

CHAPTER 4

# Functional Assessments for Long-Term Services and Supports

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## Key Points

- Functional assessment tools are sets of questions about an applicant's health conditions and functional needs that state Medicaid programs use to determine functional eligibility for long-term services and supports (LTSS) and to create specific care plans for eligible individuals.
- The federal government does not require states to use a particular assessment tool to determine eligibility or to develop a care plan.
- MACPAC's analysis of states' functional assessment tools shows that there are at least 124 tools currently in use. On average, states are using three different tools each, as they generally use separate tools for different populations.
- States that use managed care plans to deliver LTSS either require plans to use a certain tool or allow them to use a tool of their choosing. There is limited information about the tools used by plans, in part because some of these tools are proprietary.
- Almost all states use at least one tool that they developed themselves, which we refer to as homegrown tools. States report that the use of homegrown tools is driven largely by their need for customized tools for their populations and their desire to incorporate stakeholder input. Staff in states that use independently developed tools said those tools were easier to implement than homegrown tools.
- Use of a single national tool or set of core questions about functional status would facilitate analyses of LTSS use across states that would reflect the variation in beneficiary needs. Such information could be used for multiple purposes, including development of benchmarks for appropriate care, setting payment rates, and identifying strategies that promote better use of state and federal resources.
- Moving to a national tool, however, would be burdensome for those states that have recently invested in new tools, and there is currently no clear empirical or operational reason to pick one existing tool over another.
- Given the rapid change in LTSS programs and work that the Centers for Medicare & Medicaid Services is doing to test new approaches to functional assessment and electronic exchange of care plans, the Commission does not advocate moving to a national tool at this time, but we will continue to monitor developments in this area.

## CHAPTER 4: Functional Assessments for Long-Term Services and Supports

Medicaid is the nation's primary payer for long-term services and supports (LTSS) for individuals with physical and cognitive disabilities. These services generally focus on helping people maintain (and sometimes improve) their ability to perform basic tasks of everyday life, such as bathing and dressing, and skills needed for independent living, such as preparing meals and managing money. In order for individuals to receive Medicaid-covered LTSS, they must be determined eligible based on two types of criteria. First, they must meet financial eligibility criteria, with income and assets consistent with state-defined thresholds.<sup>1</sup> Second, they must meet state-defined functional eligibility criteria, which are based on physical and cognitive abilities. To determine whether an individual meets a state's functional eligibility criteria, also referred to as their level of care criteria, states use functional assessment tools—sets of questions that collect information on an applicant's health conditions and functional needs. Such tools may also be used to develop a care plan of specific services that an individual will receive upon being determined eligible for coverage.

The federal government does not require state Medicaid programs to use any particular assessment tool to determine eligibility for Medicaid-covered LTSS or to develop a care plan. In states with managed long-term services and supports (MLTSS) programs, care plans are developed using either a state-selected tool or—depending on state requirements—a tool chosen by the managed care plan into which a beneficiary is enrolled.<sup>2</sup> MACPAC's inventory of assessment tools shows that there are, at a minimum, 124 tools currently in use for eligibility determination and care planning. MACPAC also found that only a few states use the same tool across all their LTSS programs.

Methods for assessing functional status are of interest to the Commission for three reasons. First, a disproportionate share of Medicaid expenditures are for LTSS users. In fiscal year (FY) 2012, 43.4 percent of Medicaid expenditures (\$169.2 billion) were spent on LTSS users, even though LTSS users comprised only 6.2 percent (4.3 million) of Medicaid beneficiaries (MACPAC 2015). Assessment of functional status has a direct effect on eligibility determination and the services that beneficiaries use.

Second, changes in the delivery system for LTSS are highlighting the role of functional assessments. Increasingly, LTSS are being provided in homes and community-based settings rather than in institutions. In FY 2013, for the first time in the history of the Medicaid program, the proportion of LTSS expenditures for home and community-based services (HCBS) was greater than the proportion of expenditures for institutional services (Eiken et al. 2015). The movement to HCBS has expanded the breadth of services used to address individuals' LTSS needs and keep them integrated in the community. In addition, more states are establishing MLTSS programs, and these call for decisions about how managed care plans are to conduct care planning and which assessment tools they use.

Third, the substantial costs associated with providing LTSS raise concerns about whether services are delivered in the most efficient manner. This question, however, requires information about costs relative to need. But because states use such varied approaches to functional assessment, it is not currently possible to compare LTSS needs across populations in different states or compare beneficiary access to services across states. Comparable data on the needs of LTSS users would also be useful in evaluating different LTSS program designs and the relationship of payment to services provided. Such information could shed light on the quality of care provided to individuals with LTSS needs, allow for inclusion of the severity of LTSS needs in the development of payment rates, highlight state innovations that are effective and worthy of replication, and suggest potential

changes in federal policy to incentivize adoption of effective approaches.

In this chapter, we describe how functional assessment tools are currently being used across states at the state and federal level. We begin by describing how functional assessments are used in eligibility determination and in care planning. The chapter then focuses on federal guidance affecting assessments and various federal initiatives to support states in improving tools and standardizing data elements.

Next, we present the results of new research conducted for MACPAC that documents the wide variation in functional assessment tools across all 50 states and the District of Columbia. We have documented the dozens of disparate tools currently in use by state Medicaid programs as well as the many ways states are measuring needs for specific activities, such as bathing and dressing. Our interviews with Medicaid program staff in different states found that their decisions about creating a new tool or using one that already exists are influenced in part by their perceptions of the level of customization needed and the ease of implementation. Finally, we look at the advantages and disadvantages of developing a national functional assessment tool or using other means for making it possible to collect more comparable assessment data across states.

## Functional Eligibility Criteria: Variation by Eligibility Pathway

Individuals must meet functional eligibility criteria to receive Medicaid coverage for LTSS, whether in an institution or the community. These functional criteria vary by eligibility pathway and by state, and the type of pathways that are available to an individual depends on the state in which they reside (Table 4-1). About two in five Medicaid beneficiaries who received LTSS in FY 2010 enrolled through the Supplemental Security Income (SSI) eligibility pathway (MACPAC 2014).<sup>3</sup>

In most states, individuals eligible for SSI are automatically eligible for Medicaid, including—if they meet functional eligibility criteria—LTSS offered under the state plan. States also have an option to provide Medicaid coverage to individuals who have LTSS needs but whose incomes are too high for them to be eligible through the SSI-related pathway. States cover these individuals through other eligibility pathways; some of these other eligibility pathways use the SSI-related functional eligibility criteria, and others use state-established level of care criteria.

States have flexibility in determining the level of functional impairment that will be used for each of their eligibility pathways. A high threshold for the level of care criteria might be requiring an individual to be dependent in four or more activities of daily living (ADLs), while a lower threshold might require dependency in only two ADLs.<sup>4</sup> Access to most HCBS are based on having needs severe enough for institutional care, but some states use Section 1915(i) authority, which allows states to offer services to individuals meeting less stringent criteria.

## Functional Assessment Process: Eligibility Determination and Care Planning

Functional eligibility for Medicaid-covered LTSS is determined using functional assessment tools. Depending on the state, the entity responsible for conducting the Medicaid eligibility functional assessment may be the state or local health department, an area agency on aging, an aging and disability resource center, or a contracted vendor (Tucker and Kelley 2011, Shirk 2009). The functional assessment is typically conducted in a face-to-face interview in the individual's home, which helps ensure that environmental issues, such as need for home modifications, are addressed (Shirk 2009).

**TABLE 4-1. Medicaid Eligibility Pathways for Long-Term Services and Supports**

Eligibility pathway		Age group served			Functional assessment criteria	Receives full state plan benefits	Benefits conditional upon LOC criteria	
		≥ 65	19–64	<19			Institutional LTSS	HCBS waiver
SSI-related		Yes	Yes	Yes	Adults ≥ 65: None; Adults 18–64: Blindness or permanent, medically determinable impairment that results in the inability to do any substantial gainful activity	Yes	NF: Yes; All other institutions at state option	At state option
					Children < 18: Permanent, medically determinable impairment that results in marked and severe functional limitations		Children < 18: Yes, if determined medically necessary under EPSDT.	
Poverty-related		Yes	Yes	Yes	Same as SSI	Yes	NF: Yes; All other institutions at state option	At state option
Medicaid buy-in	BBA 97 eligibility	No	Yes	16–18 only	Same as SSI	Yes	At state option	At state option
	Basic eligibility group	No	Yes	16–18 only	Same as SSI	Yes	At state option	At state option
	Medical improvement group	No	Yes	16–18 only	Must have a medically improved disability (based on SSI disability determination)	Yes	At state option	At state option
	Family Opportunity Act	No	No	Yes	Same as SSI	Yes	At state option	At state option
Medically needy		Yes	Yes	Yes	Same as SSI	At state option	At state option	At state option
Special income rule		Yes	Yes	Yes	State-established LOC for NF, ICF, or hospital	Yes	At state option	At state option
TEFRA/Katie Beckett		No	No	Yes	State-established LOC for NF, ICF, or hospital	Yes	No	At state option
Section 1915(i) state plan HCBS		Yes	Yes	Yes	State-established LOC less than for NF, ICF, or hospital	At state option	No	At state option

**Notes:** LOC is level of care. LTSS is long-term services and supports. HCBS is home and community-based services. SSI is Supplemental Security Income. NF is nursing facility. EPSDT is Early and Periodic Screening, Diagnostic, and Treatment. BBA 97 is the Balanced Budget Act of 1997 (P.L. 105-33); this and other buy-in eligible pathways allow states to cover individuals with disabilities who work and have incomes too high to qualify for Medicaid. ICF is intermediate care facility. TEFRA is the Tax Equity and Fiscal Responsibility Act (P.L. 97-248), the TEFRA/Katie Beckett pathway provides Medicaid eligibility to children with severe disabilities whose family income would ordinarily be too high to qualify for Medicaid. For beneficiaries receiving institutional or HCBS waiver LTSS under any eligibility pathway, states have an option to disregard parent or spousal income and to allow beneficiaries to retain income under personal needs allowances or monthly maintenance needs allowances.

**Sources:** HRTW National Resource Center 2013, SSA 2013, Stone 2011.

If an individual is eligible for more than one LTSS program, the state may require assessment with multiple tools, which can be a time-consuming process for the individual and assessors.

Once determined eligible for Medicaid, a care plan is developed using either the eligibility determination tool or a separate tool. For individuals whose LTSS benefits are covered under fee for service, care plan development and ongoing case management is often assigned to care coordinators from the same entities that conducted the eligibility determination. Care coordinators are then responsible not only for determining which services a Medicaid beneficiary should receive and the frequency and duration of those services, but also for connecting the beneficiary to service providers. In states with MLTSS, care plans

are developed by care coordinators employed by the managed care plan in which the beneficiary is enrolled or by a third party contracted by the plans to provide these services (Box 4-1).

## Federal Role in Functional Assessment

### Federal requirements for functional assessment tools

Federal laws and regulations do not require the use of specific tools for either eligibility determination or care planning, and they do not require the collection

### BOX 4-1. Functional Assessments and Managed Long-Term Services and Supports

The number of states with managed long-term services and supports (MLTSS) programs has risen rapidly in recent years, growing from just 8 in 2004 to 22 in 2014 (Terzaghi 2015, Saucier et al. 2012). Another 11 states are in the process of implementing or considering such programs (Terzaghi 2015). In MLTSS, states contract with managed care plans to provide long-term services and supports (LTSS) to beneficiaries in exchange for a capitated payment. These plans are responsible for providing the broad range of LTSS benefits within the capitated rate. In order to coordinate the services beneficiaries receive, managed care plans may employ case managers directly or delegate coordination to a third-party case management service. In either circumstance, case managers are responsible for developing beneficiary care plans (with input from the beneficiaries, their family members, other persons providing support, and providers), and also serve as the beneficiaries' main point of contact for dealing with issues such as scheduling transportation to and from medical appointments and connecting to community resources and activities.

States that adopt MLTSS must make certain decisions about the use of assessment tools. Some states (e.g., Minnesota and Texas) require all plans to use a certain tool, while others (e.g., Tennessee and Wisconsin) allow each plan to use the tool of its choosing, albeit with certain requirements or restrictions (Ingram et al. 2013). Some plans develop proprietary tools, while others may use tools available on the market. States may also require plans to collect specific data elements and report those results to the state for purposes such as quality monitoring and the setting of capitation rates (Atkins and Gage 2014). States also set other requirements for plans, including specific timeframes for completion of assessments for new enrollees and reassessments of existing beneficiaries, as well as qualifications and training requirements for the case managers conducting assessments (Ingram et al. 2013).

of specific data elements. Federal laws and regulations do have the following requirements:

- The assessment to determine eligibility for nursing facilities must be ordered and provided under the direction of a physician (42 CFR 440.40(a)).
- Nursing facilities must conduct comprehensive assessments to determine each resident's functional capacity soon after admission and no less than once every 12 months (more often if there is a change in condition that requires a new assessment in the interim), and the assessment should be conducted or coordinated by a registered professional nurse (§ 1919(b)(3) of the Social Security Act).
- A physician must certify that an individual with intellectual disabilities needs intermediate care facility services (42 CFR 456.360).
- States that use the Community First Choice Section 1915(k) state plan option must use a person-centered care plan based on an assessment of functional need (42 CFR 441.535).<sup>5</sup> These states must also restrict eligibility to cover only individuals who require a level of care equivalent to that provided in an institution (42 CFR 441.510(c)).
- HCBS waiver eligibility must be limited to those who require a level of care equivalent to that provided in an institution (§ 1902(a)(10)(A)(ii)(VI) of the Social Security Act).
- In states with MLTSS, managed care plans are required to comprehensively assess beneficiaries' LTSS needs and use person-centered care planning processes (42 CFR 438.208(c)). Sub-regulatory guidance further specifies that states approve the tools a managed care plan uses and that such tools assess physical, psychosocial, and functional needs (CMCS 2013).

By contrast, care planning assessments for nursing facility residents are strictly prescribed: all nursing

facilities must use the same assessment tool, the Minimum Data Set (MDS), for all residents.<sup>6</sup> Similarly, home health agencies delivering Medicare-covered home health services are required to use a common care planning assessment tool, the Outcome and Assessment Information Set (OASIS)—this requirement has been in place since 1999.

## CMS functional assessment initiatives

Although requirements for functional assessment tools are limited, the Centers for Medicare & Medicaid Services (CMS) recently implemented two initiatives to provide resources to states to make changes to their existing tools.

**The Balancing Incentive Program.** The Balancing Incentive Program, for which program funding ended in 2015, was one of several recent initiatives to expand Medicaid beneficiaries' access to HCBS and reduce state reliance on institutional care.<sup>7</sup> Participating states earned an enhanced federal match for the HCBS provided to beneficiaries during the demonstration, and in turn were required to implement certain structural changes in their LTSS delivery systems. One of these structural changes was the adoption of a standardized functional assessment process and an instrument or instruments to determine eligibility for Medicaid-funded LTSS if such tools were not already in use (CMS 2016a). Further, these assessments had to include a core set of domains related to medical needs, ADLs, instrumental activities of daily living (IADLs), and mental and behavioral health needs (MAG and NEC 2015). However, CMS did not require states to use any particular questions or a specific tool if a state's existing tools covered the specified domains. Seven of the 18 participating states needed only to add questions to their existing tools to meet these requirements, and 4 of the states met all of CMS's requirements without making any changes. In addition, seven states implemented an entirely new tool during the program, although that may have been for reasons other than ensuring that the core domains were included (MAG and NEC 2015).

States that implemented a new tool during the program reported that the resources provided by the Balancing Incentive Program eased the implementation process. Some of these states had planned to overhaul their existing tools prior to their participation in the Balancing Incentive Program and found that the additional resources helped make that possible. For example, New York noted that the resources provided by the Balancing Incentive Program helped facilitate the implementation of a tool that was already in development (MAG and NEC 2016).

### Testing Experience and Functional Tools

**demonstration.** CMS is currently developing a set of assessment questions through the Testing Experience and Functional Tools demonstration. In March 2014, CMS awarded planning grants to Medicaid programs in nine states as part of the demonstration to test several tools related to LTSS quality and assessments. Six of the participating states (Arizona, Colorado, Connecticut, Georgia, Kentucky, and Minnesota) will be testing the Functional Assessment Standardized Items (FASI) tool with a sample of their Medicaid beneficiaries at the time of reassessment, sometimes alongside their existing functional assessment tools. Field testing is expected to begin in the second half of 2016, with refinements and additional testing planned through 2017 (CMS 2016b).

The FASI tool includes domains covering identifying information, functional abilities and goals, assistive devices, support needs, and caregiver assistance. The tool is based on the Continuity Assessment Record and Evaluation tool used in Medicare post-acute care settings (e.g., long-term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities, and home health agencies) and is being pilot tested as part of a broad CMS effort to standardize assessment data resulting from the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act, P.L. 113–185). The IMPACT Act requires CMS to implement standardized assessment measures for Medicare post-acute care settings to replace

certain setting-specific questions currently in use, and eventually to develop a unified post-acute care payment system. This effort arose in part due to concerns raised by the Medicare Payment Advisory Commission (MedPAC) and others that Medicare patients with similar characteristics are often served in different settings with different payment rates (MedPAC 2015). Gathering similar assessment information from all such providers will increase understanding of the cost of care across settings and the extent to which variation in costs reflects local practice patterns, provider availability, and other factors as opposed to measurable differences in patients' needs.

Once the FASI testing is completed, CMS plans to make it available for use by state Medicaid programs, providing access to a set of pretested and validated data elements for use in functional assessment. CMS may also consider additional uses (Smith 2016). For example, it could potentially be used to collect assessment information across all states, an idea discussed later in this chapter.

The demonstration also includes the electronic Long-Term Services and Supports (eLTSS) Initiative, which is a joint effort between CMS and the Office of the National Coordinator (ONC). CMS and ONC are working to develop standards for interoperable LTSS service plans, which would include information from functional assessments that could be shared among LTSS providers, payers, and individuals receiving the services (ONC and CMS 2016). Six states will be piloting this component of the demonstration, which according to CMS, could improve coordination of health and social services (CMCS 2016).

## State Variation in Functional Assessment Tools

Because we could find no published source that examined functional assessment tools in use across all states in a consistent manner, in

2015, MACPAC commissioned a comprehensive inventory of assessment tools used in 50 states and the District of Columbia.<sup>8</sup> NORC at the University of Chicago, our contractor, reviewed state websites, training materials, and other documentation, and contacted Medicaid officials in states that had not posted information online. This review identified 124 distinct functional assessment tools in use across 50 states and the District of Columbia. Information received directly from states indicated that some are in the process of implementing new tools, which may push that number upward. In addition, in states with MLTSS that permit plans to use a tool of their choosing rather than mandating a tool, those plan-selected tools were not captured by this inventory. Given the proprietary nature of some plan-selected tools, little information is available on them.

On average, states used three functional assessment tools. Moreover, functional assessment tools in use by state Medicaid programs vary widely on virtually every dimension examined, a finding consistent with prior research (MAG et al. 2013, Shirk 2009). Key themes are described below.

### States use tools specialized to subpopulations of LTSS users

States often used more than one tool because they used separate tools for different LTSS subpopulations—that is, a state might use one tool for individuals with physical disabilities and another for individuals with intellectual or developmental disabilities. Use of different tools can identify concerns specific to different populations because individuals in each population have different characteristics that are relevant to determining their LTSS needs. For example, a tool for individuals with intellectual or developmental disabilities may ask questions about clarity of the individual's speech, which may not need to be assessed for individuals with physical disabilities. In addition, some states use multiple assessment tools among their waiver

programs if those programs provided different types of services. Some states have separate waivers for administering in-home personal care services and adult day care services.

### Almost all states used homegrown tools

Almost all states used homegrown tools rather than those developed independently. Nearly every state (49 of 51) used at least one tool for either eligibility determination or care planning that was state-specific. Only two states used independently developed tools exclusively. However, 28 states used one or more tools developed independently, such as the Supports Intensity Scale (American Association on Intellectual and Developmental Disabilities) and the interRAI Home Care Assessment System (interRAI), alongside the state-specific tools. Another five states used a combination of nationally used tools and tools adapted by the state from existing tools.

### Most states use the same tools for care planning

In most states, information from functional assessment tools used to establish eligibility is also used to develop care plans. Forty-one states (using 73 different tools) report using assessment tools to inform plans of care. In some cases, state documents reference the assessment as a source of information to support an independent care planning process. In others, information from the assessment directly enters care management software to populate the plan of care. This may reduce duplication in the collection of information from beneficiaries by case managers.

### All states assess health needs

Virtually all states assess functional limitations, clinical needs or health status, and behavior and cognitive status. Assessment of functional support needs, included in tools in 49 states (114

tools), is the most commonly included domain, although how states ask these questions can vary (Box 4-2). Nearly all states use tools that also assess clinical care needs or health and medical concerns (50 states, 108 tools) or cognitive and behavioral support needs (49 states, 108 tools). Clinical and health questions frequently solicit information on an individual's health history, active diagnoses, medications, and clinical services (e.g., wound care or dialysis). Cognitive and behavioral questions used among individuals with intellectual or developmental disabilities are often focused on adaptive and maladaptive behaviors, while tools assessing other populations cover more general ground, such as memory and behaviors that put the individual or others at risk.

### Most states seek information on other factors

Most tools also ask about a person's physical environment, psychosocial needs, or other issues. Thirty-nine states use tools that include questions that go beyond identifying needs related to physical, intellectual, or cognitive functioning by gathering information about the individual's physical environment, such as accessibility, functioning appliances, or pests (50 tools). In addition, 43 states use tools that assess psychosocial needs, such as community or social engagement and leisure activities (55 tools).

### Most states use paper to record assessments

For data from functional assessments to be reported at the national level, they need to be available electronically; however, many states appear to record results of assessments only on paper. Although some tools are completed electronically and data are stored electronically, it appears that tools used in 42 states (74 tools) are still being recorded on paper. In seven states (10 tools), assessments are recorded on paper but are

eventually stored electronically or linked to another data source.

### Some states link assessment results to payments

Functional assessment tools collect a great deal of information that could be used to determine payment rates based on the intensity of services an individual needs. Evidence in this area was limited because the documentation for most tools did not address payment specifically, but in 21 states (27 tools), state documents noted some link between assessment results and payment for LTSS.

## Factors Influencing States' Choice of Tools

Given the wide variation among states in tools used for functional assessment, MACPAC sought to understand what influences state choices when it comes to such tools. To gain perspective on states' choices, MACPAC analysts interviewed individuals responsible for administering LTSS programs in eight states: Kansas, Maryland, Massachusetts, Minnesota, Mississippi, Nebraska, Ohio, and Wyoming. Interviewees were typically employees of state Medicaid agencies. States were selected to represent a mix of those using homegrown and independently developed tools, and several states were in the process of selecting a new assessment tool. These interviews helped to illustrate a variety of factors affecting states' choice of tools.

### Why states develop homegrown tools

States develop homegrown tools when they feel existing tools do not offer any clear advantages. Staff in one state noted that none of the existing tools had been demonstrated to be better than another. In the absence of a strong case for using

## BOX 4-2. Details Matter: Examples of Variation in Specific Assessment Questions

MACPAC’s study found that most states included similar domains (e.g., clinical care needs, functional needs, and cognitive or behavioral needs) in the functional assessment tools used for either eligibility determination or care planning. However, tools differ in how they assess similar characteristics, such as an individual’s need for assistance with activities of daily living (ADLs), assistance with instrumental activities of daily living (IADLs), or cognitive deficits. As illustrated below, the level of detail can vary significantly; the assessment of bathing used in the District of Columbia requests the frequency and duration required, while the assessment in Kentucky does not. The level of detail states collect may be due to differences in their functional eligibility criteria. In addition, greater detail may be useful where states are using a tool to develop a care plan.

**TABLE 4-2a.** Information on Bathing Needs Collected by the District of Columbia Long-Term Care Assessment Tool

1) Bathing					
7aa–7ad. How frequently is this activity required and for what duration?	___ Minutes per occurrence		= ___ minutes per week		
	___ Times per day				
	___ Days per week				
7ba. Type of assistance required	Required Frequency of Assistance				Bathing Score (7bb):
	Never	Sometimes	Usually	Always	
Cueing or supervision	(0)	(0)	(1)	(2)	
Mechanical assistance only	(0)	(0)	(1)	(1)	
One-to-one 1:1 person physical assist	(0)	(1)	(2)	(3)	
Totally dependent on another person	(0)	(2)	(3)	(4)	
7c. Observations:					

Source: MACPAC reproduction of DC Department of Health Care Finance, 2013, LTCSS Assessment Tool V 1.1, <http://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Long%20Term%20Care%20Assessment%20Tool.pdf>.

**TABLE 4-2b.** Information on Bathing Needs Collected by the Kentucky Medicaid Waiver Assessment Tool

4) Is member independent with bathing	Comments:
<input type="checkbox"/> Yes <input type="checkbox"/> No (If no, check below all that apply and comment)	
<input type="checkbox"/> Requires supervision or verbal cues	
<input type="checkbox"/> Requires hands-on assistance with upper body	
<input type="checkbox"/> Requires hands-on assistance with lower body	
<input type="checkbox"/> Requires peri-care	
<input type="checkbox"/> Requires total assistance	
<input type="checkbox"/> Assistance with the use of equipment or assistive devices	

Source: MACPAC reproduction of Commonwealth of Kentucky, 2008, Medicaid Waiver Assessment, <http://chfs.ky.gov/nr/ronlyres/dbec3c06-f397-45ad-8cbb-91f339533fae/0/351revised814web.pdf>.

a particular tool, and without a great deal of federal guidance, the state decided to develop its own tool.

### Availability of funding affected tool decisions

States' decisions to implement a new assessment tool, and their choice of tool, were often driven by the availability of resources. Of the state officials we interviewed, two said that funding from the Balancing Incentive Program assisted them in implementing a new tool. Another state that did not participate in the Balancing Incentive Program used administrative funds that were freed up during a transition to MLTSS to implement a new tool. Officials in another state that did not participate in the Balancing Incentive Program noted that they were using several tools and wanted to streamline them but could not do so until they obtained funding for this purpose.

### Some states found independently developed tools easier to implement

States were generally motivated to select an independently developed tool rather than develop homegrown tools because they were perceived as easier to implement. States that were using or planning to implement an independently developed tool such as the interRAI noted that adopting independently developed tools had the advantage of requiring fewer resources than developing a homegrown tool. Independent tools are validated and have training materials available.

### Some states want customized tools

States that developed their own tools were often motivated by a desire for customization. Several state officials we interviewed told us that state leadership and stakeholders preferred homegrown tools, and emphasized that obtaining buy-in from these groups was important to them. In their judgment, independently developed tools were not sufficiently flexible to meet the state's assessment

needs or to satisfy stakeholders. For example, stakeholders might wish to edit the terminology used in particular questions. However, the three states we interviewed that used the interRAI noted that they had been able to customize it enough to meet their needs.

### LTSS delivery models drive use of multiple tools

The way a state organizes delivery of LTSS can lead to the use of multiple tools. In some cases the use of different assessment tools is the result of how different waivers are administered; for instance, when the state Medicaid agency administers the LTSS waivers for individuals age 65 and older and individuals with physical disabilities, and a different agency administers waivers for individuals with intellectual or developmental disabilities. Even when multiple LTSS waivers are run within one agency, different staff members may be responsible for managing different waivers, leading to the use of multiple assessment tools.

## Issues in Moving Toward a National Functional Assessment Tool

As noted earlier, the needs of individuals using Medicaid LTSS cannot be easily compared among states. More comparable and reliable data from functional assessments combined with claims data could help federal and state policymakers better understand how different state approaches to eligibility and LTSS delivery affect use of services and expenditures. Combined with information on outcomes, such analyses would allow policymakers and program administrators to judge the effectiveness and efficiency of different approaches and identify practices that should be replicated. This would require either the use of a standardized tool for functional assessment across all states or at least a limited set of comparable

measures such as those currently being tested in the Testing Experience and Functional Tools demonstration. A fully standardized national tool would need to capture the varied needs of different LTSS subpopulations (e.g., by using modules with customized questions for particular groups). Such a tool could be used for eligibility determination, care planning, or both. A national tool for eligibility determination alone might be more feasible to develop than a tool for care planning, which would likely have to capture a broader range of measures.

In 2013, the federal Commission on Long-Term Care recommended the development of a single national assessment tool for care planning that could be used for individuals with cognitive or functional limitations. That commission pointed to two potential benefits of a national tool: helping to ensure that individuals' needs were assessed in a consistent manner, and providing information to be used in program performance and quality of care evaluations (CLTC 2013).

Given the limitations of currently available information, studies of the use of LTSS cannot highlight instances in which individuals with similar LTSS needs are not eligible for the same services because they reside in different states with different eligibility thresholds. A national tool for either eligibility determination or care planning would permit analyses across states that compare beneficiaries' level of assessed need to LTSS use. Data from a national assessment tool, or a set of comparable measures, would make studies of LTSS use more informative by allowing federal and state policymakers to understand how variation along a standard measure of beneficiary need affects use of services. For example, linking standardized data on assessed needs with actual claims data would allow policymakers to see whether individuals with similar ADL limitations were receiving similar (or different) amounts of personal care services, and to compare these levels based on the state of residence. These data could also help policymakers set benchmarks for appropriate levels of service based on need and set payments accordingly.

A national tool would also improve understanding of the cost of LTSS provided. Given the great differences in LTSS programs among states, additional information on LTSS users' needs could provide insight into the cost of services that are being provided in different states. Analyses might demonstrate that certain states are able to provide a higher value of services than others for beneficiaries of similar risk or need, which may in turn help states identify strategies to promote better use of state and federal resources.

A third benefit of a national tool is that it could save states time and money that would otherwise be used to develop new assessment tools. In our research and in the literature, states have noted that federal resources have been vital to their efforts to improve their assessment processes, including reducing duplication (MAG and NEC 2016).<sup>9</sup> As described earlier, staff in one state we interviewed expressed interest in streamlining the multiple tools they were using but lacked the necessary resources to do so. A national assessment tool would assist states in that situation by providing validated tools, as well as any future updates to the tools.

There are, however, disadvantages to use of a national assessment tool. First, implementation would be burdensome for states that have recently invested in establishing new assessment tools. Implementing a new assessment tool requires substantial resources including purchasing tools from vendors, consulting stakeholders, upgrading information technology, and training of assessors. States that have made recent investments in implementing new tools would likely resist moving to a national tool, especially if such a tool required additional infrastructure upgrades. On the other hand, those states' investments in new tools and infrastructure could be added to the knowledge base informing a national assessment approach.

Another barrier to a national tool is that there is currently no clear favorite. The relative strengths and limitations of existing tools are not well

understood, so there is little basis for making recommendations to states of one tool over another. Instead, states we spoke with said they typically consult peers in other states to better understand their experience with existing tools. Without evidence of a clear advantage of a particular existing tool, states have often developed their own customized tools.

In addition, the rapidly changing landscape of LTSS programs presents a challenge to selecting one tool for all states at this time. States are continuing to change how they organize their LTSS programs, including increasing the use of HCBS, changing or consolidating HCBS waivers, and implementing MLTSS programs. Thus, it might be difficult to develop a tool that meets the needs of all programs and pathways in such a period of experimentation and innovation.

## Next Steps

Functional assessment tools play a key role in the provision of Medicaid LTSS by determining which individuals are eligible and which services they should receive. MACPAC's inquiry found that most states are using homegrown assessment tools for both eligibility determination and care planning, and that these tools collect details about beneficiaries' ability to conduct daily tasks in quite different ways. States make choices about assessment tools based on a desire for customization and the availability of funding. Even so, there are potential benefits of moving toward a national assessment tool or at least the standardization of some elements, which would allow comparisons of LTSS program costs and outcomes across states.

The delivery of LTSS is in a period of rapid change. States are expanding the use of managed care, and plans, providers, and beneficiaries are adapting to these developments. In addition, CMS is testing new approaches to functional assessment and the electronic exchange of care plans. Given

these activities, it seems prudent not to move to a national assessment tool until we can learn more from existing tools and approaches. For now, the Commission plans to monitor the continuing evolution of these tools, and looks forward to CMS's findings from the Testing Experience and Functional Tools demonstration, which could inform future efforts for a national assessment approach.

## Endnotes

<sup>1</sup> The focus of this chapter is on functional eligibility; more information on financial eligibility can be found in Chapter 2 of the Commission's June 2014 report to Congress on Medicaid's role in providing assistance with long-term services and supports (MACPAC 2014).

<sup>2</sup> As of 2014, 22 states had established MLTSS programs, in which a managed care plan contracts with the state to provide LTSS (Terzaghi 2015).

<sup>3</sup> In order for individuals to qualify under this pathway, they must generally meet the SSI program functional eligibility standards, which include being age 65 or older, or for adults age 18–64, having an impairment that impedes their ability to do any gainful work, or for children age 0–17, having an impairment that results in marked or severe functional limitations (SSA 2013).

<sup>4</sup> Level of care criteria may be based on specific diagnoses or conditions, on functional status as measured by ADLs, on functional performance measured by instrumental activities of daily living (IADLs), on other functional skills such as adaptive behaviors, or on other criteria. States may also examine an individual's cognitive status, behavioral or other impairments, medical or nursing needs, presence of informal supports, and functional limitations related to ability to perform ADLs and IADLs or other major life activities.

<sup>5</sup> In 2014, CMS finalized regulations requiring a person-centered care planning process for HCBS provided through state plans and waivers. The regulations require that a person-centered care planning process be driven by the beneficiary to the greatest extent possible. For example, the regulations specify that beneficiaries should be able to choose the individuals who are involved in the planning process on their behalf, that they have choices about the services they receive and the providers they receive services from, and that they contribute to the process by identifying their own goals and preferences (CMS 2014).

<sup>6</sup> The MDS grew out of the Federal Nursing Home Reform Act in the Omnibus Budget Reconciliation Act of 1987 (OBRA, P.L. 100-203), which required nursing facilities to use a resident assessment process to create a plan of care. At the time, there was no common assessment procedure

in use and each facility had its own process to develop a care plan, which did not provide data that would allow comparisons of resident acuity or care across facilities (Black and Leitch 2012). The MDS has subsequently been used to develop quality indicators for nursing facility care and to develop nursing facility payments for Medicare and, in some states, for Medicaid programs as well (Black and Leitch 2012, Zimmerman et al. 1995).

<sup>7</sup> The Balancing Incentive Program targeted states that spent less than 50 percent of total LTSS expenditures on HCBS in 2009, and it provided participating states with an enhanced federal match for HCBS that had to be used to expand access to HCBS and implement structural changes to states' LTSS delivery systems (CMS 2016a). One of these structural changes was the adoption of a standardized functional assessment process and instruments to determine eligibility for Medicaid-funded LTSS, if states were not already using such tools (MAG et al. 2013).

<sup>8</sup> In exploring prior research on functional assessment tools, MACPAC found that most published studies in this area have focused on a sample of states. For example, the Balancing Incentive Program implementation manual contained a comparison of 23 assessment tools, 5 of which were used in more than one state. An in-depth study of nine of the tools used in Balancing Incentive Program states noted that each of them covered ADLs and IADLs as well as cognitive, social, emotional, and behavioral indicators (MAG et al. 2013). Another study of functional assessment tools examined 15 tools used in 13 states, finding similarities in the domains examined (Shirk 2009).

<sup>9</sup> In states where different assessment tools are used to determine eligibility for different LTSS programs, duplication occurs from maintaining multiple tools because beneficiaries may need to be separately assessed on similar functions to move from one program to another. This can be a substantial burden, not only for staff that conduct the assessments but also for the individuals being assessed.

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