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Determining Medicaid Nursing Home Eligibility: A Survey of State Level of Care Assessment

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Table of Contents

Table of Figures

SUMMARY

This study is intended to describe the nursing facility level of care determination processes in use by the states and to draw general conclusions from the data collected. When read in conjunction with the previous work in this area, this study will aid state staffs, CMS, and other parties interested in understanding how to improve post acute care assessment.

All states were contacted by phone to identify the agency, and the person within the agency, best suited for responding to survey questions. This was followed up with additional phone calls and email inquiries to obtain the information requested: how the assessment was done, definitions in use, connection with plan of care recommendations, populations served, format of the instrument, cost-effectiveness and efficiency and assessment administration.

Assessment instruments used to collect data on nursing home and HCBS waiver applicants are focused on obtaining clinical and activities of daily living (ADL) information. Three states emphasize clinical information, seven appear to emphasize ADL information in the assessment, and the remaining states report using both clinical and ADL information. In 2008, more states report using a mix of these two types of information to make LOC determinations than in earlier time periods. Assessments focus primarily on Medicaid-eligible populations and secondarily on state-funded health care programs. Information collected falls into three clusters: demographic/personal information, clinical/functional information, and plan of care or recommendations. The information gathered through the assessment forms is not used to make Medicaid financial eligibility determinations. The assessment instruments were often available at an agency website but were seldom fully automated to allow for completion on line.

In 25 states, the medical staffs in nursing homes play a central role in completing the assessment for applicants. State staff who responded to the survey saw themselves as clinical specialists serving in a gatekeeper role for Medicaid and similar state programs. Staffs were not in regular contact with other assessment offices such as those conducting MR/DD assessments, or their organization's information technology staff. Regular reports on the costs or savings of assessment practices were not routinely done. States would benefit by strengthening their management data collection about assessment activity. Persons working in assessment would benefit from sharing information about what is done in different states. For example, states could call or organize regional meetings to discuss, assessment philosophy and regulation, new information technology, and ways to operate programs more efficiently.

The tables in the Appendix provide a brief description of data the state collects, the name of the assessment form, the website of the assessment form if the state has one, and contact information to learn more about what the state does.

BACKGROUND

This study looks at the methods that states use to determine the medical eligibility of persons who wish to receive Medicaid-paid nursing home services. In June 2007, the country's 15,850 Medicare and Medicaid certified nursing homes contained 1,428,400 residents of whom 64.4%, or 919,890, had nursing home stays that were being paid by Medicaid.[1] However, the number of unduplicated persons who had a Medicaid-paid stay in a nursing home is higher. For example, records of the Centers for Medicare & Medicaid Services (CMS) for 2004 show that 1,718,000 persons had a stay in a nursing home that was paid for by Medicaid.[2]

All state Medicaid programs have two eligibility requirements that regulate which persons may obtain Medicaid financial support for their nursing home stay(s). The first is a review of their financial eligibility, and the second is a review of their medical eligibility. With respect to medical eligibility, states adopt their own procedures and set their own criteria as CMS leaves medical necessity determinations to the states. This study focuses on how medical eligibility is determined.[3] The process of determining medical eligibility is often referred to as a level of care determination or LOC.

This study takes place within the context of a national concern with how medical conditions are assessed to determine appropriate post-hospital care of persons. Over the last 15 years, hospitals have been discharging more persons and discharging them faster. Plus, there were more persons using Medicare-paid inpatient hospital services, and the utilization rate of inpatient services per 1,000 Medicare enrollees was higher. Between 1990 and 2005, the number of Medicare short-stay hospital discharges increased from 10.5 million to 13.0 million, an increase of 24%, while the hospital average length of stay for Medicare patients decreased from 9.0 days in 1990 to 5.7 days in 2005, a decrease of 37%.[4] In 1990, there were 31,241,831 persons aged 65 and older.[5] In 2005 there were 34,760,527 persons aged 65 and older, an increase of 11%.[6]

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[1] Available from http://www.ahcancal.org/research_data/oscar_data/Pages/default.aspx. Readers are advised that this page changes and data are updated as new Online Survey, Certification and Reporting (OSCAR) information becomes available.

[2] US Dept. of Health and Human Services (2007). Available at http://www.cms.hhs.gov/CapMarketUpdates/Downloads/2007CMSstat.pdf.

[3] Federal language uses the term medical necessity and state staffs tend to use the term medical eligibility in discussions of level of care determination. This paper uses the term medical eligibility since most readers will be more familiar with it.

[4] US Department of Health and Human Services, Table 38. Available at http://www.cms.hhs.gov/CapMarketUpdates/Downloads/2007CMSstat.pdf.

[5] US Department of Commerce (1990). Available at http://factfinder.census.gov/servlet/QTTable?_bm=y&-geo_id=04000US72&-qr_name=DEC_1990_STF1_DP1&-ds_name=DEC_1990_STF1_.

[6] US Department of Commerce (2005). Available at http://factfinder.census.gov/servlet/IPTable?_bm=y&-qr_name=ACS_2005_EST_G00_S0201&-qr_name=ACS_2005_EST_G00_S0201PR&-qr_name=ACS_2005_EST_G00_S0201T&-qr_name=ACS_2005_EST_G00_S0201TPR&-geo_id=01000US&-

The Deficit Reduction Act of 2005, Section 5008 charged the Centers for Medicare & Medicaid Services (CMS) with the responsibility for establishing a "demonstration program for such purposes of understanding costs and outcomes across different post-acute care sites." CMS currently reimburses post-acute care in skilled nursing facilities, home health agencies, long-term care hospitals, and inpatient rehabilitation facilities. The three-year, $6 million demonstration was to be established by January 14, 2008. As part of the demonstration CMS was to use a "standardized patient assessment instrument across all post-acute care sites to measure functional status and other factors during treatment and at discharge from each provider."[7]

PREVIOUS WORK ON LEVEL OF CARE DETERMINATIONS

Level of care assessment processes have been examined by other researchers. Janet O'Keefe conducted a study in August 1999 to determine if states' LOC criteria presented barriers to nursing home care and home and community-based services (HCBS) waivers for people with dementia who need long-term care services.[8] She examined two questions: first, whether a state's LOC criteria incorporate the recommendation of the Advisory Panel on Alzheimer's Disease on which eligibility criteria should or should not be used; and second, whether individuals who met the Advisory Panel's recommended criteria would also meet the states' LOC criteria. She found significant disparities and potential inequities among the states in terms of the criteria applied and determined that only seven of the 42 states surveyed would allow an individual who meets either of the recommended criteria to be eligible for service.

Enid Kassner and Lee Shirey conducted a study in April 2000 on the financial eligibility criteria used by states for older persons with disabilities who seek services.[9] The purpose of the study was to catalogue the financial eligibility criteria used for older beneficiaries of Medicaid nursing home and HCBS waiver services and to analyze the extent to which these criteria contribute to Medicaid's institutional bias. The study found that the financial eligibility criteria that states impose do indeed contribute to a continuing bias in the program and that the criteria are paradoxically more restrictive for the HCBS waiver program than for the nursing home coverage.[10] Kassner and Shirey conclude by making recommendations aimed at altering the criteria to favor in-home

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reg=ACS_2005_EST_G00_S0201:001;ACS_2005_EST_G00_S0201PR:001;ACS_2005_EST_G00_S0201T:001;ACS_2005_EST_G00_S0201TPR:001&-ds_name=ACS_2005_EST_G00_&-_lang=en&-format=

[7] Deficit Reduction Act of 2005, Public Law 109-171, Section 5008, February 8, 2006.

[8] O'Keefe (1999).

[9] Kassner & Shirey (2000).

[10] It is possible for states to use financial eligibility criteria that are lower, and thus stricter, for access to HCBS than for nursing home services. One such example is the use of a medically needy program for nursing homes, but having no medically needy program for HCBS. Another is a state having a medically needy program for both, but using a higher income standard for home and community programs. As of January 2008, approximately 30 states had a medically needy program for nursing home services.

placements and relax undue financial hardships on HCBS waiver service recipients and their spouses.

In December 2004, Jennifer Gillespie conducted a survey of long-term care assessment instruments in 12 states.[11] Her study also examines the functions, populations served, levels of automation, integration with other systems, administration of the assessment, and questions included in it.

In October 2005, Robert Mollica and Susan C. Reinhard summarized 2002 data examining how nursing home level of care varies across states.[12] These researchers outlined the kinds of approaches that states use to establish level of care thresholds for an applicant to become eligible for care in a long-term care institution or for community care under a HCBS waiver program. The 2002 data for 42 states found that two used medical criteria, 13 used a combination of medical and functional criteria, 22 used activities of daily living (ADL's), 8 based their decision on an assessment score, one used professional judgment, and one used a physician's statement. These criteria were then arrayed from a low to high threshold for nursing home admission.[13]

The National Academy of State Health Policy (NASHP) has published 2004 descriptions of each state's nursing home level of care assessment policy and this current study can be read in conjunction with the 2004 descriptions.[14]

One other study bears directly on the subject at hand. A draft of a study conducted by Heather Johnson-Larmarche with the University of Massachusetts Center for Health Policy and Research can be found online.[15] This draft study examines the elements of an optimal universal assessment tool suitable for level of care assessments across programs, services, and populations. The study addresses and analyzes the standard functional components of assessment and also seeks to include other elements that make the assessment process more responsive to consumer-driven interests. The preliminary "Key Findings and Recommendations" should be reviewed by those with an interest in developing assessment instruments and by those focused on quality of care and flexibility in assessment processes. A range of scholarly and pragmatic literature is also available, which touches on the assessment process but does not directly address the main topics at hand.[16]

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[11] Gillespie, J. (2004). Available at: http://www.cshp.rutgers.edu/cle/Products/GillespieAssesmentWEB.pdf

[12] Mollica R. & Reinhard, S. (2005, October). Available at: http://www.cshp.rutgers.edu/cle/products/NursinghomelevelofcareWEB.pdf

[13] The same researchers also conducted a study in February 2005 examining the role of physicians in the level of care determination process, with emphasis on federal requirements concerning physician involvement. See Mollica, R. & Reinhard, S. (2005, February). Available at: http://www.cshp.rutgers.edu/cle/products/DetermineLevelofCareIssueBriefWEB.pdf .

[14] Mollica, R., Johnson-Lamarche, H. & O'Keeffe, J. (2005, March Available at http://aspe.hhs.gov/daltcp/reports/04alcom.htm

[15] Johnson-Lamarche, H. (2006, November).

[16] Examples include: Rosenbaum, S., et al. (2002, October). Available at: http://www.chcs.org/usr_doc/Integration_assessment.pdf; Wisconsin Department of Health and

ASSESSMENT FUNCTIONS AND DEFINITIONS

Information on assessment procedures was collected by contacting all 50 states and the District of Columbia. The researchers making the calls first attempted to identify who was involved with assessment and then make contact with them.[17] A persistent data collection effort eventually yielded information from all states. The methodology used to collect the results is described in the Appendix A.

The assessment forms in use by the states were similar in content but differed significantly in form and detail. The data collected through the forms can be characterized as falling into three clusters: demographic/personal information, clinical/functional information, and plan of care or recommendations.

The assessment forms for Alabama, Delaware, Indiana and Tennessee collected minimal personal information because the applicant's data were already collected and available through a prior application for Medicaid or another state medical program. For example, the Delaware Functional Care Summary is used after intake, and its personal information includes only the recipient's name, facility, Medicaid number, and room number. No other personal identifying information is included; the focus of the Summary is on levels of assistance required by the resident.

Other states' assessment forms, such as those in use in California, Florida, Idaho, Maine, Massachusetts, New Jersey, New Mexico, New York, and Washington, are more exhaustive, at least in part because their completion constitutes an initial stage in the medical review or program application process. For example, the Washington state "Comprehensive Assessment Reporting Evaluation (CARE)" includes seven full pages of personal information. The first two pages include innumerable "client details" and, among other options, provide a checklist of 45 different primary languages and 16 housing options from which to select. CARE also includes full separate pages for "collateral contacts" and "caregiver's status," and three separate pages for financial information. The remainder of the form, which is 48 pages in length, encompasses comprehensive information on applicants, including medical treatment and diagnosis, auditory and vision status, hospitalization history, behavior, personal goals, use of tobacco and alcohol, and activities of daily living.

Family Services and APS Healthcare, (2006, September). Available at: http://www.dhfs.state.wi.us/LTCare/ResearchReports/PDF/qcthrpt-full.pdf

[17] Assessment has a weak organizational identity. Making contact with the person in a state who is responsible for assessment is not a trivial task. There are no national, or state organizations, or professional associations for assessors that have membership lists and contact information. Nor is assessment a typical organizational unit that is distinct in telephone books or tables of organization such as a Medicaid Budget Office. In addition, both assessment forms and state regulations defining nursing home admission criteria are not readily found on state websites.

The use of Demographic and Personal information

The demographic/personal information collected on LOC assessment forms used by states included the following:

- Name
- Sex
- Date of birth
- Address
- Contact person and/or legal representative
- Dependents
- Income
- Financial assets
- Employment status
- Primary care giver
- Living arrangement
- Medicare/Medicaid eligibility/other insurance
- Attending physician
- Referral source
- Primary language

The Use of Clinical and Functional Information

The clinical/functional information collected on the LOC assessment forms included the following:

- Medical history
- Mental health status
- Vital signs
- Activities of daily living (ADLs)
- Instrumental activities of daily living (IADLs)
- Medications
- Treatments and procedures
- Medical condition
- Diagnoses
- Special treatments or diets
- Assistive devices
- Assessment of social situation

Respondents provided the functional definitions and the assessment instruments used for assessing and making level of care determinations in their state.[18] As expected, the definitions fit with the assessment tools used to gather information for LOC assessment purposes. Of the states that responded to each survey question, 39 states said they included both clinical and ADL information in their functional definitions and/or incorporated these parameters into their assessment instruments. The functional definitions provided by these states are perhaps best summarized by the definition provided by Michigan, which states that, "The criteria utilized in the MI Medicaid Nursing Facility LOCD to determine a beneficiary's functional/medical eligibility assess ADLs, cognitive skills, clinical instability, treatments and conditions, skilled rehabilitative therapies, challenging behaviors and the requirement of ongoing services to maintain current functional status." The specific types of information gathered in assessment forms and the corresponding detail varied significantly across these 39 states, with some stressing clinical information over ADLs and some stressing ADLs over clinical information.

The states were divided into three categories based on whether they: 1) used a mixed clinical and ADL-based model; 2) stressed clinical information; or, 3) stressed ADL information (see Table 1: Respondent States by Level of Care Definition). States continually modify their assessment, or are in transition to adopting new processes and forms. For example, North Carolina is field testing a new LOC data collection form at the time of this writing, Alaska issued new data collection forms in May 2006 and California just released its new assessment tool on January 3, 2008. Maine and Hawaii, which at the time of the 2005 Mollica-Reinhard study were identified as stressing clinical needs, are now more reflective of a mixed clinical and ADL-based model. Part of this continual change is that every state has its own form(s) and there is no required federal form, like the Minimum Data Set (MDS) for reporting the results of assessments.

[18] In an email inquiry to identified state respondents, we asked them to complete a column in a spreadsheet with their functional definition. Specifically, we asked them "to provide a brief 2-4 sentence explanation of the functional definition your state uses to determine if an applicant meets the LOC standard. Tell us how you use diagnosis codes, ADLs, diseases, weighted scoring of impairments, etc., to determine if an applicant is eligible for a LTC placement."

Table 1: States by Level of Care Definition

Table 1: States by Level of Care Definition				
Clinical	**Mixed Clinical – ADL**			**ADL**
Alabama	Alaska	Maryland	North Carolina	Delaware
Pennsylvania	Arizona	Massachusetts	North Dakota	Idaho
Rhode Island	Arkansas	Michigan	Ohio	Illinois
	California	Mississippi	South Carolina	Iowa
	Colorado	Missouri	South Dakota	Kansas
	Connecticut	Minnesota	Tennessee	Oklahoma
	Florida	Montana	Texas	Oregon
	Georgia	Nebraska	Utah	
	Hawaii	Nevada	Vermont	
	Indiana	New Hampshire	Virginia	
	Kentucky	New Jersey	Washington	
	Louisiana	New Mexico	West Virginia	
	Maine	New York	Wisconsin Wyoming	

Among the states relying on a mixed clinical and ADL model there were two states, Texas and Missouri, which make use of brief, one-page forms to collect the relevant information. Tennessee and South Carolina also employ relatively simple assessment procedures. The Texas "Client Assessment, Review and Evaluation (CARE)"[19] requires diagnosis codes and values for ADLs, health status/problems, therapeutic interventions, and other functional and clinical categories. A summary of scoring determines the appropriate level of care for the applicant. Missouri collects information on nine categories listing assessed needs, and the state utilizes a weighted scoring system to determine the appropriate level of care for applicants. The Missouri assessment has a heavy focus on ADLs and only addresses clinical needs through assessment categories related to medications and treatments. A similar model is in use in South Carolina where level of care is determined by whether the applicant: needs a skilled nursing service and has a functional deficit; needs an intermediate service and has a functional deficit; or, has two functional deficits. The applicable functional deficits include: extensive assistance to transfer; assistance to locomote; assistance to bathe, dress, toilet and feed; and, assistance with frequent bowel or bladder incontinence.

By far, the more common practice among the states using both clinical and ADL information for LOC placement purpose is to collect detailed clinical and ADL information, and to use these data to develop weighted scores for placement categories. California, Colorado, Florida, Hawaii, Idaho, Maine, Massachusetts, New Jersey, and Washington are characteristic of states that use instruments that fall into this category.

[19] Texas Form 3652: A Level of Care. Available at: www.dads.state.tx.us/forms/3652-A/3652-A.pdf

The LOC assessment forms used by these states require specific answers to questions regarding the applicant's functional status and clinical condition and go far toward removing any ambiguity regarding the capability of an applicant to function within different care settings.

The Washington "Comprehensive Assessment Reporting Evaluation (CARE)" elicits details regarding specific behaviors (e.g., disrobes in public, hoarding, obsessive regarding health, and other similar behaviors) that would be useful in making placement decisions, as well as for preparing plans of care. CARE enables collection of information on ten categories related to diagnosis and it drills down to details such as whether a treatment is "received or needed," how frequently the treatment is provided, and the type of provider delivering the treatment. Maine's "Medical Eligibility Determination (MED)" [20] form includes similar fields for clinical and ADL data and also calls for an exhaustive array of codes for cognitive and mental health information. The last page of the MED provides for a "total nursing score," a "Physical Functioning/Structural Problems" score, and a composite score which combines and weights the two. Idaho and Maryland use similar weighted scores utilizing less detailed inputs.

Six states, Delaware, Iowa, Kansas, Louisiana, Oregon and Tennessee, stress ADLs in their functional definitions, and this emphasis is also reflected in their assessment instruments. Two of these states, Iowa and Louisiana, make extensive use of the Minimum Data Set (MDS) in their LOC assessment processes. The functional definition used by Kansas requires "an impairment of (2) ADLs with a minimum combined weight of (6); and impairment in a minimum of (3) IADLs with a minimum combined weight of (9); and a total minimum level of care weight of 26."[21] Oregon makes use of four ADLs for level of care and service eligibility, and once service eligibility is determined, other ADLs, IADLs, and treatments required are used to determine placement and the number of hours required for care.[22] Tennessee's assessment form[23] and functional definition only require a deficiency in one or more of the following areas, daily or multiple times per week: transfer, mobility, toileting, incontinence care, ostomy/indwelling catheter care, communication, orientation, medications, insulin-administration, and behaviors.

The functional definitions provided by Pennsylvania and Rhode Island have a pronounced emphasis on the clinical aspects of the assessment process.[24] Pennsylvania staff in the Area Agencies on Aging that administer assessments describe their assessment as focusing on identifying whether needed services require a licensed staff to administer them. If a licensed staff person has to administer them then the chances of the

[20] Maine Medical Eligibility Determination. Available at: www.maine.gov/dhhs/beas/medxx_me.htm
[21] See Table I, functional definition column.
[22] Ibid.
[23] Tennessee Preadmission Evaluation for Nursing Facility Care. Available at: www.tennessee.gov/tenncare/forms/paeform.pdf
[24] Ibid.

person being determined eligible of nursing facility services increases.[25] However, a review of the assessment instruments demonstrated that ADLs and other functional elements were also included in the assessment process for these two states.

An additional complicating factor is that states use complex assessment tools that can collect both clinical and ADL information. For example, Alabama's "Clinical Detail" for nursing facility level of care appears to have a decidedly clinical emphasis, and this is reflected in its functional definition, whereas the emphasis on assessment for community services appears to use the ADL-related parts of its assessment tool. Assessment elements that are used for community placement result in collection of information with more of a home environment, caregiver focus.

The mental health information on the majority of LOC assessment forms was minimal, except for those states with exhaustive assessment forms and processes. This finding highlights the potential for under-reported or undiscovered intellectual disabilities or mental illness in applicants for long-term care placement or in-home services. Certainly the "Pre-Admission Screening and Resident Review (PASRR)" process is more effective in identifying these individuals than the LOC assessment process, and respondents indicated that their state placed a high reliance on the PASRR process to identify individuals with mental retardation or mental illness.[26] At the same time, three respondents shared with the researchers that the PASRR Level I was often not completed before admission to a nursing facility. This suggests a common possibility for the inappropriate placement into nursing facilities of persons who are mentally ill or who have intellectual disabilities.

State assessments results are generally not tied into nursing home reimbursement procedures. State assessment results are used to determine medical eligibility for Medicaid paid nursing home services, but are not used to determine the amount of reimbursement. Almost all states use a prospective cost-based reimbursement in which, acuity information, if it is used, will be taken from the MDS data of the residents.[27]

The Plan of Care or Recommendations

Thirty-one of the state respondents indicated that the assessment form was used for developing a plan of care, while the remaining 20 respondents stated that it was not. The plan of care or recommendations section of the assessment forms indicated that care

[25] Rutgers Center for State Health Policy staff interviewed staff in ten Area Agencies on Aging in the summer of 2007 and asked them how the medical eligibility for nursing home admission was done.

[26] PASRR is a federally mandated screening process for individuals with Serious Mentally Ill and/or Mentally Retarded/Mentally Retarded Related diagnosis who apply or reside in Medicaid Certified beds in a nursing facility regardless of the source of payment. The federal regulations, 42 CFR 483.100 through 483.138, governing PASRR can be found at: www.access.gpo.gov/nara/cfr/waisidx_03/42cfr483_03.html. For an example of state regulations see http://www.dhss.mo.gov/NursingHomes/580-2462.pdf

[27] New Jersey includes self-reported acuity data provided by the homes to determine the amount of additional reimbursement that can be obtained for the acuities.

planning and recommendations were clearly secondary to the assessment process, and as a result the information associated with plan of care considerations was incomplete at best. Some assessment forms provided a checklist of services to be provided upon admission. Delaware provided space for a "Summary of Response to Nursing Plan of Care" that is a blank section for free form prose. Florida provides an "Assessment Summary" page that provides a column for "Gaps Need to be Met in Care Plan." Maine's process was one of the most comprehensive and includes a "Community Options Care Plan Summary" for community service placements. The Maine summary includes such elements as the extent of help required, informal helpers, caregiver status, and details regarding the funding source for services and the types and hours of services to be provided.

One observation is that these states are more likely to use a different process, outside the initial LOC assessment process, to make plans of care and specific recommendations for individuals placed. Vermont specified that a different tool was used for plans of care, and the Illinois tool is used only for in-home services. In the states that said the assessment was not used to develop a plan of care, it might be assumed that the information collected on the assessment form was likely to be used by facility nursing staff, at least in part, for developing a plan of care. The respondent answers are probably indicative of the intent of the assessment form, rather than how the information is used in a clinical setting. Respondents were not asked if the assessment form was forwarded to medical staff providing care to applicants. If it is used only for internal administrative processing and not forwarded with the applicants' medical records, it would, of course, not play a role in care planning.

Respondents were asked if the assessment form was used for categorical or financial Medicaid eligibility, and they answered universally in the negative. LOC forms are not designed for this purpose, and states have separate processes for determining Medicaid eligibility. This is a moot point in many states where the LOC assessment process is only used for Medicaid-eligible beneficiaries. The LOC assessment process is used in Oklahoma to determine eligibility for personal care services and, in Minnesota as the basis for service plan development, which is part of service eligibility for the HCBS waiver and case-mix class for HCBS budgets. Hawaii indicated that the process is used as prior authorization for reimbursement of nursing home services, and Massachusetts indicated it is used as a case-mix payment tool. California, Delaware, Maine and Nebraska specified a link between the assessment and the payment or funding source.

POPULATIONS SERVED

LOC assessments focused primarily on clinical assessments for the Medicaid program, including Medicaid waiver programs, and secondarily on state health programs and other non-Medicaid populations. All respondents indicated that the assessment process was used for LOC determinations for the Medicaid populations. When asked about HCBS waiver programs, 44 of the respondents indicated that the LOC forms were also used for eligibility to HCBS waiver services. Twenty respondents indicated that the forms were used for non-Medicaid populations, although few indicated that the

assessment form was used for private pay patients. As indicated in Table 2 in the Appendix, a smattering of states use the LOC assessment form to evaluate applicants for the Program of All Inclusive Care for the Elderly (PACE), state-funded Medicaid, residential care, assisted living, adult care, and other waiver services.

FORMAT OF THE INSTRUMENT

Assessment instruments vary in technical complexity and the degree to which the forms are automated. Some of the state applications are web-based and others are accessed through a secured client server. Twenty-one states responded that their assessment forms were automated, and 31 indicated the forms were accessible via the web. Tables in the Appendix have these website links. Some states have a system that operates exclusively through paper forms, but that number is declining and several respondents indicated that their state is moving toward some degree of automation. The most common format for the instrument is an agency or department website where the form can be accessed and completed either online or downloaded into another application. For example, Louisiana's assessment form is available online but must be downloaded and completed in hard copy form. At the other extreme, New Hampshire is currently using a web-accessible process and will be moving to a fully automated system in April 2008. Larger states tended to use automation to a greater extent than small states. Automation appeared more prevalent and sophisticated in states where contractors, both private and not-for-profit, were involved in the assessment process

COST-EFFECTIVENESS AND EFFICIENCY

This section focuses on the degree to which states were collecting information and evaluating the cost-effectiveness and efficiency of how assessments were done. Was information on cost-effectiveness and efficiency of assessment collected as part of how assessments are done? For example, information on the time taken to complete the assessment was not found on assessment forms, nor was any estimation of how many and what kind of staff might have been involved. States do not routinely collect data as to how much of the collected information is actually used, consistent with Minimum Data Set (MDS) information, or transferred to other parties such as care providers .

The answers provided indicate that the respondents did not view the LOC assessment process from a cost-effectiveness or efficiency perspective. Most respondents, 39 of 51, replied that the LOC assessment process did not include any specific measures of cost-effectiveness or efficiency. New Mexico and Hawaii indicated that the data are used for utilization review purposes. Minnesota makes use of the data for comparing costs between facility and community placement. A few, such as Oregon, mentioned administrative processes (e.g., using laptops to collect data remotely) that enhanced the effectiveness or efficiency of the LOC assessment process, but these evaluative criteria were not seen as central to the purpose of the assessment.

This pattern is reinforced by the respondents' replies regarding the cost of the assessment. Most respondents were not aware of any cost attributed to the assessment,

and many replied there was no cost whatsoever because facility or state staff conducted the assessment. For 14 states, costs were identified but these costs were often attributed exclusively to the direct administration of the assessment and did not include other costs related to the assessment process.

Respondents were asked about their follow-up processes after placement, and many deferred to financial staff that tracked and authorized payment and collected case-mix information. The state LOC staff processes for reviewing placements were varied. Maine conducts a review 90 days after placement and then 24 months later. Kansas conducts a review on all placements at 30 and 90 days, with a goal to redirect as many as possible to home placement.

Iowa conducts a periodic random sample of residents in placement. Georgia accepts an "attestation" from a physician that a resident continues to require care in a placement setting. New Hampshire recognizes that follow-up is missing from the state LOC process and anticipates moving to a 30-60-90 day process by July 2008. A database that links information on how staffs allocate their time across programs with program information may offer cost-effectiveness and efficiency benefits.[28]

Two sorts of respondents were most frequently encountered in the state assessment processes: clinical staff and non-clinical management staff. With few exceptions, the staffs directly responsible for the LOC assessment process are trained and educated in clinical processes. In a few states respondents possess job titles that reflected non-medical backgrounds. For example, in Maryland the respondent's title was reported as "Health Policy Analyst," in Minnesota the title was "Strategic Planner," and in Alaska "Health Program Manager". These same individuals made reference in their answers to other programs, budget and policy issues, and the use of complimentary data for analytical purposes, especially the Minimum Data Set (MDS) and the Outcome and Assessment Information Set (OASIS). This latter group appeared to be more inclined to use collected assessment data for policy creation or analysis.

ASSESSMENT ADMINISTRATION

The assessment function and its associated staff are most frequently found in state umbrella agencies serving health, human and/or social service needs. In large states there are multiple parties involved in assessment. For example, in California eligibility for waiver services is done by Care Coordination Agencies (CCAs) which employ both registered nurses and social services coordinators. The CCAs are specific to the Assisted Living Waiver Pilot Project, an HCBS waiver and do the initial assessment and reassessment every 6 months. Eligibility for the In-Home Supportive Services (IHSS) program is assessed by the county agencies, and persons who enter nursing homes are

[28] Neither the Social Security Act nor the Code of Federal Regulations requires periodic assessments of persons in nursing homes to see if they still meet medical/functional standards for nursing home eligibility. However, the CMS instructions to states regarding waiver applications do require states to conduct annual assessments of persons receiving home and community-based services.

assessed by nursing home staff with a state approval. The state looks like it has three separate ways of doing assessments for nursing home eligibility.

With respect to the administration of the assessments, there are significant differences among the states. A total of 40 states indicated that they used a contractor or subcontractors in some part of the LOC assessment process. In a few instances a contractor takes a lead role in the LOC process. This is seen in North Dakota, Montana, The District of Columbia and, until quite recently, Alaska. In 25 states, the medical staffs in the nursing homes play a central role in completing the assessment for applicants. In these instances, the process is most often administered through a state government central office, with direct oversight by state or contract staff. In other states the assessment is completed by a combination of contractor and state staff.

Nurses play the dominant role in the assessment process and a physician usually supervises their work to some degree, where they operate "under the direction of a licensed physician." Only two states, Rhode Island and Oregon, have indicated specific social worker involvement in the process. However, five states indicated participation by home health agencies or Area Agencies on Aging (AAAs). Texas, Vermont, Washington, Oklahoma, and Illinois indicated participation by home health agencies or similar bodies with different names. The AAAs are engaged in the process in Indiana, Kansas, Nebraska, New Jersey, Ohio, Oregon, Pennsylvania, Vermont and Washington, and these agencies tend to rely significantly on social worker participation in the process. Managed care organizations (MCOs), case management units, local health departments, Native American tribes and other community not-for-profit organizations are common partners with the states for LOC assessments. The AAAs typically employ field staff and conduct interviews in support of state or other contract staff. For the most part, regardless of the party conducting the assessment, interviews are conducted in person at the applicant's place of residence or at a medical facility.

The majority of respondents indicated that they did not belong to any professional organization for LOC assessment although a few did mention membership or participation in a medical/clinical organization or attendance in continuing education activities. Many expressed an interest in a national organization, and a few were members of the National Association of PASRR Professionals, which was recently created in October 2006.[29]

CONCLUSIONS

Information on state level assessment activities is hard to obtain since there are no federal or national reporting statistics that track the millions of persons who receive assessments. However, states have been conducting them for decades and have considerable experience in designing assessment instruments and scoring them. Assessments instruments collect information regarding applicants, with a focus on clinical and ADL information, in order to make a determination regarding the proper setting for care. Two broad trends that were observed are that states are moving from simple clinical assessment instruments to more complex instruments using both clinical

[29] The website for this organization is: www.pasrr.org

and ADL information, and states are modifying their processes to take advantage of advanced information technology.

The assessments focus primarily on Medicaid-eligible populations and also often serve a similar purpose for state-funded health care programs, both institutional and in the home. With regard to home placements, there is recognition within the assessment process of the needs of caregivers.[30] Information from level of care assessments is not used for the purpose of determining financial eligibility for the Medicaid program. A secondary purpose for the assessment is to collect information for creating a plan of care, but plan of care development does not appear well integrated into the assessments.

Staff who responded to the survey tended to see themselves as technical and clinical experts serving in a gatekeeper role for Medicaid and other similar programs. Respondents were familiar with the PASRR Level One and Level Two assessments, but the LOC assessment processes were not fully integrated into these processes from an organizational or information technology perspective. Respondents were not familiar with how the LOC assessment data are shared with others in the agency for reimbursement or other purposes. Nor were they familiar with how the data are shared and integrated with other IT systems and functions.

Generally speaking, the LOC staff, especially in larger states, indicated that they were not aware of other assessment processes in their state and in the larger health and human services community. They reported that the assessment data were not being used to measure cost-effectiveness or efficiency and they were generally unaware of the cost of the entire assessment process. Promoting communication among the states through calls and meetings with respect to assessment matters, operational and policy issues, and information technology would be useful.

State LOC assessment forms collect information regarding special medical needs, but the scope of this survey did not include questions about how these data are used beyond the LOC determination. In terms of future study, it would be interesting to examine how these data are used for other purposes. To what extent can assessment data be matched to facility data and used for placement, for example, the placement of persons with special medical needs. Coordinating special health care needs with facility capabilities would positively impact the cost and quality of care.

This study contributes to ongoing and future planning efforts by states and CMS around the topic of state assessment efforts. Because CMS contributes 50% of the cost for state assessment through a federal administrative match, the development of a post-acute assessment form can take into account the significant advances incorporated into existing state assessment efforts. States have developed more comprehensive assessment that collects different kinds of data than their earlier versions, and states have also made

[30] The National Family Caregiver Alliance's "The State of the State in Family Caregiver Support: A 50-State Study" is available at:http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=1276

impressive technical inroads in automating and streamlining the collection and processing of assessment data.

The guiding principles for post-acute care reform stress increased consumer choice and control of post-acute services by beneficiaries, their family members, and caregivers. Clearly, the respondent states are beginning a movement in this direction. These same principles stress a linkage between the care setting, based on patient needs and effective measures to drive the system toward the delivery of high-quality care and efficiency, as well as providing a higher quality of care for beneficiaries.

States and CMS have wonderful challenges ahead of them as the quality of state assessment work improves. For example, is it possible to develop a common form that will provide the basis for determination of necessity for nursing facility services, and other post acute services, while also providing a basis for payment across all post acute settings?

To what extent can CMS develop a technology platform, similar to the Minimum Data Set technology, to allow for the uniform collection and analysis of the data collected on the one and a half to two million persons a year who have Medicaid paid assessments? How can assessment data be shared across the states?

To what extent can the states and CMS work in partnership to promote continuing education, conferences, and other staff development efforts to encourage the type of collaboration that will advance the principles espoused for post-acute care reform, and provide more effective, efficient, equitable, and responsive health care delivery systems for beneficiaries requiring these types of services?

The tables in the Appendix provide a brief description of what data the state collects, the name of the assessment form, the website of the assessment form if the state has one, and contact information to learn more about what the state does. When read in conjunction with other studies, they provide useful state-specific information.

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This study would not have been possible without the cooperation of the many state staff who volunteered their time and valuable information regarding their respective state level of care assessment processes. We recognize that state staff members often work quietly on their appointed tasks without fanfare or full appreciation of their efforts by the public and we want to take this opportunity to thank them for their cooperation in this effort. We hope that the document will be of use to them in their professional endeavors.

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APPENDIX A: METHODOLOGY

An initial telephone survey was undertaken to identify state agencies and staff within those agencies that conduct initial level of care (LOC) assessments for applicants potentially in need of medical services in long-term care facilities or through home health care providers. LOC assessment processes operate parallel to and separate from assessments for the intellectual disabilities/developmental disabilities (ID/DD populations) and other applicant groups.[31] The intent was to collect information from all 50 states and the District of Columbia. The questions posed were purposely limited in number and required minimal time to answer because of the study's reliance on voluntary participation by busy state staffs. After repeated inquiries, completed survey forms were received from 50 states and the District of Columbia. Initial responses were followed up with an additional email inquiry of respondents to allow them to review the information summaries and provide their current functional definition for LOC determinations. Forty-three of the initial 51 respondents replied to the follow-up inquiry. A detailed listing of the information provided by respondents is provided in Table I.

At the outset of this study an effort was made to find a common job title, department, organization, or professional association that would aid in the identification of state staff who are responsible for performing LOC determinations. This effort was largely unsuccessful. On the one hand, it is the responsibility of the state Medicaid agency to determine level of care as per 42 CFR 440.230(d). On the other hand, state Medicaid agencies can be large, are organizationally complex and multiple state departments may carry out Medicaid activities. No central theme or national organization was found that would help identify either the agencies or the staff persons performing for the LOC processes in each state. The one common element that emerged is that each state's Long-term Care Ombudsman was useful in providing general assistance in locating agency staffs responsible for LOC assessments. Because there was no common location for staff that conducts LOC assessments, responsible agencies and respondents were identified through a labor-intensive telephone screening process using preliminary questions related to LOC functions.

Based on past direct experience with these processes, the assumption was made that the LOC function would be located in state Departments of Health. These entities focus largely on collecting medical information to make medical determinations. This assumption was generally correct. However, more often than not, the traditional state Health Departments have been absorbed into a comprehensive health, human, or social services agency, where the health agency is now a division or sub-unit of the larger entity.

[31] The Center for State Health Policy is publishing a separate survey of MR/DD assessment instruments which will be available at http://www.cshp.rutgers.edu/cle/ and at hcbs.org in May 2008. Readers interested in level-of-care assessment for ID/DD are directed to this paper.

The location of the LOC function was placed in comprehensive health, human, or social service agencies in 34 states, and in five instances it was located in the state Medicaid agency or medical services agency. Eleven states have created separate agencies of elder affairs, aging, or long-term care, which constitutes recognition of the unique social and medical needs of the elderly in society. Many of the respondents were registered nurses serving in administrative capacities as managers or analysts, and not surprisingly, 44 respondents were female. Because of the overwhelmingly clinical nature of the LOC assessment process, the process tended to have a technical medical focus, and the staff that responded to the surveys had decidedly more medical background, and fewer managerial, policy, or fiscal backgrounds.

One future study that would be useful to conduct would be to consider how the state's level of care practices implement section 1919(a)(1) of the Social Security Act. Are states setting the lower threshold of NF LOC above 1919(a)(1)(C), the former Intermediate Care Facility level, requiring physical diagnoses and in effect excluding individuals who would have been served under 1919(a)(1)(C). Such a study was beyond the scope of this paper but would be informative.

Table 2: Data Collection Sheet for State NF Level of Care Survey

Table 2: Data Collection Sheet for State NF Level of Care Survey				
State	Functional Definition	Name	Phone Number	Title
Alabama	AL does not use a functional definition in current waivers. The LOC criteria are based upon medical needs.	Marilyn Chappelle	334-242-5009	Director, Long Term Care Division
Alaska	Need for skilled or intermediate care nursing or structured rehabilitation ordered by and under the direction of a physician that is provided in a certified ICF and not requiring care in a hospital or SNF. Level of care is determined by considering the type of care required, the qualifications of the person necessary to provide direct care and whether the recipient's overall condition is relatively stable or unstable. This decision is made through a level of care evaluation by State staff.	Barbara Knapp	907-269-6065	Health Program Manager II Policy Unit
Arizona	Arizona uses an 1115 waiver rather than 1915(c) waivers. The Uniform Assessment Tool (UAT) is used to assess the acuity of NF residents. Each of the MCOs has their care assessment tool that helps them determine possible service needs. The Uniform Assessment Tool (UAT) the MCO CMS use is to determine the member's acuity (class 1, 2 or 3) for determining reimbursement to the NF and for HCBS members it uses that acuity determination to identify the upper limit for HCBS expenditures. The UAT is used on HCBS members when determining the NF rate to use when developing a Cost Effectiveness Study. The UAT is made up of eight Characteristics: Bathing/Dressing/Grooming; Feeding/Eating; Mobility; Transferring; Bowel/Bladder; Orientation/Behavior; Medical Condition; Medical/Nursing Treatment; Characteristic is assessed for one of three acuity levels. Each is given a rating of 1, 2 or 3 (3 being the highest). The cumulative score determines their acuity (1, 2 or 3).	Alan Schafer	502-417-4614	Arizona Long Term Care System Manager

Table 2: Data Collection Sheet for State NF Level of Care Survey				
State	Functional Definition	Name	Phone Number	Title
Arkansas	1. The individual is unable to perform either of the following: A. At least one (1) of the three (3) activities of daily living (ADL) of transferring/locomotion, eating or toileting without extensive assistance from or total dependence upon another person; or, B. At least two (2) of the three (3) activities of daily living (ADL) of transferring/locomotion, eating or toileting without limited assistance from another person; or, 2. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors that pose serious health or safety hazards to him or others; or, 3. The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening.	Sherri Proffer	501-682-8481	Nursing Services Program Administrator
California	LOC determined by a point system in an automated (Excel)) Assessment Tool. Points are credited for limitations in ADL/IADLs, cognitive function, medication assistance, treatments, and physical function.	Mark Mimnaugh, R.N.	916-552-9379	Nurse Consultant III
Colorado	SEPs use ADL scoring and the Professional Medical Information Page (PMIP) to verify functional/medical necessity.	W. Sean Bryan	303-866-5902	Single Entry Point (SEP) Agency Contract Manager

Table 2: Data Collection Sheet for State NF Level of Care Survey				
State	Functional Definition	Name	Phone Number	Title
Connecticut	For NF LOC we look at the need for continuous skilled nursing services as well as the need for substantial assistance with hands on care. We look at 7 critical needs, bathing, dressing, transferring, Toileting, eating/feeding, meal preparation and medication management as critical needs. NF LOC is determined by having a need for assistance with 3 or more critical needs.	Kathy Bruni	860-424-5192	Medical Administration Program Manager
Delaware	The Level of Care for NH is determined through an intricate process. After all necessary data is gathered and the entire medical assessment is done, we use a scoring system that is based on ADL ability. Four areas of ADLs (eating, transferring, mobility, & toileting) as well as selected Clinical Care Services are assessed for his or her level of independence or dependency to determine the basic level of care. The form we use, both electronically and manually, for this is the Functional Care Summary. This same form is used by the Nursing facilities monthly and kept as part of the medical record. Our Reimbursement nurses visit, and assess all facility MA residents quarterly, incorporating the facility's Functional Care Summaries as part of the medical record as well as resident and staff interview. This determines ongoing medical eligibility (Level of Care Approval) as well as the correct payment methodology.	Mary Anne Colbert, R.N.	302-255-9577	Senior Administrator
District of Columbia	Not Provided	Annette Price	202-535-2011	Nursing Home Administrator
Florida	Must require 24 hour continuous nursing supervision, monitoring or observation	Sam Fante	850-414-2164	Bureau Chief

Table 2: Data Collection Sheet for State NF Level of Care Survey				
State	Functional Definition	Name	Phone Number	Title
Georgia	Georgia utilizes weighted scoring of impairments to determine an applicant's eligibility for a nursing service LOC. The three (3) columns for scoring are: Column A/ [8 fields] for Medical Status (Required Field: the individual with a stable medical condition requires intermittent skilled nursing services under the direction of a licensed physician, and one other qualifying selection). Additional requirements are qualifying selections with 1 from Column B/ [4 fields] for Mental Status or 1 from Column C/ [5 fields] for Functional Status.	Pamela Madden	404-657-9946	Program Specialist 2
Hawaii	Utilizes a point system, however; determination not solely based on functional capabilities. Functional Limitations is one criteria in which we utilize to determine NF LOC. Functional Limitations in vision, hearing, speech, communication, memory, mental status/behavior, feeding/meal prep., transferring, mobility/ambulation, bowel function, bladder function, bathing, and dressing/grooming are based on a point system. The points range from 0-41.	Kathy Ishihara	808-692-8159	Nurse Consultant
Idaho	The Uniform Assessment Instrument is a multidimensional questionnaire which assesses a client's functioning level, social skills, and physical and mental health. The client's functional abilities are assessed and a weighted scoring system is utilized to determine if the client meets nursing facility level of care.	Susan Scheuerer	208-287-1156	Alternative Care Coordinator
Illinois	Case managers conduct prescreens utilizing the Determination of Need Assessment which includes questions on six activities of daily living and nine instrumental activities of daily living and a Mini-Mental State Examination. The extent and degree of an applicant's need for long term care shall be determined on the basis of impaired cognitive and functional status as well as the available physical/environmental supports provided to the applicant by family friends, or others in the community.	Mary Gilman	217-557-6710	Lead Community Care Program Specialist

Table 2: Data Collection Sheet for State NF Level of Care Survey				
State	Functional Definition	Name	Phone Number	Title
Indiana	To qualify for skilled nursing care the services must be ordered by a physician and must be required and provided at least five days per week, the therapy must be of such complexity and sophistication that the judgment, knowledge and skills of a licensed therapist are required and the overall condition of the patient must be such that the judgment, knowledge and skills of a licensed therapist are required. The determination of the differences between skilled and intermediate level of care is based upon the patient's condition, along with the complexity and range of medical services required by the patient on a daily basis.	Mary Gordon	317-232-4355	Nurse Consultant
Iowa	Based on the minimum data set (MDS), the individual requires supervision, or limited assistance, provided on a daily basis by the physical assistance of at least one person, for dressing and personal hygiene activities of daily living as defined by the minimum data set, section G, entitled "physical functioning and structural problems", or, based on MDS, the individual requires the establishment of a safe, secure environment due to modified independence or moderate impairment of cognitive skills for daily decision making.	Jennifer Steenblock	515-725-1299	Long Term Care Program Manager, Executive Officer 2
Kansas	The customer has impairment in a minimum of (2) ADLs with a minimum combined weight of (6); and impairment in a minimum of (3) IADLs with a minimum combined weight of (9); and a total minimum level of care weight of 26; OR a total weight of 26, with at least 12 of the 26 being IADL points and the remaining being combined IADL, ADL or Risk Factors. (Risk factors include Falls, ANE, Cognition, Incontinence and Unavailable supports)	Susan Schuster	785-296-0895	CARE Senior Manager
Kentucky	We list 12 criteria in our Regulation 907 KAR 1:022, Section 4 and the resident must meet 2 out of the 12 criteria to meet NF Level of Care. Nursing Facility Regulation 907 KAR 1:022, Section 4 (3): (3) An individual shall be determined to meet low-intensity patient status if the individual requires, unrelated to age appropriate dependencies with respect to a minor, intermittent high-intensity nursing care,	Judy Montfort	502-564-5707	Nurse Service Administrator

Table 2: Data Collection Sheet for State NF Level of Care Survey				
State	Functional Definition	Name	Phone Number	Title
	continuous personal care or supervision in an institutional setting. In making the decision as to patient status, the following criteria shall be applicable: (a) An individual with a stable medical condition requiring intermittent high-intensity nursing care services not provided in a personal care home shall be considered to meet patient status; (b) An individual with a stable medical condition, who has a complicating problem which prevents the individual from caring for himself in an ordinary manner outside the institution shall be considered to meet patient status. For example, an ambulatory cardiac patient with hypertension may be reasonably stable on appropriate medication, but have intellectual deficiencies preventing safe use of self-medication, or other problems requiring frequent nursing appraisal, and thus be considered to meet patient status; or (c) An individual with a stable medical condition manifesting a significant combination of at least two (2) or more of the following care needs shall be determined to meet low-intensity patient status if the professional staff determines that the combination of needs can be met satisfactorily only by provision of intermittent high-intensity nursing care, continuous personal care or supervision in an institutional setting: 1. Assistance with wheelchair; 2. Physical or environmental management for confusion and mild agitation; 3. Must be fed; 4. Assistance with going to bathroom or using bedpan for elimination; 5. Old colostomy care; 6. Indwelling catheter for dry care;			

Table 2: Data Collection Sheet for State NF Level of Care Survey				
State	Functional Definition	Name	Phone Number	Title
	7. Changes in bed position; 8. Administration of stabilized dosages of medication; 9. Restorative and supportive nursing care to maintain the individual and prevent deterioration of his condition; 10. Administration of injections during time licensed personnel is available; 11. Services that could ordinarily be provided or administered by the individual but due to physical or mental condition is not capable of self-care; or 12. Routine administration of medical gases after a regimen of therapy has been established. (d) An individual shall not be considered to meet patient status criteria if care needs are limited to the following: 1. Minimal assistance with activities of daily living; 2. Independent use of mechanical devices, for example, assistance in mobility by means of a wheelchair, walker, crutch or cane; 3. A limited diet such as low salt, low residue, reducing or another minor restrictive diet; or 4. Medications that can be self-administered or the individual requires minimal supervision.			

Table 2: Data Collection Sheet for State NF Level of Care Survey				
State	Functional Definition	Name	Phone Number	Title
Louisiana	The Level of Care Eligibility Tool (LOCET) establishes uniform criteria serves as the determination for level of care for all long term care services which require a nursing facility level of care. These 7 Pathways are at the center of the LOCET: Activities of Daily Living, Cognitive Function, Behavior, Physician Involvement, Rehab Therapies, Treatments and Conditions, Service Dependency .In order for Nursing Facility Level of Care to be determined, an individual must qualify through one of these pathways. The information elicited in this assessment is derived from the Minimum Data Set (MDS) assessment tool. Additional assessment and screening tools may also be used to aid in this determination. The threshold approval level will generally include those who score as having needs beyond those identified by the lowest levels of the RUG-III system.	Janet St. Angelo	225-342-2777	Level of Care Administrator
Maine	The assessment includes an evaluation of demographic characteristics, clinical and functional needs, and caregiver and environmental information. The MED form is based on what consumers can do for themselves and how much assistance they need in order to do "activities of daily living" (such as moving from one place to another, toileting, getting in and out of bed, moving about their living area, and eating.) Also considered are bathing and dressing, grocery shopping, preparing meals, routine house work, and getting laundry done. The MED assessment is used to determine eligibility for the program and funding source and to authorize a plan of care.	Diana Scully	800-262-2232	Director
Maryland	Measure nursing needs, cognitive and functional status, ADLS and IADLs. Instrument provides a weighted score. If applicant does not meet benchmark score, provider may present additional clinical information to substantiate nursing facility level of care.	Christa Speicher	410-767-1458	Health Policy Analyst
Massachusetts	Not provided.	Ken Smith	617-222-7432	Assistant Director, Institutional Services

Table 2: Data Collection Sheet for State NF Level of Care Survey				
State	Functional Definition	Name	Phone Number	Title
Michigan	The MI Medicaid Nursing Facility Level of Care Determination (LOCD) determines a financially eligible Medicaid beneficiary's functional/medical eligibility to receive Medicaid services from Medicaid reimbursed nursing facilities, MI Choice Waiver Program and the Program of All Inclusive Care for the Elderly. The criteria utilized in the MI Medicaid Nursing Facility LOCD to determine a beneficiary's functional/medical eligibility assesses ADLs, cognitive skills, clinical instability, treatments and conditions, skilled rehabilitative therapies, challenging behaviors and the requirement of ongoing services to maintain current functional status.	Elizabeth Aastad	517-241-2115	LTC Program Policy Analyst
Minnesota	See DHS Form 3361 at http://www.dhs.state.mn.us. Both medical and functional needs are considered.	Jolene Kohn	651-431-2579	Strategic Planner
Missouri	MO evaluates the applicants in 9 areas including mobility, dietary, restorative, monitoring, medication, behavior, treatments, personal care & rehab services.	Brenda Seaton	573-526-8609	Administrative Office Assistant
Montana	Clinical information which includes: diagnoses, medications, ADL status, cognitive status, etc. are assessed through a systematic analysis and compared to state established criteria. If criteria are met the client is approved for long term care services.	Paulette Geach and Pam Yeager	406-457-5823	Manager of Review Services and Unit Manager
Nebraska	NF LOC is met if a person as 3 ADLs or more and a medical treatment or observation, 3 ALDS or more and a risk factor, 3 ADLS or more and a cognition factor, or one or more ADLS as well as one or more cognitions and risks factors. The 7 ADLS used are defined in regulations. Diagnosis codes are not used but a medical treatment of observations is determined, per regulations, based on certain medical conditions and/or specific medical/nursing services. Risk factors are also defined in regulations and relate to behavior, frailty and safety. Cognition is also defined in regulations and relate to memory, orientation, communication and judgment.	Jodie Gibson	402-471-9384	Program Coordinator, Division of Medicaid and Long Term Care

Table 2: Data Collection Sheet for State NF Level of Care Survey				
State	Functional Definition	Name	Phone Number	Title
Nevada	The assessment includes medical history pertinent to nursing facility placement, ability to safely self administer medications; special needs such as durable medical equipment or frequency and duration of any treatments; the level of assistance (self care, supervision, assistance, dependent) needed with activities of daily living (mobility, transfers, locomotion, dressing, eating, feeding, hygiene, bathing, bowel and bladder); need for supervision; ability to perform instrumental activities of daily living (meal preparation and homemaking services related to personal care). Additional consideration given to social history and current living environment, family (or other) support systems available, discharge planning information, potential risk of injury or danger to self or others. The assessment determines if the condition requires the level of services offered in a nursing facility with at least 3 functional deficits identified in sections 1-5 of the screening tool or a more integrated service which may be community based.	Tammy Ritter	775-687-4210 ext. 229	Chief Community Based Care
New Hampshire	Pursuant to NH State Statute individuals who are eligible for Medicaid nursing facility services are provided the opportunity to choose home and community based services, including residential options or care in their own home. Individuals are considered medically eligible if they require 24 hour care for medical monitoring, restorative nursing/rehab care, medication administration or assistance with 2 or more ADLs (eating, toileting, transferring, dressing and continence.	Donna Mombourquette	603-271-0541	LTC Services Administrator
New Jersey	Not Provided	Nancy Day	609-943-3486	Director, Office of Global Options for LTC and Quality Management
New Mexico	Not Provided	Consuelo Martinez	505-827-3164	Bureau Chief, Program Operations and Support
New York	Not Provided	Kathleen Minucci	518-408-1272	Hospital Nursing Services Consultant
North Carolina	Not Provided	Julie Budzinski	919-855-4368	Medicaid Program Services Chief --- Adult Care Homes

Table 2: Data Collection Sheet for State NF Level of Care Survey				
State	Functional Definition	Name	Phone Number	Title
North Dakota	Assessment is based on medical needs, rehabilitation potential and deficits with ADLS.	Joan Ehrhardt	701-328-4864	Administrator, Long Term Care Projects
Ohio	Ohio uses a combination of criteria to determine if someone meets a LOC standard. Criteria include ADL and IADL function, skilled nursing and therapy needs and supervision needs due to a cognitive impairment. See OAC 5101:3-3-05 and OAC 5101:3-3-06. (1) Require hands-on assistance with at least two activities of daily living (ADL), (2) Need hands-on assistance with at least one ADL and also require the help of another person to administer medication, (3) Need 24-hour-per-day supervision from another person to prevent harm to self or others because of cognitive impairment including, but not limited to dementia, and (4) Have an unstable medical condition and require at least one skilled nursing service at less than 7 days per week, and/or a skilled rehabilitation service at less than 5 days per week (at a lower level of care than skilled level of care (SLOC), see the next section on SLOC)	Lauren Phelps	614-644-7130	Medicaid Health Systems Analyst
Oklahoma	Not Provided	Tom Dunning	405-522-3078	Programs Administrator
Oregon	We determine LOC or service eligibility using 4 ADLs (Mobility, Eating, Toileting and Cognition/Behavior). Once the client has been determined eligible, other ADLs, IADLs and Treatments are also figured in to determining placement or number of hours needed for care.	Judy Giggy	503-947-1179	Manager, Adult Protective Services/Performance Evaluation & Community-Based Care CBC) Policy and Licensing

Table 2: Data Collection Sheet for State NF Level of Care Survey				
State	Functional Definition	Name	Phone Number	Title
Pennsylvania	Level of care criteria that are used to evaluate and reevaluate level of care: Nursing Facility Clinically Eligible (NFCE) consumer is an individual who is assessed and determined to be clinically eligible for Nursing Facility care. In ordered to be Nursing Facility Clinically Eligible, An individual Must: w Have an illness, injury, disability or medical condition diagnosed by a physician; and w As a result of that diagnosed illness, injury, disability or medical condition, require care and service that are: • above the level of room and board; and • ordered by, and provided under the direction of a physician, and; • skilled nursing or rehabilitation services as specified in 42 CFR §409.31§409.35; or • health-related care services that are not inherently complex as skilled nursing or rehabilitation services but which are needed and provided on regular basis in the context of a planned program of health care and management and are usually available only through institutional facilities.	Sue Getgen	717-783-6207	Director, Bureau of Home and Community Based Services
Rhode Island	NF LOC requires the services of a nurse or rehabilitation professional or assistance with activities of daily living	Catherine Gorman	401-462-1933	Chief, Family Health Systems
South Carolina	One can meet LOC by having 1) a skilled service and a functional deficit or 2) by having an intermediate service and a functional deficit or 3) by having two functional deficits. The four functional deficits are: 1) requires extensive assistance to transfer, 2) requires extensive assistance to locomote, 3) requires extensive assistance to bathe and dress and toilet and feed, 4) requires extensive assistance with frequent bowel or bladder incontinence.	Margaret L (Susie) Boykin	803-898-2699	Department Head
South Dakota	LOC reflect ADL scoring from MDS definitions. Executive functioning based on cognitive loses.	Judy Schemata	605-773-3656	Program Manager

Table 2: Data Collection Sheet for State NF Level of Care Survey				
State	Functional Definition	Name	Phone Number	Title
Tennessee	To meet level of care the applicant must be deficient in one or more of the following areas daily or multiple times per week. Transfer, mobility, Toileting, incontinence care, ostomy/indwelling catheter care, communication, orientation, medications, insulin administration and behaviors.	Kaye Swindell	615-507-6976	Public Health Nurse Consultant 2
Texas	Ensure that potential residents with Mental Illness, Mental Retardation, or Related Condition conditions are medically appropriate (require 24 hour nursing care) for placement in nursing facilities and can receive specialized services if eligible.	Stacy Reynolds	512-438-5464	++
Utah	The department must document that at least two factors exist. Due to diagnosed medical conditions, the applicant requires at least substantial assistance with ADLS above the level of verbal prompting, supervising or setting up; 2) The attending physician has determined that the applicant's level of dysfunction in orientation to person, place or time requires nursing care; or 3) The medical condition and intensity of service indicate that the care needs of the applicant cannot be safely met in a less structured setting. R414-502-3. Approval of Level of Care. (1) In determining whether the applicant has mental or physical conditions that can only be cared for in a nursing facility, or equivalent care provided through an alternative Medicaid health care delivery program, the department shall document that at least two of the following factors exist: (a) Due to diagnosed medical conditions, the applicant requires at least substantial physical assistance with activities of daily living above the level of verbal prompting, supervising, or setting up; (b) The attending physician has determined that the 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. (2) The department shall assign a level of care based upon the severity	Gayle Monks	801-538-9282	Acting Manager of Residential Assessment Section of Bureau of Health Facility Licensing, Cert and Resident Assessment

Table 2: Data Collection Sheet for State NF Level of Care Survey				
State	Functional Definition	Name	Phone Number	Title
	of illness, intensity of service needed, anticipated outcome, and setting for the service. The department shall not assign a more intense level of care if, as a practical matter, the applicant's care and treatment needs can be met at a less intense level of care. Levels of care, ranked in order of intensity from the least intense to the most intense, are: (a) nursing facility III care; (b) nursing facility II care; (c) nursing facility I care; and (d) intensive skilled care. R414-502-4. Criteria for Nursing Facility III Care. The following criteria must be met before the department may authorize Medicaid coverage for an applicant at the nursing facility III care level: (1) A physical examination was completed within 30 days before or seven days after admission; (2) A registered nurse completed, coordinated, and certified a comprehensive resident assessment; (3) A person licensed as a social worker, or higher degree of training and licensure, completed a social services evaluation that meets the criteria in 42 CFR 456.370; (4) A physician established a written plan of care; (5) All less restrictive alternatives or services to prevent or defer nursing facility care have been explored;			
Vermont	Limited or extensive assist with ADLs, severe- moderate cognitive impairment, daily skilled nursing need, unstable medical assistance - combination of.	Adele Edelman	802-241-2402	Medicaid Waiver Manager

Table 2: Data Collection Sheet for State NF Level of Care Survey				
State	Functional Definition	Name	Phone Number	Title
Virginia	The level of care (LOC) information is used for yearly evaluations of waiver recipients. The evaluations are designed to ensure that the individuals continue to meet the established criteria for waiver services. There is a different type of assessment that occurs prior to entry for waiver services, however, the criteria for initial entry and continued stay are the same. We use the combination of ADLS (for functional dependency) and medical nursing needs to determine if a person meets criteria for placement in a waiver. For additional information, please see: http://websrvr.dmas.virginia.gov/manuals/NHPAS/appendixB_nhpas.pdf	Melissa Fritzman	804-225-4206	Program Administration Supervisor II
Washington	A person meets NFLOC when they need assistance with 3 or more Activities of Daily Living (ADL) or a combination of cognitive impairment and one ADL or substantial assistance with 2 ADLs. CARE, an MDS based tool, further classifies persons into one of 12 (Residential) or 17 (In-home) classification groups based on ADL need, Clinical Complexity, Mood & Behaviors, and Cognitive Performance Score. The assessor completes all mandatory fields and CARE generates the Classification Group and corresponding daily rate (Residential) or Hours/month (In-home) based on client choice of setting. If In-home, adjustments to hours may be calculated to adjust for informal support or environmental factors.	Susan Engels	360-725-2353	Care Coordination, Assessment and Service Planning Program Manager
West Virginia	Not Provided	Nora McQuain	304-558-5959	Not Provided
Wisconsin	Simple nursing care procedures required by residents with long-term illnesses or disabilities in order to maintain stability and which can be provided safely only by or under the supervision of a person no less skilled than a licensed practical nurse who works under the direction of a registered nurse.	Lyle Updike	608-266-6989	Unit Chief, Nursing Home Analysis Unit
Wyoming	LT 101 is performed by a trained PHNurse. It is a Nursing assessment. If the residents has 13 or more points they are eligible for LTC care either in a NF or the waiver program	Lura Crawford	307-777-5382	Long Term Care Program Manager

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)				
	Agency	Name of LOC Assessment Form	Do you use an automated form? Complete Online?	Is your form accessed on the web?
Alabama	Alabama Medicaid Agency	Admission and Evaluation Data Form #161	No	Yes
Alaska	Dept of Health and Social Services, Senior & Disabilities Services	Consumer Assessment Tool	No	No
Arizona	Arizona Health Care Cost Containment System	Uniform Assessment Tool	No	Yes
Arkansas	Department of Human Services, Office of Long Term Care, Division of Medicaid Services	DHS-703 Arkansas Depart of Human Services Evaluation of Medical Need Criteria	No	Yes
California	Dept of Health Care Services	Assisted Living Waiver Assessment Form	No	No

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)				
Colorado	Health Care Policy and Financing	Uniform Long Term Care 100.2 (ULTC 100.2) Instrumental Activities of Daily Living (IDAL) Assessment	No	Yes
Connecticut	Dept of Social Services	Electronic Health Screen, W1506web	No	Yes
Delaware	Division of Medicaid and Medical Assistance	Functional Care Summary	No	No
District of Columbia	Department of Health	Not Provided	No	Yes
Florida	Dept of Elder Affairs	Form 701B, Comprehensive Assessment	No	No
Georgia	Dept of Community Health/Dept of Medical Assistance	DMA-6, Physician's Recommendation Concerning Nursing Facility Care	No	Yes
Hawaii	Med-Quest	Level of Care (LOC) Evaluation, Form 1147	Yes	Yes
Illinois	Dept on Aging	Dept on Aging Choices for Care Assessment Form	No	No
Idaho	Dept of Health and Welfare	Uniform Assessment Instrument	Yes	No

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)				
Indiana	Family and Social Services Administration, Division of Aging	LTC Services Eligibility Screen	Yes	Yes
Iowa	Dept of Human Services, Iowa Medicaid Enterprises	Form 470-4393 LOC Certification form for Facility	No, no	Yes
Kansas	Dept of Aging	CARE Level I Assessment	No, no	Yes
Kentucky	Medicaid Services - Long Term Care and Community Alternatives	Patient Status Determination (PSD)	No	Yes
Louisiana	Dept of Health and Hospitals, Office of Aging and Adult Services	Level of Care Eligibility Tool (LOCET)	No, available in electronic form, not completed online	Yes, but completed in hard copy form
Maine	Dept of Health & Human Services, Office of Elder Services	Medical Eligibility Determination (MED)	Yes	Yes

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)				
Maryland	Dept of Health and Mental Hygiene - LTC and Community Support Services	Maryland Medical Assistance Medical Eligibility Review Form #3871B	Yes	Yes
Massachusetts	MassHealth, Office of Long Term Care at Elder Affairs	Management Minutes Questionnaire (MMQ)	No	No
Michigan	Dept of Community Health, Medical Services Administration	MI Medicaid Nursing Facility Level of Care Determination	Yes, yes	Yes
Minnesota	Dept of Human Services	LTC Consultation Assessment Form	LTCC staff can use mergeable forms for assessment and services planning	Yes
Mississippi	Mississippi Division of Medicaid	Medicaid Long Term Care Pre-Admission Screening (PAS) Form	Yes	Yes
Missouri	Dept of Health and Senior Services	DA124A/B Initial Assessment	Yes	Yes

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)				
Montana	Mountain Pacific Quality Health	Level of Care	No	No
Nebraska	Dept of Health and Human Services	14AD Part B, Nursing Facility Level of Care (NFLOC) form	No, some access a partially automated database	No
Nevada	Division for Aging Services	Level of Care Assessment Form for Nursing Facilities	Yes	Yes
New Hampshire	DHHS/Division of Community Based Services/ Bureau of Elderly and Adult Services	Medical Eligibility Determination (MED)	Yes, Yes (April 2008)	Yes
New Jersey	Dept of Health and Senior Services, Division of Aging and Community Services	MI Choice, soon revised and to be named NJ Choice	Yes, No	No
New Mexico	Human Services Dept, Medical Assistance Division	LTC Assessment Abstract, Form ISD 379	Yes, No	Yes
New York	Dept of Health	Patient Review Instrument (HC-PRI)	Yes, yes	Yes

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)				
North Carolina	DHHS, Division of Medical Assistance	Medicaid Uniform Screening Tool (MUST)	No, but under development	Currently in field testing
North Dakota	Dept of Human Services, Medicaid Services Division	Level of Care/Continued Stay Determination Form	yes	Yes
Ohio	Dept of Job and Family Services, Office of Ohio Health Plans	ODJFS 3697 Form (LOC admission). In addition, for ODJFS administered waivers: the Program Evaluation Assessment Tool (PEAT) and for Ohio Department of Aging administered waivers: the Comprehensive Assessment/Referral Evaluation (CARE) tool.	No	Yes
Oklahoma	Dept of Human Services - Aging Division	Uniform Comprehensive Assessment Tool	Yes	No
Oregon	Dept of Human Services, Seniors and People with Disabilities Division	Client Assessment/Planning System (CAPS)	Client server, not on the WEB	No
Pennsylvania	Dept of Aging	Level of Care Assessment (LOCA)	Yes	Yes
Rhode Island	Dept of Human Services	CP-1 Form and physician's AP-72.1	No	No, internal LAN

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)				
South Carolina	Dept of Health and Human Services	South Carolina Long Term Care Assessment Form	Yes,yes	Yes
South Dakota	Dept of Social Services, Division of Adult Services and Aging	Determination of Medical Review Team	No	No
Texas	Dept of Aging and Disability Services	3652_A Level of Care (Client Assessment, Review and Evaluation (CARE)	No however form accessible for copying off intranet.	Yes
Utah	Dept of Health	Continued Stay Transmittal (10A)	No, only MDS is automated	No
Vermont	Dept of Disability and Aging and Independent Living	Independent Living Assessment,Form 703 Choices for Clinical Care Assessment	No, hope to be automated by July 08	Yes
Virginia	Dept of Medical Assistance Services, LTC Division	DMAS99C Community-Based Care Recipient Assessment Report	No	Yes
Washington	Dept of Social Services, Home and Community Service Administration	Comprehensive Assessment and Report Evaluation (CARE)	Yes	NO, Java based downloadable database
West Virginia	Bureau of Medical Services	Not Provided.	Not Provided.	Not Provided.
Wisconsin	Dept of Health and Family Services	No forms used, information extracted from MDS. Authors note: this seems to imply the assessment is done after admission to the nursing home.	Yes, no	No

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)				
Wyoming	Dept of Health, Aging Division	Lt 101	No	No

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)		Function of the Assessment Form				
	Web-site	Determine Level of Care or Need?	Determine Medicaid Eligibility?	Determine Financial Eligibility for Medicaid?	Use as basis for creating care plan?	Other (Describe)
Alabama	http://www.medicaid.alabama.gov/documents/3D-3a-1-AdmissionAndEvaluation%20DataForm161.pdf		No	No	Yes	
Alaska	None	Yes	No	No	Yes	
Arizona	http://www.azahcccs.gov/Regulations/OSPpolicy/chap1600/Chap1600.pdf See Exhibit 1620-3 in Case Management document	Yes	No	No	No	
Arkansas	https://www.medicaid.state.ar.us/InternetSolution/General/units/oltc/forms/forms.aspx http://www.medicaid.state.ar.us/Download/general/units/oltc/forms/dhs_703.doc	Yes	No	No	Yes	

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)		Function of the Assessment Form				
	Web-site	Determine Level of Care or Need?	Determine Medicaid Eligibility?	Determine Financial Eligibility for Medicaid?	Use as basis for creating care plan?	Other (Describe)
California	Self-scoring Assessment Tool in Excel	Yes	No	No	Yes	Determines one of four tiers that sets the reimbursement rate for the provider
Colorado	http://www.chcpf.state.co.us/HCPF/LTC/sepindex.asp	Yes	No	No	Yes	
Connecticut	http://www.ct.gov/dss/cwp/view.asp?a=2352&q=390780	Yes	No	No	No, prescreen for waiver and community services	
Delaware	None	Yes	No	No	Yes	
District of Columbia	None	Yes	No	No	No	
Florida	None	Yes	No	No	Yes	
Georgia	https://www.ghp.georgia.gov/wps/output/en_US/public/Provider/DocumentsAndForms/DMA_6_Physicians_Recommendation_Concerning_Care.pdf	Yes	No	No	Yes	
Hawaii	http://www.med-quest.us/PDFs/Frequently%20Used%20Forms%20for%20Providers/1147%20Form.pdf	Yes	No	No	No	PA for reimbursement
Illinois	None	Yes	No	No	Yes, but only for in-home services	

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)		Function of the Assessment Form				
	Web-site	Determine Level of Care or Need?	Determine Medicaid Eligibility?	Determine Financial Eligibility for Medicaid?	Use as basis for creating care plan?	Other (Describe)
Idaho	Not provided.	Yes	No	No	Yes	
Indiana	The only form that we could find on line is the following PASARR Level I - Identification Evaluation Criteria - Certification by Physician for Long-Term Care Services http://www.state.in.us/icpr/webfile/formsdiv/45277.pdf	Yes	No	No	Yes	
Iowa	http://www.ime.state.ia.us/LTC/LevelOfCare.html	Yes	No	No	Yes	
Kansas	http://www.aging.state.ks.us/Programs/Careinfo/careindex.htm	Yes	No	No	Yes	MI/MR screen, community options
Kentucky	None	Yes	No	No	No	
Louisiana	http://www.dhh.louisiana.gov/offices/publications/pubs-105/NF%20Hardcopy%20LOCET%209-26-07.doc.pdf See also http://www.dhh.louisiana.gov/offices/publications.asp?ID=105&Detail=1497	Yes	No	No	No	
Maine	http://www.maine.gov/dhhs/beas/medxx_me.htm	Yes	No	No	Yes	
Maryland	http:www.dhmh.state.md.us/mma/longtermcare/pdf/Guide3871BBooklet.pdf	Yes	No	No	No	
Massachusetts		No	No	No	No	Case-Mix payment tool

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)		Function of the Assessment Form				
	Web-site	Determine Level of Care or Need?	Determine Medicaid Eligibility?	Determine Financial Eligibility for Medicaid?	Use as basis for creating care plan?	Other (Describe)
Michigan	https://sso.state.mi.us - This site requires a login This document is a description of the process: http://www.michigan.gov/documents/AttachC_Process_Guidelines_pc-WEB_107342_7.pdf	Yes	No, but determines Medicaid functional/medical eligibility)	No	No	
Minnesota	http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-3428A-ENG	Yes	No	No	Yes	Basis for service plan development, part of service eligible for HCBS, establishes case mix class for HCBS budgets
Mississippi	: http://www.dom.state.ms.us/Long_Term_Care/long_term_care.html	Yes	No	No	No	
Missouri	http://www.dhss.mo.gov/NursingHomes/580-2460.pdf	Yes	No	No	Yes	
Montana	None	Yes	No	No	Yes	
Nebraska	None	Yes	No	No	Yes	Used to determine if approved for Medicaid paid nursing facility stays.
Nevada	https://nevada.fhsc.com/Downloads/provider/FH-19_Nursing_facility_level_of_care_and_service_placement_assesment.pdf (Instructions) https://nevada.fhsc.com/Downloads/provider/FH-19i_Nursing_facility_level_of_care_and_service_placement_assesment_instructions.pdf	Yes	No	No	Yes	
New Hampshire	http://www.dhhs.nh.gov/NR/rdonlyres/ezllat7r7aq443obd5saaacfjfkxvf5qmzblzuyqeyjcdyykz7ekzoqman24wlpjzwlcikewvuknn2touvh6bobyq5g/application.pdf	Yes	Yes (Medical eligibility)	No	Yes	In conjunction with Medically-Needy application.

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)		Function of the Assessment Form				
	Web-site	Determine Level of Care or Need?	Determine Medicaid Eligibility?	Determine Financial Eligibility for Medicaid?	Use as basis for creating care plan?	Other (Describe)
New Jersey	None	Yes	No	No	Yes	
New Mexico	Not provided.	Yes	No	No	Yes	
New York	http://www.health.state.ny.us/forms/doh-694.pdf	Yes	No	No	Yes	
North Carolina	None	Yes	No	No	No	
North Dakota	http://www.ascendami.com/ND/forms/NDLOCScreen.pdf	Yes	No	No	No	
Ohio	None regarding the form. For a discussion of pre-admission screening results seehttp://goldenbuckeye.com/_pdf/nhreschar04.pdf	Yes	No	No	No	
Oklahoma	Restricted to staff use.	Yes	No	No	Yes	Eligibility for personal care
Oregon	None	LOC for NF or CBC	No	No	Yes	
Pennsylvania	HTTP://www.aging.state.pa.us/aging/cwp/view.asp?a=558&Q=254481	Yes and locus of care	No	No	Yes	
Rhode Island	None	Yes	No	No	Yes	
South Carolina	http://www.dhhs.state.sc.us/dhhsnew/insidedhhs/bureaus/BureauofLongTermCareServices/forms.asp	Yes	No	No	Yes	

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)		Function of the Assessment Form				
	Web-site	Determine Level of Care or Need?	Determine Medicaid Eligibility?	Determine Financial Eligibility for Medicaid?	Use as basis for creating care plan?	Other (Describe)
South Dakota	None	No	No	No	No	
Tennessee	http://tennessee.gov/tenncare/forms/paeform.pdf	Yes	No	No	Yes	
Texas	http://www.dads.state.tx.us/forms/3652-A/3652-A.pdf	Yes	No	No	Yes	
Utah		Yes	No	No	Yes	
Vermont	http://www.ddas.vermont.gov/ddas-forms/forms-cfc/forms-cfc-highest-needs-documents/clinical-assessment	Yes	No	No	No, different assessment tool used	http://www.ddas.vermont.gov/ddas-forms/forms-adult-day/forms-adult-day-documents/ila-29-pgs-revised_sept-13-2006
Virginia	http://www.dmas.virginia.gov/downloads/forms/DMAS-99.pdf	Yes	No	No	No	
Washington	None	Yes	Yes	No	Yes	
West Virginia	Not provided.	Not Provided.	Not Provided.	Not Provided.	Not Provided.	
Wisconsin	None	Yes	No	No	Unknown	
Wyoming	N.A.	Yes	No	No	No	

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)

	Medicaid	Non-Medicaid	HCBS Waiver Services	Other (Describe)	Who administers the assessment?
Alabama	Yes	No	Yes	Used for all applicants to the HCBS Waivers	Facility RN staff
Alaska	Yes	No	Yes	LOC for Personal Care	State staff effective November 1, 2007
Arizona	Yes	No	Yes, but only to compare to NF costs		Case manager employed by ALTCS HCO
Arkansas	Yes	Yes	Yes		NF staff or hospital staff
California	Yes	No	Yes		RNs employed by waiver service providers
Colorado	Yes	No	Yes		SEP staff
Connecticut	Yes	No	Yes		Facility staff
Delaware	Yes	No	No		State Nursing staff
District of Columbia	Yes	No	Yes		Delmarva Foundation staff
Florida	Yes	Yes	Yes	Private pay	CM entities and state staff
Georgia	Yes	Yes	Yes	Other waiver programs, community care, independent care	Family physician

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)					
	Medicaid	Non-Medicaid	HCBS Waiver Services	Other (Describe)	Who administers the assessment?
Hawaii	Yes	No	Yes		Facility or Referring agency staff
Illinois	Yes	Yes	Yes	Used for all individuals over age 60.	Case Coordination Units (CCU's)
Idaho	Yes	Yes	Yes		Medicaid Regional Nurse Reviewers
Indiana	Yes	Yes	Yes		Local AAA's, 16 in Indiana
Iowa	Yes	No	Yes	Other similar forms used for HCBS waivers and ICF/MR	Medical Professional (MD, DO, ARNP, PA) conducts assessment and info reviewed by IME nurses
Kansas	Yes	No	No, UAI form used for waivers		AAA's, hospital and nursing facility staff
Kentucky	Yes	No	No		SHPS (A Peer Review Organization)
Louisiana	Yes	No	Yes		NF staff
Maine	Yes	Yes	Yes		Assessing Service Agency, Goold Data Management

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)					
	Medicaid	Non-Medicaid	HCBS Waiver Services	Other (Describe)	Who administers the assessment?
Maryland	Yes	No	Yes		Provider and local health department staff.
Massachusetts	Yes	No	No		NF staff
Michigan	Yes	No	Yes		Medical professional employed by provider
Minnesota	Yes	Yes	Yes	State-funded Alternative Care program, Special Income standard EW	PHNS and SW at the county, tribe or MCO. Can request waiver to use RNs with 1 yr. home care experience
Mississippi	Yes	No	Yes		Provider of Services
Missouri	Yes	No	No		NF staff
Montana	Yes	No	Yes		NF staff with phone contact with contractor
Nebraska	Yes	No	Yes	Individuals seeking Medicaid payment for nursing facility care	HHS staff or contractors, sometimes via phone
Nevada	Yes	Yes	Yes	Group Home, Assisted Living	State staff and facility staff

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)					
	Medicaid	Non-Medicaid	HCBS Waiver Services	Other (Describe)	Who administers the assessment?
New Hampshire	Yes	No	Yes	State funded Medicaid program	State employed RNs and contracted nurses
New Jersey	Yes	Yes	Yes	non-Medicaid state funded general assistance	State staff in facilities, ADRC staff in homes
New Mexico	Yes	Yes	Yes	PACE, Personal Care, other waivers	TPA administers assessment
New York	Yes	Yes	Yes		Assessors, qualified through the Dept of Health PRI Training Program
North Carolina	Yes	Yes	Yes	State assistance programs	NF staff, County Health staff, Hospital discharge planners, etc.
North Dakota	Yes	PASRR only	Yes	Money Follow Person Grant and PACE Program	DDM Ascend of Nashville, TN

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)					
	Medicaid	Non-Medicaid	HCBS Waiver Services	Other (Describe)	Who administers the assessment?
Ohio	Yes	No	Yes		NF staff, SW's and RN's
Oklahoma	Yes	No	Yes	Personal care services	Independent case management agencies or home care agencies.
Oregon	Yes	Project Independence	Yes	Project Independence	Local AAA's and State staff
Pennsylvania	Yes	State funded Medicaid	Yes		AAA assessors
Rhode Island	Yes	No	Yes		Facility staff, DHS Social Workers or Community Case Managers approved by DHS Nurses
South Carolina	Yes	No	Yes		RN's employed by DHHS and Case Manager employed by/contracted with DHHS
South Dakota	Yes	No	Yes	None	NF staff in facility, data reviewed by Regional RN's
Tennessee	Yes	Yes	Yes	PACE	NF staff in facility

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)					
	Medicaid	Non-Medicaid	HCBS Waiver Services	Other (Describe)	Who administers the assessment?
Texas	Yes	Yes	Yes		Facility staff or DADS PASRR Regional Staff
Utah	Yes	Yes	Yes	No	NF staff in facility
Vermont	Yes	Yes	Yes	Adult Day Service and Personal Services, State-funded Medicaid	state nurses for LOC assessment Case Managers from AAAs, Home Health Agency or Adult Day for functional assessment used for care planning
Virginia	Yes	No	Yes	EDCD and AIDS waiver	Nurses employed by provider agencies
Washington	Yes	Yes, some	Yes	Family Home, Residential Care, Assisted Living, Respite/Family Caregiver	AAA Case Manger or Nurses, or HCS Social Workers or Nurses
West Virginia	Not Provided				
Wisconsin	Yes	No	No	None	Data extracted from MDS data base.
Wyoming	Yes	No	Yes		Public Health Nurse

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)					Contractors
	Where are the assessments conducted?	What is the cost per assessment?	Are there any measures of cost effectiveness or efficiency?	Do you belong to any professional associations related to LOC determinations?	Are contractors engaged in any aspects of the assessment process? Who are they?
Alabama	Resident domicile	Not specified, included in facility per diem	No	No	APS Healthcare performs a retrospective review of admissions, readmissions and transfers
Alaska	Resident domicile	$320 for up to November 1, 2007	Combined assessment for PCA and Waivers in one process thereby cutting dup costs.	No	Arbitre was assessment contractor until November 1, 2007
Arizona	Resident domicile	Unknown, part of HCO business costs	No	No	ALTCS which employs the case managers.
Arkansas	Resident domicile	Unknown	No	Yes, National Association of PASRR Professionals	Bock Associates, only to determine if applicant requires specialized services.
California	Resident domicile	Contractor paid $200 per month/per beneficiary	No	No	NCB Capital Impact developed the Assessment Tool and the scoring method.
Colorado	NF	Unknown	No	No	23 Single Entry Point agencies conduct the assessments.

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)					Contractors
	Where are the assessments conducted?	What is the cost per assessment?	Are there any measures of cost effectiveness or efficiency?	Do you belong to any professional associations related to LOC determinations?	Are contractors engaged in any aspects of the assessment process? Who are they?
Connecticut	Resident domicile	If hospitals conduct as part of MI/MR screen, $35	No	No	Waiver subcontractors verify LOC.
Delaware	Resident domicile	Unknown	No	No	No
District of Columbia	Resident domicile	Unknown	No	No	Delmarva Foundation does assessments
Florida	Resident domicile	$147 in 2005	Assessment used to prioritize for waitlists	Yes, National Association of PASR Professionals	CM entities, lead agencies, and some county governments contract to conduct assessments
Georgia	Resident domicile	Physician bills standard fee	No	No	No, for the LOC. Contractor (GHP, Georgia Health Partnership) for the PASRR DMA-613/ Level 1 assessment
Hawaii	Facility or Referring agency	Unknown	Data reports can be used for determining proper utilization and cost effectiveness	No, but two LTC associations assisted with development of forms.	Health Services Advisory Group conducts the assessments.

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)					Contractors
	Where are the assessments conducted?	What is the cost per assessment?	Are there any measures of cost effectiveness or efficiency?	Do you belong to any professional associations related to LOC determinations?	Are contractors engaged in any aspects of the assessment process? Who are they?
Illinois	Resident domicile	$89.53 or $114.95 if a translator is required.	No	No	Case Coordination Units (CCU's)
Idaho	Resident domicile	Unknown	Costs tracked for effectiveness	No	No
Indiana	Resident domicile	Unknown	No	No	Area Agencies on Aging conducts assessments
Iowa	Resident domicile	Unknown	No	No	IME Medical Services Unit review staff are contracted through the Iowa Foundation for Medical Care
Kansas	Resident domicile	Hospital assessments $35.67-$88.87, AAA's $62.78-166.19	Costs tracked for effectiveness	No	AAA's and their subcontractors
Kentucky	NF	Unknown	No	No	SHPS staff conduct the assessments through 35 nurses covering the whole state

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)					Contractors
	Where are the assessments conducted?	What is the cost per assessment?	Are there any measures of cost effectiveness or efficiency?	Do you belong to any professional associations related to LOC determinations?	Are contractors engaged in any aspects of the assessment process? Who are they?
Louisiana	NF and by phone	Unknown	No	No	Affiliated Computer Services (ACS) conducts telephone interview for HCBS
Maine	Resident domicile	$172	No	No	Assessing Services Agency, Goold Data Management, conducts assessments
Maryland	Resident domicile	Ranges from $21.88 to $113.40	No	No	KePro is the utilization control contractor--- determines level of care from assessment forms.
Massachusetts	NF	Unknown	No	No	No
Michigan	Resident domicile	Unknown	In 2004 there was a projected cost savings of $11 million	No	Yes, MI Peer Review Organization conducts exception reviews for those not meeting criteria
Minnesota	Wherever the person is, NF, hospital or person's residence	Unknown	Comparison between community and facility placement cost savings is measured.	No	MCOs and tribes manage and deliver waiver services.

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)					Contractors
	Where are the assessments conducted?	What is the cost per assessment?	Are there any measures of cost effectiveness or efficiency?	Do you belong to any professional associations related to LOC determinations?	Are contractors engaged in any aspects of the assessment process? Who are they?
Mississippi	Resident domicile	Unknown	No	No	Medicaid providers conducting assessments
Missouri	NF	Unknown, limited to facility staff and admin costs	No	No	No
Montana	Resident domicile	Unknown, part of contract with State	No	No	Mountain-Pacific Quality Health
Nebraska	Resident domicile	Unknown, part of service coordination	No	No	AAA's, independent living centers, educational service units, health departments, CAP agencies Head Start
Nevada	Resident domicile	$25.75 per 15 minute increment	No	No	First Health Services does the assessment for Nursing Homes
New Hampshire	Resident domicile	Unknown	Yes	No	Individual contractual nurses conduct the assessments

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)					Contractors
	Where are the assessments conducted?	What is the cost per assessment?	Are there any measures of cost effectiveness or efficiency?	Do you belong to any professional associations related to LOC determinations?	Are contractors engaged in any aspects of the assessment process? Who are they?
New Jersey	Resident domicile	Unknown	No, but in process	No	ADRC (Aging and Disability Resource Center) assessors, who are part of AAA's
New Mexico	Resident domicile	Unknown, varies by the administrator	Report from UR contractor measure efficiency	No	TPA and UR contractors
New York	Resident domicile	Unknown	No	No	Assessors who are discharge planners, RN's, and other utilization review personnel employed by facilities
North Carolina	Resident domicile	Unknown	No	No	Only the contractor developing the new Uniform Assessment Tool

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)					Contractors
	Where are the assessments conducted?	What is the cost per assessment?	Are there any measures of cost effectiveness or efficiency?	Do you belong to any professional associations related to LOC determinations?	Are contractors engaged in any aspects of the assessment process? Who are they?
North Dakota	Resident domicile	$40.50 per unit	No	No	contractor is responsible for all level of care screens, Level I's and Level II/MI
Ohio	Resident domicile	Unknown	No, but travel costs kept down by scheduling close to assessor home	No	Only Carestar which provides certain admin functions related to the waiver, including assessment
Oklahoma	Resident domicile	Unknown	No	No	Case management agencies or home care agencies
Oregon	Resident domicile	Unknown	Laptops used remotely for data completion.	No	AAA's
Pennsylvania	Resident domicile	$225 per assessment	No	No	AAA's conduct assessments in some parts of the state.
Rhode Island	Resident domicile	Unknown	No	No	Yes, Case Management Agencies gather information for LOC process
South Carolina	Resident domicile	Unknown	No	No	No

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)					Contractors
	Where are the assessments conducted?	What is the cost per assessment?	Are there any measures of cost effectiveness or efficiency?	Do you belong to any professional associations related to LOC determinations?	Are contractors engaged in any aspects of the assessment process? Who are they?
South Dakota	Resident domicile	Unknown	No	No	No
Tennessee	Resident domicile	Unknown	DADS Regional Nurses conduct a UR of a sample to determine if property category is used.	No	No
Texas	Resident domicile, hospital, doctor's office, or clinic	$157.21 per assessment	No	No	Private Psychologist for Psychological Evaluations
Utah	Resident domicile	Unknown	No	No	No
Vermont	Resident domicile	$65 per hour with an average assessment of 2-3 hours for functional assessment	No	No	AAA and Home Health Agencies are reimbursed as part of the fee for service for Choices for Care services for functional assessment
Virginia	Resident domicile	Unknown	No	No	No

Table 2: Data Collection Sheet for State NF Level of Care Survey (cont.)					Contractors
	Where are the assessments conducted?	What is the cost per assessment?	Are there any measures of cost effectiveness or efficiency?	Do you belong to any professional associations related to LOC determinations?	Are contractors engaged in any aspects of the assessment process? Who are they?
Washington	Resident domicile	Unknown, bundled w/cm cost of $120/month	Used a Time Study to help set Case Management reimbursement rates.	No	Yes, AAA's and their subcontractors
West Virginia					No response.
Wisconsin	N/A	Unknown	No	No	EDS processes MDS data
Wyoming	Resident domicile	$80	No	No	Public Health Nurses conduct the assessments