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Determining Level of Care:
Must Physicians Have a Role
in the Process?

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Determining Level of Care: Must Physicians Have a Role in the Process?

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Summary

States that are trying to streamline policies and paperwork to help people receive long-term care and support in community settings are re-examining the processes they use to determine eligibility for programs. This technical assistance document focuses on one of those processes, determining *level of care*, and provides clarification about federal requirements for physician involvement.

Background

A fundamental question in how to promote Medicaid home and community-based services (HCBS) is:

How does the state determine whether a person qualifies to receive Medicaid nursing home level of care services in either a nursing home or HCBS alternative?

There are two parts to this determination: the *criteria* (policy) and the *process*.

The *criteria* used to decide whether a person qualifies to be admitted to a nursing home or enrolled in an HCBS waiver vary widely across states. Many are based on functional and cognitive criteria. Some include medical conditions as well as functional and cognitive criteria.

The *process* for assessing and determining level of care also varies. A few states require that a physician make the determination. Others allow case managers or registered nurses to conduct the assessment and make a recommendation that is reviewed by a physician. Still others allow case managers or registered nurses who are responsible for the assessment to determine the individual's level of care.

At a recent meeting of Money Follows the Person grantees, funded by the Centers for Medicare & Medicaid Services (CMS), participants in two states noted that they require physicians to sign a form authorizing or approving the need for a *nursing home level of care*. Obtaining the physician's signature was difficult and created barriers to access HCBS. One participant stated that Federal Medicaid regulations require physician approval of the level of care before an individual could be enrolled in an HCBS waiver

program. Other states indicated that physicians are not involved in the level of care determination in their programs. Why the disagreement?

What the Regulations Say

Regulations governing HCBS waivers describe the assurances that states provide to CMS to receive a waiver. The Code of Federal Regulations, 42 CFR 441.302(c) and 441.352(c), provide direction for the *evaluation of need*. The agency must provide for an initial evaluation (and periodic reevaluations) of the need for the level of care furnished in a NF¹ when there is a reasonable indication that individuals age 65 or older might need those services in the near future, but for the availability of home and community-based services. The procedures used to assess level of care for a potential waiver recipient must be at least as stringent as any existing State procedures applicable to individuals entering a NF. The qualifications of individuals performing the waiver assessment must be as high as those of individuals assessing the need for NF care, and the assessment instrument itself must be the same as any assessment instrument used to establish level of care of prospective inpatients in NFs. A periodic reevaluation of the level of care must be performed. The period of reevaluation of level of care cannot extend beyond 1 year.

The regulation does not specify how the assessment is done, what it includes, who completes it, or the criteria that must be used. Those decisions are made by the state and are included in the waiver application. The regulation does say that the qualification of assessors must be as high as those assessing the need for nursing facility care and the instrument must be the same as the instrument used to establish level of care in a nursing facility.

The regulations governing nursing facility services do provide a role for physicians. The Code of Federal Regulations 42 CFR 483.40 provides:

Physician services. A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.

The physician services provisions are part of the requirements for long-term care facilities that describe the facility's responsibilities upon and following admission. By requiring physician approval for admission *to a facility*, the physician determines that the individual is appropriate for the specific facility and the facility can adequately meet the individual's needs. **The role is specific to the facility admitting the individual. It does not extend to the process of assessing whether the individual meets the state's criteria for receiving a level of care that is available from nursing facilities or HCBS waiver programs.**

The physician services provision is located after the requirements for the resident assessment and care planning, and it falls within a group of requirements describing the

¹ NF refers to nursing facilities (nursing homes)

resident's rights, quality of care and the services available from the nursing home (nursing services, dietary services, rehabilitation, pharmacy, and dental services). The resident assessment specifies that facilities must have physician orders at the time of admission. The section of the regulations containing requirements for long-term facilities does not specify how the level of care is determined.

Clarification of Federal Requirements for Physician Involvement

Does the physician services section require that the physician determine or approve the level of care? Or is the physician's role to determine that the resident's needs can be met by the specific nursing home? Since the level of care determination occurs before the requirements for long-term care facilities apply, **states do not have to obtain a physician's approval of the level of care for admission to a nursing home or to qualify for an HCBS waiver.** While states may have other reasons for requiring a physician's approval, it is not required by federal regulations.