alzheimer's association

Public Policy Issue Brief

Medicaid Eligibility Criteria for Long Term Care Services: Access for People with Alzheimer's Disease and Other Dementias

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Summary

In the face of tight budgets and rising expenditures for Medicaid long-term care services, states may seek to reduce costs by limiting the number of people who are eligible for these services. One method for doing so is to tighten the level-of-care criteria used to determine eligibility for nursing home and home and community waiver services.

Almost everyone who has Alzheimer's disease or other dementias (hereafter, dementia) and lives long enough will eventually need long-term care services and many will require nursing home care when their needs overwhelm informal caregivers. The Alzheimer's Association (hereafter, the Association) has a critical interest in ensuring that people with dementia have access to Medicaid-funded nursing home care and home and community services when needed. The Association is particularly concerned that States not tighten their eligibility criteria for long-term care services in a way that has a disproportionately negative effect on people with dementia.

Given the Association's concerns about the tightening of level-of-care criteria, the Association undertook a study of six states' level-of-care criteria and assessment processes to determine whether people with dementia can qualify for Medicaid funding of nursing home care and home and community waiver services. This issue brief describes Medicaid eligibility issues for people with dementia and discusses how these six states determine eligibility for Medicaid-funded long-term care services. Based on an analysis of these states, the Association makes recommendations (1) for appropriately assessing the long-term care needs of people with dementia, and (2) for setting level-of-care criteria that treat people with physical and cognitive impairments equitably.[1]

Recommendations

1. The need for assistance with activities of daily living (ADLs) must be defined to include verbal assistance and the extent or severity of need must be determined by the duration of the assistance required, not the type of assistance.

2. ADLs and the terms used to assess the need for assistance must be defined clearly and comprehensively and the terms must be used consistently in the assessment process.

3. When states tighten their level-of care criteria by considering only a limited number of ADLs to determine eligibility or require a very high level of assistance for ADLs, they must develop comparable measures of need for people with dementia and weight them appropriately so that people with severe impairments will be eligible.

4. Level-of-care criteria must include measures of individuals' need for supervision to protect them from the negative effects of impaired judgment and decision-making; impulsive, inappropriate or disruptive behaviors; and other potentially harmful behavior such as wandering. These measures must be weighted appropriately so that people with severe impairments will be eligible.

5. Level-of-care criteria must not require individuals to have medical or nursing needs.

6. States must not use a score on the Mini-Mental Status Examination (MMSE) or similar mental status tests to determine eligibility for services or to assess the need for services.

People with dementia must be appropriately assessed and equitably treated in the functional eligibility determination process under Medicaid. States should review these recommendations and determine if their assessment processes and level-of-care criteria must be modified to incorporate them.

Section I

Introduction

In the face of tight budgets and rising expenditures for Medicaid long-term care services, states may seek to reduce costs by limiting the number of people who are eligible for these services. One method for doing so is to tighten the level-of-care criteria used to determine eligibility for nursing home and home and community waiver services.

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This issue brief describes Medicaid eligibility issues for people with dementia and discusses how six states determine eligibility for Medicaid-funded long-term care services. Based on an analysis of these six states, the Association makes recommendations (1) for appropriately assessing the long-term care needs of people with dementia, and (2) for setting level-of-care criteria that treat people with physical and cognitive impairments equitably.[2]

Background

Level-of-care criteria vary considerably among states. Some states require applicants to have moderate to severe functional limitations, some require nursing and medical needs, and others require a combination of both. States have also developed unique approaches for assessing whether an applicant meets these criteria. A consequence of this variability is that people eligible for long-term care services in one state may not be eligible in another.[3]

In response to concerns that people with dementia were being excluded from publicly funded long-term care programs, in 1991, the Advisory Panel on Alzheimer's Disease[4] (hereafter, the Advisory Panel) made several recommendations to ensure that eligibility criteria accurately and appropriately measure the functional limitations characteristic of individuals with dementia.[5] In particular, the Panel recommended that eligibility criteria should be based on measures of impaired functioning that are characteristic of people with dementia:

1. Measures of activities of daily living (ADLs) that define assistance to include a need for prompting, physical cueing, and supervision to perform an activity.
2. Measures of the need for supervision to protect against the consequences of impaired judgment, fluctuations in decision-making capacity, and impulsive, inappropriate, or disruptive behaviors.

Research on Medicaid level-of-care criteria in the late 1990s found that although most of the 42 states studied used the recommended measures when assessing the need for care, only seven—Connecticut, Delaware, Minnesota, New Hampshire, New Jersey, New York, and Oregon—allowed

people with dementia to qualify for nursing home coverage under either of the Advisory Panel's suggested eligibility criteria, as described above. [6]

To determine eligibility for services, States generally perform a comprehensive assessment of an individual's nursing/medical needs and functional limitations. Most states measure functional limitations by assessing individuals' ability to perform ADLs (bathing, dressing, toileting, transferring, and eating), and less frequently, their ability to perform instrumental activities of daily living (IADLs) such as medication management and meal preparation. Many states also assess the presence of cognitive impairment, impaired decision making, and behavioral symptoms that limit individuals' ability to live independently and safely. Because an assessment often serves a dual purpose—determining eligibility and developing a service plan—all of the factors assessed are not necessarily counted for determining eligibility.

States use the assessment results to determine eligibility using one of three approaches:

- The state scores specific factors and requires a threshold score.
- The state selects specific factors that will be considered and requires a minimum number of functional impairments or needs.
- The state has level-of-care definitions and guidelines, which are used to guide assessors in evaluating the information obtained through an assessment.[7]

None of these methods necessarily disadvantages people with cognitive impairment compared to people with physical impairments. Whether a state's eligibility determination process treats people with cognitive impairment appropriately and equitably is determined by a combination of factors: (1) what needs are assessed; (2) how needs are measured; and most importantly (3) whether the needs are counted, and if so, how they are weighted in determining eligibility.

Even if a state accurately and appropriately assesses the functional limitations that indicate a need for long-term care by individuals with dementia, if they do not weight them sufficiently in the eligibility determination process, people with dementia may not be eligible. For example, a state requiring a specific score for eligibility could score the need for verbal assistance with bathing and dressing as a '1' and the need for hands-on assistance as a '2.' Additionally, States may require such a high level of functional limitations for people with either physical or cognitive impairments that few will be eligible. For example, the state could only count the need for assistance with transferring, eating, and toileting and not count the need for assistance with bathing and dressing.

Given the Association's concerns about the tightening of level-of-care criteria, and given that the data for the study cited above were collected about eight years ago, the Association undertook a study of six states' level-of-care criteria and assessment processes to determine whether people with dementia can qualify for Medicaid funding of nursing home care and home and community waiver services.

Methods

Funding permitted an in-depth analysis of only six states. The Association reviewed previous studies of eligibility criteria and selected six states that represented different approaches to determining eligibility: Arizona, Colorado, Florida, Oregon, South Dakota, and Vermont. The

Association then commissioned an expert review of the six States' assessment forms and level-of-care criteria to evaluate their appropriateness for people with dementia. In addition, the consultant spoke with Medicaid eligibility staff in each state to clarify any ambiguities in the assessment forms and level-of-care criteria.[8] (See Section II for a detailed description of each State's assessment process and level-of-care criteria.) Based on this analysis, the authors developed policy recommendations for States to consider for their assessment processes and level-of-care criteria. We sent a draft of the paper to Medicaid staff in each of the six states to review. We also asked twelve experts in relevant areas—such as dementia assessment and Medicaid eligibility for nursing home care—to review the paper. We used their comments to revise the final paper.

Recommendations

The analysis of the six States revealed a variety of approaches, including some that were inappropriate, to assessing service needs and determining eligibility for people with dementia. Based on the findings of this analysis, the Association makes six recommendations to improve the assessment and eligibility determination process for people with dementia. Some recommendations reiterate those of the Advisory Panel, but most go beyond the Panel's recommendations, to specifically address deficiencies in states' approaches.

1. The need for assistance with ADLs must be defined to include verbal assistance and the extent or severity of need must be determined by the duration of the assistance required, not the type of assistance.

While defining ADL assistance to include prompting and cueing is necessary, it is not sufficient to assure that a person needing this type of assistance will meet ADL eligibility criteria. A common problem in the eligibility determination process is weighting or scoring the need for "hands-on" assistance higher than the need for verbal assistance even though formal caregivers are not paid for their physical effort but for their time.

A caregiver may need to be present throughout an activity to provide significant verbal assistance (prompting and cueing) to assure its completion or may need to physically perform the activity. In both cases, the time spent determines the severity of need. It can even take more time to coax, encourage, and cue someone to bathe themselves, particularly if the person is resisting care, than to give a person a bath.

Therefore, when determining eligibility, States must weigh severity of need by the amount of time it takes to provide the assistance not the level of physical effort. Colorado's scoring system takes the right approach by giving equal weight to physical and verbal assistance, basing the ADL score on the duration of the assistance with each activity. In contrast, South Dakota's approach is inadequate because it counts only weight bearing assistance when determining whether someone meets the ADL eligibility criterion.

2. ADLs and the terms used to assess the need for assistance must be defined clearly and comprehensively and the terms must be used consistently in the assessment process.

The definition of the assistance needed to complete an ADL must cover all of its essential components. For example, toileting can be defined merely as using the toilet for elimination, or more comprehensively. For example, Colorado's assessment form takes the correct approach by

defining toileting to include changing protective garments, cleansing, washing hands, and keeping oneself and one's environment clean. This definition includes a component of personal and environmental hygiene that can be impaired in people with cognitive impairment but is not generally measured when assessing toileting.

The type of assistance needed to address behavioral issues must also be appropriate and clearly specified. Oregon's approach is good because it defines assistance for cognitive and memory deficits to include monitoring, reassurance, redirection, verbal and written reminders, and support in addition to cueing.

States may define the terms for different types of assistance appropriately but use them inconsistently. Unfortunately, Colorado's assessment form uses three different terms for the type of ADL assistance generally needed by people with dementia but uses them inconsistently. For example, the state assesses the need for "standby" assistance with bathing, "significant verbal assistance" with dressing, and "cueing" with toileting. However, a person with dementia may need significant verbal assistance to complete all three of these ADLs, not just dressing.

To assure valid and reliable assessments, ratings, and eligibility determination, key terms must have standard unambiguous definitions and must be used consistently. Additionally, individuals performing assessments must have some training in assessing persons with cognitive impairment.

Need for Supervision with ADLs. Some states consider a need for supervision with ADLs to be a distinct type of assistance and define it explicitly or implicitly as standby assistance – both to assure safety (e.g. during bathing to be prepared to catch someone if they start to fall) and to be available as needed to provide any other type of assistance needed—verbal or hands-on. Whether a state uses "standby assistance" or "supervision" the terms must be clearly defined.

States generally consider the need for "supervision" or "standby assistance" to indicate a lesser severity of need because the term implies that individuals *may* need assistance, not that they do need assistance.

3. When states tighten their level-of care criteria by considering only a limited number of ADLs to determine eligibility or require a very high level of assistance for ADLs, they must develop comparable measures of need for people with dementia and weight them appropriately so that people with severe impairments will be eligible.

When states tighten eligibility criteria, a common, harmful approach is to not count the need for assistance in bathing and dressing, instead counting only impairments in toileting, eating, and transferring. This type of stringency is unfair to people with dementia because it is less likely that they will need help with these three ADLs than with bathing and dressing.

States that seek to restrict nursing home admission to people with the most severe impairments must set comparable measures of severe need among individuals with dementia. Arizona has a good approach that uses a different scoring mechanism to determine eligibility for people with and without organic brain syndrome and dementia, which recognizes that specific cognitive and behavioral factors indicate a need for long-term care. In addition, the level-of-care

criteria must be weighted fairly so that people with dementia do not need to be severely impaired to be eligible when people with physical impairments only have to be moderately impaired.

4. Level-of-care criteria must include measures of individuals' need for supervision to protect them from the negative effects of impaired judgment and decision-making; impulsive, inappropriate or disruptive behaviors; and other potentially harmful behavior such as wandering. These measures must be weighted appropriately so that people with severe impairments will be eligible.

Functional limitations other than those related to ADLs can indicate a need for long-term care services. Many individuals with dementia need varying amounts of protective supervision for all the reasons cited directly above. Arizona, Colorado, Oregon and Vermont have good approaches to this issue because they use a level of care criterion related to the need for protective supervision that many people with severe impairments could meet.

5. Level-of-care criteria must not require individuals to have medical or nursing needs.

While it is very important that level-of-care criteria consider the impact of cognitive impairment on self-management of chronic conditions and the ability to address one's health-related needs, people with severe functional limitations must be able to meet the level-of-care criteria without also having a nursing or medical need. If states require nursing needs, they must be defined broadly to include interventions to address behavioral symptoms that compromise an individual's or others' safety. Also, an assessment of nursing needs must consider the impact of cognitive impairment on a person's ability to handle his or her health needs, such as medication management.

6. States must not use a score on the Mini-Mental Status Examination (MMSE) or similar mental status tests to determine eligibility for services or to assess the need for services.

None of the six states use a Mini-Mental Status Examination (MMSE) score to determine eligibility but Florida uses the MMSE as part of an assessment process to determine service needs. Earlier research found that 16 states use some version of a mini-mental status test to determine the presence of cognitive impairment and three of them use a mental test score as one of several measures that together determine eligibility.[9]

The Mini-Mental Status Examination and similar mental status tests were not designed to determine whether or to what extent an individual needs long-term care services. These tests were developed as clinical screening tools to determine whether more in-depth assessment is needed to make a diagnosis of dementia. Most importantly, as the Advisory Panel on Alzheimer's Disease noted, these tests are not correlated with the specific functional limitations or service needs of people with dementia.

Many mental status tests have a high false negative rate because they primarily measure left brain functioning and will not identify impairments in many people with right brain damage. The MMSE will not detect many impairments caused by conditions such as Parkinson's, most vascular disease and many medical disorders. People with extensive deficits in executive control functions can have a normal score on the MMSE. [10]

Routine mental status tests directed at more familiar cognitive skills may miss even major executive control function deficits, which recent research has shown are a major determinant of the

level of assistance needed by elderly people.[11] If a state wants to use a mental status test as part of its assessment process, one that measures executive control function deficits would be more appropriate than the MMSE.

Although traditional descriptions of dementia have emphasized the role of memory loss and related behavioral symptoms, recent research suggests that it might be better understood as a syndrome of impaired executive control.[12] Executive control functions (ECF) are the cognitive processes that integrate more traditional cognitive domains—memory, language, and motor skills—into complex goal-directed behaviors. These cognitive processes make the difference, for example, between simply being able to walk and successfully getting to a specific destination.

However, even if executive control function deficits are measured, states still must assess their impact and the impact of behavioral symptoms on an individual's *functioning* to determine the need for long-term care services.

Conclusions

People with dementia need to be appropriately assessed and equitably treated in the functional eligibility determination process under Medicaid. States should review the Alzheimer's Association recommendations and determine if the assessment processes and level-of-care criteria must be modified to incorporate them.

Section II

Summaries of Six States' Level-of-care Criteria and Eligibility Determination Processes for Determining Medicaid Coverage of Nursing Home Care and Home and Community Waiver Services.

Arizona

Arizona uses a score on a standardized assessment tool to determine whether someone meets the level-of-care criteria. A combination of weighted medical and functional factors are evaluated and assigned a numerical value for scoring purposes. Meeting or exceeding the threshold score establishes initial eligibility for nursing home care and for alternative home and community services, if the person can be safely served in the community.

Eligibility decision reviews by a physician consultant are an integral part of the assessment process to address situations where the assessor thinks that applicants' scores are not a complete reflection of their needs. The physician consultants have expertise in geriatrics and have received training to complete Arizona Long Term Care System (ALTCS) reviews.

Medical Assessment

The medical section assesses a number of factors that are relevant to people with dementia—some of which duplicate factors assessed in the functional assessment. The medical assessment addresses three areas: medical conditions (including psychiatric); medications/treatments/allergies; and services and treatments.

Factors assessed that are relevant to person with cognitive impairment are:

- Whether a person's medical condition—including dementia and psychiatric conditions—has impaired the applicant's ability to independently perform ADLs.
- Whether a person receives or needs assistance taking medications. Providing a medi-set or a similar process is considered assistance.
- Whether a person receives or needs mechanical or chemical restraints to protect from injury to self or others. Mechanical constraints include a locked room to prevent egress.

The summary evaluation considers the impact of psychosocial factors, behaviors and cognitive abilities on health status and caregiving.

Functional Assessment

Activities of Daily Living (ADLs) are defined to include mobility, transfer, bathing, dressing, grooming, eating, and toileting. *Supervision* is defined as "observing the person and being readily available to provide assistance.

People with cognitive impairment are more likely to have impairments in bathing, dressing, and grooming than in the other ADLs. For these three ADLs, the need for supervision, reminding, and set up receives a score of 1; the need for supervision with more than half of the activity receives a score of two. For eating and toileting, a person who needs supervision, reminding or set-up would get a score of one, and someone who needs supervision for more than half of the activity would

receive a score of two. Only people who need hands-on assistance receive scores of three, four, or five.

This scoring system as described in the assessment instrument does not seem to take account of the need for cueing and prompting *for more than half* of the activity to assure its completion. But the state has clarified that the term "supervison" includes verbal assistance and that all of its assessors are trained to assess the need for supervision in this way.

Continence. Continence scores are based solely on the frequency of incontinence.

Communication/Sensory Impairment. Hearing and vision are assessed as the absence or presence of perception. A better approach is to assess functional limitations caused by vision and hearing impairments because someone impaired since birth will have far fewer functional limitations than someone impaired for some part of their lives.

Expressive—but not receptive aphasia is assessed. Someone with limited expressive ability who can make concrete requests for basic needs such as food, drink, sleep and toileting would receive a score of 2. Someone who is rarely or never understood would receive a score of 3.

Emotional and Cognitive Functioning. Orientation to time, person, and place is assessed. A person who was disoriented in either category more than three times a month but less than "half the time" would receive a score of 2 for each category. It is not clear what time frame is being considered by the term "half the time."

Behaviors—wandering, self-injury, aggression, disruptive, suicidal—are assessed. Each behavior is scored differently. For example, wandering that occurs predictably (in response to particular situations) and which poses a threat to the safety of self or others requiring supervision or intervention weekly or every other day would receive a score of 2.

Threshold Eligibility Score

Individuals who do <u>not</u> have a diagnosis of Organic Brain Syndrome (or dementia), must either have a combined medical and functional score $\geq$ 60 OR a medical score $\geq$ 13 AND a functional score of $\geq$ 30.

People with only physical impairments must be severely impaired (i.e., have a score of 60) to be eligible in the absence of medical needs scoring 13 or more.

Individuals with Organic Brain Syndrome or dementia must either have a combined medical and functional score $\geq$ 60 OR a functional score > 30. The functional score includes the scores for orientation and behavior. A person who received the highest score on all of the cognitive and behavioral factors would be eligible. A person who needed supervision with three ADLs and a score of 2 on five of the cognitive and behavior factors would also be eligible.

Strengths

- Uses a score, an approach that takes account of multiple minor impairments when determining eligibility.
- Allows exceptions based on professional judgment.
- Assesses factors that are relevant to people with dementia.
- The state has different threshold scoring requirements for people with and without Organic Brain Syndrome and dementia, which recognize the specific cognitive and behavioral factors that affect people's ability to live independently.

Weaknesses

Unless the functional and medical assessments together achieve a score $\geq$ 60, medical factors are not counted for people with dementia. The state assesses the ability to manage medications as part of its medical assessment, but not the functional assessment.

Recommendations

The ability to manage medications and other aspects of one's health care are important measures of functioning. The state should either (1) include the ability to manage medications as part of the functional assessment, or (2) allow any medical need sub-score to count towards the threshold scoring requirement for people with dementia. The first approach is less complicated and in keeping with recommendations by experts that eligibility for people with dementia be based on functional needs.

Colorado

Colorado determines eligibility by requiring a minimum number of needs with a specific score. The scores in each functional area are based on a set of criteria that measures the degree of impairment.

Activities of Daily Living

Six ADLs are assessed—mobility, bathing, dressing, eating, toileting, transferring.

- A need for hands-on help or standby assistance throughout ***bathing*** is scored as 2.
- A need for significant verbal or physical assistance to complete ***dressing*** or undressing within a reasonable amount of time is scored as 2.
- A need for cueing with parts of the ***toileting*** task, such as changing protective garments, cleansing, and washing hands, receives a score of 1. A person who needs physical or standby assistance with toileting or who is unable to keep self or environment clean is scored as 2.
- A need for reminding to maintain adequate food intake or assistance cutting up food scores as 1.

In addition to scoring the level of assistance required to perform ADLs, the assessor must also indicate the cause of the impairment—whether physical (e.g., pain, paralysis, weakness, shortness of breath), cognitive (e.g., memory, behavior, lack of awareness), or mental health (e.g., apathy).

Need for Supervision

The need for supervision due to a significant impairment in behavior is assessed. The factors considered are wandering, disruptive or self-injurious behavior, resistance to care, and self-neglect. A score of 2 would be given to a person who exhibits inappropriate behavior that puts self and others at risk and who needs more than verbal redirection to interrupt the behavior; OR to someone who needs medication assistance, monitoring, or supervision; OR who is unable to make safe decisions.

Memory/Cognition Deficit.

The assessment of memory/cognition considers the ability to plan, to adjust to new and familiar routines (including medication regimes), to make safe decisions, and to make basic needs known. A score of 2 would be given to a person who requires consistent and ongoing reminding and assistance with planning; OR requires regular assistance with adjusting to both new and familiar

routines, including medication regimens; OR who requires ongoing supervision to make safe decisions; OR who cannot make their needs known.

Threshold Eligibility Requirement

A person must have deficits in two of the six ADLs with at least a score of 2 OR have a minimum score of 2 in the need for supervision, OR a minimum score of 2 in memory/cognition deficits. *[The scoring guidelines say that a score of 2+ is needed. The interpretation here assumes that this means "2 or more" and not "greater than 2."]*

Strengths

- A score of 2—the minimum required—gives equal weight to the need for physical or verbal assistance.
- In assessing mobility and transferring, the terms assistance, cueing, and stand-by assistance are used and issues related to safety are assessed. The assessment recognizes that mobility impairments may be due to cognitive or memory impairment, behavior issues, lack of awareness, difficulty learning, and apathy.
- The assessment of toileting includes the ability to keep oneself and one's environment clean, including a component of "cleanliness" not generally captured when assessing bathing, and indirectly measuring the IADL "housekeeping."
- The assessment of dressing recognizes the need for assistance to assure that the task is completed within a reasonable amount of time.

Weaknesses

The state does not use consistent terminology to describe the type of assistance relevant for people with dementia; e.g., for bathing, it uses oversight help, reminding, and standby assistance; for dressing, it uses reminding, supervision, and significant verbal assistance; for toileting, it uses cueing (with parts of the task such as cleansing) and standby assistance. People with dementia may need significant verbal assistance to complete all of these ADLs.

Recommendations

- When assessing the need for assistance with ADLs, the state should consistently use all the terms that describe the type of assistance needed by people with dementia—cueing and prompting (verbal assistance) and supervision for safety.
- If the score is based in part on the level of assistance provided, the scoring should recognize that significant verbal assistance may be needed throughout an entire activity to assure its completion in a timely fashion, just as physical assistance may be needed to complete some or all of a task.

Florida

Florida requires both functional and nursing needs to be eligible. ADL deficits and the need for supervision due to cognitive deficits are <u>not</u> sufficient to establish eligibility. Providing supervision to assure safety is considered custodial care. To meet the level of care criteria an individual must require intermediate care services including 24 hour observation and care and the constant availability of medical and nursing treatment and care. The state defines two levels of intermediate care. Level I is defines as "extensive health related care and service required by an

individual who is incapacitated mentally or physically." Level II is defined as "limited health related care and services required by an individual who is mildly incapacitated or ill to a degree to require medical supervision."

Nursing services do not have to be skilled; they can be delegated under the supervision of a licensed nurse. A need for medication management could meet the nursing criterion depending on the medications prescribed.

Factors Assessed

The assessment form is used both to determine eligibility and as a service planning tool for people who are seeking services in home and community settings. In the latter case, a greater number of factors are assessed in order to determine what services individuals will need and whether their needs can be safely met at home or in a community setting. For purposes of service planning, a number of factors relevant to the LTC needs of people with dementia are assessed, but they are not considered when determining eligibility unless they have an impact on an individual's health-related needs. The factors are:

- Mental status (assessed with two general questions regarding satisfaction with life and attitude towards life);
- Behavioral symptoms that indicate a need for supervision;
- Presence of specific conditions (wandering; significant memory problems; depression; lonely or dangerously isolated; suicidal thoughts; abusive, aggressive, or disruptive behavior);
- Mini-mental status test score; and
- Orientation to time, place, and person.

ADLs and IADLs. The state assesses the five core ADLs plus walking/mobility and eight IADLs (heavy chores, light housekeeping, phone use, money management, meal preparation, shopping, taking medication, and transportation use.) Assistance is defined and scored as follows: supervision (2), "some help" (3), and total help (4) and the frequency with which a person receives adequate assistance is also recorded: rarely (1), sometimes (2), never (3).

Health Conditions and Special Services. One of the conditions assessed is dementia. If a person has health needs that generally can be self-managed, e.g., determining sliding-scale insulin dosages, the inability to handle such needs due to cognitive impairment would be considered a need for nursing care. Compliance with medication regimens and reasons for non-compliance (including "confusion") are specifically assessed. While combative behavior and resistance to care are not considered functional or nursing needs, a person who needed medications to control these behaviors could be eligible.

Threshold Eligibility Requirement

Florida does not require a specific score or number of impairments or needs for eligibility. The eligibility determination is based on professional judgment, which takes account of the information from the assessment (including an assessment score) and any other relevant factors not addressed on the assessment form.

Strengths

People who cannot meet their health care needs due to cognitive impairment can be eligible.

Weaknesses

§ People without health-related care needs or nursing needs are not eligible.

§ The assessment form uses the mini-mental status exam for people who want to be served in home and community settings. This approach will not provide useful information for service planning and it will fail to identify individuals with severe cognitive deficits. The assessment form asks about memory problems and orientation to time and place, but people without deficits in these areas can still have significant cognitive impairment.

Recommendations

§ The state should drop the nursing need requirement for people with severe functional limitations due to either physical or cognitive impairments.

§ The state should include the need for constant supervision due to behavioral symptoms in its level of care criteria.

§ The state should drop the use of the mini-mental status exam and use more appropriate functional measures of cognitive impairment when determining service needs.

Oregon

Oregon determines eligibility using a computerized assessment and planning tool. The tool is comprehensive and assesses many more functions than are considered in making the level-of-care determination, but which are incorporated into service planning.

Functional Levels

The level of care criteria specify 18 functional levels with 1 representing the most impaired and 18 the least impaired. The state does not consider medical or nursing needs to determine eligibility. Funding availability determines the minimum level for eligibility, which currently is 13.

Levels 1 to 13 represent fairly severe functional limitations. Most individuals in nursing homes are at levels 1 to 3. The state assesses the need for assistance with mobility (ambulation and transferring), eating, and elimination (toileting, bowel, and bladder care), and assistance due to impaired mental status (cognition and behavior.) To be eligible at Level 13—the least impaired category—a person must need assistance with toileting and bowel and bladder care.

The definitions of ADL assistance recognize that the need for assistance can be the result of a physical impairment, limited endurance, or cognitive impairment.

Mental Status Assessment

The assessment form has a section on mental status that assesses memory, orientation, adaptation to change, awareness of needs and judgment. Memory is defined as the ability to remember and appropriately use current information, which affects an individual's health, safety and welfare.

Behaviors that may affect living arrangements and/or jeopardize the safety of self or others are also assessed; these include wandering, those that pose a danger to self or others, and those that negatively affect living arrangements, providers, and/or others.

Two levels of assistance are defined; the definition differs slightly to match the measure being assessed. The types of assistance recognized for cognition/memory are: cueing, monitoring, reassurance, redirection, reminders-verbal, reminders-written, and support. For Cognition/ Memory, a person who has difficulty remembering and using information and requires frequent reminding is considered to need assistance. A person who cannot remember or use information and requires directions beyond reminding is considered to need full assistance.

Threshold Eligibility Requirement

Within these 13 levels, levels 1 and 2 require a physical impairment *in addition to* cognitive impairment. Only one level—level 3—considers functional limitations *solely* due to cognitive impairment to be sufficient for eligibility. To be eligible at level 3, a person must need either full assistance with ambulation, OR transfer, OR eating, OR full assistance *in at least 3* of the following eight areas: wandering, adaptation, awareness, danger to self or others, demands on others, judgment, memory, or orientation.

The definition of "full assistance" differs for the eight areas. For some areas it is defined as the provision of assistance on a constant, or daily and ongoing basis. For others, it is defined in terms of the safety risk. For example, someone who only wanders indoors and does not jeopardize safety is considered to require "assistance" but someone who wanders inside and outside and jeopardizes safety is considered to require "full assistance."

Strengths

The assessment of cognitive and behavioral issues is comprehensive and considers the type of impairments and assistance relevant for people with dementia.

Weaknesses

§ Individuals who need less than "full assistance" in the eight cognitive and behavioral areas cannot be eligible even if they need assistance in all eight of the areas. But people who need only assistance (as compared to full assistance) with various ADLs and other physical functions can be eligible at levels 5 through 13.

§ The level-of-care criteria do not consider any health needs.

Recommendations

§ The state should have a functional level for people with cognitive impairment that is equivalent to levels 5 through 13 for people with physical impairments who require less than full assistance. An equivalent functional level could be the need for assistance in five or more of the cognitive or behavioral areas; or a need for full assistance in one area and assistance in four or more areas; or some other combination that recognizes that a need for less that full assistance in multiple areas can constitute a severe impairment.

§ The state should consider health care needs as well as functional needs.

South Dakota

A person who meets one of three level of care criteria can be eligible. (1) An individual needs services ordered by a physician that can only be provided by or under the supervision of a professional nurse. (2) An individual needs extensive assistance with 3 out of 5 ADLs. The state

used the definition of extensive assistance in the Minimum Data Set (MDS)—i.e. weight bearing assistance. The provision of prompting and cueing are not considered "extensive" assistance even if needed throughout the entire activity. (3) An individual needs skilled therapeutic services (physical, occupational, or speech/language) or skilled mental health services at least once a week. People with dementia with behaviors such as wandering that compromise their safety would be eligible. *[It is unclear under which of the 3 criteria the need for supervision is considered.]*

Factors Assessed

For individuals seeking nursing home care, the level of care determination is based on information in the MDS, which is obtained from the nursing home. The state repealed a rule that everyone entering a nursing home have a social work assessment. Nursing homes determine if they think a person meets the level of care criteria prior to admission, putting themselves at financial risk if the person is subsequently determined not eligible.

For individuals seeking services in home and community settings, a comprehensive assessment form is used. Factors assessed include the following.

Health Status

Types of conditions or diagnoses listed include "any psychiatric diagnosis," memory loss, Alzheimer's disease, non-Alzheimer's dementia, traumatic brain injury, and aphasia.

Medication Use

How a person remembers to take medications is assessed.

Behavior and Cognition

Sixteen factors are assessed, including wandering, socially inappropriate behavior, poor hygiene, short and long-term memory loss, ability to understand others, decision making, confusion, and orientation to time, place and person. Frequency is assessed as "sometimes" or "often."

Functional Assessment

The five core ADLs and walking in the home are assessed as are IADLs. Categories of assistance listed are: with assistive devices; limited; total; and unwilling to perform.

The assessment also asks whether the primary caregiver provides supervision and assistance with medications, as well as whether the individual has a guardian conservator, or other legal oversight.

Threshold Eligibility Requirement

South Dakota does not require a specific score or number of impairments or needs for eligibility. The eligibility determination is based on professional judgment. Whether someone requires professional nursing services depends on the type, severity, and combination of impairments, which are assessed on a case-by-case basis.

Strengths

People with behaviors that compromise their safety can be eligible.

Weaknesses

The MDS definition of assistance with ADLs that is used to determine eligibility requires weight-bearing assistance and does not recognize that the degree of assistance can also be measured

by the amount of time required to provide it. People who do not meet the ADL criterion must meet the nursing or skilled therapeutic criteria to be eligible.

Recommendations

The state should include the need for significant verbal assistance throughout an activity to assure its completion as "extensive" assistance.

Vermont

The level-of-care criteria in the state's 1115 waiver program designate three groups that are prioritized as highest needs, high needs, and moderate needs.

Highest Needs. Individuals who have a severe impairment with decision-making skills or a moderate impairment with decision-making skills and one of the following behavioral symptoms/conditions, which occurs frequently and is not easily altered: wandering, resists care, behavioral symptoms, verbally or physically aggressive behavior.

High Needs. (1) Individuals who have impaired judgment or impaired decision-making skills that require constant or frequent direction to perform at least one of the following: bathing, eating, transferring, dressing, toilet use, personal hygiene; OR (2) individuals who exhibit at least one of the following behaviors requiring a controlled environment to maintain safety for self: constant or frequent wandering; behavioral symptoms; physically or verbally aggressive behavior.

Moderate Needs. (1) Individuals who require supervision or any physical assistance three or more times in a 7 day period with any single ADL or IADL, or any combination of ADLs or IADLs; OR (2) individuals who have impaired judgment or decision making skills that require general supervision on a daily basis.

Threshold Eligibility Requirement

All people who meet the eligibility criteria for the highest needs group are entitled to services, according to their needs.

Those in the high needs groups are "entitled" to services but the state has the ability to place them on a waiting list for receipt of care, if funding is not sufficient to provide immediate access to services. Enrollment from the waiting list is based on established procedures, which include the date of application and a consideration of various factors, including cognitive functioning and behavioral symptoms. However, if individuals in these groups have emergency circumstances (e.g., death or illness of a primary caregiver) they may receive immediate access to services.

Individuals in the moderate needs group receive care management, homemaker, and adult day care services from a limited pool of funding dedicated to this group. There is no entitlement to services for this group.

Strengths

- Each of the three categories of need include measures of assistance that are relevant for people with dementia.
- When considering the need for assistance with ADLs, the criteria for the high and moderate categories treat the need for supervision as comparable to the need for physical assistance.

§ The stringency of the criteria for the three levels appears to be similar for people with physical and cognitive impairments.

Weaknesses

§ If only the highest level is funded, the criteria are stringent.

§ The regulations do not include definitions of terms such as severe, frequent, or constant. The state may have an assessment manual that defines these terms. In the absence of definitions, the reliability of assessments may be an issue.

Recommendation

If the state does not define the terms used in the criteria, it should do so.

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[1] To be eligible for Medicaid, individuals must also meet financial eligibility criteria, which are not discussed in this issue brief.

[2] To be eligible for Medicaid, individuals must also meet financial eligibility criteria, which are not discussed in this issue brief.

[3] O'Keeffe J., *People with Dementia: Can they Meet Medicaid Level of Care Criteria for Medicaid Nursing Home and Home and Community-Based Waiver Programs*, AARP Washington DC 1999.

[4] The Advisory Panel was established by congressional mandate and charged with making recommendations to the U.S. Congress and the U.S. Department of Health and Human Services. The Panel issued a number of reports on a wide range of topics relevant to research and services for people with dementia.

[5] Advisory Panel on Alzheimer's Disease. Second Report of the Advisory Panel on Alzheimer's Disease (1991). Us Department of Health and Human Services Publication No.(ADM)91-1791. Washington, DC:US Government Printing Office. 1991.

[6] O'Keeffe J., *People with Dementia: Can they Meet Medicaid Level of Care Criteria for Medicaid Nursing Home and Home and Community-Based Waiver Programs*, AARP Washington DC 1999.

[7] O'Keeffe J., *People with Dementia: Can they Meet Medicaid Level of Care Criteria for Medicaid Nursing Home and Home and Community-Based Waiver Programs*, AARP Washington DC 1999.

[8] Janet O'Keeffe, Dr.P.H., R.N., Senior Researcher and Policy Analyst at Research Triangle Institute performed the analysis. Dr. O'Keeffe conducted the two earlier studies on level-of-care criteria cited in this issue brief. State Medicaid staff in each of the six states reviewed the description of their assessment process and level-of-care criteria to assure its accuracy.

[9]The three states were Connecticut, Colorado, and Illinois. O'Keeffe J., *People with Dementia: Can they Meet Medicaid Level of Care Criteria for Medicaid Nursing Home and Home and Community-Based Waiver Programs*, AARP Washington DC 1999.

[10] Royall, D.R. (1994) Precis of executive dyscontrol as a cause of problem behavior in dementia. Nelson, A., Fogel, B., and Faust, D. (1986) Bedside screening instruments: A critical assessment. *The Journal of Nervous and Mental Disease*. Vol. 174(2):73-83. *Experimental Aging Research*. 20:73-94. Royall, D.R.

(1997) Use of the mini-mental status examination to categorize dementia. Letter to the Editor in Nursing Home Medicine, Vol. 5 No. 11, 11A-13A. Royall, D.R., Mahurin, R.K., and Gray, K.F. (1992) Bedside assessment of executive cognitive impairment: The Executive Interview. Journal of the American Geriatric Society. 40: 1221-1226. Fogel, B., Brock, D., Goldscheider, F., Royall, D. (1994) *Cognitive dysfunction and the need for long-term care: Implications for public policy*. Washington, DC: AARP Public Policy Institute.

[11] Royall, D.R., Chiodo, L.K., and Polk, M.J. (2000) Correlates of disability among elderly retirees with "subclinical" cognitive impairment. *Journal of Gerontological Medical Science*, 55A: M541-M546. Royall, D.R., Cabello, M., and Polk, M.J. (1998) Executive dyscontrol: An important factor affecting the level of care received by elderly retirees. Journal of the American Geriatric Society, 46: 1519-1524.

[12] Executive control functions (ECF) are poorly assessed by routine mental status tests. Information on ECF is from the following publications: Royall, D.R. (1994) Precis of executive dyscontrol as a cause of problem behavior in dementia. *Experimental Aging Research*, 20:73-94. Royall, D.R., Mahurin, R.K., and Gray, K.F. (1992) Bedside assessment of executive cognitive impairment: The Executive Interview. *Journal of the American Geriatric Society*. 40:1221-1226. Royall, D.R. (1997) Use of the mini-mental status examination to categorize dementia. Letter to the Editor in *Nursing Home Medicine*. 5(11):11A-13A.