

DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF EMERGENCY AND THIRD PROPOSED RULEMAKING

The Director of the Department of Health Care Finance (DHCF), pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02 (2016 Repl.)) and Section 6(6) of the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.05(6) (2012 Repl.)), hereby gives notice of the intent to amend, on an emergency basis, Section 989, entitled “Long Term Care Services and Supports Assessment Process” of Chapter 9 (Medicaid Program) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

These emergency and proposed rules establish standards governing the assessment process for the level of need for beneficiaries who receive Long Term Care Services and Supports (LTCSS), with the exception of Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (ICF/IID) services, and Home and Community-Based Waiver Services for Individuals with Intellectual and Developmental Disabilities (IDD Waiver). This includes nursing facility services, services offered through the Home and Community-Based Services Waiver for the Elderly and Persons with Physical Disabilities (EPD Waiver), Personal Care Aide (PCA) services available under the District’s Medicaid State Plan, Adult Day Health Program (ADHP) services offered under the 1915(i) Home and Community-Based State Plan Option, and other LTCSS not intended to serve individuals with intellectual and developmental disabilities such as the Program of All Inclusive Care for the Elderly (PACE).

Under the assessment process, a nurse employed by DHCF or its designated agent conducts face-to-face assessments and reassessments using a standardized needs-based assessment tool to determine a person’s support needs for LTCSS. Emergency action is necessary in order to ensure timely access to EPD Waiver services for vulnerable beneficiaries to ensure the maintenance of their health and safety and avoidance of unnecessary institutionalization in accordance with newly approved procedures for LTCSS delivered under the EPD Waiver.

An initial Notice of Proposed Rulemaking was published in the *D.C. Register* on June 6, 2014 at 61 DCR 005781. Comments were received and incorporated into the Notice of Second Proposed Rulemaking, which was published in the *D.C. Register* on March 18, 2016 at 63 DCR 004086. Additional comments were received on the second proposed rulemaking and were taken into consideration in this emergency and third proposed rulemaking, as detailed below.

DHCF received comments on the second proposed rulemaking from two (2) entities (Disability Rights DC at University Legal Services and District of Columbia Hospital Association). The majority of the seventeen (17) comments received were related to the rule; DHCF also received comments on the tool itself. All comments received were carefully considered by DHCF, and substantive changes were made as appropriate, as summarized below.

References to Existing Rules

Commenters voiced concerns that these regulations do not appropriately include or reference existing regulations setting eligibility requirements and assessment procedures. In fact, the rule clearly states that its purpose is to establish standards governing the Medicaid assessment process, including the creation of numerical scores pertaining to the level of need necessary to establish eligibility for a range of long term care services and supports (LTCSS). More detailed eligibility information regarding the services and supports can be found in the program rules specific to each long term care service and support. These rules do not replace the existing program-specific regulations.

Assessment Process

A number of the comments related to the proposed assessment process. One commenter expressed a concern that the regulations are silent on how to request LTCSS services (including the required assessment). In order to address this, DHCF amended the proposed rules to include information about the process to request an assessment. Specifically, information was added to clarify that the requests shall be submitted via a publicly available request form.

A commenter also noted that the second proposed rule requires a registered nurse (RN) employed by DHCF (or its agent) to conduct the face-to-face assessment for LTCSS, and that the initial proposed rules allowed DHCF or its designated agent to conduct the assessment. DHCF notes that this change was made to address comments from stakeholders in the first Notice of Proposed Rulemaking that the section did not specify who can be considered as the designated agent of the DHCF. DHCF will not amend the requirement that the assessment should be conducted by an RN employed by DHCF or its designated agent.

A commenter felt that the rule failed to include language acknowledging an applicant's right to decide who may be involved in the assessment process, and that while the original proposed regulations stated the assessment shall "be developed in consultation," the new regulations simply changed "developed" to "conducted." Because DHCF uses a pre-developed, standardized assessment tool to determine the person's long term care needs, the assessment cannot be altered for each assessment. However, the process does allow an applicant to decide who may be involved in the assessment by including the option for the applicant to complete the assessment in the presence of members of his/her support team or other people who are important to the person.

A commenter noted that the regulations improperly rely on informal supports and non-Medicaid resources in determining the level of an applicant's LTCSS needs. In fact, DHCF developed the tool in consultation and collaboration with advocates and the stakeholder community, and the scoring model was drawn largely from a model implemented in another jurisdiction, with some adaptation based on unique characteristics of the District's population. The requested information about the tool development methodology and the scoring process is not regulatory information; DHCF intends to explain the scoring methodology in policies and procedures and/or a presentation or transmittal.

Relatedly, one commenter believed that by relying on the current utilization of informal supports and resources prior to the completion of the assessment, DHCF is determining a person's level of need on resources for which the applicant cannot control the reliability or availability. DHCF disagrees with this assumption; although the assessment determines a person's unmet level of need (which is very important in assessing a holistic picture of a person's overall support needs), the tool does not penalize a person based on the presence or lack of informal supports in his/her access to long term care services.

Timeliness of Assessments

One commenter expressed concern about wanting to ensure that assessments could be made and decisions could be reached quickly when needed and specifically suggested the rule set standards for expedited assessment, deadlines for completion, opportunities for documentation by the applicant, and determination of service needs. DHCF partly disagrees with this comment because the rule already includes deadlines for RNs to conduct assessments and issue assessment determinations, and makes exceptions for persons whose health conditions necessitate expedited assessments. In particular, the rule states that the deadline for conducting the assessment can be shortened if "the person's condition requires that an assessment be conducted sooner to expedite the provision of LTCSS." These reviews will be conducted on a case by case basis. Although DHCF believes the necessary information was included in the previous rulemaking, DHCF clarified this section in these third proposed rules by providing further detail on the assessment timelines and expediting process.

Another comment expressed concern with the provision allowing for five (5) calendar days to conduct the required assessment, since in the hospital environment five (5) calendar days is too long for a patient to wait for an assessment. DHCF agrees with this comment, and adjusted the timeline for completing the assessment for hospital discharges to forty-eight (48) hours.

A commenter provided positive feedback regarding the amendment of the time period for the face-to-face assessment for PCA services to once every twelve (12) months. The provision still allows for an early reassessment if a beneficiary experiences a significant change in condition or acuity level. Another commenter believed it was helpful that new language was included to permit DHCF to extend the LTCSS reassessment and reauthorization period pursuant to the face-to-face assessment for up to eighteen (18) months to align the assessment date with a beneficiary's Medicaid renewal date.

Assessment Tool Requirements

A number of comments expressed concern about the assessment tool requirements. One commenter wrote that the assessment tool is not sufficiently described in a way that codifies LTCSS eligibility standards. In 2013, DHCF conducted a pilot study during which the agency assessed a sample of Medicaid long term care (LTC) beneficiaries. Based on the study, DHCF mapped current eligibility criteria with the numerical scores on the tool.

Another commenter expressed concern that the section describing how people will be assessed (providing three (3) separate scores for functional, cognitive/behavioral, and skilled care needs)

lacked an adequate description of services relating to the separate scores for cognitive/behavioral and skilled care needs. The referenced section clearly states that the tool will produce one (1) total numerical score that combines the three (3) separate scores related to functional, cognitive/behavioral and skilled nursing assessments. With the exception of PCA services which is determined by the person's functional score, the scores associated with the respective functional, cognitive/behavioral, and skilled care needs sections do not qualify a person for a unique set of services, so the additional detail the commenter requested is not needed.

A commenter expressed confusion over the purpose of scoring an applicant's cognitive and behavioral needs separately from functional/ADL and IADL needs and skilled nursing needs. DHCF's new assessment tool assesses three (3) distinct areas of support needs; cognitive/behavioral, functional, and skilled care. This assessment is much broader than DHCF's previous tool or assessment, and once the person completes the assessment, there are scores assigned to each combination of assessed needs, which are then provided to the person immediately after the assessment is completed.

Another commenter expressed confusion regarding whether medication management is, in fact, factored into an applicant's functional assessment score. DHCF proposed the new language (i.e., a score of four (4) or higher with a medication management score of at least one (1) to address stakeholders' previous concerns during the first Notice of Proposed Rulemaking comment period of not taking into account a person's needs for medication management into his/her overall need for PCA services. However, the Department of Health (DOH) is currently drafting a regulation to certify medication aides in the District, which would allow PCAs with DOH's requisite training to administer medications. DHCF will update the long term care assessment rule and PCA rules after DOH promulgates the medication aide certification regulation. DHCF is reverting back to the original scoring for PCA services which allows a person to qualify for PCA services if he/she receive a functional score without medication management of four (4) or higher.

One commenter rightly highlighted that the rule fails to explicitly incorporate the applicant's preference for setting of his/her services; DHCF has amended the language to incorporate the person's preferred setting.

Another comment notes that the regulations regarding the application of the assessment tool fail to provide disability accommodation during the LTCSS assessment process. DHCF is revising the assessment tool to include information to determine if a person who is speech and/or hearing impaired needs a Sign Language Interpreter, to ensure that the person will be assisted.

Notice and Appeal Rights

A number of comments related to concerns about notice and appeal rights. With regard to the section detailing the process for referral when a person has not selected or needs further assistance selecting a provider, commenters expressed that the revised proposed regulations still fail to provide an applicant with notice as to what needs are being assessed or what range of potential services a person may receive. In fact, when a person is assessed he/she is given a choice of various LTC services including nursing home, EPD Waiver, PCA, and Adult Day

Health. DHCF revised the regulation to explain that a person's eligibility for specific LTCSS will be explained in the determination sheet.

Within the section calling for a notice in the event of a service denial or change of services where "a person is found to be ineligible for, or does not meet the level of need for LTCSS," one commenter expressed a concern that this language did not explicitly cover assessment determinations leading to service reductions or require that notices will describe the reasons for the service denial, reduction or termination. DHCF agrees that reasons should be stated in the letter, and has amended the language accordingly.

With regard to requests for reconsideration, a commenter felt the regulations fail to allow beneficiaries to make reconsideration requests verbally, as required by D.C. Code § 4-210.05. The citation referenced in the comment pertains to "hearings," while the regulation references requests for reconsiderations or administrative review process, which is different from a hearing and precedes the formal hearing process. Given this, DHCF does not believe a change is necessary.

Related to the reconsideration process, a commenter mentioned that the requirement for beneficiaries seeking to appeal an adverse reconsideration decision should also allow beneficiaries to make requests for a fair hearing verbally, in accordance with applicable Office of Administrative Hearing regulations. DHCF agrees, and has amended the relevant language accordingly.

A commenter also suggested that DHCF add a new provision to the regulations to make clear that beneficiaries are not required to seek reconsideration prior to seeking administrative hearings before the OAH to challenge service denials, reductions, and terminations. Additional clarifying language has been added to these rules to address the commenter's concern.

With regard to concerns presented on the circumstances under which Medicaid LTCSS is provided during the pendency of a fair hearing, this section does not address those circumstances. Instead, it explains that when a beneficiary receives a reconsideration decision, information including an explanation of circumstances under which Medicaid LTCSS is provided during the pendency of a fair hearing will be included.

One commenter expressed concern that the section detailing a beneficiary's receipt of benefits pending appeal during the pendency of a fair hearing does not conform to federal requirements found at 45 CFR § 205.10. DHCF respectfully asserts that the citation provided by the commenter is not applicable to the Medicaid program. In fact, federal Medicaid requirements, codified at 42 CFR § 431.230, do not mandate that a beneficiary's current services be preserved if a beneficiary files a hearing request within ninety (90) days of receipt of an adverse determination, and instead require that current services be maintained if a beneficiary files a hearing request prior to the effective date of the intended action stated in the notice. These rules allow beneficiaries ninety (90) days to appeal determinations made in a Beneficiary Denial or Change of services letter, and provide that DHCF will not reduce or terminate LTCSS while a fair hearing is pending if a beneficiary who was receiving services files the hearing request prior

to the effective date of the intended action reflected in the Administrative Denial Letter or the Beneficiary Denial or Change of Services Letter.

Definitions

Within the Definitions section of the rule, a commenter felt that “acuity level” should specify whether intensity is gauged by the number of hours needed or whether the services would be provided hands-on versus under supervision. In addition, the commenter felt that the definitions for “level of need,” “informal supports,” “representative,” “support team” and “person-centered plan” lacked in specificity. DHCF took the suggested language into consideration and revised the definitions for “informal supports,” “representative,” and “support team.”

LTCSS Assessment Tool

DHCF also received a number of comments related to the Assessment Tool itself. One commenter pointed out that the assessor should not seek information from anyone other than the applicant without the applicant's express consent to elicit information from specific people. DHCF agrees with this comment, and has amended the instructions in this section of the tool. One commenter also suggested that Section III of the tool should include the dates of each contact with the applicant or referral source. DHCF agrees with this comment and made changes accordingly.

A commenter contended Section IV improperly elicits information about legal services, financial management, counseling, and housing assistance the applicant may have sought or received, where access to legal services should have no bearing on an applicant's eligibility for LTCSS. In fact, DHCF does not believe that collecting legal information is harmful, and the goal is to better understand the person's ability to make healthcare decisions and whether other designated individuals need to be involved in the healthcare planning process, and be a designated part of the applicant's interdisciplinary care planning team.

Within Section V, one commenter suggested that the language be modified regarding “Guardian/Power of Attorney” to inquire whether the person has anyone making healthcare decisions on his/her behalf in order to support the presumption that an applicant for LTCSS make his or her own healthcare decisions. DHCF does not believe this section needs to be rephrased. Information about assistance with financial management and medical decisions is necessary to ascertain whether someone, other than the applicant, has the right to make decisions on behalf of the applicant. DHCF does not believe that collecting this information is harmful, and the goal is to better understand the person's ability to make healthcare decisions and whether other designated individuals need to be involved in the healthcare planning process, and be a designated part of the applicant's interdisciplinary care planning team.

Within Section VI, one commenter mentioned that information about an applicant's landlords and/or environmental conditions is irrelevant to the LTCSS assessment and should be deleted. In fact, one of the goals of the assessment is to determine whether or not the applicant lives in a HCBS setting which meets the characteristics of CMS' January 2014 regulation. It is incumbent

upon the Medicaid agency to elicit any information to ensure that the setting that the person is residing in meets the criteria of CMS' rule.

One commenter suggested that the assessment of an applicant's speech clarity should not be in Section X (cognitive/behavioral issues), but in the physical conditions section instead. DHCF believes that clarity of speech is a commonly used indicator of a person's cognitive abilities. The clinician who administers the tool will determine whether or not the speech clarity was associated with a physical condition or side effects of a medication, and make adjustments as necessary.

A commenter sought clarity within Section X, given that the scoring in this section points to a maximum of 21 points which appears to conflict with the maximum score of up to 3 on the cognitive assessment. Although this section of the assessment may result in 21 points, only 3 of the 9 total points which would warrant a need for nursing facility level of care services (*i.e.*, EPD Waiver) would come from a person's cognitive/behavioral needs.

Questions about a person's status as homebound (Section XI) was questioned by a commenter, saying this is irrelevant. In fact, this information is used by the nurse to have a better understanding of the applicant's overall functioning and healthcare needs, so that he/she can better determine the number of hours needed for various Medicaid LTCSS services. In addition, Section XI is not scored.

A commenter felt that the questions in Section XII on "informal supports" failed to capture the regularity or sporadic/intermittent level of such supports, and that these should not be factored into the assessment. Actually, this section is not scored, and the information is necessary to allow the clinician to have more information about a person's overall needs with PCA services. For example, some nurses report that an applicant does not want the full allotment of PCA hours because the applicant prefers that a family member provide services.

In sum, these emergency and third proposed rules amend the previously published standards in the Notice of Second Proposed Rulemaking by: (1) clarifying that assessment requests can be made by submitting a publicly available Prescription Order Form, and including the website for accessing the form; (2) specifying that for all hospital discharges, the timeline for conducting the assessment in addition to issuing an assessment determination is forty-eight (48) hours from the receipt of a request for an assessment; (3) amending the scoring criteria for PCA services by removing the provision allowing PCA services to be accessed if a person's functional score without medication management is three (3) or higher and a medication management score is at least a one (1); (4) adding that the Beneficiary Denial or Change of Services Letter will also include the reasons for the service denial, reduction, or termination of services; (5) adding a description of the Administrative Denial Letter issued to beneficiaries when an assessment could not be conducted; (6) adding specific language for each component of the assessment tool; (7) clarifying re-assessment requirements and processes for all LTCSS; (8) clarifying language to make the requirements more understandable; and (9) amending definitions used in the Section.

These emergency rules were adopted on March 14, 2017 and became effective on that date. The emergency rules shall remain in effect for not longer than one hundred and twenty (120) days

from the adoption date or until July 12, 2017, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*.

The Director also gives notice of the intent to take final rulemaking action to adopt this proposed rule not less than thirty (30) days after the date of publication of this notice in the *D.C. Register*.

Chapter 9 MEDICAID PROGRAM, of Title 29 DCMR, PUBLIC WELFARE, is amended as follows:

Section 989, LONG TERM CARE SERVICES AND SUPPORTS ASSESSMENT PROCESS, is amended to read as follows:

989 LONG TERM CARE SERVICES AND SUPPORTS ASSESSMENT PROCESS

- 989.1 The purpose of this section is to establish the Department of Health Care Finance (DHCF) standards governing the Medicaid assessment process for Long Term Care Services and Supports (LTCSS) and to establish numerical scores pertaining to the level of need necessary to establish eligibility for a range of LTCSS.
- 989.2 LTCSS are designed to assist persons with a range of services and supports including assistance with basic tasks of everyday life over an extended period of time. These include, but are not limited to, the Home and Community-Based Services Waiver for the Elderly and Persons with Physical Disabilities (EPD Waiver), Personal Care Aide (PCA) services offered under the Medicaid State Plan, nursing facility services, Adult Day Health Program (ADHP) services under the 1915(i) Home and Community-Based State Plan Option, and other services not intended to serve individuals with intellectual and developmental disabilities.
- 989.3 A Registered Nurse (R.N.) employed by DHCF or its designated agent shall conduct an initial face-to-face assessment following the receipt of a request for an assessment for LTCSS made by any individual identified in Subsection 989.5.
- 989.4 Individuals identified in Subsection 989.5 may request an assessment for LTCSS by submitting a Prescription Order Form (POF). The POF is available on the DHCF website at <http://dhcf.dc.gov>.
- 989.5 The request shall include any supporting documentation established by the respective long term care program's regulations. An initial request for an assessment or a subsequent request for re-assessment based upon a change in the person's condition or acuity level may be made by the person seeking services, the person's representative, the person's EPD Waiver case manager, a family member, or health care or social services professional.
- 989.6 With the exception of hospital discharge timelines, which are referenced under Subsection 989.15, the R.N. employed by DHCF or its designated agent shall be

responsible for conducting the face-to-face assessment of each person using a standardized needs-based assessment tool within five (5) calendar days of the receipt of a request for an assessment, unless:

- (a) The person's condition requires that an assessment be conducted sooner to expedite the provision of LTCSS to that person;
- (b) The person has requested an assessment at a later date;
- (c) DHCF or its designated agent is unable to contact the person to schedule the assessment after making three (3) attempts to do so within five (5) calendar days of receipt of the assessment request; or
- (d) DHCF determines that an extension is necessary due to extenuating circumstances.

989.7 The assessment shall:

- (a) Confirm and document the person's functional limitations, cognitive/behavioral and skilled care support needs;
- (b) Be conducted in consultation with the person and his/her representative and/or support team;
- (c) Determine and document the person's unmet need for services taking into account the current utilization of informal supports and other non-Medicaid resources required to meet the person's need for assistance; and
- (d) Determine the person's level of need for LTCSS.

989.8 The standardized needs-based assessment tool shall be available on DHCF's website at www.dhcf.dc.gov.

989.9 The face-to-face assessment using the standardized needs-based assessment tool to determine each person's level of need for LTCSS shall result in a total numerical score which includes three (3) separate scores pertaining to his/her assessed functional, cognitive/behavioral, and skilled care needs. The functional assessment score includes an assessment and corresponding score correlated to the person's ability to manage medications. The three (3) separate assessment scores are used to determine eligibility for specific LTCSS as follows:

- (a) For State Plan PCA services, only the functional score, without consideration of the medication management assessment and corresponding score, is used to determine eligibility; and

- (b) For all other LTCSS, eligibility is based on the sum of the scores for functional, cognitive/behavioral, and skilled care needs, and includes medication management.

989.10 The total numerical score consists of a value from zero to thirty-one (0-31), which may include a score of up to twenty-three (23) on the functional assessment, a score of up to three (3) on the cognitive/behavioral assessment, and a score of up to five (5) on the skilled care needs assessment.

989.11 Each of the assessments that comprise the total numerical score contains the following components:

- (a) The functional assessment evaluates the type and frequency of assistance the person requires for each of the following activities of daily living (ADLs) and instrumental activities of daily living (IADLs) based on typical experience under ordinary circumstances within the last seven (7) days prior to assessment:

- (1) Bathing;
- (2) Dressing;
- (3) Eating/Feeding;
- (4) Transfer;
- (5) Mobility;
- (6) Toileting;
- (7) Urinary Continence and Catheter Care;
- (8) Bowel Continence and Ostomy Care; and
- (9) Medication Management, for which the score is not considered for State Plan PCA service eligibility in accordance with § 989.9(a);

- (b) The cognitive/behavioral assessment evaluates the presence of and frequency with which the following conditions and behaviors occur:

- (1) Serious mental illness or intellectual disability;
- (2) Difficulty with receptive or expressive communication;
- (3) Hallucinations;

- (4) Delusions;
 - (5) Physical behavioral symptoms directed toward others (*e.g.*, hitting, kicking, pushing, grabbing, sexual abuse of others);
 - (6) Verbal behavioral symptoms directed toward others (*e.g.*, threatening, screaming, cursing at others);
 - (7) Other physical behaviors not directed toward others (*e.g.*, self-injury, pacing, public sexual acts, disrobing in public, throwing food or waste);
 - (8) Rejection of assessment or health care; and
 - (9) Eloping or wandering;
- (c) The skilled care needs assessment evaluates whether and how frequently the following skilled services and therapies were required during the past thirty (30) days and during the seven (7) days prior to assessment:
- (1) Occupational therapy;
 - (2) Physical therapy;
 - (3) Respiratory therapy;
 - (4) Speech therapy;
 - (5) Ventilator care;
 - (6) Tracheal suctioning or tracheostomy care;
 - (7) Total parenteral nutrition;
 - (8) Complex wound care;
 - (9) Wound care of moderate complexity;
 - (10) Early or preventive wound care;
 - (11) Hemodialysis;
 - (12) Peritoneal dialysis;
 - (13) Enteral tube feeding;

- (14) Intravenous fluid or medication administration;
 - (15) Intramuscular or subcutaneous injections;
 - (16) Isolation precautions; and
 - (17) Patient-controlled analgesia pump.
- 989.12 The total numerical scores reflect a person's eligibility for LTCSS as follows:
- (a) A score of four (4) or higher on the functional assessment, as described in § 989.9(a), is needed for State Plan PCA services;
 - (b) A score of four (4) or five (5) is needed for ADHP acuity level 1 services;
 - (c) A score of six (6) or higher is needed for ADHP acuity level 2 services; and
 - (d) A score of nine (9) or higher is needed for nursing facility, EPD Waiver, or other programs/services that require a nursing facility level of care.
- 989.13 Based upon the results of the face-to-face assessment, DHCF or its authorized agent shall issue to the person an assessment determination that specifies his/her level of need for a range of LTCSS for which the person is eligible.
- 989.14 The assessment determination shall include the types of LTCSS available to the person based on the scores received and shall be issued to the person no later than forty-eight (48) hours after the assessment is completed, unless the person's condition necessitates that services be authorized and provided earlier.
- 989.15 For hospital discharges, the timeline for completing the LTCSS assessment, including the issuance of an assessment determination referenced in Subsection 989.13 and the authorization of services included in the determination, shall be forty eight (48) hours from the receipt of a request for an assessment.
- 989.16 An R.N. employed by DHCF or its designated agent shall conduct a face-to-face re-assessment of each person's need for the receipt of LTCSS as follows:
- (a) For ADHP services, a re-assessment shall be conducted at least every twelve (12) months or upon a significant change in the person's health status or acuity level;
 - (b) For State Plan PCA services, the supervisory nurse employed by the home health agency shall conduct an evaluation of each person's need for the continued receipt of PCA services at least once every twelve (12) months or upon a significant change in the person's health status, as follows:

- (1) The evaluation shall determine whether there is a significant change in the person's health status;
 - (2) If the evaluation results in a determination that there is no significant change, the supervisory nurse shall attest that a face-to-face re-assessment is not required and services shall continue to be provided at the level set forth in the current assessment determination; and
 - (3) If the evaluation results in a determination that there is a significant change, the supervisory nurse shall request that a face-to-face re-assessment be conducted in accordance with § 989.5; and
- (c) For all EPD Waiver services, effective April 1, 2018, the case manager shall conduct an evaluation of each person's health status at least once every twelve (12) months or upon a significant change in the person's health status, as follows:
- (1) The evaluation shall determine whether there is a significant change in the person's health status;
 - (2) If the evaluation results in a determination that there is no significant change, the case manager shall attest that the person continues to require a nursing facility level of care and that a face-to-face re-assessment is not required; and
 - (3) If the evaluation results in a determination that there is a significant change, the case manager shall request that a face-to-face re-assessment be conducted in accordance with § 989.5;

989.17 For nursing facility services, DHCF or its designated agent shall conduct periodic continued stay reviews to evaluate a person's continued eligibility for nursing facility services, as follows:

- (a) The evaluation shall determine whether the person continues to meet nursing facility level of care; and
- (b) If the evaluation results in a determination that the person does not meet nursing facility level of care, DHCF or its designated agent shall request that a face-to-face re-assessment be conducted in accordance with policy guidance issued by DHCF.

989.18 For EPD Waiver services, DHCF may extend the level of need reauthorization period pursuant to the face-to-face reassessment for a timeframe not to exceed

eighteen (18) months to align the level of need assessment date with the person's Medicaid renewal date.

- 989.19 Requests to conduct re-assessments shall be made in accordance with the requirements under Subsection 989.5.
- 989.20 If the person meets the level of need as determined by a numerical score affiliated with each long-term care service in accordance with Subsection 989.12, and chooses to participate in a long-term care program, DHCF or its authorized agent shall refer the person to the long-term care service provider of his/her choice.
- 989.21 The person shall choose a provider based upon the level of need, availability, and the ability of the provider to safely care for him/her in the setting of the person's choice.
- 989.22 DHCF or its authorized agent shall maintain the completed standardized assessment tool and documentation reflecting that the person was given a free choice of providers from a list of qualified providers.
- 989.23 If the person has not made a choice, or needs further assistance, DHCF or its authorized agent shall refer the person to the Aging and Disability Resource Center for additional assistance, options counseling, and person-centered planning as appropriate.
- 989.24 If the R.N. employed by DHCF or its agent is unable to conduct the face-to-face assessment or re-assessment described in this section after making three (3) attempts to do so within five (5) calendar days, an initial Administrative Denial Letter shall be issued to the person. The initial Administrative Denial Letter shall contain the following information:
- (a) A clear statement of the administrative denial of the assessment request;
 - (b) An explanation of the reason for the administrative denial, including documentation of the three (3) attempts that were made to conduct the assessment;
 - (c) Citation to regulations supporting the administrative denial;
 - (d) A clear statement that the person has twenty-one (21) days from the date the letter was issued to contact DHCF or its agent to request the assessment, including all necessary contact information; and
 - (e) For re-assessment requests, a clear statement that if the person fails to contact DHCF or its agent within twenty-one (21) days of the date the letter was issued, the person's current LTCSS shall be terminated.

989.25 If a person currently receiving LTCSS receives an initial Administrative Denial Letter in accordance with § 989.24 and fails to contact DHCF or its agent to request a re-assessment within twenty-one (21) days of the date the letter was issued, a subsequent Administrative Denial Letter shall be issued to the person. The subsequent Administrative Denial Letter shall contain the following information:

- (a) A clear statement of the intended termination of the person's current LTCSS due to administrative denial of the re-assessment request;
- (b) An explanation of the reason for the administrative denial, including documentation of the three (3) attempts that were made to conduct the assessment and reference to the Administrative Denial Letter;
- (c) Citation to regulations supporting the administrative denial and intended termination;
- (d) Information regarding the right to appeal the decision by filing a hearing request with the Office of Administrative Hearings (OAH) and the timeframe for filing a hearing request, as well as an explanation that a reconsideration request is not required prior to filing a hearing request;
- (e) An explanation of the circumstances under which the person's current level of LTCSS will be continued if the person files a timely hearing request with OAH; and
- (f) Information regarding legal resources available to assist the person with the appeal process.

989.26 DHCF, or its agent, shall issue a Beneficiary Denial or Change of Services Letter if, based upon the assessment or re-assessment conducted pursuant to this section, a person is found to be ineligible for, or does not meet the level of need for, LTCSS. The Beneficiary Denial or Change of Services Letter shall contain the following information:

- (a) A clear statement of the intended denial, reduction, or termination of LTCSS;
- (b) An explanation of the reason(s) for the intended denial, reduction, or termination of LTCSS;
- (c) Citation to regulations supporting the intended denial, reduction, or termination of LTCSS;
- (d) Information regarding the right to request that DHCF reconsider its decision and the timeframe for making a reconsideration request;

- (e) Information regarding the right to appeal the decision by filing a hearing request with OAH and the timeframe for filing a hearing request, as well as an explanation a reconsideration request is not required prior to filing a hearing request;
- (f) An explanation of the circumstances under which the person's current level of LTCSS will be continued if the person files a timely hearing request with OAH; and
- (g) Information regarding legal resources available to assist the person with the appeal process.

989.27 A request for reconsideration of a person's level of need as determined by the assessment tool, pursuant to § 989.26(d), must be submitted in writing, by mail, fax, or in person, to DHCF's Office of the Senior Deputy Director/Medicaid Director, within twenty-one (21) calendar days of the date of the notice of denial, termination, or reduction of LTCSS services. The request for reconsideration shall include information and documentation as follows:

- (a) A written statement by the person, or the person's designated representative, describing the reason(s) why the decision to deny, terminate, or reduce LTCSS services should not be upheld;
- (b) A written statement by a physician familiar with the person's health care needs; and
- (c) Any additional, relevant documentation in support of the request.

989.28 For beneficiaries currently receiving services, a timely filed request for reconsideration will stay the reduction or termination of services until a reconsideration decision is issued.

989.29 DHCF shall issue a reconsideration decision no more than forty-five (45) calendar days from the date of receipt of the documentation required in § 989.27.

989.30 If DHCF decides to uphold the assessment determination, the reconsideration decision shall contain the following:

- (a) A description of all documents that were reviewed;
- (b) The justification(s) for the intended action(s) and the effective date of the action(s);
- (c) An explanation of the beneficiary's right to request a fair hearing; and

(d) The circumstances under which Medicaid LTCSS is provided during the pendency of a fair hearing.

989.31 A request to appeal the reconsideration decision, pursuant to § 989.30, must be submitted within ninety (90) calendar days of the date of issuance of the reconsideration decision by requesting a fair hearing with OAH in writing, in person, or by telephone, in accordance with 1 DCMR § 2971.

989.32 A request to appeal the denial, reduction, or termination of services, pursuant to § 989.26(e), must be submitted within ninety (90) calendar days of the date of the Beneficiary Denial or Change of Services Letter by requesting a fair hearing with OAH in writing, in person, or by telephone, in accordance with 1 DCMR § 2971.

989.33 DHCF shall not reduce or terminate LTCSS services while a fair hearing is pending if a beneficiary who was receiving services files the hearing request prior to the effective date of the proposed action to reduce or terminate LTCSS.

989.99 DEFINITIONS

When used in this section, the following terms and phrases shall have the meanings ascribed:

Acuity level - The intensity of services required for a Medicaid beneficiary wherein those with a high acuity level require more care and those with lower acuity level require less care.

Beneficiary - A person deemed eligible to receive Medicaid services.

Face-to-face assessment - An assessment that is conducted in-person by a registered nurse to determine an applicant's need for long-term care services.

Informal supports - Assistance provided by the person's family member or another individual who is unrelated to the person, and the frequency of supports provided.

Level of Need - A determination used to assess a person's need for supports for the purposes of allocating Medicaid resources or services.

Non-Medicaid Resources - The person's utilization of resources including but not limited to, housing assistance, vocational rehabilitation or job help, and transportation.

Person - An applicant who submits a service assessment request to DHCF and/or its designated agent to determine his/her level of need for long-term care services and supports.

Person-centered Planning Process - A process used to assess a person's needs and options for choices of services that focuses on the person's strengths, weaknesses, needs, and goals.

Provider - The individual, organization, or corporation, public or private, that provides long-term care services and seeks reimbursement for providing those services under the Medicaid program.

Representative - Any person other than a provider:

- (a) Who is knowledgeable about the applicant's circumstances and has been designated by that applicant to represent him or her with his/her express consent or those with appropriate legal authority; or
- (b) Who is legally authorized either to administer an applicant's financial or personal affairs or to protect and advocate for his/her rights.

Support Team - A team chosen by the beneficiary that includes, including, but is not limited to, the person's family, friends, community social worker, and/or medical providers.

Comments on these rules should be submitted in writing to Claudia Schlosberg, J.D., Senior Deputy Director and State Medicaid Director, Department of Health Care Finance, Government of the District of Columbia, 441 4th Street, NW, Suite 900 South, Washington DC 20001, via telephone on (202) 442-8742, via email at DHCFPubliccomments@dc.gov, or online at www.dcregs.dc.gov, within thirty (30) days of the date of publication of this notice in the *D.C. Register*. Additional copies of these rules are available from the above address.