# Preadmission Screening Redesign Report

## Family and Social Services Administration – Division of Aging

Legislation enacted in the 2015 session (SB 465) amended IC 12-10-12 as follows:

Sec. 35. (a) Before September 1, 2015, the division shall meet with stakeholders, including representatives of:

(1) the area agencies on aging;
(2) hospitals licensed under IC 16-21;
(3) health facilities licensed under IC 16-28; and
(4) other advocacy groups for the elderly.

To collaborate on the implementation of changes in the health facility preadmission screening assessment process for individuals.

(b) Before November 1, 2015, the division shall submit a written report to the general assembly in an electronic format under IC 5-14-6 on any recommendations for statutory changes to the health facility preadmission screening assessment process that were determined in any meetings held under subsection (a).

Sec. 36. This chapter expires June 30, 2016.

# Indiana's PASRR Redesign

## Executive Summary

Indiana's preadmission screening (IPAS) requirements were created more than thirty years ago amid concerns that individuals were being placed in nursing facilities with little consideration for whether or not a nursing facility was the appropriate care setting for a person's needs, or the availability of home and community-based care. Home and community-based care is the first choice for many individuals with long-term care needs. It also aids states in addressing obligations under the Supreme Court's *Olmstead* decision, which found that the unjustified institutionalization of persons with disabilities violates the Americans with Disabilities Act.

The administrative IPAS requirements have largely remained unchanged since its implementation in the 1980s. These are largely paper processes though sometimes done via fax and email. "Wet" signatures are required on some documents. The extremely low denial rate (less than 1% of total screenings) indicates that the screening process is merely serving as confirmation of an assumed need and not effectively identifying alternative options.

The current state statute for IPAS, IC 12-10-12, will sunset in June of 2016. The Division of Aging (DA) believes a new system can be designed without introducing a new statute by relying on existing federal requirements. These requirements include Preadmission Screening Resident Review (PASRR), and that the state ensures individuals receiving Medicaid-paid nursing facility care meet the appropriate level of care needs.

PASRR is a two-stage process designed to identify persons with mental health conditions or intellectual/developmental disabilities who can appropriately be diverted from nursing facilities, and those who would benefit from specialized services while in a nursing facility. Further, PASRR assists with identifying services those individuals need as well as the most appropriate care setting in which to meet those needs. The first stage, a Level I, identifies individuals who have, or are suspected of having, a mental illness (MI) or intellectual/developmental disability (ID/DD), and need further evaluation. The Level II, or second stage, is a more comprehensive evaluation to confirm whether the individual has MI/ID/DD, assess that individual's need for nursing facility services, and determine a person's service needs and the best care setting in which to meet those needs.

While PASRR focuses on preventing inappropriate placement of individuals with MI/ID/DD, individuals of any age with physical disabilities also seek nursing facility placement, many of whom are older adults. Frequently, individuals could safely access home and community-based options if they are aware of all the possible choices, but institutional placement has become a default care setting.

Identification of these individuals is a critical function, and is not being accomplished effectively with the current IPAS system. Robust, targeted options counseling is a key component of the newly designed system and will allow the state to be far more effective in diverting and transitioning this "non-Level II" population from long-term institutionalization.

# Indiana's PASRR Redesign

Even before the legislative session of 2015, the DA had begun to engage stakeholders in conversations about preadmission screening processes. Throughout 2014, the DA held meetings on the IPAS program with representatives of the state's Area Agencies on Aging (AAAs), nursing facilities, the Indiana Hospital Association, consumer advocacy organizations, and other divisions within the Family and Social Services Administration (FSSA). Discussions revealed that issues surrounding IPAS were of concern to all parties. In early 2015, DA staff began working with the PASRR Technical Assistance Center (PTAC) to understand the shortcomings of the IPAS system currently in use and opportunities for improvement.

Since Senate Bill 465 was enacted in May of 2015, the DA has worked with stakeholders (AAAs, nursing facilities, and hospitals) on system redesign options. It was agreed upon as a group that the goal is to provide a person-centered PASRR system that effectively and efficiently identifies the most appropriate services and settings. Together, we made the following assumptions:

- A person-centered system allows the individual's input in the outcome;
- Statewide standardization would promote consistency; and
- The right automation would promote timeliness, efficiency, and consistency.

We also agreed that alternatives must be evaluated on the following criteria: timeliness, efficiency, standardization, validity, accuracy, diversions, costs, access to information, and simplicity. Consensus was reached on a general approach.

During this time, the DA also obtained a previously identified software solution offering web-based technology as well as tested screening tools for the PASRR process. The new software will allow for a far more automated, paperless system with enhanced reporting and monitoring capabilities. Software development and implementation is already underway, and will continue until the system is ready to go live July 1, 2016.

Representatives of the AAAs, nursing facilities, and hospitals will continue to work with the state on the design and implementation of the new system and procedures. The DA will also continue to consult with advocacy groups for older adults such as AARP and the Centers for Independent Living (CILs). These discussions have centered largely on person-centered planning efforts and access to services. The CILs are particularly interested in facilitating transitions or diversions from institutional placements. PTAC will continue to advise and consult to ensure compliance with the federal PASRR requirements.

To successfully support potential diversion and transition to avoid long term institutionalization of the non-Level II population, it will be critical to formalize the options counseling service. The DA will work with the Office of Medicaid Policy and Planning (OMPP) and the AAAs to create a service definition, reimbursement structure, provider requirements and guidelines, practice standards, and a system to trigger targeted options counseling to create effective opportunities for diversion and transition from institutional placements. A new administrative rule will be promulgated to regulate the new PASRR process and the options counseling that is a critical

element to a robust process. Additional funding sources for options counseling reimbursement will also have to be determined.

**Background**

PASRR: PASRR is a requirement under Medicaid, pursuant to OBRA1987 (Omnibus Budget Reconciliation Act) and 42 CFR 483.100 through 483-138. PASRR has been in effect since 1989, and applies to all individuals applying to Medicaid-certified nursing facilities. PASRR screening is required regardless of an individual's payor source. The ability to access Federal Financial Payments (FFP) depends upon completion of the process prior to admission.

As referenced previously, PASRR is a two-stage process. The first stage, a Level I, identifies individuals who have, or are suspected of having, a mental illness (MI) or intellectual/developmental disability (ID/DD), and need further evaluation. The Level I must be designed to ensure that individuals are evaluated for evidence of any possible mental illness (MI) and/or intellectual disabilities and related conditions (ID/DD/RC). The second stage, the Level II, is intended to confirm whether the individual has MI/ID/DD, assess the individual's need for nursing facility services, and determine a person's service needs and the best care setting to meet those needs.

A nursing facility admission is appropriate only when minimum standards are met and any additional services can, and will, be provided for individuals requiring them. The Level I, and the Level II if needed, must be completed prior to admission to a nursing facility. Additional federal regulations require that all nursing facility residents on Medicaid meet the appropriate level of care requirements. These are the requirements upon which the DA believes Indiana can build the new system without additional state legislation.

Legal Considerations: The Americans with Disabilities Act (ADA) Title II (1990) declared that no qualified individual with a disability shall be excluded from participation in or be denied benefits of services, programs, or activities in the most appropriate setting that meets his/her needs. Additionally, the "integration mandate" in the ADA requires that individuals with a disability shall interact with individuals who do not have a disability to the fullest extent possible. A well-designed PASRR system can be a critical element in a state's efforts to meet these requirements.

In 1999, the landmark Supreme Court *Olmstead* decision offered further interpretation of the ADA guidelines. The *Olmstead* ruling requires states to assure that individuals with disabilities receive services in the most integrated setting appropriate to their needs. This has been a top enforcement priority for the Department of Justice as evidenced by recent litigation to enforce *Olmstead* in federal courts in more than twenty states. These cases have involved a broad range of disability groups (including people with mental illness, developmental disabilities, and physical disabilities) and a range of institutional settings (including state-run psychiatric and DD institutions, private and public nursing facilities, private adult homes, and ICF/IIDs). Again, PASRR can be a very effective vehicle for avoiding *Olmstead* issues.

# Indiana's PASRR Redesign

Recent Federal Focus: The Centers for Medicare and Medicaid Services (CMS) increased its focus on PASRR in 2009 with the creation of PTAC, which provides information and technical assistance to states. PTAC has shared that nationally, more than half of people with disabilities are still residing in institutions, and over 500,000 individuals with mental illness still reside in nursing facilities. Also on a national level, nursing facilities serve the same number of persons with intellectual and developmental disabilities as do large developmental centers. As a result, many states are reevaluating their PASRR processes. PTAC advisors have noted that with the sun-setting of the IPAS statute, Indiana has a unique and exciting opportunity to redesign a system that will address all intended goals of PASRR requirements in today's world.

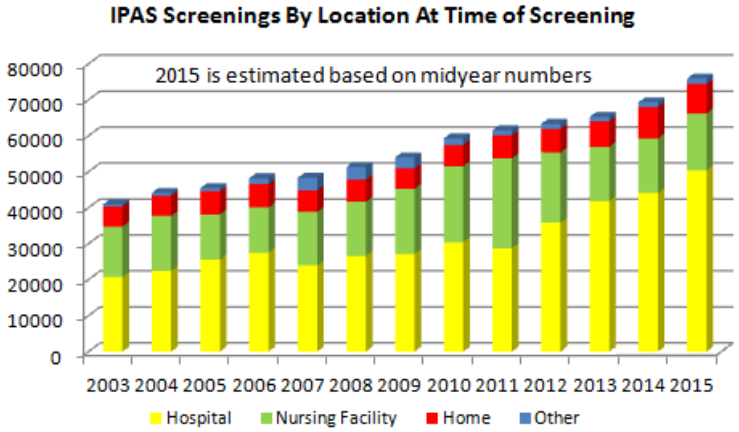
PTAC has identified fourteen elements of an effective Level I assessment tool. In the most recent evaluation of Indiana's current Level I, only five of the fourteen elements were found to be comprehensively covered. Another two elements were found to be partially covered, and seven were completely absent from the current tool (Table 1). Ascend, the developer of the software solution identified by the DA, ensures compliance with federal PASRR sensitivity requirements on its Level I tool.

**Table 1: State PASRR Level I Data Elements – Results for Indiana in 2015 Report**

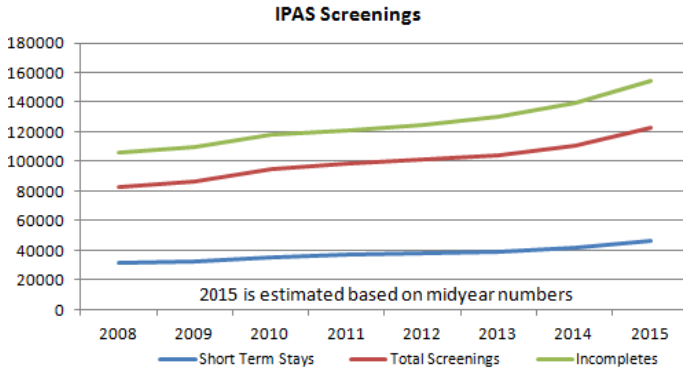
| # | Level I Data Elements | Key Words/Phrases | | Level of Detail |
|---|---|---|---|---|
| | Contains questions to assist in identifying previously unreported disabilities (MI) | | | |
| 1.1 | Mental illness diagnosis | diagnosis; serious mental illness; mental disorder | | Comprehensive |
| 1.2 | Substance related disorder | substance use | | Absent |
| 1.3 | Interpersonal symptoms (MI) | interpersonal; serious difficulty interacting with others; altercations, evictions, unstable employment, frequently isolated, avoids others | | Absent |
| 1.4 | Completing tasks (MI) | serious difficulty completing tasks, required assistance with tasks, errors with tasks; concentration; persistence; pace | | Absent |
| 1.5 | Adapting to change (MI) | self-injurious, self-mutilation, suicidal, physical violence or threats, appetite disturbance, hallucinations, delusions, serious loss of interest, tearfulness, irritability, withdrawal | | Absent |
| | Contains questions to assist in identifying previously unreported disabilities (ID/DD) | | | |
| 2.1 | ID/DD diagnosis | diagnosis; intellectual disability; developmental disability; mental retardation | | Comprehensive |
| 2.2 | ID/DD age of onset | age 18 (age of onset); evidence | | Partial |
| 2.3 | Evidence of related condition | evidence, history, diagnosis; affects intellectual functioning, affects adaptive functioning; autism, epilepsy, blindness, cerebral palsy, closed head injury, deaf | | Comprehensive |
| 2.4 | Related condition age of onset | age of onset; evidence; history; age 22 | | Partial |
| 2.5 | Receipt of services | agency serving individuals with ID/DD; past and present; services; services received; referred/referrals | | Absent |
| | Captures key symptoms or behavioral indicators (ID/DD) | | | |
| 3.1 | Evidence of undiagnosed condition | evidence; presenting evidence; suspected diagnosis; undiagnosed; indications | | Comprehensive |
| 3.2 | Functional limitations | mobility, self-care, self-direction, learning, understanding/use of language, capacity for living independently | | Absent |

| | | | | |
|---|---|---|---|---|
| | When co-morbid dementia and mental illness are present, captures presenting and collateral information to determine which condition is primary | | | |
| 4.1 | Primary dementia diagnosis | Dementia; primary diagnosis | | Comprehensive |
| 4.2 | Documented evidence of primary dementia diagnosis (outside of physician's diagnosis) | Dementia work up; comprehensive mental status exam; primary diagnosis; evidence | | Absent |

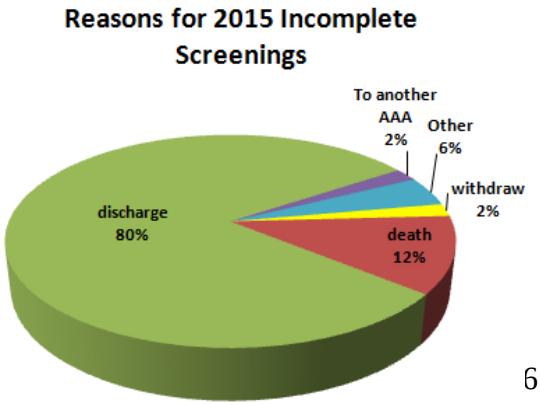
IPAS data over the past ten years shows steady growth in screenings occurring in hospital settings. The healthcare landscape is much different in 2015, than it was over thirty years ago when IPAS was first created.




Today the vast majority of nursing facility admissions are only for short-term rehabilitation stays that are often covered by Medicare or private insurance. IPAS comprehensive requirements for level of care screenings for all participants are out-of-date in that environment. The cumbersome, largely manual IPAS process creates delays and barriers to timely placement from hospital to nursing facility, particularly in these rehabilitation situations.




Indiana's data clearly reflects increasing numbers of short-term admissions. There is also a steady growth in incomplete screenings, which occur when an individual is deceased, has moved, or has discharged from the facility before the IPAS-required level of care screening ever takes place. The growing numbers of incomplete screenings are also evidence of even more potential short-term admissions even if a level of care determination was made immediately.




## The Process

The DA has sought the input of stakeholders in the PASRR system, both internal and external to FSSA, and the technical assistance of PTAC in the PASRR design process. Over the course of the past fifteen months, the DA engaged in multiple conversations with individual

stakeholder groups, regarding issues with the current PASRR process. PTAC conducted a two-day site visit on June 4-5, 2015, and met with all stakeholder groups to present its suggestions regarding the elements of a strong PASRR design. On June 21, 2015, the DA held a problem-solving workshop meeting with representatives of the nursing facilities, hospital association, and the AAAs. During that workshop, the group collectively agreed on a defined problem statement: "To provide a person-centered PASRR system that effectively and efficiently identifies the most appropriate services and settings."

The group then reviewed and refined evaluation criteria for the analysis conducted on the alternative courses of actions that were presented. Representatives of that group presented those criteria to larger stakeholder groups for additional review, comment, and weighting. Results were then used as scoring criteria in the evaluation process (see Appendix A and Appendix B).

The groups were presented with four alternative courses of action developed by the DA (see Appendix C). Previously agreed-upon screening criteria were applied in the selection of alternative courses of action for analysis by the stakeholder groups, which included:

- The system must be automated, and centered on a computerized database and decision support platform that is under development no later than September 1, 2015.
- The system must be person-centered in that it can provide face-to-face contact with client and/or family members.
- There is a deadline: the system must be in place and ready to use no later than July 1, 2016.

The alternative courses of action varied in terms of roles, timelines, when level of care determinations would be required, and costs. All four alternatives shared some common characteristics and features:

- A product developed by Ascend would be the software solution.
- All followed the same process/flow chart.
- All stakeholders: hospitals, nursing facilities, and AAAs will have access to the system. (Level II providers will likely have access as well, but that will be addressed through efforts led by FSSA's Division of Mental Health and Addictions (DMHA) and Division of Disability and Rehabilitative Services (DDRS).
- Nursing facilities will submit requests for continued stay, Medicaid-related notifications, and transfers between facilities through Ascend.
- The Ascend system will connect to the state's Medicaid Management Information System (MMIS) for automated recording of level of care start and stop dates and Medicaid notifications.
- Per PASRR regulations, Level Is and Level IIs when indicated must be completed on all applicants to all Medicaid-certified nursing facilities.

- The Ascend algorithm will allow approximately 70% of the Level I screenings to be completed without additional review. For the other 30%, additional review will be required.
- Level of care (LOC) determinations, at a minimum, must be made on all applicants utilizing Medicaid as their payor. (This is a federal requirement.)
- All LOC information will be subject to desk review, at a minimum.
- Requests for continued stay will be treated as a LOC determination.
- If a case requires independent, onsite verification of LOC, the AAA will complete that assessment along with the provision of options counseling.

All alternatives concentrated exclusively on the Level1 and LOC process. DMHA and DDRS are taking the lead in reviewing the Level II processes. Options counseling was not addressed in the alternatives. Options counseling is critical to effective diversion and transition, particularly in the older population, and the inclusion of appropriate triggers for options counseling was a given with each of the four alternatives.

Each group then evaluated the options independently. Group representatives distributed the options to their membership through whatever method they chose, delivering one response to the DA. This response was required to include a rationale based on the established evaluation criteria. The DA facilitator collated those evaluations and circulated the collected evaluations back to the entire group to contemplate the evaluations and reasoning of their peers (see Appendix D and Appendix E). Responses were kept anonymous at that point. Each representative could again circulate to their membership, compile results once more, and re-submit to the DA. This process of collating and re-evaluating was planned to repeat until a consensus emerged. The DA planned to alter courses of action if such alterations served to move the groups closer to consensus. The schedule allowed for four to six iterations, but only two were required. The second iteration found all respondents recommending the same course of action (see Appendix F and Appendix G).

**The Recommended Course of Action**

The selected course of action, entitled "Alternative Course of Action 4 – Level of Care for Medicaid Only, Review by Ascend," adheres most closely to the federal requirements. In this option, only Medicaid applicants are subject to a level of care determination and Ascend provides all clinical desk reviews of level of care and Level 1 assessments when needed. Course of Action 4 had the least projected expenditures associated with it.

**Options Counseling**

As mentioned previously, options counseling is a critical component in overall efforts to rebalance long-term care spending. According to a recent CMS report, Indiana is 41st in the nation in spending on Medicaid case management services, at only $.75 per resident as compared with the national average of case management cost of $7.84 (Eiken et al, Truven 2015). Options

counseling is a part of those necessary case management services. Indiana must invest in options counseling for those persons with extensive needs in order to provide planning and discussion around selecting appropriate options for long-term care.

The Administration for Community Living (ACL) defines options counseling as "an interactive process where individuals receive guidance in their deliberations to make informed choices about long-term supports (National Standards for Options Counseling, 2012)." ACL has identified four elements of the process: a face-to-face personal interview, a supported decision-making process, development of an action plan, and quality assurance and follow up. This should be a very person-centered process in which the individual's strengths, values, and preferences are identified and respected, and one that includes exploring the individual's own resources, financial and otherwise. The decision process aids in identifying all long-term services and supports options available to the person, who should be given the information in order to make an informed decision. Options counseling certainly may benefit all individuals seeking long-term services and supports at all income levels. However, the reality is that there are limited resources available along with an ever-growing need for long-term care services. Therefore, it is important that options counseling is "targeted for persons with the most immediate concerns, such as those at greatest risk for institutionalization (National Standards for Options Counseling, 2012)."

The DA worked with stakeholders to identify potential trigger points for options counseling in the PASRR process. Representatives of AAAs, nursing facilities, and hospitals were asked to provide a list of potential trigger points that were compiled and reviewed by the DA staff (see Appendix H and Appendix I). Work will continue with stakeholders and advocates to refine these trigger points. The DA agrees with many of the stakeholders that options counseling could benefit every individual entering a nursing facility for a non-rehabilitative stay. However as noted above, given limitations in financial resources as well as a need to create standards of practice for options counseling and consistently train staff that perform this critical function, trigger points will have to be prioritized and implemented in phases.

Data from the current system is incomplete in many ways, making it challenging to budget for options counseling needs with each trigger point. The DA staff will continue to work with stakeholders to access the best possible data. This process will evolve over time and become more refined as better data become available in the new system. The DA will also continue to engage with stakeholders to refine some of the suggested triggers. For instance, it was proposed that admission of any individual under age sixty should prompt options counseling. Age could certainly be a significant factor but refinements to this trigger are needed. If the admission is for a short-term rehabilitation stay not covered by Medicaid, options counseling is perhaps not needed. It was also suggested that anyone requesting options counseling should receive it. Hopefully, there will be adequate funding for this, but the DA would like to work with stakeholders to refine these triggers further to more precisely target options counseling in those cases in which it can be most effective.

The DA will continue to work with the AAAs to finalize required components of options counseling, including qualifications for options counselors, and a reimbursement structure. It is critical that Indiana invest in the service of options counseling in order to achieve the important goals of diversion and transition from institutional settings. The estimated annual costs associated with the selected course of action will represent significant savings over the cost of the current IPAS system. These savings must be repurposed for targeted options counseling. Additionally, resources from other programs (CHOICE, SSBG, and Title III) can provide options counseling, particularly for the non-Medicaid population.

Even with these financial options, additional resources may be necessary. The new software solution for PASRR, as well as new case management software in development by FSSA, will facilitate data collection through which the effectiveness of options counseling can be measured. As the use of the service evidences true savings in institutional care costs, the choice about committing more resources will become clearer.

**System Implementation**

The federal PASRR regulations allow states flexibility in some areas. States can choose to allow an exempted hospital discharge under certain circumstances, dementia exclusions, and other categorical determinations, such as adult protective services emergency admissions and respite admissions. Details surrounding these items will have to be determined and eventually included in an administrative rule based on the federal PASRR regulations.

Software: Ascend will be ready to deploy Indiana's PASRR software solution by July 1, 2016. Testing and training will occur April through June of 2016. As part of the implementation, the DA will be switching to a new evidence-based level of care tool that replaces a homegrown tool that is more than thirty years old. A software solution utilizing the InterRAI screening and assessment tool (InterRAI) will be implemented by Ascend for nursing facility admission determinations. Shortly after July 2016, the DA will implement the use of powerful case management planning tools that are associated with the InterRAI instrument for use in FSSA's new case management software, CaMSS (Case Management for Social Services), for use in home and community-based service programs, including the Aged and Disabled waiver, Traumatic Brain Injury waiver, CHOICE, and Older Americans Act programs. InterRAI will be a nursing facility level of care eligibility tool, but also a broad assessment tool that is part of an overall service planning process.

Training: Training of hospital discharge planners will be a key area of focus in implementation. Discharge planners will have responsibility for entering appropriate and accurate information on the Level I tool and on short-form versions of the InterRAI tool when level of care decisions are required. Their ability to use the system effectively and provide reliable data will help create an efficient and effective process.

Data Management/Quality Assurance: The Ascend system offers another great advantage allowing for interconnectivity with the state's Medicaid Management Information System (MMIS). Currently, transferring information on nursing facility admissions, facility transfers, decisions regarding level of care, requests for continued stays, and Medicaid eligibility from the IPAS process into the MMIS so that nursing facilities can be reimbursed through Medicaid is a very manual, cumbersome, and time-consuming process. A number of DA staff members devote significant hours to this work. With the automation of this process, these individuals can devote more time to robust quality assurance and improvement activities related to the new PASRR system.

The DA will continue to work with stakeholders to identify appropriate performance metrics and outcome measures for the new system. At a very basic level, there will be output measures related to the numbers of Level Is and level of care decisions annually as well as the percentage of positive Level Is, i.e., those indicating the need for a Level II due to the possibility of a mental illness or intellectual/developmental disability. Average times will also be a measure of efficiency: time from data entry to review, from Level II trigger to completion of the Level II, from options counseling trigger to completion of options counseling, etc. In terms of outcomes, FSSA will be able to look at the number and percentage of positive Level IIs that result in institutional or community placement. Data on categorical determinations, dementia exclusions and exempted hospital discharges will also be available. Evaluations can be made if there are organizations or individuals who are consistently making inaccurate decisions, and corrective action taken. With enhanced software solutions, it will become possible to compare Minimum Data Set (MDS) data from nursing facilities to the PASRR data to help ensure program effectiveness and the quality of care provided to individuals.

## Conclusion

The opportunity Indiana has now to redesign its PASRR system is rare. We essentially have a clean slate to work with now that the current state statute will sunset in June of 2016. A new streamlined, efficient, and effective system can be designed to meet all the applicable federal requirements, and incorporate targeted options counseling to affect the greatest possible rate of diversion and transition from institutional care. Stakeholders all agree: the new system must be person-centered, consistent in implementation, and automated to the highest extent possible. The DA is well underway in not only the design, but also the implementation of this new system.

The DA is responsible for the Level I and the level of care determinations as well as the integration of options counseling. The changes for the Level 1 and level of care can be ready for implementation July 1, 2016. New administrative rules will need to be promulgated and that will take some additional time to complete. Legally, the federal requirements provide the framework for the system to function while the rulemaking process is completed. At this time, there is no identified need for additional legislation to support this effort.

Analysis and possible redesign of the Level II process is also underway in the DA's sister divisions, FSSA's Division of Mental Health and Addiction and the Division of Disability and Rehabilitative Services. This effort is a critical element in the state's overall efforts to rebalancing Medicaid long-term care spending more towards home and community-based services.

Stakeholder engagement efforts through system design will continue through implementation and post-implementation as well. The current IPAS system stayed much the same for thirty years. The new system will need to be responsive and adaptable as the environment in which it works changes. The ongoing inclusion of stakeholder groups in system assessment and governance will help make that possible.

**References**

2014 PASRR National Report: A Review of Preadmission Screening and Resident Review (PASRR) Programs. (2014). Truven Health Analytics and Mission Analytics Group, Inc. PASRR Technical Assistance Center (PTAC). Prepared for the Center for Medicare and Medicaid Services (CMS).

42 CFR 483.100. Federal regulation on PASRR.

Eiken, S., Sredl, K., Burwell, B., & Saucier, P. (June 30, 2015). Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013: Home and Community-Based Services were a Majority of LTSS Spending. Mathematica Policy Research, Inc., Centers for Medicare & Medicaid Services, and Truven Health Analytics.

National Center for Health Statistics (2013). Long-Term Care in the United States: 2013 Overview. Retrieved May 8, 2014 from http://www.cdc.gov/nchs/data/nsltcp/long_term_care_services_2013.pdf.

National Options Counseling Standards. (2012). Administration for Community Living.

Olmstead v. L.C., 527 U.S. 581. (1999).

PASRR Level I Screen State Fact Sheet: Indiana. (2015). PASRR Technical Assistance Center (PTAC).

Tetrick III, Frank L. and Stanley, Julie. A Model PASRR Program: The Indiana Journey. (2015). PASRR Technical Assistance Center (PTAC).

**List of Appendixes**

Appendix A – Course of Action Analysis Worksheet
Appendix B – Weighted Criteria with Definitions
Appendix C – PASRR Alternative Courses of Action for Stakeholder Review 070815
Appendix D – All Responses for Iteration #1
Appendix E – Q&A from Iteration #1Appendix F – IAAAA COA Analysis Worksheet for Iteration #2
Appendix G – IHCA COA Analysis Worksheet for Iteration #2
Appendix H – Suggested Options Counseling Triggers from Stakeholder Groups
Appendix I – Summary Comments from Feedback on Suggested Options Counseling Triggers

# Indiana's PASRR Redesign – Appendix A

## Course of Action Analysis Worksheet

| Recommended COA | |
|---|---|

Evaluation Criteria and Relative Weight (Lowest # is most important; highest # is least important; equal #s - same importance)

| | | | | | |
|---|---|---|---|---|---|
| Timeliness (L1) | 3 | Timeliness (LOC) | 5 | Access | 7 |
| Standardization | 4 | Accuracy | 6 | Annual Cost | 9 |
| Validity | 4 | Efficiency (LOC) | 6 | Simplicity | 9 |
| Efficiency (L1) | 5 | Diversion | 7 | | |

* Weights assigned are based on average rankings by stakeholders

COA Analysis

| COA 1: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| COA 2: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| COA 3: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| COA 4: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Instructions: Analyze each COA individually using the evaluation criteria. For example, does COA 1 provide for good "timeliness (LOC)" or not so good "timeliness (LOC)"? If the answer is good "timeliness (LOC)," place "timeliness (LOC) in the advantage column. Do this for all evaluation criteria and all COAs. Once complete you will see if any COA stands out with more advantages and you can begin to compare one COA to another. By listing the criteria weight in the tables, you will be able to better distinguish between COAs in case more than one COA has the same number of advantages. If a criterion is neither an advantage nor disadvantage or can't be assessed, do not list it in the table. Once complete, make your selection and place it in the top right corner. Use the next page to explain the rationale for your selection. Since there are few quantifiable benchmarks, your analysis will be subjective. This makes a persuasive narrative important to the process. Please do not exceed more than one page for your narrative.

# Indiana's PASRR Redesign – Appendix B

Criteria with Definitions and Relative Weight

| Short Title | Definition | Weight |
|---|---|---|
| Timeliness (L1) | The amount of time it takes from application to level 1 decision (less is better) | 3 |
| Standardization | The degree to which processes are standardized statewide (more is better) | 4 |
| Validity | The correctness and reliability of the level 1 and LOC decision (more is better) | 4 |
| Efficiency (L1) | The number of steps need from application to level 1 decision (less is better) | 5 |
| Timeliness (LOC) | The amount of time it takes from application to level of care decision (less is better) | 5 |
| Accuracy | The data in the system is consistently without substantial error (more is better) | 6 |
| Efficiency (LOC) | The number of steps needed from application to level of care decision (less is better) | 6 |
| Diversion | The number of diversions to options other than NF (more is better) | 7 |
| Access | The availability of relevant information available to those needing access that that information (more is better) | 7 |
| Annual Cost | The maximum annual cost of administering the system (less is better) | 9 |
| Simplicity | The amount of time it takes to train new personnel to use the system (less is better) | 9 |

# Indiana's PASRR Redesign – Appendix C

## Overview of Alternative Courses of Action For Indiana's PASRR System Design

The Division of Aging (DA) has sought the input of stakeholders in the Preadmission Screening and Resident Review (PASRR) system, both internal and external to FSSA, and the technical assistance of PASRR Technical Assistance Center (PTAC) in the PASRR design process. Over the course of the past fifteen months, DA had engaged in multiple conversations with stakeholder groups individually regarding issues with the current PASRR process.

PTAC conducted a two day site visit on June 4th and 5th meeting with all stakeholder groups and presenting their suggestions regarding the elements of a strong PASRR design. Then on June 21st, DA held a problem solving workshop meeting with representatives of the nursing facilities, hospital association, and the area agencies on aging (AAAs). During that workshop the group collectively agreed on a defined problem statement, "To provide a person-centered PASRR system that effectively and efficiently identifies the most appropriate services and settings."

Additionally the group reviewed and refined evaluation criteria for the analysis to now be conducting on the alternative courses of action presented here. Those criteria were then taken back to larger groups of stakeholders by those representatives for additional review and comment and weighting. The results of that are included here as scoring criteria.

Each group will now evaluate the options independently. The representatives will distribute to their membership through whatever method they choose delivering one response to DA. This response must include a rationale based on the established evaluation criteria. The facilitator will collate the evaluations. He will then circulate the collected evaluations back to the entire group to contemplate the evaluations and rationalization of their peers. Responses will be anonymous at that point.

Each representative can again circulate to their members and again compile the results and resubmit to DA. The response must include rationale based on the established evaluation criteria. This process of collating and re-evaluating will be repeated until a consensus emerges. DA may alter courses of action if such alternations serve to move the groups closer to consensus.

The following assumptions, agreed to in the June 21st meeting, were made in the design of the alternative courses of action:

- A person-centered system allows the client and/or family members input in the outcome
- Statewide standardization would promote consistency
- The right automation would promote timeliness, efficiency and consistency

Agreed to screening criteria were also applied in the selection of alternative courses of action for analysis by the stakeholder groups. Those screening criteria included:

- The system must be automated. System must be centered on a computerized database and decision support platform that is under development no later than September 1, 2015.
- The system must be person centered in that it can provide face-to-face contact with client and/or family members.

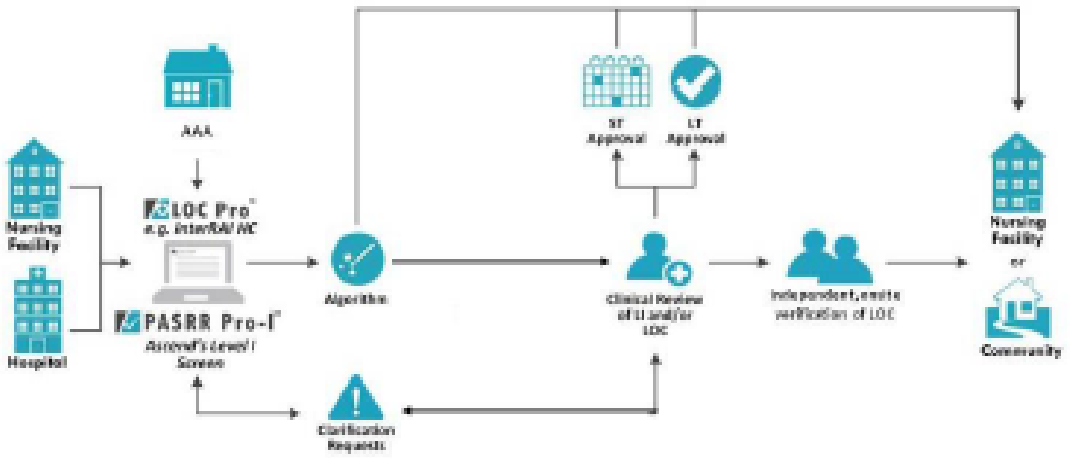
# Overview of Alternative Courses of Action For Indiana's PASRR System Design

- There is a deadline. The system must be in place and ready to use no later than July 1, 2016.

The courses of action presented here are intended to represent an overview of a possible PASRR system design. They will not cover every possible scenario or detail of design or implementation. It should be noted that these potential solutions focus on the PASRR requirements and as such they do not specifically reference options counseling.

However, diversion of all populations to home and community based alternatives is an important shared objective. Throughout these alternatives, when the AAA is designated to complete an assessment, either level I or level of care, there is an assumption that this activity will include options counseling. Note though, that appropriate referrals for options counseling can occur at multiple points in the PASRR process.

Diagram 1 – General Overview of PASRR System (Level I and LOC)




All four alternative courses of action will share some basic features and design characteristics. These are listed here.

- System
  - Ascend will be the software solution.
  - All follow the same process/flow chart (diagram 1 above).
  - All stakeholders: hospitals, nursing facilities, and AAAs will have access to the system. (Level II providers will likely have access as well but that will be addressed through DMHA and DDRS led efforts.)
  - Nursing facilities will submit requests for continued stay, Medicaid related notifications, and transfers between facilities through Ascend.

## Overview of Alternative Courses of Action For Indiana's PASRR System Design

- The Ascend system will connect to the state's Medicaid Management Information System (MMIS) for automated recording of level of care start and stop dates and Medicaid notifications.

- Level I's
  - Per PASRR regulations, Level I's must be completed on all applicants to nursing facilities.
  - The Ascend algorithm will make approximately 70% of the Level I without additional review. Additional quality reviews will be conducted by DA staff on those reviews.
  - The remaining 30% will be subject to a desk review at a minimum.
- Level of care determinations
  - Level of care (LOC) determinations, at a minimum, must be made on all applicants utilizing Medicaid as their payor.
  - All LOC information will be subject to desk review at a minimum.
  - Requests for continued stay will be treated as a LOC determination.
  - If a case requires independent, onsite verification of LOC, the AAA will complete that assessment along with the provision of options counseling.
- Some roles will be the same in certain admission types. Those are outlined below (diagram 2).

Diagram 2 – Roles Special Admissions Common to Each Course of Action for PASRR System (Level I and LOC)

| | Level I Entry | Level I Review | LOC entry | LOC Desk Review | LOC independent, onsite verification |
|---|---|---|---|---|---|
| From Home - Non Emergency | AAA | AAA | AAA | AAA | n/a |
| Out of State | receiving NF | Ascend | receiving NF | Ascend | n/a |
| Emergency Admits | NF | Ascend | NF | Ascend | AAA & APS |
| 30 Day Exemptions | hospital discharge planner | Ascend | Per course of action | Per course of action | Per course of action |
| Respite Admits | NF | Ascend | n/a | n/a | n/a |

Attached there are more specific flow charts and narratives that describe each alternative course of action. The summary that follows is intended a reference tool highlighting the differences in each alternative.

# Indiana's PASRR Redesign – Appendix C

## Overview of Alternative Courses of Action For Indiana's PASRR System Design

Given the same general process flow, the primary variables in each alternative course of action are found in the roles and responsibilities of the stakeholder groups as well as when level of care determinations are needed. These variations are indicated in the summary charts below (diagrams 3a and 3b). Timelines for reviews also vary in each option (diagram 3c).

Diagram 3a – Roles Regular Admissions in Alternative Courses of Action for PASRR System (Level I and LOC)

| | Course of Action 1 | Course of Action 2 | Course of Action 3 | Course of Action 4 |
|---|---|---|---|---|
| **Who does Level I Data Entry?** | AAA on from home/discharge planner otherwise | AAA on from home/discharge planner otherwise | AAA on from home/discharge planner otherwise | AAA on from home/discharge planner otherwise |
| **Who does the Level I Review?** | AAA | Ascend | Ascend | Ascend |
| **Who does LOC Data Entry?** | AAA on from home/discharge planner otherwise | AAA on from home/discharge planner otherwise | AAA on from home/discharge planner otherwise | AAA on from home/discharge planner otherwise |
| **Who does LOC Clinical Review?** | AAA | AAA | Ascend | Ascend |
| **Who reviews the continued stay request?** | DA | DA | Ascend | Ascend |

Diagram 3b – LOC Determinations in Alternative Courses of Action for PASRR System (Level I and LOC)

| | Course of Action 1 | Course of Action 2 | Course of Action 3 | Course of Action 4 |
|---|---|---|---|---|
| **Who requires a LOC determination?** | everyone | everyone but short-term, Medicare admits | everyone but short-term, Medicare admits | only Medicaid admits |

Diagram 3c – Timelines in Alternative Courses of Action for PASRR System (Level I and LOC)

| | Course of Action 1 | Course of Action 2 | Course of Action 3 | Course of Action 4 |
|---|---|---|---|---|
| **Level I Review** | 2 business days (based on previous IAAAA proposal) | 5 business hours; 24/7 coverage | 5 business hours; 24/7 coverage | 5 business hours; 24/7 coverage |
| **LOC Review** | 2 business days (based on previous IAAAA proposal) | 2 business days (based on previous IAAAA proposal) | 4 to 6 business hours; 24/7 coverage | 4 to 6 business hours; 24/7 coverage |

# Indiana's PASRR Redesign – Appendix C

## Overview of Alternative Courses of Action For Indiana's PASRR System Design

The other significant variation in the alternative courses of action is in the total projected annual costs. Those costs (diagram 4 below) are based on several key assumptions drawn from the data currently available from the IPAS process. For the cost calculations the following assumptions were made:

- Approximately 65,000 level I's screenings annually.
- Based on data from recent years,
  - 17% of applicants are already Medicaid recipients, 47% are will apply, and 36% are private pay.
  - 64% of applicants admit to NF from hospital, 23% are in the NF, 15% from home.
- Ascend has supplied the following rates:
  - Per Level I entered - $5.95
  - Per clinical review of Level I and/or LOC - $32.37
- Another entity providing desk review of Level I and/or LOC would have to be competitive with the Ascend rate of $32.37.
- The Level 1 and Level of Care counts for both desk review and onsite verification are very rough estimates. Current data does not provide reliable numbers in terms of Medicaid status. Additionally the desk review element will be new to the process and as such difficult to predict. Ascend has made some rough estimates based on their experience in other states

Diagram 4 – Cost Analysis of Alternative Courses of Action for PASRR System (Level I and LOC)

| | Course of Action 1 | Course of Action 2 | Course of Action 3 | Course of Action 4 |
|---|---|---|---|---|
| **Annual costs for Level I forms (estimated at 65,000 annually)** | $386,750 ($5.95 per screening) | $386,750 ($5.95 per screening) | $386,750 ($5.95 per screening) | $386,750 ($5.95 per screening) |
| **Annual costs for Level I Clinical desk reviews** | n/a (all have LOC reviews anyway) | $493,513 (est. 16,250 @ $32.37) | $493,513 (est. 16,250 @ $32.37) | $493,513 (est. 16,250 @ $32.37) |
| **Annual costs for combined Level I & LOC Clinical desk reviews** | $2,104,050 (est. 65,000 @ $32.37) | $607,100 (est. 18,755 @ $32.37) | $607,100 (est. 18,755 @ $32.37) | $485,550 (est. 15,000 @ $32.37) |
| **Annual costs for independent, onsite LOC verification** | $2,250,000 (est.12,500 @ $180 per) | $1,800,000 (est. 10,000 @ $180 per) | $1,800,000 (est.10,000 @ $180 per) | $900,000 (est. 5,000 @$180) |
| **Annual costs for review of continued stay requests** | $150,000 (2 FTEs) | $150,000 (2 FTEs) | $161,850 (est. 5,000 @ $32.37) | $161,850 (est. 5,000 @ $32.37) |
| **Total Annual Costs for Level I and LOC** | $4,890,800 | $3,437,363 | $3,449,213 | $2,427,663 |

# PASRR Redesign
## Alternative Course of Action 1 – Level of Care on All By AAA

The attached flow charts depict a few common scenarios in nursing facility admissions under this course of action. In course of action 1, referred to as Level of Care on All by AAA for reference, all nursing facility applicants are subject to a level of care determination regardless of payor source and the AAA provides desk review of level of care and Level 1 assessments when needed. These same scenarios are described in narrative below. The same scenarios are offered for all courses of action for purposes of comparison.

| Scenario #1 - Medicaid applicant applies for nursing facility admission from hospital: |
|---|
| The hospital discharge planner completes the face-to-face assessment and enters into Ascend all the required Level 1 and level of care information. If the Level 1 is positive and there is not a 30 day exemption involved, a Level 2 request is sent through the Ascend system to the Level 2 provider.<br><br>If, based on the programmed algorithm, the system is able to determine that level of care is met and the Level 1 is negative, i.e. a Level 2 is not triggered, then the decision is issued immediately. Approval could be for a short term or long term stay based on level of care.<br><br>If additional information is needed, the AAA, as the reviewer, can request additional information from the discharger planner or decide that onsite verification is needed. Additional information requests route through Ascend and are paperless. The AAA would act within two business days.<br><br>In the case of a 30 day exemption or short term level of care, if the approved stay is to be exceeded, the nursing facility would, through the Ascend software, make a request for continued stay. For a 30 day exemption, this would trigger a request for Level 2 as well. The Division of Aging would review the level of care for an extension or long term stay. |

| Scenario #2 – Medicare short term admit applicant applies for nursing facility admission from hospital: |
|---|
| Same as Scenario #1 for this course of action. |

| Scenario #3 – Private pay applicant applies for nursing facility admission from hospital: |
|---|
| Same as Scenario #1 for this course of action. |

| Scenario #4 – Medicaid applicant applies for nursing facility admission from home: |
|---|
| The AAA completes the face-to-face assessment within two business days of referral and enters into Ascend all the required Level 1 and level of care information. If the Level 1 is positive, a Level 2 request is sent through the Ascend system to the Level 2 provider.<br><br>If, based on the programmed algorithm, the system is able to determine that level of care is met and the Level 1 is negative, i.e. a Level 2 is not triggered, then the decision is issued immediately. Approval could be for a short term or long term stay based on level of care.<br><br>In the case of a short term level of care, if the approved stay is to be exceeded, the nursing facility would, through the Ascend software, make a request for continued stay. The Division of Aging would review the level of care for an extension or long term stay. |

| Scenario #5 – Private pay applicant applies for nursing facility admission from home: |
|---|
| Same as Scenario #4 for this course of action. |

# Indiana's PASRR Redesign – Appendix C

## PASRR Redesign
## Alternative Course of Action 1 – Level of Care on All By AAA

# Indiana's PASRR Redesign – Appendix C

## PASRR Redesign

## Alternative Course of Action 2 – No LOC for Medicare with AAA Reviews

The attached flow charts depict a few common scenarios in nursing facility admissions under this course of action. In course of action 2, referred to as No Level of Care for Medicare with AAA Reviews for reference, all nursing facility applicants are subject to a level of care determination except those applying for a short term admit under Medicare and the AAA provides desk review of level of care but Level 1 assessments are reviewed by Ascend when needed. These same scenarios are described in narrative below. The same scenarios are offered for all courses of action for purposes of comparison.

| Scenario #1 - Medicaid applicant applies for nursing facility admission from hospital: |
|---|
| The hospital discharge planner completes the face-to-face assessment and enters into Ascend all the required Level 1 and level of care information. If the Level 1 is positive and there is not a 30 day exemption involved, a Level 2 request is sent through the Ascend system to the Level 2 provider.<br>If, based on the programmed algorithm, the system is able to determine that level of care is met and the Level 1 is negative, i.e. a Level 2 is not triggered, then the decision is issued immediately. Approval could be for a short term or long term stay based on level of care.<br>If additional information is needed, the AAA, as the reviewer of level of care, can request additional information from the discharger planner or decide that onsite verification is needed. Additional information requests route through Ascend and are paperless. The AAA would act within two business days.<br>In the case of a 30 day exemption or short term level of care, if the approved stay is to be exceeded, the nursing facility would, through the Ascend software, make a request for continued stay. For a 30 day exemption, this would trigger a request for Level 2 as well. The Division of Aging would review the level of care for an extension or long term stay. |

| Scenario #2 – Medicare short term admit applicant applies for nursing facility admission from hospital: |
|---|
| The hospital discharge planner completes the face-to-face assessment and enters into Ascend all the required Level 1 information. No level of care determination is required. If the Level 1 is positive and there is not a 30 day exemption involved, a Level 2 request is sent through the Ascend system to the Level 2 provider.<br>If, based on the programmed algorithm, the system is able to determine that the Level 1 is negative, i.e. a Level 2 is not triggered, then the decision is issued immediately.<br>If additional information is needed on the Level 1, Ascend will provide a clinical desk review within 4 to 6 business hours and can ask the discharge planner for more information. Ascend can trigger an onsite verification by the AAA if required. Additional information requests route through Ascend and are paperless. The AAA would be required to provide any onsite verification within two business days. |

| Scenario #3 – Private pay applicant applies for nursing facility admission from hospital: |
|---|
| Same as Scenario #1 for this course of action. |

| Scenario #4 – Medicaid applicant applies for nursing facility admission from home: |
|---|
| The AAA completes the face-to-face assessment within two business days of referral and enters into Ascend all the required Level 1 and level of care information. If the Level 1 is positive, a Level 2 request is sent through the Ascend system to the Level 2 provider.<br>If, based on the programmed algorithm, the system is able to determine that level of care is met and the Level 1 is negative, i.e. a Level 2 is not triggered, then the decision is issued immediately. Approval could be for a short term or long term stay based on level of care.<br>In the case of a short term level of care, if the approved stay is to be exceeded, the nursing facility would, through the Ascend software, make a request for continued stay. The Division of Aging would review the level of care for an extension or long term stay. |

| Scenario #5 – Private pay applicant applies for nursing facility admission from home: |
|---|
| Same as Scenario #4 for this course of action. |

# Indiana's PASRR Redesign – Appendix C

## PASRR Redesign
## Alternative Course of Action 2 – No LOC for Medicare with AAA Reviews

# Indiana's PASRR Redesign – Appendix C

## PASRR Redesign

## Alternative Course of Action 3 – No Level of Care for Medicare with Ascend Review

The attached flow charts depict a few common scenarios in nursing facility admissions under this course of action. In course of action 3, referred to as No Level of Care for Medicare with Ascend Review for reference, all nursing facility applicants are subject to a level of care determination except those applying for a short term admit under Medicare and Ascend provides all desk reviews of level of care and Level 1 assessments when needed. These same scenarios are described in narrative below. The same scenarios are offered for all courses of action for purposes of comparison.

| Scenario #1 - Medicaid applicant applies for nursing facility admission from hospital: |
|---|
| The hospital discharge planner completes the face-to-face assessment and enters into Ascend all the required Level 1 and level of care information. If the Level 1 is positive and there is not a 30 day exemption involved, a Level 2 request is sent through the Ascend system to the Level 2 provider.<br>If, based on the programmed algorithm, the system is able to determine that level of care is met and the Level 1 is negative, i.e. a Level 2 is not triggered, then the decision is issued immediately. Approval could be for a short term or long term stay based on level of care.<br>If additional information is needed, Ascend will provide a clinical desk review within 4 to 6 business hours and can ask the discharge planner for more information. Ascend can trigger an onsite verification by the AAA if required. Additional information requests route through Ascend and are paperless. The AAA would be required to provide any onsite verification within two business days.<br>In the case of a 30 day exemption or short term level of care, if the approved stay is to be exceeded, the nursing facility would, through the Ascend software, make a request for continued stay. For a 30 day exemption, this would trigger a request for Level 2 as well. Ascend would review the level of care for an extension or long term stay. |

| Scenario #2 – Medicare short term admit applicant applies for nursing facility admission from hospital: |
|---|
| The hospital discharge planner completes the face-to-face assessment and enters into Ascend all the required Level 1 information. No level of care determination is required. If the Level 1 is positive and there is not a 30 day exemption involved, a Level 2 request is sent through the Ascend system to the Level 2 provider.<br>If, based on the programmed algorithm, the system is able to determine that the Level 1 is negative, i.e. a Level 2 is not triggered, then the decision is issued immediately.<br>If additional information is needed on the Level 1, Ascend will provide a clinical desk review within 4 to 6 business hours and can ask the discharge planner for more information. Ascend can trigger an onsite verification by the AAA if required. Additional information requests route through Ascend and are paperless. The AAA would be required to provide any onsite verification within two business days. |

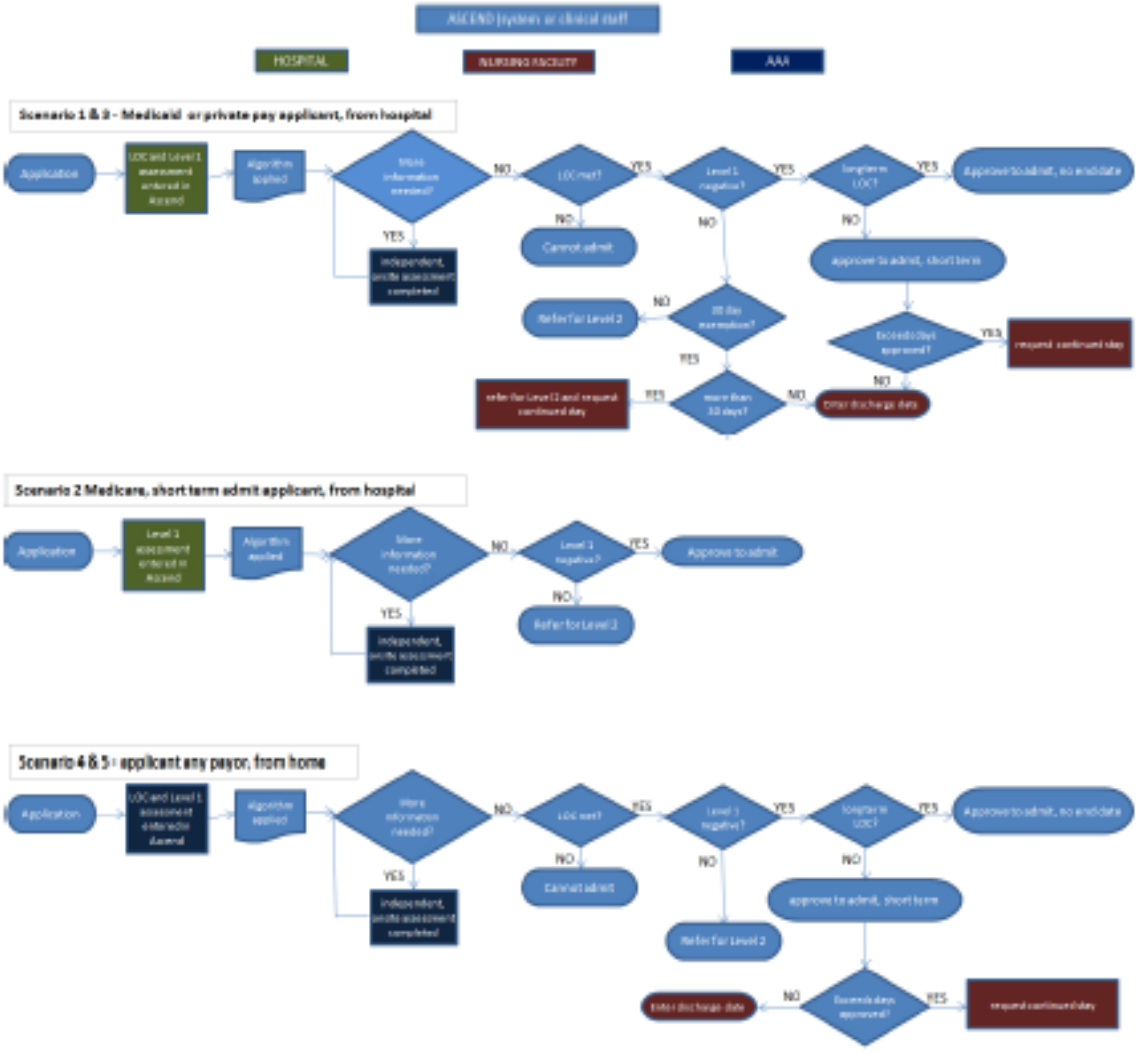
| Scenario #3 – Private pay applicant applies for nursing facility admission from hospital: |
|---|
| Same as Scenario #1 for this course of action. |

| Scenario #4 – Medicaid applicant applies for nursing facility admission from home: |
|---|
| The AAA completes the face-to-face assessment within two business days of referral and enters into Ascend all the required Level 1 and level of care information. If the Level 1 is positive, a Level 2 request is sent through the Ascend system to the Level 2 provider.<br>If, based on the programmed algorithm, the system is able to determine that level of care is met and the Level 1 is negative, i.e. a Level 2 is not triggered, then the decision is issued immediately. Approval could be for a short term or long term stay based on level of care.<br>In the case of a short term level of care, if the approved stay is to be exceeded, the nursing facility would, through the Ascend software, make a request for continued stay. Ascend would review the level of care for an extension or long term stay. |

| Scenario #5 – Private pay applicant applies for nursing facility admission from home: |
|---|
| Same as Scenario #4 for this course of action. |

# Indiana's PASRR Redesign – Appendix C

## PASRR Redesign
## Alternative Course of Action 3 – No Level of Care for Medicare with Ascend Review



# Indiana's PASRR Redesign – Appendix C

## PASRR Redesign

### Alternative Course of Action 4 – Level of Care for Medicaid Only, Review By Ascend

The attached flow charts depict a few common scenarios in nursing facility admissions under this course of action. In course of action 4, referred to as Level of Care for Medicaid Only, Review by Ascend for reference, only Medicaid applicants are subject to a level of care determination and Ascend provides all desk reviews of level of care and Level 1 assessments when needed. These same scenarios are described in narrative below. The same scenarios are offered for all courses of action for purposes of comparison.

| Scenario #1 - Medicaid applicant applies for nursing facility admission from hospital: |
|---|
| The hospital discharge planner completes the face-to-face assessment and enters into Ascend all the required Level 1 and level of care information. If the Level 1 is positive and there is not a 30 day exemption involved, a Level 2 request is sent through the Ascend system to the Level 2 provider.<br>If, based on the programmed algorithm, the system is able to determine that level of care is met and the Level 1 is negative, i.e. a Level 2 is not triggered, then the decision is issued immediately. Approval could be for a short term or long term stay based on level of care.<br>If additional information is needed, Ascend will provide a clinical desk review within 4 to 6 business hours and can ask the discharge planner for more information. Ascend can trigger an onsite verification by the AAA if required. Additional information requests route through Ascend and are paperless. The AAA would be required to provide any onsite verification within two business days.<br>In the case of a 30 day exemption or short term level of care, if the approved stay is to be exceeded, the nursing facility would, through the Ascend software, make a request for continued stay. For a 30 day exemption, this would trigger a request for Level 2 as well. Ascend would review the level of care for an extension or long term stay. |

| Scenario #2 – Medicare short term admit applicant applies for nursing facility admission from hospital: |
|---|
| The hospital discharge planner completes the face-to-face assessment and enters into Ascend all the required Level 1 information. No level of care determination is required. If the Level 1 is positive and there is not a 30 day exemption involved, a Level 2 request is sent through the Ascend system to the Level 2 provider.<br>If, based on the programmed algorithm, the system is able to determine that the Level 1 is negative, i.e. a Level 2 is not triggered, then the decision is issued immediately.<br>If additional information is needed on the Level 1, Ascend will provide a clinical desk review within 4 to 6 business hours and can ask the discharge planner for more information. Ascend can trigger an onsite verification by the AAA if required. Additional information requests route through Ascend and are paperless. The AAA would be required to provide any onsite verification within two business days. |

| Scenario #3 – Private pay applicant applies for nursing facility admission from hospital: |
|---|
| Same as scenario #2 for this course of action. |

| Scenario #4 – Medicaid applicant applies for nursing facility admission from home: |
|---|
| The AAA completes the face-to-face assessment within two business days of referral and enters into Ascend all the required Level 1 and level of care information. If the Level 1 is positive, a Level 2 request is sent through the Ascend system to the Level 2 provider.<br>If, based on the programmed algorithm, the system is able to determine that level of care is met and the Level 1 is negative, i.e. a Level 2 is not triggered, then the decision is issued immediately. Approval could be for a short term or long term stay based on level of care.<br>In the case of a short term level of care, if the approved stay is to be exceeded, the nursing facility would, through the Ascend software, make a request for continued stay. Ascend would review the level of care for an extension or long term stay. |

| Scenario #5 – Private pay applicant applies for nursing facility admission from home: |
|---|
| The AAA completes the face-to-face assessment within two business days and enters into Ascend all the required Level 1 information. If the Level 1 is positive, a Level 2 request is sent through the Ascend system to the Level 2 provider.<br>If, based on the programmed algorithm, the system is able to determine that the Level 1 is negative, i.e. a Level 2 is not triggered, then the decision is issued immediately.<br>Otherwise Ascend will complete the review within 4 to 6 business hours and request additional information if needed. |

# Indiana's PASRR Redesign – Appendix C

# Indiana's PASRR Redesign – Appendix D

## Course of Action Analysis Worksheet

| Recommended COA | **COA 3** |
|---|---|

Evaluation Criteria and Relative Weight (Lowest # is most important; highest # is least important; equal #s - same importance)

| | | | | | |
|---|---|---|---|---|---|
| Timeliness (L1) | 3 | Timeliness (LOC) | 5 | Access | 7 |
| Standardization | 4 | Accuracy | 6 | Annual Cost | 9 |
| Validity | 4 | Efficiency (LOC) | 6 | Simplicity | 9 |
| Efficiency (L1) | 5 | Diversion | 7 | | |

* Weights assigned are based on average rankings by stakeholders

COA Analysis

| COA 1: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| Simplicity | 9 | Annual Cost | 9 |
| Diversion | 7 | Timeliness L1 | 3 |
| | | Timelines LOC | 5 |
| | | Access | 7 |
| | | Accuracy | 6 |
| | | Efficiency L1 | 5 |
| | | Efficiency LOC | 6 |
| | | Validity | 4 |
| | | Standardize | 4 |
| | | | |
| | | | |

| COA 2: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| Standardize | 4 | Efficiency | 6 |
| Diversion | 7 | Timeliness loc | 5 |
| Timeliness L1 | 5 | Accuracy | 6 |
| Annual cost | 9 | Validity | 4 |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| COA 3: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| Timeliness L1 | 3 | Annual Cost | 9 |
| Timelines loc | 5 | Diversion | 7 |
| Efficiency L1 | 5 | Simplicity | 9 |
| Efficiency loc | 6 | | |
| Standardize | 4 | | |
| Accuracy | 6 | | |
| Validity | 4 | | |
| | | | |
| | | | |
| | | | |
| | | | |

| COA 4: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| Annual Cost | 9 | Diversion | 7 |
| Timeliness L1 | 3 | Simplicity | 9 |
| Timelines loc | 5 | | |
| Standardize | 4 | | |
| Accuracy | 6 | | |
| Efficiency L1 | 5 | | |
| Efficiency loc | 6 | | |
| Validity | 4 | | |
| | | | |
| | | | |
| | | | |

Instructions: Analyze each COA individually using the evaluation criteria. For example, does COA 1 provide for good "timeliness (LOC)" or not so good "timeliness (LOC)"? If the answer is good "timeliness (LOC)," place "timeliness (LOC) in the advantage column. Do this for all evaluation criteria and all COAs. Once complete you will see if any COA stands out with more advantages and you can begin to compare one COA to another. By listing the criteria weight in the tables, you will be able to better distinguish between COAs in case more than one COA has the same number of advantages. If a criterion is neither an advantage nor disadvantage or can't be assessed, do not list it in the table. Once complete, make your selection and place it in the top right corner. Use the next page to explain the rationale for your selection. Since there are few quantifiable benchmarks, your analysis will be subjective. This makes a persuasive narrative important to the process. Please do not exceed more than one page for your narrative.

# Indiana's PASRR Redesign – Appendix D

Course of Action Analysis Worksheet

**Rationale:** Our recommendation following completion of the COA Analysis is to adopt COA 3 for PASRR in Indiana. This is based on our understanding of the current system, and takes into consideration the relative weights of the evaluation criteria. Our analysis indicates that COA 3, while more costly than COA 4, does offer the targeted interaction with residents, by utilizing the LOC for long-term residents, not entering NF via the ST Medicare system. The use of Ascend as the 'gatekeeper' to the decision making process for LOC is more timely and efficient as well as improves the standardization of the process across the state. (This is our assumption, having only been advised that, "Ascend will be the software solution".) While the COA 3 disadvantages are 3 of the 4 least important of the criteria, the advantages under this COA, include 7 of 7, out of those criteria ranked most important. This COA provides for the client and/or family to have the most input in the outcome of their interaction with the PASRR system.

COA 4 limits LOC decisions at the time of admission, or shortly into a Medicare stay for all Medicare and private pay residents. Only those requiring Medicaid as a payer source would be required to have a LOC determination made initially. This is not recommended, as often the initial payment source changes quickly, (when Medicare criteria is no longer in place), and having a decision regarding length of stay as well as LOC becomes crucial, earlier in the process. If Diversion, and LOC / options counselling are applied consistently through the continuum of the resident's interaction with the PASRR system, then COA 3 which requires all patients other than ST Medicare residents to have LOC determinations made at admission to the NF, will allow for more interaction with the client and focus on person centered care at the time of discharge from hospital or home into the long term care system. Access to community support systems at time of discharge from the NF should also be improved for clients who already know they are under a limited (short-term) approval. Since requests for continued stay will be treated as a LOC determination, the number of potential requests when only Medicaid clients receive a LOC review at admit (COA 4), would be greatly magnified and burdensome.

Our analysis can only assume that the statewide decision support platform provided by the computerized database (Ascend) will improve the accuracy and lessen the subjectivity of the LOC / Level 1 decisions. It must be emphasized that the input of the data by the hospital discharge planer, will be crucial to the success rate. The information provided to us ranks the Ascend algorithm able to complete 70% of the Level 1 review without additional desk review, or AAA / DA review. We are also aware that ongoing quality reviews of Ascend usage and client outcomes will be conducted by the DA. COA 3 will allow for communication to the discharge planner, and allow the involvement of the AAA when an onsite review is triggered by the Ascend algorithm.

While we are aware the focus of this analysis does not focus on the Level 2 requirements, the system (Ascend or AAA) notifying the appropriate mental health contractor, of the need for the Level 2 appears to be streamlined, thru the Ascend data collection, no matter who inputs the correct data (AAA, NF or Discharge Planner).

We are still struggling with the "once a Level 2, always a Level 2" instruction from the AAA. Will all clients with Level 2 determinations be available to Ascend, so that this will automatically trigger? We had a case today, for example, where the HDC planner sent the Level 1 filled out incorrectly, not triggering a level 2. Only because our admission clerk recalled that the resident in her prior stay (3 years ago), had been a Level 2, were we able to avoid a missed Level 2 review. Had the discharge planner been entering the data she collected into Ascend, the Level 2 would NOT have been triggered.

# Indiana's PASRR Redesign – Appendix D

## Course of Action Analysis Worksheet

| Recommended COA | See conclusion next page |
|---|---|

Evaluation Criteria and Relative Weight (Lowest # is most important; highest # is least important; equal #s - same importance)

| | | | | | |
|---|---|---|---|---|---|
| Timeliness (L1) | 3 | Timeliness (LOC) | 5 | Access | 7 |
| Standardization | 4 | Accuracy | 6 | Annual Cost | 9 |
| Validity | 4 | Efficiency (LOC) | 6 | Simplicity | 9 |
| Efficiency (L1) | 5 | Diversion | 7 | | |

* Weights assigned are based on average rankings by stakeholders

COA Analysis

| COA 1: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| Access | 7 | | |
| Standardization | 4 | | |
| Efficiency (L1) | 5 | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| COA 2: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| Access | 7 | | |
| Standardization | 4 | | |
| Efficiency (L1) | 5 | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| COA 3: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| Access | 7 | | |
| Standardization | 4 | | |
| Efficiency (L1) | 5 | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| COA 4: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| Access | 7 | | |
| Standardization | 4 | | |
| Efficiency (L1) | 5 | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Instructions: Analyze each COA individually using the evaluation criteria. For example, does COA 1 provide for good "timeliness (LOC)" or not so good "timeliness (LOC)"? If the answer is good "timeliness (LOC)," place "timeliness (LOC) in the advantage column. Do this for all evaluation criteria and all COAs. Once complete you will see if any COA stands out with more advantages and you can begin to compare one COA to another. By listing the criteria weight in the tables, you will be able to better distinguish between COAs in case more than one COA has the same number of advantages. If a criterion is neither an advantage nor disadvantage or can't be assessed, do not list it in the table. Once complete, make your selection and place it in the top right corner. Use the next page to explain the rationale for your selection. Since there are few quantifiable benchmarks, your analysis will be subjective. This makes a persuasive narrative important to the process. Please do not exceed more than one page for your narrative.

# Indiana's PASRR Redesign – Appendix D

## Course of Action Analysis Worksheet

The [redacted] group is hesitant to prioritize a COA in this iteration for the following reasons. However, we do provide a conclusion below.

Overall, the [redacted] were very disappointed that none of the Courses of Action (COAs) reflected explicit triggering for community diversion and Options Counseling. Given the PTAC presentation of June 4, 2015, emphasized PASSR as a tool for diversion and person-centered planning, we believe this should have been explicitly reflected in one or more of the COAs. The proposed COAs negate the advocacy and progress the AAA system has made over the past several years in moving Options Counseling into the hospital setting to better integrate care and facilitate care transitions. The redesign of the PASSR is an opportunity to further strengthen this care integration and the state's overall rebalancing efforts; however, with the proposed COAs, this opportunity is seemingly lost.

The [redacted] group developed a list of questions related the following criteria regarding the proposed COAs, however the Division of Aging simply urged us to follow the instructions in order to preserve the integrity of the process. This limited the group's ability to conduct a thorough analysis of the COAs. The following points regarding the evaluation criteria reflect some of those questions/concerns.

**Timeliness (L1) and Timeliness (LOC)** - References regarding timeframes formerly proposed by IAAAA should not be used as the former proposal assumed hospital-based AAA Options Counseling and the ability to negotiate appropriate reimbursement rates to assure staffing to meet those timeframes. Those conditions are not met in the current COAs.

**Validity** - It is unclear as to what aspects of the proposed COAs are considered to be person-centered. It is unclear as to exactly what triggers a request for more information / need for an on-site verification. It is unclear as to where in the process someone is determined to be Medicaid, Medicare or private pay since that was relevant to the scenarios. It is unclear as to where Medicaid will-apply's will be accounted; are they simply lumped into the Medicaid total? In Scenario 1, it is unclear as to why private pay is treated like Medicaid when it used to be treated like Medicare. It is unclear as to the appeal process for consumers regarding Level I and LOC determinations. Finally, it is unclear how the validity of the assessment will be evaluated, particularly as it relates to the independence of the assessment. i.e., that the judgements made during the face-to-face interview with the consumer and data entered by the discharge planner or nursing facility are not influenced by the financial interests of the hospitals and nursing facilities related to fast discharge/ease of facility admission and/or considerations related to ACO status of health system and facilities.

**Accuracy** - Outside of desk review, it is unclear as to how the accuracy of the assessment will be evaluated. i.e., that the judgement and professional discretion used during the face-to-face interview with the consumer and data entered by the discharge planner/AAA is accurate as to patient history, patient capabilities, basic data entry, etc.

**Efficiency (LOC)** – it is unclear as to how to evaluate this as there are two differentiating factors in each COA rather than one: what consumers qualify for a LOC assessment and who actually completes the LOC assessment.

**Diversion** – In addition to lack of explicit triggers for Options Counseling and diversion, it is unclear as to the whether any QA process will be implemented to determine whether approved nursing facility admissions could have actually been diverted to the community.

**Annual Cost** –It is unclear as to whether there is some additional cost related to the use of Ascend not indicated in the analysis. i.e., is it Ascend that will be reimbursed $5.95 for each Level I entered, (i.e., the $5.95) or is there some other cost? It is unclear how the current proposed reimbursement rates will cover the actual costs of holding a person-centered, in-depth, face-to-face assessment/discussion with the consumer and follow-up documentation. It is unclear how the rates themselves have been established other than price quotes from Ascend. We believe a more thorough rate setting process is called for. Finally, we believe annual costs should also include an estimate of cost savings related to diversion.

**Simplicity** – We cannot rate simplicity of the system without having had a software demonstration.

Finally, in thinking about the results of the evaluation criteria weights, we find that because all three nursing facility associations were given equal weight in the calculations rather than averaged together to create a composite score, the weights are largely influenced by facilities as compared to the interests of hospitals and community. We would respectfully request that reconsideration of that calculation be made to assure that facilities, hospitals and community are represented equally.

**Conclusion** – If forced to choose among the four COA's, we choose COA 1 as we believe this provides the best chance for diversion, referrals to Options Counseling and validity/independence among the four. However, as stated above, we need more information to provide a thorough analysis and ranking of each criterion.

# Indiana's PASRR Redesign – Appendix D

## Course of Action Analysis Worksheet

| Recommended COA | 4 |
|---|---|

Evaluation Criteria and Relative Weight (Lowest # is most important; highest # is least important; equal #s - same importance)

| | | | | | |
|---|---|---|---|---|---|
| Timeliness (L1) | 3 | Timeliness (LOC) | 5 | Access | 7 |
| Standardization | 4 | Accuracy | 6 | Annual Cost | 9 |
| Validity | 4 | Efficiency (LOC) | 6 | Simplicity | 9 |
| Efficiency (L1) | 5 | Diversion | 7 | | |

* Weights assigned are based on average rankings by stakeholders

COA Analysis

| COA 1: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| Access | 7 | Annual Cost | 9 |
| | | Standardization | 4 |
| | | Timeliness (L1) | 3 |
| | | Timeliness (LOC) | 5 |
| | | Validity | 4 |
| | | Efficiency (LOC) | 6 |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| COA 2: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| Standardization | 4 | Annual Cost | 9 |
| Accuracy | 6 | Timeliness (L1) | 3 |
| Access | 7 | Timeliness (LOC) | 5 |
| | | Validity | 4 |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| COA 3: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| Standardization | 4 | Annual Cost | 9 |
| Timeliness (L1) | 3 | | |
| Accuracy | 6 | | |
| Timeliness (LOC) | 5 | | |
| Validity | 4 | | |
| Access | 7 | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| COA 4: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| Annual Cost | 9 | Access | 7 |
| Standardization | 4 | | |
| Timeliness (L1) | 3 | | |
| Accuracy | 6 | | |
| Timeliness (LOC) | 5 | | |
| Validity | 4 | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Instructions: Analyze each COA individually using the evaluation criteria. For example, does COA 1 provide for good "timeliness (LOC)" or not so good "timeliness (LOC)"? If the answer is good "timeliness (LOC)," place "timeliness (LOC) in the advantage column. Do this for all evaluation criteria and all COAs. Once complete you will see if any COA stands out with more advantages and you can begin to compare one COA to another. By listing the criteria weight in the tables, you will be able to better distinguish between COAs in case more than one COA has the same number of advantages. If a criterion is neither an advantage nor disadvantage or can't be assessed, do not list it in the table. Once complete, make your selection and place it in the top right corner. Use the next page to explain the rationale for your selection. Since there are few quantifiable benchmarks, your analysis will be subjective. This makes a persuasive narrative important to the process. Please do not exceed more than one page for your narrative.

# Indiana's PASRR Redesign – Appendix D

Course of Action Analysis Worksheet

Rationale:

We believe COA 3 or 4, based on the available information and our present understanding, are best to pursue. We indicated that COA 4 is recommended on page 1, but would like to explore the issue of the options counseling process between COA 3 and 4. COA 3 permits more LOC interactions, which ostensibly would allow more options counseling opportunities. However, a full LOC is not required on anyone other than Medicaid residents. The cost consideration for COA 4 pushes COA 4 over the line with the expectation that options counseling will be figured out and targeted efficiently to those that would most benefit.

In the analysis of each COA, it was difficult to place the diversion criteria as it was not clear whether the diversion was focused on the Level 1/Level 2 or on the LOC/options counseling. If diversion is focused on the Level 1/Level 2, then it seems from the COA scenarios that diversion would be relatively even across each COA. If diversion focus should have been place on LOC/options counseling, it does seem that more needs to be explored with respect to how the process is patient centered and focus on the options counseling opportunities. COA 3 requires all patients other than ST Medicare to be examined, which may provide for an additional interaction (perhaps, and dependent on questions below). In addition, it would appear that COA 3 and 4 will be more efficient in communicating with the discharge planner for additional information requests for LOC and still involve the AAA when onsite verification is necessary.

Additional questions/comments:

- We are not being familiar with Ascend and we would assume it is user friendly and would be set up with "logic" to ensure accurate decision was made. In addition, we assume thorough training would be available to all that must use the system and understand what data is necessary to ensure the most appropriate outcome is obtained. More information on Ascend is requested.
- We understand if Level 2 not triggered, the decision issued immediately. However, what occurs if a Level 2 is required? What is the DMHA and DDRS process and when will they be brought into this? Many of the issues we face are with obtaining Level 2 in a timely manner.
- Currently the AAA's are going by the process "once a Level 2, always a Level 2". If a resident comes to an NF and previously was a Level 2, but that didn't make it into the system, how will that impact the resident and NF at the time it is discovered? Will all current clients with Level 2 determinations be entered into Ascend for future Level 1 determinations?
- Does a potential NF admission have the ability to decline the process? If so, what happens?

# Indiana's PASRR Redesign – Appendix D

[redacted]

| Recommended COA | 4 |
|---|---|

Evaluation Criteria and Relative Weight (Lowest # is most important; highest # is least important; equal #s - same importance)

| | | | | | |
|---|---|---|---|---|---|
| Timeliness (L1) | 3 | Timeliness (LOC) | 5 | Access | 7 |
| Standardization | 4 | Accuracy | 6 | Annual Cost | 9 |
| Validity | 4 | Efficiency (LOC) | 6 | Simplicity | 9 |
| Efficiency (L1) | 5 | Diversion | 7 | | |

* Weights assigned are based on average rankings by stakeholders

COA Analysis

| COA 1: | | | |
|---|---|---|---|
| **Advantages** | **wt** | **Disadvantages** | **wt** |
| | | Timeliness (L1) | 3 |
| | | Timeliness (LOC) | 5 |
| | | Standardization | 4 |
| | | Annual Cost | 9 |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| COA 2: | | | |
|---|---|---|---|
| **Advantages** | **wt** | **Disadvantages** | **wt** |
| Timeliness (L1) | 3 | Timeliness (LOC) | 5 |
| Efficiency (L1) | 5 | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| COA 3: | | | |
|---|---|---|---|
| **Advantages** | **wt** | **Disadvantages** | **wt** |
| Timeliness (L1) | 3 | | |
| Timeliness (LOC) | 5 | | |
| Standardization | 4 | | |
| Efficiency (L1) | 5 | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| COA 4: | | | |
|---|---|---|---|
| **Advantages** | **wt** | **Disadvantages** | **wt** |
| Timeliness (L1) | 3 | | |
| Timeliness (LOC) | 5 | | |
| Efficiency (LOC) | 6 | | |
| Annual Cost | 9 | | |
| Standardization | 4 | | |
| Efficiency (L1) | 5 | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Instructions: Analyze each COA individually using the evaluation criteria. For example, does COA 1 provide for good "timeliness (LOC)" or not so good "timeliness (LOC)"? If the answer is good "timeliness (LOC)," place "timeliness (LOC) in the advantage column. Do this for all evaluation criteria and all COAs. Once complete you will see if any COA stands out with more advantages and you can begin to compare one COA to another. By listing the criteria weight in the tables, you will be able to better distinguish between COAs in case more than one COA has the same number of advantages. *If a criterion is neither an advantage nor disadvantage or can't be assessed, do not list it in the table.* Once complete, make your selection and place it in the top right corner. Use the next page to explain the rationale for your selection. Since there are few quantifiable benchmarks, your analysis will be subjective. This makes a persuasive narrative important to the process. Please do not exceed more than one page for your narrative.

[redacted]

Rationale:

Course of Action 4 promotes a more timely, efficient and standardized system that would be beneficial to patients and hospital staff. Eliminating files and paperwork will streamline reviews for discharge planners, and may even save them time if the system is truly easy to navigate.

The timely reviews provided by the algorithm in the Ascend software should translate to less unnecessary wait time for patients, and would allow a more timely and efficient process for hospitals and nursing facilities to manage the patients' needs and placement.

Streamlining the work through at vendor should promote greater standardization and reduce variation across the state. This will be especially helpful for statewide hospital systems and nursing facility systems that have multiple facilities in various AAA regions. Standardization would also lend to simplicity in training as the training would be the same across the state with no need to tailor the trainings around each unique AAA process.

With the increased involvement of discharge planners, we would like understand what LOC data entry and screening would entail and if it would be a large increase in their work load.

Feedback received from stakeholders:

Discussing the software algorithm - "Any of the scenarios that issue an immediate decision (on reviews) would be effective"

"It seems this would eliminate the need for files and files of paperwork. I am all about streamlining processes. And if the system is truly as easy-to-use as indicated, I think this may even save us some time."

"Without knowing the criteria for the LOC screening and data entry, I don't have a good idea how much it would impact our work load, but if we are required to do additional screening on everyone before they leave the hospital I imagine it would create more work."

# Indiana's PASRR Redesign – Appendix D

## Course of Action Analysis Worksheet

| Recommended COA | 4 |
|---|---|

Evaluation Criteria and Relative Weight (Lowest # is most important; highest # is least important; equal #s - same importance)

| | | | | | |
|---|---|---|---|---|---|
| Timeliness (L1) | 3 | Timeliness (LOC) | 5 | Access | 7 |
| Standardization | 4 | Accuracy | 6 | Annual Cost | 9 |
| Validity | 4 | Efficiency (LOC) | 6 | Simplicity | 9 |
| Efficiency (L1) | 5 | Diversion | 7 | | |

* Weights assigned are based on average rankings by stakeholders

COA Analysis

| COA 1: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| Diversion | | Annual Cost | |
| | | Standardization | |
| | | Efficiency LOC | |
| | | Timeliness LOC | |
| | | Validity | |
| | | Accuracy | |
| | | Simplicity | |
| | | Efficiency L1 | |
| | | Timeliness L1 | |
| | | | |
| Access | | Access | |

| COA 2: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| Diversion | | Annual Cost | |
| Timeliness L1 | | Standardization | |
| Efficiency L1 | | Efficiency LOC | |
| | | Timeliness LOC | |
| | | Validity | |
| | | Accuracy | |
| | | Simplicity | |
| | | | |
| | | | |
| Access | | Access | |
| | | | |

| COA 3: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| Standardization | | Diversion | |
| Timeliness L1 | | | |
| Timeliness LOC | | | |
| Efficiency L1 | | | |
| Efficiency LOC | | | |
| Simplicity | | | |
| Annual Cost | | | |
| | | | |
| Validity | | Validity | |
| Access | | Access | |
| Accuracy | | Accuracy | |

| COA 4: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| Standardization | | Diversion | |
| Timeliness L1 | | | |
| Timeliness LOC | | | |
| Efficiency L1 | | | |
| Efficiency LOC | | | |
| Simplicity | | | |
| Annual Cost | | | |
| | | | |
| Validity | | Validity | |
| Access | | Access | |
| Accuracy | | Accuracy | |

Instructions: Analyze each COA individually using the evaluation criteria. For example, does COA 1 provide for good "timeliness (LOC)" or not so good "timeliness (LOC)"? If the answer is good "timeliness (LOC)," place "timeliness (LOC) in the advantage column. Do this for all evaluation criteria and all COAs. Once complete you will see if any COA stands out with more advantages and you can begin to compare one COA to another. By listing the criteria weight in the tables, you will be able to better distinguish between COAs in case more than one COA has the same number of advantages. If a criterion is neither an advantage nor disadvantage or can't be assessed, do not list it in the table. Once complete, make your selection and place it in the top right corner. Use the next page to explain the rationale for your selection. Since there are few

# Indiana's PASRR Redesign – Appendix D

## Course of Action Analysis Worksheet

quantifiable benchmarks, your analysis will be subjective. This makes a persuasive narrative important to the process. Please do not exceed more than one page for your narrative.

Rationale:

After reviewing and analyzing all the data, COA #3 and COA #4 stand out as the best Course of Actions. Out of these 2, I am recommending COA #4. There are significant advantages with the use of the Ascend software for the clinical review for Level I and LOC determination. The timeliness, efficiency, and simplicity are vital to hospital discharge planners as well as nursing facilities. Sometimes these decisions need to be made within hours.

The major advantage to COA #4 is a lower annual cost. Comparing the annual cost between COA #3 and COA #4 there is a considerable difference. LOC should only be completed on Medicaid recipients or individuals that intend to apply for Medicaid. Individuals who are entering facilities under Medicare, Medicare Advantage plans, or other private insurance need to meet Medicare guidelines for reimbursement, therefore the Medicare and/or other insurance companies will dictate the duration of the individual's care needs.

We have seen an increase in individuals that pay privately for the nursing facility while receiving Medicare Part B services since hospitals are keeping patients in observation or discharging from the hospital prior to the required 3 day stay. These individuals are unable to discharge home due to the lack of 24/7 care. In these cases, LOC is not needed since the state nor federal governments are using any funding for reimbursement. It would be the responsibility of the nursing facility and local AAA to provide the individuals with other alternative that can be determined outside of a LOC assessment.

In all of these scenarios, it is difficult to weigh the accuracy and validity. It appears that these could only be truly assessed by the accuracy of the individual entering the data into the software system. If the data is accurate, then the final determinations is valid, however I remain somewhat cautious in this area. From past experiences, some discharge planners are not forthcoming with information in order to avoid triggering a Level II assessment which would keep the individual in the hospital longer. Under the current regulation, nursing facilities incur the monetary penalties in these situations. We would like to see this change.

# Indiana's PASRR Redesign – Appendix E

Questions from First Iteration of PASRR Redesign Evaluations
And Answers from DA, 07/24/15

1. We are not being familiar with Ascend and we would assume it is user friendly and would be set up with "logic" to ensure accurate decision was made. In addition, we assume thorough training would be available to all that must use the system and understand what data is necessary to ensure the most appropriate outcome is obtained. More information on Ascend is requested.

   Simplicity – We cannot rate simplicity of the system without having had a software demonstration.

   Answer: We do understand that seeing the technology piece would be helpful; we continue to work to schedule a date for a web demonstration and will let you know as soon as we know that. Since that piece is the same in all four alternative courses of action, we really want this evaluation to focus more on the process, roles, and level of care requirements.

2. We understand if Level 2 not triggered, the decision issued immediately. However, what occurs if a Level 2 is required? What is the DMHA and DDRS process and when will they be brought into this? Many of the issues we face are with obtaining Level 2 in a timely manner.

   Answer: This is an area where DMHA and DDRS leadership will be essential. We believe both agencies are committed to this process and making a person centered PASRR process. We will all work together to accomplish the best possible outcomes for the individuals we serve.

3. Currently the AAA's are going by the process "once a Level 2, always a Level 2". If a resident comes to an NF and previously was a Level 2, but that didn't make it into the system, how will that impact the resident and NF at the time it is discovered? Will all current clients with Level 2 determinations be entered into Ascend for future Level 1 determinations?

   We are still struggling with the "once a Level 2, always a Level 2" instruction from the AAA. Will all clients with Level 2 determinations be available to Ascend, so that this will automatically trigger? We had a case today, for example, where the HDC planner sent the Level 1 filled out incorrectly, not triggering a level 2. Only because our admission clerk recalled that the resident in her prior stay (3 years ago), had been a Level 2, were we able to avoid a missed Level 2 review. Had the discharge planner been entering the data she collected into Ascend, the Level 2 would NOT have been triggered.

   Answer: No, we do not plan to bring all the history over into Ascend. It is largely not accessible to all the stakeholders in the current systems anyway. However, in time Ascend will build its own historical records and the level 2 history should be available.

Questions from First Iteration of PASRR Redesign Evaluations
And Answers from DA, 07/24/15

This is the primary reason we are asking DMHA and DDRS to use the Ascend solution regardless of how they manage the rest of their process.

4. Does a potential NF admission have the ability to decline the process? If so, what happens?

   Answer: Applicants cannot decline the PASRR process. The provision for declining is part of the statute that will sunset.

5. It is unclear as to what aspects of the proposed COAs are considered to be person-centered.

   Answer: Person centeredness is a screening criterion not an evaluation criterion. All alternatives are required to be person centered. Questions that lead the assessor to be person centered can be included as part of the level 1 screening tool itself.

6. It is unclear as to exactly what triggers a request for more information / need for an on-site verification.

   Answer: If the algorithm finds insufficient information or other triggers (yet to be determined) for desk/clinical review, then whoever is completing the desk/clinical review would evaluate the need to request additional information if needed or request an on-site verification.

7. It is unclear as to where in the process someone is determined to be Medicaid, Medicare or private pay since that was relevant to the scenarios.

   Answer: Medicaid or Medicare status is relative to the time of admission.

8. It is unclear as to where Medicaid will-apply's will be accounted; are they simply lumped into the Medicaid total?

   Answer: There is no will-apply category; as stated above, Medicaid or Medicare status is relative to the time of admission. If an individual later becomes Medicaid eligible the nursing facility will have to submit for a level of care decision at that time, as they do now.

9. In Scenario 1, it is unclear as to why private pay is treated like Medicaid when it used to be treated like Medicare.

   Answer: This is a complete system redesign. PASRR required of all individuals seeking admission to Medicaid certified facilities. Based Medicaid requirements, the level of care determination is only required for Medicaid covered admissions. The alternative courses of action offer variations to provide for additional determinations with non-Medicaid

populations. The populations are identified as private (out of pocket, consumer paid), Medicare, and Medicaid.

10. It is unclear as to the appeal process for consumers regarding Level I and LOC determinations.

    Answer: Requirements for the state to offer appeal opportunities relative to decisions issued do not change. The Ascend system will facilitate the mailing of notices to consumers.

11. Finally, it is unclear how the validity of the assessment will be evaluated, particularly as it relates to the independence of the assessment. i.e., that the judgments made during the face-to-face interview with the consumer and data entered by the discharge planner or nursing facility are not influenced by the financial interests of the hospitals and nursing facilities related to fast discharge/ease of facility admission and/or considerations related to ACO status of health system and facilities.

    Answer: We would note that all the stakeholders here have financial and other interests that impact their behavior and motivation. This is true in the current system and will be true in the new system. We believe that the system can capitalize on those motivations and utilize checks and balances to result in valid determinations. Additionally, as in the current system and multiple other programs, the Division will implement quality assurance measures.

12. In addition to lack of explicit triggers for Options Counseling and diversion, it is unclear as to the whether any QA process will be implemented to determine whether approved nursing facility admissions could have actually been diverted to the community.

    Outside of desk review, it is unclear as to how the accuracy of the assessment will be evaluated. i.e., that the judgment and professional discretion used during the face-to-face interview with the consumer and data entered by the discharge planner/AAA is accurate as to patient history, patient capabilities, basic data entry, etc.

    Answer: Many of the QA processes will be the same as they are now; some will change and evolve. Division of Aging staff currently engaged in lot of data entry due to system constraints will be repurposed for QA activities. Nursing facilities will provide a verification and check of data as well. As in the current system they have motivations tied to payment to monitor for correct level 1 and level of care decisions. Again, this is part of what we believe is a strong system that is reliant on checks and balances created by the sometimes competing motivations of all stakeholders.

Questions from First Iteration of PASRR Redesign Evaluations
And Answers from DA, 07/24/15

13. It is unclear as to how to evaluate this as there are two differentiating factors in each COA rather than one: what consumers qualify for a LOC assessment and who actually completes the LOC assessment.

    Answer: There are multiple variations in each course of action. They are alternatives, not designed to isolate the impact of any one factor.

14. It is unclear as to whether there is some additional cost related to the use of Ascend not indicated in the analysis. i.e., is it Ascend that will be reimbursed $5.95 for each Level I entered, (i.e., the $5.95) or is there some other cost?

    Answer: Refer to the Summary which states "Ascend has supplied the following rates: Per Level I entered - $5.95; Per clinical review of Level I and/or LOC - $32.37". There are additional, one-time, implementation costs associated with Ascend that will be covered by monies earned through the Balancing Incentives Program.

15. It is unclear how the current proposed reimbursement rates will cover the actual costs of holding a person-centered, in-depth, face-to-face assessment/discussion with the consumer and follow-up documentation.

    Answer: The assessment you describe is perhaps more applicable to the level 2 assessment. In the absence of a level 2, we do not believe that what you describe here is necessary for all individuals prior to nursing facility placement.

16. It is unclear how the rates themselves have been established other than price quotes from Ascend. We believe a more thorough rate setting process is called for.

    Answer: The rates provided by Ascend are from current contract negotiations.

17. We believe annual costs should also include an estimate of cost savings related to diversion.

    Answer: As noted in the brainstorming session and in the PTAC conversations, diversions in PASRR are largely centered on the level 2 process and focused on the MI and IID populations. We believe that targeted options counseling with the right people at the right time will also result in more diversions or at least transition after shorter stays with all populations but as noted in the Summary, options counseling will need to be dealt with separately and is not a part of PASRR per se except in the context of the level 2 process. Options counseling is a valued service and we hope to construct a system of targeting and appropriate reimbursement for that service.

18. Would the system recognize a patient from a previous admission and be able to auto-fill their information for a re-admission to a nursing home?

Questions from First Iteration of PASRR Redesign Evaluations
And Answers from DA, 07/24/15

Answer: Yes it would. We do not plan to transfer all current PAS system data into Ascend though. So, that history would be built up in time.

19. Would the system forward the PASRR approval and records to the nursing homes or would that no longer be necessary?

    Answer: The nursing facility will be able to access the system and appropriate referrals and approvals would workflow to them with the system.

20. How is diversion triggered and monitored in these courses of action?

    Answer: Again diversion in PASRR is focused on the level 2 process.

21. What are the trigger points for referral to Options Counseling in conjunction with diversion?

    How will we know that appropriate referrals are being made for Options Counseling?

    Answer: Please refer to the Summary "It should be noted that these potential solutions focus on the PASRR requirements and as such they do not specifically reference options counseling. However, diversion of all populations to home and community based alternatives is an important shared objective. Throughout these alternatives, when the AAA is designated to complete an assessment, either level 1 or level of care, there is an assumption that this activity will include options counseling. Note though, that appropriate referrals for options counseling can occur at multiple points in the PASRR process." Specific trigger points will be determined in the system design/implementation. A person centered process will provide multiple opportunities to identify need for options counseling.

# Indiana's PASRR Redesign – Appendix F

## Course of Action Analysis Worksheet

| Recommended COA | 4 |
|---|---|

Evaluation Criteria and Relative Weight (Lowest # is most important; highest # is least important; equal #s - same importance)

| | | | | | |
|---|---|---|---|---|---|
| Timeliness (L1) | 3 | Timeliness (LOC) | 5 | Access | 7 |
| Standardization | 4 | Accuracy | 6 | Annual Cost | 9 |
| Validity | 4 | Efficiency (LOC) | 6 | Simplicity | 9 |
| Efficiency (L1) | 5 | Diversion | 7 | | |

* Weights assigned are based on average rankings by stakeholders

COA Analysis

| COA 1: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| Access | 7 | Timeliness (L1) | 3 |
| Standardization | 4 | Timeliness (LOC) | 5 |
| Efficiency (L1) | 5 | Efficiency (LOC) | 6 |
| Validity | 4 | Cost | 9 |
| Accuracy | 6 | | |
| | | | |
| | | | |

| COA 2: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| Access | 7 | Timeliness (LOC) | 5 |
| Standardization | 4 | Efficiency (LOC) | 6 |
| Timeliness (L1) | 3 | Cost | 9 |
| Efficiency (L1) | 5 | | |
| | | | |
| | | | |
| | | | |
| | | | |

| COA 3: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| Access | 7 | Efficiency (LOC) | 6 |
| Standardization | 4 | Cost | 9 |
| Timeliness (L1) | 3 | | |
| Timeliness LOC | 5 | | |
| Efficiency (L1) | 5 | | |
| | | | |
| | | | |
| | | | |
| | | | |

| COA 4: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| Access | 7 | | |
| Standardization | 4 | | |
| Efficiency (L1) | 5 | | |
| Efficiency (LOC) | 6 | | |
| Timeliness (L1) | 3 | | |
| Timeliness (LOC) | 5 | | |
| Cost | 9 | | |
| | | | |
| | | | |
| | | | |

Instructions: Analyze each COA individually using the evaluation criteria. For example, does COA 1 provide for good "timeliness (LOC)" or not so good "timeliness (LOC)"? If the answer is good "timeliness (LOC)," place "timeliness (LOC) in the advantage column. Do this for all evaluation criteria and all COAs. Once complete you will see if any COA stands out with more advantages and you can begin to compare one COA to another. By listing the criteria weight in the tables, you will be able to better distinguish between COAs in case more than one COA has the same number of advantages. If a criterion is neither an advantage nor disadvantage or can't be assessed, do not list it in the table. Once complete, make your selection and place it in the top right corner. Use the next page to explain the rationale for your selection. Since there are few quantifiable benchmarks, your analysis will be subjective. This makes a persuasive narrative important to the process. Please do not exceed more than one page for your narrative.

# Indiana's PASRR Redesign – Appendix F

## Course of Action Analysis Worksheet

**Summary**

Thank you for your thorough responses to questions by the reviewers. They enabled us to more fully consider the proposed courses of action in light of the evaluation criteria. Compared to the other Courses of Action, in our opinion COA 4 is differentiated on the basis of efficiency, timeliness and cost. Access and standardization would appear to be consistent across all four COAs.

Regarding validity and accuracy, we believe that COA 1 has an advantage over the other three COAs, especially if AAAs retain access to historical PAS data and other consumer related information through InSite or its replacement.

Regarding diversion, we find we cannot discern a difference among the four COAs related to rates of diversion because this is reliant on independent Options Counseling which is not specifically part of this proposal. We discuss proposals below related to triggers for Options Counseling which may influence the evaluation of the remaining two iterations.

Regarding simplicity, we cannot assess simplicity at this time but look forward to the demonstration on August 17th.

**Concerns**

On behalf of the consumers touched by PAS, we are still concerned about the independence of the assessment in the system as proposed. Perhaps this will supported by enhanced Level I and LOC screening tools. However, in the absence of an independent PAS assessor actually seeing the consumer, we remain concerned regarding the validity of Level 1 and LOC assessments. Here are three frequent examples:

- Discharge planners that do not indicate there is any evidence of mental illness, yet the current medication list includes psycho-active medications.
- Discharge planners that fail to identify I/DD, but previous PAS assessments indicated that person has an I/DD that triggered a Level II assessment. Given the nature of I/DD, we would not expect the need for a Level II to change over that person's lifetime.
- Discharge planners underestimating the capabilities of the consumer and related caregivers relative to the Level of Care determinations.

**Proposals**

We look forward to the definition of explicit triggers for Options Counseling. At a minimum, we would propose that any person approved for a long-term or continuing nursing facility stay be automatically referred to Options Counseling that is inclusive of an in-person needs-based assessment. Further, we would propose to refer any person expected to have a chronic, long-term care need as indicated by their diagnosis and LOC assessment, regardless of their status related to nursing facility admission. There may be other identifiable populations that would be appropriate for referral.

A phrase that continues to surface regarding the current set of proposals is that "the fox is guarding the hen house" related to incentives for rapid discharge and/or bias toward nursing facility admission/continuing stays. For that reason, we would propose a discussion regarding the levying of penalties (or incentives) related to accurate, unbiased assessment by hospital and nursing facility staff. We would also propose a discussion regarding a role for the AAAs in Q/A process, e.g., as an onsite evaluator of the accuracy of Level 1 and LOC assessments.

Finally, we hope that the No Wrong Door planning process will address the quality and independence of LTSS and HCBS referral information provided by hospitals and nursing facilities so as to avoid biasing the consumer. Although there is existing statute in place regarding such referral information, it is often incomplete, out-of-date and actively promotes providers in which the referrer has a financial stake. We are also concerned about in-hospital interactions by facility staff that seek to influence direct admission to their facilities.

**Questions**

We would offer two additional questions at this time:

- Will AAAs retain access to historical data in the InSite PAS module that might inform decision making in the cross-over to Ascend? We believe this would be an advantage for COA 1 related to Validity and Accuracy of the Assessment, and potentially for the other courses of action should a PAS assessor choose to confer with the AAA.
- Will you share the Level I and LOC screening tools proposed by Ascend? This may help to alleviate some of the concerns regarding independence of the assessment described above.

# Indiana's PASRR Redesign – Appendix G

## Course of Action Analysis Worksheet

| Recommended COA | 4 |
|---|---|

Evaluation Criteria and Relative Weight (Lowest # is most important; highest # is least important; equal #s - same importance)

| | | | | | |
|---|---|---|---|---|---|
| Timeliness (L1) | 3 | Timeliness (LOC) | 5 | Access | 7 |
| Standardization | 4 | Accuracy | 6 | Annual Cost | 9 |
| Validity | 4 | Efficiency (LOC) | 6 | Simplicity | 9 |
| Efficiency (L1) | 5 | Diversion | 7 | | |

* Weights assigned are based on average rankings by stakeholders

COA Analysis

| COA 1: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| Access | 7 | Annual Cost | 9 |
| | | Standardization | 4 |
| | | Timeliness (L1) | 3 |
| | | Timeliness (LOC) | 5 |
| | | Validity | 4 |
| | | Efficiency (LOC) | 6 |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| COA 2: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| Standardization | 4 | Annual Cost | 9 |
| Accuracy | 6 | Timeliness (L1) | 3 |
| Access | 7 | Timeliness (LOC) | 5 |
| | | Validity | 4 |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| COA 3: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| Standardization | 4 | Annual Cost | 9 |
| Timeliness (L1) | 3 | | |
| Accuracy | 6 | | |
| Timeliness (LOC) | 5 | | |
| Validity | 4 | | |
| Access | 7 | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| COA 4: | | | |
|---|---|---|---|
| Advantages | wt | Disadvantages | wt |
| Annual Cost | 9 | Access | 7 |
| Standardization | 4 | | |
| Timeliness (L1) | 3 | | |
| Accuracy | 6 | | |
| Timeliness (LOC) | 5 | | |
| Validity | 4 | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Instructions: Analyze each COA individually using the evaluation criteria. For example, does COA 1 provide for good "timeliness (LOC)" or not so good "timeliness (LOC)"? If the answer is good "timeliness (LOC)," place "timeliness (LOC) in the advantage column. Do this for all evaluation criteria and all COAs. Once complete you will see if any COA stands out with more advantages and you can begin to compare one COA to another. By listing the criteria weight in the tables, you will be able to better distinguish between COAs in case more than one COA has the same number of advantages. If a criterion is neither an advantage nor disadvantage or can't be assessed, do not list it in the table. Once complete, make your selection and place it in the top right corner. Use the next page to explain the rationale for your selection. Since there are few quantifiable benchmarks, your analysis will be subjective. This makes a persuasive narrative important to the process. Please do not exceed more than one page for your narrative.

# Indiana's PASRR Redesign – Appendix G

## Course of Action Analysis Worksheet

Rationale:

Options counseling is an issue that needs more consideration under any scenario. I would assume it will take place at the PAS, whether a LOC is required or not. However, how this will work is not clearly addressed in the documents we have.

Also, resident and family interaction is somewhat vague, beyond the initial meeting with the hospital discharge planner who is putting the data into Ascend for the initial determination. Just want to make sure we are not asking residents to interaction in an automated system in ways they are not able to handle (as when we first went to the on-line Medicaid application).

The first COA Analysis in the attached states that COA 3 provides this more targeted interaction, but I don't reach the same conclusion in my reading.

I still feel a full LOC should only be done on those Medicaid residents who require it for reimbursement purposes. Why utilize the additional resources for something that is not necessary for reimbursement? Even if done at admission, I would expect it would need to be redone at payor changes to update the Medicaid claims system.

# Indiana's PASRR Redesign – Appendix H

Options Counseling Triggers Suggested By Stakeholders:

| | Description of Trigger for Options Counseling | When Notice Should Go To AAA | Work Days AAA Has To Complete Counseling |
|---|---|---|---|
| 1 | When the patient is under 60 | At Level 1 determination | 5 |
| 2 | Any resident who requests options counseling or expresses in an interest in HCBS | Within 48 hours of request | 5 |
| 3 | Admitted to SNF due to loss of a caregiver | Upon SNF admission | 5 |
| 4 | Anyone identifying that they wish to return home | Within 48 hours of request | 5 |
| 5 | When resident's caregiver indicates a desire to return the resident home | Within 48 hours of request | 5 |
| 6 | Mutiple ER Visits/Admissions | At Level 1 determination | 5 |
| 7 | All Level 2 cases which often do not meet LOC for long term care due to MI issues | At Level 2 determination | 5 |
| 8 | All short term stay approvals, so clients can be more aware of the options once they leave the Nursing Facility. | At Level 1 determination | 5 |
| 9 | Any time a family member requests information and assistance | Within 48 hours of request | 5 |
| 10 | Anyone expressing a willingness or ability to pay for services (develop a private-pay Options Counseling service) | At Level 1 determination | 5 |
| 11 | Anyone with a continued stay request | Within 48 hours of request | 5 |
| 12 | Anyone admitted on an emergency basis | Upon SNF admission | 5 |
| 13 | request for continued stay for low acuity individual now eligible for Medicaid | at clinical review of the request | 5 |
| 14 | Patient or family requests Options Counseling | When request is received | 3 |
| 15 | Patient eligible for Medicaid is transferring from community to SNF | Upon formulation of dc plan in hospital setting or receipt of referral to SNF | 3 |
| 16 | Patient under 55 requests a continued stay and is eligible for Medicaid | at clinical review of the request | 3 |
| 17 | Patient with a permanent disability/development disability requests a continued stay and is eligible for Medicaid | at clinical review of the request | 3 |
| 18 | When an acute short term stay turns into a request for a longer stay | | |
| 19 | When the MDS states the individual wants to go home before they have been there 90 days | | |
| 20 | When they are out of Medicare days, but still meet NF LOC | | |
| 21 | When they are discharged from skilled therapy | | |
| 22 | If they are 55 or younger and have been given long term approval for NF | | |

# Indiana's PASRR Redesign – Appendix I

## Summary Comments from Suggestion Options Counseling Triggers

**Comments from stakeholders:**

We agree that the current process for preadmission screening needs to be improved, and we welcome the opportunity to be part of the changes that are needed. We recommend an increased emphasis on impartial options counseling as the best way to achieve better outcomes at lower costs.

The stakeholders group that participated in the PAS redesign was primarily comprised of institutional care providers. Several options were presented to us for the redesign of PAS. At that time, we expressed our concern that desired outcomes from PAS were not adequately reflected in the options presented. However, we were committed to the process and moved forward with the group consensus, based on additional conversations with you that options counseling and resources to support it would be part of the larger conversation about home and long-term care in Indiana.

It is our understanding that the same group of stakeholders from the PAS redesign process will now be determining triggers for options counseling, using a similar format for consensus building. Indiana's Area Agencies on Aging have worked with thousands of Hoosier families on the difficult process of determining the best options for their loved ones' long-term care. We believe that allowing the same small group to proceed with establishing triggers for options counseling does not represent the interests of all affected stakeholders.

We request that the discussion of options counseling triggers include the following:

Expand the stakeholder group to include consumers and providers of home- and community-based services.

The decision on what factors should trigger "options counseling" should not be made by a group that primarily represents stakeholders providing institutional care. This stakeholder group should be expanded to include:

- Mental health services providers and consumers
- Persons with developmental disabilities
- Home- and community-based care providers
- Older adults
- Persons with physical disabilities

Provide a definition of "options counseling" and desired outcomes.

Establishing meaningful triggers for options counseling requires consensus on what options counseling includes, as well as desired outcomes. The AAAs believe that options counseling should include the goal of providing consumers with long-term care in the least-restrictive environment possible, as well as providing consumers with access and information to affordable care in the setting of their own choosing.

Apply the proposed savings from the automation of PAS to options counseling.

The automation of the PAS process is anticipated to save the state approximately three million dollars per year. Committing this funding to options counseling through the AAAs will provide guidance on the available resources, as well as a baseline for establishing service goals and outcomes.

"In general, our overall lens included person-centeredness, unbiased information so as to reach an appropriate decision about the LTSS to be provided, and the desire to achieve more diversions in support of rebalancing.

## Summary Comments from Suggestion Options Counseling Triggers

Our group has some reservations about developing triggers prior to having reached a shared agreement on what the Options Counseling service will entail, including desired outcomes. It seemed to us that should have come first, with the triggers falling out from those parameters. Therefore, we hope the decision making-process doesn't narrow too soon in light of this concern.

There is further concern about identifying different timeframes for completion of Options Counseling in different kinds of cases. We don't want to necessarily overcomplicate things by inserting multiple timeframes. We also want to assure that persons be medically stable prior to the provision of Options Counseling. There is also concern that the service should be recognized not just as a one-time event. i.e., depending on the person, their family and caregivers, and overall situation, one counseling session may not be enough to arrive at the most appropriate conclusion.

We did identify situations in which we think it was not productive to trigger Options Counseling:

- Anyone already on AAA services because the AAAs will already be seeing them anyway
- Anyone who was already permanently placed with a long-term approval who has a short-term hospital stay
- Anyone who is medically fragile or has advanced dementia with no caregiver and no ability to pay

The group is requesting a clarification on the definition of in-home PASSR in the context of the new system. i.e., currently, anyone in the hospital in observation status or ER is considered an in-home PAS and thus the responsibility of the AAA. We hope that definition remains the same."

**DA Responses:**

COMMENT/QUESTION: "We recommend an increased emphasis on impartial options counseling as the best way to achieve better outcomes at lower costs."

RESPONSE: We agree. This is a key argument for conflict-free case management/conflict-free assessment.

COMMENT/QUESTION: "It is our understanding that the same small group of stakeholders from the PAS redesign process will now be determining triggers for options counseling, using a similar format for consensus building."

RESPONSE: Actually the process is different in this phase due to the more narrow focus just on triggers for options counseling. We have asked for suggestions and are compiling them for comments and then will make decisions on what to include in the report to the legislature.

COMMENT/QUESTION: "Expand the stakeholder group to include consumers and providers of home and community based services."

RESPONSE: The Division has been in conversations with other advocacy groups, specifically the Centers for Independent Living. Additionally, assessment and stakeholder comments collected from both the 1391 LTSS report process and the No Wrong Door planning process and informed our considerations about PASRR. We will be continuing this engagement with other groups and are happy to expand that if there are specific suggestions.

COMMENT/QUESTION: "Provide a definition of options counseling and desired outcomes."

# Indiana's PASRR Redesign – Appendix I

## Summary Comments from Suggestion Options Counseling Triggers

RESPONSE: As stated at the last meeting, we will be engaging the AAAs directly in defining options counseling (in line with the ACL/CMS definition and guidelines), setting criteria, outcome measures and reimbursement.

COMMENT/QUESTION: "Apply the proposed savings from the automation of PAS to options counseling."

RESPONSE: We have already stated that is our intention as well as working to secure additional funds dedicated to options counseling.

COMMENT/QUESTION: "Our group has some reservations about developing triggers prior to having reached a shared agreement on what the Options Counseling service will entail, including desired outcomes. It seemed to us that should have come first, with the triggers falling out from those parameters."

RESPONSE: We believe triggers can be established while the service definition is being nailed down. We do have the ACL/CMS guidelines on options counseling and we will not be defining it contrary to those requirements. So, there is a definition from which we can start.

COMMENT/QUESTION: "There is further concern about identifying different timeframes for completion of Options Counseling in different kinds of cases."

RESPONSE: We recognize there could be different timelines in different situations. But there must be defined requirements for options counseling to occur within specific time parameters. There must be accountability in the system and so expectations must be clear.

COMMENT/QUESTION: "The group is requesting a clarification on the definition of in-home PASSR in the context of the new system. i.e., currently, anyone in the hospital in observation status or ER is considered an in-home PAS and thus the responsibility of the AAA. We hope that definition remains the same."

RESPONSE: That is not the current definition of at home PAS as the Division understands it. This will be something for which we will need to establish a clear definition in conjunction with the stakeholder groups.