

**DETERMINING MEDICAID NURSING FACILITY  
LEVEL OF CARE ELIGIBILITY  
IN MARYLAND**

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Management for the Maryland Department of Health and Mental Hygiene  
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## EXECUTIVE SUMMARY

The purpose of this report is to provide an analysis of Maryland's medical eligibility or Level-of-Care (LOC) criteria (medical eligibility) for nursing facility services and the process used to implement the criteria for Medicaid-reimbursed nursing facility services and community-based alternatives. The report also provides options for improvement. The improvement options focus on various goals and expectations of the LOC process.

### **Maryland in the National Context**

Maryland generally reflects national nursing facility characteristics in several key areas:

- Beds per 1,000 people age 65 or above
- Percent of services paid by Medicaid
- Percent of services paid privately
- Occupancy rates

The average home and community based services waiver expenditure per participant age 65 and older in Maryland falls within the highest twenty states in the nation. Expenditures for all waiver programs in the State are somewhat higher than the national average. A national study in 1993 examining eight indicators (listed in text) concluded that Maryland ranked favorably regarding state-level infrastructure for home and community-based services. Like several other states, Maryland is planning for significant enrollment expansion of its waiver program for older adults.

### **How Maryland's Nursing Facility LOC Process is Structured**

Each state designs and implements its medical eligibility (LOC) system based on its interpretation of federal law and regulation. There is no single commonly accepted practice for determining eligibility for Medicaid long-term care. In a 1996 survey of 42 states, three categories of criteria were identified:

- Criteria based on general definitions and guidelines (17 states including Maryland)
- Criteria that require a minimum number of needs or impairments (19 states)
- Criteria that require a threshold score based on an assessment that may have an added clinical review component (7 states).

States' LOC criteria, utilizing any of these categories, have been further characterized either as Medical Necessity Only, Medical/Functional, or Comprehensive (assessing informal supports in addition to medical/functional factors). Maryland's LOC process does not fit any of these commonly used assessment types. Maryland's system has some attributes of Medical Necessity Only but operates more as a Medical/Functional assessment type.

## **Determining Eligibility/Ineligibility in Maryland**

“Sensitivity” and “specificity” can be used to examine the accuracy of LOC criteria. A completely “sensitive” screening instrument/process will identify all individuals who are in need of care, but may also qualify individuals not truly eligible (false positives). Conversely, a completely “specific” screening instrument/process will effectively eliminate false positives, but may also result in the exclusion of some eligible individuals (false negatives). There are considerable data to indicate that Maryland’s process is sensitive, including:

- High approval/low disapproval rates
- Comparative analysis conducted for this report
- Other comparative studies which have been conducted.

The structure of Maryland’s assessment process, with clinical review of initial denials and sometimes multiple review, adds to the medical eligibility safeguards. There are less data and analyses regarding the level of specificity in Maryland. It is more difficult to be precise and predictable regarding any individual’s eligibility/ineligibility within Maryland’s general definitions-and-guidelines approach. Nursing and medical needs approved in one state are highly likely to be approved in other states. Variation between states is more likely to occur in applicants with functional and cognitive impairments.

The three-state comparison conducted for this report with a sample of Maryland approvals and denials generally found that Maryland’s LOC has a comparable or higher approval rate for the identical cases in other states. The three states were selected after consultation with Department staff and from suggestions in a community/provider forum. The states reflect a variety of approaches and LOC methodologies that are described in the Report. One of the three states denied all of the Maryland approvals. Another state collected considerably more assessment data than was available on the Maryland assessment form. The results of a third state were similar to Maryland’s although it denied two Maryland approvals and approved three Maryland denials.

Maryland can improve its screening process by:

- Providing clearer criteria and a more detailed assessment instrument
- Periodically reviewing approvals for reliability
- Moving to a more quantified instrument and process
- Defining “most in need” criteria
- Including additional measures of function and social support.

## **LOC and the Care Planning Process**

In addition to the three-state comparison, interviews also were conducted with officials in four states (Colorado, Arizona, Florida and Connecticut) to learn more about their screening and assessment processes. Colorado has established a

single-point-of-entry system and has linked its LOC process to a comprehensive instrument for screening, assessment, and care planning. Similarly Connecticut screens all seniors including nursing home candidates and has linked its assessment process with care planning through its contracted case management agencies. Florida has a comprehensive assessment instrument used to evaluate clients for state programs, waivers and home care. Almost all applicants in the State are assessed through a home visit by a professional caseworker employed by the state and trained in the administration of the assessment instrument.

While Maryland has not developed a consolidated assessment/care planning instrument or a statewide single point of entry system, the Statewide Evaluation and Planning Services (STEPS) provides a positive step in that direction. The expansion of the home and community-based waiver program may provide an opportunity to move toward a more comprehensive, coordinated, Statewide process that links the LOC determination process and instrument with care planning and case management.

### **LOC and Public Confidence and Predictability**

In addition to determining eligibility and ineligibility, Maryland may also want its LOC process to engender increased public confidence and predictability. There is some evidence of misunderstanding, skepticism, and lack of confidence in the process. Use of a clear and precise scoring system to screen for level of care can reduce the appearance of subjectivity, identify those most in need, allow comparison with private insurance triggers, and provide a level of standardization among State programs. A short-term option to clarify the Maryland criteria and process would include modifications to Transmittal #135 and COMAR. In addition, a LOC instrument and determination process that is more quantifiable, could be used to establish risk-sensitive long term care payment systems for programs serving individuals needing long term care services.

### **Improvement Options**

1. More Effectively Determining Eligibility/Ineligibility
  - Expand the assessment of functional and cognitive impairments to include certain IADLs
  - Expand assessment data to include family and social support services
  - Reliability testing of the approval process
  - Establishing “most-in-need” criteria
2. Enhance the care planning and community placement processes
  - Develop a single point of entry system
  - Develop uniform assessment tools and training for assessors
3. Enhance predictability and promote public confidence through the use of an empirically based assessment process
  - Develop a LOC process and instrument which uses a scoring system
  - OR modify existing regulations or Departmental guidance

- OR assess individuals on a minimum number of impairments/needs basis

## **PURPOSE AND BACKGROUND**

The purpose of this report is to provide an analysis and recommendations regarding Maryland's medical eligibility ("level of care") criteria for Medicaid-reimbursed nursing facility services and community-based alternatives, as well as the processes used to implement those criteria. The information contained in this report focuses on how to accomplish, among others, the following goals:

- The Nursing Facility LOC criteria should appropriately identify eligibility/ineligibility,
- The medical eligibility screening process should enhance care planning and appropriate placement for the individual,
- The criteria and processes should enhance public confidence and predictability by use of an empirically-based assessment process.

The report presents various options and a prioritization framework for pursuing options for change. Providing a national context for Medicaid long-term care (LTC) in Maryland is intended to assist in the prioritization process. The report's analysis is constructed on the following:

- a literature review of pertinent studies and research,
- various analyses of the eligibility assessment criteria and determination process in Maryland,
- comparison of Maryland's criteria and processes with those of selected other states, and case studies from states that have addressed similar issues.

These components are synthesized in four sections. Section I provides a general context for Medicaid LTC in Maryland as well as a specific context for the level of care (LOC) criteria and processes by examining elements common to Maryland and other states, as well as those that differentiate Maryland's approach. Section II examines eligibility/ineligibility determinations to assess the efficacy of the LOC criteria and processes. Section II also examines aspects of Maryland's eligibility assessment process, and identifies options for change. Three additional goals that could be linked to the assessment process and the LOC criteria, ranging from care planning to establishing objective criteria for providers and consumers also are examined. Section III reviews the experience of selected states with the LOC criteria and processes. Section IV contains select observations and conclusions drawn from the issues presented in this report.

## I. MARYLAND MEDICAID LTC IN NATIONAL CONTEXT

### A. LTC Service Use and Spending

Maryland is a microcosm of U.S. long-term care service use and institutional spending. The majority of nursing facility services are funded by the Medicare and Medicaid programs. Nursing facility services reimbursable by Medicare are covered under the “Hospital Insurance Benefits for the Aged and Disabled” provisions of Title XVIII of the Social Security Act, popularly known as “Medicare Part A - Hospital Benefits.” Medicare covers post-hospitalization skilled nursing care and rehabilitation services provided by a “skilled nursing facility” (‘1819(a)(1) of the Social Security Act, 42, U.S.C. 1395i-3(a)(1)). Medicaid-reimbursed “nursing facility” (NF) services are provided to state residents who meet the Medicaid technical, financial, medical, and functional eligibility requirements. Nationally, as of 1997, there were approximately 1,813,665 beds in 16,995 nursing facilities, with an average occupancy rate of 83 percent. This translates into 51 nursing facility beds per 1,000 people age 65 or above.

Throughout Maryland, there are 239 facilities and 28,936 beds, also equaling 51 beds per 1,000 people age 65 or above. Nationally, nursing facility services are funded by Medicare (8 percent), Medicaid (68 percent), and private pay (23 percent). In Maryland, nursing facility services are funded by Medicare (8 percent), Medicaid (66 percent), and private pay (26 percent) (American Health Care Association, 1997).

Maryland has 239 nursing facilities and 28,936 beds, which equals the national average of 51 beds per 1,000 people age 65 or above.

In Maryland, nursing facility services are funded by Medicare (8 percent), Medicaid (66 percent), and private pay (26 percent), closely reflecting national funding averages.

### Home and Community-Based Services

Over the past fifteen years, Medicaid 1915(c) home and community-based services (HCBS) waivers have made a substantial contribution to states’ efforts to transform their long-term care delivery systems from largely institutional to community-based. By 1997, with the exception of Arizona, every state had implemented a 1915(c) waiver program for at least some subgroups of individuals with disabilities. Waiver expenditures have increased from \$3.8 million in 1982 to over \$8.1 billion in 1997. States vary markedly in their use of home and community-based waivers relative to optional community-based services, such as personal care, and institutional services, such as nursing facility care. The average annual Medicaid long-term care expenditure per person age 65 and older in 1995 was \$967, varying from \$2,440 in New York to \$383 in Arizona. Maryland’s average expenditure was \$721 per person, placing it in the top twenty states. Average annual payments for HCBS waivers ranged from \$1,180 in New York to \$29 in Mississippi (Wiener et al., 1997).

## **Nursing Facility/HCBS Spending Ratio**

The cost to Medicaid of treating the average person in an HCBS waiver program is typically lower than the average cost of a nursing home day in the same state. However, the lower reported daily costs of waiver care as compared to nursing home care do not necessarily translate into Medicaid savings. Program savings would depend upon whether a waiver recipient would have actually used nursing home care had the recipient not received waiver services, as well as for how long.

Recent research has suggested that expansion of HCBS waiver programs may increase total long-term care spending due to the participation of individuals who would not have sought institution-based long-term care services. As a result, the costs that would have been saved by diverting individuals from nursing home care could be more than offset by an increase in those seeking home and community-based care (Wiener & Stevenson, 1997).

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## **Waiver Programs**

All fifty states and the District of Columbia have been approved for 1915(c) waiver programs, although Arizona has opted to institute an 1115 waiver instead. In 1997, Maryland operated three waiver programs; one targeted at persons age 62 and over, one at individuals with mental retardation or developmental disabilities, and one at medically fragile children. Maryland spent \$146 million on these programs in 1997, which was 3.5 percent above the national average and 17.9 percent of total LTC spending in the State. The majority of those monies were spent on the program serving individuals with developmental disabilities.

## **Infrastructure Analysis**

Infrastructure includes quality assurance measures and systems for coordination of care. It covers both the providers and services available and the state agencies that oversee such delivery. Research suggests that there are eight components to ensuring optimal, cost-effective infrastructure (Leutz et al., 1993). The components are:

- Pre-admission Screening (PAS)
- Comprehensive Assessment, Planning, and Management of Care (CAPM)
- Single Entry Points for CAPM and PAS
- Medical Linkage between Providers and CAPM Agency
- Licensure/Certification
- Contracts or Memoranda of Understanding

- Statewide Availability of Basic Services
- Insurance Oversight

Research indicates that, as of 1993, there were no states that met all eight or even seven of the criteria. Nine states (Connecticut, Georgia, Illinois, Maryland, Massachusetts, Minnesota, Nevada, Oregon, and Washington) met either five or six of the criteria. Among these nine states with well-developed infrastructures for LTC services in 1993 all had statewide Medicaid 1915(c) HCBS programs in place, as well as other community-based programs.

A study of state LTC programs determined that Maryland was one of only nine states with a well developed infrastructure for LTC services

## B. Defining Elements of Maryland’s LOC Criteria and Processes

### 1. Definition and Criteria

Medicaid eligibility for nursing facility services is set by federal law and regulation. The states design and implement their individual Medical Assistance programs, and independently interpret application of federal eligibility rules subject to federal oversight. Before 1987, skilled nursing facility and intermediate care facility services were separate Medicaid benefits: the former was mandatory, the latter optional. The Omnibus Budget Reconciliation Act of 1987 (OBRA 87) combined them into a single mandatory “nursing facility” benefit.

Maryland promulgated eligibility criteria for “nursing facility services” as COMAR 10.09.10.01B(31). “Nursing facility services” are defined as services *“provided to individuals who do not require hospital care, but who, because of their mental or physical condition, require skilled nursing care and related services, rehabilitation services, or, on a regular basis, health-related care and services (above the level of room and board) which can be made available to them only through institutional facilities under the supervision of licensed health care professionals.”*

Maryland’s Department of Health and Mental Hygiene (referred to as “the Department” or “DHMH”) employs official advisories termed “transmittals” to notify its contractors and providers of the agency’s interpretation of law and regulations governing the Medical Assistance Program. In 1994, the Department issued Nursing Home Transmittal #135, which summarizes and explains eligibility criteria for the combined skilled/intermediate “nursing facility services” based on applicable federal and State law (Maryland’s LOC criteria is discussed in more detail in Section II of this report).

Eligibility criteria in seven states rely on scoring, 19 states require a minimum number of impairments and/or needs, and 17 states, including Maryland, use eligibility criteria based on general definitions and

There is no commonly accepted practice for determining eligibility for Medicaid LTC programs. At the macro level, states employ three types of eligibility criteria: those that employ an instrument which assesses and scores specific factors, such as ADLs, and requires a minimum score for eligibility (7), those that identify specific factors that will be considered and require a minimum number of impairments and/or needs for determining eligibility (19), and those, like Maryland, that establish eligibility criteria based on general definitions and guidelines, culled from the Federal regulatory definition for NF LOC eligibility, which are used to guide assessors in evaluating information obtained through the assessment process (17) (O’Keeffe, 1996).

## **2. Maryland’s NF LOC Determination Assessment and Review**

### **Assessment Type**

Long-term care screening and assessment programs are designed by states to control LTC costs and to prevent unnecessary institutionalization of Medicaid participants. A 1995 study conducted by Snow indicated that a state’s criteria can typically be grouped into one of three classifications. The three classifications are:

- Medical Necessity Only
- Medical/Functional
- Comprehensive

*Medical Necessity* requires that an applicant need the services of a licensed professional for help with medical problems, and as such, it is considered the most stringent of the three types of criteria. Only two states were determined to be using such criteria.

*Medical/Functional* classification considers applicants’ need for nursing services as well as their cognitive functioning and functional ability to carry out activities of daily living (ADLs). Twenty-four states employ these criteria.

*The Comprehensive* category includes the components of the Medical/Functional definition, but also considers issues such as the ability to perform instrumental activities of daily living (IADLs) and other social support factors. Twenty-two states currently use the Comprehensive assessment type.

Snow concluded that Maryland does not easily fit into any of these three criteria types, but rather contained elements of both the Medical Necessity and Medical/Functional classifications. Maryland’s criteria cannot be easily categorized because Maryland employs broader-based criteria derived

from the federal Medicaid definition of nursing facility services. Maryland requires that a beneficiary must need skilled nursing care or related services, rehabilitation services, or health-related services above the level of room and board, but in order to establish medical eligibility, these services must be available only in an institutional setting and performed under the supervision of a licensed health professional (Transmittal #135). At least one other study was unable to classify Maryland's criteria determining that although it was probably best categorized as Medical Necessity, items such as incontinence, functional status, cognition, and orientation are included in the physician assessment that Maryland uses, meaning that functional concerns may impact eligibility determination (CHSRA, 1998).

### **Assessment and Review Process**

Tonner, LeBlanc, and Harrington (2000) studied data collected from all fifty states and Washington, D.C. on state variations in LTC screening and assessment programs during 1998 and 1999. Overall, there were 247 screening and assessment programs for LTC in the states, which were administered by 190 agencies. Only four states had a single administrative agency for all LTC screening and assessment. There is a lack of uniform criteria across programs and states, which may be the result of having multiple agencies responsible for screening and assessment. As of 1992, twenty-eight states relied on providers to make pre-admission screening (PAS) assessments, eleven relied on state staff, seven relied on a combination of state and provider staff, and five relied on private contractor staff (Harrington & Curtis, 1996).

As of 1992, twenty-eight states relied on providers to make pre-admission screening (PAS) assessments, eleven relied on state staff, seven relied on a combination of state and provider staff, and five relied on private contractor staff

Maryland uses DHMH form 3871 for Medicaid nursing facility LOC, chronic hospital, waiver, and medical day care eligibility certification. Any provider may fill out form 3871, but it must be signed by a physician as certification that such services are needed. The signed form is then forwarded to the Delmarva Foundation for Medical Care, Inc., the Peer Review Organization (PRO) contracted by Maryland to make medical eligibility determinations. Nurses employed by Delmarva make the eligibility determinations, but denials require review by a physician advisor. Prior to any denial being made a nurse assessor personally visits with the applicant.

## II. EVALUATING THE EFFICACY OF LOC CRITERIA AND PROCESSES

The following analysis considers three primary goals of a level of care determination process:

- 1. The Nursing Facility LOC criteria should appropriately identify eligibility/ineligibility**
- 2. The medical eligibility screening process should enhance care planning and appropriate placement for the individual**
- 3. The criteria and processes should enhance predictability and promote public confidence through the use of an empirically-based assessment process**

Each goal is discussed in terms of the current status in Maryland, comparative information from selected other states and national studies, and options for improving the Maryland process.

### **1. Goal #1: The Nursing Facility LOC criteria should appropriately identify eligibility/ineligibility.**

Maryland's performance against this threshold goal is examined through the consideration of:

- A. Maryland LOC Criteria and Other States**
- B. Maryland Approval/Disapproval Rates**
- C. Maryland Criteria and Processes and Targeting the Functionally and Cognitively Impaired**

This section examines these three issues and highlights some options for improvement.

#### **A. Maryland LOC Criteria and Other States**

##### *Background:*

A paper comparison of LOC criteria and measurements used by states is of limited utility since each state is unique in how it actually measures, weights, and combines these factors for determining eligibility (O'Keeffe, 1996). Therefore, in order to examine the interstate variance between Maryland and other states, actual Maryland applications (approvals and denials) were evaluated by other states, using their instruments and processes, to compare their approval /disapproval outcomes. A select sample of twenty Maryland applications was chosen for comparison. This was a non-random sample selected to identify individuals whose eligibility was considered borderline, with primarily functional rather than medical indicators, by Maryland. The twenty cases were selected by a DHMH

Medical Review Team from a sample of cases drawn by the contracted agency (Delmarva). The cases generally represent individuals with a variety of functional and cognitive impairments. These cases consisted of 10 approvals and 10 denials of a NF LOC. The three states selected for comparison contrast with Maryland in their types of assessment process, instruments, and criteria (TABLE ONE, p. 50). Clinical information from Maryland's 3871s was applied to each state's PAS by CHPDM. (Demographic information and Maryland's determination of LOC for the cases was not disclosed to the three states). The cases were then reviewed by the three states applying their individual LOC criteria. This was a first level review; denied applications were not forwarded through the state's second level process.

*Considerations:*

*State A's Results*

The results from State A's review revealed that seventy-five percent of their determinations were the same as the Maryland determinations (TABLE THREE, p.52). Of the twenty-five percent of the determinations that were different, State A approved three cases that Maryland had denied and denied two cases that Maryland had approved.

State A is most like Maryland in three significant areas:

- Guidelines and definitions are used to determine NF LOC
- The majority of the criteria that is used for determinations is in the medical/functional sections of the PAS (TABLE TWO, p. 51)
- Clinical professionals are utilized to make the determinations, RNs in Maryland, and RNs and social workers (SWs) in State A.

These similarities may account for the relatively high rate of consistency between the two states' determinations. The variance between the results of Maryland and State A are as follows:

- 1) On one Medical Day Care case that Maryland denied, State A slimly approved, the diagnosis was hypertension and history of dementia.
- 2) Maryland approved two Medical Day Care cases with psychiatric diagnoses; State A denied both of these cases.
- 3) Maryland denied two cases for NF LOC -one had a primary diagnosis of dementia, the other one had a secondary diagnosis of dementia (primary diagnosis was general weakness). State A approved both of these cases.

Compared to State A, Maryland is more liberal in applying criteria to Medical Day Care applications. State A denied two out of four of the

Medical Day Care applications that Maryland approved (TABLE THREE, p.52).

State A may be more liberal in applying criteria to certain diagnoses like dementia-as none of the cases they denied contained a dementia diagnosis regardless of ADL need.

Transmittal #135 includes under NF LOC “health-related care and services to individuals who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities . . . which must be performed by, or under the supervision of licensed professionals.” State A’s definition of the lowest intermediate nursing home care requires that health related services be provided to individuals who are disabled and ill and require medical supervision or nursing services. Maryland and State A’s definitions are similar in that eligibility for “intermediate” type LOC is based on medical and functional components requiring the services or supervision of a medical professional.

#### State B’s Results

State B denied LOC eligibility to every Maryland case (TABLE THREE, p. 52). Although half of State B’s determinations were the same as Maryland’s, it is important to note that the variance is significant. State B uses a scoring system. An RN or SW tallies scores obtained from the PAS results. Two scores are given to each case from information on the PAS. The first is a functional score. This score includes weighted scores for ADLs, continence (bowel and bladder), sensory (vision only), orientation, and emotional/cognitive behavior. The most heavily weighted scores are given to eating, mobility, bathing, dressing grooming and toileting respectively. The second score is the medical score. This score includes services and treatments (skilled nursing responsibilities). A total score is produced from the sum of the functional and medical scores. Approval for eligibility requires a total score at or above a fixed, weighted threshold (60) on the PAS; a total score of less than 60 is forwarded to a physician advisor who reviews the case and makes the final LOC determination.

The scores received from State B given to the Maryland cases ranged from 2 to 58.25. The diagnoses on the least scored case are hypertension and insulin dependent diabetes mellitus and the case was approved for Medical Day Care by Maryland. This case was given a medical score of 2 and denied by State B as the functional score was zero. Documentation on the PAS indicated that the applicant was functioning independently in ADLs.

Maryland approved State B’s highest scored case (58.25) for NF LOC. The primary diagnosis on this case is change in mental status with

delirium. Although the functional score equaled 48.75, and the medical score included points for behavior issues and required skilled nursing services (9.5), the total score did not equal the points required to meet the threshold score (60) and the case was denied.

State B also limits eligibility to only those likely to require at least three months of long-term care. State B's criteria are very strict as suggested by their denial of each of the cases both Maryland and State A approved for intermediate NF LOC. Clearly, a LOC assessment process based on a scoring system can be applied strictly or liberally by adjusting elements such as the threshold score and the weight applied to the information collected.

### State C's Results

State C's process and assessment form used to determine LOC is very different from Maryland's. State C utilizes a single point of entry system for all aged persons seeking LTC services. Also, their PAS form is a comprehensive assessment used for two purposes; first, to develop a care plan and, second, to place applicants for LTC services into the appropriate LTC program that best fits their needs. State C's eligibility determination methodology is similar to State B's as scoring is used to determine LOC eligibility, although their scoring is less severe. A threshold, weighted score of 20 must be obtained on the PAS to be eligible for NF LOC. A physician advisor reviews the case if a score of less than 20 is obtained, and makes the final LOC determination. Case managers (usually social workers and some RNs) complete State C's PAS form. Upon completion, the form is sent to an RN at the PRO for LOC determination.

State C could not establish a level of care determination with the limited information transcribed from Maryland's 3871s. Maryland does not gather information sufficient to complete State C's pre-admission screening form. In an effort to analyze State C's PAS and to learn what was important in their LOC determination process, required information was constructed from reasonable professional assumptions based on available information from the 3871s. The information constructed included documentation of need for caregiver and how often for ADLs (client's ADL functional capacity score "independent to severe" was transcribed from the 3871), need for caregiver and how often for IADLs, previous hospitalizations within the last six months, and a mini-mental score. This information was applied to State C's assessment forms and re-submitted to their PRO for determination scoring.

It would not be appropriate to compare the LOC results of State C with States A and B, however discussion of the results is pertinent as it provides insight into State C's scoring process. The distinguishing characteristics that either led a State C PAS to approval or denial were the

heavily weighted criteria for disabilities such as mobility, bowel and bladder incontinence, and mental impairment. The score for these disabilities increases as their severity intensifies. Scoring for IADL criterion is more lightly weighted. State C places emphasis when making a LOC determination, on the severity of physical disabilities and mental impairment, instead of instrumental activities of daily living.

State C approved eight of the Maryland cases and denied 12. None of the denied cases, however, were reviewed by a physician advisor. Of the cases that Maryland approved State C approved 40% and consensus with Maryland denials was 60%. Of the ten cases that Maryland approved and State C denied (6) constructive information was applied to IADLs indicating “severe impairments”, requiring a paid care taker. ADLs were documented as “independent to moderate impairments” (information transcribed from the 3871s) requiring a paid caretaker (constructed information). Two cases had low scores in mobility and none had scores in bowel or bladder incontinence. Two of these cases had documentation of a hospitalization within the last six months (information transcribed from the 3871s) and none had a “failing” mini-mental score (constructed information based on the primary and secondary diagnoses). Four of these denied cases were Medical Day Care applications.

Of the four approved cases by State C that Maryland also approved, all of the ADL functional capacity scoring was constructed to reflect a much more “severe” impairment score than the ADL functional impairment score documented on the corresponding 3871. IADLs were also scored as “severe” impairments (constructed information). Two cases reflected documentation from the 3871 that indicated recent hospitalizations and one case had a “failed” mini-mental score (constructed information).

Of the ten Maryland denials, State C approved four cases and denied six. All of the approved cases contained transcribed information from the 3871s that indicated “little to moderate” impairments in ADLs; and constructed information requiring a caregiver for ADLs, and “severe” impairments in IADLs requiring a caregiver. None of these cases had a recent hospitalization documented and one case had information constructed to indicate a “failing” mini-mental score. The important aspect to note in this group is that they all had “moderate” impairment scores in both mobility or bowel/bladder incontinence and “severe” impairment scores in IADLs.

The six cases that State C and Maryland denied contained information transcribed from the 3871s indicating functional capacity in ADLs ranging from “independent to moderate” impairments; and constructed information depicting “little to moderate” impairments in IADLs and requiring no caregiver for either ADLs or IADLs. One case contained information about

a recent hospitalization (transcribed from the 3871) and none contained a “failing” mini-mental score.

Without the constructed information in the IADL section of the PAS demonstrating “severe” impairments and caregiver needs, State C would have denied all but two cases. The two cases that would have been approved without the enhanced IADL information scored very high in the ADL categories of mobility and bowel/bladder incontinence. Information regarding level of impairment (independent to severe) of functional capacity in these categories was transcribed from the 3871s, but other needed information describing the functioning of the client within these levels of impairment (i.e. caregiver help and how often) was constructed.

**Comparison of State C’s Determinations with Maryland’s by Percentages**

	Maryland	State C*	State C**
Total % Approved	50%	returned	40%
Total % Denied	50%	returned	60%
Consensus on MD Approvals		returned	40%
Consensus on MD Denials		returned	60%

\* State C’s PAS forms containing limited information transcribed from 3871s.

\*\* State C’s PAS forms containing constructed information.

Summary

Each of the states participating in this review were different in the method and type of information they collected on their PAS forms, and in placing importance on the criteria used to make the final determinations.

This study was developed to compare three other states’ LOC determinations with the state of Maryland using twenty cases selected by a DHMH Review Team. Both States A&B denied eighty-five percent of Maryland’s denials (State C’s findings are not included as some of the information applied to those reviews was constructed). State A denied seventy- percent and State B denied 100% of the cases denied by Maryland. Of the cases that were approved by Maryland, eighty percent were also approved by State A and zero per cent were approved by State B. (Please see table below).

**Comparison of State A & B's Determinations with Maryland's by Percentages**

	Maryland	State A	State B	State C***
Total % Approved	50%	55%	0%	40%
Total % Denied	50%	45%	100%	60%
Consensus with MD Approvals		80%	0%	40%
Consensus with MD Denials		70%	100%	60%

\*\*\* State C's PAS forms containing constructed information.

The comparison between the final determinations is illustrated in TABLE THREE (p. 52).

Important information can be noted from this study that reaches beyond comparing the final determinations. First, a severe scoring system can prevent "intermediate care" individuals from entering the LTC arena. In State B's example, the threshold score was set quite high; applicants require significant needs in ADLs and skilled nursing to be approved for NF LOC. In State C's example, approved cases are limited by requiring moderate to severe impairments in several categories i.e. mobility, bowel/bladder functioning, IADLs and mental impairments. Second, state processes for determining the LOC are quite unique yet there were similarities between all of them. For example, the three states used either RNs or SWs who are trained to perform the assessment and uniformly complete the PAS. Finally, the PAS forms served as examples that reflected the State's LTC programs and priorities. An illustration of this is State C which collects information about the applicant's need for help from someone on every ADL and IADL, and assesses significant recent life events (death of a spouse, change in residence, injury/accident). This information is used to develop a plan of care and to determine the long-term care program that is of most benefit to the applicant.

The results of the three state analysis of Maryland approvals/denials indicates that Maryland is the same or less restrictive than the comparison states.

*Additional Studies*

Another multi-state study indicates that Maryland's criteria, although initially considered strict in application, tended to yield a high degree of approvals. The PACE Rate Work Final Report issued by the Center for Health Systems Research and Analysis (CHSRA) in 1998 presented the results of a study to determine if participants of the Program for All-Inclusive Care of the Elderly (PACE) were consistently eligible in states using different LOC criteria. Based on the criteria identified by Snow and referenced in Section I of this document, CHSRA randomly selected

states representing each criterion. Maryland was initially selected as a state using Medical Necessity Only criteria but was then determined to be unique in its criteria. CHSRA chose to keep Maryland as one of the sample states but added another “true” Medical Necessity Only state. The CHSRA study determined that, although states use varied criteria, there is a great deal of overlap among the definitions. Individuals who met the LOC criteria in states using Comprehensive criteria were nearly all likely to be deemed eligible in states using the Medical Necessity Only and Medical/Functional criteria. It was also determined that regardless of the criteria used, twenty to thirty percent of all those starting a year as eligible and surviving the year will not remain eligible. CHSRA also determined that its study could not account for the importance or influence of the role that clinical judgement plays in determining eligibility. Of the nine states studied, Maryland was found to have a relatively high rate of approvals among the sample population. This finding also contradicted the study’s initial determination that Maryland’s was a Medical Necessity Only system.

Of nine states studied by the Center for Health Systems Research and Analysis, Maryland was found to have a relatively high rate of approvals among a sample population of PACE participants. This finding contradicted the study’s initial determination that Maryland’s was a Medical Necessity Only system.

## **B. Maryland Approval/Disapproval Rates**

### *Background:*

The goal of a state’s LOC criteria and medical eligibility processes is to identify those who are in need of nursing facility level of care among those who meet the technical and financial requirements of the Medical Assistance Program, and to then provide the most appropriate care available within the state’s finite resources. The effectiveness of determining medical eligibility can be measured in several ways, including the “sensitivity and specificity” approach (Jackson et al., 1992). A completely “sensitive” screening instrument/process will identify all individuals who are in need of care, but may also qualify individuals not truly eligible (false positives). Conversely, a completely “specific” screening instrument/process will effectively eliminate false positives, but may also result in the exclusion of some eligible individuals (false negatives). One goal of a state’s LOC screening process should be to establish criteria that balances sensitivity and specificity.

Sensitivity and specificity can be used to examine the accuracy of LOC criteria. High sensitivity casts a wider net but increases the likelihood of false positives. Increased specificity narrows the field but also may increase the number of false negatives.

*Considerations:*

Maryland has for several years maintained a high approval rate for nursing facility applicants seeking a LOC determination (e.g. 99.7% in 1998). This high rate of approval indicates that there is a high level of sensitivity, i.e. needs are identified through the assessment instrument and process. These high rates of approval must, however, be interpreted with caution since the applicant population does not necessarily reflect the need of the general population. Research has determined, for example, that PAS programs can discourage applications from those who feel they would be found ineligible (Harrington & Michael, 1996). Members of the advocate community have expressed concern that this factor may account for Maryland's relatively low disapproval rates. In addition, the knowledge of the professional assessor (or provider who is conducting the assessment) regarding the state LOC criteria and guidelines can be a major factor influencing whether the application process is conducted or completed. (The assessor in these instances acts as a pre-screener.) The relatively high approval rates in Colorado and Florida (see State Case Studies in Section III) were attributed by state representatives, to this pre-screening factor. While exercising caution in interpreting approval rates there are reasonable indications that Maryland is not strict in the application of its criteria.

The high applicant approval rate in Maryland indicates a high level of sensitivity to those *applicants* who are in need of a nursing home level of care. Comparisons with other states as well as recent studies of Maryland's criteria fortify this conclusion.

Finally, a flexible *interpretation* of the LOC criteria and guidelines could be a contributor to Maryland's high approval rates rather than the nature of the criteria and guidelines themselves. As noted in more detail in Section II of this report, a "criteria and definitions" approach to LOC assessment and determination used in Maryland and several other states, involves more "subjectivity" since a health professional plays a key role in determining the need for services. In contrast, "sensitivity" and "specificity" measures require that objective decision rules be applied when determining eligibility (Jackson et al., 1993). In Maryland, the medical decision making also involves a separate review of all initial disapprovals, by a physician advisor. This could be a contributor to Maryland's high approval rates.

The low *disapproval* rates signal the possibility of a low level of "specificity" in Maryland's determination process, resulting in the admission of applicants whose eligibility would be denied pursuant to assessment with a more specific instrument. This factor is particularly important as Maryland seeks to expand its waiver program for seniors.

The waiver expansion initiative will likely induce a wider “demand” resulting in an applicant pool with more varied needs.

### **C. Maryland Criteria and Processes and Targeting the Functionally and Cognitively Impaired**

#### *Background:*

How the Maryland criteria and processes respond to the needs of individuals who are functionally impaired is of particular interest in a system that cannot be easily categorized as a Medical Necessity or Medical/Functional type system. As noted earlier, Maryland’s criteria cannot be categorized unequivocally (Snow, 1995), but does contain attributes of a Medical Necessity system which also considers functional limitations. Regardless of the type of approach used by any given state, almost all (94 percent) state LOC assessment programs (including Maryland) consider ADLs and mental impairment in addition to nursing/medical conditions (Tonner et al., 2000). Maryland’s assessment process, while assessing the need for cueing and prompting, does not significantly consider IADLs in addition to ADLs.

Nearly all state LOC assessment programs consider ADLs and mental impairment in addition to nursing/medical conditions.

Maryland’s criteria also attempts to account for cognitive impairments. The Advisory Panel on Alzheimer’s Disease recommended in 1991 that eligibility criteria should be based on the following measures of impaired functioning:

- ADL measures, including cueing
- The need for supervision to protect against the consequences of impaired judgement or disruptive behavior

In consultation with representatives from the Alzheimer’s Association, a new section was added to Maryland’s medical eligibility review form (3871) in 1994. Included were indicators for memory/orientation, cognitive skills for daily decision making and safety, communication, behavior issues, and mini-mental scores. Even though the information requested as part of the review process was changed to allow full consideration under the existing criteria of individuals with dementia, Maryland has been identified (O’Keeffe, 1999) as one of sixteen states that require meeting a medical criteria (nursing need) in addition to the criteria recommended by the Advisory Committee.

*Considerations:*

Individuals with defined medical/nursing needs requiring skilled nursing services are the most likely to be successfully screened for a NF LOC in any state. Individuals with medical/nursing (skilled) needs who are determined to require a NF LOC in Maryland are likely to be determined eligible in almost all other states as well (CHSRA, 1998). Individuals with cognitive and/or functional impairments are more problematic when being assessed for NF LOC and will experience more interstate variance. Any expansion or enhancement of the Maryland LOC determination process will necessarily focus on the screening criteria relating to functional/cognitive impairments.

Using IADLs as well as ADLs allows for a more precise assessment of the functional disability of applicants. Studies have indicated that a combined ADL/IADL scale serves to more effectively target individuals with functional impairments (Spector & Fleishman, 1998). (Adding IADLs may or may not increase the number of new eligibles since the setting of the ADL/IADL scale “cut-off point” by the state determines the eligibility threshold.)

The identification of appropriate criteria to determine home and community-based waiver eligibility for the cognitively impaired is a major concern of advocates. For individuals with functional disabilities, the effects of introducing IADLs into the assessment process have been previously described. Some of these same effects apply to individuals with dementia. In general, “people with dementia are more likely to meet LOC criteria that consider IADLs because IADL limitations typically precede the development of ADL limitations” (O’Keeffe, 1999). However, IADL eligibility criteria may be inadequate to determine the level of cognitive impairment and thus the appropriate level of care needed. The use of both behavioral and mental-status-test criteria may be an important consideration in determining need for care (Fox et al., 1999).

Individuals with dementia are more likely to meet LOC criteria that consider IADLs, however, such criteria may fail to determine the level of cognitive impairment. Using behavioral and mental-status-test criteria may be an important consideration in determining need for care.

The “Medical/Functional” assessment type (See Section I,B,2) used by Maryland does not weigh (or record) the level of informal supports provided by the family or community (Comprehensive Assessment type). Approximately half the states capture and consider this information in the LOC process. The general definitions and criteria approach used in Maryland, does not rely on detailed functional and cognitive impairment data. The Maryland assessment instrument does not record IADL limitations. The lack of detailed information presents limitations in

identifying and weighing functional and cognitive impairments and assessing individual needs. For example, it has been estimated that functional triggers based on ADLs alone (no IADLs) may exclude over half the people with cognitive impairments (Alecxi & Lutzky, 1996). Using IADLs as well as ADLs allows for a more precise assessment of functional disability and generally increases sensitivity to dementia as noted earlier in this section.

*Improvement Options Related to the Threshold Goal of Effectively Determining Eligibility/Ineligibility*

- Expand the assessment of functional and cognitive impairments to include certain IADLs that will allow the opportunity for targeting priority populations and improved identification of individuals with functional and cognitive impairments. This may be beneficial since the waiver expansion initiative may induce a wider “demand” resulting in an applicant pool with more varied needs.
- Expand assessment data to include information regarding individuals’ community, family, and social supports (transition from “Medical/Functional” assessment type to a “Comprehensive” assessment type) in order to better identify needs and individuals at higher risk.
- Ensure the appropriateness of “approvals” through periodic review by the Department of the contracted agency determinations.
- Consider establishing clearly defined “most in need” functional/cognitive criteria.
- Test the consistency of the screening process (e.g. inter-rater and time sensitive reliability tests) to identify and correct as necessary and practicable, the variation or subjectivity that accompanies a “criteria and definitions” approach.

**2. Goal #2: The medical eligibility screening process should enhance care planning and placement for the individual**

In 1994, The General Accounting Office (GAO) issued a report that highlighted the connection between the medical eligibility assessment efforts conducted by state Medicaid agencies and individual care planning. The report determined that, of the forty-nine states that responded to the survey, all used an assessment instrument to determine individual care plans. Forty-three states used the assessment to determine an elderly person’s functional eligibility for waiver programs, and thirty-one states use part of the instrument as the preadmission screen for nursing facility care. The GAO also found that

all instruments gathered information about physical health, mental health, and functioning. The vast majority of assessment instruments also collected information regarding availability of social services, economic resources, and the applicant's physical environment. The report concluded that less comprehensive instruments should be evaluated in the context of their particular programs to determine if sufficient information is being collected (GAO, 1994).

The efforts of several states in linking assessment and care planning have been recorded. Colorado's, Oregon's, and other states' efforts to reduce fragmentation and institutional reliance have resulted in the use of uniform assessment tools for multiple state waiver and LTC programs (Coleman, 1996). Consequently, client transition across various long-term care settings and programs is facilitated. A number of strategic initiatives contribute to effectively linking the assessment and care planning process:

- Ensure that assessors are trained in the use of any new instrument
- Develop uniform assessment tools requiring a high level of cooperation among state-sponsored programs
- Develop a single-point-of-entry system at the local level

The Colorado and Connecticut experiences (see Section III of this report) suggest that the significant effort to link care planning and assessment requires a clear policy direction by the state. The magnitude of such an undertaking also requires the support that emanates from a state strategic long-term care plan and considerable interagency collaboration. Maryland has had considerable experience with care planning and coordination of services under previous and current programs including:

- Adult Evaluation and Review Services (AERS) which performs Comprehensive Long Term Care Evaluations including Statewide Evaluation and Planning Services (STEPS), Preadmission Screening and Resident Review (PASRR) and Geriatric Evaluations Services.
- Home and community-based waivers and other State programs (i.e., Senior Assisted Housing, Project Home) (LTMCAC, 1996).

Maryland has developed some significant care planning/case management programs and the current waiver expansion effort presents an opportunity to further introduce and train professional nurses and clinical social workers through the AERS Program. AERS provides evaluation and assessment services to aged and functionally disabled adults who are at risk of institutionalization with the goal of identifying alternatives to nursing facility placement. Everyone evaluated receives a comprehensive evaluation, including medical/nursing, functional, psychosocial and environmental assessments. Under STEPS, any Medical Assistance recipient or individual who would establish Medical Assistance eligibility within six months of

admission to a nursing facility is mandated by State law to be evaluated. Under PASRR, individuals who have a serious mental illness or, are developmentally disabled and seeking nursing facility placement are evaluated to determine appropriate services. Non STEPS/PASRR individuals receive the same comprehensive evaluation. After evaluating the individual, AERS staff develops a Recommended Care Plan through a multidisciplinary assessment process to identify service needs to help an individual remain in the community or in the least restrictive environment, while functioning at the highest possible level of independence and personal well-being. Referrals are accepted from concerned individuals, hospitals, nursing facilities, private physicians, or other health care providers by phone, fax, mail or in person. The evaluations are usually conducted in the individual's home or wherever they are located. If, based upon the multidisciplinary assessment, the individual appears to have needs that require nursing facility level of care, a Medical Eligibility form (DHMH 3871) is completed and sent to Delmarva for a level of care determination. In every case, if an individual chooses to remain at home, every effort is made to obtain-home and community based services to address the needs of the individual.

While AERS and the waiver expansion have begun to bridge the assessment and care-planning process, the utilization of a single, uniform assessment instrument that includes LOC determination factors and fuller integration across all LTC programs, as in Colorado, will require a strategic commitment and program modifications by Maryland.

Uniform assessment instruments and processes, and comprehensive, single-point-of-entry systems can provide opportunities to introduce incentives for community placement and mechanisms to assist in deflecting nursing facility admissions. Colorado (See Section III) has successfully introduced financial incentives and program mechanisms for the single-point-of-entry (SPE) agencies to divert individuals to home and community-based care. The Colorado SPE agencies are reimbursed for only those assessments and case management activities which result in community placement. Oregon and Washington also have made home and community-based care a cost effective alternative by screening people applying for Medicaid-funded nursing facility care to determine if they can remain in the community (Alecxi et al., 1996).

Maryland has no similar uniformly-applied incentives for community placement. Maryland has taken steps to expand the availability of community-based care, and to enhance coordination (assisted living) and access (HCBS waiver). However, the LOC determination process is not fully integrated with a coordinated, comprehensive, assessment and care-planning process.

A more detailed LOC review instrument and process developed with care planning considerations can:

- Provide an assessment of whether an individual can appropriately be placed in a community setting
- Collect information that can be used to develop a community-based care plan
- Collect aggregate data on community-based services needed as institutional alternatives and to identify unmet needs
- Be used to determine whether individuals already in institutional settings can be appropriately served in the community
- Be used to collect adequate data to document:
  - The client's preference with regard to community placement
  - Results of the assessment and evaluation for community placement
  - The linkage to a care plan for community placement
- The LOC criteria and processes could facilitate capitation and other purchasing arrangements
  - A LOC instrument and determination process that is specific in nature and establishes several levels of scoring could be used in the risk-adjustment process to set rates for a capitated long-term care payment system.

**3. Goal #3: The LOC criteria and processes could enhance predictability and promote public confidence through the use of an empirically based assessment process**

It has been noted that the Maryland criteria are largely based on the federal Medicaid definition of a nursing facility and, as such, the criteria are seen as very broad (Snow, 1995). It has also been noted that, in Maryland and other states using definitions rather than functional scoring or a minimum number of impairments/needs, it is often unclear whether people with specific functional limitations could meet LOC criteria (Kane, et al., 1997).

There are a variety of reasons why clear and precise scoring systems for functional and cognitive deficits present advantages. Although Maryland's current system allows for flexibility to account for exceptional cases that may not qualify under scoring systems, scorings systems may improve flexibility by incorporating clinical review. Other advantages of scoring systems are:

- Reduce subjectivity or the appearance of subjectivity, although scoring systems can also include a medical review/override provision (See Arizona, Section III)
- Opportunity to target services for those with higher scores if there is a waiting list (O'Keeffe, 1999)
- Avoid problems with definitions for functional and cognitive impairment that are often *uninterpretable* (Alecxi & Lutzky, 1996) since disabilities

run along a continuum, and are too *vague* when, for purposes of eligibility, they are simply defined as being present (Kane et al., 1991)

- Allows for comparison by the consumer with private insurance “triggers” and other program coverages
- Provides a platform for introducing coverage or enrollment change (e.g., expanding or contracting eligibility)
- Could provide a level of standardization among various waiver and state programs

A number of issues have been the subject of public discussion and concern regarding Maryland’s LOC assessment process and Transmittal #135. The controversy revolves around claims that the eligibility criteria set forth in the transmittal may be inconsistent with OBRA 87 because, they include additional requirements not mandated by federal law (O’Keeffe, 1996), may not properly respond to functional/cognitive impairments (O’Keeffe, 1999), and are confusing (CHSRA, 1998; Snow, 1995). Definitive resolution of these issues is beyond the scope of this report, but the ongoing disagreement they fuel clearly warrants State attention.

The unresolved and contentious issues surrounding Transmittal #135 have a negative effect. It appears that some of the conflicting technical understandings cannot be resolved through the current level of debate. One such conflict is whether the “licensed professional supervision” provision is tantamount to requiring eligibility for skilled nursing services. A sample of Maryland’s approvals/disapproval was analyzed for this report and a limited comparison with other states was conducted. Results indicate that individuals who reflect the pre-OBRA 87 intermediate care facility (ICF) standard have, in fact, been determined medically eligible for NF services in Maryland. There is the possibility, however, the application of Maryland’s criteria may be less stringent than the criteria alone would suggest. The public perception that Transmittal #135 effectively requires medical necessity and “skilled care” is not grounded in the *de facto* application, but is advanced by researchers and advocates who have carefully studied Transmittal #135, and by researchers who have cited confusion regarding Maryland’s criteria (Snow, 1995 & CHSRA, 1998).

The effect of the continuing lack of agreement regarding federal requirements and the negative public perception may include:

- Jeopardizing waiver expansions and new waiver proposals
- Failure to enlist public confidence in the Department’s intent to support home and community-based care
- Discouraging the applications of individuals who legitimately require HCBS or nursing facility services but fear they will not meet Transmittal #135 criteria

A clearer explanation of the criteria used by the State for NF LOC determination could be accomplished by either:

- Modifying the provisions of Transmittal #135 regarding licensed supervision and explicitly defining NF care extending beyond room and board
- Issuing a superceding Transmittal or amending COMAR to clarify the actual Maryland practice

**Additional background and explanation of issues surrounding Transmittal #135 can be found in ATTACHMENT ONE.**

### III. STATE CASE STUDIES

The determination of LOC has become an issue in some states as they have expanded community alternatives to nursing home care under Medicaid and implemented community-based waiver programs. As Maryland analyzes its LOC determination process, it is useful to identify issues that other states have faced and any changes that were made to resolve them. Four states were selected for this analysis based on their participation in the comparative study described in the previous section of this report, and the fact that they had considered and, in some cases, implemented significant changes to their LOC system. The four selected states are Colorado, Florida, Arizona, and Connecticut.

The information was gathered in interviews with staff from each state identified through professional contacts or from the literature describing each state's LOC system and key contacts. Each informant was asked questions related to the LOC determination process and changes that have taken place in the process. The results of the interviews are presented in a question and answer format.

Table Four (p. 53) provides an overview of the key elements in this comparison. As the interviews were completed, it became apparent that the selected states tended to consolidate systems to better serve the needs of long-term care recipients. The LOC determination process is one element that is closely coordinated with other key elements in consolidated systems in these states.

#### A. Colorado

The Colorado participant was Dann Milne, Manager of Delivery System Development, Office of Program Development in the Colorado Department of Health Care Policy and Financing. Mr. Milne has over 18 years experience in designing and implementing long-term care systems. He worked with Colorado over a five to six year period to develop a consolidated long-term care system.

#### ***What is Colorado's mechanism for assessing individuals' LOC eligibility?***

When a Medicaid client needs long-term care services, he or she is referred to a Single Entry Point (SEP) agency that can be a government or private care management agency. The SEP is used for waiver services and nursing home placement. There are twenty-five SEPs in Colorado, distributed among 63 counties. An assessment worker at the SEP does a brief screening to determine if the person needs a more comprehensive assessment and, if so, a case manager is sent to the client's residence within 48 hours to complete a comprehensive assessment form (CAF).

***What is the primary purpose of the comprehensive assessment form and what type of information does it collect?***

The ULTC-100 is designed for two purposes: to determine level of care for eligibility, and to assist in the development of a plan of care for people placed in the home and community-based waiver. Care plans are not developed by the SEP for nursing home placements. The comprehensive assessment takes about an hour.

***What does a comprehensive assessment form include and what is done with the results?***

The first page of the ULTC-100 form is for a doctor to complete and sign. The case manager collects the client's medical, ADL, and IADL information on subsequent pages. Prior to introducing the new instrument, the PRO reviewed only medical and ADL information to determine eligibility. When the form is completed, the case manager forwards it to the Peer Review Organization (PRO), a contracted private agency, the Colorado Foundation for Medical Care.

***How is the LOC eligibility determination made?***

Registered nurses at the PRO review the form and make a determination as to program eligibility and nursing home level of care. If necessary, the nurses will call the case manager to get clarification. The ULTC-100 is scored and if the score is 20 or higher, the person is determined eligible for nursing home level of care. If the score is lower than 20, the nurse may still certify eligibility if deemed necessary. The criteria for decision combine two elements: a formula using scoring and guidelines. The PRO nurse transmits the approval back to the case manager who then completes a plan of care for the client.

***Is there a review process for people who are not financially eligible for Medicaid?***

Colorado does not have a pre-admission review for people who are not Medicaid eligible. If a person applies for Medicaid while in care in the community or in a nursing home, a SEP case management agency gets involved and uses the ULTC-100 as an assessment instrument. The case management agency can and does provide referral services and private case management (for a fee) for people who do not qualify for Medicaid. Some of the agencies also provide assessment and case management for long-term care insurance carriers.

***What about people already in nursing homes or being discharged from hospitals?***

Private pay individuals already in nursing homes do not go through the SEP. The nursing home nurse completes the ULTC-100 form and sends it to the PRO.

This represents a loophole in the system and State officials have been advocating for nursing home pre-admission screening regardless of payment status. If a Medicaid eligible person is already in nursing home, the SEP does not complete the ULTC-100; it is completed by nursing home staff. People who are being discharged from hospitals may be referred to a SEP, but the hospital is not required to do so. The hospital may complete the ULTC-100 and forward it to the PRO.

***What kind of personnel is involved in reviewing eligibility and implementing the assessment form?***

Most of the case managers are social workers or nurses with undergraduate degrees. SEPs are required to have both nursing and social work staff in order to assure the presence of both perspectives in completing the form and developing care plans. PRO staff reviewing eligibility are nurses and social workers.

***Is there a training program for case managers and reviewers?***

There are two required trainings per year. Case managers are required to have 30 hours per year of training. There is a single annual training for SEP administrators. There has been a lot of training and development of best practices. The PRO reviewers and supervisors are nurses and help train the case managers and administrators. PRO reviewers have in-staff training provided by State staff. The PRO reviewers are required to maintain continuing education requirements.

***Is there an internal or external auditing system?***

The PRO conducts an internal audit. At the SEP, supervisors review each ULTC-100 form completed by the caseworkers for accuracy and completeness. If the form is forwarded to the PRO with inaccurate or incomplete information, the payment to the SEP is reduced.

A number of ongoing tests are conducted on the system to determine reliability and consistency. Tests have included inter-rater reliability for the PRO reviewers and the SEP staff. Changes can be (and have been) made to the instrument to sharpen the scoring methodology. Changes are administrative and are not subject to the same process as changes in the State Plan.

***Have there been any discrepancies observed in the administration of the ULTC-100?***

When form ULTC-100 was first introduced, the PRO did a “look behind” assessment at the case management agencies. The impetus for the “look behind” audit was to see if the case managers were scoring people higher than

the PRO or State staff would and thus allowing more people eligibility than was prudent. It was found that the PRO gave higher scores than the case managers, i.e. the case managers interpreted eligibility more narrowly. This audit was followed up with additional training.

***How has the system developed over time?***

At the time of this interview, the system can be described as mature. The case managers are experienced and there is seldom any discrepancy in the determinations between the PRO and the SEPs.

***How does an agency become a SEP and what is the overall payment system?***

Case management agencies apply to the State to become SEPs. They may be a private care management or a county nursing care agency, a county department of social services, or an Area Agency on Aging. SEPs are prohibited from providing services except in rural areas that have limited service agencies. The county commissioners in their region must nominate the organization. In some cases, this involves more than one county commission.

The case management agency is paid \$844 per person per year, divided into twelve monthly payments. The payment is both for assessment and care management. Payment is made for those people who are managed in the community; nothing is paid for people who go into a nursing home. The PRO is paid on a per person review regardless of the determination. Payments are reduced for incomplete or inaccurate information on the CAF.

***Has the financial incentive for SEPs to deflect individuals from nursing facilities been effective?***

Yes, we have documented declines in nursing facility admissions as the SEPs were introduced. Nursing home admissions dropped immediately upon introduction of the SEP in each region and there has been no growth in nursing home use, i.e. the use of nursing homes has remained at or below 10,000 residents since the time the SEP system was introduced. Colorado's home and community-based waiver was introduced in 1983. The consolidation of instruments and processes used to determine LOC were subsequently introduced to refine the system and address concerns of cost and consistency.

***Have there been significant milestones in the development of Colorado's LOC system?***

In 1989, Colorado began a process of consolidating its LOC determination instruments, processes, and its connections with service delivery. As a first step in reshaping its long-term care system, Colorado developed a comprehensive

State plan for long-term care in 1989. The second step was to develop a single comprehensive assessment instrument to determine level of care eligibility. The third step was to institute a Single Entry Point (SEP) system.

***What was involved in implementing a consolidated assessment instrument?***

The consolidated comprehensive assessment instrument, the ULTC-100, replaced three or four other instruments. Its purposes were to bring consistency to the process, give clients choices, and assist in developing the plan of care. Previously, different instruments had been used for nursing facility, adult foster care, assisted living, home care allowance, and home and community-based services. The core additive ingredients in the new instrument were the ADL and IADL information assessments.

***How were the Single Entry Points implemented?***

The next step was to implement a single-point-of-entry system. It was implemented in three phases. In the first year, five SEPs were implemented, and by the third year, all twenty-five were in operation. After the first year of implementation, the nursing home admission rates went down immediately in the five regions.

***Were there interagency consolidations?***

Finally, State agencies reorganized and consolidated several program administrations into the Long-Term Care Division. Currently, excluding the DD, ICFMR, and mental health populations, the Medicaid Agency is responsible for all nursing home, hospice, waiver, and State only programs. The Medicaid agency is responsible for all physical disability programs.

***What was the final consolidation?***

To implement the changes, the State brought all the shareholders together, e.g., provider groups, consumers, Area Agencies on Aging, the American Association of Retired Persons, and the younger disabled. Colorado's focus is on all ages: it is not limited to persons 65 or over. The process reduced the number of assessment instruments from three or four to one: it reduced the number of program doors a person had to check through from several to one. The previous system required the client to know which program best fit their needs and then to apply to that program.

***How long did the consolidations take and where did the impetus and leadership come from?***

The process took five to six years. It was headed by the Colorado Medicaid Agency. Impetus for change grew out of the need to control Medicaid nursing home costs, which were growing at twelve percent a year. Other major reasons for change were to save money, offer clients more choices, and reduce confusion.

***Are there anymore steps to be taken?***

The next phase of consolidation will be integrated care, the integration of acute and long-term care including capitation and managed care.

***Were there any surprises in the process?***

Before the pre-admission review program began, the PRO found that twenty percent of the people who were legally eligible for nursing home level of care could actually be cared for in the community. As the new system has matured, this number has gone down considerably. As the consolidated system has matured, inappropriate nursing home placements have declined.

***Do you have a program to get people out of nursing homes?***

Two years ago, the State initiated a Deinstitutionalization Project where case management agencies are paid a bounty to find people in nursing homes who can be appropriately cared for in the community. The case management agency is paid for the assessment and is given a relative high yearly payment if the person is transferred to the community. Most of the transfers out of nursing homes have been to assisted living (sixty-four percent). The average length of nursing home stay for people transferred to the community is fourteen months. The first year of the effort saw sixty-eight people transfer out of nursing homes. The current total is 250.

***What is the eligibility rate?***

The level of care determination turndown rate has always been low, both before and after the changes. The major change has been shifting or diverting more people to community care. The introduction of the changes has resulted in keeping the rate of growth in nursing home use at or below the initial number of 10,000 when the SEP system was implemented.

***How do you control growth in the waiver program?***

After the Home and Community-Based Waiver Services Program was implemented, there was concern that the waiver might grow too quickly and become too costly. In response, a "most in need" system was implemented. Three factors became most heavily weighted in determining waiver eligibility: incontinence, mobility (transferring), and mental impairment. The implementation

of this system did slow the rate of growth and Colorado has never hit the waiver slot ceiling.

The total cost per person in the long-term care system has gone down. More than 50% of the long-term clients are in community settings. The total cost of care has gone up, but not as fast as it would have without the systems' changes. The changes have slowed the rate of growth and costs for nursing home care as well.

## **B. Florida**

Interview participants were Sam Fante and Chuck Conditt of the Florida Department of Elder Affairs. Mr. Fante has been the Statewide Director of Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) since 1996. Prior to his current position, he was a Director at a CARES field office. Mr. Fante oversees pre-admission screening for eligibility to HCBS waiver programs and nursing homes. Chuck Conditt is a Senior Policy Advisor to the Statewide CARES program. Previously, he was a CARES program administrator. From 1988 to 1996, Mr. Conditt was responsible for developing and implementing a consolidation of forms and processes for determining eligibility for nursing home level of care and assessment for community-based care.

### ***What is the role and function of the State agencies?***

The Agency for Health Care Administration (the Agency) is the Medicaid Agency in Florida that contracts with HCFA. The Medicaid Agency delegates the administration of all Medicaid waivers to the Florida Department of Elder Affairs. The Department of Elder Affairs also operates other State-funded programs serving the elderly. The Department of Elder Affairs has oversight of the Level of Care Determinations for waivers and nursing home placement, administration of the Comprehensive Assessment instrument for case management, and the operation of field case management agencies under contract with the statewide Medicaid HCBS waiver for older adults. The program administering the waiver is the Comprehensive Assessment Review and Evaluation for Long-term Care Services (CARES).

### ***What mechanism and instruments are used to determine level of care eligibility?***

Currently, a client's personal physician completes a form No. 3008, which is forwarded either to a field caseworker employed by a government county-based lead agency or the State CARES office. Form 3008 is used to determine eligibility for nursing home level of care. Form 3008 may be completed for people in the community seeking a level of care determination, or it may be completed for people already in a nursing home.

### ***Is there any further assessment?***

A State caseworker reviews and confirms the information on form 3008 and completes a comprehensive assessment form (CAF). The primary purpose of the CAF is to determine a person's proclivity to be served in the community rather than in a nursing home. The CAF is used for assessment for the Community Care for the Elderly (CCE) program, waivers, and home care for the elderly. In cases where it is known that a person has a specific level of care for

nursing home placement, a CAF may not be conducted. Ninety-five percent of clients are seen personally by a caseworker in their homes or in the nursing home or other residential site.

***What about people who are not financially eligible for Medicaid?***

CARES administer a number of State-funded programs serving seniors. Individuals who do not meet the LOC eligibility requirements can be referred to these programs. CARES will also provide assessments, care plans, etc. to private pay individuals.

***How do you staff the CARES program?***

There is currently 200 State employees that conduct CAFs. Physicians are also employed by the State to assist the field staff. All caseworkers are part of the state system and all are trained and certified to apply the CAF.

***What is your training program?***

There is a statewide training program and training team. Experienced caseworkers are encouraged to refresh their training.

***What are the professional qualifications of your caseworkers?***

Caseworkers reviewing the 3008 form and completing the CAF are nurses or social workers normally working at the local level. They do not always have degrees. They may be part of an Area Agency on Aging.

***How do you monitor the reliability of the determinations?***

The local CARES field offices conduct monitoring of LOC determinations and comprehensive care assessments. All cases are reviewed by a supervisor and a State physician. The State CARES office attempts to conduct monitoring of field sites annually. From time to time, HCFA conducts external audits.

***How are caseworkers reimbursed?***

Individuals making LOC determinations are the State-employed caseworkers. Caseworkers' time is reimbursed on a fee-for-service basis.

***Have there been any issues over using state employees for eligibility determination?***

There was legislative debate on whether the determination process should be privatized to use private contractors rather than State employees. There was concern about allowing providers to independently complete verification

information for form 3008 without on-site State review. The Florida legislature has remained convinced that it is cost effective to continue to use State employees. The consolidation and expansion of the waiver slots have required that the casework staffing be stepped up from 112 in 1988 to about 200 today.

***Do you have a consolidated assessment instrument?***

Yes, a two-year process was initiated to consolidate all assessment tools and processes for waivers and nursing home eligibility. In 1988, the new CAF instrument and process was implemented with a statewide training program.

***What are you trying to achieve with the consolidation?***

The goal is to obtain consistency and uniformity in the application process. The consolidated instrument, the use of State employees, and the training program have all contributed to successfully meeting this goal.

***Who was involved in the consolidation and what were their concerns?***

The consolidation process took two years and primarily involved the “buying in” of several State programs and agencies. All affected agencies were involved. The impetus for change came from HCFA and mid-level and senior management in the Medicaid department. Most resistance came from State programs, not advocacy groups.

***Did you observe any changes upon introducing the CAF?***

When the CAF and face-to-face assessment were initiated, it was discovered that there were hundreds of people in nursing homes who had legally met the nursing home level of care but could be cared for in the community.

***How do you make adjustments to the CAF?***

The CAF is part of the State Plan and changes to it are subject to public hearings. The CAF has undergone changes three times since 1985 simultaneous with changes in the organization of State agencies. It was originally in the Medicaid division, then moved to Services for Aging and Adults, and then to the Department of Elder Affairs. The people handling the operations have remained essentially the same; the departmental names have changed.

***What is your eligibility rate?***

Florida’s eligibility determination rate is high. In fiscal year 1999/2000, 14,500 applications for nursing home level of care were reviewed. No more than several hundred were declined.

***Have there been changes in the eligibility rate since the introduction of the CAF?***

There have not been any changes in the rate of determinations of eligibility simultaneous with changes in the CAF. The 3008 form is used to determine eligibility. The CAF is used to determine appropriateness for community placement and to develop a care plan. It is only applied after determination of eligibility per form 3008.

***How large is your program?***

All together last year, Florida had 54,000 new applicants for services plus 12,000 reviews for continuing eligibility.

***What type of program growth have you observed?***

In FY 94/95, the combined federal/state Medicaid costs were \$4.5 million. In FY 99/00, combined Medicaid costs were \$9.3 million.

***Are there many disagreements with your eligibility determinations?***

Florida has a ninety- percent success rate on administrative appeals and very few appeals to Circuit Court. The same criteria are applied to determining eligibility whether it is for the HCBS waiver or nursing home. There is little disagreement on the determination. The differences of opinion occur over whether community placement is appropriate.

## **C. Arizona**

Participants from Arizona were Diane Ross, the Assistant Director of the Division of Member Services of Arizona Health Care Cost Containment System (AHCCCS), and Melanie Norton, Eligibility Administrator in charge of staff operating in the regional long-term care offices. Ms. Ross has been working in Arizona's Medicaid program since it began in 1982 and the Medicaid Long Term Care Program, ALTCS, since its implementation in 1988. Prior to that, she worked in Missouri's Medicaid Agency. Ms. Norton is a social worker and has worked in the AHCCCS program for 12 years.

### ***How does the state provide long-term care services?***

The Arizona Long-Term Care System (ALTCS) is Arizona's Medicaid program for individuals who qualify for long-term care services. In 1982, Arizona began providing acute care services to Medicaid-eligible residents through the Arizona Health Care Cost Containment System (AHCCCS), a Section 1115 Research and Demonstration Waiver demonstration program. In December 1988 for the population with developmental disabilities and January, 1989 for the elderly and physically disabled individuals, ALTCS began providing Medicaid-covered long-term care services. Currently, ALTCS provides acute care, behavioral health, and long-term care services to the elderly, the physically disabled, and people with developmental disabilities with incomes up to 300% of the federal SSI benefit standard. Developmentally disabled (DD) members are reviewed using a different PAS and scoring method than that used for disabled adults. DD members constitute 38% of the ALTCS population. Members must also meet a nursing home level of care determination. ALTCS is a capitated managed care program and enrollment is mandatory in an ALTCS managed care contractor. The average capitation is approximately \$2,300 per month regardless of whether the person is in the community or in a nursing home.

### ***What is the mechanism for determining eligibility?***

A client may be referred from a number of sources: hospital discharge, nursing facility, caregiver, or acute care provider. If it is thought that the person is in the AHCCCS Acute Care Program and is in need of long-term care for ninety or more days, he or she is a candidate for referral. If the need for nursing facility care were for less than ninety days, these Long-Term Care services would be provided by the Acute Care health plans. The ninety-day time frame does not apply to ALTCS applicants not in the AHCCCS Acute Care program. The first screen is a financial screen. If the person is already eligible for SSI, he or she is deemed financially eligible for the program. About thirty-six percent of program clients receive SSI. Other people receive a face-to-face assessment by a financial eligibility worker who is an employee of the State.

### ***What happens once a person is determined financially eligible?***

If the person is financially eligible, they are referred to a Pre-admission Screen (PAS) assessor, also an employee of the State. The PAS assessor is either a registered nurse or a social worker. The PAS assessor goes out to interview the person and other information is gathered from caregivers, records, and personal physicians. A 20-page assessment form (the PAS) is completed reviewing the person's medical and functional status.

### ***How is the PAS scored?***

The information is scored by a computerized automated system. If a score of 60 is obtained for the elderly or physically disabled population, the person is considered eligible for nursing home level of care. If the score is less than 60, the case is reviewed by a group of physician consultants who independently decide if the person is at risk of needing nursing home care. If a person is determined "at risk" of needing nursing home care, they have met the medical criteria. If the score is almost 60 or the PAS assessor believes the applicant is medically eligible even though they didn't score 60, the case is referred to a contracted physician who independently decides if the person is at risk of needing care in a nursing facility.

For the individuals with developmental disabilities (DD) the required score is 40 but the remainder of the process is the same. There is a separate PAS document used for the population with developmental disabilities; there are actually four different age related tools; 0 through age 2; 3 through age 5; 6 through age 11 and age 12 and older. For children under age 6 on the elderly and physically disabled side of the program, the PAS tool for the DD population is used and there is a physician review.

### ***What about people who are not financially eligible for Medicaid?***

For individuals who do not meet financial criteria but whose family wants to know if they need nursing home placement, the PAS assessor will conduct a private pay PAS. The same review process is completed but the client is responsible for payment. If a person does not qualify on the PAS, the caseworker tries to refer to alternate resources for needed long term care services.

### ***What are the professional qualifications of the personnel who review eligibility?***

Reviewers are RNs or social workers.

***Do you have a training program?***

Reviewers receive two weeks of training to administer the assessment instrument. On the job training involves a new PAS assessor accompanying an experienced PAS assessor on home visits to conduct PASs. Plus, the PASs completed by a new assessor are reviewed by their supervisor who provides “one on one” on the job training. Refresher training is conducted at least once a year. Field conferences during which training related to specific diseases and conditions are held annually.

***How do you monitor the reliability of the determination system?***

The PAS tools were tested extensively when developed by having two individuals complete a PAS on the same individual to evaluate inter-rater reliability. Also, supervisors review PASs completed by their staff. In addition Quality Control PAS assessors review a sample for each assessor. Currently there is no other reliability testing.

Quarterly meetings are held with physician consultants to “staff” borderline or questionable PAS eligibility decisions. This is to ensure consistency of decisions by the contracted physicians who conduct physician reviews. The Medical Eligibility Manager, who is a registered nurse, coordinates these meetings. Other PAS assessors and managers attend. Also present during these staffing/training meetings is the AHCCCS Chief Medical Officer.

Different types of cases are assigned to specialists (i.e. pediatrics, gerontologists or neurologists) in that area. A percentage of the PAS reviews is audited regularly throughout the State. The system is fairly mature, so there is not a lot of review of experienced assessors. New assessors’ work is reviewed by their manager.

***How do you handle the case management and care provision once a person is determined eligible?***

Once a person is determined eligible, he or she is enrolled with a Program Contractor. These Program Contractors (PC) function like HMOs under contract with ALTCS. The PCs provide acute care, long term care, behavioral health services and case management on a pre-paid capitated payment basis. Program contractors can be county or private agencies. Five county agencies are under contract. Historically, the largest two counties, that contained 75% of the ALTCS population, were legislatively mandated to provide the services. This changed two years ago and private entities were allowed to bid. Counties no longer have the right of first refusal. Agencies are paid a blended per member, per month capitation rate and are responsible for care in the community or the nursing facility.

***What do you do to promote getting people out of nursing homes?***

Program contractors bid for their contract. Included in the bid is an estimate of the number of people they can keep in the community and the number of people they can transition from nursing homes to the community. The financial incentive is to keep people community-based. The average cost of nursing home care is \$3,000 per month; the average cost of community-based care is \$800 per month. The capitation rate is about \$2,330 per month which acts as an incentive to keep people out of nursing homes.

***What motivated you to develop the PAS?***

With the introduction of the 1115 waiver and Medicaid funding in 1988, HCFA and the Arizona State statute for ALTCS required AHCCCS to establish financial criteria and implement a pre-admission screening instrument. The PAS that was introduced in 1988 was the same for Elderly and Physically Disabled (EPD) and the Developmentally Disabled (DD).

***Did the “one size fits all” PAS work?***

No. In 1991 it was determined that a single PAS tool was not effective in addressing the needs of the EPD and DD populations, and the PAS was revised for both populations. The revisions were made to comply with HCFA requirements and to be responsive to findings by an outside evaluator of the entire AHCCCs program, both acute and long-term care, hired by HCFA.

***How did you go about developing the two new instruments?***

Separate panels of nationally recognized clinical experts reviewed the two new instruments. The revised EPD instrument was introduced in 1992; the revised DD instrument was introduced in 1995. The revised documents were tested extensively for reliability.

***Did you encounter any difficulties in revising the instruments?***

The EPD revision process in 1992 was fairly smooth and took about one and a half years. The process for DD was more complicated and took about three years. There was concern from advocates that the criteria would tighten up and cause some people to become ineligible. The process involved numerous public hearings and presentations of research by recognized experts.

***Did people lose their eligibility with the introduction of the new DD instrument? And, if so, what did you do?***

The new DD instrument was expected to cause about 1,200 individuals to lose eligibility. With HCFA's approval and support, a new ALTCS Transitional

program was initiated for persons losing eligibility who still needed home and community-based services based on a functional test administered by AHCCCS. Elderly and physically disabled individuals, who no longer require nursing facility care but who continue to need significant long term care services, may also move from the regular ALTCS program into the Transitional Program. The Transitional ALTCS program is not available to new applicants. The ALTCS Transitional program is federal 65% and state 35% funded. It is on going and contains about 3,600 members.

***Have you seen a trend in reduced rates of eligibility since the new PASs were introduced?***

The PAS approval and denial rates have been monitored since the new instruments were implemented. A comparison of the 1995 rates to the 1988 rates showed that approximately one percent more individuals were being denied continued eligibility; about six percent more new applicants were being denied initial eligibility.

***What is the rate of eligibility?***

The ALTCS denial rate is about 65%.

***What happens if an applicant disagrees with the determination?***

If a person disagrees with a denial, the face-to-face assessment is completed again and the applicant can present additional information. If the disagreement continues, a hearing is held. No one in the program is discontinued without a physician review.

***What percentage of your program members is in waivers?***

Arizona's entire ALTCS program is a "waiver" program. Forty-four percent of the Elderly and Disabled population are in the HCBS settings receiving HCBS services. Ninety-eight and a half percent of the DD population are in the HCBS waiver portion of the ALTCS program.

***What rate of growth do you see in the program?***

Before last year, the average annual growth in the LTC program was 6.5%. Last years growth was at 8.7%. Arizona reached the waiver cap (the maximum percent of individuals in HCBS settings) only one year early in the program. HCFA abolished the HCBS Cap for Arizona effective 10/01/99.

## **D. Connecticut**

The interview was conducted with Michele Parsons, Manager of the Alternate Care Unit in the Connecticut Department of Social Services. Ms. Parsons is a nurse with 25 years of experience working in nursing facilities. She came to the Department as a Utilization Review Nurse for the program she is now managing.

### ***How does the state system relate to the level of care determination?***

The Connecticut Department of Social Services is the State Medicaid agency and administers additional services to a variety of populations. The Connecticut Home Care Program for Elders is administered by the Alternate Care Unit within the Department of Social Services. The Home Care Program, which started in 1985, provides long-term care services and case management for people age 65 and older who live at home. The Program is organized in three tiers based on financial eligibility and functional dependence. The first two categories are funded through State and block grant funds; individuals in the third category qualify for Medicaid. Medicaid reimbursement is through a Home and Community-Based Services waiver. Seventy-five percent of the program's 10,350 clients are on the waiver (category three). One toll-free phone number serves as a single point of entry to the program statewide.

### ***What is Connecticut's current mechanism for determining eligibility? What instruments are used?***

Individuals over age 65 are referred to the Home Care Program by family members, providers, community agencies, or other State agencies, usually by phone. A two page screening instrument is administered over the phone to a relative, provider, or other respondent other than the client. Although the screen requests medical information, the key indicators are activities of daily living, instrumental activities of daily living, and social activity.

### ***Do you use the same process for all people, regardless of age?***

All individuals over age 65 are screened by the Home Care Program, including those who go into a nursing home. Individuals who are under age 65 and reviewed by other units in the Department of Social Services use a version of the same form.

### ***What criteria are reviewed for clinical eligibility?***

Critical needs defined as hands-on activities or tasks that are essential for a client's health and safe existence are used to identify eligibility. Critical needs include bathing, dressing, toileting, transferring, eating, meal preparation, and medication management.

***What is the connection between your clinical screen and financial eligibility?***

If the client is functionally eligible, a financial eligibility liaison checks the client's Medicaid status using a statewide database. All applicants screened into the program are required to complete a 14-page Medicaid application.

***Is the screening process connected to a case management process?***

Yes, case management agencies, known as Access Agencies, do assessment and care planning with clients and will assist clients in completing the Medicaid application, if necessary. Referrals must be made to the Access Agency within 24 hours and the comprehensive assessment done by the Access Agency must be completed within 7 days.

***What about people who are not financially eligible for Medicaid?***

State funds or federal Social Services Block Grant funds cover clients who are screened into the Home Care Program but who are not financially qualified for Medicaid. In addition, Access Agency staff members are expected to know all programs in the State, including those for individuals who do not qualify for the Home Care Program.

***What professional qualifications are required of staff that conducts the eligibility review and assessment form?***

Nurses in the Alternate Care Unit using the W-10ALT form determine functional eligibility. The Access Agencies are under contract with the Department of Social Services to assess clients and provide care planning and case management. They are required to have face-to-face contact with clients at least every six months. Case managers in the Access Agencies are social workers or registered nurses.

***What type of training do you provide?***

Home Care Program staff trains Access Agency case managers.

***How do you monitor the review process?***

A system of "peer monitoring" of client records is in place in the Program. The quality of records and the consistency of decision-making are reviewed. The audit system involves:

- Quarterly on-site reviews of subcontractors, e.g. homemaker/companion agencies
- Home visits to clients

- Peer review of the client records
- Complaint log
- Client satisfaction surveys
- Health and safety logs

***Are all staff reviewing and determining eligibility State employees?***

Yes, State staff completes the review and determination.

***How did the Home Care Program come into existence?***

The Connecticut Home Care Program in its current form is the result of the merger on July 1, 1992, mandated by the Governor, of all the clients on the former Pre-admission Screening/Community-Based Service Program, the former Promotion of Independent Living Program, and the Home Care Demonstration Project. In 1992, the Governor reorganized State agencies to avoid duplication of services. Several agencies were consolidated into the Department of Social Services. Clients from other agencies were “grand-fathered” into the Home Care Program.

***How did the instrument for assessing eligibility change?***

A 12-page form was used prior to the consolidation to screen and assess clients. The Department now uses a two-page interagency form (W-10ALT) to screen clients for medical (functional) eligibility.

***Have issues emerged as a result of the consolidation?***

Some issues have emerged as a result of the consolidation of services concerning the elderly. A commission was created to act as an advocate for older adults in the consolidated system. The commission is developing a long-term care plan for dealing with issues of the elderly to be presented to the governor and the legislature.

***What is Connecticut’s eligibility rate?***

Between fifty-one and sixty-nine percent of referred applicants has been determined eligible each year between FY 94 and FY 99. The only exception was in FY 96, when ninety-five percent of the people assessed were determined eligible. In 1995, there was a funding shortage; screenings and program admissions were cut back, resulting in a significant waiting list. Corrections were made in 1996 and the waiting list has been eliminated.

***What percentage of your members are waiver clients?***

In 1999, approximately seventy-four percent of the persons receiving services were Medicaid waiver clients.

***What has been the rate of program growth?***

The program growth rate for the overall Home Care Program (State-funded and Medicaid Waiver) for the time period SFY 94 through SFY 00 has been 11.7%. The growth rate for the waiver has been 18.4%.

Total waiver client expenditures in FY 98 were \$76,871,581; total waiver client expenditures in FY 99 were \$92,128,923, representing a growth rate of twenty percent. There were 6,526 waiver clients at the end of 1998 and 7,140 at the end of 1999.

#### **IV. CONCLUSIONS AND SUMMARY OF IMPROVEMENT OPTIONS**

##### *Conclusion*

This report analyzes Maryland's Level of Care criteria (medical eligibility) for nursing facility services and the process used to implement the criteria. The analysis is based upon the following key elements:

- A review of the current LOC process and instruments
- Consultation with DHMH representatives
- Interviews with representatives from other states
- Comparative analysis of Maryland determinations with select other states
- Review of studies and research conducted in Maryland and other states

The Report is constructed on an exploration of three expectations: the system appropriately establishes eligibility (Goal 1) in a reasonable and predictive manner (Goal 2) and in a way which enhances care planning for the client (Goal 3). For Maryland and other states, analysis of performance against each of these goals is not a "pass/fail" exercise. The Report's findings are suggestive of areas of strengths and weaknesses.

The Maryland LOC process, as viewed by its current actual performance and in relation to other states, is not unduly restrictive nor does it systematically exclude individuals who appear to meet the established level of care. It is less clear whether Maryland's criteria are implemented in a way that systematically excludes individuals who are ineligible.

The process used by Maryland (criteria and definitions with clinical judgment) is inherently more subjective or less "empirical". This subjectivity allows for flexibility and may have resulted in the current "inclusive" approach. However, this approach does not always lend itself to predictability and consistency over time. The functional impairment data collected by Maryland in the LOC process is limited. This limitation restricts the ability to target and define eligible populations. The inherent subjectivity and reduced predictability also make public understanding and confidence more problematic.

Finally, the Maryland LOC process is largely unconnected with individual care planning as measured by uniform assessment instruments across programs, single points of entry at the local level, and sufficient detail on the LOC assessment form. The use of AERS in the waiver expansion could serve as a beginning platform for building linkage between the assessment process and care planning/care management.

The following summary of improvement options reflects the efforts and successes of other states in addressing these three expectations of the LOC criteria and processes.

## *Goals and Improvement Options*

Goal #1: Effectively determine Eligibility/Ineligibility.

### Improvement Options:

- Expand the assessment of functional and cognitive impairments to include certain IADLs, allowing the opportunity for targeting priority populations and improved identification of individuals with functional and cognitive impairments.
- Expand assessment data to include information regarding individuals' community, family, and social supports (transition from "Medical/Functional" assessment type to a "Comprehensive" assessment type) in order to better identify needs and individuals at higher risk.
- Ensure the validation of "approvals" through periodic review by the Department of the contracted agency determinations.
- Consider establishing clearly defined "most in need" functional/cognitive criteria if applicants exceed waiver resources.
- Test the consistency of the screening process (e.g. inter-rater and time sensitive reliability tests) to identify and correct as necessary and practicable, the variation or subjectivity that accompanies a "criteria and definitions" approach.

Goal #2: The medical eligibility screening process should enhance care planning and placement for the individual.

### Improvement Options:

- Ensure that assessors are trained in the use of any new instrument,
- Develop uniform assessment tools requiring a high level of cooperation among state-sponsored programs.
- Develop a single-point-of-entry system at the local level (See discussion on page 20).
- The LOC criteria and processes could facilitate capitation and other purchasing arrangements
  - A LOC instrument and determination process that is specific in nature and establishes several levels of scoring could be used in the risk-adjustment process to set rates for a capitated long-term care payment system.

Goal #3: The LOC criteria and processes should enhance predictability and promote public confidence through the use of an empirically based assessment process.

### Improvement Options:

- Adopt a LOC process and instrument that uses a scoring system or a minimum needs criteria to assess functional, cognitive and physical/medical need

OR

- Improve the current Definitions and criteria approach by modifying Transmittal #135, issuing a superceding Transmittal, or amending COMAR to clarify the actual Maryland practice.

## Attachment One

### Transmittal 135

Medicaid eligibility for nursing facility services is governed by federal law and regulations. The responsibility to interpret these laws and regulations and to implement them in the context of their individual Medical Assistance programs belongs to the states, though it is subject to federal oversight.

Federal Law: the Social Security Act and OBRA 87. Until late 1987, federal law distinguished between skilled and intermediate nursing facilities. State Medical Assistance programs' coverage of skilled nursing facility services was a mandatory condition of federal financial participation. Intermediate care services, however, were an optional benefit that states were free to cover or exclude under their individual state plans. The Nursing Home Reform Provisions (Title IV, Subtitle C, Part 2) of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) consolidated the previously distinct Medicaid definitions of "skilled nursing facility" and "intermediate care facility" into a single "nursing facility" definition found in §1919 of the Social Security Act (42 USC §1396r). The change was intended to "establish a single set of requirements" for skilled nursing and intermediate care facilities, . . . "to refer to such facilities as 'nursing facilities,'" and to set forth requirements that such facilities . . . "primarily engage in providing residents with nursing care, rehabilitation services, and other health-related services which can only be provided through such facilities . . ." Numerous companion requirements included in the Medicaid Nursing Home Reform Provisions of OBRA 87 concerned the provision of care, residents' rights, and facility administration (House Report 100-495: Conference Report on H.R. 3545, P. L.100-203, 12/22/87.) The text of the Committee report quoted above paraphrases OBRA 87 provisions now found in §1919(a)(1) of the Social Security Act (42 USC §1396r(a)(1)). This aspect of the statute's "nursing facility" definition is pivotal because it identifies a "nursing facility" in terms of the categories of services it provides. Categories (A) and (B) below correspond to pre-OBRA "skilled nursing facility" services. Category (C) encompasses services previously provided by an "intermediate care facility."

- (A) Skilled nursing care and related services for residents who require medical or nursing care
- (B) Rehabilitation services for the rehabilitation of injured, disabled, or sick persons
- (C) On a regular basis, health-related care and services to individuals who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases . . .

The Social Security Act includes no definition of the term “health-related care and services” in paragraph (C).

Although the §1919(a) “nursing facility” definition and the report of the OBRA Conference Committee make it clear that Congress intended to combine the two types of facility services, the drafters may have accorded inadequate attention to conforming Medicaid’s “nursing facility services” definition to the new “nursing facility” definition. “Nursing facility services” are defined in §1905(f) of the Social Security Act (42 U.S.C. §1396d (f)) as “services . . . required to be given to an individual who needs . . . on a daily basis nursing care (provided directly by or requiring the supervision of nursing personnel) or other rehabilitation services which as a practical matter can only be provided in a nursing facility on an inpatient basis.” This is narrower than the list of service categories included in the §1919(a) “nursing facility” definition, since it omits the unskilled services described in §1919(a)(1)(C). Although the difference may be regarded as a carry-over from the pre-OBRA law, it is still highly relevant to identifying the scope of Medicaid’s nursing facility/services mandatory benefit.

Section 1902(a)(10)(A) of the Social Security Act provides that “[a] State plan for medical assistance must . . . provide . . . for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), . . . of section 1905(a) . . . .” The referenced provision identifies the relevant benefit as “nursing facility services,” which, as discussed above, is defined narrowly and includes a skilled supervision requirement (Social Security Act, §§1902(a)(10) and 1905(a)(4)(A) (42 U.S.C. §§1396a(a)(10) and 1396d(a)(4)(A))). Since §1902 requires “nursing facility services” rather than “services provided by a nursing facility” to be included in Title XIX State Plans, the requirement is arguably satisfied if a state’s Medical Assistance nursing facility benefit is no broader than the more restrictive federal “nursing facility services” definition of §1905(f).

Federal regulations. Regulations promulgated by the Department of Health and Human Services to interpret and implement the statutory provisions discussed above provide little help in understanding the Social Security Act’s apparent “nursing facility”/“nursing facility services” disconnect. If anything, they perpetuate it. For example, 42 CFR §440.40(a) defines (for Medicaid) nursing facility services for adults as requiring a physician’s order and direction, and as “needed on a daily basis and required to be provided on an inpatient basis under Secs. 409.31 through 409.35 . . . .” This incorporation by reference of §§440.31-.35, Medicare regulations (which apply only to skilled nursing and skilled rehabilitation services) are incorporated by reference into the Medicaid nursing facility services standard. On the other hand, 42 CFR §440.155(a)(1) defines “nursing facility services” more broadly, to include “*services provided in a facility that:*

*Fully meets the requirements for a State license to provide, on a regular basis, health-related services to individuals who do not require hospital care, but whose mental or physical condition requires services that:*

- (i) *Are above the level of room and board*
- (ii) *Can be made available only through institutional facilities”*

The side-by-side existence of 42 CFR §§440.40(a) and 440.155(a)(1) in their present form could be a source of confusion. It might be incomprehensible were it not for their historical origins in pre-OBRA “skilled” and “intermediate” care, respectively. William Davis (HCFA Region III letter of 3/25/99) relies on regulatory history to support an interpretation that these dissimilar “nursing facility services” definitions can be aggregated to yield a single combined definition instead of two separate inconsistent ones. The absence of any express regulatory language or cross-reference supporting this interpretation, however, will continue to impede a definitive resolution of the issue. It also begs the question of whether the §440.155(a)(1) definition of “nursing facility services” can be considered consistent with the same term’s statutory definition in §1905(f) of the Social Security Act (42 U.S.C. §1396d (f)).

Maryland Regulations and Transmittal #135. Prior to OBRA 87, Maryland’s Medicaid benefits package included both the federally-required skilled nursing facility services and the optional intermediate care facility services as separate benefits. The governing regulations were COMAR 10.09.10 (“Skilled Nursing Facility Services”) and COMAR 10.09.11 (“Intermediate Care Facility Services”). In 1998, with the intention of combining the separate benefits in response to OBRA 87, COMAR 10.09.11 was eliminated and COMAR 10.09.10 was revised and renamed “Nursing Facility Services.” The Department issued Transmittal #135 in 1994 to explain and interpret the new regulations and related federal law.

A key provision of Maryland’s nursing facility services regulations is the definition of “nursing facility services,” as it is the standard for preauthorization of NF services pursuant to COMAR 10.09.10.06B. COMAR 10.09.10.01B(31) defines “nursing facility services” as:

services provided to individuals who do not require hospital care, but who, because of their mental or physical condition, require skilled nursing care and related services, rehabilitation services, or, on a regular basis, health-related care and services (above the level of room and board) which can be made available to them only through institutional facilities *under the supervision of licensed health care professionals* [Emphasis added].

Both this and the definition of “nursing facility” at COMAR 10.09.10.01B(30) track the federal law definition of “nursing facility” (Social Security Act, §1919(a)(1), 42 U.S.C. §1396r(a)(1)), except that the NF “services” definition at COMAR 10.09.10.01B(31) also imposes a requirement that supervision of health-related services by a licensed health care professional is necessary. Although not specified at §1919(a)(1), this skilled supervision criterion is supported by the “nursing facility services” definition (Social Security Act, §1905(f), 42 U.S.C. §1396d (f)), requiring that an eligible

individual need services that must be “provided directly by or requiring the supervision of nursing personnel.”

Transmittal #135 and Litigation. Transmittal #135 articulates the specifics of Department policy for determining eligibility for nursing facility services under COMAR 10.09.10 and federal law upon which the regulations are based. The transmittal’s most controversial aspects center on the interpretation of “health related services above the level of room and board” as requiring “the performance or supervision of performance by licensed health care professionals.” The Department has stated consistently, even prior to OBRA 87, that “health-related services” must by definition address a medical condition, and their provision must require specialized training.

Based on the information available, which covers the State’s administrative review experience for the last 12 years, it appears that the Department has been quite successful in defending its nursing facility eligibility criteria. Of the approximately 200 cases reviewed on the administrative level (i.e., by the Office of Administrative Hearings) during this period, all have resulted in the Department’s NF eligibility denial being upheld. One case was appealed as far as the Maryland Court of Special Appeals, which reinstated the Department’s determination of ineligibility. There was an additional case that was upheld at the administrative level of review, but reversed on appeal to the Circuit Court, Maryland’s Court of Special Appeals then reinstated the Department’s denial. In each of the 200 cases, the eligibility criteria articulated in Transmittal #135 were at issue and the Departments determinations ultimately were upheld. Even so, information (sometimes misinformation) about these cases has been disseminated to litigants, legislators, advocates, and even State and federal officials who accept it as evidence that Maryland’s current NF eligibility criteria and processes are too restrictive and of questionable legality.

**TABLE ONE**  
**Select States Criteria for Long-Term Care Services**

STATE	LOC METHODOLOGY			TYPE OF NEEDS***				ENTITY: CONDUCTING ASSESSMENT (A)*** DEEMING DETERMINATION (D)***								NUMBER OF FACTORS IN LOC (States using definitions/guidelines only)****				
	Scoring	Min# of needs	Def/guide-lines	Medical	Med/Func	Comprehensive	Ment/Phys	NF, Hosp or MD	MCO	CM Agency	Dept. of Aging & Admin	DSS	PRO	Public Health	Med/Nsg	Phys. Impair	Mental Impair	IADLs	ADLs	
A			X	X							A D				7	2	1	0	6	
B**	X*			X*					A* D											
C	X				X				A				D							
MD			X			X	X	A					D		7	1	5	0	9	

Data from "Determining the Need for Long-Term Care Services: An Analysis of Health and Functional Eligibility Criteria in Medicaid Home and Community-Bases Waiver Programs" O'Keefe, Janet, Dr. P.H., R.N.

**TABLE TWO**

**Comparison of Select States Criteria  
on their Preadmission Assessment Tools**

States	Medical							Social							Cognitive/Functional				
	Skilled Nsg.	Clients' Rating * of Health *	List of Diagnosis	Phys. Exam	Phys. Sign.	Med List	Advanced Medical Directive Assessed	Life Events *****	Living arrangements****	Assessment of Living Environment	Outside Resources Identified	Caregiver Assessed	Interview Required on PAS ****	IADLs**	ADLs	Mental Health	Cognitive Problems Identified	Oriented to Person, Place and Time.	
A	X	X	X	X	X	X	X		X		X			X	X				
B	X		X			X			X					X	X		X	X	
C	X	X	X		X	X			X	X	X	X	X	X	X		X	X	
<b>MD</b>	<b>X</b>		<b>X</b>		<b>X</b>	<b>X</b>								<b>X</b>	<b>X</b>		<b>X</b>	<b>X</b>	

\* The client is interviewed and asked the following: for FL-adjustment to illness; for CO-if strong enough to get through normal routine.  
 \*\* IADLs include: heavy chores, light housekeeping, phone use, money management, meal preparation, shopping, taking meds, transportation use.  
 \*\*\* Interview of caregiver or client required on the PAS.  
 \*\*\*\* Documentation of whom the client lives with or if the client lives alone.  
 \*\*\*\*\* Life events such as illness/injury to client or family, losses: death of a spouse, friend, pet, job, changes: divorce, in residence, retirement, threats: financial and safety concerns, victim: of assault/theft, exploitation, abuse/neglect

**TABLE THREE**

**Results of the Level of Care Study between States**

<b>Applicant</b>	<b>MARYLAND</b>	<b>State A</b>	<b>State B</b>	<b>State C *</b>	<b>State C** Enhanced</b>
<b>1</b>	approved	approved	denied	Returned	denied
<b>2</b>	approved	approved	denied	Returned	approved
<b>3</b>	approved	approved	denied	Returned	approved
<b>4</b>	approved	approved	denied	Returned	denied
<b>5</b>	approved	approved	denied	Returned	approved
<b>6</b>	approved	approved	denied	Returned	approved
<b>7</b>	denied	denied	denied	Returned	denied
<b>8</b>	denied	approved	denied	Returned	denied
<b>9</b>	denied	denied	denied	Returned	approved
<b>10</b>	denied	approved	denied	Returned	denied
<b>11</b>	approved	denied	denied	Returned	denied
<b>12</b>	approved	approved	denied	Returned	denied
<b>13</b>	approved	approved	denied	Returned	denied
<b>14</b>	approved	denied	denied	Returned	denied
<b>15</b>	denied	denied	denied	Returned	denied
<b>16</b>	denied	denied	denied	Returned	approved
<b>17</b>	denied	denied	denied	Returned	denied
<b>18</b>	denied	slim approval	denied	Returned	approved
<b>19</b>	denied	denied	denied	Returned	denied
<b>20</b>	denied	denied	denied	Returned	approved
<b>Approved/ Denied</b>	10/10	11/9	0/20	0/20	8/12

\* Maryland does not collect sufficient information to complete State C's PAS form. All cases were returned for more information.

\*\* Most information applied to these reviews was constructed from reasonable professional assumptions based on available information from Maryland's 3871s. This information included IADLs (client needs assistance with, by whom and how often), previous hospitalizations within the last six months and a minimal score. A level of care could only be determined with completion of these areas on their pre-admission screening form.

**TABLE FOUR**  
**Comparison of Select States Screening, Assessment, and Management of Care**  
**for Person's with Disabilities**

ITEMS	AZ	CO	FL	CT
<b>POPULATION</b>	Elderly/ Disabled/DD		Aged/ Disabled	Elderly
<b>STATE-WIDE WAIVER</b>	Yes	Yes	Yes	Yes
<b>ELIGIBILITY REVIEWERS</b>	RN, BSW	BSW, RN MD back- up	RN, BSW MD back-up	RN, BSW
<b>REVIEW INSTRUMENTS</b>	One for EDP and one for DD	Consolidated – one instrument eligibility/care management	Consolidated – <ul style="list-style-type: none"> <li>• One for eligibility</li> <li>• One for Care Planning</li> </ul>	Consolidated
<b>FACE TO FACE REVIEW</b>	70% - financial 98% - clinical	95%	95%	<ul style="list-style-type: none"> <li>• Not for eligibility</li> <li>• Case Management - yes</li> </ul>
<b>SINGLE POINT OF ENTRY FOR LTC SERVICES**</b>	Yes	Yes, at Regional Level	No, but forms are the same and end placement consolidated	Yes
<b>IS THE LOC DETERMINATION LINKED TO A CAPM*</b>	Yes	Yes	Yes	Yes
<b>REIMBURSEMENT SYSTEM FOR REVIEWERS</b>	State Staff		State Staff	State Staff
<b>HOW IS THE DETERMINATION PROCESS MONITORED</b>	<ul style="list-style-type: none"> <li>• Percentag e of PAS' audited</li> <li>• Quarterly Meetings</li> </ul>	<ul style="list-style-type: none"> <li>• PRO conducts Internal audits</li> <li>• Reliability Tests</li> </ul>	<ul style="list-style-type: none"> <li>• HCFA audits</li> <li>• State Cares Office annually</li> <li>• Local supervisions</li> </ul>	Peer Monitoring
<b>CASE MANAGEMENT SYSTEM</b>	Contracted public and private agencies	Contracted Public Private Agencies	State agencies at local level	

\* Comprehensive assessment, planning, and management of care

\*\* How the assessor and reviewer are reimbursed by the state.

**TABLE FOUR**  
**Comparison of Select States Screening, Assessment, and Management of Care**  
**for Person's with Disabilities**

ITEMS	AZ	CO	FL	CT
<b>PAYMENT OF CASE MANAGEMENT</b>	Flat Rate per Person	<ul style="list-style-type: none"> <li>• Flat Rate if client is kept in the community,</li> <li>• 0 if the client is admitted to a NH</li> <li>• Incentives for community transition</li> <li>• Incentives for complete form data</li> </ul>	<ul style="list-style-type: none"> <li>• Reimbursed on fee-for-service at agency level</li> </ul>	State staff
<b>TRAINING OF ASSESSOR REQUIRED</b>	Yes	Yes, Reviewers/Case management	Yes	Yes
<b>COORDINATION FOR NON-MEDICAID ELIGIBLES</b>	Yes	Yes	Yes-98%	Yes
<b>AGENCY PLURALITY</b>	Medicaid Waivers in One agency	All LTC programs consolidated in one agency	All waiver and Senior programs in Elder affair	Program for Seniors consolidated in Medicaid Agency
<b>TRANSITION OUT OF NURSING HOMES</b>	United Program	Yes, Financial Incentives to Case Management Agencies	Yes	
<b>FACTORS THAT PRECIPITATED CHANGE</b>	Cost of long Term care services	<ul style="list-style-type: none"> <li>• Save money</li> <li>• Reduce cost growth in Medicaid</li> <li>• Offer client more choices</li> <li>• Reduce confusion</li> </ul>	Obtain consistency and uniformity in the application process.	HCBS Waiver HCFA Requirement
<b>LEADERSHIP FOR CHANGE</b>	Medicaid Agency ALTCS	Medicaid Agency And Medicaid Agency Administrator	Mid-level and Senior Management in Medicaid Agency	Governor
<b>RATE OF ELIGIBILITY</b>	91%		99/2000-98%	51-69%
<b>RATE OF PROGRAM GROWTH</b>	<i>Pre 99-6.5% annually</i> 99-8.7%		94/95-\$4.5 mil 99/2000-\$9.3 mil	98/99-20%

## **Determining Medicaid Nursing Facility Level of Care Eligibility in Maryland** **References**

Alecxih, L. M. & Lutzky, S. (1996). *How do alternative eligibility triggers affect access to private long-term care insurance?* Washington, D.C., American Association of Retired Persons, Public Policy Institute, Report #9605.

*Examined the various triggers that 18 insurance companies currently use to assess eligibility for long term care benefits and used national survey data to estimate the number of people who would be eligible to receive long term care services under alternative benefit triggers. Data from the 1989 National Long Term Care Survey were used for estimates of the community-dwelling population, and data from the 1987 National Medical Expenditure Survey were used for the institutionalized population. Results suggest that insurers should consider the use of benefit triggers for community-based services that are more responsive to the need for care than triggers based on having impairment in a particular number of ADLs. The vagueness of current benefit triggers raises concerns about their being subject to abuse by both insurers and consumers. Further refinement and standardization of triggers will make it somewhat easier for consumers to understand and compare triggers across policies. Trained assessors who are independent of both the insurer and the insured may be the most advantageous to consumers and insurers alike.*

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Examined the long term care systems of three states--Colorado, Oregon, and Washington--to determine whether the expansion of home and community-based care (HCBC) services has diverted persons with disabilities from institutions and controlled increases in Medicaid spending. All three states have developed extensive HCBC programs under the Medicaid waiver program, using both Medicaid dollars and state general revenues. Results revealed that the number of people receiving Medicaid-funded nursing facility care in the three states grew at a much slower rate than in the rest of the nation during the study period, while the number of people in nursing homes as a proportion of the population aged 75 and over decreased faster than the national average. In 1994, Colorado served 21 percent fewer people in nursing homes than the study projected, given population growth; Oregon served 39 percent fewer; and Washington served 18 percent fewer; and the states saved between 9 and 23 percent of the amount that they would have spent on long term care.

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Bruen, B. K., Wiener, J. M., Kim, J., & Miazad, Ossai (1999). *State usage of Medicaid coverage options for aged, blind, and disabled people*. Washington, D.C., The Urban Institute.

Federal law requires that Medicaid programs cover certain low-income aged, blind, and disabled people, primarily recipients of Supplemental Security Income (SSI). In addition, most states use at least one of several optional categories of Medicaid eligibility to insure other aged, blind, and disabled people. Nonetheless, in 1995, only 42 percent of people age 65 and older with family incomes below 100 percent of the FPL were covered by Medicaid. Although several changes to eligibility policies in the last decade were designed to increase coverage of the low-income, uninsured population, nearly all of these expansions have targeted children and pregnant women. Federal Medicaid eligibility policies for aged, blind, and disabled people have remained virtually unchanged since the mid-1980s. *This paper presents data on state Medicaid eligibility policy for aged, blind, and disabled people drawn from a 1998 Urban Institute survey of state Medicaid programs, as well as information collected by the National Academy for State Health Policy and Commerce Clearing House, Inc. In brief, analysis of these data*

*suggests that Medicaid eligibility for the aged, blind, and disabled is very complex and confusing, with multiple ways of covering the same population. Coverage of the aged, blind, and disabled populations varies considerably by state, with many states not taking advantage of available options to extend coverage beyond that required by federal law. Even within a single state, Medicaid may use several income and resource criteria to determine eligibility for aged, blind, and disabled people. This variation is partly a result of the piecemeal evolution of Medicaid and its historical linkage to the cash welfare programs. As it evolved, Medicaid took on different roles. For some low-income aged, blind, and disabled people, Medicaid functions as their regular health insurance, providing coverage for a comprehensive range of acute care benefits. For others, Medicaid covers home and community-based services and is the primary payer for nursing home care. For those eligible for both Medicare and Medicaid, Medicaid provides financial assistance for Medicare premiums and cost-sharing requirements. Each of these new roles brought with it new eligibility criteria, and often multiple layers of eligibility criteria, leading to the tangle of rules that apply today.*

Capitman, J. A., Arling, G., & Bowling, C. (1987). Public and private costs of long-term care for nursing home preadmission screening program participants. *The Gerontologist*, 27(6), 780-787.

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services, consolidate state agency administration and financing of long term care services, develop single points of entry at the local level to facilitate access to long term care services, and encourage the development of residential settings for people with disabilities. Examples of states using each of these strategies are presented, and issues states should consider when implementing each approach are discussed. Oregon and Washington have particularly strong policies to reduce reliance on nursing homes for long-term care services. Since the 1980s, these two states have used a combination of all of these strategies.

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Long-term care eligibility criteria are applied to a sample of 8,437 people with dementia enrolled in the Medicare Alzheimer's Disease Demonstration to examine the potential impact of alternative criteria that have been proposed in legislation and that are being used in various programs. Various Instrumental Activities of Daily Living, Activities of Daily Living, and mental status test criteria are examined. Mental status test cut points substantially affect the pool of potential beneficiaries. IADL criteria include almost the entire sample. ADL eligibility criteria leave out people with relatively severe dementia and with behavioral problems which potentially pose health or safety risks. It is important to consider behavioral and mental status test criteria in establishing eligibility for community-based services for people with dementia.

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*The study examines the recommendations that some variant of activities of daily living (ADLs) serve as the basis for determining LTC eligibility. There is concern, however, that the reliance on ADLs may not be adequate to reach the cognitively impaired as their disability is less well expressed by the need for physical assistance than by supervision and cueing. The study's analysis suggests that expanding the definition of ADL dependency to include the need for supervision or cueing would offer a simple but effective means of determining the eligibility for LTC for all persons at risk. This approach also would preclude the need to make special provision targeted at the cognitively impaired, ensuring that no special sub-groups were created.*

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As the population ages and chronic disease becomes the more dominant form of illness, measures of functional loss and disability assume greater importance in the assessment of both quality of life and the cost-effectiveness of care. The authors studied the responses of consumers and health care professionals regarding the impact on dependency of various levels of disability. Striking differences in perception were noted, raising concerns about the ability of those providing care to assume that the recipients share their values about what is important. This study makes clear the need for more research on functional outcome measurements that incorporate the values of consumers.

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*Pressures to turn over responsibility for long-term care to the states will exacerbate the already sizable difference in such efforts. This article describes the nature of the interstate variation in the types and amounts of long-term care provided under Medicaid. The average Medicaid long-term care expenditure on persons sixty-five years and older varies from \$2,720 in New York to \$380 in*

*Arizona. Likewise, payments for home and community-based services (HCBS) vary from \$1,180 in New York to \$29 in Mississippi. Only a modest portion (28 percent) of the variance in total long-term care expenditures appears to be related to differences in population characteristics, and even less (7 percent) appears to be related to differences in HCBS expenditures. When supply factors (e.g., nursing home beds) are added, the explained variance increases to 52 percent and 17 percent, respectively. Medicare replaces some---but not most---of the difference in Medicaid home and community-based services payments.*

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*The article presents the findings of a national survey of HCB care waiver programs established under Section 2176 of OBRA 1981. The cost to Medicaid of treating the average person in a waiver program is significantly lower than the average cost of a nursing home day in the same state. However, the lower reported daily costs of waiver care as compared to nursing home care do not necessarily translate into Medicaid savings. Program savings would depend upon whether a waiver recipient would have actually used nursing home care had they not received they waiver as well as for how long. In addition, nursing home beds not filled by waiver recipients are likely to be filled by someone else.*

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Leutz, W., Abrahams, R., & Capitam, J. (1993). The Administration of Eligibility for Community Long-Term Care, *The Gerontologist*, 33(1), 92-104.

*Eligibility assessment for community long-term care vary widely across programs funded by states and Medicaid and in proposals to expand federal funding. The models for eligibility contained in this article are based largely on some of the most rigorous examples in the community LTC field, especially demonstration programs such as the SHMO, On Lok, and Channeling. The article recommends defining eligibility criteria to include not only ADL but also need for skilled services and need for supervision due to cognitive impairment , flexibility in short-*

*term eligibility in transitioning and post-acute situations and long-term eligibility in chronic situations.*

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Over the past 15 years, Medicaid 1915(c) home and community-based waivers have made a substantial contribution to states' efforts to transform their long-term

care systems from largely institutional to community-based systems. By 1997, every state had implemented a 1915(c) waiver program for at least some subgroups of individuals who are disabled. Expenditures have increased from \$3.8 million in 1982 to over \$8.1 billion in 1997. That same year, the 1915(c) waiver program comprised 14.4 percent of Medicaid long-term care expenditures. Yet states vary markedly in their use of home and community-based waivers relative to optional community-based services, such as personal care, and institutional services, such as nursing facility care. Emerging, as well as long standing, policy issues related to the 1915(c) waiver program include concerns with access, variation in availability by disability group, state decisions related to the provision of community-based long term care, and evidence on effectiveness.

Mollica, R. L. (1997). *State eligibility rules and assessment instruments: Implications for people with Alzheimer's disease*. Portland, ME, National Academy for State Health Policy.

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*The study details a model development process that represents a useful step in classifying populations in terms of risk of institutionalization (Inst-Risk II). A four category risk classification system – “High risk, Some risk, Low risk, and Very low risk” – was developed, based on combinations of measures of functional status, age, health status, demographics, and social supports. The authors posit that functional impairment, diagnostic conditions, and advanced age are major predictors of institutional placement.*

Neuhaus, B. E. & Miller, P. A. (1995). Status of functional assessment in occupational therapy with the elderly. *Journal of Allied Health*, 24(1), 29-40.

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*The report was intended to document the factors that states consider and the eligibility criteria they use to determine eligibility for nursing facility care and home and community-based LTC services in Medicaid waiver programs. The report found that there is no commonly accepted practice for determining eligibility for Medicaid LTC waiver programs. At the macro level, states employ three types of eligibility criteria: those that require scoring (7), those that require a minimum number of impairments and/or needs (19), and those that use eligibility criteria based on general definitions and guidelines (17).*

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*The purpose of this study was to determine if state’s LOC criteria present barriers to nursing home care and HCB waiver services for people with dementia who need LTC services. In 1991 the Advisory Panel on Alzheimer’s Disease established a number of recommendations to make LOC eligibility criteria more sensitive to the functional limitations and LTC needs of people with dementia.*

The study determined that 26 of 42 states surveyed have LOC criteria that recognize to varying degrees the unique LTC needs of people with dementia. Seven states consider meeting either of the recommended criteria to be sufficient to meet LOC criteria, 12 states consider one but not the other to be sufficient, and seven require both. In 16 states, meeting both of the recommended criteria is still not sufficient to meet the LOC criteria; other nursing or functional criteria must be met.

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*This study is an effort to determine the rate of compliance with placement and mental health recommendations of the preadmission screening and annual resident review (PASARR) program. The study participants were all Washington state Medicaid recipients screened from 1992 through 1993. Results of the study determined that inpatient psychiatric care was recommended for four of the 523 Medicaid recipients (0.8%), all of whom received it. Screeners recommended alternate dispositions in 131 (25%) subjects, and compliance occurred in 29% of these. Recommendations for new services were made in 310 (59%) cases. Compliance rates averaged 35%, ranging from 73% for medication recommendations to 7% for consultation. Depressed individuals were less likely to receive recommended services. The study concluded that many individuals needed additional mental health services but did not receive them, and a*

*significant minority of patients could have been given an alternate disposition but rarely were.*

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*Measures of functional disability typically contain items that reflect limitations in performing activities of daily living (ADLs) or instrumental activities of daily living (IADLs). Combining IADL and ADL items in the same scale would provide enhanced range and sensitivity of measurement. This article presents psychometric justification for a combined ADL/IADL scale. Data from 2,977 disabled respondents in the 1989 National Long-Term Care Survey. Respondents indicated whether they received human help on 7 ADL items; they also indicated whether they were unable to perform each of 9 IADL items due to health reasons. Factor analyses using tetrachoric correlations demonstrated that 15 of 16 items reflected one major dimension. Item response theory (IRT) methods were used to calibrate the items; a one-parameter IRT model fit the data. Item calibrations showed that ADL and IADL items were not hierarchically related. Analyses showed that a simple sum of item responses could be used to derive a measure of functional disability. Implications of using a 15-item ADL/IADL scale for eligibility determination and for comparing groups were discussed.*

Spector, W. D., Reschovsky, J. D., & Cohen, J. W. (1996). Appropriate placement of nursing-home residents in lower levels of care. *The Milbank Quarterly*, 74(1), 139-159.

*The findings of this study indicate that, based on clinical criteria, there may be a large number of nursing-home residents who could be cared for in lower-level settings. This would suggest that the potential for cost savings achieved by transferring or diverting persons needing LTC from nursing homes to lower-level settings may be substantial. The study conservatively estimates that approximately 15% of nursing-home residents could be diverted to lower levels of care. These residents require help with less than 3 ADLs, are continent, do not exhibit serious behavior problems, and do not have substantial rehabilitation or medical needs. One possible solution to this problem would be to implement more stringent pre-admission screening criteria for nursing homes. However, more stringent criteria may have the added effect of denying care to those truly needing nursing-home level of care.*

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Long-term care screening and assessment programs are designed by states to control LTC costs and to prevent unnecessary institutionalization of Medicaid participants. This study reports data collected from all 50 states and DC on state variations in LTC screening and assessment programs. Overall there were 247 screening and assessment programs for LTC in the states and these were administered by 190 agencies. Only four states had a single administrative agency for all LTC screening and assessment. Over 50% of screening and assessment programs were administered outside of government agencies. There is a lack of uniform criteria, which may be the result of the many different agencies responsible for screening and assessment.

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Vertrees, J. C., Manton, K. G., & Adler, G. S. (1989). Cost effectiveness of home and community-based care. *Health Care Financing Review*, 10(4), 65-78.

Wade, S., Kacprowicz, A., & Hamilton, B. (1996). A rehabilitation services research bibliography: Functional Independence Measure (FIM) 1986-March 1996. Durham, NC: Rehabilitation Services R & D Unit.

Ware, J. E. & Sherbourne, C. D. (1992). The MOS 36-Item Short-Form Health Survey (SF-36): Conceptual framework and item selection. *Medical Care*, 30, 473-483.

Weissert, W. (1986). Hard choices: Targeting long-term care to the at risk aged. *Journal of Health Politics, Policy and Law*, H(3), 463-481.

*Home and community-based care, although advanced as a substitute, is often a complement to nursing home care typically raising overall health services use and costs. Strict requirements to demonstrate cost savings have forced many states to keep their programs small. A better solution may be to abandon the requirement that community care save money by avoiding institutionalization and instead ration publicly financed community care to the population most in need. Using coefficients from a study of institutionalization determinants, it is possible to estimate the risk of institutionalization of individuals or groups based on age, sex and race. When coupled with estimates of utilization and costs, budget targets can be set which would serve a large or small proportion of the risk population, depending on the size of the budget that is set.*

Weissert, W. G. & Cready, C. M. (1989). Toward a model for improved targeting of aged at risk of institutionalization. *HSR: Health Services Research*, 24(4), 485-510.

Weissert, W. G., Lesnick, T., et al. (1997). Cost savings from home and community-based services: Arizona's capitated Medicaid long-term care ..... *Journal of Health Politics, Policy and Law*, 22(6), 1329-1358.

*The Arizona Long-Term Care System is the first capitated, long-term care Medicaid program in the nation to operate statewide. This study compares actual costs incurred to an estimate of what costs would have been in the absence of*

*home and community-based (HCB) services. HCB services appeared to save substantial amounts on costs of nursing home care. Estimates of savings were very robust and did not appear to be declining as the program matured. Savings probably came from several sources: the assessment teams that judged client eligibility were employed by a state agency and thus were independent from the program contractors; clients were required to be in need of at least a three-month nursing home stay; a cap was placed on the number of HCB services clients contractors were allowed to serve each month; the capitated payment methodology forced managed care contractors to hold down average HCB services costs or lose money; and the HCB services and nursing home costs were blended in the capitated rate, so that plans that failed to place clients in HCB services would lose money by using more nursing home days than their monthly capitated rate allowed.*

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States are likely to turn to more traditional strategies to reduce LTC spending such as reducing reimbursement rates to nursing homes, especially with repeal of the Boren Amendment. Although states have considerable flexibility to reduce long-term care spending through rate cuts, eligibility determinations, and benefit decisions, these cuts could potentially have a negative impact on quality of care and access to long-term care services for the elderly. If states maintain current levels of access and quality, they eventually will need to utilize other cost-saving strategies, such as increasing the amount of outside resources used to finance Medicaid long-term care, coordinating acute and long-term care through use of managed care, and expanding home and community-based care. It is uncertain how much reforms could reduce spending in the short or long term, but there are some encouraging developments in the integration of acute and long-term care and in creative home and community-based programs. States will seek to build on the promise of these findings as they attempt to reform Medicaid long-term care and to contain spending.

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