



Minnesota Department of **Human Services**

Bulletin

NUMBER

#14-25-12

DATE

December 5, 2014

OF INTEREST TO

- NF Administrators
- County Directors
- Social Services Supervisors
- Public Health Supervisors
- Financial Worker Supervisors
- Tribal Health Directors
- Managed Care Organizations
- LTCC Administrative Contacts

ACTION/DUE DATE

Understand changes to NF level of care effective January 1, 2015. Access other resources to ensure timely transition services for individuals.

EXPIRATION DATE

December 5, 2016

Nursing Facility Level of Care Criteria Changing January 1, 2015 – Home and Community-Based Programs

TOPIC

The 2014 Legislature revised the nursing facility level of care criteria for Medical Assistance payment of long-term care services, and amended notice and appeal timelines.

PURPOSE

Provide information about the impact on eligibility for the Elderly Waiver, Alternative Care, Brain Injury–NF and Community Alternatives for Disabled Individuals home and community-based programs, and transition supports available.

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TERMINOLOGY NOTICE

The terminology used to describe people we serve has changed over time. The Minnesota Department of Human Services (DHS) supports the use of “People First” language.

I. Background

Strengthening the nursing facility level of care (NF LOC) criteria is part of Minnesota's strategy to ensure sustainability of its health care system, including the long term care services sector. Strengthening the criteria that establishes the need for NF LOC is paired with efforts to redirect people with lower care needs to other types of supports. In addition, more clearly defined NF LOC criteria will contribute to greater consistency in the assessment of need for and access to long term services and supports (also referred to as long term care). These combined efforts will help ensure continued access to services for people with the greatest long-term care needs.

In 2009, the Minnesota Legislature revised the NF LOC criteria in Minnesota Statutes, section 144.0724, subdivision 11 governing nursing facility resident classifications and reimbursement.

Implementation of the change in NF LOC criteria has been delayed until January 1, 2015 for individuals aged 21 and older for various reasons, including changes to the Affordable Care Act and other federal reform efforts.

The statute specifies:

- The types and extent of need that defines the NF LOC criteria;
- The assessments that are to be used to establish that NF LOC criteria are met, and the timelines for valid assessments; and
- That this need must be established and documented prior to payment under the Alternative Care (AC) program or Medical Assistance (MA) payment for long-term services and supports, including nursing facility and home and community-based services (HCBS) provided under the Elderly Waiver (EW), Community Alternatives for Disabled Individuals (CADI) waiver, and Brain Injury-NF (BI-NF) waiver; and
- Requirements related to establishment of a qualifying 90 day stay for continuation of MA payment for nursing facility services.

This bulletin provides information about the change in NF LOC and the potential impact of this change for individuals participating in the EW, CADI, AC, or BI-NF home and community-based programs. It also includes information about the role and responsibilities of lead agency assessors in the final determination of NF LOC for all individuals.

See bulletin 14-25-09 for a broader overview of the change to NF LOC and 2014 legislative changes. See bulletin 14-25-10 for an overview of the NF LOC criteria, the potential impact of this change for nursing facilities and residents, and information about the qualifying 90 day stay.

II. Nursing Facility Level of Care Criteria and MA

A. “Level of Care” and Eligibility for Long-Term Care under MA

Long-term care eligibility under MA requires that an individual meets an institutional level of care, also referred to as *service eligibility*, and MA *financial eligibility* requirements. The requirement that an individual meet an institutional level of care in order to establish MA eligibility for long-term care (LTC) is *not* new policy.

LTC service eligibility for MA can be based on nursing facility level of care, or on other institutional levels of care, including acute hospital, neurobehavioral hospital, or intermediate care facility for persons with developmental disabilities (ICF-DD) levels of care. This bulletin and the legislative revisions to criteria focus on only nursing facility level of care.

NF LOC must be established for MA payment for nursing facility services or for services provided under the AC, EW, CADI, or BI-NF programs.

B. How NF LOC is Established for Home and Community-Based Services

NF LOC is established during a face-to-face Long Term Care Consultation (LTCC) or MnCHOICES assessment¹ completed by a lead agency (counties, and tribes and managed care organizations under contract with the Department). This assessment is performed as part of eligibility determination for EW, AC, CADI, and BI-NF, and at required reassessments for continuing participation in these programs. An individual can also choose facility-based services as a result of this assessment.

An individual in any setting may request a LTCC or MnCHOICES visit and assessment at any time. This assessment is available to any individual with long term or chronic care needs, regardless of eligibility for public programs. The information and services to be provided by the lead agency assessor are described in Minnesota Statutes, section 256B.0911.

¹Long-term Care Consultants become certified assessors and perform assessments using the MnCHOICES assessment application when the lead agency launches into MnCHOICES.

III. NF LOC Criteria Effective January 1, 2015

The revised nursing facility level of care criteria are described in Minnesota Statutes, section 144.0724, subdivision 11. Attachment A has a detailed description of the NF LOC criteria effective January 1, 2015 for individuals age 21 and older. NF LOC criteria are also contained in DHS Form 7028. NF LOC criteria for people under age 21 are found in DHS Form 3361.

There are five general categories of need that will satisfy the revised level of care criteria requirements. An individual is only required to meet *one* criterion to meet NF LOC.

1. The person does or would live alone/is homeless, or is or would be homeless without their current/planned housing type AND
 - o has had a fall resulting in a fracture within the last 12 months OR
 - o has sensory impairment that substantially impacts functional ability and maintenance of a community residence OR
 - o is at risk of maltreatment or neglect by another or at risk of self-neglect.

OR

2. The person has significant difficulty with memory, using information, daily decision-making, or behavioral needs that require intervention.

OR

3. The person needs the assistance of another person or constant supervision in order to complete toileting, *or* transferring, *or* positioning and the assistance cannot be scheduled.

OR

4. The person has a dependency in four or more activities of daily living (ADLs).

OR

5. The person needs formal clinical monitoring at least once a day.

The assessment items used to establish NF LOC criteria, including new items and valid values listed in this bulletin, are included in DHS Forms 3428 and 3428A (LTCC Assessment), as well as in the MnCHOICES web-based assessment tool. Attachment A has a detailed description of the assessment items and scores needed to establish NF LOC.

Maltreatment or Self-Neglect

The criteria related to living arrangement and risk of maltreatment or self-neglect can ONLY be determined on the basis of a face-to-face LTCC or MnCHOICES assessment, including as needed to establish NF LOC on this basis for individuals seeking admission to a NF or to establish LOC based on this criteria to meet the qualifying 90 day stay.

The criteria related to NF LOC determinations that rely on risk of maltreatment by another or self-neglect only apply to vulnerable adults as defined in Minnesota Statute, section

626.5572, subdivision 21. Attachment C contains this definition, as well as the definition of maltreatment, which includes self-neglect..

The level of need that results in a determination of “risk” by the assessor is not identical to those circumstances required to be reported to the Common Entry Point. “Risk” is not required to be reported, but assessors may discover circumstances that trigger a report under Adult Protection mandates.

All criteria, with the exception of the criteria related to a person’s risk of maltreatment by another or self-neglect, are present in the online preadmission screening tool used to verify NF LOC for NF admissions and to establish NF LOC to satisfy the qualifying 90 day stay criteria for most NF residents.

See bulletin 14-25-10 for more detailed information about NF LOC and NF residents, including the role of lead agency assessors in making final determinations of NF LOC. Also see bulletin 14-25-11 for preadmission screening policy, process and tools.

IV. Effective Dates Related to HCBS Participants

While “nursing facility” level of care may seem to imply that only NF services will be affected by this change, this change *does* affect eligibility determination for the **EW, CADI, and BI-NF waivers**. Each of these programs requires a NF LOC determination as part of program eligibility. In addition, NF LOC is used as part of eligibility determination for the **AC program** for people age 65 and older.

This change applies only to individuals age 21 and older, and will affect MA eligibility and payment for NF services as well as services available under HCBS programs requiring NF LOC as part of eligibility determination.

This change is effective January 1, 2015, and will affect current HCBS participants in the waiver programs listed above, and new HCBS program applicants on or after January 1, 2015.

1. The revised criteria may affect individuals who are participating in EW, AC, CADI or BI-NF on January 1, 2015 **BUT** is only applied at their next reassessment occurring on or after January 1, 2015. Most individuals participating in these programs will continue to meet NF LOC using the revised criteria.

For individuals 21 and older participating in EW, AC, CADI, or BI-NF **on** January 1, 2015, the revised criteria will be applied at the person’s next reassessment with an Activity Date (assessment date) occurring on or after January 1, 2015. The Medicaid Management Information System (MMIS) will use the Activity Date to verify NF LOC in MMIS only in combination with Activity Type 06 (reassessment).

2. The revised criteria will be applied to new applicants to EW, AC, CADI or BI-NF on or after January 1, 2015.

The revised criteria will be used to determine initial eligibility for long term care for all new applicants to HCBS programs age 21 and older who are assessed and opened to EW, CADI, AC, or BI-NF, with an Effective Date (eligibility start date) in MMIS that occurs on or after January 1, 2015.

3. The revised criteria will continue to be applied at all subsequent initial assessments and reassessments occurring on or after January 1, 2015, regardless of HCBS program start date.

Lead agencies that perform NF LOC assessment (face-to-face Long-term Care Consultation or MnCHOICES assessment) must not apply the revised criteria prior to the dates outlined above.

V. Support Available for Transition Populations

A. Definition of Transition Populations

Transition support is available for individuals affected by the change in NF LOC criteria and who meet the definition of the transition population:

1. The transition population for HCBS programs is defined as:
 - a. Individuals participating in EW, CADI, BI-NF or AC on January 1, 2015
 - b. Do not meet the revised NF LOC criteria at their next reassessment occurring on or after January 1, 2015
 - c. Are of any age
 - d. May remain on MA
 - e. Meet financial eligibility criteria for AC if no longer eligible for MA
 - f. Have an assessed need for the transition support available.
2. The transition population for NF residents is defined as:
 - a. Individuals admitted to a Minnesota-certified nursing facility between October 1 and December 31, 2014
 - b. Are eligible for MA for at least one day during this same time period
 - c. Do not meet NF LOC to establish a qualifying 90 day stay
 - d. Are of any age
 - e. May remain on MA
 - f. Meet financial eligibility criteria for AC if no longer eligible for MA
 - g. Have an assessed need for the transition support available.

LTCC or MnCHOICES assessors will provide access to transition support for NF residents as part of their role in making a final determination of NF LOC through a face-to-face

assessment, and in developing a community support plan as required under Minnesota Statutes, section 256B.0911.

See bulletin 14-25-10 for complete information about NF residents and establishing the qualifying 90 day stay criteria.

B. Transition Services

1. MA State Plan Services: Individuals previously participating in EW, CADI or BI-NF, or receiving NF services, who no longer meet NF LOC will no longer remain eligible for long-term care under MA. However, most individuals will remain eligible for MA state plan services or “basic” MA, and can access state plan services, including personal care assistant (PCA) and other home care services.

If an individual in the transition population is eligible for state plan PCA services, they are not eligible for services under the Essential Community Supports program as described in 2.

2. Essential Community Supports: Essential Community Supports (ECS) is a new program that includes services to be made available to the transition populations of all ages affected by the revisions to NF LOC. ECS services can support transition individuals who:
 - a. Remain eligible for MA but do not meet service eligibility criteria for state plan PCA or
 - b. Are no longer eligible for MA but meet AC financial eligibility criteria.
 - c. Have an assessed need for service available under the ECS program.
 - d. Do not reside in congregate housing (foster care, residential care, or board and lodge²).
3. Housing: The MA-funded waiver and AC programs do not pay for housing. Many individuals participating in HCBS programs may also receive housing support under the Group Residential Housing (GRH) program. Eligibility for GRH is not dependent on eligibility for any HCBS waiver or AC program. Please go to [Group Residential Housing](#) for more information about the GRH program, as well as [the Housing Tool Box](#) for a collection of information and resources about housing access and supports.

² “Board and lodge” here means a setting in which an individual has a bedroom/bath only, and shares other living and dining accommodations with other unrelated individuals. For purposes of ECS eligibility, it does not include apartments in settings that may be required to carry a board-only or lodge-only license to meet other food service, environmental and/physical plant licensing requirements. An apartment means a self-contained unit that includes a sleeping, living, and cooking area, and a bathroom.

See section X for more information about eligibility for ECS.

VI. Provider Notification of Scheduled Assessments

There are requirements in Minnesota Statutes, section 256B.0911, subdivision 3a, paragraph (d), and section 256B.49, subd.14 related to lead agency responsibility to notify providers of pending assessments. While providers are prohibited from being present at an assessment under section 256B.0911, this notification and provider response can provide an assessor with useful information that can be considered during the assessment.

As required in Minnesota Statute, section 256B.0911, subdivision 3a, paragraph (d), for persons who are to be assessed for EW customized living services under section 256B.0915, with the permission of the person being assessed or the person's designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining its recommendations regarding the client's care needs. The person conducting the assessment will notify the provider of the date by which this information is to be received if the provider chooses to submit such information. This information shall be provided to the person conducting the assessment prior to the assessment.

For a person who is to be assessed for waiver services under section 256B.49 governing the CADI and BI-NF programs, with the permission of the person being assessed or the person's designated legal representative, the person's current provider of services may submit a written report outlining recommendations regarding the person's care needs prepared by a direct service employee with at least 20 hours of service to that client. The person conducting the assessment or reassessment must notify the provider of the date by which this information is to be received if the provider chooses to submit such information.

This information shall be provided to the person conducting the assessment and the person or the person's legal representative, and must be considered prior to the finalization of the assessment or reassessment.

VII. Implementation of the Changes in NF LOC in EW, CADI, BI-NF and AC Programs

A. MMIS and HCBS

Upon completion of a LTCC or MnCHOICES assessment, the lead agency enters the assessment and other information into the Medicaid Management Information System (MMIS) using the Long Term Care Screening Document (LTC SD) subsystem, part of the Prior Authorization subsystem in MMIS.

The completed LTC SD in MMIS is used for a variety of purposes, including “opening” a person to or continuing a person on the EW, CADI, BI-NF or AC programs. MMIS is used for the administration and management of these programs by applying multiple “rules” or edit logic to the data entered into a LTC SD. For example, these edits verify that all required data is completed, that the data entered is valid, and that the data entered is consistent with the assessment result recorded in the LTC SD. Edits verify MA financial eligibility from another subsystem in MMIS, and ensure that individuals meet level of care and other requirements before program participation can begin or continue.

For information about how the multiple LTC SD and service agreement edits operate in MMIS related to EW, AC, CADI, and BI-NF programs, see the manual, “*Instructions for Completing and Entering the LTCC Screening Document and Service Agreement into MMIS*”, **DHS-4625**; the versions used by managed care organizations are **DHS-4669** for Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+), and **DHS-5020A** for Special Needs Basic Care (SNBC).

All edits must be resolved before MMIS will allow a LTC SD to be approved (accepted) in MMIS as valid. Only approved documents can be used by lead agencies for HCBS program management and administration.

B. MMIS Support for NF LOC Changes

In order to support implementation of the revised NF LOC criteria, several new valid values have been incorporated into the assessment tools as well as the LTC SD.

- **Toileting Item:** A new item has been added to all assessment tools and to MMIS to indicate the type and level of support a person may need to assist in meeting continence needs. See Attachment A, item 3.A.

This item does not replace the toileting item that captures information about incontinence. The new item reflects the need for assistance or supervision rather than the presence of continence needs. Individuals who manage any level of incontinence independently are considered independent and should be scored as such on the continence item.

- **New Living Arrangement Code:** The Living Arrangement valid values for purposes of meeting *one part* of the NF LOC criteria related to living alone/homeless plus another risk factor include
 - 01 (living alone)
 - 05 (homeless), and
 - 06 (would live alone/be homeless without *planned (congregate) housing type*). This is a new valid value to reflect a 2014 amendment to Minnesota Statutes, section 144.0724, subdivision 11 where NF LOC criteria is defined for purposes of MA payment for long term care.

In the LTC SD, “Living Arrangement” indicates *who* a person lives with, while “Housing Type” indicates *where* a person lives. Both of these fields are completed with information

VII. B - Con't

related to the person's current and planned status. All rules in MMIS consider *planned* living arrangement and/or housing type in determining eligibility. For example, if a person's planned housing type is a nursing facility, the person could not be opened to an HCBS program.

A new valid value 06 that indicates that a person would live alone or be homeless without their *planned (congregate) housing type* has been added to use when assessing an individual who is being served or would be served in a congregate setting (such as foster care).

This additional choice was needed for coding in *planned* living arrangement in order to avoid disrupting services for individuals at reassessment, when the current and planned living arrangement both would otherwise be coded as "living in a congregate setting". Under these circumstances, an individual would not be able to be considered under the NF LOC criteria related to "living alone/homeless plus another risk factor" (such as sensory limitation or a fall resulting in a fracture). This additional value was added primarily to account for individuals living in congregate settings.

For example, a person may currently live in a foster care setting:

- Their current living arrangement would be coded as "living in a congregate setting", and their current housing type is foster care.
- In this case, the PLANNED living arrangement would be coded as "would live alone/be homeless without *current/planned housing type*", and the planned housing type would be foster care.
- Risk factors related to living arrangement criteria: The criterion related to living arrangement is paired with information about additional risk factors. Additional assessment items have been added to capture these risk factors.
 - Fall Resulting in a Fracture: The question related to falls includes a valid value 03: Fall resulting in a fracture within the last 12 months. This is one of the additional risk factors, when paired with living alone/homeless, that meets NF LOC. Coding this level of need is based on a diagnosed fracture in the last 12 months (12 months from the assessment).
 - Self-Neglect or Maltreatment by Another: The current professional conclusions captured in MMIS related to self-neglect or maltreatment by another, when coded as "Y" for vulnerable adults and in combination with living alone/homeless, meets NF LOC criteria. These conclusions read:

"The person has not or may not ensure his/her own care, hygiene, nutrition or safety."

OR

“The person has been or may be neglected, abused, or exploited by another person.”

This NF LOC criterion related to self-neglect or maltreatment can only be established through a face-to-face LTCC or MnCHOICES assessment. Additional information has been included in DHS-3428, DHS-3428A and MnCHOICES to allow the assessor to record the basis of their professional conclusion of risk of maltreatment by another or self-neglect. This information is included in DHS Form 7028, the January 1, 2015 NF LOC criteria brochure. This information has NOT been added to the LTC SD in MMIS at this time.

C. Case Mix Classification and NF LOC Criteria

While case mix classification is not equivalent to the NF LOC criteria, lead agencies can rely on their understanding of this classification scheme to assist in understanding the revised NF LOC criteria.

An individual who is classified as case mix B-K, and, for EW, as case mix V (vent dependent) meets at least one of the NF LOC criteria. Case mix classification can be used as an indicator of NF LOC because many of the same assessment items, such as ADLs, are used for both case mix classification purposes and NF LOC determination.

This does NOT mean that individuals classified as case mix A or, for individuals age 65 and older, case mix L, do not meet NF LOC. For example, an individual in case mix A may have a single dependency in a critical ADL (toileting) and meets NF LOC. An individual in case mix L may have the need for *occasional* behavioral intervention, which meets the NF LOC criteria as described in Attachment A.

Many individuals in case mix A or L will meet NF LOC criteria that are simply not apparent in the case mix classification.

D. Edit 179: Level of Care

Information captured in the LTC SD includes the individual’s institutional level of care, or the determination that an individual meets no level of care criteria; this field is labeled “Level of Care” on DHS-3427 (field 82). An individual must meet NF LOC criteria as part of the editing related to opening or re-opening a person to, or continuing a person on, the EW, CADI, BI-NF or AC programs, or if the person will be admitted to a nursing facility..

The revised NF LOC criteria have been built into “rules” in MMIS using Edit 179, to verify that, when the lead agency indicates NF LOC in this field (value 02), the assessment data entered matches *at least one* of the criteria as described in section III and Attachment A.

For example, if “NF/Certified boarding care” is indicated as the “Level of Care”, MMIS will determine whether the data is consistent with the criteria related to ADL dependencies, *or* self-preservation, *or* the combination of living arrangement (living alone/homeless) AND a fall resulting in a fracture. The edit logic works through all of the data and all of the criteria systematically to determine whether the data satisfies *any* NF LOC criteria.

Edits are also inter-related. Edits related to the HCBS program type entered into MMIS (such as CADI program type) will check against the Level of Care information, and if this status is not NF LOC, then this program type will not be allowed in MMIS.

As previously noted, individuals participating in EW, CADI, BI-NF and AC on January 1, 2015 will be reassessed using the revised criteria at their next reassessment occurring on or after January 1, 2015.

E. Lead Agency Operational Information

Lead agency operational information will be provided to each agency’s LTCC Administrative Contact and MNCHOICES Administrative Contact. Operational information will also be included in the manual, *“Instructions for Completing and Entering the LTCC Screening Document and Service Agreement into MMIS”*, **DHS-4625**; the versions used by managed care organizations are **DHS-4669** for Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+), and **DHS-5020A** for Special Needs Basic Care (SNBC), will also be updated.

Step-by-step information will be provided to lead agencies to implement NF LOC changes in MMIS, open individuals to transition supports, and/or continue services when requested as part of an appeal. The videoconference scheduled for December 11, 2014 will focus on lead agency operations.

VIII. Notifications and Appeals

A. Notice of Action

For purposes of information provided below related to NF LOC determinations, a “notice of action” is a communication between a lead agency related to an agency decision that affects eligibility for and access to long-term care services under MA or AC. This notice can be in the form of an approval for services, or can be an “adverse” action in which a person has been denied services, or whose services will be terminated or reduced.

“Lead agencies” with the authority to determine NF LOC include counties, and tribes and managed care organizations under contract with the Minnesota Department of Human Services that deliver Long Term Care Consultation services defined in Minnesota Statutes, section 256B.0911.

There are existing notices required to be used by lead agencies when there is a denial, termination or reduction of long term care (or other) services:

- For fee-for-service MA participants and applicants and AC, the Notice of Action (DHS-2828) is used to communicate this information. This form has been revised to include the legislative changes related to extended timelines for notification, as well as extended timelines related to filing an appeal with requested continuation of services, described in B. below.
- Managed care enrollees receive this notice using a "DTR" (denial, termination, reduction) template approved by DHS; this notice is used for all managed care denials, terminations or reductions, for all types of service (or payment).

There are separate templates used for individuals enrolled in Minnesota Senior Health Options (MSHO) and Special Needs Basic Care (SNBC), and one used for enrollees in other managed care products. Copies of the templates will be posted at the NF LOC initiative website at [NF LOC Initiative](#) in December 2014.

Reason codes related to NF LOC determination for use in a DTR are under development for managed care organizations. There will be a reason code for use when the DTR is related to EW services and one related to nursing facility services. The codes will include information similar to that contained in Attachment B.

Regardless of the type of notice used, all must contain information about the action taken, the reason for the action, the statutory or other legal basis for the action, appeal rights, request for continuation of services and timelines associated with this request, how to file an appeal, and other timelines.

Only lead agency assessors can provide notification that an individual does NOT or no longer meets NF LOC. This determination can only be made through a face-to-face assessment.

B. Changes to Notification and Appeal Timelines

Minnesota Statutes, section 144.0724, subdivision 12, was amended during the 2014 Legislative Session.

1. **Changes the *minimum* advance notification timeline requirements to 30 days** when notifying an individual that long term care services will be terminated because, at reassessment, the person no longer met NF LOC criteria.

This 30 day notification requirement applies whether the "reassessment" is an annual reassessment required for home and community-based program participation or a face-to-face assessment used to establish the "qualifying 90 day stay" for continuing MA payment of nursing facility services.

“Advance notice” means that the individual’s effective date of termination of long-term care services can be **no sooner than 30 days from the date the Notice of Action or DTR is sent** to the individual.

This requirement is effective January 1, 2015 and is an **ongoing requirement** when termination of long term care service is related to a NF LOC determination.

2. **Changes the timeline in which a person can file an appeal that includes a request for continuation of services from 10 to 30 days from the receipt of the notice of action** by the individual.

This change **applies to individuals defined as part of the “transition” population** potentially affected by changes to the NF LOC criteria, and is limited to **appeals related to the change in NF LOC criteria filed between January 1, 2015 and December 31, 2016.**

The transition populations are defined in section V.

IX. Assessor Communication

A. Notifications for Consumers

An individual can only be informed that they do NOT meet NF LOC by a Long Term Care Consultant or MnCHOICES Certified Assessor. Only lead agency assessors can provide notification that an individual does NOT or no longer meets NF LOC. This determination can only be made through a face-to-face assessment.

When a lead agency assessor has completed a face-to-face visit with a NF applicant or resident, an HBCS participant, or HCBS applicant for purposes of determining NF LOC, the lead agency will provide the person with:

- Information including the results of the NF LOC determination, and the meaning of the LOC determination for purposes of MA payment of long term care services;
- Information about supports available, including state plan home care services, other community supports available, housing supports, the availability of relocation services coordination or other assistance in returning to the community from a nursing facility, and the availability of Essential Community Supports for individuals who qualify for ECS;
- A Community Support Plan as required under Minnesota Statutes, section 256B.0911.
- Information that the person will receive a notification from their financial worker about their MA financial eligibility, including any changes to their MA eligibility status for current MA participants that may result from the level of care determination.

B. When an Adverse Action is Required

An individual can only be informed that they do NOT meet NF LOC by a Long Term Care Consultant or MnCHOICES Certified Assessor.

When an individual is assessed and does not meet or no longer meets NF LOC criteria, the lead agency will prepare a Notice of Action or DTR. As with all such notices, the lead agency must include in the notice:

- The reason for denial, termination or reduction;
- The legal basis for the lead agency decision;
- Information about how to file an appeal if the individual disagrees with the determination;
- Timelines associated with appeals; as well as
- The person's right to request continuation of services during an appeal.

In addition, Minnesota Statutes, section 144.0724, subdivision 12 was amended in 2014 by adding a new paragraph that outlined additional information required to be included with notices related to eligibility changes resulting from changes to NF LOC to include:

- How to obtain more information about the changes;
- How to receive assistance in obtaining other services; and
- A list of community resources.

For purposes of implementation of the revision to NF LOC criteria, the communication to the individual must include:

- Information explaining why the individual was not determined to meet NF LOC criteria;
- The meaning of the LOC determination for purposes of MA payment of NF and HCBS services;
- The right to appeal the LOC determination and timelines associated with filing an appeal;
- The right to request continuation of services during an appeal, and the 30 day timeline for this request;
- Information that the person will receive a notification from their financial worker about their MA *financial eligibility* for long-term care payment, including any changes to their MA eligibility status;
- The effective date of the change:
 - The notice provided by the lead agency assessor to the individual will include a "no sooner than" date that meets the requirement of 30 day advance notice from the date the notice is sent.

This "no sooner than" date must also be provided on the **Assessor/Case Manager/Financial Worker Communication Form (DHS-5181)** forwarded by the assessor to the financial worker.

- For NF residents, information that the notification from their financial worker will include a date when payment for NF services will be discontinued.

Financial workers will determine the date when NF payment discontinues based on the “no sooner than” date indicated by the assessor on DHS-5181, as well as based on financial eligibility notification timelines.

B. Information for Lead Agency Use

DHS created consumer notification language, contained in Attachment B, for use by lead agencies related to NF LOC determinations.

Providing this information for lead agency use in completing a Notice of Action or DTR is intended to ensure that an individual understands what a NF LOC determination means in terms of access to, or continuation of, long-term care payment under MA or AC.

Because level of care is considered service eligibility for long term care under MA, changes to service eligibility for long term care will prompt a redetermination of an individual's MA financial eligibility. The language provided includes information that the person will also receive a notice from their financial worker with information about any changes to their MA that result from the level of care determination.

This information will be used as part of the lead agency's written communication with an individual following a face-to-face assessment.

C. Communication with a Financial Worker – DHS-5181

The Lead Agency Assessor/Case Manager/Financial Worker Communication Form, DHS-5181 is used by lead agency assessors to notify the financial worker of assessment results, requests for MA payment of long-term care, waiver program status, and other information about MA applicants and enrollees. It is also used for some AC applicants for purposes of asset assessment. Financial workers use the same form to communicate MA eligibility information back to lead agency assessors.

It is very important that both assessors and financial workers are timely and consistent in the use of this form to communicate long term care service and financial eligibility determinations and changes. It is only when both service and financial eligibility have been determined that MA payment of HCBS program services or nursing facility services can begin.

The form has been revised to clarify this communication. Financial workers will take the appropriate action regarding MA eligibility determination upon receipt of the DHS-5181 and communicate any changes to MA eligibility back to the assessor.

A financial worker will not terminate MA payment of LTC services based on LOC unless and until DHS-5181 is received from a lead agency assessor indicating that an individual does not or no longer meets LOC.

X. Eligibility for Essential Community Supports

Essential Community Supports (ECS) is a new program intended to provide services to two populations. ECS services can provide support to individuals of all ages affected by the change in NF LOC at implementation to assist in transition. The transition population is defined in section V.

The ECS program will also support individuals age 65 and older with emerging long-term care needs, who do not meet NF LOC criteria, who are not financially eligible for Medical Assistance but who meet financial eligibility criteria for AC.

A. Eligibility Determination for ECS

Eligibility for ECS must be established based on a face-to-face LTCC or MnCHOICES assessment, and a community support plan that indicates a need for an ECS service.

Individuals in the transition group who remain eligible for MA state plan services and who have dependencies in activities of daily living cannot access ECS, and must access state plan PCA services.

While most individuals included in the transition group will continue to be eligible for MA, ECS is also available to individuals in the transition group, both over and under age 65, who are no longer eligible for MA state plan coverage as a result of no longer meeting NF LOC. *For this non-MA group, an individual must meet the financial eligibility criteria for Alternative Care in order to be eligible for ECS.*

Individuals who live in or would live in a congregate setting (foster care, board and lodge settings that are not apartments, non-certified boarding care, or residential care settings) are not be eligible for ECS.

B. ECS Program Services and Requirements

The Essential Community Supports program includes the following services:

- Homemaker
- Personal emergency response
- Chore
- Caregiver education/training

- Home delivered meals
- Service coordination (case management)
- Community living assistance as developed by the commissioner
- Adult day service (as amended and added under Minnesota Statutes, section 256B.0922 in the 2014 Legislative Session)

When offered under ECS, the definition and scope of these services, provider qualifications and standards, and rates are the same as when these services are provided under the EW program. For more information about each of these services, please see the [Community-Based Services Manual](#)

Other ECS program requirements include:

- \$424 monthly maximum budget³
- Required service coordination and ongoing monitoring, limited to \$600 annually
- For the transition group, an additional \$600 for service coordination to assist in transition planning is available one time.
- ECS will be authorized by a LTCC or MnCHOICES assessor, using MMIS service agreements, for needed services, including for individuals in managed care

More detailed information about Essential Community Supports will be included in the final bulletin related to implementation of the revised NF LOC criteria.

XI. Other Communication Strategies

A. DHS Notice to Participants

Using HCBS enrollment information in MMIS, DHS will provide information to all current EW, AC, CADI and BI-NF participants in December 2014 describing the change and notifying all participants that they might, as a result of this change, be offered alternative services and supports at their next reassessment occurring on or after January 1, 2015.

This notice will include direction for the participant to contact their case manager or care coordinator if they have questions or concerns about the notice. The notice directs the participant to contact the Senior LinkAge Line[®] or Disability Linkage Line[®] if they are not sure who their case manager or care coordinator is.

³ The ECS monthly budget was increased in 2014 as a result of increases to HCBS provider rates.

Lead agencies, Senior LinkAge Line® and Disability Linkage Line® will receive a copy of the letter, and the date that the letter will be mailed to participants.

B. DHS Reports for Lead Agencies

DHS will also provide lead agencies with a report containing information about individuals who *may* no longer meet the revised NF LOC criteria at their next reassessment, based on analysis of the participants' most recent assessment information in MMIS. This information will assist lead agencies to prepare for the transition of potentially affected individuals.

The first report, to be forwarded to lead agencies in December 2014, will include individuals who are enrolled in EW, AC, CADI, or BI-NF on October 31, 2014, and who are anticipated to be reassessed in January through April, 2015. Each lead agency will receive a report that includes only that lead agency's participants, based on the "LTCC County" listed on the most recent LTC SD in MMIS for the person.

DHS will continue to provide similar information throughout 2015 to assist in transition planning as current participants are scheduled for reassessment throughout the year.

Each report will be based on the most recent information available in MMIS about continuing program participation and the assessment and/or waiver span end dates for individuals who were in CADI, BI-NF, EW or AC on January 1, 2015 (i.e. individuals with a waiver or AC program span that overlaps with January 1, 2015).

These reports MUST NOT be interpreted to mean that individuals appearing in a report do not or will not meet NF LOC. It is simply a method to identify individuals who *may not* meet the revised criteria at their next reassessment, and is provided to assist lead agencies in transition planning for individuals potentially affected by the changes in NF LOC criteria at their next reassessment occurring on or after January 1, 2015.

B. Provider Communication with Residents/Service Participants

Provider requirements related to discharge notices and discharge planning requirements, including the requirement to assist in coordinating transfer to other services, remain in place. Nursing facility residents that do not meet level of care retain all applicable transfer and discharge rights pursuant to 42 C.F.R. §483.12.

Providers do not have the authority in statute to determine NF LOC and should not begin discharge activities on a presumption that a person will no longer meet NF LOC at their next reassessment. Individuals retain tenants' rights and due process rights.

XII. Communications and Training Opportunities

Communication and training is a vital part of the implementation strategy for changes in NF LOC. Training opportunities for NF and HCBS providers, lead agencies, and other

interested parties will continue to be developed. Please go to www.dhs.state.mn.us/nfloc periodically for additional information about additional training opportunities.

Information about **videoconference** schedules and registration information can be found at <http://agingtraining.dhs.state.mn.us>

Other presentations and training: Organizations can request presentations and training, and department staff will accommodate as many of these requests as possible. Please forward any requests to dhs.nfloc@state.mn.us

NF LOC materials are posted at www.dhs.state.mn.us/nfloc Lead agencies will be notified when materials are posted.

The **NF LOC Stakeholder Group** will continue to meet with CCA staff to assist in review of communication materials, clarify policy, and review draft content for publication.

Stakeholders provide an important communication link to their constituents. Information about the NF LOC Stakeholder Group can be found at www.dhs.state.mn.us/nfloc

Lead agency communications and reports will also be used to assist lead agencies in implementing the changes to NF LOC.

XIII. Additional Resources

All DHS Forms can be found at [DHS Forms](#) This web site includes a subscription option to receive notification when forms are revised, or when new forms are published.

More information about the **Preadmission Screening** initiative can be found at [Preadmission Screening](#)

All DHS bulletins can be found at [DHS Bulletins](#) This web site includes a subscription option.

See Minnesota Statutes, section 144.0724, subdivision 11, for the **statutory criteria** at [Minnesota Statutes](#)

See Minnesota Statutes, section 256B.0911 for more information about the **role of Long Term Care Consultants** and **MnCHOICES Certified Assessors** at [Long Term Care Consultation/MnCHOICES](#)

A listing of statewide **LTCC Administrative Contacts for all counties** can be found at [LTCC Contacts](#) **Contact information for each MCO** can be found at in DHS Form 6581A found at [DHS Forms](#)

Information related to Adult Protection and mandated reporting of maltreatment can be found at [Mandated Reporting Training](#) This website contains a Vulnerable Adults

Mandated Reporting course designed to introduce the Vulnerable Adults Act, definition of maltreatment and vulnerable adult, who are mandated reporters, and the Common Entry Point (CEP). Also go to DHS.AdultProtection@state.mn.us with requests for more information.

XIV. Americans with Disabilities Act (ADA) Advisory

This information is available in accessible formats for people with disabilities by calling (651) 431-2600 (voice) or toll free at (800) 882-6262 or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator.

Attachment A

NF LOC Criteria Effective January 1, 2015

The revised nursing facility level of care criteria are described in Minnesota Statutes, 144.0724, subdivision 11. There are five general categories of need that will satisfy the revised level of care criteria requirements. A person will meet NF LOC criteria through assessment of need at any *one* of these levels. See also DHS Form 7028.

The same criteria, and same assessment items and scores described below and taken from the Minnesota LTCC Services Assessment Form (DHS-3428, 5-14) are used in determining NF LOC as part of preadmission screening, as well as in determining NF LOC through the LTCC or MnCHOICES assessment process. For individuals age 21 and older, and effective January 1, 2015:

1. **The person does or would live alone, or be homeless without their current housing type AND has another assessed risk.** Individuals coded as living alone, homeless, or would be homeless without current housing type (valid values 01, 05 or 06) in their planned living arrangement meet this part of this criteria, **and** meets one the following risk criteria. Planned Living Arrangement is item J.18 in the DHS 3428 assessment tool.

One of the following risks must be paired with the valid living arrangement codes listed above:

- A. The person has a sensory impairment based on hearing and vision, when an individual has no useful hearing or vision, or can hear only loud sounds, or has difficulty seeing obstacles in the environment. These levels of impairment are described in the LTCC assessment items related to hearing and vision at G.10 and G.11. OR
 - B. The assessment item related to falls indicates a fall in the last 12 months that resulted in a fracture (Item I.5). OR
 - C. The person is at risk of maltreatment or self-neglect. Only LTCC staff can make NF LOC determinations that rely on risk of maltreatment or self-neglect. These circumstances are assessed at I.7 and I.8 and coded as "Y/N" in the face-to-face assessment at J.3 and in MMIS.
-
2. **The person has significant difficulty with memory, using information, daily decision making, or behavioral needs that require intervention.** The items as included below include the *minimum* score (reflecting a level of need) that is required to meet NF LOC using this criterion. An individual may meet NF LOC through any *one* of these items as follows:
 - A. **Self-preservation:** This assessment item is related to an individual's judgment and physical ability to cope, make appropriate decisions and take action in a changing environment or a potentially harmful situation. An individual will meet NF LOC if they are mentally or physically unable or both (score greater than 01 in item G.15).

Attachment A – Con't

- B. Orientation: Orientation to person, place and time. An individual will meet NF LOC if they have partial or intermittent periods of disorientation (score greater than 01 in item G.12).
- C. Behavioral intervention: An individual who needs occasional staff intervention or support (score of 01 or greater in item G.13) meets NF LOC. "Occasional" is defined as less than four times per week.
- D. Mental Status Evaluation (MSE) (a screening tool indicating memory issues): A score of 10 or greater (which indicates the possible presence of dementia) and less than 29 (scores higher than 29 are used to indicate not applicable or refused) indicates NF LOC. The MSE is at H.10 in the assessment tool.

3. A single dependency in toileting, positioning, or transferring.

- A. An individual must need assistance from another or constant supervision in the definition in statute related to this criterion, and level of care is not based solely on the experience of incontinence.

An individual who manages continence needs independently is not considered to be dependent. For clarification and consistency in assessing this need, an item has been added in the PAS tools and in the face-to-face assessment tools (DHS 3428 and MnCHOICES) to ask: "Does the person need constant supervision or the assistance of another to complete toileting?" Yes or no. A "yes" response coded in the face-to-face assessment at J.3 and in MMIS will meet LOC criteria.

- B. Positioning (bed mobility) or transferring: For each of these ADLs, a score of 2 (which indicates needs help from another) or greater indicates a dependency. This need is assessed in items G.5 and G.6.

4. NF LOC based on 4 ADL dependencies: "Dependency" is indicated by the following scores in each ADL.

- A. Dressing, grooming, eating, walking: For each of these ADLs, a score of 2 (which indicates needs help from another) or greater indicates a dependency. These are items G.1, G.2, G.4 and G.7 respectively.
- B. For bathing, a score of 4 (needs help washing/drying body) or greater is considered a dependency. This need is assessed at G.3

- 5. **NF LOC related to clinical monitoring**, the individual must require clinical monitoring at least once every 24 hours to meet NF LOC on this basis. Clinical monitoring is described in DHS Form 3428B. Clinical monitoring must meet the definition in 3428B. The frequency of clinical monitoring is captured at G.17.

Attachment B - Language for Lead Agency Notices

This language must be used in the lead agency notice when either nursing facility or EW, CADI, BI-NF or AC services are denied or terminated on the basis of NF LOC determination. Counties and tribes can copy this text into the Notice of Action (DHS-2828) or attach it to DHS 2828. All other notice requirements – information about the change, providing the reason for action, the legal authority for the action, an effective date of the action, and so on - must also be reflected in the notice itself. Managed care organizations will prepare their DTR with the reason codes and associated text provided by the department.

HCBS Applicants and Participants – Nursing Facility Level of Care Not Met

Medical Assistance (MA) or the Alternative Care (AC) Program help pay for the care received at home or in other community living settings or in a nursing home only if you meet what are called “level of care requirements” in addition to financial eligibility requirements. Level of care requirements means that you must have certain kinds of needs, and need certain kinds of services, before MA or state-funded programs will pay for your long-term care (LTC) services. A “level of care” decision is made during an assessment visit.

You participated in a face-to-face assessment visit on _____ (DATE). During the visit, you provided information about your needs and the type of help you might need. Based upon this information, **it has been determined that you do not meet the Nursing Facility Level of Care.**

This means you do not qualify for payment of services under the Elderly Waiver (EW), the Alternative Care (AC) program, or the Community Alternatives for Disabled Individuals (CADI) or Brain Injury (BI-NF) programs because you do not meet the nursing facility level of care requirement.

If you are currently receiving EW/CADI/BI-NF or AC services, MA or AC will stop paying for these services on _____ (DATE).

If you disagree with this decision about your services, your assessment, or your level of care decision, you can file an appeal. **If you want your EW/CADI/BI-NF or AC services to continue during an appeal, you must file the appeal within 30 days of receiving this notice.** Directions for making an appeal are provided with this notice.

Additional Information

You will also receive a notice from your financial worker telling you about any changes to your MA eligibility that may result from your level of care decision explained here.

Attachment B – Con't

Nursing Facility Residents - Nursing Facility Level of Care Not Met

Medical Assistance (MA) helps pay for the care received in a nursing home only if you meet what are called “level of care requirements” in addition to financial eligibility requirements. “Level of care” means that you must have certain kinds of needs, and need certain kinds of services, before MA will pay for your nursing home services. A “level of care” decision is made during an assessment visit.

You recently participated in a face-to-face assessment visit on _____ (DATE). Based upon information that you provided during the assessment, **it has been determined that you do not meet the Nursing Facility Level of Care.**

This means you do not qualify for MA payment of nursing home services because you do not meet the nursing facility level of care requirement. MA may still pay for your other services.

If you disagree with this decision about your level of care, you can file an appeal. **If you want your Nursing Facility services to continue during an appeal, you must file the appeal within 30 days of receiving this notice.** Directions for making an appeal are provided with this notice.

You will also receive a notice from your **financial worker** telling you about any changes to your MA eligibility that may result from your level of care decision explained here. **This notice will include the last day that MA will pay for your nursing home services.** DO NOT wait for the notice from your financial worker if you want to file an appeal about your assessment and level of care decision.

Statutory Citations

All notices must have the relevant statutory citations. The citations include here are the statutory sections that govern a program *overall*. Lead agencies must provide a more specific citation (paragraph, clause, e.g.) when a specific portion of statute (or rule) is the legal basis for the action.

Minnesota Statutes 144.0724 and Minnesota Statutes 256B.0911 (Level of care)

Minnesota Statutes 256B.0913 (AC)

Minnesota Statutes 256B.0915 (EW)

Minnesota Statutes 256B.49 (CADI and BI-NF)

Attachment C- Statutory Definition of a Vulnerable Adult and Maltreatment

From Minnesota Statutes, section 626.5572:

Subdivision 15. Maltreatment. "Maltreatment" means abuse as defined in subdivision 2, neglect as defined in subdivision 17, or financial exploitation as defined in subdivision 9. (Note: The definition of neglect in subdivision 17 includes self-neglect.)

Subdivision 21. Vulnerable adult.

(a) "Vulnerable adult" means any person 18 years of age or older who:

(1) is a resident or inpatient of a facility;

(2) receives services at or from a facility required to be licensed to serve adults under sections [245A.01](#) to [245A.15](#), except that a person receiving outpatient services for treatment of chemical dependency or mental illness, or one who is served in the Minnesota sex offender program on a court-hold order for commitment, or is committed as a sexual psychopathic personality or as a sexually dangerous person under chapter 253B, is not considered a vulnerable adult unless the person meets the requirements of clause (4);

(3) receives services from a home care provider required to be licensed under section [144A.46](#); or from a person or organization that exclusively offers, provides, or arranges for personal care assistance services under the medical assistance program as authorized under sections [256B.04](#), [subdivision 16](#), [256B.0625](#), [subdivision 19a](#), [256B.0651](#), [256B.0653](#) to [256B.0656](#), and 256B.0659; or

(4) regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:

(i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and

(ii) because of the dysfunction or infirmity and the need for care or services, the individual has an impaired ability to protect the individual's self from maltreatment.

(b) For purposes of this subdivision, "care or services" means care or services for the health, safety, welfare, or maintenance of an individual.