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Streamlining Access to Home and
Community-Based Services:
Lessons from Washington

Jennifer Gillespie
Robert L. Mollica



This document was prepared by Jennifer Gillespie and Robert Mollica of the National Academy for State Health Policy

Prepared for:



Rutgers Center for
State Health Policy

Susan C. Reinhard & Marlene A. Walsh



Robert Mollica

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STREAMLING ACCESS TO HOME AND COMMUNITY-BASED SERVICES: LESSONS FROM WASHINGTON

Jennifer Gillespie
Robert L. Mollica

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Summary

Many states are considering, or are in the process of streamlining access to home and community-based services (HCBS). States seek to streamline access to HCBS in order to expedite and simplify the experience of consumers seeking services so that they receive the services they need in community settings, preventing or delaying the need for institutional care. To assist states, the Rutgers CSHP/NASHP Community Living Exchange developed the following issue brief describing access to home and community-based services in Washington. The design of the Washington long-term support system for older adults and people with physical disabilities provides examples for other states interested in simplifying or expediting access to long-term supports. This is the first in a series of issue briefs describing access to HCBS.

Major Points

- One agency, the Aging and Disability Services Administration (ADSA) of the Department of Social and Health Services (DSHS), manages all state supported long-term support services for older adults and people with physical disabilities.
- The Comprehensive Assessment Reporting Evaluation (CARE) is used to assess functional, health, cognitive and behavior status. It is also used to determine eligibility for long-term support services, to develop a care plan, and to determine the maximum number of hours of service that may be authorized (for in-home services).
- Medicaid financial and functional eligibility determinations are closely coordinated. Financial eligibility workers are located in the same ADSA office as the individuals who determine functional eligibility.

Background

Many states are considering, or are in the process of streamlining access to home and community-based services (HCBS). States seek to streamline access to HCBS in order to expedite and simplify the experience of consumers seeking services so that they receive the services they need in community settings, preventing or delaying the need for institutional care.

State efforts to streamline access have increased with the support of the President's New Freedom Initiative. This initiative includes Aging and Disability Resource Center (ADRC) grants jointly funded by the Centers for Medicare & Medicaid Services (CMS) and the Administration on Aging (AoA), and CMS Real Choice Systems Change grants. Grantees requested guidance on streamlining access to long-term supports. To assist states, the Rutgers CSHP/NASHP Community Living Exchange developed the following issue brief describing access to home and community-based services for older adults and people with disabilities in Washington State. This is the first in a series of issue briefs describing access to HCBS.

How Do State's Streamline Access?

States can streamline access to HCBS by coordinating the functions that must be performed in order for a consumer to receive services and by simplifying the operational procedures related to these functions as described below. There is a great deal of variation across the states in how the functions are performed and the entities responsible for them. The states highlighted in this series provide examples of different approaches to performing the functions necessary to receive services. Our intent is to describe how functions are coordinated in the individual states, to help other states consider how they might reform, revise, or restructure their own systems.

Functions

The range of functions that must be performed in order for a consumer to receive services may include:

- Information and referral includes assistance provided by phone, sending written materials, and communicating via a website. It includes the provision of follow-up assistance to help consumer's access both privately, and publicly financed services.
- Screening, sometimes called triage, refers to the brief assessment conducted by phone to help understand the type of information and assistance needed.
- A nursing facility preadmission assessment screening (PAS) is completed to record information about a person's health, environment, social/cognitive/psychological state, and functional status. Information obtained on the assessment is used to determine whether a person meets the state's nursing facility level of care criteria and eligibility for admission to a nursing facility or for Medicaid home and community-based services.
- A similar process, ICF/MR preadmission screening, is used for people with mental retardation/developmental disabilities.

- The assessment function is similar to the PAS, but is used to assess capacity and service needs that lead to a care or individual service plan. Assessment and PAS may be combined into one assessment instrument to serve both purposes. The assessment may also gather the information required to make eligibility determinations.
- Programmatic and functional eligibility determination is the process for determining whether a person meets the eligibility and functional requirements, if any, for the program providing services.
- Financial eligibility determination is the process for determining whether a person meets the income and resource requirements, if any, for the program providing services.
- The care plan is built on findings from the assessment process and lists the services that may be selected by the consumer based on their individual preferences.
- Once a care plan is developed, the authorized services that may be provided by outside agencies or arranged by the consumer must be determined.
- Monitoring service delivery from providers of services must occur to make sure the care plan is being implemented. This is often referred to as case or care management.
- Reassessment is the process for re-determining the person's functional eligibility for the program and whether any changes have occurred that require modification of the care plan.

Operations

In addition to consolidating all of the functions that must be completed in order for a consumer to receive services, states can further streamline or simplify the operational procedures for performing the functions necessary to access services. Operational procedures can be simplified through the integration of information technology, online applications, and reduction of the:

- number, length, and duplication of forms,
- amount of time to determine eligibility and initiate services,
- number of entities that the consumer must interact with to obtain services, and
- number of interactions between program staff and consumers.

Some states have also merged the departments responsible for certain functions and others have developed a memorandum of understanding between departments to help processes appear seamless to the consumer.

Lessons from Washington

This issue brief discusses access to public and privately financed long-term support services in Washington for older adults and adults with physical disabilities. It is organized by the functions performed. Discussions of operational procedures that further streamline, expedite,

or simplify access to services are interspersed where applicable. Washington's is an example of a state in which:

- One agency manages all state-supported long-term support services for older adults and adults with physical disabilities;
- A single automated system is used to assess functional, health, cognitive and behavior status, determine eligibility for long-term support services, develop a care plan, and determine the maximum number of hours of service that may be authorized (for in-home services); and,
- Medicaid financial eligibility workers are located in the same office as the individuals who determine functional eligibility.

The design of Washington's system provides lessons for other states interested in data integration, reducing unnecessary consumer interactions, and ensuring timely start of services.

Program Practices

Washington has a mature home and community-based care system with seventy-one percent of long-term support services provided in home and community-based settings. One agency, the Aging and Disability Services Administration (ADSA) of the Department of Social and Health Services (DSHS), manages all state-supported long-term support services for older adults and adults with physical disabilities. In Washington, DSHS is the Medicaid single state agency with delegated responsibility for financial and functional eligibility determination for long-term support services to ADSA.

ADSA administers long-term support services through regional offices and Area Agencies on Aging (AAA). Thirteen AAAs perform the information and referral function. Regional offices of the ADSA conduct the initial assessment for Medicaid funded services, functional eligibility determination and care plan development functions. On-going case management and reassessment is provided by the regional ADSA staff for beneficiaries in nursing facilities, adult family homes and assisted living settings. Area Agencies on Aging provide case management for in-home participants. Figure 1 illustrates how responsibility for the functions is distributed in Washington. The ADSAs and AAAs use a common database of applicant and consumer information. The state currently operates a separate system for people with developmental disabilities.

Figure 1. Access to HCBS in Washington for Older Adults and Adults with Physical Disabilities	
Function	Responsible Entity
Information and referral	AAAs
Screening	na
Nursing facility preadmission screening	ADSA assessor
ICF/MR preadmission screening	na
Assessment	ADSA assessor
Programmatic and functional eligibility determination	ADSA assessor for Medicaid programs and AAA for state and Older Americans Act funded programs.
Financial eligibility determination	ADSA financial eligibility worker
Care plan development	ADSA assessor
Determination of authorized service levels	ADSA assessor
Monitoring of service delivery (case management)	AAAs for in-home consumers, ADSA for consumers in nursing facilities, adult family homes and assisted living settings.
Reassessment	AAAs for in-home consumers, ADSA for consumers in nursing facilities, adult family homes and assisted living settings.

Information and Referral

The AAAs help consumers identify, understand, and access available resources. If a consumer who contacts the AAA appears to be eligible for, or requests, Medicaid services, the AAA makes a referral to the local ADSA office for assessment. If the consumer does not appear to be eligible for Medicaid, one of two things happens. If the caller's inquiry is fairly simple, the assistant specialist makes the appropriate referral for non-Medicaid community services. If the caller's inquiry is more complicated, the assistance specialist refers the caller to an AAA case manager for an assessment for non-Medicaid services, including Older Americans Act (OAA) and state funded respite care and case management services.

Screening

The AAAs do not use a formal screen for Medicaid or non-Medicaid services. Anyone who requests an assessment receives one. The state agency field offices also do not have a screening tool that indicates whether or not the person needs a full assessment. The state prefers not to risk screening people out inappropriately. As a result, all potential consumers who request it receive the complete assessment.

Nursing Facility Preadmission Screening

Preadmission screening (PAS) determines eligibility for a state's nursing facility level of care. The PAS may be completed for current Medicaid beneficiaries, people who are likely to become Medicaid beneficiaries within six months, or private pay applicants. In some states it is

conducted separately from the functional eligibility determination process for Medicaid and other programs (discussed below).

Washington conducts preadmission screening for all people who seek nursing facility services from the community, with the exception of private pay applicants. Consumers who enter a nursing facility from a hospital receive a visit and assessment within seven days of admission. In Washington, the PAS to determine nursing facility level of care is integrated into the assessment discussed below.

ICF/MR Preadmission Screening

ICF/MR preadmission screening is for people with mental retardation or developmental disabilities. In Washington, services for people with mental retardation or developmental disabilities are obtained from a separate system and are not the focus of this paper.

Assessment

A comprehensive assessment that addresses eligibility criteria for multiple programs and populations can facilitate access to all publicly financed programs. WA implemented a comprehensive assessment system in 1984 and computerized the assessment tool in 1995. However, state staff and external evaluators observed significant variations in the use of the tool across case managers and the questions did not adequately address cognitive and behavioral issues. Reports from the Washington state executive and legislative branches recommended that ADSA create a new assessment.¹ In response, the ADSA developed an assessment system that:

- Accurately measures needs (medical, cognitive, behavioral, personal care, and caregiver/respite);
- Provides an objective and reliable assessment;
- Allocates resources fairly (based on severity of need); and,
- Standardizes documentation for federal audit and quality purposes.

Applicants who appear to be eligible for Medicaid, or request assessment for Medicaid eligibility, are assigned to an assessor who conducts an assessment in the consumer's home within seven days of initial contact. In some instances it is determined that the individual is not eligible for Medicaid. If the person has unmet needs, they are referred to the AAA for case management, respite, or other services available to those with higher incomes.

The Comprehensive Assessment Reporting Evaluation (CARE) is used to assess functional, health, cognitive and behavior status, determine eligibility for long-term support services. It is also used to develop a care plan, and to determine the maximum number of hours of service that may be authorized. Implementation of the CARE system began in March 2003 and was completed in February 2005.

¹ A 1998 report commonly referred to as the "Ladd Report" was commissioned by the Office of Financial Management and the state Senate. The Joint Legislative and Executive Task Force on Long-term support (JLARC) also recommended changes.

Nurses and social workers employed by the state and located in the ADSA field offices conduct the initial assessment. The initial CARE assessment takes approximately three hours to complete on a laptop computer. Assessors upload completed assessments to ADSA's central computer. Assessors receive extensive technical training to use the CARE system and they complete between 15-20 assessments each month.

The assessment instrument

One of Washington's goals was to accurately measure needs (medical, cognitive, behavioral, personal care, and caregiver/respite). The foundation of the Washington CARE assessment is the Minimum Data Set (MDS). CARE also incorporates other standardized, nationally recognized tools to assess the consumer's mood, behavior, and cognition. These include: the Mini Mental Status Exam (MMSE), which is recognized as a reliable indicator of the consumer's memory, orientation, motor planning, and perception; the Iowa Version of the CES-D Depression Symptoms Index; CAGE, a screen for alcohol and substance abuse; a Suicide screen; and the Cognitive Performance Scale, which also measures cognitive ability. Assessors and case managers commented that the questions about depression are among the most important recent improvements in the assessment.

The questions in CARE address the consumer's activities of daily living, instrumental activities of daily living, and a wide range of issues not limited to the consumer's environment, medical needs, skin care indicators, and psychological/ social issues. All activities of daily living (bathing, dressing, eating, bed mobility, transfer, locomotion, toileting and personal hygiene) are coded for self performance. The codes are: Independent; Supervision; Limited assistance; Extensive assistance; Total dependence; and, Activity did not occur. The code definitions for all ADLs except bathing are:

- **Independent** is defined as help or staff oversight or staff help/oversight provided only 1 or 2 times during the last seven days.
- **Supervision** is defined as oversight (monitoring, standby), encouragement, or cueing provided 3 or more times during last seven days or supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last seven days.
- **Limited assistance** is defined as individual highly involved in activity, received limited assistance or physical help in guided maneuvering of limbs or other non-weight bearing assistance on 3 or more occasions plus more help provided only 1 or 2 times during last seven days.
- **Extensive assistance** is defined as help of following type(s) was provided 3 or more times while the individual performed part of activity over last seven days: weight-bearing support or full caregiver performance of activity during part (but not all) of last seven days.
- **Total dependence** is defined as full caregiver performance of the activity during entire seven-day period. Complete non-participation by the individual in all aspects of the ADL definition.

- **Activity did not occur** during entire 7-day period because:
 - no provider was available and the client would have accepted assistance with task if a caregiver had been available.
 - client is not capable of task.
 - client declined or refused assistance with task.

The ADL self performance codes for bathing only are: Independent – no help provided; Supervision – oversight help only; Physical help limited to transfer only; Physical help in part of bathing activity; Total dependence; and, Activity itself did not occur during entire 7 days.

The assessment also captures the level of available informal support. The assessors use the CARE system to identify assistance that the consumer is receiving, the level of assistance provided, the continued assistance needed, and how the need will be met and/or continued to be met, either through informal provider(s), formal provider(s), or a combination of both.

Another goal of the CARE system was to produce a more objective and reliable assessment. Inter-rater reliability means that two workers assessing the same consumer will get the same results. Inter-rater reliability of the CARE system was tested by the University of Washington, and it was determined to be reliable and consistent between assessors.

An important feature of comprehensive assessments is the use of modules. Rather than asking every applicant every possible question related to eligibility determination, “trigger” questions are used to identify when the assessor should complete a particular module. Modules might assess the need for employment supports or mental health services, for example.

The CARE assessment includes critical indicators that trigger a referral for a nursing review. Potential critical indicators include: unstable/potentially unstable diagnosis; medication regimen affecting plan of care; nutritional status affecting plan of care; immobility risks affecting plan of care; and, past or present skin breakdown.

Programmatic and Functional Eligibility Determination

Ideally, eligibility for all publicly financed long-term support services is determined simultaneously. This could include Medicaid HCBS waiver programs, Medicaid state plan services, the Older Americans Act (OAA), Social Services Block Grant (SSBG), state general revenues, county funds, and fees from people who are not eligible for subsidized programs.

In Washington, the ADSAs determine eligibility for Medicaid HCBS waiver and Medicaid state plan personal care services using the CARE system. The state regional office may refer a client to the AAA to determine eligibility for state funded respite care, non-Medicaid case management services, and OAA services. The ADSA offices and the AAAs both use the CARE system. Therefore information obtained by either organization is available to both.

Care Plan Development

Upon completion of the assessment, CARE generates a report on the computer screen for the assessor identifying which of these programs the consumer is eligible for and the assessor describes the advantages of the programs for the consumer. Most HCBS in Washington are provided using consumer direction, whereby consumers hire independent in-home support providers. State staff indicated that when a person contacts the state regional office to receive services, they usually have an independent provider in mind. If the provider is not already licensed, they must pass a background check and complete required state training. The assessor is responsible for ensuring that the provider becomes licensed in order for the care plan to be completed. The care plan is sent to the consumer, who must sign and return or verbally approve.

Determination of Authorized Service Levels

CARE authorizes the number of in-home hours consumers can receive per month with a maximum authorization of 420 hours per month. Before CARE, the numbers of hours of services were authorized based on varying program or policy limits, not on unmet need. The limits have been standardized under CARE and consumers receive more or less services based upon their clinical and functional characteristics. Payment levels are also established if the consumer chooses to live in an adult home or assisted living facility.

Time Study

ADSA commissioned a time study of 1,100 consumers in 2001-2002 to measure the amount of time the staff spent with consumers. Researchers followed consumers for three days in their care setting and recorded all interventions. ADSA staff combined the time study results with the assessment information and determined the characteristics that were associated with the cost of care. These interventions were factored into the Resource Use Classification Model algorithm that is built into the CARE system (discussed below). Mental illness and depression were identified as cost drivers and included into the algorithm as were certain diagnosis related to occupational and physical therapy, ADLs and IADLs.

Algorithms

The eligibility algorithm for the Medicaid personal care state plan service and the COPES Medicaid HCBS waiver looks at activities of daily living, treatments and skin conditions, and cognitive impairments requiring supervision due to memory impairment or impaired decision making, and behaviors such as wandering. The information is scored and grouped into 14 categories (see table).

Clinical complexity is based on the presence of a health condition (e.g., ALS, CP, pressure ulcers, incontinence) or treatments. Based on their ADL and cognition scores, people meeting the clinical complexity criteria are assigned to groups 7-12.

Mood and behavior factors include a range of specific behaviors that may be current or addressed through current interventions. In other words, scores are not reduced if the person no longer engages in the problem behavior because of successful interventions.

A Resource Use Classification Model algorithm converts the categories to hours of service and assigns a base number of hours, which is modified by the availability of informal supports and other adjustments (e.g., offsite laundry, distance to essential shopping). Instrumental Activities of Daily Living (IADLs) are not considered as part of the functional eligibility determination. However, unmet IADLs are reflected in the hours generated for the care plan. The resulting hours of care can be used to authorize in-home services, adult day care, and home delivered meals.

Separate algorithms are used for residential settings such as adult family homes, enhanced adult residential care, and assisted living. Consumers who choose to receive services in adult family homes and assisted living (boarding homes) are assigned to one of six levels of payment.

Washington State Resource Use Classification Model		
Classification	ADL Score	Group
Exceptional care group (in home only) Diagnosis + ADL >=22 + Treatment + Programs	ADL score 26-28	14
	ADL score 22-25	13
Severely impaired cognition (CPS 4-6) And Clinically Complex	ADL score 21-28	12
	ADL score 13-20	11
	ADL score 2-12	10
Cognition intact-moderately impaired (CPS 0-3) and Clinically complex	ADL score 18-28	9
	ADL score 9-17	8
	ADL score 2-8	7
Mood & behavior – Yes Not clinically complex CPS = 0-6	ADL score 15-28	6
	ADL score 6-14	5
	ADL score 0-5	4
Mood & behavior – No Not clinically complex CPS = 0-6	ADL score 10-28	3
	ADL score 5-9	2
	ADL score 0-4	1

The goal of allocating resources fairly (based on unmet care needs) was achieved through the new assessment and algorithms. State administrators stated that the new assessment prevents consumers from employing relatives solely as a means to bring income into their home, rather than based on unmet need for services. The study also revealed that some consumers received more or less service than other consumers with similar needs.

Medicaid Financial Eligibility Determination

Ideally, the Medicaid financial eligibility determination is either integrated with functional eligibility determination or closely coordinated with the functional determination process to make the process as seamless as possible. In Washington, at the same time that the functional eligibility determination process begins, financial eligibility determination is initiated. If the consumer is not already in the system (i.e. not enrolled in Medicaid) financial eligibility

determination is initiated. The ADSA assessor who conducts the initial home visit to determine functional eligibility may also help the consumer complete the financial application at that time. The Medicaid financial eligibility workers who make the decision are located in the same ADSA office as the assessors.

Federal rules require that determinations of financial eligibility for Medicaid must be made within 45 days from the date of application and within up to 90 days when a disability determination must be made. The current internal goal in Washington is 15 days. State officials and case managers often contend that a delay in determining financial eligibility may dictate whether a person remains in a community setting or enters a nursing facility (Chapin, 1999). Self-declaration of income and presumptive eligibility are two strategies to expedite the financial eligibility determination process. (See Mollica 2004 for a detailed discussion on expediting Medicaid financial eligibility.)

Self-declaration of income

Self-declaration of income is the practice of allowing applicants to attest to their income instead of submitting documents as evidence of their income levels, such as pay stubs or tax statements. States have the flexibility to simplify their income verification requirements and must balance these measures with appropriate safeguards so that simplification efforts do not result in erroneous eligibility determinations (Hollahan, 2004). Washington does not allow self-declaration of income.

Presumptive eligibility

Presumptive eligibility allows eligibility workers or case managers, nurses or social workers responsible for the functional assessment and level of care decision, to decide whether the individual is likely to be financially eligible and to initiate services before the official determination has been made by the eligibility staff. In Washington, eligibility workers are able to “presume” eligibility and approve Medicaid coverage in a day for individuals who are being discharged from a hospital, if it means that a beneficiary can receive services in a residential or community setting instead of a nursing facility (Mollica 2004). Assessors and financial eligibility workers are employed by the same state agency. If the information obtained by the assessor seems clear, eligibility workers may “presume” a person is eligible before the application is completed and verified. Full applications must be completed within 90 days or home care services are stopped.

ADSA case managers expedite applications from individuals applying for Medicaid from the community. Case managers help the applicant complete the financial application, gather necessary documentation, and submit the completed application to the eligibility staff. This initiative reduced the average time required to make a decision from 37 days to 25 days (Mollica, 2004).

Submission of financial eligibility applications

Washington allows application by fax or email, and determination at a home visit by a case manager or eligibility worker.

Monitoring and Case Management

Once the assessor has determined that the services have begun, they transfer responsibility for the consumer to a case manager, who monitors service delivery and provides on-going case management. Monitoring and case management is provided by local ADSA staff for beneficiaries in nursing homes, adult family homes and assisted living settings, and by case managers at Area Agencies on Aging for in-home participants. Case managers are social workers who have a master's degree in social work or a BA in social work and at least 3 years of experience. Caseloads average 80 consumers per case manager, but vary based on complexity.

Notes and changes in the consumer's status may be entered into the CARE record by any approved department representative (including assessors, case managers and agency-based service providers). This feature enhances communication between agency service providers who are providing services for the same consumer.

Quality

By design, CARE standardizes documentation for CMS waiver reviews and state quality assurance functions. Five percent of assessments are reviewed by staff from the ADSA quality assurance unit. State agency field office supervisors conduct a monthly quality review of all cases by case managers employed for six months or less. For all case managers employed for more than six months, field supervisors perform a quality assessment at least four times per year. The system is designed to allow managers to generate reports from the data to monitor and measure performance of individual workers, reporting units, regions, assessment status, and date. The management reports can identify:

- Total number of assessments completed;
- Consumer specific care plan details;
- Various clinical scores;
- Intake totals and outcomes of intakes;
- Consumers preparing for nursing facility discharge and the barriers to discharge;
- Nursing referrals; and,
- Response time from initial intake.

A competency/consistency rating can also be generated for individual case managers. Additional staff training is provided when this rating is low. These reports assist in internal monitoring and analysis of quality service delivery, risk management, and budgetary forecasting. Data reports are sent to the aging network, field network, and the developmental disabilities network. These individuals can generate reports from this data. ADSA has convened a change board, a group of representatives from the field and the State, to determine what other functional enhancements can be made to CARE.

Reassessment

Reauthorization is conducted at least annually by the AAA case manager for in-home consumers and by the ADSA case manager for people in residential settings. The complete care assessment is conducted as described above.

Program Results/Lessons Learned

Accuracy, quality, equity and fairness were the primary reasons for developing the CARE system. CARE eliminated the subjectivity that resulted in consumers who were not eligible but received services, or consumers who received more or fewer hours than needed under the previous system. Statewide implementation of CARE resulted in a slight reduction in the caseload. Between June and September 2003, caseloads declined by 0.9 percent, or 200 consumers.

Data integration

CARE combines assessment, eligibility and service authorization information and it links with the state's payment system. The payment linkage reduces duplication of data entry, allows verification of the bill against authorized services, and the data can also support quality assurance and monitoring activities.

Fewer unnecessary consumer interactions

CARE captures demographic information and contains all of the consumer's identified collateral contacts -- informal supports, doctors, religious representatives, family, friends, etc. Department representatives (including the assessors, eligibility determination workers, and case managers) that have access to CARE are able to enter a Service Episode Record (SER), often referred to as a case note, for any consumer entered into CARE. All contacts with the consumer are documented with a SER. The availability and accessibility of this information eliminates the need for the consumer to provide the same information multiple times.

Timely start of services

Streamlining access to services can reduce the amount of time between when the consumer inquires about services and when services begin. Washington found that prior to the implementation of CARE, the assessment and eligibility determination took from one month to one year to complete. The CARE system standardized the length of the eligibility process to one month.²

Replication Requirements

Washington invested a significant amount of time and money in developing and implementing the CARE system. Revision of its assessment and testing of its inter-rater reliability began in 2000. The time study used to develop a new payment system was conducted in 2001-2002. ADSA contracted with Deloitte Consulting to develop the software system used by case managers for the new assessment and payment system. In the first year of operation the state identified 200 changes to improve the program. The one-year contract amount was \$3

² Presentation by Penny Black at the ADRC Spring 2005 National Meeting, March 9, 2005

million. Implementation required the training of 1,000 workers over 11 months. Two to three state information technology (IT) staff provides support on-going maintenance of the software. Other locally based IT staff provides technical support to users. Training was required to ensure that the project and IT staff communicate effectively.

The assessment could easily be adopted by other states. The software is available to other states because it was developed with federal funding. However, adaptations would be needed to tailor the algorithm for eligibility determination, service authorization and payment limits to a state's eligibility requirements and array of covered services.

Conclusions

The design of Washington's long-term support system provides examples for other states interested in centralizing and simplifying access to long-term supports. The centralization of access to services in the regional offices, the coordination of Medicaid functional and financial eligibility and the comprehensive assessment reflect Washington's long tradition of offering consumers a choice of in-home, residential and institutional settings.

Useful Resources

CARE Assessment Paper Version

http://www.nashp.org/Files/Washington_CARE_Paper_Version.pdf

CARE Eligibility and Rates for Long-term Care Services

http://www.nashp.org/Files/WA_Care_eligibility_manual.doc

Washington Aging and Disability Services Administration

<http://www.aasa.dshs.wa.gov/>

The Washington State Regulations on CARE

<http://www.leg.wa.gov/wac/index.cfm?fuseaction=chapterdigest&chapter=388-72A>

Washington State Residential Time Study Report

<http://www.aasa.dshs.wa.gov/professional/documents/timestudyreport.doc>

Expediting Medicaid Financial Eligibility

This technical assistance document developed by the Rutgers CSHP/NASHP Community Living Exchange presents examples of presumptive and fast track eligibility programs implemented by several states to reduce the time it takes to process the Medicaid application.

<http://www.hcbs.org/files/45/2200/813A47D0.pdf>

States in Action: Building Nursing Home Transition into a Balanced Long-term Care System: The Washington Model

This technical assistance document is a summary of a site visit to the state of Washington in April 2003 organized by the Rutgers/NASHP Community Living Exchange. Thirteen representatives from Nursing Home Transition Grantees from Alaska, California, Delaware, Indiana, Maryland, Massachusetts and New Jersey participated in the site visit.

<http://www.hcbs.org/files/20/967/WAsitevisitsummaryfinal.doc>

Single Entry Point Systems: State Survey Results

This report presents the findings of a survey of the 50 states and the District of Columbia conducted by the Rutgers Center for State Health Policy/NASHP Community Living Exchange Collaborative to identify states that operate single entry point (SEP) systems and to describe the characteristics of SEPs.

<http://www.hcbs.org/files/19/915/SEPReport11.7.03.pdf>

Online Screening and Applications

This issue brief prepared by The Lewin Group, describes how different states have designed and implemented online applications for assessing and determining eligibility for health and social service programs.

<http://www.adrc-tae.org/tiki-page.php?pageName=TAE+Issue+Brief-+Online+Screening+and+Applications>

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