Memorandum on the Current Assessment Approaches and Domains used by Three HCBS Programs in California

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Introduction

The purpose of this memo is to support the development of a universal assessment instrument (UAI) in California by describing how the state currently assesses adults within three of its home and community-based services (HCBS) programs. These programs are: In-Home Supportive Services (IHSS), Community-based Adult Services (CBAS), and the Multipurpose Senior Services Program (MSSP). For each program, we identify and compare the domains of the assessment instruments currently used and describe the process involved with the data collection, needs determination, care planning, and program coordination. For a description of the methods we used to collect this information, see Appendix A.

We begin with a brief summary of the unique California context in which these HCBS programs are provided. Next, to compare and contrast the content of assessment instruments, we place domains and topics in each of California's three HCBS assessments into a framework of model standards. This is followed by a description of assessment processes in the three HCBS programs, including how assessments are used for care planning and service allocation. The domains are summarized in Appendix B and the assessment processes are summarized in Appendix C. A glossary of terms used in this memo is provided at the end of the document in Appendix F.

Background

California, the most populous state in the nation, is home to roughly 11% of the overall US population. The state also has the largest number of adults aged 65 and over in the country; more than four million. California is ranked 6th in the US in balancing HCBS and placement in a nursing facility; more than half (55%) of California's spending on Long Term Services and Supports (LTSS) goes toward HCBS.[1] Compared to other states, California has a relatively small percentage of seniors (adults aged 65 and over) and persons with disabilities in waiver programs; it was ranked 48th on HCBS Waiver spending in 2007.[2] On the other hand, California offers the largest personal assistance program in the US, currently serving over 447,000 people in IHSS. California has a strong system of county

[1] AARP (2012). Across the States: Profiles of Long-Term Services and Supports (9th Edition, p. 51)
[2] Molica, R. and Hendrikson, (2009). Home and Community Long Term Care: Recommendations to Improve Access for Californians. California Community Choices, California Health and Human Services Agency, p. ii.

government with substantial variety in available services seen among its 58 counties. IHSS is available statewide and managed in partnership with the counties. HCBS waiver services, including MSSP are geographically limited to select counties.

Historically, HCBS programs in California have been based on diverse funding streams. These unique services have developed individually at different times through specific waivers and state plan amendments, often in response to different issues and opportunities. Because these programs have been developed at different times in response to different opportunities and initiatives, they have developed separate and siloed eligibility assessments, care planning approaches, and service authorization. Legislation enacted as part of California's Coordinated Care Initiative (CCI) seeks to remedy the fragmented delivery system by integrating services.

One component, set forth in the CCI trailer bill (SB 1036, Chapter 45, Statutes of 2012) contained in the California Welfare and Institutions Code (14186.36), is the development of a universal assessment process. The expectation is that, as part of the CCI, this process will lead to "improved care quality, greater beneficiary satisfaction with care, and enhanced system efficiencies."[3] The legislation calls for a "Universal Assessment Instrument" (UAI) to be implemented in the HCBS programs that are part of the CCI: IHSS, CBAS, and MSSP. The term "Universal Assessment" is used in the statute; other similar terms include "Common" and "Uniform." In addition to various terminologies, universal assessments can be associated with a variety of approaches, uses, and definitions. On one hand it can be defined as "a common assessment tool and process to assess an individual's functional capacity and needs that is used across programs and services to guide care planning and resource utilization."[4] This definition implies that the same tool or instrument is used for evaluation across defined populations (such as applicants, recipients, or persons considered at risk) and is collected through a standardized approach at a defined interval (such as program entry, annually, with a change in status, or other specified period). Using a less stringent definition, uniform can be more narrowly interpreted to mean that the same items are used across multiple

[3] Coordinated Care Initiative (January 22, 2013). Draft Assessment and Care Coordinated Standards: www.chhs.ca.gov retrieved 7-19-13.

[4] Shugarman, L. HCBS universal Assessment Update. Presentation to Olmstead Advisory Committee, March-13-13.

assessment or screening instruments in various programs. Thus commonality may refer to the use of a single tool or instrument across multiple programs, or it may allow for a hybrid instrument where there may be variations in the breadth and scope of the instruments and data elements, but that the same measures are used for core items.

Considerations

The following issues should be considered in assessing the options and next steps to move the state forward:

1) IHSS, which serves almost 450,000 people, is the dominant program in the state. CBAS serves approximately 23,000 people and MSSP serves less than 10,000.

2) There are multiple issues driving and constraining the assessment process in California. These include the size, history, and investment in the IHSS program; court settlements that define some services (e.g., CBAS); the restriction inherent in federal waivers; and the shared responsibility across departments for many of the programs.

3) California has a number of HCBS programs, resulting in a variety of assessments, different qualifications for assessors, and different "Level of Care" (LOC) requirements. A summary of LOC criteria is provided in Appendix E.

4) There is variation across HCBS programs and within programs based on county and/or provider differences.

5) In addition to specified assessment measures, "clinical judgment" is also involved in determining if an individual meets the LOC for services and which level of need they meet. This suggests that the qualifications and training background of assessors are important. Moreover, to assure equity and fairness, it is important to examine and report the reliability of the

assessment instruments to ensure that there are minimal biases across participants, programs, and counties.

6) Responsibility for some HCBS is shared between two departments such that different functions and areas of expertise are split between departments. Oversight is also divided and/or shared among the state and counties.

7) Many HCBS programs have been in existence for decades, and there is a lack of historical understanding about how the instruments were developed and the processes and inputs used to develop them. There is, however, a long-standing investment in these programs and instruments. These programs involve many different providers who use standard operating procedures that have been developed over decades. In addition to client stakeholders, professional groups and unionized providers are highly invested in the programs and the instruments and processes they use to assess those seeking or participating in services.

8) People "on the ground" doing the assessments might have more or different information than those overseeing the programs. In addition, different professionals are involved in assessment and care planning (e.g., registered nurses, social workers) who bring diverse expertise and distinct perspectives. Although this variation is a positive, it can lead to fragmentation.

9) Each program does its own LOC assessment based on specified criteria. It was noted that the LOC process and approach used by the California Department of Social Services (CDSS) in the IHSS program are very different from those done by the Department of Health Care Services (DHCS) in the waivers and in CBAS.

10) Data are shared on a limited basis in two distinct ways. One approach is driven by the requirement that waiver services are cost neutral. Therefore, at the state level, cost data must be obtained to determine overall cost of services. Data sharing also occurs as part of care planning and care

management at the program/client level. Those conducting the assessment and/or care planning, with the permission of the consumer and in compliance with the Health Insurance Portability and Accountability Act (HIPAA) rules, obtain information to arrange and coordinate services to meet the needs of individual clients. Data sharing for cost neutrality purposes has no bearing on clinical activities or on the care planning that is done with the consumer.

Assessment Domains in Three HCBS

To compare the items used to assess participants across the three California HCBS programs, we began by identifying core assessment domains. A domain is an assessment category (e.g., informal support system, self-rated health) rather than a specific question or measure. We evaluated standards in the field that have been recommended by expert panels to establish the domains for organizing assessment items.[5] [6] We then added domains and topics used by four comparison states (New York, Michigan, Pennsylvania, and Washington) that have or are in the process of implementing UAI for their HCBS programs. These domain categories provided the framework we used to compare the assessment of California's three HCBS, which is shown in Appendix B.

Appendix B lists the candidate domains and then applies items extracted from the assessments provided by California's three HCBS programs: CBAS, IHSS and MSSP. Topics recommended by one or more of the external standards groups are indicated with an asterisk. Any topics present in a HCBS assessment that were not included by an external standard or one of the four states were added as a new California specific domain.

For each of the three California HCBS programs, we included the principal instruments identified by program representatives as being used in care plan development. Only items and domains that were explicit items on the assessment form were included; domains do not include items that may be incorporated into training or considered at the discretion of the assessor. These items were reviewed

[5] Saliba D, et al. Memorandum on External Recommendations for Standardized Assessment in the US. March 2013.
[6] Ray L, Saliba D, et al. Memorandum Comparing Four States' Comprehensive Assessment Systems. May 2013.

by program representatives and revised where they were able to identify additional items on the form or items that were inadvertently omitted.

Assessment Processes: Eligibility, Assessment, and Care Planning

In addition to comparing the domains for each of the three programs, we briefly describe the assessment process (Appendix C offers a summary). We include flow charts that were provided by each program to illustrate the steps used to conduct the assessment. Information used to describe the assessment process came from interviews with state-level key informants as well as program manuals and other written material. Source documents are identified in footnotes (see Appendix A – Methods for more detail).

In-Home Supportive Services (IHSS)[7]

The Program: IHSS is administered by the CDSS Adult Programs Division (APD). The program serves over 440,000 individuals,[8] and depending on their assessed need, recipients receive up to 283 hours of assistance per month with an average rate of 88.5 hours per month.[9] The IHSS assessment information is entered in the Case Management, Information and Payrolling System (CMIPS). The CMIPS II system, which is replacing the CMIPS legacy system that California had used for several decades, will roll out statewide by November 4, 2013. The CMIPS system is electronic and web-based and is expected to process over $5.8 billion in annual payments in FY 2013-14.

IHSS includes several different programs: the Personal Care Services Program (PCSP), the IHSS Plus Option Program (IPO), the Residual Program (IHSS-R), and Community First Choice Option (CFCO). IHSS provides funds and administrative/payroll support for aged, blind, and disabled persons to hire and manage the activities of care providers who assist them with individualized help including support for activities of daily living (ADLs) such as bathing and dressing, and instrumental activities of daily living (IADLs) such as housekeeping and meal preparation. In cases meeting specified regulation criteria, other services

[7] In addition to interviews, information was taken from the California website: www.cmips2project.ca.gov.

[8] As of the 2013 May Revise, in Fiscal Year 2012-13 the program will serve 442,769 recipients per month by providing personal assistance services to people of all ages who reside in the community.

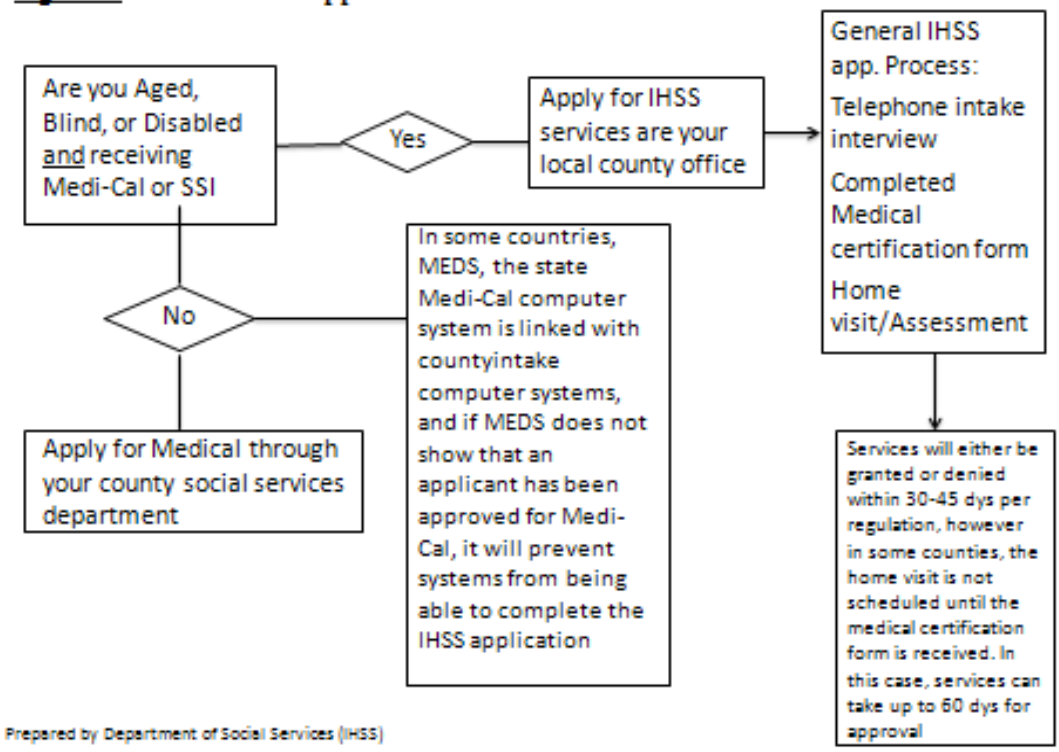
[9] Revision of the local Assistance Estimates for the 2013 May Revision, California Department of Social Services.

such as protective supervision and paramedical services may be provided. IHSS is a state program that is administered locally by County welfare offices. Within state guidelines, counties determine each person's eligibility and service needs. Participants select and hire their own care provider; they may request that the social worker assist them with finding a care provider through a referral to the local Public Authority. Public Authorities within the counties serve as the employer of record and also maintain a registry of care providers from which participants may choose.

The IHSS Application and Assessment Process: The application process for IHSS is detailed in the flow chart below (see Figure 1: General IHSS Application Process).[10] Service authorizations are based on an initial assessment and reassessments are conducted every 12-18 months by an IHSS social worker in the person's home. The assessment determines the person's level of need for personal assistance with the services available in IHSS.

[10] If an individual is already receiving Supplemental Security Income/State Supplementary Payment and/or Medi-Cal, they become eligible for the IHSS assessment at application. For those who are not on Medi-Cal, they must first have an income eligibility determination by Medi-Cal county staff before moving into the IHSS assessment phase.

Figure 1: General IHSS Application Process



Level of Care: The LOC for IHSS is that the individual is "at risk of out of home placement" without specified IHSS services.

Intake: IHSS referrals can originate with an individual or they can come from other agencies (e.g., Adult Protective Services, Office of the Public Guardian, Hospitals, etc.) The assessment process (shown in Figure 2: IHSS Intake Process) begins with an application (SOC 295 form), which can be done by phone or onsite at the county social services agency. Some counties also provide an online application. The form used as the application for social services collects basic client identification information, demographics, living arrangements, and additional benefits. Additionally, the client agrees to the IHSS terms and regulations by signing the form.

Assessment: After the intake process is complete, an IHSS social worker is assigned to conduct the assessment. That social worker contacts the applicant or his/her authorized representative (usually by phone) to schedule a face-to-face assessment. The applicant or his/her authorized representative may also receive a

letter confirming the appointment. See Appendix D for a list of the IHSS and Service Forms that are included in the assessment process.

The home visit starts with the completion of necessary paper work, including the review of the application, risk assessment plan, and other service forms (see Table 1). These forms are explained, reviewed, and signed by the applicant or authorized representative. The forms are all hard copies rather than electronic. The assessment that is used to authorize services is an evaluation of the applicant's physical and cognitive functioning. This assessment process is completed whether or not the social worker believes the person will be eligible for services.

In addition to functional abilities (ADL and IADL), the assessment includes: health history, medications/dosage, diagnoses, doctor information, living arrangements, and household composition. The functional assessment component includes questions about the individual's functional abilities and limitations based on the Annotated Assessment Criteria (AAC), the amount of assistance required, and the frequency and amount of time required to perform tasks as determined by the standardized Hourly Task Guidelines (HTGs) discussed below. The assessment also includes the social worker's observations regarding the environment and how the recipient or applicant functions during the assessment. A Functional Index (FI) score is assigned by ranking the degree of assistance required for each ADL and IADL based on the severity of the person's functional limitation. FI scores are also assigned to cognitive function measured by three items: memory, orientation, and judgment using probes within the AAC as a guide.

After determining the amount of time required for each service category, social workers compare the total time required with the Hourly Task Guidelines (HTGs). Hours may be authorized above or below HTGs based on information documented from the assessment visit and additional information from collateral contacts. A onetime Health Care Certification, signed by a physician, is required prior to the authorization of services. CMIPS II contains case details including the FI score for each task, time per task, and how often the task must be provided per day. After the social worker completes the assessment, the worker's supervisor reviews the documentation of the worker in accordance with current county procedures and current program regulations. A notice of action, which includes hours and services authorized, is provided within 30 days for those eligible for SSI and 45 days for all others. The key determinant for eligibility is if the individual is "at risk for out-of-

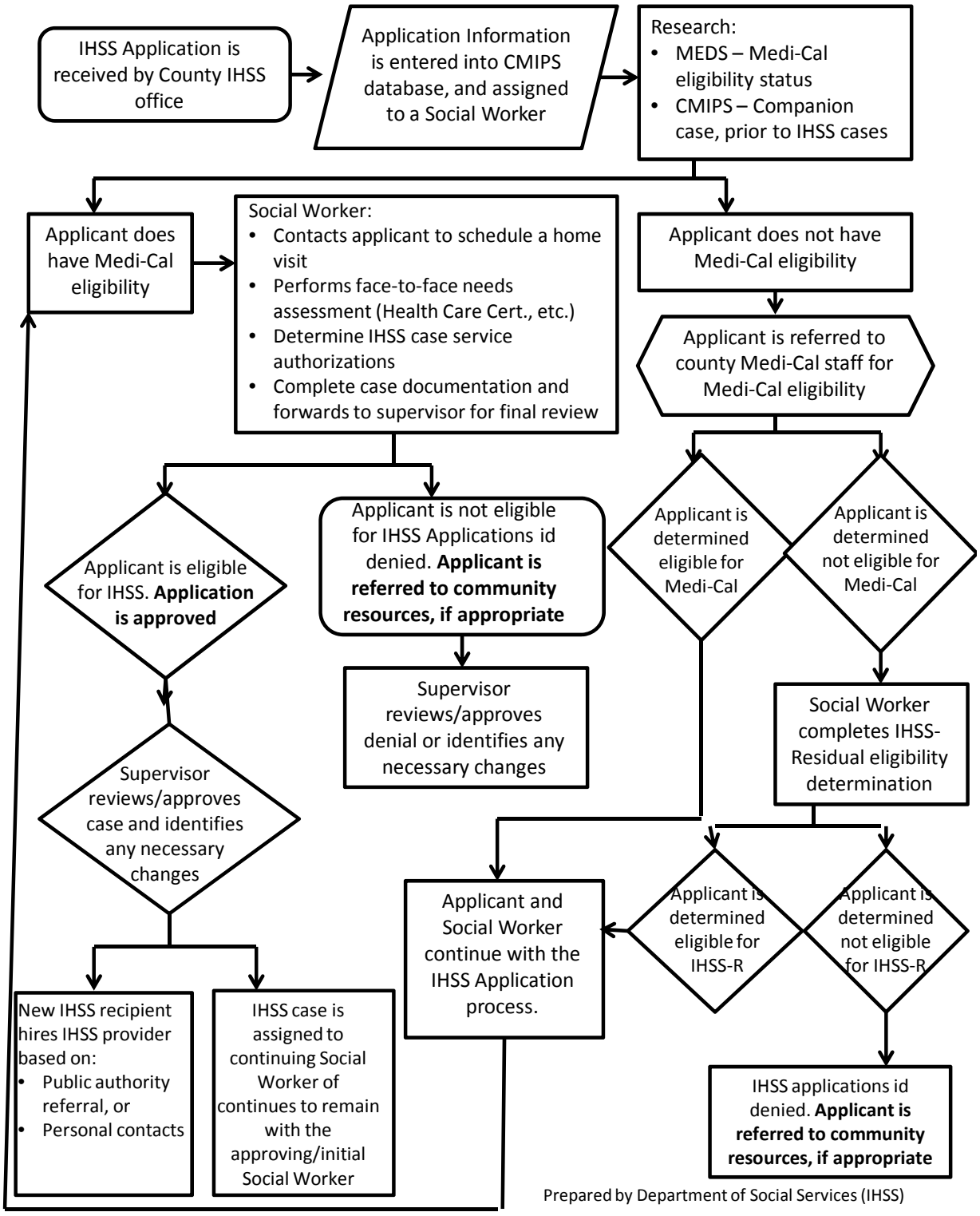
home placement" without IHSS. If the answer is yes, then the assessment is used to determine the hours of eligibility per month.

Care Planning: For the purpose of IHSS, care planning means needs assessment and periodic reassessment, and care coordination including identifying alternate resources and facilitating access to additional services. To develop a care plan requires that the IHSS social worker collaborate with other HCBS programs such as MSSP, CBAS, nursing facilities, and hospitals. Depending on the consumer's varying needs (low to high), IHSS social workers may perform daily, weekly, and/or monthly case management and care planning services. Reassessments are required to be completed annually or as requested by the consumer based on his or her needs and circumstances. Some counties have social workers who only handle initial assessments and other social workers who do reassessments. Other counties have social workers who do both initial assessments and reassessments. IHSS social workers may participate in care planning involving a multi-disciplinary approach requiring meetings with sister departments/agencies and intensive case management at the county level, depending on the consumer's needs.

Education and Training: There is no state-level educational requirement for IHSS social workers. Counties have flexibility to establish requirements and most require IHSS social workers to have post-secondary education in social work or a related field. All IHSS social workers are required to complete extensive training provided by the Social Worker Training Academy (SWTA), which operates through an Interagency Agreement between CDSS and California State University Sacramento.

Data sharing: Data sharing is individualized and involves sharing information with other community resources. This requires HIPAA compliance including client authorization and must be part of the care plan. Currently only workers in IHSS can access CMIPS II data.

Figure 2: IHSS Intake Process



Community Based Adult Services (CBAS)

The Program: CBAS centers are licensed Adult Day Health Centers (ADHCs) approved by the state to provide a medical, therapeutic, and social model of care to eligible Medi-Cal beneficiaries. Currently, there are 244 sites operating CBAS programs. As the result of a lawsuit settlement, CBAS became a benefit under the 1115 Bridge to Reform Waiver on April 1, 2012, and the ADHC program was retired after over three decades of operation in California. Medi-Cal beneficiaries must meet strict CBAS eligibility requirements, and with few exceptions, must enroll in a Medi-Cal managed care plan or County Organized Health System (COHS), if one exists in the beneficiary's county of residence.[11]

Unlike IHSS, which is statewide, CBAS is offered in nearly half—25—of California's 58 counties. Therefore, participants must reside in an area served by a CBAS Center. The first eligibility tool (the CBAS Eligibility Determination Tool [CEDT 1.0]) was implemented for the purpose of the ADHC to CBAS transition in December 2011, and the revised CEDT 2.0 was implemented on April 1, 2013. The CEDT is an eligibility determination tool, not a comprehensive assessment instrument. As described below, the assessment occurs in two stages: 1) eligibility using the CEDT; and 2) the development of an individualized plan of care (IPC).

Table 2: CBAS Level of Care Determination	
The Level of Care for CBAS can be met by any of the following:	
Category 1	Nursing Facility-A Level of Care
Category 2	Diagnosis of Organic, Acquired or Traumatic Brain Injury, or Mental Illness as defined by DSM IV
Category 3	Severe Alzheimer's disease or Other Dementia at Stage 5, 6, or 7
Category 4	Mild Cognitive Impairment or Moderate Alzheimer's disease at Stage 4
Category 5	Developmental Disabilities

[11] Taken From CAADS Website http://www.caads.org/adultdday/adultday.html May 4, 2013

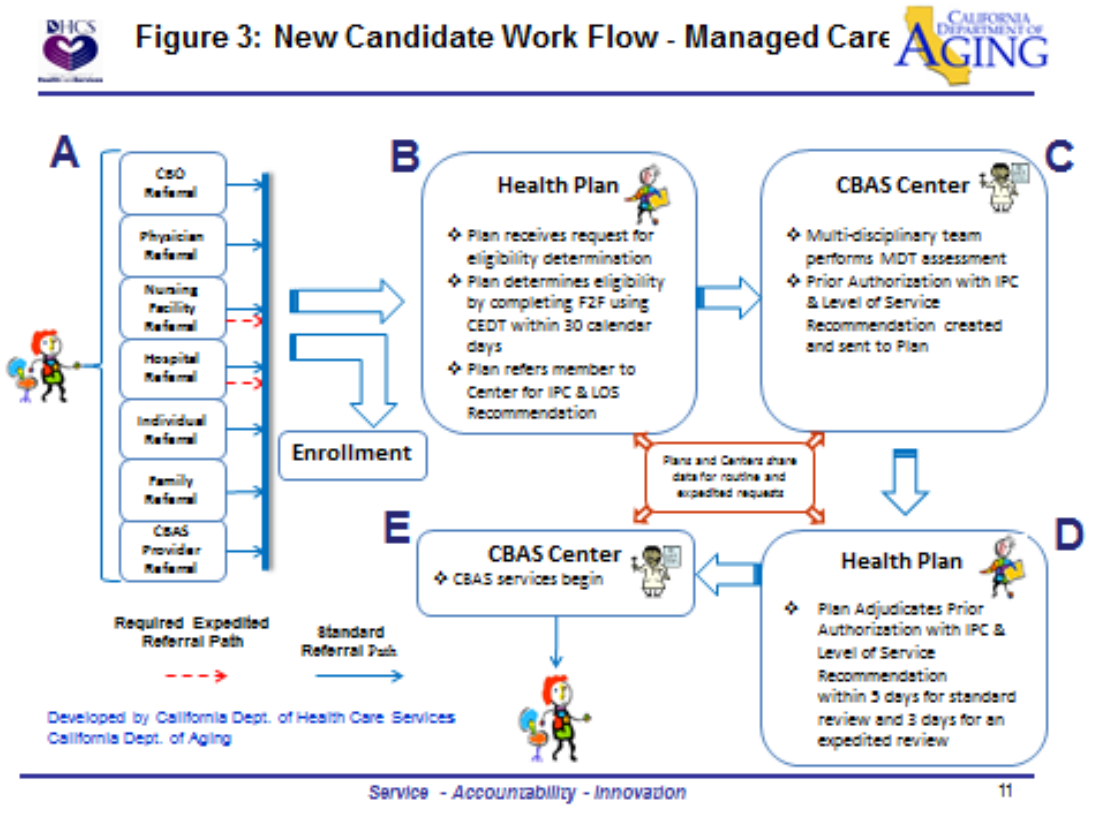
After eligibility has been determined using the CEDT, the CBAS center's multidisciplinary team (MDT) completes a comprehensive assessment for the CBAS participant using multiple discipline-specific assessment instruments to complete this process. There is no industry-wide standard comprehensive assessment instrument. Eligibility is determined in-person by registered nurses using the standardized CEDT form and process in order to promote clear and consistent eligibility outcomes.

Level of Care: The program serves Medi-Cal eligible adults aged 18 and over who meet the waiver eligibility criteria, including the LOC requirements. For more specific information on LOC see Table 2 above for LOC and Table 3, which includes the specific criteria used to determine LOC in CBAS).

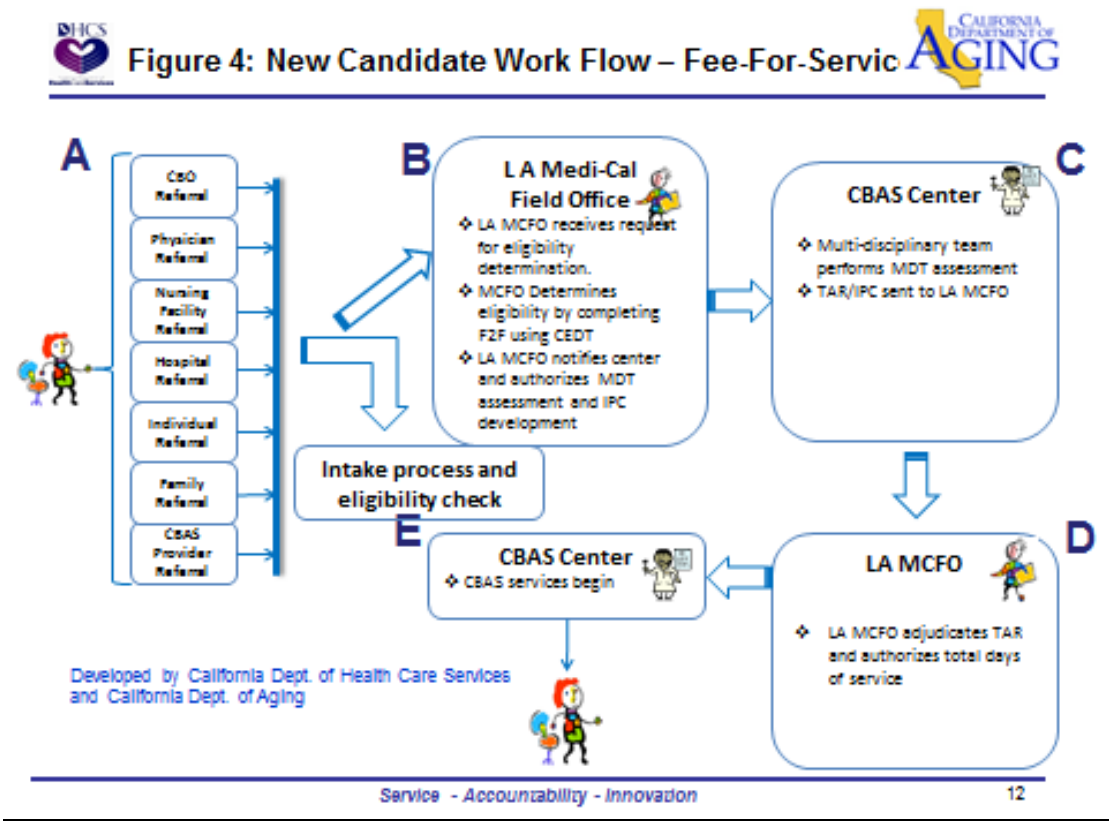
Table 3: Additional CBAS Criteria
Category 1, 3, and 5 individuals must meet ADHC medical necessity criteria in the Welfare and Institutions Code, Section 14526.1(d)(1)(3)(4)(5) and need **not** have functional impairments to be eligible.
Category 2 and 4 individuals must meet ADHC criteria in the Welfare and Institutions Code Section 14526.1(d)(1)(3)(4)(5) as well as meet functional impairment criteria specified in Section (d)(2) as follows: • **Category 2** – need assistance or supervision with: Two or more of the following ADL/IADLs: o Bathing o Dressing o Self-feeding o Toileting o Ambulation o Transferring o Medication management o Hygiene **OR** One of the ADL/IADLs above and one of the following: o Money management o Accessing resources o Meal preparation o Transportation • **Category 4** – need assistance or supervision with: Two or more of the following ADL/IADLs: o Bathing o Dressing o Self-feeding o Toileting o Ambulation o Transferring o Medication management o Hygiene

Intake: Referrals come from multiple sources, including each site's marketing materials. The multi-staged assessment process shown in Figure 3 (Managed Care) and Figure 4 (Fee-For-Service)[12] starts when a potential participant or most often a caregiver makes an inquiry about the program to a CBAS provider.

Generally an initial visit to the site is arranged that serves as an informal screening. During the visit, a representative of the CBAS provider organization discusses the program and goes over eligibility requirements including determining if the individual is enrolled in a managed care health plan or is otherwise exempt (exemptions currently include those with share of cost, residence in long-term care facilities, and enrollment in non-matching Medicare plans).



[12] Taken from http://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/Forms/2013/2013_03_New_CBAS_FFS_Eligibility_Process_Training-Providers.pptx: slides 11 & 12



Assessment: After the initial visit, if the beneficiary decides to move forward, the provider submits an inquiry to either the Medi-Cal Managed Care Plan (MCP) or DHCS to initiate a face-to-face eligibility evaluation. Once the inquiry is received, a face-to-face evaluation is scheduled. This evaluation takes approximately one to two hours to complete and focuses on the different body systems. Some MCPs complete the CEDT in electronically. DHCS nurses complete it in hard copy.

The CEDT includes three parts:

1) Findings from the evaluation;
2) Application of program criteria;
3) Eligibility outcome.

The eligibility process timeframe is as follows:

1) Within 14 calendar days of the request, the MCP or DHCS contacts the beneficiary to schedule the face-to-face eligibility evaluation;

2) The face-to-face eligibility evaluation must be completed within 30 days; and
3) Once eligibility has been determined the MCP or DHCS has 24 hours to notify the CBAS center of the result.

Care Planning: If, based on the face-to-face eligibility evaluation, the MCP or DHCS determine that the participant is eligible, the CBAS center's MDT is authorized to conduct a comprehensive assessment used to develop the IPC. The IPC and the center's recommendation for days per week of services are submitted to the MCP or DHCS for adjudication. In some cases, the provider assessment is done on paper, converted to a pdf file, uploaded and submitted to the MCP so it can become part of the participant's medical record.

Participants are reassessed by the CBAS MDT at least every six months. Every six months, the MDT develops a new IPC and requests authorization to continue providing services from either the MCP or DHCS. A face-to-face evaluation is required using the CEDT for all new CBAS participants and for continuing participants any time the MCP or DHCS reduce the days per week authorized.

Data Sharing: The Court settlement requires CBAS programs to collect program and participant data for the court to monitor. CBAS does not share data with IHSS or waiver programs.

Waiver Services

In addition to IHSS[13] and CBAS, California has a number of 1915 (c) HCBS wavier programs, including MSSP. For the purpose of this memorandum, we focus on MSSP. A waiver program requires that the state negotiate with the federal government to waive Medicaid requirements by allowing subgroups targeted in the waiver to be served outside of a health facility. The 1915 (c) waivers can waive other Medi-Cal requirements, specifically statewideness of services. Waiver programs must meet a nursing facility level of care or higher and must demonstrate cost neutrality. Waiver services are allocated to individuals as an all-or-nothing "slot," which means that the person is entitled to the range of services offered through the waiver with the caveat that the federal government requires that state plan services must be exhausted before waivers services are tapped. Depending on

[13] As noted, some parts of IHSS are covered under a waiver but it is not a 1915 (c) waiver

the waiver, cost neutrality can be individual (each individual is required to meet cost criteria) or total (the average for the group cannot exceed the established cost criteria; although some participants may be over if others are under the cost benchmark).

To be accepted into a HCBS waiver in California an individual has to first meet Level of Care (LOC) criteria, which vary depending on the waiver (see Appendix E for a summary of the LOC requirements).[14] Federal regulations require an annual reassessment at a minimum. Some programs reassess more frequently.

Because each waiver's assessment instrument was developed to meet the specific criteria of that program, there are barriers to sharing assessment across waiver programs. The federal government requires "evidentiary documentation" for each program demonstrating that the program meets qualification assurances. Information on these criteria is required to be submitted in an annual evidentiary report. Documentation is audited to ensure that the program meets assurances. Federal regulations also require that individuals who transition from one waiver to another must go through the entire process from the beginning and follow the normal eligibility determination and assessment process including a face-to-face assessment. Data cannot be shared across waiver programs.

Multipurpose Senior Services Program (MSSP)

The Program: MSSP serves people aged 65 and over who are eligible for an NF-A or B LOC (*Title 22 51334/5)*. In 1977, the California Legislature authorized MSSP as a four-year research and demonstration project. The objective of the project was to obtain information on cost-effective methods of preventing inappropriate institutionalizations of people aged 65 and over. In FY 1983-84, MSSP received approval to operate as a HCBS waiver. At that time, there were eight sites that served a caseload of 1900 elderly waiver participants. MSSP continued to expand, up to FY 2000-01, when the number of sites increased to 41 and the number of funded slots increased to 11,789.

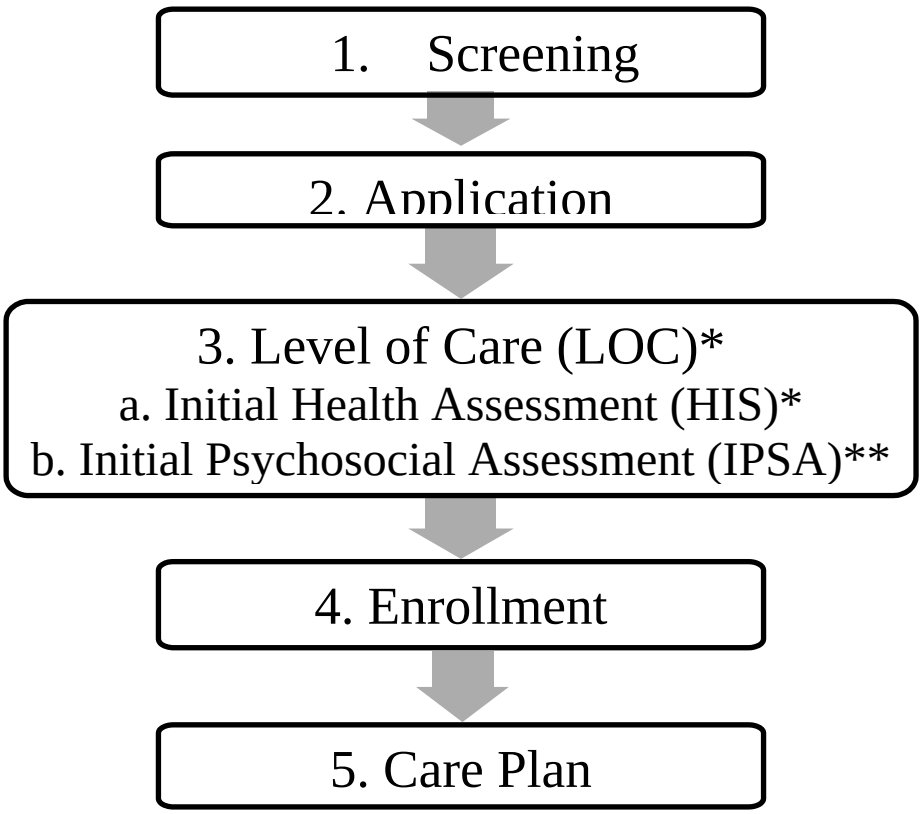
MSSP is under the supervision of DHCS and through an interagency agreement is implemented and operationalized by the California Department of Aging (CDA).

[14] From the Medicaid Manual of Criteria Chapter 7 on Long-Term Care Services: http://www.dhcs.ca.gov/services/medi-cal/Documents/ManCriteria_26_LTC.htm

CDA's MSSP Branch is the unit responsible for reviewing and monitoring local MSSP sites' compliance with waiver and program standards. CDA provides training regarding waiver and program requirements and provides on-going technical assistance to MSSP sites. The program currently has 9,440 funded slots in 39 MSSP sites throughout the state. Most sites have a waiting list.

Intake: People are referred to MSSP sites from a variety of sources, including hospital discharge planners, IHSS social workers, other community service providers, self-referrals and referrals from families (see Figure 5 for the Assessment and Care Management Process). The initial screening of a potential MSSP applicant can be performed by telephone or in person, at a community agency, at the person's place of residence, in an acute care hospital, or nursing facility. If screening is conducted in an institution, the person may not be enrolled until he or she is discharged from the facility. If the local MSSP site has an available funded slot available, the Nurse Care Manager (NCM) will perform an Initial Health Assessment and complete a LOC determination within 30 days of the person's application.

Figure 5: MSSP Care Planning Process



*LOC determination is a clinical judgment made by the Nurse Care Manager (NCM). The NCM gathers applicant information through observation, and/or information collected through the screening tool and other sources (IHA, IPSA, etc.)

**The IHA or IPSA can be completed in any order, but the second assessment must be completed within two weeks of the first assessment.

California Department of Aging (June 2013)

The person applying must be aged 65 or older, Medi-Cal eligible, "appropriate for care management," and meet the level of care consistent with need for institutionalization per the California code of Regulations, Title 22 Section 51334-51335. According to the MSSP Site Manual chapter 3 (3.110.1):

> *"Clinical Judgment—LOC determination is a clinical judgment made by the NCM in accordance with the California Code of Regulations, Title 22, Sections 51334 and 51335. The initial LOC certification is completed after the application is signed by the client and before enrollment occurs (Section 3.040, Sequence of Care Management Processes). LOC determinations are*

based on the nurse's professional assessment and observations and/or information gathered through the screening tool and other sources such as care management staff, the client, the attending physician and others involved in caring for the client. The information required for this analysis may be obtained by conducting a home visit, by a record review, or by a combination of both activities."

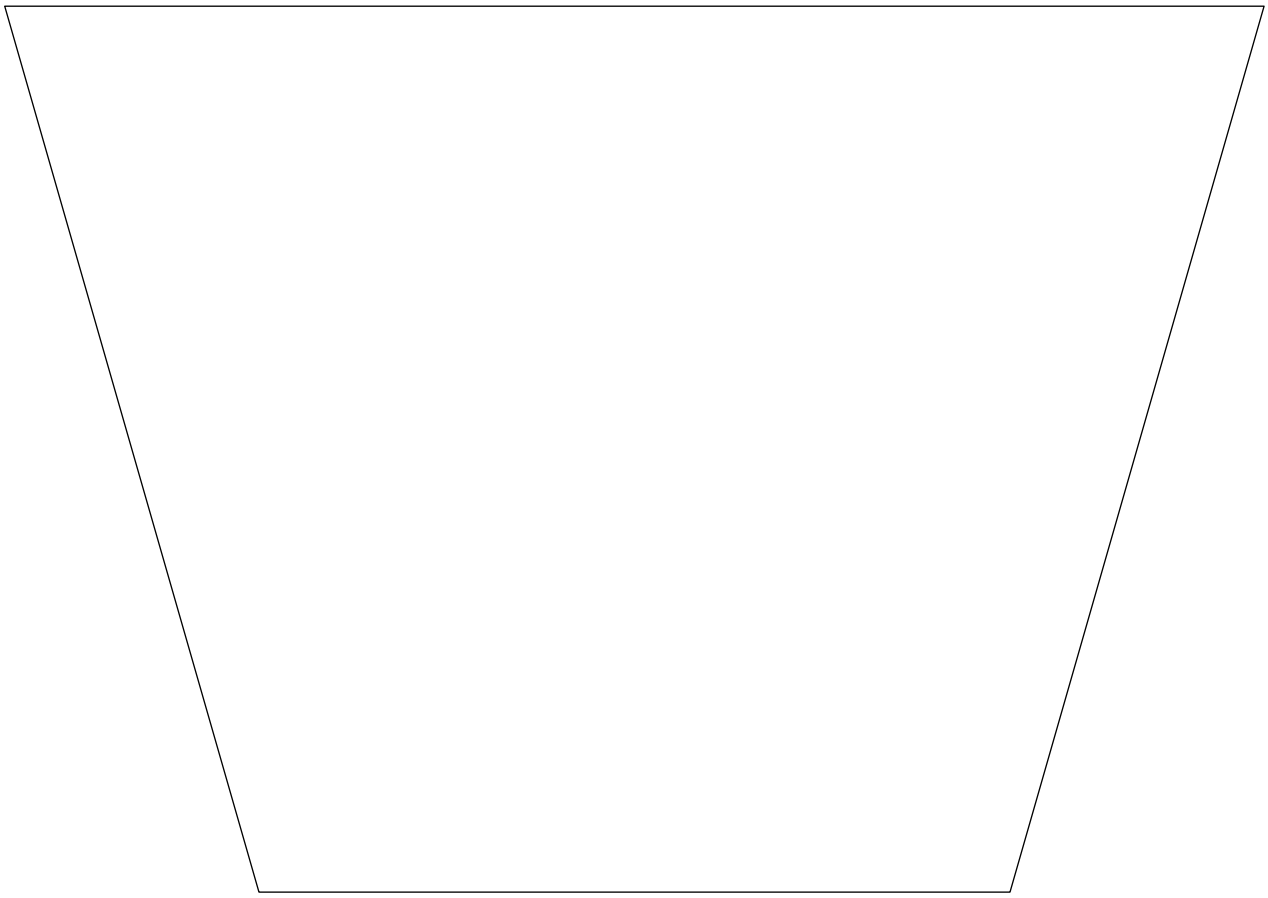
Assessment: Reflecting its emphasis on linking medical and social services, a comprehensive assessment is conducted by a registered nurse and a social worker as a team. (See Figure 5) The purpose of the assessment is to determine need for service and to develop a care plan.

Care Planning: MSSP Case Managers assess clients' needs and link them to appropriate services, including IHSS. Services can be arranged by linking to other programs such as CBAS, IHSS, home-delivered meals, housing, and transportation. Needed items and/or services not available through other programs can also be obtained through purchase-of-service arrangements. Purchase of services requires that the case manager obtain three bids.

According to the MSSP Site Manual, "the MSSP care plan reflects several elements that are interdependent. They must support each other and combined, validate the necessity and appropriateness of program services." These elements are shown in Figure 6.

Although care management/care planning is the core of MSSP, operational characteristics of the program vary by site. Some sites have electronic data records using a software vendor-provided template, and other MSSP sites use paper forms stored in files onsite.

Figure 6: The MSSP Care Planning Process



The process is described in section 3.640.1 of the MSSP site manual:
http://www.aging.ca.gov/ProgramsProviders/MSSP/SiteManual/docs

According to the MSSP Site Manual:

> *"The assessments, reassessments, care plans, progress notes and Service Plan and Utilization Summary (SPUS) are the tangible elements of the care management process. The goals and outcomes of care management must be clear.... The client's choice and functional needs must be reflected and incorporated in the documentation. All clients must be monitored monthly by a member of the care management team. Monitoring entails review of each care plan problem statement and evaluating the effectiveness of the care plan through face-to-face or telephone contact. The preferred contact is*

between the care manager and the client. If it is necessary to California Department of Aging, Multipurpose Senior Services Program to communicate with another party (e.g., support person or caregiver), the reason should be stated. A face-to-face visit with each client by a member of the care management team must be conducted quarterly (at 3 month intervals) in the client's residence. In the event that extenuating circumstances exist and the visit cannot be conducted in the client's home, the reason must be documented in the progress notes." [15]

Education and Training: To ensure the health and welfare of individuals served by the MSSP Waiver, the federal Centers for Medicare & Medicaid Services (CMS) require specific education and work experience for employment by an MSSP site. At a minimum, the nurse case manager must have a license that is current and in good standing, plus one year of work experience. The social work case manager must have at least a bachelor's degree in social work or a related field and two years of experience working with the elderly.

Data Sharing: The MSSP site manual notes that during the application, the client is informed that they are granting permission to share personal information among MSSP staff, governmental regulatory agencies, consultants, and service vendors to facilitate service. Beyond those parameters, sharing and obtaining information requires the specific consent of the client. To monitor budget neutrality, MSSP (and other waiver services) obtain information on service allocations through the Service Planning and Utilization Summary. This form authorizes and tracks units and costs of services that are obtained or purchased through MSSP. As shown in Figure 6 above, it includes IHSS and associated costs and is used to monitor cost thresholds, which are benchmarks for cost neutrality.

[15] *MSSP Site Manual: Chapter 3.* Accessed on May 4, 2014 from http://www.aging.ca.gov/ProgramsProviders/MSSP/SiteManual/docs/Chapter_3.pdf

Key Resources

Figures 1 and 2: Information prepared by and obtained through personal communication with the California Department of Social Services.

Figures 3 and 4: DHCS and CDA. CBAS New Fee-For Service Eligibility Determination Process Training for CBAS Providers (March 2013). http://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/Forms/2013/2013_03_New_CBAS_FFS_Eligibility_Process_Training-Providers.pptx.

MSSP Site Manual May 2012. Retrieved 5-2013 http://www.aging.ca.gov/ProgramsProviders/MSSP/SiteManual/

Newcomer R, Harrington C, Stone J, Bindman AB, & Helmar M (2011). California's Medi-Cal Home & Community Based Services Waivers, Benefits & Eligibility Policies 2005—2008. Report to The SCAN Foundation. http://camri.universityofcalifornia.edu/documents/medi-cal-waiver-report.pdf

Newcomer R, Harrington C, Stone J , Chattopadhyay A, Lee SJ, Kang T, Chu P, Kao C, & Bindman AB (2012). Recipients of Home and Community-Based Services in California. Report to The SCAN Foundation. http://camri.universityofcalifornia.edu/documents/hcbs-report-dhcs.pdf. Retrieved Feb 14, 2013

APPENDIX A: Methods

Domain Comparison

In a separate analysis, we compared domains externally recommended by recognized entities with the purpose of providing assessment standards.[16] Topics recommended by one or more of these external standards are indicated with an asterisk. Those were then coupled with domains and topics included by four example state assessment extractions.[17] This provided the framework for the assessment comparison depicted in Appendix A. Any topics present in a HCBS assessment that were not included by an external standard or an example state were added to a new California specific domain.

We reviewed assessment instruments for three HCBS and entered which domains each included in a table of assessment domains. We then asked representatives of each HCBS to review and, where needed, make revisions to the Table. Because the focus of the effort was on three HCBS (IHSS, CBAS, and MSSP) those are in the final table, which is included as Appendix A.

Comparing the Assessment Process

To learn about and compare the process of conducting assessments across the HCBS programs, we interviewed representatives from each program. Questions included how the assessment is conducted, the training and qualifications of the assessors, care planning processes and discussion of any data sharing that might occur. We also describe the Level of Care (LOC) requirements of each program. In California, LOC determinations are spelled out in the California Code of Regulations Title 22. We augmented information from the interviews with public documents, reports, and websites. We interviewed one or more representatives from each of the seven California HCBS programs. Representatives from the Advisory Group discussed the draft memo at several meetings and reviewed and modified the draft to ensure accuracy, comprehensiveness, and completeness.

[16] Saliba D, et al. Memorandum on External Recommendations for Standardized Assessment in the US. March 2013.
[17] Ray L, Saliba D, et al. Memorandum Comparing Four States' Comprehensive Assessment Systems. May 2013.

APPENDIX B: Assessment Comparison of Three HCBS Programs in California

	CBAS		IHSS		MSSP[5]
	CEDT[1]	IPC[2]	SOC 295[3]	SOC 293[4]	
Background Information					
Active Legal Issues					X
Assessment Context	X			X	X
Collateral Contacts	X			X	X
Communication*	X	X		X	
Comprehension	X			X	X
Cultural History and Influences*					
Demographics			X	X	
Education*					X
Formal Services and Providers*	X	X	X	X	X
Health Insurance*					
Health Literacy*					X
Informal Support Systems*		X		X	
Language Issues*	X		X	X	X
Legal Representatives/Documents*				X	X
Others Living in the Home*	X		X	X	X
Primary Caregiver*	X	X		X	
Primary Health Care Provider*		X		X	X
Residential Status				X	X
Source of Information					
Spiritual Support*					
Veteran Status			X		
Financial Assessment					X
Employment History*					X
Income/Assets/Other Private Resources*					X
Out-of-Pocket Expenses and Impact*					
Program Eligibility*					
Health					X
Abuse or Neglect (potential for or history of) *				X	X
Activity Level				X	X
Allergies/Adverse Drug Events*					X
Assistive Devices or Adaptations*	X	X		X	X
Client Self-Rated Health			X	X	X
Continence*		X		X	
Dental Status*	X	X			X
Fluid Intake*					X
Gait & Balance Assessment/Falls*	X	X			
Genetic History of Family Health*					X
Hearing*	X	X		X	
Improvement or Discharge Potential	X				
Stability/Instability of Conditions					X
Medical History, Active Diagnoses*	X	X		X	X

APPENDIX B: Assessment Comparison of Three HCBS Programs in California

	CBAS		IHSS		MSSP[5]
	CEDT[1]	IPC[2]	SOC 295[3]	SOC 293[4]	
Medications*	X	X		X	X
Medication adherence*	X				X
Understanding of medications*					
Mode of Nutritional Intake	X			X	X
Nutritional Status/Weight Change*	X	X		X	X
Pain*	X				X
Patterns of Health Services Use	X	X		X	X
Physical Exam*					
Preventive Health					X
Skin Condition	X			X	
Special Treatments*	X				
Swallowing*	X	X		X	X
Tobacco Use					X
Vision*	X	X		X	
Functional Assessment*					
Activities of Daily Living (ADLs)					X
Ambulating*	X	X		X	X
Bathing*	X	X		X	X
Bed Mobility				X	X
Dressing*	X	X		X	X
Eating*	X	X		X	X
Hygiene*	X	X		X	X
Mobility (in/out of home)*				X	X
Oral Care*				X	X
Toilet Use*	X	X		X	X
Transferring*	X	X		X	
Instrumental Activities of Daily Living (IADLs)					
Equipment/Supply Management*					X
Managing Finances*	X	X			X
Managing Medications*	X	X			X
Meal Preparation*	X	X		X	X
Ordinary Housekeeping*				X	X
Shopping*				X	X
Stair Climbing				X	X
Telephone Use*					X
Transportation*	X	X		X	
Cognitive/Social/Emotional/Behavioral					X
Alcohol or Other Substance Use*	X				X
Behavioral Symptoms*	X	X			
Cognitive Functioning*	X				
Level of consciousness	X			X	X

APPENDIX B: Assessment Comparison of Three HCBS Programs in California					
	CBAS		IHSS		MSSP[5]
	CEDT[1]	IPC[2]	SOC 295[3]	SOC 293[4]	
Judgment/decision-making capacity*	X	X		X	X
Memory*	X			X	X
Mood and Affect*	X				X
Other Psychiatric*		X			
Psychological Therapy					
Readiness to Change*					X
Recent Change in Cognition/Delirium*				X	
Sexual Functioning/Body Image*					X
Social Participation/Isolation*	X	X			
Stressors					X
Suicide Risk*					
Use Of Physical Restraint					X
Wandering	X				
Goals and Preferences					
Advance Care Planning*					
Care Goals, Expectations, Preferences*		X		X	
Health Goals, Expectations, Preferences*					
Personal Values or Beliefs*					
Transitional/Discharge Plan*					
Environmental Assessment (Home, Community) *					
Access to Food				X	
Adequate Space*					
Communication with Utilities and Emerg. Svcs. *				X	
Community Resources*	X	X		X	X
Condition of Home				X	X
Emergency Preparedness*				X	X
Housing Accessibility*				X	
Housing Stability*					
Neighborhood Safety*					X
Safety In-Home*				X	X
Telephone Access*					X
Transportation Access*				X	
Caregiver Assessment					
Availability to Provide Care*					
Emotional Competence/Stability*					
History of Abusive Behaviors*					
Hours/Tasks*		X		X	
Physical Capacity*					
Receiving Support Services					
Stress or Need for Respite*	X			X	
Willingness & Ability to Implement Care Plan*	X			X	
Willingness & Ability to Work with Care Team*					

APPENDIX B: Assessment Comparison of Three HCBS Programs in California					
	CBAS		IHSS		MSSP[5]
	CEDT[1]	IPC[2]	SOC 295[3]	SOC 293[4]	
Other					X
Family Dynamics*				X	
Learning and Technology Capabilities*					
Need for Supervision	X	X		X	X
Pet Care					
Presence of Developmental Disability	X	X			X
Primary Mode of Locomotion Indoors	X	X			X
Recreational/Leisure Pursuits*					X
Self-Care Capability/Clients Strengths*	X	X		X	
Stage in Life Cycle & Related Developmental Issues*					
Supervision of Plan of Care (Client or Other)				X	
California Specific					
Back-up Caregiver Plan					
Informed Consent to Participate					
Request for Change in Authorized Services				X	
Risk Assessment		X			
Seizure Activity	X				
Sexual History					X
Sleep Pattern					

[1] Community Based Adult Services Eligibility Determination Tool (CEDT), Version 2.0.
[2] Community Based Adult Services Individual Plan of Care (IPC), 2012.
[3] In-Home Supportive Services SOC 295 Application for Social Services, 2009.
[4] In-Home Supportive Services SOC 293A: Needs Assessment Face Sheet and SOC 293: Needs Assessment.
[5] Multipurpose Senior Services Program Level of Care (LOC) Determination Tool, 2012.
* Externally Recommended Standards: Saliba D et al. Memorandum on External Recommendations for Standardized Assessment in the United States. March 2013.

CBAS uses the CBAS Eligibility Determination Tool (CEDT) for eligibility determination purposes while the Individual Plan of Care (IPC) is used by sites to determine the recommended program days per week. However, the CBAS center's interdisciplinary care team develops the IPC using information gathered through a variety of assessment instruments that may or may not be standardized and are not State-required. The SOC 295 is the IHSS application for social services which is completed by the client during intake before a home visit occurs. Of the nine forms completed at the IHSS home visit, we extracted the form SOC 293 which is the IHSS Needs Assessment. There is a one-page face sheet (SOC 293A) which accompanies the Needs Assessment; the two are coupled together in the matrix column. MSSP determines a care plan through a level of care (LOC) determination which is comprised of the Initial Health Assessment (IHA) and the Initial Psychosocial Assessment (IPSA); both are always completed.

APPENDIX C: Comparison of Assessment Processes in Three HCBS Program			
Program	MSSP	CBAS	IHSS
	39 sites	244 sites in 25 counties	Statewide
Number of Participants/Slots	9,440 slots	23,000 approximately	447,000
Waitlist	Yes	No; not a slot-based program	No
Age	65+	18+	All
Type of Assessment			
Screen for Eligibility	If slot	Pre-screened at each center	Varies by Co
Electronic	No	No	No for assessment; yes - CMIPS II
LOC	NF A and B, RN clinical judgment, Title 22 51334/5	NF-A or above; moderate to severe CI, MCI + 2 ADL, TBI, need supervision	Risk for "out of home placement" without IHSS
Unit of Service	Slot	Days/week	Hours per month
Comprehensive Assessment			
Performed by	RN & SW	Health Plan or Fee-for-service RN	Social Worker
Location	Home or Facility	Home	Home
Purpose	Eligibility & care planning	1) Assessment 2) Meets eligibility criteria 3) Service planning	1) Assess needs 2) Determine hours/mo
Care Planning			
	Linked and PoS: ADC/Center support, housing assistance, chore and PAS, protective supervision, care management, respite, transportation, meal services, social services, communication services, OAA programs	Provider MDT for IPC, occupational therapy, physical therapy, speech therapy, skilled nursing, social work, psychology services, nutritional services, transportation, therapeutic activities, at least one meal/day	Identifying needs and authorizing hours for 26 different services including protective supervision, paramedical
Reassessment	Annually	Every 6 months or with change in condition	Annually/specific cases 18 months
Cost Neutrality	Average cost	No	No
Data Sharing[18]	Service planning and utilization summary; MSSP/IHSS	No	SPUS; Eligibility; Payroll

[18] This excludes client authorized information sharing that is done as part of care planning and care coordination by each program

Terms	
ICP	Individual Care Plan
ISP	Individual Service Plan
TBI	Traumatic Brain Injury

Programs		
MSSP	Multipurpose Senior Services Program; aged 65+	DHCS/CDA
CBAS	Community-Based Adult Services (formally Adult Day Health Care); aged 18+	DHCS/CDA
IHSS	In-Home Supportive Services; all ages	DSS

APPENDIX D: IHSS Assessment and Service Forms

- SOC 295 (Application for Social Services)
- SOC 293 (IHSS Needs Assessment)
- SOC 293A (IHSS Needs Assessment Face Sheet)
- SOC 332 (Recipient/Employer Responsibility Checklist)
- SOC 864 (IHSS Back-up Plan/Risk Assessment)
  - The SOC 864 risk assessment form is completed at the time of application and during the annual reassessment. However, the SOC 864 may be valid for two years and is only required to be completed every other year in the event there have been no changes in the consumer's back-up plan and risk assessment from the previous year. In this case, the county IHSS social worker may sign the SOC 864 in the designated area confirming there are no changes from the previous year.
- SOC 426A (IHSS Recipient Designation of Provider)
- SOC 873 (IHSS Health Care Certification)
  - Per ACL 11-55, the Health Care Certification is completed at the time of application (i.e., during the intake assessment). After the initial Health Care Certification or alternative documentation is received and the county finds the consumer eligible for IHSS services, a new certification is not required at subsequent reassessments.
- The SOC 321 (Request for Order and Consent – Paramedical Services), SOC 450 (Voluntary Services Certification), and SOC 821 (Assessment of Need for Protective Supervision/SOC 825 (Protective Supervision 24-Hours-A-Day Coverage Plan – optional) is only completed if the consumer needs paramedical services, has voluntary services provided by family/friends who do not want financial compensation from IHSS, and protective supervision services are requested/needed, respectively.

APPENDIX E: Level of Care (LOC) Summary Criteria for Waiver Programs

1) NF-A *(Title 22 §§ 51120 51334)*: The patient at this LOC needs protective and supportive care ***without*** the need for continuous, licensed nursing. NF-A patients may require minor assistance or supervision in personal care, such as in bathing or dressing.

2) NF-B **(***Title 22 §§51124 51335***)**: "[Need] for 24-hour skilled nursing care to render treatment to unpredictable, unscheduled and/or unmet needs. Patients at the SNF level of care may have such an excess of ADL and IADL needs that they exceed the capacity of the ICF LOC and therefore qualify for SNF services, such as bedridden patients, quadriplegics, and full assist patients."

   Note: The major distinction between NF-A and NF-B LOC is that the NF-A LOC is characterized by scheduled and predictable nursing needs. NF-A and NF-B are combined with the standard set at the NF-A level as baseline. The level is equivalent to an intermediate care facility level of care, which is no longer operational in most programs in CA.

3) Sub-acute ***(****Title 22 §51124.5****)****:*** "[dependency] on medical technology to supplant or replace a major organ system function characterizes the adult S/A LOC. This is often, but not exclusively limited to, tracheostomy and ventilator support."

4) Acute: IHO and NF/AH (*Title 22 §51110***)**: "[Need] for the continuous availability of nursing and medical care as only available at an acute care facility. Specific medical and surgical conditions are described which warrant such care. The need for daily physician visits is required."

5) NF-A *(Title 22 §§ 51120 51334)*: The patient at this LOC needs protective and supportive care ***without*** the need for continuous, licensed nursing. NF-A patients may require minor assistance or supervision in personal care, such as in bathing or dressing.

6) NF-B **(***Title 22 §§51124 51335***)**: "[Need] for 24-hour skilled nursing care to render treatment to unpredictable, unscheduled and/or unmet needs. Patients at the SNF level of care may have such an excess of ADL and IADL needs that they exceed the capacity of the ICF LOC and therefore qualify for SNF services, such as bedridden patients, quadriplegics, and full assist patients."

   Note: The major distinction between NF-A and NF-B LOC is that the NF-A LOC is characterized by scheduled and predictable nursing needs.

7) Sub-acute ***(****Title 22 §51124.5****)****:*** "[dependency] on medical technology to supplant or replace a major organ system function characterizes the adult S/A LOC. This is often, but not exclusively limited to, tracheostomy and ventilator support."

8) Acute: IHO and NF/AH (*Title 22 §51110***)**: "[Need] for the continuous availability of nursing and medical care as only available at an acute care facility. Specific medical and surgical conditions are described which warrant such care. The need for daily physician visits is required."

APPENDIX F: Glossary of Key Terms

AAC – Annotated Assessment Criteria

ADHC – Adult Day Health Care

ADL – Activity of Daily Living

APD – Adult Programs Division

CCI – Coordinated Care Initiative

CBAS – Community-Based Adult Services

CDA – California Department of Aging

CDSS – California Department of Social Services

CEDT – CBAS Eligibility Determination Tool

CFCO – Community First Choice Option

CMIPS – Case Management, Information and Payrolling System

COHS – County Organized Health System

DHCS – Department of Health Care Services

FI – Functional Index

HCBS – home and community-based services

HIPAA – Health Insurance Portability and Accountability Act

HTG – Hourly Task Guidelines

IADL – Instrumental Activity of Daily Living

IHO Waiver – In-Home Operations Waiver

IHSS – In-Home Supportive Services

IHSS-R Program – IHSS Residual Program

IPC – Individual Plan of Care

IPO Program – IHSS Plus Option Program

LOC – level of care

LTSS – long-term services and supports

MCP – managed care plan

MDT – multi-disciplinary team

MSSP – Multipurpose Senior Services Program

NCM – nurse case manager

NF/AH Waiver – Nursing Facility/Acute Hospital Waiver

PCSP – Personal Care Services program

SSI – Supplemental Security Income

SWTA – Social Worker Training Academy

UAI – universal assessment instrument