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OFFICE OF LONG TERM LIVING BULLETIN

ISSUE DATE:

EFFECTIVE DATE:

NUMBER:

Immediately

DRAFT 00-08-01

SUBJECT:

DRAFT Nursing Facility Clinically Eligible (NFCE)
Clarification

BY:

PURPOSE:

This bulletin clarifies the standard that is used to assess whether an individual needs the level of care in a nursing facility.

SCOPE:

This bulletin is directed to all Area Agencies on Aging (AAA) and AAA staff responsible for conducting the nursing facility level of care assessments, which are used to authorize eligibility for Medical Assistance (MA) nursing facility services and MA Home and Community-Based (HCB) waiver services under the Attendant Care Waiver, the Independence Waiver, the COMMCARE waiver and the Aging Waiver. This bulletin clarifies and supplements the guidance regarding Nursing Facility Clinical Eligibility determinations found on pages 7-8 of Chapter 1 (Assessments) of the Home and Community-Based Services Procedures Manual (Procedures Manual) and in the Level of Care Assessment Instructions.

BACKGROUND:

The Department of Public Welfare (DPW) is the state agency that has overall responsibility for the administration of the Commonwealth's Title XIX Medicaid Program, which is known in Pennsylvania as the MA Program. The MA Program provides eligible recipients with coverage for health care and services, including nursing facility services, under the Commonwealth approved Title XIX Medicaid State Plan. In addition, the MA Program provides coverage for HCB services under the Commonwealth's approved 1915(c) Waivers to a limited number of

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eligible recipients who meet certain criteria and who would otherwise require services in an institutional setting, including a nursing facility.

An individual must meet both financial and clinical eligibility criteria to receive MA nursing facility services or MA HCB waiver services. To be clinically eligible for either MA nursing facility services or the MA HCB waiver services provided as an alternative to nursing facility care, an individual must be assessed and determined to require the level of care provided in a nursing facility. See 55 Pa. Code § 1187.22(2) and 42 CFR 441.302(c). In addition to meeting financial and clinical eligibility, the individual must also meet whatever criteria are specified in the individual Waiver to receive MA HCB waiver services. For example, in addition to being financially eligible and requiring the nursing facility level of care, an individual must be 60 years or older to receive MA HCB services under the Aging Waiver.

The AAAs conduct the level of care assessments which DPW uses to authorize eligibility for both MA nursing facility services and HCB waiver services under the Attendant Care Waiver, the Independence Waiver, the COMMCARE Waiver and the Aging Waiver. An individual who is assessed and determined by an AAA to need the level of care provided in a nursing facility is considered “nursing facility clinically eligible” (NFCE). An individual who is assessed and determined not to require the level of care provided in a nursing facility is considered “nursing facility ineligible” (NFI). An individual who is NFI is not clinically eligible for either MA nursing facility services or those HCB waiver services which are provided in lieu of nursing facility care.

As specified in the Commonwealth’s Waivers, the AAAs use the same level of care assessment instrument to assess clinical eligibility for MA nursing facility and MA HCB waiver services.

In October 2007, the Centers for Medicare and Medicaid Services (CMS) completed a review of Pennsylvania’s Aging Waiver services program. Although finding that Pennsylvania demonstrated compliance with Federal waiver requirements, CMS recommended that DPW take measures to better assure that level of care assessments are conducted consistently throughout the Commonwealth in determining whether individuals are clinically eligible to receive MA services in either institutional and community settings.

Consumers and their advocates have also expressed concerns about perceived inconsistencies in level of care assessments and outcomes, particularly those conducted in re-determining consumers’ continued eligibility for HCB waiver services. Specifically, they have suggested that, in applying the current Procedures Manual NFCE provisions, some AAAs have found an individual to be NFCE only if he or she required the skilled level of care that would be funded under the Medicare Program, rather than the broader level of care that is provided in a MA nursing facility and funded under the MA Program.

Although we do not view the current Procedures Manual NFCE provisions as unduly restricting eligibility to individuals requiring the Medicare skilled level of care, we do agree that the outcome of an individual’s level of care assessment should not differ either because it is conducted by one AAA rather than another or because the individual is seeking MA services under a HCB waiver rather than in an MA nursing facility. To better assure consistency in level of care assessments and to remove any question as to the scope of individuals whom we

consider to be NFCE, we are issuing this guidance to AAAs for use in conducting level of care assessments for MA nursing facility and HCB waiver services.

DISCUSSION:

An individual is NFCE if he or she needs the level of care provided in a nursing facility.

Under Federal and State law and regulations, which identify the level of care provided in a nursing facility,¹ a consumer should be considered NFCE if:

1. The consumer has an illness, injury, disability or medical condition diagnosed by a physician; **and**
2. As a result of that diagnosed illness, injury, disability or medical condition, the consumer requires care and services above the level of room and board that are ordered by, and provided under, the direction of a physician; **and**
3. The care and services are **either**
 - a) skilled nursing or rehabilitation services as specified by the Medicare Program in 42 CFR §§ 409.31(a), 409.31(b)(1) and (3), and 409.32 through 409.35; **or**
 - b) health-related care and services that are not as inherently complex as skilled nursing or rehabilitation services but which are needed and provided on a regular basis in the context of a planned program of health care and management and are usually available only through institutional facilities.

Although a consumer must have an illness, injury, disability or medical condition diagnosed by a physician to require the level of care provided by a nursing facility, a diagnosed medical condition alone does not automatically make a consumer NFCE. Many consumers have diagnosed medical conditions and are able to take care of their own medical needs. They would not require care and services at the level provided in a nursing facility.

Other consumers may have functional and cognitive impairments or experience symptoms of a disease process that do impact their ability to meet their own medical needs. When a consumer cannot take care of his or her own medical needs, a planned program of health care management provided by or under the supervision of a skilled medical professional may be required to address the consumer's medical needs. In such instances, the consumer may be determined NFCE even though the consumer does **not** require or

¹ See 42 U.S.C §§ 1396d(f) (defining "nursing facility services") and 1396r(a) (defining a "nursing facility"); 35 P.S. § 448.802a (defining "long-term nursing facility"); 42 CFR §§ 440.40 (defining "nursing facility services") and 440.155 (defining "nursing facility services, other than in institutions for mental diseases"); 35 P.S. § 448.802a (defining "long-term care nursing facility"); 28 Pa. Code § 201.3 (defining "nursing care" and "skilled or intermediate nursing care:") and 55 Pa. Code § 1181.2 (defining "intermediate care" and "skilled nursing facility services;").

receive services at the Medicare skilled nursing or rehabilitation services level. Under both Federal and State law, and under Department of Health (DOH) and DPW regulations, an individual who needs care and services that meet the definition of intermediate care in 55 Pa. Code § 1181.2² would require the level of care in a nursing facility.

For example, under Medicare requirements, a consumer must require skilled nursing services on a daily basis to receive Medicare coverage for post hospital skilled nursing facility care. For MA nursing facility and MA HCB waiver services, however, an individual may be NFCE if he requires skilled services on a regular, but not daily basis. Further, an individual who requires only personal care services may be NFCE if his mental or physical condition is such that the overall development, management and evaluation of his care plan must be performed by technical or professional personnel, such as registered nurses or licensed practical nurses, even though these care plan activities are not required by or provided to the individual on a daily basis.

On the other hand, an individual may need assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs), but not require that assistance as part of a planned program of health care and management for the treatment of a diagnosed medical condition or disability. Under these circumstances, the individual could receive care and services in a licensed personal care home,³ and, as a result, would be considered NFI.

A consumer who has been determined eligible for MA nursing facility services or MA HCB waiver services must undergo a re-determination of eligibility at least on an annual basis. As part of the re-determination process, the consumer's clinical eligibility must be reassessed and evaluated to determine if the consumer continues to be NFCE.

Generally, once a consumer has been properly determined to be NFCE, the consumer should remain NFCE unless there is some change in circumstance that warrants a different outcome. For example, a consumer may have been assessed NFCE and determined eligible for MA HCB waiver services as an alternative to nursing facility care. Since his last assessment, the consumer's medical condition may have improved to the extent that he no longer requires regular health-related care and services in the context of a planned program of health care and management, and would not be institutionalized if waiver

² "Intermediate care ... [is] ... care ... ordered by, and provided under the direction of a physician [that] is available on a continuous 24-hour basis to a person who does not require the degree of care and treatment provided in a hospital or skilled nursing facility. Because of a mental or physical disability, the person does, however, require nursing and related health and medical services in the context of a planned program of health care and management." 55 Pa. Code § 1181.2. See also 42 U.S.C. § 1396r(a)(1)(C) (a "nursing facility" provides "(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, or (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").

³ A personal care home is a "premise in which food, shelter and personal assistance or supervision are provided for a period exceeding 24 hours, for four or more adults who are not relatives of the operator, who do not require the services in or of a licensed long-term care facility, but who do require assistance or supervision in activities of daily living or instrumental activities of daily living." 55 Pa. Code § 2600.4. See also 62 P.S. § 1001 (defining "personal care home"). Personal care homes are not medical facilities. Although they must hire staff who meet basic education requirements, unlike nursing facilities, they are not required to have a medical director or to employ licensed professional nurses and trained nurses aides.

services were discontinued. Under these circumstances, the consumer would be NFI even though the consumer was previously determined NFCE.

Although, in most cases, a change in a consumer's status from NFCE to NFI will be based on an improvement in a consumer's medical condition, there may be limited instances in which a consumer may be found to be NFI even though his or her medical condition has not improved. For example, the AAA may find that it used inaccurate information in assessing the consumer or that its conclusion that the consumer was NFCE was clearly incorrect given the information that was available and considered at the time. The AAA may also conclude that a prior assessment was incorrect based on new information that was not available at the time of the prior assessment which, if it had been available and considered, would have resulted in a different outcome. Based upon the information available to it at the time of it is reassessing the consumer, the AAA may conclude that the consumer does not require the level of care provided in a nursing facility.

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