DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF SECOND EMERGENCY AND PROPOSED 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, on an emergency basis, 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).

The purpose of this second emergency and proposed rulemaking is to update the requirements of the Long Term Care Services and Supports (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.

The initial emergency and proposed rulemaking, published on February 15, 2019, added the requirement that, in order to ensure that all beneficiaries receiving State Plan Personal Care Aide (PCA) services or EPD Waiver services have their LTCSS eligibility determined using the new assessment tool, all evaluations conducted prior to August 1, 2019 must include a face-to-face reassessment. The corresponding State Plan Amendment (SPA) was approved by CMS on May 21, 2019 with an April 1, 2019 effective date. Because each beneficiary receiving State Plan PCA services or EPD Waiver services must be evaluated to determine level of care needs at least once every twelve (12) months, the addition of this requirement was intended to result in all beneficiaries receiving such services having been reassessed with the new assessment tool by August 1, 2019. In the initial emergency and proposed rulemaking, evaluations conducted on or after August 1, 2019, for beneficiaries receiving State Plan PCA services or EPD Waiver services, would require face-to-face reassessments only when determined that there had been a significant change in the beneficiary's health status.

This second emergency and proposed rulemaking removes the August 1, 2019 expiration date from the provision described above, thereby requiring an annual face-to-face reassessment for all State Plan PCA and EPD Waiver beneficiaries regardless of whether there has been a significant change in health status. DHCF is proposing the annual face-to-face reassessment requirement to improve its 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.

Subsection 989.16 of the current rule allows beneficiaries whose health status has not significantly changed to submit provider attestations that a face-to-face reassessment is not needed and that services should continue to be provided at the level set forth in their most recent assessment determination. Although less administratively burdensome, allowing provider attestations in lieu of a face-to-face reassessment increases the risk of fraudulent continuance of care to beneficiaries because the process is not conflict free. Because improvements in health status often result in decreased service eligibility and declines in health status often result in increased service eligibility, providers have an incentive to request reassessments only in those cases where a beneficiary's health status has declined. As a result, potential changes in the beneficiaries' needs are being ignored and DHCF is reimbursing providers for unnecessary care. DHCF seeks to address these concerns in this rulemaking, by requiring an annual reassessment of all beneficiaries, regardless of whether there has been any significant change in health status since their last assessment.

Emergency action is necessary for the immediate preservation of the health, safety, and welfare of District Medicaid beneficiaries eligible for and in need of covered long-term care services. These rules are being enacted on an emergency basis to ensure that, by authorizing LICSWs to begin conducting LTCSS assessments immediately, beneficiaries continue to receive assessments in the timely manner required in order to retain eligibility for necessary services; and to ensure that, by requiring that all annual evaluations conducted include a face-to-face reassessment with the District's standardized needs-based assessment tool, all beneficiaries receiving State Plan PCA or EPD Waiver services continue to be accurately determined eligible for the appropriate services.

These second emergency and proposed rules correspond to a related SPA, which requires approval by CMS. Accordingly, the requirement that face-to-face reassessments be conducted annually for all beneficiaries receiving State Plan PCA services shall become effective upon publication of this rulemaking in the *D.C. Register*, or on an alternative effective date established by CMS in its approval of the corresponding SPA, whichever is later.

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 University Legal Services (ULS) and Legal Counsel for the Elderly (LCE). A summary of these comments and the additional revisions to the rule proposed by DHCF in response, are as follows:

Timeliness of Assessment and Recertification Process

ULS commented that, by imposing the requirement that all LTCSS beneficiaries receive annual face-to-face reassessments, DHCF has caused home health agencies and beneficiaries to experience delays in the assessment and recertification process. ULS suggested that DHCF should rescind this reassessment requirement amendment to Subsection 989.16.

DHCF disagrees with the assertion that the implementation of the new standardized needs-based assessment tool and annual face-to-face reassessment requirement are responsible for the assessment and recertification process backlogs experienced by LTCSS beneficiaries in 2018. Instead, these assessment process delays occurred due to the timing and nature of the transition of DHCF's assessment contract from the previous vendor to a new one. Moreover, DHCF has long

since successfully cleared the backlog. Beneficiaries are not currently experiencing delays in the scheduling of assessments following the submission of the request.

DHCF also disagrees that the proposed requirements concerning the frequency of reassessments should be rescinded. 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. Additionally, the authorization of LICSWs proposed in this rule is intended to increase the total number of practitioners allowed to conduct LTCSS assessments, thereby reducing the likelihood that beneficiaries will encounter delays with the assessment and recertification processes in the future. For these reasons, DHCF is not proposing any changes to the provisions of this rulemaking authorizing LICSWs to conduct LTCSS assessments.

Effect of Assessment Determination on Services

ULS asserted that the majority of beneficiaries and applicants face unwarranted, erroneous service denials, reductions, and terminations, and that as a result, DHCF is putting beneficiaries and applicants at serious risk of health declines and institutionalization. ULS also contended that the utilization of the new standardized needs-based tool has radically shifted the structure and scoring mechanism of the face-to-face assessment.

During 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.

DHCF is aware of and is committed to addressing ongoing issues affecting the LTCSS assessment and recertification process generally. However, DHCF does not believe that requiring face-to-face reassessments for all LTCSS beneficiaries puts them at risk of health problems and institutionalization. DHCF disagrees with ULS's suggestion that eliminating the face-to-face reassessment requirement for all LTCSS beneficiaries is an appropriate or effective long-term solution leading to improved health outcomes for these individuals. For this reason, DHCF is not proposing additional amendments at this time.

Requests for Assessments

ULS commented that although Subsection 989.3 provides that the "person seeking services, the person's representative, family member, or health care professional" may request an assessment to qualify for LTCSS, the rule contains no guidance as to how people may access or submit an application for services, including the face-to-face assessment. ULS recommended that instructions on applying and requesting recertification for LTCSS be added to the rules.

DHCF disagrees with the recommendation that this rulemaking incorporate more detailed instructions on applying for LTCSS. Information on how to request LTCSS is already provided in Subsection 989.4, which states: "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." For this reason, DHCF is declining to make any further changes to Subsection 989.3.

Presence of Advocates at Assessments

ULS suggests that Subsection 989.6 should acknowledge the right of beneficiaries and applicants to have their chosen advocates, family members, or friends present during their face-to-face assessments.

DHCF agrees that it is within the rights of an individual to have others of his or her choosing present during the face-to-face assessment and proposes the addition of language in the rule stating this. However, DHCF does not agree that Subsection 989.6, which addresses the timeframe within which an assessment will be conducted following receipt of the request, is the appropriate section of rulemaking for this change. Instead, DHCF is proposing to add a paragraph (e) to Subsection 989.7, which identifies the required characteristics of an assessment. The new proposed paragraph, adopted in this rulemaking, states that the assessment shall, at the option of the individual, be conducted in the presence of one or more members of his/her support team.

Expedited Assessments

ULS commented that Subsection 989.6(a) states that the required five (5) day turnaround time for face-to-face assessments may be expedited if the individual's condition requires that an assessment be conducted sooner to expedite the provision of LTCSS, but then fails to describe the conditions that would trigger the expedited assessment and fails to identify who may submit a request for such an assessment.

Requests for an expedited assessment may be made by any of the individuals identified in Subsection 989.5. Such expedited assessment requests are granted based on an individual's need, as determined by DHCF or its designated agent. DHCF disagrees that the rule should provide a list of conditions that could potentially trigger an expedited assessment, as this is a clinical determination that falls outside the scope of rulemaking. However, DHCF is proposing changes, adopted by this rulemaking, to revise Subsection 989.6(a) to clarify that any of the individuals identified in Subsection 989.5 may request an expedited assessment and that DHCF or its designated agent will make the determination as to whether the individual's condition warrants an expedited assessment.

Deadline for Completion of Assessment Report

ULS asserted that the rule fails to require completion of the assessment report by DHCF or its designated agent within any set time frame and recommends that a deadline of ten (10) business days should be incorporated.

DHCF disagrees that the rule fails to include a time frame requirement for completion of the assessment report. Subsection 989.14 of the rule, as written, states that the assessment

determination shall be issued to the individual no later than forty-eight (48) hours after the completion of the assessment, unless the person's condition necessitates that services be authorized sooner. Accordingly, DHCF is declining to make any further changes to Subsection 989.6.

Accessibility of Assessment Tool

Both LCE and ULS expressed various concerns regarding the accessibility of the assessment tool and corresponding user manual. LCE commented that the assessment tool had previously been available for review online, but under the proposed rules can now only be accessed in-person at the DHCF offices. While acknowledging the necessity of making a summary of the tool and steps to locate a complete copy of the tool must be made available online, LCE contended that accessing the complete tool in-person at DHCF offices would be impossible for many EPD Waiver beneficiaries who are homebound, and extremely difficult for beneficiaries with no or limited access and/or capacity to use the internet. ULS asserted that Subsection 989.8 restricts access to the standardized assessment tool and user manual by making available only through in-person visits to DHCF's office or via website access to a summary, and thereby fails to constitute legally sufficient notice prior to the denial, reduction, or termination of LTCSS. LCE also expressed concern that the summary and steps to locate the complete tool are not currently available online through DHCF's website; and that the assessment tool and user manual are available only in English. LCE recommended that the tool and user manual be made publicly available on DHCF's website in all appropriate languages.

The InterRAI Home Care (HC) Assessment System is a proprietary tool with copyright protections that restrict its reproduction or transmittal. In accordance with DHCF's licensing agreement for using the InterRAI HC, the assessment tool and user manual cannot be posted online. As a result, DHCF is unable to make the assessment materials publicly available on its website. To ensure accessibility, the assessment tool and user manual will remain available to review in-person at the DHCF office and translation services will be provided upon request as necessary. The summary and instructions for reviewing a copy of the assessment tool and manual are posted in the long-term care section on DHCF's website.

Disclosure of Assessment Scoring Reports

ULS recommended that, in order to comply with federal and District notice and due process requirements, the rules include a requirement that DHCF or its designated agent provide completed assessment reports, including scoring results, to all beneficiaries and applicants facing service denial, reduction, or termination. ULS commented that the rules must incorporate the mandated notice provisions in District law and regulations. D.C. Code §4-205.55; 29 DCMR 4202.2 (requiring 30-day advance notice prior to reduction or termination of EPD Waiver services). ULS further contended that the general score ranges set forth in Subsection 989.10 are meaningless without disclosure of the individual sub-scores assigned to beneficiaries and applicants. For this reason, ULS recommended that the rules describe and require DHCF to disclose to beneficiaries and applicants their scores on each sub-component of the assessment and an explanation of how the sub-score on each ADL and IADL need was determined.

DHCF disagrees with the assertion that compliance with federal and District notice and due process requirements mandate that DHCF provide completed assessment reports and scores to all applicants and beneficiaries facing LTCSS denial, service reduction, or termination actions. 29

DCMR § 4202.2 sets forth the notice requirements for EPD waiver provider intended actions to discontinue, discharge, suspend, transfer, or terminate services to an applicant or beneficiary, and is therefore not applicable to this rulemaking. 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

ULS commented that Subsection 989.11 shortens the assessment look-back period from seven (7) to three (3) days prior to the assessment, and that the three (3) day timeframe is far too short to accurately assess the service needs of beneficiaries. LCE also recommended that DHCF restore the seven (7) day assessment look-back period, contending that it provides a more complete and accurate picture of a beneficiary's activities than the shorter three (3) day window.

DHCF does not agree that the updated assessment look-back period is too short to accurately assess the care needs of beneficiaries. 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. 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. Alternatively, if the beneficiary believes that the three (3) days used for an assessment did not provide an accurate representation of his/her typical activities or condition, the beneficiary may request a reassessment. For these reasons, DHCF is not proposing further amendments at this time.

Scored Components of Assessments

ULS and LCE both commented that, although Subsection 989.11(a) mentions that Instrumental Activities of Daily Living (IADL) needs are part of the functional assessment, there is no indication as to how IADLs factor into the total numeric score and the delineated tasks do not include IADLs such as meal preparation, laundry, light house cleaning, and grocery shopping. Likewise, Subsection 4201.4(a) does not include IADLs in the description of the functional assessment. ULS contended that DHCF should revise the rule to incorporate all IADL needs into the LTCSS functional assessment.

DHCF acknowledges the incongruity between the introductory sentence at Subsection 989.11(a) and the list of exclusively ADL tasks that follow but disagrees that it must revise the rule to incorporate all IADL tasks into the functional assessment. While the functional component of the interRAI HC assessment does include an evaluation of the need for assistance with IADLs such as meal prep, house cleaning, laundry, or shopping, DHCF does not factor the IADL needs into its

calculation of the functional assessment score or total numeric score. To more clearly indicate that the functional assessment score does not factor in the need for assistance with IADL tasks, DHCF is proposing changes, adopted by this rulemaking, to revise Subsection 989.11(a) by removing "and instrumental activities of daily living (IADLs)" from the introductory sentence.

Medication Management Score

ULS commented that Subsection 989.11(a)(9) of the rules requires the functional assessment score to include medication management for EPD Waiver services only, thereby failing to factor in medication management as an ADL need for purposes of calculating the functional score for State Plan PCA services. ULS contended that medication management is a critical need and should be factored into the functional score for all LTCSS beneficiaries, not just EPD Waiver participants.

DHCF would like to clarify that Subsection 989.11(a)(9) does not limit the consideration of medication management to determinations of EPD Waiver eligibility; it does however preclude any consideration of medication management in determinations of eligibility for State Plan PCA services. Medication management is not factored into the functional score when determining eligibility for State Plan PCA services because most assistance with medication falls outside the allowed scope of practice for PCAs. Pursuant to 22-B DCMR §3915.10(d), the scope of practice for PCAs is limited to assisting an individual with the self-administration of medication. If an individual has medication management needs that go beyond assistance with self-administration, PCA services could not appropriately provide the care that is necessary. Thus, DHCF is declining to make any changes to the limitations on the consideration of medication management in Subsection 989.11.

Cognitive/Behavioral Assessment

LCE commented that the rules state that cognitive/behavioral evaluations factor into the total numeric assessment score, but there is no indication as to how or if cognitive/behavioral evaluations are integrated into the total numeric assessment score that dictates the hours determination. LCE recommended that the rules be revised to make clear the way in which these measurements factor into the total numeric score and hours determinations for beneficiaries.

The determination as to the number of service hours appropriate for an individual already deemed eligible for LTCSS is separate and distinct from the determination of the level of care an individual needs. The total numerical assessment score, which is calculated by adding together the functional, cognitive/behavioral, and skilled care assessment scores as described in Subsection 989.10, determines an individual's level of care needs and the corresponding range of LTCSS for which he/she is eligible based on his/her level of care determination. In contrast, the hours determination does not include any consideration of the individual's cognitive/behavioral assessment score. The criteria used for service hours determinations is not within the scope of this rulemaking on the assessment process used to establish eligibility for LTCSS under the District Medicaid program. DHCF acknowledges the lack of formal guidance concerning the process by which service hours are determined for beneficiaries and will provide additional clarity as it applies to specific services in future DHCF rulemakings or policy transmittals.

Functional Assessment Score

ULS commented that Subsection 989.11(b) fails to incorporate dementia into the cognitive/behavioral score; and that there are beneficiaries and applicants with dementia who may require LTCSS but may not demonstrate it via their functional assessment scores. Thus, ULS asserted that DHCF must factor dementia into the functional assessment score.

Although dementia is not one of the conditions and behaviors listed at Subsection 989.11(b), DHCF disagrees that it is not factored into the cognitive/behavioral assessment score. Instead of looking at whether an individual has been formally diagnosed with dementia, the cognitive/behavioral assessment evaluates the presence and frequency of a variety of behaviors and abilities, many of which correspond to the symptoms of dementia. DHCF acknowledges that, in cases where an individual with dementia nonetheless requires minimal or no assistance with the performance of ADLs, the functional assessment score may not capture the full extent to which he/she needs LTCSS. However, because the scope of the functional assessment is limited solely to an individual's ability to carry out ADLs, DHCF does not agree that it is appropriate to include dementia as a factor in the functional assessment score. For this reason, DHCF is declining to make the suggested changes.

Assessment's Consideration of Safety Monitoring and Cueing

ULS commented that Subsection 4201.4(b) defines skilled care as well as skilled nursing services but fails to indicate whether or how safety monitoring and cueing needs are factored into the functional assessment score. ULS also commented that Subsection 989.11(c)(3) amends the activity needs that are scored as part of the LTCSS assessment process, but fails to include safety monitoring and cueing, which are offered under 29 DCMR § 5000.2: *Medicaid reimbursable PCA services support and promote the goals of (a) To provide cueing, hands-on assistance, and safety monitoring related to activities of daily living to beneficiaries who are unable to perform one or more ADLs.* ULS stated that Subsection 989.11(c) mentions skilled care needs, but safety monitoring and cueing needs are not adequately factored into the functional assessment score, which is capped at two (2) regardless of the level of skilled care needs. ULS further asserted that the inclusion of such skilled needs is essential to creating an accurate picture of beneficiaries' and applicants' LTCSS needs.

DHCF would first like to clarify that neither safety monitoring nor cueing are considered skilled care services. Safety monitoring and cueing are levels of assistance that an individual may need to perform an ADL; but neither is itself an ADL that is factored into the LTCSS assessment score. Thus, an individual's need for safety monitoring and cueing are factored into the functional assessment score only insofar as it pertains to an individual's ability to perform one or more ADLs. The functional assessment does look at whether a beneficiary needs assistance with the ADLs, but does not factor in the particular type of assistance required, such as safety monitoring or cueing. For this reason, DHCF disagrees that safety monitoring and cueing needs should be evaluated separate from the performance of ADLs and is declining to make any changes to Subsection 4201.4(b).

Assessment Question Concerning the Use of Physical Restraints

LCE expressed concerns with Subsection 989.11(c)(5), which asks the assessor to review whether physical restraints "were required" during a three (3) day look-back period. LCE commented that requiring an assessor to consider the need for physical restraints is inappropriate because physical

restraints should not be used under any circumstances. For this reason, LCE requested that the language referencing physical restraints be removed.

DHCF acknowledges that those conducting the assessments should not be tasked with considering whether physical restraints were needed during the three (3) days prior to the assessment. The intent of this component of the assessment is to determine whether physical restraints had been used at any point during the preceding three (3) days. Accordingly, DHCF is proposing changes, adopted by this rulemaking, that revise Subsection 989.11(c)(5) to read as follows: "For individuals in a hospital or nursing facility, whether physical restraints were used during the last three (3) days prior to the assessment."

Face-to-Face Reassessment Requirement

ULS commented that Subsection 989.16 of the proposed regulations requires all participants in the State Plan PCA and EPD Waiver programs prior to August 1, 2019 to have face-to-face reassessments regardless of whether there is a significant change in their conditions. ULS further commented that this contravenes the existing PCA State Plan regulations at 29 DCMR § 5003.9, which waive the need for annual reassessments unless the beneficiaries' and applicants' conditions have changed in a way that impacts their service needs.

DHCF is proposing corresponding changes to the State Plan PCA Services rule at 29 DCMR § 5003.9 to be published on the same date as this rulemaking. Please see the PCA services rulemaking for further discussion of this issue.

Nursing Facility Utilization Review Determinations

LCE commented that the proposed rule requires DHCF to conduct "utilization reviews" at 6- and 12-month intervals post-admission to a nursing facility. LCE stated that, problematically, utilization reviews "shall determine whether the person continues to be appropriate for nursing facility care." LCE contended that the former requirement inquired whether the individual met the nursing home level of care threshold; that this change is vague and creates a high level of discretion; and that there is no guidance in the provisions explaining how this determination is to be made and what factors should be considered. LCE expressed concern that subjective bias against an individual may result in an adverse determination, and recommended that the previous provision, which adequately provided for an objective level of care determination, be restored.

LCE also commented that Subsection 989.17(b) requires a reevaluation "if the review results in a determination that there has been an improvement in the person's health status". LCE stated that there is no explanation as to what constitutes an "improvement," which may lead to unnecessary reassessment; and there is no definition of "reevaluation" in Subsection 989.99.

In response to LCE's comments, DHCF is declining to restore Subsection 989.17 to its previous iteration but is proposing further revisions, adopted in this rulemaking, to paragraph (a) to more clearly reflect the intent of the provision. The revised paragraph reads as follows: "The utilization review shall determine whether there has been an improvement in the beneficiary's health status."

In addition, DHCF disagrees that the rule should include an explanation of what constitutes an improvement in the health status of an individual. The determination of an individual's health

status, and whether it has improved, is clinical in nature and falls within the scope of the licensed practitioner conducting the utilization review. For that reason, DHCF is declining to further revise the rulemaking to include a definition of what constitutes an improvement in health status. The face-to-face "reassessment" that appears in Subsection 989.17 and throughout this rulemaking has the same meaning as the face-to-face assessment defined in Subsection 989.99, with the only difference being that the beneficiary receiving the assessment has already been assessed at least once before. Accordingly, DHCF does not agree with the recommendation and is not proposing a separate definition for "reassessment.".

Administrative Denials

ULS commented that Subsection 989.24 improperly authorizes DHCF to "administratively deny", i.e., deny or terminate long-term care services for beneficiaries and applicants following three unsuccessful attempts by DHCF's designated agent to conduct their face-to-face assessments within five calendar days. ULS alleged this violates Federal Medicaid law, which requires DHCF to "[c]ontinue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible..." 42 CFR § 435.930(b).

ULS commented that the regulations fail to articulate the nature of the "attempts" to schedule the assessment of beneficiaries and applicants, whether they are written notices or telephone calls; and that the contractors must be held accountable for documenting their attempts to schedule the assessments prior to denying applicants' request for services or terminating beneficiaries' services. In addition, ULS commented that the regulations must incorporate exemptions for beneficiaries and applicants who are unavailable due to hospitalization or other medical appointments, or availability of beneficiaries' and applicants' chosen advocates seeking to be present at the assessments.

DHCF disagrees with the assertion that Subsection 989.24 authorizes DHCF to deny or terminate LTCSS for beneficiaries in contravention of federal Medicaid law at 42 CFR § 435.930(b). Subsection 989.24 describes the circumstances under which an initial administrative denial letter shall be issued, as well as the required contents of such a letter. The next section, Subsection 989.25, provides that if no response to the initial letter is received within twenty-one (21) days, a subsequent administrative denial letter shall be sent to the beneficiary. This subsequent letter will contain an explanation of the circumstances under which the individual's current level of LTCSS will be continued if a timely hearing request is filed with the Office of Administrative Hearings.

However, DHCF agrees that defining the term "attempts" for the purposes of scheduling assessments would provide valuable clarity and is therefore proposing the addition of a definition of "contact attempt" to Subsection 989.99; DHCF is adopting the new definition in this rulemaking. With respect to the comment regarding the need to hold the contractors accountable, DHCF agrees that this is crucial, but maintains the position that it is best done via its contract and not in these regulations. The methods for holding its contractor accountable are enumerated in the current contract and therefore, DHCF is declining to include these provisions in the rulemaking.

Accommodations under Title II of the Americans with Disabilities Act

ULS commented that the proposed regulations fail to include a provision that requires DHCF or its designated agent to reasonably accommodate beneficiaries and applicants during the assessment

process in accordance with Title II of the Americans with Disabilities Act (ADA). They also alleged that the regulations must describe a mechanism for eliciting and granting beneficiaries' and applicants' requests for accommodations, such as access to sign language interpreters during the face-to-face assessment and large print or alternative format printed materials during and following the assessments. Finally, ULS commented that the regulations must include instructions for requesting such accommodations prior to the assessments, *i.e.,* names and contact information of people handling the requests (via telephone, TTY, and/or email).

DHCF is committed to providing reasonable accommodations, as required under Title II of the Americans with Disabilities Act (ADA) and all other applicable federal civil rights laws, to all Medicaid beneficiaries and applicants for whom they are necessary. All requests for such accommodations 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.

Reconsideration Requests

ULS commented that, in order to request reconsideration of the assessment results and service recommendation(s), the rules require beneficiaries and applicants to "submit[] in writing, by mail, fax, or in person, to DHCF[]" their request with the reasons justifying reconsideration, along with a physician's statement and additional documentation, and that this fails to incorporate the right of the beneficiaries and applicants to make reconsideration requests verbally, as required by D.C. law. D.C. Official Code § 4-210.05. ULS suggested that DHCF must revise the rule accordingly.

DHCF disagrees that there is a need for this change. 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, pursuant to Subsections 989.26(d) and 989.27, is different than a request for a fair hearing, pursuant to Subsection 989.26(e), and is therefore bound by different procedural requirements. For this reason, DHCF is declining to incorporate any changes to Subsection 989.27 into this rulemaking.

Definitions

ULS commented that many of the terms in this rule are either insufficiently defined or have definitions that conflict with those found in the corresponding rules governing the EPD Waiver and State Plan PCA services. The ULS comments and DHCF responses regarding the definitions in question are as follows:

"Representative"

ULS stated that the definition of "representative" fails to specifically include people designated by the applicant or beneficiary (or the Probate Court) to make health care decisions in the event the beneficiary is incapable of making his/her own health care decisions. DHCF generally disagrees with the necessity of adding to the definition of "representative" a specific reference to individuals designated to make health care decisions on behalf of the beneficiary. Paragraph (b) of the definition sufficiently addresses individuals who are legally authorized to administer a beneficiary's financial or personal affairs, a category which reasonably includes health care-related decisions. However, to better align with the definition used in the State Plan PCA rule at Chapter

50, Title 29 DCMR, DHCF is revising this rule by replacing the term "representative" with "authorized representative" and making technical changes to the language used to define it.

"Acuity Level"
ULS stated that the definition of "acuity level" is vague without reference to intensity of the beneficiary's service needs, gauged by the number of hours needed or whether the services would be provided hands-on versus less direct oversight or cueing. For the purposes of this rule, a higher level of acuity does not inherently correlate with the need for a higher number of hours or indicate that services need be provided in a more direct, hands-on manner. DHCF disagrees that the current definition does not sufficiently describe the intended meaning of the term. However, to avoid confusion with the more technical "acuity level" terminology used in other Medicaid-financed programs, DHCF is revising the defined term used in this rule by replacing "acuity level" with simply "acuity".

"Beneficiary"
ULS recommended that the definition of "beneficiary" be tied to eligibility for Medicaid long-term care services under the EPD Waiver or State Plan PCA programs. DHCF disagrees that the definition of "beneficiary" should be revised so as to reference only those individuals eligible under the EPD Waiver or State Plan PCA benefits. In this rule, "beneficiary" is also used in reference to individuals receiving nursing facility care and ADHP services, as well as others who have been determined ineligible for LTCSS but remain eligible for other Medicaid services. DHCF is not proposing any substantive changes to this definition, but is making a technical revision by replacing "person" with "individual" to align with terminology used elsewhere in the rule.

"Informal Supports"
ULS recommended that "informal supports" be defined more specifically to incorporate the nature, consistency, and level of assistance provided by unpaid individuals chosen by the beneficiary (*e.g.*, daily, weekly, number of hours provided, for which ADLs or IADLs). ULS further commented that indicators of the consistency of informal supports should include whether the individuals providing informal support services live with the beneficiary and whether they are employed outside of the home. DHCF disagrees that it is necessary to include a detailed explanation of the different factors considered in determining the utility of the informal supports provided to a beneficiary. The purpose of the definition is to set forth the meaning of the term for the purposes of this particular rule. To that end, DHCF is revising the definition of "informal supports" by removing the language that references the frequency of supports provided.

"Level of Need"
ULS recommended that "level of need" be defined so as to distinguish it from "acuity level". ULS commented that the definition fails to capture the description of the range of long-term care services needs provided under Medicaid. DHCF agrees that the definition of "level of need" does not fully capture the determination of the level of long-term care services needed by a beneficiary. To address this, DHCF is revising the rule by replacing "level of need" with "level of care" throughout the rule to ensure consistency and more accurately align with the terminology most commonly used to reference the care needs of LTCSS beneficiaries. DHCF is also proposing to add a definition for "level of care" to mean a determination of the long-term care services or

supports required by an individual. DHF has adopted the new definition as a part of this emergency rulemaking.

"Person-Centered Planning Process"
ULS stated that the definition of "person-centered plan" does not sufficiently incorporate a description of the range of ADL and IADL services needed. Presuming that this comment is in reference to the definition for "person-centered planning process"—as this section of rule does not include a definition for "person-centered plan"— DHCF disagrees that the definition of the term "person-centered planning process" should include a description of the range of services needed by beneficiaries. The purpose of a definition is to set forth the meaning of the term; the ADLs with which assistance may be needed are listed in Subsection 989.11 of the rule. As a result, DHCF is not proposing any changes to this definition.

"Person"
ULS recommended that the definition of "person" not be limited to applicants who submit service assessment requests, because assessment requests are oftentimes instead submitted by agencies. ULS also recommended that the definition include beneficiaries who are already participating in the EPD Waiver or State Plan PCA programs. DHCF agrees that the definition of "person" does not accurately capture the range of individuals potentially involved in the LTCSS assessment process. In response, DHCF is revising the rule by removing the definition of "person" and replacing the term throughout the rule with more specific terms to reference the various parties involved, namely "applicant", "beneficiary", "representative", and "individual", as appropriate.

"ADLs", "IADLs", "Behavioral/Cognitive" and "Skilled Care"
ULS recommended that the rules define the terms "ADLs", "IADLs", "behavioral/cognitive" and "skilled care". In response to an earlier comment regarding the consideration of IADL needs in determining the functional assessment score, DHCF proposed removing the reference to IADLs from Subsection 989.11(a). As a result, because the term "IADLs" is no longer used in Section 989, it is unnecessary to include a definition. DHCF agrees that the other terms—"ADLs", "cognitive/behavioral", and "skilled care"—should be defined and is therefore proposing the addition of the following definitions, adopted by this rulemaking, to Subsection 989.99:

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

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.

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.

These emergency rules were adopted on August 24, 2020 and shall remain in effect for not longer than one hundred and twenty (120) days from the adoption date or until December 22, 2020, 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 these rules 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:

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) a 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 – 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's. 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.

Comments on these rules should be submitted in writing to Melisa Byrd, Senior Deputy Director/State Medicaid Director, Department of Health Care Finance, Government of the District of Columbia, 441 4th Street N.W., Suite 900, Washington D.C. 20001, via telephone at (202) 442-8742, or via email at DHCFPubliccomments@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.