a single point of contact throughout the eligibility determination and enrollment process.
- States co-locate financial and functional eligibility entities and/or staff to help coordinate and expedite determinations.
- Via the NWD/SEP system, States provide information to individuals not eligible for Medicaid-funded community LTSS, so they can access needed services covered by other programs.

Requirements and Recommendations

The Balancing Incentive Program Structural Change 1: NWD/SEP System

Website

Requirements:

- A NWD/SEP system includes an informative community LTSS website. Website content is developed or overseen by the NWD/SEP Operating Agency and reflects the full range of Medicaid community LTSS options available in the State. Information is current. Website is 508 compliant and accessible for individuals with disabilities.
- Website lists 1-800 number for NWD/SEP network.

Strongly Recommended:

- Website includes an automated Level I screen with basic questions about functional and financial status, which results in a list of services for which an individual may be eligible. Individuals are provided instructions for “next steps” and contact information for follow up with a NWD/SEP.
- Level I screen includes results related to services outside of Medicaid for which the individual may be eligible (e.g. CHIP, LIHEAP, SNAP, housing choice and other locally funded services).
- Results of Level I screen are downloadable and printable.

Recommended:

- Website provides mechanism to make an appointment for a Level II assessment or to find out “more information” about community LTSS options.
- After the online Level I is complete and results are generated, individuals can choose to save data, provide contact information and agree that a NWD/SEP may contact them for follow up. The Level I data are then “pushed forward” to the NWD/SEP system database. The NWD/SEP then reaches out to the individual to schedule a Level II assessment.

1-800 Number

Requirements:

- Single 1-800 number routes individuals to central NWD/SEP staff or to a local NWD/SEP, where they can find out about community LTSS options in the State, request additional information, and schedule appointments at local NWD/SEPs for an assessment. The 1-800 number is accessible to non-native English speakers and those with disabilities, providing translation services and TTY.
- Website lists 1-800 number for NWD/SEP network.

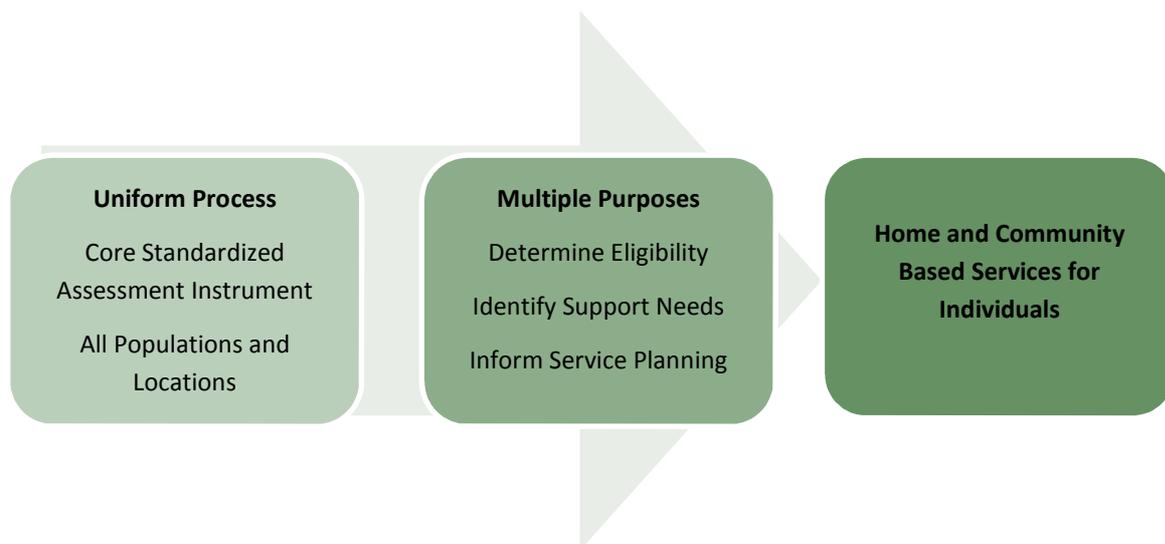
4. STRUCTURAL CHANGE 2: CORE STANDARDIZED ASSESSMENT

The Balancing Incentive Program also requires as a structural change the development and use of a Core Standardized Assessment (CSA) process and instrument(s). The Program requires the following of participating States:

“development of core standardized assessment instruments for determining eligibility for non-institutionally-based long-term services and supports described in subsection (f)(1)(B), which shall be used in a uniform manner throughout the State, to determine a beneficiary’s needs for training, support services, medical care, transportation, and other services, and develop an individual service plan to address such needs.”

In short, the Balancing Incentive Program CSA requires participating States to design a uniform process for: 1) determining eligibility for Medicaid-funded long-term services and supports (LTSS), 2) identifying individuals’ support needs, and 3) informing their service and support planning (e.g., plan of care). The CSA figures into the delivery of community LTSS for eligible individuals as depicted in Figure 4.1.

Figure 4-1: Structural CSA Requirements for Determining Community LTSS Eligibility and Needs



This chapter begins by reviewing various efforts across the country to produce uniform assessment instruments. Next, a model of the CSA that is based upon a more abstract set of data elements is introduced, which is called the Core Dataset (CDS). [Appendix G](#) contains a summary of State and national CSA instruments, while [Appendix H](#) contains the steps States must take to comply with the requirements of the CSA component of the Balancing Incentive Program.

4.1. BACKGROUND INFORMATION AND CONTEXT

To provide background and context for the requirements and recommendations presented in this section, included here is: 1) a discussion of national trends toward uniform assessments and the resulting benefits and 2) key definitions tied to the Balancing Incentive Program Core Standardized Assessment process.

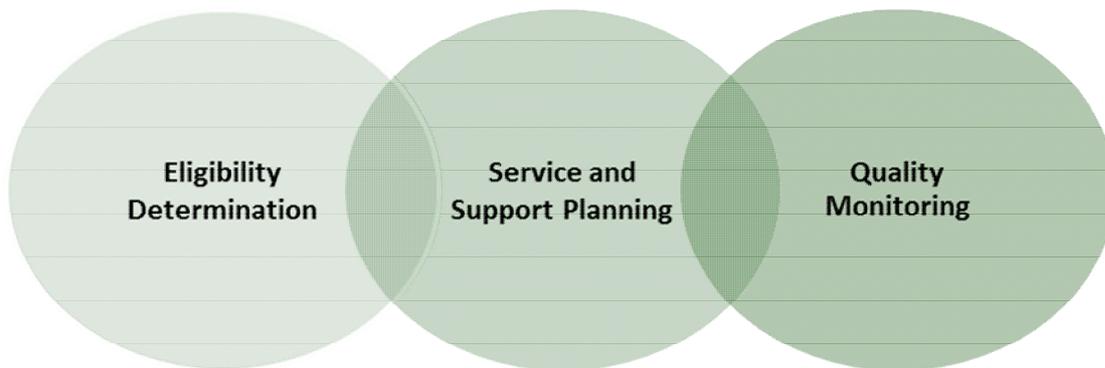
National Trends toward Uniform Assessment

The inclusion of the CSA requirement in the Balancing Incentive Program reflects a current trend nationwide toward the use of universal assessments. A well-designed universal assessment can offer several benefits to a State, such as promoting choice for consumers, reducing administrative burdens, promoting equity, capturing standardized data, and automating data systems to indicate programs for which an individual is likely eligible (Engelhardt & Guill, 2009). Universal assessment information and data systems can also support State efforts to project future service, support and budget needs and prioritize individuals for services when waitlists are present or budgets are limited. New York³ and Arkansas⁴, for example, have identified the use of a universal assessment and No Wrong Door (NWD) system as important steps to balancing care and controlling costs within their long-term care service systems.

Review of State and National Efforts to Conduct Uniform Assessments

Several universal assessment tools have been created across the country, designed to collect uniform or standardized data across service programs, populations, or geographic locations. These tools have been developed with three general purposes in mind: eligibility determination, service and support planning, and/or quality monitoring (see graphic below). Some tools are specifically designed to address one function, while others tackle more than one. Within this framework, the Balancing Incentive Program CSA effort focuses on eligibility determination and portions of service and support planning (i.e., identification of support needs and the general support of service planning).

Figure 4-2: Three Common Uses of Universal Assessment Tools



A review of twelve long-term care assessment tools used across the country (Gillespie, 2005) noted that while there is consistency in many of the topic areas addressed across tools, assessments vary by function/purpose, population assessed, level of automation, extent of integration with other systems, administration of the tools, and the specific questions included. The study also noted a movement toward using assessment instruments that could be completed over the internet. Questions were found to fall into the broad categories of background information, health, functional assessment, and cognitive/social/emotional assessments.

To develop a framework for creating a program-compliant CSA, a range of instruments that serve the goals outlined in the Balancing Incentive Program (i.e., eligibility determination, identification of support

³ <http://www.hca-nys.org/reformblueprint.pdf>

⁴ <http://www.daas.ar.gov/pdf/RecommendationstoBalanceArkansas'sLong-TermCareSystemFinal-nm.pdf>

needs, and support planning) was reviewed. Some of the tools reviewed were developed for use within one particular State, while others were designed for use across multiple States. Some were designed to assess one particular population (e.g., aging adults, people with developmental disabilities), while others included multiple populations. Regardless, it is recognized that the design of uniform/universal assessment tools is a complex and involved process, requiring many person-hours, negotiations, instrument testing, and stakeholder buy in. Therefore, the logical first step in developing guidance related to a Balancing Incentive Program CSA involved reviewing these existing tools and processes. Presented in [Appendix G](#) are selected results of this environmental scan. They include:

Profiles of Selected State and National Tools

- Descriptions of notable State-specific efforts where work was undertaken to bring uniformity to their processes for assessing needs and making eligibility determinations across programs and populations.
- Descriptions of selected nationally recognized and utilized tools for functional and support need assessment.

Comparisons of Uniform Assessment Tools

- Comparisons of multiple assessment tools used throughout the United States for determining an individual's eligibility and/or needs for long-term services.
- Identification of common domains and data elements.

4.2. CORE STANDARDIZED ASSESSMENT CONCEPT

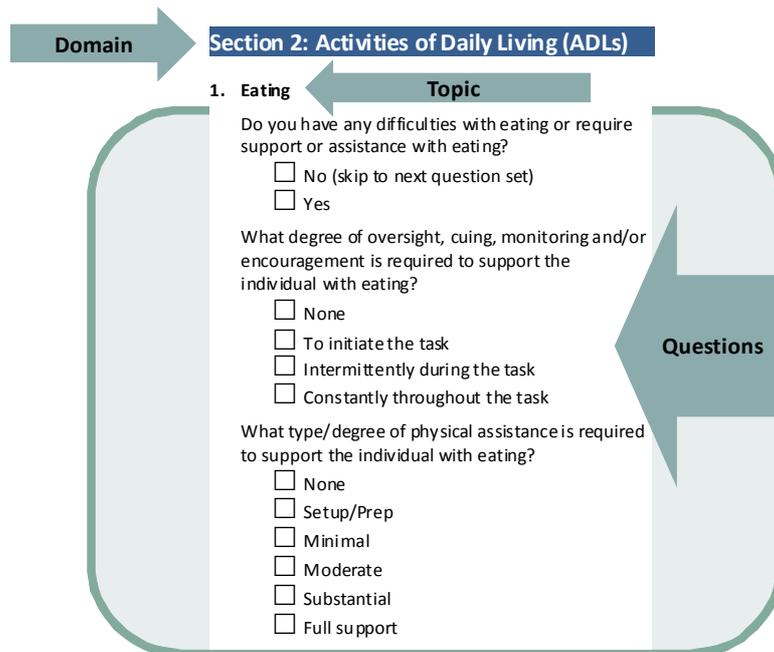
A State could meet the requirements of the Balancing Incentive Program by replacing all of its existing assessment instruments with a single instrument that would be used across all populations and settings. However, given the investment States have made in their existing instruments and the close links between those instruments and eligibility for services (especially Medicaid waiver services), this kind of mass substitution would be practically impossible. Instead, States must ensure that their CSAs capture certain required domains and topics, which together form the CDS. The purpose of the CDS is to promote uniform and comprehensive functional assessments across populations and geographic areas within a State; CMS does not plan to collect client-level CDS data to aggregate across States. Using the CDS, States can make adjustments *to their existing instruments* in a way that will satisfy the requirements of the Balancing Incentive Program *with minimal effort and with little or no change to existing practices*. When a State completes the process of modifying its existing instruments to meet the requirements of the Balancing Incentive Program, it must be able to assure CMS that those modifications will not change eligibility requirements in a way that reduces its maintenance of eligibility (MOE).

A State that applies for the Balancing Incentive Program funding needs to ensure that, for each population served, all topics and domains of the CDS are included. States will be able to choose the specific questions/items collected within each required topic; the only requirement is that those questions capture the data elements in the CDS. In some cases, the CDS may be collected via a single assessment instrument (e.g. the Supports Intensity Scale). In other cases, States may use a combination of instruments to collect the CDS.

Figure 4-3 illustrates the terminology used to describe the Core Dataset. The CDS contains:

- Domains
- Topics
- Questions/Items

Figure 4-3: Example Domain, Topic, and Questions



The remainder of this section is devoted to the required and recommended characteristics of a Balancing Incentive Program CSA process and tools, with the CDS being a primary requirement.

Required Characteristics of a Balancing Incentive Program CSA

This section describes the required characteristics of a CSA tool and process under the Balancing Incentive Program to assure uniformity in data collection process. States can meet the requirements of a CSA by: 1) using their existing tool(s), given that all or part of these tools gather information consistent with the Balancing Incentive Program purposes or 2) complementing the tool(s) already in use with additional items as warranted.

Uniformity in Using a Level I Screen/Level II Assessment Process across Populations Seeking LTSS – As previously described, CMS requires States to implement a two-level assessment process across populations seeking LTSS, involving a Level I screen and a Level II assessment. The Level I screen and Level II assessment are likely to cover at least some of the same domains. This two-level assessment process must be appropriate for assessing individuals across LTSS populations, be uniform in its use across the State, and meet Balancing Incentive Program requirements by determining LTSS eligibility, identifying individual support needs, and informing service planning.

A Level I screen's purpose is to identify those individuals who are *likely* to be eligible candidates for Medicaid-funded community LTSS. The Level I screen must be available for completion by the potential applicant and/or his/her representatives online (with online support), in person, or over the phone (by

calling a 1-800 number with live support available). It should be as short, concise, and as simple to complete as possible, recognizing that the screening tool might be completed by the individual with support needs themselves or by family members, friends, advocates or others on behalf of the individual. The Level I screen, for those considered likely eligible for community LTSS, provides a foundation of information or springboard for determining if a Level II assessment is appropriate.

A Level II assessment's purpose is to determine if an individual meets minimum criteria for the State's Medicaid-funded community LTSS. The Level II assessment must be completed in person, as in a face-to-face interview, between a qualified professional (e.g., social worker, case manager, nurse) and the individual seeking supports (who may choose to have a family member, caregiver, support person or advocate accompany him or her). Additional information (e.g., physician's records) may also be collected as part of the Level II assessment.

The Level II assessment information, as a whole, can also be used to identify support needs and inform individual service planning. CMS anticipates, however, that States will address individualized care/support need planning with more in-depth assessment tools, obtaining more comprehensive information than what is required in the Level II assessment.

Guidance for designing or choosing Level I screens and Level II assessments are provided later in [Appendix H](#).

Uniformity in Purpose – the Balancing Incentive Program requires that the CSA instrument(s) be used across the State and across populations to determine eligibility, identify support needs, and inform service planning. While the assessment instruments need not be identical, CMS does require that the Level I screen and Level II assessment are targeted to meet the three intentions/purposes of the Balancing Incentive Program CSA.

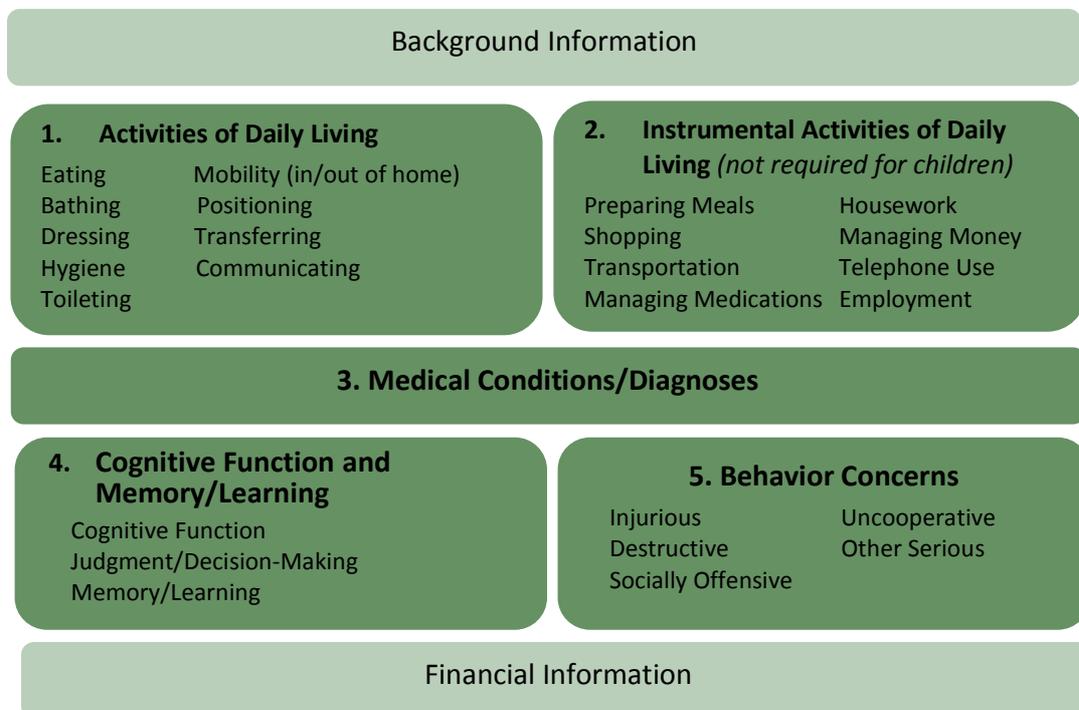
Uniformity in Collecting a Core Dataset – CMS requires that the Balancing Incentive Program CSA instrument(s) contain, across populations and throughout the State, a CDS of required domains and topics. Based on the environmental scan described earlier, this CDS was developed to be inclusive of the key areas of assessment necessary to meet the purposes of a Balancing Incentive Program CSA. CMS recognizes that many States may utilize a more focused set of domain/topic areas for determining program eligibility or a more expansive set of domain/topic areas for developing a service plan. However, the Balancing Incentive Program requires that, at a minimum, the State's instrument(s) capture the data elements in the CDS.

The CDS contains five domains: activities of daily living (ADLs), instrumental activities of daily living (IADLs), medical conditions/diagnoses, cognitive functioning/memory, and behavior concerns. Four of these domains (ADLs, IADLs, cognitive functioning/memory, and behavior concerns) contain topics (sub-domains) that are also required components of the CDS. These topics are listed in the graphic and further detailed below. One domain, medical conditions/diagnoses, does not have topics identified, as specific topics or questions within this domain are left to the discretion of the State. Figure 4-4 illustrates the five functional domains that comprise the Balancing Incentive Program CDS (in dark shading). Also displayed, but not part of the CDS, are background information and financial information (light shading). States will clearly need to collect this information. But because these data are not requirements of the Balancing Incentive Program in particular, they are set aside for now.

Please note that Domain 2 (Instrumental Activities of Daily Living) is not required for children, and that Domain 4 is altered somewhat for children, replacing memory concerns with learning difficulties. These

adaptations to the CDS for children recognize that developmental expectations for children are more directly tied to their age at the time of assessment (i.e., for ADLs, judgment, decision-making) and that there are expectations for adults that do not exist for children (e.g., IADLs).

Figure 4-4: Core Dataset: Required Domains and Topics for a CSA



Domain 1: Activities of Daily Living (ADLs) – For adults, ADLs are those typical tasks or activities necessary for independent, everyday living. They include activities such as eating, bathing, maintaining personal hygiene, dressing, mobility inside and outside the home, transferring, using the toilet, and communicating with others. *For children, these activities must be assessed against age-appropriate developmental expectations for children of a similar age.*

Domain 2: Instrumental Activities of Daily Living (IADLs) - IADLs are an additional set of more complex life functions necessary for maintaining a person's immediate environment and living independently in the community. IADLs include activities such preparing meals, performing ordinary housework, managing finances, managing medications, using the phone, shopping for groceries, and getting around in the community. *Assessment of IADLs is not required for children.*

Domain 3: Medical Conditions - Medical conditions or diagnoses (e.g., cerebral palsy, HIV/AIDS, stroke, epilepsy, quadriplegia, autism, schizophrenia) can potentially impact an individual’s daily functioning. Common categories of medical conditions/diagnoses for exploration include eating disorders, skin conditions, heart disease, musculoskeletal disease, neurological/cognitive disease or diagnosis, respiratory disease, behavioral diagnoses, gastrointestinal disease, autoimmune disease, and cancer.

Domain 4: Cognitive Function and Memory/Learning Difficulties - Problems with memory or cognitive functioning can interfere at home, school, work, or in the community. Areas to explore might include: limitations with cognitive functioning attributable to a diagnosed condition (e.g., intellectual disability, traumatic brain injury, Alzheimer’s disease) or noted difficulties in the areas of attention/concentration,

learning, perception, task completion, awareness, communication, decision-making, memory, planning or problem-solving. *For children, these skills must be assessed against age-appropriate developmental expectations for children of a similar age.*

Domain 5: Behavior Difficulties - Challenging behaviors are commonly characterized as those behaviors that are self-injurious, hurtful to others, destructive to property, disruptive, unusual or repetitive, socially offensive, uncooperative, or withdrawn or inattentive.

Non-Required CDS Domain: Background Information - Background information includes basic contact and demographic information for the individual applying for services or supports (e.g., name, address, date of birth, contact information). Inquiries pertaining to insurance coverage, current use of public benefits, and a depiction of the individual's overall support needs are also contained in this section. If the respondent is not the applicant him/herself, additional questions may be included on the respondent (especially about his or her role as a source of natural support).

Non-Required CDS Domain: Financial Information – Financial information typically includes individual or household income (including wages, benefits, and other income) and general assets.

Recommended Characteristics of a Balancing Incentive Program CSA

CMS also provides the following recommendations to ensure that the CSA data collection process is both well-conceived and well-received by respondents. Based upon the environmental scan conducted, it is recommended that, when possible, States incorporate the following best practices in their CSA development and implementation. These recommendations fall into two broad categories: 1) sound underpinning and infrastructure of a well-constructed tool and 2) a welcoming and easy to use process for respondents. Most of these recommendations are easier to implement when designing an instrument from scratch. However, many of these principles can be applied to existing instruments as well.

Sound Underpinnings and Infrastructure

Involve stakeholders – When selecting or designing a comprehensive assessment process, it is critical to have early and consistent involvement from all of the key stakeholder groups (across agencies and populations), including but not limited to individuals who will be assessed using the tool, family members/ caregivers, advocates, front-line administrators of the tool, intake/eligibility specialists, program administrators, policy makers, data analysts, and program evaluators.

Set a clear purpose for the effort – If developing new CSA instruments, State leaders and/or the stakeholder group must determine, up front, the driving rationale and function of the instruments to be developed. What types of assessment (functional, financial, or both) will be accomplished with the tools? Will the tools be used to determine program/service eligibility (for one or many programs/service)? Will the tools be used to inform or develop a support plan? For whom will the tools be appropriate (e.g., age groups, population groups)? Which agencies/programs will be involved?

Automate assessment surveys/data – Automating the survey/interview protocol can potentially reduce data entry errors and facilitate an interview protocol where only those questions considered appropriate for the respondent are asked. For example, both the Massachusetts and Minnesota assessments utilize “trigger” questions where certain responses either lead directly to an additional line of questioning, or direct the interviewer/interviewee to skip a set of questions (in fact, in an automated system, a respondent might never see the skipped or unnecessary questions). Data automation is also critical for data collection across sites, data sharing, and data analysis. Washington, Georgia, and Minnesota are

examples of States that use automated processes to complete both the assessment of functional eligibility and level of care determination. Automation of data collection is discussed further in Chapter 6.

Evaluate the quality and utility of the data collected – Long-term success will depend on the confidence users have in the measures used and the data collection process. States should periodically assess the validity and reliability of the information that is collected, making changes as warranted to maintain the integrity of the process. In addition, the information collected should be analyzed to assess the characteristics of individuals applying for services, their support needs, the rate of successful enrollments, and service use later. Such analyses can help policy makers to improve the efficiency and effectiveness of data collection.

The assessment structure is logical and easy to understand – An assessment tool should be logically structured; that is, questions should appear collectively in content-related groups, and there should be a logical sequence to the content areas and questions presented. Questions should be worded clearly and presented in a way that is easy to understand. When an assessment is complete, there should be clear guidelines or criteria (through scoring or some other means) to determine if an individual is eligible for community LTSS, and the next steps for gaining access to the needed supports.

Questions deliver a summative view of an individual's support needs – A Balancing Incentive Program CSA should apply a summative approach to understanding an individual's support needs within each domain and topic. That is, questions should seek to sum up the supports a person needs to complete an overall task, such as shopping, toileting, or getting around town. This approach can result in a need for fewer questions to gather an impression of capability or support needs. The approach, however, may require further inquiry to construct a well-fitted plan of support.

Questions utilize a strengths or supports-based approach – It is recommended that the CSA utilize a strengths or supports-based approach, rather than a deficits-based approach. That is, when possible, questions should be formatted in a manner to assess the extent of supports needed to complete an activity, rather than focusing on the portions of an activity that an individual cannot perform. For example, response options for questions on ADL skills could be: independent, setup or clean-up assistance, supervision or touching assistance, partial/moderate, substantial/maximal assistance, dependent – with their accompanying definitions. This is consistent with assessing levels of “support need” rather than extent of “functional deficit.”

Information gathered is adequate, but not burdensome - There is a need to collect adequate information to make an accurate determination of an individual's need for community LTSS. Also, assessment processes are often linked with service/support planning and/or referral processes. For these reasons, it can be appealing to include and ask a large number of questions. Individuals, however, should only be asked questions that are relevant (i.e., the questions do not unnecessarily invade their privacy) and requests for information should not be over-burdensome (i.e., the burden of supplying information should not exceed the benefit of receiving the services/supports offered).

Assessment instruments are tested for validity and reliability - To assure that assessment instruments do indeed test what they are testing for (validity), and do so, regardless of the interviewer/rater/respondent (reliability), tools should be tested for both validity and reliability.

A Welcoming and Easy to Use Process

The assessment process should be easily accessible. Easy access may be achieved through a “no wrong door” approach: where many doors in the community (e.g., doctor's offices, community help-giving organizations, schools) lead individuals to the assessment process and support them once they arrive; or

through a “single point of entry” approach: where one door (e.g., a toll-free phone number, a website) is accessible to all. Making both approaches available clearly has its advantages in reaching as many potentially eligible individuals as possible. Whatever the approach, it is imperative that:

Individuals feel welcome and heard - Individuals should feel welcomed by the assessment process, listened to, supported, and not pre-judged. Individuals are the experts when it comes to their own lives. They know their strengths, preferences and needs, and their opinions should be heard and respected.

Practices are culturally competent - No two individuals are exactly alike. Regardless of age or disability, household and support configurations will be unique for each individual. Likewise, individuals will vary in their ethnic origins and the languages they prefer to speak. Some individuals may be very difficult to reach, living in rural areas, or urban areas that are hard to penetrate. The assessment process should be respectful and culturally competent in anticipating and responding to the varying goals, needs and preferences of individuals across cultures, traditions, and beliefs.

Information flows in two directions - The assessment instrument and process require individuals to share needed information about themselves in a timely fashion. The assessment process, too, must be able to communicate back to the individual in a timely fashion about eligibility determinations, potential services/supports available, and requirements for the individual to proceed in accessing needed services.

Family/caregiver needs are considered – Families and/or caregivers often have needs outside of the needs specific to the individual eligible for services. These needs are typically connected to caregiver stress, a need for information and referral, support groups and/or respite care. An assessment process that incorporates components tied to caregiver needs will result in a more well-rounded assessment of the service and support needs of the whole family.

4.3. SUMMARY OF REQUIREMENTS AND RECOMMENDATIONS

The following table summarizes the required and recommended elements of the CSA described above.

Requirements and Recommendations																									
The Balancing Incentive Program Structural Change 2: CSA																									
<u>Core Standardized Assessment</u>																									
<i>Requirements:</i>																									
Assure uniformity in data collection process as follows:																									
<ul style="list-style-type: none"> • Uniformity of having a Level I screen/Level II assessment process across populations seeking LTSS. <ul style="list-style-type: none"> • A Level I screen is available for completion in person and over the phone. • Level II assessment is completed in person, with the assistance of a qualified professional. • A Balancing Incentive Program CDS is captured Statewide for all populations seeking community LTSS. The CDS is used to support the purposes of determining eligibility, identifying support needs, and informing service planning. • The CSA contains the CDS (required domains and topics), which includes: <ul style="list-style-type: none"> • Activities of Daily Living (ADLs) <table border="0" style="margin-left: 20px;"> <tr> <td>Eating</td> <td>Mobility (in-home and out of home)</td> </tr> <tr> <td>Bathing</td> <td>Positioning</td> </tr> <tr> <td>Dressing</td> <td>Transferring</td> </tr> <tr> <td>Hygiene</td> <td>Communicating</td> </tr> <tr> <td>Toileting</td> <td></td> </tr> </table> • Instrumental Activities of Daily Living (IADLs) (not required for children) <table border="0" style="margin-left: 20px;"> <tr> <td>Preparing Meals</td> <td>Managing Money</td> </tr> <tr> <td>Shopping</td> <td>Telephone Use</td> </tr> <tr> <td>Transportation</td> <td>Managing Medications</td> </tr> <tr> <td>Housework</td> <td>Employment</td> </tr> </table> • Cognitive function and memory/learning difficulties <ul style="list-style-type: none"> • Cognitive function • Judgment and Decision Making • Memory and Learning • Medical conditions • Behavior difficulties <table border="0" style="margin-left: 20px;"> <tr> <td>Injurious (to self or others)</td> <td>Uncooperative</td> </tr> <tr> <td>Destructive</td> <td>Other Serious</td> </tr> <tr> <td>Socially Offensive</td> <td></td> </tr> </table> 		Eating	Mobility (in-home and out of home)	Bathing	Positioning	Dressing	Transferring	Hygiene	Communicating	Toileting		Preparing Meals	Managing Money	Shopping	Telephone Use	Transportation	Managing Medications	Housework	Employment	Injurious (to self or others)	Uncooperative	Destructive	Other Serious	Socially Offensive	
Eating	Mobility (in-home and out of home)																								
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Shopping	Telephone Use																								
Transportation	Managing Medications																								
Housework	Employment																								
Injurious (to self or others)	Uncooperative																								
Destructive	Other Serious																								
Socially Offensive																									

Requirements and Recommendations

The Balancing Incentive Program Structural Change 2: CSA

Strongly Recommended:

Assure that the CSA data collection process is well conceived and received by respondents, as follows:

- Sound underpinnings and infrastructure
 - Involve stakeholders when designing the CSA.
 - Set a clear purpose for the CSA, ensuring a focus on eligibility determination.
 - Automate the assessment process.
 - Evaluate the quality and utility of data collected.
 - Ensure the CSA structure is logical and easy to understand.
 - Ensure the CSA delivers a summative view of an individual's strengths and support needs.
 - Ensure the CSA, when possible, utilizes a strengths or support-based approach, rather than a deficits-based approach.
 - Balance the need for adequate data with the burden data collection creates.
 - Test assessment tools for validity and reliability.
- A welcoming and easy to use process
 - Ensure individuals feel welcome and heard.
 - Implement assessments in a culturally competent way.
 - Allow information to flow in two directions.
 - Ensure Family/caregiver needs are considered.

5. STRUCTURAL CHANGE 3: CONFLICT-FREE CASE MANAGEMENT

The Balancing Incentive Program requires States to develop, as part of their No Wrong Door/Single Entry Point (NWD/SEP) systems, conflict-free case management services to:

“develop a service plan, arrange for services and supports, support the beneficiary (and, if appropriate, the beneficiary’s caregivers) in directing the provision of services and supports for the beneficiary, and conduct ongoing monitoring to assure that services and supports are delivered to meet the beneficiary’s needs and achieve intended outcomes.”

This chapter describes the requirements of this structural change in more detail. We refer to entities responsible for the independent evaluation, independent assessment, the plan of care, and case management as “agents” to distinguish them from “providers” of community long-term services and supports (LTSS).

5.1. DEFINITION OF CONFLICT OF INTEREST

“Conflict of interest” is defined as a “real or seeming incompatibility between one’s private interests and one’s public or fiduciary duties.”⁵ Some State social services systems allow the agent that conducts the functional assessment and/or case management to also provide services to that individual. These systems have assessors and case managers performing quality oversight activities over their own agency and their own employers. “Self-policing” puts assessors and case managers in the position of evaluating the performance of co-workers, supervisors and leadership within the very organization that employs them. Problems arise because assessors and case managers are typically not the direct line supervisors of the other workers and therefore do not have the authority to require changes.

This structure can lead to obvious conflicts, such as:

- Incentives for either over- or under-utilization of services.
- Interest in retaining the individual as a client rather than promoting independence. Agents may also be reluctant to suggest providers outside their agency because the agency may lose revenue.
- Issues that focus on the convenience of the agent or service provider rather than being person-centered.

Many of these conflicts of interest may not be conscious decisions on the part of agents; rather, in many cases, they are outgrowths of inherent incentives or disincentives built into the system that may or may not promote the interests of the individual receiving services.

⁵ Black’s Law Dictionary, Eighth Ed., Thomson West, St Paul, MN (2004)

5.2. CONFLICT-FREE CASE MANAGEMENT

The plan of care must offer each individual all of the community LTSS that are covered by the State, that the individual qualifies for, and that the evaluation and assessment process shows to be necessary. The plan of care must be based only on medical necessity (for example, needs-based criteria), not on available funding. Conflict-free case management has the following characteristics:

- ***There is separation of case management from direct services provision:*** Structurally or operationally, case managers should not be employees of any organization that provides direct services to the individuals. Ideally, conflict-free case management agencies are stand-alone and provide **no** other direct services. This prevents financial pressure for case managers to make referrals to their own organization or the “trading” of referrals.
- ***There is separation of eligibility determination from direct services provision:*** Eligibility for services is established separately from the provision of services, so assessors do not feel pressure to make individuals eligible to increase business for their organization. Eligibility is determined by an entity or organization that has no fiscal relationship to the individual.
- ***Case managers do not establish funding levels for the individual:*** The case manager’s responsibility is to develop a plan of supports and services based on the individual’s assessed needs. The case manager cannot make decisions as to the amount of resources (individual budget, resource allocation, or amount of services).
- ***Individuals performing evaluations, assessments, and plans of care cannot be*** related by blood or marriage to the individual or any of the individual’s paid caregivers, financially responsible for the individual, or empowered to make financial or health-related decisions on behalf of the individual.

5.3. MITIGATING CONFLICT

CMS is aware that in certain regions there may only be one provider available to serve as both the agent performing independent assessments and developing plans of care, and the provider of one or more of the community LTSS. To address this potential problem, the State may permit a single provider to supply case management and direct support services. The State will need to explain why no other providers are available and why no resource can be developed (this explanation is a Work Plan deliverable – see [Appendix E](#)).

In this instance, CMS will require the State to develop conflict of interest protections that demonstrate the State is taking strong steps to prevent conflict of interest. Examples of protections include:

- Assuring that individuals can advocate for themselves or have an advocate present in planning meetings.
- Documenting that the individual has been offered choice among all qualified providers of direct services.
- Establishing administrative separation between those doing assessments and service planning and those delivering direct services.
- Establishing a consumer council within the organization to monitor issues of choice.

- Establishing clear, well-known, and easily accessible means for consumers to make complaints and/or appeals to the State for assistance regarding concerns about choice, quality, and outcomes.
- Documenting the number and types of appeals and the decisions regarding complaints and/or appeals.
- Having State quality management staff oversee providers to assure consumer choice and control are not compromised.
- Documenting consumer experiences with measures that capture the quality of case management services.

CMS is currently reviewing the options for conflict-free case management in a managed care environment, and will provide updated guidance to States when it has been developed.

5.4. SUMMARY OF REQUIREMENTS AND RECOMMENDATIONS

The following table summarizes the required elements of conflict-free case management explained above.

Requirements and Recommendations
The Balancing Incentive Program Structural Change 3: Conflict-Free Case Management Services
<u><i>Conflict-Free Case Management Processes</i></u>
<i>Requirements:</i>
<ul style="list-style-type: none">• States must establish conflict of interest standards for the Level I screen and Level II assessment and care planning processes.• These standards must include the establishment of an independent agent to mitigate conflicts of interest during these processes.• The independent agent retains the final responsibility for the assessment and plan of care functions.• The independent agent cannot be any of the following:<ul style="list-style-type: none">• Related by blood or marriage to the individual, or any paid caregiver of the individual.• Financially responsible for the individual.• Empowered to make financial or health-related decisions on behalf of the individual.• Providers of State plan LTSS for the individual, or those who have interest in or are employed by a provider of State plan LTSS – EXCEPT, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area AND the State devises conflict of interest protections, such as “firewall” policies.• States should not implement policies to circumvent these requirements by suppressing the enrollment of any qualified and willing provider.• The independent agent must not be influenced by variations in available funding, either locally or from the State.• An individual’s plan of care must be created independently from the availability of funding to provide services: the plan of care must offer each individual all of the community LTSS that are covered by the State that the individual qualifies for, and that are demonstrated to be necessary through the evaluation and assessment process.• Referrals cannot be made between a referring entity and provider of services when there is a financial relationship between these parties.

6. THE ROLE OF AN ELECTRONIC INFORMATION EXCHANGE IN A NWD/SEP SYSTEM

An Electronic Information Exchange (EIE) can be a key component of a No Wrong Door/Single Entry Point (NWD/SEP) system. By capturing, storing and transferring data electronically, an EIE ensures that each entity involved in community long-term services and support (LTSS) eligibility determination and program enrollment has the information necessary to conduct its piece of the process accurately and in a timely manner. Although CMS does not require that States implement EIEs as part of their NWD/SEP systems, EIEs can serve an important role in streamlining and coordinating eligibility determination, a requirement for Balancing Incentive Program funding. By reducing the need for phone calls, emails, faxes and letters, an EIE can expedite referrals and enrollment. Individuals are also less likely to “fall through the cracks” given that EIEs often store data centrally, allowing multiple parties to access data and providing case managers with task reminders. In addition, automated functional assessment tools, a key piece to an EIE, can reduce data entry error through drop-down menus and fields with pre-designated formatting and skip logic, which guide users to the appropriate questions when conducting assessments.

No single NWD/SEP EIE model will be right for all States. Therefore, this chapter presents examples of EIEs, demonstrating how different technological approaches work within different contexts for community LTSS enrollment. To conceptualize the moving pieces within these examples, we use two different perspectives – the “person flow” and the “data flow.” As noted previously, the person flow refers to the logistics of enrollment from the human perspective – how an individual moves through each stage of the process. The data flow describes what data are collected and how these data are used and shared to assess, determine, and communicate eligibility. These two flows happen simultaneously during the enrollment process. The chapter also situates the Balancing Incentive Program within the context of the Affordable Care Act. Significantly, States are required to build a single portal for enrollment into Medicaid, Children’s Health Insurance Program (CHIP) and the Health Insurance Exchanges by 2014. Suggestions are provided to help States coordinate their NWD/SEP EIE and Exchange IT systems.

6.1. WHAT IS AN ELECTRONIC INFORMATION EXCHANGE?

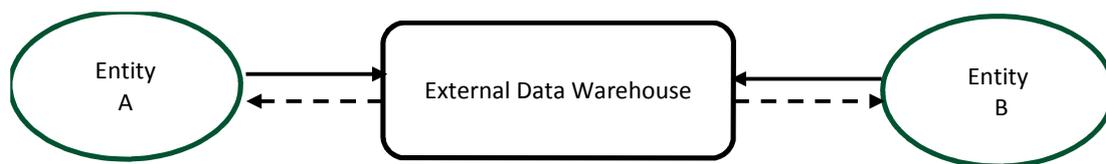
EIEs can serve many purposes, such as helping medical providers share patient clinical information or allowing States to enroll families into multiple social programs through one portal. We use the term EIE to broadly encompass systems that share client demographic, financial, health and functional data across applicants, entities, programs and/or providers. Within this context, there are three overarching models for an EIE: central, federated, and hybrid. These models use different strategies for sharing data across multiple users; they also often manage their data with differing programming language and architecture.

The Central Model

The central model relies on a data repository where entities deposit and access data. The model requires enough hardware to store all data in one location – either at an agency site or at a location external to all participating entities (e.g., a vendor location). Each entity sets up an interface with the repository and interacts with the data depending on the level of user access; while some users can only view data, other

users can modify them. In the central model, when data are updated, entities do not maintain a local copy. Entities concerned with data security and client privacy may consider this approach less appealing if an external entity stores and manages their data. Figure 6-1 is a simplified depiction of the central model, where entities A and B input data into an external warehouse, allowing them to share these data. Note that data do not flow back to the entities and update their local systems.

Figure 6-1: Central Model

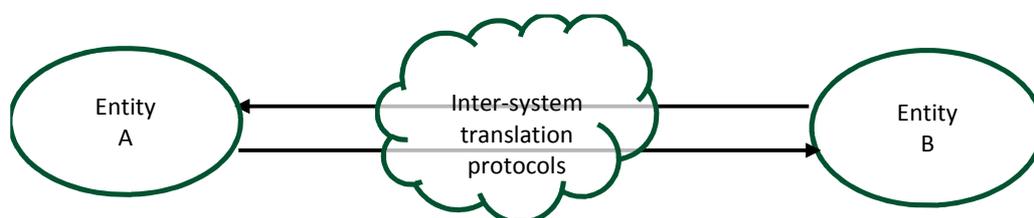


Solid arrows represent ability to update data; dashed arrows represent ability to view data.

The Federated Model

The federated model facilitates access to data located at agency/provider sites. Within a federated model, each entity is responsible for maintaining its own data. Information is typically exchanged on a “need to know” basis. An entity requests data, which are then pulled from the originating system into the requestor’s interface. The entity can then use these data to update its local system. Given that the systems of participating entities may have different data storage and retrieval protocols, variable names and programming code, the federated model acts as a translation service that allows these systems to communicate. Figure 6-2 demonstrates how entities A and B share data directly through a federated model; they pull data from the other entity to update their own data.

Figure 6-2: Federated Model

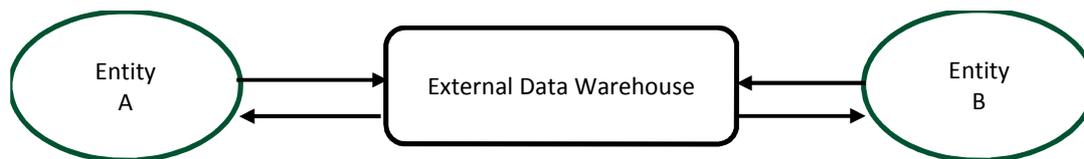


Solid arrows represent ability to update data

The Hybrid Model

The hybrid model combines both systems. Data are stored centrally, but entities can pull data from the central repository to update their systems or update the central repository based on their systems' data. Figure 6-3 depicts a hybrid model, where entities A and B push data into the external data warehouse, updating its contents, and pull data from the warehouse to update their local systems.

Figure 6-3: Hybrid Model



Solid arrows represent ability to update data

An Example Hybrid Model: One e-App

One e-App is a web-based application used in Arizona, California, Indiana and Maryland that serves as a single point of entry for enrollment into a range of health, social services, food, work support and other programs, such as Medicaid, State Children's Health Insurance Program (SCHIP), SNAP (Food Stamps), Earned Income Tax Credit (EITC), Temporary Aid for Needy Families (TANF), Women, Infants, Children (WIC), low-income energy subsidy programs, and other federal, State and county programs. One e-App was designed to address the fragmented public program application process, whereby individuals had to visit multiple entities to fill out applications for programs, often filling out the same information on paper multiple times. With One e-App, applicants input information into an online system one time; this information is then distributed to the multiple entities that conduct eligibility determination.

Person Flow through One e-App: Applicants can access One e-App on their home computers or with assistance at pre-designated user locations, typically a county office, medical provider, food bank, or community-based organization (CBO). The application process has two steps. First, the applicant inputs demographic and financial information into relevant One e-App screens. A table, listing the programs for which the individual may be eligible, is then generated. At that time, the applicant can choose which programs they would like to apply for. As a second step, the applicant submits required documents (such as pay stubs and birth certificates) by fax or scan to validate the information they provided in the first step. Once the application is routed to and processed by the relevant entity, the applicant receives notice of final eligibility determination from that entity.

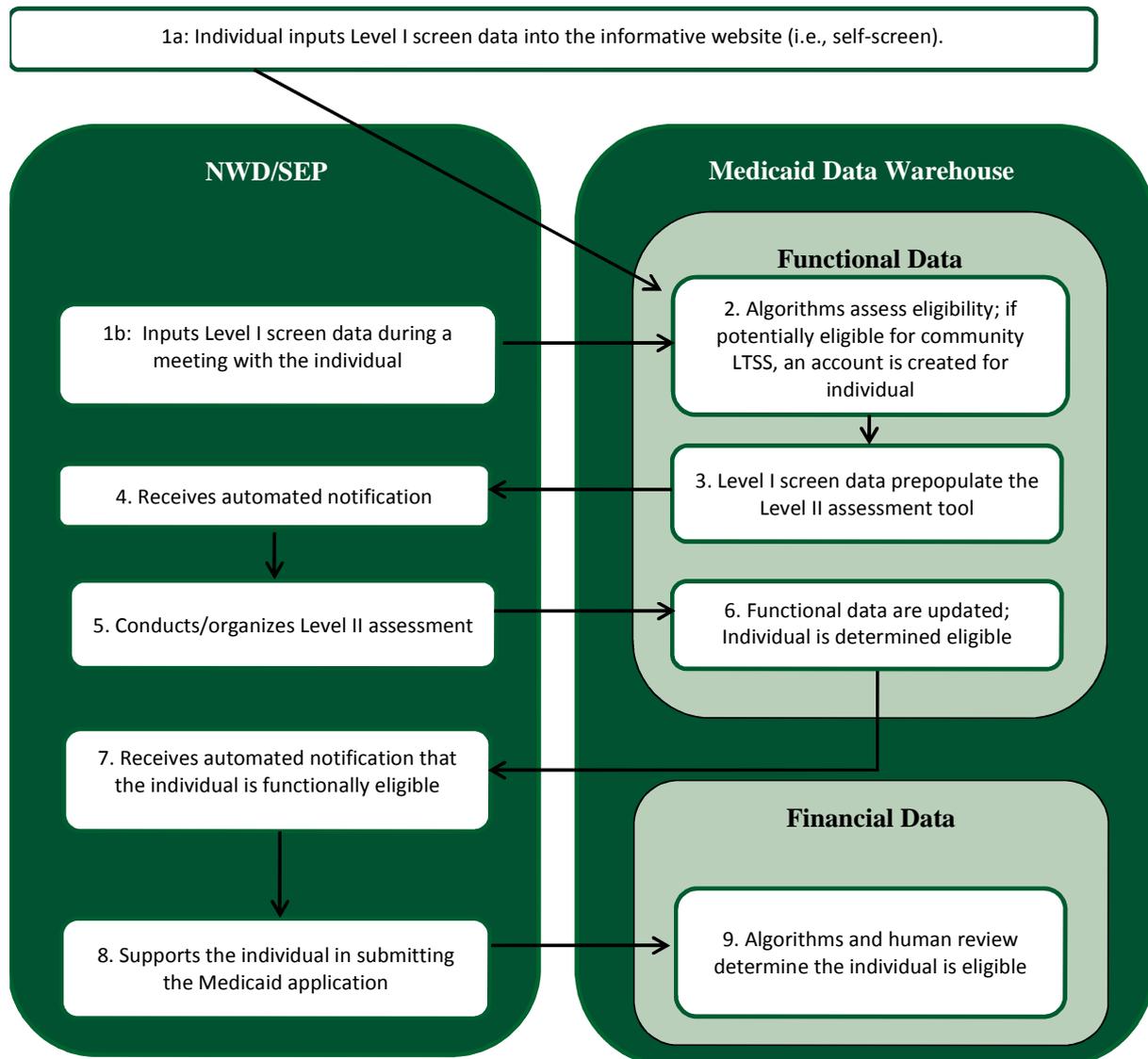
Data Flow through One e-App: One e-App is a hybrid system because data move through a centralized location and data in local systems are constantly updated. Data enter the centralized data warehouse through the thousands of user sites. The data warehouse interfaces easily with local entities, which then use the data to determine eligibility. At this point, the data flow varies by State. In Arizona, once the final eligibility determination is made, the One e-App data warehouse is updated with the relevant information from the local entity system. This allows One e-App to communicate disposition with users (e.g., medical providers, CBOs) and applicants. Users and applicants receive a notification via email or text that the eligibility determination has been made and they can then log onto their accounts to obtain the results. In California, for some programs, the One e-App data warehouse is not updated with information on the final eligibility determination; each entity is responsible for informing the applicant, which is often done via mail.

Source: Interviews with Social Interest Solutions (SIS) staff

6.2. PROTOTYPE NWD/SEP EIE SYSTEM

Any of these three overarching approaches could act as the model for a NWD/SEP EIE system. To illustrate how a NWD/SEP EIE system could work, we present an example of a centralized approach where community LTSS financial and functional data are stored and processed within the State’s Medicaid database. The NWD/SEP responsible for the functional assessment need not be the same as the entity responsible for the financial assessment. Therefore, this NWD/SEP EIE system allows multiple entities to share and update information, thus maintaining a streamlined and coordinated approach. Figure 6-4 depicts the example NWD/SEP EIE system; each activity is represented by a numbered box to demonstrate the order of steps in the data flow. The following discussion presents these steps in more detail.

Figure 6-4: NWD/SEP EIE Idealized Data Flow



Steps 1a and 1b: Level I Screen Data Enters the EIE

As a first step, Level I screen data are input into a web-based tool that feeds into the State Medicaid’s centralized NWD/SEP EIE system. Individuals may access the online Level I screen through the informative website and input the information into the NWD/SEP EIE system themselves (i.e., method 1a in the figure above). Alternatively, a NWD/SEP may input the Level I data collected from the individual via a phone call or an in person visit (i.e., method 1b in the figure above).

Although not a Balancing Incentive Program requirement, an online Level I screen that allows an individual to conduct a self-assessment is highly recommended by CMS to improve efficiency and access. In addition, CMS strongly recommends that the Level I online self-screen result in a list of programs and services for which an individual may be eligible. Alternatively, in more ambitious designs (as depicted in our example model above), the data input by the individual and the results of the Level I screen are “pushed forward” and saved within the NWD/SEP EIE system.

Step 2: The System Assesses Potential Eligibility

Once the Level I screen data enter the system, internal algorithms based on pre-determined decision rules automatically assess if the individual is potentially eligible for Medicaid-funded community LTSS. These algorithms reduce human error, which can lead to false determinations. If the individual is considered potentially eligible, an account (i.e., record) is created for that individual. The State may choose to create an account for any individual that completes a Level I screen, regardless of eligibility, to better track all initial applicants to community LTSS. However, individuals may be more likely to fill out an online assessment if personal information needed to initiate the account is only requested after the individual completes the assessment and is considered potentially eligible.

Steps 3 and 4: NWD/SEP Receives Automated Referral

Ideally, two activities occur with the completion of a positive Level I screen. First, the NWD/SEP receives an automated notification that the individual is potentially eligible for LTSS and arranges for a Level II assessment. If an individual submitted the Level I self-screen via the website, the NWD/SEP could provide a “person-to-person hand off” to the next step in the process by contacting the individual to schedule the Level II assessment. Alternatively, the individual would be responsible for contacting the NWD/SEP to schedule a Level II assessment. While the person-to-person hand off improves access, it is also more resource intensive.

interRAI Home Care (HC): Automated Functional Assessment Tool

interRAI is a network of researchers in over 30 countries aimed to promote evidence-based decision-making in health care for the elderly and disabled. interRAI develops instruments for evaluating the needs, strengths, and preferences of individuals seeking various levels of care. The Home Care (HC) instrument “was developed to provide a common language for assessing the health status and care needs of frail elderly and disabled individuals living in the community.” This automated tool, compatible with many systems, is equipped with algorithms for assessing and determining eligibility. Commonly used in the US, Canada, Europe and Asia, interRAI HC has been shown to have robust inter-rater reliability.

Second, in ideal situations, the Level I screen data prepopulate the Level II assessment tool to facilitate further functional assessment. By including this initial information in the Level II assessment, the assessor can gain an understanding of the individual’s needs before the Level II assessment occurs. In addition, the assessor does not have to ask the same question twice.

Steps 5 and 6: Level II Assessment is Completed

The NWD/SEP coordinates the Level II assessment. Under this mode, the assessor inputs data into a web-based functional assessment tool. If the assessment takes place outside of the entity's office, the assessors use laptops to record assessment data. These data are fed directly into the NWD/SEP EIE system; algorithms and human review would determine if the beneficiary is functionally eligible. Once again, although CMS does not require an automated functional assessment tool for States to be eligible for Balancing Incentive Program funding, it is highly recommended given the ability of these tools to streamline eligibility determination.

Example of EIE Components: Michigan

In Michigan, the LTSS waiver for the elderly and younger adults with disabilities is called the MI Choice program. The Medicaid LTSS medical/functional eligibility determination, enrollment, and provision of services are largely managed by Organized Health Care Delivery Systems (OHCDs) called Waiver Agents. Waiver Agents include Area Agencies on Aging (AAAs) and others. Referrals come from many sources, including family members, hospital discharge planners, service providers, Centers for Independent Living and nursing homes. Typically, the Waiver Agent communicates with the applicant via phone and conducts an initial screening. If the applicant satisfies the Telephone Intake Guidelines criteria, he/she is placed on a waitlist for an in person visit. When a waiver slot becomes available, a supports coordination team (RN and Social Worker) from the Waiver Agent visits the individual to conduct a more in-depth functional assessment and perform a formal Level of Care determination (which is later submitted to the web-based level of care determination system). The supports coordinators carry laptops, into which they enter the functional assessment information, which is later synced with either an individual entity's or a contracted service bureau's web-based portal and then submitted to a Data Warehouse. If the individual meets functional eligibility criteria, is Medicaid eligible, and requires MI Choice services on a continual basis, the Waiver Agent enrolls the participant in the MI Choice program. The Waiver Agents are responsible for contracting with, overseeing, and funding LTSS providers. Medicaid pays Waiver Agents a monthly amount based on budgeted and historical expenditures. Entities individually or via the service bureau submit claims to Medicaid, and approved claims are used for final cost reconciliation of payments to actual service and administrative costs at the end of each year.

Source: Interviews with program staff

Steps 7-9: NWD/SEP Helps the Individual Submit Medicaid Application

As depicted in Figure 6-4, once the Level II assessment is complete and the NWD/SEP receives an automated notification that the beneficiary is functionally eligible, the NWD/SEP works with the individual to facilitate the completion of the financial Medicaid application. This may involve providing assistance to the individual over the phone or holding an in person meeting during which the application is completed jointly.

While many States have online systems for functional eligibility determination, they use paper-based systems and human review to determine financial eligibility for LTSS populations because of the complexity of eligibility criteria. Therefore, financial determination may occur outside of the NWD/SEP EIE system. Ideally, the NWD/SEP EIE system would communicate with the financial eligibility system, so it is automatically updated with the final financial determination. Also, note that while Figure 6-4 places the financial eligibility process after the functional eligibility process, these processes can occur in parallel or in reverse order.

Regardless of timing, if the individual is functionally and financially eligible, he/she is enrolled in Medicaid-funded community LTSS. Although not

depicted in the figure, the community LTSS provider becomes an additional user of the NWD/SEP EIE system, creating a plan of care with the data and updating the database with annual functional assessments.

See [Appendix J](#) for information on sharing data legally and securely in a NWD/SEP EIE system.

6.3. HOW DOES A NWD/SEP EIE FIT WITHIN THE CONTEXT OF THE AFFORDABLE CARE ACT?

As mandated by Section 1413 of the Affordable Care Act, starting in 2014, Health Information Exchanges, (“Exchanges”) will perform two central functions: They will help qualified individuals and small employers learn about, select, and pay for private health plans; and they will help eligible individuals enroll in public health programs. As described by *Guidance for Exchange and Medicaid Information Technology Systems* (http://cciio.cms.gov/resources/files/exchange_medicaid_it_guidance_05312011.pdf), consumers will interact with the Exchanges through an easy-to-use, web-based system that provides a one-stop shopping experience. The system will evaluate an individual’s eligibility for coverage through one of four programs: qualified private health plans (with or without advance premium tax credits and cost-sharing reductions), Medicaid, CHIP, or a Basic Health Program (if the State chooses to establish one).

CMS envisions a streamlined, secure, interactive, and automated customer experience that will enable individuals to learn, in real-time, which program they qualify for (if any). Supported by clear navigation tools, individuals will answer a small number of questions and have the option at appropriate points to seek additional information or express their preferences. The system will allow an individual to accept or decline screening for financial assistance, and it will tailor the rest of the eligibility and enrollment process accordingly. In a rapid fashion invisible to consumers, the system will verify the accuracy of the information they supply. It will do so through a common, Federally managed “data hub” that will poll multiple databases and retrieve information on citizenship, immigration status, and Modified Adjusted Gross Income (MAGI) as defined by Federal tax information.

Because Medicaid financial assessments for the LTSS population in many States are considerably more complex (involving asset testing, look-back periods, and so on), individuals in this population will be “MAGI exempt.” According to the “Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010” proposed rules, published August 17, 2011, (<http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20756.pdf>), States are explicitly not required to build systems that determine eligibility for individuals in the MAGI exempt population. States that build systems that exclude the LTSS population risk creating separate and uncoordinated eligibility systems. As a result, individuals who are eligible for Medicaid-funded community LTSS may mistakenly believe they are not eligible for any program. Alternately, they may conclude that they are eligible for *something*, but have no idea how to apply for the appropriate services. Ideally, then, the Exchange IT system and the NWD/SEP EIE would communicate. For instance, through initial prompts, the Exchange IT system could intercept individuals seeking community LTSS before they complete the MAGI-only process and route them seamlessly to the NWD/SEP system for further assessment. Ideally, States should also consider how to connect individuals already enrolled in Medicaid to community LTSS, whether they qualify for those services now or will qualify for them in the future.

The Center for Consumer Information and Insurance Oversight (CCIIO) (<http://cciio.cms.gov/>) and Healthcare.gov (<http://www.healthcare.gov/>) have additional resources on the Health Information Exchanges.

6.4. SUMMARY OF REQUIREMENTS AND RECOMMENDATIONS

This table summarizes the required and recommended elements of a NWD/SEP EIE system as they relate to the Balancing Incentive Program structural changes.

Requirements and Recommendations
<p>These requirements and recommendations are relevant across the Balancing Incentive Program Structural Changes 1, 2 and 3</p>
<p><u>Level I Screen</u></p> <p><i>Strongly Recommended:</i></p> <ul style="list-style-type: none">• The NWD/SEP website includes an automated Level I screen with basic questions about functional and financial status, which results in a list of services for which an individual may be eligible. Individuals are provided instructions for “next steps” and contact information for follow up with a NWD/SEP. <p><i>Recommended:</i></p> <ul style="list-style-type: none">• The Level I screen prepopulates relevant fields in the Level II assessment.
<p><u>Level II Assessment</u></p> <p><i>Strongly Recommended:</i></p> <ul style="list-style-type: none">• Automation includes real-time electronic collection of functional assessment data. <p><i>Recommended:</i></p> <ul style="list-style-type: none">• Financial eligibility system communicates with the functional eligibility system, so a final eligibility determination can be made in a more streamlined manner.• Financial eligibility data are pulled from existing data sources (e.g. IRS, Social Security) to the extent possible.• The Level II assessment prepopulates plans of care.
<p><u>Case Management Tools</u></p> <p><i>Recommended:</i></p> <ul style="list-style-type: none">• Case managers receive notifications and task reminders to facilitate eligibility determination and enrollment.• Multiple users can share and update information based on their level of access and role in the eligibility determination process.

Requirements and Recommendations

These requirements and recommendations are relevant across the Balancing Incentive Program Structural Changes 1, 2 and 3

Health Information Exchange IT System Coordination

Recommended:

- The NWD/SEP EIE and the Exchange IT system communicate so individuals that enter through the Exchange IT system portal who seek community LTSS are transferred to the NWD/SEP system for eligibility determination.
- The NWD/SEP EIE and the Exchange IT system communicate so information about individuals already enrolled in Medicaid who eventually seek community LTSS are transferred to the NWD/SEP system.

7. DATA COLLECTION AND REPORTING REQUIREMENTS

The Balancing Incentive Program requires States to collect the following data, as described by the legislation:

“(A) SERVICES DATA. — Services data from providers of non-institutionally-based long-term services and supports described in subsection (f)(1)(B) on a per-beneficiary basis and in accordance with such standardized coding procedures as the State shall establish in consultation with the Secretary.

(B) QUALITY DATA. — Quality data on a selected set of core quality measures agreed upon by the Secretary and the State that are linked to population-specific outcomes measures and accessible to providers.

(C) OUTCOMES MEASURES. — Outcomes measures data on a selected set of core population-specific outcomes measures agreed upon by the Secretary and the State that are accessible to providers and include —

(i) measures of beneficiary and family caregiver experience with providers;

(ii) measures of beneficiary and family caregiver satisfaction with services; and

(iii) measures for achieving desired outcomes appropriate to a specific beneficiary, including employment, participation in community life, health stability, and prevention of loss in function.”

States will not be required to submit the collected data directly to CMS, though CMS does reserve the right to request these data at any time. Rather, as part of their Work Plan deliverables, States must report to CMS the data and measures that will be collected and the methodology for collecting those measures.

In this section, we first describe data collection requirements, including examples of the three data types above, recommended measures, and potential data collection tools. Second, we describe CMS’ reporting requirements, including the Work Plan, quarterly Programmatic Progress Reports accompanied by Work Plan deliverables, and long-term care services and supports (LTSS) financial information submitted quarterly to help CMS assess the State’s progress in hitting community LTSS target levels.

7.1. DATA COLLECTION

Per the statute, Balancing Incentive Program States will be required to collect three types of data: service data, quality data linked to population-specific outcomes, and outcomes measures. These are described in greater detail below.

Services Data

Community LTSS service providers should report to the State all community LTSS services an individual receives at the individual level. States should already have mechanisms in place for collecting these data for payment and budgetary purposes in the form of claims data or encounter data.

Quality Data

Quality data include clinical measures that capture the extent to which service providers are supplying comprehensive, quality care. To meet this statutory requirement, CMS strongly recommends that States calculate a subset of Medicaid Adult Health Quality Measures – a core set of health care quality measures determined in the Final rule for Section 2701 of the Affordable Care Act. The Home Health Program, authorized by Section 2703 of the Affordable Care Act, already requires participating States to calculate a subset of these measures. Therefore, to reduce burden on Balancing Incentive Program States, CMS

recommends they calculate this same subset. These measures, including calculation methodology and source data, are presented in [Appendix I](#). Most of these measures can be calculated with claims data or encounter data, which States should already be collecting from community LTSS providers. Once States calculate the measures based on the data submitted by providers, CMS strongly recommends that States report back measures to providers to encourage quality improvements.

Outcomes Measures

As a final data collection requirement, States should collect outcomes measures by population to assess beneficiary and family caregiver experience and satisfaction with providers. Data should also be collected regarding activities that help individuals achieve higher quality of life, including employment, participation in community life, health stability, and prevention of loss in function.

To meet this statutory requirement, States must first identify a series of measures that capture these required topic areas. The Home Health Care Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey is an example of a survey instrument that could help States meet data collection requirements of the Balancing Incentive Program. Currently, the survey is implemented voluntarily by Health Home providers by mailing the questionnaire to or conducting the survey over the phone with a sample of beneficiaries. Because this survey, described at <https://homehealthcahps.org/Home.aspx>, was developed to assess Medicare Home Health providers, States would need to adapt questions to better fit the Medicaid community LTSS population.

States may also use their Level II functional assessment data to calculate measures that assess participation in community life, health stability, and loss of function. With this approach, States would collect functional assessment data over time – not just for eligibility purposes – and develop measures based on Level II functional assessment questions.

7.2. DATA REPORTING

States are not required to report quality and outcome data and/or measures to CMS. However, CMS does require that States submit a Work Plan and quarterly Programmatic Progress Reports accompanied by Work Plan deliverables. States must also report services and financial data on a quarterly basis, so CMS can monitor whether States are meeting their community LTSS targets. These requirements are described in greater detail below.

Work Plan, Programmatic Progress Reports, and Deliverables (Quarterly)

Six months after the submission of the Balancing Incentive Program application, States are required to submit a Work Plan, consisting of the table in [Appendix E](#) and several deliverables (highlighted in grey in the table). The Work Plan includes a series of subtasks necessary for achieving the structural change requirements, deliverables that demonstrate the completion of each subtask, and due dates for deliverable submission.

Each State will also be required to submit a quarterly Programmatic Progress Report with information that delineates its current standing in meeting the deliverables specified in the Work Plan. So that CMS can support States in implementing the structural changes, States are also required to submit Work Plan deliverables along with the quarterly Progress Reports. Several deliverables relate to the data collection requirement described above. States must submit their data collection strategy, including the measures,

calculation methodology, survey instruments, and sampling frame.⁶ All Work Plan deliverables will be reviewed by CMS' technical assistance team, allowing CMS to monitor State progress and more importantly, support States in identifying and working through implementation challenges. As we expect that many States already have components of the required structural changes in place, States should often be able to use or adapt existing documents/materials as their deliverables.

During the Balancing Incentive Program implementation period, CMS will work with grantees to finalize and submit their Progress Reports and deliverables in a timely manner. However, if a State consistently fails to demonstrate satisfactory progress in reaching its milestones, the State will be asked to submit a Corrective Action Plan. Failure to carry out their Corrective Action Plan may result in discontinued funding.

Services and Financial Reporting (Quarterly)

The statute requires that States reach either the 25 percent target for community LTSS spending or the 50 percent target by October 1, 2015, depending on which level the State is under at the time of the application. CMS will monitor States' progress on meeting these targets through a review of the CMS-64 form, submitted by States quarterly. This form will allow the State and CMS to track expenditures associated with participants receiving Program-eligible services.

⁶ To conserve resources, States may survey a percentage of the population receiving Medicaid-funded community LTSS, as opposed to the entire population. This sample may be selected at random or stratified to ensure that certain population types are represented.

8. FUNDING THE STRUCTURAL CHANGES

Various provisions of the Affordable Care Act align with the goals of the Balancing Incentive Program; in some cases where goals and requirements overlap, funding for these initiatives may be used to cover Program activities and the required structural changes in particular.

States are encouraged to confer with CMS regarding the use of funds, originally intended for other initiatives, to support the structural requirement of the Balancing Incentive Program. In general, however, CMS will support the flexible use of funds if States can demonstrate that the proposed use of funds will support the goals of the initiative for which the funds were allocated and follow all requirements for use of those funds.

8.1. POTENTIAL FUNDING SOURCES

Following are the potential funding sources that States may be able to use to support the Balancing Incentive Program structural changes.

Medicaid Eligibility Determination and Enrollment Activities

On April 19, 2011, CMS released a final rule titled “Medicaid: Federal Funding for Medicaid Eligibility Determination and Enrollment Activities.” The rule provides for enhanced Federal Financial Participation (FFP) for the design, development and installation or enhancement of eligibility determination systems. Under the new rule, the Federal matching rate for building Medicaid eligibility and enrollment systems (i.e., E&E systems) is 90 percent; ongoing maintenance is matched at 75 percent. The final rule can be found at <http://edocket.access.gpo.gov/2011/pdf/2011-9340.pdf>.

States may claim the enhanced FFP to support E&E enhancements that incorporate community long-term services and support (LTSS) eligibility and enrollment. This could involve adapting Medicaid eligibility and enrollment systems to accommodate the various income limits for community LTSS, storing key functional assessment data, or building a bridge between Medicaid E&E systems and the community LTSS system.

Requirements to be eligible for the “90/10 FFP” are:

1. The E&E enhanced match applies only to the development costs of a new system. It does not apply to the operations and/or maintenance of an old/legacy system.
2. Any system for which the 90/10 E&E match is being sought must meet the “Seven Conditions and Standards” mentioned in the final rule.
3. The focus of the E&E enhanced match is to facilitate States meeting the January 2014 deadline to enroll members per the Affordable Care Act. Additions to E&E systems to incorporate LTSS eligibility may impede the State making progress toward this deadline. Therefore, it is imperative that any such requests for system modifications, enhancements or new development be coordinated with the State’s current efforts to improve the Medicaid eligibility determination system that will be utilized by the Health Insurance Exchange.
4. The enhanced match for E&E is time-limited. Enhanced match for development is not available after December 31, 2015 for any product or service delivered after that date.

In order to apply for these funds, States must submit an Advanced Planning Document (ADP) outlining their plans for eligibility and enrollment enhancements. Although this document is reviewed and

approved by CMS Central Office in Baltimore, States should coordinate efforts with their Regional Office. Requirements are described in greater detail in 45 CFR Part 95, Subpart F (Code of Federal Regulations, 2011).

Money Follows the Person

Money Follows the Person (MFP) was established by the Deficit Reduction Act of 2005, with a goal of helping States to balance their long-term service delivery systems and help Medicaid beneficiaries transition from institutions to the community. Section 2403 of the Affordable Care Act extended the MFP Demonstration Program through 2016 and appropriated an additional \$2.25 billion to the program. The new funding is to strengthen existing Demonstration Programs and for additional States to participate. Currently 43 States and the District of Columbia participate in MFP.

MFP funding provides enhanced FMAP for LTSS received by individuals transitioned from an institution into the community. Additionally, as stated in the MFP application, “The enhanced FMAP funding, as well as significant financial resources to support the administration of the demonstration are available for the implementation of broader infrastructure investments. These investments include initiatives such as...building ‘no wrong door’ access to care systems.”⁷

There are two major sources of MFP funding that may be used to support Balancing Incentive Program infrastructure development: administrative funds and State balancing funds.

Administrative Funds

MFP administrative funds can be used for services or infrastructure development, including IT costs. Use of the administrative funds must also be tied to the MFP goals; a State must be able to show how use of the funds will help move more individuals out of institutions and help a State meet its transition benchmark. States may spend up to twenty percent of their MFP budgets on administrative costs. Some States already spend up to this maximum, while others do not. Administrative funds may be used to cover costs for activities such as:

- Developing LTSS and provider databases to assist local contact entities working with individuals transitioning out of institutions.
- Training staff on the collection of the Core Standardized Assessment (CSA), which contains the required Core Dataset (CDS) of domains and topics.
- Creating a data system to support: the collection of core functional assessment data, the transmission of these data among applicable providers, and the collection and reporting of financial data for community LTSS eligibility determination.

States will need to submit a formal request for use of Administrative funding to CMS with the following items: the funds required in a detailed line item budget, description of the project and a justification for the use of the funds, and how the request relates to increasing the number of MFP transitions to help meet or exceed transition benchmarks. CMS will then process the request for review and approval.

⁷ Centers for Medicare and Medicaid Services. (June 22, 2010). Extension of the money follows the person rebalancing demonstration program (State Medicaid Director Letter# 10-012, ACA# 3.)

*Rebalancing Funds*⁸

As previously noted, MFP States receive enhanced FMAP for qualified services provided to MFP participants during their first year of community living after transition from an institution. The enhanced match a State receives has restricted use and is identified as the Rebalancing Fund; these restricted funds are to be used to support activities that contribute to rebalancing the State's LTSS system toward community-based care. States have fairly wide latitude in how they use their rebalancing funds; they may use rebalancing funds for all of the activities listed above as well as other activities (e.g., adding additional waiver slots or new community LTSS options). States are required to receive advance approval for the use of the rebalancing funds.

Aging and Disability Resource Centers Funding

Aging and Disability Resource Center (ADRC) funding is another potential source of funding for the structural changes required under the Balancing Incentive Program. While the Balancing Incentive Program mission certainly differs from the ADRC mission in some key ways, some components of the ADRC mission align with the NWD/SEP requirements. For example, ADRCs are to serve as "a visible and trusted source of information on the full range of long-term care options, including both institutional and home and community-based care, which are available in the community" (109th Congress, 2007). They are to provide a single point of entry to all publicly-funded LTSS, including Medicaid. ADRCs are expected to perform consumer intake and screening, needs assessment, development of service plans, and both functional and financial eligibility determinations (O'Shaughnessy, 2010).

In 2010, the Department of Health and Human Services dedicated \$60 million through the Affordable Care Act to "help people navigate their health and long-term care options" (Department of Health and Human Services, 2010). ADRCs are among the entities eligible for this funding, with a section of the legislation (Section 2405) specifically dedicating \$10,000,000 each fiscal year between 2010 and 2014 to ADRCs. In particular, the funding is focused on options counseling through ADRCs, improving ADRCs' activities with regard to the MFP initiative, and coordinating with State Medicaid programs to help individuals leave nursing homes for community care (Department of Health and Human Services, 2010).

States should be able to make a fairly straightforward case for using ADRC funding to support the development of a truly Statewide comprehensive NWD/SEP system under the Balancing Incentive Program, which provides consumers streamlined access to community LTSS. Additionally, using ADRC funds to support development of a CSA would be supporting the ADRC mission to conduct intake, screening, and needs assessment based on both financial and functional eligibility.

Federal Financial Participation for Administrative Activities

The Federal Medicaid program pays States 50 percent of allowable expenses necessary for the "proper and efficient" administration of the State Medicaid Plan. Activities that fall under this mandate include Medicaid eligibility determination and outreach related to the Medicaid program (among other activities).

⁸ While referred to within the context of MFP as "rebalancing", "balancing" and "rebalancing" should be interpreted as identical terms for the purposes of this Manual.

States may be able to secure administrative matching funds to support the data collection requirements under the Balancing Incentive Program. States should consult with their Regional Offices to confirm that their plan is acceptable. In addition, to receive reimbursement for administrative activities through FFP, States must submit a cost allocation plan to CMS, indicating the percentage of total administrative costs actually attributable to Medicaid-eligible individuals. We briefly review cost allocation for all Federal funding sources in greater detail in the following section.

8.2. COST ALLOCATION

The Balancing Incentive Program structural changes will likely benefit other non-Medicaid funded human services programs, raising issues of cost allocation. CMS recognizes that shared services among multiple programs saves time and money and promotes a high quality customer experience. However, it is important that each program pays its way. The Office of Management and Budget (OMB) Circular A-87, found at http://www.whitehouse.gov/omb/circulars_a087_2004, provides guidance on “determining costs for Federal awards carried out through grants, cost reimbursement contracts, and other agreements with State and local governments and federally recognized Indian tribal governments (governmental units).” Section C.3 specifically describes the rules of cost allocation:

- A cost is allocable to a particular cost objective if the goods or services are chargeable or assignable to such cost objective in accordance with relative benefits received.
- All activities which benefit from the governmental unit's indirect cost will receive an appropriate allocation of indirect costs.
- Any cost allocable to a particular Federal award or cost objective may not be charged to other Federal awards to overcome fund deficiencies, to avoid restrictions imposed by law or terms of the Federal awards, or for other reasons.
- Where an accumulation of indirect costs will ultimately result in charges to a Federal award, a cost allocation plan will be required as described in the Circular.

CMS is interested in helping States develop cost allocation plans by disseminating best practices. To this end, please reach out to CMS at info@balancingincentiveprogram.org with best practices for developing cost allocations plans.

AFTERWORD

CMS hopes this Implementation Manual for the Balancing Incentive Program has shown that the requirements of the Program are eminently realistic and will meaningfully impact the lives of people who need community long-term services and supports (LTSS). CMS is committed to supporting States throughout the implementation of the Balancing Incentive Program. CMS welcomes feedback from States on ways to improve this Manual, which will continue to evolve over time. As we receive feedback from States on lessons learned through implementation – including challenges and best practices – and as CMS refines its guidance, we will release one or more updated versions of the Manual. In addition, CMS aims to adopt new technical assistance products and avenues for disseminating information based on States' needs.

Please do not hesitate to contact CMS or the technical assistance team with your suggestions, concerns, or questions.

- Contact Mission Analytics Group (info@balancingincentiveprogram.org) regarding structural change requirements, completion of the Work Plan, reporting requirements, and suggestions for technical assistance.
- Contact CMS (balancing-incentive-program@cms.hhs.gov) regarding policy-related questions or comments.

We look forward to embarking on this journey with you – working together to successfully implement the Program and to help more individuals live healthy, independent, fulfilled lives in the community.

APPENDIX A: THE BALANCING INCENTIVE PROGRAM LEGISLATION

SEC. 10202. INCENTIVES FOR STATES TO OFFER HOME AND COMMUNITY-BASED SERVICES AS A LONG-TERM CARE ALTERNATIVE TO NURSING HOMES.

(a) STATE BALANCING INCENTIVE PAYMENTS PROGRAM. — Notwithstanding section 1905(b) of the Social Security Act (42 U.S.C.1396d(b)), in the case of a balancing incentive payment State, as defined in subsection (b), that meets the conditions described in subsection (c), during the balancing incentive period, the Federal medical assistance percentage determined for the State under section 1905(b) of such Act and, if applicable, increased under subsection (z) or (aa) shall be increased by the applicable percentage points determined under subsection (d) with respect to eligible medical assistance expenditures described in subsection (e).

(b) BALANCING INCENTIVE PAYMENT STATE. — A balancing incentive payment State is a State—

(1) in which less than 50 percent of the total expenditures for medical assistance under the State Medicaid program for a fiscal year for long-term services and supports (as defined by the Secretary under subsection (f)(1)) are for non-institutionally-based long-term services and supports described in subsection(f)(1)(B);

(2) that submits an application and meets the conditions described in subsection (c); and

(3) that is selected by the Secretary to participate in the State balancing incentive payment program established under this section.

(c) CONDITIONS. — The conditions described in this subsection are the following:

(1) APPLICATION. — The State submits an application to the Secretary that includes, in addition to such other information as the Secretary shall require—

(A) a proposed budget that details the State’s plan to expand and diversify medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program during the balancing incentive period and achieve the target spending percentage applicable to the State under paragraph (2), including through structural changes to how the State furnishes such assistance, such as through the establishment of a “no wrong door—single entry point system”, optional presumptive eligibility, case management services, and the use of core standardized assessment instruments, and that includes a description of the new or expanded offerings of such services that the State will provide and the projected costs of such services; and

(B) in the case of a State that proposes to expand the provision of home and community-based services under its State Medicaid program through a State plan amendment under section 1915(i) of the Social Security Act, at the option of the State, an election to increase the income eligibility for such services from 150 percent of the poverty line to such higher percentage as the State may establish for such purpose, not to exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1) of the Social Security Act (42 U.S.C. 1382(b)(1)).

(2) TARGET SPENDING PERCENTAGES. —

(A) In the case of a balancing incentive payment State in which less than 25 percent of the total expenditures for long-term services and supports under the State Medicaid program

for fiscal year 2009 are for home and community-based services, the target spending percentage for the State to achieve by not later than October 1, 2015, is that 25 percent of the total expenditures for long-term services and supports under the State Medicaid program are for home and community-based services.

(B) In the case of any other balancing incentive payment State, the target spending percentage for the State to achieve by not later than October 1, 2015, is that 50 percent of the total expenditures for long-term services and supports under the State Medicaid program are for home and community-based services.

(3) MAINTENANCE OF ELIGIBILITY REQUIREMENTS. — The State does not apply eligibility standards, methodologies, or procedures for determining eligibility for medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program that are more restrictive than the eligibility standards, methodologies, or procedures in effect for such purposes on December 31, 2010.

(4) USE OF ADDITIONAL FUNDS. — The State agrees to use the additional Federal funds paid to the State as a result of this section only for purposes of providing new or expanded offerings of non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program.

(5) STRUCTURAL CHANGES. — The State agrees to make, not later than the end of the 6-month period that begins on the date the State submits an application under this section, the following changes:

(A) “NO WRONG DOOR—SINGLE ENTRY POINT SYSTEM”. — Development of a Statewide system to enable consumers to access all long-term services and supports through an agency, organization, coordinated network, or portal, in accordance with such standards as the State shall establish and that shall provide information regarding the availability of such services, how to apply for such services, referral services for services and supports otherwise available in the community, and determinations of financial and functional eligibility for such services and supports, or assistance with assessment processes for financial and functional eligibility.

(B) CONFLICT-FREE CASE MANAGEMENT SERVICES. — Conflict-free case management services to develop a service plan, arrange for services and supports, support the beneficiary (and, if appropriate, the beneficiary’s caregivers) in directing the provision of services and supports for the beneficiary, and conduct ongoing monitoring to assure that services and supports are delivered to meet the beneficiary’s needs and achieve intended outcomes.

(C) CORE STANDARDIZED ASSESSMENT INSTRUMENTS. — Development of core standardized assessment instruments for determining eligibility for non-institutionally-based long-term services and supports described in subsection (f)(1)(B), which shall be used in a uniform manner throughout the State, to determine a beneficiary’s needs for training, support services, medical care, transportation, and other services, and develop an individual service plan to address such needs.

(6) DATA COLLECTION. — The State agrees to collect from providers of services and through such other means as the State determines appropriate the following data:

(A) SERVICES DATA. — Services data from providers of non-institutionally-based long-term services and supports described in subsection (f)(1)(B) on a per-beneficiary basis

and in accordance with such standardized coding procedures as the State shall establish in consultation with the Secretary.

(B) QUALITY DATA.—Quality data on a selected set of core quality measures agreed upon by the Secretary and the State that are linked to population-specific outcomes measures and accessible to providers.

(C) OUTCOMES MEASURES.—Outcomes measures data on a selected set of core population-specific outcomes measures agreed upon by the Secretary and the State that are accessible to providers and include—

- (i) measures of beneficiary and family caregiver experience with providers;
- (ii) measures of beneficiary and family caregiver satisfaction with services; and
- (iii) measures for achieving desired outcomes appropriate to a specific beneficiary, including employment, participation in community life, health stability, and prevention of loss in function.

(d) APPLICABLE PERCENTAGE POINTS INCREASE IN FMAP.—The applicable percentage points increase is—

- (1) in the case of a balancing incentive payment State subject to the target spending percentage described in subsection (c)(2)(A), 5 percentage points; and
- (2) in the case of any other balancing incentive payment State, 2 percentage points.

(e) ELIGIBLE MEDICAL ASSISTANCE EXPENDITURES.—

(1) IN GENERAL.—Subject to paragraph (2), medical assistance described in this subsection is medical assistance for noninstitutionally-based long-term services and supports described in subsection (f)(1)(B) that is provided by a balancing incentive payment State under its State Medicaid program during the balancing incentive payment period.

(2) LIMITATION ON PAYMENTS.—In no case may the aggregate amount of payments made by the Secretary to balancing incentive payment States under this section during the balancing incentive period exceed \$3,000,000,000.

(f) DEFINITIONS.—In this section:

(1) LONG-TERM SERVICES AND SUPPORTS DEFINED.—The term “long-term services and supports” has the meaning given that term by Secretary and may include any of the following (as defined for purposes of State Medicaid programs):

(A) INSTITUTIONALLY-BASED LONG-TERM SERVICES AND SUPPORTS.—Services provided in an institution, including the following:

- (i) Nursing facility services.
- (ii) Services in an intermediate care facility for the mentally retarded described in subsection (a)(15) of section 1905 of such Act.

(B) NON-INSTITUTIONALLY-BASED LONG-TERM SERVICES AND SUPPORTS.—Services not provided in an institution, including the following:

- (i) Home and community-based services provided under subsection (c), (d), or (i) of section 1915 of such Act or under a waiver under section 1115 of such Act.
- (ii) Home health care services.

(iii) Personal care services.

(iv) Services described in subsection (a)(26) of section 1905 of such Act (relating to PACE program services).

(v) Self-directed personal assistance services described in section 1915(j) of such Act.

(2) BALANCING INCENTIVE PERIOD.—The term “balancing incentive period” means the period that begins on October 1, 2011, and ends on September 30, 2015.

(3) POVERTY LINE.—The term “poverty line” has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

(4) STATE MEDICAID PROGRAM.—The term “State Medicaid program” means the State program for medical assistance provided under a State plan under title XIX of the Social Security Act and under any waiver approved with respect to such State plan.

APPENDIX B: STATE MEDICAID DIRECTOR LETTER

See next page

APPENDIX C: APPLICATION

See next page

Requirement	Part of System?
Website	
8. NWD/SEP system includes an informative community LTSS website. Website content is developed or overseen by the NWD/SEP Oversight or Operating Agency and reflects the full range of Medicaid community LTSS options available in the State. Information is current. Website is 508 compliant and accessible for individuals with disabilities.	<input type="checkbox"/>
9. Website lists 1-800 number for NWD/SEP network.	<input type="checkbox"/>
1-800 Number	
10. Single 1-800 number routes individuals to central NWD/SEP staff or to local NWD/SEP, where they can find out about community LTSS options in the State, request additional information, and schedule appointments at local NWD/SEP for an assessment. 1-800 number is accessible to non-native English speakers and those with disabilities, providing translation services and TTY.	<input type="checkbox"/>
Streamlined Eligibility and Enrollment Process - Data Considerations	
11. <i>Coordination of functional and financial assessment data:</i> Functional and financial assessment data and results are accessible to NWD/SEP staff so that eligibility determination and access to services can occur in a timely fashion.	<input type="checkbox"/>
Advertising of the NWD/SEP System	
12. <i>Advertising the NWD/SEP system:</i> State advertises the NWD/SEP system to help establish it as the “go to system” for community LTSS.	<input type="checkbox"/>
The Core Standardized Assessment (CSA)	
13. Uniformity of Level I/Level II assessment processes across populations seeking LTSS.	<input type="checkbox"/>
14. A Level I screen is available for completion online, in person, and over the phone.	<input type="checkbox"/>
15. Level II CSA is completed in person, with the assistance of a qualified professional.	<input type="checkbox"/>
16. The CSA is used to support the purposes of determining eligibility, identifying support needs, and informing service planning – across the State and across populations.	<input type="checkbox"/>
17. The CSA includes a Core Dataset (CDS) of required domains and topics.	<input type="checkbox"/>
Conflict-Free Case Management	
18. States must establish conflict of interest standards for the Level I screen, Level II assessment and care planning processes.	<input type="checkbox"/>
19. An agent independent of community LTSS service provision retains the final responsibility for the assessment and plan of care functions.	<input type="checkbox"/>

Requirement	Part of System?
<p>20. The independent agent cannot be any of the following:</p> <ul style="list-style-type: none"> • Related by blood or marriage to the individual, or any paid caregiver of the individual. • Financially responsible for the individual. • Empowered to make financial or health-related decisions on behalf of the individual. • Providers of State plan LTSS for the individual, or those who have interest in or are employed by a provider of State plan LTSS - EXCEPT, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area AND the State devises conflict of interest protections, such as “firewall” policies. 	<p style="text-align: center;"> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> </p>
<p>21. States should not implement policies to circumvent these requirements by suppressing the enrollment of any qualified and willing provider.</p>	<p style="text-align: center;"><input type="checkbox"/></p>
<p>22. The independent agent must not be influenced by variations in available funding, either locally or from the State.</p>	<p style="text-align: center;"><input type="checkbox"/></p>
<p>23. An individual’s plan of care must be created independently from the availability of funding to provide services: the plan of care must offer each individual all of the LTSS that are covered by the State that the individual qualifies for, and that are demonstrated to be necessary through the evaluation and assessment process.</p>	<p style="text-align: center;"><input type="checkbox"/></p>
<p>24. Referrals cannot be made between a referring entity and provider of services when there is a financial relationship between these parties.</p>	<p style="text-align: center;"><input type="checkbox"/></p>

APPENDIX E: INSTRUCTIONS FOR COMPLETING THE WORK PLAN

Six months after the submission of the Balancing Incentive Program application, States are required to submit a Work Plan, consisting of the below table and several deliverables (highlighted in gray in the table). In addition, to help CMS support States in implementing the structural changes, States are required to submit additional deliverables on a quarterly basis throughout the grant period. These quarterly deliverables will be accompanied by a Programmatic Progress Report. Deliverables and Progress Reports will be reviewed by CMS' technical assistance team, allowing CMS to monitor State progress and more importantly, support States in identifying and working through implementation challenges. As we expect that many States already have components of the required structural changes in place, States should be able to use existing documents/materials as their deliverables. In this section, we provide instructions for completing the Work Plan. Any deviation from the due dates stated in the Work Plan table must be approved by CMS. However, all structural changes must be made by October 1, 2015. The Work Plan should be signed by the lead of the State Medicaid Agency (the Oversight Agency) and by the Operating Agency (if those two agencies are different).

- The Balancing Incentive Program website (<http://www.balancingincentiveprogram.org/>) contains additional information on developing the Work Plan.
- For technical assistance, email: info@balancingincentiveprogram.org.
- CMS will provide guidance on the process of submission at a later date.

The Work Plan Table Template below consists of six main columns:

1. *Category*: This column represents the main components of the structural changes, including the No Wrong Door/Single Entry Point (NWD/SEP) system, the participating NWD/SEPs, the 1-800 number, website, advertising, the Core Standardized Assessment (CSA)/Core Dataset (CDS), conflict-free case management, data reporting, sustainability, and coordination with the Health Information Exchange IT system.
2. *Major Objective/Interim Tasks*: Within each category, we indicate major objectives and the tasks required to complete objectives. States may modify these tasks with approval from CMS.
3. *Due Date*: For each interim task, we have indicated a date by which that task should be completed and the corresponding deliverable submitted to CMS. The due date refers to the number of months from the time of the Work Plan submission. States should replace the number of months from Work Plan submission with an actual date to facilitate monitoring.
4. *Lead Person*: To support Work Plan implementation, the State should indicate which staff person in each agency is responsible for leading the task.
5. *Status of Task*: The State should also include a very brief description of the status of the task (e.g. not started, in progress, completed).
6. *Deliverables*: CMS has completed this column with deliverables that indicate that a related task has been completed. The State is responsible for submitting these deliverable to CMS on the respective due date.

Following the table, we provide a detailed described of each task outlined within the table.

Work Plan Table Template

*Please replace the number of months with an actual date.

Category	Major Objective / Interim Tasks	Due Date (from time of Work Plan submission)*	Lead Person	Status of Task	Deliverables
General NWD/SEP Structure	All individuals receive standardized information and experience the same eligibility determination and enrollment processes.				
	• Develop standardized informational materials that NWD/SEPs provide to individuals	3 months			Informational materials
	• Train all participating agencies/staff on eligibility determination and enrollment processes	18 months			Training agenda and schedule
	A single eligibility coordinator, "case management system," or otherwise coordinated process guides the individual through the entire functional and financial eligibility determination process. Functional and financial assessment data or results are accessible to NWD/SEP staff so that eligibility determination and access to services can occur in a timely fashion. (The timing below corresponds to a system with an automated Level I screen, an automated Level II assessment and an automated case management system. NWD/SEP systems based on paper processes should require less time.)				
	• Design system (initial overview)	0 months (submit with Work Plan)			Description of the system
	• Design system (final detailed design)	6 months			Detailed technical specifications of system
	• Select vendor (if automated)	12 months			Vendor name and qualifications
	• Implement and test system	18 months			Description of pilot roll-out
	• System goes live	24 months			Memo indicating system is fully operational
	• System updates	Semiannual after 24 months			Description of successes and challenges
NWD/SEP	State has a network of NWD/SEPs and an Operating Agency; the Medicaid Agency is the Oversight Agency.				
	• Identify the Operating Agency	0 months (submit with Work Plan)			Name of Operating Agency
	• Identify the NWD/SEPs	0 months (submit with Work Plan)			List of NWD/SEP entities and locations
	• Develop and implement a Memorandum of Understanding (MOU) across agencies	3 months			Signed MOU
	NWD/SEPs have access points where individuals can inquire about community LTSS and receive comprehensive information, eligibility determinations, community LTSS program options counseling, and enrollment assistance.				
	• Identify service shed coverage of all NWD/SEPs	3 months			Percentage of State population covered by NWD/SEPs
	• Ensure NWD/SEPs are accessible to older adults and individuals with disabilities	9 months			Description of NWD/SEP features that promote accessibility

Category	Major Objective / Interim Tasks	Due Date (from time of Work Plan submission)*	Lead Person	Status of Task	Deliverables
Website	The NWD/SEP system includes an informative community LTSS website; Website lists 1-800 number for NWD/SEP system.				
	• Identify or develop URL	3 months			URL
	• Develop and incorporate content	6 months			Working URL with content completed, screen shots of main pages
	• Incorporate the Level I screen (<i>recommended, not required</i>)	18 months			Screen shots of Level I screen and instructions for completion
1-800 Number	Single 1-800 number where individuals can receive information about community LTSS options in the State, request additional information, and schedule appointments at local NWD/SEPs for assessments.				
	• Contract 1-800 number service	6 months			Phone number
	• Train staff on answering phones, providing information, and conducting the Level I screen	6 months			Training materials
Advertising	State advertises the NWD/SEP system to help establish it as the “go to system” for community LTSS				
	• Develop advertising plan	3 months			Advertising plan
	• Implement advertising plan	6 months			Materials associated with advertising plan
CSA/CDS	A CSA, which supports the purposes of determining eligibility, identifying support needs and informing service planning, is used across the State and across a given population. The assessment is completed in person, with the assistance of a qualified professional. The CSA must capture the CDS (required domains and topics).				
	• Develop questions for the Level I screen	6 months			Level I screening questions
	• Fill out CDS crosswalk (see Appendix H) to determine if your State’s current assessments include required domains and topics	0 months (submit with Work Plan)			Completed crosswalk(s)
	• Incorporate additional domains and topics if necessary (<i>stakeholder involvement is highly recommended</i>)	6 months			Final Level II assessment(s); notes from meetings involving stakeholder input
	• Train staff members at NWD/SEPs to coordinate the CSA	12 months			Training materials
	• Identify qualified personnel to conduct the CSA	12 months			List of entities contracted to conduct the various components of the CSA
	• Continual updates	Semiannual after 12 months			Description of success and challenges

Category	Major Objective / Interim Tasks	Due Date (from time of Work Plan submission)*	Lead Person	Status of Task	Deliverables
Conflict-Free Case Management	States must establish conflict of interest standards for the Level I screen the Level II assessment and plan of care processes. An individual's plan of care must be created independently from the availability of funding to provide services.				
	<ul style="list-style-type: none"> Describe current case management system, including conflict-free policies and areas of potential conflict 	0 months (submit with Work Plan)			Description of pros and cons of case management system
	<ul style="list-style-type: none"> Establish protocol for removing conflict of interest 	9 months			Protocol; if conflict cannot be removed entirely, explain why and describe mitigation strategies
Data Collection and Reporting	States must report service, outcome, and quality measure data to CMS in an accurate and timely manner.				
	<ul style="list-style-type: none"> Identify data collection protocol for <i>service data</i> 	0 months (submit with Work Plan)			Measures, data collection instruments, and data collection protocol
	<ul style="list-style-type: none"> Identify data collection protocol for <i>quality data</i> 	0 months (submit with Work Plan)			Measures, data collection instruments, and data collection protocol
	<ul style="list-style-type: none"> Identify data collection protocol for <i>outcome measures</i> 	0 months (submit with Work Plan)			Measures, data collection instruments, and data collection protocol
	<ul style="list-style-type: none"> Report updates to data collection protocol and instances of <i>service data</i> collection 	Semiannual**			Document describing when data was collected during previous 6-month period and updates to protocol
	<ul style="list-style-type: none"> Report updates to data collection protocol and instances of <i>quality data</i> collection 	Semiannual**			Document describing when data was collected during previous 6-month period and updates to protocol
	<ul style="list-style-type: none"> Report updates to data collection protocol and instances of <i>outcomes measures</i> collection 	Semiannual**			Document describing when data was collected during previous 6-month period and updates to protocol
Sustainability	States should identify funding sources that will allow them to build and maintain the required structural changes.				
	<ul style="list-style-type: none"> Identify funding sources to implement the structural changes 	0 months (submit with Work Plan)			Description of funding sources
	<ul style="list-style-type: none"> Develop sustainability plan 	12 months			Estimated annual budget to maintain the structural changes and funding sources

Category	Major Objective / Interim Tasks	Due Date (from time of Work Plan submission)*	Lead Person	Status of Task	Deliverables
Exchange IT Coordination	States must make an effort to coordinate their NWD/SEP system with the Health Information Exchange IT system.				
	<ul style="list-style-type: none"> Describe plans to coordinate the NWD/SEP system with the Health Information Exchange IT system 	6 months			Description of plan of coordination
	<ul style="list-style-type: none"> Provide updates on coordination, including the technological infrastructure 	Semiannual			Description of coordination efforts

*** If States do not submit satisfactory information regarding data collection protocol, they will be required to submit this information on a quarterly basis.*

Signature of Lead of Operating Agency

Signature of Lead of Oversight Agency (Medicaid)

Name:

Agency:

Position:

Name:

Agency:

Position:

In the following discussion, we define the above tasks and deliverables in greater detail.

- **All individuals receive standardized information and experience the same eligibility determination and enrollment processes.**
 - *Develop standardized informational materials that NWD/SEPs provide to individuals:* Informational materials can include pamphlets, summaries of programs and related eligibility criteria, and case worker scripts. States may already have developed these materials and distributed them to individuals seeking community LTSS.
 - *Train all participating agencies/staff on eligibility determination and enrollment processes:* All staff should be trained on these processes by the time the NWD/SEP system is implemented for testing (18 months after date of Work Plan submission). This timing corresponds to an automated NWD/SEP system; the implementation of a paper-based system should require less time. As a related deliverable, States should submit the training documents used by NWD/SEP staff to follow the NWD/SEP processes, in addition to the training agenda. To be effective, documents should include flow diagrams and clear guidelines for each type of NWD/SEP staff member.
- **A single eligibility coordinator, “case management system,” or otherwise coordinated process guides the individual through the entire functional and financial eligibility determination process.**
 - *Design system (initial overview):* The State should submit with the Work Plan a general description of the NWD/SEP system, including the major actors (i.e., Operating Agency, NWD/SEPs), overview of processes (e.g., flow diagram), and the level of automation expected within the system. For example, States should indicate whether they plan on using an online Level I screen and an automated Level II assessment that feed into a central database, accessible to all NWD/SEPs.
 - *Design system (final detailed design):* This second task involves a much more detailed design structure of the NWD/SEP system. If the State plans to contract a vendor to build an automated system, the deliverable associated with this task could be the Request for Proposal (RFP) disseminated to potential vendors. The RFP should include the data flow, highlighting which entity(ies) will house the data, data transfer mechanisms, levels of user access, and data security measures. If the NWD/SEP system is paper-based, the description should include how information will be transferred to different participating entities in a timely manner (e.g. phone, fax) and how non-electronic data will be stored and retrieved securely.
 - *Select vendor (if automated):* Once a vendor is selected to build or enhance the NWD/SEP system, the State should submit a memo indicating the vendor name and qualifications (i.e., reason for selection).
 - *Implement and test system:* We expect many States will gradually roll out the NWD/SEP system, incorporating NWD/SEPs one at a time or in groups. This will allow States to test processes, identify lessons learned, and make improvements. This task requires a description of the roll-out plan, including which entities will implement the system when, and protocols for evaluating processes and incorporating lessons learned.

- *System goes live:* Once the system is live or fully operational, States should submit a memo to CMS indicating that it is fully operational and any major system changes implemented since the detailed design.
- *System updates:* After the system goes live, States should submit a brief semiannual report describing the successes and challenges associated with the system.
- **State has a system of NWD/SEPs and an Operating Agency; the Medicaid Agency is the Oversight Agency.**
 - *Identify the Operating Agency:* The name of this agency should be included in the initial description of the NWD/SEP system.
 - *Identify the NWD/SEPs:* The names of the entities and their locations should be included in the initial description of the NWD/SEP system.
 - *Develop and implement a Memorandum of Understanding (MOU) across agencies, including the State Medicaid Agency and the Operating Agency:* Given that many agencies will be involved in the NWD/SEP system, it is essential that each agency has a clear role and is on board with completing its responsibilities. MOUs are a key resource in helping define tasks and garner/confirm support. An example MOU is located in [Appendix F](#).
- **NWD/SEPs have access points where individuals can inquire about community LTSS and receive comprehensive information, eligibility determinations, community LTSS program options counseling, and enrollment assistance.**
 - *Identify service shed coverage of all NWD/SEPs:* As previously noted, a NWD/SEP's service shed covers all residents within a certain distance. Ideally, the combined service sheds of all NWD/SEPs should cover the State's entire population. Given this is not always feasible, States should submit the percentage of the State's population actually covered by the NWD/SEP and a description of why 100 percent coverage is not feasible.
 - *Ensure NWD/SEPs are accessible to older adults and individuals with disabilities:* States should indicate the features of the NWD/SEPs that promote accessibility, including wheelchair ramps, closeness to public transportation, bilingual staff, etc.
- **The NWD/SEP system includes an informative community LTSS website; Website lists 1-800 number for NWD/SEP network.**
 - *Identify or develop URL:* Many States already have websites with information on community LTSS. If the State plans to use a website already in existence, it should submit the URL of that website.
 - *Develop and incorporate content:* The State should incorporate additional information into that website as necessary. Once the website is completed, the State should submit screenshots of and documents available through the website.
 - *Incorporate the Level I screen (recommended, not required):* If the State chooses to incorporate a Level I screening tool into its community LTSS website, it should submit screenshots of the tool, in addition to the instructions for users to complete the screen.

- **Single 1-800 number where individuals can receive information about community LTSS options in the State, request additional information, and schedule appointments at local NWD/SEPs for assessments.**
 - *Contract 1-800 number services:* Many States already have 1-800 numbers for providing information on community LTSS. If the State plans to use a number already in existence, it should submit that phone number. If not, it must describe its method for contracting a 1-800 number service.
 - *Train staff to answer phones, provide information, and conduct the Level I screen:* NWD/SEP staff must be trained on how to provide information and conduct assessments in a standardized fashion. The State should submit related training materials and schedules.
- **State advertises the NWD/SEP system to help establish it as the “go to system” for community LTSS**
 - *Develop advertising plan:* Nursing homes, hospitals, community-based organizations, medical providers, and other governmental social programs should be aware of and refer clients to the NWD/SEP system. Therefore, the State must develop and submit a plan for advertising the system to all potential referring partners.
 - *Implement advertising plan:* To indicate that the advertising plan has been implemented, States should submit related materials, such as posters and pamphlets.
- **A CSA, which supports the purposes of determining eligibility, identifying support needs and informing service planning, is used across the State and across a given population. The assessment is completed in person, with the assistance of a qualified professional. The CSA includes a CDS (required domains and topics).**
 - *Develop questions for the Level I screen:* The Level I screen should include a series of basic financial and functional questions that indicate whether a person may be eligible for Medicaid-funded community LTSS. States must identify and submit these questions. Many will submit a Level I screen already in use.
 - *Fill out CDS crosswalk to determine if State’s current assessments include required domains and topics:* Refer to [Appendix H](#) for instructions on how to determine if the assessment already in use has all required domains and topics within the CDS.
 - *Incorporate additional domains and topics if necessary (stakeholder involvement is highly recommended):* Many States already use assessments that meet all of the required domains and topics within the CDS. If not, the State should incorporate additional domains and topics using input from stakeholders. The State should submit the final assessment in addition to any materials that indicate stakeholder involvement as the required deliverable.
 - *Train staff members at NWD/SEPs to coordinate the CSA:* NWD/SEP staff must be trained to initiate and coordinate the collection of Level II assessment. This involves working with the clinical staff responsible for actually conducting the assessment and ensuring the assessment is completed in a timely fashion. Once again, States should submit training materials and schedules associated with this task.

- *Identify qualified personnel to administer the CSA:* States should submit a list of entities responsible for conducting the different portions of the assessment in addition to their qualifications, such as certification, education, or training.
- *Continual updates:* After the implementation of the CSA, States should submit brief semiannual reports with successes and challenges associated with the CSA.
- **States must establish conflict of interest standards for the Level I screen the Level II assessment and plan of care processes. An individual's plan of care must be created independently from the availability of funding to provide services.**
 - *Describe current case management system.* This description should include policies that encourage conflict-free case management, in addition to areas of potential conflict.
 - *Establish protocol for removing conflict of interest:* The State must also submit established protocol on how it is ensuring that the community LTSS eligibility determination, enrollment, and case management processes are free of conflict of interest.
- **States must report service, outcome, and quality measure data to CMS in an accurate and timely manner.** For each data type (service data, outcome data, and quality measures), the States should submit the sources for these data and/or the surveys that will be used to collect these data. Information should also include sampling and data collection protocol when applicable. On a semiannual basis, States should submit any changes in protocol and instances of data collection.
- **States should identify funding sources that will allow them to build and maintain the required structural changes.**
 - *Identify funding sources to implement the structural changes:* Before building their systems, State should know from where they plan to receive their funding. Ideally, States will submit information on the total cost of implementing the structural changes and the amount to be received from each funding source.
 - *Develop sustainability plan:* States must also have a clear idea on the cost of maintaining the structural changes once they are in place. Therefore, States should submit the overall maintenance budget of the structural changes and sources of funding.
- **States must make an effort to coordinate their NWD/SEP system with the Health Information Exchange IT system.**
 - *Describe plans to coordinate systems:* This may include discussions with State Exchange IT system staff, the identification of key data fields that should be shares across the systems, and the development of a bridge between the systems.
 - *Provide updates on coordination:* On a semiannual basis, States should report to CMS updates on coordination including new infrastructure developments.

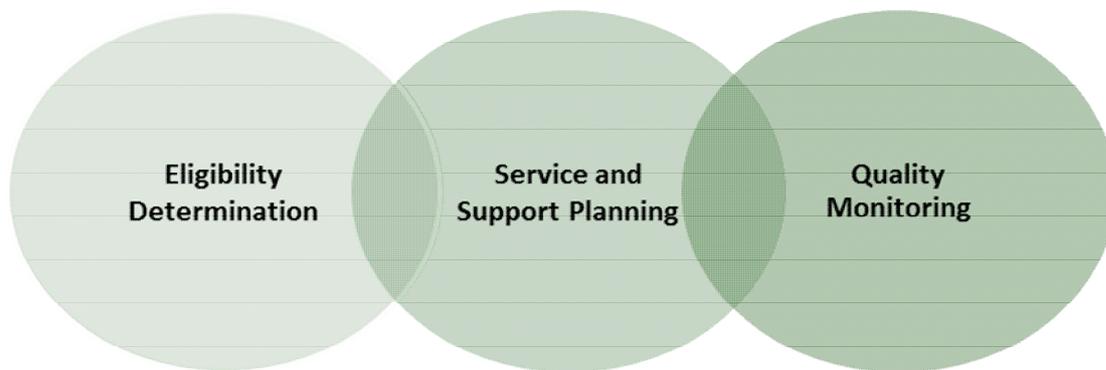
APPENDIX F: COORDINATION ACROSS MULTIPLE AGENCIES

To improve access across diverse populations and large geographic areas, CMS expects that States will rely on multiple types of NWD/SEPs within their systems. These entities may not have worked together in the past. Therefore, it is essential that States foster productive working relationships by establishing clear guidelines on each entity's responsibilities and confirming support through Memoranda of Understanding (MOUs). MOUs should specify changes that NWD/SEPs need to make to their current processes to become compliant with the Balancing Incentive Program. For example, the development and adoption of the same Level I screen across all entity types could be a cumbersome task requiring serious commitment from NWD/SEPs. The MOU should also spell out expectations for cross-training and quality assurance measures to promote the standardization of processes. This Appendix provides an example MOU between various agencies collaborating with ADRCs. In addition, the ADRC technical assistance website (<http://www.adrc-tae.org>) has additional examples of MOUs, considerations for MOU development, and MOU templates. Finally, the Office of the Assistant Secretary for Planning and Evaluation released a paper on the process an agency should follow to develop interagency MOUs and presents examples of MOUs which can be used as models: <http://aspe.hhs.gov/daltcp/reports/mouguide.htm>.

APPENDIX G: REVIEW OF UNIFORM ASSESSMENT EFFORTS

Review of State and National Efforts to Conduct Uniform Assessments

Several universal assessment tools have been created across the country, designed to collect uniform or standardized data across service programs, populations, or geographic locations. These tools have been developed with three general purposes in mind: eligibility determination, service and support planning, and/or quality monitoring (see graphic below). Some tools are specifically designed to address one function, while others tackle more than one. Within this framework, the Balancing Incentive Program CSA effort focuses on eligibility determination and portions of service and support planning (i.e., identify support needs and inform service planning).



A review of twelve long-term care assessment tools used across the country (Gillespie, 2005) noted that while there is consistency in many of the topic areas addressed across tools, assessments vary by function/purpose, population assessed, level of automation, extent of integration with other systems, administration of the tools, and the specific questions included. The study also noted a movement toward utilizing assessment instruments that could be completed over the internet, and that questions generally fall into the broad categories of background information, health, functional assessment, and cognitive/social/emotional assessments.

To develop a framework for creating a program-compliant CSA, a range of instruments that serve the goals outlined in the Balancing Incentive Program (i.e., determine eligibility, identify support needs, and inform service planning) were reviewed. Some of the tools reviewed were developed for use within one particular State, while others were designed for use across multiple States. Some were designed to assess one particular population (e.g., aging adults, people with developmental disabilities), while others included multiple populations. Regardless, it is recognized that the design of uniform/universal assessment tools is a complex and involved process, requiring many person-hours, negotiations, instrument testing, and stakeholder buy in. Therefore, the logical first step in developing guidance related to a Balancing Incentive Program CSA and CDS involved reviewing these existing tools and processes.

Presented below are selected results of this environmental scan. They include:

Profiles of Selected State and National Tools

- Descriptions of notable State-specific efforts where work was undertaken to bring uniformity to their processes for assessing needs and making eligibility determinations across programs and populations.
- Descriptions of selected nationally recognized and utilized tools for functional and support need assessment.

Comparisons of Uniform Assessment Tools

- Comparisons of multiple assessment tools used throughout the United States for determining an individual's eligibility and/or needs for long-term services.
- Identification of common domains and data elements.

Profiles of Selected State and National Tools

Our national inventory of tools identified seven assessment tools developed at the State level, and six assessment instruments used more broadly across States worth profiling for their unique design qualities, processes, use across multiple populations or programs, functions, and/or capacity for automation. Each is briefly described below, highlighting its unique qualities:

Colorado – The Department of Human Services (DHS) and Department of Health Care Policy and Financing (HCPF) use the *Uniform Long Term Care* (ULTC) tool to assess individuals of all ages, and across populations. The tool is used alone or in combination with other tools to assess LTSS needs for DHS' community-based programs. For example, in the developmental disability system, the ULTC is used to determine an individual's level-of-care eligibility for Colorado's home and community-based services (HCBS) waiver programs, and in combination with the Supports Intensity Scale (SIS) to identify support needs to inform an individual's service planning process.⁹

Maine – Maine's *Medical Eligibility Determination (MED) Tool* is used to determine medical eligibility for a variety of State and Medicaid funded long-term care services. In use since 1998, the MED was built using the MDS-HC tool (described below) as a foundation, but modified and expanded to meet eligibility requirements for Maine-specific programs and services. The tool is automated and used Statewide. The MED also has a section assessing an individual's capacity for consumer-directed services.¹⁰

Massachusetts – The *Massachusetts Real Choice Functional Needs Assessment* was developed by the University of Massachusetts Medical School and the Center for Health Policy and Research between 2003 and 2005 as part of a CMS-funded Real Choice Systems Change Grant. While not ultimately selected for widespread use across the State, this modular assessment tool contains a core set of questions (including a Level I Intake section and a Level II Long-Term Supports section) that can be used regardless of

⁹ More information may be found at:

http://www.hcbs.org/moreInfo.php/source/152/ofc/100/doc/847/Colorado_Screening_Tool_ULTC_100.2

¹⁰ More information can be found at: <http://www.maine.gov/dhhs/oes/medxx/medxx.pdf>

population or program, and a set of additional Level 3 “modules” to meet specific population, program or service information needs.¹¹

Minnesota – In 2011, Minnesota’s Department of Human Services (DHS) will begin using the web-based, *MnCHOICES Comprehensive Assessment* to assess the needs of children, adults, and the elderly for LTSS. DHS currently uses a variety of assessment and screening documents to determine eligibility for LTSS. The MnCHOICES tool will replace all long-term assessment processes to ensure greater consistency across all lead agencies in the State. Their goal is to implement a single framework for access to and assessment of coverage and services options. The assessment has three phases: initial screening/intake, a full health and functional assessment, and a support planning module. As an automated application, responses to specific questions trigger the addition or removal of subsequent questions, as required.

Virginia – Since 1994, all publicly funded health and human resource agencies in Virginia have been using the *Virginia Uniform Assessment Instrument (UAI)* to collect information for determining the long-term care needs and service eligibility for individuals, and for planning and monitoring their needs across agencies and services. The UAI contains both a short assessment (Part A) and a full assessment (Parts A and B). Part A is primarily an intake/screening document, which can be completed by phone, and used to assess whether or not a full assessment is needed. The full assessment (Part B) is a comprehensive evaluation of individual functioning, and is designed to gather enough information to begin a service plan. It is designed to be completed as a face-to-face interview with the individual.¹²

Washington – The Washington State Department of Social and Health Services uses the *Comprehensive Assessment Reporting Evaluation (CARE)* tool to determine eligibility for individuals applying to or receiving aging or disability services. Washington has used the CARE tool since 2003 to gather information for determining program eligibility, benefit level, and assist with services planning (including consumer choices and preferences).¹³

Wisconsin – Developed by the State’s Department of Health Services, Wisconsin’s Functional Screen system consists of three functional assessment tools: the *Wisconsin Adult Long Term Care Functional Screen*, the *Functional Eligibility Screen for Children’s Long Term Support Programs*, and the *Functional Eligibility Screen for Mental Health and AODA (Co-Occurring) Services*. Each tool uses a web-based application to collect information about an individual’s functional status, health, and need for assistance from programs serving the elderly, and/or people with physical or developmental disabilities. The screen determines functional eligibility for certain mental health services, adult long-term care programs and children’s long-term support programs. Screeners (typically social workers, nurses or other professionals) who have taken an online training course and passed a certification exam are able to access and administer the screen. The children and adult tools have been tested and considered valid and reliable.¹⁴

CARE Tool - The CARE Tool was designed for implementation with Medicare populations, primarily those who are aging and/or have physical disabilities. Developed for use in acute and post-acute-care (PAC) settings participating in the PAC Payment Reform Demonstration, CARE was originally tied to payments made for services in relation to impacts on individuals. In other words, it was meant to serve as a tool for measuring quality of care in different contexts. It has been shown to be a valid and reliable

¹¹ More information can be found at: http://www.adrc-tae.org/tiki-download_file.php?fileId=26933

¹² More information can be found at: <http://www.dmas.virginia.gov/downloads/forms/UAI.pdf>

¹³ More information can be found at:

[http://www.hcbs.org/moreInfo.php/type_tool/147/ofs/80/doc/1129/Comprehensive_Assessment_Reporting_Evaluation_\(CAR](http://www.hcbs.org/moreInfo.php/type_tool/147/ofs/80/doc/1129/Comprehensive_Assessment_Reporting_Evaluation_(CAR)

¹⁴ More information can be found at: <http://www.dhs.wisconsin.gov/ltcare/FunctionalScreen/>

instrument. CARE contains a variety of questions that measure functional capabilities and limitations (e.g., activities of daily living).¹⁵

Inventory for Client and Agency Planning (ICAP) – The ICAP is a standardized assessment instrument that measures adaptive and maladaptive behavior. Specifically, it collects descriptive and diagnostic information and measures functional limitations, needed assistance, motor skills, social and communication skills, personal living skills, community living skills, and broad independence as well as eight categories of maladaptive behavior. It can be used for both children and adults and includes program planning and evaluation, transition testing, and eligibility determination for services, including home and community-based services.¹⁶

Minimum Data Set (MDS) – The MDS is a 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. Resident Assessment Protocols (RAPs) are part of the assessment process, and provide a basis for developing each person's individual care plan. These assessments are required on admission to the nursing facility and then periodically thereafter. MDS information is transmitted electronically, first to State databases and then into the national MDS database at CMS.¹⁷

Minimum Data Set-Home Care (MDS-HC) - The MDS-HC is a validated assessment tool created by interRAI Corporation, that was built off of the MDS 2.0 (see above). 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. The MDS-HC tool incorporates many sections including demographics, cognition, mood and behavior, social functioning, activities of daily living (ADLs), instrumental activities of daily living (IADLs), informal supports, health and medical conditions, medications, and environmental factors. Some States use the MDS-HC tool to conduct level of care determination for Medicaid and other State-funded programs and to develop individual service plans.¹⁸

Outcome and Assessment Information Set (OASIS) - The OASIS tool was developed by the Health Care Financing Administration (HCFA – now CMS), Robert Wood Johnson Foundation (RWJF), and University of Colorado. The 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. The OASIS tool is used across all Medicare-certified home health agencies in the country. A national data repository, referred to as HAVEN, gathers State-level information on a regular basis. These data are analyzed as part of CMS' outcomes-based quality improvement efforts and used to compare State and national level statistics on provider performance and clinical outcomes.¹⁹

Supports Intensity Scale (SIS) - The SIS is a validated and normed tool developed by the American Association on Intellectual and Developmental Disabilities (AAIDD). The tool is designed for use with adults (16 and over) with developmental disabilities; a similar version appropriate for children is anticipated in 2011. The SIS is novel in that it assesses the frequency and level of support needed by the individual, rather than documenting performance deficits or behaviors that lead to the needs for supports. The SIS uses a structured interview to assess support needs over several topical areas: home

¹⁵ More information can be found at: <http://www.pacdemo.rti.org/meetingInfo.cfm?cid=caretool>

¹⁶ More information can be found at: <http://icaptool.com/>

¹⁷ More information can be found at:

https://www.cms.gov/NursingHomeQualityInits/30_NHOIMDS30TechnicalInformation.asp#TopOfPage

¹⁸ More information can be found at: <http://www.interrai.org/section/view/?fnode=15>

¹⁹ More information can be found at: <http://www.cms.gov/oasis/>

living, community living, lifelong learning, employment, health and safety, social activities, protection and self-advocacy, medical health, and behavioral conditions. The SIS is noteworthy in that it is used by many States for planning purposes, and is increasingly used for resource allocation purposes as well.²⁰

Comparisons of Uniform Assessment Tools

Our environmental scan identified 23 uniform assessment tools used with an array of long-term service and support populations (i.e., individuals with physical disabilities, individuals with developmental disabilities, individuals with mental illness, children, adults, and the elderly). They were comprehensive and consistent (at least in part) with the intentions of the Balancing Incentive Program CSA – that is, at a minimum, they included a functional assessment component and could be used to inform support planning. Eighteen of these tools are State-specific, three (SIS, ICAP, and MDS-HC) are used in multiple States, and two (MDS, OASIS) are used nationally.

The table below summarizes the features of these tools, with information on each to illustrate their target populations, the age groups for which they are intended, as well as the intention of the tool (i.e., for functional or financial assessment, and/or to inform the development of a support plan). Of the 23 assessment tools, 19 are applicable for assessing the elderly; 16 are for people with physical disabilities; 13 are designed for individuals with developmental disabilities; and nine are for use with individuals with mental illness.

Most (21) are for use with adults; two are intended for use with children only, and eight can be used for people of all ages. Of the 23 tools, seven were for use in all LTSS populations. Many cross-population assessment tools were developed as a component of State Aging and Disability Resource Center (ADRC) programs, which helps to explain why so many of the tools are appropriate for multiple populations²¹.

All 23 instruments measure an individual's functional capabilities and limitations (e.g., activities of daily living). Ten assessment tools also capture financial information (e.g., income, assets, public benefits) for the individual being assessed; 14 instruments are designed to inform support planning for the person being assessed.

²⁰ More information can be found at: <http://www.siswebsite.org/>

²¹ ADRCs are a collaborative effort between the Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS). 46 States (all except Louisiana, Mississippi, Missouri, Pennsylvania), the District of Columbia, and two territories (Guam, Puerto Rico) had ADRC programs.

Comparison of Intended Populations and Uses for Select Assessment Tools

St.	Assessment Tool	Pop: Aging	Pop: PD	Pop: DD	Pop: MH	Age Group: Child	Age Group: Adult	Use: Financial Assessment	Use: Functional Assessment	Use: Inform Planning
CO	Colorado Uniform Long Term Care Initial Screening and Intake	X	X	X	X	X	X	X	X	X
CO	Colorado Long Term Care Assessment for Instrumental Activities of Daily Living	X	X	X	X	X	X		X	X
CT	Connecticut ADRC Assessment Tool	X	X	X	X		X	X	X	
FL	Florida Department of Elder Affairs Assessment Instrument	X					X	X	X	
GA	Georgia Determination of Need (DON) Functional Assessment Tool	X					X		X	
IL	Illinois Dept. on Aging Statewide Comprehensive Needs Assessment Form	X	X				X	X	X	X
KS	Kansas Developmental Disability Profile (DDP)			X			X	X	X	
ME	Medical Eligibility Determination (MED) Tool	X	X	X	X	X	X	X	X	X
MA	Massachusetts Real Choice Functional Needs Assessment	X	X	X	X	X	X	X	X	X
MN	MnCHOICES (to be implemented in 2011)	X	X	X	X	X	X		X	X
NC	Community Alternatives Program/Adults Data Set	X	X		X		X		X	
NC	Comm. Alternatives Program/Children Case Manager Assessment		X	X		X			X	X
NY	New York COMPASS - Comprehensive Assessment for Aging Network Community-Based Long Term Care Services	X					X		X	X
RI	Rhode Island Uniform Comprehensive Assessment Tool (UCAT)	X					X	X	X	
VA	Virginia Uniform Assessment Instrument	X	X	X	X	X	X	X	X	X
WA	WA State Comprehensive Assessment Reporting Evaluation (CARE)	X	X				X	X	X	X
WI	Wisconsin Adult Long-Term Care Functional Screen	X	X	X			X		X	
WI	Functional Eligibility Screen for Children's Long-Term Supports Programs		X	X	X	X			X	
US	Inventory for Client and Agency Planning (ICAP)	X	X	X		X	X		X	X
US	Supports Intensity Scale (SIS)			X		2011	X		X	X
US	Minimum Data Set (MDS)	X				X	X		X	X
US	Minimum Data Set for Home Care (MDS-HC)	X	X				X		X	X
US	Outcome and Assessment Information Set (OASIS)	X	X				X		X	

Of the State-specific tools, information indicating the tool was deemed valid and reliable could only be found for the two Wisconsin tools. All of the nationwide assessments, however, were tested and determined to be valid and reliable instruments.

From these 23 assessment tools, nine instruments were selected for more in-depth review. Figure 4-2 depicts these tools, chosen because they are designed to be used across multiple populations or because they could be automated. Many of these tools were comprehensive, and most were designed to perform functions similar to those required by the Balancing Incentive Program (i.e., they focused on eligibility determination, identification of support needs, and support planning).

Crucially, the efforts abstracted away from the specifics of these tools to identify six broad content *domains*, including background information; financial assessment; health; functional assessment; cognitive, social, emotional, behavioral assessment; and other. Across these domains, 56 common *topics* were found. These domains and topics were based from categories identified in earlier studies (Gillespie, 2005), and supplemented as necessary.

The table below illustrates that:

- Of the 56 topics areas, three tools (MA, MN, and WA) include at least 53 topics. The Massachusetts and Minnesota tools are not currently in use. The Colorado, Maine and Virginia tools include about 70 percent of the topics (38, 40, and 41 respectively). Wisconsin includes nearly 60 percent (32), and the two tools used across several States contain about half of the topic areas (the ICAP covers 27, the SIS 28).
- All of these tools cover ADLs, IADLs, and cognitive/social/emotional/behavioral indicators. Within ADLs, each of the nine tools includes the topics of bathing, dressing, in-home mobility, toileting and eating. Eight of the nine tools include the topic of communication. Within IADLs, each of the nine tools includes the topics of meal preparation, housework, and managing finances. Finally, eight of the nine tools include the topics of managing medications, phone use, shopping, and transportation.
- A financial assessment, to some degree, is included in each State-specific tool, but in neither multi-State tool.
- A topic covering caregiver/support person stress is included in about half of the tools.

	CO	ME	MA	MN	VA	WA	WI Adult	ICAP	SIS
Background Information									
Demographics	X	X	X	X	X	X	X	X	X
Emergency Contacts		X	X	X	X	X	X	X	
Primary Caregiver			X	X	X	X			X
Legal Representatives/Documents	X	X	X	X		X	X	X	
Health Insurance	X		X	X	X	X	X		
Primary Health Care Provider	X		X	X	X	X			
Client Report of Functional Status/Needs	X		X	X	X	X	X		
Support Systems	X		X	X		X	X		X
Current Formal Services and Providers	X		X	X	X	X	X	X	X
Living Arrangements	X	X	X	X	X	X	X	X	
Language or Cultural Issues	X	X	X	X	X	X	X	X	X
Interpreter Requires/Present			X	X		X	X		
Citizenship/Vet Status		X	X	X		X			
Request for Assistance	X	X	X	X		X			
Financial Assessment									
Income	X	X	X		X	X			
Assets/Real Estate			X		X	X			
Employment			X	X	X	X	X		
Health									
Vital Signs			X			X			
Preventive Health (vaccines, breast exams)			X	X		X			
Medical Condition/Diagnosis	X	X	X	X	X	X	X	X	
Special Treatments, Assistive Devices	X	X	X	X	X	X			X
Professional Nursing/Therapy Services	X	X	X	X	X	X	X	X	X
Medications	X	X		X	X	X	X	X	
Pain or Palliative Care			X	X		X			
Vision	X	X	X	X	X	X		X	
Hearing	X	X	X	X	X	X		X	
Nutrition Status/Lifestyle		X	X	X	X	X			X
Skin Condition		X	X	X		X			X
Dental Status		X	X	X					
Alternative Medicine				X					
Potential for Abuse or Neglect	X	X	X	X	X	X	X		X
Functional Assessment									
Activities of Daily Living (ADLs)									
Bathing	X	X	X	X	X	X	X	X	X
Personal Hygiene	X	X	X	X		X		X	X
Dressing	X	X	X	X	X	X	X	X	X
Mobility Outside of Home	X	X	X	X		X		X	X
Mobility In Home	X	X	X	X	X	X	X	X	X
Transferring	X	X	X	X	X	X	X		
Toilet Use	X	X	X	X	X	X	X	X	X
Mobility in Bed		X	X	X		X			
Eating	X	X	X	X	X	X	X	X	X
Communication		X	X	X	X	X	X	X	X
Instrumental Activities of Daily Living (IADLs)									
Meal Preparation	X	X	X	X	X	X	X	X	X
Ordinary Housework	X	X	X	X	X	X	X	X	X
Managing Finances	X	X	X	X	X	X	X	X	X
Managing Medications	X	X	X	X	X	X	X		X
Phone Use	X	X	X	X	X	X	X	X	
Shopping	X	X	X	X	X	X		X	X
Transportation	X	X	X	X	X	X	X		X
Pet Care				X		X			
Physical Environment		X	X	X	X	X			
Cognitive/Social/Emotional/Behavioral									
Cognitive Functioning	X	X	X	X	X	X	X	X	X
Memory Concerns	X	X	X	X	X	X	X		
Psychosocial (mental status, stressful events)	X	X	X	X	X	X	X		X
Social Participation	X		X	X	X	X		X	X
Behavior Problems	X	X	X	X	X	X	X	X	X
Other									
Caregiver/Support Person Stress			X	X	X	X			

APPENDIX H: CSA IMPLEMENTATION

GUIDANCE

This section offers guidance for States to meet the Balancing Incentive Program’s Core Standardized Assessment (CSA) requirements tied to uniformity across populations and geography: 1) implementing a Level I screening process, 2) meeting the three CSA purposes, and 3) capturing a uniform Core .

IMPLEMENTING A LEVEL I SCREENING PROCESS

The purpose of a Level I screen is to identify those individuals who are *likely* to be eligible candidates for Medicaid-funded community LTSS. The Level I screen must be available for completion by the potential applicant or his/her representatives online (with online support), in person, or over the phone (by calling a toll-free number with live support available). It should be as short, concise, and as simple to complete as possible, recognizing that the screening tool might be completed by the individual with support needs themselves, by family members, or others on behalf of the individual. The Level I screen, for those considered likely eligible for community LTSS, provides a base of information for determining if a Level II assessment is appropriate.

The Level I screen may be specific to Medicaid community LTSS or be part of a screen that is broader in scope, that is, one that helps respondents identify and access a variety of community supports. The following pages provide three examples of screening tools, where Medicaid-funded services are just one of many community resources to which individuals may be linked. Additional links to existing screening tools are provided in the “Additional Links and Resources” section at the end of this chapter.

Web-based Level I Screen Examples:

Example 1: Arizona: <https://www.azdes.gov/main.aspx?menu=8&id=584>

DES Office Locator | Español | DES Events | Press Room | Site Map

[Basic Needs](#) | [Child & Family](#) | [Seniors](#) | [Disabilities](#) | [Employment](#) | [Online Services](#)

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[Financial & Legal](#)

[Health](#)

[Home & Community](#)

[Partners](#)

[Frequently Asked Questions](#)

[Contact AZ Links](#)

[AZ Links Website Feedback](#)

Arizona Links Screening Tool for Yuma County Residents



When you have completed the form, click the 'Submit' button at the bottom of the page, an Information Specialist from the Area Agency on Aging, Western Arizona Council of Governments (WACOG) will contact you to discuss the options that are available to you.

Please submit a separate Screening Tool for each person seeking services.

If you need assistance to complete this screening tool or would like additional information, please contact (in Yuma County) the WACOG Aging and Disability Helpline at (928) 753-6247

- What is your primary reason for filling out this Screening Tool?
- Have you contacted the WACOG AAA before?
 No Yes
- I am seeking information/care for:
- Please select a Zip Code / Location:
- The date of birth of the person identified above is (month-day-year):
 Month: Day: Year (four-digit format 1944):
- Assistance with the following tasks is needed: (check all that apply)
 - Bathing
 - Eating
 - Communicating
 - Dressing/Grooming
 - Medication reminders or supervision
 - Mobility
 - Toileting
 - Transferring (from bed into wheelchair)
 - None
 - Other
- Assistance with the following household chores is needed: (check all that apply)
 - Cooking
 - Housekeeping
 - Money Management
 - Shopping
 - Telephone Calls
 - Transportation
 - None
 - Other
- The current care situation is such that: (check all that apply)
 - Periods of more than 24 hours when left alone
 - Care needs are often unmet
 - Inadequate opportunities to socialize with others
 - Family and friends do not live close enough to visit on a regular basis
 - Periods of memory loss
 - Episodes of grief and loss
 - Frequent or occasional falling
 - Thoughts of depression or suicide
 - Generally sufficient care for my needs
- Most pressing needs are: (check all that apply)
 - Assistance with Housekeeping
 - Assistance with Personal Care
 - Assistance with reconciling medical bills and insurance records
 - Behavior assistance
 - Benefits counseling (public benefits)
 - Care in case of emergency
 - Care management
 - Companionship
 - Educational assistance
 - Employment
 - End of Life Care/Hospice
 - Food
 - Grandparent services
 - Housing
 - In-home instructions for daily living
 - Legal advice or estate planning
 - Mental health support
 - Medication and appointment reminders
 - Medication management
 - Nutrition counseling
 - Occupational Therapy
 - Ombudsman (advocacy rights)
 - Physical Therapy
 - Prescription drug assistance
 - Rehabilitation (from surgery/accident/stroke/etc.)
 - Respite (temporary relief for a Caregiver)
 - Skilled nursing care

Example 2: Oregon: <http://oregonhelps.org/>



49%

Household Information

Information about Yourself

What county do you live in?

Where are you using Oregon Helps from?

How did you hear about Oregon Helps?

Other Household Members

Do you have a spouse that lives with you?

* How many of your and/or your spouse's children under 21 live with you?

* How many other children under 21 live with you?

* How many other adults, age 21 or older, live with you?

Note: Include all children 21 and older, but do not include your spouse.

Does everyone in your household share food?

Does anyone in your household have a disability or is anyone blind?

Information About Yourself

Background Information

* How old are you?

Are you pregnant?

If you pay child support how much do you pay per month?

Are you a veteran of the US military?

Earnings and Income

Do you work for an employer for pay?

Are you self-employed?

Do you have income from other sources?

Housing Information

Please tell us about your housing situation:

Rent Information

Rent Amount

How much is your rent each month?

Utilities

Do you pay for heating and/or cooling?

Do you pay for electricity?

Do you pay for phone?

Other Household Information

FICA Information

Have any of these people ever worked in a job where taxes were paid?

Yourself:

Medical Expenses Information

Please report the average monthly out-of-pocket medical expenses for the following household members who are age 60 or older, disabled, or both.

Out-of-pocket medical expenses include:

- health insurance premiums
- deductibles
- co-payments
- costs of other medical goods and services not covered by insurance (for example, prescription drugs, dentures, hearing aids, eyeglasses, nursing care)

Yourself:

Example 3: Virginia: <http://www.srnv.org/virginiannavigator/IndexEasyNav.aspx>

- Community Supports
- Emergency Preparedness
- Financial Help
- Housing
- My Rights: Who Can Help?
- Transportation
- Veterans
- Related Links
- About Easy Access
- Contact Us
- Site Map
- Home

Version: 2.0.0.7



1. I have difficulty or anticipate it in the future with my ...

- Vision
- Hearing
- Speech/Language

2. I am able to do the following tasks without any assistance:

- Bathing
- Grooming
- Toileting
- Dressing
- Eating
- Shopping
- Preparing meals
- Housework (cleaning, yard work)
- Handling personal finances (balancing checkbook, paying bills, etc.)

3. I need help with transportation:

- Yes
- No

4. I...

- Walk without assistance
- Have difficulty standing or walking for more than 10 minutes
- Use a cane
- Use a white cane (vision impairment)
- Use crutches
- Use a walker
- Use a wheelchair unassisted
- Need assistance with my wheelchair
- Am unable to get around without assistance

5. I'd like a list of housing options in my community to help me live as independently as possible:

- Yes
- No

6. I have fallen recently or am concerned about the risk of falling:

- Yes
- No

7. I have chronic conditions including:

- Arthritis, fibromyalgia or a related condition
- Depression or mental health issues (post-traumatic stress disorder, bi-polar, schizophrenia, substance abuse)
- Diabetes
- Heart Disease, hypertension or a related condition (high cholesterol, high blood pressure, stroke)

8. If you had a medical emergency, could you call someone for assistance?

- Yes
- No

9. I'd like to talk with an expert about my needs and resources in the community:

- Yes
- No

10. I have the following insurance and resources:

- Long Term Care
- Medicaid

MEETING THE THREE PURPOSES OF A BALANCING INCENTIVE PROGRAM CSA

To review, the purpose of a Balancing Incentive Program CSA is to: 1) determine LTSS eligibility, 2) identify support needs, and 3) inform a service and support plan.

Determine Eligibility for Medicaid-Funded LTSS – The domains and topics identified in the CDS must be incorporated, in part or as a whole, alone or in combination with other factors, in determining an individual’s eligibility for a State’s Medicaid-funded LTSS. CMS recognizes that different programs and services may have different eligibility criteria and leaves to State discretion the manner which it determines/weights specific eligibility criteria for each service/program. In other words, while the CDS must be collected on all individuals, the methods by which this dataset is used to determine eligibility for a particular program or service are up to the State. Eligibility criteria, however, must incorporate some portion of the CDS.

Identify an Individual’s Needs for Services and Supports and Inform an Individual Service Planning – The required CDS can provide a direct link to identifying essential long-term services and support needs, and informing (i.e., providing a springboard for) individual service planning.

The CSA/CDS Crosswalk provided in the following section will help States assess the extent to which their existing instruments comply with the requirements of the Balancing Incentive Program.

CAPTURING THE LEVEL II CORE DATASET

CMS recognizes States already have assessment processes in place, for both eligibility determination and support planning purposes. In some cases, these tools have been used for many years, providing States with opportunities to analyze longitudinal data. In some cases, large financial resources have been spent to assure the validity and reliability of tools used. In an effort to recognize the practical constraints that States might face in shifting, full-on, to a universal CSA, CMS is requiring that a CDS be captured by the CSA.

CMS, too, has adopted a flexible approach for States to collect the CSA. In fact, States have three options for meeting the CSA/CDS requirements under the Balancing Incentive Program. A State may: 1) use their existing assessment tool(s) to ensure that the CDS is collected for all individuals seeking community LTSS via the NWD/SEP system; 2) adapt or supplement their existing assessment tool(s) with new question sets to ensure that all domains and topics of the CDS are fully covered; or 3) completely replace their existing processes for collecting assessment information, and develop new CSA instruments that fulfill the CDS requirements.

Here, tools are provided to guide States as they assess their current data collection tools and processes, and determine which option best suits their needs. These tools include:

1. A CSA/CDS Crosswalk – for States to identify, tool-by-tool, topic-by-topic, how their existing assessment instrument(s) measure up to the Balancing Incentive Program CDS.
2. Sample question sets for each required domain and topic area, to provide an array of approaches to achieving a summative assessment of the stated topic area, with references indicating from where the samples were derived.
3. References and links to additional sources of information (e.g., assessment tools, question sets) for States to review as they ensure that their CDS requirements are fulfilled, across populations and throughout the State.

Once again, when a State completes the process of modifying its existing instruments to meet the requirements of the Balancing Incentive Program, it must be able to assure CMS that those modifications will not change eligibility requirements in a way that reduces its maintenance of effort (MOE).

States must demonstrate that each of these domains and topics (sub-domains) within the CDS is addressed for all community LTSS populations within the State, across all geographic locations of the State, and that the questions within each domain and topic area are sufficient to meet the three purposes or intentions of the Balancing Incentive Program CSA (i.e., determine eligibility, identify support needs, and inform support planning).

Under the CDS model, States can exercise considerable discretion in the specific questions they ask. As an example, all States must collect data on the domain, “*Activities of Daily Living*,” and the topic, “*Eating*.” However, States have a number of options available to them to meet this requirement. For instance, our sample State may choose to cover “eating” for their aging and developmental disability populations with *Tool A: Questions 10-14*, as Tool A is an assessment already in place for individuals in these populations. Alternatively, the State may choose *Tool B: Questions 6-8* for individuals with physical disabilities and/or mental health issues. This is fine, given both sets of questions adequately assess the individual’s support needs for eating (i.e., there is enough information to determine eligibility, generally identify support needs, and inform service planning). Key is that the topic area “Eating” is adequately addressed for all populations across the State. The CSA/CDS Crosswalk Tool provides additional guidance to support States as they identify which domains/topics are fully covered, which are partly covered, and which are not addressed at all.

States also have discretion in the response options provided for each question, the scoring methodology, and how this methodology is used to determine community LTSS eligibility. This approach provides States with additional

flexibility when incorporating the CDS into their current community LTSS assessment processes, while also ensuring that a core set of data domains and topics is collected by all participating States.

Completing the CSA/CDS Crosswalk with Existing State Tools – As is previously described, CMS has adopted a flexible approach for States to collect the CSA/CDS. States may either:

- Use their existing assessment tool(s) to assure that the CDS is collected for all individuals seeking LTSS via the NWD/SEP system.
- Adapt or supplement their existing assessment tool(s) with new question sets to assure that all domains and topics of the CDS are fully covered.
- Replace their existing processes for collecting assessment information, and develop new CSA instruments that fulfill the CDS requirements.

For States choosing either of the first two options, they will need to complete the CSA/CDS Crosswalk, matching CDS domains and topics to their existing State tools. A *Sample Section of the Crosswalk Tool* is provided below. States may use the full crosswalk to map their existing tools to the CDS to ensure data on all required domains and topic areas are collected during the community LTSS assessment process. The crosswalk will support State efforts to:

- Identify assessment tools currently in use across populations and purposes in their State.
- Match question sets from these existing tools to required domains/topics of the CDS.
- Determine the extent to which each topic is adequately addressed.
- Note whether the Balancing Incentive Program CSA requirements and recommendations for the CDS have been met.
- Identify domains/topics where action is required to meet BIP requirements.

***Please note: an electronic version of the CSA/CDS Crosswalk is available to download from the Balancing Incentive Program website (<http://www.balancingincentiveprogram.org/>).*

CSA/CDS Crosswalk with Existing State Tool(s)

Populations: Aging Physical Disabilities Mental Health/Substance Abuse
 Children Developmental Disabilities Traumatic Brain Injury
 Alzheimer's Disease

DOMAIN: ACTIVITIES OF DAILY LIVING

TOPIC	Which assessment tools are being used?	Which questions are relevant to this topic?	Which program purposes will these questions address?	Which requirements and recommendations are being met?	What further actions are required?
Eating			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
Bathing			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
Dressing			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
Hygiene			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
Toileting			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
Mobility			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
Positioning			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
Transferring			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
Communicating			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	

DOMAIN: INSTRUMENTAL ACTIVITIES OF DAILY LIVING (not required for children)					
TOPIC	Which assessment tools are being used?	Which questions are relevant to this topic?	Which program purposes will these questions address?	Which requirements and recommendations are being met?	What further actions are required?
Preparing Meals			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
Shopping			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
Transportation			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
Housework			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
Managing Money			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
Telephone Use			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
Managing Medications			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
Employment			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	

DOMAIN: MEDICAL CONDITIONS/DIAGNOSES					
TOPIC	Which assessment tools are being used?	Which questions are relevant to this topic?	Which program will these questions address?	Which requirements and recommendations are being met?	What further actions are required?
Medical Conditions/ Diagnoses			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning		
DOMAIN: COGNITIVE FUNCTIONING/MEMORY CONCERNS					
TOPIC	Which assessment tools are being used?	Which questions are relevant to this topic?	Which program purposes will these questions address?	Which requirements and recommendations are being met?	What further actions are required?
Diagnoses tied to Cognitive Functioning			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning		
Memory & Learning			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning		
Judgment & Decision-Making			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning		
DOMAIN: BEHAVIOR					
TOPIC	Which assessment tools are being used?	Which questions are relevant to this topic?	Which program purposes will these questions address?	Which requirements and recommendations are being met?	What further actions are required?
Injurious Behavior			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning		
Destructive Behavior			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning		
Socially Offensive Behaviors			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning		

DOMAIN: BEHAVIOR (continued)

Uncooperative Behaviors			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
Other Serious Behaviors			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
			<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input type="checkbox"/> Statewide <input type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	



INSTRUCTIONS FOR COMPLETING THE CORE DATASET CROSSWALK

To complete the Crosswalk, States should follow the following steps:

1. Pick a Population - Complete a CDS Crosswalk for each population of individuals seeking LTSS (e.g., aging, physical disabilities, developmental disabilities, mental health). To begin, at the top of the chart, check the box or boxes for the selected population(s). See example below.

CSA/CDS Crosswalk with Existing State Tool(s)					
Populations: <input type="checkbox"/> Aging <input checked="" type="checkbox"/> Developmental Disabilities <input type="checkbox"/> Physical Disabilities <input type="checkbox"/> Mental Health					
DOMAIN: ACTIVITIES OF DAILY LIVING					
TOPIC	Which assessment tools are being used?	Which questions are relevant to this topic?	Which Balancing Incentive Program purposes will these questions address?	Which requirements and recommendations are being met?	What further actions are required?
Eating	XYZ Eligibility Tool	Q14, Q18a-c	<input checked="" type="checkbox"/> Eligibility Determination <input checked="" type="checkbox"/> ID of Support Needs <input checked="" type="checkbox"/> Inform Support Planning	<input checked="" type="checkbox"/> Requirements Met <input checked="" type="checkbox"/> Statewide <input checked="" type="checkbox"/> 2 or 3 Purposes <input type="checkbox"/> Recommendations Met <input checked="" type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
	ABC Assessment Tool	Q22	<input type="checkbox"/> Eligibility Determination <input checked="" type="checkbox"/> ID of Support Needs <input checked="" type="checkbox"/> Inform Support Planning	<input type="checkbox"/> Requirements Met <input checked="" type="checkbox"/> Statewide <input checked="" type="checkbox"/> 2 or 3 Purposes <input checked="" type="checkbox"/> Recommendations Met <input checked="" type="checkbox"/> Summative View <input type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
Bathing	XYZ Eligibility Tool		<input type="checkbox"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<input checked="" type="checkbox"/> Requirements Met <input checked="" type="checkbox"/> Statewide <input checked="" type="checkbox"/> 2 or 3 Purposes <input checked="" type="checkbox"/> Recommendations Met <input checked="" type="checkbox"/> Summative View <input checked="" type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	
	ABC Assessment Tool	Q32-34	<input type="checkbox"/> Eligibility Determination <input checked="" type="checkbox"/> ID of Support Needs <input checked="" type="checkbox"/> Inform Support Planning	<input checked="" type="checkbox"/> Requirements Met <input checked="" type="checkbox"/> Statewide <input checked="" type="checkbox"/> 2 or 3 Purposes <input checked="" type="checkbox"/> Recommendations Met <input checked="" type="checkbox"/> Summative View <input checked="" type="checkbox"/> Supports-Based <input type="checkbox"/> Action Required	

2. Find Current Assessments - Identify any/all assessment instruments that the State currently uses to determine LTSS eligibility and/or inform service and support planning for this population. There is space on the chart for two tools per population (i.e., two rows each, under the column “Which assessment tools are being used?”). If more than two tools for a given population are used, extra charts will be required. See example above.
3. Identify the Question Sets – Next to each assessment tool, in the column labeled “Which questions are relevant to this topic?”, identify the question sets that get at “the heart” of each topic area (e.g., see sample above where Q14 and 18a-c are used from one tool to address the topic of eating).

For the purpose of a Balancing Incentive Program CSA, the question set need not be exhaustive. In fact, it is recommended that the question set apply a “summary” approach to understanding an individual’s support needs within each topic. That is, select an item or items that tend to sum up the individual’s support needs to complete an activity (e.g., shopping, toileting), rather than selecting questions that “pin point” a specific component of an activity (e.g., asking if a person can cut with a knife provides isolated utility for understanding a person’s overall ability to eat).

Sample questions/question sets from existing assessment tools are provided below to provide an array of approaches to achieving a summative assessment of each topic.

4. Identify the Purpose/Intention of the Question Set - In the column labeled "Which program purposes will these questions address?", identify the Balancing Incentive Program purposes for which this question set is appropriate (i.e., determine eligibility, identify support needs, and/or inform service planning). Mark all boxes that are appropriate.

**Note: For each topic, the questions, as a whole, *must* meet the two Balancing Incentive Program purposes of identifying support needs and informing support planning. It is left to the State's discretion, however, to determine which topics will be used for eligibility determination purposes. If a topic is NOT USED in the State's eligibility determination for a particular population, write "NA" (i.e., not applicable) next to eligibility determination on the chart (see example above).

5. Determine if Requirements and Recommendations Have Been Met - In the "Which requirements and recommendations are being met?" column, indicate whether the questions, as are, meet the Balancing Incentive Program CSA requirements tied to uniformity. For example, are the questions adequate to assess the topic area for this population across all portions of the State? If so, check the "Statewide" box.

Are the questions adequate to assess the topic area across two or three Balancing Incentive Program CSA purposes? If so, check the "2 or 3 purposes box" and circle whether two or three of the purposes are reached.

Next, indicate whether the recommendations for question design have been met (i.e., whether the questions are support-based rather than deficit-based²², and whether the question set provides a summative view of the individual's support needs for the topic). If additional actions are required, indicate by checking the "Action Required" box, and provide further detail in the "What further actions are required?" column.

6. Notes - The final column, labeled "What further actions are required?" can be used to provide any additional clarification necessary.
7. Repeat this process (Steps 1-5) for additional populations.
8. Attach all referenced tools to the completed crosswalks.
9. Completion of the CSA/CDS Crosswalk is a milestone listed in the Work Plan. Therefore, the completed crosswalks (and attachments) should be submitted to meet this requirement.

²² CMS anticipates that question sets for each of these domains/topics, when possible, will be support-need oriented as opposed to deficits-based, and will inquire about both frequency and intensity of support needs for each topic, to provide adequate bases for the purpose of eligibility determination and informing a support plan.

SAMPLE QUESTIONS/QUESTION SETS FOR DOMAINS AND TOPIC AREAS

On the following pages, sample question sets are provided for each of the domains and topic areas required within the Balancing Incentive Program CDS. These questions are derived from a variety of sources across the country, and references are provided for each question set.

The goal of offering these samples is to illustrate an array of approaches that are used for assessment purposes across the nation. Here, these questions have been plucked from existing tools, to give examples of how a summative assessment of each topic area might be achieved.

The question sets can be used for several purposes. For example, they can be used to help States fill in the gaps of their current instruments. In addition, if the State wishes to replace existing questions, these may be useful options.

***Please note, however, that before adopting any questions/question sets from the samples below, proper measures must be taken to ensure that copyright laws are not infringing upon.*

Sample Core Dataset Question Sets

SAMPLE QUESTIONS WITHIN EACH DOMAIN & TOPIC	
ACTIVITIES OF DAILY LIVING	
<p>1. ating (Source: MNChoices -Minnesota) Do you have any difficulties with eating or require support or assistance with eating?</p> <p><input type="checkbox"/> No (skip to next question set) <input type="checkbox"/> Yes</p> <p>What degree of oversight, cueing, monitoring and/or encouragement is required to support the individual with eating?</p> <p><input type="checkbox"/> None <input type="checkbox"/> To initiate the task <input type="checkbox"/> Intermittently during the task <input type="checkbox"/> Constantly throughout the task</p> <p>What type/degree of physical assistance is required to support the individual with eating?</p> <p><input type="checkbox"/> None <input type="checkbox"/> Setup/Prep <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Substantial <input type="checkbox"/> Full support</p>	<p>2. Bathing (Source: CARE Tool – Admission) The ability to bathe self in shower or tub, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower. <i>Activities may be completed with/without assistive devices.</i></p> <p>6. Independent – Individual completes the activity by him/herself with no assistance.</p> <p>5. Setup or clean-up assistance – Support person SETS UP or CLEANS UP; individual completes activity. Support person assists only prior to or following the activity.</p> <p>4. Supervision or touching assistance – Support person provides VERBAL CUES or TOUCHING/STEADYING assistance as individual completes activity. Assistance may be provided throughout the activity or intermittently.</p> <p>3. Partial/moderate assistance – Support person does LESS THAN HALF the effort. Support person lifts, holds or supports trunk or limbs, but provides less than half the effort.</p> <p>2. Substantial/maximal assistance – Support person does MORE THAN HALF the effort. Support person lifts or holds trunk or limbs and provides more than half the effort.</p> <p>1. Dependent – Support person does ALL of the effort. Individual does none of the effort to complete the task.</p>
<p>3. Dressing (Source: Supports Intensity Scale) Frequency 0 = none or less than monthly 1 = at least once a month, but not once a week 2 = at least once a week, but not once a day 3 = at least once a day, but not once an hour 4 = hourly or more frequently</p> <p>Daily Support Time 0 = none 1 = less than 30 minutes 2 = 30 minutes to less than 2 hours 3 = 2 hours to less than 4 hours 4 = 4 hours or more</p> <p>Type of Support 0 = none 1 = monitoring 2 = verbal/gestural prompting 3 = partial physical assistance 4 = full physical assistance</p>	<p>4. Grooming/Hygiene (Source: MNChoices -MN) Do you have any difficulties with personal grooming/hygiene or require support or assistance with personal grooming/hygiene?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (skip to next question set)</p> <p>What degree of oversight, cuing, monitoring and/or encouragement is required to support the individual with personal grooming/hygiene?</p> <p><input type="checkbox"/> None <input type="checkbox"/> To initiate the task <input type="checkbox"/> Intermittently during the task <input type="checkbox"/> Constantly throughout the task</p> <p>What type/degree of physical assistance is required to support the individual with personal grooming/hygiene?</p> <p><input type="checkbox"/> None <input type="checkbox"/> Setup/Prep <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate</p>

	<input type="checkbox"/> Substantial <input type="checkbox"/> Full support
SAMPLE QUESTIONS WITHIN EACH DOMAIN & TOPIC (continued)	
ACTIVITIES OF DAILY LIVING	
<p>5. Toileting (Source: Massachusetts Real Choice Functional Needs Assessment) ____ Overall Toilet Use Performance (0-9) ____ Overall Toilet Use Difficulty (0-3) Performance/Ability Code:</p> <p>0 INDEPENDENT—No help, setup, or oversight—OR—Help, setup, oversight provided only 1 or 2 times (with any task or subtask)</p> <p>1 SETUP HELP ONLY— Article or device provided within reach of client 3 or more times</p> <p>2 SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last 3 days—OR—Supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision)</p> <p>3 LIMITED ASSISTANCE—Individual highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times—OR—Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help)</p> <p>4 EXTENSIVE ASSISTANCE—Individual performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 or more times: Weight-bearing support--OR--Full performance by another during part (but not all) of last 3 days</p> <p>5 MAXIMAL ASSISTANCE—Individual involved and completed less than 50% of subtasks on own (includes 2+ person assist); received weight bearing help or full performance of certain subtasks 3 or more times</p> <p>6 TOTAL DEPENDENCE—Full performance of activity by another</p> <p>8 ACTIVITY DID NOT OCCUR (regardless of ability)</p> <p>9 UNABLE TO PERFORM</p> <p>ADL Difficulty Code: How difficult it is (or would it be) for individual to do activity on own</p> <p>0 NO DIFFICULTY</p> <p>1 SOME DIFFICULTY-e.g. needs some help, is very slow, or fatigues</p> <p>2 GREAT DIFFICULTY-e.g. little or no</p>	<p>6. Mobility (Source: New York COMPASS – Comprehensive Assessment for Aging Network Community-Based Long Term Care Services) What can the person do?</p> <ol style="list-style-type: none"> 1. Walks with no supervision or assistance. May use adaptive equipment. 2. Walks with intermittent supervision. May require human assistance at times. 3. Walks with constant supervision and/or physical assistance. 4. Wheels with no supervision or assistance, except for difficult maneuvers, or is wheeled chairfast or bedfast. Relies on someone else to move about, if at all. <p>Check if assistance is/will be provided by:</p> <p><input type="checkbox"/> Informal supports</p> <p><input type="checkbox"/> Formal supports</p> <p>Comments: Describe parts of tasks to be done and responsibilities of informal supports and formal supports.</p> <hr/> <hr/> <hr/>

involvement in the activity is possible 3 UNABLE TO PERFORM	
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SAMPLE QUESTIONS WITHIN EACH DOMAIN & TOPIC (continued)

ACTIVITIES OF DAILY LIVING

<p>7. Positioning (Source: Minimum Data Set – HC) MOBILITY IN BED—Including moving to and from lying position, turning side to side, and positioning body while in bed. The following address the individual's physical functioning during the LAST 3 DAYS, considering all episodes of these activities. For individuals who performed an activity independently, be sure to determine and record whether others encouraged the activity or were present to supervise or oversee the activity.</p> <ol style="list-style-type: none"> 0. INDEPENDENT—No help, setup, or oversight —OR— Help, setup, oversight provided only 1 or 2 times (with any task or subtask) 1. SETUP HELP ONLY—Article or device provided within reach of client 3 or more times 2. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last 3 days —OR— Supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision) 3. LIMITED ASSISTANCE—Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times — OR— Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help) 4. EXTENSIVE ASSISTANCE—Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 or more times: — Weight-bearing support —OR— — Full performance by another during part (but not all) of last 3 days 5. MAXIMAL ASSISTANCE—Client involved and completed less than 50% of subtasks on own (includes 2+ person assist), received weight bearing help or full performance of certain subtasks 3 or more times 6. TOTAL DEPENDENCE—Full performance of activity by another 7. ACTIVITY DID NOT OCCUR (regardless of ability) 	<p>8. Transferring (Source: Wisconsin LTC Functional Screen) The physical ability to move between surfaces: from bed/chair to wheelchair, walker or standing position. The ability to get in and out of bed or usual sleeping place. The ability to use assistive devices for transfers. <i>Excludes toileting transfers.</i></p> <p><input type="checkbox"/> USES MECHANICAL LIFT (not a lift chair)</p> <p><input type="checkbox"/> USES TRANSFER BOARD, TRAPEZE OR GRAB BARS</p> <p>Help Needed?</p> <ol style="list-style-type: none"> 0 Person is independent in completing the activity safely. 1 Help is needed to complete task safely but helper DOES NOT have to be physically present throughout the task. "Help" can be supervision, cueing, or hands-on assistance. 2 Help is needed to complete task safely and helper DOES need to be present throughout task. "Help" can be supervision, cueing, and/or hands-on assistance (partial or complete). <p>Who will help in next 8 weeks?</p> <p>U Current UNPAID caregiver will continue</p> <p>PP Current PRIVATELY PAID caregiver will continue</p> <p>PF Current PUBLICLY FUNDED paid caregiver will continue</p> <p>N Need to find new or additional caregiver(s)</p>
<p>9. Communicating (Source: Kansas Uniform Assessment Instrument) Expresses information content, however able.</p> <ol style="list-style-type: none"> 1. 2. 3. 	<p>Ability to understand other verbal information, Understandable however able.</p> <p>Usually understandable 1. Understandable</p> <p>Sometimes understandable 2. Usually</p>

<p>understandable</p> <p>4.</p>	<p>Rarely or never understandable 3.</p> <p>Sometimes understandable</p> <p>4. Rarely or never understandable</p>
SAMPLE QUESTIONS WITHIN EACH DOMAIN & TOPIC (continued)	
INSTRUMENTAL ACTIVITIES OF DAILY LIVING	
<p>1. Preparing Meals (Source: Supports Intensity Scale)</p> <p>Frequency</p> <p>0 = none or less than monthly</p> <p>1 = at least once a month, but not once a week</p> <p>2 = at least once a week, but not once a day</p> <p>3 = at least once a day, but not once an hour</p> <p>4 = hourly or more frequently</p> <p>Daily Support Time</p> <p>0 = none</p> <p>1 = less than 30 minutes</p> <p>2 = 30 minutes to less than 2 hours</p> <p>3 = 2 hours to less than 4 hours</p> <p>4 = 4 hours or more</p> <p>Type of Support</p> <p>0 = none</p> <p>1 = monitoring</p> <p>2 = verbal/gestural prompting</p> <p>3 = partial physical assistance</p> <p>4 = full physical assistance</p>	<p>2. Shopping (Source: MN Choices)</p> <p>Do you need assistance with shopping?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No (skip to next question set)</p> <p>With which level of support is the individual able to shop and purchase goods and services?</p> <p><input type="checkbox"/> Assistance with Setup/Arrangements</p> <p><input type="checkbox"/> Minimal Assistance</p> <p><input type="checkbox"/> Moderate Assistance</p> <p><input type="checkbox"/> Substantial Assistance</p> <p><input type="checkbox"/> Full Support</p> <p>With support, what level of difficulty does this individual experience procuring goods and services?</p> <p><input type="checkbox"/> No difficulty</p> <p><input type="checkbox"/> Some difficulty</p> <p><input type="checkbox"/> Great difficulty</p> <p>Summary: When purchasing goods and services, this individual:</p> <p><input type="checkbox"/> Needs no help or supervision</p> <p><input type="checkbox"/> Sometimes needs assistance or occasional supervision</p> <p><input type="checkbox"/> Often needs assistance or constant supervision</p> <p><input type="checkbox"/> Always or nearly always needs assistance</p>
<p>3. Transportation (Source: Wisconsin LTC Functional Screen)</p> <p><input type="checkbox"/> 1a Person drives regular vehicle</p> <p><input type="checkbox"/> 1b Person drives adapted vehicle</p> <p><input type="checkbox"/> 1c Person drives regular vehicle, but there are serious safety concerns</p> <p><input type="checkbox"/> 1d Person drives adapted vehicle, but there are serious safety concerns</p> <p><input type="checkbox"/> 2 Person cannot drive due to physical, psychiatric, or cognitive impairment. Includes no driver's license due to medical problems (e.g., seizures, poor vision).</p> <p><input type="checkbox"/> 3 Person does not drive due to other reasons</p>	<p>4. Housework (Source: Colorado ULTC Initial Screening and Intake)</p> <p>Definition: The ability to maintain cleanliness of the living environment.</p> <p><input type="checkbox"/> 0=The individual is independent in completing activity.</p> <p><input type="checkbox"/> 1=The individual is physically capable of performing essential housework tasks but requires minimal prompts/cues or supervision to complete essential housework tasks.</p> <p><input type="checkbox"/> 2=The individual requires substantial prompts/cues or supervision and/or physical assistance to complete essential housework tasks. The individual may be able to perform some housekeeping tasks but may require another person to complete heavier cleaning tasks.</p> <p><input type="checkbox"/> 3=The individual is dependent upon others to do all housework in his/her use area.</p>

SAMPLE QUESTIONS WITHIN EACH DOMAIN & TOPIC (continued)

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

<p>5. Managing Money (Source: Colorado ULTC Initial Screening and Intake) Definition: The ability to handle money, pay bills, plan, budget, write checks or money orders, exchange currency, handle coins and paper work, i.e. to do financial management for basic necessities (food, clothing, shelter). Do not check if limitation is only cultural (e.g., recent immigrant who has not learned U.S. currency and/or English language).</p> <p><input type="checkbox"/> 0=The individual is independent in completing activity.</p> <p><input type="checkbox"/> 1=The individual requires cueing and/or supervision. May need minimal physical assistance.</p> <p><input type="checkbox"/> 2=The individual requires assistance in budgeting, paying bills, planning, writing checks or money orders and related paperwork. Individual has the ability to manage small amounts of discretionary money without assistance.</p> <p><input type="checkbox"/> 3=The individual is totally dependent on others for all financial transactions and money handling.</p>	<p>6. Telephone Use (Source: Massachusetts Real Choice Functional Needs Assessment)</p> <p>___ Overall Phone Use Performance (0-8) ___ Overall Phone Use Difficulty (0-3)</p> <p>Self-Performance Code/Ability Code (Code for individual's performance during LAST 7 DAYS)</p> <p>0. INDEPENDENT- did on own 1. SOME HELP- help some of the time 2. FULL HELP- performed with help all of the time 3. BY OTHERS- performed by others 8. ACTIVITY DID NOT OCCUR</p> <p>Difficulty Code: How difficult it is (or would it be) for individual to do activity on own</p> <p>0. NO DIFFICULTY 1. SOME DIFFICULTY-e.g. needs some help, is very slow, or fatigues 2. GREAT DIFFICULTY-e.g. little or no involvement in the activity is possible 3. UNABLE TO PERFORM</p>
<p>7. Medication Management (Source: MN Choices)</p> <p>Do you need assistance managing your medications?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (skip to next question set)</p> <p>With which level of support is the individual able to administer/manage their medications?</p> <p><input type="checkbox"/> Self directs medication assistance or administration <input type="checkbox"/> Assistance Required <input type="checkbox"/> Must be administered</p> <p>How often does this individual require medications?</p> <p><input type="checkbox"/> Several times daily <input type="checkbox"/> Daily <input type="checkbox"/> 2-6 days a week <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Monthly <input type="checkbox"/> As needed</p> <p>Summary: In regard to the ability to manage and take medications, this person:</p> <p><input type="checkbox"/> Needs no help or supervision <input type="checkbox"/> Doesn't take medications</p>	<p>8. Employment (Source: MN Choices)</p> <p>Are you currently employed or involved in volunteer/educational/ training activities?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable (e.g., retired)</p> <p>If yes: What type of employment/volunteer/ education/ training activities are you currently involved in?</p> <p><input type="checkbox"/> Competitive – without job support <input type="checkbox"/> Competitive – with job supports/coaching <input type="checkbox"/> Self-employment – without job support <input type="checkbox"/> Self-employment – with job support <input type="checkbox"/> Supported work in an enclave/group/ crew setting <input type="checkbox"/> Center-based sheltered employment/ activity <input type="checkbox"/> Volunteer activity - describe: _____ <input type="checkbox"/> Educational program - describe: _____ <input type="checkbox"/> Training program – describe: _____ <input type="checkbox"/> Other - describe: _____</p> <p>If no: Are you interested in any of the following?</p> <p><input type="checkbox"/> Obtaining a full time or part time job</p>

<input type="checkbox"/> Needs medication setup only <input type="checkbox"/> Needs visual or verbal cues only <input type="checkbox"/> Needs medication setups and reminders <input type="checkbox"/> Needs medication setups and administration	<input type="checkbox"/> Finding a volunteer work opportunity <input type="checkbox"/> Obtaining more education or training Would you like to look for another opportunity? <input type="checkbox"/> Yes <input type="checkbox"/> No
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SAMPLE QUESTIONS WITHIN EACH DOMAIN & TOPIC (continued)

COGNITIVE FUNCTIONING/MEMORY CONCERNS

1. Diagnoses contributing to cognitive limitations (Source: MN Choices)

Check if any of the following exist:

- Learning disability
- Communication, sensory or motor disabilities
- Diagnosed Traumatic Brain Injury prior to the person turning 22 years of age
- Diagnosed Traumatic Brain Injury since turning 22
- Memory Loss

Is there a diagnosis on record that explains the functional memory and cognitive issues?

- Yes, specify: _____
- No

Does the person have a problem with cognitive functioning due to mental retardation or a related condition, which manifested itself during the developmental period (birth through age 21)?

- No
- Yes

2. Memory (Source: Massachusetts Real Choice Functional Needs Assessment)

Do you have trouble remembering things (e.g. difficulty remembering the right word, being forgetful)?

- No
- Yes (if "Yes," complete the following questions)

Do you ever forget what someone just said to you? Do you forget what you were going to do or say?

- Short-term memory is OK – seems/appears to recall after 5 minutes)
- Short-term memory is a problem

Do you ever start to do something and then forget what comes next?

- Procedural memory OK – can perform all or almost all steps in a multitask sequence without cues for initiation
- Procedural memory is a problem

Do you ever go out of your home and forget where you are or where you are going?

- No
- Yes

Do you know what the current year is? _____

Do you know what the current season is? _____

Do you know what the current day is? _____

Do you know what the current month is? _____

Do you know what State we are in? _____ What city we are in? _____

Do you know what street you live on? _____

Can you repeat these three objects after me? APPLE? PENNY? TABLE?

- No
- Yes

Can you repeat the following phrase: "No ifs, ands, or buts"?

- No
- Yes

Can you recall the three objects I asked you to say before? (APPLE, PENNY, TABLE)

<input type="checkbox"/> No
<input type="checkbox"/> Yes

SAMPLE QUESTIONS WITHIN EACH DOMAIN & TOPIC (continued)

COGNITIVE FUNCTIONING/MEMORY CONCERNS

3. **Judgment and Decision-making** (MN Choices – Minnesota)

What type of support does the person need in the home for assistance with activities that require remembering, decision-making or judgment?

- Someone else needs to be with the person always, to observe or provide supervision.
- Someone else needs to be around always, but they only need to check on the person now and then.
- Sometimes the person can be left alone for an hour or two.
- Sometimes the person can be left alone for most of the day.
- The person can be left alone all day and night, but someone needs to check in on the person every day.
- The person can be left alone without anyone checking in.

What type of support does the person need to help with remembering, decision-making, or judgment when away from home?

- The person cannot leave home, even with someone else, because of behavioral difficulties (becomes very confused or agitated during outings, engages in inappropriate behavior, becomes aggressive, etc.).
- Someone always needs to be with the person to help with remembering, decision making or judgment when away from the home.
- The person can go places alone as long as they are familiar places.
- The person does not need help going anywhere.

3. **COGNITION FOR DAILY DECISION MAKING:** (Source: Wisconsin LTC Functional Screen)

(Beyond medications and finances, which are captured elsewhere)

- 0 Independent - Person can make decisions that are generally consistent with her/his own lifestyle, values, and goals (not necessarily with professionals' values and goals)
- 1 Person can make safe decisions in familiar/routine situations, but needs some help with decision making when faced with new tasks or situations
- 2 Person needs help with reminding, planning, or adjusting routine, even with familiar routine
- 3 Person needs help from another person most or all of the time

MEDICAL CONDITIONS/DIAGNOSES

Current Diagnoses (CARE Tool – Admissions)

A. Primary Diagnosis: _____

B. Other Diagnoses, Comorbidities, and Complications: List other diagnoses being treated, managed, or monitored. Include all diagnoses (e.g., depression, schizophrenia, dementia, protein calorie malnutrition).

Current Health Status (Source: MNChoices - Minnesota)

1. Overall, how would you rate your health?

- Excellent
- Good
- Fair
- Poor

2. Immediate health concerns:

- No
- Yes (describe) _____

3. Allergies to medication or food

- No
- Yes (describe what the individual is allergic to, and describe the severity of the reaction)

SAMPLE QUESTIONS WITHIN EACH DOMAIN & TOPIC (continued)

MEDICAL CONDITIONS/DIAGNOSES (continued)

Risk Screen (Source: MNChoices – Minnesota)

In this section, identify the types of services received and any health risks that may exist for the individual.

Number of times in last 90 days

1. Calls to 911 to address medical needs
 None
 ___ times – Reason(s)
2. Emergency room (not counting overnight stay)
 None
 ___ times – fall related
 ___ times – not fall related, Reason(s)
3. Inpatient acute hospital with an overnight stay
 None
 ___ times – fall related
 ___ times – not fall related, Reason(s)

Events in LAST YEAR

4. Nursing facility stay(s)
 None
 ___ times for a total of day - Reason(s)
5. Inpatient psychiatric facility stay(s)
 None
 ___ times for a total of days - Reason(s)
6. In-home crisis services
 None
 ___ times - Reason(s)
7. Out-of-home crisis services
 None
 ___ times for a total of days - Reason(s)

BEHAVIOR CONCERNS

1. Injurious behaviors

(Source: Supports Intensity Scale)

How much support is needed for the prevention of self-injury?

- No support needed
- Some support needed
- Substantial support needed

How much support is needed for the prevention of assault or injury to others?

- No support needed
- Some support needed
- Substantial support needed

How much support is needed for the prevention of sexual aggression?

- No support needed
- Some support needed
- Substantial support needed

2. Destructive behaviors

(Source: Supports Intensity Scale)

How much support is needed for the prevention of destruction of property (i.e. fire setting, breaking furniture)?

- No support needed
- Some support needed
- Substantial support needed

SAMPLE QUESTIONS WITHIN EACH DOMAIN & TOPIC (continued)	
BEHAVIOR CONCERNS	
<p>3. Socially offensive/disruptive behaviors (Source: Supports Intensity Scale) How much support is needed for the prevention of stealing?</p> <p><input type="checkbox"/> No support needed <input type="checkbox"/> Some support needed <input type="checkbox"/> Substantial support needed</p> <p>How much support is needed for the prevention of nonaggressive but inappropriate behavior (e.g., exposes self in public, exhibitionism, inappropriate touching or gesturing)?</p> <p><input type="checkbox"/> No support needed <input type="checkbox"/> Some support needed <input type="checkbox"/> Substantial support needed</p> <p>How much support is needed for the prevention of substance abuse?</p> <p><input type="checkbox"/> No support needed <input type="checkbox"/> Some support needed <input type="checkbox"/> Substantial support needed</p>	<p>4. Uncooperative behaviors (Source: Supports Intensity Scale) How much support is needed for the prevention of tantrums or emotional outbursts?</p> <p><input type="checkbox"/> No support needed <input type="checkbox"/> Some support needed <input type="checkbox"/> Substantial support needed</p>
<p>5. Other serious behaviors (Source: Supports Intensity Scale) How much support is needed for the prevention of other serious behaviors? Specify: _____</p> <p><input type="checkbox"/> No support needed <input type="checkbox"/> Some support needed <input type="checkbox"/> Substantial support needed</p>	

REFERENCES AND LINKS TO ADDITIONAL RESOURCES

References and links for finding additional information on each of the assessment tools cited in the Sample Questions chart (and other uniform/universal assessment instruments or processes) can be found below. This list, however, is by no means all-inclusive. These resources can be used to support efforts to design a CSA that captures the CDS, across populations and throughout the State.

- Continuity Assessment Record and Evaluation (CARE) Tool – Admissions: <http://www.pacdemo.rti.org/meetingInfo.cfm?cid=caretool>
- Colorado ULTC Initial Screening and Intake: http://www.hcbs.org/moreInfo.php/source/152/ofc/100/doc/847/Colorado_Screening_Tool_ULTC_100.2
- Inventory for Client and Agency Planning (ICAP): <http://icaptool.com/>
- Kansas Uniform Assessment Instrument: http://www.srs.ks.gov/agency/css/Documents/PD%20Waiver/UAI_Revision.pdf

- Maine Medical Eligibility Determination (MED) Tool: <http://www.maine.gov/dhhs/oes/medxx/medxx.pdf>
- Massachusetts Real Choice Functional Needs Assessment: http://www.adrc-tae.org/tiki-download_file.php?fileId=26933
- Minimum Data Set (MDS): https://www.cms.gov/NursingHomeQualityInits/30_NHQIMDS30TechnicalInformation.asp#TopOfPage
- Minimum Data Set – HC: <http://www.interrai.org/section/view/?fnode=15>
- Minnesota MN Choices: http://www.hcbsstrategies.com/Client_Project%20Page_MN_subpage.html#JUMP
- New York COMPASS – Comprehensive Assessment for Aging Network Community-Based Long Term Care Services: http://www.adrc-tae.org/tiki-download_file.php?fileId=28119
- Outcome and Assessment Information Set (OASIS): <http://www.cms.gov/oasis/>
- Supports Intensity Scale: <http://www.siswebsite.org/>
- Virginia Uniform Assessment Instrument (UAI): <http://www.dmas.virginia.gov/downloads/forms/UAI.pdf>
- Washington Comprehensive Assessment Reporting Evaluation (CARE): http://www.hcbs.org/moreInfo.php/type_tool/147/ofs/80/doc/1129/Comprehensive_Assessment_Reporting_Evaluation_CAR
- Wisconsin Long Term Care Functional Screen: <http://www.dhs.wisconsin.gov/ltcare/FunctionalScreen/>
- Wisconsin Functional Eligibility Screen for Children’s Long Term Support Programs: <http://www.dhs.wisconsin.gov/ltcare/FunctionalScreen/>
- Wisconsin Functional Eligibility Screen for Mental Health and AODA (Co-Occurring) Services: <http://www.dhs.wisconsin.gov/ltcare/FunctionalScreen/>

APPENDIX I: SUBSET OF MEDICAID ADULT HEALTH QUALITY MEASURES RECOMMENDED FOR DATA COLLECTION

Topic	Measure & URL	Numerator/Denominator	Data Source
AMI	The percentage of patients age 35 years and older during the measurement year who were hospitalized and discharged alive July 1 of the year prior to the measurement year through June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge. http://www.qualitymeasures.ahrq.gov/content.aspx?id=23969	Numerator Description A 180-day course of treatment with beta-blockers Identify all members in the denominator population whose dispensed days supply is greater than or equal to 135 days in the 180 days following discharge. Persistence of treatment for this measure is defined as at least 75 percent of the days' supply filled. Denominator Description Members age 18 years and older as of December 31 of the measurement year who were discharged alive from an acute inpatient setting with an acute myocardial infarction (AMI) from July 1 of the year prior to the measurement year through June 30 of the measurement year	Claims EMR
Asthma Admission Rate	Adult asthma: hospital admission rate. http://qualitymeasures.ahrq.gov/content.aspx?id=15426	Numerator Description All non-maternal discharges, age 18 years and older, with International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) principal diagnosis code for asthma Denominator Description Population in Metro Area or county, age 18 years and older	Claims
Bipolar Disorder	Percentage of patients diagnosed with bipolar disorder and treated with lithium who have evidence of a lithium serum medication level within 12 weeks of beginning treatment http://qualitymeasures.ahrq.gov/content.aspx?id=11496&search=therapeutic+monitoring	Numerator Description Patients with a serum medication level within 12 weeks of beginning treatment with lithium Denominator Description Patients diagnosed and treated for bipolar disorder with a lithium agent	Claims EMR
Bipolar Disorder	Proportion of patients with bipolar I disorder treated with mood stabilizer medications during the course of bipolar I disorder treatment.	Numerator Description The number of patients from the denominator who were treated with mood stabilizer medications Denominator Description Total number of patients with bipolar disorder	Claims EMR
Bipolar	Percentage of patients on lithium therapy	Numerator Description	Claims

Topic	Measure & URL	Numerator/Denominator	Data Source
Disorder	with a record of lithium levels in the therapeutic range within the previous 6 months. http://qualitymeasures.ahrq.gov/content.aspx?id=14518&search=therapeutic+monitoring	Number of patients from the denominator with a record of lithium levels in the therapeutic range within the previous six months Denominator Description Patients who are on lithium therapy	EMR
Breast Cancer Screening	Percentage of women 50 to 69 years of age screened in the past two years for breast cancer http://www.qualitymeasures.ahrq.gov/content.aspx?id=14620	Numerator Description Women with evidence of a mammography performed in the past two years Denominator Description Women aged 50 to 69 at the time of the qualifying visit	Claims EMR
CAD	Percentage of patients who had a blood pressure measurement during the last office visit http://qualitymeasures.ahrq.gov/content.aspx?id=7821&search=cad	Numerator Description Patients from the denominator who had a blood pressure measurement during the last office visit Denominator Description All patients with coronary artery disease (CAD)	Claims
Care Transitions – Transition Records	Care transitions: percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements. http://qualitymeasures.ahrq.gov/content.aspx?id=15177	Numerator Description Patients or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge (more details in URL) Denominator Description All patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care	Claims (Denom.) Survey/EMR (Num.)
Care Transitions – Reconciled Medication List	Care transitions: percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories. http://qualitymeasures.ahrq.gov/content.aspx?id=15176	Numerator Description Patients (age 65 and older) or their caregiver(s) who received a reconciled medication list at the time of discharge (see URL for medication list) Denominator Description All patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care	Claims (Denom.) Survey/EMR (Num.)

Topic	Measure & URL	Numerator/Denominator	Data Source
Cervical Cancer Screening	Percent of women age 21 to 64 screened for cervical cancer in the past three years. http://www.qualitymeasures.ahrq.gov/content.aspx?id=14621&search=cervical+cancer	Numerator Description Women age 24 to 64 screened for cervical cancer in the past three years Denominator Description Women age 24 to 64 at the time of the qualifying visit	EMR
Colorectal Cancer Screening	Percentage of patients age 50 and older who meet criteria for colorectal cancer screening who are up-to-date with screening. http://www.qualitymeasures.ahrq.gov/content.aspx?id=23870&search=colorectal+cancer	Numerator Description Number of patients in the denominator having one or more of the following screenings: •Fecal occult blood test yearly 1. Annual guaiac-based fecal occult blood test with high test sensitivity for cancer, or 2. Annual fecal immunochemical test with high test sensitivity for cancer •Flexible sigmoidoscopy every five years •Computed tomographic colonography every five years •Colonoscopy every 10 years Denominator Description Number of patients age 50 and older who meet criteria for colorectal cancer screening who were up to date with colorectal cancer screening at the time of their last visit	EMR
COPD	Chronic obstructive pulmonary disease (COPD): hospital admission rate. http://www.guideline.gov/content.aspx?id=15417	Numerator Description All non-maternal discharges, age 18 years and older, with International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) principal diagnosis code for chronic obstructive pulmonary disease (COPD) Denominator Description Population in Metro Area or county, age 18 years and older	Claims
COPD	Percentage of patients aged 18 years and older with a diagnosis of COPD who were assessed for COPD symptoms at least annually http://qualitymeasures.ahrq.gov/content.aspx?id=9039&search=copd	Numerator Description All patients with chronic obstructive pulmonary disease (COPD) symptoms assessed during one or more office visits each year Denominator Description All patients aged 18 years and older with the diagnosis of chronic obstructive pulmonary disease (COPD)	Claims
Depression	Percentage of patients who were diagnosed with a new episode of depression, and treated with antidepressant medication, and who remained on an antidepressant drug for	Numerator Description Patients diagnosed with a new episode of depression and treated with antidepressant medication who have adequate medication for at least 84 treatment days (12 weeks) after the Index Prescription Date	Claims

Topic	Measure & URL	Numerator/Denominator	Data Source
	at least 84 treatment days (12 weeks) after the Index Prescription Date. http://qualitymeasures.ahrq.gov/content.aspx?id=14648	Denominator Description Patients diagnosed with a new episode of depression and treated with antidepressant medication	
Diabetes	Diabetes mellitus: hospital admission rate for uncontrolled diabetes. http://www.guideline.gov/content.aspx?id=15425	Numerator Description All non-maternal discharges, age 18 years and older, with International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) principal diagnosis code* for uncontrolled diabetes, without mention of a short-term or long-term complication Denominator Description Population in Metro Area or county, age 18 years and older	Claims
Emergency Department Visits	Preventable/ambulatory care-sensitive emergency room visits [algorithm, not formally a measure] http://wagner.nyu.edu/chpsr/index.html?p=61	(See article)	Claims
Heart Failure	Congestive heart failure (CHF): hospital admission rate. http://qualitymeasures.ahrq.gov/content.aspx?id=15419	Numerator Description All non-maternal discharges, age 18 years and older, with International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) principal diagnosis code for congestive heart failure (CHF) Denominator Description Population in Metro Area or county, age 18 years and older	Claims
Heart Failure	Percentage of patients with heart failure weighed as per physician's orders. http://qualitymeasures.ahrq.gov/content.aspx?id=6392&search=heart+failure	Numerator Description Number with heart failure weighed as per physician's orders Denominator Description Number with diagnosed heart failure	EMR
Heart Failure	Percentage of patients aged greater than or equal to 18 years with diagnosed heart failure who were provided with patient education on disease management and health behavior changes during one or more visit(s). http://qualitymeasures.ahrq.gov/content.aspx?id=7809	Numerator Description Patients in the denominator who were provided with patient education at one or more visit(s) Denominator Description All patients aged greater than or equal to 18 years with diagnosed heart failure (HF) and with one or more visit(s) during a six-month period	EMR

Topic	Measure & URL	Numerator/Denominator	Data Source
Heart Failure	Percentage of patients with heart failure sent to emergency room (ER) for acute exacerbation. http://qualitymeasures.ahrq.gov/content.aspx?id=6414&search=heart+failure	Numerator Description Number with heart failure sent to emergency room (ER) for acute exacerbation Denominator Description Number with diagnosed heart failure	Claims
Heart Failure	Percentage of patient visits with assessment of clinical <i>symptoms</i> of volume overload (excess) for patients aged greater than or equal to 18 years with diagnosed heart failure (HF). http://qualitymeasures.ahrq.gov/content.aspx?id=7806&search=heart+failure	Numerator Description Patient visits for patients in the denominator with assessment of clinical <i>symptoms</i> of volume overload (excess) Denominator Description All patient visits for patients aged greater than or equal to 18 years with diagnosed heart failure (HF)	Claims
Heart Failure	Percentage of patients discharged with any diagnosis of congestive heart failure who are referred for chronic disease management service that includes physical rehabilitation, during the 6 month time period. http://qualitymeasures.ahrq.gov/content.aspx?id=15977&search=heart+failure	Numerator Description Total number of patients discharged with any diagnosis of congestive heart failure (CHF) who are referred for a chronic disease management service that includes physical rehabilitation, during the 6 month time period Denominator Description Total number of patients discharged with any diagnosis of congestive heart failure (CHF), during the 6 month time period	Claims
HIV/AIDS	Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with at least one medical visit in each 6 month period with a minimum of 60 days between each visit	Numerator Description Total number of patients from the denominator with at least one medical visit in each 6 month period with a minimum of 60 days between each visit Denominator Description Total number of patients with a diagnosis of HIV/AIDS	Claims EMR
Home health patients admitted to a hospital	Home health care: percentage of patients who had to be admitted to the hospital. http://qualitymeasures.ahrq.gov/content.aspx?id=3931	Numerator Description Patients from the denominator who were admitted to a hospital for 24 hours or more while receiving home health care services Denominator Description All patients with a completed home health episode of care except those defined in the denominator exclusion	Claims
Hospital Re-admission	Hospital readmissions within 30 days http://www.nejm.org/doi/pdf/10.1056/NEJMSa0803563	Numerator Description The hospital-specific risk-standardized readmission rate (RSRR) is calculated as the ratio of predicted to expected readmissions, multiplied by the national unadjusted rate. The "numerator" of the ratio component is the predicted number of readmissions for each hospital within 30 days given the hospital's performance with its observed case mix.	Claims

Topic	Measure & URL	Numerator/Denominator	Data Source
		Denominator Description This cohort includes admissions for Medicare fee-for-service beneficiaries aged greater than or equal to 65 years	
Hyper-tension	Percent of outpatients with a diagnosis of hypertension (uncomplicated) on antihypertensive multi-drug therapy where the regimen includes a thiazide diuretic. http://qualitymeasures.ahrq.gov/content.aspx?id=14619&search=hypertension	Numerator Description Number of unique outpatients with a diagnosis of hypertension (uncomplicated) on antihypertensive multi-drug therapy with an active prescription for a thiazide diuretic Denominator Description Number of unique outpatients with a diagnosis of hypertension (uncomplicated) on antihypertensive multi-drug therapy	Claims EMR
Hyper-tension	Percent of eligible patients with an active diagnosis of hypertension whose most recent blood pressure recording was less than 140/90 mm Hg. http://qualitymeasures.ahrq.gov/content.aspx?id=14632&search=hypertension	Numerator Description Patients with an active diagnosis of hypertension whose most recent blood pressure recording was less than 140/90 mm Hg Denominator Description Patients with a diagnosis of hypertension	Claims EMR
Schizophrenia	Annual assessment of weight/BMI, glycemic control, lipids	Numerator Description Total number of patients from the denominator who have had a documented measurement of BMI, glycemic control, and lipids during the measurement year Denominator Description All patients diagnosed with schizophrenia	Claims EMR
Schizophrenia	Proportion of schizophrenia patients with long-term utilization of antipsychotic medications.	Numerator Description Total number of patients from the denominator who have long-term utilization of antipsychotic medications Denominator Description All patients diagnosed with schizophrenia	Claims EMR
Schizophrenia	Proportion of selected schizophrenia patients with antipsychotic polypharmacy utilization.	Numerator Description Total number of patients from the denominator who have documented overutilization of antipsychotic medications Denominator Description All patients diagnosed with schizophrenia	Claims EMR
Tobacco Cessation	Percentage of patients who received advice to quit smoking; and	Numerator Description Patients using tobacco who, within the past year, have been provided with	EMR

Topic	Measure & URL	Numerator/Denominator	Data Source
Screening	Percentage of patients whose practitioner recommended or discussed smoking cessation medications http://www.qualitymeasures.ahrq.gov/content.aspx?id=14633	direct brief counseling on how to quit Denominator Description All patients using tobacco	

APPENDIX J: SHARING DATA SECURELY

The protection of sensitive client health, service, and demographic information is a top priority for social service programs. Therefore, entities are often hesitant to share patient information with partners, including other governmental agencies and private organizations. In fact, the developers of One e-App (see text box in Chapter 6) indicated that the most complicated aspect of building the system was not the technological infrastructure. Instead, they struggled to arrive at data sharing arrangements acceptable to all participating parties. The technology exists to store data securely, including firewalls, encryption techniques, and sophisticated protocols for limiting access by user type. However, entities are often hesitant to release their data to outside entities for fear of a security breach and noncompliance with federal data security regulations.

Federal regulations, such as the Health Insurance Portability and Accountability Act (HIPAA) of 1996, aim to balance the need for maintaining private health information and the necessary and beneficial sharing of this information. The federal regulations that govern data use and exchange do not preclude its sharing. In fact, through the appropriate use of data use principles, data security methods and systems, and data sharing agreements, NWD/SEP systems and the participating organizations can maintain high levels of security while increasing general efficiency within the health care system.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA was enacted to address concerns over client data security due to the increasing use and sharing of electronic protected health information (e-PHI). PHI, also known as “individually identifiable health information” has the following properties:

- It relates to the individual’s past, present or future physical or mental health or condition, in addition to the provision and payment of health care to that individual.
- It identifies the individual (Code of Federal Regulations, 45 CFR 160.103). Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

All “covered entities,” which include health care providers, health plans, and health clearinghouses, have to comply with HIPAA. Health plans include government agencies that pay for health care, such as State Medicaid offices.

Covered entities must obtain the individual’s written authorization for the use or disclosure of PHI, unless the purpose of the disclosure meets certain criteria, such as “Treatment, Payment, and Health Care Operations.” In other words, written authorization is not required in these situations because securing such authorization would unnecessarily interfere with an individual’s access to health care or the efficient payment for such health care. Further information on use and disclosure of PHI for treatment, payment, and health care operations information can be found here:

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/usesanddisclosuresfortpo.html>
(U.S. Department of Health and Human Services).

To use or disclose PHI, entities must establish certain safeguards to ensure that data are properly protected. One of the guiding principles of HIPAA is the “minimum necessary” use and disclosure of data. This means that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of PHI needed to accomplish the intended purpose of the use, disclosure, or request (Code of Federal Regulations, 45 CFR 164.502(b); Code of Federal Regulations, 45 CFR 164.514(d)).

Administrative, physical, and technical security methods and systems should also be developed and implemented to strengthen data security and promote data sharing. Administrative safeguards include continual analyses to evaluate potential risks to e-PHI and the effectiveness of security measures that are introduced to address these risks, in addition to designating personnel to oversee an entity's security procedures, providing trainings regarding these procedures, and enforcing appropriate sanctions against workforce members who violate procedures. Physical safeguards include limiting and specifying proper physical access to facilities and workstations. Numerous technical safeguards should also be considered when designing a secure data environment. Various technology controls, including role-based access and transmission security, can help a covered entity maintain secure data. Role-based access provides varying levels of access to PHI as a function of users' data needs or roles within the entity. Transmission security involves developing security measures that guard against unauthorized access to e-PHI that is being transmitted over an electronic network.

Data Sharing Agreements

Data sharing agreements facilitate interagency data sharing and collaboration. Two methods for legally establishing interagency collaboration are Data Use Agreements (DUA) and Business Associate Agreements.

A DUA is a legal binding agreement between two or more parties that concerns the use of PHI that is governed by regulation or policy. The agreement delineates the confidentiality requirements of the relevant legal authority, security safeguards, and the parties' data use policies and procedures. The DUA can serve as both a means of informing data users of the requirements as well as a means of obtaining their agreement to comply with these requirements.

A Business Associates Agreement, or Business Associates Contract, provides the means for HIPAA-covered entities to safely use the services of other persons or business, i.e. "business associates." A business associate is a person or entity that performs or assists with certain functions or activities involving the use or disclosure of PHI for a covered entity. These functions and activities include: claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, re-pricing, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services (Code of Federal Regulations, 45 CFR 160.103). Examples of business associates within the NWD/SEP EIE system context include a private third party vendor hired to conduct functional assessments for community LTSS applicants or other county or State organizations, such as Aging and Disability Resource Centers (ADRCs), working as NWD/SEPs.

A Business Associates Agreement assures each party involved -- including the relevant governing authority -- that the business associate will use the data only for the purposes for which it was engaged by the covering entity and that the data will be safeguarded from misuse. Business Associates Agreements must describe the permitted and required uses of protected health information by the business associate; provide that the business associate will not use or further disclose the protected health information other than as permitted or required by the contract or as required by law; and require the business associate to use appropriate safeguards to prevent a use or disclosure of the protected health information other than as provided for by the contract. A sample business associate agreement can be found here: <http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/contractprov.html>.

APPENDIX K: ACCESSIBILITY

This Appendix identifies some basic principles of accessibility. It provides resources for learning more about accessibility, so that States can create accessible websites in-house, or talk productively with a vendor hired to create websites that help fulfill the requirements of the Balancing Incentive Program.

All website pages should *at minimum* follow [U.S. Federal Government Section 508 Standards](#). Ideally, they should also observe priorities A and AA of the [W3C Web Content Accessibility Guidelines 2.0](#).

Below we provide some guidance on constructing a site that will be accessible to a wide range of users.

Note that we list a set of standards first and later provide references to support and explain those standards (i.e., links to informative websites).

Note, too, that we do not provide the URLs; rather, we have linked to the relevant sites. If you are reading this document in Microsoft Word, you can reach these sites by right clicking on the URL (Ctrl-click for Macintosh users) and choosing "Open Hyperlink" from the pop-up menu. If you are reading this document as a PDF, you can simply click on the link and you will be taken directly to the site.

Structural Markup

Websites should include three basic areas:

- A header section that includes a site search and the main navigation;
- A main content area; and,
- A footer containing links to Help, Resources, and Contact information.

Cascading Style Sheets (CSS) should be used for visual layout. When CSS are not applied to a document, or when a visitor is using a screen reader, the three central areas of the site are rendered or read in the order above.

Visual Design

- Websites should use cascading style sheets for visual layout.
- The content of each page should still be readable even if a user's browser does not support style sheets.
- Any information conveyed through the use of color should also be available without color (i.e., it should be text based).

Images

- Unless they are purely decorative items, all images used on the website should have alternative attributes (alt-attributes, or alt-text) that convey the meaning described by the image.
- The content should be usable/accessible even if images are turned "off" (disabled).

Links

- Text that is hyperlinked should be written to make sense out of context. For example, a sentence that says to “Click here,” with the word *here* hyperlinked, would be inappropriate.
- The first link in every document should be a "SkipNav"; it should bypass the navigation and take the user directly to the main content of the page.
- URLs should be permanent whenever possible (that is, they should be unlikely to change and therefore “break” at a later date).
- Clicking on links should generally not result in the creation of new pages. Instead, the new content should replace the content the user is currently viewing. If a new window *is* created, the user should first receive a clear warning. The one exception to this is a window that provides a printer-friendly version of the page.
- Links to external sites should be accompanied by a special symbol that makes it clear the site is external.

Scripts

- Scripts should be non-obtrusive client-side scripts.
- The content of the site should be usable even if the user’s browser lacks JavaScript support.

Information for Users: Software That Enhances Accessibility

The accessibility section of your website should include information on how users with visual impairments can more easily use your site. These include:

- [JAWS](#), a screen reader for Windows. A time-limited, downloadable demo is available.
- [IBM Easy Web Browsing](#), free software that magnifies text that you point to with the mouse and reads the magnified text aloud.
- [Lynx](#), a free text-only web browser for blind users with refreshable Braille displays.
- [Links](#), a free text-only web browser for visual users with low bandwidth.
- [Opera](#), a visual browser with many accessibility-related features, including text zooming, user style sheets, and image toggle. A free downloadable version is available. Compatible with Windows, Macintosh, Linux, and several other operating systems.
- [Window-Eyes](#), a screen reader for Windows. A thirty-minute renewable demo version is available.

Accessibility Services

- [Coblis Color Blindness Simulator](#)
- [Color Contrast Check](#), uses the WCAG 2.0 contrast ration formula to determine whether foreground and a background color provide adequate contrast.

- [HTML Validator](#), a free service for checking that web pages conform to published HTML standards.
- [Web Page Backward Compatibility Viewer](#), a tool for viewing your web pages *without* a variety of modern browser features.
- [Lynx Viewer](#), a free service for viewing what your web pages would look like in Lynx.
- [WAVE](#) (Web Accessibility Evaluation Tool), a free online accessibility evaluation tool that shows via embedded icons where any problems might exist on a web page.
- [WebAIM](#), a non-profit organization dedicated to improving accessibility to online learning materials.
- [Designing More Usable Web Sites](#), a large list of additional resources.
- [Browsershots](#), a free online tool to test browser compatibility.
- [W3C Link Checker](#), checks link and anchors in web pages or full websites.

Accessibility Resources

The links below provide explanations for many of the accessibility principles described in this Appendix.

- [U.S. Federal Government Section 508 accessibility guidelines](#).
- [W3 accessibility guidelines](#), which explains the reasons behind each guideline.
- [W3 accessibility techniques](#), which explains how to implement each.
- [W3 accessibility checklist](#), a busy developer's guide to accessibility.

APPENDIX L: GLOSSARY OF ACRONYMS

- AAA – Area Agencies on Aging
- AAIDD – American Association on Intellectual and Developmental Disabilities
- ACCEL – Access El Dorado
- ADA – Americans with Disabilities Act
- ADL – Activity of Daily Living
- ADP – Advanced Planning Document
- ADRC – Aging and Disability Resource Center
- AoA – Agency on Aging
- BIPP – State Balancing Incentive Payments Program
- CAHPS – Consumer Assessment of Healthcare Providers and Systems
- CARE – Comprehensive Assessment Reporting Evaluation
- CBO – Community-Based Organization
- CDS – Core Dataset
- CFC – Community First Choice
- CIL – Center for Independent Living
- CMS – Centers for Medicare and Medicaid Services
- CSA – Core Standardized Assessment
- DHS – Department of Human Services
- DUA – Data Use Agreements
- E&E – eligibility and enrollment
- EHR – Electronic Health Record
- EIE – Electronic Information Exchange
- EITC – Earned Income Tax Credit
- EMPI – Enterprise Master Patient Index
- e-PHI – electronic protected health information
- FFP – Federal financial participation
- FMAP – Federal Matching Percentage
- HAVEN – Home Assessment Validation and Entry
- HC – Home Care
- HCFA – Health Care Financing Administration
- HCPF – Department of Health Care Policy and Financing
- HHS – Health and Human Services
- HIPAA – Health Insurance Portability and Accountability Act
- HIX – Health Insurance Exchange
- HSRI – Human Services Research Institute
- IADL – Instrumental Activity of Daily Living
- ICAP – Inventory for Client and Agency Planning
- ICF-MR – Intermediate Care Facilities for the Mentally Retarded
- IMD – Institution for Mental Diseases
- LTSS – Long-Term Services and Supports

- MAGI – Modified Adjusted Gross Income
- MDCH – Michigan Department of Community Health
- MDS – Minimum Data Set
- MDS-HC – Minimum Data Set – Home Care
- MED – Medical Eligibility Determination
- MFP – Money Follows the Person
- MITA – Medicaid IT Architecture
- MOE – Maintenance of Effort
- MOU – Memorandum of Understanding
- NAMD – National Association of Medicaid Directors
- NASDDS – National Association of State Directors of Developmental Disabilities Services
- NASMHPD – National Association of State Mental Health Program Directors
- NASUAD – National Association of States United for Aging and Disabilities
- NWD/SEP – No Wrong Door/Single Entry Point
- OASIS – Outcome and Assessment Information Set
- OHC DS – Organized Health Care Delivery Systems
- PAC – Post-acute-care
- PACE – Program of All-Inclusive Care for the Elderly
- PAS – Personal Assistance Services
- RAP – Resident Assessment Protocol
- RFP – Request for Proposal
- RWJF – Robert Wood Johnson Foundation
- SAMHSA – Substance Abuse and Mental Health Service Administration
- SCHIP – State Children’s Health Insurance Program
- SIS – Supports Intensity Scale
- SNAP – Supplemental Nutrition Assistance Program
- SSA – Social Security Act
- TANF – Temporary Aid for Needy Families
- TBD – to be determined
- UAI – Uniform Assessment Instrument
- ULTC – Uniform Long Term Care
- VA – Veterans’ Affairs
- WIC – Women, Infants, Children

APPENDIX M: REFERENCES AND RESOURCES

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RESOURCES

ADRC Technical Assistance Exchange Website: <http://www.adrc-tae.org>.

Balancing Incentive Program Technical Assistance Website: <http://www.balancingincentiveprogram.org/>

HIPAA Privacy: <http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html>.

The Office of Management and Budget (OMB) Circular A-87 regarding allowable costs and cost allocation for Federal grants: http://www.whitehouse.gov/omb/circulars_a087_2004

Office of the Assistant Secretary for Planning and Evaluation with Temple University. A Guide to Memorandum of Understanding Negotiation and Development: <http://aspe.hhs.gov/daltcp/reports/mouguide.htm>.