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Functional Assessment Processes for Medicaid Personal Care Services

By Susan M. Tucker and Marshall E. Kelley

The Community Living Assistance Services and Supports (CLASS) Plan – a groundbreaking component of the Affordable Care Act – creates a voluntary federally-administered insurance program to help individuals pay for needed assistance in a place they call home if they become functionally limited. Implementation will require knowledge translation from various sectors, including research and existing public and private programs. This Technical Assistance Brief Series seeks to answer questions pertinent to developing and implementing the program.

This brief focuses on components of states' Medicaid functional assessment processes with an eye toward how these processes could potentially inform the development of regulations for CLASS. We explore how states handle the assessment process and determine who performs the assessment and where it is performed. Each of these components is important to the design of CLASS so that those determined eligible can receive appropriate benefits.

Introduction and Overview of State Medicaid Functional Assessment Processes

Each state develops its own unique set of criteria, policies, infrastructure and procedures specific to its Medicaid program, including detailed processes for State plan personal care services and/or home and community-based waiver programs. Understanding how functional assessments are performed is critical to appropriately determining the need for and level of personal care services (PCS) and home- and community-based services (HCBS) for Medicaid-eligible individuals. Clearer insight into all these facets of a state's process can potentially inform the development of CLASS regulations.[1]

This is the third of three issue briefs[i] on states' experience with Medicaid personal care services and the relevance of that experience to the development of CLASS.

To set the background for the evaluation of functional assessment processes in Medicaid programs across the states, we conducted a review of the fifty states' and the District of Columbia's Medicaid programs to capture information on personal care services offered through the Medicaid state plan PCS program or through a HCBS waiver for older adults or persons with physical disabilities. The purpose of this review was to gain a basic understanding of the size and design of each state's program and then identify states for a more thorough review. This review was primarily conducted through internet-based research that captured high level information on the number of enrollees, expenditures, type of personal care programs offered, policies, instruments used, functional eligibility

[i] The other two briefs are: The SCAN Foundation's CLASS Technical Assistance Series Brief #5: ("Elements of a Functional Assessment for Medicaid Personal Care Services") and The SCAN Foundation's CLASS Technical Assistance Series Brief # 6: ("Determining Need for Medicaid Personal Care Services"). These discuss the actual elements of a functional assessment, instruments used for the assessment and scoring, ranking and thresholds that states use in their Medicaid personal care services programs.

criteria, prior authorization criteria and related data on consumer involvement and direction of services.

Based on the review, we selected for further examination ten states that represented a cross section of the various program design characteristics. The ten states selected for study were: Arkansas,[2] California,[3-6] Florida,[7-9] Georgia,[10] Maine,[11] Maryland,[12-13] Massachusetts,[14-15] Michigan,[16-17] Nebraska,[18] and Oregon.[19-20] To better understand these states' processes, policy manuals, forms and assessment instruments were reviewed and interviews were conducted with state officials who administer the programs.

The initial review of 50 states and the District of Columbia found, specific to functional assessment processes for Medicaid personal care services:

- States have developed policy manuals and defined processes; almost 90 percent of states have identified a specific instrument for assessment and determination of functional eligibility whether provided as part of the state plan or through a home and community-based waiver.
- Approximately half of the states use their own staff for the assessment and level of care determination process while other states contract with counties, area agencies on aging or vendors.
- Approximately two-thirds of the states that offer personal care services require some form of prior authorization for the personal care benefit, once the individual has been determined functionally eligible.
- Most states offer beneficiaries the option to direct their own care, i.e., hiring, firing, and supervising personal care workers.
- Some states provide personal care services through a managed care delivery system. These states have varying degrees of participation by the managed care entities in the assessment process.

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Collection of Assessment Data

The assessment process includes activities to determine if an individual is functionally eligible for Medicaid personal care services. Assessments compile the necessary information about an individual to evaluate the individuals' need for services based upon their ability to function independently.

The process for evaluating the individual to determine functional eligibility for HCBS waiver services requires that the individual meet a standard known as institutional level of care. PCS provided through the Medicaid state plan do not require an individual to meet this standard; however, all states have processes to evaluate an applicant's functional eligibility and need for PCS regardless of whether the service is provided through the Medicaid state plan or an HCBS waiver.

In all of the states selected for further review, a face-to-face assessment of functional needs with the individual applying for services was standard. While face-to-face assessment for

gathering information is more costly, it allows the assessor to review the physical environment and abilities of the individual on a first-hand basis. Not only will assessors meet with individuals in their residence, but family members and their caregivers are included in the assessment process. The state officials who were interviewed discussed the importance of including the individual's preferences in the assessment process, but some also pointed out the importance for assessors to be able to distinguish between an individual's needs and desires.

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The process can be further complicated by conflict of interest for the select group of states where assessment is performed by the same entity that provides case management and related services. If the same entity that performs an assessment for functional eligibility also provides the services, there may be less incentive for the assessment to be performed objectively; benefits, then, may be provided to individuals who do not truly meet minimum eligibility requirements.

In states that allow consumer direction, there are varying approaches by which an assessor determines if an individual is capable of directing their own care. Most states rely on the judgment of the assessor and training provided to the beneficiary. While all of the states reviewed consider the individuals' cognitive ability, a more formal determination process is used in some states to assess individuals' cognitive ability to direct their own care.

Assessor Entities

The review found that the functional assessment process may be conducted by a variety of entities:

- State governmental workers;
- County workers;
- Local health department workers;
- Area Agencies on Aging (AAAs); and/or
- Contracted vendors.

The type of entity conducting the assessment in a state can be based upon the program, the population assessed or the setting of the individual being assessed. One state that was reviewed uses both state workers and contracted entities to perform assessments depending on the individual (an older adult or an individual with physical disabilities) and the residence (nursing facility or community). Another state contracts with AAAs to conduct assessments for the older population and with another not-for-profit organization to perform assessments for adults with physical disabilities. One of the states reviewed contracts with a vendor to perform the entire process of functional assessment, eligibility determination, care plan development and authorization for covered services. State employees are most commonly responsible for conducting functional assessments.

Assessor Qualifications

The level of education, experience, and training for workers who perform functional assessments varies across the states. The assessors' required qualifications range from workers without a bachelor's degree, such as case managers with some training, to registered nurses with geriatric experience. One state, with a county-based system, uses county social workers to conduct assessments and relies on the counties to set criteria for the social workers' qualifications. There are counties that require workers performing assessments to hold a Master's degree in social work, while other counties (typically rural ones) require workers to have only training from the county. However, most of the states that were reviewed require assessors to be either a registered nurse or a case manager with a bachelor's degree (preferably in a human services field).

Most of the states reviewed provide some level of training for the assessors. Striving for more consistency in the assessment, California legally requires uniform training for the social workers in the state PCS program. The training materials and curriculum were developed through a partnership of the California Department of Social Services, California Welfare Directors' Association, and California State University; these materials are available online through the California Department of Social Services website.[4] Other states require initial training on the assessment process and on the assessment tool, which is provided by the state or by area agencies on aging.

Re-evaluation

States are required as part of their HCBS waiver programs to conduct a re-evaluation of "level of care" at least annually or more frequently if the beneficiaries' condition changes. One state that was reviewed recently changed the re-evaluation requirement from semi-annually to annually in their HCBS waiver program. The state decided that it was not necessary to perform more frequently than the HCBS waiver requirement. Two other states require an initial re-assessment before the end of twelve months of services, then annually thereafter.

Federal regulation does not require re-evaluation of a beneficiary's continued need for state plan personal care services; however, all of the states selected for review do require that beneficiaries be re-evaluated. Of the states selected for further review, only one state requires reassessment of the state plan PCS beneficiaries more frequently than once per year. Reassessment is required in this state every six months or more often if a beneficiary's condition changes. Another state allows an extension to the annual re-evaluation requirement of up to six months for the PCS provided through the State Medicaid plan, as decided on a case-by-case basis. All states reviewed require a re-evaluation of PCS (whether provided through an HCBS waiver or the state Medicaid plan) at least annually. All of the states reviewed conduct a reassessment more frequently if the beneficiary's condition changes as identified by the beneficiary or the case manager.

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Most states use the same entity and process to conduct the assessment and the reassessment. One exception was found in a state with a managed long-term care program. The initial assessment is conducted by state staff and the managed care organizations conduct reassessments.

Use of Technology

Most of the states reviewed have an electronic system tailored to their states' program(s) to capture the information gathered during the assessment process. The information is either gathered through paper forms or on laptops, then is uploaded into an electronic system. Only one state reviewed does not use an electronic system and relies solely on paper forms. Most of the states' systems compile information specific to the program and are not a central repository for all the beneficiaries' information. This fragmented approach causes duplication of effort and redundant information stored by multiple state systems.

Four of the ten states have systems that go much further than just capturing assessment information. These more comprehensive systems can perform at least one of the following functions:

- Calculate scores related to functional ability;
- Process billing;
- Calculate the number of service hours needed; and/or
- Determine level of care.

One such state system has programmed algorithms which calculate an individual's priority for receiving services based upon the degree of assistance an applicant requires with specific activities of daily living. Another state's electronic system is used to track case information and processes payments for the program that provides state plan PCS. It also interfaces with other county, state and federal agencies. Another state's system produces the level of care determination and the number of hours allowed for the service plan.

One state reviewed has designed a comprehensive electronic system that encompasses the majority of human services programs administered by the state. It is used for the eligibility, assessment, authorization, notifications, and payment for personal care services. However, an early study of this system did caution that too much automation can be counterproductive; in at least one state's experience, such automation restricts flexibility and increases data input time.

The states' experiences suggest that automated systems can help reduce errors and duplication, provide accessible data, support consistency, and can provide decision support tools for assessors. While states recognize the value of technology to automate their assessment processes and indicate the desire for more automation, they are constrained by limited budgets.

Functional Eligibility Determination

The final step in the functional assessment eligibility process is the

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actual determination of eligibility to receive personal care services. Again, there is range among states in how this step is completed. Judgment by an individual assessor or interdisciplinary team is the predominant method by which an individual is determined eligible for PCS. The determinations may be handled by state staff, through contracts with AAAs, other vendors or county workers. Some states use an electronic system to produce the eligibility determination based on input from the assessment.

Considerations for CLASS Plan Design and Implementation

This review of state functional assessment processes for Medicaid-funded PCS was performed within the context of its applicability to the implementation of the CLASS Plan. These findings help illustrate the variation of processes implemented to determine functional eligibility for PCS and HCBS waiver programs across states. Even though states varied in the different components of the assessment process, one common component is that the states consistently require that the assessments be performed face-to-face. This is considered important to accurately capture information about the individual's condition and physical environment at the time of application. All of the states reviewed also required a reassessment if the beneficiary's condition changes; these reassessments are conducted at least annually, if not more frequently, and generally in the same manner as the initial assessment.

Some variation among the states was found when it comes to who performs the assessment, both in terms of the qualifications and training of the individual assessor, the type of entity responsible for the assessment process, and the level of technology used in the process. Regardless, states need assessors to have a level of expertise (through education, experience and/or training) to have sound professional judgment to accurately assess the needs of an individual seeking Medicaid-funded PCS. Additionally, states appear to be moving toward more automated systems to help provide consistency and accessibility of data for the assessment process.

In summary, the aspects of the states' processes that may be applied to the design of the CLASS Plan include:

- Face-to-face assessment by an entity independent of the service delivery and case management functions;
- Determination of need by trained professionals;
- Re-evaluation of the beneficiary's condition at least annually or more frequently if conditions change; and
- Use of an electronic system to compile beneficiaries' assessment information that includes a methodology for the determination of the need for and level of benefits applicable.

Lessons learned from the states described in this brief should be useful to policymakers in designing the most efficient and effective system possible for the CLASS Plan.

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