## DEPARTMENT OF HEALTH CARE FINANCE

## NOTICE OF PROPOSED RULEMAKING

The Director of the Department of Health Care Finance (DHCF or the Department), pursuant to the authority set forth in An Act to enable the District of Columbia (District) to receive federal financial assistance under Title XIX of the Social Security Act (the Act) for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat.774; D.C. Official Code § 1-307.02 (2014 Repl. & 2015 Supp.)), and Section 6(6) of the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.05(6) (2012 Repl.), hereby gives notice of the intent to adopt an amendment to Chapter 95 (Medicaid Eligibility) by adding a new Section 9512 (Non-MAGI Eligibility Group: Katie Beckett Pathway), of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR), and to amend Section 9500 (General Provisions) of Chapter 95 (Medicaid Eligibility) of Title 29 DCMR (Public Welfare) to add definitions.

DHCF is the single state agency responsible for the administration of the State Medicaid program under Title XIX of the Act and the Children's Health Insurance Program (CHIP) under Title XXI of the Act in the District. Pursuant to Section 1902(e) of the Act and Section 134 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, approved September 3, 1982 (Pub. L. 97-248, 42 USC § 1396a), children with disabilities, who would not be eligible for Medicaid benefits due to their parent's income, may become eligible for Medicaid. Eligibility under the Katie Beckett Pathway allows the District to waive the deeming of parental income and resources for children who meet certain criteria. To be found eligible for Medicaid through the Katie Beckett Pathway, a child must be age zero (0) through eighteen(18) years old; have income at or below three hundred (300%) of the Supplemental Security Income (SSI) federal benefit; have resources equal to or less than $4,000; have a disability which can be expected to result in death or to last for more than twelve (12) months in accordance with Section 1614(a) of the Act; have a level of care that is typically provided in either a hospital, intermediate care facility, or skilled nursing facility; be able to safely live at home; not otherwise eligible for Medicaid; have estimated Medicaid costs of care received at home that do not exceed the estimated Medicaid costs of care received in an institution pursuant to the District's cost effectiveness methodology; and meet non-financial eligibility factors in accordance with Section 9506.9 of this chapter. Accordingly, these proposed amended rules establish the eligibility factors and standards governing eligibility determinations for children under the age of nineteen (19) who are disabled, and enable them to receive medical care outside of a hospital, intermediate care facility, or nursing facility. Additionally, these rules allow these children to have access to the same set of services, such as early periodic screening diagnosis and treatment (EPSDT) services, that are available to children who are eligible for Medicaid on another basis.

The District of Columbia Medicaid Program is also amending the District of Columbia State Plan for Medical Assistance (State Plan) to reflect the methodology in determining cost effectiveness of providing care for the child at home instead of an institution. These proposed rules correspond to the amendment, which require approval by the Council of the District of Columbia (Council) and the U.S. Department of Health and Human Services, Centers for Medicaid and Medicare Services (CMS). These rules shall become effective for services

rendered on or after January 1, 2016, if the corresponding State Plan Amendment (SPA) has been approved by CMS with an effective date of January 1, 2016, or the effective date established by CMS in its approval of the corresponding SPA, whichever is later. These proposed rules amend Chapter 95 of Title 29 DCMR by incorporating the Medicaid eligibility requirements for children to receive reimbursable services through the Katie Beckett Pathway. The District approximates that there will be no fiscal impact related to these updates.

The Director gives notice of the intent to take final rulemaking action to adopt these rules not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

**CHAPTER 95, MEDICAID ELIGIBILITY, of Title 29 DCMR, PUBLIC WELFARE, is amended by adding a new Section 9512 to read as follows:**

**9512 NON-MAGI ELIGIBLITY GROUP: KATIE BECKETT PATHWAY**

9512.1 A child below the age of nineteen (19) years old that applies for Medicaid eligibility under the Katie Beckett pathway shall comply with the following requirements:

(a) Submit a complete application for Medicaid, in accordance with § 9501.5 of this chapter, which shall include but not be limited to supplying information on household income; and

(b) Be evaluated for Medicaid eligibility based on Modified Adjusted Gross Income (MAGI Medicaid) pursuant to the requirements set forth under § 9506.6 of this chapter .

9512.2 The District of Columbia (District) shall provide Medicaid benefits under the Katie Beckett Pathway to eligible children with disabilities who do not qualify for MAGI Medicaid due to being over the MAGI Medicaid income threshold for children in the District, subject to the provisions of this section.

9512.3 If an applicant is deemed to be ineligible for MAGI Medicaid due to being over the income threshold set forth in § 9506.6(b), then the Department shall submit notice of the applicant's ineligibility of MAGI Medicaid and the applicant's opportunity to be evaluated for Medicaid through the Katie Beckett Pathway. The Department shall also submit the following documents for the applicant's completion to determine the applicant's eligibility for Medicaid under the Katie Beckett pathway:

(a) A Care Plan that is completed by the applicant and the applicant's physician, containing the prescribed or ordered services for the child; and

(b) Level of Care (LOC) forms that are completed by the applicant's physician, and are accompanied with documentation that supports a LOC in accordance with § 9512.4(e).

9512.4 In order to be eligible for Medicaid through the Katie Beckett Pathway, a child shall meet the following non-financial and financial requirements:

(a) Be age zero (0) through eighteen (18) years old;

(b) Have individual income at or below three hundred percent (300%) of the Supplemental Security Income (SSI) federal benefit level;

(c) Have individual resources equal to or less than two thousand six hundred dollars ($2,600) after application of a disregard of all countable resources between $2,600 and four thousand dollars ($4,000);

(d) Have a disability which can be expected to result in death or to last for at least twelve (12) months in accordance with Section 1614(a) of the Social Security Act;

(e) Have a LOC that is typically provided in one of the following settings:

(1) A hospital, as described in 42 C.F.R. § 440.10, pursuant to the criteria set forth under § 9512.6;

(2) An intermediate care facility, as described in 42 C.F.R. § 440. 150, pursuant to the criteria set forth under § 9512.7; or

(3) A nursing facility, as described in the "Health Care and Community Residence License Act of 1983, approved October 28, 1983 (D.C. Law 5-48; D.C. Official Code § 44-501), pursuant to the criteria set forth under § 9512.9;

(f) Be able to safely live at home;

(g) Not otherwise be eligible for Medicaid;

(h) Have estimated Medicaid costs of care received at home that do not exceed the estimated Medicaid costs of care received in an institution pursuant to the cost effectiveness methodology set forth in § 9512.10; and

(i) Meet non-financial eligibility factors in accordance with § 9506.9.

9512.5 Only the income and assets of the child shall be considered in determining financial eligibility under § 9512.4. The parents' income and assets shall not be deemed to the child.

9512.6 A child shall meet a hospital LOC if a child meets all of the following criteria:

(a) The child has a condition for which room, board, and professional services furnished under the direction of a physician is expected to be medically necessary for a period of forty eight (48) hours or longer;

(b) The professional services needed are something other than intermediate care facility and nursing facility services, under §§ 9512.7 and 9512.9, respectively;

(c) The child's condition is such that requires treatment which is ordinarily furnished in an inpatient setting;

(d) The service that the child needs has been ordered by a physician who is licensed in accordance with District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.)) and complies with screening and enrollment requirements set forth under § 9512.14;

(e) The service that the child receives is furnished either directly by, or under the supervision of, a physician that is licensed pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.)) and in compliance with screening and enrollment requirements set forth under § 9512.15; and

(f) The service that the child receives is ordinarily furnished, as a practical matter, in a hospital, certified by the Health Regulation and Licensing Administration (HRLA) in the Department of Health (DOH) pursuant to §§ 2000 – 2099 of Title 22, Subtitle B, of the District of Columbia Municipal Regulations (DCMR), for the care and treatment of individuals with disorders other than mental diseases.

9512.7 A child shall meet an intermediate care facility LOC if a child meets all of the following criteria:

(a) The child has the diagnosis of an intellectual disability that meets one of the criteria set forth under § 1902.4 of Title 29 DCMR;

(b) The child is referred for an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) LOC based on a medical evaluation by a physician that is licensed pursuant to the District of Columbia Health

Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.)) and complies with screening and enrollment requirements set forth under § 9512.14;

(c) The child requires active treatment by meeting the following requirements:

(1) The child's needs have not been met with the child's current plan of treatment, *i.e.*, wraparound services in school and in the community;

(2) The child requires twenty-four (24) hour supervision by a licensed practical nurse or nursing assistive personnel, as appropriate, who are acting within the scope of practice authorized under District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.));

(3) The child requires ongoing care, either directly or on-call, by one or more of the following, as appropriate:

(A) A physician who is licensed in accordance with District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.));

(B) A psychiatrist who is licensed as a physician in accordance with District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.)), and has completed a residency program in psychiatry accredited by the Residency Review Committee for Psychiatry of the Accreditation Council for Graduate Medical Education and is eligible to sit for the psychiatric board examination;

(C) An advanced practice registered nurse who is licensed in accordance with District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.));

(D) A registered nurse that is licensed in accordance with District of Columbia Health Occupations Revision Act of

1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.));

(E) A psychologist that is licensed to practice psychology in accordance with the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.));

(F) A social worker that is licensed as a licensed independent social worker, a licensed graduate social worker, or a licensed independent clinical social worker, in accordance with the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.));

(G) A physical therapist that is licensed in accordance with the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.));

(H) An occupational therapist that is licensed in accordance with the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.));

(I) A speech pathologist that is licensed in accordance with the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.));

(J) An audiologist that is licensed in accordance with the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.)); or

(K) A recreational therapist that is registered in accordance with the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99;

D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.));

(4) Subject to limitations under § 9512.8 of this chapter, the child requires specialized services through an integrated program of therapies and other activities that are developed and supervised by medical and rehabilitative professionals, as appropriate, in order to improve the child's ability to function at a higher less dependent level;

(5) The child requires more behavior modification than is provided in a six (6) hour school day;

(6) The child has severe functional limitations in three (3) or more of the following areas of major life activities:

(A) Self-care;

(B) Understanding the use of language;

(C) Learning;

(D) Mobility;

(E) Self-direction; and

(F) Capacity for independent living;

(d) The services that the child requires will be furnished either directly by, or under the supervision of, appropriately qualified professionals that are licensed and practicing within the scope of their license pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.)) and in compliance with screening and enrollment requirements set forth under § 9512.15; and

(e) The services that the child requires would have ordinarily been provided in an intermediate care facility, licensed by HRLA pursuant to §§ 3100 – 3199 of Title 22, Subtitle B, of the DCMR, in the absence of community services.

9512.8 Specialized services under § 9512.7(c)(4) shall not include:

(a) Interventions that address age-appropriate limitations;

(b) General supervision of children whose age is such that supervision is required for all children of the same age; or

(c) Physical assistance for children who are unable to physically perform tasks but who understand the process needed to do them.

9512.9 A child shall meet a nursing facility LOC if a child meets all of the following criteria:

(a) The child requires service that is inherently complex (*e.g.*, treatment for cystic fibrosis, osteogensis imperfecta, sickle cell, spina bifida, etc.) and can be safely and effectively performed only by, or under the supervision of, professional personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, social workers, and speech pathologists or audiologists, who are licensed pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.)) and in compliance with screening and enrollment requirements set forth under § 9512.15;

(b) The child requires one (1) of the following three (3) categories of services:

(1) The service is required seven (7) days per week and is one (1) of the following, or similar:

(A) Overall management and evaluation of a care plan for a child who is totally dependent in all activities of daily living;

(B) Observation and assessment of a child's changing condition when the documented instability of his or her medical condition is likely to result in complications, or because the documented instability of his or her mental condition is likely to result in suicidal or hostile behavior;

(C) Intravenous or intramuscular injections or intravenous feeding;

(D) Enteral feeding that comprises at least twenty-six (26) percent of daily calorie requirements and provides at least five hundred and one (501) milliliters of fluid per day;

(E) Nasopharyngeal or tracheostomy aspiration;

(F) Insertion and sterile irrigation or replacement of uprapubic catheters;

(G) Application of dressings involving prescription medications and aseptic techniques;

(H) Treatment of extensive decubitis ulcers or other widespread skin disorder;

(I) Heat treatments as part of active treatment which requires observation by nurses;

(J) Initial phases of a regimen involving administration of medical gases;

(K) Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment;

(2) The service is required five (5) days per week and is one (1) of the following or similar:

(A) Ongoing assessment of rehabilitation needs and potential services concurrent with the management of a patient care plan;

(B) Therapeutic exercises and activities performed by physical therapy or occupational therapy;

(C) Gait evaluation and training to restore function to a child whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality;

(D) Range of motion exercises which are part of active treatment of a specific condition that has resulted in a loss of, or restriction of mobility;

(E) Maintenance therapy when specialized knowledge and judgment is needed to design a program based on initial evaluation;

(F) Ultrasound, short-wave, and microwave therapy treatment;

(G) Hot pack, hydrocollator, infrared treatments, paraffin baths, and whirlpool treatment when the child's condition is

complicated by circulatory deficiency, areas of desensitization, open wounds, etc. and specialized knowledge and judgment is required;

(H) Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing; or

(3) The service is one (1) of the following only if an additional medical complication requires that it be performed or supervised by professional personnel:

(A) Administration of routine medications, eye drops, and ointments;

(B) General maintenance care of an ostomy;

(C) General maintenance care in connection with a plaster cast;

(D) Routine services to maintain satisfactory functioning of indwelling bladder catheters;

(E) Changes of dressings for non-infected postoperative or chronic conditions;

(F) Prophylactic and pain relief for skin care, including bathing and application of creams, or treatment of minor skin problems;

(G) Routine care of an incontinent child, including use of diapers and protective sheets;

(H) Use of heat as a pain relief and comfort measure (e.g., whirlpool and hydrocollator);

(I) Routine evaluation of blood gases after a regimen of oxygen therapy has been established;

(J) Assistance in dressing, eating, and toileting;

(K) Periodic turning and positioning of the child;

(L) General supervision of exercises that were taught to the child and can be safely performed by the child including the actual carrying out of maintenance programs;

(c) The service needed has been ordered by a physician who is licensed pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.)), and complies with screening and enrollment requirements set forth under § 9512.14;

(d) The service is furnished either directly by, or under the supervision of, qualified professionals that are licensed pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.)) and in compliance with screening and enrollment requirements set forth under § 9512.15; and

(e) The beneficiary requires skilled nursing or skilled rehabilitation services, or both, at a minimum of five (5) days per week.

9512.10 The Department, or its agent, shall determine whether the estimated Medicaid cost of caring for the child outside of an institution exceeds the estimated cost of appropriate institutional care based on the following methodologies:

(a) Upon initial application, the Department shall:

(1) Identify the services that the child is prescribed or ordered to receive based on forms submitted by the applicant under § 9512.3(a) – (b);

(2) Estimate the annual cost of the services using the established Medicaid Fee Schedule, available at http://www.dc-medicaid.com. The beneficiary's acuity level and severity of illness shall be factored into the estimation;

(3) Estimate the annual costs of services if services were provided in an institution by multiplying the current institutional per diem reimbursement rate, in accordance with § 9512.10(b), with the number of days in one year. The beneficiary's acuity level, severity of illness, and length of stay shall be factored into the estimation. This estimate shall be the maximum allowable costs; and

(4) Compare the annual costs identified in § 9512.10(a)(2) with the maximum allowable costs identified in § 9512.10(a)(3). If the annual cost is more than the maximum allowable costs, the applicant will be ineligible for Medicaid under the Katie Beckett Pathway.

(b) The institutional per diem reimbursement rate of services, described in § 9512.10(a)(3), shall be determined as follows:

(1) If the Department determines that the child has a hospital LOC pursuant to § 9512.6, the Department shall use the applicable per-diem reimbursement rates of a specialty hospital provider that most closely meets the medical needs of the child, in accordance with Chapter 48 of Title 29 DCMR, and is enrolled with the Department pursuant to Chapter 94 of Title 29 DCMR;

(2) If the Department determines that the child has an intermediate care facility LOC pursuant to § 9512.7, the Department shall use applicable per-diem reimbursement rates in accordance with the ICF/IID fee schedule, set forth under Subsection 4102.15 of Title 29 DCMR; or

(3) If the Department determines that the child has a nursing facility LOC pursuant to § 9512.9, the Department shall use the applicable per-diem reimbursement rates of the pediatric nursing facility that most closely meets the medical needs of the child, pursuant to Chapter 65 of Title 29 DCMR or pursuant to the Medicaid rates of the jurisdiction in which the facility is located, and is enrolled with the Department pursuant to Chapter 94 of Title 29 DCMR.

(c) The Department shall employ the following methodology during annual renewals, unless § 9512.19 applies:

(1) Calculate the actual annual costs of care incurred for the child in the preceding year by aggregating the actual monthly costs of care;

(2) Compare actual annual costs determined under § 9512.10(c)(1) with the maximum allowable costs that was previously determined under § 9512.10(a)(3). If the actual annual cost is more than the maximum allowable costs, the applicant will be ineligible for renewed Medicaid under the Katie Beckett Pathway.

9512.11 If an applicant is found eligible for Medicaid through the Katie Beckett Pathway, the Department shall notify the applicant within sixty (60) calendar days of receipt of completed documents set forth in § 9512.3, in accordance with § 9501.9(a) of this Chapter. The applicant shall be automatically enrolled in fee-for-service Medicaid. However, the applicant shall have the option to transition his or her enrollment to a managed care plan, subject to the Department's approval.

9512.12 Retroactive eligibility, pursuant to §§ 9501.10 – 9501.12, shall apply to Katie Beckett Pathway applicants if the applicant was eligible in accordance with the

requirements set forth under § 9512.4 and received covered services during that period.

9512.13 Pursuant to § 9501.15, each beneficiary shall notify the Department within ten (10) calendar days of any change in circumstances that directly affects the beneficiary's eligibility to receive Medicaid. Once changes are reported, the Department shall review the beneficiary's eligibility in accordance with the requirements of this chapter to determine if the beneficiary remains eligible for Medicaid under the Katie Beckett pathway.

9512.14 The physician that orders or refers services for a child that meets a LOC criteria set forth under §§ 9512.6, 9512.7, or 9512.9 and is found eligible through the Katie Beckett Pathway shall be subject to the following screening and enrollment criteria:

(a) If a child enrolls in a managed care plan contracted with the Department, the physician that continues to order or refer services for the child shall be subject to the managed care plan's screening and enrollment requirements pursuant to the managed care contract;

(b) If a child enrolls in fee-for-service Medicaid, the physician that continues to order or refer services for the child shall be subject to screening and enrollment requirements set forth under Chapter 94 of Title 29 DCMR; and

(c) If a physician, who is not already enrolled with the Department, orders or refers services for a child that requires services to be furnished by a qualified professional who must to enter into a Single Case Agreement with the Department pursuant to § 9512.17, the physician shall submit a streamlined application for enrollment to the Department.

9512.15 The qualified professionals that furnish services to a child that meets a LOC criteria set forth under §§ 9512.6, 9512.7, or 9512.9 and is found eligible through the Katie Beckett Pathway shall be subject to the following screening and enrollment criteria:

(a) If a child enrolls in a managed care plan contracted with the Department, the qualified professionals that continue to furnish services for the child shall be subject to the managed care plan's screening and enrollment requirements, unless a Single Case Agreement has been approved subject to § 9512.16; and

(b) If a child enrolls in fee-for-service Medicaid, the qualified professionals that continue to furnish services to the child shall be subject to screening and enrollment requirements set forth under Chapter 94 of Title 29

DCMR, unless a Single Case Agreement has been approved subject to § 9512.17.

9512.16 If a child that is enrolled in a managed care plan requires service(s) from a qualified professional that is not within the managed care plan's network, the managed care plan may enforce conditions under which it will engage in Single Case Agreements with qualified professionals that are reflective of the conditions set forth in § 9512.17 (a) – (b), in addition to any other conditions set forth in the managed care contract with the Department.

9512.17 Services may be delivered to a beneficiary pursuant to a Single Case Agreement between a qualified professional and the Department if all of the following conditions are met:

(a) The child requires a service that is Medicaid-reimbursable pursuant to the District's State Plan for Medical Assistance;

(b) The service is medically necessary based on the submitted supporting documentation; and

(c) The service cannot be delivered by providers that are currently enrolled with the Department pursuant to Chapter 94 of Title 29 DCMR.

9512.18 If a qualified professional is interested in entering into a Single Case Agreement with the Department, the following requirements shall be met:

(a) An ordering, referring, or prescribing physician who is enrolled with the Department pursuant to Chapter 94 of Title 29 DCMR submits a request for a Single Case Agreement with supporting clinical documentation of the required service to be furnished by a non-enrolled qualified professional;

(b) The qualified professional submits a separate short application for a Single Case Agreement;

(c) The qualified professional is screened by the Department pursuant to Chapter 94 of Title 29 DCMR; and

(d) Claims are reimbursed pursuant to the Department's fee schedule, available at www.dc-medicaid.com.

9512.19 If upon annual renewal there is a change to the services prescribed or ordered for a child in the Care Plan, described in § 9512.3(a), the Department shall conduct a cost effectiveness review using the methodology set forth under § 9512.10(a).

9512.20 If additional or a change of services are prescribed or ordered for the child before the end of the child's certification period, the following shall occur:

(1) If a child is enrolled in fee-for-service Medicaid, the child's physician shall submit a new Care Plan to the Department, and the Department shall conduct a new cost effectiveness review using the methodology set forth under § 9512.10(a).

(2) If the child is enrolled in a managed care plan, the child's physician shall submit the new Care Plan to the managed care plan in which the child is enrolled. The managed care plan shall submit the Care Plan to the Department, and the Department shall conduct a new cost effectiveness review using the methodology set forth under § 9512.10(a).

9512.21 Each applicant and beneficiary shall be subject to the provisions of Chapter 14 of Title 29 DCMR, including but not limited to providing the Department with written notice of any known or suspected third-party liability at the time the child applies for Medicaid and at all times the beneficiary is receiving Medicaid through the Katie Beckett Pathway.

9512.22 In addition to the requirements set forth under § 9512.21, if an applicant or beneficiary requires a service that is covered within the applicant's or beneficiary's primary health insurance plan, each applicant or beneficiary shall follow the rules and requirements of the primary health insurance before seeking reimbursement from the Department or managed care plan for the service.

9512.23 For continued Medicaid coverage through the Katie Beckett Pathway, each beneficiary shall complete and submit the following documents every twelve (12) months in order for the Department to determine all of the eligibility requirements set forth under § 9512.4:

(a) A completed and signed renewal form;

(b) A new Care Plan as described in § 9512.3(a);

(c) A new LOC form with documentation as described in § 9512.3(b); and

(d) Supporting documentation to verify other financial and non-financial eligibility factors described in § 9512.4.

9512.24 The Department shall send a renewal package, containing the documents described in §§ 9512.23(a) - (c) for the beneficiary's completion, no later than ninety (90) days prior to the end of the eligibility period.

9512.25 If the beneficiary's annual renewal documents reveal that the beneficiary no longer meets all of the eligibility factors set forth under § 9512.4, the beneficiary's Medicaid coverage under the Katie Beckett Pathway shall be terminated and the Department shall evaluate the beneficiary's eligibility for Medicaid under other pathways pursuant to 42 C.F.R. § 435.916. The Department shall provide notice to the beneficiary or the beneficiary's authorized representative prior to termination in accordance with the provisions under Section 9508 of this chapter. The Department shall also provide notice to the beneficiary of its eligibility determination under other pathways.

9512.26 If a cost effectiveness review conducted pursuant to § 9512.20 reveals that a beneficiary's estimated Medicaid costs of care received at home exceed the estimated Medicaid costs if care is received in an institution, the beneficiary's Medicaid coverage under the Katie Beckett Pathway shall be terminated. The Department shall provide notice to the beneficiary prior to termination in accordance with the provisions under Section 9508 of this chapter.

9512.27 At all times during the beneficiary's enrollment in Medicaid through the Katie Beckett Pathway, the beneficiary shall meet all eligibility factors described in § 9512.4.

9512.28 Eligibility through the Katie Beckett Pathway shall not continue once a beneficiary turns nineteen (19) years old. Upon the beneficiary's nineteenth ($19^{th}$) birthday, the Department shall re-evaluate the beneficiary's eligibility for Medicaid under another eligibility category.

**The following definitions shall be added to Section 9500, GENERAL PROVISIONS, Subsection 9500.99:**

**9500.99 DEFINITIONS**

**Active treatment** - a continuous program, which includes consistent implementation of training, therapies, health and related services designed to address the child's social, intellectual, and behavioral deficits and, further, that are directed toward the acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible. The program is designed to prevent or decelerate the regression or loss of current optimal functional status. Additionally, the program shall address a child's need for a combination and sequence of interdisciplinary supports that are individually planned, coordinated and are of lifelong or extended duration.

**Activities of Daily Living** - shall have the same meaning as set forth in D.C. Official Code § 44-102.01(1).

**Katie Beckett Pathway** - a pathway that provides Medicaid benefits for eligible children with disabilities, who would not ordinarily qualify for Medicaid due to being over the Medicaid income threshold for children in the District.

**Single Case Agreement** - an agreement between a rendering non-enrolled Medicaid provider and the Department for Medicaid reimbursement of covered services for an eligible D.C. Medicaid beneficiary.

**Skilled nursing**- medical and educational services that address healthcare needs related to prevention and primary healthcare activities.

**Skilled rehabilitative services**- services delivered in an inpatient or outpatient setting that assists with retention, regaining, or improving skills and functioning for daily living that are lost or impaired due to a new medical condition, an acute exacerbation of a chronic medical condition, sickness, injury, or disability. Services require the judgment, knowledge and skill of a qualified therapist and may include, but are not limited to, physical and occupational therapy, speech pathology, and audiology.

Comments on these rules should be submitted in writing to Claudia Schlosberg, J.D., Senior Deputy Director/State Medicaid Director, Department of Health Care Finance, Government of the District of Columbia, 441 4th Street, NW, Suite 900, Washington DC 20001, via telephone on (202) 442-8742, via email at DHCFPubliccomments@dc.gov, or online at www.dcregs.dc.gov, within thirty (30) days of the date of publication of this notice in the *D.C. Register*. Additional copies of these rules are available from the above address.