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Establishing "Nursing Home Level of Care:" How States Vary

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Background

Many states are trying to streamline access to home and community-based services so that consumers have choices about where they can obtain the long-term supportive services that they need. Streamlining access to services funded through Medicaid is a two-part process. One part involves establishing financial eligibility. Technical assistance documents that address ways to streamline financial eligibility have been developed by the Rutgers/NASHP technical assistance team.[1] Establishing "functional eligibility" or "nursing home level of care" for Medicaid is the other part of the process. This technical assistance document briefly outlines the kind of approaches that states are using to establish the "nursing home level of care" threshold that consumers must meet to be eligible for either institutional care or long-term supportive services under a Medicaid "waiver."[2]

Stakeholders who are trying to streamline the "eligibility determination" path to services often ask where they need to focus their energies to make desired changes. In the case of establishing "nursing home level of care thresholds," the states are the primary player. It is true that federal regulations require that states limit eligibility for home and community-based "waiver" services to Medicaid beneficiaries who meet the state's criteria for admission to an institution. However, **states have the responsibility for setting the criteria**. The criteria may be strict or flexible. Stricter criteria limit eligibility for admission to an institution, but they also limit who may be functionally or clinically eligible to receive home and community based services. This fact sheet presents the primary approaches states use to set their criteria and some examples from selected states. The examples were obtained by NASHP during a review of state-assisted living policy and reimbursement practices in 2002.

[1] Expediting Medicaid Financial Eligibility, (2004); Fast Track, Presumptive and Expedited Eligibility, (2005); Medicaid Financial Eligibility, (2005); Maintenance Allowance, (2005); Medically Needy Individuals, (2005). Accessed from www.hcbs.org, www.nashp.org, and www.cshp.rutgers.org.

[2] Determining Level of Care: Must Physicians Have a Role? (2005). Accessed from www.hcbs.org, www.nashp.org or www.cshp.rutgers.org.

State Approaches

States use one of four criteria to determine an individual's eligibility for admission to a nursing home and/or participation in a Medicaid home and community-based services waiver. The four approaches are:

- Medical conditions or needs;
- A combination of medical conditions/needs and functional impairments;
- Functional impairment alone; and,
- Scores from an assessment instrument.

A review of criteria used in 45 states in 2002 found that two states used medical criteria; 13 used a combination of medical and functional criteria; 22 used activities of daily living (ADL) thresholds; eight based their decision on the assessment score; one used professional judgment; and, one used a physician's statement.[3] Assessment score approaches included a mix of medical/functional and functional assessment items.

Examples of each approach are presented below:

Medical: Alabama's criteria allow admission to a nursing facility when nursing care is required on a daily basis, which as a practical matter, can only be provided in a nursing facility on an in-patient basis. Residents must need two services from a list of designated medical services on a regular basis. Hawaii requires intermittent skilled nursing, daily skilled nursing assessment, and 24-hour supervision by a registered nurse or a licensed practical nurse.

Medical/functional: Maine requires individuals to need skilled care on a daily basis (nursing or rehabilitation therapies); *or* extensive assistance with three of the following ADLs (bed mobility, transfer, locomotion, eating, and toileting); *or* one of several specified combinations of nursing and functional needs.

Functional: New Hampshire uses ADLs to establish its minimum criteria. Individuals must need either assistance with two or more activities of daily living, *or* they must need 24-hour care for at least one of the following: medical monitoring and nursing care; restorative nursing or rehabilitative care; or, medication administration.

Scores: Eligibility in Illinois is based on a determination of need (DON) score. The score is derived from the Mini-Mental State Examination (MMSE), six ADLs, nine instrumental activities of daily living (IADLs) (including the ability to perform routine health and special health tasks and the ability to recognize and respond to danger when left alone). Each ADL, IADL, and special factor is rated by level of impairment (0-3)

[3] Mollica, R. (2002). State Assisted Living Policy 2002. Portland, Maine: National Academy for State Health Policy.

and unmet need for care (0-3). Scores for each area are totaled and applicants with a DON score of 29 or more are eligible. The MMSE component is weighted toward people with moderate or severe dementia. The process is designed to target services to people with high levels of impairment who may have informal supports, and to people with lower levels of impairment without informal supports.

States can be arrayed along a continuum from low to high thresholds for nursing home admission (see Table 1 below). Admissions based solely on impairments in one or two out of five to six ADLs would be placed on the low end of the spectrum, those based on ADLs and medical criteria in the middle, and those based on medical criteria on the high end. It should be noted that the placement of states within this continuum is based on a review and comparison of the criteria by the primary author. The actual application of the criteria may be somewhat stricter or more lenient than a state's placement within these categories suggests.

Table 1

Array of Selected States Along Continuum of Nursing Home Admission Criteria									
1 (low)	**2**				**3 (moderate)**			**4**	**5 (high)**
CA	AR	MS			AK	MO		AZ	AL
DE	IL	NE			CO	MT		NC	HI
KS	IA	OK			CT	NJ		UT	ME
NH	IN	TX			FL	NM			MD
OH	LA	VT			GA	ND			TN
OR	MI	WI			ID	PA			VA
RI	MN				MA	SC			
WA									
WY									

Implications of Changes in Criteria

States may change their criteria in response to budget pressures. It is important to note that when the threshold for admission to a nursing home is raised, individuals who no longer meet the criteria cannot be covered by Medicaid in an institution or under a home and community-based services waiver. With this issue in mind, Michigan recently modified its criteria (see Table 2 below) and created a category called "service dependency" that allows Medicaid beneficiaries who have lived in a nursing home for a year or more to remain.

Summary

This technical assistance document is intended to heighten stakeholders' awareness that states set their own criteria for "functional" eligibility, commonly known as the "nursing home level of care threshold." Streamlining access to services should include a close examination of these criteria and how they are implemented.

Table 2

Michigan Level of Care Criteria		
Door	**Areas Scored**	**Threshold**
1: ADLs	(A) Bed mobility, transfers, toilet use and (B) eating	Score of 6: (A) independent or supervision, 1; limited assistance, 3; extensive or total, 4; did not occur, 8. (B) independent/supervision, 1; limited assistance, 2; extensive or total, 3; did not occur, 8
2: Cognitive performance	Short-term memory, cognitive skills for daily decision making, communication	Must have severely impaired decision making, memory problems and moderate or severely impaired decision making, or memory problem and sometimes or rarely understood
3: Physician involvement	Under care for an unstable medical condition	Based on frequency of physician visits and orders
4: Treatments and conditions	Stage 3–4 pressure sores; intravenous or parenteral feedings; intravenous medications; end-stage care; daily trach care, respiratory care, or suctioning; pneumonia; daily oxygen therapy; daily insulin with two order changes in past 14 days; peritoneal or hemodialysis	At least one of nine conditions
5: Skilled rehabilitation therapies	Speech, occupational, or physical therapy	Requires at least 45 minutes of active therapy in last 7 days and continues to require therapy
6: Behavior	Wandering, physical/verbal abuse, socially inappropriate/disruptive, resists care, delusions/hallucinations	Either has delusions/hallucinations or exhibits other behaviors at least 4 of last 7 days
7: Service dependency	Currently receiving services in a NF or waiver program	Must be a participant for 1 year