

**Title 19—DEPARTMENT OF
HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 81—Certification**

PROPOSED AMENDMENT

19 CSR 30-81.030 Evaluation and Assessment Measures for Title XIX Recipients and Applicants. The department is amending section (1), adding sections (7) and (8) and amending DHSS-DRL 110 (10-20) form included herein in sections (2) and (3).

PURPOSE: This amendment adds the level-of-care evaluation and assessment requirements back that were effective prior to October 31, 2021, in order for those individuals who would have qualified for Title XIX funded services prior to October 31, 2021, to be eligible to receive services funded through the American Rescue Plan Act. The amendment also removes the words “an Intellectual Disability/” on the DHSS-DRL-110 (10-20) form included herein in sections (2) and (3).

*PURPOSE: This rule sets the requirements for the periodic evaluation and assessments of residents in long-term care facilities in relationship to evaluation and assessment processes, level-of-care needed by individuals, and appropriate placement of individuals in order to receive this care. The rule also includes the algorithm utilized for the department’s Home and Community Based Services program for its level of care determination. **The rule includes a second level-of-care determination to be utilized from October 31, 2021, until the funding from the American Rescue Plan Act (temporary enhanced federal medical assistance percentage) has been expended.***

(1) For purposes of this rule only, the following definitions shall apply:

(A) Applicant—any resident or prospective resident of a certified long-term care facility who is seeking to receive inpatient Title XIX assistance;

(B) Certified long-term care facility—any long-term care facility which has been approved to participate in the inpatient program and receives Title XIX funding for eligible recipients;

(C) Initial assessment forms—the forms utilized to collect information necessary for a level-of-care determination pursuant to 19 CSR 30-81.030 and designated Forms DHSS-DRL-109 (10-20), Nursing Facility Level of Care Assessment and DHSS-DRL-110 (10-20), Level One Nursing Facility Pre-Admission Screening for Mental Illness/Intellectual Disability or Related Condition, included herein;

(D) Inpatient Title XIX assistance—Title XIX payments for intermediate or skilled nursing care in a certified long-term care facility;

(E) Level-of-care assessment—the determination of level-of-care need based on an assessed point count value for each category cited in subsection (4)(B) of this rule;

(F) Level-of-care determination—the decision whether an individual qualifies for long-term care facility care;

(G) Long-term care facility—a skilled nursing facility (SNF), an intermediate care facility (ICF), or a hospital which provides skilled nursing care or intermediate nursing care in a distinct part or swing bed under Chapter 197, RSMo;

(H) Pro re nata (PRN)—medication or treatment ordered by a physician to be administered as needed, but not regularly scheduled;

(I) [(H)] Recipient—any resident in a certified long-term care facility who is receiving inpatient Title XIX assistance;

(J) Redetermination of level-of-care—the periodic assessment of the recipients' continued eligibility and need for continuation at the previously assigned level-of-care. Periodic assessment includes but is not limited to the following:

- 1. Assessment of new admissions to a long-term care facility;**
- 2. Assessment of a change in mental and/or physical status for a resident who is being readmitted to a long-term care facility after transfer to an acute care facility, and the previous DA-124 A/B or C forms do not reflect the resident's current care needs; and**
- 3. Assessment of DA-124 forms as requested by the Department of Social Services, Family Support Division.**

(K) [(I)] Reevaluation of level-of-care—the periodic assessment of the recipients' continued eligibility and need for continuation at the previously assigned level-of-care. Periodic assessment includes but is not limited to the following:

- 1. Assessment of new admissions to a long-term care facility;**
- 2. Assessment of a change in mental and/or physical status for a resident who is being readmitted to a long-term care facility after transfer to an acute care facility, and the previous DHSS-DRL-109 (10-20), Nursing Facility Level of Care Assessment or DHSS-DRL-110 (10-20), Level One Nursing Facility Pre-Admission Screening for Mental Illness/Intellectual Disability or Related Condition forms do not reflect the resident's current care needs; and**
- 3. Assessment of DHSS-DRL-109 (10-20), Nursing Facility Level of Care Assessment or DHSS-DRL-110 (10-20), Level One Nursing Facility Pre-Admission Screening for Mental Illness/Intellectual Disability or Related Condition forms as requested by Department of Social Services, Family Support Division;**

(L) [(J)] Resident—a person seventeen (17) years or older who by reason of aging, illness, disease, or physical or mental infirmity receives or requires care and services furnished by a long-term care facility and who resides in, is cared for, treated or accommodated in such long-term care facility for a period exceeding twenty-four (24) consecutive hours; and

(M) (K) The department—Department of Health and Senior Services.

(7) Dual level of care assessments to be performed to determine level-of-care need from October 31, 2021, until the date that all of the temporary enhanced federal medical assistance percentage funds from the American Rescue Plan Act of 2021 are expended.

(A) The department is eligible to receive an additional ten (10) percent enhanced federal medical assistance percentage for home and community based services provided from April 1, 2021 through March 31, 2022, through the American Rescue Plan Act of 2021. This funding will allow the department to determine level-of-care need under the department's previous scoring system directly prior to the department's level-of-care transformation which takes effect on October 31, 2021, through formal rulemaking. Therefore, if an individual does not qualify for level-of-

care under the current level-of-care assessment as set forth in sections (5) and (6) of this rule from October 31, 2021, until the date that all of the temporary enhanced federal medical assistance percentage funds from the American Rescue Plan Act of 2021 are expended; then individuals shall also be assessed using a level-of-care assessment as set forth in section (8) of this rule. An individual may qualify for level-of-care need under either of these level of care assessments from October 31, 2021, until the date that all of the temporary enhanced federal medical assistance percentage funds from the American Rescue Plan Act of 2021 are expended.

(8) Second level-of-care determination to be performed from October 31, 2021, until the date that all of the temporary enhanced federal medical assistance percentage funds from the American Rescue Plan Act of 2021 are expended.

(A) Initial Determination of Level-of-Care Needs Requirements.

1. For the purpose of making a determination of level-of-care need and in accordance with 42 CFR sections 456.370 and 483.104, the department or its designated agents, or both, will conduct a review and assessment of the evaluations made by the attending physician for an applicant in or seeking admission to a long-term care facility. The review and assessment shall be conducted using the criteria in subsection (8)(D) of this rule.

2. The department shall complete the assessment within ten (10) working days of receipt of all documentation required by subsection (8)(D) in this rule unless further evaluation by the State Mental Health Authority is required by 42 CFR 483.100 to 483.138.

(B) Redetermination of Level-of-Care Requirements.

1. Redetermination of level-of care of individual recipients who are eligible for placement in long-term care facilities shall be conducted by the department through a review and assessment of the DA-124A/B (10-21) Initial Assessment – Social And Medical, DA-124C (10-21) Level One Nursing Facility Pre-Admission Screening For Mental Illness/Intellectual Disability or Related Condition, and DA-124C ATT (10-21) Notice To Applicant included herein and any documentation provided by the resident's attending physician. A referring individual shall fill out and submit the forms to the department at COMRU@health.mo.gov.

(C) Level-of-Care Criteria for Long-Term Care Facility Care- Qualified Title XIX Recipients and Applicants.

1. Individuals will be assessed with the ultimate goal to achieve placement for these individuals in the least restrictive environment possible, yet enable them to receive all services required by their physical/mental condition.

2. The specific areas which will be considered when determining an individual's ability or inability to function in the least restrictive environment are—mobility, dietary, restorative services, monitoring, medication, behavioral, treatments, personal care and rehabilitative services.

3. To qualify for intermediate or skilled nursing care, an applicant or recipient shall exhibit physical impairment, which may be complicated by mental impairment or mental impairment which may be complicated by physical impairment, severe enough to require intermediate or skilled nursing care.

(D) Assessed Needs Point Designations Requirements.

1. Applicants or recipients will be assessed for level-of-care by the assignment of a point count value for each category cited in subsection (8)(C)2 of this rule.

2. Points will be assessed for the amount of assistance required, the complexity of the care, and the professional level of assistance necessary, based on the level-of-care criteria. If the applicant's or recipient's records show that the applicant's or recipient's attending physician has ordered certain care, medication or treatments for an applicant or recipient, the department will assess points for a PRN order if the applicant or recipient has actually received or required that care, medication, or treatment within the thirty (30) days prior to review and evaluation by the department.

3. For individuals seeking admission to a long-term care facility on or after October, 31, 2021, the applicant or recipient will be determined to be qualified for long-term care facility care if he or she is determined to need care with an assessed point level of twenty-four (24) points or above, using the assessment procedure as required in subsection (8)(D)7 of this rule.

4. For individuals seeking admission to a long-term care facility on or after October 31, 2021, an applicant with twenty-one (21) points or lower will be assessed as ineligible for Title XIX-funded long-term care in a long-term care facility, unless the applicant qualifies as otherwise provided in sections (5), (6) or (8)(D)5 or 6 in this rule.

5. Applicants or recipients may occasionally require care or services, or both, which could qualify as long-term care facility services. In these instances, a single nursing service requirement may be used as the qualifying factor, making the individual eligible for long-term care facility care regardless of the total point count. The determining factor will be the availability of professional personnel to perform or supervise the qualifying care services. Qualifying care services may include, but are not limited to

- A. Administration of levine tube or gastrostomy tube feedings;**
- B. Nasopharyngeal and tracheotomy aspiration;**
- C. Insertion of medicated or sterile irrigation and replacement catheters;**
- D. Administration of parenteral fluids;**
- E. Inhalation therapy treatments;**
- F. Administration of injectable medications other than insulin, if required other than on the day shift; and**
- G. Requirement of intensive rehabilitation services by a professional therapist at least five (5) days per week.**

6. An applicant or recipient will be considered eligible for inpatient Title XIX assistance regardless of the total point count if the applicant or recipient is unable to meet physical/mental requirements for residential care facility (RCF) or assisted living facility (ALF) residency as specified by section 198.073, RSMo.

7. Points will be assigned to each category, as required by subsection (8)(C)2 in this rule, in multiples of three (3) according to the following requirements:

A. Mobility is defined as the individual's ability to move from place-to-place. The applicant or recipient will receive—

(I) Zero (0) points if assessed as independently mobile, in that the applicant or recipient requires no assistance for transfers or mobility. The applicant or recipient may use assistive devices (cane, walker, wheelchair) but is consistently capable of negotiating without assistance of another individual;

(II) Three (3) points if assessed as requiring minimum assistance, in that the applicant or recipient is independently mobile once the applicant or recipient receives assistance with transfers, braces or prosthesis application or other assistive devices, or a combination of these (example, independent use of wheelchair after assistance with transfer). This category includes individuals who are not consistently independent and need assistance periodically;

(III) Six (6) points if assessed as requiring moderate assistance, in that the applicant or recipient is mobile only with direct staff assistance. The applicant or recipient must be assisted even when using canes, walker or other assistive devices; and

(IV) Nine (9) points if assessed as requiring maximum assistance, in that the applicant or recipient is totally dependent upon staff for mobility. The applicant or recipient is unable to ambulate or participate in the ambulation process, requires positioning, supportive device, application, prevention of contractures or pressure sores and active or passive range of motion exercises;

B. Dietary is defined as the applicant's or recipient's nutritional requirements and need for assistance or supervision with meals. The applicant or recipient will receive—

(I) Zero (0) points if assessed as independent in dietary needs, in that the applicant or recipient requires no assistance to eat. The applicant or recipient has physician's orders for a regular diet, mechanically altered diet or requires only minor modifications (example, limited desserts, no salt or sugar on tray);

(II) Three (3) points if assessed as requiring minimum assistance, in that the applicant or recipient requires meal supervision or minimal help, such as cutting food or verbal encouragement. Calculated diets for stabilized conditions shall be included;

(III) Six (6) points if assessed as requiring moderate assistance, in that the applicant or recipient requires help, including constant supervision during meals, or actual feeding. Calculated diets for unstable conditions are included; and

(IV) Nine (9) points if assessed as requiring maximum assistance, in that the applicant or recipient requires extensive assistance for special dietary needs or with eating, which could include enteral feedings or parenteral fluids;

C. Restorative services are defined as specialized services provided by trained and supervised individuals to help applicants or recipients obtain and/or maintain their optimal highest practicable functioning potential. Each applicant or recipient must have an individual overall plan of care developed by the provider with written goals and response/progress documented. Restorative services may include, but are not limited to: applicant or recipient teaching program (self-transfer, self-administration of medications, self-care), range of motion, bowel and bladder program, remotivational therapy, validation therapy, patient/family program and individualized activity program. The applicant or recipient will receive—

(I) Zero (0) points if restorative services are not required;

(II) Three (3) points if assessed as requiring minimum services in order to maintain level of functioning;

(III) Six (6) points if assessed as requiring moderate services in order to restore the individual to a higher level of functioning; and

(IV) Nine (9) points if assessed as requiring maximum services in order to restore to a higher level of functioning. These are intensive services, usually requiring professional supervision or direct services;

D. Monitoring is defined as observation and assessment of the applicant's or recipient's physical and/or mental condition. This monitoring could include assessment of—routine laboratory work, including but not limited to, evaluating digoxin and coumadin levels, measurement and evaluation of blood glucose levels, measurement and evaluation of intake and output of fluids the individual has received and/or excreted, weights and other routine monitoring procedures. The applicant or recipient will receive—

(I) Zero (0) points if assessed as requiring only routine monitoring, such as monthly weights, temperatures, blood pressures and other routine vital signs and routine supervision;

(II) Three (3) points if assessed as requiring minimal monitoring, in that the applicant or recipient requires periodic assessment due to mental impairment, monitoring of mild confusion, or both, or periodic assessment of routine procedures when the recipient's condition is stable;

(III) Six (6) points if assessed as requiring moderate monitoring, in that the applicant or recipient requires recurring assessment of routine procedures due to the applicant's or recipient's unstable physical or mental condition; and

(IV) Nine (9) points if assessed as requiring maximum monitoring, which is intensive monitoring usually by professional personnel due to applicant's or recipient's unstable physical or mental condition;

E. Medication is defined as the drug regimen of all physician-ordered legend medications, and any physician-ordered nonlegend medication for which the physician has ordered monitoring due to the complexity of the medication or the condition of the applicant or recipient. The applicant or recipient will receive—

(I) Zero (0) points if assessed as requiring no medication, or has not required PRN medication within the thirty (30) days prior to review and evaluation by the department;

(II) Three (3) points if assessed as requiring any regularly scheduled medication and the applicant or recipient exhibits a stable condition;

(III) Six (6) points if assessed as requiring moderate supervision of regularly scheduled medications, requiring daily monitoring by licensed personnel; and

(IV) Nine (9) points if assessed as requiring maximum supervision of regularly scheduled medications, a complex medication regimen, unstable physical or mental status or use of medications requiring professional observation and assessment, or a combination of these;

F. Behavioral is defined as an individual's social or mental activities. The applicant or recipient will receive—

(I). Zero (0) points if assessed as requiring little or no behavioral assistance. Applicant or recipient is oriented and memory intact;

(II) Three (3) points if assessed as requiring minimal behavioral assistance in the form of supervision or guidance on a periodic basis. Applicant or recipient may display some memory lapses or occasional forgetfulness due to mental or developmental disabilities, or both. Applicant or recipient generally relates well with others (positive or neutral) but needs occasional emotional support;

(III) Six (6) points if assessed as requiring moderate behavioral assistance in the form of supervision due to disorientation, mental or developmental disabilities or uncooperative behavior; and

(IV) Nine (9) points if assessed as requiring maximum behavioral assistance in the form of extensive supervision due to psychological, developmental disabilities or traumatic brain injuries with resultant confusion, incompetency, hyperactivity, hostility, severe depression, or other behavioral characteristics. This category includes residents who frequently exhibit bizarre behavior, are verbally or physically abusive, or both, or are incapable of self-direction. Applicants or recipients who exhibit uncontrolled behavior that is dangerous to themselves or others must be transferred immediately to an appropriate facility;

G. Treatments are defined as a systematized course of nursing procedures ordered by the attending physician. The applicant or recipient will receive—

(I) Zero (0) points if no treatments are ordered by the physician;

(II) Three (3) points if assessed as requiring minimal type-ordered treatments, including nonroutine and preventative treatments, such as whirlpool baths and other services;

(III) Six (6) points if assessed as requiring moderate type-ordered treatments requiring daily attention by licensed personnel. These treatments could include: daily dressings, PRN oxygen, oral suctioning, catheter maintenance care, treatment of stasis or pressure sore ulcers, wet/moist packs, maximist and other such services; and

(IV) Nine (9) points if assessed as requiring maximum type-ordered treatments of an extensive nature requiring provision, direct supervision, or both, by professional personnel. These treatments could include: intratracheal suctioning; insertion or maintenance of suprapubic catheter; continuous oxygen; new or unregulated ostomy care; dressings of deep draining lesions more than once daily; care of extensive skin disorders, such as advanced pressure sore or necrotic lesions; infrared heat and other services;

H. Personal care is defined as activities of daily living, including hygiene; personal grooming, such as dressing, bathing, oral and personal hygiene, hair and nail care, shaving; and bowel and bladder functions. Points will be determined based on the amount of assistance required and degree of assistance involved in the activity. The applicant or recipient will receive—

(I) Zero (0) points if assessed as requiring no assistance with personal care in that the applicant or recipient is an independent, self-care individual. No assistance is required with personal grooming; the applicant or recipient has complete bowel and bladder control;

(II) Three (3) points if assessed as requiring minimal assistance with personal care, in that the applicant or recipient requires assistance with personal grooming, and/or exhibits infrequent incontinency (once a week or less);

(III) Six (6) points if assessed as requiring moderate assistance with personal care, in that the applicant or recipient requires assistance with personal grooming, requiring close supervision or exhibits frequent incontinency (incontinent of bladder daily but has some control or incontinent of bowel two (2) or three (3) times per week), or a combination of these; and

(IV) Nine (9) points if assessed as requiring maximum assistance with personal care, in that the applicant or recipient requires total personal care to be performed by another individual, and/or exhibits continuous incontinency all or most of the time; and

I. Rehabilitation is defined as the restoration of a former or normal state of health through medically-ordered therapeutic services either directly provided by or under the supervision of a qualified professional. Rehabilitation services include, but are not limited to: physical therapy, occupational therapy, speech therapy, and audiology. If ordered by the physician, each resident must have an individually planned and implemented program with written goals and response/progress documented. Points will be determined by intensity of required services and the applicant's or recipient's potential for rehabilitation as determined by the rehabilitation evaluation. The applicant or recipient will receive—

(I) Zero (0) points if assessed as requiring no ordered rehabilitation services;

(II) Three (3) points, if assessed as requiring minimal-ordered rehabilitation services of one (1) time per week;

(III) Six (6) points if assessed as requiring moderate-ordered rehabilitative services of two (2) or three (3) times per week; or

(IV) Nine (9) points if assessed as requiring maximum-ordered rehabilitative services of four (4) times per week or more.

AUTHORITY: sections 192.006, 192.2000, and 198.079, RSMo 2016. This rule was previously filed as 13 CSR 40-81.084 and 13 CSR 15-9.030. Original rule filed Aug. 9, 1982, effective Nov. 11, 1982. Emergency rescission filed Nov. 24, 1982, effective Dec. 4, 1982, expired March 10, 1983. Rescinded: Filed Nov. 24, 1982, effective March 11, 1983. Readopted: Filed Dec. 15, 1982, effective March 11, 1983. Emergency amendment filed Dec. 21, 1983, effective Jan. 1, 1984, expired April 11, 1984. Emergency amendment filed March 14, 1984, effective April 12, 1984, expired June 10, 1984. Amended: Filed March 14, 1984, effective June 11, 1984. Moved to 19 CSR 30-81.030, effective Aug. 28, 2001. Emergency amendment filed June 20, 2005, effective July 1, 2005, expired Dec. 27, 2005. Amended: Filed June 20, 2005, effective Dec. 30, 2005. Emergency amendment filed July 5, 2017, effective July 15, 2017, expired Feb. 22, 2018. Amended: Filed July 5, 2017, effective Feb. 28, 2018. Amended: Filed Jan. 12, 2021, effective Oct. 31, 2021. **Emergency amendment filed October 15, 2021, effective October 29, 2021, expires April 26, 2022.***

**Original authority: 192.006, RSMo 1993, amended 1995; 192.2000, RSMo 1984, amended 1988, 1992, 1993, 1994, 1995, 2001, 2014; and 198.079, RSMo 1979, amended 2007.*

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions forty nine million six hundred eighty-one thousand one hundred seventy-seven dollars (\$49,681,177) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Carmen Grover-Slattey, Regulation Unit Manager, Section for Long-Term Care Regulation, PO Box 570, Jefferson City, MO 65102-0570 or at RegulationUnit@health.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*