OVERVIEW

A level of care assessment determines an individual's clinical eligibility for programs/services in institutions and in the community. Medical and functional information is gathered through the administration of the Level of Care Determination tool (LCD) and results in two possible outcomes – Nursing Facility Clinically Eligible and Nursing Facility Ineligible. Additional tools are required to gather information on individuals you serve for state reporting requirements that affect federal reimbursement.

I. Assessment Tools

A. Needs Assessment Tool – Express (NAT- E)

The NAT-E can be used as a self-declaration tool or can be completed by a Care Manager or a Case Aide under the direction of a Care Manager or Care Management Supervisor.

The NAT-E is used for individuals who receive:

- Non-Congregate/In-Home Meals
- Congregate Meals (Section 1 – Introduction and Section 2 – Nutrition only)
- Emergent Service (after 72 hours if this service is still needed, there must an LCD and NAT completed)

B. Caregiver Assessment Tool (CAT)

The CAT is a comprehension assessment of a primary caregiver and used to identify caregivers who meet program requirements and in the development of a care plan in the Caregiver Support Program.

C. Needs Assessment Tool (NAT)

The NAT is a compensative assessment of an individual's needs and is used to develop a care plan. (See Chapter 13: Care Management)

D. Level of Care Determination (LCD)

The Department of Aging has administrative responsibility for the oversight of all federal and state funding that is paid or allocated to the AAAs for the provision of level of care assessments.

The Level of Care Determination Tool (LCD) is a comprehensive assessment that contains documentation of an individual's clinical eligibility for programs/services in institutions and in the community. Medical and functional information is gathered to determine two possible outcomes – Nursing Facility Clinically Eligible and Nursing Facility Ineligible. All individuals that have been assessed and for whom a level of care determination has been made must receive a Determination Notice (see Appendix B).

II. Level of Care Requirements

A. Individuals to be assessed

LCDs are completed on the following individuals who are:

- Applying for OPTIONS service/s
- Applying for MA reimbursement for nursing home placement
- Applying for Waiver Home and Community Based service/s
- Identified as OBRA assessments (see Section VII OBRA Assessments),
- Completing an initial application for the PCH/Dom Care supplement
- Being re-certified for the PCH/Dom Care supplement
- LIFE applicants
- As requested by Department of Aging (PDA) or the Department Public Welfare (DPW)

B. Time Frames

Initial Level of Care Assessments:

The assessor must complete an assessment within **15 calendar days** from the date of referral to the date the assessment is approved and issued to the appropriate entity. If the 15th day falls on a week-end, it diverts to the following business day. This time frame must be strictly adhered to.

The 15 day time frame applies for all individuals applying for the following:

- OPTIONS
- MA reimbursement for Nursing Facility Placement
- MA Waiver Home and Community Based service/s
- All individuals who are identified as OBRA assessments and applying for Nursing Facility Placement.
- Individuals applying for the PCH/Dom Care supplement
- LIFE applicants

Note: Time frames for individuals applying for all MA Waiver Programs conducted by the AAA detailed in the Office of Long - Term Living Bulletin, Number 55-12-03. (This bulletin also outlines Enrollment activities for the Aging Waiver)

PCH and Dom Care Re-certifications:

The AAA must complete the Annual Re-certifications **365** days from the date of the last LCD. It is the responsibility of the PCH to notify the AAA when a recertification is due as required by the Licensing Agency. Absent a referral or receipt of an MA-51 a PCH re-certification must be completed within this timeframe on all individuals known to the AAA in SAMS. Question 13.A.5 should indicate that no physician input was received and the CAO notified of same.

Aging Waiver Annual Re-evaluations:

The AAA must complete the Annual Re-evaluation of level of care within **365** days of the last completed LCD. It is the responsibility of the Service Coordination Entity (SCE) to notify the AAA when a recertification is due.

Note: The rare exceptions to these timeframes shall be documented as journal entries in the appropriate case record clearly stating the reason(s) for the exception. Workload and staffing issues are not considered a valid exception.

The following scenarios must be taken into consideration and given priority when scheduling a level of care determination

- Individuals who are at imminent risk of nursing home placement as evidenced by the identification of a nursing home with an established admission date.

- Individuals who present with current evidence of abuse, neglect or exploitation in their present living situation, presenting emergency or urgent conditions that place the individual at immediate risk of harm.

- Individuals who have lost their primary hands-on caregiver or whose hands-on caregiver has suddenly lost the ability to provide the necessary care and support and who, in the absence of any alternate primary caregiver(s) would require nursing facility placement if services were not provided.

III. Physician Input

For a level of care determination to be made, a physician (MD or DO) must certify the level of care of the individual. Acceptable forms of this medical certification include the MA-51, Prescription, or a Medical Certification Form (An example in located in Appendix B) and retained in the case record.

AAAs that border other states may accept a medical from an out-of-state licensed physician. This may be allowed for individuals residing in counties not bordering other states if it is determined that this out-of-state physician has primary responsibility for the care of the individual. In all instances this must be documented in the LCD in the notes section of Question 13.A.2.

The following outlines what form of medical certification is required.

MA-51 (can be no more than 90 days old)

- Individuals who request nursing facility placement and who would be applying for Medical Assistance (MA) reimbursement upon entering the nursing facility, including consumers under the age of 18.

- Nursing facility residents who were admitted as “private pay” and after “spending down” their assets and resources, are applying for Medical Assistance. Individuals within this category shall be assessed no later than 45 calendar days prior to the expiration of private pay coverage to allow for safe and orderly discharge by the facility should the nursing facility resident be found to be Nursing Facility Ineligible (NFI)

- Individuals requesting nursing facility placement with a diagnosis related to Mental Health (MH), Mental Retardation (MR), or Other Related Conditions (ORC) consistent with the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) (Required medical form is an MA51). A completed PASRR-ID must be received from referral source. (see Section II OBRA Assessments).

- Individuals who are applying for placement in an approved/licensed Personal Care Home or Dom Care Home and are requesting the Supplemental Security Income (SSI) Personal Care Supplement and annually thereafter for individuals who continue to receive the supplement Personal Care and Dom Care Supplement (Chapter 391.32 and 391.5).

Prescription/medical certification/MA-51

- All individuals requesting MA funded home and community based services

- All individuals applying for OPTIONS who have a level of care determination of Nursing Facility Clinically Eligible (NFCE)

- All individuals requesting the LIFE Program

IV. Level of Care Definitions

Nursing Facility Clinically Eligible (NFCE)

Under State and Federal laws and regulations and in accordance with 55 Pa. Code § 1187.22(2) and 42 CFR 441.302(c), which identify the Level of Care provided in a Nursing Facility, an individual should be considered Nursing Facility Clinically Eligible (NFCE) if the following criteria are met:

The individual has an illness, injury, disability or medical condition diagnosed by a physician; and**,** as a result of that diagnosed illness, injury, disability or medical condition, the individual requires care and services above the level of room and board; and**,** a physician certifies that the individual is NFCE with a recommendation made on a MA-51, script or medical certification form; *and*, the care and services are either:

- Skilled nursing or rehabilitation services as specified by the Medicare Program in 42 CFR 409.31(a), 409.31 (b)(1) and (3), and 42 CFR 409.32 through 42 CFR 409.35 ; or,

- Health-related care and services that may not be as inherently complex as skilled nursing or rehabilitation services but which are needed and provided on a regular basis in the context of a planned program of health care and management and were previously available only through institutional facilities.

Note: It is not the responsibility of the AAA to determine Long Term or Short Term Nursing Facility Clinically Eligibility.

Nursing Facility Ineligible (NFI)

All individuals who do not meet the above definition of Nursing Facility Clinically Eligible are considered NFI.

V. Completion of the LCD

All LCDs must be completed with the informed consent of the individual being assessed. It is acceptable that consent be given by the individual's legal representative (i.e. POA or guardian) or the person that the individual has informally designated. (See Appendix X for required Informed Consent Form). In rare instances where a written informed consent cannot be obtained (i.e. individual unable to sign, representative not available at time of assessment) a verbal consent is acceptable and must be documented in a journal entry in SAMS.

Note: The signature in Box 10 of the MA-51 is a not considered informed consent to conduct an assessment.

The LCD shall be administered during a face-to face visit with the individual in their current location or place of residence. The assessor is required to inform the individual as to the purpose of the assessment. The assessor must engage the individual in every aspect of the assessment process. In cases where cognitive impairment is identified the individual should provide input as they are able.

For accuracy in completing a level of care determination, the assessor must identify and document four important criteria when assessing an individual:

- Current diagnosis which requires treatment
- How the diagnoses and treatment impacts their functional ability
- The individual's physical and/or psychological ability to manage their care with current available resources
- The full completion of the SLUMS (as appropriate per instructions) to screen for cognitive deficits

Assessors must remember to assess the individual solely on what they can do and not what support systems may be assisting the individual. It is also important for an assessor to focus only on the level of care and not the individual's needs (needs are addressed in the NAT). The assessor should not base a level of care on the location (locus) of the individual at the time of the assessment, the reason for the referral nor where the individual chooses to receive services such as in the community or an institution.

For completion of the LCD, the assessor shall use a wide variety of source information including, but not limited to:

- Information provided by the individual
- Direct observation of the individual
- Information provided by the attending physician
- Medical record review in hospitals, nursing facilities or personal care homes
- Information provided by family members and/or informal caregivers and supports (subject to the receipt of the appropriate Releases of Information, or in situations where the individual is mentally incapacitated and unable to fully participate)

All Area Agencies on Aging (AAA) must have professional consultants available to them when a level of care is uncertain, questioned or an appeal may be evident. They are as follows:

- AAA Registered Nurse (RN) for all NFCE assessments reviews and in cases when a level of care determination is difficult to determine. The RN may be asked by the supervisor at any time to make a face to face visit with the individual. This may be with or without the assessor.

- Attending Physician for clarification of an individual's condition when it is not clear during an interview. The Attending Physician should always be contacted when the assessor's determination for level of care is different from the Attending Physician's recommendation. The physician must also be notified in the case of an appeal by the individual.

- AAA Physician Consultant is always notified in the event that the individual is filing an appeal and when the Attending Physician does not agree with the level of care determined by the AAA. They must always either be in attendance for the phone hearing, or provide detailed documentation of their recommendation. The Physician Consultant may also be used to interact with the Attending Physician when there is a difficult case to determine.

- Quality and Compliance Specialist is available to be contacted in the event that the supervisor, the RN and the assessor have consulted on a case and cannot come to a level of care determination. The Quality and Compliance Specialist will review the case and provide technical assistance and/or may refer to the case to PDA's chief medical officer.

- PDA Chief Medical Officer may be utilized when the Attending and the Consulting Physician cannot agree on a difficult level of care determination. Referrals to the PDA Chief Medical Officer must go through the Quality and Compliance Specialist.

For a level of care assessment to be deemed complete, the following must be met:

- The assessor has completed the face-to-face determination of the individual

- The assessor has fully documented the LCD using all sources of information available as outlined above

- The assessor has completed question #5 in Section 13A that summarizes the LCD information and supports the level of care determination.

- The AAA nurse (if required) and Supervisor have reviewed, signed and dated the LCD in section 13C. The MA-51/Script is received by the AAA as required (see Section X above)

Note: Another LCD needs to be completed only is if there a change in condition

(medical or functional) that impacts and changes the individuals most current level of care determination or as requested by the Department of Aging or the Department of Public Welfare. The individual's Attending Physician should complete a MA51\script prior to responding to another request for assessment.

Exceptions to a Face to Face Visit

An assessment without the individual present may occur only in the following situations:

- A nursing home resident in need of Medical Assistance benefits has died before the assessment could be conducted,

- The individual has already been discharged from a nursing home and the assessment is for eligibility for MA during a time period that the individual was in the facility. This should be a rare occurrence as the Nursing Facility is required to contact the AAA for an assessment prior to a discharge.

VI. Other Considerations

- A level of care determination is made regardless of the location (locus) of care at the time of the assessment/re-certification or what program/services the individual may have requested at the time of the referral.

- When an individual has a locus of care change, there is no requirement for an assessment to be completed unless there is reason to believe that a change in condition has occurred that would affect the level of care.

- When a nursing facility requests an assessment to be completed for an MA resident for a second time, there must be evidence that there was a change in condition or the resident requested the assessment. An MA51 is required and a signed consent by the resident or designated other must be submitted with the request.

- When a nursing facility requests an assessment on a private pay resident, there must be an MA51, a signed consent of the resident or designated other submitted with the request.

- All applicants who have been determined to be Nursing Facility Clinically Eligible (NFCE) must apply for the Aging Waiver by completing a PA 600 which determines financial eligibility. The AAA must receive a PA 162 from the CAO to verify eligibility/ineligibility for the Waiver Program. (See OPTIONS Chapter VIII: Mandatory Enrollment)

VII. OBRA Assessments

Federal laws governing nursing facilities were revised, effective January 1989, by *Public Law 100-203*, the Omnibus Budget Reconciliation Act (OBRA) of 1987 (Nursing Home Reform Act), and 42 Code of Federal Regulations (CFR) Sections 483.100 - 483.116. These laws require Pre-Admission Assessments for all individuals initially entering Nursing Facilities to determine if they are Mentally Ill (MI), Intellectually Disabled (ID), or diagnosed with an Other Related Condition (ORC). If an individual is found to be mentally ill or mentally retarded, or diagnosed with another related condition the screening helps determine whether nursing facility care is appropriate or whether the individual needs specialized services.

The Department designates the AAAs as the evaluation agencies responsible for the pre-admission screening under the OBRA statute. The AAA must complete a level of care determination (LCD) and a PASRR-EV on all individuals who are identified as a target and seeking admission to a Pennsylvania nursing home irrespective of funding (see Appendix C for OBRA timeframes).

Forms completed in the OBRA process are:

- Medical Evaluation form (MA-51) - Completed by the physician as part of the level of care determination.

- PASRR-ID Identification Form (PA-PASRR-ID/Level I) - Designed to evaluate whether an individual, requesting admission to a nursing facility, is subject to the determination requirements of the OBRA or document the basis for exempting the individual from the process. The form is a screening assessment and is done for all individuals entering a nursing facility, regardless of diagnosis or payment status. All referrals for a level of care determination for individuals who are applying for nursing home admission) must include a completed PA-PASRR-ID for individuals with a target diagnosis. The OBRA process will address individuals identified as part of one or more of the target

group(s): diagnosis of mental illness, intellectual disability or other related conditions.

- Pre-Admission Screening Instrument (PASRR-EV/Level II) - Designed to enable the AAA to gather additional information and confirm an individual's target diagnosis.

- Level of Care Determination (LCD) - This is the standardized instrument that is used to assess all individuals seeking nursing facility placement. The Level of Care Determination is forwarded to the appropriate Program Office with the assessment packet.

- Transmittal Form - Provides the AAA's recommendation regarding the individual's level of care and recommendation for the need for specialized services. There are two Transmittal Forms currently being used:

    - The Transmittal Form Evaluation Agency to Program Office is completed and sent with assessment packets going to OMHSAS and OLTL.

    - The Transmittal – Preliminary Evaluation Report Recommendation for the ID Target Population form is completed and sent with the assessment packets to the Regional Developmental Disabilities Program Office.

- Program Office Letter of Determination – Generated by the Program Office to notify the individual and the AAA of the final determination. The form letter identifies whether the individual requires a nursing facility level of care and if specialized services for either mental illness, mental retardation or other related conditions is required.

- Your Right to Appeal and to a Fair Hearing– Along with the Program Office Letter of Determination, the Right to Appeal and to a Fair Hearing is sent to consumers by the Program Office as a notification to their hearings and appeals rights under the OBRA process.

Once the AAA has completed the level of care determination (LCD) and the PASRR-EV, the following information is to be included in the assessment packet that is sent to the Program Office. Please refer to the link for specifics by Program Office (Program Office submission packet checklist)**:**

- Completed LCD with Supervisor and RN signatures in Section 12D
- PASRR-ID and if applicable the Out of State ID
- MA-51 (unsigned)
- PASRR-EV.
- Include any information/consultations obtained to document the need for specialized services on the PASRR-EV.
- Transmittal form with recommendation.
- Any other relevant information.

The OBRA process is complete when the AAA receives the Letter of Determination from the Program Office.

Note: The AAA should review each case individually and contact the appropriate Program Office with any questions about what information should be included in the transmittal.

OBRA Special Circumstances

1. Exceptional Admission:

An individual with a target diagnosis that enters a nursing facility based on a PA-PASRR-ID exemption, as indicated in Section V of the form, represents an exceptional admission. There are four exceptions for identified individuals that require nursing facility services:

- Exempted hospital discharge for convalescent care (not more than 30 days);
- Respite care (not more than 14 days);
- Persons requiring emergency placement as certified by the AAA Protective Services Unit (not more than 30 days);
- Persons in a coma or functioning at a brain stem level.

2. Dual and Multiple Target Diagnoses

The assessment may identify individuals who could be appropriately served by more than one Program Office. If an individual is identified who could be served by more than one Program Office, **all** applicable Program Offices are to review the assessment packet. The AAA is responsible to send out only one packet. For individuals who are identified as dual target for OMHSAS and ODP, the order of Program Office review is OMHSAS first and then ODP. Similarly, if the

individual is a dual target for ORC and OMHSAS, the order of Program Office review is OMHSAS first and then ORC. If the individual is a target for all three, the order for review is: OMHSAS, ODP second, and then ORC.

3. Out of State Admissions

The Program Offices cannot accept an ID from another state to issue the Letter of Determination. The AAA can make a determination on an individual's targeted status using the Out of State ID if the AAA determines they have sufficient supporting documentation and completes the PA-PASRR-EV. It is the responsibility of the in-state nursing facility to complete and send to the AAA office a PA-PASRR-ID before or by the day of the individual's admission to the facility. In these circumstances the AAA is to send the entire packet including the Out of State ID, PA-PASRR-ID, and the PA-PASRR-EV to the appropriate Program Office.

4. Current Nursing Facility Residents

In these circumstances, the AAA can at the time of the level of care determination (LCD) complete the PASRR-EV. The AAA should coordinate with the appropriate Field Operations Unit for completion of the PASRR-EV for those individuals who are a target, already residing in a nursing home due to exceptional admission, and now applying for MA funding.

VIII. Personnel Requirements

All AAA staff completing the LCD must be a credentialed assessor. The Department has set forth minimum credentialing requirements for current assessors and they will include:

- Boston University prerequisites
- Pennsylvania Department of Aging Assessor training
- SAMs competency demonstration
- Communication competency demonstration
- Competency Demonstration of basic medical terminology
- Other identified perquisites as determined by the Department
- Successful completion of assessor certification test

LCDs conducted in AAAs who are part of county government and hire staff through the State Civil Service system must be completed by, reviewed and signed off as required by individuals who meet the METS (Minimum Education and Training Standards - click on title for hyperlink to MET's) for one of the following job classifications:

- Aging Program Assessor
- Aging Care Manager 1, 2 or Aging Care Manager 3
- Aging Care Management Supervisor 1, 2 or 3
- Community Health Nurse 1 or 2

Level of care determinations conducted in AAAs that do not use the PA State Civil Service system and complete review and sign off on LCDs must also meet the METs of the positions listed above. Waivers of MET requirements cannot be considered by the Department.

Note: All questions relative to the substitution of "related" education for the required experience or appropriate experience for the required education" should be directed to the Department of Aging, Human Resource Division.

VI. Quality Assurance

Quality Assurance in the AAA and at the state level is critical in measuring processes and procedures required within the program that ensure that quality standards are being met.

AAA

The AAAs must establish and implement a quality assurance procedure to ensure clinical validity, assessor reliability and accuracy of the level of care determination. This may be accomplished through various processes such as:

- Direct oversight of assessment activity
- Utilizing SAMS Reports for monitoring the scheduling of assessments, caseload management, time management, time frames, etc.

- Utilizing benchmark reports for statistical purposes and for monitoring of any outliers against statewide averages.

- Initial and on-going training assessment staff

PDA

The Quality and Compliance Division in the Bureau of Quality Assurance is responsible for monitoring assessment activity in all AAAs by various processes such as:

- SAMS Reports for time frames, re-certification outliers, change in condition referrals, etc

- Benchmark Reports for statistical purposes and outliers of AAAs against statewide averages

- On-site monitoring of assessment activity. The on-site monitoring is conducted by the Quality and Compliance Specialists. A quality tool is completed after a SAMS review of all selected level of care cases. The on-site review includes but is not limited to confidentiality requirements, copies of required forms and fiscal reporting requirements.

- During a quality monitoring review or at the request of the AAA, the Quality and Compliance Division staff will provide technical assistance to assist with quality initiatives.

Resources:

Appendix A - Documentation Requirements

- LCD Instructions

Appendix B – Forms

- Physician Certification Form (example)
- Level of Care Determination Notice
- OBRA Forms

Appendix C - Regulations and Citations- links in this chapter

- OBRA Time Frames

Appendix D - SAMS data entry requirements

- Journal Entries
- Service Delivery
- Activities and Referrals (recommendations)