

DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF FINAL RULEMAKING

The Director of Department of Health Care Finance (DHCF), pursuant to the authority set forth in An Act to enable the District of Columbia (District) 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. & 2019 Supp.)) and 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) (2018 Repl.)), hereby gives notice of the adoption of amendments to Section 989 (Long Term Care Services and Supports Assessment Process) of Chapter 9 (Medicaid Program); and Section 4201 (Eligibility) of Chapter 42 (Home and Community-Based Services Waiver for Persons who are Elderly and Individuals with Physical Disabilities) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

This final rulemaking finalizes two important changes to the Long Term Care Services and Supports (LTCSS) assessment process to align with federal requirements and District authority. First, it updates the requirements of the LTCSS assessment process to align with the new standardized needs-based assessment tool utilized by the District and to add Licensed Independent Clinical Social Workers (LICSW) as a provider type allowed to conduct the LTCSS assessment, as was authorized by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) in its approval of DHCF's Elderly and Persons with Physical Disabilities HCBS Waiver (EPD Waiver) amendment on June 5, 2018.

Second, it adds the requirement that all beneficiaries receiving State Plan Personal Care Aide (PCA) services or EPD Waiver services receive an annual face-to-face reassessment regardless of whether there has been a significant change in health status, thereby removing the option to submit provider attestations. The annual face-to-face reassessment requirement is intended to improve DHCF's ability to identify and address fraud and/or abuse and to ensure that beneficiaries continue to receive high quality care that appropriately addresses their needs and conforms to District requirements under the Medicaid State Plan.

These rules correspond to a related State Plan Amendment (SPA), which was approved by CMS on August 7, 2020 with an effective date of July 1, 2020. The corresponding SPA was added to the District's Medicaid State Plan, which can be found on DHCF's website at <https://dhcf.dc.gov/page/medicaid-state-plan>.

An initial Notice of Emergency and Proposed Rulemaking was published in the *D.C. Register* on February 15, 2019 at 66 DCR 002175. Comments were received from Disability Rights DC at University Legal Services (DRDC) and Legal Counsel for the Elderly (LCE). DHCF summarized and proposed additional revisions in response in a second emergency and proposed rulemaking.

A Notice of Second Emergency and Proposed Rulemaking was published in the *D.C. Register* on September 4, 2020 at 67 DCR 010817. The following comments were received from Disability

Rights DC at University Legal Services (DRDC) and Legal Counsel for the Elderly (LCE). Based on careful review of the comments, no changes have been made to the text of proposed rules.

Presence of Advocates at Assessments

DRDC commented that, while it supports DHCF's addition of language to Subsection 989.7(e) stating that an individual has the right to have others of his or her choosing present during a face-to-face assessment, such option is not meaningful if DHCF or its agent does not advise the individual of this right prior to the assessment. DRDC urges DHCF to further amend the regulations to require DHCF or its agent to, when scheduling an assessment, ask the individual if he or she wishes to include others to support them in completing the assessment, note their names, and ensure that they are present at the time of the assessment.

DHCF agrees with the importance of ensuring that the applicant, beneficiary, or his/her authorized representative is aware of his/her rights concerning the assessment process. For this reason, DHCF's designated agent already asks individuals who, if anyone, they would like to have present at their assessment. DHCF's designated agent then makes note of anyone that the individual indicates for inclusion at the assessment. However, DHCF finds that the questions asked during the assessment scheduling process, including whether an individual wishes to have others present at the assessment, are most appropriately set forth in policy guidance directed to those scheduling and conducting the assessments, and potentially in educational outreach to beneficiaries and their caregivers. For this reason, DHCF declines to propose further amendments to Subsection 989.7 at this time.

Disclosure of Assessment Scoring Reports

DRDC requested that DHCF add a requirement that DHCF provide individuals their LTCSS assessment scores, and a corresponding explanation for each sub-component of the assessment explanation of their scores (i.e., how the sub-score for each ADL and IADL need was determined). In support of this change, DRDC argues that the general score ranges set forth in Subsection 989.10 are meaningless without an explanation of the individual sub-scores assigned to beneficiaries an applicant was scored on and why that domain score resulted in the service reduction or denial.

DHCF disagrees with the assertion that DHCF must provide completed detailed LTCSS assessment reports and scores to all applicants and beneficiaries facing LTCSS denial, service reduction, or termination actions. D.C. Official Code Section 4-205.55 requires that a written notice of intended action to discontinue, withhold, terminate, suspend, or reduce assistance, include a statement of the intended action, the reasons for the intended action, the specific law and regulations supporting the action, an explanation of the individual's right to request a hearing, and the circumstances under which assistance will be continued if a hearing is requested. Likewise, the federal notice and due process requirements at 42 CFR 431.210 mandate that DHCF provide a statement of the intended action, a clear statement of the specific reasons supporting the intended action, and the specific regulations that support or require the action. DHCF does not agree that the inclusion of completed assessment reports and scores is necessary for compliance with the notice and due process requirements described above. For this reason, DHCF is not proposing further amendments at this time.

Assessment Look-Back Period

LCE expressed concern that the proposed 3-day look-back period for the functional assessment under Subsection 989.11(a) is only a short snapshot in time and may not accurately capture a beneficiary's true overall condition, especially for individuals with cognitive impairment (e.g., dementia), or those receiving chemotherapy or dialysis where there can be longer stretches of very good or bad days. LCE further contended that DHCF's implementation of the 3-day look back period for assessments prioritizes efficiency over a holistic approach that more accurately captures the overall state of the beneficiary's health, which will ultimately lead to more litigation, an increase and waste of government resources, and a lower quality of care for beneficiaries. LCE urged DHCF amend Subsection 989.11(a) to change the functional assessment look-back period from three (3) to seven (7) days. LCE alternatively recommended that, if the functional assessment look-back period remains three (3) days, DHCF add language to these rules to ensure that relevant information regarding the beneficiary's condition from outside of the 3-day look-back period is not excluded from consideration, and that individuals may request a reassessment based on their concerns with the length of the look-back period.

DHCF disagrees that the updated assessment look-back period is too short to accurately capture the overall condition and care needs of a beneficiary, or that a seven (7) day look-back period would inherently provide more holistic results. The three (3) day look-back period for the functional assessment is the length required by the standardized assessment tool now utilized by DHCF (InterRAI HC) to provide a more precise understanding of an individual's current care and support needs while reducing the likelihood of recall errors common with longer look-back periods. In addition, the behavioral/cognitive assessment component does not limit responses to a look-back period of any length.

The functional assessment evaluates the assistance required by the beneficiary to complete activities of daily living. While the majority of individuals may have days where more or less assistance is required, the intent of the assessment methodology is to capture the typical level of assistance needed on a daily basis. To that end, if circumstances in the three (3) days immediately preceding an assessment do not reflect a typical three (3) day period for a beneficiary, the beneficiary may request to reschedule the assessment for a later date. It is not DHCF's intent that reassessments be requested simply due to a dissatisfaction with the hours/level of care determined based on a previous assessment. However, if the beneficiary believes that the three (3) days used for an assessment did not provide an accurate representation of her/his typical activities or condition, or the her/his condition has changed since the date of the assessment, the beneficiary may request a reassessment. Alternatively, upon receipt of the determination based on the assessment, the beneficiary may request a reconsideration and/or fair hearing.

Given the availability of options to reschedule, reconduct, or contest the results of an assessment, DHCF is not proposing further amendments to Subsection 989.11 at this time.

Annual Reassessment Requirement / Removal of Attestation Process***Lack of Need Based on Fraud***

DRDC commented that requiring an annual face-to-face reassessment for all State Plan PCA and Elderly Persons with Physical Disabilities (EPD) Waiver beneficiaries regardless of whether the beneficiary has had a significant change in their health condition places a significant and unnecessary burden on DC Medicaid beneficiaries and harms individuals who have a demonstrated need to maintain their existing service hours. LCE commented that DHCF claims that this decision was made to address fraud and abuse are not warranted for two reasons. First, LCE claims there is insufficient data to prove such fraud or abuse exists when healthcare provider attestations are allowed. Second, LCE suggests the prior language of § 989.16(c) already provides protection from potential fraud by requiring the case manager, not the provider, to conduct the evaluation regarding need for an assessment. LCE argues that, because the case manager is not affiliated with the home health agency and conflict free, having the case manager refer for assessment should be sufficient to prevent fraud.

While appreciating the concerns expressed by DRDC and LCE regarding the impact on beneficiaries of this change, DHCF disagrees with commenters' assertion that the change is unnecessary. DHCF has an obligation to hold its providers accountable. To support this goal, DHCF must proactively prevent fraud and abuse by its providers through surveillance and fraud detection, provider reviews, and audits to protect the integrity of the Medicaid system.

Although fraud prevention was a driver for this change, DHCF's rationale for requiring an annual reassessment is not limited to the identification and addressing of fraud and abuse by providers. The annual reassessment requirement also provides DHCF the ability to ensure that each beneficiary is informed of and connected with the most appropriate care options at least annually.

However, DHCF's prior experience with fraud should also provide sufficient justification for the proposed changes. As stakeholders are aware, the District has ample past experience with fraud and abuse in the context of PCA services and has incurred substantial financial costs resulting from a failure to have protective measures in place. DHCF is committed to the sustainability of the EPD waiver program. Without the types of protective measures being proposed in these rules, the viability of the entire program is put at risk. For these reasons, DHCF declines to make the requested changes at this time.

Risk of Inappropriate/Inaccurate Decisions

DRDC commented that requiring yearly face-to-face assessments, regardless of a change in need, will result in more improper service cuts and terminations for beneficiaries with chronic health conditions and permanent disabilities, putting these beneficiaries' health, safety, and welfare at risk and increasing the risk of institutionalization in nursing facilities and other institutions. Instead, DRDC requests that the rule require face-to-face reassessment only when there has been a significant change in a beneficiary's health status, as determined by a case manager or home health agency supervisor.

LCE also commented that in the past, they have seen that when multiple assessments are conducted within a short period of time, inaccurate and inconsistent results were yielded. Coupled with this, LCE is concerned about the removal of the attestation process, arguing that the combination of disallowing an attestation when no significant change in health status is

present along with the inconsistent nature of this assessment tool may lead to an unnecessary burden on beneficiaries, which could result in beneficiaries not receiving necessary and consistent quality of care.

DHCF disagrees that the annual reassessment requirement will result in improper service cuts and terminations for beneficiaries, or will result in poorer health outcomes or institutionalization for these individuals. The purpose of the annual reassessment is to ensure that the beneficiary is receiving the appropriate type and amount of services to best meet their care needs, and to update their service plan as determined necessary. A reassessment should still be requested any time a beneficiary has a significant change in health status. The required annual reassessment ensures that care needs continue to be met even for those beneficiaries who do not appear to have had any significant changes in health status.

For the duration of the public health emergency, DHCF is implementing changes to its assessment process to ensure safety and continuity of services for Medicaid beneficiaries. DHCF will permit assessments and service planning meetings to occur telephonically and will only require in-person, face-to-face assessments when safe and appropriate given public health conditions. Similarly, to the extent possible, DHCF will offer any additional flexibilities approved by our federal partners to facilitate eligibility processing and service authorizations that promote continuity of services during this public health emergency. Providers, beneficiaries, and other stakeholders can find guidance on these changes on DHCF's website at <https://dhcf.dc.gov/page/long-term-care-administration>. For the reasons cited above and given the public health emergency adjustments, DHCF is not proposing additional amendments at this time.

Compliance with Federal Assessment Requirements

LCE also commented that the prior version of Subsection 989.16, which allowed for a caseworker attestation that no change occurred in lieu of a full face-to-face annual reassessment, complies with federal Medicaid rules requiring annual LTCSS assessments at 42 C.F.R. § 441.365(e) and 42 C.F.R. § 441.302(c)(2). LCE asserts that the prior approach would be compliant because the provider would still conduct an annual evaluation of the EPD Waiver beneficiaries' level of need before submitting an attestation that a face-to-face reassessment is not needed.

The frequency with which periodic evaluations and assessments of LTCSS beneficiaries must be conducted is set forth in federal regulations at 42 CFR § 441.365(e), which requires that periodic evaluations and assessments be conducted at least annually for each waiver beneficiary. Furthermore, under 42 CFR § 441.302(c)(2), DHCF must provide assurances to CMS that it will ensure that each waiver beneficiary is reevaluated at least annually to determine if the beneficiary continues to need the level of care provided. DHCF has determined that a full annual face-to-face reassessment using the District's approved assessment tool is required in order to faithfully make such assurances to our federal oversight agency, CMS.

Efficiency Concerns

LCE commented that almost every case LCE has been involved in regarding a dispute with a beneficiary's EPD Waiver hours has resulted in a restoration of the reduced hours or an increase

in hours. LCE suggested that if DHCF's goal is to be efficient and not waste government resources, then allowing for an attestation process is imperative to reduce litigation and ensure beneficiaries receive care to which they are entitled.

DHCF's primary goal is to ensure that all beneficiaries are provided with the appropriate types and amount of care to best meet their LTCSS needs. DHCF appreciates LCE's concern for the program and its beneficiaries but reiterates that the proposed changes are consistent and necessary based on federal requirements and will ultimately promote efficiency by ensuring that all EPD Waiver beneficiaries' service authorization is consistent with a recent and comprehensive assessment. For this reason, no additional changes are needed.

Accommodations Under Title II of the Americans with Disabilities Act

DRDC raised concerns about whether the rule appropriately complies with federal disability requirements. DRDC specifically commented that the proposed regulations fail to include a provision that requires DHCF or its designee to reasonably accommodate beneficiaries and applicants during the assessment process in accordance with Title II of the ADA. DRDC asserts that the regulation must describe a mechanism for eliciting and granting beneficiaries' and applicants' request for accommodations, such as: access to sign language interpreters, assistive technology, supports needed during the face-to-face assessment, and large print or alternative format printed materials during and following the assessments. DRDC also stated that the regulations must include instructions for requesting reasonable accommodations from the Office of the Health Care Ombudsman prior to the assessments, *i.e.*, names and contact information of people handling the requests (via telephone, TTY, and/or email).

DHCF is already subject to federal requirements of providing reasonable accommodations to all Medicaid beneficiaries and applicants for whom they are necessary, as required under Title II of the Americans with Disabilities Act (ADA) and other applicable federal civil rights laws. Therefore, it is unnecessary to restate such requirements in this rule. In addition, DHCF already provides information for consumers on the Ombudsman's office and how to request assistance with health care needs, including reasonable accommodations on DHCF's website at: <https://dhcf.dc.gov/page/dhcf-notice-non-discrimination-and-accessibility-requirements-statement-001>. DHCF believes it is appropriate to provide this direction centrally and not in rulemaking, especially as procedures may change over time. Importantly, the right to request reasonable accommodations under Title II of the ADA extends to all aspects of the District's Medicaid program and would be equally applicable for multiple sections of District rules governing the Long Term Care program. It would be impracticable to provide these requirements in one section of the rule and not others. For these reasons, DHCF is declining to include the mechanism for submitting such requests in this section of the rule.

Verbal Requests for Reconsideration

DRDC commented that the regulations must also allow verbal requests for reconsideration and requested rescission of the proposed requirement in Subsection 989.27 that beneficiaries and applicants "submit... [their request]... in writing, by mail, fax or in person, to DHCF" with the reasons justifying their request for reconsideration. DRDC was specifically concerned that the requirement that individuals submit a written request for reconsideration could create accessibility barriers for people with print related disabilities (e.g., people who are blind, have

low vision, have a physical and/or learning disability that makes it hard for the individual to read, write, sign, or use paper). DRDC further asserted that Title II of the ADA requires this option.

DHCF respectfully disagrees with DRDC's assertion that this change is required. Under D.C. Official Code Section 4-210.05, beneficiaries and applicants have the right to make oral requests for hearings, but this requirement does not apply to reconsiderations. A request for reconsideration, which is governed by Subsections 989.26(d) and 989.27, is different than a request for a fair hearing, which is governed by Subsection 989.26(e), and is therefore bound by different procedural requirements. If a beneficiary or applicant requires reasonable accommodations to access the reconsideration process, or any other DHCF process to which they are guaranteed access, such a request should be directed to the Office of the Health Care Ombudsman, contact information for which can be found on DHCF's website at: <https://dhcf.dc.gov/page/dhcf-notice-non-discrimination-and-accessibility-requirements-statement-001>. Because the right to request reasonable accommodations extends to all aspects of the District's Medicaid program, DHCF is declining to include language notifying of its availability in each section of rule to which it may be applicable.

Use of Emergency Rulemaking Process

LCE submitted a comment expressing concern that DHCF's continued use of the emergency rulemaking process does not appear to meet the requirements of D.C. Official Code § 2-505(c) and 1 DCMR. § 311.5. These concerns, which are shared by LCE, DCLTO, and other stakeholders, stem back to the original introduction of the InterRAI/Liberty assessment process, which they assert was put in place without adequate input or pilot programs. Stakeholders also raise concern that the staging of implementation preceded additional emergency rules, which they feel should have allowed public comment before allowing for implementation. LCE particularly expressed concern about what they see as DHCF's overuse of the emergency rulemaking process. Instead, they request that DHCF use the regular rulemaking process for additional changes to the EPD Waiver or assessment tool.

DHCF respectfully disagrees with stakeholders on the assertion that its use of the emergency rulemaking process fails to meet the District's statutory and regulatory requirements. D.C. Official Code § 2-505(c) states that District agencies have the option to promulgate rules on an emergency basis if the Mayor or executive agency determines that the adoption of a rule is necessary for the immediate preservation of the public peace, health, safety, welfare or morals. District rules at 1 DCMR § 311.5 set forth the components that must be included in the notice preceding any emergency rulemaking. DHCF has complied with all of these requirements in its publication of both LTCSS assessment emergency rulemakings. An executive agency seeking to promulgate an agency rule in the District must follow the rulemaking approval procedures as published in Mayor's Memorandum 2011-2, dated October 19, 2011. This process includes submitting draft rules to the Office of Policy and Legislative Affairs as well as the Office of the Attorney General Legal Counsel Division to be reviewed for legal sufficiency. Once the Executive Office of the Mayor and the Office of Attorney General have approved the rule for legal sufficiency, the Office of Policy and Legislative Affairs will certify the rule for publication in the *D.C. Register*. DHCF followed the procedure as required, and received a memorandum of approval dated July 20, 2020, certifying that the District Office of the Attorney General had reviewed the rule for legal sufficiency, including the need for publication on an emergency basis.

DHCF appreciates the concern stakeholders raise regarding the importance of consultation with beneficiaries and other stakeholders affected by policy changes in advance of implementation. To that end, DHCF has taken great efforts to ensure it is keeping beneficiary, provider, and other stakeholders aware of policy changes being planned in advance of their implementation. DHCF welcomes additional opportunities for dialogue and collaboration to ensure advance notice is provided in future policy initiatives to the greatest extent feasible.

The Director adopted these rules on March 26, 2021, 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:

Subsections 989.1, 989.3, 989.5, 989.6, 989.7, 989.8, 989.9, 989.11, 989.13, 989.16, 989.17, 989.18, 989.20, 989.21, 989.24, 989.26, 989.27, and 989.99 of Section 989, LONG TERM CARE SERVICES AND SUPPORTS ASSESSMENT PROCESS, is amended as follows:

- 989.1 The purpose of this section is to establish the Department of Health Care Finance (DHCF) standards governing the District Medicaid assessment process for Long Term Care Services and Supports (LTCSS) and to establish numerical scores pertaining to the level of care required to establish eligibility for a range of LTCSS.
- 989.3 A Registered Nurse (RN) or Licensed Independent Clinical Social Worker (LICSW) 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.
- 989.5 The request for an assessment 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 reassessment for recertification or based upon a change in the individual's health status or acuity, may be made by the individual seeking services, his/her authorized representative, Elderly and Persons with Physical Disabilities HCBS Waiver (EPD Waiver) case manager, 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 RN or LICSW employed by DHCF or its designated agent shall be responsible for conducting the face-to-face assessment of each applicant or beneficiary using a standardized needs-based assessment tool within five (5) calendar days of the receipt of a request for an assessment, unless:
- (a) A request for an expedited assessment has been made by an individual identified in Subsection 989.5 and DHCF or its designated agent has

determined that the individual's health status requires that an assessment be conducted sooner to expedite the provision of LTCSS;

- (b) The individual has requested an assessment at a later date;
- (c) DHCF or its designated agent is unable to contact the individual 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 or its designated agent determines that an extension is necessary due to extenuating circumstances.

989.7 The assessment shall:

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

989.8 The standardized needs-based assessment tool and corresponding user's manual are available for review in-person at the DHCF offices. To access a paper copy of the assessment tool for review, beneficiaries should contact their case managers and potential applicants should contact DHCF's Long-Term Care Administration (LTCA) via the LTCA Hotline at 202-442-9533. A summary of the assessment tool and instructions on how to access a paper copy of the complete assessment tool and corresponding user's manual are available on DHCF's website at www.dhcf.dc.gov.

989.9 The face-to-face assessment using the standardized needs-based assessment tool for LTCSS shall result in a total numerical score, which is comprised of three (3) separate scores pertaining to the assessed functional, cognitive/behavioral, and skilled care needs of an individual. The functional assessment includes an assessment and corresponding score correlated to the individual'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 Personal Care Aid (PCA) services, eligibility is determined based on only the functional score, without consideration of the medication management assessment score; and
- (b) For all other LTCSS, eligibility is determined based on the sum of the scores for assessed functional, cognitive/behavioral, and skilled care needs, and includes medication management.

989.11 Each face-to-face assessment of an individual using the standardized needs-based assessment tool contains the following components:

- (a) The functional assessment evaluates the type of assistance required for each of the following activities of daily living (ADLs), based on typical experience under ordinary circumstances within the last three (3) days prior to assessment:
 - (1) Bathing, which means taking a full-body bath or shower that includes washing of the arms, upper and lower legs, chest, abdomen, and perineal area;
 - (2) Dressing, which means dressing and undressing, both above and below the waist, including belts, fasteners (e.g., buttons, zippers), shoes, prostheses, and orthotics;
 - (3) Eating, which means eating and drinking (regardless of skill), including intake of nourishment by a feeding tube or intravenously;
 - (4) Transferring, which includes moving in and out of the bathtub or shower, and moving on and off the toilet or commode;
 - (5) Mobility, which means moving, whether by walking or using a wheelchair, between locations on the same floor; and moving to and from a lying position, turning from side to side, and positioning one's body while in bed;
 - (6) Toileting, which includes using the toilet, commode, bedpan, or urinal and cleaning oneself afterwards, adjusting clothes, changing bed pads, and managing ostomy or catheter care; and
 - (7) Medication Management, which means how medications are managed, including remembering to take medicines, opening bottles, taking correct dosages, giving injections, and applying ointments. The need for assistance with medication management is not considered in determinations of eligibility for State Plan PCA services, in accordance with § 989.9(a);

- (b) The cognitive/behavioral assessment evaluates the presence of and frequency with which certain conditions and behaviors occur, for example:
- (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 certain treatments and procedures were provided during the applicable look-back period, for example:
- (1) Whether and how frequently each of the following treatments were provided during the last three (3) days prior to assessment:
 - (A) Chemotherapy;
 - (B) Dialysis;
 - (C) Infection Control;
 - (D) IV Medication;
 - (E) Oxygen Therapy;
 - (F) Radiation;
 - (G) Suctioning;

- (H) Tracheostomy Care;
 - (I) Transfusion;
 - (J) Ventilator or Respirator; and
 - (K) Wound Care.
- (2) Whether and how frequently certain programs were used during the last three (3) days prior to assessment, for example:
- (A) Scheduled toileting program;
 - (B) Palliative care program; and
 - (C) Turning/repositioning program.
- (3) Whether and how frequently (days and total minutes) certain types of formal care were provided during the last seven (7) days prior to assessment, for example:
- (A) Home health aides;
 - (B) Home nurse;
 - (C) Homemaking services;
 - (D) Meals;
 - (E) Physical therapy;
 - (F) Occupational therapy;
 - (G) Speech-language pathology and audiology; and
 - (H) Psychological therapy by any licensed mental health professional.
- (4) Whether and how frequently certain types of medical visits occurred during the last ninety (90) days prior to assessment, for example:
- (A) Inpatient acute hospital visit with overnight stay;
 - (B) Emergency room visit with no overnight stay; and

- (C) Physician visit (includes authorized assistant or practitioner).
- (5) For individuals in a hospital or nursing facility, whether physical restraints were used during the last three (3) days prior to the assessment.
- 989.13 Based on the results of the face-to-face assessment, DHCF or its designated agent shall issue to the individual an assessment determination that specifies his/her required level of care and a corresponding range of LTCSS for which the individual is eligible.
- 989.16 An RN or LICSW employed by DHCF or its designated agent shall conduct a face-to-face reassessment of each beneficiary's need for the receipt of LTCSS as follows:
- (a) For Adult Day Health Program services, a reassessment shall be conducted at least every twelve (12) months or upon a significant change in the beneficiary's health status or acuity. Requests for reassessments shall be made by the supervisory nurse.
- (b) For State Plan PCA services, a reassessment shall be conducted at least once every twelve (12) months or upon a significant change in the beneficiary's health status. Requests for reassessments shall be made by the supervisory nurse.
- (c) For all EPD Waiver services, a reassessment shall be conducted at least once every twelve (12) months or upon a significant change in the beneficiary's health status. Requests for reassessments shall be made by the beneficiary's case manager.
- 989.17 For nursing facility services, DHCF or its designated agent shall conduct utilization reviews at six (6) months and twelve (12) months post admission, and annually thereafter, as follows:
- (a) The utilization review shall determine whether there has been an improvement in the beneficiary's health status; and
- (b) If the utilization review results in a determination that there has been an improvement in the beneficiary's health status, DHCF or its designated agent shall request that a face-to-face reassessment be conducted in accordance with policy guidance issued by DHCF.
- 989.18 For EPD Waiver services, DHCF may, at its discretion, extend the level of care reauthorization period pursuant to the face-to-face reassessment for a timeframe

not to exceed eighteen (18) months to align the assessment date with the beneficiary's Medicaid renewal date.

- 989.20 If an individual meets the required level of care as determined by a numerical score affiliated with each long-term care service in accordance with § 989.12, and chooses to participate in a long-term care program, DHCF or its designated agent shall refer the individual to the long-term care service provider of his/her choice.
- 989.21 The individual shall choose a provider based upon the level of care determination and the availability and ability of the provider to safely care for him/her in the setting of the individual's choice.
- 989.24 If the RN or LICSW employed by DHCF or its designated agent is unable to conduct the face-to-face assessment or reassessment 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 individual. 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 individual has twenty-one (21) days from the date the letter was issued to contact DHCF or its designated agent to request the assessment, including all necessary contact information; and
 - (e) For reassessment requests, a clear statement that if the beneficiary fails to contact DHCF or its designated agent within twenty-one (21) days of the date the letter was issued, the beneficiary's current LTCSS shall be terminated.
- 989.26 DHCF or its designated agent shall issue a Beneficiary Denial or Change of Services Letter if, based upon the assessment or reassessment conducted pursuant to this section, an applicant or beneficiary is determined ineligible, or to not meet the level of care, 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 individual's current level of LTCSS will be continued if the individual files a timely hearing request with OAH; and
- (g) Information regarding legal resources available to assist the individual with the appeal process.

989.27

A request for reconsideration of an individual's required level of care 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. The request for reconsideration shall include the following information and documentation:

- (a) A written statement by the individual, or the individual's authorized 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 individual's health care needs; and
- (c) Any additional, relevant documentation in support of the request.

Subsection 989.99 of Section 989, LONG TERM SERVICES AND SUPPORTS ASSESSMENT PROCESS, is amended as follows:

989.99

DEFINITIONS

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

Activities of Daily Living – Daily tasks required to maintain an individual's health including eating, bathing, dressing, toileting, grooming, transferring, walking, and continence.

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

Authorized Representative – An individual other than a provider:

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

Beneficiary – An individual deemed eligible to receive Medicaid services.

Cognitive/Behavioral Functionality – An individual's ability to appropriately acquire and use information, reason, problem solve, complete tasks, and communicate needs; as well as the presence of serious mental illness or intellectual disability, hallucinations or delusions, and verbal or physical behaviors directed at oneself or others.

Contact Attempt – A completed or incomplete telephonic or other person-to-person outreach by DHCF or its designated agent intended to permit communication or information-sharing. Contact attempts may include outbound telephone calls to individuals or their representatives in order to complete contact.

Face-to-Face Assessment – An assessment that is conducted in-person by a Registered Nurse (RN) or Licensed Independent Clinical Social Worker (LICSW) to determine an individual's need for long-term care services.

Informal Supports – Assistance provided by the beneficiary's family member or another individual who is unrelated to the beneficiary.

Level of Care – A threshold determination as to the long-term care services or supports required by an individual.

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

Person-Centered Planning Process – A process used to assess an individual's needs and options for choices of services that focuses on the individual'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.

Skilled Care – Medically necessary care ordered by a doctor and provided by or under the supervision of skilled or licensed health care professionals such as nurses and physical therapists. Examples of skilled care include, but are not limited to, physical therapy, occupational therapy, wound care, intravenous injections, and catheter care.

Support Team – A team chosen by the applicant or beneficiary that includes, but is not limited to, the applicant’s or beneficiary’s family members, friends, community social worker, and/or medical providers.

Chapter 42, HOME AND COMMUNITY-BASED SERVICES WAIVER FOR PERSONS WHO ARE ELDERLY AND INDIVIDUALS WITH PHYSICAL DISABILITIES, of Title 29 DCMR, PUBLIC WELFARE, is amended as follows:

Subsection 4201.4 of Section 4201, ELIGIBILITY, is amended to read as follows:

4201.4 A Registered Nurse (RN) or Licensed Independent Clinical Social Worker (LICSW) hired by, or under contract with, DHCF or its designee shall conduct a face-to-face assessment to determine if a beneficiary or applicant meets a nursing facility level of care. The assessment shall utilize a standardized assessment tool which will also evaluate the individual’s care and support needs across three (3) domains including:

- (a) Functional – impairments including assistance with activities of daily living such as bathing, dressing, eating or feeding;
- (b) Skilled Care – sensory impairments, other health diagnoses and the need for skilled nursing or other skilled care (e.g., wound care, infusions); and
- (c) Cognitive/Behavioral – communications impairments including the ability to understand others, presence of behavioral symptoms such as hallucinations, or delusions.