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STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
AND HEALTH SERVICES

A.M., PETITIONER, v. CAMDNED COUNTY BOARD OF SOCIAL SERVICES AND OFFICE OF COMMUNITY CHOICE OPTIONS, RESPONDENTS.	ADMINISTRATIVE ACTION FINAL AGENCY DECISION OAL DKT. NO. HMA 8879-2019 ON REMAND FROM OAL DKT. NO. HMA 16181-2018

As Assistant Commissioner for the Division of Medical Assistance and Health Services, I have reviewed the record in this case, including the Initial Decision, the OAL case file and the documents filed below. Respondent filed exceptions in this matter. Procedurally, the time period for the Agency Head to render a Final Agency Decision is April 23, 2020 in accordance with an Order of Extension.

The matter arises regarding the denial of Petitioner's application for Medicaid due to excess income. Petitioner's income of $1,443.50 exceeds the 2018 limit of $1,102. Petitioner's only path to eligibility for Medicaid benefits is under the Long-Term Care Services and Supports (LTSS) program that permits the use of a higher income level - 300 percent of the SSI benefit amount. In order for eligibility to be granted using this higher income level, Petitioner must be in need of nursing level of care. See 42 CFR § 435.236 and 42 CFR § 435.1005. That level of care requires that a pre-admission screening (PAS) be completed by "professional staff designated by the Department, based on a comprehensive needs assessment which demonstrates that the recipient requires, at a minimum, the basic NF services described in N.J.A.C. 8:85-2.2." N.J.A.C. 8:85-2.1(a). See also N.J.S.A. 30:4D-17.10, et seq. The assessment must be done in person and prior to receipt of benefits so as not to create a Medicaid program in the community using the higher income level.

The Initial Decision finds that since "medical chart reviews are able to be done by OCCO for clinical assessments for other Medicaid programs" one can be done here. ID at 16. The decision accuses OCCO of hiding behind a Medicaid Communication as its basis for being unable to perform a chart review for Petitioner. I find there is no support for this finding and it misrepresents the medical charts that can be reviewed for a determination of nursing home level of care. That Med Comm. operationalizes various regulatory requirements that that require OCCO to assess clinical eligibility based on a comprehensive assessment. N.J.A.C. 8:85-2.1(a). Only medical charts, kept by a nursing home or an assisted living facility can be reviewed to determine clinical level of care. These facilities as part of their federal and state requirements to operate must perform and chart functional assessments for every resident regardless of whether the resident is seeking Medicaid eligibility. Simply put, there are no comprehensive functional assessments to review for an individual seeking clinical eligibility in the community.

Regulations require that a PAS that is completed by "professional staff designated by

the Department, based on a **comprehensive needs assessment** which demonstrates that the recipient requires, at a minimum, the basic NF services described in N.J.A.C. 8:85-2.2." N.J.A.C. 8:85-2.1(a) (emphasis added). See also N.J.S.A. 30:4D-17.10, et seq. Individuals found clinically eligible "may have unstable medical, emotional/behavioral and psychosocial conditions that require ongoing nursing assessment, intervention and/or referrals to other disciplines for evaluation and appropriate treatment. Typically, adult NF residents have severely impaired cognitive and related problems with memory deficits and problem solving. These deficits severely compromise personal safety and, therefore, require a structured therapeutic environment. NF residents are dependent in **several activities of daily living** (bathing, dressing, toilet use, transfer, locomotion, bed mobility, and eating)." N.J.A.C. 8:85-2.1(a)1. (emphasis added).

The only medical charts that would align with clinical eligibility based on a comprehensive needs assessment are those completed in a nursing home or an assisted living facility. To that end nursing facilities are required to chart functional limitations both in the residents' medical chart and in the Minimum Data Set (MDS). See 42 CFR § 483.20. Nursing homes are required to perform an initial assessment and care plan for a resident within 48 hours of admission N.J.A.C. 8:39-11.2(d). Within 14 days of admission, the nursing home must complete a comprehensive assessment using the MDS. N.J.A.C. 8:39-11.2(e).[1] Those assessments must contain any limitations of activities of daily living (ADLs).

Similarly, assisted living facilities document and record each resident level of care N.J.A.C. 8:36-7.1. The initial assessment on admission to an assisted living facility must be

[1] "The Minimum Data Set (MDS) is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. Care Area Assessments (CAAs) are part of this process, and provide the foundation upon which a resident's individual care plan is formulated. MDS assessments are completed for all residents in certified nursing homes, regardless of source of payment for the individual resident. MDS assessments are required for residents on admission to the nursing facility, periodically, and on discharge. All assessments are completed within specific guidlines [sic] and time frames. In most cases, participants in the assessment process are licensed health care professionals employed by the nursing home. MDS information is transmitted electronically by nursing homes to the national MDS database at CMS." https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Minimum-Data-Set-3-0-Public-Reports

done to determine if the residents needs assistance with ADLs or other activities. N.J.A.C. 8:36-7.1. The assessment completed by a registered professional nurse must at minimum evaluate:

1. Need for assistance with "activities of daily living";
2. Cognitive patterns;
3. Communication/hearing patterns;
4. Vision patterns;
5. Physical functioning and structural problems;
6. Continence;
7. Psychosocial well-being;
8. Mood and behavior problems;
9. Activity pursuit patterns;
10. Disease diagnoses;
11. Health conditions and preventive health measures, including, but not limited to, pain, falls, and lifestyle;
12. Oral/nutritional status;
13. Oral/dental status;
14. Skin conditions;
15. Medication use;
16. Special treatment and procedures;
17. Restraint use; and
18. Outside service utilization.

N.J.A.C. 8:36-7.2 (d).

It is these charts that contain standardized assessments and evaluations of functional capabilities including ADL limitations of the individual that can be reviewed by OCCO to ascertain if that individual would be meet clinically eligibility. In this case, no such charts exist and the conclusion that a chart review is possible is unsupported by the pertinent regulations.

While OCCO admitted it was late in contacting Petitioner for an in-person assessment that is the only assessment that could be used in this case. In a thorough review, however, I have considered available information from the hospital discharge documentation. As noted in the prior decision hospitals are required to create and document a discharge plan. See N.J.A.C. 8:43G-11.5. That regulation requires "[p]atients who require post-discharge continuity of care shall be linked to needed resources." Examples of the needed

resources included placement in a nursing home or enrollment with home care services, both of which could demonstrate Petitioner needed assistance with his ADLs. The hospital did not make any such determination.

The only standardized form produced by Petitioner is New Jersey Universal Transfer Form. P-5. That form's purpose is to "communicate pertinent accurate clinical patient care information at the time of transfer between health care facilities/programs." N.J.A.C. 8:43E-13.2. Additionally the form "conveys the patent information required under Federal regulation and conveys specific facts that the physician and nurse need to begin caring for a patient." Ibid. That form was completed by Our Lady of Lourdes in Camden for Petitioner's transfer on August 30, 2018. That document contains an assessment of Petitioner's functions at that time. The nurse completing the form found that Petitioner had no risk alerts; could bear his own weight; was alert and oriented; was continent of bowel and bladder and was independent for walking, transferring, eating and toileting. P-5. While I do not find this form is analogous to the assessments done by nursing homes and assisted living facilities and the form is not controlling in the process set forth in the Med Comm., it is persuasive that as late as August 30, Petitioner had no deficiencies in his ADLs.

It is unfortunate that Petitioner was not eligible for Medicaid due to his income, but the use of the higher income limit must be applied only to those where the need for nursing home level of care can be documented. I note that OCCO provided options counseling to Petitioner's wife regarding public and private avenues that could assist her. R-12.

Therefore, I hereby REVERSE the decision and uphold the denial of Petitioner's Medicaid application due to excess income.

THEREFORE, it is on this 23rd day of APRIL 2020,

ORDERED:

That the Initial Decision is hereby REVERSED.

Jennifer Langer Jacobs, Assistant Commissioner
Division of Medical Assistance
and Health Services