Nursing Facility Level of Care Initiative: Final Report to the Legislature

Aging and Adults Services Division
Disability Services Division

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Legislative Report

Minnesota Department of Human Services

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Minnesota Statutes, Chapter 3.197 requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $6,000.

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I. Executive Summary

Minnesota Statutes §144.0724 was enacted in 2009 to revise the criteria required for payment for long-term care services under Medical Assistance (MA), including payment for nursing facility (NF) services and home and community-based services (HCBS) programs. While the revised criteria were adopted by the Legislature in 2009, Minnesota could not implement this change until January 1, 2014 for individuals age 21 and older, and until October 1, 2019 for individuals under the age of 21 due to federal requirements included under the Affordable Care Act enacted in March 2010.

Implementation was further delayed until January 1, 2015 by executive order to allow additional time for systems changes needed to fully implement transition services intended to support potentially affected populations.

A preliminary report was delivered to the Legislature in October 2015. This final report describes the final results of the 2015 implementation experience, which are consistent with the results previously reported.

- The number of individuals who lost eligibility for the Elderly Waiver (EW), Alternative Care (AC), Brain Injury-Nursing Facility (BI-NF), or Community Access for Disability Inclusion (CADI) waivers as a result of the changes to the nursing facility level of care (NF LOC) criteria is small. Four hundred and fifty-seven (457) or approximately 1.2% of individuals age 21 and older reassessed during 2015 were no longer eligible for their HCBS program due to level of care (LOC).

- The majority of HCBS individuals who no longer met NF LOC at reassessment in 2015 were age 65 and older. This distribution is consistent with previous samples in which the majority of individuals affected by the change in NF LOC criteria were anticipated to be aged 65 and older.

- In comparing the HCBS program sample populations to the actual transition population, differences in how individuals have met LOC are notable, with an increase in acuity the most apparent difference between the actual transition population and previous samples.

- The number of individuals who lost eligibility for MA as a result of the loss of HCBS program eligibility is extremely small (19 people), and is also significantly less than previous estimates. This number necessarily declined as the impact related to service eligibility (LOC) declined.

- Most individuals who lost HCBS program eligibility accessed services through the Essential Community Supports (ECS) program. The services included in formal service plans prior to and after the loss of eligibility for HCBS programs appear to change little.

- There is no apparent impact on the living or housing situation of individuals who lost eligibility for HCBS due to NF LOC changes.

II. Legislation

Minnesota Laws 2013, Chapter 108, Article 7, Section 58 as revised under Minnesota Laws 2015, Chapter 78, Article 6, Section 29.

Sec. 58. NURSING HOME LEVEL OF CARE REPORT.

(a) The commissioner of human services shall report on the impact of the modification to the nursing facility level of care to be implemented January 1, 2015, including the following:

(1) the number of individuals who lose eligibility for home and community based services waivers under Minnesota Statutes, sections 256B.0915 and 256B.49, and alternative care under Minnesota Statutes, section 256B.0913;

(2) the number of individuals who lose eligibility for medical assistance; and

(3) for individuals reported under clauses (1) and (2), and to the extent possible:

(i) their living situation before and after nursing facility level of care implementation; and

(ii) the programs or services they received before and after nursing facility level of care implementation, including, but not limited to, personal care assistant service and essential community supports.

(b) The commissioner of human services shall report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance with the information required under paragraph (a). A preliminary report shall be submitted on October 1, 2015, and a final report shall be submitted February 15, 2016.

III. Introduction

Minnesota Statutes §144.0724 was enacted in 2009 to revise the criteria required for payment for long-term care services under Medical Assistance (MA), including payment for nursing facility services and home and community-based service (HCBS) programs. The nursing facility level of care (NF LOC) initiative was intended to:

- Contribute to sustainability in MA-funded long-term care programs by providing lower cost alternatives to individuals with lower needs;
- Standardize NF LOC criteria used statewide for both HCBS and NF populations; and
- Create objective NF LOC criteria to support equity in access to HCBS and NF services.

While the revised criteria were adopted by the Legislature in 2009, Minnesota could not implement this change until January 1, 2014 for individuals age 21 and older, and until October 1, 2019 for individuals under the age of 21 due to federal requirements included under the Affordable Care Act enacted in March 2010.

Implementation was further delayed until January 1, 2015 by executive order to allow additional time for systems changes needed to fully implement transition services intended to support potentially affected populations.

Institutional Level of Care and Eligibility for Publicly-Funded Long Term Care

The establishment of an institutional level of care, including NF LOC, is required as part of eligibility determination for public payment of long term care, including institutional services and the HCBS services developed as alternatives to those services. Level of care (LOC) determination is used to establish service eligibility for long term care under MA.

Changes to NF LOC criteria affect the service eligibility determination for MA payment of NF services, as well as for the Alternative Care (AC) program, Brain Injury-Nursing Facility (BI-NF) waiver, Community Access for Disability Inclusion (CADI) waiver, and the Elderly Waiver (EW).

In addition, MA financial eligibility is determined using different income and asset calculations and/or thresholds for individuals who have been determined to require an institutional level of care. These differences can result in eligibility for MA for some individuals who would not otherwise be eligible under state plan or “basic” MA financial eligibility rules.

Changing institutional level of care criteria can also then have an impact on MA financial eligibility for some people.

IV. Nursing Facility Level of Care Implementation Activity

A. Preparing for Transition Populations

In planning for implementation of the changes to NF LOC criteria, potential transition populations were defined. This population included:

- Individuals, age 21 or older, participating in one of the HCBS programs listed above on January 1, 2015, and who no longer meet the revised NF LOC criteria at their next annual reassessment occurring on or after January 1, 2015.

- MA eligible individuals admitted to a certified nursing facility between October 1 and December 31, 2014 who no longer meet the revised NF LOC criteria 90 days after admission.

B. Preparing for Transition Services

In addition to defining the transition populations potentially affected by this change, transition services were identified that can support transition individuals with alternative resources to assist in meeting their functional needs. These services can provide needed support to help people remain in their own communities until higher intensity services are required.

- **Personal Care Assistance (PCA) Service -** Individuals who do not meet the revised NF LOC criteria and who have need for assistance with activities of daily living are able to access PCA services and other home care services under MA state plan benefits.

- **Essential Community Supports -** Minnesota Statutes, section 256B.0922 established the Essential Community Supports (ECS) program for people that do not meet the revised NF LOC criteria. This program was also implemented January 1, 2015. ECS services are not available to individuals who can access MA state plan PCA services.

ECS was established to provide a modest budget and benefit set of services to provide support to people affected by NF LOC criteria changes. ECS services are available to individuals in both the HCBS and NF transition populations who meet the ECS program eligibility criteria. Services available under the ECS program include:

- Homemaker
- Chore
- Personal Emergency Response
- Home-delivered Meals
- Caregiver Supports (Training, Education and Counseling)
- Community Living Assistance
- Adult Day Service (was added to the service menu during the 2013 legislative session)

- Required case management

These particular services were selected for transition support in ECS because these were the services typically used by individuals who would no longer meet NF LOC in the sample analysis used to estimate the impact of changes to NF LOC criteria.

For more information about the ECS program, please go to www.dhs.state.mn.us/ecs or Essential Community Support Program

C. Preparing Lead Agencies and Providers

Lead agencies, including counties administering, or tribes and health plans under contract with the commissioner to administer, HCBS programs determine service eligibility for these programs, including level of care determinations. Providers deliver services to HCBS participants and NF residents, including individuals in the transition populations. The department engaged both lead agencies and providers extensively throughout the planning for and implementation of the change in NF LOC criteria.

In particular, the NF LOC External Stakeholder group proved invaluable in developing training content and materials for lead agencies and providers, amending consumer materials, revising forms used in the administration of HCBS programs, developing advance notice and appeals materials, and partnering with the Senior Linkage Line® (SLL) in designing the web-based preadmission screening tool used for LOC determination for NF admissions. This web-based tool also provides verification of LOC to satisfy the qualifying 90 day stay criteria for continuing MA payment of NF services.

Extensive training was provided to lead agencies and providers related to the revised criteria, and potential impacts. Training content was developed in light of the roles that financial workers, case managers, assessors, and Ombudsmen play in supporting access to and continuation of HCBS and other services.

Training occurred via video conferencing, conference presentations, bulletin publication, the creation of a NF LOC “mailbox” for communication, and the establishment of “office hours” to provide question/answer opportunities. Training included changes to assessment tools necessary to ensure standardization and equity in LOC determinations, as well as about options for supporting individuals affected by the change, whether those potentially affected at reassessment, or for individuals determined ineligible at initial application for HCBS.

For more information about the NF LOC Initiative, including External Stakeholder products, please go to www.dhs.state.mn.us/nfloc or NF LOC Initiative.

D. Preparing Systems

Many systems changes were needed in order to support the implementation of standardized NF LOC assessment criteria and verification of LOC in the Medicaid Management Information System (MMIS) and other systems relied upon for establishing eligibility for HCBS programs

and NF services. Extensive programming was also needed to support the new ECS program intended to provide transition support, as well as create a modest set of services for older Minnesotans who have emerging needs for community supports. Implementing the ECS program required work in all subsystems used by the department to manage and administer public HCBS programs: provider enrollment, financial eligibility, prior authorization, Social Service Information System (SSIS), MnCHOICES, and financial operations. And as previously noted, the web-based preadmission screening tools were designed and developed by SLL to support the NF LOC initiative as it applied to NF services and MA payment of those services.

V. Requirements of Final Report

The report on the impact of the NF LOC criteria changes that were implemented January 1, 2015, must include:

1. The number of individuals who lose eligibility for home and community-based services waivers under Minnesota Statutes, sections 256B.0915 and 256B.49, and alternative care under Minnesota Statutes, section 256B.0913;

2. The number of individuals who lose eligibility for medical assistance; and

3. For individuals identified under 1. and 2., to the extent possible:

   (i) Their living situation before and after nursing facility level of care implementation; and

   (ii) The programs or services they received before and after nursing facility level of care implementation, including, but not limited to, personal care assistant services and essential community supports.

Period Covered in the Report

This report includes an analysis of the impact of NF LOC changes on individuals age 21 and older who were participating in the HCBS programs listed above as of January 1, 2015, and who were reassessed between January 1 and December 31, 2015.[1]

While not required to be addressed here, the report also includes a brief discussion related to individuals admitted to a nursing facility during the same period, and preliminary observations related to other individuals assessed during 2015 who were not continuing on an HCBS program and who did not begin participating in (initially open) to an HCBS program in 2015.

VI. Findings

A. Previous Estimates of Impact

[1] Findings are based on data available on January 6, 2016.

Previous samples of both NF and HCBS program populations have been used to estimate the potential impact of changing NF LOC criteria. As noted, this change could also affect some individuals' financial eligibility for MA. The potential impact on service eligibility has been estimated by comparing information available in the Medicaid Management Information System (MMIS) about assessed needs to the assessed level and type of need necessary to meet the revised criteria.

The estimated impact on HCBS populations has varied from sample to sample, with sampling completed over the course of time since initial adoption of the revision in statute in 2009 through October, 2014.

For example, using a sample from October 2013, the estimated impact across all HCBS programs was approximately 7%. This means that about 7% of the HCBS program participants would not meet the revised LOC criteria, based on the most recent assessment information about them in MMIS. Using a sample from October 2014, the estimated impact across all HCBS program populations was approximately 6.4%, with a range between programs.[2]

The estimated impact on the NF population has remained relatively stable across all samples, at less than 2%.[3]

The analysis of potential impact on financial eligibility was based on information available about sample individuals related to income and assets, and by applying assumptions about individual decision-making related to estimated changes in spend down or other participant contribution amounts that might be incurred concurrently with the loss of service eligibility.

B. Numbers of People Losing HCBS Eligibility

The number of individuals who lost eligibility for EW, AC, BI-NF or CADI as a result of the changes to the NF LOC criteria is small.

- Of 38,557 unduplicated in-person reassessments performed for individuals in the EW, CADI (age 21 and older) or AC programs between January 1 and December 31, 2015, 38,100 or 98.8% remained eligible for their HCBS program.[4]

- 457 individuals were no longer eligible at their reassessment because they no longer met the NF LOC requirement.

[2] These estimates were anticipated to be somewhat high, since application of the new criteria depended on new data elements created to support the revised criteria in MMIS that were not available for analysis in previous samples.
[3] The potential impact for NF populations is based on two points in time when LOC must be established: at preadmission screening (PAS), and again at approximately 90 days after admission to meet the "qualifying 90 day stay" criteria included in statute. The majority of individuals in the NF population met and continue to meet NF LOC criteria at admission; the estimated impact for this population has rested primarily on individuals who would not meet the "qualifying 90 day stay" criteria.
[4] An additional 921 unduplicated reassessments for individuals participating the BI-NF program were completed during 2015. All met LOC and continued on the BI-NF program. For this reason, and to simplify discussion of findings, this program population was removed from additional analysis presented here.

- This represents approximately 1.2% of individuals reassessed during the time period, and is significantly less than previous estimates of the number of individuals at risk for loss of HCBS program eligibility under the NF LOC initiative.

The majority of HCBS individuals who no longer met NF LOC at reassessment in 2015 were in EW or AC.

- Of the 457 individuals who lost eligibility for their HCBS waiver program, slightly more than 71% were on EW (326 people).

- 9% who lost eligibility at reassessment were on AC (41 people).

- 20% of individuals who lost eligibility at reassessment were on the CADI waiver program (90 people).

- No individuals lost eligibility for the BI-NF waiver program during this time period due to LOC.

- This distribution of loss of HCBS program eligibility is consistent with previous samples in which the majority of individuals affected by the change in NF LOC criteria in the transition population were anticipated to be aged 65 and older, and that no individuals in the BI-NF program would be affected.

C. Explanation of Findings

In comparing the HCBS program sample populations to the actual transition population, differences in how individuals have met LOC are notable. The differences provide some insight into why the actual impact of the change in NF LOC criteria is significantly less than previously estimated.

Acuity appears to have increased in the 2015 population as signified by changes in case mix distribution.

- Case mix classification is based on many of the same assessment items used to determine NF LOC. Therefore it is possible to use certain case mix classifications as a proxy for NF LOC. Among the HCBS populations, all but two of the thirteen case mixes automatically meet LOC (A and L).

- 68.9% of all individuals in 2015 who remained eligible for their HCBS program met the LOC criteria via case mix classification, compared to 65% of all individuals in the October 2014 sample population.

- This means that nearly 4% more of the HCBS program populations met the revised LOC criteria because their case mix changed.

More individuals met LOC criteria based on cognitive or behavioral needs or clinical monitoring in 2015.

- These criteria are based on assessed need in behavior, clinical monitoring, self-preservation, orientation, or the possible presence of dementia based on a screening tool imbedded in the assessment.

- 18.8% of individuals reassessed in 2015 who remained eligible for their HCBS program met LOC under these criteria, compared to 15.3% in the October 2014 sample population, with the most change occurring in assessed cognitive or behavioral need.

Adoption of additional LOC criteria has revealed additional individuals who meet LOC.

- One of the NF LOC criterion in statute links the person's living arrangement to other specific limitations or risks, including the risk of maltreatment. This criterion reflects the understanding that a person who lives alone or is homeless may be more vulnerable because of lack of social or informal supports.

- This criterion was amended in 2013 to allow consideration of how the potential loss of housing, regardless of who the person lives with, can result in increased vulnerabilities as well. Information contained in MMIS to signify this consideration was not available in previous samples.

- While 8.7% of the 2015 population met LOC based on living alone plus another risk, 5.2% of the October 2014 sample population met this same criteria. The addition of criterion related to potential loss of housing paired with another risk and changes in MMIS data collection resulted in individuals who met LOC that were not visible in the October 2014 sample.

D. Number of People Losing Eligibility for Medical Assistance

The number of individuals who lost eligibility for Medical Assistance as a result of the loss of HCBS program eligibility is extremely small.

- Of the 457 individuals who lost HCBS eligibility due to NF LOC changes, only 20 individuals appear to have lost eligibility for MA at or near the same time of loss of HCBS.[5]

- This number is also significantly less than previous estimates of the number of individuals at risk for loss of MA financial eligibility under the NF LOC initiative. This number necessarily declined as the impact related to service eligibility declined.

[5] Individuals may lose MA for other reasons such as a change in financial situation, or failure to complete and return redetermination forms, for examples.

E. Services Before and After Loss of HCBS Program Eligibility

Most individuals who lost HCBS program eligibility between January 1 and December 31, 2015 accessed HCBS services through the Essential Community Supports program.

- 310 or 68% of the 457 individual who lost HCBS program eligibility were immediately eligible for ECS services upon exiting their previous program.[6] This includes individuals in managed care.

- Some of the remaining individuals accessed state plan home care, while others chose to receive no services as indicated in case manager notes in MMIS.

The services included in formal service plans prior to and after the loss of eligibility for EW, AC or CADI appear to change little.

- Little difference is seen in the services authorized under the previous HCBS program and ECS for individuals in fee-for-service.

- For many individuals in managed care, information about services is provided via encounter claims, which are submitted periodically. For this reason, there is a lag in the information available about individuals in managed care for this report. However, information contained in the service plan screens in MMIS show little difference before and after loss of HCBS program eligibility.

- This is to be expected, since the services included in the ECS program are based on an analysis of services in place for previous sample populations who did not meet the revised LOC criteria.

F. Living Situation of HCBS Population

There was no impact on the living situation of individuals who lost HCBS eligibility when comparing planned living arrangement information in MMIS.

G. Assessment of Non-Transition Populations

The change in NF LOC criteria will also be applied to the eligibility determination of new applicants for HCBS programs. In an attempt to identify any effect upon individuals not included in the transition group but assessed in 2015, three years of assessment data were analyzed. This analysis included individuals assessed and opened to an HCBS program for the first time during each year, as well as individuals assessed with different results.

[6] This figure underrepresents individuals reassessed in the last months of 2015 for whom the change to the ECS program is not yet entered into MMIS. With a minimum of 30 days advance notice required to end the previous HCBS services for reason of LOC, individuals reassessed in November and December 2015 may not yet have been transitioned to the ECS program.

This analysis showed no changes in the outcomes for individuals under age 65 that can be directly attributable to the change in LOC at this time.

- Between 10 and 12% of individuals under age 65 who receive a face-to-face assessment are not determined to meet LOC criteria. This has been consistent during 2013, 2014 and 2015.

- The percentage of individuals opening to CADI for the first time during 2015 as a percentage of all face-to-face assessments was also consistent with previous years: 15.8% in 2013, 14% in 2014, and 14.8% in 2015.

- However, the total number of assessments recorded in MMIS has sharply increased for individuals under age 65, from 7,816 in 2013 to 13,173 in 2015. This means that small percent changes can reflect more significant effects when considered on the basis of more people.[7]

- Further analysis is needed to account for expansion of CADI during 2015, as well as to account for the addition of assessments in MMIS for populations that were not previously represented in this data.

This analysis showed no changes in the outcomes for individuals age 65 and older that can be directly attributable to the change in LOC at this time.

- The total number of face-to-face assessments of individuals age 65 and older has not experienced the sharp increase noted for people under age 65. Many of these assessments are performed by health plans as part of required health risk assessments for individuals age 65 and older.[8]

- An average of 18,350 assessments for people age 65 and older were performed each year during 2013, 2014 and 2015, with a range between 17,788 and 18,777.

- On average, 63.8% of all assessments completed each year for people age 65 and older result in a determination that the person meets LOC, including those that reflect an initial opening to EW or AC. The percentage for 2015 assessments was lower than the average by .6% and 2.7% lower than 2014 (from 65.9% in 2014 to 63.2% in 2015). Further analysis is needed to determine if this decrease continues in the future.

- On average, 29.5% of assessments for older adults result in an initial opening to AC or EW. The percentage of assessments resulting in an opening in 2015 was .5% lower, and

[7] This increase in assessment data for individuals under age 65 is due to the statewide implementation of the MnCHOICES initiative which results, in part, to more information about assessments performed for individuals who receive state plan home care or other services in addition to those who enter HCBS programs.
[8] In addition, MnCHOICES has not yet been fully implemented for managed care organizations that perform assessments for managed care enrollees.

1% lower than 2014 (from 29.9% in 2014 to 28.9% in 2015). Further analysis is needed to determine if this decrease continues in the future.

H. Nursing Facility Population

LOC criteria are applied to determine service eligibility for both HCBS and institutional services. Changes in the LOC criteria was anticipated to have some effect on the MA nursing facility resident population, but it has been minimal.

Like the HCBS population, the actual impact seen in 2015 is lower than previous estimates.

- **Level of Care at Admission:** Of the 64,567 preadmission screenings conducted between January 1 and December 31, 2015, 63,954 or 99% met NF LOC at admission. The remaining 610 individuals were referred for face-to-face assessment for final determination.[9]

- **Qualifying 90 Day Stay:** Of the 236 individuals requiring re-establishment of LOC to meet the qualifying stay criteria during 2015, 217 or 92% met LOC.[10]

    - Nursing facilities are required to submit a quarterly assessment to the Minnesota Department of Health approximately 90 days after admission, using the Minimum Data Set (MDS) assessment tool.

    - The MDS assessment is used to establish the Resource Utilization Group or RUGs category for an individual based on information contained in the MDS assessment.

    - Like case mix classification used in HCBS programs, the RUGs classifications also include information about the type and level of need used to determine LOC and can thus be used as a proxy for LOC.

    - Because of this crosswalk between MDS and LOC, nursing facilities only have to re-establish LOC for a very small percentage of the resident population.

VII. Conclusions

The observable impact of the revision to NF LOC criteria is significantly less than previously estimated. In examining how individuals retained their eligibility, it is apparent that the HCBS population has experienced an increase in acuity since the original adoption of the revised criteria in 2009.

[9] Information about the outcome of referrals was not available at the time of this report.
[10] Satisfying the qualifying 90 day stay requirement is accomplished either by the NF using the online PAS tool, or through referral to a lead agency for face-to-face assessment. Fifty-seven individuals were referred for assessment for LOC determination.

Investments in strategies such as Transitional Consultation and Live Well at Home, as well as expansion of community services available under the Older Americans Act may have contributed to a change in the needs of individuals who eventually seek assistance through publicly funded long term care programs.

The availability of the Essential Community Supports program for people aged 65 and older who are not yet eligible for MA and do not yet meet LOC criteria may support older people who have emerging needs for support, further delaying more intense services and assistance in the future.

Other investments such as Return to Community and the expansion of Transitional Consultation have perhaps played a similar role in the changing profile of NF residents. Additional relocation services and sources of assistance, continuing efforts to relocate identified populations, as well as changes in rate setting and NF payment policy will likely yield continuing higher acuity in the NF population as well.

It is important to note that the figures included in this report do not reflect all of the people that were reassessed over the first year of implementation because of lags in data available at the time of preparing the report.

Further Study

More complete assessment of the impact, follow up analysis of the transition population, analysis of statistical significance of findings, and longitudinal study will be completed by the University of Minnesota via the contract held by the department that includes evaluation of several initiatives over time.

The primary policy concerns in the evaluation will be public and private cost, long-term care utilization patterns, and health and well-being of persons affected by these initiatives.

- What are the characteristics of persons involved in one or more initiative? For example:
    - Health, functional status and mental health
    - Demographics
    - Geographic location
    - Living situation and caregiving arrangements (including housing settings)
    - Service use history - NH, waivered services, mental health and other LTC services
- What transitions in settings (NH, assisted living, private residence with family, private residence alone, etc.) and caregiving arrangements (formal and informal services) do individuals experience during the 5-year period after being exposed to the initiative (including persons who do not pass the LOC screen or for other reasons do not receive Medicaid-funded or other public LTC services)?
- Do these initiatives result in a net savings or cost shifting? If so, to whom - Medicaid? Medicare? Individuals and families?

- What consequences for individuals and families might follow from these initiatives?
    - How much will individuals rely on private resources to meet their long-term care needs; that is, rely on unpaid care or pay for care themselves?
    - Will persons maintain or recover their health and functioning or might they experience deterioration and require nursing home admission?
    - Will they have increased use of acute care, particularly hospitals and emergency rooms?
    - Will caregivers be able to manage the care situations or will there be excessive caregiver burden?
    - How satisfied are individuals and family members with their caregiving arrangements?

- How will cost, utilization, or health outcomes vary by:
    - The individual's health and functional status, informal supports, or financial resources?
    - Type of initiative - eligibility restriction, voluntary transition, or gap filling?
    - Local or regional variation in access to services, community resources, or nursing home markets?