NASUAD
National Association of States United for Aging and Disabilities

March 2012

Assessments, Reassessments and Care Plans

Overview

In response to requests for assistance by two members, the National Association of States United for Aging and Disabilities (NASUAD) sent a survey to all states on February 3, 2012, asking for information about Medicaid funded Long-Term Services and Supports.

Methodology

An online survey instrument sent to all states included 30 questions focusing on three topics: 1) consumer-directed services and related processes; 2) assessments, reassessments and care plans; and 3) case management. A total of 16 states responded, with four filling out separate surveys for multiple programs. The 16 states provided information about 27 programs.

Because the topics of the survey were diverse, the results will be presented in three separate summaries. This summary focuses on the second topic—assessments, reassessments and care plans. Throughout the summary, when a percent is shown it is based on the respondents and is not a percent of the total number of states.

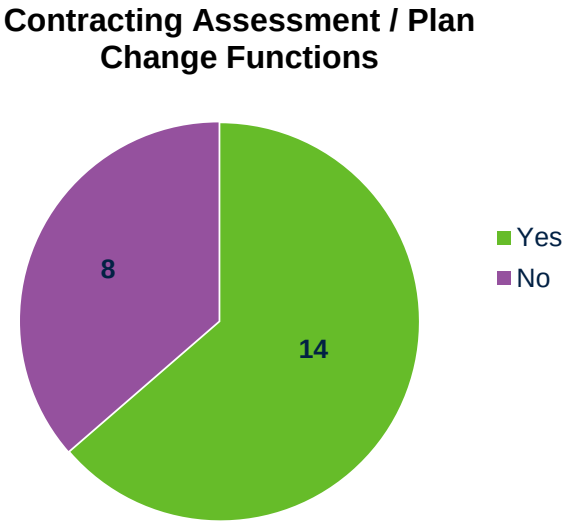
Trends

Five overall trends emerged:

- Almost two-thirds of the programs contract out all or part of the process of doing assessments, reassessments and care plan changes. They use a variety of means to monitor the contracts and pay a wide range of rates for this work.
- More than half the programs allow providers of home and community-based services to do assessments, reassessments and care plan changes.
- Almost every program uses a standardized assessment instrument.
- A majority of programs rely on a team, including the consumer, to develop the care plan.
- Over two-thirds of the programs do not categorize their Home and Community Based Services participants by levels of service.

Contracting for Assessments, Reassessments and Care Plan Changes

When NASUAD asked states whether they contract for assessments, reassessments and care plan changes, almost two-thirds of the respondents answered "yes".



The 14 state programs that have contracts were asked to list the services for which they contract:

- Nine programs responded that they cover all three services through their contracts—assessments, reassessments and care plan changes.
  Of these:
  - Four mentioned that state employees are responsible for final authorization or determination of eligibility.
  - One indicated that it also provides level of care determination via contract.
  - Another said it contracts these services through area agencies on aging as part of case management (considered an administrative function).
- Two programs stated that they contract for a more limited range of services. One includes only assessment and reassessments, while the other focuses on health and behavioral assessments.
- One program indicated that it has a contract with an independent assessor.
- One reported that assessments are contracted out in four counties; state employees complete the assessments in the other counties; and contracted care management agencies are responsible for reassessment and care plans.

Role of HCBS Providers

NASUAD asked states whether providers of Home and Community-Based Services are allowed to do assessments, reassessments and care plan changes. Of the 23 respondents:

- 13 programs (57 percent) allow providers to conduct assessments.
- 14 programs (61 percent) allow providers to conduct reassessments.
- 12 state programs (52 percent) allow providers to make care plan changes.

State Oversight

NASUAD asked states about the number of state staff devoted to the oversight of contractors (including HCBS providers) performing assessments, reassessments and/or care plan changes. Twenty respondents provided a variety of answers:

- One program reported that there are 125.5 FTE case managers and 24 FTE supervisors.
- Two programs reported having more than 20 state staff—one with 22 (including 10 RNs) and the other with 25.
- Six reported having fewer than 10 staff (ranging from 2 to 9). Of these:
    - Two indicated that oversight is performed by quality assurance staff.
    - One mentioned that billing and payment staff are devoted to FMS reviews.
- Two programs provided information about oversight by managed care organizations. One mentioned that each Managed Care Organization has approximately 2-3 state staff working with it in the oversight of the care management process.

When asked how the state monitors the contractors performing assessments, reassessments and care plan changes, the respondents described numerous approaches:

- In terms of frequency of review, the largest number of programs (seven) described an annual review process. The others described a biennial process (three programs in one state), an 18-24 month process (one program), and a 90 day process (one program).
- One program indicated that it relies on regional quality specialists and regional contract specialists.
- Another stated that it uses a team process and quality assurance certification process through targeted case management.

- One said it pays a set rate per completed assessment and the program determines whether the assessment is complete.
- Several programs referred to sampling in monitoring/auditing cases. Sample sizes indicated were 5%, 10%, and "statistically significant". One program said it has randomly selected samples.
- Several states referred to specific forms and monitoring tools.

Please see Attachment A for more details about how states monitor contractors doing assessments, reassessments or care plan changes.

Assessment Instruments

NASUAD asked states what instruments they use for assessments, and a complete list can be seen in Attachment B.

Level of Care

NASUAD asked states to identify who makes the level of care determination. As with previous questions, there was a range of responses.

- Nine programs indicated that state employees do level of care determinations and three said a contracted entity does this.
- Two reported that AAAs perform some level of care determinations.
- Four programs identified nurses and two identified social workers as the people who do level of care determinations.
- Three programs reported that the provider agency does the level of care determinations with final review and determination by state staff.

Care Plan Development and Approval

NASUAD asked states, "Who develops and approves the care plan?" With regard to ***who develops*** the care plan, the 23 respondents provided the following information:

- Seven programs said a team develops the care plan, including the consumer, authorized representative (if any), case manager and contracted provider. Of these, one noted that others identified by the consumer also may be part of the team.

- Five programs mentioned that a case manager or support broker and the consumer develop the plan of care.
- Six identified professionals as the ones developing the plan of care (including nurses, social workers and case managers), but did not mention the consumer or a team.
- Two programs indicated that the plan of care is developed through managed care organizations. One said the managed care organization does this through an interdisciplinary team that includes the consumer.

State programs reported the following about ***who approves*** the care plan:

- Thirteen programs identified state staff.
- Five identified case manages.
- Three identified nurses.
- Two programs identified managed care organizations. One mentioned review by a qualified medical professional. The other said no external approval is required.

Reimbursement for Assessments, Reassessments and Care Plan Changes

States were asked how much they reimburse for assessments, reassessments and/or care plan changes.

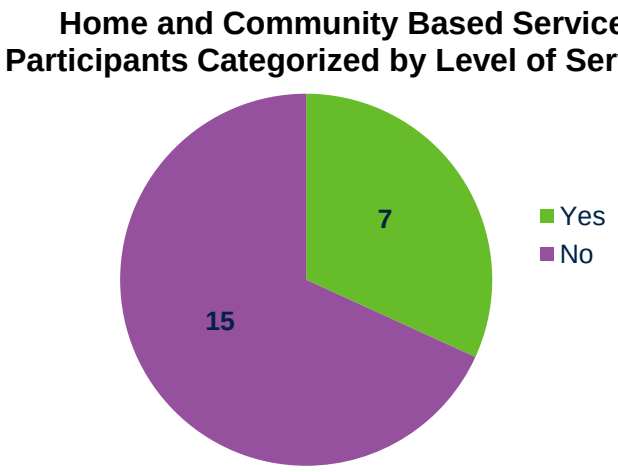
- The 20 respondents reported a range of rates:
    - $37.62 per hour for pre-enrollment assessment.
    - $13.50 to $18.80 per quarter hour, depending on geographic location.
    - $60 per completed assessment when completed by a community nurse.
    - $100 per year per consumer.
    - Part of case management, which is reimbursed from $113 to $121 per month, depending on geographic area.
    - $157.21 per pre-assessment, with reassessments and care plan changes paid as units of nursing services at hourly nursing rate.
    - $190.64 for full assessment by direct service agency, $285.95 for full assessment by case management agency, and $104.32 for partial assessment by either.
    - $200 per initial assessment, with annual reassessment done as part of case management monthly rate.

- Three programs indicated that reimbursement is included in the case management rate and one program said reimbursement is part of the hourly nursing rate.
- Another state program not included above, reported different rates for assessments for different types of services. For assessments of need for personal care services provided under the Medicaid State Plan, physical therapists and occupational therapists are paid $150.62 per assessment in someone's home and $75.31 per assessment in a clinical setting. Under the Waiver, the rate paid for a nursing assessment is $55.50 per hour and other rates are paid for nutritional assessment, and health and behavioral health interventions.

Levels of Service; Case Mix

NASUAD asked whether states categorize their Home and Community Based Services participants for levels of service. Fifteen state programs (more than two-thirds) replied that they do not do this.

The seven state programs answering that they do categorize participants for levels of service then were asked two additional questions:



- First, they were asked whether the service provider and participant may change services, so long as services remain within the level of service authorized. Four state programs responded "yes" and three responded "no".
- Second, they were asked whether there has been a financial impact, if they had changed to a Resource Utilization Group (RUG)/service utilization case mix model. All except one of the seven programs answered "no".

Attachment A

How State Programs Monitor Contractors Doing

Assessments, Reassessments and/or Care Plan Changes

Audits are done annually and all care plans are reviewed.
Regional quality specialists and regional contract specialists.
Through targeted case management duties, the team process and Quality Assurance Certifications.
We pay a set rate per completed assessment, and this office determines whether the assessment document is complete. We train the community providers who choose to complete assessments and perform post-training tests.
Per contractual agreement with Department for Medicaid Services, On an at least annual basis, conducting on site visits with each of 28 agencies participating in program, auditing at least 10% through programming (case management)and at least 10% through financial tracking; additionally conducting 10 home visits with consumers during site review.
Case managers are responsible for monitoring the service plan of the participant and must meet face-to-face with the participant at a minimum of every ninety days. The case managers complete a ninety (90) day checklist to assure that services approved by the Division on Aging (DA) waiver specialist continue to meet the medical needs and goals of the participant. If changes in the POC are warranted in order to meet the medical needs and goals of the participant, the case manager must submit additional information and updated POC/CCB to the DA's Waiver Operations Unit. The DA's waiver specialist determines if the additional services are appropriate based on the assessment and documentation provided and if cost effectiveness is maintained.
DADS utilizes a monitoring tool to ensure compliance from those providing Financial Management Services. Reviews are scheduled every two years for all open-ended contracts.

A contract monitoring review is conducted using a Contract Monitoring Tool on all providers at least every two years. DADS notifies the program provider of an onsite monitoring review with written notice at least 14 calendar days before the review. The contract monitoring review is a systematic review of a contractor's financial, personnel and individual service records to determine compliance with program and contract requirements and includes the review of care plans, completion of assessments and submissions of information to DADS. DADS randomly selects a sample of 5% of the individuals being served by the contracted provider before the review. A provider must attain a minimum compliance level of 90% or above. If a provider attains an overall compliance level of 90% or more, but scores less than 90% on any individual standard, the provider is required to submit a CAP for the standards for which it scored less than 90%. If the overall compliance score is below 90%, DADS determines the provider to be out of compliance and will submit a referral to the Sanction Action Review Committee (SARC).

Each waiver CM agency is reviewed every 18 to 24 months using a random sample of cases. Review is conducted by the Department of Health and Senior Services. The Department of Human Services is the single state entity and they oversee the operating agencies of the waivers. They review files from the care managers for all waivers.

For the Adult DD 1915-c Waiver, the State Assigns a State Worker as the Contract Monitor overseeing the work of the Independent Assessment Provider contract through ongoing review of contract performance metrics.

Each service plan or plan change including assessments/reassessments are reviewed for approval by state staff. Each CM agency must complete a performance audit conducted by state staff annually.

Oversight of managed care organizations includes: Initial certification prior to contracting, to assure the MCO has adequate infrastructure and competencies in care management, self-directed services, and an adequate provider network. Annual on-site reviews of MCOs implementation of their own quality management programs and performance in care management and service delivery. Monitoring of MCOs' programs to conduct root cause analysis of critical incidents and to respond effectively. Continual monitoring and follow upon consumer appeals, grievances and complaints.

The program has multiple program standards that dictate when and how changes are to be made to the plan of care. Each contract is monitored at least annually to evaluate the provider's compliance to each program standard. Verification that changes have been made as necessary is based on interview of the individuals who receive services or their involved family members or documentation of assessments performed using waiver or non-waiver services.

The HCS program has multiple program standards that dictate when and how changes are to be made to the plan of care. Each HCS contract is monitored at least annually to evaluate the provider's compliance to each program standard. Verification that changes have been made as necessary is based on interview of the individuals who receive services or their involved family members or documentation of assessments performed using waiver or non-waiver services.	
Annual cycle of file reviews using a statistically significant sample. 100% remediation and Performance Improvement Plans required.	

Attachment B

Instruments Used for Assessments

703 assessment instrument for 1915(c) waivers; 618 assessment instrument for 1915(j) state plan.
Department for Medicaid Services' generated form MAP 351.
Eligibility screen and assessment for combined case management.
Form 2060 Consumer Needs Assessment Questionnaire and Task Hour Guide.
InterRAI HC.
Medical necessity and level of care (MN/LOC) assessment.
Nursing Facility Level of Care Assessment, Social Health Assessment.
State LTC functional screen.
The NJCHOICE is used to determine NF LOC eligibility.
Uniform Comprehensive Assessment Tool (UCAT).
Harmony SAMS web based system.
All IDD programs administered by DADS use the Mental Retardation/Related Conditions (MR/RC) assessment form (8578) to document program eligibility information. The functional assessment tool used for TxHmL is Inventory for Client and Agency Planning (ICAP).
Department of Aging programs use a standard electronic assessment tool designed for waivers.

In the waiver, the Individual Support Team is responsible for assessing the needs of the individual supported. In the State Plan, there is a standardized functional assessment that is conducted by physical and occupational therapists for all State Plan PCS services.
Long Term Care Consultation assessment is performed by Counties, Tribes or MCOs (lead administrative agencies)
All IDD programs administered by DADS use the Mental Retardation/Related Conditions (MR/RC) assessment form (form 8578) to document program eligibility information. Functional assessment tools used for DBMD are Inventory for Client and Agency Planning (ICAP), Scales of Independent Behavior (SIB-R), Vineland Adaptive Behavior Scales (VABS), or the American Association on Mental Deficiencies Adaptive Behavior Scales (AAMD). The Related Conditions Eligibility Screening Instrument (form 8662) is used to verify a diagnosis of a related condition.
Medical necessity and level of care (MN/LOC) assessment.
CARE (Comprehensive Assessment & Reporting Evaluation) is a web-based tool with algorithms for determining eligibility and level of benefit.
Managed care does not have a standardized instrument for assessments at this time. Each MCO must meet contract requirements for their assessment tools and have them approved by the state.
All IDD programs administered by DADS use the Mental Retardation/Related Conditions (MR/RC) assessment form (8578) to document program eligibility information. Functional assessment tool used for HCS is Inventory for Client and Agency Planning (ICAP).
For the A&D 1915-c waiver: The Uniform Assessment Instrument (UAI) For the DD 1915-c Waiver: The Scales of Independent Behavior-Revised (SIB-R)
Our Medicaid Eligibility Determination (MED) form was created with elements from the Maine tool and the MDS in mind.