TEFRA Care Coordinator Manual

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July 2021

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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 Modified Adjusted Gross Income (MAGI) 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 (SSI) 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 who do not qualify for MAGI Medicaid access to Medicaid coverage while their child lives in the family home as it only considers the child's income and resources (assets).

For MAGI Medicaid, the child's household composition is based on IRS tax filing rules. In many cases, individuals in the same household will all have the same MAGI Medicaid household composition. However, as each person's (or child's) household is determined individually, members of the same household may have different MAGI Medicaid household compositions.

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 MAGI Limits

Due to the number of agencies and contract agents involved in the administration of TEFRA Medicaid, it is highly encouraged to have MAGI eligible children access Medicaid via MAGI instead of TEFRA Medicaid. **MAGI 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 MAGI limits. When completing this screening it is important to know the following:

- MAGI Medicaid does not count resources (assets), this includes bank accounts.
- MAGI Medicaid household composition is determined using tax filing rules.

There are benefits to MAGI:

- The application and renewal process are simpler and less time consuming.
- A child determined eligible for MAGI Medicaid will be certified for 12 months.

However, parents do have the right to choose which category of Medicaid a child receives if they are eligible for more than one. If a parent insists on TEFRA Medicaid, this request needs to be honored.

Meet a Social Security Definition of Disability

Another way to define 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 Intellectually Developmentally Disabled (ICF/IDD) (LOC criteria is equivalent to the IDD Waiver)
- Nursing Facility (NF) (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 resources. To meet income and resource eligibility for TEFRA, the child's income and resources must be within the following limits:

- $2,382 per month in monthly income for 2021
- $2,000 in countable resources. Resources are defined as any assets, including cash or any other real or personal property, that an individual owns and can convert to cash to be used for his or her support and maintenance. Examples include cash, savings bonds, financial accounts, vehicles, and property.

Accessing TEFRA Medicaid

The Division of Public Assistance administers TEFRA Medicaid. 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 to meet the child's needs.

Completing the required paperwork is also essential for a child to access TEFRA Medicaid. The parent(s) are mainly responsible for completion of the paperwork.

TEFRA Medicaid Forms

Eligibility Forms (Submitted to the Division of Public Assistance)

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 Comagine Health (formerly Qualis Health)

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

- MED 24 – TEFRA Medicaid Nursing Facility (NF) Level-of-Care (Rev 04/20)
- TEFRA Inpatient Psychiatric Hospital (IPH) Level- of-Care (LOC) Determination Dated 10/21/04 Rev 7/18/08
- TEFRA Cost of Care Form Dated 1/4/05 – Estimated Annual Expenses
- TEFRA Medicaid Plan of Care 8/17/05

The DPA caseworker submits the following form to Comagine Health:

- GEN 140 B (Rev 04/20) – Referral to Comagine Health

Agencies / People Involved in TEFRA Medicaid Processing

Agencies involved in TEFRA Medicaid processing are:

- Parent(s)
- Care Coordination Agency / Care Coordinator
- Division of Public Assistance (DPA)
- Comagine 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 Comagine Health via e-mail which will initiate the Comagine 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 Comagine health.
- Sending yearly Medicaid renewal notices to the parent(s).

DPA TEFRA/Specialized Medicaid PAA

The DPA Long Term Care Coordinator is located in the DPA Division Operations Support Team (DOST)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 Comagine Health.
- Troubleshooting difficult cases and providing guidance for parents and care coordinators.
- Interfacing with DSDS for ICF/IDD LOC decisions.
- Providing care coordination training and assistance regarding TEFRA Medicaid.
- Issuing all LOC and Disability denial letters.

- Reviewing timeframe extension requests and approving / denying. Please note, extensions cannot be approved in excess of the current Medicaid certification period. This is because the Gen 72 recertification requirement is separate from the LOC requirement.

Comagine Health

Comagine 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. Comagine Health performs the following functions:

- Referring families to care coordination agencies and the DPA caseworker to ensure appropriate paperwork is submitted.

Referring new ICF/IDD applicants and ICF/IDD 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.

- Determining 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 Fair Hearings regarding NF and IPH LOC denials.

Division of Senior and Disability Services (DSDS)

DSDS is responsible for the following:

- Determining ICF/IDD LOC decisions.
- Completing ICAP assessments based on referrals (both new and renewals) from Comagine 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/IDD LOC denials.
- Communicating directly with Comagine Health the status of ICF/IDD 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 Comagine Health or DSDS 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 to Comagine Health
- 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 DSDS for children under three years of age for LOC review and decision.
- Completing the POC and COC documentation for ICF/IDD applicants and renewals to Comagine 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. Please ensure a separate Med 2 is completed for each provider the child sees. We also need one Med 2 for the school district in which the child is enrolled as well as a separate Med 2 for the physical school the child attends.
- 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. Please note, this renewal is separate from any renewals with Comagine Health and/or DSDS. Not receiving the annual Gen 72 review is a common reason for case closure.
- Completing the MED 1 and MED 2 forms for periodic disability reviews.
- Reporting all private health insurance coverage to the DPA caseworker.
- Ongoing communication with Comagine 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 the Intellectually Developmentally Disabled (ICF/IDD)
Referrals to DSDS for ICF/IDD 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 Comagine 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 Comagine Health for assistance in determining the appropriate LOC. If LOC is determined without Comagine Health assistance the care coordinator must notify Comagine Health which LOC is being submitted within the first 30 days of application.
2. If a Comagine Health reviewer determines or is notified that ICF/IDD is the appropriate LOC, Comagine Health will then make a direct referral to DSDS. The referral will include the child's name, date of birth, , care coordinator name and agency contact information, and a copy of the Gen 140b.
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/IDD LOC Renewals for Children Age Three Years Through Age Seven

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

1. Ninety days prior to the renewal month, Comagine Health will e-mail DSDS a list of children with ICF/IDD LOC renewals due in that month. The list will contain the child's name, date of birth, renewal month, and the name and agency of the care coordinator.
2. Upon receiving the renewal 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. 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 and COC) is submitted directly to Comagine Health.
4. After DSDS receives sufficient documentation the case will be assigned to an evaluator.

ICF/IDD Renewals for Children Over Age Seven

TEFRA recipients, who meet an ICF/IDD 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 Comagine Health will e-mail DSDS a list of children with ICF/IDD 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. 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 and COC) is submitted directly to Comagine 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/IDD 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 current 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 Division of Senior and Disability Services)*
    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 IDD HCB Medicaid Waiver, the care coordinator will provide a signed copy of the Uni-05 Appointment for Care Coordinator 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 140.600

(1) intellectual or developmental disability that meets the diagnostic criteria for code 317 or 318.0, 318.1, or 318.2, as set out in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, adopted by reference in 7 AAC 160.900; the recipient must have an intelligence quotient of 70 points or less as determined by an individual, standardized psychological evaluation, plus up to five points to account for any measurement error;
(2) a condition that is
  (A) one other than mental illness, psychiatric impairment, or a serious emotional or behavioral disturbance; and
  (B) found to be closely related to intellectual or developmental disability because that condition results in impairment of general intellectual functioning and adaptive behavior similar to that of individuals with intellectual or developmental disabilities; the condition must be diagnosed by a licensed physician and require treatment or services similar to those required for individuals with intellectual or developmental disabilities;
(3) cerebral palsy that is diagnosed by a licensed physician; however, a deficit in intellectual ability need not be present;
(4) seizure disorder that is diagnosed by a licensed physician; however, a deficit in intellectual ability need not be present;
(5) autism that has been diagnosed by a mental health professional clinician and that meets the diagnostic criteria for code 299.00, as set out in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, adopted by reference in 7 AAC 160.900.

Note: each condition identified in this section must
(1) have originated before the age of 22 years;
(2) be likely to continue indefinitely; and
(3) constitute a substantial disability to the individual's ability to function in society, as
  (A) measured by the Inventory for Client and Agency Planning (ICAP), adopted by reference in 7 AAC 160.900; and
  (B) evidenced by a broad independence domain score equal to or less than the cutoff scores in the department's Table of ICAP Scores by Age, adopted by reference in 7 AAC 160.900.

ICF/IDD 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/IDD 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/IDD LOC the following steps will be taken:

1. Comagine Health will make an e-mail referral to DSDS with the child's name, date of birth, care coordinator name and agency contact information, and a copy of the Gen 140b.
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. Comagine Health will track to ensure that the care coordinator submits all documentation to DSDS within the specified time frames.

TEFRA ICF/IDD Renewals for Children Under Three Years of Age:
Ninety days prior to the renewal month Comagine 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)

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 may meet the NF Level of Care (LOC) Assessment. The Comagine Health Nurse Reviewer will review all documentation and determine if a child meets the NF LOC, in either the Intermediate or Skilled Nursing category.

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

7 AAC 140.510. Intermediate care facility services

(c) The department will pay an intermediate care facility for providing the services described in (b) and © of this section if those services are

(1) needed to treat a stable condition;

(2) ordered by and under the direction of a physician, except as provided in © of this section; and

(3) provided to a recipient who does not require the level of care provided by a skilled nursing facility.

(b) Intermediate nursing services are the observation, assessment, and treatment of a recipient with

long-term illness or disability whose condition is relatively stable and where the emphasis is on maintenance rather than rehabilitation, or care for a recipient nearing recovery and discharge whose condition is relatively stable but who continues to require professional medical or nursing supervision.

© Intermediate care may include occupational, physical, or speech-language therapy provided by

an aide or orderly under the supervision of licensed nursing personnel or a licensed occupational,

physical, or speech-language 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

7 AAC 140.515. Skilled nursing facility services (a) The department will pay a skilled nursing facility for providing skilled nursing described in (b) of this section or structural rehabilitation services described in (c) of this section if those services are (1) needed to treat an unstable condition; (2) ordered by and under the direction of a physician; and (3) provided directly by or under supervision of qualified technical or professional personnel who are authorized by state law to provide that service and who are on the premises at the time service is rendered; technical or professional personnel include a registered nurse, a licensed practical nurse, a licensed physical therapist, a licensed physical therapy assistant, a licensed occupational therapist, a certified occupational therapy assistant, a licensed speech-language pathologist, a registered speech-language pathologist assistant, and an audiologist. (b) Skilled nursing services are the observation, assessment, and treatment of a recipient's unstable condition requiring the care of licensed nursing personnel to identify and evaluate the recipient's need for possible modification of treatment, the initiation of ordered medical procedures, or both, until the recipient's condition stabilizes. (c) Structural rehabilitation services are the following services required by physician orders and provided at least five days a week until the recipient's condition fails to show continued improvement through objective evidence: (1) ongoing assessment of structured rehabilitation needs and potentials; services must be concurrent with the management of a recipient care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficiencies, and speech, language, or hearing disorders; (2) therapeutic exercises or activities that, because of the type of exercises employed or the condition of the recipient, must be performed by or under the supervision of a qualified physical therapist or occupational therapist, to ensure the safety of the recipient and the effectiveness of the treatment; (3) gait evaluation and treatment; (4) range-of-motion exercises that are part of the active treatment of a specific disease that has resulted in a loss of or restriction of mobility; (5) maintenance occupational or physical therapy if specialized knowledge and judgment of a qualified occupational or physical therapist are required to design and establish a maintenance therapy program based on an initial evaluation and periodic reassessment of the recipient's needs and consistent with the recipient's capacity and tolerance; (6) ultrasound, short-wave, and microwave therapy treatments; (7) hot pack, infrared treatments, and paraffin baths in particular cases where the recipient's condition is complicated by circulatory deficiencies, areas of desensitization, open wounds, fractures, or other complications; (8) services of a communications specialist, a speech-language pathologist, or an audiologist if necessary for the restoration of function in speech or hearing.

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 Comagine Health along with current medical documentation from the past – 6-12 months as appropriate to substantiate the

claim that the child meets the NF LOC. Additionally, the POC and COC must be submitted.
3. Ongoing communication with Comagine Health regarding the status of obtaining requested or additional documentation, especially if requesting an extension.

The Role of the Care Coordinator – Renewals

Ninety days prior to the renewal month Comagine 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 Comagine 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, along with pertinent and current medical documentation to support the NF LOC.
2. The POC and COC must be submitted with the MED 24 on a yearly basis.
3. Ongoing communication with the Comagine 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 admission to an institution.
- Every diagnosis or condition listed on the MED 24 must have hard copy documentation submitted to Comagine 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 Comagine 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 MAGI 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 MAGI.

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.

IPH
7 AAC 100.424 (c) 7 AAC 100.424.

(c) For the purpose of determining eligibility under this section, a child requires a level of care provided in an inpatient psychiatric hospital if the child

(1) has a mental illness or severe emotional disturbance that

(A) is diagnosed by a psychiatrist or mental health professional;

(B) is likely to result in harm to self and others; and

(C) has persisted six months and is expected to persist for a total of 12 months or longer;

(2) has at least one of the following mental health symptoms:

(A) psychotic symptoms, characterized by defective or lost contact with reality, hallucinations, or delusions;

(B) a suicide attempt, in the 90-day period before the date of application;

(C) suicidal thoughts, in the 30-day period before the date of application, that include a plan for suicide;

(D) violent behavior as the result of an emotional disturbance, in the 30-day period before the date of application, characterized by a documented attempt by the child to cause injury to a person or substantial property damage;

(3) has functional impairments, relative to expected developmental levels for the child's age and at a level that qualifies the child to receive inpatient psychiatric hospitalization, in at least three of the following areas:

(A) self-care;

(B) interaction with the community;

(C) social relationships;

(D) family relationships;

(E) functioning at school or work;

(4) absent appropriate intervention in the home and community, requires psychiatric hospitalization as documented by a mental health professional; and

(5) can be expected to functionally improve or can avoid further deterioration if care is provided in the home and community.

Nursing Facility and Inpatient Psychiatric Hospital Level-of-Care Determinations:

1. The Contractor will be responsible for making both initial and renewal level-of-care decisions for the Nursing Facility level-of-care and the Inpatient Psychiatric Hospital level-of-care categories.
2. For Nursing Facility level-of-care (NFLOC) decisions, the Contractor will utilize the following as guidance when making level-of-care determinations:
    a. Intermediate LOC characteristics at 7 AAC 140.510
    b. Skilled LOC characteristics at 7 AAC 140.515
    c. Criteria for placement section of the Manual for Prior Authorization of Long-Term Care Services (Appendix F)
3. For Inpatient Psychiatric Hospital (IPH) Level-of-care decisions, the Contractor will utilize state regulatory authority 7 AAC 100.424 (c)

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 Rev7/18/08 – this form must be completed and submitted to Comagine 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 6-12 months.

The Role of the Care Coordinator – Renewals

Ninety days prior to the renewal month Comagine 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 Comagine 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 Rev 7/18/08
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/IDD 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/IDD 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 Comagine Health Nurse to determine which LOC is most appropriate. It may be that there is more substantiating documentation for an ICF/IDD 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 Comagine 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, Comagine 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 Comagine 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 but all the documentation is not submitted and LOC approved until September, the renewal month will remain July not September of the following year..

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 Comagine Health and request an extension. DPA will grant extensions on a case-by-case basis.

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

The 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/IDD LOC decisions care coordinators should submit the POC and COC forms to Comagine Health at the same time the documentation is provided to DSDS for the ICAP evaluation.

TEFRA and MAGI

Referrals from Denied or Closed MAGI

Question 27 of the MAGI application asks if the individual has a physical, mental, or emotional health condition that causes limitations (like bathing, dressing, chores) … If this question is answered “yes” and the name of the child is written down, the following will happen if MAGI is denied or closed for excess income:

- The MAGI 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 Comagine Health the GEN 140B referral form.
- Upon receiving the GEN 140B form Comagine Health will send the parent(s) a welcome letter including a referral list of care coordinators. The parent(s) have 30 days to notify Comagine Health of the care coordinator selected to provide services. Failure to notify Comagine 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 for TEFRA. 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 Comagine Health of the care coordinator selected to provide services. Upon selecting a care coordinator, the LOC paperwork should be submitted to Comagine 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 Comagine Health sending notification 90 days prior to renewal it is expected that LOC paperwork will be submitted to Comagine 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.