H-Assessments/Reassessments

H-100 Overview

The interRAI Home Care (iHC) is a comprehensive and standardized assessment tool used to evaluate the needs, strengths, and preferences of the individual for all initial, annual, status change, and follow-up assessments.

- The iHC assessment is completed with the individual in order to:
- Verify that the individual meets Nursing Facility Level of Care (NFLOC) criteria.
- Identify paid and unpaid supports (including family and community supports).
- Determine the Resource Utilization Groups (RUG) score, Activities of Daily Living (ADL) Index score, and corresponding Service Hour Allocation of Resources (SHARe) budget allocation.
- Establish baseline information in regards to the individual's functional abilities.
- Identify acute and chronic health conditions that may impact the individual's self-performance.
- Identify health and welfare concerns.
- Determine if the individual has the capacity to make decisions for himself/herself.

H-110 Completion of the Assessments/Reassessments

The iHC assessment, including the Degree of Difficulty Questions (DDQs) when applicable, must be completed at an in-person visit with the individual by a certified assessor, refer to Section D-SC Assessment and Care Planning Certification section of the manual. For guidance on completing the iHC assessment, refer to the iHC Manual and the OAAS Nursing Facility Level of Care Eligibility Manual, OAAS-MAN-13-005.

NOTE: The iHC assessment must always be completed in person. There is no virtual option allowance for the completion of the iHC assessment.

In order to obtain an accurate assessment, the Support Coordinator (SC) will need to evaluate the individual's capacity to accurately self-report information. To make this determination, the SC will:

- Use professional judgment and observation to determine the individual's cognitive, mental/behavior and communication status.

- Use iHC assessment sections regarding cognition, communication barriers and behavioral challenges to determine if an individual has the capacity to make decisions for himself/herself and provide accurate information to complete the assessment.

    - SC shall use a procedural memory problem code of 1, daily decision making code of 3, 4 or 5, making self-understood or understanding others code of 3 or 4, delusions or hallucinations code of 1 to indicate the participant may not have the capacity to be considered a reliable self-informant.

- Review secondary documents, such as medical records, home health plan of care, nursing notes, therapy notes, service logs, etc.

If it is determined that an individual does not have the capacity to provide accurate information, a Responsible Representative (RR) or secondary informant may be needed to accompany, assist, and represent the individual in the iHC assessment process.

If the individual does not have a RR, a secondary informant may be another family member, Direct Service Worker (DSW), friend, neighbor, home health representative, social worker, mental health counselor, or any person that may be familiar with the individual.

Once identified, the SC will invite the secondary informant to the assessment meeting.

(The iHC assessment meeting may need to be rescheduled for an alternate date and time if the informant is not available for the original assessment date.)

If the SC is unable to identify a RR or secondary informant, the SC will contact the Office of Aging and Adult Services (OAAS) Regional Office (RO) for guidance. RO will review the case to ensure there is no available secondary informant and refer to OAAS Service Review Panel (SRP) for guidance.

NOTE: If an individual designates someone as the responsible representative or secondary informant, the individual will still have the right and responsibility to actively take part in their assessment as they are able.

Individuals, who are competent majors, aged eighteen years of age or older and not interdicted, have the right to control who participates in the assessment process and have the right to refuse participation by secondary informants.

Participants may request another iHC assessment at any time.

All iHC assessments must be approved by an iHC certified SC supervisor. The assessment can be approved any time after the assessment is submitted into the OAAS Participant Tracking System (OPTs) but must be approved in OPTs by the date of the POC or revision approval date. Example: If a POC is approved on 12/2/2022, the iHC must be approved on 12/2/2022 or before.

iHC assessments should not be completed in a hospital or long term acute care facility (LTAC). **iHC assessments should be completed at minimum 7 calendar days after the individual discharges home.**

H-120 Initial Assessments

The initial assessment process is the same for individuals residing in the community and individuals residing in a Nursing Facility (NF). The initial assessment and POC meeting must take place on separate days; the POC occurring after the iHC is completed and submitted in OPTs. All initial iHC assessments and initial POC meetings must be completed in person with the individual, there is no virtual option allowance for iHC assessments or initial POC meetings. Refer to Section-K Plans of Care of this manual for more information.

SC will:

- Complete the iHC assessment in person with the individual and/or members of his/her support network within 3 working days of starting the iHC assessment.
    - The assessment process requires communication with the person and primary caregiver/family member (if available), observation of the person in the home environment, review of secondary documents and communication with secondary informants when applicable.
        - Secondary informants may include, but are not limited to, home health nurse, Physical Therapist (PT), Occupational Therapist (OT), Nursing Facility (NF) staff, Transition Coordinator (TC), behavioral health provider, etc.
        - Secondary documentation may include, but is not limited to, documentation from the individual's physician, home health nurse, PT, OT, NF, TC, behavioral health provider, etc.
        - Assessors should not delay the assessment's completion pending receipt of secondary documents/information, but reasonable attempts to obtain the documents/information must be demonstrated.
- Input the iHC assessment into OPTs within 5 working days from the completion date of the assessment.
- Obtain the RUGs score, ADL Index score, and corresponding SHARe budget allocation.
- Determine if the individual meets NFLOC. Refer to the OAAS Nursing Facility

Level of Care Eligibility Manual, OAAS-MAN-13-005.

NOTE: In order to receive Long-Term Personal Care Services (LT-PCS) in conjunction with the Adult Day Health Care (ADHC) waiver, the individual must meet LT-PCS program requirements; which is needing at least limited assistance with at least 1 Activity of Daily living (ADL). Assessors must review OPTs Participant Summary LT-PCS Program Requirements filed to determine if this requirement is met. If the individual meets NFLOC but does NOT meet LT-PCS program requirements, the individual can receive ADHC waiver services but NOT LT-PCS.

- Proceed with POC development once all assessment information is gathered, the assessment is entered and it appears that the individual meets NFLOC and/or programmatic criteria. Refer to Section-K Plans of Care of this manual.

If the individual does **NOT meet NFLOC**, the SC will complete a narrative (including documentation to substantiate that the individual does not meet NFLOC) and submit the narrative to the SC supervisor for review.

SC supervisor will review the denial for submission to RO for closure.

SC supervisor will email the denial documentation to RO for review.

RO will:

- Review and verify that the individual does not meet NFLOC, ensuring the assessment procedure was followed and is accurate, within 3 business days.

- Send a denial notice to the individual with appeal rights, copying the SCA.

If the denial is for a NF transition case, RO will conduct an iHC assessment with the NF resident with a 7 day extended ADL lookback period to validate the Nursing Facility MDS 3.0 assessment. If the resident does not meet NFLOC, RO will coordinate a Medicaid Stop Vendor Payment notice to the NF resident with the OAAS Nursing Facility Admissions Unit (NFA).

If the individual appeals the decision, refer to Section N-Appeals of this manual.

If the individual does not appeal after the 30 calendar day appeal period:

- RO will request an electronic 148W for closure from the SC.

- SC will submit an electronic 148W for closure to RO. (Refer to HCBS Waiver 148W Instructions, OAAS-ADM-13-016).

RO will:

- o Process the 148W, electronically signing, saving and uploading to the Louisiana Medicaid Eligibility Determination System (LaMEDS).
- o Send a copy of the signed/processed 148W to the DMC and SCA.
- o Complete a BHSF form 142 (Refer to 142 instructions, OAAS-ADM-13-017), upload to LaMEDS, and email a copy to, the Data Management Contractor (DMC) and the SCA.
- o Review the OAAS Request for Services Registries (RFSR) and remove the individual if on either the CCW or ADHC Waiver RFSR.

If the individual does **NOT appear to be a good candidate to transition from the NF**, the SC will complete a narrative (including sufficient documentation to substantiate findings) and email all documentation to SC Supervisor.

SC supervisor will review and approve the case to be submitted to RO and TC.

RO and TC will:

- ▪ Review and verify that the individual appears to not be a good candidate for NF transition, ensuring that OAAS SHARe exceptions and community resources were explored.
- ▪ Meet with the individual, natural support and/or SC to discuss.
- ▪ RO and TC will coordinate the submission of a referral packet for review to the OAAS Service Review Panel (SRP) if case closure is recommended.

If SRP determines that the individual is not a good candidate to transition from the NF (due to health and welfare, waiver services not appropriate, etc.), RO will send a denial letter with appeal rights to the individual and copy the TC and SCA.

If the individual appeals the decision, refer to the Section N-Appeals of this Manual.

After 30 calendar days for appeal rights have passed AND the individual did NOT appeal, the SC and RO will follow the 148W and 142 processes outlined above.

H-130 Follow-Up Assessments

For NF Transitions Only:

If the individual is certified for the Community Choices Waiver (CCW) or Adult Day Health Care (ADHC) Waiver when he/she moves out of the NF, the SC must complete a Follow-Up iHC assessment 6 months from the date the participant moves out of the NF.

If the individual is NOT certified for the CCW or ADHC Waiver until after he/she moves out of the NF, the SC must complete a Follow-Up iHC assessment 6 months from the date the individual is certified for CCW services.

NOTE: If the 6 month date falls on a weekend or holiday, the reassessment should be completed on the following business day.

This Follow-Up assessment does not need to be completed if a status change reassessment was conducted within 4 to 6 months from the date of the initial iHC assessment.

If the Follow-Up assessment indicates that the participant DOES NOT meet NFLOC, the SC proceeds with discharge procedures.

SC will:

- Complete the Follow-Up iHC assessment face-to-face with the participant and/or members of his/her support network 6 months from the date the participant moves out of the NF.

  NOTE: Provider(s) are not required to attend the assessment meeting, UNLESS the participant requests the provider(s) attend.

- Input and submit the iHC assessment into within 5 business days of the completion date of the follow-up reassessment.

- Obtain the RUGs score, ADL Index score, and corresponding SHARe budget allocation to see if different from previous iHC assessment.

- Determine if the participant meets NFLOC.

If the participant does NOT meet NFLOC, the SC will complete a narrative (including

sufficient documentation to substantiate that the participant does not meet LOC) and email to RO and the Transition Coordinator (TC).

RO will:

- Review and verify that the participant does not meet LOC.
- Send a discharge notice to the participant with appeal rights and copy the TC and SCA.

If the participant appeals the decision, refer to the Section N-Appeals of this Manual.

After the 30 calendar days for appeal rights have passed AND the participant does NOT appeal,

SC will:

- Complete a 148W for closure (Refer to HCBS Waiver 148W Instructions, OAAS-ADM-13-016).

RO will:

- Process the 148W, electronically signing, saving and uploading to LaMEDS.
- Send a copy of the signed/processed 148W to the DMC and SCA.
- Review the OAAS Request for Services Registries (RFSR) and remove the individual's name from the CCW and/or ADHC Waiver RFSR.

SC will:

- Notify the provider(s) by communicating directly with a representative, by email and/or via fax on the same date that e148-W denial is approved by RO.

If the participant meets NFLOC, AND the RUG score, ADL Index Score, triggered CAPs and/or concerns are the same as the previous iHC assessment, the SC will review the current POC with the participant. If there are changes that are not reflected on the iHC assessment but warrant addressing, the POC changes should be made on the Support Coordination Contact Documentation (SCD),

OAAS-SC-19-004. The SCD must be distributed to the DSP and RO if affecting the POC.

If the participant meets NFLOC, AND RUGs score, ADL Index Score, triggered CAPs and/or concerns are different from the previous iHC assessment, the SC must proceed with a POC Revision to address the change(s) (Refer to Section-K Plans of Care of this manual).

H-140 Change in Status Assessments

A significant change in status is an improvement or decline in the participant's condition that is NOT temporary in nature, i.e., not expected to resolve in a short period of time, such as two weeks. Some examples of significant status changes that may require a change in status reassessment are:

- Completing a therapy regimen resulting in improved functioning.
- Undergoing a hospitalization due to injury/condition resulting in a decline in functioning.
- Experiencing a fall resulting in a fracture and decreased mobility.

If the SC determines that the participant has a significant status change the SC will:

- Complete a face-to-face status change assessment with the participant and/or members of his/her support network within 14 calendar days from the date notification of participant status change. If the change in status involves a hospital or Long-term Acute Hospital (LTAC) stay, the reassessment will need to be completed 7 to 14 calendar days from the date the participant was discharged home.

  NOTE: If the 14th day falls on a weekend or holiday, the reassessment should be completed on the following business day.

  NOTE: Provider(s) are not required to be at the reassessment meeting, UNLESS the participant requests the provider(s) attend.

  - Input and submit the iHC assessment into the database within 5 business days from the date of completing the Change in Status reassessment.
  - Obtain the RUG score, ADL Index score, and corresponding SHARe budget allocation and determine if it is different from the previous iHC assessment.
  - Determine if the individual continues to meet NFLOC. Refer to the OAAS Nursing Facility Level of Care Eligibility Manual, OAAS-MAN-13-005.
  - If the participant does NOT meet NFLOC, the SC will complete a narrative (including sufficient documentation to substantiate that the participant does not meet LOC) and send to RO.

If NFLOC is not met, RO will:

- Review and verify that the participant does not meet NFLOC within 3 business days of NFLOC closure narrative receipt from SC.
- Send a discharge notice to the participant with appeal rights and a copy the SCA.

If the participant appeals the decision, refer to Section N-Appeals of this Manual.

After the 30 calendar days for appeal rights have passed AND the participant does NOT appeal,

SC will:

- Complete and submit a 148W (Refer to HCBS Waiver 148W Instructions, OAAS-ADM-13-016).

RO will:

- Process the 148W, electronically signing, saving and uploading to the LaMEDS.
- Send a copy of the signed/processed 148W to the DMC and SCA.
- Review the OAAS Request for Services Registries (RFSR) and remove the individual's name if on the CCW and/or ADHC Waiver RFSR.

SC will:

- Notify the provider(s) by communicating directly with a representative via phone, fax or email on the same date that e148-W is received from RO.

If the participant meets NFLOC, AND the RUG score, ADL Index Score, triggered CAPs and/or concerns are the same as the prior iHC assessment, the SC will review the current Plan of Care with the participant. If there are preferences, requested supports, etc. that are not reflected on the current POC but warrant addressing, the POC changes should be made on the Support Coordination Documentation (SCD), OAAS-SC-19-004. The SCD must be distributed to the participant, DSP and RO since it is an update to the current POC.

If the participant meets NFLOC, AND RUGs score, ADL Index Score, triggered CAPs and/or concerns are different from the previous iHC assessment, the SC must proceed with a POC Revision to address the change(s). Refer to Section-K Plans of Care of this manual.

H-150 Annual Assessments

Support Coordinators (SCs) are responsible for completing annual iHC assessments on **all** participants, including participants residing in Nursing Facilities (NFs) awaiting transition.

NOTE: If the annual iHC reassessment indicates that the participant DOES NOT meet NFLOC, the SC proceeds with waiver discharge procedures.

SC will:

- Complete the annual iHC assessment in person with the participant and/or members of their support network no earlier than 90 calendar days from the POC Expiration Date. **Provider(s) are not required to attend the assessment meeting, UNLESS the participant requests that the provider(s) attend.**

  NOTE: The POC expiration date is the day after the POC end date. A POC end date of 9/28/21 would have an expiration date of 9/29/21.

- Input and submit the iHC assessment into OAAS Participant Tracking System (OPTs) within 5 business days from the date of completion of the assessment.

- Obtain the RUGs score, ADL Index score, and corresponding SHARe budget allocation and compare to the prior iHC assessment to determine if there is a reduction.

  - If there is a reduction in services, SC must indicate the reduction on the POC by selecting the appropriate field in the *Adverse Action* section. The POC must be approved at least 17 calendar days before the POC expiration.

    - Regional Office (RO) is notified of the reduction once the POC with reduction is submitted.

  - After reviewing the iHC for accuracy and verifying the reduction, RO will send a notice with appeal rights to the participant notifying them of the reduction in services at least 14 days before the new POC begins.

  - If the participant appeals, RO will complete a POC extension and submit the extension to the data management contractor, advising services are to remain in place until the hearing is finalized and a

judgement is received. Refer to Section N-Appeals of this Manual.

- Determine if the participant continues to meet NFLOC. Refer to the OAAS Nursing Facility Level of Care Eligibility Manual, OAAS-MAN-13-005.

If the participant does NOT meet NFLOC, the SC will send a narrative (including sufficient documentation to substantiate that the participant does not meet LOC) to RO at least 35 days prior to the POC expiration date.

RO will:

- Review and verify that the participant does not continue to meet LOC.
- Send out a discharge notice to the participant with appeal rights and copy the SCA.

If the participant appeals the decision, refer to Section N-Appeals of this manual.

After 30 calendar days for appeal rights have passed AND the participant does NOT appeal,

SC will:

- Complete a 148W for closure. Refer to HCBS Waiver 148W Instructions, OAAS-ADM-13-016.

RO will:

- Process the 148W, electronically signing, saving and uploading to LaMEDS.
- Send a copy of the signed/processed 148W to the DMC and SCA.
- Review the OAAS Request for Services Registries (RFSR) and remove the participant's name if on the CCW and/or ADHC Waiver RFSR.

SC will:

- Notify the provider(s) of case closure by communicating directly with a representative, by email and/or via fax, on the same date that the 148W is approved by RO.

If the participant meets LOC, the SC will proceed with developing a new POC.

If the SC completes the iHC assessment electronically and can view the iHC results including the Participant Summary with CAPs while in the home, the annual iHC reassessment and annual POC meeting can be held at the same time.

If the SC is unable to complete the iHC reassessment electronically while in the home, the annual POC meeting must occur on a different day once the iHC is submitted in the database. The iHC assessment must be completed in person with the participant. The subsequent POC meeting can be completed in person or virtually (not by telephone) following Section V-Virtual Contacts of this manual and the OAAS Telehealth/Virtual Contact Policy, OAAS-ADM-23-011, however, all POC documents and forms must be signed by the involved parties. Verbal signatures are not allowed.