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THE BALANCING INCENTIVE PROGRAM: IMPLEMENTATION MANUAL

FEBRUARY 2013

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under contract with

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WHAT'S NEW IN THE MANUAL?

The following changes have been made to the Balancing Incentive Program Implementation Manual since it was previously released in October 2011.

- Page iii (and Page 51): Clarified that States should contact CMS regarding the application process and eligibility requirements.
- Page iii: Acknowledged the “pioneer” Balancing Incentive Program States for their contributions to this manual.
- Page 2: Added section, “Eligibility Requirements and Benefits,” confirming the additive nature of the Program’s enhanced Federal Medical Assistance Percentages (FMAP) with other Affordable Care Act opportunities and clarifying the methodology for calculating the share of total Medicaid long-term services and supports (LTSS) expenditures spent on community LTSS.
- Page 3: Added requirement that States meet certain target levels of community LTSS spending by the end of the Program.
- Page 3: Included HCBS under 1915(b) as a Medicaid Program Authority with Community LTSS.
- Page 4 – 5: Added section, “Program Timeline,” including information on when States begin receiving payments and submit the Work Plan and Programmatic Progress Reports.
- Page 4: Confirmed that States applying to the Program after the \$3 billion has been awarded, based on projected expenditures, will not be approved for participation.
- Page 5: Included graphical presentation of the Program timeline.
- Page 21 – 22: Clarified that while the completion of the Level I screen is required via phone and in person, an online Level I self-screen is not a requirement.
- Page 22: Removed mention of “single instrument.” States may use multiple assessment instruments within a given population, as long as those instruments are uniformly used across that population.
- Page 22: Added footnote to clarify the definition of “qualified professionals.”
- Page 29-31: Added new chapter on Conflict-Free Case Management to clarify the elements of a conflict-free case management system.
- Page 42: Clarified that if CMS requests service, quality, or outcomes data from a State, the State will have at least 30 days to submit the data to CMS.
- Page 43: Clarified Work Plan requirements, including a completed Work Plan Table Template, deliverables, and companion text for each task in the Work Plan. Included location of a 508-compliant user-friendly Work Plan Template (<http://www.balancingincentiveprogram.org/resources/work-plan>). These changes were also made in [Appendix E](#).
- Page 44: Clarified Progress Report submission timing.
- Page 49: Added section titled, “Use of the Enhanced FMAP,” clarifying spending requirements.

- Page 117: Added Appendix of the Balancing Benchmark Tracker, an Excel tool to help States track their community LTSS expenditures and progress toward meeting the benchmark.

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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 years 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 an overview of the Balancing Incentive Program, as well as the organizational structure of this Manual, the purpose of which is to help States implement the Program's required structural changes.

1.1. THE PROGRAM AT A GLANCE

The Balancing Incentive Program provides financial incentives to States to offer community LTSS as an alternative to institutional care. In this section, we present the Program's benefits, eligibility and program requirements, and timeline.

Eligibility Requirements and Benefits

States that spend less than 50 percent of their *total* Medicaid LTSS expenditures on community LTSS are eligible for the Balancing Incentive Program.¹ States that spend less than 25 percent of total Medicaid LTSS expenditures on community LTSS are eligible for a 5 percent enhanced Federal Medical Assistance Percentage (FMAP); States that spend between 25 percent and 50 percent of total Medicaid LTSS expenditures on community LTSS are eligible for 2 percent enhanced FMAP. Funding provided through the Program is additive with other Medicaid program authorities as well as other financing opportunities provided through the Patient Protection and Affordable Care Act, including the Community First Choice (CFC) Option (1915(k)) and the State Option to Provide Health Homes for Enrollees with Chronic Conditions.

The share of total Medicaid LTSS expenditures spent on community LTSS for each State can be found at the end of [Appendix C](#). A description of the methodology for calculating this measure for each State can be found in articles "Medicaid Managed Long-Term Services and Supports Expenditures" (Kasten et al., 2011) and "Medicaid Expenditures for Long-Term Services and Supports: 2011 Update" (Eiken et al., 2011). Note that because CMS does not have access to all LTSS expenditure data, States may present CMS their own data sources and calculations for determining eligibility.

Program Requirements

States that meet eligibility requirements and participate in the Program must ensure their systems include, or will include, the following structural features, as described by the legislation:

¹ States may not apply for the Program based on expenditures by target population; States must apply based on *total* Medicaid LTSS expenditures. CMS does not have statutory authority to provide States the flexibility to apply based on target-population spending.

- **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 legislation also requires States to meet certain target levels of community LTSS spending by the end of the Program. 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 Program, States should demonstrate to CMS that they are making reasonable progress toward these targets in quarterly financial reports (described in [Chapter 7](#)). States will continue to receive payments throughout the life of the Program (September 30, 2015 or until the Program funds are exhausted, whichever occurs first) even if they reach their target before the end the Program. The full legislation can be found in [Appendix A](#).

Medicaid Program Authorities with Community LTSS

- HCBS under 1915(b), (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

Affected Services

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.² Many population groups can receive these services, including the elderly and individuals with mental illness, developmental disabilities, physical disabilities such as traumatic brain injury, and other conditions that warrant community LTSS such as Alzheimer's disease. A list of the Medicaid program authorities offering community LTSS that may be impacted by the Program can be found in the box above.

Program Timeline

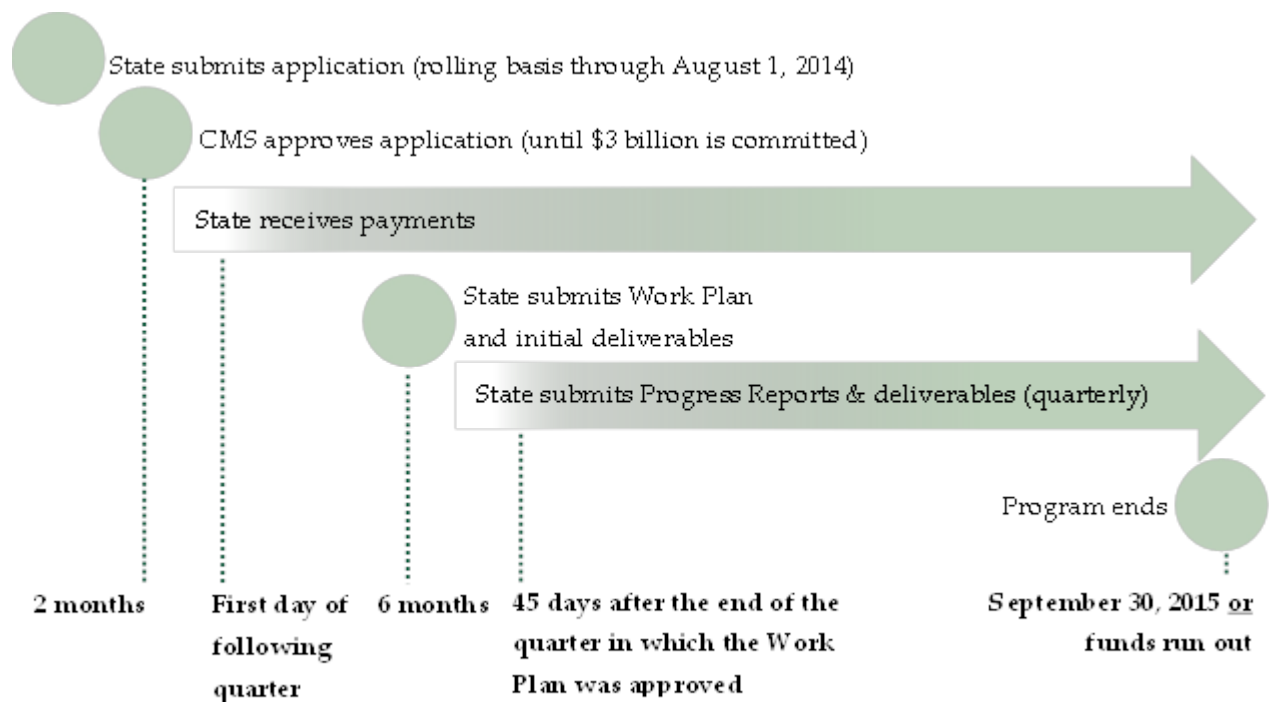
Applications for participation in the Program will be accepted on a rolling basis through August 1, 2014. State Medicaid Agencies are responsible for completing and submitting a State's application. CMS has sixty days after receiving an application to approve or deny the State. Approved States begin receiving payments on the first day of the first full quarter following CMS approval of the application.

CMS will award funds to approved States until the \$3 billion authorized by Section 10202 of the Affordable Care Act has been awarded based on projected expenditures. States applying after the \$3 billion has been awarded will not be approved for participation.

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 Program. [Appendix E](#) contains guidance for creating and submitting the Work Plan and its related deliverables. Each quarter during the Program, States are required to submit Programmatic Progress Reports and Work Plan deliverables (through a website), and services and financial data (through Form CMS-64). A more detailed description of reporting requirements can be found in [Chapter 7](#). The Program ends on September 30, 2015 or until the full \$3 billion allocated for the Program is expended, whichever is earlier.

The timing of a State's application determines the starting point and duration of payments. The sooner a State applies and is approved, the greater number of payments it will receive before the end of the Program. In addition, CMS has sixty days to approve or deny a State for the Program. States would be wise to apply within the first month of a given quarter to begin receiving payments at the start of the subsequent quarter. The timeline of the Program and the benefits of applying early are presented below.

² Institutional settings 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.



1.2. ORGANIZATIONAL STRUCTURE OF THE MANUAL

The purpose of this Implementation Manual is to provide States with guidance on the implementation of the structural changes and other Balancing Incentive Program requirements. 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.
- [Chapter 3](#), [Chapter 4](#), and [Chapter 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 requirements and recommendations associated with a given structural change.
- [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 ([Appendix A](#)), State Medicaid Director Letter ([Appendix B](#)), and application form ([Appendix C](#)).
- A checklist of Balancing Incentive Program requirements to help States track their progress ([Appendix D](#)).
- Instructions for completing the Work Plan, including a table of subtasks, deliverables, and due dates ([Appendix E](#)).
- Information to help States coordinate efforts across multiple and diverse entities, including an example Memorandum of Understanding (MOU) ([Appendix F](#)).
- Implementation guidance for the CSA, including descriptions of State and national practices ([Appendix G](#)) 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 ([Appendix H](#)).
- Suggested Medicaid Adult Health Quality Measures recommended to help States meet the data collection requirements ([Appendix I](#)).
- Information to help States share data securely ([Appendix J](#)) and build websites accessible to people with physical and developmental disabilities ([Appendix K](#)).
- The Balancing Benchmark Tracker, a tool to help States track their community LTSS, is located in [Appendix L](#).
- Glossary of acronyms ([Appendix M](#)), references, and website resources ([Appendix N](#)).

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 (CFC), 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 across 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, individuals 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 for Community Living (ACL) 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 uniform set of instruments 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.

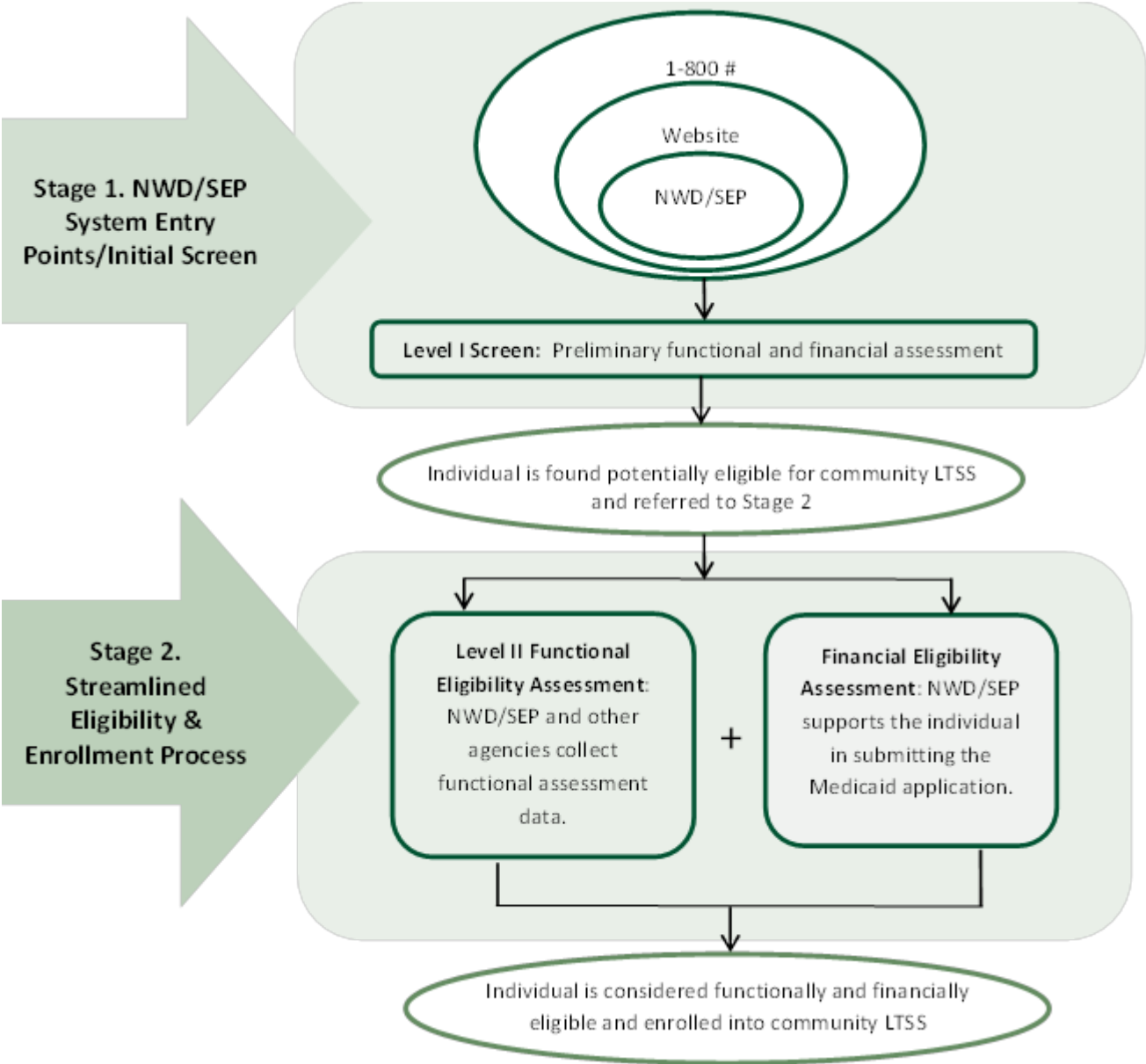
3.1. OVERVIEW OF CONCEPT

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.

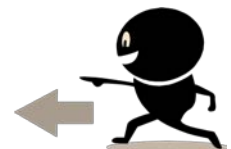
NWD/SEPs

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](#).

Although not a requirement, 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.

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

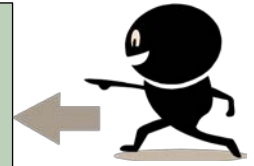


- The most basic community LTSS websites would not contain an online Level I self-screening. Individuals would find out about the range of community LTSS available in the State by reviewing the website content; they may choose to pursue community LTSS by contacting a NWD/SEP.
- Websites that include 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.

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.

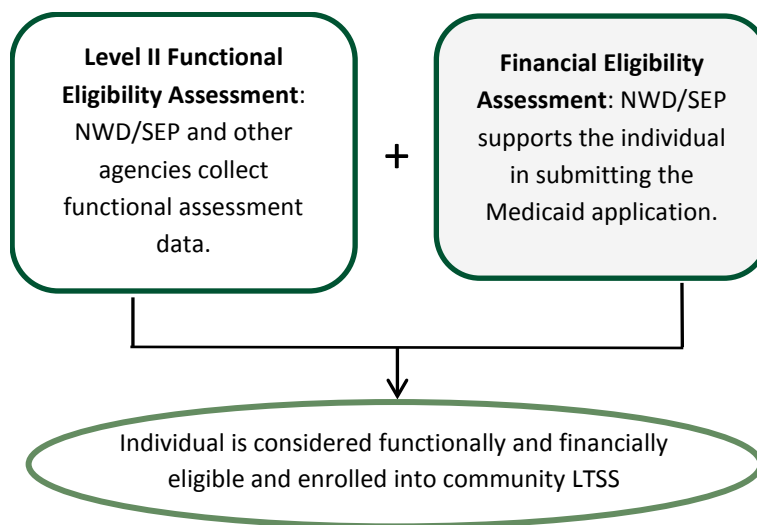
Path from 1-800 Number to Stage 2: CMS encourages States to set up systems by which individuals are able to have a Level I screen completed via the 1-800 number. A 1-800 number can create a “person-to-person hand off” to the next step towards receiving services. An individual may call a 1-800 number, 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.³

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:

³ 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 a 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><i>General NWD/SEP Structure</i></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.

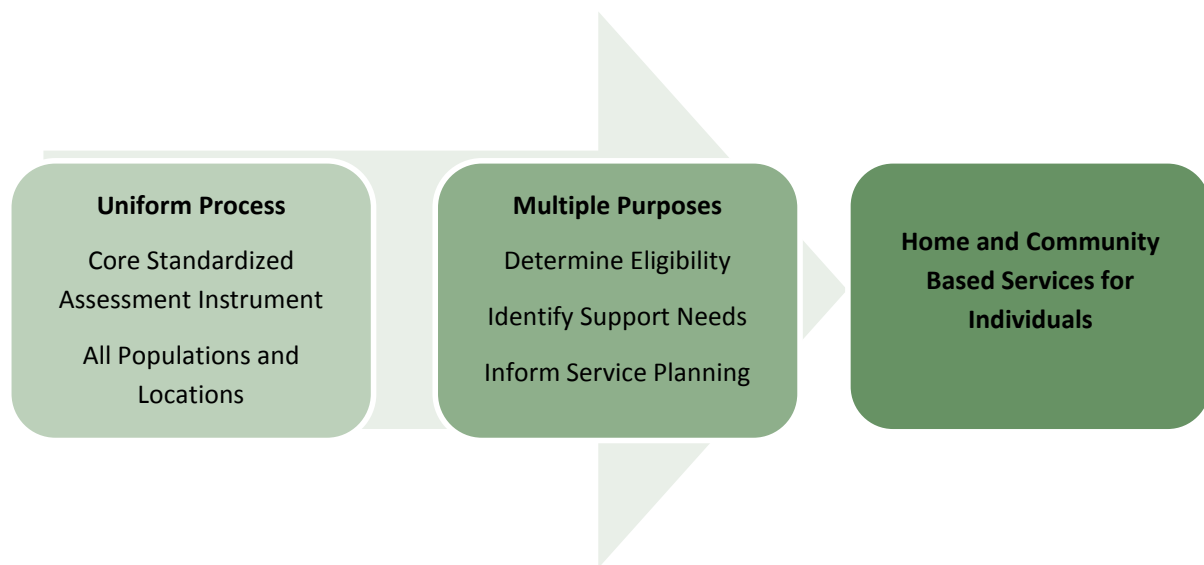
4. STRUCTURAL CHANGE 2: CORE STANDARDIZED ASSESSMENT

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.

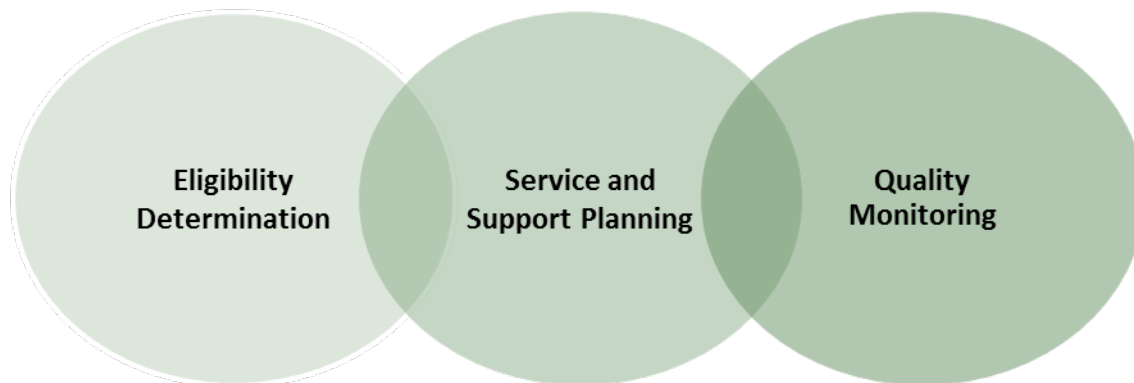
National Trends toward Uniform Assessment

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 York⁴ and Arkansas⁵, 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

⁴ <http://www.hca-nys.org/reformblueprint.pdf>

⁵ <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

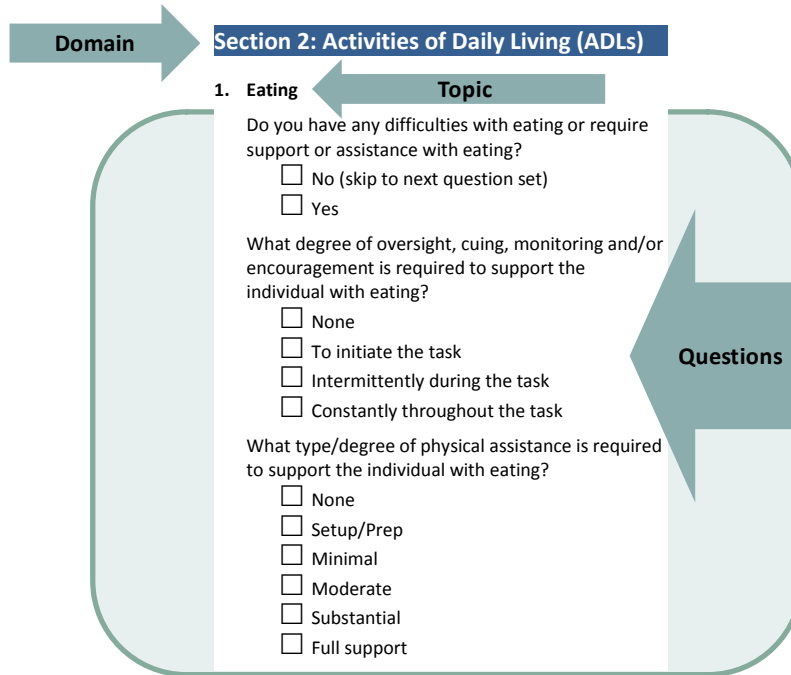
A State could meet the requirements of the Balancing Incentive Program by replacing all of its existing assessment instruments with a single instrument that would be used across all populations and settings. However, given the investment States have made in their existing instruments and the close links 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 community 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.

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 and/or his/her representatives in person or over the phone (by calling a 1-800 number with live

support available). CMS also strongly recommends that States develop a self-screening tool that allows individuals to conduct a Level I screen online. 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.

The purpose of a Level II assessment 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 and the individual seeking supports (who may choose to have a family member, caregiver, support person or advocate accompany him or her).⁶ 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 Core Dataset (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. Please note that these data elements need not be collected using a single instrument across all populations.

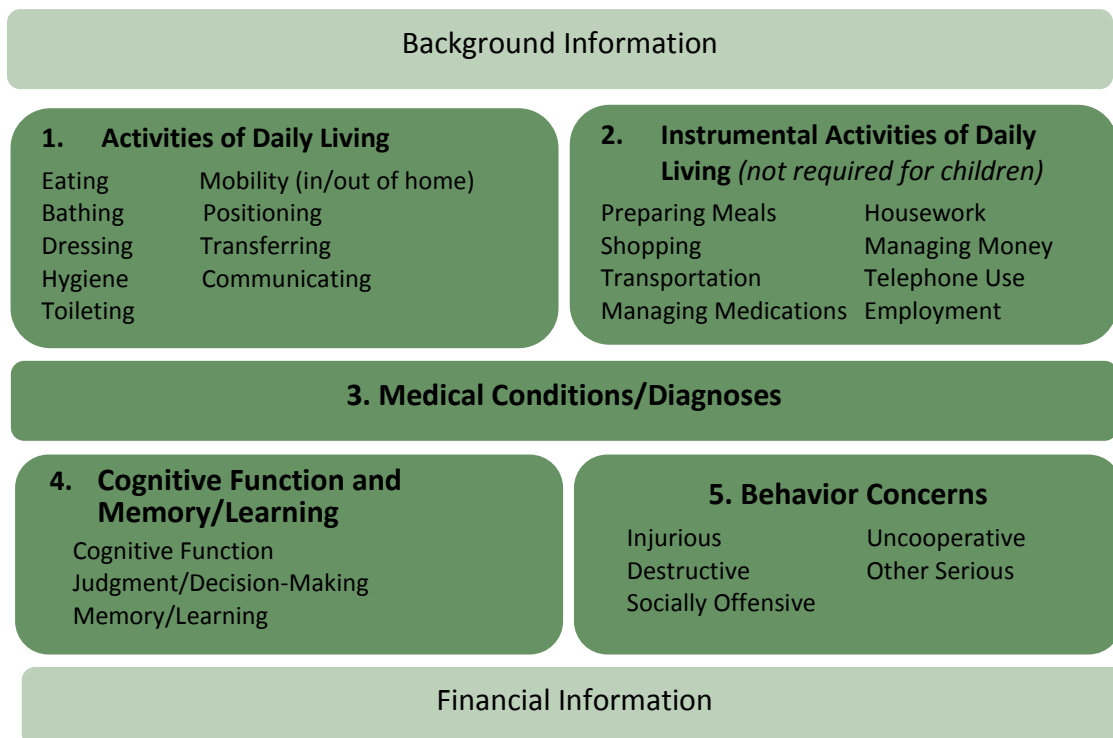
The CDS contains five domains: activities of daily living (ADLs), instrumental activities of daily living (IADLs), medical conditions/diagnoses, cognitive functioning/memory, and behavior concerns. Four of these domains (ADLs, IADLs, cognitive functioning/memory, and behavior concerns) contain topics (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).

⁶ What constitutes a qualified professional should be thought of in broad terms and is not limited to only those holding a clinical degree. Acceptable qualified professionals for the purposes of the Program include, but are not limited to social workers, case managers, and nurses.

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>																									
<ul style="list-style-type: none"> • The Level I screen/Level II assessment process is uniform 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 Core Dataset (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 style="margin-left: 20px; border: none;"> <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 style="margin-left: 20px; border: none;"> <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 style="margin-left: 20px; border: none;"> <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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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:

- Individuals can conduct a Level I self-screen online.
- 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.”⁷ 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.

⁷ Black’s Law Dictionary, Eighth Ed., Thomson West, St Paul, MN (2004)

5.2. CONFLICT-FREE CASE MANAGEMENT

Optimally, a conflict-free case management system includes the following design elements:

1. Clinical or non-financial eligibility determination is separated from direct service provision. Case managers who are responsible for determining eligibility for services, do so distinctly from the provision of services. In circumstances where there is overlap, appropriate firewalls are in place so that there is not an incentive to make individuals eligible for services to increase business for their organization. Eligibility is determined by an entity or organization that has no fiscal relationship to the individual. This separation applies to re-determinations as well as to initial determinations.
2. Case managers and evaluators of the beneficiary's need for services are not related by blood or marriage to the individual; to any of the individual's paid caregivers; or to anyone financially responsible for the individual or empowered to make financial or health-related decisions on the beneficiary's behalf.
3. There is robust monitoring and oversight. A conflict-free case management system includes strong oversight and quality management to promote consumer-direction and beneficiaries are clearly informed about their right to appeal decisions about plans of care, eligibility determination and service delivery.
4. Clear, well-known, and accessible pathways are established for consumers to submit grievances and/or appeals to the managed care organization or State for assistance regarding concerns about choice, quality, eligibility determination, service provision and outcomes.
5. Grievances, complaints, appeals and the resulting decisions are adequately tracked and monitored. Information obtained is used to inform program policy and operations as part of the continuous quality management and oversight system.
6. State quality management staff oversees clinical or non-financial program eligibility determination and service provision business practices to ensure that consumer choice and control are not compromised, both through direct oversight and/or the use of contracted organizations that provide quality oversight on the State's behalf.
7. State quality management staff track and document consumer experiences with measures that capture the quality of care coordination and case management services.
8. In circumstances when one entity is responsible for providing case management and service delivery, appropriate safeguards and firewalls exist to mitigate risk of potential conflict.
9. Meaningful stakeholder engagement strategies are implemented which include beneficiaries, family members, advocates, providers, State leadership, managed care organization leadership and case management staff.

5.3. 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">• Clinical or non-financial eligibility determination is separated from direct service provision.• Case managers and evaluators of the beneficiary’s need for services are not related by blood or marriage to the individual; to any of the individual’s paid caregivers; or to anyone financially responsible for the individual or empowered to make financial or health-related decisions on the beneficiary’s behalf.• There is robust monitoring and oversight.• Clear, well-known, and accessible pathways are established for consumers to submit grievances and/or appeals to the managed care organization or State for assistance regarding concerns about choice, quality, eligibility determination, service provision and outcomes.• Grievances, complaints, appeals and the resulting decisions are adequately tracked, monitored and used.• State quality management staff oversees clinical or non-financial program eligibility determination and service provision business practices to ensure that consumer choice and control are not compromised.• State quality management staff track and document consumer experiences with measures that capture the quality of care coordination and case management services.• In circumstances when one entity is responsible for providing case management and service delivery, appropriate safeguards and firewalls exist to mitigate risk of potential conflict.• Meaningful stakeholder engagement strategies are implemented which include beneficiaries, family members, advocates, providers, State leadership, managed care organization leadership and case management staff.

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 supports (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?

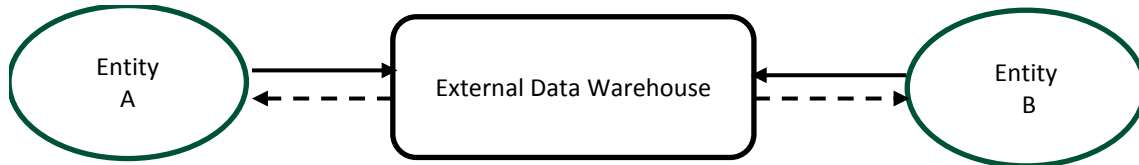
EIEs can serve many purposes, such as helping medical providers share patient clinical information or allowing States to enroll families into multiple social programs through one portal. We use the term EIE to broadly encompass systems that share client demographic, financial, health and functional data 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

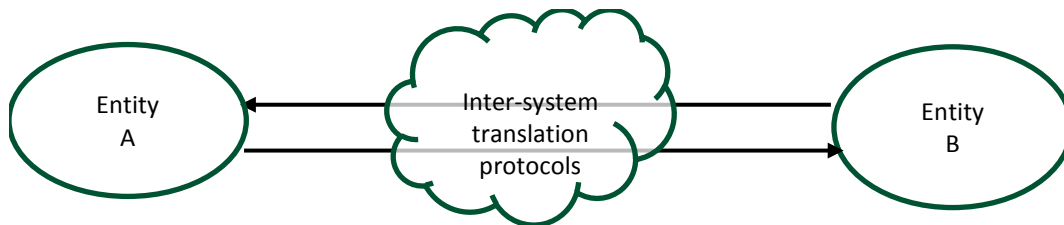


Solid arrows represent ability to update data; dashed arrows represent ability to view data.

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

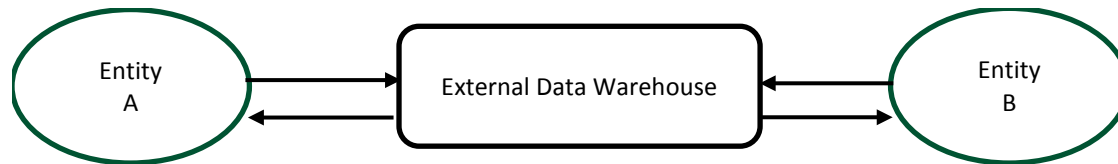


Solid arrows represent ability to update data

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.

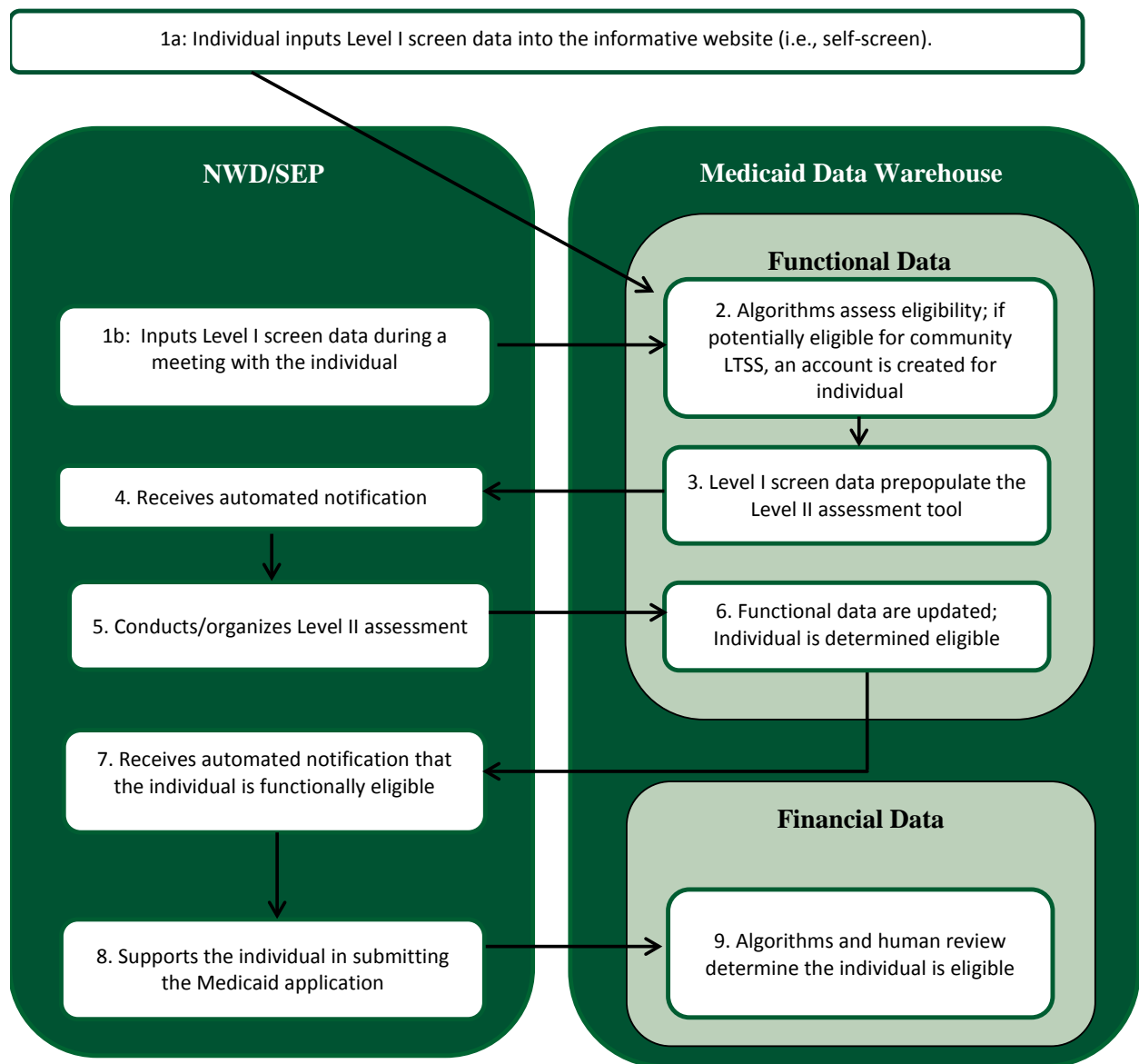
Data Flow through One e-App: One e-App is a hybrid system because data move through a centralized location and data in local systems are constantly updated. Data enter the centralized data warehouse through the thousands of user sites. The data warehouse interfaces easily with local entities, which then 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 the 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 Insurance 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 Insurance 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 Insurance 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.”

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. 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. If CMS requests data from a State, the State will have at least 30 days to submit the data.

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 (Six Months after Application Submission)

Six months after the submission of the Balancing Incentive Program application, States are required to submit a Work Plan, consisting of:

1. A completed **Work Plan Table Template**, found in [Appendix E](#). User-friendly 508 compliant versions in Word and Excel are also available on the Balancing Incentive Program Website: <http://www.balancingincentiveprogram.org/resources/work-plan>. The Work Plan Table Template includes a series of interim tasks necessary for achieving the structural change requirements, deliverables that demonstrate the completion of each interim task, and due dates for deliverable submission.
2. Several **deliverables** (highlighted in grey in the Work Plan Table Template).

3. **Companion text for each interim task.** The State should describe the current state of the task, experienced or anticipated challenges to completing this task, and the State’s plans to address these challenges.

More information on how to develop and submit the Work Plan can be found in [Appendix E](#).

Programmatic Progress Reports and Deliverables (Quarterly)

Through an online system, each State will be required to submit a quarterly Programmatic Progress Report with information that delineates its current standing in completing the tasks 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.

States are required to submit Progress Reports on a quarterly basis 45 days after the end of each quarter. The reporting periods and due dates are the following:

- January 1 – March 31: Report due April 30
- April 1 – June 30: Report due July 31
- July 1 – September 30: Report due October 31
- October 1 – December 31: Report due January 31

The first Progress Report should be submitted for **the quarter during which the Work Plan was approved**. See the below table for examples of submission timing.

Work Plan Approved	First Progress Report Reporting Period	Due Date of First Progress Report
June 15	April 1 – June 30	August 15
July 15	July 1 – September 30	November 15
November 20	October 1 – December 31	February 15

Some States may be submitting a Progress Report very soon after the Work Plan submission. Therefore, the first Progress Report will likely contain the same information as the Work Plan. The Progress Report will essentially be an opportunity for the State to input information into the online reporting form and update information where necessary.

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 September 30, 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. In addition, there will be a section of the Programmatic Progress Report where States will indicate their total LTSS expenditures in order to demonstrate movement towards the spending targets.

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 Federal Matching Assistance Percentages (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."⁸

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.

⁸ 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 FUNDS⁹

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).

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,

⁹ 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 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.

8.3. USE OF THE ENHANCED FMAP

States are required to spend the Balancing Incentive Program enhanced FMAP on efforts that improve access to community LTSS, including the implementation of the structural changes. According to the legislation:

“(c)(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.”

CMS has developed a three-part test to help States assess whether the use of enhanced FMAP meets legislative requirements. If a State can answer “Yes” to all three of the following questions, its proposed use of funds is acceptable.

- Does the proposal increase offerings of or access to non-institutional LTSS?
- Does the proposed expansion/enhancement of offerings/access benefit Medicaid recipients?

- Is the proposal something that Medicaid funds can typically be spent on (i.e., the proposal does not involve a prohibited use of Medicaid funding)?

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, the application process, and eligibility requirements.

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

Center for Medicaid, CHIP and Survey & Certification

SMDL# 11-010
ACA# 20

Dear State Medicaid Director:

This letter provides guidance to States on the implementation of Section 10202 of the Affordable Care Act, which establishes the “State Balancing Incentive Payments Program.” hereafter referred to as the Balancing Incentive Program.

The Balancing Incentive Program provides a strong financial incentive to stimulate greater access to non-institutionally based long-term services and supports (LTSS). This provision will assist States in transforming their long-term care systems by improving systems performance and efficiency, creating tools to facilitate person-centered assessment and care-planning, as well as enhancing 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 realization of the integration directive included in the Americans with Disabilities Act (ADA), as upheld by the *Olmstead* decision.

This letter provides a high-level overview of the Balancing Incentive Program, along with the required structural changes and timeframes for implementation. As described in more detail in the accompanying application, the funding authorized in Section 10202 of the Affordable Care Act will provide an increased Federal Medical Assistance Percentage (FMAP) payment to States participating in the Balancing Incentive Program for non-institutional LTSS and will be made available as a non-competitive grant to States. This letter and the accompanying application serve as a notice of this funding opportunity. All questions regarding this opportunity, as well as all application materials, should be sent to BalancingIncentiveProgram@cms.hhs.gov.

Background

Effective October 1, 2011, the Balancing Incentive Program offers a targeted increase in the FMAP for non-institutional LTSS to States that undertake structural reforms to increase access to non-institutional LTSS. The enhanced matching payments are tied to the percentage of a State’s non-institutional LTSS spending, with lower FMAP increases going to States with a less significant need for reforms. Total funding over the four-year period (October 1, 2011 – September 30, 2015) cannot exceed \$3 billion in Federal increased matching payments.

Implementation of Structural Changes

As part of the Balancing Incentive Program application, the State agrees to make the following structural changes:

1. A No Wrong Door–Single Entry Point system (NWD/SEP);
2. Conflict-free case management services; and
3. A core standardized assessment instrument.

States must provide a letter of commitment to make the required structural changes and submit a work plan for the implementation of the structural changes within six months from the date of application submission. The draft work plan must demonstrate that the structural changes will be in effect no later than September 30, 2015 and that States will meet the statutory rebalancing spending targets.

This opportunity aligns with other provisions and activities that move toward the development and implementation of these important structural changes. CMS will work with States to help accomplish these changes. CMS will monitor compliance with the structural changes required under the program and agreed to under the State work plan. Failure to meet required changes under the work plan will result in loss of the Balancing Incentive Program increased FMAP.

Detailed information about the classification of long-term services and supports for the purposes of determining States' eligibility and the required structural changes can be found in the accompanying application.

We hope the guidance set forth in the application increases the likelihood of States' participation in this exciting opportunity to support balancing the States' long-term services and supports system. We look forward to working with States, individually and collectively, to provide assistance and to facilitate collaboration in implementing this new grant program. CMS would like to reiterate that this option is but one tool among many in current law and Affordable Care Act that States can use to improve service delivery for all people, not just those with chronic conditions or those covered by Medicaid.

Please send any comments or questions to BalancingIncentiveProgram@cms.hhs.gov.

Sincerely,

/s/

Cindy Mann
Director

Enclosure

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health

Matt Salo
Executive Director
National Association of Medicaid Directors

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Christine Evans, M.P.H.
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Debra Miller
Director for Health Policy
Council of State Governments

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Heather Hogsett
Director of Health Legislation
National Governors Association

APPENDIX C: APPLICATION

See next page

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Center for Medicaid, CHIP, and Survey & Certification

**Patient Protection and Affordable Care Act
Section 10202
State Balancing Incentive Payments Program**

Initial Announcement

CFDA 93.543

OMB Control No: 0938-1145, Expiration Date: 03/31/2012

Applicable Dates:

Grant Period of Performance: October 1, 2011 – September 30, 2015

Applications for participation in the Balancing Incentive Payments Program will be accepted on an ongoing basis beginning [insert revised date] through August 1, 2014, or until the full provision of the \$3 billion has been projected to be expended, whichever date is earlier.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-New. The time required to complete this application is estimated to average 40 hours per response, including the time to review instructions and complete/submit the State Medicaid Agency Cover Letter; Project Abstract; Letters of Agreement, Endorsements and Support; Application Narrative; Preliminary Work Plan; Proposed Budget (using the Informational Financial Reporting Form in Attachment B); and the Final Work Plan. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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I. FUNDING OPPORTUNITY DESCRIPTION

1. Background: Need and Opportunity

Section 10202 of the Patient Protection and Affordable Care Act (Pub. L. 111-148) (The Affordable Care Act), entitled the “State Balancing Incentive Payments Program,” hereafter referred to as the Balancing Incentive Program, authorizes additional Federal funds to States to provide financial incentives to increase access to non-institutionally based long-term services and supports (LTSS).

Effective October 1, 2011, the Balancing Incentive Program offers a targeted increase in the Federal Medical Assistance Percentage (FMAP) to States that undertake structural reforms to increase access to non-institutional LTSS. The increased matching payments are tied to the percentage of a State’s non-institutional LTSS spending, with lower FMAP increases going to States that need to make fewer reforms. The Balancing Incentive Program provides increased FMAP to States in return for their implementation of structural changes, including a No Wrong Door/Single Entry Point System (NWD/SEP), conflict-free case management services, and a core standardized assessment instrument. Total funding over the four-year period (October 2011 – September 2015) cannot exceed \$3 billion in Federal increased matching payments.

Historically, some States have been successful at rebalancing their long-term care systems toward community-based care. The Balancing Incentive Program targets those States that need assistance starting up their rebalancing initiatives, offering support in the form of increased FMAP.

States can qualify for a five percentage point increase in FMAP through Balancing Incentive Program if less than twenty-five percent of the total LTSS expenditures for medical assistance under the State Medicaid program for fiscal year 2009 are for non-institutionally based LTSS, and by submitting an application that meets the programmatic requirements and structural reforms specified in the authorizing legislation (Section 10202 of the Affordable Care Act). These States must achieve a benchmark of twenty-five percent of total Medicaid expenditures on home and community-based LTSS, and complete the structural reforms, no later than September 30, 2015.

Additionally, States can qualify for receiving a two percentage point increase in FMAP through Balancing Incentive Program if less than fifty percent of the total LTSS expenditures for medical assistance under the State Medicaid program for fiscal year 2009 are for non-institutionally based LTSS, and by submitting an application that meets the Balancing Incentive Program provision’s programmatic requirements and structural reforms. These States must achieve a benchmark of fifty percent of total Medicaid expenditures on home and community-based LTSS, and complete the required structural reforms, no later than September 30, 2015.

In both cases, as specified in Section 10202(c) of the Affordable Care Act, States may not restrict eligibility for LTSS more than eligibility standards, methodologies, or procedures in place as of December 31, 2010.

Over the last several decades, the Social Security Act (the Act) has been amended several times to help reduce the institutional bias in Medicaid long-term care. These amendments have given States increasing authority to create community-based systems of care and still receive Federal financial participation (FFP) for the home and community-based services (HCBS) they provide. Under Section 1915(c) of the Act, States can ask the Secretary of Health and Human Services (HHS) – via the Centers for Medicare & Medicaid Services (CMS) – to waive certain statutory requirements of the SSA, including the requirement to provide the same services to everyone who is eligible based on their needs and income ("comparability") and the requirement to provide the same services throughout the State ("statewideness"). Under Section 1915(i), States can amend their Medicaid plans to provide HCBS based on needs-based criteria, rather than diagnosis, and to individuals whose needs do not necessarily rise to institutional level of care. Under Section 1915(j), States can amend their plans to give individuals the power to self-direct their personal assistance services (PAS). Finally, under Section 1115, States can create demonstration programs to deliver community-based care in innovative ways.

In addition to the Balancing Incentive Program, the Affordable Care Act established new authorities for providing Medicaid-funded HCBS and support the balancing of LTSS. These new authorities include the Community First Choice Option, a State Plan option to provide HCBS, which provides an increased FMAP of 6 percentage points for program costs, and a Health Homes State plan option to coordinate care for individuals with chronic conditions, and receive 90 percent FMAP for health home services for the first 8 fiscal quarters. The Affordable Care Act also amended existing authorities that complement the Balancing Incentive Program and support the growth of HCBS. These include the extension of the Money Follows the Person demonstration program and the Aging and Disability Resource Center program.

2. Grant Program Requirements

The Balancing Incentive Program provides that participating State grantees make important structural changes to qualify for the increased Federal match, including the development of a No Wrong Door/Single Entry Point System (NWD/SEP), Conflict-free Case Management, and the development and use of a Core Standardized Assessment Instrument, and must submit a detailed budget (outlined later) that specifies how States plan to expand non-institutional LTSS to achieve their rebalancing targets. Grantees must create a statewide system of LTSS that ensures that: all individuals have the same access to information and resources on LTSS, regardless of their first point of entry into the system; individuals are assessed once for the entire range of LTSS for which they may be eligible; and that the eligibility determination and enrollment process proceeds in a streamlined manner, with the functional and financial components of eligibility coordinated. An important part of a NWD/SEP system is that individuals are assessed for the entire range of services and programs for which they might be eligible only once using a single instrument – a Core Standardized Assessment Instrument. By facilitating access to LTSS, the Balancing Incentive Program aims to reduce institutionalization and improve access to care.

States must submit a preliminary work plan at the time of application that describes in detail the plans for achieving the requirements of the Balancing Incentive Program within the program period. States must commit to produce a final work plan within six months from the date of application submission. The State must also submit a proposed budget that details the State's

plan to expand and diversify medical assistance for non-institutionally-based long-term services and supports during the balancing incentive period and achieve the target spending percentage applicable to the State.

A. Implementation of Structural Changes

As part of this application, the State agrees to make the following structural changes:

1. A No Wrong Door/Single Entry Point system (NWD/SEP);
2. Conflict-free case management services; and
3. A core standardized assessment instrument.

CMS strongly urges States to use this opportunity to think strategically about implementation of other provisions in the Affordable Care Act that require these structural changes or a variation thereof. Several of these provisions are discussed in more detail beginning on page 14 of this document.

CMS supported an environmental scan of opportunities and challenges to the implementation of a NWD/SEP and utilization of core standardized assessment instruments. This information informs this application and a subsequent Balancing Incentive Program user manual. The user manual will be made available to all States in September 2011.

As part of the application process, States will be expected to provide a letter of commitment to make structural changes and to submit a work plan for the implementation of the structural changes within six months from the date of application submission. The draft work plan must demonstrate that the structural changes will be in affect no later than September 30, 2015.

In addition to the structural changes, States are encouraged to consider other structural changes, such as optional presumptive eligibility, which are outside of those required in the legislation but can be used as tools to help the State achieve the target spending percentages.

Structural Changes Required

A. No Wrong Door/Single Entry Point System

A key component of the structural changes promoted by the Balancing Incentive Program is development of a “No Wrong Door/Single Entry Point System” (NWD/SEP) for long-term care services and supports. A NWD/SEP requires 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(s) 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.

A Statewide System:

A NWD/SEP ensures that individuals accessing the system experience the same process and receive the same information about LTSS options wherever they enter the system. After entering the system, the needs assessment and eligibility determination process proceeds smoothly, with

designated NWD/SEP agencies guiding the individual through the entire process from eligibility determination to enrollment in services.

LTSS Information & Initial Assessment:

An important component of a Balancing Incentive Program NWD/SEP system is that it is a statewide system. A true statewide system ensures that individuals can access the system from any location within the State, and assures all individuals accessing the system experience the same process and receive the same information about LTSS options. To be statewide, a NWD/SEP system must include the following three components, which make up the key entry points to the system:

- 1) A set of designated Single Entry Point (SEP) agencies
- 2) An informative website about LTSS options in the State
- 3) A statewide 1-800 number that connects individuals to the SEP agencies or their partners

The three components of a NWD/SEP system are also the entry points through which an individual may enter the system.

A set of designated Single Entry Point (SEP) agencies form the core of the “no wrong door” system in each State. The Medicaid Agency is the lead SEP agency. Other participating agencies might include agencies such as: Area Agencies on Aging, Aging and Disability Resource Centers, and Centers for Independent Living. The SEP agencies have physical locations where individuals can inquire about LTSS, and receive initial and comprehensive eligibility assessments and determinations for Medicaid-funded LTSS. The SEPs design and disseminate standardized processes for information and referral and eligibility assessments for LTSS to all participating SEP agencies, ensuring a consistent experience for individuals seeking information and assistance.

An informative website about LTSS options in the State is another important component of a statewide NWD/SEP system. The content of the NWD/SEP website must be overseen by the lead SEP agency and must contain, at a minimum, basic information about the range of LTSS services available in the State and must list the statewide NWD/SEP 1-800 number and provide contact information for local SEP offices by county. The State must ensure that the NWD/SEP website is accessible to individuals with disabilities and compliant with Section 508 of the Rehabilitation Act of 1973.

A recent CMS statewide inventory determined that almost all States currently make available an informational website for potential LTSS applicants, and over one quarter of States currently have initial assessments online. Nearly all of these assessments are part of a general self-assessment tool which allows individuals to conduct initial eligibility checking for a host of medical and social public programs within the State (e.g., the Children’s Health Insurance Program, Temporary Assistance for Needy Families). Tools tend to result in a list of programs for which the individual may be eligible; a list of agencies and contact information are provided. In some cases results are tailored for the county where an applicant lives and a few systems let an applicant download the list of recommended agencies or convert it into a printer-friendly format. Additionally, a few States provide a mechanism for individuals to create a log in and save their

data, with the option to pass the data forward to the appropriate agency for the next step in the assessment process.

Even a simple self-evaluation is a valuable component of a NWD/SEP system. Self-assessments can be an important tool for informing consumers about the range of services for which they might be eligible. These systems also provide a way for individuals to make initial inquiries about services casually and outside of business hours. CMS encourages States to consider incorporating an online self-assessment into their NWD/SEP system, and ideally one that allows data to be passed forward to the SEP agency.

A 1-800 number is another important component of a NWD/SEP system, especially for individuals who are more comfortable talking to a “real person” rather than searching extensively for information on a website or for those individuals who do not have internet access. Toll-free numbers can also provide the ability to create a person to person hand off. For example, a consumer may call an 800 number, receive an initial screening of needs and eligibility for LTSS, and an appointment may be made over the phone for the next step in a needs assessment or application process. Toll-free numbers should also provide a web link to information and referral services for those with internet access and provide translation services for non-English speaking individuals. A recent environmental scan found that, while the majority of States do operate an 800 number that can provide callers with general information about LTSS options, few States indicated that callers could be screened for eligibility for such options. CMS encourages States to set up systems by which individuals are able to have an initial evaluation completed via the 800 number. Additionally, States must ensure that the toll-free number is accessible to participants with disabilities.

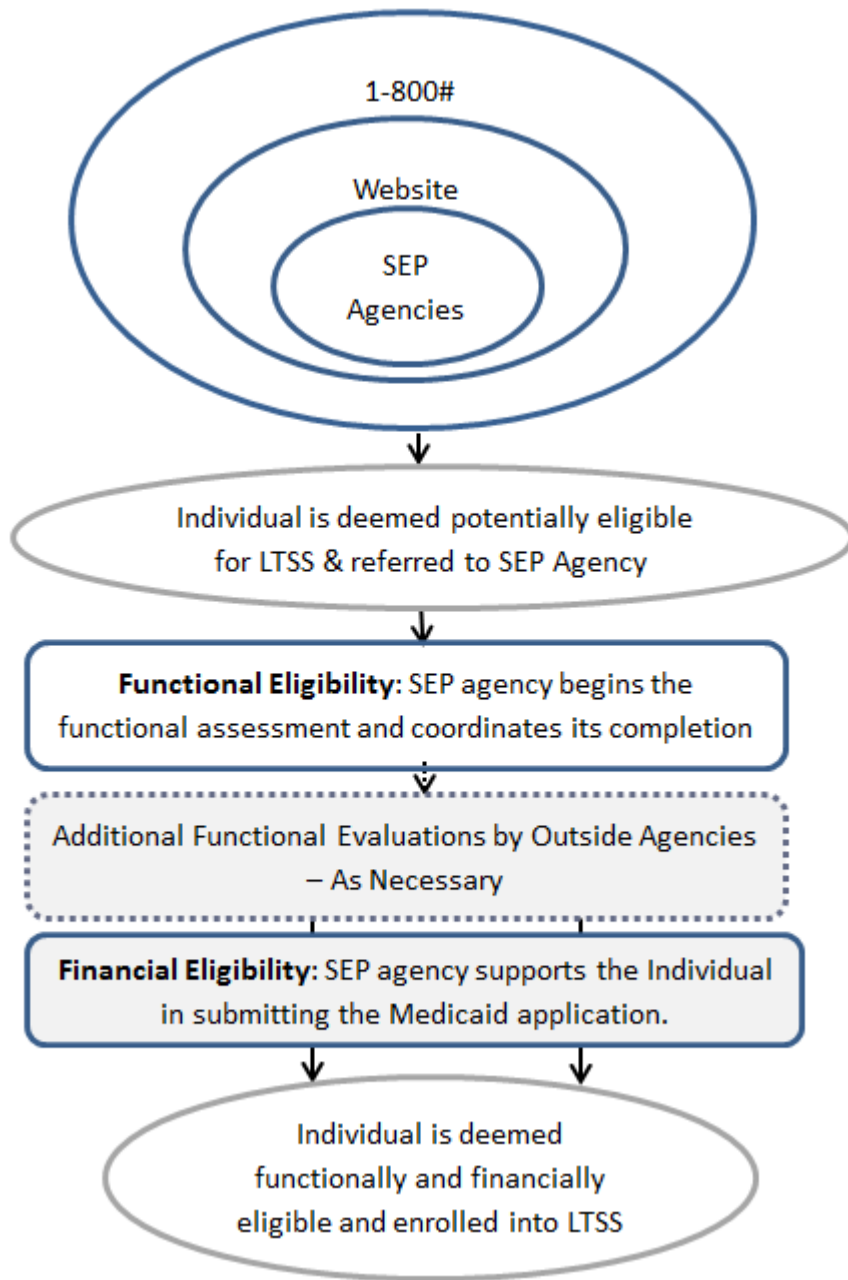
Together these three components form the basis of a statewide NWD/SEP system, allowing access to local services by phone, internet, and in person. More information regarding the physical proximity of individuals to SEP agencies is available below.

**Beneficiary is deemed potentially eligible for LTSS & referred to SEP Agency -
Beneficiary is assigned an eligibility coordinator at SEP Agency:**

In a NWD/SEP system, the SEP agency coordinates all components of the eligibility determination: both functional and financial, allowing individuals to receive streamlined eligibility determinations. SEP staff complete initial assessments and a comprehensive assessment. The same SEP agency also assists the individual to complete and submit the Medicaid financial application and any accompanying documentation, following the process through to eligibility determination. After determinations are made, SEP agencies help individuals choose among programs for which they are eligible, enroll in services, and apply eligibility decisions when appeals are requested by individuals. Ideally, under a NWD/SEP system one person – an eligibility coordinator – takes ownership of the complete eligibility determination process for an individual, providing the individual a single point of contact within the SEP agency.

States should consider co-locating functional and financial eligibility determination staff, as this will help expedite eligibility determinations.

The basic concept of how a person moves through a NWD/SEP system is illustrated by the following diagram, which presents the “person flow” through a NWD/SEP system. CMS expects that States will create a NWD/SEP system that reflects the person flow concept and expands it.



Data Considerations

In addition to considering the “person flow” of a NWD/SEP system, States will need to consider the “data flow” of such a system; that is the path data take from the point of initial collection of financial or functional information through to the final eligibility determination. There are many ways a State can structure data flow within a NWD/SEP system, and a robust NWD/SEP system considers data systems on many levels.

At the point of entry into the NWD/SEP system, the following are just a few questions States must consider: what information to include on the NWD/SEP website, how to keep this information up to date, whether to build an initial self-assessment tool into the website, and whether to create an option to save and transmit initial assessment data to NWD/SEP agencies. In cases where States maintain websites with comprehensive information about local LTSS resources, the SEP agency must keep this information up to date.

Coordination of financial and functional data is a key component of a NWD/SEP system and another important data consideration. All functional assessment data collected via the Core Standardized Assessment must be stored in a central location by the State Medicaid Agency. States will need to determine how the financial data required to determine eligibility for Medicaid LTSS will be handled. If financial data are processed in a separate system from the functional assessment data, the State will have to create a way to allow SEP staff to access both types of data – or the eligibility determinations based on both data sets – in order to make eligibility determinations. It is important that the SEP agency staff be apprised of the status of the financial eligibility determination and that data be processed quickly, and the results shared quickly as well. Ideally, States have systems in which financial and functional data systems are integrated or “talk to each other,” and the SEP agency staff are able to both input data into these systems and extract data necessary for making eligibility determinations.

Access to & Advertising for the NWD/SEP System

States should consider how true statewide access to the NWD/SEP system will be achieved. While the NWD website and 1-800 number will provide statewide access to LTSS information and to SEP agencies, individuals in each State will need to have local access to physical SEP agencies – or partners - in order to complete the full Core Standardized Assessment (CSA)/functional assessment. States must consider how SEPs are distributed relative to individuals likely to need them for evaluations and determinations. In the ideal situation, all individuals needing to interact with an SEP agency would be able to travel there and return home within a single day, accompanied or alone, by private or by public transportation. Individuals who can travel to a given SEP are considered to be in its service area. Individuals who cannot travel to a given SEP fall outside its service area. States must consider how individuals with disabilities and older adults will access the local SEP agency, including how access can be made available to individuals needing public transportation.

For a NWD/SEP system to be truly statewide, a large share of a State’s population should live within the service area of at least one SEP. CMS recognizes, however, that individuals living in rural areas may not fall within the service area of any SEPs. For this share of the population, the State should consider making other arrangements, such as contracting with home health agencies to make visits, either in-home or at a central location (such as a nearby hospital).

States should also plan to advertise their NWD/SEP system. The SEP agencies should become known as the “go to” agencies for LTSS. Advertisements and educational materials about the system must be made available in a variety of formats in order to be accessible to people of all disabilities, and must be made available to individuals in locations throughout the State.

Timeliness of Eligibility Determinations

If States are to truly balance their LTSS systems from institutional to community-based care, the timeliness of LTSS eligibility determinations must be improved. Often, people inquire about LTSS when they have an acute need for supports with activities of daily living (ADLs). In these cases, individuals need assistance immediately and cannot wait for a lengthy eligibility determination process to be completed before receiving services. For a variety of reasons, institutions are often more willing to admit individuals and provide services immediately. CMS encourages States to propose innovative methods for improving efficiencies in the eligibility determination process for LTSS.

B. Conflict-Free Case Management Services

States that participate in the Balancing Incentive Program will develop, as part of their NWD/SEP system, 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.

For purposes of Balancing Incentive Program, States will establish conflict of interest standards for the independent evaluation and independent assessment. In this section, we refer to persons or entities responsible for the independent evaluation, independent assessment, and the plan of care as “agents” to distinguish them from “providers” of home and community-based services.

The design of services, rate establishment, payment methodologies, and methods of administration by the State Medicaid agency may all contribute to potential conflicts of interest. These contributing factors can include obvious conflicts such as incentives for either over- or under-utilization of services; subtle problems such as interest in retaining the individual as a client rather than promoting independence; or 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 deliberate decisions on the part of individuals or entities responsible for the provisions of service; 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.

To mitigate any explicit or implicit conflicts of interest, the independent agent should not be influenced by variations in available funding, either locally or from the State. 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. The plan of care must be based only on medical necessity (for example, needs-based criteria), not on available funding. Conflict-free case management prohibits certain types of referrals for services when there is a financial relationship between the referring entity and the

provider of services. Payment to the independent agent for evaluation and assessment, or qualifications to be an independent agent, cannot be based on the cost of the resulting care plans.

We are aware that in certain areas 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 LTSS. To address this potential problem, the State may permit providers in some cases to serve as both agent and provider of services, but with guarantees of independence of function within the provider entity. In certain circumstances, CMS may require that States develop "firewall" policies, for example, separating staff that perform assessments and develop plans of care from those that provide any of the services in the plan (and ensuring that the evaluations of that staff are not based on the cost of the care plan); and meaningful and accessible procedures for individuals and representatives to appeal to the State. States should not implement policies to circumvent these requirements by suppressing enrollment of any qualified and willing provider.

CMS recognizes that the development of appropriate plans of care often requires the inclusion of individuals with expertise in the provision of long-term services and supports or the delivery of acute care medical services. As discussed previously, this is not intended to prevent providers from participating in these functions, but to ensure that an independent agent retains the final responsibility for the evaluation, assessment, and plan of care functions.

The State must ensure the independence of persons performing evaluations, assessments, and plans of care. Written conflict-free case management ensures, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual,
- related by blood or marriage to 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. *(If the State chooses this option, specify the conflict of interest protections the State will implement).*

C. Core Standardized Assessment Instruments

States participating in Balancing Incentive Program will develop core standardized assessment (CSA) instruments for determining eligibility for non-institutionally-based long-term services and supports, 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 to develop an individual service plan to address such needs.

There are two major benefits of adopting a CSA for statewide use. First, because CSAs focus on an individual's need for assistance with ADLs and instrumental activities of daily living

(IADLs), the evaluation is focused on an individual's true needs, rather than on their current or potential diagnoses; in other words, a CSA promotes a person-centered approach to needs assessment. Second, a CSA used statewide will provide States with a true picture of the needs of all individuals seeking LTSS in their State. A dataset comprised of CSA data for all LTSS consumers can help States with future budget and services planning. CSA data can also be used to help States prioritize individuals with the highest need in cases where services have wait lists. Finally, CSAs may be used to develop individualized budgets for self-directed consumers.

CMS expects that the CSA will be developed under the leadership of the designated lead NWD/SEP agency in each State and that each SEP agency will have staff trained to administer the CSA. The CSA should provide the minimum dataset for eligibility for Medicaid-funded LTSS.

In practice, CMS anticipates that States will implement a CSA that involves two parts: an initial evaluation and a comprehensive evaluation. Not everyone who enters the NWD/SEP system will be an appropriate candidate for a complete CSA evaluation. In other words, not everyone who walks in the door of a NWD/SEP agency, or otherwise inquires about LTSS services (e.g. via phone or website) will be a likely candidate for these services. Therefore, individuals making initial inquiries about LTSS will go through an initial assessment to determine whether a full CSA is warranted.

The initial assessment will point to potential needs and program eligibility, and may be conducted over the phone or in person by trained designated agency staff, or completed as a self-assessment online. If an individual "tests positive" for LTSS needs on the initial evaluation, they may complete the full CSA evaluation. The CSA provides a more complete picture of an individual's abilities and needs and must be completed in person by trained designated agency staff.

D. Advantages to Participating States

Technical Assistance to States

CMS will provide a User Manual to all States in September, 2011. The Manual will provide guidance to State grantees on implementing Balancing Incentive Program, including materials such as: example case studies of person flow and data flow in a NWD/SEP system, presentation of varied models for data sharing in a NWD/SEP system, guidance for selecting a vendor or an internal team to develop or administer NWD/SEP data systems, guidance on developing the Balancing Incentive Program work plan, and a checklist for grantees to evaluate their planned NWD/SEP system against the Balancing Incentive Program criteria.

CMS is also creating a prototype CSA, which may be adopted by grantees. The prototype CSA will be provided to grantees upon award. Grantees that do not wish to adopt the prototype CSA will have the option to use an alternate CSA, provided it collects a core set of data elements. The core set of data elements will likely contain data items in the following categories: demographic information and current enrollment in programs such as Medicare and Social Security Income (SSI), ADLs, IADLs, known medical conditions, and problem behaviors. The final core data set will be provided to grantees in the Manual. The Manual will also include guidance on cross-

walking an alternate CSA to the core set of data elements under the Balancing Incentive Program.

Streamlined Eligibility & Enrollment Requirements

Streamlining and simplifying eligibility and enrollment into Medicaid is an important focus of the Affordable Care Act. By 2014, States will upgrade their eligibility systems to process Medicaid enrollment using a simplified eligibility determination process for most non-aged, non-disabled beneficiaries, as well as support integrated eligibility determination among insurance affordability programs. We encourage States to consider the relationship between their Affordable Care Act-related system changes, and how they plan to accommodate eligibility verification and enrollment (including functional and financial eligibility) for LTSS programs.

Funding Available for Development & Implementation of NWD/SEP System & CSA

Because the increased Federal matching dollars under the Balancing Incentive Program can only be used to cover services, States will need to utilize other funding sources to cover the costs of the structural changes required to participate in the Balancing Incentive Program. 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 the Balancing Incentive Program activities. The following potential funding sources may be sources for funding NWD/SEP system development. Additional guidance on the potential use of these funds to support the Balancing Incentive Program infrastructure development will be forthcoming.

- **Medicaid Management Information Systems (MMIS):** On April 19, 2011, CMS released a final rule titled “Medicaid: Federal Funding for Medicaid Eligibility Determination and Enrollment Activities.” The rule increases the Federal matching rate for Medicaid eligibility and enrollment system development from 50 percent to 90 percent through December 2015, contingent on States meeting certain conditions and standards. The rule explicitly expanded the definition of Medicaid Management Information Systems (MMIS) activities to include eligibility determinations (eligibility determinations had previously been explicitly excluded from MMIS functions eligible for enhanced Federal Financial Participation (FFP)). The final rule can be found at <http://edocket.access.gpo.gov/2011/pdf/2011-9340.pdf>.

In order to be eligible for the enhanced MMIS match, States must meet certain standards and requirements applicable to both claims management and eligibility and enrollment procedures within MMIS. For example, both the eligibility system and the MMIS will need to process claims, communicate with providers, beneficiaries, and the public, produce transaction data and reports, and ensure coordination between Medicaid, CHIP and the Exchanges. In addition, States must build a MMIS infrastructure based on the Medicaid Information Technology Architecture (MITA) standards. A key goal of MITA is to modernize State Medicaid systems, with a focus on streamlining and simplifying enrollment, and moving away from sub-system components toward a Service Oriented Architecture. States should consider how to incorporate functional assessment, financial eligibility processing, enrollment, and key data sharing for LTSS into their transformed MMIS. It is important to note that these enrollment and eligibility systems must be in compliance with Section 504 of the Americans with Disabilities Act (ADA), which requires that individuals

with disabilities have an equal opportunity to benefit from Federally-funded programs, including those using electronic and information technology. More information about the standards and requirements are available at the link above.

- **Money Follows the Person (MFP):** Money Follows the Person was established by the Deficit Reduction Act of 2005, with a goal of helping States to balance their long-term care systems and help Medicaid enrollees 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; \$450 million for each fiscal year during 2012-2016. 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 and have been awarded \$2,095,172,282 for program efforts through 2016.

MFP funding provides increased FMAP for HCBS received by individuals transitioned from an institution into the community. As stated in the MFP application, “The increased 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.”¹

- **Aging and Disability Resource Centers Funding (ADRC):** ADRC funding, administered by the Administration on Aging (AoA), is one potential source of funding for the structural changes promoted by the Balancing Incentive Program. While the Balancing Incentive Program mission differs from the ADRC mission in some key ways, some components of the ADRC mission align with the NWD/SEP component of the Balancing Incentive Program. 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.” 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.²

In partnership with the State Unit on Aging and other ADRC operating agencies, States should be able to make a fairly straightforward case for using ADRC funding to support development of a truly statewide comprehensive NWD/SEP system under the Balancing Incentive Program, which enables consumers streamlined access to all long-term services and supports. 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. Using a single CSA statewide would support the

¹ Center for Medicare and Medicaid Services. (July 26, 2010). Initial Announcement. Invitation to Apply for 2011. Money Follows the Person Rebalancing Grant Demonstration. Funding Opportunity Number: CMS-1L1-11-001. CFDA 93.791. Retrieved January 28, 2011. <https://www.cms.gov/CommunityServices/Downloads/MFP2011SolicitationFinalJuly29RH.pdf>

² O’Shaughnessy, Carol V. (November 19, 2010). Aging and Disability Resource Centers (ADRCs): Federal and State Efforts to Guide Consumers Through the Long-Term Services and Supports Maze. National Health Policy Forum. The George Washington University.

ADRC being a true single point of entry to all LTSS in the State. ADRCs may be “users” of or partners within the NWD/SEP system under Balancing Incentive Program, and supporting the Balancing Incentive Program can help ADRCs move toward the ideal of a statewide system of access to LTSS.

In 2010, HHS 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 FY between 2010 and 2014 to ADRCs. In particular, recent ADRC funding has focused on options counseling standards to support the functions of intake, assessment, action plan development and follow-up through ADRCs, in turn improving ADRCs’ activities with regard to the Money Follows the Person initiative, and to coordinate with State Medicaid programs to help individuals leave nursing homes for community care (Department of Health and Human Services, 2010). Additional guidance on the potential use of these funds as well as others to support the Balancing Incentive Program infrastructure development will be forthcoming.

- **Other Administration on Aging (AoA) Funding:** The AoA also provides ongoing formula grants for the general implementation of their mission. Many of these grants complement and support the functions within a NWD/SEP system, even if the grants do not specifically mention ADRC (Administration on Aging website <http://www.aoa.gov/AoARoot/Grants/Funding/>).

3. Number of Grant Awards

CMS will accept only one application from each State Medicaid Agency interested in participating in the Balancing Incentive Program. CMS expects that the Medicaid agency to partner with other State agencies; however the State Medicaid agency must be the lead applicant.

The number of grant awards approved by CMS depends on the scope (i.e., proposed enrollment and scope of services) and quality of the proposed programs; however, CMS anticipates the funding level to be sufficient to support approximately 20-25 States with up to \$3 billion dollars over the life of the program.

4. Grant Program Duration and Scope

Applications for participation in the Balancing Incentive Payments Program opportunity will be accepted on an ongoing basis beginning September 1, 2011 through August 1, 2014, or until the full provision of the \$3 billion has been expended, whichever date is sooner. Funding will be awarded for the Federal Fiscal Year beginning October 1, 2011. Continued funding will be awarded on an annual basis to all participating States, contingent upon progress, through September 30, 2015, or until the full \$3 billion has been expended. To receive continued funding in subsequent years (every 12 months), grantees will be awarded through a non-competitive process contingent upon the progress of the State towards meeting the benchmarks set forth in the State’s Work Plan and detailed in the Terms and Conditions.

5. Grant Program Technical Elements

A. State Eligibility Requirements

A Balancing Incentive Program State is a State in which less than fifty percent of the total LTSS expenditures for medical assistance under the State Medicaid program for fiscal year 2009 are for non-institutionally based LTSS and which submits an application that meets the programmatic requirements and structural reforms dictated by the authorizing legislation (Section 10202 of the Affordable Care Act). Specifically, States in which 25-50 percent of the total expenditures for medical assistance under the State Medicaid program are for non-institutionally-based LTSS are eligible for a two percentage point FMAP increase. States in which less than twenty-five percent of total expenditures are for non-institutionally based LTSS are eligible for five percentage point FMAP increase.

Eligible States receiving two percentage point increase in FMAP must achieve benchmarks of fifty percent of total LTSS expenditures under the State Medicaid program for non-institutionally based LTSS, while eligible States receiving five percentage point increase in FMAP must achieve benchmarks of twenty-five percent of total LTSS expenditures under the State Medicaid program for non-institutionally based LTSS, no later than September 30, 2015. The Balancing Incentive Program State must agree to use the increased FMAP only for purposes of providing new or expanded offerings of home and community-based LTSS. States must also commit to implement key structural reforms including a no NWD/SEP system, conflict-free case management services, and a core standardized assessment instrument. Finally, the State may not restrict eligibility for LTSS more than eligibility standards, methodologies, or procedures in place as of December 31, 2010.

Conditions for Receiving Increased FMAP under the Balancing Incentive Program: In order to receive the increased FMAP for services provided to Balancing Incentive Program-participating States, grantees must demonstrate ongoing progress toward developing a statewide NWD/SEP system utilizing a CSA, and progress toward implementing conflict-free case management. Progress will be measured by each grantee meeting the milestones specified in their Work Plan; the progress towards the achievement of these milestones will be reported to CMS through a semi-annual reporting process. CMS will provide, via the Balancing Incentive Program User Manual, a set of core milestones to grantees for incorporation into the Balancing Incentive Program Work Plan. Milestones may include, but are not limited to, the following example milestones:

- Development of MOUs with SEP agencies
- Development of protocol for information & referral
- Development of a training plan for staff administering the CSA
- Identification & training of individuals to administer CSAs
- Securing a vendor or identifying an in-house group to develop the State CSA database
- Identifying provider or services agencies to serve as potential partners to administer the CSA for local individuals in areas far from a SEP agency location.

B. Defining Long-Term Services and Supports

The classification of LTSS is important for several aspects of Balancing Incentive Program implementation: determining State eligibility for Balancing Incentive Program participation; establishing the appropriate services for increased FMAP; and service reporting dictated by the authorizing legislation.

State Eligibility for Program Participation: During CMS deliberations to determine the service classifications to establish State eligibility for the Balancing Incentive Program, several issues were considered, including: State variation in service definitions for LTSS, LTSS that are provided in institutional and non-institutional settings, variation within and across States in claiming for LTSS by funding authority, and the quality and timeliness of key LTSS program and expenditure data. Using available data sources, CMS established a high-level classification of institutional and non-institutional LTSS (as defined below) to establish State eligibility for the Balancing Incentive Program. A presumptive summary of State expenditures based on data available to CMS, and Balancing Incentive Program eligibility based upon this classification, is in the Attachment C of this application.

States may provide more detailed information than included in Attachment C regarding total Medicaid expenditures for institutional and non-institutional LTSS for fiscal year 2009 for purposes of determining Balancing Incentive Program eligibility. Further, States may possess more detailed information than available on the national level and are therefore encouraged to do so. Additional data submitted by States for eligibility purposes is subject to verification by CMS. CMS will review submitted financial data and service classifications for meeting eligibility on a State by State basis. Please note, State eligibility is based on total Medicaid expenditures for LTSS and may not be based on expenditures by target populations. However, please be advised that during the Balancing Incentive Program application and implementation period, we intend to work with eligible States to establish a more robust service categorization and reporting structure.

LTSS Eligible for the Balancing Incentive Program Increased FMAP:

The applicable percentage point increase is two percent for non-institutionally-based LTSS in States in which 25-50 percent of the total expenditures for medical assistance under the State Medicaid program are for non-institutionally-based LTSS and five percentage point increase in FMAP for non-institutionally-based LTSS in States in which less than twenty-five percent of total expenditures are for non-institutionally based LTSS. The increased FMAP under Balancing Incentive Program does not apply to the FMAP determined under Section 1905(y) of the Social Security Act for newly eligible mandatory individuals.

However, CMS acknowledges that data limitations using the eligibility methodology proposed above do exist. For example, the program authorities listed below where non-institutionally-based services may actually afford services provided in institutional settings. In order to meet the legislative intent of the Balancing Incentive Program and progress beyond existing measurement limitations, CMS will work with each State to establish a mechanism to expand the Balancing Incentive Program service classification and determine how State-specific services and encounters will be mapped to the Balancing Incentive Program service classifications.

The States' claiming process for the base FMAP for LTSS will not change; those services will continue to be reported on the traditional Form CMS 64. During the Balancing Incentive Program implementation period, CMS will partner with the Balancing Incentive Program grantees to improve the quality and timeliness of data for CMS, and to make national Medicaid data more readily available to States and other stakeholders. We expect to see an evolution in the service categorization that will enrich the national portrayal of LTSS.

Balancing Incentive Program Service Categorization

Institutionally-Based Services: For purposes of Balancing Incentive Program eligibility, CMS defines institutionally-based Medicaid LTSS as services provided in:

- 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.

Non-institutionally-Based Services: 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 the institutions defined above. Non-institutionally based LTSS are provided under the following Medicaid program authorities:

- HCBS under 1915 (c) or (d) or under an 1115 Waiver;
- Home health care services;
- Personal care services;
- PACE;
- Home and community care services defined under Section 1929(a); and
- LTSS provided under managed long-term care programs authorized under Sections 1915(a) or 1915(b), including programs that do not have a co-occurring 1915(c) waiver.

There are several LTSS that were not included in the initial Balancing Incentive Program eligibility calculation due to the lack of available or sufficient data, or limited program implementation. These include, but are not limited to, State plan rehabilitation services authorized under 1905(a)(13), 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), services that may be offered under new program authorities authorized by the Affordable Care Act (Community First Choice, Health Homes, etc.). CMS will work with interested States to collect the data necessary to include other LTSS in determining each States' service eligibility for the Balancing Incentive Program increased FMAP.

C. Reporting Requirements

Work Plan: Upon application, States will submit a preliminary Work Plan. Within six months of the date of application submission, each grantee must submit a Finalized Work Plan describing in detail how the NWD/SEP utilizing a CSA and conflict-free case management will be operationalized in the State during the four year Balancing Incentive Program period. The Work

Plan must be developed by the SEP Agencies in consultation with key stakeholders. The Work Plan should include a detailed operational plan and budget for all years, which describe how the grantee plans to develop the NWD/SEP system, develop and implement use of a CSA, and what funding sources the grantee plans to utilize to develop the system. The budget should include details of the grantee's plan to expand and diversify services for non-institutional LTSS and achieve the applicable targeted spending percentage for these services, and projections of estimated LTSS expenditures through the end of the performance period. This Work Plan must also describe measurable milestones to be achieved throughout the performance period. As previously stated, CMS will provide a Work Plan template to Balancing Incentive Program grantees within the Balancing Incentive Program User Manual.

Balancing Incentive Program Reporting Requirements: The Balancing Incentive Program provision (Affordable Care Act Section 10202) describes key data to be reported under the program. Each grantee will submit an annual Data Report and Programmatic Progress Report. The Balancing Incentive Program Data Report must include data that will delineate the grantee's current standing concerning meeting the milestones specified in their Work Plan. Progress Reports will be measured based on implementing core milestones necessary to successfully implement the program prior to the end of the grant period. These include: services data from providers of non-institutional LTSS, quality data that are linked to population-specific outcomes measures and accessible to providers, and specific outcomes measures to be collected and submitted that measure beneficiary and family caregiver experience and satisfaction with providers and services. Data will also be collected on employment, participation in community life, health stability, and prevention of loss in function. During the Balancing Incentive Program implementation period, CMS will work with grantees to finalize data specifications and procedures for the approved services, quality, and outcomes measures specified in the legislation. However, if a grantee consistently and materially fails to demonstrate satisfactory progress in reaching their milestones, it will be asked to submit a Corrective Action Plan. Failure to carry out their Corrective Action Plan may result in suspension or termination for non-compliance.

All grantees will submit services data from providers of non-institutional LTSS, quality data linked to population-specific outcomes, and outcomes measures data as directed by CMS and required by the Balancing Incentive Program legislation. Data will be submitted to CMS via the reporting platform designated by CMS. Upon award, CMS will work in consultation with grantees to develop and finalize all aspects of data reporting requirements and procedures.

The quality measures are derived from: Medicaid Adult Health Quality Measures: a subset, to be determined, of the identified core set of health care quality measures as determined in the Final rule for Section 2701 of the Affordable Care Act; Medicaid Experience of Care Measures: a subset, to be determined, of the HCBS experience of care measures (Consumer Assessment of Healthcare Providers and Systems, or CAHPS); and Functional Assessment Elements Measures: a subset, TBD, of functional assessment information collected by States in their HCBS programs.

The Balancing Incentive Program grantees will not be required to submit any quality data until the beginning of calendar year (CY) 2012. Data reporting and submission requirements will be phased in, that is, after CMS completes the development of data specifications, conducts

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The Balancing Incentive Program grantees will not be required to submit any quality data until the beginning of calendar year (CY) 2012. Data reporting and submission requirements will be phased in, that is, after CMS completes the development of data specifications, conducts

necessary training, and provides guidance for the collection of data at the State and Provider level for each of the major areas of data listed above.

D. Services and Financial Reporting

All Balancing Incentive Program State grantees will submit the financial reporting form on an annual basis (see Attachment B). This form will provide projected and actual LTSS expenditures. It will allow the State and CMS to track expenditures associated with the demonstration participants. Grantees will provide CMS with their current FMAP rate, eligible increased Balancing Incentive Program percentage, and service codes used that map to those services. They will also project the cost of their LTSS services for each budget period.

II. AWARD INFORMATION

1. Amount of Funding

Section 10202 of the Affordable Care Act includes an appropriation for \$3 billion. The amount of funding for each grant approved by CMS depends on the scope (i.e., proposed enrollment and scope of services) and quality of the proposed programs; however, CMS anticipates the funding level to support between 20-25 States with \$3 billion over the life of the program.

2. Period of Performance

The grant period-of-performance begins upon application approval. Increased FMAP is available beginning October 1, 2011 through September 30, 2015.

III. ELIGIBILITY INFORMATION

1. Eligible Applicants

Applicants must be any single State Medicaid Agency. Only one application can be submitted for a given State. 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.

The CMS expects that the single State Medicaid Agency will partner with local governments, other agencies, and service providers who contribute to successful public health preventive initiatives in the State.

Applicants are strongly encouraged to include, in an appendix, letters of support indicating a history of collaboration from major partners, including consumers and advocacy groups. These

letters and memorandums of agreement should critique and substantiate the applicant's readiness to implement the structural changes.

2. Eligibility - Threshold Criteria

Applications for participation in the Balancing Incentive Payments Program opportunity will be accepted on an ongoing basis beginning [insert revised date] through August 1, 2014 or until the full provision of the \$3 billion has been projected to be expended, whichever date is earlier. However, an application will not be funded if the application fails to meet any of the requirements as outlined in Section III., Eligibility Information, and Section IV., Application Submission Information.

IV. APPLICATION AND SUBMISSION INFORMATION

1. Submission of Application and Materials

Applicants must submit their applications via email to Balancing-Incentive-Program@cms.hhs.gov.

2. Content and Form of Application Submission

Form of Application Submission

i. Cover Letter

A letter from the State Medicaid Director identifying the Medicaid agency applicant as the lead organization, indicating the title of the project, the Principal Investigator, contact person, amount of funding requested, and the name of the agency that will administer the grant under the Medicaid office and all major partners, departments, divisions, services, and organizations actively collaborating in the project is required. This letter should be addressed to:

Jennifer Burnett
Centers for Medicare & Medicaid Services
Disabled and Elderly Health Programs Group
7500 Security Boulevard
Mail Stop: S2-14-26
Baltimore, MD 21244-1850

ii. Project Abstract and Profile (maximum of one page)

The one-page abstract should serve as a succinct description of the proposed project and should include a summary of the overall project, the total budget, the State's plan for increasing the percentage of Medicaid LTSS dollars spent on community-based care, and a preliminary

timeline for completing the structural changes promoted by the Balancing Incentive Program.

iii. Preliminary Work Plan

Each State must submit a Preliminary Work Plan describing in detail how the NWD/SEP system, utilizing a CSA and conflict-free case management will be operationalized in the State during the four year Balancing Incentive Program period. The Work Plan must be developed by the SEP Agencies in consultation with key stakeholders. The Work Plan should include a detailed operational plan and budget for all years (see budget details below), which describe how the State plans to develop the NWD/SEP system, develop and implement the use of a CSA, and what funding sources the State plans to utilize to develop the system. The budget should include State projections of estimated LTSS expenditures through the end of the performance period. This Work Plan must also describe measurable milestones to be achieved throughout the performance period. A Finalized Work Plan will be due to CMS within six months of the date of application.

iv. Required Letters of Endorsement

Letters of endorsement from major partners that are not the lead agency, but will be integrally involved in developing and implementing the demonstration grant to the target population(s), are expected. Please submit all letters in support and memoranda/letters of agreement for your application in an application appendix with a table of contents for all included documents.

v. Application Narrative

The application is expected to address how the State will implement the grant program, and ultimately, meet the requirements of Section 10202 of the Affordable Care Act for the Balancing Incentive Payments Program.

The required elements (sections) of the application are listed below. Also, provided is a brief description of the type of information that is required to be addressed within each specific section. The application must be organized by these headings, noted as the operational element sections, outlined below.

In general, CMS is looking for initial plans for NWD/SEP systems, conflict-free case management, and implementation of Core Standardized Assessments in the application. CMS expects States to provide more detailed plans for each component of the NWD/SEP system in the Work Plan due six months after application. CMS will provide States with additional guidance on Balancing Incentive Program standards prior to the Work Plan deadline, including but not limited to the Balancing Incentive Program User Manual.

Required Elements

a. Understanding of Balancing Incentive Program Objectives: The State has demonstrated an understanding of and a commitment to the goals of the Balancing Incentive Program, and the concepts of a true NWD/SEP system for LTSS.

b. Current System's Strengths and Challenges: The State has provided a description of the

existing LTSS information and referral, eligibility determination, and case management processes in the State.

c. NWD/SEP Agency Partners and Roles: The State has described the designated agencies that will likely comprise the SEP Agencies and has described each agency's anticipated role in the NWD/SEP system.

d. NWD/SEP Person Flow: The State has provided an initial description of the planned "person flow" through the NWD/SEP system (i.e., the experience of the eligibility determination process from an individual's perspective, from start to finish), including how the State plans to coordinate functional and financial eligibility within the eligibility determination process and how these processes differ from the current system.

e. NWD/SEP Data Flow: The State has provided a discussion of the "data flow" within the eligibility determination process and has described where functional and financial assessment data will be housed and how they will be accessed by SEP Agencies to make eligibility determinations.

f. Potential Automation of Initial Assessment: The State has described potential opportunities for and challenges of automating the initial assessment tool via the NWD/SEP website.

g. Potential Automation of CSA: The State has described potential opportunities for and challenges of automating a CSA/functional assessment tool. Automation includes, at a minimum, real time electronic collection of functional assessment data.

h. Incorporation of a CSA in the Eligibility Determination Process: The State has described the current functional assessment instruments and processes used to determine eligibility for LTSS. Does the State currently use a single CSA for all LTSS populations? If not, how might the State incorporate a CSA into its current process? What would be the major challenges to adopting a CSA? What technical assistance might the State need to make this happen?

i. Staff Qualifications and Training: The State has discussed considerations related to staff qualifications and training for administering the functional assessment.

j. Location of SEP Agencies: The State has provided a discussion of the issue of access to physical SEP agency locations. How will the State ensure access to physical SEP agency locations? What share of the State's population is likely to live within the service area of at least one SEP? (Rough estimates are acceptable.) What will the State do to maximize the share of the State's population living within the service area of at least one SEP? How will the State arrange evaluation services for individuals who do not live within the service area of any SEPs? How will the State ensure that these physical locations are accessible by older adults and individuals with disabilities requiring public transportation?

k. Outreach and Advertising: The State has described plans for advertising the NWD/SEP system.

l. Funding Plan: The State has provided a discussion of anticipated funding sources to support the requirements of Balancing Incentive Program, including development of a NWD/SEP system and use of CSA.

m. Challenges: The State has provided a discussion of the characteristics of the State's current system of LTSS that might present barriers to rebalancing.

n. NWD/SEP's Effect on Rebalancing: The State has discussed how the NWD/SEP system will help the State achieve rebalancing goals.

o. Other Balancing Initiatives: The State has described other current initiatives in which it is currently involved that share similar goals and requirements as the Balancing Incentive Program. The State has described any more general commitment made toward rebalancing LTSS.

p. Technical Assistance: The State has described anticipated technical assistance needs to achieve rebalancing.

vi. Proposed Budget

The applicant must submit a proposed budget that details the State's plan to expand and diversify medical assistance for non-institutionally-based long-term services and supports during the balancing incentive period and achieve the target spending percentage applicable to the State. The budget should include the funding sources for the establishment of the structural changes and a description of the new or expanded offerings of such services that the State will provide and the projected costs of such services.

3. Submission Dates and Times

A. Applicant's Teleconference

Information regarding the date, time and call-in number for an open applicants' teleconference will be e-mailed to all State Medicaid Directors.

B. Grant Applications

Applications for participation in the Balancing Incentive Payments Program opportunity will be accepted on an ongoing basis beginning [insert revised date] through August 1, 2014 or until the full provision of the \$3 billion has been expended, whichever is earlier.

C. Late Applications

Late applications will not be reviewed.

D. Grant Awards Timeframe

Grants are planned to be awarded within 60 days of application.

4. Funding Restrictions

All funds awarded under the Balancing Incentive Program are for non-institutionally-based long-term services and supports only for the balancing incentive period.

5. Review and Selection Process

CMS has the authority to approve or deny any or all proposals for funding that do not meet the programmatic requirements of this funding opportunity.

VI. AWARD ADMINISTRATION INFORMATION

Award Notices

Successful applicants will receive an award letter will set forth the amount of the award and other pertinent information. The award will also include Terms and Conditions, and may also include additional “special” terms and conditions. Potential applicants should be aware that special requirements could apply to grant awards based on the particular circumstances of the effort to be supported and/or deficiencies identified in the application by the review panel.

A. Prohibited Uses of Grant Funds:

Balancing Incentive Program Grant funds may not be used for any of the following:

1. To match any other Federal funds.
2. To provide services, equipment, or supports that are the legal responsibility of another party under Federal or State law (e.g., vocational rehabilitation or education services) or under any civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.
3. To supplant existing State, local, or private funding of infrastructure or services such as staff salaries for programs and purposes other than those disclosed in the application for the Balancing Incentive Program, etc.

VII. AGENCY CONTACTS

Programmatic Content

Questions about the Balancing Incentive Program should be addressed to Balancing-Incentive-Program@cms.hhs.gov or to

Effie R. George, Ph.D.
Centers for Medicare & Medicaid Services
Disabled and Elderly Health Programs Group
7500 Security Boulevard
Mail Stop: S2-14-26
Baltimore, MD 21244-1850
Effie.George@cms.hhs.gov

VIII. ENFORCEMENT ACTIONS

A grantee's failure to comply with the terms and conditions of award may cause CMS to take one or more of the following enforcement actions, depending on the severity and duration of the non-compliance. CMS will undertake any such action in accordance with applicable statutes, regulations, and policies. CMS will afford the grantee an opportunity to correct the deficiencies before taking enforcement action. However, even if a grantee is taking corrective action, CMS may take proactive steps to protect the Federal government's interests, including placing special conditions on awards or precluding the grantee from obtaining future awards for a specified period, or may take action designed to prevent future non-compliance, such as closer monitoring.

1. Modification of the Terms and Conditions of Award

During grant performance, CMS may include special conditions in the award to require correction of identified financial or administrative deficiencies. When the special conditions are imposed, CMS will notify the grantee of the nature of the conditions, the reason why they are being imposed, the type of corrective action needed, the time allowed for completing corrective actions, and the method for requesting reconsideration of the conditions. (See 45 CFR 92.12.)

CMS may also withdraw approval of the Project Director (PD) or other key personnel if there is a reasonable basis to conclude that they are no longer qualified or competent to perform. In that case, CMS may request that the recipient designate a new PD or other key personnel. The decision to modify the terms of an award—by imposing special conditions, by withdrawing approval of the PD or other key personnel, or otherwise—is discretionary on the part of CMS.

2. Suspension or Termination

If a grantee has failed to materially comply with the terms and conditions of award or to demonstrate satisfactory progress in reaching their milestones, CMS may suspend the award or temporarily or permanently stop the payment of increased FMAP, pending corrective action, or may terminate the grant for cause. The regulatory procedures that pertain to suspension and termination are specified in 45 CFR 92.43. CMS generally will suspend (rather than immediately terminate) an award and allow the recipient an opportunity to take appropriate

corrective action before making a termination decision. CMS may decide to terminate the grant if the grantee does not take appropriate corrective action during the period of suspension.

CMS may terminate—without first suspending—the award if the deficiency is so serious as to warrant immediate termination. Termination for cause may be appealed under the HHS grant appeals procedures.

An award also may be terminated, partially or totally, by the grantee or by CMS with the consent of the grantee. If the grantee decides to terminate a portion of a grant, CMS may determine that the remaining portion of the award will not accomplish the purposes for which the award was originally awarded. In any such case, the grantee will be advised of the possibility of termination of the entire award and will be allowed to withdraw its termination request. If the grantee does not withdraw its request for partial termination, CMS may initiate procedures to terminate the entire award for cause.

Attachment A – Application Submission Checklist

- _____ State Medicaid Agency Cover Letter
- _____ Project Abstract
- _____ Letters of Agreement, Endorsements and Support
- _____ Application Narrative
- _____ Preliminary Work Plan
- _____ Proposed Budget (using the Informational Financial Reporting Form in Attachment B)

Please see Section IV *Required Contents* for detailed information on the application submission requirements.

The final work plan is due to CMS no later than six months from date of application.

Attachment B

**DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
BALANCING INCENTIVE PAYMENTS PROGRAM (Balancing Incentive Program) APPLICANT FUNDING ESTIMATES
LONG TERM SERVICES AND SUPPORTS**

State		State FMAP Rate	
Agency Name		Extra Balancing Incentive Program Portion (2 or 5 %)	
Quarter Ended			
Year of Service (1-4)			

						Projected LTSS Spending			
LTSS	Total Service Expenditures	Regular FEDERAL Portion	Regular STATE Portion	Amount Funded By Balancing Incentive Program (4 year total)	Year 1	Year 2	Year 3	Year 4	
					(A)	(B)	(C)	(D)	(E)
Case Management									
Service 1	\$0	\$0	\$0	\$0					
Service 2	\$0	\$0	\$0	\$0					
	\$0	\$0	\$0	\$0					
Homemaker									
Service 1	\$0	\$0	\$0	\$0					
Service 2	\$0	\$0	\$0	\$0					
	\$0	\$0	\$0	\$0					
Homemaker Basic									
Service 1	\$0	\$0	\$0	\$0					
Service 2	\$0	\$0	\$0	\$0					
	\$0	\$0	\$0	\$0					
Homemaker Chore services									
Service 1	\$0	\$0	\$0	\$0					
Service 2	\$0	\$0	\$0	\$0					
	\$0	\$0	\$0	\$0					
Home Health Aide									
Service 1	\$0	\$0	\$0	\$0					
Service 2	\$0	\$0	\$0	\$0					
	\$0	\$0	\$0	\$0					
Personal Care									
Service 1	\$0	\$0	\$0	\$0					
Service 2	\$0	\$0	\$0	\$0					
	\$0	\$0	\$0	\$0					
Personal care ADLs									
Service 1	\$0	\$0	\$0	\$0					
Service 2	\$0	\$0	\$0	\$0					
	\$0	\$0	\$0	\$0					
Personal Care IADLs									
Service 1	\$0	\$0	\$0	\$0					
Service 2	\$0	\$0	\$0	\$0					
	\$0	\$0	\$0	\$0					

LTSS	Total Service Expenditures	Regular FEDERAL Portion	Regular STATE Portion	Amount Funded By Balancing Incentive Program (4 year total)	Year 1	Year 2	Year 3	Year 4
	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
Personal Care Health-related								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Personal Care Adult Companion								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Personal Care PERS								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Pers. Care Assistive Technology								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Habilitation Day								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Habilitation Behavioral								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Habilitation Prevocational								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Hab. Supported Employment								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Hab. Educational Services								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Respite Care								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Day Treatment / Partial Hosp.								
Service 1	\$0	\$0	\$0	\$0				

Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				

LTSS	Total Service Expenditures	Regular FEDERAL Portion	Regular STATE Portion	Amount Funded By Balancing Incentive Program (4 year total)	Year 1	Year 2	Year 3	Year 4
	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
Psychosocial Rehabilitation								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Clinic Services								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Other HCBS Services								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
<i>(Add row for each service as named in approval letter)</i>								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Capitated HCBS Services ²								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
Health Homes								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
CFC								
Service 1	\$0	\$0	\$0	\$0				
Service 2	\$0	\$0	\$0	\$0				
	\$0	\$0	\$0	\$0				
TOTALS	\$0	\$0	\$0	\$0				
CMS MOD-Balancing Incentive Program DEMO 64i Application Form								

Attachment C

Percentage of LTSS Spending for HCBS Using FFY 2009 Data

LTSS is defined as Services Listed in the ACA, Section 10202(f)(1)* and Mental Health Facilities (including DSH). Data includes estimated expenditures for managed care (MC) long-term services and supports from FFY 2009.

Number of States Below 50%: 38

Number of States Below 25%: 1

Number of States At or Above 50%: 13

State	Nursing Facility FFS	ICF/MR FFS	MC NF and ICF/MR**	MH Facilities - Regular	MH Facilities - DSH	Total Institutional	HCBS FFS	MC HCBS**	HCBS	Percent HCBS
New Mexico	\$59,720,513	\$24,014,829	\$71,050,749	\$5,029,475	\$254,786	\$160,070,352	\$419,908,376	\$373,016,434	\$792,924,810	83.2%
Oregon	\$341,814,529	\$7,098,075		\$3,775,444	\$14,981,318	\$367,669,366	\$958,979,907		\$958,979,907	72.3%
Minnesota	\$835,049,290	\$176,405,610	\$35,987,316	\$53,639,400	\$82,060	\$1,101,163,676	\$2,164,351,802	\$166,714,270	\$2,331,066,072	67.9%
Arizona	\$33,119,468	\$0	\$442,609,336	\$1,443,268	\$28,474,900	\$505,646,972	\$9,033,182	\$1,013,604,110	\$1,022,637,292	69.3%
Vermont	\$118,215,099	\$0	-\$403,252	\$0	\$0	\$117,811,847	\$56,856,875	\$161,076,254	\$217,933,129	64.9%
Alaska	\$118,855,368	\$1,454,971		\$16,628,109	\$13,357,682	\$150,296,130	\$252,561,562		\$252,561,562	62.7%
Washington	\$582,533,776	\$156,180,487		\$24,975,999	\$120,336,661	\$884,026,923	\$1,447,943,331		\$1,447,943,331	62.1%
Colorado	\$548,943,656	\$23,440,493		\$3,898,823	\$0	\$576,282,972	\$797,996,360		\$797,996,360	58.1%
California	\$3,945,503,021	\$634,412,454	\$450,379,907	\$254,170,718	\$0	\$5,284,466,100	\$6,517,886,786	\$0	\$6,517,886,786	55.2%
Kansas	\$375,257,360	\$66,104,633		\$15,527,519	\$22,749,884	\$479,639,396	\$579,383,292		\$579,383,292	54.7%
Wisconsin	\$1,098,776,448	\$283,288,787	\$72,914,961	\$30,161,950	\$3,945,475	\$1,489,087,621	\$873,203,370	\$746,572,981	\$1,619,776,351	52.1%
Wyoming	\$72,834,891	\$17,520,919		\$30,153,861	\$0	\$120,509,671	\$124,489,528		\$124,489,528	50.8%
Washington DC	\$197,295,629	\$73,766,501		\$9,945,625	\$2,093,737	\$283,101,492	\$286,662,072		\$286,662,072	50.3%
Maine	\$254,107,927	\$63,010,003		\$52,510,334	\$51,447,476	\$421,075,740	\$405,782,955		\$405,782,955	49.1%
Montana	\$158,289,932	\$12,147,430		\$16,075,461	\$0	\$186,512,823	\$166,786,079		\$166,786,079	47.2%
Texas***	\$2,151,950,372	\$898,706,862	\$55,895	\$23,932,285	\$292,457,483	\$3,367,102,897	\$2,584,970,257	\$390,390,523	\$2,975,360,780	46.9%
New York	\$7,618,853,959	\$3,112,018,238	\$56,394,896	\$504,603,782	\$347,100,000	\$11,638,970,875	\$9,506,953,405	\$683,578,809	\$10,190,532,214	46.7%
Idaho	\$157,450,986	\$55,032,345		\$14,643,485	\$0	\$227,126,816	\$194,964,284		\$194,964,284	46.2%
Rhode Island	\$294,059,457	\$11,424,484		\$5,342,942	\$1,578,394	\$312,405,277	\$265,920,855		\$265,920,855	46.0%
Massachusetts	\$1,616,521,340	\$265,098,972	\$159,660,054	\$144,913,316	\$0	\$2,186,193,682	\$1,739,056,166	\$35,157,317	\$1,774,213,483	44.8%
Connecticut	\$1,239,838,546	\$524,279,815		\$52,752,285	\$101,160,516	\$1,918,031,162	\$1,516,168,534		\$1,516,168,534	44.1%
Utah	\$149,490,224	\$60,964,653		\$16,351,840	\$89,866	\$226,896,583	\$177,905,204		\$177,905,204	43.9%
North Carolina	\$1,287,569,396	\$511,407,803		\$84,935,419	\$149,908,784	\$2,033,821,402	\$1,530,426,971		\$1,530,426,971	42.9%
Hawaii****	\$104,752,171	\$9,911,448	\$104,752,171	\$0	\$0	\$219,415,790	\$139,073,151	\$24,245,483	\$163,318,634	42.7%
Virginia	\$769,097,900	\$283,507,550		\$137,039,082	\$7,129,293	\$1,196,773,825	\$883,322,914		\$883,322,914	42.5%
Tennessee	\$975,022,948	\$267,567,506	\$0	\$1,214,388	\$349,231	\$1,244,154,073	\$674,182,772	\$242,356,000	\$916,538,772	42.4%
Nevada	\$162,315,188	\$16,426,532		\$41,944,771	\$0	\$220,686,491	\$157,082,327		\$157,082,327	41.6%
Oklahoma	\$529,503,379	\$126,206,862		\$99,920,358	\$3,273,248	\$758,903,847	\$539,127,664		\$539,127,664	41.5%
New Hampshire	\$314,619,705	\$3,252,472		\$4,600,087	\$34,392,417	\$356,864,681	\$249,996,686		\$249,996,686	41.2%
Missouri	\$870,160,260	\$152,896,442		\$44,112,202	\$198,763,354	\$1,265,932,258	\$870,174,316		\$870,174,316	40.7%
South Dakota	\$142,270,277	\$23,336,646		\$3,649,448	\$751,299	\$170,007,670	\$115,695,916		\$115,695,916	40.5%
West Virginia	\$459,260,145	\$64,027,039		\$49,589,094	\$18,873,019	\$591,749,297	\$394,606,696		\$394,606,696	40.0%
Iowa	\$460,741,103	\$305,373,772		\$39,657,577	\$0	\$805,772,452	\$532,145,157		\$532,145,157	39.8%
Nebraska	\$317,950,416	\$66,975,809		\$44,510,525	\$8,556,063	\$437,992,813	\$273,186,838		\$273,186,838	38.4%
South Carolina	\$513,252,844	\$166,524,666		\$56,661,502	\$52,761,795	\$789,200,807	\$491,575,117		\$491,575,117	38.4%
Georgia	\$1,149,417,503	\$79,700,951		\$21,566,400	\$0	\$1,250,684,854	\$748,012,573		\$748,012,573	37.4%

Percentage of LTSS Spending for HCBS Using FFY 2009 Data										
State	Nursing Facility FFS	ICF/MR FFS	MC NF and ICF/MR**	MH Facilities - Regular	MH Facilities - DSH	Total Institutional	HCBS FFS	MC HCBS**	HCBS	Percent HCBS
Maryland	\$1,061,474,895	\$44,205,359		\$192,620,414	\$50,547,776	\$1,348,848,444	\$784,496,744		\$784,496,744	36.8%
Louisiana	\$744,256,941	\$468,057,200		\$17,816,489	\$110,557,148	\$1,340,687,778	\$767,292,107		\$767,292,107	36.4%
Delaware	\$185,844,847	\$27,903,771		\$1,176,289	\$5,853,198	\$220,778,105	\$120,014,480		\$120,014,480	35.2%
Florida	\$2,402,791,045	\$328,017,908	\$12,157,471	\$14,415,216	\$112,437,431	\$2,869,819,071	\$1,507,068,472	-\$12,157,471	\$1,494,911,001	34.2%
Michigan	\$1,534,989,618	\$3,410,277		\$21,493,058	\$141,909,300	\$1,701,802,253	\$837,890,881		\$837,890,881	33.0%
Pennsylvania	\$3,605,567,586	\$617,822,886		\$75,580,478	\$241,000,002	\$4,539,970,952	\$2,234,687,629		\$2,234,687,629	33.0%
Ohio	\$2,561,349,803	\$686,875,994		\$409,575,379	\$93,432,758	\$3,751,233,934	\$1,803,755,463		\$1,803,755,463	32.5%
Kentucky	\$827,779,576	\$100,520,929		\$50,745,362	\$37,443,075	\$1,016,488,942	\$459,366,913		\$459,366,913	31.1%
Indiana	\$1,206,919,909	\$315,550,361		\$60,141,320	\$96,145,012	\$1,678,756,602	\$740,060,814		\$740,060,814	30.6%
Arkansas	\$572,795,228	\$144,399,452		\$142,810,938	\$0	\$860,005,618	\$365,276,497		\$365,276,497	29.8%
Alabama	\$938,113,372	\$37,940,939		\$60,947,000	\$3,301,620	\$1,040,302,931	\$438,806,576		\$438,806,576	29.7%
North Dakota	\$173,635,728	\$78,192,543		\$11,961,292	\$987,735	\$264,777,298	\$107,501,966		\$107,501,966	28.9%
Illinois	\$1,631,062,689	\$545,816,762		\$96,762,565	\$111,393,766	\$2,385,035,782	\$916,517,066		\$916,517,066	27.8%
New Jersey	\$1,943,333,776	\$664,713,723		\$155,568,662	\$506,221,035	\$3,269,837,196	\$1,146,377,769		\$1,146,377,769	26.0%
Mississippi	\$727,351,102	\$277,194,524		\$61,561,997	\$0	\$1,066,107,623	\$178,917,475		\$178,917,475	14.4%

* Data does not include expenditures authorized under 1915(d), 1915(i), and only includes some expenditures authorized under 1915(j). The CMS 64 database did not clearly identify 1915(i) and 1915(j) expenditures until 2010. No states use 1915(d).

** Managed long-term care are estimates for FFY 2009 based on data provided by state staff unless otherwise noted.

*** Texas managed care data are for SFY 2009, which is from September 2007 to August 2008.

*** Hawaii MLTC data are estimates developed by Thomson Reuters based on FFS expenditures reported during the first half of FFY 2009 for NF and HCBS for older adults and people with physical disabilities. Hawaii moved these services to managed care during FY 2009 and has not yet submitted MLTC estimates for FFY 2009. During FFY 2009, reported FFS expenditures were approximately half of expenditures for previous years.

APPENDIX D: STRUCTURAL CHANGES REQUIREMENTS CHECKLIST

Requirement	Part of System?
General NWD/SEP System	
1. Individuals accessing the system experience the same process and receive the same information about community LTSS options wherever they enter the system.	<input type="checkbox"/>
2. A single eligibility coordinator, "case management system," or otherwise coordinated process guides the individual through the entire assessment and eligibility determination process, such that: <ul style="list-style-type: none"> • 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. • The eligibility determination, options counseling, and enrollment processes proceed in as streamlined and timely a manner possible. • Individuals can easily find out eligibility status and next steps. 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
NWD/SEP Network	
3. <i>NWD/SEP network</i> : State has a system of "No Wrong Door/Single Entry Point" entities that form the core of the NWD/SEP system. The Medicaid Agency is the Oversight Agency; The Medicaid Agency may delegate an Operating Agency.	<input type="checkbox"/>
4. <i>Coordinating with existing community LTSS counseling initiatives</i> : NWD/SEP network includes or at a minimum coordinates with Centers for Independent Living (CILs), Aging and Disability Resource Centers (ADRCs), Area Agencies on Aging (AAAs), and/or other entities that have been functioning as entry points to community LTSS in the State.	<input type="checkbox"/>
5. <i>Full service access points</i> : NWD/SEP network has access points where individuals can inquire about community LTSS, receive comprehensive information, eligibility determinations, and community LTSS program options counseling and enrollment assistance. If physical NWD/SEPs are provided, they must be accessible to older adults and individuals with disabilities, including consideration of access for users of public transportation.	<input type="checkbox"/>
6. <i>Ensuring a consistent experience and core set of information</i> : NWD/SEP network designs and follows standardized processes for providing information, referrals, and eligibility determinations so that individuals accessing the community LTSS 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.	<input type="checkbox"/>
7. <i>Coordinated eligibility and enrollment process</i> : The NWD/SEP network coordinates both the functional and financial assessments from start to finish, helping individuals choose among services and programs for which they are qualified after eligibility determination.	<input type="checkbox"/>

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. Clinical or non-financial eligibility determination is separated from direct service provision.	<input type="checkbox"/>
19. Case managers and evaluators of the beneficiary’s need for services are not related by blood or marriage to the individual; to any of the individual’s paid caregivers; or to anyone financially responsible for the individual or empowered to make financial or health-related decisions on the beneficiary’s	<input type="checkbox"/>

Requirement	Part of System?
behalf.	
20. There is robust monitoring and oversight.	
21. Clear, well-known, and accessible pathways are established for consumers to submit grievances and/or appeals to the managed care organization or State for assistance regarding concerns about choice, quality, eligibility determination, service provision and outcomes.	<input type="checkbox"/>
22. Grievances, complaints, appeals and the resulting decisions are adequately tracked, monitored and used.	<input type="checkbox"/>
23. State quality management staff oversees clinical or non-financial program eligibility determination and service provision business practices to ensure that consumer choice and control are not compromised.	<input type="checkbox"/>
24. State quality management staff track and document consumer experiences with measures that capture the quality of care coordination and case management services.	<input type="checkbox"/>
25. In circumstances when one entity is responsible for providing case management and service delivery, appropriate safeguards and firewalls exist to mitigate risk of potential conflict.	<input type="checkbox"/>
26. Meaningful stakeholder engagement strategies are implemented which include beneficiaries, family members, advocates, providers, State leadership, managed care organization leadership and case management staff.	<input type="checkbox"/>

APPENDIX E: INSTRUCTIONS FOR COMPLETING THE WORK PLAN

Six months after submitting their applications for the Balancing Incentive Program, States are required to submit a Work Plan, consisting of:

1. A completed **Work Plan Table Template**, found below. The Work Plan Table Template includes a series of interim tasks necessary for achieving the structural change requirements, deliverables that demonstrate the completion of each interim task, and due dates for deliverable submission.
2. Several **initial deliverables**, highlighted in grey in the Work Plan Table Template.
3. **Companion text for each interim task**. Specifically, the State should describe the current status of the task, experienced or anticipated challenges to completing this task, and the State's plans to address these challenges. Space to provide this companion text can be found along with detailed deliverable descriptions after the Work Plan Table Template.

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 September 30, 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/resources/work-plan>) contains additional information on developing the Work Plan, including user-friendly 508 compliant templates in Word and Excel.
- 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 Insurance Exchange IT system.
2. *Major Objective/Interim Tasks*: Within each category, we indicate major objectives and the tasks required to complete these objectives. While States may modify interim tasks, they should be prepared to explain any substantial deviations from the Template. We provide a detailed description of each task outlined in the Work Plan Table Template after the table.
3. *Suggested Due Date*: We have suggested a date by which each deliverable associated with an interim task should be completed and submitted to CMS. The suggested due dates refer to the number of months from the time of the Work Plan submission. They also correspond to the dates when quarterly Progress Reports will be submitted. In other words, States will submit

subsequent deliverables with their quarterly Progress Reports. While States may modify these dates, they should be prepared to explain any substantial deviations from the Template. States should replace the number of months from Work Plan submission with an actual date.

4. *Lead Person*: To support Work Plan implementation, the State should indicate which staff person in each agency is responsible for leading each 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*: Information in this column describes the content of the deliverable the State is expected to submit.

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	Suggested Due Date (from time of Work Plan submission)*	Lead Person	Status of Task	Deliverables
General NWD/SEP Structure	1. All individuals receive standardized information and experience the same eligibility determination and enrollment processes.				
	1.1. Develop standardized informational materials that NWD/SEPs provide to individuals	3 months			Informational materials
	1.2. Train all participating agencies/staff on eligibility determination and enrollment processes	18 months			Training agenda and schedule
	2. 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. <i>(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 to put into place.)</i>				
	2.1. Design system (initial overview)	0 months (submit with Work Plan)			Description of the system
	2.2. Design system (final detailed design)	6 months			Detailed technical specifications of system
	2.3. Select vendor (if automated)	12 months			Vendor name and qualifications
	2.4. Implement and test system	18 months			Description of pilot roll-out
	2.5. System goes live	24 months			Memo indicating system is fully operational
	2.6. System updates	Semiannual after 24 months			Description of successes and challenges
NWD/SEP	3. State has a network of NWD/SEPs and an Operating Agency; the Medicaid Agency is the Oversight Agency.				
	3.1. Identify the Operating Agency	0 months (submit with Work Plan)			Name of Operating Agency
	3.2. Identify the NWD/SEPs	0 months (submit with Work Plan)			List of NWD/SEP entities and locations
	3.3. Develop and implement a Memorandum of Understanding (MOU) across agencies	3 months			Signed MOU
	4. 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.				

Category	Major Objective / Interim Tasks	Suggested Due Date (from time of Work Plan submission)*	Lead Person	Status of Task	Deliverables
	4.1. Identify service shed coverage of all NWD/SEPs	3 months			Percentage of State population covered by NWD/SEPs
	4.2. Ensure NWD/SEPs are accessible to older adults and individuals with disabilities	9 months			Description of NWD/SEP features that promote accessibility
Website	5. The NWD/SEP system includes an informative community LTSS website; Website lists 1-800 number for NWD/SEP system.				
	5.1. Identify or develop URL	3 months			URL
	5.2. Develop and incorporate content	6 months			Working URL with content completed
	5.3. Incorporate the Level I screen into the website (<i>recommended, not required</i>)	18 months			Working URL of Level I screen and instructions for completion
1-800 Number	6. 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.				
	6.1. Contract 1-800 number service	6 months			Phone number
	6.2. Train staff on answering phones, providing information, and conducting the Level I screen	6 months			Training materials
Advertising	7. State advertises the NWD/SEP system to help establish it as the “go to system” for community LTSS				
	7.1. Develop advertising plan	3 months			Advertising plan
	7.2. Implement advertising plan	6 months			Materials associated with advertising plan
CSA/CDS	8. 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 (a Core Data Set of required domains and topics).				
	8.1. Develop questions for the Level I screen	6 months			Level I screening questions
	8.2. Fill out CDS crosswalk (see Appendix H in the Manual) to determine if your State’s current assessments include required	0 months (submit with Work Plan)			Completed crosswalk(s)

Category	Major Objective / Interim Tasks	Suggested Due Date (from time of Work Plan submission)*	Lead Person	Status of Task	Deliverables
	domains and topics				
	8.3. 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
	8.4. Train staff members at NWD/SEPs to coordinate the CSA	12 months			Training materials
	8.5. Identify qualified personnel to conduct the CSA	12 months			List of entities contracted to conduct the various components of the CSA
	8.6. Regular updates	Semiannual after 12 months			Description of success and challenges
Conflict-Free Case Management	9. <u>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.</u>				
	9.1. Describe current case management system, including conflict-free policies and areas of potential conflict	0 months (submit with Work Plan)			Strengths and weaknesses of existing case management system
	9.2. Establish protocol for removing conflict of interest	9 months			Protocol for conflict removal; if conflict cannot be removed entirely, explain why and describe mitigation strategies
Data Collection and Reporting	10. <u>States must report service, outcome, and quality measure data to CMS in an accurate and timely manner.</u>				
	10.1. Identify data collection protocol for <i>service data</i>	0 months (submit with Work Plan)			Measures, data collection instruments, and data collection protocol
	10.2. Identify data collection protocol for <i>quality data</i>	0 months (submit with Work Plan)			Measures, data collection instruments, and data collection protocol
	10.3. Identify data collection protocol for <i>outcome measures</i>	0 months (submit with Work Plan)			Measures, data collection instruments, and data collection protocol
	10.4. Report updates to data collection protocol and instances of <i>service data</i> collection	Semiannual**			Document describing when data were collected during previous 6-month period, plus updates to protocol
	10.5. Report updates to data collection protocol and instances of <i>quality data</i> collection	Semiannual**			Document describing when data were collected during previous 6-month period, plus updates to protocol

Category	Major Objective / Interim Tasks	Suggested Due Date (from time of Work Plan submission)*	Lead Person	Status of Task	Deliverables
	10.6. Report updates to data collection protocol and instances of <i>outcomes measures</i> collection	Semiannual**			Document describing when data were collected during previous 6-month period plus updates to protocol
Sustainability	11. <u>States should identify funding sources that will allow them to build and maintain the required structural changes.</u>				
	11.1. Identify funding sources to implement the structural changes	0 months (submit with Work Plan)			Description of funding sources
	11.2. Develop sustainability plan	12 months			Funding sources and estimated annual budget necessary to maintain structural changes after award period ends.
	11.3. Describe the planned usage for the enhanced funding	0 months (submit with Work Plan)			Description of how the State will use the enhanced funding earned through the program. Detail how these planned expenditures: 1. Increase offerings of or access to non-institutional long-term services and supports; 2. Are for the benefit of Medicaid recipients; and 3. Are not a prohibited use of Medicaid funding.
Exchange IT Coordination	12. <u>States must make an effort to coordinate their NWD/SEP system with the Health Insurance Exchange IT system.</u>				
	12.1. Describe plans to coordinate the NWD/SEP system with the Health Insurance Exchange IT system	6 months			Description of plan of coordination
	12.2. 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.

1. All individuals receive standardized information and experience the same eligibility determination and enrollment processes.

- 1.1. *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.
- 1.2. *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.

2. A single eligibility coordinator, “case management system,” or otherwise coordinated process guides the individual through the entire functional and financial eligibility determination process.

- 2.1. *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.
- 2.2. *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.
- 2.3. *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).
- 2.4. *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.

- 2.5. *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.
 - 2.6. *System updates:* After the system goes live, States should submit a brief semiannual report describing the successes and challenges associated with the system.
- 3. State has a system of NWD/SEPs and an Operating Agency; the Medicaid Agency is the Oversight Agency.**
- 3.1. *Identify the Operating Agency:* The name of this agency should be included in the initial description of the NWD/SEP system.
 - 3.2. *Identify the NWD/SEPs:* The names of the entities and their locations should be included in the initial description of the NWD/SEP system.
 - 3.3. *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](#).
- 4. 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.**
- 4.1. *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.
 - 4.2. *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.
- 5. The NWD/SEP system includes an informative community LTSS website; Website lists 1-800 number for NWD/SEP network.**
- 5.1. *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.
 - 5.2. *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.
 - 5.3. *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.

6. **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.**
 - 6.1. *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.
 - 6.2. *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.
7. **State advertises the NWD/SEP system to help establish it as the “go to system” for community LTSS**
 - 7.1. *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.
 - 7.2. *Implement advertising plan:* To indicate that the advertising plan has been implemented, States should submit related materials, such as posters and pamphlets.
8. **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).**
 - 8.1. *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.
 - 8.2. *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.
 - 8.3. *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.
 - 8.4. *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.

- 8.5. *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.
- 8.6. *Continual updates:* After the implementation of the CSA, States should submit brief semiannual reports with successes and challenges associated with the CSA.
- 9. 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.**
- 9.1. *Describe current case management system.* This description should include policies that encourage conflict-free case management, in addition to areas of potential conflict.
- 9.2. *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.
- 10. 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.
- 11. States should identify funding sources that will allow them to build and maintain the required structural changes.**
- 11.1. *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.
- 11.2. *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.
- 11.3. *Describe the planned usage for the enhanced funding.* The State must identify the projected amount of funding to be earned through the Program and describe how the State will use this enhanced funding by September 30, 2015. The State should also describe how the planned expenditures meet the following criteria: 1. Increase offerings of or access to non-institutional long-term services and supports; 2. Are for the benefit of Medicaid recipients; and 3. Are not a prohibited use of Medicaid funding.
- 12. States must make an effort to coordinate their NWD/SEP system with the Health Insurance Exchange IT system.**
- 12.1. *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.

12.2. *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>.

**Memorandum of Agreement
Between the
Florida Department of Elder Affairs
and the
Agency for Persons with Disabilities
Regarding Aging and Disability Resource Centers**

I. Parties To The Agreement

The parties to this memorandum are the Florida Department of Elder Affairs (DOEA) and the Agency for Persons with Disabilities (APD).

II. Purpose

The purpose of this Memorandum of Agreement (MOA) is to set forth the roles and responsibilities of each party in the development, implementation, operation and evaluation of the Aging and Disability Resource Center (ADRC) projects in the St. Petersburg and Fort Myers areas as they relate to the expansion of services to persons with developmental disabilities.

III. Summary of the Aging and Disability Resource Centers Initiative

In 2004, the Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) awarded a grant to DOEA to develop and implement the ADRC initiative in Florida. Three of the state's eleven Area Agencies on Aging (AAAs) were designated as ADRCs to provide a single, coordinated system for all persons seeking long-term care resources through multiple entry points, ensuring consistent information and referral and streamlined access to public and private long-term care services. In addition to elders and their caregivers, the ADRC sites, established in PSA 5 (St. Petersburg area), PSA 7 (Orlando area) and PSA 10 (Broward County), also serve individuals with severe and persistent mental illness (SPMI).

In conjunction with the AoA/CMS ADRC grant award, the Florida Legislature passed legislation, creating Aging Resource Centers (ARCs). This laid the groundwork for each of the other eight AAAs to transition to an ARC. The ARCs operate the same as the ADRCs, but are not required to serve a targeted disability population.

In 2009, AoA awarded a grant to DOEA for a proposal, developed in collaboration with the Agency for Persons with Disabilities (APD) to implement an ADRC expansion project. The project expands the disability population served by the St. Petersburg ADRC to include persons with developmental disabilities and transitions the Ft. Myers ARC to a fully functioning ADRC by adding services to persons with developmental disabilities. The ADRC will provide information and referral assistance regarding aging, developmental disabilities, and long-term care resources and "no wrong door" access to designated ADRC long-term care and financial assistance programs for elders, persons with developmental disabilities and their caregivers. The ADRC will not replace any role or responsibility of the state or local offices of the Agency for Persons with Disabilities or developmental disabilities service providers.

The goal for the designated two ADRC pilot sites is to begin serving persons with developmental disabilities by September 30, 2010.

IV. Specific Roles and Responsibilities Related to this Memorandum of Agreement

Under this MOA, the parties agree to collaborate, as specified in this section, on the development, implementation, operation, monitoring and evaluation of the ADRC initiative in serving persons with developmental disabilities.

DOEA agrees to:

1. Assign an employee(s) as a point of contact for the APD regarding the ADRC initiative.
2. Dedicate appropriate and adequate staff and resources to support and facilitate the development, implementation and on-going operation of the ADRC initiative in meeting its objective of serving persons with developmental disabilities.
3. Include APD staff in the ADRC Statewide Advisory Council and other relevant workgroups, as well as the inclusion of developmental services stakeholders identified by APD to participate in workgroups and related activities.
4. Include APD staff in other appropriate activities related to ADRC development, implementation, operations, monitoring and evaluation.
5. Educate the APD staff on the purpose, goals, requirements, and functions of an ADRC and the system in which it will operate, with specific emphasis on serving the target population of persons with developmental disabilities.
6. Assist the APD in informing and educating its Local Offices of their role and responsibilities related to the ADRC initiative.
7. Provide technical assistance and oversight to each ADRC, in consultation with the APD, in developing and establishing a memorandum of understanding with their respective APD Local Office.
8. Collaborate with the APD to develop protocols to ensure the establishment of a comprehensive and current statewide and locally specific developmental disabilities resource database that will be part of the ADRC information and referral system.
9. Collaborate with the APD to ensure appropriate and adequate protocols and operating systems are adopted or developed by the local ADRC partners, for accepting, handling and processing inquiries made by or on behalf of the target population(s) for access to developmental disabilities resources and/or the aging and long-term care systems.
10. Incorporate developmental disabilities resources and linkages into the ADRC Information and Referral (I&R) protocols and database.
11. Provide support and technical assistance to ADRCs, in consultation with the APD, in developing training curriculum and materials relevant to serving persons with developmental disabilities.

12. Coordinate and schedule regular meetings with the APD staff and designated stakeholders regarding the ADRC.

13. Collaborate with the APD when developing data protocols, required by the ADRC grantor, to evaluate the initiative in reference to serving persons with developmental disabilities.

APD agrees to:

1. Assign an employee(s) from APD as a point of contact for DOEA regarding the ADRC initiative.

2. Ensure collaboration of its staff and that of the respective Local Office in each of the pilot sites to develop, implement and support the on-going operation of the ADRC activities relevant to persons with developmental disabilities.

3. Identify stakeholders serving the target population, within its network, essential to the development, implementation and/or operations of the ADRC initiative.

4. Ensure the participation of the APD staff in the ADRC Statewide Advisory Council and other relevant workgroups, as well as facilitating the participation of APD Local Offices and other stakeholders identified by APD to participate in workgroups and related activities.

5. Ensure the APD staff and the designated Local Offices participate in ADRC activities related to development, implementation, operations, monitoring and evaluation. Facilitate the participation, as appropriate, of developmental disability providers and other stakeholders.

6. Advise DOEA staff regarding developmental disability providers, stakeholders and resources.

7. Support DOEA in educating and providing technical assistance to the Local Offices and other developmental disability stakeholders regarding the ADRC initiative.

8. Provide technical assistance and oversight to each Local Office, in consultation with DOEA, in developing and establishing a memorandum of understanding with their respective ADRC.

9. Collaborate with DOEA in its efforts to establish a comprehensive and current statewide and locally specific developmental disability resource database that will be part of the ADRC web-based information and referral system.

10. Encourage developmental disability providers to include aging and long-term care resources and linkages in their information and referral (I&R) protocols and databases.

11. Consult with DOEA in developing a training curriculum and materials relevant to serving persons with developmental disabilities.

12. Participate in meetings with DOEA staff and its partners regarding the ADRC initiative.

13. Collaborate with DOEA in its efforts to develop data protocols, required by the ADRC grantor, to evaluate the initiative in reference to serving persons with developmental disabilities.

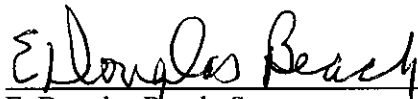
V. Confidentiality

Both parties shall protect the confidentiality of information obtained or accessed in the implementation of the MOA. The use of confidential information is confined to the activities that are essential for the purpose of the MOA. Client information must be protected in accordance with the state and federal laws governing the programs and with the federal Health Insurance Portability and Accountability Act (HIPAA). If it is determined that the relationship between the parties to this memorandum of understanding requires the sharing of data information defined in HIPAA as personal health information, a Business Associate Agreement will be executed.

VI. Terms of Memorandum

The MOA shall become effective with the signatures of the Department of Elder Affairs Secretary or designee and the Agency for Persons with Disabilities Director or designee and will continue unless terminated by either party in writing. The MOA may be amended as deemed necessary and agreed to by the signing parties.


VII. Signatures



E. Douglas Beach, Secretary
Department of Elder Affairs

4/9/10

Date Signed



Jim DeBeaugrine
Agency for Persons with Disabilities

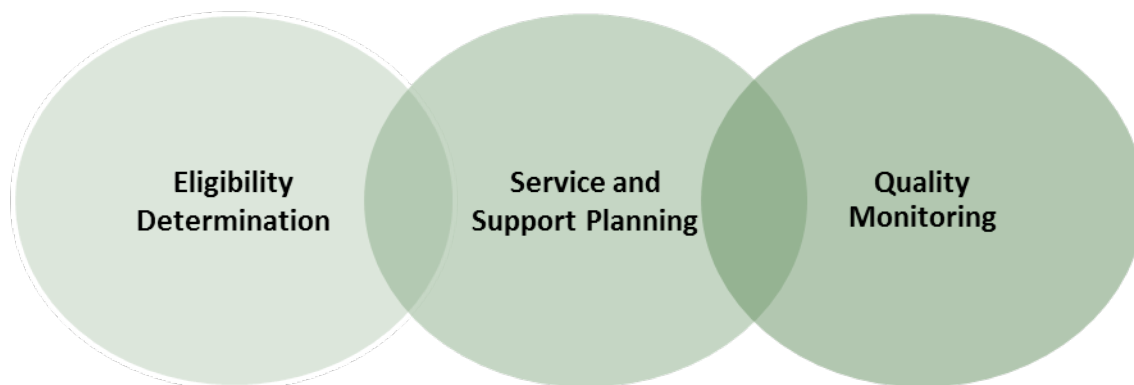
3/29/10

Date Signed

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.¹⁰

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.¹¹

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

¹⁰ More information may be found at:

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

¹¹ 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.¹²

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.¹³

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).¹⁴

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.¹⁵

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

¹² More information can be found at: http://www.adrc-tae.org/tiki-download_file.php?fileId=26933

¹³ More information can be found at: <http://www.dmas.virginia.gov/downloads/forms/UAI.pdf>

¹⁴ More information can be found at:

http://www.hcbs.org/moreInfo.php/type_tool/147/ofs/80/doc/1129/Comprehensive_Assessment_Reporting_Evaluation_CAR

¹⁵ More information can be found at: <http://www.dhs.wisconsin.gov/lcicare/FunctionalScreen/>

instrument. CARE contains a variety of questions that measure functional capabilities and limitations (e.g., activities of daily living).¹⁶

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.¹⁷

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.¹⁸

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.¹⁹

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.²⁰

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

¹⁶ More information can be found at: <http://www.pacdemo.rti.org/meetingInfo.cfm?cid=caretool>

¹⁷ More information can be found at: <http://icaptool.com/>

¹⁸ More information can be found at: https://www.cms.gov/NursingHomeQualityInits/30_NHOIMDS30TechnicalInformation.asp#TopOfPage

¹⁹ More information can be found at: <http://www.interrai.org/section/view/?fnode=15>

²⁰ 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.²¹

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 populations²².

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.

²¹ More information can be found at: <http://www.siswebsite.org/>

²² ADRCs are a collaborative effort between the Administration for Community Living (ACL) 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	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>

The screenshot displays the Arizona Department of Economic Security (AZDES) website. At the top, there is a navigation bar with links for 'Basic Needs', 'Child & Family', 'Seniors', 'Disabilities', 'Employment', and 'Online Services'. The main header features the AZ.GOV logo and the text 'ARIZONA DEPARTMENT OF ECONOMIC SECURITY'. Below the header, a search bar is visible. The left sidebar contains a menu with various service categories such as 'AZ Links Home', 'Screening Tool', 'Featured Topics', 'Arizona Events', 'About AZ Links', 'Important Phone Numbers', 'Options Counselor', 'Disability Resources', 'Employment & Civic Engagement', 'Financial & Legal', 'Health', 'Home & Community', 'Partners', 'Frequently Asked Questions', 'Contact AZ Links', and 'AZ Links Website Feedback'. The main content area is titled 'Arizona Links Screening Tool for Yuma County Residents'. It includes a sub-header with 'THE AZ LINKS SCREENING TOOL' logo and a brief explanation of the tool's purpose. Below this, there is a section for assistance contact information. The form itself consists of nine numbered questions, each with multiple-choice or checkbox options. Question 1 asks for the primary reason for filling out the tool. Question 2 asks if the user has contacted the WACOG AAA before. Question 3 asks for the type of information or care sought. Question 4 asks for the zip code or location. Question 5 asks for the date of birth of the person identified. Question 6 asks for assistance with various tasks, including bathing, eating, communicating, dressing/grooming, medication reminders, mobility, toileting, and transferring. Question 7 asks for assistance with household chores like cooking, housekeeping, money management, shopping, telephone calls, and transportation. Question 8 asks about the current care situation, including periods of more than 24 hours when left alone, unmet care needs, socialization opportunities, family visits, memory loss, grief, falling, depression, and sufficient care. Question 9 asks for the most pressing needs, listing a wide range of services from housekeeping to skilled nursing care.

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



Oregon Helps!

[Home](#) [About](#) [Prescreener](#) [Programs](#) [Local Resources](#) [What to Bring](#)

4%

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>

VirginiaNavigator
for EASY ACCESS

Powered by SeniorNavigator

Text Size:  

Home » Virginia Navigator

- 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: 3.0.0.7

MEMBER PROVIDER ACCESS

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.L...

- 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"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<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"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<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"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<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"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<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"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<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"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<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"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<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"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<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"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<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	<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: 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	<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	
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	<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	
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	<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: 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	<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	
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	<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	
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	<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: 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"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<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"/> Eligibility Determination <input type="checkbox"/> ID of Support Needs <input type="checkbox"/> Inform Support Planning	<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	
	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"/> 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 NA <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	
	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"/> 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-based²³, 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.

²³ 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. Eating (Source: MNChoices -Minnesota) Do you have any difficulties with eating or require support or assistance with eating? <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? <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? <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? <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? <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? <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>

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: 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—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) 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 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 6 TOTAL DEPENDENCE—Full performance of activity by another 8 ACTIVITY DID NOT OCCUR (regardless of ability) 9 UNABLE TO PERFORM ADL Difficulty Code: How difficult it is (or would it be) for individual to do activity on own 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>6. Mobility (Source: New York COMPASS – Comprehensive Assessment for Aging Network Community-Based Long Term Care Services) What can the person do? 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. Check if assistance is/will be provided by: <input type="checkbox"/> Informal supports <input type="checkbox"/> Formal supports Comments: Describe parts of tasks to be done and responsibilities of informal supports and formal supports. _____ _____ _____</p>
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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) <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 PP Current PRIVATELY PAID caregiver will continue PF Current PUBLICLY FUNDED paid caregiver will continue 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. Understandable 2. Usually understandable 3. Sometimes understandable 4. Rarely or never understandable 	<p>Ability to understand other verbal information, however able.</p> <ol style="list-style-type: none"> 1. Understandable 2. Usually understandable 3. Sometimes understandable

SAMPLE QUESTIONS WITHIN EACH DOMAIN & TOPIC (continued)

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

<p>1. Preparing Meals (Source: Supports Intensity Scale)</p> <p>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>2. Shopping (Source: MN Choices)</p> <p>Do you need assistance with shopping? <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 shop and purchase goods and services? <input type="checkbox"/> Assistance with Setup/Arrangements <input type="checkbox"/> Minimal Assistance <input type="checkbox"/> Moderate Assistance <input type="checkbox"/> Substantial Assistance <input type="checkbox"/> Full Support</p> <p>With support, what level of difficulty does this individual experience procuring goods and services? <input type="checkbox"/> No difficulty <input type="checkbox"/> Some difficulty <input type="checkbox"/> Great difficulty</p> <p>Summary: When purchasing goods and services, this individual: <input type="checkbox"/> Needs no help or supervision <input type="checkbox"/> Sometimes needs assistance or occasional supervision <input type="checkbox"/> Often needs assistance or constant supervision <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 <input type="checkbox"/> 1b Person drives adapted vehicle <input type="checkbox"/> 1c Person drives regular vehicle, but there are serious safety concerns <input type="checkbox"/> 1d Person drives adapted vehicle, but there are serious safety concerns <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). <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. <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. <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. <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)</p> <p>___ 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</p> <p>1. SOME HELP- help some of the time</p> <p>2. FULL HELP- performed with help all of the time</p> <p>3. BY OTHERS- performed by others</p> <p>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</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 involvement in the activity is possible</p> <p>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</p> <p><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</p> <p><input type="checkbox"/> Assistance Required</p> <p><input type="checkbox"/> Must be administered</p> <p>How often does this individual require medications?</p> <p><input type="checkbox"/> Several times daily</p> <p><input type="checkbox"/> Daily</p> <p><input type="checkbox"/> 2-6 days a week</p> <p><input type="checkbox"/> Weekly</p> <p><input type="checkbox"/> Every two weeks</p> <p><input type="checkbox"/> Monthly</p> <p><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</p> <p><input type="checkbox"/> Doesn't take medications</p> <p><input type="checkbox"/> Needs medication setup only</p> <p><input type="checkbox"/> Needs visual or verbal cues only</p> <p><input type="checkbox"/> Needs medication setups and reminders</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</p> <p><input type="checkbox"/> No</p> <p><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</p> <p><input type="checkbox"/> Competitive – with job supports/coaching</p> <p><input type="checkbox"/> Self-employment – without job support</p> <p><input type="checkbox"/> Self-employment – with job support</p> <p><input type="checkbox"/> Supported work in an enclave/group/ crew setting</p> <p><input type="checkbox"/> Center-based sheltered employment/ activity</p> <p><input type="checkbox"/> Volunteer activity - describe: _____</p> <p><input type="checkbox"/> Educational program - describe: _____</p> <p><input type="checkbox"/> Training program – describe: _____</p> <p><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> <p><input type="checkbox"/> Finding a volunteer work opportunity</p> <p><input type="checkbox"/> Obtaining more education or training</p> <p>Would you like to look for another opportunity?</p> <p><input type="checkbox"/> Yes</p>

<input type="checkbox"/> Needs medication setups and administration	<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)

- No
- 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

<p>1. Injurious behaviors (Source: Supports Intensity Scale) How much support is needed for the prevention of self-injury? <input type="checkbox"/> No support needed <input type="checkbox"/> Some support needed <input type="checkbox"/> Substantial support needed How much support is needed for the prevention of assault or injury to others? <input type="checkbox"/> No support needed <input type="checkbox"/> Some support needed <input type="checkbox"/> Substantial support needed How much support is needed for the prevention of sexual aggression? <input type="checkbox"/> No support needed <input type="checkbox"/> Some support needed <input type="checkbox"/> Substantial support needed</p>	<p>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)? <input type="checkbox"/> No support needed <input type="checkbox"/> Some support needed <input type="checkbox"/> Substantial support needed</p>
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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#IUMP
- 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: BALANCING BENCHMARK TRACKER

CMS has developed an Excel template – the Balancing Benchmark Tracker – to help States track the enhanced FMAP and their progress toward meeting the benchmark. This Excel template can be found here: <http://www.balancingincentiveprogram.org/resources/balancing-benchmark-tracker>.

State				State FMAP Rate	50.00%			
Agency Name				Extra Balancing Incentive Program Portion (2 or 5 %)	2.00%			
Quarter Ended				INSTRUCTIONS: PLEASE COMPLETE ONLY THE NON-SHADED CELLS - BLUE CELLS WILL AUTO-CALCULATE.				
Year of Service (1-4)	FFY 2012 - FFY 2015			Projected LTSS Spending				
LTSS	Total Service Expenditures	Regular FEDERAL Portion	Regular STATE Portion	Amount Funded By Balancing Incentive Program (4 year total)	Year 1 FFY 2012	Year 2 FFY 2013	Year 3 FFY 2014	Year 4 FFY 2015
	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
Case Management								
Total								
Homemaker								
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Homemaker Basic								
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Homemaker Chore Services								
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Home Health Aide								
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Personal Care								
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Personal Care ADLs								
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Personal Care IADLs								
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Personal Care Health-Related								
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Personal Care Adult Companion								
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Personal Care PERS								
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Pers. Care Assistive Technology								
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Habilitation Day								
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Habilitation Behavioral								
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Habilitation Prevocational								
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Hab. Supported Employment								
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Hab. Educational Services								
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Respite Care								
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Day Treatment / Partial Hosp.								
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Psychosocial Rehabilitation								
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Clinic Services								
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Other HCBS Services								
Service 1	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Service 2	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Service 3	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Health Homes								
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
CFC								
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Money Follows the Person*								
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TOTALS*	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Tab 1 of the Balancing Benchmark Tracker:

Input State FMAP rate and percentage of enhanced FMAP from the Program.

Input projected community LTSS expenditures for the years of the Program.

The blue cells will auto-calculate.

*MFP does not receive enhanced FMAP through BIP, but the expenditures do count towards the state's target spending of 50% or 25%.

*Total for Federal and State share for MFP reflect regular state share; does not calculate MFP enhanced FMAP.

Tab 2 of the Balancing Benchmark Tracker

Input actual community – LTSS expenditures for each year of the Program. The blue cells will auto-calculate

Balancing Incentive Payment Program		INSTRUCTIONS: PLEASE COMPLETE ONLY THE NON-SHADED CELLS - BLUE CELLS WILL AUTO-CALCULATE.						
LTSS Expenditure Trends		Actual			Projected			
	FFY 2009	FFY 2010	FFY 2011	FFY 2012	FFY 2013	FFY 2014	FFY 2015	
<u>Non-Institutional Expenditures</u>								
Non-Institutional LTSS Total	\$ 100,000	\$ 100,000	\$ 100,000	\$ -	\$ -	\$ -	\$ -	
<u>Institutional Expenditures</u>								
Institutional LTSS Total	\$ 200,000	\$ 200,000	\$ 200,000	\$ 200,000	\$ 200,000	\$ 200,000	\$ 200,000	
Total LTSS	\$ 300,000	\$ 300,000	\$ 300,000	\$ 200,000	\$ 200,000	\$ 200,000	\$ 200,000	
% Non-Institutional	33.33%	33.33%	33.33%	0.00%	0.00%	0.00%	0.00%	
% Institutional	66.67%	66.67%	66.67%	100.00%	100.00%	100.00%	100.00%	

APPENDIX M: GLOSSARY OF ACRONYMS

- AAA – Area Agencies on Aging
- AAIDD – American Association on Intellectual and Developmental Disabilities
- ACCEL – Access El Dorado
- ACL – Administration for Community Living
- ADA – Americans with Disabilities Act
- ADL – Activity of Daily Living
- ADP – Advanced Planning Document
- ADRC – Aging and Disability Resource Center
- 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 N: 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>.