PART II

POLICIES AND PROCEDURES
for
TEFRA/KATIE BECKETT DEEMING WAIVER

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

Revised: July 1, 2018

Policy Revisions Record
Part II Policies and Procedures Manual for Katie Beckett Medicaid Manual

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE **A**=Added **D**=Deleted **M**=Modified	CITATION (Revision required by Regulation, Legislation, etc.)
01/01/2016	Cover Page	Updated with new manual cover page	M	N/A
04/1/2016	Table of Contents/ Entire Manual	Removed Roman numerals and added Chapter numbers	M	N/A
4/1/2016	103, pg 6	Added diagnosticians as approved psychological evaluators	A	N/A
4/1/2016	205	Updated Medicaid Rates for Cost effectiveness Determination	M	Y
7/1/2016	Pg 24	Updated TEFRA/KATIE BECKETT MEDICAL NECCESSITY/LEVEL OF CARE STATEMENT INSTRUCTIONS	M	N
10/1/2016		No Revisions for this quarter		
1/1/2017		No Revisions for this quarter		
4/1/2017		No Revisions for this quarter		
7/1/2017		No revisions for this quarter		
10/1/2017	103, pg 6 &7; Appendix E, pg 28, Appendix F, pg 38	Removed “annual”, replaced with “at each periodic redetermination of eligibility”, added paragraph concerning 2 year LOC approval, Updated credentials for approved psychological evaluators; Updated GMCF initial determination letter; removed MR, replaced with ID	M	N
10/1/17	Appendix G, pg 39	Updated Georgia Families Appendix	M	Y
1/1/2018	Entire Manual	Removed Hospital LOC	D	N
	Pgs 17 & 18, Pgs 26-32, Pgs 33-34	Updated DMA 6, GMCF Letters updated to exclude hospital LOC, LOC criteria updated	D, M	N
4/1/2018	Pgs 10, 23, 26-31, 33-34	Removed hospital LOC inormation, updated LOC form to include Autism services, updated GMCF letters to include autism spectrum disorder services, Added autism service qualified health care providers	A	N
7/1/2018	Appendix G, pg 39	Updated Georgia Families Appendix	M	N

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PART II – CHAPTER 100
TEFRA/KATIE BECKETT MEDICAID COVERAGE (ALSO KNOWN AS DEEMING WAIVER)

101. Background

The Department of Community Health (DCH) provides Medicaid benefits under the TEFRA/Katie Beckett Medicaid program as described under §134 of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248). States are allowed, at their option, to make Medicaid benefits available to children (age 18 or under) at home who qualify as disabled individuals under §1614(a) of the Social Security Act, provided certain conditions are met, even though these children would not ordinarily be eligible for Supplemental Security Income (SSI) benefits because of the deeming of parental income or resources. The specific statutory provisions establishing this option are contained in §1902(e) of the Social Security Act.

To establish Medicaid eligibility for a child under this program, it must be determined that:

- If the child was in a medical institution, he/she would be eligible for medical assistance under the State plan for Title XIX;
- The child requires a level of care provided in a hospital, skilled nursing facility, or intermediate care facility (including an intermediate care facility for the intellectually disabled);
- It is appropriate to provide the care to the child at home; and
- The estimated cost of caring for the child outside of the institution will not exceed the estimated cost of treating the child within the institution.

The Department reviewed the procedure for determining which children qualify medically for the TEFRA/Katie Beckett coverage in 2003. A sub-committee comprised of legal, clinical and eligibility staff met over several months to revise the criteria used in making the medical necessity and level of care determinations.

In the past, the same medical criteria was used for adults and children. The criteria used to determine a child's eligibility in the program is found in Title 42 Code of Federal Regulations. Medical necessity is **not** based on specific medical diagnoses. The reviewer must review all available medical information to determine whether services are medically necessary. In addition, the reviewer must determine whether the child requires the level of care provided in a hospital, nursing facility, or intermediate care facility (including an intermediate care facility for the intellectually disabled). DCH has developed standardized forms to be used in obtaining the information needed for the disability, level of care and cost effectiveness determinations. Georgia Medical Care Foundation (GMCF) the vendor responsible for making the level of care determinations, and the Right From

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the Start Medicaid (RSM) Centralized Katie Beckett Team are trained on the criteria.

The Level of Care criteria review guidelines have been revised to reflect more examples of pediatric-specific cases. The Level of Care criteria is used for all Initial applications submitted to GMCF. The Level of Care criteria is also used for the periodic review of medical eligibility. Once the child's records have been reviewed, a Level of Care determination is made by the Katie Beckett Review Team at GMCF. Parents /caregivers will be notified via a Letter of Determination. Information regarding the Right to an Appeal will accompany all Letters of Determination. Parents not satisfied with the determination regarding the level of care have the right to request an Administrative Review or an Administrative Hearing. Refer to Section III regarding the Hearing and Appeals Process.

102. What is TEFRA/"Katie Beckett"?

TEFRA is section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) allowing states to make Medicaid services available to certain disabled children who would not ordinarily be eligible for Supplemental Security Income (SSI) benefits because of their parents' income. Income qualifications for TEFRA/"Katie Beckett" are based solely on the child's income, but a number of different factors are considered for approval. If approved, the same eligibility for health coverage will be available to the child as to other Medicaid members.

1. Eligibility for Medicaid under TEFRA/"Katie Beckett" will only be approved if **ALL** of the following conditions are met:

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- Child is under 18 years of age.
- Child meets the federal criteria for childhood disability.
- Child meets an institutional level of care criteria.
- Even though the child may qualify for institutional care, it is appropriate to care for the child at home.
- The Medicaid cost of caring for the child at home does not exceed the Medicaid cost of appropriate institutional care.

The childhood disability determination is completed by the Georgia Medical Care Foundation Medical Review Team.

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The child must require an institutional level of care provided in a hospital, nursing facility or intermediate care facility for the intellectually disabled as defined in 42 C.F.R. 435.225(b) (1).

The child's physician is required to certify that it is appropriate to provide care for the child in the home setting. The Medicaid cost of caring for the child at home must be less than the cost of caring for the child in an institution. The RSM Katie Beckett (KB) Team will be responsible for the cost-effective determination task.

103. Policy and Procedural Changes

1. No procedural changes were made in the categorical eligibility determination section in 2003.

2. Level of Care Determinations

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Georgia Medical Care Foundation (GMCF) determines whether the child requires a level of care (LOC) provided in a hospital, skilled nursing facility, or intermediate care facility (including an intermediate care facility for the intellectually disabled) for the TEFRA/Katie Beckett Medical program. The Department developed a new DMA-6 form specifically for children – *Pediatric DMA-6(A), PHYSICIAN'S RECOMMENDATION CONCERNING*

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NURSING FACILITY CARE OR HOSPITAL CARE (Pediatric DMA-6(A)). stocks the form DMA-6(A). The form may be reproduced locally.
The Department is also working on making the form interactive within

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the GAMMIS web portal. www.mmis.georgia.gov/portal

To make the LOC determination, the KB Medicaid Specialist must submit a complete packet of documents to GMCF, consisting of the Pediatric DMA-6(A), Medical Necessity/Level of Care Statement, Individualized Family Service Plan (IFSP), Individualized Education Plan (IEP), and Psychological Evaluation, if necessary. These documents must be completed and submitted to GMCF as part of the LOC determination. In most cases, the family will be responsible for submitting this information to the KB Team. However, there may be instances when the KB Medicaid Specialist must assist the family in obtaining the necessary information.

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All medical level of care determinations that are verified to meet the standard for Katie Beckett approval will be authorized for a period of no less than two (2) years. This authorization applies ONLY to the medical level of care review.

3. Application Requirements for LOC Review

- Pediatric DMA-6(A) Form

  The Pediatric DMA-6(A) form has been developed to appropriately capture pertinent information regarding the medical needs and care of the child. The DMA-6(A) form must be completed in its entirety, signed and dated by the physician and parent prior to being submitted to GMCF. The 30-day period of validity has been changed to 90 days.

Instructions for completion of the DMA-6(A) form are included in the appendices of this manual. The DMA-6(A) form must be completed at the time of application, and at each periodic redetermination of eligibility. Clinical information obtained from the DMA-6(A) is used to determine level of care.

- Medical Necessity/Level of Care Statement

  The Medical Necessity/Level of Care Statement form must be completed, signed and dated by the physician and the primary caregiver at a minimum. Other members of the planning team may participate in the completion of this form. The planning team may include, but is not limited to, the child's primary and secondary caregivers, physician, nursing provider, social worker, and therapist(s) (i.e., physical, occupational, speech). A copy of the Medical Necessity/Level of Care Statement is included in the appendices of this manual. A current Medical Necessity/Level of Care Statement plan must be completed at the time of application and at each periodic redetermination of eligibility.

- Psychological Assessment

  An evaluation is performed by a licensed certified professional to assess the child's level of intellectual capacity. If the child has a diagnosis or condition that results with cognitive impairment Georgia Medical Care Foundation (GMCF) will request that the caregiver obtain and submit a psychological or developmental assessment. The following diagnoses require a psychological or developmental assessment:

  - Cerebral Palsy
  - Developmental Delay
  - Autism
  - Autism-Spectrum Disorder
  - Asperger Syndrome
  - Pervasive Developmental Disorder
  - Intellectual Disability
  - Epilepsy
  - Down's Syndrome, and
  - Any diagnoses related to the above listed diagnoses.

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A comprehensive psychological evaluation must be performed and the level of intellectual disability with appropriate treatment intervention must be stated. The psychological evaluation must be completed by a licensed professional and is required every three (3) years. Licensed professionals approved to do this testing include Developmental Pediatricians and Ph.D. Psychologists. Psychological evaluations completed by school psychologists, preschool diagnosticians, and

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education diagnosticians with M.Ed., Ed.S., M.A., M.S., CAS, CAGS, Psy.S, Psy.D, SSP, or Ed.D degrees are also accepted. Developmental Evaluations done by Early Interventionist with Babies Can't Wait are accepted for children with an Individualized Family Service Plan (IFSP). Also an IFSP or an Individualized Education Plan (IEP) must be submitted, if in place. All of the above documents and the psychological assessment may be used to determine level of care.

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Parents should submit the complete packet of documents to the Centralized Katie Beckett unit at the address below:

RSM/LTC Centralized Katie Becket Unit
5815 Live Oak Parkway Ste 2-D
Norcross, GA 30093
678-248-7449 Office
678-248-7459 Fax

PART II – CHAPTER 200
INSTITUTIONAL LEVEL OF CARE (LOC) CRITERIA

Rev. 4/01/2015

All references to ICF/MR and mental retardation have been updated to ICF/ID and intellectual disability.

As provided in 42 C.F.R 435.225(b) (1), the child must require the level of care provided in a hospital, nursing facility, or intermediate care facility for the intellectually disabled (ICF/ID).

201. Nursing Facility

1. Nursing facility level of care is appropriate for individuals who do not require hospital care, but who, on a regular basis, require licensed nursing services, rehabilitation services, or other health-related services *ordinarily provided in an institution*. For an individual who has been diagnosed with a mental illness or intellectual disability, nursing facility level of care services are usually inappropriate unless that individual's mental health needs are secondary to needs associated with a more acute physical disorder.

2. The criteria set forth herein encompass both "skilled" and "intermediate" levels of care services.

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3. A nursing facility level of care is indicated if all the conditions of Column A or Column B are satisfied. Conditions are derived from 42 C.F.R. 409.31 409.34.

202. Intermediate Care Facility/Intellectual Disability (ICF/ID)

1. ICF/ID level of care is appropriate for individuals who require the type of active treatment typically provided by a facility whose primary purpose is to furnish health and rehabilitative services to persons with intellectual disabilities or related conditions.

2. An ICF/ID level of care is indicated if one condition of Column A is satisfied in addition to meeting all the conditions Column B and Column C. Conditions are derived from 42 C.F.R. 440.150, 435.1009 and 483.440(a).

203. Level of Care Determination Routing Form

The Level of Care Determination ***Routing Form 705*** must accompany all the child's information and documents submitted to GMCF. It is imperative that identifying information such as Social Security number and Medicaid

identification remain consistent whenever communicating with GMCF to ensure adequate tracking for the child's case.

204. Cost-Effectiveness Determination

The estimated Medicaid cost of caring for the child outside the institution must not exceed the estimated Medicaid cost of appropriate institutional care. The Physician's Referral Form has been replaced with the **TEFRA/Katie Beckett Cost-Effectiveness Form-704**. The revised form includes places for the physician to include the estimated cost for therapy(s) and skilled nursing services and will assist the Department in establishing a process for providing the actual cost of services provided to a child that will be used during the periodic redetermination. However, until the process has been established, workers will continue to use the TEFRA/Katie Beckett Cost-Effectiveness Form-704 at the time of initial application and the periodic redetermination of eligibility to complete the cost-effectiveness determination.

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The amounts listed below are the averaged amounts to be used for completion of the nursing facility and ICF/ID level-of-care cost-effectiveness determination.

Level-of-Care	**Monthly Amount (average Medicaid rates)**
▪ Skilled Nursing Facility	$ 5,281.78
▪ ICF/ID	$ 14,738.64

PART II - CHAPTER 300
HEARING AND APPEALS PROCESS

301. Hearing and Appeal Process

Due process rights associated with the denial of admission to the "Katie Beckett" program begin after the level of care assessment and disability assessment by GMCF. Participants in the "Katie Beckett" program are subject to periodic assessments by GMCF. Should the level of care assessment or disability assessment result in the denial of admission/continuation into the Katie Beckett program, GMCF will forward an "Initial Denial of Admission/Continued Stay" to the family (with a copy to the KB Medicaid Specialist). This notice informs the parents of the reason for the denial and their administrative review rights.

The Department offers the opportunity for administrative review to any applicant or recipient against whom it proposes to take an adverse action, unless otherwise authorized by law to take such action without having to do so. Parents may request an administrative review of the level of care assessment and/or the disability assessment within thirty (30) days "Initial Denial of Admission/Continued Stay." The request must include all relevant issues in controversy and must be accompanied by any additional medical information and explanation that the applicant or recipient wishes the Department to consider. The additional documentation will be considered to determine the appropriateness of the initial denial. Georgia Medical Care Foundation personnel should instruct parents to supply the additional documentation to GMCF for consideration during the administrative review process. If the parent fails to request an administrative review or if the parent fails to submit additional documentation, the initial denial will become final on the 30th day after the date of the "Initial Denial of Admission/Continued Stay" notification.

The Georgia Medical Care Foundation must *receive* requests for administrative review within the 30-day time limit. When counting days, allow the parents a two (2) day time period for receipt of the letter. Then, beginning on the third day after the date of the letter, regardless of whether that day is a weekend or holiday, count thirty (30) days. However, if the 30th day falls on a weekend or holiday, the next full business day is counted as the 30th day.

Upon completion of the Administrative Review, GMCF will notify the parents of the results of the review, with a copy to the KB Medicaid Specialist . Should GMCF uphold the initial decision and the family fails to request an administrative review or fails to submit additional documentation, then a "Final Denial of Admission/Continued Stay" letter is sent to the parents with a copy to the KB Medicaid Specialist. This notice informs the parents of the reason for the denial and their hearing rights. The Legal Services Section of DCH must receive a parent's request for a hearing (and continuation of services, if applicable) before an administrative law judge within thirty (30) days of the date of the "Final Denial of Admission/Continued Stay" letter. The hearing request must state the specific reasons for requesting the hearing. Parents must also state whether they would like a continuation of services pending the outcome of the hearing. This

option is only available for those members requesting continued stay in the program. However, these members must be cautioned that should the Department prevail, the Department may seek reimbursement for services rendered during the appeals period. Additionally parents must include a copy of the "Final Denial of Admission/Continued Stay" letter with their hearing request.

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After receiving the hearing request, Legal Services will e-mail a request for documentation to GMCF. Legal Services will also notify the Eligibility Section of a parent's request for a continuation of services. Upon receiving the file from GMCF, Legal Services will prepare the file to be assigned to an attorney and forward the appropriate documentation to the Office of State Administrative Hearings for scheduling. Files submitted to Legal Services must contain, among other things, DMA-6(A), any additional documents submitted during the administrative review process, the initial and final determination letters, the parent's hearing request, the contact information for the KB Medicaid Specialist and the contact information for the GMCF assessor. The GMCF assessor will work with the DCH attorney to prepare for the hearing. If the denial of eligibility issued by the KB Team is solely based upon the level of care determination, the DCH Policy Specialist will be required to testify regarding the denial of eligibility determination. This will prevent the need for two hearings, since the denial of eligibility and the level of care determination are intertwined.

If the administrative review decision is upheld at the hearing, the parents will be notified and a copy will be sent to the KB Medicaid Specialist. The decision will include a ruling on the denial of eligibility, if the denial was based solely upon the level of care determination and/or disability determination. The KB Medicaid Specialist will send notice to parents of the denial of eligibility and close the case. The decision from the Administrative Law Judge will include appeal rights for any party dissatisfied with the decision. If the Administrative Law Judge determines that the level of care criteria and/or disability criteria have been met, a written decision will be forwarded to the parent, with a copy to the KB Medicaid Specialist. At this time, the KB Medicaid Specialist will use the level of care and/or disability determinations with other information to render an eligibility decision.

A denial of eligibility based upon factors not associated with the level of care or disability will create additional due process rights. However these hearings are handled by the Department of Human Services/Right From The Start Medicaid Project and may occur subsequent to or concurrent with the level of care hearings. The timing of these hearings is based upon the timing of the decision on eligibility.

302. Notice of Your Right to a Hearing

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

NOTICE OF YOUR RIGHT TO A HEARING

You have the right to a hearing regarding this decision. To have a hearing, you must ask for one **in writing.** You must send your request for a hearing, along with a copy of the adverse action letter, within **thirty (30) days** of the date of the letter to:

Department of Community Health
Legal Services Section
Two Peachtree Street, NW 40th Floor
Atlanta, Georgia 30303-3159

If you want to maintain your services pending the hearing decision, you must send a written request **before** the date your services change. **If the denial is upheld by a hearing decision, you may be held responsible for the repayment of continued services that were provided during the appeal.**

The Office of State Administrative Hearings will notify you of the time, place and date of your hearing. An Administrative Law Judge will hold the hearing. In the hearing, you may speak for yourself or let a friend or family member to speak for you. You also may ask a lawyer to represent you. You may be able to obtain legal help at no cost. If you desire an attorney to help you, you may call one of the following telephone numbers:

1. **Georgia Legal Services Program**
   1-800-498-9469
   (Statewide legal services, EXCEPT for the counties served by Atlanta Legal Aid)

2. **Georgia Advocacy Office**
   1-800-537-2329
   (Statewide advocacy for persons with disabilities or mental illness)

3. **Atlanta Legal Aid**
   404-377-0701 (DeKalb/Gwinnett counties)
   770-528-2565 (Cobb County)
   404-524-5811 (Fulton County)
   404-669-0233 (So. Fulton/Clayton counties)
   678-376-4545 (Gwinnett County)

4. **State Ombudsman Office**
   1-888-454-5826
   (Nursing Home or Personal Care Home)

303. Member Review Process

PART I POLICIES AND PROCEDURES FOR MEDICAID/PEACHCARE FOR KIDS

MEMBER REVIEW PROCESS

504. Medicaid Member Administrative Law Hearings (Fair Hearings)

a. This section does not apply to PeachCare for Kids® members. PeachCare for Kids members should consult Appendix D of Part 1, Policies and Procedures Manual, for the Review and Appeal Process.

B. Children participating in the Georgia Pediatric Program (GAPP) or the TEFRA/Katie Beckett Program shall participate in the administrative review process prior to an Administrative Law Hearing. Parents may request an administrative review within 30 days of the date the initial decision is transmitted to the parent. During the administrative review additional documentation may be considered to determine the appropriateness of the initial decision. Parents will be instructed in the initial decision letter to supply the additional documentation to the appropriate personnel at the Georgia Medical Care Foundation. If the parent fails to submit additional documentation, the initial decision will become final on the 30th day after the date of the initial decision. At the end of the administrative review, the member will be sent a notice of the Department's final decision.

C. Should the Department's decision be adverse to the member, the parent may request a hearing before an Administrative Law Judge. A hearing must be requested in writing. Members must send the request and a copy of the final decision letter, within thirty (30) days of the date that the notice of action was mailed, to the following address:

Georgia Department of Community Health
Legal Services Section
Rev. 01/01/2011 **Division of Medicaid**
2 Peachtree Street, NW 40th Floor
Atlanta, Georgia 30303-3159

D. Members may continue their services during the appeal if they submit a written request for continued services before the date that the services change. If the
Rev. 01/01/2011 Administrative Law Judge rules in favor of the Department, the member may be required to reimburse the Department for the cost of any Medicaid benefits continued during the appeal.

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E. If a TEFRA/Katie Beckett appeal has been granted and the child's condition changes significantly or if the parent has current information that he/she would like the agency to consider, the parent may withdraw the hearing and submit a new application.

F. The Office of State Administrative Hearings will notify the member of the time, place and date of the hearing.

304. Technical Denials

TREATMENT OF TECHNICAL DENIALS

504B Medicaid Member Administrative Law Hearings (Fair Hearings)

Rev. 10/01/12

1. When an initial technical denial and a final technical denial have been issued and the parent subsequently fails to respond by requesting a hearing but rather submits the requested information to ***GMCF*** **more** ***than 30 days after the date of the final technical denial,*** GMCF will not accept the additional information. A hearing request must be submitted to DCH Legal Services **within 30 days of the date of the final technical denial** or a new application may be filed for services. If a hearing request is submitted to Legal Services within 30 days of the date of the final technical denial, the request will be processed and the case will be sent to the Office of State Administrative Hearings. Legal Services will assign an attorney to represent the respondent (DCH).

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2. When an initial technical denial and a final technical denial have been issued and the parent then submits the requested information to ***GMCF within 30 days of the date of the final technical denial***, GMCF will not accept the additional information. A hearing request must be submitted to Legal Services *within 30 days of the date of the final technical denial* or a new application may be filed for services. If a hearing request is submitted to Legal Services **within 30 days of the date of the final technical denial**, the request will be processed and the case will be sent to the Office of State Administrative Hearings. Legal Services will assign an attorney to represent the respondent (DCH).

3. If the parent has requested and been granted an extension by the DCH Member Services and Policy Section all appropriate parties will be notified.

505. Commissioner's Review for a Member

Should the Administrative Law Judge's decision be adverse to a member, the member may file a written request to the DCH Commissioner for an agency review within thirty (30) days of receipt of the decision.

APPENDIX A

TEFRA/Katie Beckett

Level-of-Care and Disability Determination Routing Form/Checklist

Routing Form 705

DATE SENT: _____

TO: **Georgia Medical Care Foundation (GMCF)**
ATTN: TEFRA/Katie Beckett
P.O. Box 105406
Atlanta, GA 30348-5406

FROM: **Katie Beckett Medicaid Team**

Medicaid Specialist's Name: _____ Direct Phone #: _____

Medicaid Specialist's E-mail Address: _____

Medicaid Specialist's Mailing Address: _____

_____

RE: Applicant's Name: _____

Applicant's Address: _____

_____

Applicant's SSN: _____

Parent/Guardian Name: _____

Physician Name: _____

A complete packet must be submitted to GMCF for a review the Level of Care Determination review. A complete packet consists of the following with:

____ DMA-6(A)*
____ TEFRA/Katie Beckett Medical Necessity/Level of Care Statement*
____ Psychological, IQ test or Adaptive Functioning Evaluation -- only required for children with intellectual disabilities or related conditions such as Cerebral Palsy, Epilepsy, Autism, Autism-Spectrum Disorder, Asperger Syndrome, Down's Syndrome, Pervasive Developmental Disorder or other Developmental Delays (required with initial application for ICF/ID determinations and again every three years)
____ IEP or IFSP if one is in effect*
____ Rehab Therapy/Nursing Notes (if applicable)

* Required for all level of care determinations

Type of Program: ☐ Nursing Facility ☐ GAPP ☐ TEFRA/Katie Beckett ☐ ICF/ID

PEDIATRIC DMA 6(A)
PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE

Section A – Identifying Information

1. Applicant's Name/Address:

DFCS County_____

_____
Mailing Address

2. Medicaid Number:

3. Social Security Number

4. Sex | Age | 4A. Birthdate

5. Primary Care Physician

6. Applicant's Telephone #

7. In the caretaker's opinion, would the child require institutionalization if the child did not receive community services? ☐ Yes ☐ No

8. Does child attend school? ☐ Yes ☐ No

9. Date of Medicaid Application / /

Name of Caregiver #1: _____ Name of Caregiver #2: _____

I hereby authorize the physician, facility or other health care provider named herein to disclose protected health information and release the medical records of the applicant/beneficiary to the Department of Community Health and the Department of Human Resources, as may be requested by those agencies, for the purpose of Medicaid eligibility determination. This authorization expires twelve (12) months from the date signed or when revoked by me, whichever comes first.

10. Signature:_____ 11. Date:_____
(Parent or other Legal Representative)

Section B – Physician's Report and Recommendation

12. History: *(attach additional sheet if needed)*

13. Diagnosis — 1. ICD | 2. ICD | 3. ICD

1)_____ 2)_____ 3)_____
(Add attachment for additional diagnoses)

14. **Medications**

Name	Dosage	Route	Frequency

15. **Diagnostic and Treatment Procedures**

Type	Frequency

16. Treatment Plan **(Attach copy of order sheet if more convenient or other pertinent documents)**

Previous Hospitalizations:_____ Rehabilitative/Habilitative Services:_____ Other Health Services:_____

Hospital Diagnosis: 1)_____ 2) Secondary_____ 3) Other_____

17. Anticipated Dates of Hospitalization: _____/_____ /

18. Level of Care Recommended: ☐ Nursing Facility ☐ ICF/ID Facility

19. Type of Recommendation:
☐ Initial
☐ Change Level of Care
☐ Continued Placement

20. Patient Transferred from (check one):
☐ Hospital ☐ Another NF
☐ Private Pay ☐ Lives at home

21. Length of Time Care Needed _____Months
1) ☐ Permanent
2) ☐ Temporary _____ estimated

22. Is patient free of communicable diseases?
☐ Yes ☐ No

23. This patient's condition could be managed by provision of ☐ Community Care or ☐ Home Health Services

24. Physician's Name (Print):

Physician's Address (Print):

25. I certify that this patient requires the level of care provided by a nursing facility, or ICF/ID

_____Physician's Signature

26. Date signed by Physician

27. Physician's Licensure No.

28. Physician's Telephone #: ( )

DMA-6A (1/2018)

Section C– Evaluation of Nursing Care Needed (check appropriate box only)

29. Nutrition	30. Bowel	31. Cardiopulmonary Status	32. Mobility	33. Behavioral Status
☐ Regular ☐ Diabetic Shots ☐ Formula-Special ☐ Tube feeding ☐ N/G-tube/G-tube ☐ Slow Feeder ☐ FTT or Premature ☐ Hyperal ☐ IV Use ☐ Medications/GT Meds	☐ Age Dependent Incontinence ☐ Incontinent - Age > 3 ☐ Colostomy ☐ Continent ☐ Other _____	☐ Monitoring ☐ CPAP/Bi-PAP) ☐ CP Monitor ☐ Pulse Ox ☐ Vital signs > 2/day ☐ Therapy ☐ Oxygen ☐ Home Vent ☐ Trach ☐ Nebulizer Tx ☐ Suctioning ☐ Chest - Physical Tx ☐ Room Air	☐ Prosthesis ☐ Splints ☐ Unable to ambulate > 18 months old wheel chair ☐ Normal	☐ Agitated ☐ Cooperative ☐ Alert ☐ Developmental Delay ☐ Mental Retardation ☐ Behavioral Problems (please describe, if checked) ☐ Suicidal ☐ Hostile
34. Integument System	**35. Urogenital**	**36. Surgery**	**37. Therapy/Visits**	**38. Neurological Status**
☐ Burn Care ☐ Sterile Dressings ☐ Decubiti ☐ Bedridden ☐ Eczema-severe ☐ Normal	☐ Dialysis in home ☐ Ostomy ☐ Incontinent – Age > 3 ☐ Catheterization ☐ Continent	☐ Level 1 (5 or > surgeries) ☐ Level II (< 5 surgeries) ☐ None	Day care Services ☐ High Tech - 4 or more times per week ☐ Low Tech – 3 or less times per week or MD visits > 4 per month ☐ None	☐ Deaf ☐ Blind ☐ Seizures ☐ Neurological Deficits ☐ Paralysis ☐ Normal

39. Other Therapy Visits ☐ Five days per week ☐ Less than 5 days per week	40. Remarks	
41. Pre-Admission Certification Number	42. Date Signed	43. Print Name of MD or RN:_____ Signature of MD or RN:_____

DO NOT WRITE BELOW THIS LINE

44. Continued Stay Review Date:_____ Admission Date _____ Approved for _____Days or _____Months

45. Are nursing services, rehabilitative/habilitative services or other health related services requested ordinarily provided in an institution? ☐ Yes ☐ No ☐ NA	46A. State Authority MH & MR Screening) Level I/II Restricted Auth. Code Date 46B. This is not a re-admission for OBRA purposes Restricted Auth. Code Date
47. Hospitalization Precertification ☐ Met ☐ Not Met	

48. Level of Care Recommended by Contractor
☐ Hospital ☐ Nursing Facility ☐ IC/MR Facility

49. Approval Period	50. Signature (Contractor) _____	51. Date / /	52. Attachments (Contractor) ☐ Yes ☐ No	

DMA-6A (1/2018)

APPENDIX B

PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE

INSTRUCTIONS FOR COMPLETING THE PEDIATRIC CARE FORM DMA-6(A)

It is important that EVERY item on the DMA- 6(A) is answered, even if it is answered as N/A (not applicable). Make sure that the physician or nurse who completes some of the sections is aware of this requirement. The form is only valid for 90 days from the date of the physician's signature. The form should be completed as follows:

Section A - Identifying Information

Section A of the form should be completed by the parent or the legal representative of the Katie Beckett child unless otherwise noted. All reference to "the applicant" means the child for whom Medicaid is being applied for.

Item 1: Applicant's Name/Address
Enter the complete name and address of the applicant including the city and ZIP code. For DFCS County enter the applicant's county of residence.

Item 2: Medicaid Number
To be completed by county staff.

Item 3: Social Security Number
Enter the applicant's nine-digit Social Security number.

Item 4 & 4A: Sex, Age and Birthdate
Enter the applicant's sex, age, and date of birth.

Item 5: Primary Care Physician
Enter the entire name of the applicant's Primary Care Physician.

Item 6: Applicant's Telephone Number
Enter the telephone number, including area code, of the applicant's parent or the legal representative.

Item 7: Does guardian think the applicant should be institutionalized?
If the Katie Beckett applicant were not eligible under this category of Medicaid, would s/he be appropriate for placement in a nursing facility or institution for the intellectually disabled. Check the appropriate box.

Item 8: Does the child attend school?
Check the appropriate box.

Item 9: Date of Medicaid Application
To be completed by county staff.

Fields below Item 9:
Please enter the name of the primary caregiver for the applicant. If a secondary caregiver is available to care for the applicant, include the name of the caregiver.

Read the statement below the name(s) of the caregiver(s) and then;

Item 10: Signature
The parent or legal representative for the applicant should sign the DMA-6 (A) legibly.

Item 11: Date
Please record the date the DMA-6 (A) was signed by the parent or the legal representative.

Section B - Physician's Examination Report and Recommendation
This section must be completed in its entirety by the Katie Beckett child's Primary Care Physician. No item should be left blank unless indicated below.

Item 12: History (Attach additional sheet(s) if needed)
Describe the applicant's medical history (Hospital records may be attached).

Item 13: Diagnosis (~~A~~dd attachment(s) for additional diagnoses)
Describe the primary, secondary, and any third diagnoses relevant to the applicant's condition on the appropriate lines. Please note the ICD codes. Depending on the diagnosis, a psychological evaluation may be required. If you have an evaluation conducted within the past three years, include a copy with this packet.
Item 13A: ICD-10 Diagnosis Code (Add attachment(s) for additional diagnoses)
Describe the primary, secondary, and any third ICD-10 diagnoses relevant to the applicant's condition on the appropriate lines.

Item 14: Medications (~~A~~dd attachment(s) for additional medication(s))
The name of all medications the applicant is to receive must be listed. Include name of drugs with dosages, routes, and frequencies of administration.

Item 15: Diagnostic and Treatment Procedures
Include all diagnostic or treatment procedures and frequencies.

Item 16: Treatment Plan (Attach copy of order sheet if more convenient or other pertinent documentation)
List previous hospitalization dates, as well as rehabilitative and other health care services the applicant has received or is currently receiving. The hospital admitting diagnoses (primary, secondary, and other diagnoses) and dates of admission and discharge must be recorded. The treatment plan may also include other pertinent documents to assist with the evaluation of the applicant.

Item 17: Anticipated Dates of Hospitalization

List any anticipated dates of hospitalization for the applicant. Enter N/A if not applicable.

Item 18: Level of Care Recommended
Check the correct box for the recommended level of care; nursing facility or intermediate care facility for the intellectually disabled. If left blank or N/A is entered, it is assumed that the physician does not deem this applicant appropriate for institutional care.

Item 19: Type of Recommendation
Indicate if this is an initial recommendation for services, a change in the member's level of care, or a continued placement review for the member.

Item: 20: Patient Transferred from (Check one)
Indicate if the applicant was transferred from a hospital, private pay, another nursing facility or lives at home.

Item 21: Length of Time Care Needed
Enter the length of time the applicant will require care and services from the Medicaid program. Check the appropriate box for permanent or temporary. If temporary, please provide an estimate of the length of time care will be needed.

Item 22: Is Patient Free of Communicable Diseases?
Check the appropriate box.

Item 23: Alternatives to Nursing Facility Placement
The admitting or attending physician must indicate whether the applicant's condition could be managed by provision of the Community Care or Home Health Care Services Programs. Check either/both the box(es) corresponding to Community Care and/or Home Health Services if either/or both is appropriate.

Item 24: Physician's Name and Address
Print the admitting or attending physician's name and address in the spaces provided.

Item 25: Certification Statement of the Physician and Signature
The admitting or attending physician must certify that the applicant requires the level of care provided by a nursing facility or an intermediate care facility for the intellectually disabled. **This must be an original signature; signature stamps are not acceptable.** If the physician does not does not deem this applicant appropriate for institutional care, enter N/A and sign.

Item 26: Date signed by the physician
Enter the date the physician signs the form.

Item 27: Physician's Licensure Number
Enter the attending or admitting physician's license number.

Item 28: Physician's Telephone Number

Enter the attending or admitting physician's telephone number including area code.

Section C - Evaluation of Nursing Care Needed (Check Appropriate boxes only)

This section may be completed by the Katie Beckett child's Primary Care Physician or a registered nurse who is well aware of the child's condition.

Items 29--38: Check **each appropriate box.**

Item 39: Other Therapy Visits
If applicable, check the appropriate box for the number of treatment or therapy sessions per week the applicant receives or needs. Enter N/A, if not applicable.

Item 40: Remarks
Enter additional remarks if needed or "None".

Item 41: Pre-admission Certification Number
Leave this item blank.

Item 42: Date Signed
Enter the date this section of the form is completed.

Item 43: **Print Name of MD or RN/Signature of MD or RN**
The individual completing Section C should print their name legibly and sign the DMA-6 (A).
This must be an original signature; signature stamps are not acceptable.

Do Not Write Below This Line
Items 44 through 52 are completed by Contractor staff only.

APPENDIX C

TEFRA/Katie Beckett Medical Necessity/Level of Care Statement

Member Name:_____ DOB: _____ SS#_____
Diagnosis: _____
_____

Recommended level of Care:
- ☐ Nursing facility level of care
- ☐ Level of care required in an Intermediate Care Facility for ID (ICF-ID)

Medical History: (May attach hospital discharge summary or provide narrative):
_____
_____

		Current Needs
	None	Description of Skilled Nursing Needs
Cardiovascular:	____	_____
Neurological:	____	_____
Respiratory:	____	_____
Nutrition:	____	_____
Integumentary:	____	_____
Urogenital:	____	_____
Bowel:	____	_____
Endocrine :	____	_____
Immune:	____	_____
Skeletal:	____	_____
Other:	____	_____

Therapy (Attach current notes) : Speech sessions/wk ____ PT sessions/wk ____ OT sessions/wk ____
Autism Spectrum Services/wk_____

Hospitalizations within last 12 months: (Attach most recent hospital discharge summary)
Date: _____ Reason: _____ Duration: _____
Comments: _____
_____

Child in school: _____ Hrs per day _____ Days per wk ___ N/A ____ IEP/IFSP __
Nurse in attendance during school day: _____ N/A ____(Attach most recent month's nursing notes)

Skilled Nursing hours received: Hrs/day _____ N/A _____
I attest that the above information is accurate and this member meets Pediatric Level of Care Criteria and requires the skilled care that is ordinarily provided in a nursing facility or facililty whose primary purpose is to furnish health and rehabilitative services to persons with intellectual disabilities or related conditions.

Physician's Signature: _____ Date: _____
Primary Caregiver Signature: _____ Date: _____
**** Foster Care Applicants must have the signature of the DFCS representative.**

TEFRA/KATIE BECKETT MEDICAL NECCESSITY/LEVEL OF CARE STATEMENT INSTRUCTIONS FOR COMPLETION

This document provides detailed instructions for completion of the TEFRA/Katie Beckett Medical Necessity/Level of Care Statement. It may be completed by physician and the primary caregiver.

Member (Applicant) Information

Enter the Member's Name, DOB and SS#.

Diagnosis

Enter the Member's primary, secondary, and any third diagnoses relevant to the member's condition.

Level of Care

Check the correct box for the recommended level of care.

Medical History

Provide narrative of member's medical history or attach documents (i.e., hospital discharge summary, etc.)

Current Needs

Check member's current needs and provide description of skilled nursing needs.

Therapy

Therapies require a plan of care. All therapies, including school based therapies, must be ordered by a physician and accompanied by current individually signed therapy notes.

Hospitalizations

Attach most recent hospital discharge summary and document date, reason and duration.

School

Enter a check for member's appropriate school attendance and IFSP or IEP plan

Signature

The primary care physician or physician of record must sign and date. The caregiver (parent or guardian) must sign and date. Foster Care members must have the signature of the DFCS representative.

Rev. 01/01/2016

APPENDIX D

TEFRA/KATIE BECKETT
Cost-Effectiveness Form
(Child's Physician Must Complete Form)

The following information is requested to determine your patient's eligibility for Medicaid:

Patient's Name _____ Medicaid #:_____

Diagnosis: _____

Prognosis: _____

Please provide the estimated **monthly** costs of Medicaid services your patient will need or is seeking from Medicaid for in-home care:

- Physician's services $_____
- Durable medical equipment $_____
- Drugs $_____
- Therapy(s) $_____
- Skilled nursing services $_____
- Other(s)_____ $_____

TOTAL: $_____

Will home care be as good as or better than institutional care? _____Yes _____No

Comments: _____

_____

_____

_____

Physician's Signature: _____

Date: _____

DMA-704
Rev. 10-04

APPENDIX E

DATE:

Member Name
Member Address
Member Address

TEFRA/KATIE BECKETT INITIAL DETERMINATION LETTER

☐ **LEVEL OF CARE DENIAL (LOC)**
☐ **TECHNICAL DENIAL**

MEMBER:
MEDICAID ID:
PA ID:

Dear Parent/Legal Guardian:

To receive TEFRA/Katie Beckett coverage under the Georgia Medicaid program, the child's medical condition must require the level of care (LOC) provided in a nursing facility, hospital, or if the child is intellectually disabled, he/she must meet criteria for placement in an intermediate care facility ("ICF/ID"). See 42 C.F.R. § 435.225(b)(1); 409.31-409.34; 440.150; 435.1010; and 483.440(a).

The Alliant/Georgia Medical Care Foundation, on behalf of the Department of Community Health (DCH), makes the level of care determination based on the information submitted. The child's name listed above does not meet criteria for the TEFRA/Katie Beckett Class of Eligibility for the following reasons:

☐ Applicant does not meet the criteria of:

☐ Nursing Facility LOC- Nursing facility level of care is appropriate for individuals who do not require hospital care, but who, on a regular basis, require licensed nursing services, rehabilitation services, or other health-related services *ordinarily provided in an institution*.

☐ ICF/ID LOC- ICF/ID level of care is appropriate for individuals who require the type of active treatment typically provided by a facility whose primary purpose is to furnish health and rehabilitative services to persons with an intellectual disability or related conditions.

☐ Although the physician has recommended Nursing Facility Level of Care, he/she has not ordered the level of skilled services required to meet criteria under this level of care which is a requirement of 42 C.F.R. §.409.31 – 409.34.

☐ Although the physician ordered skilled services, documentation submitted does not demonstrate this level of services presently in place which is requirement of 42 C.F.R. § 409.31-409.34.

☐ Rehabilitative services are not required five (5) days per week or skilled nursing services seven (7) days per week per the documentation submitted which is a requirement of 42 C.F.R. § 409.31-409.34.

☐ This child has a diagnosis of intellectual disability or a condition that is closely related to intellectual disability, but the psychological/developmental evaluation scores do not meet the Level of Care criteria. This is a requirement of 42 C.F.R. § 440.150, 435.1010 and 483.440(a).

☐ You failed to submit all the required documents for review. The following documents were missing from the packet:

- ☐ Complete Pediatric DMA-6A (Physicians Recommendation for Pediatric Care)
- ☐ Complete TEFRA/Katie Beckett Medical Necessity/Level of Care Statement
- ☐ Individualized Family Service Plan (IFSP)
- ☐ Individualized Education Plan (IEP)
- ☐ Comprehensive Developmental (ages 0-5 years) or Psychological (age 6 and up) Evaluation (required within the last 3 years for initial application for ICF/ID determinations and every three years thereafter)
- ☐ Private Rehabilitative Therapy Notes (occupational/ physical/speech therapy or autism spectrum disorder services)
- ☐ School Based Rehabilitative Notes (occupational/physical or speech therapy
- ☐ Skilled Nursing Notes
- ☐ Other

☐ The physician failed to certify the applicant requires the level of care provided by a nursing facility or ICF/ID facility (see Item 25 of DMA 6(A) form).

☐ Reviewers Comments:

In accordance with the 42 C.F.R. 435.225, your request for long-term care services under the Georgia Medicaid program will be denied unless additional medical information for the LOC denial can justify the need for institutional care. Attached is a copy of the Level of Care Criteria used for this determination for your review. Likewise, if the determination was a technical denial, all missing information must be submitted in order to make a level of care determination.

If you disagree with this initial determination, you may request a Reconsideration Review or request a hearing. You may obtain a Reconsideration Review of this decision by sending additional clinical information from your child's physician within thirty (30) calendar days of the date of this letter to:

Georgia Medical Care Foundation
Attention: TEFRA/Katie Beckett Review Nurse
P.O. Box 105406
Atlanta, Georgia 30348
Fax number: 678-527-3001

Please contact the *Right From the Start Katie Beckett Team*, attending physician, or your original referring agency if you need help with your request. Once the Department has received the additional information, it will be reviewed and a Final Determination Letter will be issued regarding your child's level of care determination.

If additional medical information is not received within thirty (30) calendar days from the date of this letter, the decision will become FINAL. You do not lose your right to a fair hearing if you choose to have a Reconsideration Review completed. You have thirty (30) calendar days from the date of this letter to request a hearing in writing to the following address:

Department of Community Health
Legal Services Section
2 Peachtree Street, NW 40th Floor
Atlanta, GA 30303-3159

Sincerely,

TEFRA/Katie Beckett Review Team

APPENDIX E

DATE:

Member Name
Member Address
Member Address

TEFRA/KATIE BECKETT
FINAL DETERMINATION LETTER

☐ **LEVEL OF CARE DENIAL (LOC)**
☐ **TECHNICAL DENIAL**

MEMBER:
MEDICAID ID:
PA ID:

Dear Parent/Legal Guardian:

To receive TEFRA/Katie Beckett coverage under the Georgia Medicaid program, the child's medical condition must require the level of care (LOC) provided in a nursing facility or hospital, or if the child is intellectually disabled, he/she must meet criteria for placement in an intermediate care facility ("ICF/ID"). See 42 C.F.R. § 435.225(b)(1); 409.31-409.34;; 440.150; 435.1010; and 483.440(a).

The Alliant/Georgia Medical Care Foundation (GMCF), on behalf of the Georgia Department of Community Health (DCH), has:
☐ reviewed the **new supplementary medical information submitted by you** or
☐ not received any additional medical information from you.

Alliant/Georgia Medical Care Foundation, on behalf of the Department of Community Health (DCH), makes the level of care determination based on the documentation submitted. The child's name listed above does not meet criteria for the TEFRA/Katie Beckett Class of Eligibility for the following reasons:

☐ Applicant does not meet the criteria of:

☐ Nursing Facility LOC- Nursing facility level of care is appropriate for individuals who do not require hospital care, but who, on a regular basis, require licensed nursing services, rehabilitation services, or other health-related services *ordinarily provided in an institution*.

☐ ICF/ID LOC- ICF/ID level of care is appropriate for individuals who require the type of active treatment typically provided by a facility whose primary purpose is to furnish health and rehabilitative services to persons with an intellectual disability or related conditions.

☐ Although the physician has recommended Nursing Facility Level of Care, he/she has not ordered the level of skilled services required to meet criteria under this level of care which is a requirement of 42 C.F.R. § 409.31-409.34.

☐ Although the physician ordered skilled services, documentation submitted does not demonstrate that this level of services is presently in place which is a requirement of 42 C.F.R. § 409.31-409.34.

☐ Rehabilitative services are not required five (5) days per week or skilled nursing services seven (7) days per week per the documentation submitted which is a requirement of 42 C.F.R. § 409.31- 409.34.

☐ This child has a diagnosis of intellectual disability, or a condition that is closely related to intellectual disability, but the psychological/developmental evaluation scores do not meet the Level of Care criteria. This is a requirement of 42 C.F.R. §440.150, 435.1010 and 483.440(a).

☐ You failed to submit all the required documents for review. The following documents were missing from the packet:

- ☐ Complete Pediatric DMA-6A (Physicians Recommendation for Pediatric Care)
- ☐ Complete TEFRA/Katie Beckett Medical Necessity/Level of Care Statement
- ☐ Individualized Family Service Plan (IFSP)
- ☐ Individualized Education Plan (IEP)
- ☐ Comprehensive Developmental (ages 0-5 years) or Psychological (age 6 and up) Evaluation (required within the last 3 years for initial application for ICF/ID determinations and every three years thereafter)
- ☐ Private Rehabilitative Therapy Notes (occupational/physical/speech therapy or autism spectrum disorder services)
- ☐ School Based Rehabilitative Therapy Notes (occupational/physical or speech therapy)
- ☐ Skilled Nursing Notes
- ☐ Other

☐ The physician failed to certify the applicant requires the level of care provided by a nursing facility or ICF/ID facility (see Item 25 of DMA 6(A) form).

☐ Reviewers Comments:

In accordance with 42 CFR δ 435.225, your request for long-term services under the Georgia Medicaid program is denied. If you disagree with this denial, you may request a fair hearing. To have a hearing, <u>you must ask for one in writing. Your request for hearing</u>

must be *received* by the Department of Community Health within thirty (30) days of the date of this letter. An explanation of your hearing rights is attached.

If you are currently receiving services, you may also request that the Department maintain your services at the current level pending the outcome of your hearing. If the Administrative Law Judge rules in favor of the Department, the Department may institute recovery procedures against the applicant or recipient to recoup the cost of any services furnished the recipient.

If you are challenging the Department's level of care determination, please send your written request for hearing to:

Georgia Department of Community Health
Legal Services
2 Peachtree Street, NW 40th Floor
Atlanta, GA 30303-3159

Please attach this letter to your request for a hearing. If you are requesting a hearing for any reason other than for the level of care determination, please send your written request to your local RSM/KB Team.

Finally, if your child's condition changes significantly (i.e., major surgery occurrence, progression/relapse of disease, etc.) or you have current information that you would like the agency to consider, you may reapply.

Sincerely,

TEFRA/Katie Beckett Review Team

APPENDIX E

DATE:

Member Name
Member Address
Member Address

TEFRA/KATIE BECKETT FINAL DETERMINATION APPROVAL LETTER

MEMBER:
MEDICAID ID:
PA ID:

Dear Parent/Legal Guardian:

To receive TEFRA/Katie Beckett coverage under the Georgia Medicaid program, the child's medical condition must require the level of care (LOC) provided in a nursing facility or if the child is intellectually disabled, he/she must meet criteria for placement in an intermediate care facility ("ICF/ID"). See 42 C.F.R. § 435.225(b)(1); 409.31-409.34; 440.150; 435.1010; and 483.440(a).

This letter is to notify you that based on our evaluation, the applicant noted above is being approved for the TEFRA/Katie Beckett Waiver.

Sincerely,

TEFRA/Katie Beckett Review Nurse

APPENDIX F

PEDIATRIC

NURSING FACILITY LEVEL OF CARE

Level of care criteria are based on definitions and guidelines derived from the Federal regulations in 42 C.F.R 409.31-409.34, and are used to assist assessors in evaluating clinical information submitted. Level of care criteria are based on the overall medical condition of the individual and the medically necessary services required. Level of care is not diagnosis specific.

Summary:

Nursing facility level of care is appropriate for individuals who do not require hospital care, but who, on a regular basis, require licensed nursing services, rehabilitation services, or other health-related services *ordinarily provided in an institution*. With respect to an individual who has a mental illness or intellectual disability, nursing facility level of care services are usually inappropriate unless that individual's mental health needs are secondary to needs associated with a more acute physical disorder.

A nursing facility level of care is indicated if all of following conditions are met:. Services received in an educational setting must meet these same conditions.

1. The service(s) has been ordered by a physician;

2. The service(s) will be furnished either directly by, or under the direct supervision of, appropriately licensed personnel;

3. The individual requires service(s) which are so inherently complex that it can be safely and effectively performed only by, or under the supervision of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, speech pathologists or audiologists; and autism service qualified health care providers; and

4. The individual requires either skilled nursing services seven days per week or skilled rehabilitation services at least five days per week.

Level of care criteria are based on definitions and guidelines.

INTERMEDIATE CARE FACILITY (ICF/ID) LEVEL OF CARE

Level of care criteria are based on definitions and guidelines derived from the Federal regulations, 42 C.F.R. 440.150, 435.1009, and 483.440(a) and are used to assist assessors in evaluating clinical information submitted. Level of care criteria are based on the overall medical condition of the individual and the medically necessary service required and is not diagnosis specific.

Summary:

ICF/ID level of care is appropriate for individuals who require the type of active treatment typically provided by a facility whose primary purpose is to furnish health and rehabilitative services to persons with intellectual disabilities or related conditions.

An ICF/ID level of care is generally indicated if any of the following conditions are met:

1. The child has an IQ of 70 or below (moderate to profound intellectual disability); or

2. The child has a standard score of less than 70 in at least three of the five domains of function (cognitive, language, motor, social-emotional, and adaptive) on a standardized developmental assessment tool or an overall standard score of less than 70; or

3. The child has a standard score of less than 70 in at least three domains of function on a standardized adaptive functioning or an overall composite score of less than 70; or

4. The child's Childhood Autism Rating Scale (CARS) score is above 37, or the Gilliam Autism Rating Scale (GARS) score is 121 or greater.

Note: An age appropriate, comprehensive functional assessment is required at least every three years. For children 0-5 years of age, a comprehensive developmental evaluation is required. For children 6-18 years of age, a comprehensive psychological evaluation is required.

APPENDIX G
Georgia Families

Georgia Families

Georgia Families® (GF) is a statewide program designed to deliver health care services to members of Medicaid, PeachCare for Kids®, and Planning for Healthy Babies® (P4HB) recipients. The program is a partnership between the Department of Community Health (DCH) and private care management organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs.

It is important to note that GF is a full-risk program; this means that the four CMOs licensed in Georgia to participate in GF are responsible and accept full financial risk for providing and authorizing covered services. This also means a greater focus on case and disease management with an emphasis on preventative care to improve individual health outcomes.

The four licensed CMOs:

Amerigroup Community Care 800-249-0442 www.myamerigroup.com	CareSource 888-901-0014 www.caresource.com
Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	WellCare of Georgia 866-231-1821 www.wellcare.com

Children, parent/caretaker with children, pregnant women and women with breast or cervical cancer on Medicaid, as well as children enrolled in PeachCare for Kids® are eligible to participate in Georgia Families. Additionally, Planning for Healthy Babies® (P4HB) recipients receive services through Georgia Families® (GF). Children in foster care are enrolled in Georgia Families 360°.

Eligibility Categories for Georgia Families:

Included Populations	Excluded Populations
PeachCare for Kids®	Aged, Blind and Disabled
Parent/Caretaker with Children	Nursing home
Children under 19	Long-term care (Waivers, SOURCE)
Women's Health Medicaid (WHM)	Federally Recognized Indian Tribe
Transitional Medicaid	Georgia Pediatric Program (GAPP)
Refugees	Hospice
Planning for Healthy Babies	Children's Medical Services program
Resource Mothers Outreach	Medicare Eligible
Newborns	Supplemental Security Income (SSI) Medicaid
	Medically Needy

Georgia Families

Medicaid and PeachCare for Kids® members will continue to be eligible for the same services they receive through traditional Medicaid as well as new services. Members will not have to pay more than they paid for Medicaid co-payments or PeachCare for Kids® premiums. With a focus on health and wellness, the CMOs will provide members with health education and prevention programs as well as expanded access to plans and providers, giving them the tools needed to live healthier lives. Providers participating in Georgia Families will have the added assistance of the of the CMOs to educate members about accessing care, referrals to specialists, member benefits, and health and wellness education.
All four CMOs are State-wide.

The Department of Community Health has contracted with four CMOs to provide these services: Amerigroup Community Care, CareSource, Peach State Health Plan and WellCare. Members can contact Georgia Families for assistance to determine which program best fits their family's needs. If members do not select a plan, Georgia Families will select a health plan for them.

Members can visit the Georgia Families Web site at **www.georgia-families.com** or call **1-800-GA-ENROLL** (1-888-423-6765) to speak to a representative who can give them information about the CMOs and the health care providers.

Included Categories of Eligibility (COE):

COE	*DESCRIPTION*
104	LIM – Adult
105	LIM – Child
118	LIM – 1st Yr Trans Med Ast Adult
119	LIM – 1st Yr Trans Med Ast Child
122	CS Adult 4 Month Extended
123	CS Child 4 Month Extended
135	Newborn Child
170	RSM Pregnant Women
171	RSM Child
180	P4HB Inter Pregnancy Care
181	P4HB Family Planning Only
182	P4HB ROMC - LIM
183	P4HB ROMC - ABD
194	RSM Expansion Pregnant Women
195	RSM Expansion Child < 1 Yr
196	RSM Expn Child w/DOB < = 10/1/83
197	RSM Preg Women Income < 185 FPL
245	Women's Health Medicaid
471	RSM Child
506	Refugee (DMP) – Adult
507	Refugee (DMP) – Child
508	Post Ref Extended Med – Adult
509	Post Ref Extended Med – Child
510	Refugee MAO – Adult
511	Refugee MAO – Child
571	Refugee RSM - Child
595	Refugee RSM Exp. Child < 1
596	Refugee RSM Exp Child DOB </= 10/01/83
790	Peachcare < 150% FPL
791	Peachcare 150 – 200% FPL
792	Peachcare 201 – 235% FPL

793	Peachcare > 235% FPL
835	Newborn
836	Newborn (DFACS)
871	RSM (DHACS)
876	RSM Pregnant Women (DHACS)
894	RSM Exp Pregnant Women (DHACS)
895	RSM Exp Child < 1 (DHACS)
897	RSM Pregnant Women Income > 185% FPL (DHACS)
898	RSM Child < 1 Mother has Aid = 897 (DHACS)
918	LIM Adult
919	LIM Child
920	Refugee Adult
921	Refugee Child

Information for Providers Serving Medicaid Members
in the Georgia Families 360^{0} SM Program

Georgia Families 360^{0} SM, the state's managed care program for children, youth, and young adults in Foster Care, children and youth receiving Adoption Assistance, as well as select youth in the juvenile justice system, launched Monday, March 3, 2014. Amerigroup Community Care is the single Care Management Organization (CMO) that will be managing this population.

Amerigroup is responsible, through its provider network, for coordinating all DFCS, DJJ required assessments and medically necessary services for children, youth and young adults who are eligible to participate in the Georgia Families 360^{0}SM Program. Amerigroup will coordinate all medical/dental/trauma assessments for youth upon entry into foster care or juvenile justice (and as required periodically).

Georgia Families 360^{0} SM Every member in Georgia Families 360^{0} is assigned a Care Coordinator who works closely with them to ensure access to care and ensure that appropriate, timely, and trauma informed care is provided for acute conditions as well as ongoing preventive care. This ensures that all medical, dental, and behavioral health issues are addressed. Members also have a medical and dental home to promote consistency and continuity of care. The medical and dental homes coordinate care and serve as a place where the child is known over time by providers who can provide holistic care. DFCS, DJJ, foster parents, adoptive parents, and other caregivers are involved in the ongoing health care plans to ensure that the physical and behavioral health needs of these populations are met.

Electronic Health Records (EHRs) are being used to enhance effective delivery of care. The EHRs can be accessed by Amerigroup, physicians in the Amerigroup provider network, and DCH sister agencies, including the DFCS, regardless of where the child lives, even if the child experiences multiple placements. Ombudsman and advocacy staff are in place at both DCH and Amerigroup to support caregivers and members, assisting them in navigating the health care system. Additionally, medication management programs are in place to focus on appropriate monitoring of the use of psychotropic medications, to include ADD/ADHD as well as other behavioral health prescribed medications.

Providers can obtain additional information by contacting the Provider Service Line at 1-800-454-3730 or by contacting their Provider Relations representative.

To learn more about DCH and its dedication to A Healthy Georgia, visit www.dch.georgia.gov