

## DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF FINAL 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 (2016 Repl. & 2019 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) (2018 Repl.)), hereby gives notice of the adoption of an amendment to Chapter 95 (Medicaid Eligibility) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (“DCMR”) by adding a new Section 9512 (Non-MAGI Eligibility Group: TEFRA/Katie Beckett), and amending Section 9599 (Definitions) 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 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 of 1982, approved September 3, 1982 (Pub. L. 97-248; 42 USC § 1396a) (TEFRA), children with disabilities, who would not be eligible for Medicaid benefits due to their parent's income, may become eligible for Medicaid under the TEFRA/Katie Beckett eligibility group.

Eligibility under the TEFRA/Katie Beckett eligibility group 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 TEFRA/Katie Beckett eligibility group, a child must meet the following criteria: be age zero (0) through eighteen (18) years old; have income at or below three hundred percent (300%) of the Supplemental Security Income (“SSI”) federal benefit rate; have resources equal to or less than four thousand dollars (\$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 (“LOC”) that is typically provided in either a hospital, intermediate care facility, or skilled nursing facility; be able to safely live at home; not be 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 of this chapter.

Accordingly, these rules establish the eligibility factors and standards governing eligibility determinations for children aged zero (0) through eighteen (18) years old 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 and periodic screening, diagnosis, and treatment (EPSDT) services, which are available to children who are eligible for Medicaid on another basis.

These rules also amend Chapter 95 (Medicaid Eligibility) by amending the definitions section (Section 9599) to add new definitions for the terms active treatment, activities of daily living, acuity level, federal benefit rate, TEFRA/Katie Beckett eligibility group, nursing assistive personnel, single case agreement, skilled nursing, skilled rehabilitation services, and streamlined application for provider enrollment.

A Notice of Proposed Rulemaking was published on February 5, 2016 at 63 DCR 1335. Comments were received from Health Services for Children with Special Needs, Inc. (HSCSN) and substantive changes were made to the rulemaking. A Notice of Emergency and Second Proposed Rulemaking was published on October 5, 2018 at 65 DCR 011064. The following comments were received from Disability Rights DC at University Legal Services (DRDC). Based on review of the comments, DHCF is making technical changes to the rulemaking as set forth below.

#### *Eligibility Criteria for TEFRA/Katie Beckett*

DRDC offers comments on the eligibility criteria for TEFRA/Katie Beckett, using an example to clarify their concern. As set forth in Subsection 9512.7(b), a child who requires an intermediate care facility level of care criteria must be referred for an evaluation by a physician. DRDC argues that this requirement has the effect of constraining eligibility criteria so as to limit access to services. DHCF disagrees. In accordance with the federal regulation governing TEFRA/Katie Beckett eligibility at 42 CFR § 435.225, DHCF must determine that the child requires the LOC provided in a hospital, skilled nursing facility, or intermediate care facility to determine eligibility via TEFRA/Katie Beckett. In order for DHCF to make the LOC determination, DHCF must require that the child's needs are properly evaluated, prescribed, ordered, or referred (as appropriate) by licensed practitioners that are acting within the scope of their licenses. DHCF believes this requirement is consistent with federal regulations and District standards governing the scope of a practitioner's license.

DRDC further comments that the rule is unclear how the LOC criteria for TEFRA/Katie Beckett eligibility is determined, *i.e.*, whether the same InterRAI assessment tool is used for assessing eligibility, particularly those individuals who otherwise qualify for nursing facility care. The assessments used to make LOC determinations are nationally recognized tools. Such tools are subject to change based upon clinical or emerging best practices, as identified by the QIO. For this reason, DHCF has chosen not to specify the assessment tools used to determine each LOC in the rulemaking. DHCF is not proposing any amendments at this time.

#### *Intermediate Care Facility LOC*

DRDC comments that the preamble of the rule and the incorporation of the LOC criteria in Subsection 1902.4 of Title 29 DCMR rule out children with developmental disabilities or "single diagnoses" and seems to subject all children to the IDD Waiver eligibility criteria, which rely on testing of IQ score and adaptive functioning. DRDC further states that such IQ testing is not feasible for babies and young children who are age-appropriate for TEFRA/Katie Beckett Medicaid. DHCF is providing a technical change to Subsection 9512.7 (the intermediate care facility LOC). The change reflects current practice and clarifies that if a child is under age two

(2), the child must be diagnosed with either one (1) of the deficits or diagnoses listed in Subsection 1902.4, including: (1) mobility deficits; (2) sensory deficits; (3) chronic health problems; (4) behavior problems; (5) autism; (6) cerebral palsy; (7) epilepsy; (8) spina bifida; or (9) prader willi. A child under the age of two (2) is not be subject to IQ tests and measures of adaptive functioning. Current standards of practice assume that IQ testing and measures of adaptive functioning is only required if clinically appropriate to administer to the child based on age.

DRDC also posits that the rule problematically refers to “active treatment” but fails to include that such treatment maintains the level of the individual’s functioning, even if it does not prevent or improve functioning. Subsection 9512.7(c) states that active treatment “is designed to prevent or decelerate the regression or loss of current optimal functional status.” DHCF believes that the description of “active treatment” in Subsection 9512.7(c) and the definition included under Section 9599, as drafted, includes the concept that such treatment maintains the level of the individual’s functioning. As such, DHCF is not proposing any changes at this time.

Subsection 9512.8 of the rulemaking excludes a number of interventions from the scope of specialized services set forth in Subsection 9512.7(c)(4). DRDC comments that DHCF creates a confusing and unworkable standard by excluding from specialized services “physical assistance services for children unable to physically perform tasks but who understand the process needed to do them.” DRDC posits that this is an unworkable standard particularly as applied to babies and young children meet the functional limitation criteria in Subsection 9512.7(c)(6), their service needs must not be excluded under Subsection 9512.8 (c). DHCF does not propose any changes since specialized services described in Subsection 9512.8 are suited for children with complex medical needs as opposed to services described in Subsection 9512.8(c), which would include services such as cueing, redirecting, or supervision.

DRDC further comments that Subsections 9512.9 through 9512.12, which refer to the nursing facility level of care, appear to conflict with Subsection 9512.8(c), which refers to the intermediate care facility LOC. DHCF is not proposing any revision based on this comment since the nursing facility LOC criteria does not require consistency with the intermediate care facilities LOC criteria. The two criteria for nursing facility LOC and intermediate care facility level of care are independent of each other. A child is only required to meet of the three (3) required LOCs to be eligible via TEFRA/Katie Beckett.

#### *Nursing Facility Level of Care*

In reference to Subsection 9512.9, DRDC comments that the revised nursing facility LOC criteria adopts vague terms such as “inherently complex based on clinical indications” and rules out individuals with “complex” cognitive conditions that may result from non-physical disabilities. DRDC argues that this makes the rules overly restrictive and internally inconsistent with the eligibility standard tied to diagnoses of intellectual disabilities. DHCF does not agree. DHCF previously revised the LOC criteria based on a comment that was received on the first notice of proposed rulemaking, which stated that nursing facility LOC can be read to require individuals to meet the LOC criteria if those individuals show significant behavioral dyscontrol. The previous commenter recommended that the criteria should be revised to reflect eligibility

based solely on clinical indications. As stated in the emergency and second proposed rulemaking, DHCF incorporated the revisions in order to reinforce that all of the criteria included for the nursing facility LOC are suited for individuals with physical disabilities rather than mental illness or significant behavioral controls in need of a psychiatric treatment facility. Additionally, the nursing facility LOC criteria does not require consistency with the eligibility standard tied to diagnosis of intellectual disabilities under the intermediate care facilities LOC. The two criteria for nursing facility LOC and intermediate care facility level of care are independent of each other, and a child is only required to meet one of the three (3) required LOCs. DHCF is not proposing amendments at this time.

#### *Cost Effectiveness Methodology*

Subsection 9512.13 details DHCF's process for determining whether the cost of delivering care to a child outside of an institution exceeds the estimated cost of appropriate institutional care. DRDC comments that the cost effectiveness methodology described in Subsection 9512.13 is confusing while failing to correspond to any Medicaid Waiver methodology. DRDC also comments that none of the Medicaid Waivers in the District include individual cost caps of the sort incorporated in this rule. To clarify, TEFRA/Katie Beckett eligibility is not a waiver program so it is not subject to methodologies used for the District's long term care waiver programs. Further, the methodology set forth in Subsection 9512.13 was deemed appropriate by CMS through its approval of the corresponding State Plan Amendment (SPA). Therefore, DHCF is not proposing any revisions to Subsection 9512.13 at this time.

#### *Notice of Termination and Evaluation of Other Eligibility Groups*

DRDC comments that the rules must track the thirty (30) day notice requirements incorporated into the rules governing the home and community-based waiver programs for the individuals with intellectual and developmental disabilities (IDD) and the Elder and Persons with Physical Disabilities (EPD). DRDC additionally states that the notice provisions must include notice provisions for service denials, reductions, and terminations, including instructions for how to access benefits pending appeal for the latter two circumstances. Notice requirements set forth in Section 9508 of Chapter 95 (pertaining to advance notice of eligibility determinations and appeal rights) apply to TEFRA/Katie Beckett applicants and beneficiaries and do not need to be restated in this Section 9512. DHCF is not proposing any revisions based on this comment.

#### *Identification of the Division in DHCF Accepting Applications and Making Determinations*

DRDC asserts that the rule should identify the division with DHCF that will accept and make determinations regarding application for TEFRA/Katie Beckett eligibility because reference to completion of a Medicaid application and submission to "the Department" is cryptic, especially in light of the fact that most Medicaid application are submitted to the Department of Human Services (DHS). DRDC further states that if the applicants are assigned to eligibility care workers, that process should be defined as well. Section 9599 of this chapter defines "the Department" as DHCF or its designee. The rulemaking does not refer specifically to agency divisions in the rulemaking because divisions that are currently designated to review specific documentation may change in the future. Detailed information on the application submission

process is maintained in DHCF policy, fact sheets, and Frequently Asked Questions (FAQ) documents. For these reasons, DHCF is not proposing amendments at this time.

DHCF made one additional technical change to the active treatment requirement under the intermediate care facility LOC, Subsection 9512.7(c), by adding an “and” after the criteria provided in § 9512.7(c)(5) in order to further clarify that all six (6) requirements laid out under the active treatment requirement of Subsection 9512.7(c) must be met. DHCF also made technical revisions to certain cross-referenced citations to include section numbers rather than pin-citing specific subsections in order to avoid incorrect cross-referencing in the event the text within the cross-referenced subsections are amended in the future.

The rules also achieve consistency with the District of Columbia State Plan to reflect the methodology in determining cost effectiveness of providing care for the child at home instead of an institution. The corresponding SPA was approved by the Council of the District of Columbia on March 18, 2016 (PR 21-0560), and the U.S. Department of Health and Human Services Centers for Medicaid and Medicare Services on May 27, 2016. This rule amends Chapter 95 of Title 29 DCMR by incorporating the Medicaid eligibility requirements for children to receive reimbursable services through the TEFRA/Katie Beckett eligibility group. The District approximates that there will be no fiscal impact related to these updates.

These rules were adopted November 6, 2019, and shall become effective upon publication 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 follow:**

**9512 NON-MAGI ELIGIBILITY GROUP: TEFRA/KATIE BECKETT**

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

- (a) Submit a complete application for Medicaid, in accordance with Section 9501 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 Section 9506 of this chapter.

9512.2 The District of Columbia (District) shall provide Medicaid benefits under the TEFRA/Katie Beckett eligibility group to eligible children with disabilities who do not qualify for MAGI Medicaid because their income is over the MAGI Medicaid income threshold for children in the District set forth in this section.

9512.3 If an applicant is deemed to be ineligible for MAGI Medicaid because his or her income is over the income threshold set forth in Section 9506, then the Department shall submit notice to the applicant of the applicant's ineligibility for MAGI Medicaid and the applicant's opportunity to be evaluated for Medicaid through the TEFRA/Katie Beckett eligibility group. The Department shall also submit the following documents to the applicant for the applicant's completion to determine the applicant's eligibility for Medicaid under the TEFRA/Katie Beckett eligibility group:

- (a) A TEFRA/Katie Beckett Application Form to be completed by the applicant;
- (b) A Care Plan to be completed by the applicant and the applicant's physician, containing the prescribed or ordered services for the child; and
- (c) Level of Care ("LOC") forms to be completed by the applicant's physician which must be accompanied with documentation that supports a LOC in accordance with Subsection 9512.4(e).

9512.4 In order to be eligible for Medicaid through the TEFRA/Katie Beckett eligibility group, 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 rate;
- (c) Have individual resources equal to or less than two thousand and six hundred dollars (\$2,600) after application of a disregard of all countable resources between two thousand and six hundred dollars (\$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 CFR § 440.10, pursuant to the criteria set forth under Subsection 9512.6;
  - (2) An intermediate care facility, as described in 42 CFR § 440.150, pursuant to the criteria set forth under Subsection 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 Subsection 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 Subsection 9512.13; and
- (i) Meet non-financial eligibility factors in accordance with Section 9506.

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

9512.6 A child's needs 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 Subsections 9512.7 and 9512.9, respectively;
- (c) The child's condition is such that it 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 Sections §§ 3-1201 *et seq.* (2016 Repl. & 2019 Supp.)) ("HORA") or the licensing requirements of the jurisdiction in which services are furnished, and complies with screening and enrollment requirements set forth under Subsection 9512.17;
- (e) The service that the child receives is furnished either directly by, or under the supervision of, a physician who is licensed pursuant to HORA or the licensing requirements of the jurisdiction in which services are furnished, and is in compliance with screening and enrollment requirements set forth under Subsection 9512.18; 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 pursuant to Sections 2000 – 2099 of Title 22-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’s needs shall meet an intermediate care facility’s LOC if a child’s needs meet all of the following criteria:

- (a) If the child is age two (2) years or older, the child has the diagnosis of an intellectual disability that meets one of the level of care criteria set forth under Section 1902 of Title 29 DCMR. If the child is under the age of two (2), the child shall be diagnosed with either one (1) of the following deficits or diagnoses:
- (1) Mobility deficits;
  - (2) Sensory deficits;
  - (3) Chronic health problems;
  - (4) Behavior problems;
  - (5) Autism;
  - (6) Cerebral Palsy;
  - (7) Epilepsy;
  - (8) Spina Bifida; or
  - (9) Prader Willi;
- (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 who is licensed pursuant to HORA or the licensing requirements of the jurisdiction in which services are furnished, and who complies with screening and enrollment requirements set forth under Subsection 9512.17;
- (c) The child requires active treatment that is designed to prevent or decelerate the regression or loss of current optimal functional status and 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. The child shall be deemed to require 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 HORA or the licensing requirements of the jurisdiction in which services are furnished;
- (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 HORA or the licensing requirements of the jurisdiction in which services are furnished;
  - (B) A psychiatrist who is licensed by a Board of Medicine in accordance with HORA or the licensing requirements of the jurisdiction in which services are furnished;
  - (C) An advanced practice registered nurse who is licensed in accordance with HORA or the licensing requirements of the jurisdiction in which services are furnished;
  - (D) A registered nurse who is licensed in accordance with HORA or the licensing requirements of the jurisdiction in which services are furnished;
  - (E) A psychologist who is licensed to practice psychology in accordance with HORA or the licensing requirements of the jurisdiction in which services are furnished;
  - (F) A social worker who is a licensed independent social worker, a licensed graduate social worker, or a licensed independent clinical social worker, in accordance with HORA or the licensing requirements of the jurisdiction in which services are furnished;
  - (G) A physical therapist who is licensed in accordance with HORA or the licensing requirements of the jurisdiction in which services are furnished;

- (H) An occupational therapist who is licensed in accordance with HORA or the licensing requirements of the jurisdiction in which services are furnished;
  - (I) A speech pathologist who is licensed in accordance with HORA or the licensing requirements of the jurisdiction in which services are furnished; or
  - (J) An audiologist who is licensed in accordance with HORA or in accordance with the licensing requirements of the jurisdiction in which services are furnished;
- (4) Subject to limitations under Subsection 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; and
  - (6) If the child is age two (2) years or older, 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 HORA or the licensing requirements of the jurisdiction in which services are furnished, and in compliance with screening and enrollment requirements set forth under Subsection 9512.18; and

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

9512.8 Specialized services under Subsection 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's needs shall meet a nursing facility LOC if a child's needs meet all of the following criteria:

- (a) The child requires service that is inherently complex based on clinical indications due to a physical disability (*e.g.*, treatment for cystic fibrosis, osteogenesis imperfecta, sickle cell, spina bifida, etc.) and can only be safely and effectively performed by, or under the supervision of, professional personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, licensed clinical social workers, and speech pathologists or audiologists, who are licensed pursuant to HORA or the licensing requirements of the jurisdiction in which services are furnished, and in compliance with screening and enrollment requirements set forth under Subsection 9512.18;
- (b) The child requires one (1) of the following three (3) categories of services:
  - (1) Extensive treatment as set forth under Subsection 9512.10;
  - (2) High-intermediate treatment as set forth under Subsection 9512.11;  
or
  - (3) Intermediate treatment as set forth under Subsection 9512.12;
- (c) The service needed has been ordered by a physician who is licensed pursuant to HORA or the licensing requirements of the jurisdiction in which services are furnished, and complies with screening and enrollment requirements set forth under Subsection 9512.17;
- (d) The service is furnished either directly by, or under the supervision of, qualified professionals who are licensed pursuant to HORA or the licensing requirements of the jurisdiction in which services are furnished,

and in compliance with screening and enrollment requirements set forth under Subsection 9512.18; and

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

9512.10 Extensive treatment, described under Subsection 9512.9(b)(1), shall mean the child requires a service seven (7) days per week and involves, or is similar to, one (1) or more of the following:

- (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 when 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 suprapubic catheters;
- (g) Application of dressings involving prescription medications and aseptic techniques;
- (h) Treatment of extensive decubitus 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; or
- (k) Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing that are part of active treatment.

9512.11 High-intermediate treatment, described under Subsection 9512.9(b)(2), shall mean the child requires a service five (5) days per week and involves, or is similar to, one (1) or more of the following services:

- (a) Ongoing assessment of physical 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; or
- (h) Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing;

9512.12 Intermediate treatment, described under Subsection 9512.9(b)(3), shall mean the child, due to an additional medical complication, requires one (1) of the following services, which is 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; or
- (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.

9512.13 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 Subsections 9512.3(b) – (c);
  - (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, as supported in the beneficiary's Care Plan and LOC forms, 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 Subsection 9512.13(b), with the number of days in one year. The beneficiary's acuity level, severity of illness, and length of stay, as supported in the beneficiary's Care Plan and LOC forms, shall be factored into the estimation. This estimate shall be the maximum allowable costs; and
  - (4) Compare the annual costs identified in Subsection 9512.13(a)(2) with the maximum allowable costs identified in Subsection 9512.13(a)(3). If the annual cost is more than the maximum allowable costs, the applicant will be ineligible for Medicaid under the TEFRA/Katie Beckett eligibility group, and the Department shall provide timely and adequate notice of ineligibility to the

applicant consistent with the requirements set forth in Section 9508.

- (b) The institutional per diem reimbursement rate of services, described in Subsection 9512.13(a)(3), shall be determined as follows:
- (1) If the Department determines that the child has a hospital LOC pursuant to Subsection 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 Subsection 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 Subsection 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 Subsection 9512.22 applies:
- (1) Calculate the actual or estimated annual costs of care incurred for the child in the preceding year by aggregating the actual monthly costs of care;
  - (2) Compare actual or estimated annual costs determined under Subsection 9512.13(c)(1) with the maximum allowable costs that was previously determined under Subsection 9512.13(a)(3); and
  - (3) If the actual or estimated annual cost is more than the maximum allowable costs, the applicant will be ineligible for renewed Medicaid under the TEFRA/Katie Beckett eligibility group.

9512.14 If an applicant is found eligible for Medicaid through the TEFRA/Katie Beckett eligibility group, the Department shall notify the applicant within sixty (60) calendar days of receipt of completed documents set forth in Subsection 9512.3,

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in accordance with Section 9501 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.

9512.15 Retroactive eligibility, pursuant to Section 9501, shall apply to TEFRA/Katie Beckett eligibility group applicants if the applicant was eligible in accordance with the requirements set forth under Subsection 9512.4 and received covered services during that period.

9512.16 Pursuant to Section 9501, 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 pursuant to Subsection 9512.4. 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 TEFRA/Katie Beckett eligibility group.

9512.17 The physician that orders or refers services for a child that meets a LOC criteria set forth under Subsections 9512.6, 9512.7, or 9512.9 and is found eligible through the TEFRA/Katie Beckett eligibility group 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 Subsection 9512.20, the physician shall submit a streamlined application for enrollment to the Department.

9512.18 The qualified professionals that furnish services to a child that meets a LOC criteria set forth under Subsections 9512.6, 9512.7, or 9512.9 and is found eligible through the TEFRA/Katie Beckett eligibility group 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 Subsection 9512.19; 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 Subsection 9512.20.

9512.19 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 Subsection 9512.20 (a) – (b), in addition to any other conditions set forth in the managed care contract with the Department.

9512.20 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.

9512.21 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 shall submit 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 shall submit 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](http://www.dc-medicaid.com).

- 9512.22 If upon annual renewal there is a significant change to the services prescribed or ordered for a child in the Care Plan, described in Subsection 9512.3(b), the Department shall conduct a cost effectiveness review using the methodology set forth under Subsection 9512.13(a). A significant change shall include, but not be limited to, a change in the child's condition that would require additional resources or services for the child.
- 9512.23 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 Subsection 9512.13(a); and
  - (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 Subsection 9512.13(a).
- 9512.24 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 TEFRA/Katie Beckett eligibility group.
- 9512.25 In addition to the requirements set forth under Subsection 9512.24, 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.
- 9512.26 For continued Medicaid coverage through the TEFRA/Katie Beckett eligibility group, 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 Subsection 9512.4:
- (a) A completed and signed renewal form;
  - (b) A new Care Plan as described in Subsection 9512.3(b);
  - (c) A new LOC form with documentation as described in Subsection 9512.3(c); and

- (d) Supporting documentation to verify other financial and non-financial eligibility factors described in Subsection 9512.4.
- 9512.27 The Department shall send a renewal package, containing the documents described in Subsection 9512.26(a) - (c) for the beneficiary's completion, no later than ninety (90) days prior to the end of the eligibility period.
- 9512.28 If the beneficiary's annual renewal documents reveal that the beneficiary no longer meets all of the eligibility factors set forth under Subsection 9512.4, the beneficiary's Medicaid coverage under the TEFRA/Katie Beckett eligibility group shall be terminated and the Department shall evaluate the beneficiary's eligibility for Medicaid under other eligibility groups pursuant to 42 CFR § 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 eligibility groups.
- 9512.29 If a cost effectiveness review conducted pursuant to Subsection 9512.23 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 TEFRA/Katie Beckett eligibility group 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.
- 9512.30 At all times during the beneficiary's enrollment in Medicaid through the TEFRA/Katie Beckett eligibility group, the beneficiary shall meet all eligibility factors described in Subsection 9512.4.
- 9512.31 Eligibility through the TEFRA/Katie Beckett eligibility group shall not continue once a beneficiary turns nineteen (19) years old. Prior to the beneficiary's nineteenth (19<sup>th</sup>) birthday, the Department shall re-evaluate the beneficiary's eligibility for Medicaid under another eligibility category.

**Section 9599, DEFINITIONS, Subsection 9599.1, is amended to add the following new 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.

**Activities of Daily Living** - Activities including eating, bathing, toileting, grooming, dressing, undressing, mobility, and in place transfers.

**Acuity level** - The intensity of services required for an applicant or beneficiary. An applicant or beneficiary with a high acuity level requires more care those with lower acuity levels require less care.

**Federal Benefit Rate** - The share of the Supplemental Security Income grant paid by the federal government, which does not include any applicable State supplement.

**Nursing assistive personnel** - Unlicensed personnel of assigned patient care tasks that do not require professional skill or judgment within a health care, residential, or community support setting; provided, that the patient care tasks are performed under the general supervision of a licensed health care professional.

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

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

**Skilled Rehabilitation 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 that 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.

**Streamlined Application for Provider Enrollment** - An enrollment application available for providers whose relationship with the Medicaid program is ordering, referring, and/or prescribing services to Medicaid-eligible beneficiaries.

**TEFRA/Katie Beckett eligibility group** - An eligibility group that provides Medicaid benefits for eligible children with disabilities, who would not ordinarily qualify for Medicaid because their income would be above the Medicaid income threshold for children in the District.