TEFRA Care Coordinator Manual

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What is TEFRA Medicaid?

TEFRA Medicaid is a specialized Medicaid category for children with disabilities and significant medical needs. It is considered a specialized category for Medicaid as it has special provisions that allow children who would not otherwise be Medicaid eligible to access Medicaid. When determining eligibility for TEFRA Medicaid the eligibility worker does not count the parental income or resources.

Eligibility Requirements

Overview

In order to be considered for TEFRA Medicaid a child must meet ALL of the following:

1. Must be less than 19 years of age
2. Be living **in the home** of the biological or adoptive parent
3. Parental income is over the Denali KidCare limits
4. Meet a definition of Social Security Disability and if not for parental income or resources the child would be eligible for Supplemental Security Income (SSI
5. Meet one of three (3) possible Level-of-Care (LOC) Categories
6. The child's income and resources must be within the Specialized Medicaid Income limits as defined in the Long Term Care Medicaid Manual

Age Requirements

The age limit for TEFRA Medicaid is set at 19 years of age. However, it is expected that at age 18 a TEFRA child (or child's parent) should apply for Supplemental Security Income and move to Adult Public Assistance and Related Medicaid prior to turning 19 years of age.

Living in Parental Home (Biological or Adoptive)

Prior to TEFRA Medicaid, families with children who had significant medical needs were faced with two options: forced impoverishment to access Medicaid coverage or placing their child in an institution. TEFRA Medicaid allows families of who do not qualify for DKC to access Medicaid coverage while their child lives in the family home as it only considers the child's income and resources (assets).

Children who live with grandparents or other family members or friends (i.e. aunts, uncles, etc.) are eligible for Denali KidCare as Denali KidCare does not count the income of grandparents or other family members. Children who enter a long-term residential treatment or rehabilitation facility for 30 or more days are eligible for Denali KidCare. This is due to Denali KidCare not counting the parental income if a child is out of the parental home for 30 or more days. If the child's personal income is over the Denali KidCare limit other options can be pursued to access Medicaid.

Children who are adopted through the State Foster Care system are able to receive Medicaid via the State Foster Care system after the adoption. This Medicaid goes through the child's 18th birthday. The Office of Children's Services (OCS) maintains these Medicaid cases.

Parental Income is Over the Denali KidCare Limits

Due to the number of agencies and contract agents involved in the administration of TEFRA Medicaid it is highly encouraged to have Denali KidCare eligible children access Medicaid via Denali KidCare instead of TEFRA Medicaid. **Denali KidCare and TEFRA Medicaid provide the same Medicaid coverage for a child.** A child on TEFRA Medicaid is not viewed any differently when requesting prior authorizations from the Fiscal Agent or receiving medical care.

It is requested that care coordinators complete a brief screening of parental income to see if the parental income is within the Denali KidCare limits. When completing this screening it is important to know the following:

- Denali KidCare does not count resources (assets), this includes bank accounts.
- Denali KidCare does not consider the income of step-parents or significant others when determining eligibility.
- Denali KidCare **only** considers the income of biological or adoptive parents who are living in the home with the child.

Therefore a child may be living in a home with very high parental income, but if the income were that of a step-parent it would not be considered in the Denali KidCare eligibility determination.

> *Example: Sue has a son, Tim, who has autism. Sue recently remarried and her husband, Tim's step-dad, has an annual income of $65,000. Sue recently cut back her hours to part time and earns $1800 gross income per month. Sue is seeking Medicaid coverage for Tim. In this situation, Tim would be eligible for Denali KidCare as his step-dad's income would not be considered and Public Assistance would only count Sue's part-time income of $1800/month.*

There are benefits to Denali KidCare:

- First, the application and renewal process is simpler and less time consuming.
- Second, a child receives an eligibility card that is good for six months. This makes it easier to plan for medical appointments, as a parent does not have the worry of the Medicaid stickers arriving on time every month.

However, parents do have the right to choose which category of Medicaid a child receives and if a parent insists on TEFRA Medicaid this request needs to be honored.

Meet a Social Security Definition of Disability

Another definition that can be used for TEFRA Medicaid children is "if it was not for parental income and resources the child would be eligible for Supplemental Security Income (SSI)." To be eligible for TEFRA Medicaid, a child must be determined disabled by the Disability Determination Services (DDS) unit which is part of the Division of Vocational Rehabilitation. When determining if a child meets a level of disability the disability adjudicators use the same Federal Regulation that is used when determining eligibility for SSI, which is the federal cash program for children and adults with disabilities. The Division of Public Assistance initiates the disability determination after the parent(s) return the needed forms. A Care Coordinator **should never** contact DDS directly to begin a disability determination.

Meet a Level of Care (LOC) Category

TEFRA Medicaid is a Medicaid category for children with significant medical, developmental or psychiatric problems. Not all children who are determined disabled meet a LOC category. Also high medical costs do not mean a child will meet a LOC or disability definition.

TEFRA Medicaid has three LOC categories:

- Intermediate Care Facility for the Mentally Retarded (ICF/MR) (LOC criteria is equivalent to the MRDD Waiver)
- Nursing Facility (NF) (LOC criteria is equivalent to the CCMC Waiver)
- Inpatient Psychiatric Hospital (IPH)

Income and Resource Limits for the Child

When determining income and resource eligibility, the caseworker will only consider the child's income and resource. To meet income and resource eligibility the child's income and resources must be within the following limits:

- $1656 per month in monthly income
- $2000 in countable resources

Accessing TEFRA Medicaid

The Division of Public Assistance administers TEFRA Medicaid. In order for a child to access and receive TEFRA Medicaid several people and agencies must work together. Some of the agencies work behind the scenes and are part of the internal eligibility processing, while other agencies will work directly with the family. Cooperation between the agencies is essential in order to meet the child's needs.

Completing the required paperwork is also essential in order for a child to access TEFRA Medicaid. The completion of the paperwork is the main responsibility of the parent(s).

TEFRA Medicaid Forms

Eligibility Forms (Submitted to the Division of Public Assistance)

In order to initiate the eligibility process for TEFRA Medicaid, parents will need to complete the following:

- MED 4 – Application for Medical Assistance for Adults and Children with Long Term Care Needs. This is the initial application that must be completed.
- MED 1 – Child's Medical History & Disability Report
- MED 2 – Authorization for Release of Medical Information
- GEN 72 – Medicaid Annual Review Form

Forms Submitted to Qualis Health

The care coordinator is responsible for submitting the following forms to Qualis Health:

- MED 24 – TEFRA Medicaid Nursing Facility Level-of-Care
- Inpatient Psychiatric Hospital (IPH) LOC Form Dated 10/21/04 – Inpatient Psychiatric LOC
- Cost of Care (COC) Form Dated 1/4/05 – Estimated Annual Expenses
- Plan of Care (POC) Renewal Form Dated 1/4/05 – Certification of Plan of Care

The DPA caseworker submits the following form to Qualis Health:

- GEN 140 B – Referral to Qualis Health

Agencies / People Involved in TEFRA Medicaid Processing

Agencies involved in TEFRA Medicaid processing are:

- Division of Public Assistance (DPA)
- Care Coordination Agency / Care Coordinator
- Parent(s)
- Qualis Health
- The Division of Senior and Disability Services (DSDS)
- Disability Determination Services (DDS)

Division of Public Assistance (DPA)

DPA is the state agency that administers the TEFRA Medicaid program and is the central agency in all TEFRA Medicaid eligibility decisions.

DPA Caseworker

The DPA eligibility caseworker is the central person in any TEFRA application and ongoing Medicaid case. The DPA caseworker is responsible for:

- Completing the financial and resource determination at both the initial application and yearly renewal.
- Submitting the MED 1 and MED 2 forms along with supporting medical documentation to the Disability Determination Services for a disability review and decision. They then track the disability review dates.
- Sending the GEN 140B to Qualis Health via e-mail which will initiate the Qualis Health process and the issuing of the TF# that the care coordinator will need for billing.
- Issuing screening coupons for care coordinators and additional medical examinations that may be needed.
- Making the final eligibility decision based on financial and resource eligibility, disability status, and Level of Care (LOC) status.
- Communicating case status changes to the parent(s) and Qualis health.
- Sending yearly Medicaid renewal notices to the parent(s). Note: These notices are auto-generated from the DPA eligibility system.

DPA Long Term Care Coordinator

The DPA Long Term Care Coordinator is located in the DPA Field Services office in Anchorage and specializes in all areas of Specialized/Long Term Care Medicaid categories. In relation to TEFRA the responsibilities of the DPA Long Term Care Coordinator are:

- Oversight and administration of the state contract with Qualis Health.
- Providing procedural and policy clarifications regarding TEFRA Medicaid to all stakeholders.
- Troubleshooting difficult cases and providing guidance for parents and care coordinators.
- Interfacing with DSDS for ICF/MR LOC decisions.
- Providing care coordination training and assistance in regards to TEFRA Medicaid.
- Issuing all LOC and Disability denial letters.

Qualis Health

Qualis Health is a contractor employed by the state. The Division of Public Assistance (DPA) administers the contract and the DPA Long Term Care Coordinator provides contract management and oversight. Qualis Health performs the following functions:

- Referring families to care coordination agencies and the DPA caseworker to ensure appropriate paperwork is submitted.
- Complete a LOC screening to determine the most appropriate LOC.
- Referring new ICF/MR applicants and ICF/MR renewals to DSDS.

- Notifying parent(s) and care coordinators when the yearly LOC is due. For renewals a notice will be sent 90 days prior to the renewal month to ensure paperwork can be submitted to DSDS in a timely manner.
- Completing LOC decisions for NF and IPH LOC.
- Tracking the case processing timeframes for all three LOC categories and issuing denials when the LOC decision is not completed within specified time frames.
- Reviewing the Plan of Care (POC) and Cost of Care (COC) for all three LOC categories.
- Notifying DPA caseworkers and care coordinators of the LOC approval decisions.
- Notifying the DPA Long Term Care Coordinator of all LOC denials, including the rationale for denial.
- Completing pre-hearing conferences and representing the State in all Fair Hearings regarding LOC denials.

Division of Senior and Disability Services (DSDS)

DSDS is responsible for the following:

- Making all ICF/MR LOC decisions.
- Completing ICAP assessments based on referrals (both new and renewals) from Qualis Health.
- Notifying the DPA Long Term Care Coordinator of all denials, including a rationale for the denial.
- Completing pre-hearing conferences and representing the State in all Fair Hearings regarding ICF/MR LOC denials.
- Communicating directly with Qualis Health the status of ICF/MR LOC decisions and any issues/concerns regarding the status of the evaluation (i.e. inadequate documentation being received from the care coordinator).

Care Coordination Agency

The care coordinator holds a very important role in TEFRA Medicaid. The care coordinator is responsible for providing all the required documentation in a timely manner to Qualis Health or DSDS in order to ensure the eligibility or continuing eligibility of a child. Care coordinators are responsible for:

- Completing the Level of Care (LOC), Plan of Care (POC) and Cost of Care (COC) documentation for Nursing Facility (NF) and Inpatient Psychiatric Hospital (IPH) applicants and yearly renewals.
- Providing adequate and appropriate documentation along with contact information for three respondents to DSDS for the ICAP evaluation for children over three years of age.
- Providing adequate and appropriate documentation to the DPA Long Term Care Coordinator for children under three years of age for submission to DSDS for LOC review and decision.

- Completing the POC and COC documentation for ICF/MR applicants and renewals to Qualis Health.
- Making appropriate referrals to DPA for the completion of the DPA application.

Disability Determination Services (DDS)

The Disability Determination Services (DDS) unit is part of the Division of Vocational Rehabilitation and completes disability decisions at the request of DPA. The only person who can make a request for a disability determination is the DPA caseworker. This is done only after all the MED 1 and MED 2 forms are completed by the parent(s) and submitted to DPA.

How a Child Meets Disability

There are two tests that a DDS adjudicator applies when determining disability:

- The first test looks to see if the child's diagnosis meets one of the medical listings as outlined in Federal Regulation 20 CFR Pt. 404. Subpt. P. App1.
- If a child's diagnosis does not meet medical listing the adjudicator then evaluates to see if the child meets disability by checking functional equivalents as outlined in Federal Regulation 20 CFR 416.924, 924a, 924b, 925 and 929. The Functional equivalents test considers six areas of life functioning and evaluates the child's delays in each of the six areas. To be considered disabled a child must be considered "extreme" in one area or "marked" in two areas of functioning. The six areas of life functioning that are evaluated are:
    - Acquiring and using information
    - Attending and completing tasks
    - Interacting and relating to others
    - Moving about and manipulating objects
    - Caring for yourself
    - Health and physical well-being

Length of a Disability Decision

If a child is determined to meet a definition of disability, a disability diary is generally set for review every three years. However, this Continuing Disability Review (CDR) date can be lessened or increased in certain circumstances. The DPA caseworker tracks these review dates and will work with the parent(s) when a review is necessary.

Helpful Information for Disability Determinations

In order to expedite a disability decision it is very beneficial for the parent(s) to provide as much medical and developmental information with the DPA application. If information is provided with the application it may eliminate the need for the disability adjudicator to request information from providers. Information that is beneficial when determining disability includes:

- Current medical records clearly indicating the child's diagnosis as well as current health condition and medical needs

- Pertinent lab reports
- Current Individual Education Plan (IEP) from the child's school
- Current Infant Learning Program assessments
- Letters from teachers and counselors
- Therapy records from Speech Therapy, Occupational Therapy and Physical Therapy that indicated the frequency of the therapy sessions
- Psychiatric and counseling records
- Records from additional support programs

Parent(s)

While there are many agencies and people involved in a TEFRA child's life the ultimate responsibility for ensuring Medicaid eligibility is obtained and then maintained is the child's parent(s). Parent(s) are responsible for:

- Completing the initial DPA application along with the MED 1 and MED 2 forms and submitting this to DPA.
- Finding a care coordinator and then working with the care coordinator on obtaining all the relevant and needed documentation for the LOC determination.
- Working with the care coordinator in completing the yearly LOC renewal within timeframes.
- Completing the annual DPA renewal (GEN 72) within timeframes.
- Completing the MED 1 and MED 2 forms for periodic disability reviews.
- Reporting any and all private health insurance coverage to the DPA caseworker.
- Ongoing communication with Qualis Health regarding the status of obtaining requested documentation, especially if a delay is anticipated (i.e. unable to get a cognitive test done within time deadlines).

Level of Care (LOC) Assessments

Intermediate Care Facility for Mental Retardation (ICF/MR)

Referrals to DSDS for ICF/MR LOC Decisions for Children Over Three Years of Age

A care coordinator will not make direct referrals to the Division of Senior and Disability Services (DSDS) for an ICAP assessment; only Qualis Health will make referrals for an ICAP assessment.

New Applicants

For new TEFRA applicants these steps will be followed:

1. The care coordinator may contact Qualis Health for assistance in determining the appropriate LOC. If LOC is determined without Qualis Health assistance the care coordinator must notify Qualis Health which LOC is being submitted within the first 30 days of application.

2. If a Qualis Health reviewer determines or is notified that ICF/MR is the appropriate LOC, Qualis Health will then make a direct referral to DSDS. The referral will include the child's name, date of birth, Social Security Number, and the name and contact information of the care coordinator.
3. Upon receiving this information DSDS will contact the care coordinator via e-mail and request the appropriate documentation. (See below for a list of mandatory information that is needed for an ICAP evaluation.)
4. After DSDS receives sufficient documentation the case will be assigned to an evaluator.

ICF/MR LOC Renewals for Children Age Three Years Through Age Seven

Children age three through age seven who meet an ICF/MR LOC will have a yearly ICAP evaluation to re-determine LOC for the following year.

1. Ninety days prior to the renewal month, Qualis Health will e-mail DSDS a list of children with ICF/MR LOC renewals due in that month. The list will contain the child's name, date of birth, renewal month, and the name and contact information of the care coordinator.
2. Upon receiving the referral list DSDS will contact the appropriate care coordinator via e-mail requesting the care coordinator gather and submit pertinent documentation for the ICAP evaluation.
3. In order to meet time deadlines, the LOC documentation needs to be to DSDS at least 30 days prior to the renewal date. All other documentation (POC, COC) is submitted directly to Qualis Health.
4. After DSDS receives sufficient documentation the case will be assigned to an evaluator.

ICF/MR Renewals for Children Over Age Seven

TEFRA recipients, who meet an ICF/MR LOC, over the age of seven will be on a three-year ICAP cycle. These children will have an "Interim Level of Care" completed as follows:

1. Ninety days prior to the renewal month Qualis Health will e-mail DSDS a list of children with ICF/MR LOC renewals due in that month. The list will contain the child's name, date of birth, renewal month, and the name and contact information of the care coordinator.
2. Upon receiving the referral list, for all children needing an Interim Level of Care, DSDS will contact the appropriate care coordinator via e-mail and request the following:
    a. A Demographic Form
    b. A Qualifying Diagnosis Certificate
3. In order to meet time deadlines, the Demographic Form and Qualifying Diagnosis Certificate, needs to be to DSDS at least 30 days prior to the renewal date. All other documentation (POC, COC) is submitted directly to Qualis Health.
4. After DSDS receives the forms an Interim Level of Care determination will be made.

The Inventory for Client and Agency Planning (ICAP) Process

The care coordinator collects and provides to DSDS within 60 days of TEFRA Medicaid renewal month, or within 30 days of a new TEFRA Medicaid application, the following materials as the complete ICAP Packet:

a. Completed ICAP Assessment Applicant/Recipient Information & Consent form
b. Current Release of Information
c. Documentation meeting DSDS requirements and supporting a diagnosis of one of the five defined ICF/MR qualifying diagnoses per 7 AAC 43.300, 7 AAC 43.1010 and 7 AAC 43.1030
d. Copies of police reports or legal documents pertaining to arrests and/or intervention by law enforcement or the judicial system, including court appointed guardian/conservator
e. For school-age children, a copy of the Interdisciplinary Team Evaluation Report (three-year evaluation)
f. Where applicable, a current behavior management plan

The care coordinator informs the respondents identified on the ICAP Assessment Information & Consent form about the ICAP process, and prepares them for contact by an assessor for scheduling of interviews.

The ICAP Assessment Applicant/Recipient Information & Consent Form

The ICAP Assessment process requires the care coordinator to gather information about the applicant/recipient including demographic and medical information such as medications. Further, the ICAP process requires that the care coordinator gather information from people who are familiar with the applicant/recipient regarding the applicant/recipient, and provide the contact information for these individuals to the Division of Senior and Disability Services (DSDS) as part of the ICAP assessment procedure. The information required is outlined below in detail and must be submitted to DSDS on the ICAP Assessment Applicant/Recipient Information & Consent form.

The care coordinator must provide complete and correct demographic information to DSDS regarding the applicant/recipient residential status and contact information as outlined below:

a. A physical address for an applicant/recipient must be provided. Physical address is the location where the applicant/recipient resides most of the time.
b. Check either “New” for initial program applications or “Renewal” for reauthorizations.
c. Check “TEFRA” for the TEFRA Medicaid program.
d. The applicant/recipient’s Social Security number must be provided.
e. The Medicaid number of the recipient must be provided.

f. The telephone number is that at the applicant/recipient's physical location where the applicant/recipient can be reached.
g. A mailing address for the applicant/recipient, or legal representative if applicable, must be provided. Mailing address is the location where the applicant/recipient or their legal representative if applicable, receives mail.
h. Information regarding the school/day program must be provided. For school-age children, indicate the name of the school and whether it is an elementary, middle or high school.
i. The name of the care coordinator, billing number (CM number), telephone number and e-mail address, and the agency name and billing number (CMG number) must be provided.
j. The name and telephone number of the legal guardian must be provided. If the applicant lives at home with a parent, provide the name of the parent even though he/she is not the legal guardian.

The care coordinator must provide information regarding the applicant/recipient's current medications. This information is required for completion of the ICAP and is gathered now because respondents may not have knowledge of medications:

a. List the name of the medication (do not include dosages) and the purpose for which it was prescribed; for example, Tegretol—to control seizures.
b. Do not list topical, over-the-counter or herbal medications.

The care coordinator must provide the names of three respondents who are familiar and knowledgeable about the applicant/recipient and who are willing and available to be interviewed by the DSDS assessor, daytime telephone number(s), and an explanation of the relationship of each to the applicant/recipient.

a. A respondent is an individual who sees the applicant/recipient daily, has known him/her for at least three months, and, consequently, has knowledge of his/her <u>current</u> skills and behaviors.
    1. One respondent should be the primary caregiver: parent, group home staff or residential staff.
    2. Another should be the primary day service provider: teacher, day habilitation staff, job coach or therapist.
    3. The third respondent should be someone who meets the criteria in #1 or #2, and who does not reside with either of the other two respondents.
        - Guardians, power of attorneys, or legal or authorized representatives who live at a distance or out-of-state are not appropriate respondents because contact with the applicant will not have been daily and knowledge of skills and behaviors will not be current.
        - Respondents must be at least 18 years of age.

b. Information regarding a respondent's need for special accommodations or a translator should be provided on the ICAP Assessment Applicant/Recipient Information & Consent form.
c. The care coordinator will provide written authorizations for disclosure of health information in the form of a Release of Information to DSDS and to identified respondents.
d. DSDS reserves the right to require additional or different respondents to ensure a complete, accurate and quality assessment.
e. The care coordinator must review the Consent page of the ICAP Assessment Applicant/Recipient Information and Consent form, including:
    1. Explain and provide a copy of this document, “Guidelines for the ICAP Process.” *(**Copies of these Guidelines can be requested from the DPA Long Term Care Coordinator)*
    2. Explain that respondents must provide accurate and truthful information that will be used in assessing the applicant/recipient’s eligibility for services.
    3. Explain that the applicant/recipient may or may not meet the criteria for eligibility for services.
    4. Provide an opportunity for the applicant/recipient, or legal representative if applicable, to ask questions and provide or assist in seeking answers to those questions.
    5. Obtain the initials of the applicant/recipient, or legal representative if applicable, in each box, as well as their signature at the end of the document, indicating their consent in having a DSDS representative proceed with the ICAP assessment process.

If the applicant/recipient is being assessed for the MRDD HCB Medicaid Waiver, the care coordinator will provide a signed copy of the Care Coordination Assignment form to DSDS. Both the care coordinator and the applicant/recipient, or legal representative if applicable, must sign the form. A copy of the form must also be provided to the applicant/recipient, or legal representative if applicable. If the applicant/recipient is being assessed for the TEFRA Medicaid program, this form is not completed.

The care coordinator will provide a copy of any police reports or legal documentation issued or related to incidents to DSDS.

The care coordinator will provide a copy of any evaluations or supportive diagnostic documentation to DSDS (See section C for specific information about supportive diagnostic documentation requirements).

The care coordinator will provide a copy of the current behavior management plan if applicable to DSDS.

Specific Information about Supportive Diagnostic Documentation Requirements

The care coordinator collects and submits to DSDS supportive documentation that meets DSDS requirements.

a. Applicants applying for their initial level of care determination must submit a comprehensive evaluation completed within the previous 12-month period.
b. Evaluations must be signed and dated. (Evaluations written on prescription forms are not acceptable documentation.)
c. Physicians must countersign nurse practitioner and physician assistant evaluations except for Qualifying Diagnosis Certification (QDC) forms completed according to the applicable guidelines.
d. The school psychologist must sign interdisciplinary Team Evaluation Reports. (Individual Education Plans are not acceptable documentation).
e. A completed QDC done within the previous 12-month period must be submitted to DSDS. Qualified providers are listed on the form and on the memorandum, and include physicians, advanced nurse practitioners, physician assistants, psychologists, school psychologists and psychological associates licensed to practice in Alaska.
f. If documentation supporting a qualifying diagnosis is unavailable within required timeframes, the care coordinator must indicate the date of the scheduled evaluation appointment on the ICAP Assessment Applicant/Recipient Information & Consent form.

The documentation must support one of the following qualifying diagnoses per 7 AAC 43.300:

a. **Mental Retardation**. Diagnosis, by a psychologist or a psychological associate, of a condition which meets the diagnostic criteria for DSM-IV-TR Code 317 Mild Mental Retardation, 318.0 Moderate Mental Retardation, 318.1 Severe Mental Retardation, 318.2 Profound Mental Retardation or 319 Mental Retardation, Severity Unspecified. (See pages 41-49, American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision). Assessment with a standardized, individually administered, intelligence test of an IQ (intelligence quotient) of 70 or less (plus or minus five points allowed as a possible measurement error depending on the test used). The condition must have originated before the age of 22, must be likely to continue indefinitely, and must constitute a substantial disability in capacity to function in society.
b. **Other mental retardation-related condition**. Diagnosis by a licensed physician of a condition (other than mental illness, psychiatric impairment, or serious emotional or behavioral disturbance) which is closely related to mental retardation because the condition results in impairment of general intellectual functioning or adaptive behavior, and requires treatment or services similar to that for individuals with mental retardation. The condition must have originated before the age of 22, must be likely to continue

indefinitely, and must constitute a substantial disability in capacity to function in society.

c. **Cerebral Palsy**. Diagnosis by a licensed physician. (A deficit in intellectual ability need not be present). The condition must have originated before the age of 22, must be likely to continue indefinitely, and must constitute a substantial disability in capacity to function in society.
d. **Seizure Disorder**. Diagnosis by a licensed physician. (A deficit in intellectual ability need not be present). The condition must have originated before the age of 22, must be likely to continue indefinitely, and must constitute a substantial disability in capacity to function in society.
e. **Autism**. Diagnosis by a clinical psychologist, child psychiatrist or developmental pediatrician of a condition with meets the diagnostic criteria of DSM-IV-TR Code 299.00 Autistic Disorder. (See pages 70-75, American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision). The condition must have originated before the age of 22, must be likely to continue indefinitely, and must constitute a substantial disability in capacity to function in society.

ICF/MR LOC Process for Children Under Three Years of Age

Children under three years of age are too young for the ICAP evaluation and will be evaluated for the ICF/MR LOC by DSDS.

New TEFRA Applications for Children Under Three Years of Age:
When it is determined that a child under 3 should be evaluated for the ICF/MR LOC the following steps will be taken:

1. Qualis Health will make an e-mail referral to DSDS with the child's name, date of birth and care coordinator.
2. DSDS will e-mail the care coordinator and instruct the care coordinator to provide the following documentation to DSDS within the application pend timeframes (as established by the DPA caseworker):
    a. A comprehensive, developmental evaluation including scores and ratings in key developmental areas (i.e. Infant Learning Assessment). This evaluation must be from within the past 12 months.
    b. Qualifying diagnosis certification or letter from physician stating the child's diagnosis and that the condition is expected to be indefinite or at least for the next 12 months.
3. Qualis Health will track to ensure that the care coordinator submits all documentation to DSDS within the specified time frames.

TEFRA ICF/MR Renewals for Children Under Three Years of Age:
Ninety days prior to the renewal month Qualis Health will:

1. E-mail the care coordinator and instruct the care coordinator to submit the following information to DSDS:

a. The most recent comprehensive, developmental evaluation including scores and ratings in key developmental areas (the evaluation must be from within the past 12 months)
b. A letter from the child's physician stating the child's diagnosis and that the condition is expected to be indefinite or at least for the next 12 months

Nursing Facility Level of Care (NF)

Children who have a high level of medical needs, but do not experience any developmental delays or mental retardation may meet the NF Level of Care (LOC) Assessment. The Qualis Health Nurse Reviewer will review all documentation and determine if a child meets the NF LOC.

Criteria for NF LOC

Intermediate Level of Care

For a child to meet the intermediate level of care must show the need for licensed nursing services ordered by and under direction of a physician, and which can only be made available through an institution. This includes observation, assessment, and treatment of a long-term illness or disability whose condition is relatively stable and where the emphasis is on maintenance. This includes an individual nearing recovery and discharge whose condition is relatively stable but who continues to require professional medical or nursing supervision. This level may also include therapy provided by a Certified Nursing Assistant (CNA) or therapy assistant under the supervision of a licensed personnel or a therapist

Skilled Level of Care

For a child to meet the definition of needing skilled care documentation must show that there is need for skilled nursing or structured (active) rehabilitation ordered by and under the direction of a physician. Rehabilitation services must be received five days per week and skilled nursing services must be provided on a 24-hour basis either directly by or under the supervision of licensed observation, assessment and the treatment of an unstable condition. There must be a treatment plan established by a physician and care by licensed personnel to identify and evaluate the individual's need for possible modification of treatment, or both, until the condition improves to point of stabilization. The treatment plan can include such services as skilled rehabilitation, medical stabilization or complex treatment of a medical condition, observation and assessment of a patient's changing condition, patient education services and other services as specified in 42CFR 409.33

The Role of the Care Coordinator – New Applicants

If it is determined that a child should be evaluated for the NF LOC the care coordinator will initiate the process by:

1. Completing the MED 24 – TEFRA Medicaid Nursing Facility Level-of-Care form and obtaining the required physician signature.

2. The MED 24 must be submitted to Qualis Health along with all current medical documentation from the past 12 - 18 months to substantiate the claim that the child meets the NF LOC.
3. Ongoing communication with Qualis Health regarding the status of obtaining requested documentation especially if requesting an extension.

The Role of the Care Coordinator – Renewals

Ninety days prior to the renewal month Qualis will send the care coordinator and parent(s) notification of renewal due. The care coordinator should begin working with the parent(s) so that all documentation can be submitted to Qualis Health at the beginning of the renewal month. Failure to submit the renewal documentation by the beginning of the renewal month may result in a lapse in the child's Medicaid coverage.

Every year the following must be completed:

1. The MED24 – TEFRA Medicaid Nursing Facility Level-of-Care form must be completed and signed by child's physician
2. Pertinent and **current** medical documentation must be submitted with the MED 24 on a yearly basis.
3. Ongoing communication with the Qualis Health nurse reviewer regarding the status of obtaining requested documentation especially if requesting an extension.

Required Documentation for NF LOC Processing (Both New and Renewals)

The MED 24 in itself does not provide the needed information for a LOC determination. Every MED 24 must be accompanied with the following:

- The documentation submitted for the NF LOC must demonstrate that the child's needs are intensive enough for the need of a licensed nursing service.
- Every diagnosis or condition listed on the MED 24 must have hard copy documentation submitted to Qualis Health to support the claims for the year being reviewed.
- Pertinent documentation may include, but is not limited to medical records, lab reports, therapy reports, school reports, infant learning records, etc. At times the Qualis Health nurse may require that the parent(s) complete a 24-hour log regarding the care of child during this specified time frame.

Once a child meets the NF LOC it cannot be assumed that he or she will continue to meet the LOC requirements on a yearly basis. Children with major health conditions can improve over time and therefore it is important to provide adequate documentation every year.

Inpatient Psychiatric Hospital (IPH)

The IPH Level of Care (LOC) is unique to TEFRA Medicaid and allows families who are over income for Denali KidCare a way to access Medicaid to cover needed services within the community. Many children who qualify for TEFRA under this LOC option often move from the parental home to enter inpatient treatment. If a stay at an inpatient facility exceeds 30 days the child will move from TEFRA to Denali KidCare.

Criteria for IPH LOC

A child must meet all six criterions before IPH LOC can be established:

1. The child must have a mental illness or severe emotional disturbance as diagnosed by a psychiatrist or mental health professional clinician. The condition must have persisted for six months and is expected to persist for a total of 12 months or longer.
2. The child **must have at least one** of the following mental health symptoms:
    a. Psychotic symptoms, characterized by defective or lost contact with reality, hallucinations or delusions.
    b. Suicidal behavior, in the 90-day period before the date of application as demonstrated by the individual having suicidal thoughts.
    c. Significant suicidal thoughts within the 30-day period before the date of application that include a plan for suicide.
    d. Violent behavior within the 30-day period before the date of application, as characterized by a documented attempt by the individual to cause injury to a person or substantial property damage as the result of an emotional disturbance.
3. The child must have functional impairments, relative to expected development levels for that age and at a level that qualified the child to receive inpatient psychiatric care, in at least three of the following areas:
    a. Self-care
    b. Social relationships
    c. Functioning at school or work
    d. Interaction with the community
    e. Family relationships
4. The child must show that absent the appropriate intervention in the home and community, the child would require psychiatric hospitalization as documented by a mental health professional.
5. The child must require a level of care in the home that is typically provided in a psychiatric hospital because the child is suffering from a mental illness or emotional disturbance that is likely to result in serious harm to self or others.
6. The child must be expected to functionally improve or can avoid further deterioration if care is provided in the home or community.

The Role of the Care Coordinator – New Applicants

If it is determined that a child may possibly meet the IPH LOC the care coordinator must complete the following:

1. The TEFRA IPH LOC Form dated 10/21/04 – this form must be completed, signed by the mental health professional and submitted to Qualis Health.
2. The IPH LOC form must be submitted and include substantiating documentation supporting the IPH LOC claim. Documentation may include but is not limited to current records from the treating psychiatrist or mental health professional, school records that document behavioral issues encountered at school, reports from teachers and support staff, records showing current medication regime, etc. for the year being reviewed. Information should be current within the past 12 - 18 months.

The Role of the Care Coordinator – Renewals

Ninety days prior to the renewal month Qualis will send the care coordinator and parent(s) notification of renewal due. The care coordinator should begin working with the parent(s) so that all documentation can be submitted to Qualis Health at the beginning of the renewal month. Failure to submit the renewal documentation by the beginning of the renewal month may result in a lapse in the child's Medicaid coverage. Every year the following must be completed:

1. The TEFRA IPH LOC Form dated 10/21/04
2. Pertinent and **current** mental health treatment documentation must be submitted with the IPH LOC form on a yearly basis.

Required Documentation for the IPH LOC (Both New and Renewals)

- As stated above in order for a child to meet the IPH LOC he or she must meet all six of the stated criteria. The care coordinator must provide documentation for each of the six criteria listed above. This documentation must come from qualified individuals or agencies that are assisting and treating the child.

Children with Dual Diagnoses – Which Level of Care (LOC)?

It is common for a child to have multiple conditions that result in the possibility of meeting more than one of the three LOC categories. For example, a child diagnosed with Cerebral Palsy has a diagnosis that meets the criteria for the ICF/MR LOC, however, the child may also have significant nursing needs that meet the NF LOC definition. The same situation may appear with a child who meets ICF/MR LOC, however, the child has significant psychiatric issues that meet the IPH LOC.

At no time should a care coordinator submit documentation for two LOC determinations. Only one LOC determination can be submitted at a time. Therefore, it is important that the care coordinator works with the Qualis Health Nurse to determine which LOC is most appropriate. It may be that there is more substantiating documentation for an ICF/MR LOC than the NF LOC resulting in an ICAP referral. If after submission of the appropriate LOC forms and documentation the child is denied

LOC the parent(s) will need to appeal this denial before Qualis Health will look at another possible LOC as part of the appeal process.

When is the Level of Care (LOC) Renewal Due?

As stated above, Qualis Health will send the parent(s) and care coordinator a letter 90 days prior to the renewal month telling them that the LOC renewal is due. At this time the parent(s) and care coordinator should begin working together to ensure that all paperwork is submitted timely. Also, to ease the process, in July 2004 Qualis Health made a processing change and made the LOC renewal month static regardless of the month LOC was approved or renewed. For example, if a LOC renewal is due in July 2004 but all the documentation is not submitted and LOC approved until September 2004, the renewal month will remain July 2005 not September 2005.

By keeping the renewal month static care coordinators should be able to maintain their own databases of renewal months, which will allow for better planning with families. However, if a care coordinator is having difficulty obtaining the necessary information the care coordinator can contact Qualis Health and request an extension. Qualis Health will grant extensions on case-by-case basis after discussing the request with the Division of Public Assistance (DPA) Long Term Care Coordinator.

Plan of Care (POC) and Cost of Care (COC)

POC and COC are required with all new applications as well as yearly renewals. Care coordinators should submit the POC and COC forms simultaneously with the LOC paperwork. For ICF/MR LOC decisions care coordinators should submit the POC and COC forms to Qualis Health at the same time the documentation is provided to DSDS for the ICAP evaluation.

TEFRA and Denali KidCare

Referrals from Denied or Closed Denali KidCare

Question 13b of the Denali KidCare application asks if any child listed on the application has a disabling condition that is expected to last more than 12 months. If this question is answered “yes” and the name of the child is written down, the following will happen if Denali KidCare is denied or closed for excess income:

- The Denali KidCare worker will make a referral to the appropriate DPA TEFRA caseworker.
- The DPA TEFRA caseworker will then send the parent(s) DPA notice – PEND TEFRA DISABLED CHILD DENIED DKC. Upon receiving this notice the parent(s) must:
    - Respond to the questions on the notice and return the completed notice to the TEFRA caseworker.

  - Complete the MED 1 and MED 2 forms that will be mailed in a separate envelope.
  - Gather pertinent medical information that should be returned with the MED 1 and MED 2 forms.
- The DPA TEFRA caseworker will e-mail Qualis Health the GEN 140B referral form.
- Upon receiving the GEN 140B form Qualis Health will send the parent(s) a welcome letter including a referral list of care coordinators. The parent(s) have 30 days to notify Qualis Health of the care coordinator selected to provide services. Failure to notify Qualis Health of the care coordinator selection will result in denial of the TEFRA Medicaid.
- The parent(s) must cooperate with the care coordinator in completing the necessary LOC paperwork

Case Processing Time Frames

New Applications

Medicaid regulations allow an agency 90 days to complete an eligibility determination. However, the goal is to complete an eligibility decision within 60 days or less. In order to meet these required time frames the following must happen:

- The parent(s) must cooperate with the DPA caseworker in completing the required interview and providing any additional information by the due date set by the DPA caseworker.
- The parent(s) should submit medical documentation along with other pertinent documentation with the MED 1 and MED 2 forms. This way DDS can begin completing a disability decision and may not need to request additional information.
- The parent(s) has 30 days to notify Qualis Health of the care coordinator selected to provide services. Upon selecting a care coordinator the LOC paperwork should be submitted to Qualis Health or DSDS within 30 days after contact with the parents.

Renewals

Division of Public Assistance (DPA) Renewal Form – GEN 72

- The parent(s) is required to complete and submit the GEN 72 renewal form every year. The parent(s) is sent a notice and renewal form the month prior to the renewal month stating that the renewal form must be submitted by the 15th of the following month. ***The parent is only required to put the child's income and asset information on the renewal form.***
- If a renewal is not received by the 15th of the renewal month, on the 16th a second notice and renewal form is mailed to the parent(s) stating that the renewal form "must be submitted by the end of the month or **Medicaid will end**."

Note: Completion of the GEN 72 is a requirement and is not an option.

Level of Care (LOC) Renewals

With Qualis Health sending notification 90 days prior to renewal it is expected that LOC paperwork will be submitted to Qualis Health or DSDS within the needed time frame to complete the LOC renewal within the renewal month. Failure to do so may result in LOC being denied for failing to submit a renewal.