UTAH DEPARTMENT OF HEALTH
MEDICAID

DIVISION OF MEDICAID & HEALTH FINANCING

Nursing Facility Level of Care Training

Bureau of Authorization and Community-Based Services

Updated October 2021

All documents referenced in this presentation can be found in PDF form on the New Choices Waiver website: https://medicaid.utah.gov/ltc-2/nc/

Individual documents can be accessed on the NCW website under the tab titled “CMAs” or by clicking on the blue hyperlink from within this presentation.

Nursing Facility Level of Care

- Nursing facility level of care is a fundamental eligibility criteria for the New Choices Waiver (NCW) program.
- It's the same medical criteria that Utah Medicaid uses to approve long term care in nursing facilities.
- All NCW participants must meet nursing facility level of care criteria at the time of enrollment and continuously to remain on the program.

Nursing Facility Level of Care

General Definition:

The person's level of physical and/or cognitive functioning, medical condition and intensity of services indicate that the care needs of the person cannot be safely met in a less structured setting or without the supports of a Medicaid home and community-based waiver program.

Level of Care Criteria

The actual administrative rule states: "… the Department shall document that ***at least two*** of the following three factors exist:

(a) … applicant requires at least substantial physical assistance with activities of daily living above the level of verbal prompting, supervising, or setting up;

(b) … applicant's level of dysfunction in orientation to person, place, or time requires nursing facility care; or equivalent care provided through an alternative Medicaid health care delivery program; or

(c) The medical condition and intensity of services indicate that the care needs of the applicant cannot be safely met in a less structured setting, or without the services and supports of an alternative Medicaid health care delivery program."

Level of Care Determination

- The MDS-HC is used to determine whether the client meets nursing facility level of care criteria. It also helps determine the service needs required for safe residence in a home or community-based setting.

- Clinical judgment must be used to make LOC determinations. The MDS-HC should ***not*** be used as a mere questionnaire. The assessment should include a review of medical records and patient history; consideration of responses from the client, family, and caregivers; and professional clinical observation.

Level of Care Determination

Factor A: Due to diagnosed medical conditions, the individual requires at least substantial physical assistance with activities of daily living above the level of verbal prompting, supervision or setting up.

- The client must need hands-on physical assistance with ***at least two*** activities of daily living, at least three times per week.

- Activities of daily living are limited to those listed on the LOC Determination Form. Instrumental activities of daily living (e.g. cooking, shopping, managing a budget, etc.) ***CANNOT*** be included for Factor A.

Level of Care Determination

Factor B: The attending provider has determined that the individual's level of dysfunction in orientation to person, place or time requires nursing facility care, or equivalent care provided through a Medicaid Home and Community Based Waiver program.

- Disorientation may be due to dementia, mental illness, brain injury or any other permanent condition.

Level of Care Determination

Factor B (continued):

- Verification can be obtained by reviewing current medical records (dated within one year of the assessment) or speaking to the client's medical provider. New verification from the medical provider is required on an annual basis. The source of information for this factor should be noted on the LOC Determination Form.

- Please do not take the LOC determination form to the medical provider to have them fill out Factor B – they are typically not trained in LOC criteria and may misinterpret the language and/or services being requested.

Level of Care Determination

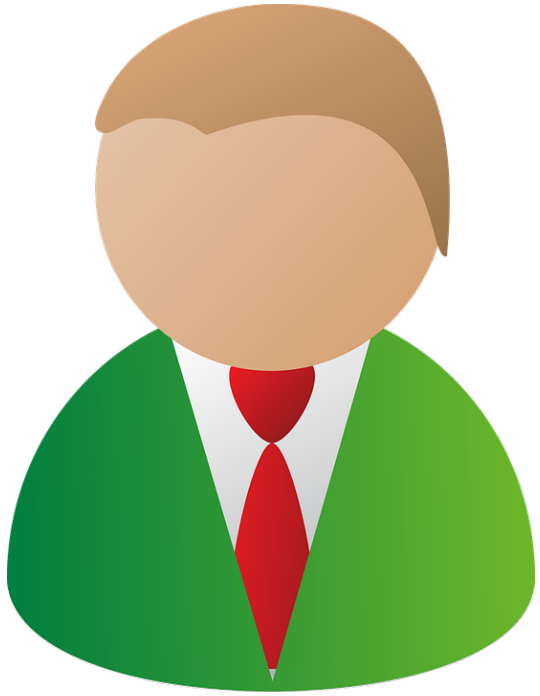
Factor C: The medical condition and intensity of services indicate that the care needs of the individual cannot be safely met in a less structured setting, or without the services and supports of a Medicaid Home and Community Based Waiver program.

- Document the medical reasons that the client requires nursing facility care or the supports of a Home and Community Based Waiver program. This will include the client's diagnoses, treatments and any exacerbating conditions, such as incontinence, chronic pain, fall risk, etc.

- Assistance needed with instrumental activities of daily living can be listed here, but ***do not*** restate the ADL assistance that is documented under Factor A.

Case Example

Let's go through the MDS-HC together. We are going to use a case study as we proceed through pertinent sections.



Client Information:

- John Doe, 74 year old male
  - Admitted to SNF following a left lower limb amputation
  - Previously lived in ALF with his wife
  - History of type 2 diabetes, chronic kidney disease, anxiety, dementia, and a coronary artery bypass
  - Receives hemodialysis 3x/week
  - Uses electric wheelchair for mobility
  - Limited to extensive assist with ADLs

Understanding the MDS-HC

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Minimum Data Set - Home Care

- The lookback period for this assessment is 3 days, except where a 7 day lookback period is listed (iADLs and continence).

- Section B (Cognitive Patterns) should be completed by referencing a standardized cognitive assessment such as a MoCA (Montreal Cognitive Assessment), SLUMS (St. Louis University Mental Status Exam), or BIMS (Brief Interview for Mental Status). Note the score of the assessment on the LOC Determination Form.

- Section C (Communication) is used to assess the client's abilities in their NATIVE language.

https://medicaid.utah.gov/Documents/pdfs/ltc/epas/ProviderFiles/MDS-HC.pdf

Understanding the MDS-HC

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- Section H (Physical Functioning) – when in doubt ask the client to demonstrate tasks that they report they are able to do.

- Line 1.a. of Section R can only be signed by a Utah licensed nurse or physician. Collaboration is expected and any other participating parties should sign in the space below.

- If there is not adequate room to list all of the client's diagnoses or medications on the assessment form, please attach a list of diagnoses/medications to the back of the assessment and make sure that they are saved together in the client's file.

LOC Determination Form

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LOC Determination Form

This form will reflect the findings from the MDS-HC. Each time an assessment is completed an MDS-HC and LOC Determination Form will be completed. Each section of the LOC Determination form needs to be filled out completely, whether the client meets criteria for that factor or not.

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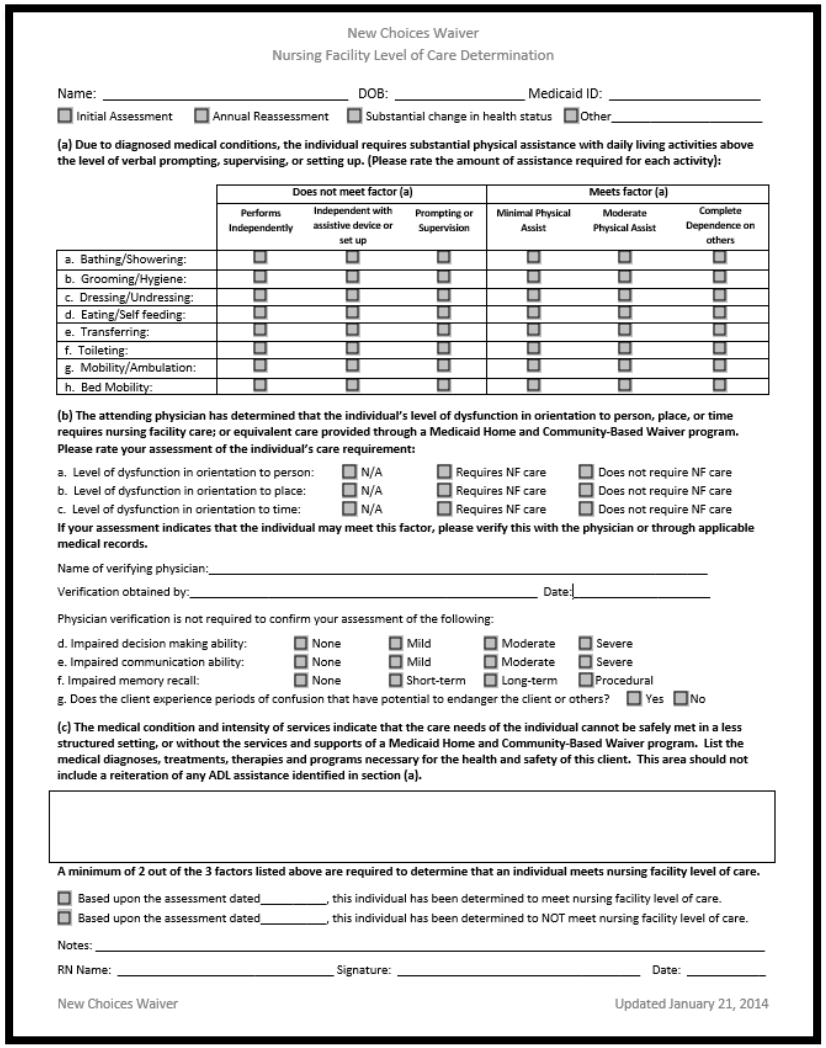

New Choices Waiver
Nursing Facility Level of Care Determination

Name: _____ DOB: _____ Medicaid ID: _____

☐ Initial Assessment ☐ Annual Reassessment ☐ Substantial change in health status ☐ Other_____

(a) Due to diagnosed medical conditions, the individual requires substantial physical assistance with daily living activities above the level of verbal prompting, supervising, or setting up. (Please rate the amount of assistance required for each activity):

	Does not meet factor (a)			Meets factor (a)		
	Performs Independently	Independent with assistive device or set up	Prompting or Supervision	Minimal Physical Assist	Moderate Physical Assist	Complete Dependence on others
a. Bathing/Showering:	☐	☐	☐	☐	☐	☐
b. Grooming/Hygiene:	☐	☐	☐	☐	☐	☐
c. Dressing/Undressing:	☐	☐	☐	☐	☐	☐
d. Eating/Self feeding:	☐	☐	☐	☐	☐	☐
e. Transferring:	☐	☐	☐	☐	☐	☐
f. Toileting:	☐	☐	☐	☐	☐	☐
g. Mobility/Ambulation:	☐	☐	☐	☐	☐	☐
h. Bed Mobility:	☐	☐	☐	☐	☐	☐

(b) The attending physician has determined that the individual's level of dysfunction in orientation to person, place, or time requires nursing facility care; or equivalent care provided through a Medicaid Home and Community-Based Waiver program. Please rate your assessment of the individual's care requirement:

a. Level of dysfunction in orientation to person: ☐ N/A ☐ Requires NF care ☐ Does not require NF care
b. Level of dysfunction in orientation to place: ☐ N/A ☐ Requires NF care ☐ Does not require NF care
c. Level of dysfunction in orientation to time: ☐ N/A ☐ Requires NF care ☐ Does not require NF care

If your assessment indicates that the individual may meet this factor, please verify this with the physician or through applicable medical records.

Name of verifying physician:_____

Verification obtained by:_____ Date:_____

Physician verification is not required to confirm your assessment of the following:

d. Impaired decision making ability: ☐ None ☐ Mild ☐ Moderate ☐ Severe
e. Impaired communication ability: ☐ None ☐ Mild ☐ Moderate ☐ Severe
f. Impaired memory recall: ☐ None ☐ Short-term ☐ Long-term ☐ Procedural
g. Does the client experience periods of confusion that have potential to endanger the client or others? ☐ Yes ☐ No

(c) The medical condition and intensity of services indicate that the care needs of the individual cannot be safely met in a less structured setting, or without the services and supports of a Medicaid Home and Community-Based Waiver program. List the medical diagnoses, treatments, therapies and programs necessary for the health and safety of this client. This area should not include a reiteration of any ADL assistance identified in section (a).

A minimum of 2 out of the 3 factors listed above are required to determine that an individual meets nursing facility level of care.

☐ Based upon the assessment dated_____, this individual has been determined to meet nursing facility level of care.
☐ Based upon the assessment dated_____, this individual has been determined to NOT meet nursing facility level of care.

Notes: _____

RN Name: _____ Signature: _____ Date: _____

New Choices Waiver Updated January 21, 2014

Group Activity – LOC Determination & Med Management Review

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New Choices Waiver
Medication Management Review

Name: _____ DOB: _____ Medicaid ID: _____

The medication management review should correspond with the MDS-HC assessment. Anytime a new MDS-HC assessment is required, a new Medication Management Review form should also be filled out. A quarterly Medication Management Review should take place every three months following the MDS-HC (i.e. January, April, July, and October).

Attach a current, complete list of the client's medications as of the date of the assessment. This list should include the medication name, associated diagnosis, dose, route and frequency.

Corresponding MDS-HC Assessment Date: _____

Who is responsible for administering medications? ☐ Facility Staff ☐ Client ☐ Other_____
If the facility staff is responsible for administering medications, was the Medication Administration Record (MAR) for the past three calendar months reviewed? ☐ Yes ☐ No

Concerns related to Medication Administration or Compliance: ☐ N/A

Potential Medication Interactions Identified: ☐ N/A

Does the client receive laboratory testing to monitor therapeutic levels of any medications listed? ☐ Yes ☐ No
If yes, please describe the services in place to provide this testing. Identify any issues or potential issues that have occurred over the past three calendar months.

Document follow- up that occurred (including outcomes) with the prescribing physician, the facility, or the client to address any concerns identified above.

The undersigned is not responsible for administering or prescribing medications. This form has been completed based on the clinical knowledge and judgment of the RN.

RN Name: _____ Signature: _____ Date: _____

New Choices Waiver
Medication Management Review

Quarterly Reviews

The quarterly review will identify any changes in the medication regimen, concerns that are ongoing or not previously identified, and follow-up that occurred (including outcomes) with the prescribing physician, the facility, or the client to address the concerns identified.

Quarter 1 Review (3 months following MDS-HC)

RN Name: _____ Signature: _____ Date: _____

Quarter 2 Review (6 months following MDS-HC)

RN Name: _____ Signature: _____ Date: _____

Quarter 3 Review (9 months following MDS-HC)

RN Name: _____ Signature: _____ Date: _____

Nursing Facility Level of Care

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Concerns?

Questions?

Health Status Screening

Health Status Screening Report

- Anytime there is a substantial change in a client's health status, including at the conclusion of an inpatient stay in a medical institution, the client must be screened in person by your agency's RN.

- If the Health Status Screening indicates that a full level of care re-evaluation is required, a full assessment should be completed including a new MDS-HC and LOC Determination Form.

- The Health Status Screening Form is due **within seven (7) business days** of learning of a substantial change in a client's health status or following discharge from an inpatient stay.

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Memory Care Requests

- Memory care requests require approval from the New Choices Waiver Program Office ***IN ADVANCE*** of client placement in a locked unit.

- The federal government requires all states to ensure that residential settings where Home and Community Based Waiver services are provided are home-like and do not have qualities that are “institutional” in nature. Locked units are viewed as having qualities that are particularly institutional in nature.

- The New Choices Waiver Program Office reviews memory care requests in detail to ensure that placement will be in the client’s best interest and will not result in a human rights violation. Requests will be approved when clinically appropriate and supported with the appropriate justification.

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Memory Care Requests

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- The Memory Care Checklist is completed and submitted to the New Choices Waiver Program Office with the following documentation attached:

    1. A completed LOC Determination Form (must indicate disorientation to person, place, and/or time) or if the last MDS-HC is outdated, the results of a more recent cognitive assessment (mini mental, MoCA, etc).
    2. A written description of the specific behaviors exhibited by this client that have endangered the client or others, records of incidents that have occurred, clinical diagnoses and any other justification to support the restrictive placement.
    3. Written documentation of less restrictive interventions tried and how these interventions failed before now OR an explanation describing long term placement in this setting already and a detailed description of how moving would be detrimental to health and safety.
    4. A description of the client's stated goals/wishes for community integration and a written plan for how to achieve their stated goals/wishes. Include the frequency and who will be responsible to assist with accessing the greater community OR an explanation for why community access will not occur
    5. A written statement from the representative explicitly "approving the restrictive placement and affirming their intent to remain involved with this client throughout NCW enrollment in order to make decisions on the client's behalf."

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Memory Care Requests

- The NCW RN may request additional documentation before approving or denying the memory care request.

- NCW cannot approve a rights restriction for a person who does not have mental capacity to understand and agree to the restriction or who does not have a representative to make the decision on their behalf.

- If your client is approved for placement in a locked unit, you will receive an email with the Memory Care Checklist signed by the NCW RN that will indicate approval. Please upload the signed memory care checklist into the client's care plan.

- If your client is denied you will receive an email with an explanation of why your client was denied.

- During the annual completion of the PCCP Addendum, the "Modifications" section will need to describe the client's placement in a secure unit in order to maintain their health and safety. This is applicable for all clients residing in memory care.

Program email: newchoiceswaiver@utah.gov

Program Fax: (801) 323-1586

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If you have additional questions, don't hesitate to contact me!

Marisol Torres, MSN, RN
(801) 538-6580
marisoltorres@utah.gov
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