

RI EOHHS MEDICAID POLICY

Subject:	<b><i>Level of Care Redeterminations</i></b>		
Applicability:	Individuals who have previously been determined to meet the NF LOC		
<b>Issue Date:</b>	<b>Effective Date:</b>	<b>Transmittal #:</b>	<b>Supersedes #:</b>
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**Scope and Purpose:**

The purpose of this guidance is to clarify State policy and procedures related to the redetermination of the nursing facility (NF) level of care (LOC) for Medicaid long-term services and supports (LTSS). This guidance will also briefly explain the role of clinical/functional assessments in the State’s needs-based system for Medicaid LTSS eligibility as well as in LOC determination.

**Background:**

Under federal regulations, clinical eligibility for Medicaid LTSS requires that persons have the need for the scope of services and supports typically provided in one of three long-term care institutional settings: nursing facility (NF), long-term care hospital (LTH), or intermediate care facility for intellectual/developmental disabilities (ICF-I/DD). (See [210-RICR-50-00-1.4](#) for details on this standard.)

Clinical eligibility for the NF LOC in Rhode Island is governed by the two tiers of needs-based criteria established in the State’s Section 1115 demonstration waiver:

1. A person with the *highest* need for the NF LOC has the choice of a NF *or* home and community-based services (HCBS) setting; and
2. A person with a *high* need for the NF LOC *must* obtain LTSS in a HCBS setting.

To be eligible for HCBS, a person must meet the federal requirement that in the absence of HCBS, they would require institutional care (42 CFR 441.302). This is referred to as the “were it not for HCBS” standard. By meeting the high or highest need for the NF LOC, a person meets this requirement. In Rhode Island, this requirement is met in a two-step process. First, a case manager conducts a *functional assessment of needs*. This assessment, combined with clinical information, is reviewed by Registered Nurses to determine whether the LOC meets the *High or Highest* requirements. After the LOC is approved, the case manager uses the functional assessment of needs to develop and authorize the HCBS service plan.

**Policy Review:**

Under current State LTSS rules, the initial determination of whether a person meets the NF LOC must be based on an evaluation related to applicable needs-based criteria that is derived from a variety of sources including, but not limited to, a functional assessment of needs conducted in conjunction with application for HCBS and the medical documentation and evaluations included in the PM1 (Patient Medical Form 1).

Accordingly, the findings of the HCBS functional assessment of needs are the basis for DHS Clinical Team’s (formerly called the Medicaid Office of Medical Review (OMR)) determination of NF LOC at the high or the highest level.

The criteria for NF LOC with the *highest* level of need for institutional care include a variety of health issues in addition to functional status, and often require review of medical documentation and evaluations included in the PM1 and from other sources, such as a NF service plan and the MDS.

- The criteria for the *high* level of need, which limits access to LTSS in HCBS settings only, concentrate almost entirely on functional issues related to the activities of daily living (ADLs), the independent activities of daily living (IADLs), and the safety and security of the living environment.

The results of these assessments are tied to a service calculator which not only establishes whether the “were it not for HCBS” standard for HCBS has been met, but which also serves as the basis for an authorized service plan. This information is derived largely from the functional assessments of needs conducted by OHA, DHS and/or one of our community partners participating in the self-directed program at the time of initial application.<sup>1</sup>

Aside from choice of setting, this determination of NF LOC has minimal impact on both the scope of LTSS coverage and whether needs can be adequately met in an HCBS setting. For example, a person with the highest level of need may opt to obtain Medicaid LTSS in either an institution (e.g., NF) or in an HCBS setting or opt to limit the amount of HCBS service they utilize irrespective of the scope of need. Moreover, service array and rates are not directly attached to the NF LOC determination (with the exception of the Shared Living Program).<sup>2</sup>

#### **NF LOC Redetermination Requirements:**

As the Medicaid LTSS eligibility business practices have evolved in response to changes in systems and business practices over the years, it has become less clear in which circumstances an NF LOC redetermination, as opposed to a functional assessment of needs, is required. The operational guide below is designed to specify when NF LOC redeterminations must be conducted to comply with federal and State policy requirements and indicate situations in which the reassessment of needs is more appropriate than the NF LOC.

#### Annual reevaluation of whether the scope, amount, and duration of services is appropriate:

Under federal regulations, States are required to **reevaluate**, at least annually, whether the scope, amount and duration of authorized services are still appropriate and whether the participant continues to meet the LOC ( [42 CFR 441.302\(c\)\(2\)](#)). Under the State’s rules, this requirement can usually be met through the annual functional reassessment of needs, which directly impacts the client’s service plan.

A full redetermination of NF LOC once clinical eligibility for HCBS has been established is only required if the findings of the annual functional reassessment of needs are that the “were it not for HCBS” standard can no longer be met or the scope, amount and/or duration of services required has changed to such an

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<sup>1</sup> A recent analysis of the various HCBS functional assessments of need currently in use by the Faulkner Consulting Group found that all incorporated the elements that tied to criteria for a high level of need established in the State’s Section 1115 waiver and implementing rules.

<sup>2</sup> For those opting for LTSS in a NF, it is the MDS which dictates both whereas for HCBS it is the functional assessment of needs that determines the amount of services and rates.

extent that either: (1) a shift in level of need from the high to highest level of need or vice versa is warranted; or (2) Medicaid LTSS clinical eligibility is no longer appropriate. The results of the MDS play this same role with respect to the redetermination of the NF LOC for LTSS provided in a nursing facility.

### LTSS Annual Renewals

Both federal regulations and State rules specify that the redetermination of an eligibility factor for purposes of annual renewal is only required if it is subject to regular change.<sup>3</sup> Unlike financial eligibility factors, the general need for a NF level of care does not typically change to such an extent in any given year that it would affect eligibility for Medicaid LTSS, even in circumstances where the scope of a person's need may require a shift from the high to the highest level of need. Although a *functional reassessment of needs* must be performed at least annually, there is no State or federal provision specifying that a full LOC redetermination must be conducted in conjunction with or as a condition for Medicaid LTSS renewal. However, functional assessments of needs that have a direct impact on the scope of a person's HCBS authorized service plan must be conducted at least annually and more often if there is a change in needs, goals, and/or preferences in the interim.

### Change in LTSS Service Setting

A LOC redetermination is not required when a person moves between and across HCBS settings, irrespective of whether he or she was last determined to have the high or the highest level of need for a NF LOC.. A LOC Redetermination is also not required if the person is moving from an institutional setting to a HCBS setting. A functional reassessment of needs is appropriate in such circumstances. If the findings of the functional reassessment of needs indicate that the needs of the customer can no longer be met or the scope, amount and/or duration of services required has changed to such an extent that either, then a LOC redetermination is required.

LOC redetermination is required when a person is seeking to transition from HCBS Setting to an institutional setting – e.g., a nursing facility. This also applies to BHDDH customers moving from DD to NH and PACE program.

### Frequency and Special Circumstances

Federal regulations require that all facets of a person's eligibility, including the NF LOC, be reconsidered at set intervals to ensure program integrity. States have the discretion within the broad parameters set in federal regulations to establish the frequency and circumstances in which the redetermination of these factors is required. As indicated below, in Rhode Island, NF LOC redeterminations are required no more than once every three (3) years. Ideally this will be done in conjunction with a financial reassessment, but that is not required.

In addition, State regulations at 210-RICR-00-5.6.6 require a NF LOC redetermination to be performed in the following circumstances:

- Upon the request of a treating health care provider or the findings of a functional reassessment of needs indicating that a person's needs have changed to such an extent that

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<sup>3</sup> See [42 CFR 435.916 \(b\)](#) and [210-RICR-50-00-4.11\(B\)](#)

more intensive or specialized services, identified in a PASRR or similar evaluation, may be required;

- When a person determined to have a high need for a NF LOC at the time of an annual reassessment or a reassessment done in conjunction with a change in health status is found to have a clinical condition that meets the criteria established for highest need and may require change to a nursing facility setting; and
- Thirty (30) to sixty (60) days after a placement in a NF when the initial LOC determination indicates that a person's condition may improve within the succeeding two (2) month period.
- When a person with a high or highest NH LOC is seeking to transition from HCBS Setting to an institutional setting – e.g., a nursing facility.

### **Operationalization:**

For movement between Elder, Aged and Disabled (non-DD) LTSS programs that require a high LOC, the process is as follows:

#### General Rules

- Functional assessments of needs must be done annually by one of the following entities: DHS; EOHHS; a CAP agency; or a Service Advisement Agency.
- In most circumstances, a Level of Care (LOC) redetermination must be completed every three (3) years. There are exceptions, which are described below.
- Approval to move an active HCBS client into a different HCBS program should be based on customer's choice of program. If the LOC determination is over 3 years old, the new program should reassess the customer and submit a program change for a LOC redetermination within 90 days of the new program approval.
- State authorization of the program change must be made within 30 days of receiving the request regardless of the date of existing LOC.
  - If a new LOC determination is needed (because more than 3 years have passed) it should be done within 90 days of the new program approval. This will be tracked by creating an LTSS Program Change form specifically for a LOC change.
  - The worker who identified the need for the new LOC determination is responsible for requesting and submitting the Program Change form and required documentation to DHS. This may require additional communication with the client and with their providers to receive updated documents.
  - The comment field on the Program Change form should be used to indicate that a new LOC – not a change in programs – is needed.
  - Once the Program Change form and supporting documents are submitted to DHS, a SCW (social case worker) will track the work through completion.

A LOC determination is NOT required every 3 years in the following scenarios:

- Client has a hospital LOC or a highest LOC and remains in a hospital or a nursing home. Note: if a client has a hospital LOC and is in a HAB (habilitation) program, they still require a LOC every three years.
- Client is on SSI disability and is remaining in an HCBS Setting. HCBS Customer transitioning from HCBS to NH regardless if on disability or has a previous highest LOC, will need a redetermination of the NH LOC

A LOC determination may be required more frequently than every 3 years in the following scenarios:

- If a client is receiving HCBS services with a high LOC and needs to move to a Nursing Facility or Long-Term Care Hospital. In this scenario, the client must be re-evaluated for the highest LOC regardless of how long it has been since their last LOC determination. Updated eligibility can go 90 days retroactive from the date that DHS received the Program Change form and/or the appropriate medical forms.
- Thirty (30) to sixty (60) days after a placement in a NF when the initial LOC determination indicates that a person's condition may improve within the succeeding two (2) month period
- If a treating health care provider or a case manager determines that person's needs have increased or decreased to the extent that the LOC determination may change. For example:
  - Client's chronic or recurring condition has improved such that they require fewer hours of assistance and/or assistance with fewer ADLs than when their LOC was last determined
  - Client's chronic or recurring condition has deteriorated such that they require more hours of assistance and/or assistance with more ADLs than when their LOC was last determined (e.g., client has experienced total loss of ambulation)
  - Client has experienced an acute condition and requires an increase of services that may extend more than 30 days
  - If a functional reassessment of needs for a client with a high level of care results in a service plan of more than 49 hours

A Functional Assessment of Needs Must Be Completed More Frequently Than Once per Year If:

- Client or provider request an increase of more than 10 additional hours of assistance

Special Circumstances:

- Sometimes an LTSS application is denied after the LOC is approved (for example, it is over asset, or there is a failure to return documentation, etc.). LTSS regulations allow for a case to be reinstated if the applicant provides documentation to rectify the cause of denial within 30 days. If the documentation is provided after 30 days, the applicant must re-apply.
  - If the application is reinstated, a new LOC determination is not needed (unless one of the above exceptions applies).
  - If the applicant reapplies, a new LOC determination is required.
- If a LOC determination older than three years is determined through the process of an HCBS program change, the DHS worker should take the following actions:

*If the Case does not have an external case management agency*

- Complete the initial task and run eligibility. For example, complete the HCBS program change, recertification, or case changes.
- Call the client to indicate that a new assessment is required.
  - Explain the need for a PM1 and fax the form to the physician if the worker has their information.
- Go back into the case via case change and take the next appropriate step to set the case up for a new LOC determination. This could include:
  - Sending an ADR (additional document request) for a PM1
  - Creating a new LOC (without end-dating the current LOC) and mark “No” for “has home assessment been completed.” Run eligibility. This will create a new Home Visit task
  - If all the documents are in the case, create a new LOC and set status as “pending.” Run Eligibility. This will create a DHS Clinical Team task.

*If the case has a case management agency (e.g., OHA or a Service Advisement Agency) – Or is moving into a program in which they will have a case management agency:*

- DHS notifies the agency that an updated LOC is required
- Agency is responsible for completing a new assessment and PM1. When these documents are sent in, they should be sent with a program change form so that DHS can track the process.