DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF FINAL 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 adoption of an amendment to 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 final 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.

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 and incorporated into the Notice of Emergency and Third Proposed Rulemaking, which was published in the D.C. Register on March 24, 2017 at 64 DCR 002989. No comments were received in response to the Notice of Emergency and Third Proposed Rulemaking, and no changes have been made for these final rules.

The Director adopted these rules on July 11, 2017, and they shall become effective on 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:
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;
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 DHCF determines that an extension is necessary due to extenuating circumstances.

The assessment shall:

- Confirm and document the person's functional limitations, cognitive/behavioral and skilled care support needs;
- Be conducted in consultation with the person and his/her representative and/or support team;
- 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
- Determine the person's level of need for LTCSS.

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

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:

- 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
- 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.

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.

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 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.

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.

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.

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.

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
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.

Requests to conduct re-assessments shall be made in accordance with the requirements under Subsection 989.5.

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;
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 that 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.

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.

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.