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**National Balancing Indicator Project (NBIP) to Conduct
Research, Development, and Technical Assistance on
Long-Term Support System Balancing Indicators**

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State Profile Self-Assessment Instrument Technical Assistance Guide (TAG)

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LIST OF ACRONYMS

ACA	Patient Protection and Affordable Care Act
ACL	Administration on Community Living
AHRQ	Agency for Healthcare Research and Quality
BRFSS	Behavioral Risk Factor Surveillance System
CI	Community Integration and Inclusion
CLC	Cultural and Linguistic Competency
CMS	Centers for Medicare and Medicaid Services
CT	Coordination and Transparency
FMAP	Federal Medical Assistance Percentage
HCBS	Home and Community-based Services
DALTCP	Office of Disability, Aging and Long-term Care Policy
DSW	Direct Service Workforce
I&A	Information and Assistance
LTSS	Long-term Services and Supports
NBIs	National Balancing Indicators
NBIP	National Balancing Indicator Project
NCCC	National Center for Cultural Competency
OASPE	Office of the Assistant Secretary for Planning and Evaluation
NF	Nursing Facility
OC	Options Counseling
OCR	Office of Civil Rights
PCP	Person-centered Planning
SA	Shared Accountability
SAMHSA	Substance Abuse and Mental Health Administration
SD	Self-Determination
SPT	State Profile Tool
TEP	Technical Expert Panel
THA	Truven Health Analytics
US DHHS	United States Department of Health and Human Services

BACKGROUND

Introduction

The Centers for Medicare & Medicaid Services (CMS), together with many other administrative agencies, organizations, and stakeholders, is tasked with ensuring that high quality health care services across the lifespan are widely available to the nation's most vulnerable citizens—those individuals with chronic illness and/or disability. Today, many of these individuals and their families or guardians require long-term health care and other support services, such as accessible and/or supervised housing, assistive devices, home modifications, personal care and assistance in daily activities (e.g., bathing, dressing, preparing meals), and psychosocial and emotional supports. Increasingly, they demand a system that is “responsive to consumer preferences” (Miller and Mor, 2006). A responsive system is one in which individuals who need services and supports have choice and control over how and by whom their care is provided, and in what setting. This preference implies that a community-based system with high quality services and supports from informal and formal networks is available to provide adequate choices for all individuals needing supports and services at any point in time from birth to death (i.e., across the lifespan).

While many Federal mandates and initiatives (e.g., Americans with Disabilities Act, Olmstead Decision, Affordable Care Act and the DHHS Community Living Initiative) provide an impetus for states to provide access to a full array of quality long-term services and supports (LTSS) that assure independence, optimal health and quality of life, there is a gap in the availability of common indicators to examine States' efforts in achieving this goal. As states continue to reform their LTSS systems, there is growing interest in examining their progress in attaining and maintaining a person-centered approach to service delivery and achieving a more equitable balance between the provision of institutional and home and community-based LTSS. To address this gap, CMS contracted IMPAQ International to develop and refine indicators that examine states' progress in offering person-driven and balanced LTSS systems, as part of the National Balancing Indicators Project (NBIP). The National Balancing Indicators (NBIs) developed and refined by the NBIP team were field tested in 2012 with seven State Profile Tool (SPT) grantees.

Purpose and Description of the Technical Assistance Guide (TAG) to the National Balancing Indicators

The purpose of the *Technical Assistance Guide (TAG) to the National Balancing Indicators* is to facilitate CMS' and States' examination of States' progress in offering person-driven and balanced LTSS systems. The TAG includes a state self-assessment survey instrument and glossary that was field tested in 2012 by the seven SPT Grantees (AR, FL, ME, MA, MI, MN and KY). Tips and instructions are included throughout the survey instrument to assist states in completing the survey. The TAG also recommends a methodology for implementing the state self-assessment survey instrument.

Finally, the state self-assessment survey instrument was implemented using a web-based application when it was field tested in 2012 with the seven SPT Grantees. The paper form of the state self-assessment survey instrument included in the TAG is the companion document to the programming language for the web-based version of the state self-assessment survey instrument. The programming language for the web-based version of the state self-assessment survey instrument is housed at CMS.

Methodology

Due to its complexity, the state self-assessment survey instrument is intended to be completed over a three month period and by multiple respondents in multiple phases. One month is needed for a State to prepare for survey implementation and then two months are needed for a State to complete the survey (Phase I).

During Phase I, States need to complete nine steps to ensure the survey's success. These steps, in order of completion, are as follows.

- **Step 1: Identify a state survey coordinator.** This person will be responsible for completing the remaining next eight steps listed below. The state survey coordinator also will be the point person responsible for answering any questions and/or comments that arise from the state agency representatives during the completion of the survey, ensuring timeline milestones and due dates are met, and ensuring the information received is complete and of high quality.
- **Step 2: Review the survey instrument.** The state survey coordinator will review the survey instrument to ensure they understand the questions being asked. This person also will begin thinking of which state agencies and related staff should participate in completing the survey.
- **Step 3: Identify state agencies where supports, services, policies, etc. discussed in survey questions are located.** The state survey coordinator will identify state agencies that would be appropriate to complete the survey based on the questions asked (e.g. questions related to housing policies and services may best be responded to by a representative within the state's housing administration).
- **Step 4: Identify and reach out to state representative(s).** Once the appropriate state agency(s) has been identified to complete the survey, the state survey coordinator will identify and reach out to a representative at each state agency who is best able to respond to the series of questions identified in the survey.
- **Step 5: Limit state representatives' access to only the sections of the survey that are applicable to them.** The survey should be programmed to allow only the identified state agency representatives from Step 4 to have access and the ability to respond to questions under their state agency's purview (e.g. housing administration representatives may not be best suited to respond to LTSS direct service workforce training policies).

- **Step 6: Share survey components with state agency representatives and allow time for questions and discussion.** The state survey coordinator should share the appropriate survey components with the applicable state agency representatives and afford sufficient time to answer any questions or comments they might have. This will facilitate the collection of quality survey data.
- **Step 7: Establish timeline for survey completion.** Each of the survey's four implementation phases should take no more than two weeks each to complete.
- **Step 8: Share timeline with state agency representatives, indicating the agency's start and end dates.** The state survey coordinator should share the survey timeline with the state agency representatives and review the agency's start and end dates for completing their section(s) of the survey with them.
- **Step 9: Discuss any final questions regarding the survey and/or timeline with agency representatives.** The state survey coordinator should afford the state agency representatives time to ask any final questions they might have about completing the survey before the survey is implemented. In addition, the state survey coordinator should address any questions or comments the state agency representative may have while they are completing their section(s) of the survey.

Once these nine steps are completed, the State can implement the state self-assessment survey. The survey is designed to be more difficult to complete during the first implementation phases of the survey. This approach allows the state survey coordinator more time to review the initial responses and respond to questions and comments from the state agency representatives who are the key data collectors.

In order to complete the survey efficiently and ensure that the best possible data is collected, it is recommended that the survey be completed in four implementation phases (Phases II – V) with two weeks allocated to completing each phase. This approach will provide state agency representatives sufficient time to respond to their survey questions. It also gives the state survey coordinator sufficient time to review state agency representatives' responses for previously completed sections of the survey that may have been challenging to complete in order to assess the completeness and quality of the data reported.

Finally, this approach allows the state survey coordinator to reach out to state agency representatives with any follow-up questions or comments they may have regarding the data reported (e.g., if a response is missing or if a response does not adequately respond to a question).

Phase II includes the completion of the Self-Determination and Community Integration and Inclusion Principles. These are considered to be the most challenging of Principles to complete. Phase III includes the completion of the Prevention and Coordination and Transparency Principles. Phase IV includes the completion of the Sustainability and Shared Accountability Principles. Finally, Phase V includes the completion of the Cultural and Linguistic Competency Principle.

Once the survey is completed, it is important that the state survey coordinator review the data collected one final time to ensure that the data collected from similar questions does not contradict itself, that as many questions are answered as possible, and that the data provided adequately responds to the survey questions.

Remember, any analysis performed is only as good as the data used to perform the analysis!

Table 1 below provides a summary of the level of difficulty to complete each Principle and related NBIs. The level of difficulty was determined based on (1) the number of questions included for each NBI, (2) the number of respondents that are needed to fully respond to each survey question, and (3) the estimated time it takes to respond to each of the survey questions. The table also recommends a sequence for completing the survey questions by Principle and related NBIs based on the level of difficulty.

Table 1. Survey Phases by Indicator and Principle

Principle		
Indicator	Difficulty Level	Phase
Self-Determination/Person-Centeredness		
SD1. Regulatory Requirements Inhibiting Consumer Control	High	II
SD2. Availability of Options for Self-Determination	High	
SD3. Risk Assessment and Mitigation	Low	
Total	Medium/High	
Community Integration and Inclusion		
CI1. Waiver Waitlist	High	II
CI2. Housing	High	
CI3. Supported Employment Options	Low	
CI4. Transportation	Medium	
Total	Medium/High	
Prevention		
P1. Health Promotion and Prevention	High	III
P2. Disaster/Emergency Preparedness	Low	
Total	Medium	
Coordination and Transparency		
CT1. Streamlined Access System	Low	III
CT2. Service Coordination	Medium	
CT3. Care Transitions	Low	
Total	Low/Medium	
Sustainability		
S1. Global Budget	Low	IV
S2. LTSS Spending	Low	
S3. Direct Service Workforce	High	

Principle		
Indicator	Difficulty Level	Phase
Sustainability (cont'd)		
S4. Support for Informal Caregivers	Low	IV
S5. Shared Long-Term Supports and Services Mission/Vision Statement	Low	
Total	Low	
Shared Accountability		
SA1. Fiscal Responsibility	Low	IV
SA2. Personal Responsibility	Low	
SA3. Individuals and Families are Actively Engaged in Policy Development	Low	
SA4. Government, Provider and User Accountability	Medium	
Total	Low	
Cultural and Linguistic Competency		
CLC1. Needs Assessment and Target Population	Low	V
CLC2. Efforts to Design Services and Supports for Culturally and Linguistically Diverse Groups	Low	
CLC3. Cultural and Linguistic Competency Training Requirements	Low	
Total	Low	

Self-Assessment Survey Tool

This section of the TAG includes the state self-assessment survey instrument. The survey instrument includes a glossary of terms and acronyms, the survey questions by Principle, Principle Feature and Indicator as well as tips for completing the survey questions.

SUSTAINABILITY

The Sustainability Principle contains five Indicators that examine whether a State’s long-term services and supports (LTSS) system is financially sustainable and is supported by an adequate infrastructure and a quality workforce. The Indicators developed for this Principle examine flexible financing (e.g., global budgeting) and LTSS expenditures as well as the size and quality of the direct service workforce and support provided for informal caregivers.

Principle Feature: Flexible Financing of LTSS

Indicator S1, Global Budget (Developmental)

Overview of Indicator

The Indicator S1, Global Budget examines the “Flexible Financing” Feature of the Sustainability Principle included in the NBIC Conceptual Framework. Global budgeting is one financing mechanism that can be used by States to promote more balanced LTSS programming and improved cost effectiveness. Also known as “pooled financing,” global budgeting has two dimensions. The first is a limit or cap on total spending. The second is the administrative freedom to manage costs within the spending limit.¹ A global budget may apply to certain services within the LTSS system (i.e., in the case of services administered by a State Department of Intellectual and Developmental Disabilities Services) or the LTSS system as a whole.

A State can use a global budget to target LTSS funds based on projected need and program and policy initiatives. Using a global budget approach also may enable a State to respond to changes in demand for LTSS through the reallocation of budget funds (from institutional care to home and community-based services (HCBS) or vice versa) within an overall spending limit.²

- 1. In the State, are funds appropriated into a global Medicaid LTSS budget that includes both nursing facility (“NF”) services and HCBS?*

TIP: See the Glossary for a definition of Global Budget.

- No (If “No”, answer item “a” below)
- Yes (If “Yes”, skip to question 2)

¹ Hendrickson, L. Reinhard, S. (2004). Global Budgeting: Promoting Flexible Funding to Support Long-term Care Choice. p.2. Document accessed at <http://www.cshp.rutgers.edu/Downloads/4710.pdf>.

² Ohio Department of Aging Unified Long-term Care System Planning. Materials accessed at <http://aging.ohio.gov/information/ultcb/default.aspx> on August 7, 2009.

2. Please indicate which Statement describes the State's Medicaid budgeting system for LTSS (Check one):

- There are separate budget line items for nursing facility services and HCBS; however the agency(s) overseeing these programs can shift funds from nursing facility to HCBS without seeking legislative approval.
- There are separate budget line items for nursing facility services and HCBS; however, the agency(s) overseeing these programs can shift funds from nursing facility to HCBS if it receives legislative approval.
- There are separate budget line items for nursing facility and HCBS, and funds cannot be shifted across line items.

TIP: Answer "Yes" if NF services and HCBS (Medicaid waiver, State Plan and State Plan Amendments (SPAs)-funded HCBS) are included in one global Medicaid LTSS budget. Then answer question 2.

3. In the State, are funds appropriated into a global Medicaid LTSS budget that includes both Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) services and any HCBS?

- No (If "No", answer item "a" below)
- Yes

TIP: Answer "Yes" if ICF/IID services and HCBS (Medicaid waiver, State Plan, and State Plan Amendments (SPAs)-funded HCBS) are included in one global Medicaid LTSS budget.

4. Please indicate which Statement describes the State's Medicaid budgeting system for LTSS (Check one):

- There are separate budget line items for ICF/IID services and HCBS; however the agency(s) overseeing these programs can shift funds from ICF/IID services to HCBS without seeking legislative approval.
- There are separate budget line items for ICF/IID services and HCBS; however, the agency(s) overseeing these programs can shift funds from ICF/IID services to HCBS if it receives legislative approval.
- There are separate budget line items for ICF/IID services and HCBS, and funds cannot be shifted across line items.

5. *Has the State implemented a Medicaid managed LTSS program?*

No (If “No”, skip to next indicator)

Yes

a. *If “Yes,” under which federal authority(s) was it implemented?*

State plan authority [§1932(a)]

Waiver authority [§1915(a) and (b)]

Waiver authority [§1115]

b. *If “Yes,” which populations are served under the Medicaid managed LTSS program? (Check all that apply)*

Older adults

Individuals with disabilities

Individuals with intellectual and/or developmental disabilities

Others (please specify)

6. *Is the State’s Medicaid managed LTSS program implemented separate from the State’s Medicaid managed care program?*

No

Yes

7. *Are the managed LTSS organizations under contract with the State at risk for all LTSS expenditures, including institutional services?*

No

Yes

8. *If a managed LTSS program has been implemented for older adults, how is the program incorporated into the State's global Medicaid budget? (Please describe)*

9. *If a managed LTSS program has been implemented for adults with disabilities, how is the program incorporated into the State's global Medicaid Budget? (Please describe)*

10. *If a managed LTSS program has been implemented for individuals with intellectual and developmental disabilities, how has the program been incorporated into the State's global Medicaid Budget? (Please describe)*

11. *If a managed LTSS program has been implemented for other populations, how has the program been incorporated into the State's the global Medicaid Budget? (Please describe)*

Principle Feature: Sustainability of Funding for LTSS

Indicator S2, LTSS Expenditures

Overview of Indicator

The Indicator S2, *LTSS Expenditures*, examines States' LTSS spending (Medicaid and non-Medicaid) for institutional services and HCBS to determine States' priorities in funding a balanced LTSS system. Recent literature has reported that States that offer Medicaid-funded HCBS as an alternative to Medicaid-funded institutional services not only were complying with the *Olmstead* decision and meeting the demands of those in need of LTSS, but the expansion of HCBS appears to entail a short-term increase in Medicaid spending, followed by a reduction in institutional spending and an increase in long-term cost savings.³ In addition, those States that utilize non Medicaid LTSS funding can provide LTSS to individuals who otherwise might not be eligible to receive Medicaid funded LTSS and may be at risk for institutional placement.

This Indicator includes four Sub-indicators:

- S2a, *Proportion of Medicaid HCBS Spending of the Total MA LTSS Spending*;
- S2b, *LTSS Spending Changes: Per Capita, Sources and Medicaid Eligibility*;
- S2c, *Medicaid Funding Sources*; and
- S2d, *LTSS Funding From Non Medicaid Sources*

The four Sub-indicators report on Medicaid LTSS expenditures and changes in expenditures at the Federal and State levels. The fourth Sub-indicator reports on LTSS Funding received by the State from Non Medicaid Sources. Due to the differences in claims reporting and services taxonomy, these are not perfect measures. However, they provide a context on the use of Medicaid and other resources across LTSS institutional services and HCBS.

Medicaid expenditure data used are based on information compiled by Truven Health Analytics (previously known as Thomson Reuters Healthcare and referred to as "Truven" in this survey) from CMS 64 data, state-reported data from Medicaid managed care programs, and MFP demonstration data.⁴ It should be noted that the data is compiled on a yearly basis and at least a one-year lag commonly exists.

There are a number of limitations for this Indicator. First, the data are based on State FMAP claims. During the CMS audit process, some claims may be disallowed. Second, the data are by date of payment, not date of service, so claims may not align with the fiscal year in which the service was actually delivered. Finally, the data includes data on services associated with LTSS.

³ Kaye, H. Stephen, La Plante, Mitchell, P., and Harrington, Charlene (2009). Do non-institutional LTC services reduce Medicaid Spending? *Health Affairs* 28, no. 1 (2009): 262–272; 10.1377/hlthaff.28.1.262.

⁴ Truven Medicaid expenditure reports include: *Medicaid Expenditures for LTSS*, *Medicaid §1915 (c) Waiver Expenditures*; and *Medicaid Managed LTSS Expenditures*.

For example, the institutional LTSS reports on mental health facilities, however, Truven does not include §1915(i) expenditures in either A/D or DD since most §1915(i) expenditures have eligibility criteria requiring a mental health condition.

Table 1 below summarizes the LTSS setting categories included in the *Medicaid Expenditures* Indicator algorithm. This algorithm uses Truven’s Medicaid data by LTSS setting category to calculate the proportion of Medicaid HCBS expenditures compared to total Medicaid LTSS expenditures. The data used in the *Medicaid Expenditures* Indicator algorithm is explained in more detail below. Please note that a definition for each Table from Truven’s *Medicaid Expenditures for LTSS* Report, revised 10/2013, referenced in Indicator S2 and related Sub-indicators may be found in the Glossary at the end of this document.

Table 1. LTSS Setting Categories Included in Medicaid Expenditures Indicator Algorithm⁵

Institutional Services	Non-Institutional Services
Nursing Facility [Truven Table B]	Personal Care [Truven Table H]*
ICF/IID [Truven Table C]	Home Health [Truven Table I]
Mental Health Facilities (also known as institutions of mental disease or IMD) [Truven Tables D & E]	HCBS Waivers [Truven Tables G & K]**
	PACE [Truven Table L]
	Rehabilitative Services [Truven Table J]
	Private Duty Nursing [Truven Table M]
	HCBS – §1915(i) SPAs [Truven Table N]
	HCBS – §1915(j) SPAs [Truven Table O]
	Self-Directed Personal Care – §1915(j)SPAs [Truven Table P]
	Targeted Case Management [Truven Table AK]***
	§1915(k) SPAs [Truven Table TBD]***
	Health Home [Truven Table TBD]***

* In the CMS 64 data (as of 2010), Personal Care (non-institutional service listed in the table above) includes: Providing assistance with activities of daily living, instrumental activities of daily living, and/or health-related tasks.

**HCBS Waivers includes §1915(a), §1915(c), and §1115 waivers. There are 13 States (and Puerto Rico) that use §1915(a) contracts to administer 24 voluntary managed care programs under §1915(a) waivers, (e.g., MA Senior Care Options Program), therefore, they are included as HCBS waivers.

***It should be noted that expenditures related to §1915(k) SPAs, and health homes, implemented under the Affordable Care Act will be included when the data become available in 2012.

⁵ Medicaid expenditures data table references are from Truven’s *Medicaid Expenditures for LTSS* Report revised 10/2013.

Sub-indicator S2a, Proportion of Medicaid HCBS Spending of the Total Medicaid Long-Term Services and Supports (LTSS) Spending

Overview of Sub-indicator

Sub-indicator S2a, *Proportion of Medicaid HCBS Spending of the Total Medicaid LTSS Spending* examines whether a State has allocated Medicaid funding in a sufficient amount for the provision of HCBS. This Sub-indicator may be examined alone or in conjunction with the Sub-indicator S2b: *Change in Per Capita Medicaid Long Term Services and Supports Spending*, to assess changes in a State’s Medicaid spending for HCBS. **Please note, States are not required to collect data to calculate this Sub-indicator.**

The Sub-indicator S2a is calculated using two secondary sources of information: a) Truven’s Medicaid LTSS Spending data obtained from CMS 64 data, state reported managed care data and MFP demonstration data and b) MAX data based on analyses and reports produced by ASPE.

It is calculated by adding the State’s Medicaid HCBS expenditures and dividing this amount by the State’s total Medicaid LTSS expenditures. Medicaid HCBS expenditures include expenditures for the non-institutional services listed in Table 1 above. Total Medicaid LTSS expenditures include expenditures for all institutional and non-institutional services listed in Table 2 below.

Table 2. Total Medicaid LTSS Expenditures

State	Expenditures	Amount	Percent
	<p>HCBS Expenditures</p> <p>[HCBS Waivers + PC + Home Health + Health Homes + PACE + Rehab + PDN + HCBS §1915(i) SPAs + HCBS §1915(j) SPAs + PC §1915(j) SPAs+ §1915(k) SPAs] [Tables F + AK from Truven’s Medicaid Expenditures for LTSS Report, revised 10/2013]</p>		<p>HCBS Expenditures/Total LTSS Expenditures</p> <p>[Tables F and AK from Truven Report] /Total LTSS Expenditures [Tables R + AK from Truven’s Medicaid Expenditures for LTSS Report, revised 10/2013.]</p>
	<p>Institutional Expenditures</p> <p>Nursing Facility + ICF/IID + MHF</p> <p>[Table A from Truven’s Medicaid Expenditures for LTSS Report, revised 10/2013]</p>		<p>Institutional Expenditures/Total LTSS Expenditures</p> <p>[Table A from the Truven’s Medicaid Expenditures for LTSS Report]/Total LTSS Expenditures [Tables R + AK from Truven’s Medicaid Expenditures for LTSS Report, revised 10/2013]</p>

State	Expenditures	Amount	Percent
	<p>Total LTSS</p> <p>HCBS Waivers + PC + Home Health + Health Homes + PACE + Rehab + PDN + HCBS §1915(i) SPAs+ HCBS §1915(j) SPAs+ PC §1915(j) SPAs+ §1915(k) SPAs+ Nursing Facility + ICF/IID + MHF + TCM</p> <p>[Tables R+AK from Truven’s Medicaid Expenditures for LTSS Report, revised 10/2013]</p>		100%

The following describes how the Sub-indicator is calculated. The share of Medicaid LTSS spending accounted for by Medicaid HCBS expenditures is calculated by adding Medicaid HCBS expenditures and dividing this amount by total Medicaid LTSS expenditures (the sum of HCBS and institutional Medicaid expenditures). All expenditure data is obtained from Truven Health Analytics data tables.

As reported in Table 1 above, each State’s numerator includes added expenditures for HCBS Waivers from Tables G & K, Personal Care (PC) from Table H, and Home Health (HH) from Table I. In addition, the numerator will include PACE from Table L, rehabilitative services (Rehab) from Table J, private duty nursing (PDN) from Table M, HCBS expenditures under §1915(i) and (j) SPAs from Tables N and O, Personal Care under §1915(j) SPA from Table P, Targeted Case Management (TCM) from Table AK and §1915(k) SPA from Table TBD. Each State’s denominator includes the HCBS expenditures described in Table 1 above as well as those for Nursing Facility Services from Table B, ICF/IID Services from Table C, and Mental Health Facilities (MHF) from Tables D and E.

The simplified equation for computing the proportion of Medicaid HCBS expenditures of total LTSS expenditures is as follows:

$$\frac{(\text{HCBS Waivers} + \text{PC} + \text{Home Health} + \text{Health Home} + \text{PACE} + \text{Rehab} + \text{PDN} + \text{HCBS } \S 1915(i) \text{ SPAs} + \text{HCBS } \S 1915(j) \text{ SPAs} + \text{PC } \S 1915(j) \text{ SPAs} + \S 1915(k) \text{ SPAs})}{(\text{HCBS Waivers} + \text{PC} + \text{Home Health} + \text{Health Homes} + \text{PACE} + \text{Rehab} + \text{PDN} + \text{HCBS } \S 1915(i) \text{ SPAs} + \text{HCBS } \S 1915(j) \text{ SPAs} + \text{PC } \S 1915(j) \text{ SPAs} + \S 1915(k) \text{ SPAs} + \text{Nursing Facility} + \text{ICF/IID} + \text{MHF} + \text{TCM})}$$

Population Group Expenditures

It is difficult to examine Medicaid and other LTSS expenditures by age and/or disability group. The following tables provide suggestions for examining these expenditures by different population groups using the Medicaid LTSS expenditures data available from Truven. Data limitations, as reported by Truven staff, include the following.

- Population categories are based on programs (e.g., the Medicaid State Plan Personal Care Service, a HCBS waiver service), and are not based on individual age or diagnosis.
- Some programs primarily serve older adults and people with physical disabilities, but also may serve people with cognitive impairments and/or people with serious mental illness.
- Some individuals have multiple conditions and could be served in multiple types of programs.

Table 3 below uses Table A from Truven Health *Medicaid Expenditures For Long-Term Services and Supports* Report to examine Medicaid Nursing Facility expenditures as a proxy for institutional spending for older adults and individuals with a physical disability (A/D). One limitation of using Table A is that it may include Medicaid expenditures for individuals that are outside of A/D population. However, it was included to allow for a comparison of institutional spending with HCBS spending for the A/D population (see Table 3). Similarly, Table 3 examines spending on ICF/IID as a proxy for institutional spending for individuals with intellectual and/or developmental disabilities (ID/DD).

Table 3. Institutional Expenditures for A/D

State	Medical Assistance Payments	Amount	Percent
	<p>Nursing Facility Expenditures</p> <p>[Table B from Truven’s Medicaid Expenditures for LTSS Report, revised 10/2013]</p>		<p>Institutional Expenditures for Aging and Physically Disabled / Total Institutional Expenditures</p> <p>[Table B from Truven’s Medicaid Expenditures for LTSS Report/Total Institutional Expenditures [Table A from Truven’s Medicaid Expenditures for LTSS Report, revised 10/2013]</p>

Table 4. HCBS Expenditures for A/D

State	Medical Assistance Payments	Amount	Percent
	<p>HCBS Expenditures for Aging and Physically Disabled Expenditures</p> <p>§1915(c) HCBS Waivers for A/D, PACE, §1915(a) Waivers , §1115 Waivers, Personal Care, Home Health, §1915(i) SPAs, §1915(j) SPAs, §1915(k) SPAs, Health Homes, Private Duty Nursing [Tables P & W from the Truven’s Medicaid Expenditures for LTSS Report, revised 10/2013]</p>		<p>HCBS Expenditures for Aging and Physically Disabled/Total HCBS Expenditures</p> <p>[Tables P & W from Truven’s Medicaid Expenditures Report for LTSS /Table F & AK from Truven’s Medicaid Expenditures for LTSS Report, revised 10/2013]</p>

Table 5. Institutional Expenditures for ID/DD

State	Medical Assistance Payments	Amount	Percent
	<p>Institutional Expenditures for ID/DD=ICF/IID: Public Providers, Private Providers, and Supplemental Payments</p> <p>[Table C from Truven’s Medicaid Expenditures for LTSS Report, revised 10/2013]</p>		<p>Institutional Expenditures for Intellectually and Developmentally Disabled/Total Institutional Expenditures</p> <p>[Table C from Truven LTSS Expenditures Report]/Total Institutional Expenditures [Table A from Truven’s Medicaid Expenditures for LTSS Report, revised 10/2013]</p>

Table 6. HCBS Expenditures for ID/DD

State	Medical Assistance Payments	Amount	Percent
	<p>HCBS Expenditures for ID/DD</p> <p>§1915(c) HCBS Waivers for A/D, PACE, §1915(a) Waivers , §1115 Waivers, Personal Care, Home Health, §1915(i) SPAs, §1915(j) SPAs, §1915(k) SPAs, Health Homes, Private Duty Nursing [Tables S + V from Truven’s Medicaid Expenditures for LTSS Report, revised 10/2013]</p>		<p>HCBS Expenditures for Intellectually and Developmentally Disabled /Total HCBS Expenditures</p> <p>[Table S + V from Truven’s Expenditures for LTSS Report] /Total HCBS Expenditures [Table F + AK from Truven’s Medicaid Expenditures for LTSS Report, revised 10/2013]</p>

Individual-Level Expenditures

To facilitate an examination of Medicaid expenditures at the person level, MAX data will be used. The individual-level expenditures will be based on analyses conducted by the Office of the Assistant Secretary for Planning and Evaluation (OASPE) using the most recent MAX data available. The examination will be conducted by disability group, age, and financial eligibility.

Table 7. Individual-Level LTSS Expenditures by Disability Group

State	Population	Institutional Expenditures	HCBS Expenditures	Total LTSS Expenditures
	Older Adults			
	Younger non-ID/DD			
	ID/DD			

Table 8. Individual Level LTSS Expenditures by Age

State	Age Group	Institutional Expenditures	HCBS Expenditures	Total LTSS Expenditures
	0 - 5			
	6 - 20			
	21 - 44			
	45 - 64			
	65 - 74			
	75 - 84			
	85+			

Table 9. Individual-Level LTSS Expenditures by Financial Eligibility Category

State	Category	Institutional Expenditures	HCBS Expenditures	Total LTSS Expenditures
	SSI			
	Poverty			
	Medically Needy			
	Other (includes 300 percent of SSI special needs cap)			

Sub-Indicator S2b, LTSS Spending Changes: Per Capita, Sources and Medicaid Eligibility

Overview of Sub-indicator

The Sub-indicator S2b, *LTSS Spending Changes: Per Capita, Sources and Medicaid Eligibility* examines the rate of change in Medicaid LTSS spending per capita. It is a proxy for measuring changes in the allocation of LTSS expenditures. Additionally, this Sub-indicator examines the change in per capita dollar amounts spent on Medicaid LTSS across years.

Per capita Medicaid LTSS spending is calculated by adding HCBS Medicaid expenditures for the two most recent reporting years and dividing this number by the total estimated State population. All expenditures are drawn from the data tables in Truven's *Medicaid Expenditures for LTSS* Report for the two most recent reporting years.

Each State's numerator is total LTSS expenditures from Tables R+AK in Truven's *Medicaid Expenditures for LTSS* Report, revised 10/2013.⁶ This figure then is divided by the estimated State population reported by the Census Bureau (American Community Survey) for the most recent year.

The percent change in per capita spending is calculated by subtracting the State's most recent Federal Fiscal Year total Medicaid LTSS expenditures from the prior Federal Fiscal Year's total Medicaid LTSS expenditures, and dividing this amount by the prior Federal Fiscal Year's total Medicaid LTSS expenditures. This proportion then is converted to a percent.

Each State's numerator is calculated by adding together the Medicaid expenditures for: This total amount of these Medicaid expenditures then is divided by the estimated State population reported by the Census Bureau for the most recent year.

The simplified equation for the per capita spending is as follows:

$$\frac{(\text{PC} + \text{Home Health} + \text{Health Homes} + \text{HCBS Waivers} + \text{PACE} + \text{Rehab} + \text{Nursing} + \text{\$1915(i)(j)(k)} \\ \text{SPAs} + \text{Nursing Facility} + \text{ICF/IID} + \text{MHF} + \text{TCM})}{\text{State population}}$$

⁶ Table R includes Medicaid expenditures for Aged & Disabled (A/D) waivers from Table T; Developmentally Disabled (DD) waivers from Table S; Personal Care (PC) from Table P; and Home Health (HH) from Table I; Nursing Facility Services in Table A; HCBS expenditures under §1915(i) and (j) SPAs from Tables N and O; HCBS expenditures under §1915(k) SPAs and Health Homes in Table TBD; ICF/IID Services in Tables Y, Z and AA; Nursing in Table B; PACE in Table L; Rehabilitation (Rehab) in Table J; and Mental Health Facilities (MHF) from Tables D and E. Table AK includes targeted case management expenses.

Sub-Indicator S2c, Medicaid LTSS Funding Sources

Overview of Sub-indicator

The Sub-indicator S2c, *Medicaid LTSS Funding Sources* examines the fiscal environment for each State and determines whether States are consistently funding LTSS during changes in the State’s economy and/or Administration. It has been reported that “Medicaid enrollment increases during economic downturns. Increased enrollment and demand for services in other eligibility categories creates fiscal stress for States and may prompt them to consider LTSS policy changes to curtail overall Medicaid expenditures, especially since HCBS are optional services” (AARP, *Weathering the Storm: The Impact of the Great Recession on LTSS*, January 2011). Medicaid enrollment also may increase in certain states due to the expansion of Medicaid under the Patient Protection and Affordable Care Act (ACA).

States will be asked to report their Federal Medical Assistance Percentage (FMAP) for each fiscal year, and any additional funding allocated to LTSS programs such as Older American Act funds or additional LTSS funding available under the ACA. States also will be asked to describe the changes (if any) in eligibility criteria for an individual to become eligible for Medicaid including the implementation of Medicaid expansion under ACA.

1. What is the State’s FMAP rate for the current fiscal year? _____
2. Has the State received additional LTSS funding in the current fiscal year?

- No
 Yes

If State responded “Yes” to question #2 above, please complete the following:	Total Dollar Amount	Total Percentage	Name of Source (e.g. Name of Legislation)	Funding Allocated Towards LTSS Programs
Federal Share				
Additional Federal Medical Assistance Percentage (FMAP)				
Federal Legislative Appropriations to the State Agency				
Federal Grants and Demonstrations				
Other, please specify				
State Share				
State Legislative Appropriations to the State Agency				
Other, please specify				

3. In the past year, has the State's Medicaid financial eligibility criteria for LTSS changed?

No

Yes

a. If "Yes" please describe the change(s) that was implemented?

4. In the past year, has the State's Medicaid clinical eligibility criteria for LTSS changed?

No

Yes

a. If "Yes" please describe the change(s) that was implemented?

Sub-indicator S2d, LTSS Funding from Non Medicaid Sources

Overview of Sub-indicator

States that utilize non-Medicaid LTSS funding can provide LTSS to individuals who otherwise might not be eligible to receive Medicaid-funded LTSS and may be at risk for institutional placement. Examples of non-Medicaid LTSS funding include, but are not limited to, Older American Act funds, SAMSHA mental health and substance abuse block grant funds, US Housing and Urban Development Housing with Services (Section 811 and 202) Program funds, state general funds and grant funds received from various not-for-profit foundations (i.e., Robert Wood Johnson Foundation, Commonwealth Fund).

1. Has the State received non-Medicaid LTSS funding in the current fiscal year?

No

Yes

a. If "Yes" please describe the type of funds received.

Principle Feature: Supported by a Highly Qualified, Motivated and Sustainable Workforce

Indicator S3, Direct Service Workforce

Indicator S3, The Direct Service Workforce, examines a State's supply, competency and stability of its direct service workforce. A competent, stable, and high quality direct service workforce in sufficient supply is essential for meeting the LTSS goal per the vision of the LTSS of the future conceptual framework.

Sub-indicator S3a, Direct Service Workforce (DSW) Registry

Overview of Sub-indicator

The Direct Service Worker (DSW) Registry Sub-indicator examines whether the State has implemented and maintains one or more types of DSW registries that address the "supported by highly qualified, motivated and sustainable workforce" Feature of the *Sustainability* Principle included in NBIC Conceptual Framework. The Sub-indicator also examines the type of entity that operates and maintains the registry(s) (i.e., State government agency and/or private entity).

A common type of DSW registry is one that is available and useful to users and service providers in recruiting direct service workers and to direct service workers who are looking for employment opportunities. The existence, comprehensiveness, and functionalities of this type of direct service workforce registry can:

- Enable users and service providers to identify and hire available and qualified direct service workers;
- Provide direct service workers with access to employment opportunities; and
- Inform a State's understanding of the capacity and quality of its DSW.

Another type of DSW registry States implement is one where the State develops and maintains a list of DSWs who have been determined to be poor performers and/or have been convicted of abusing, neglecting or exploiting older adults and/or individuals of all ages with disabilities and chronic conditions.

State government agencies and/or private entities also may include a number of other functions in their DSW registries. These may include, but are not limited to:

- Reviewing and approving/disapproving DSW training program curricula;
- Reviewing and approving/disapproving DSW testing;
- Maintaining test scores of DSWs;

- Certifying that DSWs have met the State’s initial and ongoing training and core competency requirements to provide services in institutional and/or home and community-based settings; and
- Developing rules, policies, procedures, applications and forms necessary to implement the DSW registry.⁷

A State might implement one statewide or multiple DSW registries. In addition, the registry might cover DSWs that serve all populations or one or more distinct populations (i.e., nursing facility residents).

1. Does the State have legislation prohibiting the State or its agencies from implementing and maintaining a DSW registry?

- No
- Yes (*Skip to Sub-indicator S4*)

Tip: Select “No” if the State *DOES NOT* have legislation in place prohibiting the implementation and maintenance of a State-funded and operated DSW registry(ies) that users and service providers may use to recruit DSWs and DSWs may use to access employment opportunities.

2. Does the State, through one or more of its agencies, fund and operate one or more DSW registry(ies) that users and service providers may use to recruit DSWs and DSWs may use to access employment opportunities?

- No (*Skip to question 10*)
- Yes

TIP: These DSW registries must be funded and operated by a state government agency.

3. How many State-funded and operated DSW registries are operating in the State?

⁷ Oklahoma Nurse Aide and Nontechnical Service Worker Registry website at www.ok.gov

4. What is the geography covered by this type of DSW registry?

- Statewide
- Regional (e.g. 1 or more county(ies))
- Other, please specify

5. Which populations does this type of DSW registry serve? *(Check all that apply)*

Individuals who live with:			
Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, please specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TIP: Check each population type(s) the DSW Registry serves. Note that more than one population type may be checked.

6. Which DSW type(s) does this type of DSW registry serve? *(Check all that apply)*

Workforce Type Served	
Certified Nurses Assistants (CNAs)	<input type="checkbox"/>
Home Health Aides	<input type="checkbox"/>
Personal Care Aides/Attendants (PCAs)	<input type="checkbox"/>
Direct Support Professionals (DSPs)	<input type="checkbox"/>
Other, please specify _____	<input type="checkbox"/>

TIP: Check each DSW type(s) the DSW Registry serves. Note that more than one type of DSW may be checked.

7. What types of information about DSW characteristics does this type of DSW registry provide? (Check all that apply)

DSW Characteristics	
Geographic Location	<input type="checkbox"/>
Schedule Availability	<input type="checkbox"/>
Prefers to Work in Emergency Situations	<input type="checkbox"/>
Primary Language Spoken	<input type="checkbox"/>
Training and Certification	<input type="checkbox"/>
Experience Working as a DSW	<input type="checkbox"/>
Service Population(s) to Preference	<input type="checkbox"/>
Preference for Types of Personal Care to Provide	<input type="checkbox"/>
Has a Driver's License	<input type="checkbox"/>
Has an Automobile with Required Type and Amount of Insurance	<input type="checkbox"/>
Has Allergies	<input type="checkbox"/>
Is a Smoker	<input type="checkbox"/>
Other, please specify _____	<input type="checkbox"/>

8. To whom is this type of DSW registry available to use? (Check all that apply)

Access to DSW Registry is available to:	
Users	<input type="checkbox"/>
Service Providers	<input type="checkbox"/>
Direct Service Workers	<input type="checkbox"/>
Other, please specify _____	<input type="checkbox"/>

9. Please provide documentation on this type of DSW registry.

10. Does the State fund and has a private entity operate one or more DSW registry(ies) that users and service providers may use to recruit DSWs and DSWs may use to access employment opportunities?

No (Skip to question 18)

Yes

TIP: These DSW registries must be funded and operated by a state government agency.

11. How many State-funded and private entity operated DSW registries are operating in the State? _____

12. What is the geography covered by this type of DSW registry?

- Statewide
- Regional (e.g. 1 or more county(ies))
- Other, please specify

13. Which populations does this type of DSW registry serve? *(Check all that apply)*

Individuals who live with:			
Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TIP: Check each population type(s) the DSW Registry serves. Note that more than one population type may be checked.

14. Which DSW type(s) does this type of DSW Registry serve?

Workforce Type Served	
Certified Nurses Assistants (CNAs)	<input type="checkbox"/>
Home Health Aides	<input type="checkbox"/>
Personal Care Aides/Attendants (PCAs)	<input type="checkbox"/>
Direct Support Professionals (DSPs)	<input type="checkbox"/>
Other, please specify _____	<input type="checkbox"/>

TIP: Check each DSW type(s) the DSW Registry serves. Note that more than one type of DSW may be checked.

15. What types of information about DSW characteristics does this type of DSW Registry provide? (Check all that apply)

DSW Characteristics	
Geographic Location	<input type="checkbox"/>
Schedule Availability	<input type="checkbox"/>
Prefers to Work in Emergency Situations	<input type="checkbox"/>
Primary Language Spoken	<input type="checkbox"/>
Training and Certification	<input type="checkbox"/>
Experience Working as a DSW	<input type="checkbox"/>
Service Population(s) to Preference	<input type="checkbox"/>
Preference for Types of Personal Care to Provide	<input type="checkbox"/>
Has a Driver's License	<input type="checkbox"/>
Has an Automobile and the Required Type and Amount of Insurance	<input type="checkbox"/>
Has Allergies	<input type="checkbox"/>
Is a Smoker	<input type="checkbox"/>
Other, please specify _____	<input type="checkbox"/>

16. To whom is this type of DSW registry available to use? (Check all that apply)

Access to DSW Registry is available to:	
Users	<input type="checkbox"/>
Service Providers	<input type="checkbox"/>
Direct Service Workers	<input type="checkbox"/>
Other, please specify _____	<input type="checkbox"/>

17. Please provide documentation on this type of DSW registry.

18. Does the State fund and operate a registry for reporting poor performing DSWs and DSWs convicted of abuse, neglect and/or exploitation of:

- Older Adults
- Adults with Disabilities
- Children
- Other population, please specify _____

19. If "Yes" please provide documentation for this type of DSW registry.

Sub-indicator S3b, Direct Service Workforce: Volume, Compensation, & Stability

Overview of Sub-indicator

Sub-indicator S3b. Direct Service Workforce: Volume, Compensation & Stability examines these issues in the direct service workforce. **States are only required to answer questions 1-2. States are not required to collect data to calculate the Direct Service Workforce Volume, Stability, or Compensation components of this Sub-indicator.**

The literature indicates that in order for a State to move towards implementing a person-centered and balanced LTSS system it must have a sufficient, stable and quality direct service workforce to meet individuals' LTSS needs. A number of demographic and social trends suggest that the United States will experience a dramatic increase in the number of people needing LTSS over the next 30 years. This need is projected to outpace the number of DSWs available to provide LTSS, resulting in a shortage of DSWs. In addition, the direct service workforce tends to have high turnover and vacancy rates, due in part to low wages and the unique character of home and community-based services (HCBS), including often being part-time and episodic in nature.⁸

The competency of a State's direct service workforce is also important in implementing a person-centered and balanced LTSS system. DSW competency is key to maintaining the safety and well-being of LTSS users living in the community. State policy leaders are beginning to realize that a person-centered and balanced LTSS system cannot be achieved without a commensurate direct service workforce policy.⁹

Direct Service Workforce Volume

- Number of DSWs employed in HCBS settings and number employed in Institutional settings across the State
- Percent of all DSWs employed full-time in HCBS settings and percent employed full-time in Institutional settings across the State

Direct Service Workforce Stability

- Average turnover rate of DSWs in HCBS settings and in Institutional settings in a State
 - Calculated by averaging the turnover rates reported by every employer organization in the sector (e.g., HCBS or Institutional)

⁸ University of Minnesota Research and Training Center on Community Living (May 31, 2011). Road Map of Core Competencies for the Direct Service Workforce, Phase 1: Direct Service Worker Competency Inventory retrieved from http://www.dswresourcecenter.org/tiki-download_file.php?field=470 and Robins et al. (July 13, 2013). Coverage of Direct Service Workforce Continuing Education & Training within Medicaid Policy and Rate Setting: A Toolkit for State Medicaid Agencies retrieved from <http://www.dswresourcecenter.org/tiko-index.php?page=reports>.

⁹ Ibid.

- Employer Organization Turnover Rate calculated by:
 - Number of leavers in 12 months divided by
 - Number of positions at point in time (current + vacancies)
- Average DSW Vacancy Rate in HCBS and Institutional settings in a State
 - Calculated by computing the average vacancy rates reported by every employer organization in the sector (e.g., HCBS or Institutional)
 - Employer Organization Vacancy Rate calculated by:
 - Number of current vacancies divided by
 - Number of positions (current + vacancies)

Direct Service Workforce Compensation

- Average DSW’s hourly wages paid across all DSWs in HCBS settings and average DSW’s hourly wages paid across all direct service workers in institutional settings.
- Percent of DSWs with health insurance coverage from any source in HCBS settings and percent with health insurance coverage from any source in institutional settings.
- Percent of DSWs receiving paid sick and/or vacation leave in HCBS settings and the percent of DSWs receiving paid sick or vacation leave in institutional settings.

Sub-indicator S3c, DSW Competency

1. Does the State have written competencies implemented for DSWs working in nursing facilities?

No (*If “No”, Skip to question 2*)

Yes

a. If “Yes” please provide documentation.

b. If “Yes” are the competencies mandatory for all DSWs working in nursing facilities?

No

Yes

2. Does the State have written competencies implemented for DSWs working in ICF/IIDs?

No (*If "No" Skip to question 3*)

Yes

a. If "Yes" please provide documentation.

b. If "Yes" are the competencies mandatory for all DSWs working in ICF/IIDs?

No

Yes

3. Does the State have written competencies implemented for all DSWs providing home and community-services?

No (*If "No", skip to Sub-indicator S3d*)

Yes

a. If "Yes" please provide documentation.

b. If "Yes", are the DSW competencies mandatory for all DSWs providing home and community-based services?

No

Yes

Sub-indicator S3d, DSW Training

1. Does the State have written training requirements for DSWs working in nursing facilities?

No

Yes

a. If "Yes", please provide the written training requirements for DSWs working in nursing facilities.

2. Does the State have written training requirements for DSWs working in ICF/IIDs?

No

Yes

3. If “Yes”, please provide the written training requirements for DSWs working in ICF/IID.

4. Does the State have written training requirements for DSWs working in HCBS settings?

No

Yes

5. If “Yes”, do the training requirements vary based on whether the DSW is a paid family member versus a nonrelated DSW?

No

Yes

6. Are the written training requirements for DSWs working in HCBS settings mandatory for all DSWs?

No

Yes

7. Please provide the written training requirements for DSWs (both paid family members and nonrelated DSWs, as applicable) working in HCBS settings.

8. Does the State have a written policy that supports achieving a culturally and linguistically competent direct service workforce?

No

Yes

a. If “Yes”, please provide a copy of the written policy.

9. Does the State have written procedures in place to achieve the goal of a culturally and linguistically competent direct service workforce?

No

Yes

a. If “Yes” which activities do they address? *(Check all that apply)*

Staff Recruitment	<input type="checkbox"/>
Hiring	<input type="checkbox"/>
Retention	<input type="checkbox"/>
Promotion	<input type="checkbox"/>
Other, please specify _____	<input type="checkbox"/>

b. Please provide the applicable written procedures identified in question 9 above.

Principle Feature: System Provides Support for Informal Caregivers

Indicator S4, Support for Informal Caregivers

Overview of Indicator

The Indicator S4, *Support for Informal Caregivers*, examines the “Support for Informal/Family Caregivers” Feature of the Sustainability Principle included in the NBI Conceptual Framework. Informal/family caregivers (referred to as ‘family caregivers’ throughout this Indicator) are unpaid individuals, with no requirements for clinical certification or licensure, who provide assistance with ADLs and/or IADLs to people of all ages with disabilities and chronic conditions. This group includes legally responsible adults (e.g. spouses, or parents of minor children) and other family members, and other nonrelated adults such as friends, or neighbors of the individual receiving LTSS. Informal/family caregivers are an important group of “providers” in the LTSS system.

Informal/family caregivers donate labor hours and help contain LTSS costs by delaying or preventing the receipt of institutional care and/or hospitalizations. Approximately three-quarters (78%) of adults living in the community and in need of LTSS depend on these caregivers as their only source of help, and 14 percent receive a combination of informal and formal care.¹⁰ In 2007, the value of the services provided by family caregivers was estimated at

¹⁰ Thompson, L. (2004). Long-term care: Support for family caregivers [Issue Brief]. Georgetown University Long-Term Care Financing Project. Washington, DC.

\$375 million.¹¹ Informal/family caregivers may experience negative effects on their mental and physical health and economic stability, which threatens their ability to maintain their own wellbeing as well as that of the individual they care for.

States that provide financial, social, and other supports to informal caregivers will be better able to retain this essential “workforce,” and thereby meet the LTSS needs of the target population(s) in a manner in which many prefer and in a cost-effective manner.

1. Do any tax incentives for informal caregivers exist in the State?

- No
- No, because there is no State income tax.
- Yes

TIP: Check “No” if the State has a state income tax and does not offer State-sponsored tax incentives for family caregivers. These tax benefits may include earned income or other tax credits, educational expense incentives, etc. for the family, relative or nonrelative/friend caregivers.

Check “Yes” if the State offers State-sponsored tax incentives for family caregivers. These tax benefits may include earned income or other tax credits, educational expense incentives, etc. for the family, relative or non-relative/friend caregiver.

2. Does the State offer other financial benefits to informal caregivers in lieu of, or in addition to, State income tax incentives?

- No
- Yes (*Please specify*)

TIP: A financial benefit includes a policy for allowing informal caregivers to be paid caregivers.

¹¹ AARP Public Policy Institute (2008), Valuing the Invaluable: The Economic Value of Family Caregiving, 2008 Update. Washington, DC. AARP.

3. Aside from the Federal Family and Medical Leave Act (FMLA), does the State have a State Family Medical Leave Program?

No

Yes

a. If “Yes”, does the State Family Medical Leave Program provide paid leave for the family member?

No

Yes

TIP: See the Glossary for a description of the Federal Family and Medical Leave Act and States that have state-specific family medical leave programs.

4. Does the State provide any other State-funded informal caregiver supports for family caregivers?

No

Yes

TIP: State-funded informal caregiver supports would include, but not be limited to respite services, crisis services, information and assistance services, training and education, caregiver support groups and/or counseling services, and the ability to purchase goods and services that reduce the need for physical assistance.

a. If “Yes”, please describe the supports provided and for which service populations.

b. If “Yes”, how many informal caregivers benefited from the State-funded supports provided in the past year? _____

TIP: Reporting an “unduplicated” count refers to new individuals receiving services. In other words, the same individual receiving respite services for two episodes of respite would only be counted once.

5. Are there criteria family caregivers must meet to be eligible to receive State-funded informal caregiver support services?

No

Yes (*Please describe*)

6. What, if any, the public awareness initiatives have been implemented? (*Check all that apply*)

Print Materials

Television/Radio Advertisements

Social Media Promotion (e.g., Facebook page)

Informational Services through an LTSS Counselor (e.g., Options Counselor)

Other, please specify _____

7. Does the State provide any Medicaid-funded informal caregiver supports for family caregivers?

No

Yes

TIP: Medicaid-funded informal caregiver supports would include, but not be limited to respite services, crisis services, information and assistance services, training and education, caregiver support groups and/or counseling services, and the ability to purchase goods and services that reduce the need for physical assistance.

a. If “Yes”, please describe the supports provided and for which service populations.

b. If “Yes”, how many informal caregivers benefited from the Medicaid-funded supports provided in the past year? _____

TIP: Reporting an “unduplicated” count refers to new individuals receiving services. In other words, the same individual receiving respite services for two episodes of respite would only be counted once.

8. Are there criteria family caregivers must meet to be eligible to receive State-funded informal caregiver support services?

- No
- Yes *(Please describe)*

9. What, if any, the public awareness initiatives have been implemented? *(Check all that apply)*

- Print Materials
- Television/Radio Advertisements
- Social Media Promotion (e.g., Facebook page)
- Informational Services through an LTSS Counselor (e.g., Options Counselor)
- Other, please specify _____

10. Does the State provide any other Federally-funded informal caregiver supports for family caregivers?

- No
- Yes

TIP: Federally-funded informal caregiver supports (i.e., funded with Older American Act funds or SAMHSA mental health and/or substance abuse block grant funds) would include, but not be limited to respite services, crisis services, information and assistance services, training and education, caregiver support groups and/or counseling services, and the ability to purchase goods and services that reduce the need for physical assistance.

- a. If “Yes”, please describe the supports provided and for which service populations.
- b. How many informal caregivers benefited from the Federally-funded supports provided by the in the past year? _____

TIP: Reporting an “unduplicated” count refers to new individuals receiving services. In other words, the same individual receiving respite services for two episodes of respite would only be counted once.

11. Are there criteria informal caregivers must meet to be eligible to receive informal caregiver support services?

- No
- Yes *(Please describe)*

12. What, if any, the public awareness initiatives have been implemented? (*Check all that apply*)

- Print Materials
- Television/Radio Advertisements
- Social Media Promotion (e.g., Facebook page)
- Informational Services through an LTSS Counselor (e.g., Options Counselor)
- Other, please specify _____

Secondary Data

The Behavioral Risk Factor Surveillance System (BRFSS) is a study that is conducted by the Centers for Disease Control (CDC) to assess health behaviors. It draws from a sample of adults over 18 years of age living in a household from all 50 States, the District of Columbia, Guam, the U.S. Virgin Islands, and Puerto Rico. In 2009 and 2010, the BRFSS included modules about caregiving that States could elect to include as they administered the survey. Although not exhaustive, the BRFSS data can be used to provide insight into certain aspects of the caregiver experience that give context to the data collected by the NBI. The following table demonstrates the information that will be reported by the NBI. ***It should be noted that States are not required to collect data to calculate this portion of the Indicator.***

Table 1. BRFSS Caregiving Data

Variable of Interest	Range	Number	Percentage	Average
Number of caregivers	N/A			
Length of time provided care				
Time per week spent caregiving				
Age of care recipient				
Get needed emotional support	N/A			
Difficulties experienced as a caregiver	N/A			N/A

Principle Feature: None

Indicator S5, Shared Long-Term Supports and Services Mission/Vision Statement (Developmental)

Overview of Indicator

An organization’s mission and/or vision statement represents a commitment to a set of values and shared goals. It can be beneficial to States to have and disseminate a mission and/or vision statement that mandates and supports the implementation and maintenance of a person-centered and balanced LTSS system that provides services in the most integrated settings.

The Indicator S5, Shared Long-term Supports and Services Mission/Vision Statement, examines whether the organization has a mission and/or vision statement for a person-centered and balanced LTSS system that provides LTSS in the most integrated settings and is used to guide policy and budgeting decisions.

1. What strategies did the State use to develop and implement its Mission/Vision Statement for its LTSS system? (Check all that apply)

- There is no formal Mission/Vision Statement for the State’s LTSS system.
- A LTSS System Vision Statement has been developed and implemented.
- A LTSS System Mission Statement has been developed and implemented.
- A LTSS Strategic Plan has been prepared and implemented.
- A LTSS Commission/Council has been established and convened.
- A User/Family Stakeholder Group has been established and convened.
- Other, please specify: _____

TIP: This question seeks to identify how a State determined its mission and vision for its LTSS system. In other words, how did the State identify the goals and objectives of its LTSS system?

2. Please indicate the population groups for whom these strategies were applied. (Check all that apply)

Individuals who live with:	Children/Youth	Adults	Older Adults
Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Please indicate at what level the State's LTSS system Vision and Mission Statement have been adopted by entities responsible for overseeing the provision of LTSS in the State: (Check all that apply)

Agency

Sub-Agency

Program

Other, please specify: _____

TIP: "Adopted" indicates that the LTSS Mission/Vision Statement has been implemented. For example, a State's LTSS Mission/Vision Statement that emphasizes the goal of "Community First" may guide the State in ensuring all citizens are offered the option of receiving his/her LTSS in the community first. Agencies then could monitor the effectiveness of this LTSS delivery strategy to determine if the goal articulated in its LTSS Mission/Vision Statement has been achieved.

An example of an agency might be the State's "Department of Aging" (DOA). The "Division or Office of Home and Community-based Services" within the DOA would be considered a sub-agency.

4. Please indicate what formal processes the State has in place to ensure that the State's LTSS Mission/Vision Statement are implemented and achieved: (Check all that apply)

Special Committee or Commission

LTSS Strategic Plan

Annual Report

LTSS Provider

User Feedback

Performance-based contracting with LTSS Providers and/or Subcontractors

Program Evaluation

Performance Evaluation

Other method, please specify: _____

SHARED ACCOUNTABILITY

The Shared Accountability Principle examines the level of responsibility among and between users (older adults and individual with disabilities and chronic conditions and their families), service providers, local government agencies, State program agencies, and the Federal government agencies, and encourages personal planning for LTSS needs, including greater use and awareness of private sources of funding available. There are four Principle Features and four Indicators under the Shared Accountability Principle. The following describes each and provides the survey questions that will be used to examine them.

Principle Feature: The LTSS System Encourages Fiscal Responsibility on the Part of All Entities Related to the Financing, Provision and Receipt of LTSS

Indicator SA1, Fiscal Responsibility (Developmental)

Overview of Indicator

The Indicator SA1, Fiscal Responsibility, examines whether the LTSS system encourages fiscal responsibility on the part of all entities related to the provision and receipt of LTSS.

Fiscal responsibility is an important consideration when considering shared accountability. Users, service providers, and the federal, state and local government share in the responsibility of ensuring that users' LTSS needs are being met and that funds are being used in the most responsible, efficient, and effective manner. Although cost-sharing is a part of shared fiscal responsibility for the user, states also may implement initiatives that encourage the responsible use of LTSS funds and services beyond his or her financial contribution (i.e., LTC Partnerships Program). Fiscal responsibility also should consider what mechanisms may be in place to assess the responsible use of LTSS funds and provision of LTSS services by providers and government.

1. *Has the State implemented any of the following initiatives to support user's ability to share responsibility for LTSS? (Check all that apply)*

- None at this time*
- Tax credit for individuals who purchase long-term care (LTC) insurance or annuity/life insurance with a LTC rider*
- Tax deduction for individuals who purchase LTC insurance or annuity/life insurance with a LTC rider*
- Long-term Care Partnership Program (Respond to question 1a and 1b)*
- Other, please specify _____*

If the State has implemented a LTC Partnership Program,

- a. How are users informed about the program and how to apply? (Please describe)*
- b. How many individuals are enrolled in the program in the current year? _____*

2. Does the State conduct regular financial monitoring/review of LTSS providers to ensure appropriate and responsible use of LTSS funds?

No (Skip to question 3)

Yes

a. Regular financial monitoring/review is conducted for which of the following LTSS providers? (Check all that apply)

Hospitals providing LTSS

Nursing Facilities

Assisted Living/Adult Group Foster Care Residence

ICF/IID

Other institutions that provide LTSS, please specify _____

Home health agencies

Personal care assistant agencies

Other LTSS providers, please specify _____

b. How often does financial monitoring/review occur?

Every _____ months

Annually

Every two years

Other, please specify _____

c. How are LTSS providers selected for financial monitoring/review? (Check all that apply)

In response to a complaint

In response to suspected fraud and/or abuse

A representative sample

All providers are monitored/reviewed

Other, please specify

3. *Does the State produce a report that is made available to the public, users and advocacy organizations about State LTSS financing and expenditures. If yes, please provide a copy of the report. If an online program is used, please provide the URL.*

No (Skip to Indicator SA2)

Yes, report is produces every _____ months

Yes, a report is produced annually

Yes, "Open Checkbook" or a similar online program is available and updated every _____ days/weeks/months

Other, please specify _____

Principle Feature: The LTSS System Encourages and Supports Personal Responsibility through Public Awareness and Education about the Best Use of LTSS Resources

Indicator SA2, Personal Responsibility (Developmental)

Overview of Indicator

The Indicator SA2, Personal Responsibility, examines mechanisms in a State’s LTSS system that provides outreach and educational opportunities that empower individuals and caregivers (users) to effectively use LTSS.

1. *Has the State implemented an Own Your Own Future Long-term Care Campaign to support a user’s ability to plan for future LTSS needs?*

No

Yes

a. *If the State has implemented an Own Your Own Future LTC Awareness Program, has it implemented the following to inform/educate users related to planning for their LTC needs? (Check all that apply)*

Use the Federal Department of Health and Human Services’ Planning Guide for LTC

Developed and use a State-specific Planning Guide for LTC

Developed and implemented a website for the program

Radio advertisement

Television advertisement

Newspaper advertisement

Formal training program, please describe

Other, please specify _____

b. *If the State has implemented an Own Your Own Future LTC Awareness Campaign and a LTC Partnership Program, does the State’s outreach and education materials for the two programs reference and discuss how to access each of the programs?*

No

Yes

c. Does the State's Aging and Disability Resource Center (ADRC) reference or discuss how to access each of the programs mention in item b above as part of their Information and Assistance (I&A) or Information and Referral (I&R) services?

No

Yes

d. Do Options Counselors reference and discuss how to access each of the programs mentioned in item b above as part of an individual's options plan?

No

Yes

2. Has the State implemented one or more self-directed service programs?

No

Yes

a. If "Yes," which of the following training opportunities are available to individuals and families about how to use the self-directed LTSS options available to them? (Check all that apply)

No training opportunities are available (Skip to Indicator SA3)

Formal training session(s) provided, please describe topics covered _____

Individual discussions with a service consultant (e.g. service consultant may include, but isn't limited to, case managers, care coordinators, options councilors, etc.)

Matching users who are using self-directed services with peer (Peer Mentoring)

Written training materials provided (e.g., user guide), please provide a copy

Other, please specify _____

TIP: Examples of training opportunities may include orienting individuals to use self-directed service, the "ABCs" of being an effective employer, and/or how to develop an individual budget (if budget authority is allowed in the self-directed service program).

b. Does the State agency provide specialized training that targets a specific population group?

No

Yes

TIP: Specialized training refers to training opportunities that are designed to meet the unique needs of a specific population group (e.g. adults with I/DD) and may not be relevant to other population groups.

- c. If “Yes,” please indicate the specific population group(s) targeted for specialized training.
(Check all that apply)

Individuals who live with:	Children/Youth	Adults	Older Adults
<i>Physical disabilities</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Mental illness</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Intellectual/developmental disabilities</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Other</i> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Principle Feature: Individuals and Families are Actively Involved in LTSS Policy Development and Implementation

Indicator SA3, Individuals and Families are Actively Involved in LTSS Policy Development

Overview of Indicator

Users' involvement in the development and provision of LTSS is a key aspect of an LTSS system that encourages self-determination and shared responsibility. Input from the user and his/her representative (i.e. family member), when appropriate, is an important element of developing a person-driven LTSS system. The Indicator SA3, *Individuals and Families are Actively Engaged in LTSS Policy Development*, examines if and how a State involves users and families actively in LTSS policy development and implementation.

1. Does the State have a LTSS Advisory Body (e.g., Commission, Council) that includes users and families that is administered at the following level: *(Check all that apply)*

- None
- Governor's Office Level
- Health and Human Services Executive Office Level
- State Agency Level (i.e., Aging, Physical Disability, Intellectual/Development Disability or Mental Health Departments)
- Other, *please specify*

- a. Does the State have more than one LTSS Advisory Body?

- No
- Yes *(please describe)*

- b. Which population groups are represented on the LTSS Advisory Body: *(Check all that apply)*

Individuals who live with:	Children/Youth	Adults	Older Adults
Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Does the State have a statewide LTSS Strategic Plan?

- No
- Yes

TIP: The term “Strategic Plan” refers to a written plan to guide the development of the State’s LTSS system. “Statewide” refers to a comprehensive plan that covers all LTSS in the State. This would have been implemented at the State level across all applicable agencies not just each agency developing its own plan.

3. Which users from the following groups were included in the development of the statewide LTSS Strategic Plan and provided input? (*Check all that apply*)

Individuals who live with:	Children/Youth	Adults	Older Adults
Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Please describe examples of input provided by users and how it was used to enhance the statewide LTSS Strategic Plan.

5. Does the State have an Olmstead Plan?

- No
- Yes

6. Which users from the following groups were included in the development of the Olmstead Plan and provided input? (*Check all that apply*)

Individuals who live with:	Children/Youth	Adults	Older Adults
Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Please describe examples of input provided by users and how it was used to enhance the State's Olmstead Plan.

8. Does the State require or mandate that user and family input be included in the following?

- No requirement/mandate to include individual and family input in LTSS policy development
- Yes, they provide input related to LTSS policy development at the State agency-level.
- Yes, they provide input related to LTSS policy implementation at the State agency-level.
- Yes, they provide input related LTSS quality assurance issues at the State agency-level.

9. Please indicate which of the following methods of obtaining user and family input have been employed in the State. *(Check all that apply)*

- External Stakeholder Group
- Surveys
- Town Hall Meetings
- Other, please specify _____

10. How frequently is this input obtained in the State?

- Quarterly
- Annually
- Ad-hoc
- Other, please specify _____

11. This input is sought out from which of the following population groups? *(Check all that apply)*

Individuals who live with:	Children/Youth	Adults	Older Adults
Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. How does the State encourage users/families to participate in policy development, implementation and quality assurance issues and provide input?

- Financial compensation
- Accommodation (e.g. language services, accessible facilities for individuals with disabilities, etc.)
- Funds are available to support individual/family attendance at policy development meetings, legislative hearings, etc.
- Other, please specify _____

Principle Feature: The LTSS System has Mechanisms in Place to Hold Government and Providers Accountable for Meeting the Needs of Users. Conversely, Users Have the Responsibility to Voice Their Expectations, Needs and Grievances and Comply with Federal and State Rules and Regulations.

Indicator SA4, Government, Provider, and User Accountability

Overview of Indicator

The Indicator SA4, *Government, Provider, and User Accountability*, examines the transparency in reporting and following-up with users.

In order to ensure the delivery of high quality LTSS that meets users' needs and preferences, the LTSS system should have mechanisms in place to ensure the delivery of such services. Transparency in reporting by government and providers would serve to hold these entities accountable for providing high quality LTSS that meets users' needs. For example, an incident and a complaint reporting system should not only log complaints/incidences, but report that complaints and incidents are reported to the appropriate entity(ies) and are addressed and resolved to the satisfaction of the government and users. Another way of monitoring or holding entities accountable for providing high quality LTSS might be to indicate on an users' service plan specific goals and outcomes, document whether or not they have been met and why if they have not been met.

Users also are responsible for communicating needs and preferences. When users' needs and preferences are not being met, these deficiencies should be reported to the applicable government agencies and/or provider(s) through the entities' complaint and/or incidence reporting systems and/or with the State Ombudsman Program, as appropriate.

1. Does the State have a LTSS incident reporting system?

No

Yes

a. Is the State's LTSS incident reporting system statewide or is there one specifically for each HCBS Waiver and HCBS SPA implemented by the State? (*Check all that apply*)

Statewide

By HCBS Waiver, *please specify*

By HCBS SPA, *please specify*

2. Are there other mechanisms in place in the State to address complaints about LTSS?

- No
 Yes *(Please specify)*

TIP: Complaints may be about LTSS providers, programs, and/or services.

3. Does the State have a LTSS quality assurance system?

- No
 Yes

a. Is the State's LTSS quality assurance system statewide or is there one specifically for each HCBS Waiver and HCBS SPA implemented by the State? *(Check all that apply)*

- Statewide
 By HCBS Waiver *(Please specify)*
 By HCBS SPA *(Please specify)*

b. How does the State ombudsman program relate to the State's quality assurance program? Please describe.

4. Does the State contract with an independent third party entity to evaluation the quality of its LTSS system?

- No
 Yes

5. Does the State have licensure requirements for the following LTSS entities? *(Check all that apply)*

- No State LTSS licensure requirements exist
 Nursing Facilities
 ICF/IID
 Group Homes
 Assisted Living Residences

- Board and Care Homes
- Continuing Care Retirement Communities
- Other Residential Facilities, please specify _____
- Home Health Agencies
- Personal Care Agencies
- Day Habilitation Providers
- Day Activity Providers
- Other Community-Based Services, please specify _____

6. Under what circumstances would a LTSS provider either be denied initial licensure or have its license revoked? (*Check all that apply*)

- A positive finding on a criminal record check based on State criteria
- Citation for poor quality
- Conviction for theft, fraud and/or abuse of an individual based on State criteria
- Other, please specify _____

7. Does the State provide a rating system to users for the following LTSS providers? (*Check all that apply*)

- No State LTSS licensure requirements exist
- Nursing Facilities
- ICF/IID
- Group Homes
- Assisted Living Residences
- Board and Care Homes
- Continuing Care Retirement Communities
- Other Residential Facilities, please specify _____
- Home Health Agencies
- Personal Care Agencies
- Day Habilitation Providers
- Day Activity Providers

Other Community-Based Services, please specify _____

a. Please describe the State’s rating system used to assess performance for each of the providers checked above.

8. Does the State produce a report about LTSS activities, outcomes, and/or providers and makes this report available to the public, users, and user advocacy organizations?

No

Yes, annually

Yes, other, please specify frequency _____

9. Please describe how the public, users, and user advocacy organizations are informed about the existence of this report or how it is publicized and disseminated.

10. Please provide a copy of the report.

Secondary Data

The National Ombudsman Reporting System (NORS) data is reported by each State Agency on Aging, and includes data on staffing, facilities and beds, and types of complaints from residents. Although not exhaustive, the BRFSS data can be used to provide insight into certain aspects of the ombudsman program that give context to the data collected by the NBI. The following table demonstrates the information that will be reported by the NBI. **It should be noted that States are not required to collect data to calculate this portion of the Indicator.**

Possible Question	Possible Answer Set
How many complaints were filed with the ombudsman in the State during the previous five calendar years?	N= _____ complaints
What percentage of complaints filed with the ombudsman were handled to the satisfaction of the State for the previous five calendar years?	_____ %
What percentage of the State’s LTSS providers were visited each year by an ombudsman during the previous five years?	<input type="checkbox"/> Nursing Facilities _____ % <input type="checkbox"/> Board and Care Facilities _____ % <input type="checkbox"/> Assisted Living Facilities _____ % <input type="checkbox"/> Home Care _____ % <input type="checkbox"/> Other, please specify _____ %

SELF-DETERMINATION/PERSON-CENTEREDNESS

Self-determination and control over one's life is important for all individuals including those with disabilities.¹² Self-determination provides a conceptual framework for the development of a LTSS system that is person-centered and allows for individuals, including those with disabilities, to make choices free from undue external influence or interference.¹³

The Self-Determination/Person-Centeredness Principle examines whether the LTSS system affords people with disabilities and/or chronic illness the authority to:

- decide where and with whom they live;
- have control over the services they receive and the organizations and individuals who provide them;
- have the opportunity to work and have private income; and
- have the opportunity to have friends and supports that facilitate their participation in community life.

Principle Features: System Affords Individual Choice and Control and System Allows for the “Dignity of Risk”

Indicator SD1, Regulatory Requirements Inhibiting Consumer Control (Developmental)

Overview of Indicator

User choice is a major component of a balanced, person-driven, LTSS system.¹⁴ State LTSS regulatory requirements may, in some instances, provide individuals with less freedom to “customize” the LTSS they receive and the organizations and individuals who provide them.

There are three Sub-indicators under the Indicator SD1, Regulatory Requirements Inhibiting Consumer Control: (1) residential setting requirements, (2) attendant hiring requirements,¹⁵ and

¹² Kennedy, M.J. (1996). *Self-determination and trust: My experiences and thoughts*. In D.J. Sands & Wehmeyer, M.L. (Eds.), *Self-determination across the life span: Independence and Choice for People with Disabilities* (pp. 37-49). Baltimore, MD: Paul H. Brooks.

¹³ Wehmeyer, M.L. (2003). A functional theory of self-determination: Model overview. In M.L. Wehmeyer, B. Abery, D.E. Mithaug & R.J. Stancliffe. *Theory in Self-Determination: Foundations for Educational Practice* (pp.182-201). Springfield, IL: Thomas.

¹⁴ Woodcock, C., Stockwell, I., Tripp, A., & Milligan, C. (2011, June, 14). *Rebalancing long-term services and Supports: Progress to date and a research agenda for the future*. Baltimore, MD: The Hilltop Institute, UMBC.

¹⁵ Self-directed services liberate a non-traditional direct service workforce of family and friends who in the absence of having a relationship with a person with a disability, might never wish to be a direct service worker. Often these related or previously known direct service workers know the individual and his/her needs well and have received informal training from a variety of sources (e.g., physicians, nurses, physical and occupational therapists). Increased regulatory requirements for this subset of direct service workers (e.g., formal training and certification) can provide a disincentive for them to be paid direct service workers.

(3) nurse delegation. These Sub-indicators measure the extent to which consumers' (users') have control over accessing LTSS in the least restricted environment of their choice.

Sub-indicator SD1a, Residential Setting (Developmental)

Overview of Sub-indicator

CMS' Home and Community-based Services (HCBS) Settings Final Rule, (CMS 2249-F/2296-F), establishes requirements for the qualities of settings that are eligible for reimbursement for the Medicaid HCBS provided under §1915(c), 1915(i) and 1915(k) of the Medicaid statute. In this final rule, CMS is moving away from defining home and community-based settings by "what they are not," and toward defining them by the nature and quality of individuals' experiences. The home and community-based setting provisions establish a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. It is believed that the changes related to clarification of home and community-based settings will maximize the opportunities for participants in HCBS programs to have access to the benefits of community living and to receive services in the most integrated setting and will effectuate the law's intention for Medicaid HCBS to provide alternatives to services provided in institutions.¹⁶

Sub-indicator SD1a, Residential Setting examines how States are implementing residential settings in conjunction with the provision of LTSS that maximize the opportunities for HCBS program participants to receive HCBS in the most integrated settings and effectuate the federal law's intention for States to provide Medicaid HCBS in alternative settings to institutions.

1. In which types of residential settings are Medicaid HCBS provided in the State? (Check all that apply)

- Assisted Living
- Group Homes
- Adult Foster Homes
- Group Adult Foster Care
- Board and Care Homes
- Residential Care Facilities (RCFs)

For each setting checked above, answer the following questions.

TIP: These questions will be repeated on the data collection tool for each setting checked above.

¹⁶ CMS Fact Sheet: Summary of Key Provisions of the Home and Community-Based Services (HCBS) Settings Final Rule (CMS 2249-F/2296-F). January 10, 2014.

a. *Is the residential setting integrated in and supports full access to the greater community?*

No

Yes (Please describe)

b. *Is the setting selected by the user from among setting options?*

No

Yes (Please describe)

c. *Does the residential setting ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint?*

No

Yes (Please describe)

d. *Does the resident setting optimize autonomy and independence in making life choices?*

No

Yes (Please describe)

e. *Does the residential setting facilitate choice regarding LTSS and who provides them?*

No

Yes (Please describe)

2. Does the State have provider-owned or controlled home and community-based residential settings?

No

Yes (Please describe)

a. Does the user have a lease or other legally enforceable agreement providing similar protections?

No

Yes (Please describe)

b. Does the individual have privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit?

No

Yes (Please describe)

c. Does the individual controls his/her own schedule including access to food at any time?

No

Yes (Please describe)

d. Can the individual have visitors at any time?

No

Yes (Please describe)

e. Is the setting physically accessible?

No

Yes (Please describe)

3. Has the State made any modifications to these additional requirements for provider-owned home and community-based residential settings?

- No
- Yes (Please describe)

a. Are these modifications supported by a specific assessed need and justified in the user’s person-centered plan?

- No
- Yes (Please describe)

Sub-Indicator SD1b, Attendant Selection (Developmental)

Overview of Sub-indicator

The Sub-indicator SD1b, Attendant Selection, examines State certification requirements for selecting an attendant of the user’s choice. In order to provide users’ with a high level of choice and control over a broad selection of attendants, including being able to use members of the nontraditional direct service workforce of family and friends, regulatory requirements for attendants should not be such that family and friends are discouraged from being paid direct service workers (See footnote 15).

1. Is a person-driven model(s) of LTSS provided by attendants available (e.g., self-directed LTSS where the user may select/hire, supervise and discharge their attendants)?

- No
- Yes

a. For which populations are these service delivery models available? (Check all that apply)

Individuals who live with:	Children/Youth	Adults	Older Adults
Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

b. *What tasks are users allowed to perform related to their attendants under the person-driven LTSS service delivery model(s) offered by the State? (Check all that apply)*

- Recruit attendant*
- Hire attendant*
- Refer for hire attendant to third party entity and assignment back to the user*
- Determine attendant's tasks to be performed*
- Determine attendant's work schedule*
- Train attendant*
- Supervise attendant*
- Evaluate attendant's performance*
- Discharge attendant*
- Discharge attendant from home*
- Other (Please describe)*

2. *What are the minimum Medicaid State Plan or Waiver requirements for certifying an attendant? (Check all that apply)*

- Age*
- Education*
- Training (initial and ongoing training requirements)*
- Certification/Recertification*
- Satisfactory Results of Background Checks*
- Other (Please describe)*

3. *Can a family member be designated as an attendant and receive compensation?*

- No*
- Yes*

4. Can attendants who are family receive fringe benefits?

No

Yes

5. Can a non-family member be designated as an attendant and receive compensation?

No

Yes

6. Can attendants who are non-family members receive fringe benefits?

No

Yes

Sub-Indicator SD1c, Nurse Delegation (Developmental)

Overview of the Sub-indicator

The Sub-indicator SD1c, Nurse Delegation, examines the “Dignity of Risk” and “Individual Choice and Control” Features of the Self-Determination/Person-Centeredness Principle included in the NBI Conceptual Framework. These concepts recognize that older adults and individuals with disabilities and chronic conditions should have the right to exercise choice and control related to the delivery of their LTSS while understanding that with rights come responsibilities including assuming the responsibility for potential risks associated with their choices and actions.

The Sub-indicator, Nurse Delegation, examines how restrictive a State’s Nurse Practice Act (e.g., nurse delegation/assignment) is in allowing health maintenance tasks to be performed by qualified unlicensed personnel. The “medicalization” of LTSS may restrict choice and control over a user’s LTSS, thereby minimizing their opportunities for self-determination.

Additionally, this Sub-indicator examines the degree to which persons of all ages and disability are able to receive services across a range of community settings, by examining how restrictive a State’s Nurse Delegation Act is. Ideally, language included in a State’s Nurse Practice Act would allow for nurse delegation for a full range of health maintenance activities to qualified unlicensed personnel, while protecting the health and safety of individuals receiving LTSS. For those States with less restrictive Nurse Practice Acts potential liability issues also are examined.

1. What activities may be delegated under the State’s Nurse Practice Act or other State statutes, regulations or written policy? (Check all that apply per setting)

TIP: Check all health maintenance activities that may be delegated to qualified unlicensed personnel, specifying which activities may be delegated under which setting of interest.

Activities Delegated Under the Nurse Delegation Act				
	<i>1. Private Residences</i>	<i>2. Community Group Residences</i>	<i>3. Schools</i>	<i>4. Other</i>
<i>1a. Ventilator Care</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>1aa. Perform Nebulizer Treatment</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>1ab. Administer Oxygen Therapy</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>1ac. Perform Ventilator Respiratory Care</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>1b. Medication Administration</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>1ba. Administer Oral Medication</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>1bb. Administer Medication on an as Needed Basis</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>1bc. Administer Medication via Pre-Filled Insulin or Insulin Pen</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>1bd. Draw Up Insulin for Dosage Measurement</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>1be. Administer Intramuscular Injection Medications</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>1bf. Administer Glucometer Test</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>1bg. Administer Medication Through Tubes</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>1bh. Insert Suppository</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>1bi. Administer Eye/Ear Drops</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>1c. Bowel/Bladder Regimen</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>1ca. Administer Enema</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>1d. Catheter Care</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>1da. Perform Intermittent Catheterization</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>1e. Wound Care and Dressing Changes</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>1f. Tube Feedings</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>1fa. Gastrostomy Tube Feeding</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>1g. Transfers and Positioning</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>1ga. Perform Ostomy Care Including Skin Care and Changing Appliance</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>1h. Other, please specify</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. What settings and populations are covered by the State’s Nurse Practice Act or other statutes, regulations or written policies? (Check all that apply)

TIP: Check “private residences” if nurse delegation is allowed in the user’s private residence such as single or multi-family private home, apartment or other privately-owned or rental housing.

Private residences (If checked, indicate populations below, checking all that apply)

Individuals who live with:	Children/Youth	Adults	Older Adults
Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TIP: If the “Private residence” box is checked, check each population and age group for which the State’s Nurse Delegate Act allows for nurse delegation in the table below. Note that more than one population may be checked. For each population checked, write in the specific “Age Range” served within that population. Note that the population for this Sub-indicator may include Medicaid beneficiaries as well as other individuals for which the State Nurse Practice Act allows for the delegation of medical and/or health maintenance tasks to qualified unlicensed personnel. If nurse delegation is allowed for a particular population not identified in the population types provided, write in the name of the population next to “other”. Definitions for each population may be found in the Glossary.

TIP: Check the “community group residences” box if nurse delegation is allowed in assisted living facilities, group homes, adult foster care, board and care homes and residential care homes.

Community group residences (If checked, indicate populations below, checking all that apply)

Individuals who live with:	Children/Youth	Adults	Older Adults
Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TIP: If the “Community group residences” is box checked, check each population and age group for which the State’s Nurse Delegate Act allows for nurse delegation in the table below. Note that more than one population may be checked. For each population checked, write in the specific “Age Range” served within that population. Note that the population for this Sub-indicator may include Medicaid beneficiaries as well as other individuals for whom the State Nurse Practice Act allows for the delegation of health maintenance tasks to qualified unlicensed personnel. If nurse delegation is allowed for a particular population not identified in the population types provided, write in the name of the population next to “other”. Definitions for each population may be found in the Glossary.

TIP: Check the “Schools” box if nurse delegation is allowed in public or private educational facilities, Grades K – 12.

Schools (If checked, indicate populations below, checking all that apply)

Children who live with:	
Physical disabilities	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>
Other _____	<input type="checkbox"/>

TIP: If the “Schools” box is checked, check each population and age group for which the State’s Nurse Delegate Act allows for nurse delegation in the table below. Note that more than one population may be checked. For each population checked, write in the specific “Age Range” served within that population. Note that the population for this sub-indicator may include Medicaid beneficiaries as well as other individuals for which the State Nurse Practice Act allows for the delegation of medical and/or health maintenance tasks to qualified unlicensed personnel. If nurse delegation is allowed for a particular population not identified in the population types provided, write in the name of the population next to “other”. Definitions for each population may be found in the Glossary.

TIP: Check the “Other” box if nurse delegation is allowed in settings other than those described above. Medical facilities such as hospitals and nursing facilities are excluded from this item. Write in what setting nurse delegation is allowed in.

Other (Please specify) _____ (If checked, indicate populations below, checking all that apply)

Individuals who live with:	Children/Youth	Adults	Older Adults
Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TIP: If the “Other” box is checked, check each population and age group for which the State’s Nurse Delegate Act allows for nurse delegation in the table below. Note that more than one population may be checked. For each population checked, write in the specific “Age Range” served within that population. Note that the population for this Sub-indicator may include Medicaid beneficiaries as well as other individuals for whom the State Nurse Practice Act allows for the delegation of health maintenance tasks to qualified unlicensed personnel. If nurse delegation is allowed for a particular population not identified in the population types provided, write in the name of the population next to “other”. Definitions for each population may be found in the Glossary.

3. *Does the State’s Nurse Delegation Act or other State statutes, regulations or written policies mandate training for unlicensed assistive personnel?*

- No
- Yes (Please describe)

4. *Does the State’s Nurse Delegation Act or other State statutes, regulations or written policies mandate competency for unlicensed assistive personnel?*

- No
- Yes (Please describe)

5. *Does the State's Nurse Delegation Act or other State statutes, regulations or written policies mandate certification for unlicensed assistive personnel?*

No

Yes

6. *Does the State's Nurse Delegation Act or other State statutes, regulations or written policies mandate onsite supervision for unlicensed assistive personnel?*

No

Yes

7. *Does the State's Nurse Delegation Act or other State statutes, regulations or written policies mandate background checks for unlicensed assistive personnel?*

No

Yes

Principle Feature: Availability of Options for Self Determination

Indicator SD2, Availability and Use of Self-directed Services

Overview of Indicator

States that offer a broad array of self-directed services and to large numbers of individuals through their Medicaid State Plan, State Plan Amendments (SPAs) and/or HCBS Waivers may provide greater opportunities for users and their representatives, when appropriate, to exercise choice and control over the LTSS they receive, the manner in which their LTSS are delivered and the organizations and individuals who provide them.

The Indicator *SD2, Availability and Use of Self-directed Services*, examines whether the State offers home and community-based services using a self-directed approach under their Medicaid State Plan or one or more Medicaid SPA or HCBS Waivers. The Indicator also examines under what authority these self-directed Medicaid State Plan, Medicaid SPA and/or HCBS Waiver services are offered (e.g., employer authority, budget authority or both).

TIP: Responses to questions below related to HCBS Waiver will be compared to data available on the CMS HCBS Waiver and SPA website.

1. How many active Medicaid §1915(c) HCBS waivers does the State have? _____

TIP: Questions below should be answered for each of the State's Medicaid §1915(c) HCBS Waivers the State currently has implemented.

2. Medicaid §1915(c) HCBS Waiver Number/Name: _____

3. Target Population(s) Served (*Check all that apply*)

Individuals who live with:	Children/Youth	Adults	Older Adults
Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Does the Medicaid §1915(c) HCBS Waiver offer...?

- a. Person-Centered Planning, such as defined in Appendix D: Person-Centered Planning and Service Delivery in the CMS §1915(c) Waiver Application Instructions, Technical Guide and Review Criteria and criteria included in 42 CFR Part 430, 41 et al, Medicaid Program; State Plan HCBS, 5-year Period of Waivers, Provider Payment Reassignment & HCBS Setting Requirements for Community First Choice and HCBS Waivers-Final Rule? *(Check one.)*

No

Yes *(If checked, check all that apply)*

i. Does the State's person-centered planning process:

- Develop a written service plan jointly with the individual, including his/her representative if applicable
- Includes people chose by the individual
- Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions?
- Is timely and occurs at times and locations of convenience to the individual
- Reflects the cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient
- Includes strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants
- Offers choice to the individual regarding the services and supports the individual receives and from whom
- Includes a method for the individual to request updates to the plan, as needed
- Records the alternative home and community-based settings that were considered by the individual

ii. Commensurate with the level of need of the individual, and the scope of services and supports available under the State Plan HCBS benefit, does the individual service plan: *(Check all that apply)*

- Reflect that the setting in which the individual resides is chosen by the individual
- Reflect the individual's strengths and preferences
- Reflect clinical and support needs as identified through an assessment of functional need
- Includes individually identified goals and desired outcomes
- Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports that are provided voluntarily to the individual in lieu of State plan HCBS
- Reflect risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed
- Is understandable to the individual receiving services and supports and the individuals important in supporting him or her (written in plain language, in a manner that is accessible to individuals with disabilities and persons who are limited English proficient)
- Identifies the individual and/or entity responsible for monitoring the plan
- Is finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation
- Is distributed to the individual and other people involved in the plan
- Include those services the purchase or control of which the individual elects to self-direct, meeting the requirements of §441.740 of the final rule
- Prevents the provision of unnecessary or inappropriate services and supports
- Documents that any modification of the additional conditions as specified in the final rule
- Is reviewed and revised upon reassessment of functional needed at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual

iii. How many users had the person-centered plans prepared during the previous reporting year? _____

TIP: This question captures the number of unduplicated count of users (i.e., waiver participants) who had person-centered plans prepared during the time period indicated.

b. Employer Authority? *(Check one)*

No

Yes *(If checked, check all that apply)*

i. How many users received self-directed LTSS using the joint-employer option under employer authority during the previous reporting year?

ii. Can users set their employees' (i.e., attendants') wages?

No

Yes

iii. How many users received self-directed LTSS using the common law employer option under employer authority during the previous reporting year? _____

iv. Can users set employees' (i.e., attendants') wages?

No

Yes

c. Is Budget Authority offered? *(Check one)*

No

Yes *(If checked, check all that apply)*

i. Please indicate all of the types of budget authority available:

Participant (i.e., user) decision making authority (e.g., Participant exercises decision-making authority and management responsibility for establishing and managing a self-directed budget within program rules).

Authority to modify services in budget without prior approval

Purchasing individual-directed goods and services that are approved in participant's service plan.

ii. How many participants received self-directed services using budget authority during the previous reporting year? _____

5. How many active Medicaid HCBS State Plan Amendments (SPAs) does the State have and what type(s)?

§1915(i) _____

§1915(j) _____

§1915(k) _____

6. SPA Number(s)/Name(s): _____

7. Target Population(s) Served (*Check all that apply*)

Individuals who live with:	Children/Youth	Adults	Older Adults
Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Does the SPA offer...?

a. Person-Centered Planning, such as defined in Appendix D: Person-Centered Planning and Services, in the CMS Instructions, Technical Guide and Review Criteria for the §1915(c) HCBS Waiver Application and criteria included in 42 CFR Part 430, 41 et al, Medicaid Program; State Plan HCBS, 5-year Period of Waivers, Provider Payment Reassignment & HCBS Setting Requirements for Community First Choice and HCBS Waivers-Final Rule? (*Check one*)

No

Yes (*If checked, check all that apply.*)

i. Does the State's person-centered planning process:

Develop a written service plan jointly with the individual, including his/her representative if applicable

Includes people chose by the individual

Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions?

- Is timely and occurs at times and locations of convenience to the individual
- Reflects the cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient
- Includes strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants
- Offers choice to the individual regarding the services and supports the individual receives and from whom
- Includes a method for the individual to request updates to the plan, as needed
- Records the alternative home and community-based settings that were considered by the individual

ii. Commensurate with the level of need of the individual, and the scope of services and supports available under the State Plan HCBS benefit, does the individual service plan (Check all that apply):

- Reflect that the setting in which the individual resides is chosen by the individual
- Reflect the individual's strengths and preferences
- Reflect clinical and support needs as identified through an assessment of functional need
- Includes individually identified goals and desired outcomes
- Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports that are provided voluntarily to the individual in lieu of State plan HCBS
- Reflect risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed
- Is understandable to the individual receiving services and supports and the individuals important in supporting him or her (written in plain language, in a manner that is accessible to individuals with disabilities and persons who are limited English proficient)
- Identifies the individual and/or entity responsible for monitoring the plan

- Is finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation
- Is distributed to the individual and other people involved in the plan
- Include those services the purchase or control of which the individual elects to self-direct, meeting the requirements of §441.740 of the final rule
- Prevents the provision of unnecessary or inappropriate services and supports
- Documents that any modification of the additional conditions as specified in the final rule
- Is reviewed and revised upon reassessment of functional needed at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual

iii. How many users had the person-centered plans prepared during the previous reporting year? _____

b. Employer Authority? (*Check one*)

- No
- Yes (*If checked, check all that apply*)

i. How many users received self-directed LTSS using the joint-employer option under employer authority during the previous reporting year?

ii. Can users set employees' (i.e., attendants) wages?

- No
- Yes

iii. How many users received self-directed LTSS using the common law employer option under employer authority during the previous reporting year? _____

iv. Can participants set employees' (i.e., attendants') wages?

No

Yes

c. Is Budget Authority offered? (*Check one*)

No

Yes (*If checked, check all that apply*)

i. Please indicate all of the types of budget authority available:

Participant (i.e. user) decision making authority (e.g., user exercises decision-making authority and management responsibility for establishing and managing a self-directed budget within program rules)

Authority to modify services in budget without prior approval

Purchasing individual-directed goods and services that are approved in participant's service plan

ii. How many participants took advantage of the budget authority during the previous reporting year? _____

iii. How many of the State's Medicaid §1915(c) HCBS waivers are population-specific? _____

d. Please specify the number of Medicaid §1915(c) HCBS waivers for each of the populations listed below:

Children/Youth _____

TBI/Head Injury _____

Other _____

i. If the State has one or more active children's §1915(c) HCBS waivers do any offer self-directed service opportunities?

No (*If "No", skip to the next question*)

Yes (*If "Yes", how many? _____*)

ii. If the State has one or more active §1915(c) HCBS TBI waivers do any offer self-directed service opportunities?

No (If "No" skip to the next question)

Yes (If "Yes", how many? ____)

iii. Do any of the other active population-specific Medicaid §1915(c) HCBS waivers indicated in the previous question, offer self-directed service opportunities?

No (If "No", skip to Indicator SD3)

Yes (If "Yes", how many? ____)

TIP: The following questions collect information on programs and services offered that may provide self-directed service, but are **NOT** funded by Medicaid. Examples of such programs include programs funded by the Older American's Act, mental health block grants, Veterans Directed HCBS programs, and State-funded options.

9. Does your State have a Community Mental Health Services Block Grant (MHBG)?

a. If yes, does it offer any self-directed service opportunities?

No (If "No", skip to question 10)

Yes (If "Yes", please describe) _____

10. Does your State have a Substance Abuse and Treatment Block Grant (SABG)?

a. If yes, does it offer any self-directed service opportunities?

No (If "No", skip to question 11)

Yes (If "Yes", please describe) _____

11. Does the State have a Veterans-Directed HCBS program funded by the Veteran's Administration?

No (If "No", skip to Indicator SD3)

Yes

12. Do State-funded self-directed HCBS programs exist in the State?

No (*If "No", skip to Indicator SD3*)

Yes

a. If "Yes", please describe how many, how and by whom they are implemented, and the populations served?

13. Do self-directed HCBS programs funded by Older American Act funds operate in the State?

No (*If "No", skip to Indicator SD3*)

Yes

a. If yes, please describe how many, how and by whom they are implemented.

Principle Features: System Affords Individual Choice and Control and System Allows for the “Dignity of Risk”

Indicator SD3, Risk Assessment and Mitigation

Overview of Indicator

The Indicator SD3, *Risk Assessment and Mitigation*, examines the “Dignity of Risk” and “Individual Choice and Control” Features of the Self-Determination/Person-Centeredness Principle included in the NBI Conceptual Framework. These concepts recognize that under Self-Determination, older adults and individuals with disabilities and chronic conditions should have the right to exercise choice and control related to the delivery of their LTSS. However, with rights come responsibilities, many of which are mandated by federal and state regulation (e.g., being an employer of direct service providers). States and users must exercise shared accountability for potential risks associated with users’ choice and control so that users’ health and safety can be ensured.

Potential risks associated with the user exercising self-determination, using self-directed services and living in the community should be assessed, monitored and mitigated to ensure users’ health and safety. However, the goal of these activities should be to identify and mitigate potential risks and not just make a case against the individual exercising Self Determination and using self-directed services. Activities related to risk assessment and mitigation include, but are not limited to:

- assessing and re-assessing, as needed, potential risks for a user;
- developing a risk management plan and agreement during the person-centered planning process; and
- monitoring the effectiveness of risk management plans and agreements and updating them periodically, and as needed.

Additional mechanisms for addressing users’ health and safety may include implementing a 24-hr direct service worker back-up strategy, a user call-in and complaint/grievance reporting system and a critical incident reporting and management system.

1. Has the State implemented a Risk Assessment and Mitigation System for users living in the community?

- No
 Yes

a. If yes, does the system include the following activities? (Check all that apply)

- Conducting Risk Assessment
- Conducting Re-assessment of Risk
- Developing and Implementing Risk Management Plans
- Developing and Implementing Risk Agreements
- Monitoring Risk Management Plans and Agreements
- Providing Remediation and Training to User, as needed
- Updating Risk Management Plans and Agreements, as need
- Implementing a 24-hour Direct Service Worker Back-up Strategy
- Implementing and Maintaining a User Call-in and Complaint/Grievance System
- Implementing and Maintaining a Critical Incident Reporting and Management System
- Incorporating the Risk Assessment and Mitigation System, 24-hour Direct Service Worker Backup Strategy and Critical Incident Reporting and Management Systems into the State's Quality Improvement System

b. If assessments of potential risks for community living are conducted for users, when do they occur, how are potential risks assessed, who conducts the assessments and what is the role of the user and his/her representative in the process? *(Please describe.)*

c. If re-assessments of potential risks for community living are conducted for users, when do they occur, who conducts them and what is the role of the user and his/her representative in the process? *(Please describe.)*

d. If risk management plans are developed and/or implemented for users, when does this occur, who leads the planning effort and what is the role of the user and his/her representative in the process? *(Please describe.)*

e. If risk agreements are developed and/or implemented for users, when does this occur, who prepares the agreements and what role is the role of the user and his/her representative in the process? *(Please describe.)*

f. If users' risk management plans and/or agreements are monitored, when does this occur, who performs the function, how are findings used, and what is the role of the user and his/her representative in the process? *(Please describe.)*

- g. When a user or his/her representative is found to be deficit in implementing his/her risk management plan and/or agreement, what is the process used for remediation and training to correct the deficiencies? *(Please describe)*
- h. If a 24-hour direct service worker backup strategy exists, please describe.
- i. If a user call-in and complaint/grievance system exists, please describe.
- j. If a critical incident reporting and management system exists, please describe.
- k. Please describe how the State's risk assessment and mitigation system, 24 hour direct service worker backup strategy and critical incident reporting and management system are addressed in the State's quality improvement system.

COMMUNITY INTEGRATION AND INCLUSION

The Community Integration and Inclusion Principle examines whether a State's LTSS system encourages and supports people to reside in the most integrated setting by offering a full array of options for accessing quality services and supports in the community.

Principle Features: Availability of and Access to (or Opportunities for) the Full-Range of LTSS Including Medical, Dental, Mental Health, Assistive Technology, Transportation, and Affordable Housing with Supports and People of all Ages with Disabilities and/or Chronic Conditions Reside and Participate in the Most Integrated Community Settings

Indicator CI1, Waiver Waitlist (Developmental)

Overview of Indicator

The Indicator CI1, Waiver Waitlist examines the “most integrated community settings” Feature of the Community Integration and Inclusion Principle included in the NBI Conceptual Framework. HCBS waivers allow older adults and people with disabilities the option to receive LTSS in community settings.¹⁷ However, often the number of people wishing to receive services may exceed the number of participants that are approved to receive HCBS within a State fiscal year. As a result, government authorities responsible for administering Medicaid HCBS waivers must balance multiple priorities, such as an individual's need for LTSS with the length of time individuals wait to receive HCBS waiver services, in order to achieve equity and fairness.

CMS does not require States to implement waiver waitlists. NBIP considers States that implement waitlist protocols that support diversion and transition from institutional settings to the community to be better equipped to identify individuals who are eligible for services and support individuals' access to LTSS.

TIP: Questions for this Indicator are included in SD2, Availability of Self-Direction Options, but are analyzed separately.

For each Medicaid §1915(c) HCBS waiver offered by a State:

- 1. How many active Medicaid §1915(c) HCBS waivers does the State have? (Asked as part of SD2)*

¹⁷ Shirk, C. (2006). Rebalancing Long-Term Care: The Role of the Medicaid HCBS Waiver Program. National Health Policy Forum Background Paper. Accessed at: http://scholar.google.com/scholar?q=medicaid+hcb+waivers&btnG=&hl=en&as_sdt=0%2C50

Waiver #1 (Repeat as necessary)

2. For this Medicaid §1915(c) HCBS waiver, does the State limit the number of participants that it serves at any point during a currently-approved waiver period?

TIP: Answer this question based on whether or not the State has limited the maximum number of participants able to be served under the Medicaid §1915(c) HCBS waiver at any given point in time, as per guidance from Appendix B-3-b from the CMS §1915(c) HCBS waiver application, below:

“... a State also may specify the maximum number of participants who are served at any point in time during the waiver year. Specifying such a maximum may assist in managing waiver expenditures and taking into account participant turnover during the course of a waiver year.”
Check “Yes” if the State has specified such a limitation for the Medicaid §1915(c) HCBS waiver; check “No” if it does not.

- No (If “No”, please skip to the next indicator)
 Yes

3. What is the maximum number of participants that can enroll in this Medicaid §1915(c) HCBS Waiver during the current fiscal year?
4. For this Medicaid §1915(c) HCBS waiver, does the State have a waitlist for individuals who are eligible but are not able to receive waiver services at the time their application is submitted or they are referred to the waiver?

- No (If “No”, please skip to the next Indicator)
 Yes

5. Who is eligible to be on this Medicaid §1915(c) HCBS waiver waitlist?

- The waitlist is open to everyone
 LTSS users who are receiving other LTSS, but need or would like additional or other services covered under this waiver
 LTSS users who are not receiving other LTSS, but who are eligible for services under this waiver
 Other, please describe

6. Is there a maximum number of individuals that can be on this Medicaid §1915(c) HCBS waiver's waitlist during the current fiscal year?

No

Yes

a. What is the maximum number of individuals that can be on this Medicaid §1915(c) HCBS waiver's waitlist during the current fiscal year?

7. Within the last month what is the average number of individuals on this Medicaid §1915(c) HCBS waiver's waitlist?

8. Over the last three months, what is the average length of time that an individual must wait to receive services through this Medicaid §1915(c) HCBS waiver?

Less than 1 month

1-2 Months

3-6 Months

7-12 Months

Longer than 12 months

9. Does the waitlist account for various disability types?

No

Yes

a. If yes, which of the following populations? (Check all that apply)

Individuals who live with:	Children/Youth	Adults	Older Adults
Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Does the waitlist account for other diversity groups?

- No
- Yes

a. If yes, please describe.

11. Are individuals provided information regarding other LTSS available to them while on this Medicaid §1915(c) HCBS waiver's waitlist?

- No
- Yes

TIP: Information can be provided through the Information & Assistance (I&A), Information & Referral (I&R), or Options Counseling (OP) functions, or through the receipt of other information.

a. How are individuals provided information regarding other LTSS available to them while on this Medicaid §1915(c) HCBS waiver waitlist?

Element	
7aa. Counseling on LTSS Options	<input type="checkbox"/>
7ab. Information and Referral	<input type="checkbox"/>
7ac. Information and Assistance	<input type="checkbox"/>
7ad. Other, please specify _____	<input type="checkbox"/>

b. Are individuals able to receive other LTSS while on the waitlist to receive LTSS through this Medicaid §1915(c) HCBS waiver?

- No
- Yes, fee-for-service
- Yes, other please describe

c. Are individuals able to request a reassessment of their LTSS need or an update of the initial information submitted to receive LTSS?

- No
- Yes

12. How are individuals who are waiting to receive LTSS prioritized?

TIP: Answer this question based on the strategy used by the State to serve individuals who are waiting to receive LTSS.

- First come, first served
- Based on risk of institutionalization (If checked, please answer question 12a)
- Transition from an institutional setting to the community (If checked, please answer question 12b)
- Other, please describe: _____

a. To avoid institutionalization does this §1915(c) HCBS waiver waitlist prioritize for...(For each element in the table below, put a check in the column with the number that best describes the State’s Medicaid §1915(c) HCBS waiver waitlist prioritization method)

TIP: More than one response can be prioritized at the same level (i.e. if this waitlist prioritizes both older adults with skilled nursing need and aging caregivers equally above other responses, both can receive a “1”).

Diversion Element		Prioritization Order
12ab. ...those aging with disabilities in the community (i.e. those aging out of children’s special health care services)?	<input type="checkbox"/>	
12ac. ...older adults with skilled nursing need/ADLs/IADLs in the community?	<input type="checkbox"/>	
12ad. ...those with open Adult Protective Service cases?	<input type="checkbox"/>	
12ae. ... caregivers no longer able to provide care?	<input type="checkbox"/>	
12af. ...other? (Please specify)	<input type="checkbox"/>	
12ag. ...combination/multiple of 11ab-11af?	<input type="checkbox"/>	

b. To support transition from an institution, does this §1915(c) HCBS waiver waitlist prioritize for...(For each element in the table below, put a check in the column with the number that best describes the State’s Medicaid §1915(c) HCBS waiver waitlist prioritization method)

Transition Element		Prioritization Order
12ba. ...those transitioning out of a Nursing Facility and into the community?	<input type="checkbox"/>	
12bb. ...those transitioning out of a hospital and into the community?	<input type="checkbox"/>	
12bc. ...other, please specify	<input type="checkbox"/>	

13. Is there a State or private agency responsible for central management of this Medicaid §1915(c) HCBS waiver waitlist?

No

Yes

a. Who is responsible? Please describe

14. How often is the waitlist information reviewed and updated?

Once per month

Every quarter

Biannually

Annually

Other, please describe

a. Does/Is the Medicaid §1915(c) HCBS waiver waitlist... (For each element in the table below, put a check in the column with the number that best describes this Medicaid §1915(c) HCBS waiver waitlist for that element)

	1. 0	2. 1	3. 2	4. 3
14aa. ...provide current information?				
14ab. ...serve as an eligibility monitoring or assessment tool for Medicaid §1915(c) HCBS waiver services?				
14ac. ...serve as a monitoring or evaluation tool for the State?				

TIP: Use the following descriptions for each element when responding:

Element 14aa: Waitlist provides current information

1-Check "1" if information is updated by Medicaid §1915(c) HCBS waiver agents on voluntary basis (e.g. purged of duplicate names).

2-Check "2" if information is updated by Medicaid §1915(c) HCBS waiver agents on a voluntary basis (e.g. purged of duplicate names) but agency staff can access the date when information was last updated.

3-Check "3" if information is required to be updated with regular, specified frequency, at least once per month, ensuring names and information are current.

Element 14ab: Waitlist is used for eligibility monitoring and assessment

1-Check "1" if Waitlist eligibility (e.g. LOCD; financial information) is collected.

2-Check "2" if Waiver eligibility (e.g. LOCD; financial information) is collected and tracked (reassessed).

3-Check "3" if Waiver eligibility information is required to be collected, updated with regular, specified frequency, at least once per month, ensuring names and information are current and waitlist is used as a tool for streamlining Waiver eligibility.

Element 14ac: Waitlist is used for monitoring and evaluation

1-Check "1" if Waitlist use (e.g., unique IDs; # of individuals) is tracked **or** current status (of individuals on Waitlist) is tracked.

2-Check "2" if Waitlist use (e.g., unique IDs; # of individuals) is tracked **and** current status (of individuals) is tracked.

3-Check "3" if Waitlist data are used to track capacity, availability, current status, and average wait time to receive services.

Principle Features: Availability of and Access to (or Opportunities for) the Full-Range of LTSS Including Medical, Dental, Mental Health, Assistive Technology, Transportation, and Affordable Housing with Supports and People of all Ages with Disabilities and/or Chronic Conditions Reside and Participate in the Most Integrated Community Settings

Indicator C12, Housing

Overview of Indicator

The Indicator C12, *Housing*, examines the “Availability and Access to LTSS” Feature of the *Community Integration and Inclusion Principle* included in the NBI Conceptual Framework. This Indicator also examines several aspects related to the availability of and access to LTSS and Housing Services. For example, whether the State has, or is developing resources for affordable and accessible housing options for LTSS users, and whether State LTSS program agencies have more formalized partnerships with housing agencies.

The provision and coordination of LTSS with affordable and accessible housing enables individuals with disabilities to live independently in the community^{18 19} and may prevent or delay institutional placement.²⁰ It is hypothesized that by making affordable and accessible housing available, allocating available housing units to individuals at risk of institutionalization, and increasing the number and types of partnerships between housing and LTSS provider agencies at the State and local level, more individuals wishing to remain in the community will be able to do so.

Sub-indicator C12a, Coordination of Housing and LTSS

Overview of Sub-indicator

This Sub-indicator examines the coordination of housing and LTSS based on State programs (e.g. Money Follows the Person) and the availability and accessibility of these options to older adults and adults with disabilities.

TIP: For questions 1-2, a possible contact may be the State MFP Housing Coordinator.

1. What proportion of subsidized housing residents use home and community-based services (HCBS)?

¹⁸ National MS Society (n.d.). Affordable Accessible Housing. Accessed at: <http://www.nationalmssociety.org/living-with-multiple-sclerosis/healthy-living/index.aspx>

¹⁹ Dunn, P. (1990). The impact of the housing environment upon the ability of disabled people to live independently. *Disability, Handicap & Society*, 5(1), 37-52.

²⁰ Golant, S. (2003). Political and Organizational Barriers to Satisfying Low-Income U.S. Seniors’ Need for Affordable Rental Housing with Supportive Services. *Journal of Aging & Social Policy*. (15(4), 21-48.

TIP: Home and community-based services may include Older Americans Act services such as Meals on Wheels or Medicaid-funded services and supports such as Personal Care Attendant services.

2. Does the State conduct a needs assessment for linking housing options with LTSS?

- No (*Skip to next Indicator*)
- Yes, legislative or executive order(s) or mandate(s)
- Yes, task force or commission

3. Do the public housing authorities/State housing agencies work together with the State LTSS program agencies in providing housing options in combination with LTSS?

TIP: Working together means that there is a formal relationship through a funding partnership (e.g., MFP Housing Coordinators), formal agreement (e.g., a MOU) or a legislative requirement for a task group.

- No (*Skip to next indicator*)
- Yes

a. If you answered “Yes” to question 3, please indicate what type of coordination exists between the State Medicaid Program and its LTSS program agencies and State housing agencies. (*Check all that apply*)

- Co-location of staff
- Funding partnership (e.g., MFP Housing Coordinator)
- Formal agreement (e.g., a MOU)
- Other, please specify _____

b. Please describe the mechanisms that exist in the State for ensuring regulations and procedures across housing and health and human services are consistent in providing LTSS in the most integrated setting possible.

c. What mechanisms exist in the State for coordinating housing options linked with LTSS with the housing needs of individuals? (Check all that apply)

- Housing Registry
- Number of Housing Registries _____ (Please complete 3ba-3be.)
- Housing and LTSS service coordinators (Please complete 3c.)
- Other, please specify _____

TIP: If you answered “Housing Registry” for 3c, please answer questions 3ca-3ce below indicating the existence of any/all of the following registry characteristics. These questions will be looped based on the number of housing registries listed in 11b.

3ca. What agency maintains the housing registry?	
3cb. Is the housing registry web-based?	<input type="checkbox"/> Yes <input type="checkbox"/> No Provide URL: _____
3cc. What type of housing units are identified in the housing registry?	<input type="checkbox"/> Affordable housing units <input type="checkbox"/> Affordable and accessible housing units <input type="checkbox"/> Identifies housing units that have been retrofitted or have universal design <input type="checkbox"/> Other, please specify _____
3cd. What is the geography covered by the housing registry?	<input type="checkbox"/> State-wide <input type="checkbox"/> Regional (i.e. 1 or more counties; MSA) <input type="checkbox"/> Other, please specify _____
3ce. Who can use the housing registry?	<input type="checkbox"/> General Public <input type="checkbox"/> LTSS agency employees <input type="checkbox"/> Other, please specify _____

d. What are the main services provided by the housing and LTSS coordinators?

TIP: Information & Assistance (I&A) may mean providing basic information on housing availability to a user, while Information & Referral (I&R) may mean providing information on housing availability and assisting in referring individuals to appropriate State agency or private organization for further assistance in obtaining housing and LTSS coordinated services. Definitions for each may be found in the Glossary.

- I&A (e.g. provide basic information on housing availability)
- I&R
- Other, (*please specify.*) _____

Sub-indicator CI2b, Availability and Access to Affordable and Accessible Housing Units

Overview of Sub-indicator

This Sub-indicator examines the availability of affordable housing within each State.

TIP: The term “affordable” refers to affordable housing as defined by HUD subsidy programs. The term “accessible” refers to the federal definition for accessible housing. Please refer to the glossary for federal definitions of “affordable” and “accessible” housing.

1. Does the State provide incentives for a percentage of newly constructed or retrofitted housing units to be set aside as *accessible* units for older adults and people with disabilities?

- No
- Yes

- a. What percentage of newly constructed or retrofitted housing units must be set aside to receive an incentive? _____
- b. What incentives are in place to make them accessible for older adults and people with disabilities? _____

2. Does the State provide incentives for a percentage of newly constructed or retrofitted housing units to be set aside as *affordable* units for older adults and people with disabilities?

No

Yes

a. What percentage of newly constructed or retrofitted housing units must be set aside to receive an incentive? _____

b. What incentives are in place to make them affordable for older adults and people with disabilities? _____

3. Does the State have any initiatives in place that requires builders to incorporate universal design and/or visitability features into the construction of new housing beyond the Federal Fair Housing Act requirements? (Please check all that apply.)

Initiative:	Applies to:
<input type="checkbox"/> No initiatives at this time <input type="checkbox"/> Ordinance <input type="checkbox"/> State Law <input type="checkbox"/> Statewide Voluntary Initiative (ex., monetary incentives, demonstration program, certification, etc.) <input type="checkbox"/> City/County Specific Voluntary Initiative (ex., monetary incentives, demonstration program, certification, etc.) <input type="checkbox"/> Other, please specify: _____	<input type="checkbox"/> All new construction (public and private) <input type="checkbox"/> Percentage of new construction (public and private), please specify: _____% <input type="checkbox"/> Only publicly funded construction <input type="checkbox"/> Other, please specify: _____

TIP: For questions 4-7, please provide data on subsidized housing. Subsidized housing includes public housing, Section 8, 811, and 202 programs for the current fiscal year in the State. Please contact the State Housing Agency or State Agency on Community Development for assistance in collecting this data.

4. Please provide the total number of subsidized housing units that are available in the State.

5. Please provide the percentage of subsidized housing units that are identified as both affordable and accessible. _____%

6. Please provide the total number of subsidized housing units where people with disabilities are the head of household. _____

7. Please provide the total number of subsidized housing units where older adults are the head of household. _____

Sub-indicator C12c, Housing Settings

Overview of Sub-indicator

Housing options may be limited due to inadequate availability of housing vouchers, restrictive requirements for receiving housing services, and an insufficient coordination of LTSS in housing programs. All of these factors can, in effect, significantly limit the number of options for individuals seeking housing. Sub-indicator C12c, *Housing Settings*, will compile, for informational purposes, how many people are living in institutions or congregate settings (i.e. group homes).

Data for this Sub-indicator may be located in the following sources:

- ANCOR Disability and Medicaid State Fact Sheets;
- AARP’s Across the States: Profiles of Long Term Services and Supports;
- CMS’ ICF/IDD Program Trends Report;
- SAMHSA’s State Regulation and Residential Facilities for Children with Mental Illness;
- Human Rights Watch’s Ill-Equipped: US Prisons and Offenders with Mental Illness; and
- AARP’s Adult Foster Care Fact Sheet.

Setting	ID/DD	MI	PD	Other, please specify
Nursing Facilities	Children Adults Older Adults	Children Adults Older Adults	Children Adults Older Adults	Children Adults Older Adults
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)	Children Adults Older Adults	Children Adults Older Adults	Children Adults Older Adults	Children Adults Older Adults
Psychiatric Residential Treatment Facilities (PRTF)	N/A	Children	N/A	N/A
Correctional Facilities	N/A	Adults	N/A	N/A
Adult Foster Care	Adults Older Adults	Adults Older Adults	Adults Older Adults	Adults Older Adults

Principle Feature: Opportunities to Attain/Maintain Employment within the Community

Indicator CI3, Employment

This Indicator examines a State’s efforts to integrate individuals with disabilities into the community through supported employment options and the impact those programs and services have in allowing working-aged adults with disabilities to be gainfully employed.

This indicator focuses on individuals with disabilities because this population remains under-represented in the labor force.²¹ Individuals with disabilities face unique barriers to employment that the general population does not, including mobility restrictions and limited access to certain environments essential for education, work performance, or training.²²

Sub-indicator CI3a, Employment Rates of Working-Age Adults with Disabilities

Overview of Sub-indicator

The NBIP considers higher employment rates of adults with disabilities to be evidence of more opportunities for this population to be productive, integrated members of the community. The Sub-indicator, *Employment Rates of Working-Age Adults with Disabilities* examines the “Opportunities for Individuals to Obtain/Maintain Employment, Recreation, Education, and Vocational services to enable and Enhance Community Living” Feature of the Community Integration and Inclusion Principle included in the NBI Conceptual Framework.

The data for this Sub-indicator is based on information compiled from the American Community Survey (ACS). **It should be noted that States are not required to collect data to calculate this Sub-indicator.**

- Population age 16 and over who are employed with a disability
- Population age 16 and over not in the labor force with a disability
- Total population age 16 and over who are employed
- Total population age 16 and over not in the labor force

²¹ Lindsay, S. (2010). Discrimination and other barriers to employment for teens and young adults with disabilities. *Disability and Rehabilitation*, 33(15), 1340-1350.

²² Rsenthal, D., Hiatt, E., Anderson, C., Brooks, J., Hartman, E., Wilson, M., & Fujikawa, M. (2011). Facilitators and barriers to integrated employment: Results of focus group analysis. *Journal of Vocational Rehabilitation*, 36, 73-86.

Sub-indicator C13b, Supported Employment Options

Overview of Sub-indicator

The Sub-indicator C13a, *Supportive Employment Options*, examines the “Opportunities to Obtain/Maintain Employment, Recreation, Education, and Vocational Services to Enable and Enhance Community Living” Feature of the Community Integration and Inclusion Principle included the NBI Conceptual Framework.

This Indicator also examines a State’s efforts providing support to working-age adults with disabilities in their pursuit of employment. The NBIP considers that States that offer a Medicaid Buy-In program and other services provide more opportunities for this population to be productive, integrated members of the community. Children/Youth are included in this category since some States consider individuals between 18 to 21 years of age as Youth.

1. What are the supported employment services offered by the State? *(Check all that apply)*

- Medicaid Buy-In
- Individual Placement and Support (IPS) through the Community Mental Health Agencies for individuals with mental illness. *(Please describe)*
- Customized Employment (CE) model through the One-Stop Career Centers for individuals with disabilities. *(Please describe)*
- Other *(Please describe)*
 - a. If the IPS has been implemented in the State, please describe how and by whom it is implemented and the level of preference afforded to individuals with severe mental illness.
 - b. If the CE has been implemented in the State please describe how and by whom it is implemented and the level of preference afforded to individuals with severe mental illness.

2. Does the State offer a Medicaid Buy-In Program?

- No *(If “No”, please skip to question 8)*
- Yes

TIP: Check “No” if the State does not offer a Medicaid Buy-In Program. See the glossary for a description of a Medicaid Buy-In Program.

3. Does the State's Medicaid Buy-In Program have a maximum allowable income earnings limit in order for an individual to be eligibility to participate?

No

Yes

4. What is the maximum allowable income earnings limit for eligibility to participate in the Medicaid Buy-In program? \$_____/yr

TIP: Enter the maximum annual income earnings limit an individual can earn and still participate in Medicaid Buy-In in the space below.

5. What is the co-payment amount required for an individual to pay in order to participate in the Medicaid Buy-In program? \$_____/yr

TIP: Enter the annual co-payment amount that eligible individuals must pay in order to participate in the Medicaid Buy-In.

6. Does the State's Medicaid Buy-In Program have a maximum allowable asset limit that must not be exceeded in order for an individual to be eligible to participate in the Medicaid Buy-In Program?

No

Yes

7. What is the maximum allowable asset limit for an individual to be eligible to participate in the Medicaid Buy-In program? \$_____

TIP: Enter the maximum asset limit an individual can has and still participate in Medicaid Buy-In in the space below.

8. Does the State’s Medicaid State Plan or waiver program(s) offer Employment Personal Assistant Services (EPAS)?

TIP: See the Glossary for a definition of Employment Personal Assistant (EPA).

- No
- Yes

a. For which populations under the Medicaid State Plan, State Plan Amendment or Waiver Programs does the State offer EPA?

TIP: If the “Yes” box is checked in response to question 5, check each population and age group for which EPAs are offered in the State through the Medicaid State Plan, State Plan Amendment or Waiver. For each population checked, write in the specific “age range” served within that population. Note that the population for this Sub-indicator includes Medicaid enrollees only. If EPAs are offered to individuals for a particular chronically ill population not identified through the population types described in other rows, write in the type of chronic illness in Item 8ad. If the population to which EPAs are offered is other than one listed in the rows of the table, write in the name of the population beside Item 8ae. Definitions for each population may be found in the Glossary.

Individuals who live with:	Children/Youth	Adults	Older Adults
Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

b. Can individuals receive EPAs in the workplace (*Check all that apply*)?

- No
- Yes, under Medicaid waivers/State Plan or State Plan Amendments

TIP: Check “No” if individuals in the State cannot receive EPAs in the workplace through Medicaid waivers or the State Plan or State Plan Amendments. Proceed to question 8d. See the glossary for the definition of EPA.

c. Regardless of setting (home vs. workplace), can users choose to self-direct these services?

No

Yes, under Medicaid waiver /under State Plan/under State Plan Amendment

TIP: Check “No” if individuals in the State cannot self-direct EPA services offered through Medicaid waivers or State p-Plan or State Plan Amendments, then proceed to question 9. See the glossary for the definition of EPA.
Check “Yes” if individuals in the State can self-direct EPA services offered through waivers

9. What supported employment services are funded by the State’s: Medicaid State Plan? Medicaid State Plan Amendment? Medicaid Waivers? (*Check all that apply*)

TIP: Check all of the supported employment services that are funded by the State’s Medicaid State Plan, State Plan Amendment(s) or waiver(s). The Medicaid State Plan, State Plan Amendment or waiver-funded services include job coaches, sheltered workshops, or peer supports and mentoring. If supported employment services other than job coaches, sheltered workshops or peer supports and mentoring are funded by the State’s Medicaid State Plan, State Plan Amendments or waivers, you may identify up to three other types of supported employment services by checking box 6f and describing the other types of supported employment services.

For each supported employment services (9a-9f) that you have checked, please check each population and age group for which the supported employment service is funded. For each population checked, write in the specific “Age range” served within that population. **Note that the population for this Sub-indicator includes Medicaid enrollees only.** If the supported employment service is funded for individuals for a particular disability population not identified through the population types described in other rows, write in the type of disability in 9ad. If the population for which the employment service is funded is other than one listed in the rows of the table, write in the name of the disability population beside Item 9ae. Definitions for each disability population may be found in the Glossary.

Job coaches. *If checked*, please indicate the populations for which job coaches are funded, checking all that apply.

TIP: Job coaches support individuals with disabilities and their employers, providing services such as job matching, on-site training and assistance, and career development/advancement plans.

Prevocational Services. *If checked*, please indicate the populations, for which prevocational services are funded, checking all that apply.

TIP: Sheltered workshops are nonprofit organizations or institutions that provide a program of rehabilitation for workers with disabilities that includes paid employment.

Peer support/mentoring. *If checked*, please indicate the populations for which peer support or mentoring is funded, checking all that apply.

Tip: Peer support/mentoring is a service delivered to individuals, by individuals. Persons who have a disability diagnosis are qualified to assist other persons with disabilities in work-related support and training.

Job development and/or Skills Development. *If checked*, please indicate the disability populations for which job development and/or discovery is funded, checking all that apply.

TIP: Job development and discovery services provide assistance/training on basic work skills necessary to find and maintain employment

Assessment and/or Discovery. *If checked*, please indicate the populations, for which assessment and/or discovery is funded, checking all that apply.

TIP: Assessment and/or discovery programs allow a person with disabilities to express their goals, experiences, preferences, and needs for employment that informs an individualized career plan or profile.

Job Placement. *If checked*, please indicate the populations, for which job placement is funded, checking all that apply.

TIP: Job placement programs provide assistance to place a person with disabilities in a position matched to their preferences, skills, needs, and personality.

Employment-specific transportation program(s). *If checked*, please indicate the populations, for which assessment and skills development is funded, checking all that apply.

TIP: Transportation services support individuals with disabilities get to and from the workplace and may come in the form of public transportation subsidies or pick-up services.

Travel training. *If checked*, please indicate the populations, for which travel training is funded, checking all that apply.

TIP: Travel training supports individuals with disabilities learn how to independently get to and from the workplace.

Demonstration Project. *If checked*, please indicate the populations, for which the demonstration project is funded, checking all that apply.

TIP: A demonstration project may be funded by any Federal agency and may be specific to a population (age or disability).

Other supported employment services. Describe: _____

TIP: Other supported employment services may be funded by any Federal or State agency and may be specific to a population (age or disability).

Individuals who live with:	Children/Youth	Adults	Older Adults
Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Principle Features: Availability of and Access to (or Opportunities for) the Full-Range of LTSS Including Medical, Dental, Mental Health, Assistive Technology, Transportation, and Affordable Housing with Supports and People of all Ages with Disabilities and/or Chronic Conditions Reside and Participate in the Most Integrated Community Settings

Indicator C14, Transportation (Developmental)

Overview of Indicator

The Indicator C14, Transportation, examines the “Availability and Access to LTSS” and “Opportunities to Obtain/Maintain Employment, Recreation, Education, and Vocational Services” Features of the Community Integration and Inclusion Principle. Finding accessible, affordable and convenient transportation is one of the most difficult challenges anyone needing LTSS can face, but it is crucial for individuals to remain in the community.²³ Medicaid may pay for transportation services for medical appointments, but fees for transportation services are often paid out-of-pocket by users. The limited availability of services and the out-of-pocket fees paid by users for services, may inhibit older adults and persons with disabilities from fully participating in daily life or remaining in the community if they are unable to independently attend to professional (e.g. employment) and personal (e.g. grocery shopping) needs without transportation services.²⁴

This Indicator examines State efforts to provide Medicaid-funded transportation services beyond medical transportation. Information collected for this Indicator will facilitate an examination of a State’s efforts to utilize Federal and other funding sources available to provide transportation services for older adults and adults with disabilities, as well as the types of transportation services available and the types of needs that are met (i.e. professional and personal).

²³ Robinson, K., Lucado, J., & Schur, C. (2012). Use of Transportation Services among OAA Title III Program Participants. Administration on Aging Research Brief Number 6, September, 2012. Accessed at http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CCgQFjAA&url=http%3A%2F%2Fwww.aoa.gov%2Faoaroot%2Fprogram_results%2Fdocs%2F2012%2FAoA_6th_xation_Brief_Oct_2012.pdf&ei=hL-TWUvD8N8WdyQGfWYGgDQ&usg=AFQjCNHRmTL5Kcfqd21hk0Jw8ebP_mq1bQ

²⁴ Coughlin, J. (2001). Transportation and Older Persons: Perception and Preferences. AARP. Accessed at: http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CCsQFjAA&url=http%3A%2F%2Fassets.aarp.org%2Frgcenter%2Ffil%2F2001_05_transport.pdf&ei=YbjWUo-KAoKVygHj14H4AQ&usg=AFQjCNGFgmUj0W3dCSPBxUieGRYLJW4iw

Sub-indicator CI4a, Availability and Coordination of Transportation (Developmental)

Overview of Sub-indicator

This Sub-indicator examines the number and type of transportation services available funded through State, Federal, and other funding sources by population. In addition, the coordination of transportation and LTSS programs and services will be examined using this Sub-indicator.

1. Does the State have federal transportation grant(s) to provide LTSS-related transportation program(s)?

No (Skip to question 2)

Yes

a. How many LTSS-related transportation programs are being funded by a Federal transportation grant in the State? _____

b. What is the Federal funding source, funding period, and amount of funding for the transportation program(s)?

Funding Source	Funding Amount	Funding Period	Funding is Renewable
1ba. Elderly Persons and Persons with Disabilities Program (Federal Transportation Authority Section 5310 Grant)			<input type="checkbox"/> No <input type="checkbox"/> Yes
1bb. Non-Urbanized Area Formula Grant Program (Federal Transportation Authority Section 5311 Grant)			<input type="checkbox"/> No <input type="checkbox"/> Yes
1bc. New Freedom Program (Federal Transportation Authority Section 5317 Grant)			<input type="checkbox"/> No <input type="checkbox"/> Yes
1bd. Senior Community Service Employment Program (Administration on Aging Older American's Act Title V)			<input type="checkbox"/> No <input type="checkbox"/> Yes
1be. Technical Assistance and Innovation to Improve Transportation for Older Adults (Administration on Aging Older American's Act Title IV)			<input type="checkbox"/> No <input type="checkbox"/> Yes
1bf. Veterans Transportation and Community Living Initiative (VTCLI) grant program			<input type="checkbox"/> No <input type="checkbox"/> Yes

Funding Source	Funding Amount	Funding Period	Funding is Renewable
1bg. Other, please specify _____			<input type="checkbox"/> No <input type="checkbox"/> Yes

i. If the funding source is not renewable, what is the State's plan to fund this program once funding has ended? (Check one)

- Not seeking alternative funding sources
- Seeking alternative funding sources for the same services
- Seeking alternative funding sources for different services
- Other: please describe: _____

c. What type of transportation service is provided? (Check all that apply)

- ADA Paratransit
- Access to transit services where ADA Paratransit is not required
- Accessible Taxi
- Administration of Vouchers
- Administration of Volunteer Programs
- Travel Training
- Mobility Management
- Other, please specify _____

d. Federally-funded transportation services are available in the State for the following activity(ies) (Check all that apply):

- Employment/Volunteer Work
- Emergent Health Care
- Non-Emergent Health Care
- Dental Care
- Religious Services
- Shopping/Other Errands
- Social Activities
- Other, please specify _____

i. Which populations groups are eligible to receive these Federally-funded transportation services? (Check all that apply)

Individuals who live with:	Children/Youth	Adults	Older Adults
Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Does the State have dedicated State funds to provide transportation program(s) to help older adults and people with disabilities remain in their home and active in their community?

No (Skip to question 3)

Yes

a. Are dedicated State funds to provide transportation programs statewide or by region?

Statewide

Region

Other, describe

b. Transportation services State are available for the following activity (ies): (Check all that apply)

Activity	Population Group:
<input type="checkbox"/> Employment/Volunteer Work <input type="checkbox"/> Emergent Health Care <input type="checkbox"/> Non-Emergent Health Care <input type="checkbox"/> Dental Care <input type="checkbox"/> Religious Services <input type="checkbox"/> Shopping/Other Errands <input type="checkbox"/> Social Activities <input type="checkbox"/> Other, please specify	<input type="checkbox"/> Intellectual/Developmental Disabilities <input type="checkbox"/> Children (Age ___ yrs to ___ yrs) <input type="checkbox"/> Adults (Age ___ yrs to ___ yrs) <input type="checkbox"/> Older Adults (Age ___ yrs to ___ yrs) <input type="checkbox"/> Physical Disabilities <input type="checkbox"/> Children (Age ___ yrs to ___ yrs) <input type="checkbox"/> Adults (Age ___ yrs to ___ yrs) <input type="checkbox"/> Older Adults (Age ___ yrs to ___ yrs) <input type="checkbox"/> Mental Illness <input type="checkbox"/> Children (Age ___ yrs to ___ yrs) <input type="checkbox"/> Adults (Age ___ yrs to ___ yrs) <input type="checkbox"/> Older Adults (Age ___ yrs to ___ yrs) <input type="checkbox"/> Other, please specify: _____

3. Does the State coordinate transportation options available with LTSS?

No (Skip to question 3)

Yes

a. Please describe how the State coordinates transportation options available with LTSS?

4. Are the State's LTSS coordinators, options counselors, etc. trained in private and volunteer transportation programs and services available?

No

Yes

Sub-indicator C14b, User Reporting on Adequate Transportation and Unmet Needs (Developmental)

Overview of the Sub-indicator

The second tier of the transportation Indicator, Sub-indicator C14b, examines users' perceptions of adequate transportation programs and services and where there are unmet needs. The data is based on information compiled from the National Core Indicators (NCIs).

It should be noted that States are not required to collect data to calculate this Sub-indicator.

1. *Transportation Needs Being Met: The proportion of people who report having adequate transportation when they want to go somewhere.*
2. *Unmet Need for Transportation: Percent of program participants who report not always having transportation when needed*

COORDINATION AND TRANSPARENCY

The Coordination and Transparency Principle examines whether the LTSS system coordinates a range of services funded by multiple funding sources to provide seamless supports across the health and LTSS systems (i.e. acute health, rehabilitation and LTSS). The LTSS system also makes effective use of health information technology to provide transparent information to users, providers, and payers.

Principle Feature: Universal, Timely Access to Information and Services

Indicator CT1, Streamlined Access

Indicator Overview

This Indicator examines the “Universal, Timely Access to Information and Services” Principle Feature of the Coordination/Transparency Principle included in the NBI Conceptual Framework. In addition, it examines whether a State has, or is developing, a streamlined LTSS system. Individuals in need of LTSS must navigate complicated and separate eligibility, service delivery and payment systems.

Sub-indicator CT1a, Implementation

1. Does the State have at least one streamlined system for accessing LTSS? (*Check one*)

TIP: Please note that we are interested in collecting information about any and all systems that a State has implemented to streamline a user’s access to LTSS whether they are funded by Medicaid or by other funding sources. The definition of a streamlined access is provided in the Glossary.

- No (*If checked, you have completed this indicator*)
- Yes, in development (*If checked, skip to the next indicator*)
- Yes, fully developed

2. How many streamlined LTSS access systems have been implemented in the State?

TIP: Please answer the questions 3 through 7 for each streamlined LTSS access system mentioned in question 2. Examples of streamlined LTSS access systems include Single Point of Entry (SPE), Aging and Disability Resource Centers (ADRC), Area Agencies on Aging (AAA), Area Agencies for Intellectual and Developmental Disabilities (AAIDD), Centers for Independent Living (CIL), and Community Mental Health Center (CMHC).

3. What is the name of the streamlined LTSS access system implemented in the State?

a. What is the type of streamlined access system?

ADRC

AAA

CIL

SPE

CMHC

AAIDD

Other, please specify _____

4. Which category most accurately reflects the status of implementation of the streamlined LTSS access system? (*Check one*)

Pilot phase

Partial implementation (system may not be fully functional for one or more populations checked in 2 or may not have Statewide coverage for one or more populations checked in 2)

Full implementation (fully functional, serves all target populations checked in 2, and Statewide coverage)

5. Is this streamlined LTSS access system centralized or decentralized²⁵?

TIP: *Decentralized* means there is a “No Wrong Door” model in place, or multiple agencies retain responsibility for their respective services while coordinating with each other to enhance access to those services through a single, standardized entry process that is administered and overseen by a coordinating entity²⁶. *Centralized* means there is a single entry point in place, or a system that enables users to access LTSS through one agency or organization. In their broadest form, SEPs perform a range of activities that may include information and assistance, referral, initial screening, nursing facility preadmission screening, assessment of functional capacity and service needs, care planning, service authorization, monitoring, and periodic reassessments. SEPs may also provide protective services.²⁷

Decentralized

²⁵ Blakeway, Carrie. 2007. Single entry point and no wrong door systems. The Lewin Group

²⁶ Allison Armor-Garb, *Point of Entry Systems for Long-Term Care: State Case Studies*, prepared for the New York City Department of Aging, 2004.

²⁷ Robert Mollica and Jennifer Gillespie, *Single Entry Point Systems: State Survey Results*. Rutgers/NASHP Community Living Exchange Collaborative, August, 2003.

Centralized

Other, please describe_____

6. What population is the State targeting through its streamlined access system? *(Check all that apply)*

Individuals who live with:	Children/Youth	Adults	Older Adults
Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TIP: Check each population and age group targeted by the State’s streamlined access system. Note that the population for this Indicator may include Medicaid beneficiaries as well as other individuals. If streamlined access system targets individuals for a particular population not identified through the population types described in other rows below, write in the population type next to “other”.

7. Does the streamlined LTSS access system have a five-year sustainability plan?

No

Yes *(If yes, please provide a copy of the five-year sustainability plan)*

Sub-indicator CT1b, Fully Functioning Criteria and Readiness Assessment

Overview of Sub-indicator

This Sub-indicator examines the functioning of a State’s streamlined LTSS access system based on The Lewin Group’s Fully Functioning Criteria and Readiness Assessment to assess if each streamlined LTSS access system is fully functioning across seven domains. **It should be noted that States are not required to collect data to calculate this Sub-indicator.**

Readiness Indicator	Answer Options
1. Organization & Governance	
Mission and Structure	
The organization’s mission statement was developed in collaboration with staff, users and other stakeholders.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Leadership	
This organization has a chart showing the organizational structure, staff positions and lines of authority in the organization.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization has a director that meets established minimum qualifications.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization has a governing body with by-laws and other governing documents in place.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization has an advisory body.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The advisory body meets regularly, is active and consistently engaged.	<input type="checkbox"/> Yes <input type="checkbox"/> No
There is a system in place for regularly recruiting new members for the advisory body and replacing inactive members.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization has an advisory body with significant user representation.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Budget	
The organization has formal budget development process.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization has established fiscal accountability procedures.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Readiness Indicator	Answer Options
Long Term Planning	
The organization has developed formal strategies for achieving long-term sustainability of the program.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization's operating funds come from diverse and varied sources.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Personnel Management and Training	
Qualifications	
Rate the level of experience the organization's staff have in serving all disability populations: _____ Physical Disabilities _____ Intellectual/Developmental Disabilities _____ Mental Health _____ Other	<input type="checkbox"/> No experience <input type="checkbox"/> Limited experience <input type="checkbox"/> Moderate experience <input type="checkbox"/> Significant experience
Rate the level of experience the organization's staff have in serving people under age 60 with disabilities.	<input type="checkbox"/> No experience <input type="checkbox"/> Limited experience <input type="checkbox"/> Moderate experience <input type="checkbox"/> Significant experience
Rate the level of experience the organization's staff have in serving different ethnic and cultural groups in the community.	<input type="checkbox"/> No experience <input type="checkbox"/> Limited experience <input type="checkbox"/> Moderate experience <input type="checkbox"/> Significant experience
Written job descriptions have been developed for all staff positions that describe roles, responsibilities and minimum qualifications to perform core-job duties.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Training	
There are procedures for determining the adequacy of the number of staff to perform core duties of the organization	<input type="checkbox"/> Yes <input type="checkbox"/> No
Policies and procedures are in place regarding new staff training.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Policies and procedures are in place regarding ongoing staff training.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Policies and procedures are in place to provide ongoing staff training with regard to serving older adults.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Policies and procedures are in place to provide ongoing staff training with regard to serving people under age 60 with disabilities.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Readiness Indicator	Answer Options
Policies and procedures are in place to facilitate regular cross training of the staff within the organization, as appropriate.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Policies and procedures are in place to facilitate regular cross training staff with staff of partnering organizations.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Service and Delivery Operations	
Point of Contact	
Users access services at the organization in the following ways (please check all that apply):	<input type="checkbox"/> In Person <input type="checkbox"/> By Telephone <input type="checkbox"/> By Email <input type="checkbox"/> Through a website <input type="checkbox"/> Other <input type="checkbox"/> Don't know
The organization's physical sites are well marked and clearly identifiable.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Offices are located in places convenient and accessible to all people in the organization's service area.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Services are provided in environments that ensure confidentiality.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization has a physically accessible space to meet with all potential service populations.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization routinely conducts home visits for clients needing extra assistance.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organizations main offices and satellite offices maintain regular-business hours.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Telephone services are available during regular-business hours.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Telephone services are available on weekends and after regular business hours.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Readiness Indicator	Answer Options
Telephone services are accessible to people who are Deaf or hard of hearing.	<input type="checkbox"/> Yes <input type="checkbox"/> No
An answering service or automated phone attendant service answers calls after hours and when staff are not available.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Messages left in automated answering systems are answered in a timely manner and no later than the next business day.	<input type="checkbox"/> Yes <input type="checkbox"/> No
If needed, staff can transfer calls to other organizations so that callers do not have to hang up and make another phone call.	<input type="checkbox"/> Yes <input type="checkbox"/> No
All telephone contacts are documented and recorded to support reporting.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Contact information is collected from callers, as appropriate, to support monitoring and provision of follow-up services.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization has a website with up-to-date information about the organization, directions, hours-of-operation, contact information and services that are available.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Website “visits” and “hits” are tracked and monitored.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization’s website has a searchable database of resources and services for all target populations in the service area.	<input type="checkbox"/> Yes <input type="checkbox"/> No
All listings in the resource database included on the website are updated on a regular basis.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Website users can access decision-support tools to help them identify needs and appropriate services and supports.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Information & Referral/Assistance	
The organization provides Information & Referral/Assistance for older adults and their families about senior services	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization provides Information & Referral/Assistance for people with disabilities of all ages and their families about disability services	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization maintains and uses a resource database that contains comprehensive information regarding long-term care and related services (such as housing, transportation, employment). <i>This question may apply to a local or Statewide system.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Readiness Indicator	Answer Options
The organization maintains its resource database electronically. <i>This question may apply to a local or Statewide system.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Information in the resource database is organized according to an established classification system. <i>This question may apply to a local or Statewide system.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
There are procedures for updating and revising information in the resource database on a regular basis. <i>This question may apply to a local or Statewide system.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
The resource database includes service and resources for users who can pay privately for services. <i>This question may apply to a local or Statewide system.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Referrals	
Referrals are made in an objective way that maximizes user choice.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Information about referrals made to other organizations or service providers is recorded electronically.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recorded referral information is used to assess the effectiveness and objectivity of the organization's referral policies.	<input type="checkbox"/> Yes <input type="checkbox"/> No
One or more Information and Referral/Assistance specialists in the organization is certified by the Alliance of Information and Referral Systems (AIRS).	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization has developed written procedures describing how and under what circumstances referrals will be made to and received from at least one key partnering organization.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization has written procedures concerning the processes for receiving and referring callers to crisis intervention services during and after regular-business hours.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization has written procedures concerning the processes for receiving and referring callers to crisis intervention services during and after regular business hours.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization has established partnerships and referral protocols with other local and Statewide information and assistance and/or information and referral providers.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Long-Term Services and Supports Decision-Making Support & Options Counseling	
This organization assists individuals with making decisions about long-term services and supports.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Readiness Indicator	Answer Options
<p>This organization provides options counseling to users about long-term care supports and services.</p> <p>NOTE: If Respondent Answers “No” to this question, he/she should skip the next questions related to Options Counseling and proceed to the Coordinated Access section of the survey.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Staff are specifically trained to provide options counseling.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Check the point or points in the process of interacting with users that options counseling is provided (<i>please check all that apply</i>):</p>	<input type="checkbox"/> During initial I&R call or appointment <input type="checkbox"/> When support with long-term care decision-making is requested <input type="checkbox"/> When users are referred for long-term care services <input type="checkbox"/> When assessment is made for programmatic eligibility <input type="checkbox"/> After an application for a public long term care program has been initiated <input type="checkbox"/> As part of a pre-admission screening process <input type="checkbox"/> Provided through SHIP counseling
<p>Options counselors explore the full range of community living programs and services offered locally and/or Statewide.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Options counselors explore both public and private service and support alternatives.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Options counselors provide continuing or follow-up services for users as appropriate.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>This organization can record the number of people who receive options counseling for reporting.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Follow-up is conducted with some or all individuals to determine the outcomes of options counseling.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>There are procedures in place for indentifying users who would benefit from planning for future LTSS needs and standards for providing such assistance.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Readiness Indicator	Answer Options
The organization provides information about federal and State-funded LTSS programs including Medicaid services and HCBS waiver services.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization provides information about other publicly-funded programs (such as housing, transportation, TANF, health care, food stamps).	<input type="checkbox"/> Yes <input type="checkbox"/> No
Staff know where to refer individuals in order to access all types of public-sector services.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization provides information about private-pay programs and services.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Staff know where to refer individuals in order to access private-pay programs and services.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Assessment	
Staff conduct an initial screening with users to determine their potential needs and/or to establish whether a full level of care (LOC) assessment should be conducted.	<input type="checkbox"/> Yes <input type="checkbox"/> No
If the State where the organization is located requires that users be given a pre-admission screen prior to Nursing Facility admission, describe the organization's role in this process:	<input type="checkbox"/> No pre-admission screen required in this State <input type="checkbox"/> The organization has an informal partnership with entity(ies) that conducts pre-admission screening <input type="checkbox"/> The organization has a formal partnership with an entity(ies) that conducts pre-admission screening <input type="checkbox"/> The organization's staff conduct the pre-admission screen

Readiness Indicator	Answer Options
<p>Select the Statement that best describes the role of staff in the organization in conducting functional /programmatic/level of care assessments for public long term care programs:</p>	<p><input type="checkbox"/> The organization refers clients to the organizations that perform the level of care assessments for Medicaid LTSS and other publicly-funded programs (no formal policies or protocols in place)</p> <p><input type="checkbox"/> The organization has formal policies and protocols in place to refer clients to the organizations that perform the level of care assessments for Medicaid LTSS and other publicly-funded programs</p> <p><input type="checkbox"/> Staff from the organization that performs the level of care assessments are co-located with this organization on a full-time or part-time basis</p> <p><input type="checkbox"/> The organization's staff perform the level of care assessments that determine functional/clinical eligibility for Medicaid and other publicly-funded programs</p> <p><input type="checkbox"/> Other (please describe) _____</p>

Readiness Indicator	Answer Options
<p>Select the Statement that best describes the role of staff in the organization in initiating an application or determining users' financial eligibility for Medicaid and other publicly-funded long term care programs:</p>	<p><input type="checkbox"/> The organization's staff refer individuals who inquire about public programs to another entity to initiate financial application</p> <p><input type="checkbox"/> The organization's staff routinely collect preliminary financial information from individuals to determine if completing a full application is appropriate</p> <p><input type="checkbox"/> The organization's staff assist clients with completing financial applications (e.g. answers questions, helps gather documentation)</p> <p><input type="checkbox"/> This organization is the entity that determines an individual's financial eligibility OR staff from the organization that determines financial eligibility are co-located with this organization full or part-time</p> <p><input type="checkbox"/> Other (please describe) _____</p>

Readiness Indicator	Answer Options
<p>Select the Statement that best describes the ability of the organization to track where users are in the financial eligibility determination process:</p>	<p><input type="checkbox"/> The organization does not track where users are in the process of eligibility determination.</p> <p><input type="checkbox"/> The organization's staff calls the entity that determines eligibility and inquires about eligibility status on behalf of users, upon request.</p> <p><input type="checkbox"/> The organization routinely inquires OR are routinely informed about the eligibility status of users.</p> <p><input type="checkbox"/> Staff from this organization can access eligibility status information electronically (e.g. through shared management information system).</p> <p><input type="checkbox"/> The organization is the entity that determines an individual's financial eligibility OR staff from the organization that determines financial eligibility are co-located with this organization full or part-time.</p>
4. Marketing and Outreach	
The organization has a formal outreach/marketing plan.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Outreach and marketing initiatives include diverse strategies such as written materials, presentations, participation in health fairs, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization devotes resources and staff for achieving outreach and marketing objectives.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Outreach and marketing initiatives are tailored, as appropriate, for ethnically and culturally diverse populations and different target populations.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization partners or coordinates with other organizations in its outreach and marketing activities.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Readiness Indicator	Answer Options
The outreach/marketing plan promotes the organization as a trusted place where people can obtain comprehensive information and assistance about LTSS.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization proactively reaches out to and provides information to providers along the critical pathways to long term care, including hospitals, nursing facilities, rehabilitation facilities, assisted living providers, home health agencies and physicians.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization has formal procedures for assessing the effectiveness of its outreach and marketing activities.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Assessment information is used to improve visibility and expand awareness of the organization and its services.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization has specific marketing strategies targeted to individuals with private resources.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. IT/MIS Capacity and Support	
Infrastructure	
The organization has the adequate computer hardware and the use of necessary management information systems to support its business functions.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization has the appropriate management information systems and/or software to enable staff to enter, update and maintain electronic information about contacts, clients, resources and services.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization uses software that enables staff to track clients over time (after a referral is made or eligibility determined).	<input type="checkbox"/> Yes <input type="checkbox"/> No
Policies	
The organization has written policies concerning the collection, analysis and reporting of client and service data.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Staff receive ongoing training in the use of the software they use in their jobs (e.g. as software functions or procedures change or updates are made).	<input type="checkbox"/> Yes <input type="checkbox"/> No
The database system checks for missing, inaccurate or incomplete user and service data.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Staff have access to IT support and assistance to ensure efficient operations at all times.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Readiness Indicator	Answer Options
Data Storage and Sharing	
The organization has formal policies regarding data security and confidentiality.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Data collection, sharing and storage procedures are compliant with the Health Insurance Portability and Accountability Act (as appropriate).	<input type="checkbox"/> Yes <input type="checkbox"/> No
Data collection, sharing and storage procedures comply with relevant State laws and regulations.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Electronic records are backed up regularly and appropriately.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Electronic copies of client records are stored off-site.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Formal data sharing agreements have been developed with key partnering organization.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The IT/ MIS system accommodates routine electronic transfer of information to and from partnering organizations.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Partnerships	
The organization has at least one formal partnership (characterized by an MOU, contract, or written agreement/protocol) with another organization in the community that serves older adults.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization has at least one formal partnership (characterized by an MOU, contract, or written agreement/protocol) with another organization in the community that serves people with disabilities.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization has a formal partnership with the State Medicaid Agency or Local Medicaid Agency (characterized by an MOU, contract, or written agreement/protocol) in place with either the State Medicaid Agency or a Local Medicaid Agency (Note: Answer "Yes," if you organization is a State or Local Medicaid agency).	<input type="checkbox"/> Yes <input type="checkbox"/> No

Readiness Indicator	Answer Options
<p>The organization has formal partnerships (characterized by an MOU, contract, or written agreement/protocol) with the following types of organizations:</p>	<p><input type="checkbox"/> The organization has no formal partnership, but informally partners with organizations in the community</p> <p><input type="checkbox"/> The organization has formal partnerships with public-sector agencies (e.g. governmental agencies) ONLY</p> <p><input type="checkbox"/> The organization has formal partnerships with public-sector agencies AND private-sector organizations (e.g. non-profit non-governmental organizations, businesses, foundations)</p> <p><input type="checkbox"/> Other please describe ____</p>
<p>Representatives of key partnering agencies are involved in the following activities in partnership with this organization (check all that apply):</p>	<p><input type="checkbox"/> Strategic planning</p> <p><input type="checkbox"/> Service on Advisory Body</p> <p><input type="checkbox"/> Advocacy</p> <p><input type="checkbox"/> Marketing, outreach, public education</p> <p><input type="checkbox"/> Staff training</p> <p><input type="checkbox"/> Service provision</p>
<p>The organization has a formal strategy for recruiting and developing partners to ensure representation of diverse populations served by the organization.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
7. Partnerships	
<p>The organization has a formal plan for evaluating and monitoring services.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>The organization routinely collects feedback from all of the populations served by the program.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>The organization routinely analyzes data regarding use of the agency's services and resources by users.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>There are procedures in place for using user satisfaction data to address problems that may be identified with the program or services.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Readiness Indicator	Answer Options
The organization has a process for using evaluation data to improve operations and services.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The organization produces reports and shares information with stakeholders, partners and users about its activities and outcomes.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Sub-indicator CT1c, LTSS Partnerships

Overview of Sub-indicator

This Sub-indicator examines the types of partnerships that exist within each reported streamlined LTSS access system. Each partnership is categorized as a weak, moderate, or strong relationship based on the type of partnership and shared resources that exist. **It should be noted that the information provided in response to the following questions will be compared to state home and community-based waiver(s), state plan amendment(s) and other relevant documents.**

1. Partnership agreements between the State's ADRC and the following organizations exist: *(Check all that apply)*

- No fully functioning ADRC or other streamlined access system exists in the State at this time
- Area Agency on Aging (AAA)
- Area Agency for Intellectual and Developmental Disabilities
- State Unit on Aging (SUA)
- Center for Independent Living (CIL)
- Vocational Rehabilitation Department
- Community Mental Health (CMH)
- Public Housing Authority
- State Medicaid Agency
- Local Medicaid Offices
- Regional or County DD Authority
- Other Health and Human Services Agency, *(Please specify .)*
- Other, *(Please specify)*

- a. For each of the organizations checked above, what types of partnership agreements have been executed? *(Check all that apply)*
- Funding
 - Formal Memorandum of Understanding (MOU)
 - Weekly, Bi-Weekly, Monthly Meetings, *(Please specify)*
 - Other, *(Please describe.)*
- b. For each of the partnership agreements checked above, what are the shared resources specified, if any, as part of the partnership agreement?
- No shared resources
 - Staff
 - Funding
 - Information Sharing
 - Data Sharing
 - IT Systems Sharing
 - Training Resources
 - Sponsorship of Programs
 - Non-Monetary Resources (e.g. Office Space)

Principle Feature: Federal/ State/Local Governments Collaborate and Communicate Effectively Regarding the Provision of LTSS

Indicator CT2, Service Coordination

Overview

One aspect of providing coordinated and transparent LTSS is the degree to which users receive assistance in developing their LTSS plan. This Indicator examines the variety of service coordination options that a State may provide. Whether service coordination exists and the quality of the service provided are two areas of examination for this Indicator.

Sub-indicator CT2a. Long-Term Services and Supports System(s) Coordination

Ques. #	Question	Answer Set	Source/Notes
Part 1: Provision of Options Counseling, Care Coordination, and Case Management by Population Type Current State Fiscal Year (SFY) (indicate period covered by SFY _____) or the most recent information available (If not current SFY, indicate Year _____)			
CASE MANAGEMENT			
1.	Does the State offer case management as a: <input type="checkbox"/> Medicaid State Plan Service <input type="checkbox"/> Medicaid §1915(c) HCBS Waiver Service <input type="checkbox"/> Medicaid§1915 State Plan Amendment (SPA) Service <input type="checkbox"/> Medicaid §1115 Waiver Service <input type="checkbox"/> MFP Demonstration Service <input type="checkbox"/> Other Medicaid authority, please specify	For each item listed in the column to the left that offer case management (Medicaid waiver, State Plan, State Plan Amendment MFP Demonstration, other), respond to these questions: Is coverage Statewide? <input type="checkbox"/> No <input type="checkbox"/> Yes For which populations: <input type="checkbox"/> Aged/Disabled adults 65+ <input type="checkbox"/> Adults <65 with physical disabilities <input type="checkbox"/> ID/DD <input type="checkbox"/> Children with mental illness <input type="checkbox"/> Adults with mental illness <input type="checkbox"/> Traumatic or Acquired Brain Injury <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Medically Fragile <input type="checkbox"/> Technology Dependent <input type="checkbox"/> Other	<p>TIP: Case management includes services that assist eligible individuals to gain access to needed medical, social, educational, and other services. Case management does not include the underlying medical, social, educational, and other services themselves. Case management services are comprehensive and must include all of the following: assessment of an eligible individual; development of a specific care plan; referral to services; and monitoring activities.</p> <p>This definition is based on Section 6052 of the Deficit Reduction Act (DRA) of 2005, which required reforms in case management and targeted case management. See www.cms.gov/DeficitReductionAct/Downloads/CM_TA_Tool.pdf. Case management is a billable service.</p>

Ques. #	Question	Answer Set	Source/Notes
2.	<p>Does the State offer Targeted Case Management as a:</p> <p><input type="checkbox"/> Medicaid State Plan Service</p> <p><input type="checkbox"/> Medicaid §1915 State Plan Amendment (SPA) Service</p> <p><input type="checkbox"/> Medicaid §1915(c) HCBS Waiver Service</p> <p><input type="checkbox"/> Medicaid §1115 Waiver Service</p> <p><input type="checkbox"/> MFP Demonstration Service</p> <p><input type="checkbox"/> Other Medicaid authority, please specify</p>	<p>Is coverage Statewide?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p>For which populations?</p> <p><input type="checkbox"/> Aged/Disabled adults 65+</p> <p><input type="checkbox"/> Adults <65 with physical disabilities</p> <p><input type="checkbox"/> ID/DD</p> <p><input type="checkbox"/> Children with mental illness</p> <p><input type="checkbox"/> Adults with mental illness</p> <p><input type="checkbox"/> Traumatic or Acquired Brain Injury</p> <p><input type="checkbox"/> HIV/AIDS</p> <p><input type="checkbox"/> Medically Fragile</p> <p><input type="checkbox"/> Technology Dependent</p> <p><input type="checkbox"/> Other</p>	<p>TIP: Medicaid Targeted Case Management: <i>Targeted case management is case management services (see definition above) provided only to specific classes of individuals, or to individuals who reside in specified areas of the State, or both.</i></p> <p>This definition is also based on Section 6052 of the DRA. Targeted case management is a billable service.</p>
3.	<p>Does the State offer State-Funded Case Management services? If so, through which programs?</p> <p>List State Program 1 _____</p> <p>List State Program 2 _____</p> <p>List State Program 3 _____</p>	<p>Is coverage Statewide?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p>For which populations?</p> <p><input type="checkbox"/> Aged/Disabled adults 65+</p> <p><input type="checkbox"/> Adults <65 with physical disabilities</p> <p><input type="checkbox"/> ID/DD</p> <p><input type="checkbox"/> Children with mental illness</p> <p><input type="checkbox"/> Adults with mental illness</p> <p><input type="checkbox"/> Traumatic or Acquired Brain injury</p> <p><input type="checkbox"/> HIV/AIDS</p> <p><input type="checkbox"/> Medically Fragile</p> <p><input type="checkbox"/> Technology Dependent</p> <p><input type="checkbox"/> Other</p>	<p>TIP: State - Funded Case Management: <i>Use Medicaid definition for case management (see above).</i></p> <p>States may provide case management to selected populations using State funds only (non-Medicaid), such as for DD services or for LTSS provided to people with incomes slightly higher than the Medicaid eligibility threshold.</p>

Ques. #	Question	Answer Set	Source/Notes
Part 2: Case Management Services: Expenditures and Unduplicated Number of Recipients by Population Group			
4a.	How much did the State spend in the most recent FY on Medicaid Case Management?	\$_____ Medicaid State Plan Service \$_____ Medicaid §1915 State Plan Amendment (SPA) Service \$_____ Medicaid §1915(c) HCBS Waiver Service \$_____ Medicaid §1115 Waiver Service \$_____ MFP Demonstration Service \$_____ Other Medicaid Authority	Please attach information on the State's spending breakdown by population group.
4b.	What was the number of unduplicated recipients of Medicaid Case Management in the most recent FY?	\$_____ Medicaid State Plan Service \$_____ Medicaid §1915 State Plan Amendment (SPA) Service \$_____ Medicaid §1915(c) HCBS Waiver Service \$_____ Medicaid §1115 Waiver Service \$_____ MFP Demonstration Service \$_____ Other Medicaid Authority	Please attach information on the State's spending breakdown by population group.
5a.	How much did the State spend in the most recent FY on Medicaid Targeted Case Management?	\$_____ Medicaid State Plan Service \$_____ Medicaid §1915 State Plan Amendment (SPA) Service \$_____ Medicaid §1915(c) HCBS Waiver Service \$_____ Medicaid §1115 Waiver Service \$_____ MFP Demonstration Service \$_____ Other Medicaid Authority	Please attach information on the State's spending breakdown by population group.
5b.	What was the number of unduplicated recipients of Medicaid Targeted Case Management in the most recent FY?	\$_____ Medicaid State Plan Service \$_____ Medicaid State Plan Amendment (SPA) Service \$_____ Medicaid §1915(c) HCBS Waiver Service \$_____ Medicaid §1115 Waiver Service \$_____ MFP Demonstration Service \$_____ Other Medicaid Authority	Please attach information on the State's spending breakdown by population group.

Ques. #	Question	Answer Set	Source/Notes
6a.	How much did the State spend on State-funded Case Management in the most recent FY?	\$ _____	
6b.	What was the number of unduplicated recipients of State-funded only Case Management in the most recent FY?	_____	
CARE COORDINATION			
	<p>Does the State offer LTSS care coordination?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p>If “Yes”, how?</p> <p>___ Medicaid State Plan service</p> <p>___ Medicaid §1915 State Plan Amendment (SPA) service</p> <p>___ Medicaid §1915(c) HCBS waiver service</p> <p>___ Medicaid §1115 waiver service</p> <p>___ Medicaid managed care capitation payments</p> <p>___ State-Funded Program (Please specify) _____</p> <p>___ Other (Please specify)</p>	<p>For which populations?</p> <p><input type="checkbox"/> Aged/Disabled adults 65+</p> <p><input type="checkbox"/> Adults <65 with physical disabilities</p> <p><input type="checkbox"/> ID/DD</p> <p><input type="checkbox"/> Children with mental illness</p> <p><input type="checkbox"/> Adults with mental illness</p> <p><input type="checkbox"/> Traumatic or Acquired Brain injury</p> <p><input type="checkbox"/> HIV/AIDS</p> <p><input type="checkbox"/> Medically Fragile</p> <p><input type="checkbox"/> Technology Dependent</p> <p><input type="checkbox"/> Other</p>	<p>TIP: Care coordination is a <i>client-centered, assessment-based, interdisciplinary approach to integrating health care and psychosocial support services in which a care coordinator develops and implements a comprehensive care plan that addresses the client’s needs, strengths, and goals.</i> Definition from the National Association of Social Workers (retrieved from http://www.socialworkers.org/advocacy/briefing/CareCoordinationBriefingPaper.pdf).</p>

Sub-indicator CT2b, Users Reporting That Care Coordinators or Case Managers Help Them Get What They Need

This Sub-indicator is only reported for certain States and only applies to the Intellectual Disability/Development Disability population. ***It should be noted that States are not required to collect data to calculate this Sub-indicator.***

Table 58: Proportion of people reporting that care coordinators or case managers help them get what they want²⁸

State	N	Overall In State	In Institution	In Community-Based	In Ind. Home	In Parent's Home
Significantly Above Average						
WY	200	95%	n/a	93%	n/a	n/a
AR	213	94%	96%	95%	91%	95%
IL	218	92%	97%	89%	93%	95%
NY	781	91%	n/a	89%	91%	93%
Within Average Range						
ME	261	91%	n/a	93%	87%	n/a
AL	291	91%	n/a	87%	n/a	95%
MO	213	90%	n/a	93%	91%	n/a
OH	324	90%	n/a	91%	90%	89%
RCOC	337	89%	93%	91%	87%	84%
PA	757	87%	n/a	93%	87%	85%
NC	470	87%	n/a	88%	79%	89%
OK	173	86%	n/a	89%	86%	n/a
TX	587	86%	85%	n/a	n/a	89%
KY	272	85%	n/a	84%	n/a	82%
DC	242	83%	n/a	83%	87%	90%
LA	105	77%	n/a	n/a	71%	78%
Significantly Below Average						
NJ	177	72%	n/a	72%	n/a	n/a
GA	281	71%	n/a	60%	75%	73%
Total	5,902	87%*	93%*	87%*	86%*	87%*

²⁸ This data comes from the National Core Indicators. Currently, 39 States participate in the National Core Indicators.

Principle Feature: Promotion of continuity of care and seamless transitions from setting to setting and across major developmental stages across the lifespan

Indicator CT3, LTSS Care Transition

This Indicator examines the promotion of continuity of care and seamless transitions from setting to setting across major developmental stages across the lifespan.

1. Does the State guarantee a waiver slot for an individual transitioning from an institution to the community?

- No
- Yes

a. For which settings and populations? (Check all that apply)

Institutional Setting	PD	IDD	MI	Older Adults
Acute Care Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Long-Term Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Skilled Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ICF/IID	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

2. Does the State have a written policy in place that requires nursing facilities to notify Medicaid when a dual eligible individual is admitted to a skilled nursing facility for a Medicare-paid stay?

- No
- Yes

a. For which settings and populations? (Check all that apply)

Institutional Setting	PD	IDD	MI	Older Adults
Acute Care Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Long-Term Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Skilled Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ICF/IID	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

3. Does the State have written procedures in place for managing Minimum Data Set (MDS) 3.0 Section Q referrals?

- No
- No, but procedures are being developed
- Yes

a. For which settings and populations? (Check all that apply)

Institutional Setting	PD	IDD	MI	Older Adults
Acute Care Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Long-Term Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Skilled Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ICF/IID	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

4. In the most recent State Fiscal Year (SFY), what percentage of the time did the State’s nursing facilities meet the 10-business day requirement for referring individuals responding “Yes” to Question Q0500 (Return to Community) in MDS Section Q to a State-designated local contact agency?

5. Does the State grant **presumptive eligibility** to Medicaid applicants anticipated to meet Medicaid eligibility requirements in order to expedite delivery of Medicaid LTSS?

- No
- Yes

a. For which settings and populations? (Check all that apply)

Institutional Setting	PD	IDD	MI	Older Adults
Acute Care Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Long-Term Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Skilled Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ICF/IID	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

6. Does the State currently use a single, electronic, standardized assessment instrument to conduct functional assessments to determine LTSS needs and to develop LTSS plans?

- No
- No, but a single electronic standardized assessment instrument is currently being developed.
- Yes

a. For which settings and populations? *(Check all that apply)*

Institutional Setting	PD	IDD	MI
Acute Care Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Long-Term Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skilled Nursing Facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ICF/IID	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Do any of the State’s community-based organizations, such as Area Agencies on Aging partner with area hospitals to implement any evidence-based care transition programs?

TIP: Examples of coordinating care transitions programs includes the CMS Community-based Care Transitions Program (CCTP). Examples of the evidence-based care transitions models implemented by such programs may include Eric Coleman’s Care Transitions Program or Mary Naylor’s Transitional Care Model.

- No
- Yes

- a. If so, what was the approximate enrollment in the most current FY?
- b. In approximately what percentage of the State’s provider and hospital networks are programs available?

8. Does the State have written guidelines and/or protocols for discharge planning for Medicaid clients acute care hospitals? Indicate below whether the State has established guidelines or protocols for the following:

	Hospital	Nursing Facility
Person-centered care transition planning	<input type="checkbox"/>	<input type="checkbox"/>
Culturally-sensitive care transition planning	<input type="checkbox"/>	<input type="checkbox"/>
Medication review and management	<input type="checkbox"/>	<input type="checkbox"/>
Use of a universal transfer form	<input type="checkbox"/>	<input type="checkbox"/>

9. Are health homes available in the State?

- No
 Yes

a. Please complete the table below.

Target Population	Yes/No	Approximate Enrollment for the most recent FY	Health Home Model
Medicaid	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Under development		___ Accountable Care Organization (ACO) ___ Medicaid Health Home (ACA Section 2703) ___ Primary Care Case Management (PCCM) ___ Other (specify) _____
Medicare	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Under development		___ Accountable Care Organization (ACO) ___ Medicaid Health Home (ACA Section 2703) ___ Primary Care Case Management (PCCM) ___ Other (specify) _____
Medicare-Medicaid Enrollees (MMEs)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Under development		___ Accountable Care Organization (ACO) ___ Medicaid Health Home (ACA Section 2703) ___ Primary Care Case Management (PCCM) ___ Other (specify) _____

PREVENTION

The U.S. Surgeon General's 2005 Call to Action, *To Improve the Health and Wellness of Persons with Disabilities*, states that "persons with disabilities can promote their own good health by developing and maintaining health lifestyles. People with disabilities need healthcare and health programs the same reasons anyone else does – to stay well, active and a part of the community". However, persons with disabilities are less likely to engage in regular moderate physical activity than people without disabilities.²⁹

The Healthy People 2020 initiative has a section solely dedicated to Disability and Health which focuses on the well-being of disability population. The Disability and Health objectives highlight areas for improvement and opportunities for people with disabilities to: be included in public health activities, receive well-timed interventions and services, interact with their environment without barriers, and participate in everyday life activities.³⁰

Studies have shown that LTSS users living in the community may be less likely to receive preventive health and health promotion services than those living in institutions. One study conducted by Bershadsky and Kane (2010) found that LTSS users with an intellectual or developmental disability living in the community (with their own family) are less likely to receive preventive dental cleanings than those living in ICF/MRs or an adult group home.³¹

States are encouraged to support health and wellness programs that promote healthy living, slow functional decline and ensure the optimal health, well-being, safety, and functioning of individuals with disabilities. Supporting these types of programs indicates a State's efforts towards health promotion and preventive health for people with disabilities and reducing health disparities.

Support may come in various forms and may include providing funding, offering grant opportunities, designating staff, and/or other mechanisms to sustain health promotion programs targeting individuals with disabilities. Examples of health promotion programs include health screenings, preventive care, exercise programs, health and wellness programs, health monitoring, and/or health assessment programs. The Prevention Principle and its Indicators examine how States are accomplishing these activities and meeting these objectives.

²⁹ U.S. Department of Health and Human Services. *The 2005 Surgeon General's Call to Action to Improve the Health and Wellness of Persons with Disabilities: What It Means to You*. U.S. Department of HHS, Office of Surgeon General, 2005

³⁰ *Healthy People 2020*. <http://www.healthypeople.gov/2020/default.aspx>

³¹ Bershadsky, J., & Kane, R. (2010). Place of residence affects routine. *Health Services Research*, 45(5), 1376-1389. doi: 10.1111/j.1475-6773.2010.01131.x

Principle Feature: Universal Availability and Utilization of Community, Clinical and Preventive Services

Indicator P1, Health Promotion and Prevention

Overview of Indicator

The purpose of this Indicator is to examine whether a State provides health promotion and prevention programs targeted to individuals with disabilities. In addition, the Indicator examines the availability of programs supported by a full array of State funding sources.

1. In the last three (3) years, has the State conducted an environmental scan that specifically examined access to health promotion and prevention services for individuals of all ages with disabilities and/or chronic conditions?

- No environmental scan was conducted (*If "No," please skip to question 2*)
- Yes, but the environmental scan was limited to one age group with disabilities and/or chronic conditions (*If "Yes, but..." please skip to question 1a*).
- Yes and the environmental scan examined access to health promotion and prevention services for individuals of all ages with disabilities and/or chronic conditions (*If "Yes," please skip to question 1b*).

a. For which populations?

Individuals who live with:	Children/Youth	Adults	Older Adults
Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

b. In the last three (3) years, the State has conducted an environmental scan to: (*Check all that apply*)

- Assess the health promotion and prevention needs of individuals with disabilities
- Identify gaps in available health promotion and prevention services for individuals with disabilities
- Identify barriers that individuals with disabilities encounter in accessing health promotion and prevention services

c. What were the major findings? _____

2. Which agencies in the State provide “options counseling” that includes information on health promotion and prevention services specifically targeted at individuals with disabilities? *(Check all that apply)*

- State Health Department
- State Unit on Aging
- State Agency for Developmental Disabilities
- State Mental Health Agency
- State Agency for Disability Services
- Aging and Disability Resource Center (ADRC)
- Area Agencies on Aging (AAA)
- Centers for Independent Living (CILs)
- Other, please specify _____

a. For which populations? *(Repeat for each of the agencies checked above)*

Individuals who live with:	Children/Youth	Adults	Older Adults
Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. For Medicaid beneficiaries with disabilities, does the State remind beneficiaries to make an appointment for a periodic physical and/or health screenings?

- No *(If “No,” please skip to question 4)*
- Yes

Type of Exam or Screening	For Medicaid clients with disabilities, our State:	
	Mails reminders to clients	Telephones clients
Physical exams	<input type="checkbox"/>	<input type="checkbox"/>
Dental exams	<input type="checkbox"/>	<input type="checkbox"/>
Mammograms	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Disease Screenings (i.e., blood pressure checks, diabetes monitoring)	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

a. For which populations? (Repeat for each of the exams or screenings checked above)

Individuals who live with:	Children/Youth	Adults	Older Adults
Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Medicare health risk assessments, annual wellness visits, and personalized prevention plans are now available to Medicare beneficiaries free of charge pursuant to Section 4103 of the Affordable Care Act. Does the State currently use any of the following methods to encourage Medicare-Medicaid enrollees (aka “dual eligible individuals”) to take advantage of this new Medicare service?

No (If “No”, skip to question 5)

Yes

Encouraging Dual Eligibles to Take Advantage of ACA §4103 Services	No, but we are considering this. Please explain specific steps toward implementation
Mailings to MMEs	<input type="checkbox"/>
Telephone calls to MMEs	<input type="checkbox"/>
Notices to case managers	<input type="checkbox"/>
Notices to Medicaid/Medicare health plans	<input type="checkbox"/>
Notices to health homes/ICOs/ACOs	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>

5. Does the State provide funding to provide transportation services for individuals with disabilities for preventive care appointments?

No (If “No”, please skip to question 6)

Yes

a. For which populations?

Individuals who live with:	Children/Youth	Adults	Older Adults
Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Does the State provide funding to provide transportation services for individuals with disabilities to participate in health promotion programs (e.g., physical activity programs, nutrition education programs, chronic disease management programs)?

- No
 Yes

a. For which populations?

Individuals who live with:	Children/Youth	Adults	Older Adults
Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Does the State help individuals with disabilities obtain assistive technologies that enable them to participate in health promotion programs (e.g., physical activity programs, nutrition education programs, chronic disease management programs)?

- No
 Yes

a. What kind of programs does the State offer and what are the funding sources available?

Funding Source for Assistive Technologies Programs	Type of Program		
	Financial Assistance	Loans	Trade Programs
Medicaid State Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid Waiver(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
State General Funds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Older American Act Funds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Federal Grants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

a. For which populations? *(Repeat for each of the programs checked above)*

Individuals who live with:	Children/Youth	Adults	Older Adults
Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Does the State incentivize health care professionals to serve Medicaid beneficiaries with disabilities?

- No
 Yes

b. In what ways does the State incentivize health care professionals to serve Medicaid beneficiaries with disabilities?

Incentives for Health Care Providers	Type of Provider		
	Medical	Dental	Behavioral Health
Training for providers on the unique needs of individuals with disabilities and how to more effectively serve this population	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enhanced reimbursement rates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bonus for enrolling a client with disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Financial assistance for special office equipment and supplies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Streamlining paperwork and reporting requirements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

a. For which populations? *(Repeat for each of the incentives checked above)*

Individuals who live with:	Children/Youth	Adults	Older Adults
Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. What programs does the State currently offer that are appropriate for individuals with 9. disabilities (ID/DD, MI, PD)? Below, list chronic disease management programs; physical activity, recreation, and exercise programs; nutrition education programs; oral health and hygiene programs; and transition planning programs.³²

TIP: Check the target population for which the program exists. Note that more than one population may be checked. Definitions for each population may be found in the Glossary.

Name of Program	Target Population(s) (Check all that apply)	Funding Source(s) (Check all that apply)
Chronic Disease Management Programs		
Program 1 (specify): _____ Enrollment in 2011: _____	<input type="checkbox"/> PD <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults <input type="checkbox"/> ID/DD <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults <input type="checkbox"/> MI <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults <input type="checkbox"/> Other: _____ <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults	<input type="checkbox"/> Medicaid State Plan <input type="checkbox"/> Medicaid §1915 State Plan Amendment(s) <input type="checkbox"/> Medicaid Waiver(s) <input type="checkbox"/> Medicaid Managed Care Organization(s) (MCOs) <input type="checkbox"/> Private Health Plan(s) <input type="checkbox"/> State General Funds <input type="checkbox"/> Older Americans Act Funds <input type="checkbox"/> Other Federal Grant(s) <input type="checkbox"/> Other: _____

³² Program models based on evidence-based research such as those listed in *The Guide to Community Preventive Services* (<http://www.thecommunityguide.org/index.html>); the AHRQ *Guide to Clinical Preventive Services* (<http://www.ahrq.gov/clinic/pocketgd.htm>); and the SAMHSA *National Registry of Evidence-Based Programs* (<http://nrepp.samhsa.gov/Search.aspx>).

Name of Program	Target Population(s) (Check all that apply)	Funding Source(s) (Check all that apply)
Physical Activity, Recreation, and Exercise Programs		
Program 2 (specify): _____ Enrollment in 2011: _____	<input type="checkbox"/> PD <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults <input type="checkbox"/> ID/DD <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults <input type="checkbox"/> MI <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults <input type="checkbox"/> Other: _____ <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults	<input type="checkbox"/> Medicaid State Plan <input type="checkbox"/> Medicaid State Plan Amendment(s) <input type="checkbox"/> Medicaid Waiver(s) <input type="checkbox"/> Medicaid Managed Care Organization(s) (MCOs) <input type="checkbox"/> Private Health Plan(s) <input type="checkbox"/> State General Funds <input type="checkbox"/> Older Americans Act Funds <input type="checkbox"/> Other Federal Grant(s) <input type="checkbox"/> Other: _____
Nutrition Education Programs		
Program 3 (specify): _____ Enrollment in 2011: _____	<input type="checkbox"/> PD <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults <input type="checkbox"/> ID/DD <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults <input type="checkbox"/> MI <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults <input type="checkbox"/> Other: _____ <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults	<input type="checkbox"/> Medicaid State Plan <input type="checkbox"/> Medicaid §1915 State Plan Amendment(s) <input type="checkbox"/> Medicaid Waiver(s) <input type="checkbox"/> Medicaid Managed Care Organization(s) (MCOs) <input type="checkbox"/> Private Health Plan(s) <input type="checkbox"/> State General Funds <input type="checkbox"/> Older Americans Act Funds <input type="checkbox"/> Other Federal Grant(s) <input type="checkbox"/> Other: _____

Name of Program	Target Population(s) (Check all that apply)	Funding Source(s) (Check all that apply)
Oral Health and Hygiene Education Programs		
Program 4 (specify): _____ Enrollment in 2011: _____	<input type="checkbox"/> PD <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults <input type="checkbox"/> ID/DD <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults <input type="checkbox"/> MI <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults <input type="checkbox"/> Other: _____ <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults	<input type="checkbox"/> Medicaid State Plan <input type="checkbox"/> Medicaid §1915 State Plan Amendment(s) <input type="checkbox"/> Medicaid Waiver(s) <input type="checkbox"/> Medicaid Managed Care Organization(s) (MCOs) <input type="checkbox"/> Private Health Plan(s) <input type="checkbox"/> State General Funds <input type="checkbox"/> Older Americans Act Funds <input type="checkbox"/> Other Federal Grant(s) <input type="checkbox"/> Other: _____
Fall Prevention Programs		
Program 5 (specify): _____ Enrollment in 2011: _____	<input type="checkbox"/> PD <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults <input type="checkbox"/> ID/DD <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults <input type="checkbox"/> MI <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults <input type="checkbox"/> Other: _____ <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults	<input type="checkbox"/> Medicaid State Plan <input type="checkbox"/> Medicaid §1915 State Plan Amendment(s) <input type="checkbox"/> Medicaid Waiver(s) <input type="checkbox"/> Medicaid Managed Care Organization(s) (MCOs) <input type="checkbox"/> Private Health Plan(s) <input type="checkbox"/> State General Funds <input type="checkbox"/> Older Americans Act Funds <input type="checkbox"/> Other Federal Grant(s) <input type="checkbox"/> Other: _____

10. Does the State provide incentives (e.g. cash, gift cards, and free services) for Medicaid beneficiaries with disabilities who participate in health promotion, prevention, and/or chronic disease management programs and achieve specified goals?

- No
 Yes

a. If so, describe the incentive program(s) below.

TIP: Check the target population for which the program exists. Note that more than one population may be checked. Definitions for each population may be found in the Glossary.

Name of Program	Target Population(s)	Incentive for Program Participation	Incentive for Achieving Specified Goals	Funding Source for Incentive
Program 1: _____ Enrollment in 2011: _____	<input type="checkbox"/> PD <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults <input type="checkbox"/> ID/DD <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults <input type="checkbox"/> MI <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults <input type="checkbox"/> Other: _____ <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults	<input type="checkbox"/> Cash <input type="checkbox"/> Gift Card <input type="checkbox"/> Free Gift <input type="checkbox"/> Free Services <input type="checkbox"/> Other <input type="checkbox"/> None	<input type="checkbox"/> Cash <input type="checkbox"/> Gift Card <input type="checkbox"/> Free Gift <input type="checkbox"/> Free Services <input type="checkbox"/> None	<input type="checkbox"/> Medicaid State Plan <input type="checkbox"/> Medicaid §1915 State Plan Amendment(s) <input type="checkbox"/> Medicaid Waiver(s) <input type="checkbox"/> Medicaid Managed Care Organization(s) (MCOs) <input type="checkbox"/> Private Health Plan(s) <input type="checkbox"/> State General Funds <input type="checkbox"/> Older Americans Act Funds <input type="checkbox"/> Other Federal Grant(s) <input type="checkbox"/> Other: _____
Program 2: _____ Enrollment in 2011: _____	<input type="checkbox"/> PD <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults <input type="checkbox"/> ID/DD <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults <input type="checkbox"/> MI <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults <input type="checkbox"/> Other: _____ <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Older Adults	<input type="checkbox"/> Cash <input type="checkbox"/> Gift Card <input type="checkbox"/> Free Gift <input type="checkbox"/> Free Services <input type="checkbox"/> Other <input type="checkbox"/> None	<input type="checkbox"/> Cash <input type="checkbox"/> Gift Card <input type="checkbox"/> Free Gift <input type="checkbox"/> Free Services <input type="checkbox"/> None	<input type="checkbox"/> Medicaid State Plan <input type="checkbox"/> Medicaid §1915 State Plan Amendment(s) <input type="checkbox"/> Medicaid Waiver(s) <input type="checkbox"/> Medicaid Managed Care Organization(s) (MCOs) <input type="checkbox"/> Private Health Plan(s) <input type="checkbox"/> State General Funds <input type="checkbox"/> Older Americans Act Funds <input type="checkbox"/> Other Federal Grant(s) <input type="checkbox"/> Other: _____

11. What percentage of the State’s Medicaid beneficiaries with disabilities received the following preventive services in 2011?

Service	All Medicaid Beneficiaries with Disabilities	Medicaid Beneficiaries with:		
		PD	ID/DD	MI
Percent with an ambulatory care visit	___ %	___ %	___ %	___ %
Percent receiving a dental service	___ %	___ %	___ %	___ %
Percent receiving a behavioral health service	___ %	___ %	___ %	___ %
Percent of females receiving cervical cancer screening	___ %	___ %	___ %	___ %
Percent of females receiving mammograms	___ %	___ %	___ %	___ %
Percent receiving diabetes screening (HbA1c test)	___ %	___ %	___ %	___ %

Principle Feature: State and Local Communities are Free from Preventable Illnesses and Injury

Indicator P2, Disaster/Emergency Preparedness

Overview of Indicator

The purpose of this Indicator is to examine whether or not a State includes individuals with disabilities and other at-risk groups in their statewide disaster/emergency planning efforts and policies. In addition, it examines States' approaches for planning for potential disasters and emergencies for individuals with disabilities. Evidence of the importance of the States' having disaster/emergency preparedness systems is evident on the research and recommendations from several LTSS and public health organizations, and special volumes in top journals.

1. Does the State have an emergency management/disaster preparedness plan?

No (If "No", skip to question 3)

Yes

2. Does the State's emergency management/disaster preparedness plan have specific considerations for vulnerable populations?

No (If "No", skip to question 3)

In development

Yes

a. For which populations?

Individuals who live with:	Children/Youth	Adults	Older Adults
Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual/developmental disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

b. In which settings?

- Community/Private Residences
- Nursing Facility
- ICF/IID
- Adult Group Homes
- Assisted Living Residences
- Residential Care Facilities/Board and Care Homes
- Schools
- Other, please specify

c. Does the State's emergency management/disaster preparedness plan require back-up contacts for vulnerable populations?

- No (*If "No", skip to question 3*)
- Yes

i. In which settings?

- Community/Private Residences
- Nursing Facility
- ICF/IID
- Adult Group Homes
- Assisted Living Residences
- Residential Care Facilities/Board and Care Homes
- Schools
- Other, (*Please specify*)

3. For the vulnerable populations served in the State, does the State:

- Provide specialized education/training for individuals and/or their caregivers on emergency preparedness?
- Provide specific resources (e.g., referrals to organizations, assistance with making a plan, access to shelters/food banks, etc.) in the time of emergencies/disasters?

Have a plan in place to ensure safety of/rescue/reach out to persons in a time of emergency/disaster? This could include special needs registries identifying people who may require special assistance.

4. Do any of the following organizations coordinate regularly and directly with the State emergency management agency?

Aging Network: SUAs, AAAs

Disability Network: CILs, Assistive Technology agencies, ADA agencies

ADRC/Streamlined Access programs

Other _____

For the organizations listed in Question 4, does the State:

a. Provide the State emergency agency with tracking/monitoring of vulnerable populations?

No

Yes

b. Have a specific plan for outreach in the event of a disaster/emergency?

No

Yes

5. Does the State provide training to first responders (police, firemen, EMT) on specific disabilities and populations (e.g., dementia)?

No

Yes

6. Did the State participate in the General Preparedness module of the Behavioral Risk Factor Surveillance System (BRFSS) this year?

No

Yes

a. Please describe how the Medicaid Single State Agency plans on using this data.

CULTURAL AND LINGUISTIC COMPETENCY

The Cultural and Linguistic Competency (CLC) Principle examines the infrastructure States have in place to provide services and supports for diverse populations.

The National Balancing Indicators have defined three features of a culturally and linguistically competent LTSS system based on the US Department of Health and Human Services' *National Standards for Culturally and Linguistically Appropriate Services in Health Care* (the *National CLAS Standards*).³³ These features include:

- 1) Service offerings for diverse populations.
 - Service offerings for a diverse population supported by representative diverse staff.
 - Service offerings can be modified/customized to meet individual needs and preferences based on an individual's values and beliefs related to health, mental health, family involvement, and life cycle expectations.
 - Successful communication with people of all ages, languages, races, ethnicities, disability types, levels of literacy and health literacy or sexual orientation.
- 2) Users of services and their families and community members are engaged in planning, implementing and evaluating services. Support is provided for their engagement, (i.e., language access, disability access, accommodations for literacy levels, and financial supports) when needed to facilitate their participation.
- 3) State and local organizations provide ongoing education, training, and awareness activities in cultural and linguistic competence for providers and others.

However, it should be noted that no indicator was developed for the second principle feature, *Users of services and their families and community members are engaged in planning, implementing and evaluating services. Support is provided for their engagement, (i.e., language access, disability access, accommodations for literacy levels, and financial supports) when needed to facilitate their participation.*

³³ US Department of Health and Human Services. *The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (the *National CLAS Standards*). Retrieved from: <https://www.thinkculturalhealth.hhs.gov/content/clas.asp>

Principle Feature: Services are Offered to Diverse Populations

Indicator CLC1, Needs Assessment and Target Population

Overview of Indicator

This Indicator examines whether diverse groups of users are included in LTSS and if a State is mandated to provide services to these users. The Indicator also examines if a State collects and reports data for the diverse groups users served through its LTSS programs.

1. Does the State have a written policy(ies) on providing culturally and linguistically competent LTSS?

No

Yes

- a. If “Yes,” please upload written policy(ies)

2. Does the State involve culturally and linguistically diverse LTSS users, representatives and/or advocates in CLC policy development?

TIP: For culturally and linguistically diverse LTSS users, we are defining them based on the HHS Final Data Collection Standards (found here:

<http://minorityhealth.hhs.gov/templates/content.aspx?ID=9227&lvl=2&lvlID=208>)

No

Yes, please describe

3. Does the State involve culturally and linguistically diverse users, representatives and/or advocates in CLC policy implementation?

No

Yes, please describe

4. Does the State formalize partnership(s) with users, representatives and/or advocates in order to obtain their feedback?

No

Yes, please describe

5. Since 2010, has the State conducted a needs assessment to better understand the needs of culturally and linguistically diverse LTSS users in the State?

No

Yes, please upload assessment

6. What is the State's policy for ensuring that people who need access to language services receive them? Please describe.

a. Please describe how language services are funded.

7. Please specify the diverse LTSS users that the State targets.

8. Does the State collect and/or utilize data intended to increase its understanding of the needs and characteristics of and the services provided to diverse LTSS users?

No

Yes

a. If "Yes," please describe what data is collected and how this data is being utilized to better understand LTSS users.

b. If "Yes," please describe how this data is being utilized to better understand the needs and characteristics of diverse LTSS users.

Indicator CLC2, Efforts to Design Services and Supports for Culturally and Linguistically Diverse Groups

Overview of Indicator

This Indicator examines whether a State designs LTSS that addresses the needs of diverse groups of users based on mandates and evidence-based practices. In addition to the design, this Indicator examines whether the State agency provides staff that can support the diverse groups of users that are targeted

1. Does the State mandate that an individual's cultural and linguistic needs be addressed in the individual's LTSS needs assessment?

No

Yes

- a. If "Yes," please provide a list of CLC items to be covered in the needs assessment.
- b. Please describe how often the individual's need assessment is updated to reflect any changes in CLC needs.

2. Are an individual's CLC needs that are identified in the LTSS needs assessment addressed in the individual's service/care plan?

No

Yes

- a. Please describe how often the individual's service/care plan is updated to reflect any changes in CLC needs.
- b. Please describe how the individual's CLC needs included in the service/care plan are monitored to ensure they are met and how often does the monitoring occur.

Principle Feature: State program staff, LTSS provider organizations and DSW receive cultural and linguistic competency education and training on an ongoing basis.

Indicator CLC3, Cultural and Linguistic Competency Training Requirements

Overview of Indicator

This Indicator examines whether or not a State has training requirements for LTSS and vocational rehabilitation providers that address cultural and linguistic competency.

1. Is in-service training on the provision of culturally and linguistically competent LTSS (e.g. values, principles, practices, and procedures) being provided to State program staff?

No

Yes

- a. If “Yes”, please describe the curricula used and how frequently training is provided.

2. Does the State provide cultural and linguistic diversity training within routine training(s) for State staff at all levels?

No

Yes

- a. If “Yes”, please describe the curricula and how often this training is provided.

Questions related to achieving a culturally and linguistically competent direct service workforce can be located in Sub-indicator S3b, Direct Service Workforce, as questions 1. However, it should be noted that the information collected in response to questions 1 and 2 in Sub-indicator S3b, Direct Service Workforce, will be used to examine both the Sub-indicator S3b, Direct Service Workforce, and Indicator CLC2, Efforts to Design Services and Supports for Culturally and Linguistically Diverse Groups.

In addition, the question that addresses State training requirements for LTSS providers is located in Sub-indicator S3b, Direct Service Workforce, as question 3. Similar to Sub-indicator S3b, question 3 should be examined as part of Sub-indicator S3b, Direct Service Workforce and Indicator, CLC3, Training Requirements.

GLOSSARY OF TERMS

Administration on Community Living (ACL)

The Administration on Community Living (ACL), a federal agency under the US Department of Health and Human Services, brings together the efforts and achievements of the Administration on Aging, the Administration on Intellectual and Developmental Disabilities, and the HHS Office on Disability and is responsible for increasing access to community supports, while focusing attention and resources on the unique needs of older Americans and people with disabilities across the lifespan.

Source: http://www.acl.gov/About_ACL/Index.aspx, retrieved 4/25/14

Adult Foster Homes

Adult foster homes are institutions that furnish (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

Source: CMS Policy 42 CFR 435.1010(b)(2). <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=435835724060c9e7d27c15f2025eb99c&rgn=div8&view=text&node=42:4.0.1.1.6.11.76.11&idno=42>

Adult Group Homes

An adult group home is a provider owned or controlled residential setting is one where the provider:

- Owns the unit, holds the rental lease or agreement, or otherwise has legal control over the unit; or
- Has authority (whether exercised or not) to control any of the following in unit:
 - The sleeping and living arrangements in the unit;
 - entrance and egress;
 - who lives in the setting;
 - who shares sleeping space;
 - how the unit is furnished and decorated;
 - schedules and activities of people living there, including access to food; OR
 - who visits, when visits occur, or how visitors and hosts behave.

OR

- Requires that the resident(s) receive a particular service or support as a condition for living in the unit.

Source: See CMS Application for a §1915(i) HCBS Waiver.

Accessible Housing

HUD's accessible housing guidelines cover multifamily housing consisting of four (4) or more units with an elevator built for first occupancy after March 13, 1991. All units must comply with the following seven design and construction requirements to be considered accessible:

- Accessible entrance on an accessible route
- Accessible public and common-use areas
- Usable doors
- Accessible route into and through the dwelling unit
- Accessible light switches, electrical outlets, thermostat, and environmental controls
- Reinforced walls in bathrooms
- Usable kitchens and bathrooms

Affordable Housing

According to HUD, affordable housing is housing that applies for low-income families that spend more than 30 percent of their annual income on housing.

Agency with Choice (AwC) Financial Management Service (FMS) Provider

Conducts all necessary payroll function and is legally responsible for discharging the employment –related functions and duties for participant-selected workers with the participant based on the roles and responsibilities identified by the two joint-employers (Agency with Choice (AwC) FMS provider is the primary employer or “employer of record” and a participant or his/her representative is the secondary employer or “managing employer”). The AwC FMS provider performs FMS tasks that are related to the Employer Authority and Budget Authority, as specified in the State program design. The AwC FMS provider must have an executed Medicaid provider agreement with the State in order to submit billings and receive payments for Medicaid State Plan, State Plan Amendment and/or Waiver services furnished by participant-selected direct service workers or enter into an administrative services agreement/contract to function as a limited fiscal agent. The AwC FMS provider may function solely to support participant employment of direct service workers or it may provide other employer-related supports to participants including providing traditional agency-based direct service workers. When the joint-employer, AwC FMS option is selected by a State, it must specify the types of agencies that support co-employment, the standards and qualifications that the State requires of such entities, and the safeguards in place to ensure that individuals maintain control and oversight of the employee.

Source: See CMS Application for a §1915(c) HCBS Waiver version 3.5 Instructions, Technical Guide and Review Criteria, January 2008, p. 212-213.

Agency for Healthcare Research and Quality (AHRQ)

A federal agency under the US Department of Health and Human Services. AHRQ's mission is to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work with the U.S. Department of Health and Human Services (HHS) and other partners to make sure that the evidence is understood and used.

Source: <http://www.ahrq.gov/about/index.html>, retrieved, 4/25/14

Budget Authority

This participant direction opportunity allows participants (users) and their representatives, as appropriate, to exercise choice and control over a specified amount of waiver funds (self-directed budget). Under the budget authority, the participant has decision-making authority regarding who will provide a service, when the service will be provided, and how the service will be provided consistent with the service specifications and other requirements. The participant has the authority to purchase goods and services approved in his/her service plan and accepts responsibility for managing a self-directed budget. Participants may modify the services included in the self-directed budget without advanced approval of a change in service plan, but the service plan and self-directed budget must be kept in alignment. Participants also have the authority to purchase individual-directed goods and services approved in their service plan. Participants may make changes in the distribution of funds among the services included in the self-directed budget. Budget changes and the service plan must be synchronized.

Source: See CMS Application for a §1915(c) HCBS Waiver version 3.5 Instructions, Technical Guide and Review Criteria, January 2008, p. 193 and 215-217.

Behavioral Risk Factor Surveillance System (BRFSS)

The Behavioral Risk Factor Surveillance System (BRFSS) is the world's largest, on-going telephone health survey system.

Source: <http://www.cdc.gov/brfss/>, retrieved 4/25/14

Care Coordination

Care coordination is “the deliberate organization of patient care activities between two or more participants involved in a patient’s care to facilitate the appropriate delivery of health care services.” In this definition, all providers working with a particular patient share important clinical information and have clear, shared expectations about their roles. Equally important, they work together to keep patients and their families informed and to ensure that effective referrals and transitions take place.

Source: McDonald KM, Sundaram V, Bravata DM, et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies, Volume 7—Care Coordination. Rockville, MD: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services; June 2007 and <http://www.improvingchroniccare.org>

Certified Nursing Assistants or Nursing Aides (CNAs)

A certified nursing assistant or nursing aide is a direct service worker who has taken special training, passed proficiency testing and received certification by the state, entitling him or her to work in a facility or a private home. Often they work in hospitals, nursing facilities and assisted living facilities but also may work in community-based settings. Generally they assist residents with activities of daily living (ADLs) such as eating, dressing, bathing, and toileting. They also may perform clinical tasks such as range-of motion exercises and taking blood pressure readings.

Source: <http://www.shelteringarms.org/resources/glossary.php>

Community Integration and Inclusion (CI) Principle

The Community Integration and Inclusion Principle examines whether a State's LTSS system encourages and supports people to reside in the most integrated setting by offering a full array of options for accessing quality services and supports in the community.

Source: NBIP State Self-assessment Survey Instrument

Cultural and Linguistic Competency (CLC) Principle

The Cultural and Linguistic Competency (CLC) Principle examines the infrastructure States have in place to provide services and supports for diverse populations.

Source: NBIP State Self-assessment Survey Instrument

Centers for Medicare and Medicaid Services (CMS)

A federal agency within the United States Department of Health and Human Services (DHHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards. In addition to these programs, CMS has other responsibilities, including the administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA), quality standards in long-term care facilities (more commonly referred to as nursing facilities) through its survey and certification process, clinical laboratory quality standards under the Clinical Laboratory Improvement Amendments, and oversight of HealthCare.gov.

Source: http://en.wikipedia.org/wiki/Centers_for_Medicare_and_Medicaid_Services, retrieved 4/25/14

Co-employer Option Under Employer Authority

An arrangement wherein an organization (Agency with Choice FMS provider) acts as the primary employer or the employer of record of the user's direct service workers and assumes responsibility for: (a) employing, processing human resource paperwork, and processing payroll for paying direct service workers who have been recruited/selected, and referred by participants (secondary or "managing employer") for hire to provide services to them; (b) meeting Medicaid provider requirements, (c) reimbursing approved individual-directed goods and services, as applicable; and, (d) providing other employer-related supports to the participant/representative as needed/requested. Under this Employer Authority option, the participant acts as the secondary or managing employer and is responsible for, or actively participate in, recruiting, selecting and referring their direct service worker to the AwC FMS provider for hire and assignment back to him or her; and supervising and dismissing their direct service workers, at least from the home. Often participants and their representatives, as appropriate, also may determine the terms and conditions of their direct service workers' work, train their direct service workers and evaluate their performance or actively participate in these tasks.

Common Law Employer Option Under Employer Authority

Under IRS common law rules, anyone (i.e., direct service worker) who performs services for an entity (i.e., a participant or his/her representative) is the entity's employee if the entity can control what will be done and how it will be done even if the entity gives the employee freedom of action. What matters is that the entity has the right to direct and control the details of how the services are provided and the outcomes.

As the common law employer, the participant or representative manages all of the employer-responsibilities, however, he/she may delegate the payroll and billing payment tasks to a Government or Vendor Fiscal/Employer Agent (F/EA) Financial Management Services (FMS) Organization operating under §3504 of the IRS code and Revenue Procedures 80-4 and 70-6, respectively. In addition, either the Government or Vendor F/EA FMS organization or Information & Assistance (I&A) provider may provide participants and representatives with a variety of employer-related skills training to assist them in performing their employer-related tasks. (Note: A participant who is the common law employer of his/her direct service workers and elects to receive a prospective cash disbursement pursuant to a Medicaid §1915(j) State plan option can perform some or all of the FMS functions themselves.

Source: See IRS Publication 15a, *Employer's Supplemental Tax Guide for use in 2014 CMS Application for a §1915(c) HCBS Waiver version 3.5 Instructions, Technical Guide and Review Criteria*, January 2008

Consolidated Housing Plan

According to the U.S. Department of Housing and Urban Development, “The Consolidated Plan is designed to be a collaborative process whereby a community establishes a unified vision for community development actions. It offers local jurisdictions the opportunity to shape the various housing and community development programs into effective, coordinated neighborhood and community development strategies. It also creates the opportunity for strategic planning and citizen participation to take place in a comprehensive context, and to reduce duplication of effort at the local level. The Consolidated Plan approach is also the means to meet the submission requirements for the Community Development Block Grant (CDBG), HOME Investment Partnerships (HOME), and Emergency Shelter.” U.S. Department of Housing and Urban Development. Guidelines for Preparing Consolidated Plan and Performance and Evaluation Report Submissions for Local Jurisdictions.

Source:

<http://www.hud.gov/offices/cpd/about/conplan/toolsandguidance/guidance/index.cfm>

Coordination and Transparency (CT) Principle

The Coordination and Transparency Principle examines whether the LTSS system coordinates a range of services funded by multiple funding sources to provide seamless supports across the health and LTSS systems (i.e. acute health, rehabilitation and LTSS). The LTSS system also makes effective use of health information technology to provide transparent information to users, providers, and payers.

Source: NBIP State Self-assessment Survey Instrument

Direct Support Professionals (DSPs)

A direct support professional works directly with people with physical disabilities and/or intellectual disabilities with the aim of assisting the individual to become integrated into his /her community or the least restrictive environment. In their role they assist individuals with disabilities to lead a self-directed life and contribute to the community, assist them with activities of daily living if needed, and encourages attitudes and behaviors that enhance community inclusion. A DSP may provide supports to a person with a disability at home, work, school, church, and other community places. A DSP also acts as an advocate for the disabled individual, in communicating their needs, self-expression and goals.

Source: http://en.wikipedia.org/wiki/Direct_support_professional

Disability Populations

Physical Disabilities

Physical disability pertains to total or partial loss of a person's bodily functions (e.g. walking, gross motor skills, bladder control etc.) and total or partial loss of a part of the body (e.g. a person with an amputation).

Source:

http://www.pdcnsw.org.au/index.php?option=com_content&view=article&id=49:what-is-physical-disability&catid=43:educational-info&Itemid=118

Mental Illness

A mental illness is a medical condition that disrupts a person's thinking, feeling, mood, ability to relate to others and daily functioning. Just as diabetes is a disorder of the pancreas, mental illnesses are medical conditions that often result in a diminished capacity for coping with the ordinary demands of life.

Source: http://www.nami.org/Template.cfm?Section=By_Illness

Intellectual Disability/Developmental Disability

Intellectual disability is a below-average cognitive ability with three (3) characteristics:

- **Intelligent quotient (or I.Q.) is between 70-75 or below**
- **Significant limitations in adaptive behaviors (the ability to adapt and carry on everyday life activities such as self-care, socializing, communicating, etc.)**
- **The onset of the disability occurs before age 18.**

Intelligence refers to general mental capability and involves the ability to reason, plan, solve problems, think abstractly, comprehend complex ideas, learn quickly, and learn from experience.

Sometimes intellectual disability is also referred to as developmental disability which is a broader term that includes ASD (autism spectrum disorders), epilepsy, cerebral palsy, developmental delay, fetal alcohol syndrome (or FASD) and other disorders that occur during the developmental period (birth to age 18).

The major differences are in the age of onset, the severity of limitations, and the fact that a person with a developmental disability definition may or may not have a low I.Q. While some people with intellectual disability will also meet the definition of developmental disability, it is estimated that at least half do not meet the requirements for the developmental disability definition.

Source: <http://www.thearc.org/page.aspx?pid=2543>

DALTCP - Office of Disability, Aging and Long-term Care Policy at the Office of the Assistant Secretary for Planning and Evaluation

The Office of Disability, Aging, and Long-Term Care Policy (DALTCP) within the Office of the Assistance Secretary for Planning and Evaluation at US DHHS is charged with developing, analyzing, evaluating, and coordinating HHS policies and programs which support the independence, productivity, health, and long-term care needs of children, working age adults, and older persons with disabilities.

Source: http://aspe.hhs.gov/office_specific/daltcp.cfm, retrieved 4/25/14

Direct Service Worker (DSW)

A direct service worker is an unlicensed person who provides personal care or other services and support to persons with disabilities or to the elderly to enhance their well-being and which involves face-to-face direct contact with the person. Functions performed may include, but are not limited to, assistance and training in activities of daily living, personal care services, and job-related supports.

Source: <http://law.justia.com/codes/louisiana/2006/48/321331.html>, retrieved 4/25/14

Employer Authority

Employer authority is a participant direction opportunity in which the participant exercises choice and control over individuals who furnish services is authorized in the service plan. Under the employer authority, the participant or his/her representative may function as the co-employer (managing employer) or the common law employer of his/her direct service workers who furnish LTSS to the participant. The participant is supported to recruit, hire, supervise and dismiss the direct service workers who furnish his/her LTSS. When Employer Authority is implemented, the participant (or his/her representative), rather than the waiver provider agency, carries out the employer responsibilities for his/her direct service workers with supports from an Information and Assistance (I&A) and Financial Management Service (FMS) provider as required and needed.

Source: See CMS Application for a §1915(c) HCBS Waiver version 3.5 Instructions, Technical Guide and Review Criteria, January 2008, p. 193.

Employment Personal Assistance Services (EPAS)

Employment Personal Assistance Services or (EPAS) is a Medicaid personal care service provided to individuals with disabilities to support them in maintaining employment. The service is designed to provide personal assistance for individuals who may have physical, mental cognitive and/or intellectual/developmental disabilities and are working in integrated, competitive employment. The assistance provided is for tasks directly related to maintaining employment.

Source: United States Department of Labor, 2009.

Family and Medical Leave Act (FMLA)

“The Family and Medical Leave Act (FMLA), effective August 5, 1993, provides up to 12 weeks of unpaid leave during a 12 month period to care for a newborn, adopted or foster child, or to care for a family member, or to attend to the employee’s own serious medical health condition. The law applies to private employers with 50 or more employees. The FMLA also allows states to set standards that are more expansive than the federal law and many states have chosen to do so. States that have set more expansive standards include, California, Connecticut, DC, Hawaii, Maine, Minnesota, New Jersey, Oregon, Rhode Island, Vermont, Washington, and Wisconsin, most of which have expanded either the amount of leave available or the classes of persons for whom leave may be taken. Some states also provide paid time off.

There are eligibility criteria, medical certification guidelines and other detailed rules governing FMLA leave. FMLA requires an employer to maintain coverage under any "group health plan" for an employee on FMLA leave under the same conditions coverage would have been provided if the employee had continued working. Coverage provided under the FMLA is not Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage, and FMLA leave is not a qualifying event under COBRA. A COBRA qualifying event may occur, however, when an employer’s obligation to maintain health benefits under FMLA ceases, such as when an employee notifies an employer of his or her intent not to return to work.

Source: Centers for Medicare & Medicaid Services, 2009; The National Association of Letter Carriers, 2009.

Financial Management Services (FMS)

Financial Management Services (FMS) assist participants and their representatives, as appropriate, in exercising employer and budget authorities. Two types of FMS have been recognized by CMS: Fiscal/Employer Agent (F/EA), both Government and Vendor models, and Agency with Choice (AwC). FMS includes assisting participants and representatives in: 1) understanding employer and program responsibilities; 2) performing direct service worker payroll and employer-related duties (e.g., withholding and filing Federal, State, local and unemployment taxes; purchasing workers' compensation or other forms of insurance;

collecting and processing worker timesheets; calculating and processing employee benefits; and issuing payroll checks); 3) purchasing approved individual-directed goods and services; 4) tracking and monitoring individual budget expenditures; and 5) identifying expenditures that are over or under the budget. (Note: A participant who is the common law employer of his/her direct service workers and elects to receive a prospective cash disbursement pursuant to a Medicaid §1915(j) SPA option can perform some or all of the FMS functions themselves. Typically, however, participants prefer an FMS entity perform these functions for them.)

Source: See Centers for Medicare & Medicaid Services website

http://www.cms.gov/CommunityServices/60_SelfDirectedServices.asp (8/15/10). See also CMS Application for a §1915(c) HCBS Waiver version 3.5 Instructions, Technical Guide and Review Criteria, January 2008, p. 201.

Fiscal/Employer Agent (F/EA) Financial Management Service (FMS) provider

An entity approved by IRS to act as the employer agent for the common law employer (i.e., participant or his/her representative) in accordance with §3504 of the IRS code performing all that is required of an employer for wages paid on their behalf and all that is required of the payer for requirements of back-up withholding, as applicable. Government Fiscal/Employer Agent FMS providers operate under IRS Revenue Procedures 80-4 and as modified by Notice 2003-70 and Revenue Procedure 2013-39. Vendor Fiscal/Employer Agent FMS providers operate under Revenue Procedure 70-6 as modified by IRS REG -137036-08 and Revenue Procedure 2013-39, as applicable).

Source: Internal Revenue Service.

FMAP – Federal Medical Assistance Percentage

The Federal Medical Assistance Percentages (FMAPs) are used in determining the amount of Federal matching funds for State expenditures for assistance payments for certain social services, and State medical and medical insurance expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the FMAPs each year.

Source: aspe.hhs.gov/health/fmap/cfm retrieved on 4/24/14

Global Budget

Global budgets are budgets or expenditure targets for health care spending. Specific definitions vary depending on the types of services covered and the systems to which the budgets are applied.

Source: Mathematica, 2009.

Health Promotion Program(s)

Health promotion programs are a combination of education, policy, environmental supports, community development, regulation, and public health initiatives that aid in the social, mental, and physical well-being of an individual. Through health promotion activities, individuals gain control of their well-being, and increase their health.

Source: World Health Organization, 1998.

Home Health

Home health refers to the medically-related services provided to patients in a home setting rather than in a medical facility such as a hospital or a primary health care center. Home health services include medical or psychological assessment, wound care, medication teaching, pain management, disease education and management, physical therapy, speech therapy, or occupational therapy, skilled nursing in addition to speech, occupational and physical therapy. In home health service the home care practitioner will aid patients to increase their ability to perform their daily activities of life.

The term "home health services" means the part-time or intermittent nursing care, physical or occupational therapy or speech-language pathology services, medical social services conducted under the direction of a physician, part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Secretary, and medical supplies furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan established and periodically reviewed by a physician, provided on a visiting basis in a place of residence used as such individual's home

Source: 42 USCS § 1395x (m) and <http://definitions.uslegal.com/h/home-health-services>.

Home Health Aide

A home health aide is a trained and certified health-care worker who provides assistance to a patient in the home with personal care (as hygiene and exercise) and light household duties (as meal preparation) and who monitors the patient's condition.

Source: <http://www.merriam-webster.com/medical/home-health-aide>

Information and Assistance (I&A) in Support of Self Direction

States are required to provide or arrange for the provision of Information and Assistance (I&A) services that are responsive to the participant's needs and desires. Examples of I&A services include, but are not limited to, providing information regarding system processes, individual rights and responsibilities, and available resources; providing counseling, training, and

assistance related to the use of supports broker/consultant and FMS; and providing access to an independent advocacy system available in the State. The amount and frequency with which a participant uses the available I&A services varies from person to person and circumstance to circumstance. A support broker/consultant/ counselor must be available to each participant in directing his/her services, and acts as a liaison between the participant and program, assisting participants with whatever is needed to identify potential personnel requirements, resource to meet those requirements, and the services and supports to sustain participants as they direct their own services and supports. The support broker/consultant/counselor acts as an agent of the participant and takes direction from the individual.

Source: See Centers for Medicare and Medicaid Services website
http://www.cms.gov/CommunityServices/60_SelfDirectedServices.asp (8/15/10).

Medicaid Buy-in Program

A Medicaid buy-in program offers Medicaid coverage to individuals with disabilities who are working and earning more than the allowable limits of regular Medicaid in order to retain their health care coverage. The program allows working individuals with disabilities to earn more income without the risk of losing vital health care coverage.

Individuals with a disability who earn higher wages than allowable, will most of the time, be ineligible for Medicaid coverage. However, the Medicaid Buy-In program enables working-age adults with disabilities to earn higher wages in a workforce profession while being covered by Medicaid. Participants buy-into the Medicaid program. This buy-in usually is done by having individuals pay premiums that are based off their individual income.

Source: Centers for Medicare & Medicaid Services, 2009.

Mission Statement

A Mission Statement is a description of the purpose of an organization. A mission Statement can be seen as a "Statement of Purpose". A mission Statement guides an organization's direction and performance levels.

Source: New Mexico State University, 2009.

National Center for Cultural Competency (NCCC)

The National Center for Cultural Competency is located at Georgetown University. Its mission is to increase the capacity of health care and mental health care programs to design, implement, and evaluate culturally and linguistically competent service delivery systems to address growing diversity, persistent disparities, and to promote health and mental health equity.

Source: nccc.georgetown.edu retrieved on 4/24/14

National Balancing Indicator Project (NBIP)

The Centers for Medicare & Medicaid Services (CMS) commissioned the National Balancing Indicator Project (NBIP) to develop and test the feasibility of implementing national indicators to assess States' efforts toward attaining and maintaining a balanced, person-driven long-term supports and services (LTSS) system. The mission of the NBIP is to assist CMS and States in developing indicators that will help gauge a State's success in "balancing" its long-term support program, which will in turn inform Federal and State policy making.

Source: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Balancing-Long-Term-Services-and-Supports.html>, retrieved, 4/25/14

Nursing Facility (NF)

Provides a type of residential long-term care. It is a place of residence for people who require continual nursing care and have significant difficulty coping with the required activities of daily living. Nursing aides and skilled nurses are usually available 24 hours a day. Residents include the elderly and younger adults with physical or mental disabilities. Residents in a skilled nursing facility also may receive physical, occupational, and other rehabilitative therapies following an accident or illness. Some nursing facilities assist people with special needs, such as individuals with Alzheimer Disease.

Source: http://en.wikipedia.org/wiki/Nursing_home, retrieved 4/25/14

Office of the Assistant Secretary for Planning and Evaluation at the US Department of Health and Human Services (OASPE)

The Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of the U.S. Department of Health and Human Services on policy development, and is responsible for major activities in policy coordination, legislation development, strategic planning, policy research, evaluation, and economic analysis.

Source: <http://aspe.hhs.gov/> retrieved 4/25/14

Options Counseling (OC)

A person-centered, interactive, decision-support process whereby individuals receive assistance in their deliberations to make informed long-term support choices in the context of their own preferences, strengths, and values.

Source: http://www.nasuad.org/documentation/I_R/2011-Symposium/The%20Options%20Counseling%20Standards%20Project.pdf retrieved on 4/24/14

Office of Civil Rights (OCR)

As the US Department of Health and Human Services' civil rights and health privacy rights law enforcement agency, OCR investigates complaints, enforces rights, and promulgates regulations, develops policy and provides technical assistance and public education to ensure understanding of and compliance with non-discrimination and health information privacy laws, including:

- Ensuring that the privacy practices of several million health care providers, plans, and clearinghouses adhere to Federal privacy requirements under the Health Insurance Portability and Accountability Act (HIPAA).
- Ensuring that the more than 245,000 recipients of Federal financial assistance comply with the nation's civil rights laws.
- Enforcing Federal Health Care Provider Conscience Rights.
- Annually resolving more than 10,000 citizen complaints alleging discrimination or a violation of HIPAA.
- Annually certifying more than 2,000 new Medicare applications for compliance with the nation's civil rights laws.

Source: <http://www.hhs.gov/ocr/office/about/mission-vision.html>, retrieved 4/25/14

Patient Protection and Affordable Care Act of 2010 (ACA)

The Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA) or "Obamacare", is a United States federal statute signed into law by President Barack Obama on March 23, 2010. The ACA was enacted with the goals of increasing the quality and affordability of health insurance, lowering the uninsured rate by expanding public and private insurance coverage, and reducing the costs of healthcare for individuals and the government. It introduced a number of mechanisms—including mandates, subsidies, and insurance exchanges—meant to increase coverage and affordability. The law also requires insurance companies to cover all applicants within new minimum standards and offer the same rates regardless of pre-existing conditions or sex.¹ Additional reforms aimed to reduce costs and improve healthcare outcomes by shifting the system towards quality over quantity through increased competition, regulation, and incentives to streamline the delivery of healthcare.

Source: http://en.wikipedia.org/wiki/Patient_Protection_and_Affordable_Care_Act, retrieved 4/25/14

Personal Care Attendant (PCA)

Personal care aides/attendants may work in either private or group homes. In addition to providing assistance with activities of daily living (ADLs), these workers often help with medication management and a variety of instrumental activities of daily living (IADLs) housekeeping chores, meal preparation, and laundry. They also help individuals go to work and remain engaged in their communities. A growing number of these workers are employed and supervised directly by users.

Source: Centers for Medicare & Medicaid Services, 2006.

Person-centered Planning (PCP)

Person-centered planning (PCP) is directed by the individual, with assistance as needed or desired from a representative of the individual's choosing. It is intended to identify the strengths, capacities, preferences, needs, and desired measurable outcomes of the individual. The process also assists the individual in identifying and accessing a personalized mix of paid and non-paid services and supports that assist him/her live in the most inclusive community settings. The process may include other persons freely chosen by the individual, who are able to serve as important contributors to the process. It also must include planning for contingencies such as when a needed service is not provided due to the primary direct service worker being absent from work. The contingency or "back-up" plan must become a part of the individual's person-centered plan. As part of the planning process, an assessment of the risks that a user may encounter should be completed and a discussion about how the risks will be addressed should be held.

Source: See Centers for Medicare & Medicaid Services website
http://www.cms.gov/CommunityServices/60_SelfDirectedServices.asp (8/15/10).

Registry

A registry is a database which stores information, contains basic settings, and functions off an operating system. A registry usually contains information, files, data, or official written documentation of events that have occurred.

Source: Webster Dictionary, 2009.

SAMSHA – Substance Abuse and Mental Health Administration

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

Source: <http://beta.samhsa.gov/about-us>, retrieved 4/25/14

Self-direction (SD)

Self-direction of services allows an individual to have responsibility for managing all aspects of service delivery (i.e. hiring, supervising and discharging their direct service workers and purchasing individual-directed goods and services) included in their person-centered plan and self-directed budget. Self-directed services means that an individual, or their representative, if applicable, has decision-making authority over certain LTSS and take direct responsibility for managing these services with the assistance of a system of available supports. The self-directed service delivery model is an alternative to traditionally delivered and managed services such as an agency-based service delivery model.

Source: See Centers for Medicaid & Medicare Services website 2010 http://www.cms.gov/CommunityServices/60_SelDirectedServices.asp (8/15/10) and §1915(j)(4)(A) of the Social Security Act.

Self-directed budget (also known as individualized budget)

A self-directed budget represents the amount of funds that are under the control and direction of the participant or his/her representative, as appropriate. It is developed using a person-centered planning process and is individually tailored in accordance with the individual's needs and preferences as established in the service plan. States must describe the method for calculating the dollar values of individual budgets based on reliable costs and service utilization, define a process for making adjustments to the budget when changes in participants' person-centered service plans occur and define a procedure to evaluate participants' expenditures.

Source: See Centers for Medicare & Medicaid Services website http://www/cms.gov/CommunityServices/60_SelfDirectedServices.asp (8/15/10).

Shared Accountability (SH) Principle

The Shared Accountability Principle examines the level of responsibility among and between users (older adults and individual with disabilities and chronic conditions and their families), service providers, local government agencies, State program agencies, and the Federal government agencies, and encourages personal planning for LTSS needs, including greater use and awareness of private sources of funding available. There are four Principle Features and four Indicators under the Shared Accountability Principle.

Source: NBIP State Self-assessment Survey Instrument

State Plan Amendments (SPAs)

Medicaid §1915(i) HCBS SPA Option

The §1915(i) HCBS SPA option was established under DEFRA 2005 and revised under the Patient Protection Affordable Care Act of 2010. Under the §1915(i) HCBS SPA option States may:

- Target the HCBS benefit to one or more specific populations
- Establish separate additional needs-based criteria for individual HCBS
- Establish a new Medicaid eligibility group for people who get State plan HCBS
- Define the HCBS included in the benefit, including State- defined and CMS-approved "other services" applicable to the population
- Implement the option to allow any or all HCBS to be self-directed.

Under the §1915(i) HCBS SPA guidelines States can develop the HCBS benefit(s) to meet the specific needs of a population(s) within Federal guidelines, including:

- Establishing a process to ensure that assessments and evaluations are independent and unbiased,
- Ensuring that the benefit is available to all eligible individuals within the State,
- Ensuring that measures will be taken to protect the health and welfare of participants,
- Providing adequate and reasonable provider standards to meet the needs of the target population,
- Ensuring that services are provided in accordance with a plan of care, and
- Establish a quality assurance, monitoring and improvement strategy for the benefit.

Under the §1915(i) HCBS SPA Application & Approval Process the State Medicaid agency must submit a State plan amendment to CMS for review and approval to establish a §1915(i) HCBS benefit. State plan HCBS benefits don't have a time limit on approval except when States choose to target the benefit to a specific population(s). When a State targets the benefit, approval periods are for five years, with the option to renew with CMS approval for additional five-year periods.

Source: <http://www.medicaid.gov>

Medicaid §1915(j) Self-Directed Personal Assistance Services SPA Option

The Medicaid §1915(j) Self-Directed Personal Assistance Services SPA was established under DEFRA 2005. Under the §1915 (j) Self-directed Personal Assistance Service SPA Options States can:

- Target people already getting section 1915(c) waiver services,
- Limit the number of people who will self-direct their PAS, and
- Limit the self-direction option to certain areas of the State, or offer it Statewide.

At the States' option, people enrolled in a Medicaid §1915 (j) Self-directed Personal Assistance Services SPA can:

- Hire legally liable relatives (such as parents or spouses),
- Manage a cash disbursement,
- Purchase goods, supports, services or supplies that increase their independence or substitute for human help (to the extent they'd otherwise have to pay for human help), and
- Use a discretionary amount of their budget to purchase items not otherwise listed in the budget or reserved for permissible purchases.

Source: <http://www.medicaid.gov>

Medicaid §1915(k) Community First Choice SPA Option

The Medicaid §1915(k) *Community First Choice* SPA option was established under the Patient Protection and Affordable Care Act of 2010 and was implemented on October 1, 2011. It allows States to provide home and community-based attendant services to Medicaid enrollees with disabilities under a State Plan Amendment. The primary objective of the attendant services is to assist enrollees with disabilities in accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hands-on assistance, supervision, or cueing. Person-centered planning and backup services must be provided and States' may implement one of three service delivery models: (1) agency-provided model, (2) self-directed model with service budget, and (3) other service delivery model. This type of Medicaid §1915 HCBS SPA provides a six percent increase in Federal matching payments to States for expenditures related to this option.

Source: CMS Medicaid §1915(k) Community First Choice SPA final rule

State Profile Tool (SPT)

A federal grant program designed to:

1. Help States take a critical first step in assessing their individual state long-term support systems with the completion of the “State Profile Tool;” and
2. Provide support to States as they partner with CMS and National Balancing Indicators Project (NBIP) to develop a national set of balancing indicators and enhance their State data systems capacity.

Source: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Real-Choice-Systems-Change-Grant-Program-RCSC/State-Profile-Tool-Grant-Program.html>, retrieved on 4/24/14

Streamlined Access System

A streamlined access system provides users with a "clearly identifiable" location to receive information, and access to a wide variety of community supports. These community supports define how users can obtain and utilize health and wellness services.

According to CMS, “A [streamlined access system] enables individuals to access long-term and supportive services through a single contact. [Streamlined access systems] are characterized by physical and/or virtual single entry points, multiple doors of entry, or no wrong door systems. While current one-stop system approaches may vary in the services they offer, they all provide awareness and information. Essential to the success of the system is to integrate or so closely coordinate access to services through a single point of contact that the long-term support system appears seamless to the individual entrant.”

Source: Centers for Medicare & Medicaid Services. (2005). *Real Choice Systems Change (RCSC) Grants*. Solicitation No. CFDA 93.779. Baltimore, MD: CMS, DHHS).

Technical Expert Panel (TEP)

A technical expert panel (TEP) consists of individual who are considered experts from whom an organization may obtain technical guidance and support within a particular subject, either by correspondence or at meetings to which the experts may be invited.

US DHHS – US Department of Health and Human Services

The Department of Health and Human Services (HHS) is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. HHS is headed by the Secretary who is the chief managing officer for a family of agencies, including 11 operating divisions, 10 regional offices, as well as the Office of the Secretary.

Source: <http://www.hhs.gov/about/>, retrieved 4/25/14

Vision Statement

A Vision Statement is a description of an organization's desired future outcomes. A vision Statement contains precise criterion that guides an organizations future goals.

Source: New Mexico State University, 2009.

Waiver

A Waiver is a vehicle States can use to test new or existing approaches to the delivery and payment of health care and LTSS services in Medicaid and the Children's Health Insurance Program (CHIP).

Medicaid §1915(b)(c) Waiver

States can provide traditional long-term care benefits (like home health, personal care, and institutional services), as well as non-traditional home and community-based "1915(c)-like" services (like homemaker services, adult day health services, and respite care) using a managed care delivery system, rather than fee-for-service. They accomplish this goal by combining a §1915(c) HCBS waiver with a §1915(b) waiver (or any of the Federal authorities outlined in the Managed Care Delivery System section located on the Medicaid website. The managed care delivery system authority is used to either mandate enrollment into a managed care arrangement which provides HCBS services or simply to limit the number or types of providers which deliver HCBS services.

Source: <http://www.medicaid.gov>

Medicaid §1915(c) HCBS Waiver

The Medicaid §1915(c) HCBS waiver is one of many options available to States to provide long term care services in home and community based settings under the Medicaid Program. States can offer a variety of services under this type of Medicaid waiver. Waiver programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e. supports and service coordination), homemaker,

home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose “other” types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.

Source: <http://www.medicaid.gov>

Medicaid §1115 Demonstration Waiver

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The purpose of these demonstrations, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as:

- Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible
- Providing services not typically covered by Medicaid
- Using innovative service delivery systems that improve care, increase efficiency, and reduce costs.

In general, Medicaid §1115 demonstration waivers are approved for a five-year period and can be renewed, typically for an additional three years. Demonstrations must be “budget neutral” to the Federal government, which means that during the course of the project Federal Medicaid expenditures will not be more than Federal spending without the waiver.

Source: <http://www.medicaid.gov>