

Uniform Assessment Practices in Medicaid Managed Long-Term Services and Supports Programs

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State Medicaid agencies are increasingly shifting away from fragmented, fee-for-service delivery systems toward more coordinated, cost-effective managed long-term services and supports (MLTSS) programs. By 2014, it is expected that over 50 percent of states will have an MLTSS program.¹ With the shift toward MLTSS, many states are struggling with how best to assess beneficiaries' service and support needs in a fair, consistent, and comprehensive manner. Creating more uniform assessment tools and related managed care organization (MCO) contract requirements drives many internal discussions and is a priority for beneficiaries, providers, and advocacy groups as well.

With support from The SCAN Foundation, the Center for Health Care Strategies (CHCS) interviewed five states with established MLTSS programs: **Arizona, Minnesota, Tennessee, Texas,** and **Wisconsin** to identify what uniform assessment tools are available, how they are administered, and considerations for further development and implementation. These states were chosen based on the strength, experience, and diversity of their MLTSS programs. Medicaid staff in each state recommended a representative MLTSS MCO for additional interviews to obtain their perspectives regarding implementation of uniform assessment tools and practices. Drawing from all of these interviews, this brief outlines five key considerations for states planning to implement a uniform assessment tool for MLTSS programs or for an integrated Medicare-Medicaid initiative: (1) creating flexibility in MCO contracts; (2) setting realistic expectations for data reporting; (3) building strong state-MCO relationships; (4) establishing meaningful stakeholder engagement; and (5) aligning Medicare and Medicaid requirements.

The focus of this paper is primarily on *uniform assessment* tools (commonly referred to as comprehensive assessments) that identify service needs for establishing plans of care rather than *functional assessment* tools administered to determine level of

IN BRIEF

Uniform assessment of individuals served through Medicaid managed long-term services and supports (MLTSS) programs is designed to ensure that beneficiaries' needs are appropriately identified and services are equitably delivered. This brief explores current MLTSS assessment approaches in five states, including: what uniform assessment tools are available; how they are administered; and considerations for further development and implementation. These lessons should help other states develop more uniform assessment processes across their MLTSS programs.

care for Medicaid LTSS eligibility. Nonetheless, it also highlights a few lessons from the experiences of states in administering level of care determination tools that could help inform uniform assessment processes.

MLTSS Uniform Assessment Tools

Definitions for uniform assessments vary across states. In some states, uniform means that the *same tool* is used to assess a defined population at defined intervals. In other states, uniform means that the *same data elements* are gathered by different tools for defined populations at defined intervals. Ideally, uniform assessment should refer to the use of a *single tool* for all beneficiaries receiving MLTSS to consistently and comprehensively evaluate all LTSS needs. This could be done at either a specific population level or, if developed and implemented carefully, at a broader level for all populations covered by the program.

The level of uniformity of state assessment tools and processes for administration varies significantly across states. The five states interviewed have programs that differ in their duration of operation, populations served, covered benefits, contract structure, and philosophy around delegated functions (see Appendix 1). For example, Minnesota's Senior Care Plus (MSC+) program enrolls adults age 65 and over; while

Wisconsin's Family Care Program enrolls frail older adults, adults with physical disabilities, and adults with developmental disabilities with long-term care needs. The Wisconsin Family Care Program covers Medicaid LTSS only, including nursing facility and home- and community-based services (HCBS), while the Arizona Long Term Care Services (ALTCS) program and Texas STAR+PLUS program cover acute care and behavioral health services in addition to LTSS. ALTCS includes both HCBS and nursing facility care, while STAR+PLUS only includes HCBS waiver services at this point. Texas is planning to integrate nursing facilities into the STAR+PLUS program effective September 1, 2014. These differences influenced states' choice of uniform assessment tool and the processes used for data collection.

Each of the five states uses a different uniform assessment tool and process (see Appendix 2):

- The MnCHOICES tool, under development in **Minnesota**, may be the closest thing to the "ideal" uniform assessment since it will be used across MLTSS and fee-for-service programs to assess the full spectrum of a beneficiary's LTSS needs.
- In **Tennessee**, each MCO develops its own Comprehensive Needs Assessment including a minimum common set of data elements required by the state.
- **Wisconsin** uses a similar approach and prescribes Comprehensive Assessment elements in contracts with MCOs; the MCOs develop a format for the assessment that is then approved by the state.
- **Arizona** and **Texas** require different tools for different MLTSS programs, for different enrolled populations, and/or for different time points.

While definitions of "uniform" vary across states, it is still possible to identify some common elements of assessment tools and processes.

Prevalent Themes Across States

Interviews with state Medicaid agencies and MCOs revealed key themes including the content of the tools, assessment processes, and uses of the data collected. States developing a uniform assessment tool may want to consider how these elements will be incorporated in their own MLTSS programs. Key themes emerged across: (1) assessment tool domains; (2) required timeframes; (3) case manager and care coordinator training, qualifications, and credentials; (4) information technology; and (5) oversight.

Assessment Tool Domains

While each of the five states require unique tools or data elements to assess beneficiaries' LTSS needs, a number of domains are common across assessments (see Exhibit 1). The comprehensiveness and level of detail required by each state or MCO for these domains varies. The following domains are consistent across uniform assessment tools, although some states may use slightly modified language to describe domains (e.g., medical and health status):

- Activities of daily living (i.e., bathing, dressing, mobility, transfers, eating, or toileting);
- Instrumental activities of daily living (i.e., meal preparation, medication management, money management, telephone, and employment);
- Natural (informal caregiver) supports;
- Cognition;
- Health status; and
- Mental/behavioral health status.

States may want to consider the trade-off between requiring data collection for more or fewer domains.

Minnesota: Moving Toward a Truly Uniform Assessment²

The goal of Minnesota's MnCHOICES project is to create and implement a comprehensive, person-centered assessment and planning support tool for the state's MLTSS programs. The new assessment will be used for individuals of all ages and with any type of disability or other long-term care needs, replacing several assessment processes and forms. The launch date for MnCHOICES is slated for June 2014, with an earlier implementation date of November 2013 for a small group of lead agencies. MnCHOICES will be a web-based, automated process used to assess individuals for LTSS needs; determine eligibility for publicly-funded programs; and develop individualized support plans. The state anticipates that MnCHOICES will provide data to evaluate outcomes and enhance quality assurance functions and to improve consistency and equity in accessing home- and community-based waiver programs and services.

The more domains assessed, the more complete a picture the state and MCO can draw of a member's needs. However, collecting data on a larger number of domains is more time consuming, expensive, and tiring for the beneficiaries. Also, the marginal benefit of collecting additional data elements may not translate into better care planning.

Minnesota includes a broad scope of domains in its MnCHOICES tool, including a number of areas beyond those listed above. Notably, MnCHOICES also includes questions about employment, safety and

self preservation, independent versus supported self-direction, and housing and environment.³

Exhibit 1 provides a select set of assessment domains from each of the five states and three federal assessments used for individuals who require LTSS in the community (PACE and MA-SNPs) or in nursing facilities (MDS and MA-SNPs). This information provides a high-level overview of domains across several tools. Note, Exhibit 1 is meant to present a quick snapshot for each tool and what they cover, it is not meant to serve as a comparison tool. The

Exhibit 1. Select State and Federal Assessment Tool Domains⁴

Assessment Domains	MA-SNP, MDS, PACE ⁵	(AZ) HCBS Assessment Tool ⁶	(MN) MnCHOICES ⁷	(TN) Core Data Elements ⁸	(TX) MN/LOC ⁹	(WI) Comprehensive Assessment Requirements ^{10, 11}
Quality of Life	MDS		✓			✓
Physical Functioning/Disability						
Activities of Daily Living	MA-SNP MDS PACE	✓	✓	✓	✓	✓
Instrumental Activities of Daily Living	PACE	✓	✓	✓		✓
Medical Conditions						
Medical Condition (health status)	MA-SNP PACE	✓	✓	✓	✓	✓
Clinical History and Medications	MA-SNP MDS PACE		✓		✓	✓
Pain Assessment	MDS		✓		✓	✓
Swallowing/Nutrition	MDS PACE		✓	✓	✓	✓
Oral/Dental	MDS PACE		✓		✓	✓
Elimination Status (Bladder and Bowel)	MDS	✓	✓	✓	✓	✓
Mental and Behavioral Health						
Cognitive Function and Memory/ Learning Difficulties	MA-SNP MDS PACE		✓	✓	✓	✓
Behavior Difficulties	MDS PACE	✓	✓	✓	✓	✓
Needs and Risks						
Visual and Hearing Needs	MA-SNP MDS		✓		✓	✓
Home Safety and Risks	PACE		✓	✓		✓
Social Support						
Caregiver Needs and Level of Involvement	MA-SNP PACE	✓	✓	✓	✓	✓
Available Benefits (Medicare, Medicaid, SSI, etc.)	MA-SNP		✓	✓		✓
Social Issues/Social Support	PACE	✓	✓	✓		✓
Preferences						
Cultural and Linguistic Needs	MA-SNP PACE		✓		✓	✓
Preferences for Routine Activities	MDS PACE		✓		✓	✓
Participation in Goal Planning/ Assessment	MDS		✓		✓	✓

assessment tools represented for each state are not used at the exact same point in the assessment/care planning process and do not have the same scope in purpose and thus are not comparable documents. Exhibit 1 does not account for important differences across tools, such as populations included; point of use in the assessment/care planning process; setting of care and other assessments (e.g., Arizona also requires MCOs to perform comprehensive assessments beyond the HCBS Assessment Tool).

Required Timeframes

States set timeframes within which MCOs must complete assessments after enrollment. A state can either prescribe the exact timeframes, or it can allow MCOs to establish their own standards for the timing of assessments within broader state-established parameters. For instance, Wisconsin requires that MCOs provide services needed to ensure health, safety, and continuity of care beginning on the day of enrollment. The MCOs must make contact with the beneficiary within three calendar days of enrollment, develop an initial plan of care within 10 days, and then complete a comprehensive assessment within 30 days of enrollment.¹² In contrast, Texas requires that their MCOs conduct new member assessments within 45 days of enrollment. The former creates a more structured and consistent approach across all MCOs in the program; while the latter allows the MCOs and case managers/care coordinators more discretion to determine the priority of assessments based on triage, risk level, or other factors based on the individual. All states interviewed require reassessments be done at least annually or at time of change in beneficiary status.

Case Manager and Care Coordinator Training, Qualifications, and Credentials

States and MCOs must ensure that the case managers or care coordinators administering assessments have the appropriate qualifications, credentials, and training. Each state interviewed uses a different process

to make sure that assessments are performed appropriately; however, all emphasize the importance of initial and ongoing education. All states interviewed set minimum qualifications for case managers/care coordinators, ranging from licensed registered nurses to master's-level social workers or individuals with a bachelor's degree and experience in home- and community-based care. For example, Texas originally required that case managers/care coordinators be registered nurses or master's-level social workers, but realized that certain tasks could be performed well by staff with fewer qualifications or who shared the same language or cultural background as beneficiaries. Starting October 2013, Texas will classify beneficiaries into three levels and require the service coordinators working at these levels to meet specific qualifications and credentials.¹³ Minnesota will require all care coordinators to be certified assessors prior to administering MnCHOICES. Training and certification requirements for the MnCHOICES assessment process are established in Minnesota Statute.¹⁴ Notably, the importance of training to ensure person-centered planning principles and a common set of skills across assessors is cited to ensure consistency and equitable access to services statewide.¹⁵

Information Technology

Ideally, assessment data and care plans should be available to both MCOs and the state. Minnesota's MnCHOICES assessment will be both web-based and automated. Automated systems prompt case managers or care coordinators who input data to complete the next appropriate step, and often calculate the benefit level for LTSS. This functionality makes it easier to complete the assessment and minimizes the potential for user-based errors in care planning. Theoretically, automation supports easier information sharing of both the assessment and the care plan. Some states reported that automated systems created by MCOs can be less flexible and difficult to adjust when contract requirements change. However, MCOs that contract

Tennessee: Comprehensive Training for Assessment Staff

Ongoing training is essential for MCO staff who perform uniform assessments. New case managers are hired throughout the year and current case managers need in-service programs. For its level of care assessment tool, Tennessee uses both a web-based training that is available 24/7 as well as webinars to reach geographically widespread staff. The state has a monthly newsletter to highlight particular training issues that are identified. A call center/help desk logs all calls from case managers/care coordinators, which informs the issues addressed in the newsletter. A state wishing to enhance the skills of staff that implement assessments – either eligibility determination or comprehensive assessments – could employ a similar strategy to ensure ongoing education.

in multiple states prefer to use their own automated systems, which may integrate with other in-house information systems for complaints, quality, and performance reporting, care coordination, etc. Arizona, Tennessee, and Texas allow their MCOs to determine whether or not to automate beneficiary assessment systems.

Information technology should also permit states to use information from the uniform assessment for quality measurement. For example, Minnesota's new MnCHOICES system will provide a platform for the state, MCOs, and counties to review data to inform continuous quality improvement efforts. Other states without such robust system capabilities still collect data that allow them to monitor timeliness of assessments and overall access to care.

Oversight

Monitoring MCOs adherence to required policies and procedures is an important responsibility of state Medicaid staff. Oversight of MCO compliance can help inform quality improvement objectives at both the state and MCO level. The scope and magnitude of oversight requirements varies across states. State audits of MCO practices are a straightforward way to conduct oversight. Medicaid staffs from all five states interviewed perform audits to monitor MCO adherence to contractual requirements. Tennessee conducted quarterly on-site audits when its MLTSS program was first launched, and now performs quarterly desk audits for which MCOs submit information electronically.¹⁷ Texas, which conducts its own periodic audits, emphasized the importance of thorough readiness reviews prior to delegating any assessment responsibilities from state staff to MCOs. Reliability tests administered by Wisconsin help ensure that administration of the assessment is consistent across care coordinators and case managers. Arizona also requires that its MCOs conduct quarterly monitoring activities to address inter-rater reliability between case managers and their use of the HCBS Needs Assessment Tool. These activities ensure

consistent application of Arizona's assessment tool and identify staff training needs at an individual and MCO staff level.¹⁸

Best Practices in the Development and Implementation of Uniform Assessment Tools

The development and implementation of a uniform assessment tool can be complicated. The five states interviewed each followed slightly different routes to establish final tools or set of data elements to guide assessment. Their experiences highlight potential best practices to help guide other states.

Engaging Stakeholders

The adoption of a uniform assessment tool to determine a member's level of service and support needs will represent a major change in many states and is likely to come under close stakeholder scrutiny. Engaging stakeholders is critical to successful tool development and implementation. Of the states interviewed, Arizona, Minnesota, and Tennessee provide examples of extensive stakeholder engagement.

- **Arizona** implemented its HCBS Needs Assessment Tool in 2012. This tool, meant to improve continuity of care, was developed through a strategic stakeholder engagement process. The MCOs formed a workgroup to develop an assessment tool best suited for their beneficiaries. Arizona reviewed the workgroup's recommended approach and eventually approved what is now known as the HCBS Needs Assessment Tool. It is now used across MCOs for beneficiaries receiving in-home care. Both the state and MCOs considered this process very successful given the tremendous level of stakeholder engagement and buy-in of the tool.¹⁹
- **Tennessee** conducted an environmental scan of assessment tools and requirements across both managed care and fee-for-service LTSS programs

Wisconsin: Keeping Watch

Wisconsin developed a process to help ensure reliable use of its tool, the Long Term Care Functional Screen, across assessors. This reliability check for Wisconsin's Long Term Care Functional Screen could be adapted by other states to help ensure consistency for how comprehensive assessments are used. Wisconsin's process includes reliability testing every two years, and a number of crosschecks that automatically assure the proper approach is being taken. Wisconsin has a dedicated quality unit and workgroup that oversee processes and quality monitoring for its functional screen. Each MCO has a "screen lead" – an in-house expert who facilitates organization-wide consistency and improvement through informal continuing education and administration of the tool.¹⁶

to identify core data elements required for its uniform assessment. The state also reviewed best practices and recommendations from other states. Throughout this process, the state engaged key stakeholders including MCOs that would be using the core data elements to guide assessment activities.²⁰

- **Minnesota** enlisted help from internal and external stakeholders, including advocates and providers for all MLTSS populations, to develop the MnCHOICES program. A steering committee of stakeholders and advocates helped guide the multi-year development process, providing a clear communications channel that was critical for program success. The state noted the concern voiced by stakeholders that a single, uniform assessment process for all MLTSS beneficiaries might change how eligibility is determined. The state reassured stakeholders that the tool would not change eligibility determinations through multiple comparative tests of reliability with prior tools.

Interacting Effectively with Managed Care Organizations

Striking a balance between prescriptive contract requirements that promote consistent assessment practices and autonomy for MCOs to design targeted approaches that best support their programs is a complex undertaking for states. The five MCOs interviewed indicated that while state requirements for a certain level of uniformity in assessment can be beneficial, flexibility for MCOs to integrate their own tools is also necessary. For instance, if all MCOs participating in an MLTSS program must use a uniform tool, this can support MCOs in fair hearings by allowing judges to become familiar with the tool and expectations. Additionally, assessment tools that include detailed, descriptive questions may reduce ambiguity and streamline administration and interpretation across MCOs. However, the MCOs interviewed consistently noted that a certain level of flexibility for them to tailor tools to their own assessment approach was important. Such flexibility provides the opportunity for MCOs to adjust systems according to the unique needs of their beneficiaries and to innovate and improve systems. For MCOs with multiple state MLTSS contracts, it is particularly important to be able to use a single system.

Tying Assessment Tools to Rate-Setting

Assessment tools – both level of care and functional needs assessments – can potentially be used to help set capitated rates. Arizona and Wisconsin tie their level of care determination assessment tools to capitation rates. Arizona uses data from its Uniform Assessment Tool that determines beneficiaries' level of need to help establish rates for nursing facilities.²¹ Using a uniform data set to establish rates can provide valuable information for setting capitation rates. However, states should consider the potential for stakeholders to more critically question the validity of tools that are tied to rates. By tying a tool to reimbursement rates, states must be prepared to more strongly defend the science behind the tool. Future changes to such tools may also be complicated by the additional scrutiny and interest from stakeholders, as well as the budget implications.

Using Reliable, Valid, and Evidence-Based Tools

When choosing an assessment tool and process at both the state and MCO levels, it is important to consider reliability and validity. Reliability is the consistency of the tool, while validity is the degree to which it measures the phenomenon it aims to measure. Overall, there are only a few evidence-based assessment tools that have been rigorously tested. Many of the state-developed tools discussed in our interviews with states were tested in some way for their reliability or validity. States noted that reliability was more important than validity because they were concerned with equity and uniformity across beneficiaries. Ensuring strong inter-rater reliability across case managers/care coordinators is a key component to a robust oversight platform.

Understanding Overlap with Medicare Program Requirements

One of the strongest themes that emerged from interviews with both states and MCOs was the issue of duplicative and conflicting assessment requirements across Medicare and Medicaid programs. One MCO highlighted a recent and seemingly inconsequential conflict it encountered: while the state required that MCOs conduct assessments every 12 months, CMS' requirement is every 365 days. These two unaligned requirements strain MCO administrative systems, making it difficult to adhere to agreements with both the state and CMS. Exhibit 1 provides a glimpse at different domains used in assessment tools across some common federal programs.

Another point of overlap are the health risk assessments (HRAs) to identify chronic diseases, injury risks, modifiable risk factors, and urgent health needs that all Medicare beneficiaries are to receive as part of their annual wellness visits.²² While the purpose of HRAs is to identify potentially modifiable and treatable health conditions rather than LTSS needs, the timing of the two assessments can come into conflict both at the points of initial assessment and periodic reassessment.

The five states interviewed varied in their use of HRAs in MLTSS programs. Texas eliminated the initial HRA requirement for MLTSS MCOs,²³ but some MCOs in Texas continue to call their members initially and administer something similar to an HRA.²⁴ Minnesota, which had been planning to add an HRA to its MnCHOICES assessment tool to create a single system where all the tools can be accessed, is now reconsidering this move based on recent changes to special needs plan (SNP) requirements.²⁵ Recent CMS changes now require that SNP HRAs be conducted within 365 days of the previous assessment. Adherence with this new rule will be tracked by CMS and could be a new addition to the STAR ratings. To ensure that assessments are not late, SNPs are now conducting assessments much earlier than previously or otherwise required by the state. Assessments conducted earlier than they were the prior year have implications for beneficiaries' one-year waiver eligibility period, beginning a new waiver period earlier than necessary. This creates the potential for beneficiaries to be cheated out of time they might otherwise be eligible for waiver services.²⁶ Arizona state staff also noted that SNPs are required to do HRAs annually, and that these assessments vary considerably, are not standardized, and can be duplicative to assessments done by MLTSS MCOs.²⁷

Key Takeaways

States developing MLTSS programs or integrated Medicare-Medicaid initiatives will need to address their own market and population considerations in identifying a uniform assessment approach, but can learn from the experiences of other states. Drawing from the lessons of the interviewed states, there are five key takeaways to help guide additional states:

1. **Creating Flexibility in MCO Contracts.** Most states allow their MCOs some flexibility to innovate and develop plan-specific processes,

procedures, and tools. MCOs should be encouraged to design assessment tools that fit within their systems. The states interviewed tend to set specific standards for timeliness and expectations about in-person, in-home visits, but have more general requirements for domains within the tools. All five states allow their MCOs to make additions beyond prescribed criteria or tools.

2. **Setting Realistic Expectations for Data Reporting.** While it would be ideal to use a centralized assessment database, the state should begin with smaller steps and set this as a goal for the future. A state should begin with common requirements for data reporting (e.g., monthly reports of those individuals assessed within a particular range of days) and add performance measures over time.
3. **Building Strong State-MCO Relationships.** Establishing a structure that promotes or even requires open communication and strong connections between MCOs and the state can enhance an MLTSS program by encouraging collaboration. Creating a liaison position, multiple positions, or ideally, a team in the state to help MCOs work through issues on a daily basis can greatly increase satisfaction and coordination.
4. **Establishing Meaningful Stakeholder Engagement.** Assessment tools are directly linked to the type and amount of care beneficiaries receive. With a change to an assessment tool or the introduction of a new assessment tool or process, there should be clear communication with stakeholders about the intent of any changes as part of a larger stakeholder engagement strategy.
5. **Alignment of Medicare and Medicaid Requirements.** Medicare program requirements should be considered and aligned with Medicaid requirements to the extent possible. State staff should consider Medicare requirements when setting standards for assessments. MCOs have many reporting requirements from different programs, and the timelines, assessment tools, and expectations set by Medicare should be coordinated with those of demonstrations or new programs to avoid duplication and create a seamless process for the MCOs and beneficiaries.

States continue to reform and make advancements in the financing and delivery of care for people with complex needs who are eligible for Medicaid LTSS. Managed LTSS programs are increasingly becoming an attractive option for states because of budget predictability and goals to improve coordination and quality of care. As states increasingly turn to MCOs to manage beneficiaries' LTSS needs across various programs, uniform assessment of service needs will continue to be top priority.

It takes time to develop uniform assessment standards, and, in managed care settings, it takes many years to develop common assessment tools. Interviewed states and MCOs described best practices and challenges faced in delivering a comprehensive assessment tool to LTSS beneficiaries in managed care settings. Finding a balance between state-delegated activities and tools while leaving flexibility for MCOs to innovate according to the unique needs of their beneficiaries is a constant balancing act.

Appendix 1: Managed Long-Term Services and Supports Programs in Five States²⁸

Program and Implementation Date	Arizona Long Term Care Services 1989	Minnesota Senior Health Options and Minnesota Senior Care Plus 1997 (MSHO) 2005 (MSC+)	Tennessee CHOICES 2010	Texas STAR+PLUS 1998	Wisconsin Family Care 2000
Eligible Populations	<ul style="list-style-type: none"> • Medicaid beneficiaries 65+ • Blind and disabled beneficiaries who need a nursing facility (NF) level of care • Dual eligibles 	<ul style="list-style-type: none"> • Medicaid beneficiaries 65+ 	<ul style="list-style-type: none"> • Medicaid beneficiaries receiving care in NF • Medicaid beneficiaries 65+ and adults age 21+ with physical disabilities who need a nursing home level of care • Medicaid beneficiaries age 65+ and adults age 21+ with physical disabilities “at risk” of institutionalization 	<ul style="list-style-type: none"> • Medicaid beneficiaries age 65+ • Adults age 21+ with physical disabilities “at risk” of institutionalization • Children age 20 and younger who have Medicaid and get SSI • Dual eligibles 	<ul style="list-style-type: none"> • Medicaid beneficiaries with long-term care needs, including frail older adults, adults with physical disabilities, and adults with developmental disabilities
Enrollment and Geography	<ul style="list-style-type: none"> • Mandatory • Statewide 	<ul style="list-style-type: none"> • MSC+ Mandatory • MSHO Voluntary alternative to MSC+ Statewide 	<ul style="list-style-type: none"> • Mandatory • Statewide 	<ul style="list-style-type: none"> • Mandatory for adults • Voluntary for children • Limited geographic areas (statewide by 9/1/14) 	<ul style="list-style-type: none"> • Voluntary • Limited geographic areas (in process of expanding statewide)
Covered Benefits	Medicaid acute, behavioral health, and LTSS (including HCBS and NF)	Behavioral, mental and chemical health services, LTSS and NF	Medicaid acute, behavioral health, and LTSS (including HCBS and NF)	Medicaid acute, limited behavioral health, LTSS, (HCBS Waiver Services for qualified members), and nursing facilities effective 9/1/14	Medicaid LTSS (including HCBS and NF) plus home health, therapies, etc.
Integration with Medicare for Dual Eligibles	Contractors are required to be special needs plans (SNPs)	Contractors are required to offer a Medicare SNP. MSHO is fully integrated with Medicare and serves the majority of Medicaid seniors.	Contractors are not currently required to be SNPs, but all are. They must also coordinate with other SNPs for their dual eligible members.	All STAR+PLUS MCOs are required to operate a Medicare Special Needs Plan. Service coordination offered to help members coordinate Medicaid and Medicare.	Wisconsin has a separate SNP (Family Care Partnership) that provides integrated acute, primary and long-term services for dual eligibles.
Care Management Overview/ Innovations	Require MCOs to use case manager/ beneficiary ratios: <ul style="list-style-type: none"> - 1:48 in home - 1:60 in assisted living - 1:120 in NF In-home visits are required every 90 days. SNF visits are required every 180 days.	MSHO/MSC+ facilitates alignment of incentives and cost efficiencies to improve coordination of basic health services with state plan home care, PCA, home and community based services and nursing home care under the same care management system.	Requires care management be vested within the MCOs. In-home visits are required quarterly with monthly contacts. Focus on managing transitions—inpatient admissions must be reported to MCOs in order to trigger immediate discharge planning.	Requires MCO service coordinators to assess member’s needs, develop service plans, and authorize services, including Medicaid acute care, waiver services, and other community based care. State does not mandate a service coordinator to client ratio, but has an expectation that the MCO will be able to meet member’s needs, working with community resources.	Requires beneficiaries to be assigned to a care manager and a registered nurse. In-home visits are required every 90 days. Care planning and service decisions are decided by beneficiary and care team. RNs are required to coordinate with acute care providers as well. Typical ratios are 1:40 for social service coordinators and 1:80 for RNs. MCOs also have specialty teams (such as behavioral health) which may have lower staff to member ratios. ²⁹

Program and Implementation Date	Arizona Long Term Care Services 1989	Minnesota Senior Health Options and Minnesota Senior Care Plus 1997 (MSHO) 2005 (MSC+)	Tennessee CHOICES 2010	Texas STAR+PLUS 1998	Wisconsin Family Care 2000
Contractors	Contractors at risk for all covered benefits; includes large, national MCOs	Contractors at risk for all covered benefits; includes eight local/regional MCOS, including county-based plans	Contractors at risk for all covered benefits; includes large, national MCOs and plans with national affiliations	Contractors at risk for covered services. Full nursing facility services will be included in the contracts 9/1/14. Includes locally based community plans and large, national MCOs	Contractors at risk for all covered LTSS services; includes public, multi-county-based plans

Appendix 2: MLTSS Uniform Assessment Tools and Practices

	Arizona Long Term Care Services	Minnesota Senior Health Options and Minnesota Senior Care Plus	Tennessee CHOICES	Texas STAR+PLUS	Wisconsin Family Care
Assessment Tool(s)	<p>Uniform Assessment Tool - Assesses acuity level for nursing facility and assisted living; administered by MCOs.</p> <p>HCBS Assessment Tool - Determines service hours; was developed with plan and stakeholder input; administered by MCOs.</p>	<p>MnCHOICES - Single, comprehensive and integrated assessment and support planning application for LTSS.</p> <p>Contractor-developed system with stakeholder input replaces prior assessments.</p>	<p>Uniform Pre-Admission Evaluation - Assesses nursing facility and at-risk levels of care for seniors and adults with physical disabilities.</p> <p>Comprehensive Needs Assessment - Made up of core data elements specified by the state. Tool developed by MCOs, based on state data elements that are approved by the state.</p>	<p>Form 2060 - Needs assessment, task and hourly guide created by state.</p> <p>Medical Necessity and Level of Care Assessment - Based off Minimum Data Set plus state specific criteria.</p>	<p>Long-Term Care Functional Screen - Determines functional eligibility.</p> <p>Comprehensive Assessment elements prescribed by contract, formats developed by MCOs and approved by state.</p> <p>Developed by state with input from stakeholders</p>
Core Populations/ Services Covered	Nursing facility residents, assisted living facility residents, HCBS members, Attendant Care, Personal Care, Homemaker, Habilitation, Respite, Emergency Alert Systems, and Adult Day Care	People with disabilities and long-term care needs; Developmental disability; Long-term care; Personal care; assistance; To also include private duty nursing	CHOICES members, including: Elderly (65+) and Disabled (21+)	<ul style="list-style-type: none"> • People with disabilities or age 65 or older • Acute Care, Personal Attendant Services and Day Activity and Health Services • HCBS Members: Nursing, Respite Services, Emergency Response, Home Delivered Meals, Minor Home Modifications, Adaptive Aids and Medical Equipment, medical Supplies available under State Plan, Therapies (OT, PT and ST), Adult Foster Care, Assisted Living and Transition Assistance 	<ul style="list-style-type: none"> • Family Care Program • Partnership Program • PACE • HCBS program for children and adults • Elders and people with physical disabilities or intellectual or developmental disabilities
Delegation and Ability to Change or Add to Tool	<ul style="list-style-type: none"> • State does functional eligibility determinations. MCOs develop service plans. • MCO can make additions without state approval as long as no changes made to mandated tool. 	<ul style="list-style-type: none"> • Counties, MCOs, lead agencies, and tribes complete assessment and support plan development. Completed by certified assessors at agencies. • Nurses or social workers with HCBS experience. Plans all agreed on tool, will not make changes. 	<ul style="list-style-type: none"> • State nurses make level of care determinations. • MCOs conduct comprehensive assessment and develop plan of care. • MCOs allowed to make changes to comprehensive needs assessment but must continue to meet state requirements. 	<ul style="list-style-type: none"> • MCOs conduct functional needs assessment. • RN at MCO conducts Medical Necessity Level of Care. • MCOs are required to use Form 2060 and the MN/LOC. These forms cannot be amended by the MCO. 	<ul style="list-style-type: none"> • ADRCs do initial functional screen. • MCOs do annual screens. • MCOs do not need state approval for changes; although state oversight is applied.
Method and Setting of Assessments (face-to-face, in-home requirements, etc.)	Face-to-face requirements and in-home/in-residence requirements	Will include face-to-face requirement for individuals receiving HCBS	Face-to-face requirements	Face-to-face requirements for members receiving LTSS and/or HCBS services and members with complex medical needs	Face-to-face requirements

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. This brief was made possible through the SCAN Foundation, which is supporting CHCS' work with states across the country to improve care for Medicaid beneficiaries in need of long-term supports and services. For more information, visit www.chcs.org.

Endnotes

- ¹ Truven Health Analytics. *The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update*. Prepared for CMS, July, 2012
- ² Minnesota Department of Human Services. " MnCHOICES Website: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_054837.
- ³ Ibid.
- ⁴ Adapted from NCOA. "Performance Measures for Medicaid Managed Long Term Services and Supports (MLTSS) Plans – Technical Expert Panel."
- ⁵ MA-SNP: Medicare Advantage Special Needs Plan Structure and Process Measures – Complex Case Management; MDS: Minimum Data Set for Nursing Facilities; and PACE: Program for All Inclusive Care of the Elderly.
- ⁶ Feedback from Francine Pechnick UnitedHealthcare Community Plan, Arizona.
- ⁷ Minnesota Department of Human Services. MnCHOICES Assessment Content." Available at: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&did=158687
- ⁸ Feedback from Patti Killingsworth, July 23, 2013, State of Tennessee.
- ⁹ Medical Necessity and Level of Care Assessment.
- ¹⁰ Feedback from Jen Mathwig, July 25, 2013, Community Care, Inc., Wisconsin.
- ¹¹ Feedback from Monica Deignan, August 12, 2013, Deputy Director, Office of Family Care Expansion, Division of Long Term Care, Department of Health Services, State of Wisconsin.
- ¹² Interview with Monica Deignan, May 10, 2013, Deputy Director, Office of Family Care Expansion, Division of Long Term Care, Department of Health Services, State of Wisconsin.
- ¹³ Service Coordination Workgroup, "Proposed Service Coordination Standards," December 5, 2012, State of Texas.
- ¹⁴ Minnesota Statute SS256B.0911, Subd. 2b. Long-Term Care Consultation Services. Available at: <https://www.revisor.mn.gov/statutes/?id=256B.0911>
- ¹⁵ Ibid.
- ¹⁶ Interview with Monica Deignan, op.cit.
- ¹⁷ Feedback from Teri Bowes and Mary Gause, July 17, 2013, BlueCare Tennessee.
- ¹⁸ Interview with Francine Pechnick, May 20, 2013, UnitedHealthcare Community Plan (formerly Evercare Select), Arizona.
- ¹⁹ Ibid. And interview with Katrina Cope and Jami Snyder, April 26, 2013, State of Arizona.
- ²⁰ Follow up conversation with Patti Killingsworth, June 12, 2013, State of Tennessee.
- ²¹ Interview with Carol Sanders, July 26, 2013, State of Arizona.
- ²² Patient Protection and Affordable Care Act of 2010. Pub.L. no. 111-148, 124 Stat. 119 (2010).4103(b).
- ²³ Interview with Monica Deignan, op.cit.
- ²⁴ Interview with Allison Moss, Cathryn Horton, and Paula Swenson, May 22, 2013, State of Texas.
- ²⁵ Interview with Carol Backstrom, Pamela Parker, Nancy Jergenson, Jean Wood, Jolene Kohn, and Deb Maruska, May 2, 2013, State of Minnesota.
- ²⁶ Feedback from Pam Parker, July 18, 2013, State of Minnesota.
- ²⁷ Interview with Katrina Cope and Jami Snyder, April 26, 2013, State of Arizona.
- ²⁸ Information adapted from A. Lind, S. Gore, L. Barnette, S. Somers. *Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services*. Center for Health Care Strategies, November 2010. Available at: http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf. Updated information provided by contacts in each state.
- ²⁹ Feedback from Monica Deignan, op.cit.