DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health Care Finance (DHCF), pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02 (2012 Repl. & 2016 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 adoption of amendments to Chapter 42 entitled, "Home and Community-Based Services Waiver for Persons who are Elderly and Individuals with Physical Disabilities" (EPD Waiver) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

The current EPD Waiver was approved by the Council of the District of Columbia (Council) and renewed by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) for an initial five-year period beginning January 4, 2012. An amendment to the EPD Waiver was approved by the Council through the Medical Assistance Program Amendment Act of 2014, effective February 26, 2015 (D.C. Law 20-155; D.C. Official Code § 1-307.02(a)(8)(A) (2016 Repl.)). The amendment was approved by CMS, with an effective date of October 20, 2015. Subsequently, the renewal of the EPD Waiver was approved by the Council through the Department of Health Care Finance and Department on Disability Services Medical Assistance Program Amendment Act of 2016, effective October 8, 2016 (D.C. Law 21-160; D.C. Official Code § 1-307.02(a)(10)(A) (2016 Repl.)). CMS granted a brief, temporary extension of the EPD Waiver on December 19, 2016 and approved the renewal with an effective date of April 4, 2017. These final rules modify standards for existing services and establish standards for new services provided to participants in the EPD Waiver.

An initial Notice of Emergency and Proposed Rulemaking was published in the *D.C. Register* on November 4, 2016 at 63 DCR 013719. The initial emergency and proposed rules incorporated all changes in the approved amendment to the EPD Waiver, as detailed in the Notice of Emergency and Proposed Rulemaking.

A Notice of Second Emergency and Proposed Rulemaking was published in the *D.C. Register* on April 14, 2017 at 64 DCR 003563. As discussed in detail in the Notice of Second Emergency and Proposed Rulemaking, the second emergency and proposed rules were promulgated in order to make changes in response to comments received from Disability Rights DC at University Legal Services, as well as to reflect updated content in the waiver renewal.

DHCF received one set of comments on the Notice of Second Emergency and Proposed Rulemaking from Legal Counsel for the Elderly (LCE). DHCF carefully considered the comments submitted by LCE, as discussed below, and determined that no substantive changes were required in response to the comments. Minor technical corrections have been made for these final rules, as noted below.

LCE's initial comment was that combination of the person-centered service plan (PCSP) and the four plans of care contemplated in the rule for EPD Waiver beneficiaries will be confusing and difficult for case managers to administer. LCE stated that because the case manager is responsible for coordinating and overseeing the provision of services and assessing the progress of beneficiaries, including through the development and administration of the PCSP, it is important to ensure the case manager has clear information about the beneficiaries' interests.

However, LCE raised a concern that the rule's contemplation of up to four (4) separate care plans in addition to the PCSP creates the potential for competing plans, with no mechanism for resolving a conflict among the care plans. Additionally, LCE asserted that under the rule as drafted, beneficiaries lose the benefit of having a single, centralized care plan administered by an independent case manager. To support this concern, LCE noted that the rule requires any additional care plans to be drafted by respective healthcare providers and that only one (1) of the additional care plans is expressly required to take account of and be consistent with the case manager's PCSP.

LCE reported that other jurisdictions do not contemplate multiple care plans for a single beneficiary and instead provide for a multidisciplinary approach in developing a single, comprehensive care plan. LCE urged DHCF to adopt such a multidisciplinary approach, and reported that it has received complaints that providers of personal care aide (PCA) services do not consider the PCSP in their service delivery.

DHCF acknowledges LCE's concern regarding the creation of multiple plans of care and integration of these plans into the PCSP created by the case manager. However, DHCF believes that the rules as written clearly require all plans of care created for specific EPD Waiver services to align with the PCSP and for the case manager to ensure all EPD Waiver services being delivered to the beneficiary by different providers are appropriately coordinated and reflected in the PCSP.

The Department of Health (DOH) requires a home care agency to create a plan of care for all services provided to a patient, as described in 22-B DCMR § 3914. Therefore, all home care agencies providing EPD Waiver services to beneficiaries are required under DOH regulations to create a plan of care for those services, such as physical therapy, occupational therapy, and personal care aide services. For each EPD Waiver service provided by a home care agency, DHCF has required the agency to ensure that all plans of care are consistent with the PCSP and to furnish the plans of care to the case manager (see, *e.g.*, §§ 4228.2, 4244.4, and 4246.4). Furthermore, D.C. Code § 44-106.04 requires all assisted living providers to create an individualized service plan for each resident. As reflected in § 4237.2, DHCF requires the assisted living provider to furnish the individualized service plan to the beneficiary's case manager to ensure that the plan aligns with the PCSP. Also, under 42 C.F.R. § 441.725, providers of adult day health services under the State Plan are required to develop a service plan. As DHCF anticipated that several of the same providers would furnish adult day health services under the State Plan and under the EPD Waiver, the federal care plan requirements for State Plan services were replicated for EPD Waiver services in order to create parity in the delivery of adult day health services to all Medicaid beneficiaries and subject providers to a uniform set of requirements.

As set forth in § 4223.13, case managers are required to coordinate a beneficiary's care by sharing information with all other health care and service providers identified in the PCSP to ensure that the beneficiary's care is organized. Case managers are also required to perform all of the care coordination activities described in § 4224.8 to ensure that all of the beneficiary's EPD Waiver services addressed in service-specific plans of care are provided in an integrated manner, that service utilization is appropriate, and that the services provided are maintaining the beneficiary in a home and community-based setting.

The creation of separate plans of care for certain EPD Waiver services is required under DOH and federal regulations. Therefore, DHCF cannot eliminate the requirements for these plans of care. The rules as currently drafted require each service-specific plan of care to align with the PCSP and to be shared with the case manager. The rules also require case managers to share information among all the beneficiary's service providers and perform a variety of care coordination activities to ensure that all the beneficiary's services detailed in the plans of care are provided in a manner that reflect the goals and preferences outlined in the PCSP. Therefore, DHCF believes that the rules as currently drafted clearly indicate that the PCSP is the central, overarching document that governs the provision of EPD Waiver services for each beneficiary and that all service-specific plans of care must align with the PCSP and provided to the case manager to ensure that each plan is integrated into the PCSP. As such, no substantive changes to the current regulatory language are required.

LCE's second comment was regarding provider-initiated discharges and transfers. LCE asserted that the rule generally contemplates three (3) ways a beneficiary's services could be discontinued or altered: (i) a beneficiary does not meet objective eligibility factors to receive services under the EPD Waiver (*e.g.*, death, moves out of the District of Columbia, no longer needs care, reasonable therapeutic goals at home is no longer attainable, etc.); (ii) a beneficiary requests a change in services, or (iii) a discretionary decision by the provider to discharge, terminate, or transfer the beneficiary to another provider, which may be based upon a determination by the provider that (a) beneficiary is unsatisfied with services, or (b) the provider is unable to meet the needs of the beneficiary. LCE stated that while the objective eligibility factors are generally consistent with other jurisdictions' regulations, the organization is concerned that the rule affords providers too much discretion with respect to discharging or requesting a transfer of a beneficiary.

LCE stated that in other jurisdictions, provisions regarding non-objective bases for the discontinuation of services under a waiver program focus on the beneficiary's right to transfer to another provider and do not give the provider broad discretion to unilaterally discharge or transfer a beneficiary. For example, LCE reported, in Maryland, a beneficiary receiving waiver services may choose to voluntarily disenroll from the program, but the provider does not have the authority to discharge or transfer a beneficiary at its own discretion. LCE also reported that in California, providers only have discretion to terminate services if the beneficiary is unable to receive the services and the provider has "made every effort to remove possible obstacles." LCE asserted that the approach taken in California and Maryland, which either withholds or substantially restricts a provider's discretion to unilaterally discharge or transfer a beneficiary,

best protects a beneficiary from unfair discharge or transfer for justifiable dissatisfaction with a provider.

LCE went on to report that the organization is aware of a home health agency that is attempting to discharge beneficiaries based on the agency's failure to follow the PCSP and provide culturally competent care to the beneficiary. LCE strongly recommended that the regulations be revised to specify that a provider may not discharge the beneficiary when it fails to provide proper care as mandated by other provisions in the regulations.

DHCF initially notes that the regulations do not afford a provider the discretion to unilaterally discharge or transfer an EPD Waiver beneficiary. As set forth in Subsection 4205.10, a provider may request that DHCF authorize a discharge, which will only be done if the conditions set forth in Subsection 4205.11 are met. DHCF notes that there was an apparent oversight in the current rules as transfers were not explicitly mentioned in Subsection 4205.10, as transfers are also subject to authorization. Therefore, transfers have been added to this provision to reflect current practice and DHCF's intent.

DHCF has had prior discussions with LCE regarding Subsection 4205.11 and proposed modifications to clarify the conditions under which a discharge or transfer may be authorized. DHCF has taken LCE's suggestions into consideration for these rules, and although DHCF believes that the rules as currently drafted set forth all necessary safeguards to ensure that providers do not improperly discharge beneficiaries, DHCF has used the language previously proposed by LCE to modify this provision, clarifying the requirements that must be met prior to requesting that DHCF authorize a discharge.

In sum, as noted above DHCF has made three (3) minor technical corrections for these final rules. The first technical correction is the explicit inclusion of transfers in Subsection 4205.10. The second technical correction is the modification of Subsection 4205.11 to clarify that a provider must meet all requirements set forth in Subsection 4205.12 prior to requesting that DHCF authorize a discharge or transfer. The third and final technical correction is that verb tenses have changed for dates or deadlines that have now passed.

The Director adopted these rules on July 11, 2017, and they shall become effective on the date of publication of this notice in the *D.C. Register.*

Chapter 42, HOME AND COMMUNITY-BASED SERVICES WAIVER FOR PERSONS WHO ARE ELDERLY AND INDIVIDUALS WITH PHYSICAL DISABILITIES of Title 29 DCMR, PUBLIC WELFARE, is deleted in its entirety and amended to read as follows:

CHAPTER 42 HOME AND COMMUNITY-BASED SERVICES WAIVER FOR PERSONS WHO ARE ELDERLY AND INDIVIDUALS WITH PHYSICAL DISABILITIES

4200 GENERAL PROVISIONS: IDENTIFICATION OF SERVICES; PROGRAM RESPONSIBILITIES; AND SERVICE SETTING REQUIREMENTS

4200.1 The following Home and Community-Based (HCB) Waiver services are included in this chapter, consistent with the regulations set forth herein:

(a) Case management services;

(b) Personal Care Aide (PCA) services;

(c) Personal Emergency Response System (PERS) services;

(d) Respite services;

(e) Homemaker services;

(f) Chore aide services;

(g) Assisted living services;

(h) Environmental Accessibility Adaptation (EAA) services;

(i) Adult Day Health services;

(j) Physical Therapy services;

(k) Occupational Therapy services;

(l) Individual-Directed Goods and Services;

(m) Participant-Directed Community Supports services; and

(n) Community transition services.

4200.2 DHCF or its designee shall be the first point of contact for applicants who choose to receive EPD Waiver Services. DHCF or its designee shall assist an applicant with the completion of all documents and processes needed to apply for the EPD Waiver including, but not limited to, assisting the applicant with obtaining a face-to-face assessment and obtaining a determination of financial eligibility from DHCF's designee.

4200.3 DHCF or its designee shall conduct face-to-face assessments to determine if the applicant meets the level of care requirements in accordance with Section 4201 of this chapter.

4200.4 DHCF or its designee shall perform the following operational functions:

(a) Review the Person-Centered Service Plan (PCSP) and prior-authorize the services recommended in the PCSP; and

(b) Review requests for change in services and determine if they should be approved; and

(c) Prior-authorize approved changes in services.

4200.5 The EPD Waiver services described in this chapter shall be administered by the Department of Health Care Finance (DHCF), Long-Term Care Administration.

4200.6 All Adult Day Health, Assisted Living, and Community Residence Facility settings shall meet the HCB Setting Requirements pursuant to 42 CFR § 441.301(c)(4) which require that settings:

(a) Be chosen by the beneficiary receiving EPD Waiver services;

(b) Ensure the beneficiary's right to privacy, dignity, and respect, and freedom from coercion and restraint;

(c) Be physically accessible to the beneficiary and allow him or her access to all common areas;

(d) Support the beneficiary's community integration and inclusion, including relationship-building and maintenance, support for self-determination and self-advocacy;

(e) Provide opportunities for the beneficiary to seek employment and meaningful non-work activities in the community;

(f) Provide information on beneficiary rights;

(g) Optimize the beneficiary's initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and choices for personal interaction;

(h) Facilitate the beneficiary's choices regarding services and supports, and the provision of services;

(i) Create personalized daily schedules for each beneficiary receiving supports that includes activities that align with the beneficiary's goals, interest, and preferences, and are reflected in his or her PCSP;

(j) Provide opportunities for the beneficiary to engage in community life;

(k) Provide opportunities to receive services in the community to the same degree as individuals not receiving Medicaid HCBS;

(l) Control over the beneficiary's personal funds and bank accounts; and

(m) Allow visitors at any time except as indicated in the beneficiary's PCSP, based on his or her assessed needs.

4200.7 In addition to the requirements referenced under Subsection 4200.6, all Assisted Living and Community Residence Facility settings shall:

(a) Be integrated in the community;

(b) Provide opportunities for the beneficiary to engage in community life;

(c) Allow full access to the greater community, such as opportunities to seek employment, and access to public libraries with appropriate oversight and assistance to the same extent as access is available to persons who do not receive Medicaid HCBS;

(d) Be leased in the names of the people who are being supported. If this is not possible, then the Assisted Living or Community Residence Facility provider must ensure that each beneficiary has a legally enforceable residency agreement or other written agreement that, at a minimum, provides the same responsibilities and protections from eviction that tenants have under the District's landlord and tenant law. This applies equally to leased and provider owned properties; and

(e) Develop and adhere to policies which ensure that each beneficiary receiving services has the right to the following:

(1) Privacy in the beneficiary's personal space, including entrances that are lockable by the beneficiary (with staff having keys as needed);

(2) Freedom to furnish and decorate his or her personal space (except for a beneficiary receiving Respite Daily services);

(3) Control over his or her personal funds and bank accounts;

(4) Privacy for telephone calls, texts and emails; and

(5) Access to food at any time.

4200.8 Any deviations from the requirements in Subsection 4200.7(e) must be supported by a specific assessed need, which is justified in the beneficiary's written PCSP, and reviewed and approved as a restriction by the case manager in the PCSP.

4201 ELIGIBILITY

4201.1 Individuals shall be deemed eligible for the HCB Waiver prior to the receipt of the HCB services described in this chapter.

4201.2 To be eligible for the HCB Waiver services described in this chapter, beneficiaries shall:

(a) Require the level of care furnished in a nursing facility as determined by DHCF's Long Term Care Services and Supports Contractor via standardized assessment tools in accordance with Subsections 4201.4 and 4201.5;

(b) Agree to participate in the waiver program by signing Waiver Beneficiary Freedom of Choice forms to elect to receive services in home and community-based settings rather than institutional settings;

(c) Be aged sixty-five (65) or older, or be aged eighteen (18) and older with one (1) or more physical disabilities;

(d) Not be inpatients of a hospital, nursing facility or intermediate care facility in accordance with Subsection 4201.3;

(e) Be financially eligible for long term care services and supports in accordance with the requirements set forth in Chapter 98 (Financial Eligibility for Long Term Care Services and Supports) of Title 29 DCMR; and

(f) Reside in the District of Columbia in community settings such as natural homes or approved Community Residential Facilities or EPD Waiver assisted living facilities.

4201.3 For purposes of eligibility, an inpatient shall be defined as a beneficiary who is institutionalized for a period greater than one hundred and twenty (120) consecutive days.

4201.4 A Registered Nurse (R.N.) hired by or under contract to DHCF or its designee shall conduct a face-to-face assessment to determine if a beneficiary or applicant meets a nursing facility level of care. The assessment shall utilize a standardized assessment tool which will include an assessment of the individual's support needs across three domains including:

(a) Functional - impairments including assistance with activities of daily living such as bathing, dressing, eating or feeding;

(b) Skilled Care - sensory impairments, other health diagnoses and the need for skilled nursing or other skilled care (e.g., wound care, infusions); and

(c) Behavioral - communications impairments including the ability to understand others, presence of behavioral symptoms such as hallucinations, or delusions.

4201.5 Completion of the assessment shall yield a final total score determined by adding up the individual scores from the three domains. To be eligible for EPD Waiver services a beneficiary or applicant must obtain a score of nine (9) or higher which equates to a nursing home level of care.

4201.6 Eligibility for all EPD Waiver services shall be recertified on an annual basis in accordance with any procedures established by DHCF in this chapter.

4202 APPEAL RIGHTS FOR APPLICANTS/BENEFICIARIES

4202.1 Applicants and beneficiaries shall receive advance notice and shall have the opportunity to request a Fair Hearing if:

(a) They are found ineligible for participation in the EPD Waiver based on the criteria set forth in Subsection 4201.2;

(b) They are not given the choice between HCB waiver services or institutional care;

(c) They are denied the choice of service(s) from a qualified and willing provider in accordance with 42 CFR § 431.51; or

(d) If DHCF or its designee takes action to deny, discontinue, suspend, reduce, or terminate services, or dis-enroll a beneficiary or applicant from the EPD Waiver Program.

4202.2 An EPD Waiver provider shall issue a written notice in cases of intended actions to discontinue, discharge, suspend, transfer, or terminate services to any applicant or beneficiary in accordance with the requirements sets forth in Section 4205. The notice shall be provided at least thirty (30) days prior to the effective date of the proposed action and shall provide the following information:

(a) The intended action;

(b) The reason(s) for the intended action;

(c) Citations to the law(s) and regulations supporting the intended action;

(d) A list of EPD waiver standards supporting the decision;

(e) An explanation of the applicant or beneficiary's right to request a hearing;

(f) The circumstances under which the applicant or beneficiary's current level of services will be continued if a hearing is requested; and

(g) A copy of the directory of other EPD waiver providers.

4202.3 DHCF or its designee shall issue a written notice in cases where it intends to take action to deny, discontinue, discharge, suspend, or reduce Waiver services, or dis-enroll applicants or beneficiaries from the EPD Waiver program. The notice shall be issued at least thirty (30) calendar days prior to the effective date of the proposed action and shall state the following information:

(a) The intended action;

(b) The reason(s) for the intended action;

(c) Citations to the law(s) and regulations supporting the intended action;

(d) An explanation of the individual's right to request a hearing; and

(e) The circumstances under which the individual's current level of services will be continued if a hearing is requested.

4203 CASE MANAGEMENT SERVICES REQUIRED

4203.1 As a condition of participation in the EPD Waiver services program, each beneficiary shall receive case management services which meet the requirements of Sections 4222 – 4224.

4204 WRITTEN PERSON-CENTERED SERVICE PLAN REQUIRED (PCSP)

4204.1 Services under the EPD Waiver program shall be provided to eligible beneficiaries pursuant to a written Person-Centered Service Plan (PCSP) developed for each individual.

4204.2 The PCSP shall be developed by the Case Manager in full consideration of the beneficiary's needs, preferences, strengths, and goals, which are key hallmarks of person-centered planning as defined in Section 4223. A PCSP shall be subject to the approval of DHCF or its designee.

4204.3 Except in the circumstances outlined in Subsection 4204.7, a PCSP shall be required for the initiation and provision of any EPD Waiver service and shall be reviewed by the Case Manager at least quarterly to ensure that services are delivered to meet the established goals.

4204.4 A PCSP shall be updated and revised at least annually, pursuant to the outcome of an assessment and a determination of needs or whenever a change in a beneficiary's health needs warrants updates to the plan.

4204.5 A PCSP shall, at a minimum, address and document the following:

(a) The beneficiary's, strengths, positive attributes, and preferences for plan development at the beginning of the written plan including:

(1) Consideration of the beneficiary's significant milestones, and important people in the beneficiary's life; and

(2) The beneficiary's preferences in order to tailor the plan to reflect any unique cultural or spiritual needs or be developed in a language or literacy level that the beneficiary and representative can understand;

(b) The beneficiary's goals, including:

(1) Consideration of the beneficiary's current employment, education, and community participation along with aspirations for changing employment, continuing education, and increasing level of community participation; and

(2) How the goals tie to the amount, duration, and scope of services that will be provided;

(c) List of other contributors selected by the beneficiary and invited to engage in planning and monitoring of the PCSP;

(d) End of life plan, as appropriate;

(e) Medicaid and non-Medicaid services and supports preferred by the beneficiary, including supports from family, friends, faith-based entities, recreation centers, or other community resources;

(f) The specific individuals, health care providers, or other entities currently providing services and supports;

(g) Potential risks faced by the beneficiary and a risk-mitigation plan to be addressed by the beneficiary and his or her interdisciplinary team;

(h) Approaches to be taken to prevent duplicative, unnecessary, or inappropriate services;

(i) Assurances regarding the health and safety of the beneficiary, and if restrictions on his or her physical environment are necessary, descriptions and inclusion of the following:

(1) Explicit safety need(s) with explanation of related condition(s);

(2) Positive interventions used in the past to address the same or similar risk(s)/safety need(s) and assurances that the restriction will not cause harm to the beneficiary;

(3) Necessary revisions to the PCSP to address risk(s) or safety need(s), including the time needed to evaluate effectiveness of the restriction, results of routine data collection to measure effectiveness, and continuing need for the restriction; and

(4) Beneficiary's or representative's understanding and consent to proposed modification(s) to the restrictions; and

(j) Components of self-direction (if the beneficiary has chosen self-directed delivery under the *Services My Way* program, set forth in Chapter 101 of Title 29 DCMR).

4204.6 Upon completion of development of the PCSP, the Case Manager shall ensure the following:

(a) The PCSP receives final approval and signature from all those who participated in its planning and development, including the Case Manager and the beneficiary or beneficiary's representative if applicable; and

(b) All contributors and others who were included in the PCSP development receive a copy of the completed plan or any specific component of the plan, as determined by the beneficiary.

4204.7 A beneficiary temporarily may access waiver services in the absence of a DHCF approved PCSP under the following circumstances:

(a) DHCF determines a delay in the receipt of services would put the beneficiary's health and safety at risk; or

(b) DHCF determines services are needed to effectuate a timely discharge from a hospital or nursing facility.

4204.8 If waiver services are provided in accordance with Subsection 4204.7, a PCSP shall be completed within thirty (30) days of the date that services were initiated.

4205 INITIATING, CHANGING, DISCHARGING/SUSPENDING, TRANSFERS OR TERMINATIONS

4205.1 Initiating services means a request to add services that has been approved as part of a beneficiary's PCSP.

4205.2 A change in service shall mean a request to modify the type, amount, duration, or scope of services based on the beneficiary's current level of functioning, which is supported by the assessment tool.

4205.3 A discharge shall mean a request to release a beneficiary from a particular service provider.

4205.4 A transfer shall mean a request to move a beneficiary from one service provider to another service provider.

4205.5 A suspension shall mean ending the delivery of services to a beneficiary for a temporary period not to exceed thirty (30) calendar days.

4205.6 A termination shall mean the discontinuation of services under the Waiver or a disenrollment from the EPD Waiver Program.

4205.7 The only grounds for disenrollment from the EPD Waiver Program are the following:

(a) The beneficiary no longer meets the financial eligibility criteria;

(b) The beneficiary no longer meets the required level of care as supported by the assessment tool;

(c) The beneficiary expires;

(d) The beneficiary has moved out of the District of Columbia;

(e) The beneficiary remains institutionalized for a period that is expected to exceed one hundred and twenty (120) consecutive days;

(f) The beneficiary or the beneficiary's authorized representative requests disenrollment, in writing, from the EPD Waiver ; and

(g) The beneficiary has failed to provide the case management agency with recertification documents or cooperate with the case manager to ensure that level of care evaluations are completed.

4205.8 A case manager may coordinate the receipt and subsequent approval by DHCF or its designee for all program modification requests. These include requests to initiate, change, terminate, or suspend services and to transfer or discharge from a service provider.

4205.9 The beneficiary, the beneficiary's authorized representative, family member or a service provider may recommend to DHCF or its designee one or more of the following program modifications: the initiation of a new service; a change in approved services; a transfer; or a service termination.

4205.10 The beneficiary, the beneficiary's authorized representative, a service provider or the beneficiary's case manager may make requests to DHCF or its designee to authorize a discharge, transfer or suspension.

4205.11 Conditions for authorization of a discharge or transfer consist of the following:

(a) A beneficiary is unsatisfied with the services delivered by a specific provider; or

(b) The provider is unable to meet the needs of the beneficiary; and

(c) If a service provider is requesting the discharge or transfer, the provider has demonstrated compliance with all requirements set forth in Subsection 4205.12.

4205.12 A provider shall demonstrate the following before or at the time of a request to suspend, discharge, transfer or terminate a beneficiary:

(a) Appropriate steps were taken to attempt remediation of the situation that gave rise to the conditions necessitating the action as set forth in Subsection 4205.11, including a meeting with the beneficiary to resolve conflicts and provider staff training to resolve any staff complaints; and

(b) Compliance with provider requirements outlined in Subsection 4205.15 to ensure safe suspension, discharge, transfer or termination of services.

4205.13 DHCF, a case manager or provider may suspend the services of a beneficiary when:

(a) The beneficiary's behavior poses a risk to the staff, and interventions have not successfully addressed the behavior; or

(b) The beneficiary prohibits access to provider-related visits; or

4205.14 In order to ensure that the beneficiary's health is not threatened during a discharge, transfer, suspension, or termination of services, the provider shall:

(a) Assess the beneficiary's condition to ensure that discharge, transfer, suspension or termination of services does not endanger the health and safety of the beneficiary;

(b) Document assessment findings in the beneficiary's record;

(c) Notify the physician;

(d) Ensure that the beneficiary's Medicaid eligibility is current;

(e) Refer the beneficiary to the Department of Behavioral Health or other agencies, as the case manager deems appropriate; and

(f) Document the actions taken to ensure that the beneficiary's discharge, transfer, suspension, or service termination will have no adverse effect on the beneficiary.

4205.15 In addition to the requirements specified in Subsection 4205.16, the provider shall take the following administrative actions before effectuating a discharge, transfer, suspension, or service termination:

(a) Issue written notice pursuant to Subsection 4202.2;

(b) Arrange for alternative services prior to effectuating the discharge, transfer, suspensions or service termination;

(c) Provide the beneficiary and DHCF (at DHCFLTCAProvider@dc.gov) with a copy of the plan identifying alternative services, identify the alternative services and include timelines describing when the alternative services will be put in place;

(d) Notify DHCF, the Department of Health (DOH) Health Regulation and Licensing Administration, and Adult Protective Services if the provider believes that the beneficiary's health is at risk as a result of the discharge, transfer, suspension or service termination; and

(e) In the case of transfers, including transfers to a new case management agency, ensure that an agreement between the transferring agency and receiving agency is executed before the transfer is executed.

4205.16 A case manager or case management agency shall notify DHCF or its designee of the need to send a written notice pursuant to the grounds of disenrollment from the EPD Waiver Program set forth in Subsections 4205.7(e) through (g) within five (5) business days of learning of the event in question.

4206 ASSURING CULTURAL COMPETENCY

4206.1 In accordance with Title VI of the Civil Rights Act of 1964 and its implementing regulations (42 U.S.C. §§ 2000d *et seq.*, 45 CFR part 80), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), and Title II of the Americans with Disabilities Act of 1990 (42 U.S.C.§ 12132), no individual shall, on the grounds of race, color, national origin, Limited English Proficiency (LEP), or disability, be excluded from participation, be denied the benefits of, or be otherwise subjected to discrimination under any EPD Waiver Services program.

4206.2 Each provider shall develop an effective plan on language assistance for beneficiaries who are LEP, and ensure access to translation services and free interpretation services in accordance with guidance from Department of Health and Human Services, Office of Civil Rights, available at: http://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-VI/index.html. The plan shall address the LEP needs of the population it serves and ensure compliance with the Title VI of the Civil Rights Act of 1964 (42 U.S.C. §§ 2000d *et seq.*).

4206.3 In accordance with Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), and in order to prohibit discrimination on the basis of disability in programs that receive financial assistance from the federal government, each provider of EPD Waiver services shall ensure that all handicapped beneficiaries, shall have access to a provider's facilities or not be denied the benefits of, be excluded from participation in, or otherwise be subjected to discrimination under the Medicaid program (45 CFR § 84.21), and "shall adopt and implement procedures to ensure that interested persons, including persons with impaired vision or hearing, can obtain information as to the existence and location of services, activities, and facilities that are accessible to and usable by handicapped persons" (45 CFR § 84.22 (f)).

4207 RECORDS AND CONFIDENTIALITY OF INFORMATION: GENERAL

4207.1 Each provider of waiver services shall establish and implement a privacy plan to protect the privacy and confidentiality of a beneficiary's records.

4207.2 The disclosure of information by a provider of waiver services shall be subject to all provisions of applicable District and federal laws governing the privacy and security of health and personal information.

4207.3 Each provider of waiver services shall maintain comprehensive records of the waiver services provided to each beneficiary, and shall maintain each record for a period of no less than ten (10) years.

4207.4 Each beneficiary's electronic case management record shall include, but shall not be limited to, the following information:

(a) General information including each beneficiary's name, Medicaid identification number, address, telephone number, age, sex, name and telephone number of emergency contact person, physician's name, address, and telephone number;

(b) A signed copy of the beneficiary's Bill of Rights and Responsibilities;

(c) A complete PCSP which includes all signatures as required in Section 4204 of this chapter;

(d) A copy of the initial and all subsequent level of care determinations, case manager attestation/evaluation forms, and the results of the comprehensive assessment tool;

(e) A record of the initial signed Waiver Beneficiary Freedom of Choice form;

(f) A record of all case management in-home site visits and telephone contacts;

(g) A record of all PERS plans of care, if PERS were approved under the PCSP;

(h) A record of the initial and annual Pre-Admission Screening and Resident Review (PASRR) for mental illness, cognitive deficiency, and intellectual/developmental disability and Psychiatric Evaluation, as necessary;

(i) A record of quarterly reviews and narrative notes;

(j) A record of the beneficiary's initial and annual health history;

(k) A record of all prior authorizations for services;

(l) A record of all requests for program modification requests including initiations, changes, discharges, transfers, suspensions, and terminations;

(m) A discharge summary, if applicable; and

(n) Any other records necessary to demonstrate compliance with all regulations, requirements, guidelines, and standards for the implementation and administration of this waiver.

4207.5 Each direct-services provider of waiver services shall be responsible for maintaining records related to the provision of services delivered in accordance with the specific provider requirements set forth under this chapter.

4208 ACCESS TO RECORDS

4208.1 Each provider of waiver services shall allow appropriate DHCF personnel, representatives of the U.S. Department of Health and Human Services and other authorized designees or officials of the District of Columbia government and federal government full access to all records upon request and during announced or unannounced audits or reviews.

4209 REIMBURSEMENT: GENERAL

4209.1 DHCF shall not reimburse any provider of Waiver services who:

(a) Fails to comply with any applicable regulation in this chapter;

(b) Fails to comply with all applicable federal and District of Columbia laws, and regulations;

(c) Fails to comply with all applicable transmittals, rules, manuals and other requirements for payment issued by DHCF;

(d) Provides services in the absence of an approved prior authorization from DHCF or its designee for payment identifying the authorized service, number of hours or units authorized, duration, and scope of service; and

(e) Fails to comply with the terms of the Medicaid Provider Agreement.

4209.2 Each provider of Waiver services shall agree to accept as payment in full the amount determined by DHCF as reimbursement for the authorized waiver services provided to beneficiaries.

4209.3 Each provider shall agree to bill any and all known third-party payers prior to billing Medicaid.

4209.4 For purposes of this chapter, the effective dates of EPD Waiver Year Five (5) are January 4, 2016 through April 3, 2017.

4209.5 For purposes of this chapter, the effective dates of EPD Waiver Year One (1) of the Renewal are April 4, 2017 through January 3, 2018.

4209.6 In accordance with CMS' cost neutrality requirements, DHCF may limit or deny Waiver services if the cost of the services in addition to other home care services, exceeds the estimated cost of institutional care.

4209.7 Subsequent changes to any of the reimbursement rate(s) published herein shall be posted on the Medicaid fee schedule at www.dc-medicaid.com. DHCF shall also publish a notice in the *D.C. Register* which reflects the change in the reimbursement rate(s) at least thirty (30) days before a change is made to the reimbursement rate.

4210 REIMBURSEMENT RATES: CASE MANAGEMENT SERVICES

4210.1 Case management services shall be reimbursable on a per member per month (PMPM) basis.

4210.2 The PMPM reimbursement rate during Waiver Year 5 and Waiver Year 1 of the Renewal shall be two hundred forty-five dollars and ninety-six cents ($245.96), contingent on performance of the monthly and ongoing care coordination activities outlined in Section 4224.

4210.3 In order for a case management agency to receive reimbursement for case management services, each Case Manager must perform case management duties either on a full-time or on a part-time basis. At any point in time, no more than forty-five (45) beneficiaries shall be assigned to each Case Manager.

4210.4 The case management agency shall ensure case management services are available during regular business hours and shall be on call during weekends and evenings in case of emergency.

4210.5 Reimbursement for transitional case management services provided during a hospital or nursing facility (*i.e.*, institutional) stay shall not exceed one hundred twenty (120) days. Reimbursement shall be contingent on the Case Manager's performance of activities during the institutional stay that facilitate transition to the community, consistent with the reimbursement standards for transitional case management set forth in Subsection 4224.9.

4210.6 Reimbursement for transitional case management services shall be made only after the beneficiary returns to the home or community setting and not during the beneficiary's institutional stay.

4211 REIMBURSEMENT RATES: PERSONAL CARE AIDE (PCA) SERVICES

4211.1 A home care agency seeking reimbursement for PCA services shall meet the conditions of participation for home health agencies set forth in 42 CFR part 484, and shall comply with the requirements set forth in the Health-Care and

Community Residence Facility, Hospice, and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code §§ 44-501 *et seq.*)

4211.2 For dates of services beginning November 3 through December 31, 2015, each Provider shall be reimbursed five dollars ($5.00) per unit of service for allowable services in accordance with the Patient Protection and Affordable Care Act of 2010, approved March 23, 2010 (Pub. L. No. 111-148, 124 Stat. 119), as amended, and supplemented by the Health Care and Education Reconciliation Act of 2010, approved March 30, 2010 (Pub. L. No. 111-152, 124 Stat. 1029) and the District of Columbia Accrued Sick and Safe Leave Act of 2008, effective May 13, 2008 (D.C. Law 17-152; D.C. Official Code §§ 32-131.01 *et seq.*) The reimbursement rate includes administrative costs following the recent review of the FY 2013 Home Health Agencies cost reports, of which no less than three dollars and forty-five cents ($3.45) shall be paid to the personal care aide to comply with the Living Wage Act of 2006, effective June 8, 2006 (D.C. Law 16-118; D.C. Official Code §§ 2-220.01 *et seq.* (2012 Repl.)).

4211.3 For dates of services beginning January 1, 2016, each provider shall be reimbursed five dollars and two cents ($5.02) per unit of service for allowable services as authorized in the approved plan of care, of which no less than three dollars and forty-six cents ($3.46) per fifteen (15) minutes for services rendered by a PCA, shall be paid to the PCA to comply with the Living Wage Act of 2006, effective June 8, 2006 (D.C. Law 16-118; D.C. Official Code §§ 2-220.01 *et seq.* (2012 Repl.)).

4211.4 For dates of services beginning January 1, 2017, each provider shall be reimbursed five dollars and five cents ($5.05) per unit of service for allowable services as authorized in the approved plan of care, of which no less than three dollars and forty-nine cents ($3.49) per fifteen (15) minutes for services rendered by a PCA, shall be paid to the PCA to comply with the Living Wage Act of 2006, effective June 8, 2006 (D.C. Law 16-118; D.C. Official Code §§ 2-220.01 *et seq.* (2012 Repl.)).

4211.5 A unit of service for PCA services shall be fifteen (15) minutes spent performing allowable tasks.

4211.6 Reimbursement for PCA services under the Waiver shall not exceed sixteen (16) hours of service per day per beneficiary.

4211.7 A provider of waiver services shall not bill the beneficiary or any member of the beneficiary's family for PCA services.

4211.8 DHCF shall not reimburse a provider of PCA services for services provided by the waiver beneficiary's spouse, or other legally responsible relative or court-appointed guardian with the exception of parents of adult children.

4212 REIMBURSEMENT RATES: PERSONAL EMERGENCY RESPONSE SERVICES (PERS)

4212.1 The reimbursement rate during EPD Waiver Year 5 and EPD Waiver Year 1 of the Renewal for PERS shall be forty dollars ($40.00) for one (1) installation and twenty-eight dollars and fifty cents ($28.50) per month for the rental/maintenance fee consistent with the PERS program services set forth in Section 4229.

4213 REIMBURSEMENT RATES: RESPITE SERVICES

4213.1 For individuals needing one (1) to seventeen (17) hours per day, the reimbursement rate for respite services during Waiver Year 5 shall be twenty dollars and sixty cents ($20.60) per hour. For individuals needing eighteen (18) to twenty-four (24) hours per day, the reimbursement rate during Waiver Years 4 and 5 shall be a flat rate of three hundred dollars ($ 300.00) per day.

4213.2 For EPD Waiver Year 1 of the Renewal, the reimbursement rate for respite services for individuals needing one (1) to seventeen (17) hours per day shall be twenty dollars and twenty cents ($20.20) per hour. For individuals needing eighteen (18) to twenty-four (24) hours per day, the reimbursement rate during Waiver Year 1 of the Renewal shall be a flat rate of three hundred eleven dollars and fifty cents ($311.50) per day.

4213.3 Consistent with Section 4232, respite services shall be limited to a total of four hundred and eighty (480) hours per year per beneficiary unless the need for additional services is prior authorized by DHCF or its designee.

4213.4 DHCF shall not reimburse a provider of respite services for services provided by the waiver beneficiary's spouse, or other legally responsible relative or court-appointed guardian with the exception of parents of adult children. Non-legally responsible relatives including parents of adult children may provide and be reimbursed for respite services provided they meet the requirements of Section 4231.

4213.5 DHCF shall not reimburse for the cost of room and board except when provided as part of respite care furnished in a facility approved by the District of Columbia that is not a private residence.

4213.6 When respite is provided in a facility, including an Assisted Living Facility, group home, or other Community Residential Facility, the facility must meet all HCBS setting requirements consistent with Section 4200.

4214 REIMBURSEMENT RATES: HOMEMAKER SERVICES

4214.1 The reimbursement rate for homemaker services during Waiver Year 5 shall be eighteen dollars and seventy five cents ($18.75) per hour with an annual cap of two hundred eight (208) hours per beneficiary per year.

4214.2 The reimbursement rate for homemaker services during Waiver Year 1 of the Renewal shall be eighteen dollars and eighty cents ($18.80) per hour with an annual cap of two hundred eight (208) hours per beneficiary per year.

4214.3 DHCF shall not reimburse a provider of homemaker services for services provided by the waiver beneficiary's spouse, or other legally responsible relative or court-appointed guardian with the exception of parents of adult children. Non-legally responsible relatives including parents of adult children may provide homemaker services provided they meet the requirements of Section 4233.

4215 REIMBURSEMENT RATES: CHORE AIDE SERVICES

4215.1 The reimbursement rate for chore aide services for Waiver Year 5 shall be eighteen dollars and seventy five cents ($18.75) per hour with a cap of thirty two (32) units per beneficiary throughout the Waiver period, with a unit being one (1) hour of service.

4215.2 The reimbursement rate for chore aide services for Waiver Year 1 of the Renewal shall be eighteen dollars and eighty cents ($18.80) per hour with a cap of thirty two (32) units per beneficiary throughout the Waiver Renewal period, with a unit being one (1) hour of service.

4215.3 DHCF shall not reimburse any home care agency, or licensed provider of housekeeping services that provide chore aide services in residences where another party is otherwise responsible for the provision of the services, such as group home providers.

4215.4 DHCF shall not reimburse a provider of chore aide services for services provided by the waiver beneficiary's spouse, or other legally responsible relative or court-appointed guardian with the exception of parents of adult children. Non-legally responsible relatives including parents of adult children may provide chore aide services provided they meet the requirements of Section 4235.

4215.5 Chore aide services shall not be reimbursed by the DHCF unless the agency or business provides documentation of pre- and post-cleaning activities as referenced in Subsection 4235.10.

4216 REIMBURSEMENT RATES: ASSISTED LIVING SERVICES

4216.1 The reimbursement rate for assisted living services during Waiver Year 5 shall be sixty dollars ($60.00) per day.

4216.2 The reimbursement rate for assisted living services during Waiver Year 1 of the Renewal shall be one hundred fifty five ($155) dollars per day.

4216.3 The rate shall be an all-inclusive rate for all services provided as set forth in Section 4238.

4216.4 Medicaid reimbursement will not be made for twenty-four (24) hour skilled care, costs of facility maintenance, upkeep and improvement, and room and board. Covered services shall be in accordance with Section 4238.

4216.5 Beneficiaries may seek subsidies outside of the Home and Community Based Waiver for Persons who are Elderly and Individuals with Physical Disabilities (EPD Waiver) to pay for room and board through the Optional State Supplemental Payment Program.

4216.6 DHCF shall not reimburse for assisted living services provided concurrently with the following EPD Waiver services:

(a) Homemaker services;

(b) Chore Aide services;

(c) PERS;

(d) Respite services; or

(e) Environmental accessibility adaptations services.

4216.7 PCA services are included for beneficiaries residing in assisted living as part of the all-inclusive rate. Therefore, a Home Care Agency cannot bill for Personal Care Aide Services for a beneficiary who is concurrently receiving assisted living services.

4217 REIMBURSEMENT RATES: ENVIRONMENTAL ACCESSIBILITY ADAPTATION

4217.1 Environmental accessibility adaptations services shall be reimbursed in accordance with the applicable requirements set forth in Sections 4239 through 4240 of this chapter.

4217.2 The maximum reimbursable cost per beneficiary over the duration of each waiver period is ten thousand dollars ($10,000.00) for EAA services. The ten thousand dollar ($10,000) rate shall include a five hundred dollar ($500) reimbursement rate per inspection for the costs associated with the home inspection or evaluation.

4218 REIMBURSEMENT RATES: ADULT DAY HEALTH

4218.1 The reimbursement rate for adult day health services during Waiver Year 5 and Waiver Year 1 of the Renewal shall be a per-diem rate of one hundred and twenty five dollars and seventy eight cents ($125.78).

4218.2 A provider shall not be reimbursed for adult day health services if the beneficiary enrolled in the waiver is concurrently receiving the following services:

(a) Intensive day treatment or day treatment mental health rehabilitative services (MHRS) under the District of Columbia State Plan for Medical Assistance (State Plan);

(b) Personal Care Aide services; (State Plan or Waiver);

(c) Services funded by the Older Americans Act of 1965, approved July 14, 1965 (Pub. L. No. 89-73, 79 Stat. 218); or

(d) 1915(i) State Plan Option services under the State Plan.

4218.3 If a beneficiary is eligible for adult day health services under the Waiver and intensive day treatment MHRS, a provider shall not be reimbursed for adult day health services if the beneficiary is receiving intensive day treatment mental health rehabilitation services on the same day, or during a twenty-four (24) period that immediately precedes or follows the receipt of adult day health services.

4218.4 Adult day health services shall not be provided for more than five (5) days per week and for more than eight (8) hours per day.

4218.5 Adult day health services may be used in combination or on the same day as PCA services, as long as these services are not billed "concurrently" or during the same time.

4218.6 When a beneficiary enrolled in the EPD Waiver is receiving PCA and adult day services on the same day, the combination of both PCA and adult day services shall not exceed a total of sixteen (16) hours per day.

4219 REIMBURSEMENT RATES: PHYSICAL THERAPY

4219.1 The reimbursement rate for physical therapy for Waiver Year 5 and Waiver Year 1 of the Renewal shall be sixteen dollars and twenty five cents ($16.25) per unit, where one unit of service is equivalent to fifteen (15) minutes of service delivery.

4219.2 Reimbursement of physical therapy services shall be limited to four (4) hours per day and one hundred (100) hours per calendar year. Requests for additional hours may be submitted to DHCF or its agent and approved when accompanied by a physician's order or when the request has passes a clinical review by staff

designated by the State Medicaid Director to provide oversight on the utilization of additional services.

4220 REIMBURSEMENT RATES: OCCUPATIONAL THERAPY

4220.1 The reimbursement rate for occupational therapy during Waiver Year 5 and Waiver Year 1 of the Renewal shall be sixteen dollars and twenty five cents ($16.25) per unit, where one unit of service is equivalent to fifteen (15) minutes of service delivery.

4220.2 Reimbursement of occupational therapy services shall be limited to four (4) hours per day and one hundred (100) hours per calendar year. Requests for additional hours may be submitted to DHCF or its agent and approved when accompanied by a physician's order or when the request passes a clinical review by staff designated by the State Medicaid Director to provide oversight on the utilization of additional services.

4221 REIMBURSEMENT RATES: COMMUNITY TRANSITION SERVICES

4221.1 In accordance with Section 4252, reimbursement for the household set up items specified under § 4252.2 shall not exceed five thousand dollars ($5,000) per Waiver period and shall only be reimbursed beginning one hundred twenty (120) days before a beneficiary's discharge and up to six (6) months after discharge from an institution or long term care facility.

4222 PROVIDER REQUIREMENTS: GENERAL

4222.1 Each provider approved to provide one or more Waiver services shall meet the following minimum requirements:

(a) Demonstrate compliance with all applicable provisions of Chapter 94 (Medicaid Provider and Supplier Screening, Enrollment, and Termination) of Title 29 DCMR;

(b) Have a completed, approved, and current Medicaid Provider Agreement with DHCF before providing any waiver services; and

(c) Be licensed to do business in the District of Columbia, if required by this chapter.

4222.2 Each provider of waiver services shall demonstrate a comprehensive knowledge and understanding of the EPD Waiver program including:

(a) Knowledge of Medicaid State Plan services and limitations;

(b) Knowledge of community resources (legal, housing, energy, food, transportation, and other medical and social assistance) and the methods of accessing these resources; and

(c) An understanding of the relationship between Medicaid State Plan and waiver services.

4222.3 Each provider of waiver services shall immediately notify DHCF's Long Term Care Administration when a beneficiary is institutionalized, hospitalized or has his or her waiver services suspended for a reason other than those which do not result in an official notice of suspension as set forth in Section 4205.

4222.4 Each provider of waiver services shall demonstrate a service history and current capacity to assist beneficiaries in accessing services provided through the District of Columbia Office on Aging or other agencies serving the elderly and individuals with physical disabilities.

4222.5 Each provider of waiver services shall require and thoroughly check at least two (2) professional references on all staff entering the home of a waiver beneficiary.

4222.6 Each waiver service provider with employees providing direct care in a beneficiary's home or permanent place of residence shall have a proof of compliance with the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999, as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13, 2002 (D.C. Law 14-98; D.C. Official Code §§ 44-551 *et seq.*).

4222.7 No employee of a waiver services provider who has been convicted of a felony, a crime involving abuse, neglect, or violence against the person of another, or crime involving theft or larceny under federal or District law shall provide services to a beneficiary.

4222.8 Each provider of waiver services shall conduct a performance evaluation of all staff after the first three (3) months of employment and annually thereafter, maintain all performance evaluation files for a period of no less than ten (10) years, and make such files available for review by appropriate DHCF personnel, representatives of the U.S. Department of Health and Human Services and other authorized designees or officials of the District of Columbia government and federal government.

4222.9 Each provider of direct care services shall ensure that all staff providing direct care services is trained in universal precautions prior to the provision of any service.

4222.10 Universal precautions training shall be included as a component of annual continuing education classes for all staff, including homemakers, who may encounter blood or bodily fluids while providing direct care services. https://www.osha.gov/SLTC/etools/hospital/hazards/univprec/univ.html. Documentation of universal precautions training shall be maintained in an employee's file for a period of no less than ten (10) years.

4222.11 Each provider of waiver services shall establish and implement a process to ensure that each beneficiary has:

(a) Been informed of and given his or her freedom of choice in the selection of all qualified service providers; and

(b) Been informed of his or her rights and responsibilities under the waiver program.

4222.12 When a waiver beneficiary chooses an individual, or family member other than a primary caregiver, the beneficiary's spouse, or other legally responsible relative, or court-appointed guardian to provide direct care services, these individuals shall be subject to the same certification requirements as other service providers described within this chapter.

4222.13 Each provider of waiver services shall attend all mandatory provider meetings and trainings hosted by DHCF when scheduled.

4222.14 All Case Managers, Adult Day Health, Assisted Living providers, Community Residence Facility providers and Home Care Agencies providing EPD Waiver services shall complete mandatory training in Person-Centered Thinking, Supported Decision-Making, and Supported Community Integration.

4222.15 Each provider of waiver services shall immediately report all instances of suspected fraud, theft, or abuse committed by an employee or agent of the provider, or by a beneficiary to whom the provider is rendering waiver services, to the DHCF Division of Program Integrity.

4223 SPECIFIC PROVIDER REQUIREMENTS: CASE MANAGEMENT SERVICES

4223.1 Each individual providing case management services shall meet the following requirements:

(a) Be at least eighteen (18) years of age;

(b) Be a United States citizen or alien who is lawfully authorized to work in the United States;

(c) Provide proof by submitting photocopies of the supporting documents for the Immigration and Naturalization Service's Form I-9 requirements;

(d) Be able to read and write English;

(e) Be acceptable to the beneficiary using the Waiver service;

(f) Confirm, on an annual basis, that he or she is free of active tuberculosis by undergoing an annual purified protein derivative (PPD) skin test;

(g) Confirm, on an annual basis, that he or she is free of communicable diseases by undergoing an annual physical examination by a physician, and obtaining written and signed documentation from the examining physician that confirms he or she is free of communicable diseases; and

(h) Provide to each case management service provider for whom he or she works:

(1) Evidence of acceptance or declination of the Hepatitis vaccine; and

(2) A completed DHCF Conflict-Free Case Management Self-Attestation Form described in Subsection 4223.2.

4223.2 Effective March 25, 2016, except as provided in Subsection 4223.3, an individual providing case management services, who is employed or under contract to a Home and Community-Based Services Waiver for Persons who are Elderly and Individuals with Physical Disabilities (EPD Waiver) case management service provider shall self-attest to meeting the CMS conflict-free standards in accordance with 42 CFR § 441.301(c)(1)(vi) using the DHCF Conflict-Free Case Management Self-Attestation Form. Under these standards, individual case managers shall not:

(a) Be related by blood or marriage to the person receiving services, or to any paid caregiver of the person;

(b) Be financially responsible for the person, or be empowered to make financial or health decisions on the person's behalf;

(c) Have a financial relationship, defined in 42 CFR § 411.354, with any entity that is paid to provide care for the person; and

(d) Be employed by any entity that is a provider of a person's PCA services or any other direct services under the EPD Waiver.

4223.3 An individual providing EPD Waiver case management services shall meet the requirements of Subparagraph 4223.1(h)(2) no later than July 1, 2016.

4223.4 EPD Waiver case management service providers shall ensure they have a copy of the DHCF Conflict-Free Case Management Self-Attestation Form on file for each case manager prior to submission of any claims for case management services provided by that case manager on or before July 1, 2016. DHCF Conflict-Free Case Management Self-Attestation Forms are subject to inspection and audit and must be produced upon request.

4223.5 Individuals conducting case management services shall meet one of the following educational requirements:

(a) Have a current license in nursing, social work, psychology, counseling, occupational, physical, or speech therapy with a Master's degree in social work, psychology, counseling, rehabilitation, nursing, gerontology, or sociology, and have at least one (1) year of experience working with the elderly or individuals with physical disabilities;

(b) Have a current license in nursing, social work, psychology, counseling, occupational, physical, or speech therapy with a Bachelor's degree in social work, psychology, counseling, rehabilitation, nursing, gerontology, or sociology, and have two (2) years of experience working with the elderly or individuals with physical disabilities; or

(c) Have a current license as a Registered Nurse (RN), have an Associate degree in nursing, and have at least three (3) years of experience working with the elderly and individuals with physical disabilities.

4223.6 Case management service providers shall not provide medical, financial, legal, or other services or advice for which they are not qualified or licensed to provide (except for providing referrals to qualified individuals, agencies, or programs).

4223.7 Effective March 25, 2016, except as provided in Subsection 4223.8, in accordance with 42 CFR § 441.301(c)(1)(vi), the following providers shall not be eligible to provide case management services:

(a) An entity that is a Medicaid provider of PCA services or any other direct services under the EPD Waiver; or

(b) An entity that has a financial relationship, as defined in 42 CFR § 411.354, with a Medicaid provider of PCA services or any other direct services under the EPD Waiver.

4223.8 Effective March 25, 2016, an entity that is enrolled to provide case management services that is also a Medicaid provider of PCA services or any other direct

services under the EPD Waiver; or has a financial relationship, as defined in 42 CFR § 411.354, with a Medicaid provider of PCA services or any other direct services under the EPD Waiver, shall have until July 1, 2016, to come into compliance with Subsection 4223.7.

4223.9 An entity described in Subsection 4223.8 was required to notify DHCF of its election to continue or discontinue providing case management services no later than September 1, 2015. An entity that chose to discontinue case management services was required to submit a transition plan to DHCF no later than October 1 2015, and to cooperate with DHCF to effectuate the orderly and timely transition of its enrollees to other case management providers that meet the conflict-free case management standards. These transition plans were required to include sufficient safeguards to protect individuals who were at risk of experiencing gaps in services during transitions, including demonstrating efforts to ensure compliance with any notice or due process rights governed under local and federal law in case of service suspensions, or terminations.

4223.10 Each case management service provider shall conduct an initial evaluation within forty-eight (48) business hours of receiving the waiver referral and prior to the development of the PCSP. All initial PCSPs and all renewal PCSPs were required to conform to the person-centered planning requirements in 42 CFR §§ 441.301(c)(1) – (3) by November 1, 2016, and case managers shall use DHCF's person-centered-planning template, available at http://dhcf.dc.gov/release/person-centered-planning, to develop each beneficiary's PCSP.

4223.11 Each case management service provider shall complete and submit the PCSP to DHCF or its designee for review and approval within ten (10) business days of conducting the initial evaluation.

4223.12 Each case management service provider shall include the person whose plan is being developed, other contributors chosen and invited by the person, and representatives of the person's interdisciplinary team, if possible, in the initial evaluation referenced in Subsection 4223.10 and in the development and implementation of the PCSP. The person or authorized representative shall have access to the PCSP and shall be involved in the periodic review of the PCSP.

4223.13 It is the responsibility of the case management service provider to ensure that all other professional disciplines, as identified for resolution of identified needs, are incorporated into the PCSP. Specifically, each case management service provider shall coordinate a beneficiary's care by sharing information with all other health care and service providers identified in the PCSP, as applicable, to ensure that the beneficiary's care is organized and to achieve safer and more effective health outcomes.

4223.14 Each case management service provider shall maintain, follow, and continually update a training and supervision program to ensure the individual delivering case management services is fully trained and familiar with the waiver policies and procedures, including CMS's conflict-free case management standards as set forth in this section.

4223.15 Each provider of case management services shall ensure that individuals providing case management services are appropriately supervised and that the case management service provided is consistent with the person's PCSP.

4224 PROGRAM SERVICES: CASE MANAGEMENT SERVICES

4224.1 The goal of case management services shall be to ensure EPD Waiver beneficiaries have access to the services and supports needed to live in the most integrated setting including:

(a) EPD Waiver Services;

(b) Non-waiver Medicaid funded services under the Medicaid State Plan; and

(c) Other public and private services including medical, social, and educational services and supports.

4224.2 Case management shall consist of the following:

(a) Initial evaluation of the beneficiary's current and historical medical, social, and functional status to determine levels of service needs;

(b) Person-centered process for service planning ("person-centered planning"), including development and maintenance of the Person-Centered Service Plan (PCSP) in accordance with Section 4204;

(c) Monthly or ongoing care coordination activities, in accordance with Subsection 4224.8 and transitional case management services set forth in Subsection 4224.9; and

(d) Annual reassessment activities, in accordance with Subsection 4224.14.

4224.3 Consistent with Subsection 4224.2, each Case Manager shall conduct an in-person initial evaluation of the beneficiary within forty-eight (48) hours of receiving notice of his or her enrollment in the EPD Waiver.

4224.4 The Case Manager shall develop, complete, and submit the PCSP to DHCF, or its designee, within ten (10) business days of initiating the initial evaluation.

4224.5 The Case Manager shall use a person-centered planning process to develop the PCSP, described in Section 4204, with consideration of the following:

(a) The beneficiary's personal preferences in developing goals to meet the beneficiary's needs;

(b) Convenience of the time and location for the beneficiary and any other individuals included in the planning and potential in-person discussions with all parties and representatives of the beneficiary's interdisciplinary team;

(c) Incorporating feedback from the beneficiary's interdisciplinary team and other key individuals who cannot attend in-person discussions where the beneficiary is present;

(d) Ensuring information aligns with the beneficiary's acknowledged cultural preferences and communicated in a manner that ensures the beneficiary and any representative(s) understand the information;

(e) Ensuring access to effective, understandable, and respectful services in accordance with the U.S. Department of Health and Human Services' National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care, http://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53, and providing auxiliary aids and services, if necessary;

(f) Providing interpreters and translated written documents for those with low literacy or Limited English Proficiency (LEP) to ensure meaningful access for beneficiaries and/or their representatives;

(g) Incorporating a strengths-based approach which identifies the beneficiary's positive attributes, and assesses strengths, preferences, and needs;

(h) Exploration of housing and employment in integrated settings, where planning is consistent with the goals and preferences of the beneficiary; and

(i) Ensuring that a beneficiary under guardianship, other legal assignment, or who is being considered as a candidate for such an arrangement, has the opportunity to address concerns related to the PCSP development process.

4224.6 Except for services approved to be delivered sooner, DHCF, or its designee, shall prior authorize the services recommended in the PCSP within seven (7) business days of its receipt of the request.

4224.7 Following approval of services by DHCF, or its designee, the Case Manager shall follow-up with the selected service providers within five (5) business days to ensure services are in place at the quantity and quality that is sufficient to meet the beneficiary's needs, unless services are needed earlier and not receiving them would place the beneficiary's health in jeopardy.

4224.8 In order for case management services to be reimbursable, a Case Manager shall perform the following ongoing or monthly care coordination activities:

(a) Direct observation of the beneficiary, including the evaluation described in Subsection 4224.3;

(b) Follow-up to ensure DHCF, or its designee, timely uploads the beneficiary's level of care determinations into DHCF's electronic management system;

(c) Develop and monitor the PCSP in accordance with Section 4204 and Subsection 4224.5;

(d) Assist the beneficiary with the selection of eligible EPD Waiver providers;

(e) Coordinate the beneficiary's waiver services to ensure safe, timely, and cost effective delivery;

(f) Provide information, assistance, and referrals to the beneficiary, where appropriate, related to public benefits and community resources, including other Medicaid services, Medicare, Supplemental Security Income (SSI), transit, housing, legal assistance, and energy assistance;

(g) Provide support for the beneficiary and family as needed through additional visits, telephone calls;

(h) Monitor the performance of medical equipment and refer malfunction(s) to appropriate providers;

(i) Maintain records related to EPD Waiver services that a beneficiary receives and upload all information into DHCF's electronic case management system;

(j) Ensure all information uploaded into DHCF's electronic management system is legible, including monthly assessment and status updates and telephone contacts;

(k) Assess appropriateness of beneficiary's continued participation in the waiver;

(l) Provide information to the beneficiary, authorized representative(s), family members, or legal guardian(s) about the beneficiary's rights, Waiver provider agency procedures for protecting confidentiality, and other matters relevant to the beneficiary's decision to accept services;

(m) Identify and resolve problems as they occur;

(n) Acknowledge and respond to beneficiary inquiries within twenty-four (24) hours of receipt, unless a quicker response is needed to address emergencies;

(o) Develop and implement a utilization review plan to achieve appropriate service delivery, ensure non-duplication of services, and evaluate the appropriateness, efficiency, adequacy, scope, and coordination of services;

(p) Conduct at least monthly, or more frequently as needed, in-person monitoring visits in the beneficiary's home;

(q) Supplement in-person monitoring visits described in Paragraph 4224.8(p) with ongoing telephone contact, as required by the individual needs of the beneficiary;

(r) Respond to requests received during monitoring activity within forty-eight (48) hours, making necessary updates to the PCSP within seven (7) days of monitoring activity or the beneficiary or representative's request to update the PCSP, and ensure the process and all updates comport with Section 4204 including in-person requirements;

(s) Ensure that the updated PCSP is conducted in-person with the beneficiary, the interdisciplinary team, and others chosen by the person and other requirements of the PCSP planning and development process described in this Section;

(t) Review the implementation of the PCSP at least quarterly, and as needed, in accordance with Subsection 4224.13;

(u) Promptly communicate any major updates, issues, or problems to DHCF, or its designee;

(v) Conduct all other activities related to the coordination of EPD Waiver services, including ensuring that services are utilized and are maintaining the beneficiary in the community;

(w) Provide transitional case management services for a period not to exceed one hundred twenty (120) days during an institutional stay in order to

facilitate the beneficiary's transition back to the community, in accordance Subsection 4224.9; and

(x) Perform other service-specific responsibilities and annual reassessment activities described in Subsections 4224.10 and 4224.14.

4224.9 In order for transitional case management services to be reimbursable by Medicaid, a Case Manager shall document and perform the following activities:

(a) Maintain contact with the beneficiary or representative during the institutional stay;

(b) Ensure the beneficiary stays connected to community resources (e.g., housing) during the institutional stay and provide assistance to connect to new or reconnect to existing community resources upon discharge;

(c) Participate in-person in the discharge planning meetings at the institutional care provider's site; and

(d) Secure prior authorization(s) for service(s) to ensure they are in place on the first day of the beneficiary's discharge.

4224.10 In addition to the duties described in Subsections 4224.8 and 4224.9, a Case Manager shall perform the following service-specific care coordination responsibilities, if applicable:

(a) Ensure occupational or physical therapy services provided under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) are fully utilized and waiver services neither replace nor duplicate EPSDT services for a beneficiary ages eighteen (18) through twenty-one (21);

(b) Examine existing responsibilities of the landlord or homeowner pursuant to the lease agreement (or other applicable residential contracts, laws, and regulations) prior to ordering chore aide services through the PCSP if the beneficiary needs chore aide services and resides in a rental property or a residential facility (*e.g.*, assisted living); and

(c) Assist the beneficiary with home adaptation assessments, evaluations, or bids in accordance with this chapter if the beneficiary requires EAA services.

4224.11 In accordance with Chapter 101 of Title 29 DCMR, for the participant-directed services program, *Services My Way*, Case Managers shall complete a standard training course on that program conducted by DHCF and participate in all required, ongoing training. Case Managers shall also perform activities related to *Services My Way* as follows:

(a) Provide waiver applicants/beneficiaries with information about *Services My Way* as follows: at the time an EPD Waiver beneficiary is initially evaluated; when a beneficiary is reassessed for continued EPD Waiver eligibility; when the PCSP is updated; and at any other time upon request of the beneficiary or authorized representative;

(b) Assist applicants/beneficiaries who want to enroll in *Services My Way* by overseeing the beneficiary's completion of enrollment forms and incorporating program goals into the initial PCSP or a revision of an existing PCSP;

(c) Submit all *Services My Way* forms to the designated DHCF program coordinator;

(d) Communicate with support brokers to address health and safety concerns identified for *Services My Way* participants; and

(e) Facilitate transition from *Services My Way* to agency-based personal care aide services when a beneficiary is voluntarily or involuntarily terminated from the program.

4224.12 Case Managers shall also perform any other duties specified under the individual program services sections of this chapter.

4224.13 When conducting PCSP quarterly reviews, the Case Manager shall perform the following activities:

(a) Review and update risk factors;

(b) Review stated goals, identified outcomes, services, and supports to ensure the beneficiary is receiving appropriate services for his or her needs;

(c) Review service utilization;

(d) Communicate with other providers regarding the beneficiary's goals and progress;

(e) Identify and resolve problems;

(f) Provide referrals or linkages to community resources;

(g) Revise the PCSP, if needed, to reflect changes in needs, goals, and services; and

(h) Document results of PCSP quarterly reviews in DHCF's electronic case management system, including a summary of the status of the beneficiary's receipt of services and supports.

4224.14 The Case Manager shall ensure a beneficiary timely completes Medicaid reassessment(s) as part of the annual recertification requirements. This includes, but is not limited to, the following activities:

(a) Collecting and submitting documentation to DHCF, or its designee, such as medical assessments, /clinician authorization forms, and case manager attestation/evaluation forms;

(b) Effective April 1, 2018, conducting an evaluation of each beneficiary's health status at least once every twelve (12) months or upon a significant change in the beneficiary's health status and completing the case manager attestation/evaluation form following each evaluation;

(c) Assisting the beneficiary to receive a level of care assessment from DHCF, or its designee when there is a change in health status, as determined by the evaluation described in (b);

(d) Ensuring information is uploaded to DHCF's electronic case management system at least sixty (60) days prior to the expiration of the beneficiary's current certification period;

(e) Collecting financial eligibility (*i.e.,* income) information from the beneficiary and/or the authorized representative and transmitting to DHCF, or its designee;

(f) Reevaluating the beneficiary's goals, level of service and support needs, and updating and/or revising the PCSP to reflect any updates;

(g) Assessing progress in meeting established goals, as documented in the PCSP and ensuring that the information is forwarded to DHCF;

(h) Coordinating any change requests, including adding new services; and

(i) After the approval of services by DHCF, or its designee, following-up with selected service providers within five (5) business days of the approval to ensure services are in place.

4225 CASE MANAGEMENT AGENCY AND CASE MANAGER RESPONSIBILITIES

4225.1 Case management agencies shall ensure that case managers shall not have a client caseload exceeding forty (45) persons (inclusive of Medicaid and non-Medicaid beneficiaries).

4225.2 In accordance with Section 4210, the case management agency shall be responsible for ensuring that case managers are available during regular business hours Monday through Friday, and on call during weekends and evenings in cases of emergency.

4225.3 Each case manager shall take all required trainings offered by DHCF and complete mandatory training in Person-Centered Thinking, Supported Decision-Making, and Supported Community Integration, in order to promote the efficient and effective delivery of Medicaid-financed services.

4225.4 Each case management agency shall develop an emergency response policy or plan to convey expectations of case managers whereby the case manager coordinates and implements services and ensures the beneficiary's safety, and wellness upon the beneficiary's notification to the case manager about the need for emergency care. This shall also include how the case managers are expected to be available and on call during weekends and evenings in cases of emergency as referenced in Subsection 4225.2.

4225.5 Each case management agency shall develop an incident management reporting policy to report, investigate, and follow-up the results of the investigation conducted pursuant to DHCF's Long Term Care Administration's incident management policy, as set forth in Section 4254 (Incidents and Complaints).

4225.6 In accordance with Section 4205, a case manager may coordinate the approval by DHCF or its designee for all program modification requests. These include requests to initiate, change, transfer, terminate, discharge, or suspend services.

4225.7 When coordinating program modification requests, the case manager shall ensure that provider requirements including notices and steps to ensure safe discharge, suspensions, transfers or service terminations were met.

4225.8 In the event that a change in service is requested, the beneficiary's case manager shall ensure that the PCSP is updated to reflect the change. Changes in service shall not be implemented until the PCSP is updated, approved by DHCF or its designee, and shared with the beneficiary and/or the authorized representative, unless a delay in the receipt of services would put the beneficiary's health and safety at risk, or if services are needed to effectuate a timely discharge from an institution.

4225.9 If EPD Waiver services are needed to effectuate a timely discharge from an institution during transitional case management, the case manager shall coordinate the modifications to change and/or initiate services by DHCF or its designee by

submitting a new beneficiary freedom of choice form whereby the beneficiary elects to receive HCBS services and the case manager must amend the PCSP to reflect the services within ten (10) business days of the submission of the request to DHCF or its designee to authorize services.

4225.10 The case manager or case management agency shall coordinate dis-enrollments from the EPD Waiver program in accordance with the criteria set forth in Section 4205.

4226 SPECIFIC PROVIDER REQUIREMENTS: PERSONAL CARE AIDE SERVICES

4226.1 A personal care aide services provider shall meet the provider requirements as set forth in Chapter 50 (Medicaid Reimbursements for Personal Care Aide Services) of Title 29 DCMR. These shall include, but shall not be limited to:

(a) Provider and Personal Care Aide (PCA) qualifications;

(b) Staffing and administration requirements; and

(c) Notice requirements.

4227 SPECIFIC ELIGIBILITY REQUIREMENTS: PERSONAL CARE AIDE SERVICES

4227.1 To receive Medicaid reimbursement for personal care aide (PCA) services, the beneficiary shall first exhaust all available PCA hours provided under the State Plan for Medical Assistance (Medicaid State Plan).

4227.2 To be eligible for Medicaid reimbursement of PCA services under the EPD Waiver program, each beneficiary shall have an assessed need for PCA services as established by the conflict-free assessment that cannot be met by State Plan PCA services alone.

4228 PROGRAM SERVICES: PERSONAL CARE AIDE SERVICES

4228.1 A provider shall deliver PCA services consistent with the program service requirements set forth in Chapter 50 of Title 29 DCMR. These include:

(a) Plan of Care requirements;

(b) Scope of Services; and

(c) Non-reimbursable tasks or services.

4228.2 A PCA provider shall employ an R.N. to develop a plan of care for delivering PCA services that is consistent with the goals of the PCSP.

4228.3 The plan of care shall be developed and reviewed in accordance with all of the requirements set forth in Chapter 50 of Title 29 DCMR, and be consistent with the goals of the PCSP.

4228.4 In accordance with Chapter 50 of Title 29 DCMR, PCA services under the State Plan benefit shall not be provided in a hospital, nursing facility, intermediate care facility or any other living arrangement which includes PCA services as a part of its reimbursement rate.

4228.5 A beneficiary receiving adult day health services and PCA services on the same day shall be limited to a maximum of a total of sixteen (16) hours of combined services a day.

4229 SPECIFIC PROVIDER REQUIREMENTS: PERSONAL EMERGENCY RESPONSE SERVICES (PERS)

4229.1 Each Personal Emergency Response Services (PERS) provider shall:

(a) Provide in-home installation of all equipment necessary to make the service fully operational (including batteries);

(b) Provide beneficiary and representative instruction on usage, maintenance, and emergency protocol of the PERS;

(c) Provide equipment maintenance (both in-home and response center);

(d) Provide twenty-four (24) hours per day, seven (7) days per week response center monitoring and support;

(e) Conduct equipment testing, monitoring, and maintenance (both in-home and response center equipment);

(f) Conduct monthly service checks;

(g) Provide documentation of all services provided, beneficiary contacts, equipment and system checks, and equipment servicing;

(h) Make available emergency equipment repairs to the beneficiary on a twenty-four (24) hours per day, seven (7) days per week basis; and

(i) Allow the beneficiary to designate responder(s) who will respond to emergency calls. Responders may be relatives, friends, neighbors, or medical personnel.

4229.2 PERS shall not be provided to waiver beneficiaries who:

(a) Are unable to understand and demonstrate proper use of the system; or

(b) Live with a person who assumes responsibility for providing care (to the beneficiary) and the waiver beneficiary is subsequently not left alone for significant periods of time.

4229.3 Each PERS provider shall ensure that contractors are properly supervised and that the service provided is consistent with the beneficiary's PCSP.

4229.4 A PERS provider shall be exempt from the requirement to comply with an annual tuberculosis (TB) test; and

4229.5 A PERS provider shall be licensed to do business in the state in which it is incorporated.

4230 PROGRAM SERVICES: PERS

4230.1 PERS is an electronic system located in a beneficiary's home that summons assistance from a friend, relative, or an emergency services provider (police, fire department, or ambulance) and shall be available twenty-four (24) hours a day, seven (7) days a week.

4230.2 Each PERS system shall be comprised of three (3) basic elements:

(a) A small radio transmitter (portable help button) carried by the user;

(b) A console or receiving base connected to a user's telephone; and

(c) A response center or responder to monitor the calls.

4230.3 The PERS shall be comprised of two (2) processes:

(a) Installation of the service unit; and

(b) On-going monitoring of the system.

4230.4 The unit of service shall be as follows:

(a) One (1) unit per year for installation and testing of the PERS system; and

(b) Twelve (12) units per year for monthly rental, maintenance and service fee.

4230.5 The PERS shall be:

(a) Approved by the Case Manager as part of the beneficiary's PCSP; and

(b) Completed by personnel who are employed by the PERS provider. A copy of the approved PCSP shall be incorporated into the beneficiary's service record. The record shall be maintained for a period of no less than ten (10) years.

4231 SPECIFIC PROVIDER REQUIREMENTS: RESPITE SERVICES

4231.1 In order to receive Medicaid reimbursement, a respite service provider shall be a Medicaid enrolled home care agency approved by DHCF to deliver respite services in the District of Columbia.

4231.2 In order to receive Medicaid reimbursement for respite services, a home care agency providing respite services shall require that respite staff be certified as a Home Health Aide in accordance with the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.* (2016 Repl.)), and implementing rules, Chapter 93 (Home Health Aides) of Title 17 DCMR.

4231.3 DHCF requires respite staff to undergo any training as required pursuant to their DOH certification. Additionally, a respite service provider shall ensure that staff will receive individualized-in-service training about the beneficiary's needs from the supervisory nurse. The continuing education or individualized in-service training for respite services shall be specifically designed to increase the staff's knowledge and understanding of the beneficiary's unique needs.

4231.4 Comprehensive records identifying dates of any training including the individualized in-service training and topics covered shall be maintained in each employee's personnel file.

4231.5 The respite service provider shall develop and implement an initial intake assessment that:

(a) Assesses the beneficiary's respite needs; and

(b) Identifies the appropriate qualifications of the respite staff required to meet the identified needs.

4231.6 A Registered Nurse (R.N.) who possesses the following qualifications shall conduct the initial intake assessment:

(a) Be licensed to practice registered nursing in the District of Columbia in accordance with the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official

Code §§ 3-1201.01 *et seq.* (2016 Repl.)), and implementing rules, Chapter 54 (Registered Nursing) of Title 17 DCMR;

(b) Be employed or contracted by the approved home care agency; and

(c) Have at least one (1) year of experience working with the elderly and individuals with physical disabilities.

4231.7 After conducting the initial intake assessment, the R.N. shall:

(a) Establish a written emergency notification plan for each beneficiary receiving respite services;

(b) Document that the emergency plan has been reviewed with the beneficiary or representative and the individual staff person providing respite care; and

(c) Develop a plan of care for the delivery of all respite services.

4231.8 The case manager shall coordinate the approval of respite services to ensure that it aligns with the goals of the PCSP. For respite provided for PCA services, the R.N. referenced in Subsections 4231.6 and 4231.7 shall conduct the supervision of the respite staff.

4231.9 To ensure the safety of the beneficiary, respite staff shall not leave the beneficiary unattended during the hours that respite services are authorized.

4231.10 Each respite services provider shall maintain all documentation including records documenting dates of training and the written emergency notification plan for a period no less than ten (10) years. The waiver beneficiary shall also receive a copy of the emergency notification plan and shall keep it at his or her home or place of residence.

4231.11 Respite services shall not be provided to beneficiaries who do not have primary caregivers who are responsible for the provision of the beneficiary's care on an ongoing basis.

4231.12 A waiver beneficiary may choose an individual or family member other than a primary caregiver, the beneficiary's spouse, or other legally responsible relative, or court-appointed guardian to provide respite services. Legally responsible relatives do not include parents of an adult child, so parents of an adult child are not precluded from providing respite services.

4232 PROGRAM SERVICES: RESPITE SERVICES

4232.1 Respite services are intended to relieve the beneficiary's primary caregiver to provide a range of activities associated with the PCA's role.

4232.2 Medicaid reimbursable respite services shall include:

(a) Basic personal care such as bathing, grooming, and assistance with toileting or bedpan use;

(b) Assistance with prescribed, self-administered medication;

(c) Meal preparation in accordance with dietary guidelines and other cultural/religious dietary restrictions, and assistance with eating;

(d) Household tasks related to keeping the beneficiary's living areas in a condition that promotes the beneficiary's health, comfort, and safety; and

(e) Accompanying the beneficiary to medically related appointments.

4232.3 Medicaid reimbursable Respite services shall not include services that require the skills of a licensed professional, including, but not limited to, catheter insertion, procedures requiring sterile techniques, and medication administration.

4232.4 Medicaid reimbursable Respite services shall not include tasks usually performed by chore workers or homemakers, including cleaning of areas not occupied by the beneficiary; cleaning laundry for family members of the beneficiary; and shopping for items not used by the beneficiary.

4232.5 A unit of Medicaid reimbursable service for respite care shall be one (1) to twenty-four (24) hours spent performing allowable tasks.

4232.6 Medicaid reimbursable Respite services shall be limited to a maximum of four hundred and eighty (480) hours per year. Requirements for respite services in excess of the established limits shall be prior-authorized by the DHCF.

4232.7 Medicaid reimbursable Respite services shall not be billed in combination or at the same time as Personal Care Aide services.

4232.8 No waiver beneficiary shall receive Medicaid reimbursement for PCA services other than those provided by the in-home respite staff during the period of time which respite services are provided.

4233 SPECIFIC PROVIDER REQUIREMENTS: HOMEMAKER SERVICES

4233.1 In order to be reimbursed by Medicaid, homemaker services must be provided by the following Medicaid-enrolled providers:

(a) A home care agency which meets the conditions of participation for home care agencies as set forth in 42 CFR part 484, by being enrolled as a Medicare provider, and complying with the requirements set forth in the Health-Care and Community Residence Facility, Hospice, and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code §§ 44-501 *et seq.*); or

(b) A business with a general business license issued by the D.C. Department of Consumer and Regulatory Affairs (DCRA) to perform housekeeping services in the District of Columbia.

4233.2 In order to receive Medicaid reimbursement for homemaker services, each individual providing homemaker services shall:

(a) Be at least eighteen (18) years of age;

(b) Be able to successfully communicate with the beneficiary receiving EPD Waiver services;

(c) Pass a criminal background check;

(d) Obtain, and maintain an updated Cardiopulmonary Resuscitation (CPR) certificate; and

(e) Meet the qualification and training requirements pursuant to Subsections 4233.3 or 4233.4.

4233.3 In order to receive Medicaid reimbursement for homemaker services, a home care agency shall:

(a) Require that all individual homemaker service staff be certified as a Home Health Aide in accordance with District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.* (2016 Repl.)), and implementing rules, Chapter 93 of Title 17 DCMR; and

(b) Meet any ongoing training requirements required under the DOH's Home Health Aide certification requirements.

4233.4 In order to receive Medicaid reimbursement for homemaker services, a business with a general business license issued by the D.C. DCRA to provide housekeeping services shall:

(a) Require that all individual homemaker staff shall obtain a minimum of eight (8) hours of training annually in the following areas:

(1) Beneficiary rights;

(2) Communicating effectively with beneficiaries enrolled in the waiver;

(3) Preventing abuse, neglect, and exploitation;

(4) Controlling the spread of disease and infection;

(5) Changing linens and bed bug prevention;

(6) Safe handling of cleaning chemicals (use of gloves, goggles, or masks);

(7) Handling hazardous waste;

(8) Blood-borne pathogens and bodily fluids;

(9) Food preparation, handling, and storage; and

(10) Instructions on the following:

(A) Dusting;

(B) Maintenance of floors (mopping or vacuuming);

(C) Trash handling;

(D) Laundry and safe use of detergents;

(E) Cleaning the walls and ceiling; and

(F) Kitchen and bathroom cleaning and maintenance.

4233.5 Supervisory staff employed by the homemaker service provider shall develop a written homemaker service delivery plan (Plan of Care) and the beneficiary's case manager shall approve the service delivery plan before it is implemented.

4233.6 The homemaker service provider shall document in-home visits and telephone contacts in the beneficiary's service delivery plan at least within thirty (30) days of its home visit.

4233.7 A copy of the homemaker service delivery plan shall be shared with the case manager and kept on-file at the Home Care Agency or the homemaker service provider licensed to provide housekeeping services.

4233.8 Each provider of homemaker services shall maintain comprehensive records including the service delivery plans, and records identifying dates of training and topics covered in each employee's personnel file for a period of no less than ten (10) years.

4233.9 An individualized in-service training plan shall be developed and implemented for each staff person when performance evaluations indicate a need for more training.

4233.10 A waiver beneficiary may choose an individual or family member other than a beneficiary's spouse, other legally responsible relative, or court-appointed guardian to provide homemaker services. Legally responsible relatives do not include parents of an adult child, so parents of an adult child are not precluded from providing homemaker services.

4233.11 Homemaker services shall not duplicate the duties provided through PCA services or respite services.

4234 PROGRAM SERVICES: HOMEMAKER SERVICES

4234.1 Homemaker services shall only be provided in cases where neither the beneficiary nor anyone else in the household (*i.e.*, an unpaid family caregiver) is able to provide or deliver the service.

4234.2 Homemaker staff may perform the following tasks when providing homemaker services:

(a) Food preparation and storage;

(b) General household cleaning such as:

(1) Cleaning bathrooms;

(2) Vacuuming;

(3) Dusting;

(4) Mopping floors;

(5) Sweeping floors;

(6) Bed making;

(7) Linen changing;

(8) Wiping appliances;

(9) Washing dishes;

(10) Doing laundry and ironing clothes; and

(c) Running errands necessary to maintain the beneficiary in the home (for example, shopping for food or essentials needed to clean the home; picking up medicine or mailing payments for utilities).

4234.3 Food preparation and storage shall consist of any tasks to promote maintaining a tidy kitchen including overseeing the proper storage of any groceries by ensuring that all perishable foods are stored in the freezer or fridge.

4234.4 A unit of service for homemaker services shall be one (1) hour spent performing the allowable task(s).

4235 SPECIFIC PROVIDER REQUIREMENTS: CHORE AIDE SERVICES

4235.1 In order to receive Medicaid reimbursement, Chore Aide services shall be provided by the following Medicaid-enrolled providers:

(a) A home care agency which meets the conditions of participation for home care agencies as set forth in 42 CFR Part 484, by being enrolled as a Medicare provider, and complying with the requirements set forth in the Health-Care and Community Residence Facility, Hospice, and Home Care Licensure Act of 1983, effective Feb. 24, 1984 (D.C. Law 5-48; D.C. Official Code §§ 44-501 *et seq.*); or

(b) A business with a general business license issued by the DCRA to perform housekeeping services in the District of Columbia.

4235.2 Each individual providing chore aide services shall:

(a) Be at least eighteen (18) years of age;

(b) Pass a criminal background check; and

(c) Meet the qualification and training requirements pursuant to Subsections 4235.3 or 4235.4.

4235.3 In order to receive Medicaid reimbursement for chore aide services, a home care agency shall:

(a) Require that all individual chore aides be certified as Home Health Aides in accordance with the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official

Code §§ 3-1201.01 *et seq.* (2016 Repl.)), and implementing rules, Chapter 93 of Title 17 DCMR, and;

(b) Meet any ongoing training requirements required under the Department of Health's Home Health Aide certification requirements.

4235.4 In order to receive Medicaid reimbursement for chore aide services, a business with a general business license issued by the DCRA to provide housekeeping services shall:

(a) Require that all individual chore aides shall obtain a minimum of eight (8) hours of training annually in the following areas:

(1) Beneficiary Rights;

(2) Communicating effectively with beneficiaries enrolled in the waiver;

(3) Preventing Abuse, Neglect, and Exploitation;

(4) Controlling the Spread of Disease and Infection;

(5) Changing linens and bed bug prevention;

(6) Safe handling of cleaning chemicals (use of gloves, goggles/masks);

(7) Handling hazardous waste;

(8) Blood-borne pathogens and bodily fluids; and

(9) Instruction on the following:

(A) Maintenance of floors (mopping/vacuuming);

(B) Trash handling;

(C) Cleaning the walls and ceiling; and

(D) Kitchen and bathroom cleaning and maintenance.

4235.5 Supervisory staff employed by the provider shall develop a written chore aide service delivery plan (Plan of Care), and the beneficiary's case manager shall approve the service delivery plan before it is implemented.

4235.6 The chore aide provider shall document in-home visits and telephone contacts in the beneficiary's service delivery plan at least within thirty (30) days of its home visit.

4235.7 A copy of the chore aide service delivery plan shall be shared with the case manager and kept on-file at the Home Care Agency or the chore aide service provider licensed to provide housekeeping services.

4235.8 Each provider of chore aide services shall maintain comprehensive records including the service delivery plans, and records identifying dates of training and topics covered in each employee's personnel file for a period of no less than ten (10) years.

4235.9 An individualized in-service training plan shall be developed and implemented for each chore aide when performance evaluations indicate a need for more training.

4235.10 A chore aide service provider shall provide a pre- and post-cleaning inspection of the home or place of residence with documentation indicating that the home environment is in a state that can be maintained by ongoing and routine housekeeping.

4235.11 Each home care agency or business with a general business license issued by DCRA to provide housekeeping services shall ensure that the appropriate supervision of chore aide staff is conducted by an individual who has the following qualifications:

(a) Be trained to evaluate the activities of chore aide staff;

(b) Has at least two (2) years of experience supervising the activities of chore aides; and

(c) Has been trained in basic supervision by the home care agency, or the chore aide service provider licensed to provide housekeeping services.

4235.12 An EPD waiver beneficiary may choose an individual or family member other than a beneficiary's spouse, other legally responsible relative, or court-appointed guardian to provide chore aide services. Legally responsible relatives do not include parents of an adult child, so parents of an adult child shall not be precluded from providing chore aide services.

4236 PROGRAM SERVICES: CHORE AIDE SERVICES

4236.1 In order to receive Medicaid reimbursement, a unit of service for chore aide services shall be one (1) hour spent performing allowable task(s). The maximum amount of service permitted under the waiver shall be thirty-two (32) units per

beneficiary for the five-year Waiver period. Service shall be limited to thirty two (32) units per beneficiary.

4236.2 Allowable tasks for chore aide services include the following:

(a) Washing floors;

(b) Washing windows and walls;

(c) Tacking down loose rugs and tiles;

(d) Moving items or furniture in order to provide safe access and egress;

(e) Trash removal;

(f) Removal of animal waste; and

(g) Any other activity designed to bring the environment up to a cleanliness and safety level to enable it to be maintained by ongoing and regular housekeeping.

4236.3 Prohibited tasks for chore aide service include the following:

(a) Hands-on care normally provided by personal care aides;

(b) Housekeeping duties normally provided under the Homemaker service description; and

(c) Respite services.

4237 SPECIFIC PROVIDER REQUIREMENTS: ASSISTED LIVING

4237.1 In order to receive Medicaid reimbursement, each facility providing assisted living services shall be licensed by the District of Columbia DOH and comply with the requirements set forth in the Assisted Living Residence Regulatory Act of 2000, effective June 24, 2000 (D.C. Law 13-127; D.C. Official Code §§ 44-101.01 *et seq.*) and attendant rules.

4237.2 In accordance with the DOH licensure requirements, each assisted living provider shall develop an individualized service plan (Plan of Care) that identifies the services to be included for the beneficiary, and ensure that the plan is shared with the beneficiary's case manager to facilitate coordination of all services received under the EPD Waiver program's PCSP.

4237.3 In accordance with the Home and Community-Based setting requirements described in Subsections 4200.6 and 4200.7, each assisted living residence shall

support the resident's dignity, privacy, independence, individuality, freedom of choice, decision making, spirituality and involvement of family and friends.

4238 PROGRAM SERVICES: ASSISTED LIVING SERVICES

4238.1 In order to receive Medicaid reimbursement, assisted living services shall be personal care and supportive services that are furnished to beneficiaries who reside in a homelike, non-institutional setting that includes twenty-four (24) hour on-site response capability to meet any scheduled or unpredictable needs of the beneficiary and to provide supervision, safety, and security.

4238.2 Assisted living services shall consist of any combination of the following services that meet the beneficiary's needs as outlined in the written PCSP:

(a) Twenty-four (24) hour supervision and oversight to ensure the well-being and safety of beneficiaries;

(b) Assistance with activities of daily living and instrumental activities of daily living, such as PCA services to meet the scheduled and unscheduled service needs of the beneficiaries;

(c) Laundry and housekeeping tasks that a beneficiary is unable to perform and is normally provided under the Chore Aide and Homemaker services benefit;

(d) Coordinating social and recreational activities;

(e) Coordinating activities to enable access to health and social services, including social work, nursing, rehabilitative, hospice, medical, dental, dietary, counseling and psychiatric services; and

(f) Coordinating scheduled transportation to community-based activities.

4238.3 Consistent with Subsection 4238.2(e), the assisted living provider shall coordinate the delivery of all services provided by third parties. A third party may include home care agencies, hospitals, or clinics or Adult Day Health providers.

4238.4 In situations where a beneficiary is prior authorized for PCA services to supplement services provided by the assisted living provider, the assisted living provider shall facilitate coordination by providing a copy of the individualized service plan (Plan of Care) to the case manager and the home care agency providing PCA services.

4239 SPECIFIC PROVIDER REQUIREMENTS: EAA

4239.1 In order to receive Medicaid reimbursement, the case manager shall ensure that a home adaptation assessment is conducted by a licensed physician, occupational therapist, or physical therapist per a physician's order, prior to ordering EAA service(s) included in the beneficiary's PCSP.

4239.2 In order to receive Medicaid reimbursement, the home adaptation assessment shall include, but not be limited to, the following:

(a) Consulting (phone or in-person) with the beneficiary seeking EAA services, the case manager, and support team;

(b) Conducting an on-site assessment to address the beneficiary's accessibility needs and what modifications will be needed to his or her residence; and

(c) Drafting an EAA written report which includes a summary of the on-site assessment and recommendations of the home modifications based upon the beneficiary's needs.

4239.3 No EAA services shall be approved or reimbursed by Medicaid for a beneficiary seeking EAA services who qualifies for the Handicap Accessibility Improvement Program (HAIP) administered by the District of Columbia Department of Housing and Community Development (DHCD). The only qualified applicant for the HAIP is a certified home owner. An applicant who is a renter does not need to apply for HAIP.

4239.4 The case manager shall assist all eligible and certified home owners to apply for the HAIP program. If a home owner is denied participation in the program, he or she must provide a copy of the denial letter to the case manager.

4239.5 In the case of rental property or leased property, no EAA services shall be approved or reimbursed by Medicaid unless:

(a) The current rental, lease agreement, or other residential agreement or contract governing the beneficiary's current residence is thoroughly examined by the Case Manager and DHCF or its designee to determine that the services are not the responsibility of the property owner or manager; and

(b) A signed release was obtained from the management of the property authorizing the EAA home modifications to be made.

4239.6 Prior to initiating EAA services, the case manager shall assist the beneficiary seeking the receipt of EAA services to obtain an evaluation or home inspection from a Certified Third Party Construction Inspector or a Licensed Contractor.

4239.7 The Certified Third Party Construction Inspector shall be certified under the District of Columbia Department of Consumer and Regulatory Affairs (DCRA), Third Party Inspector Program.

4239.8 The Licensed Contractor shall be licensed to do business in the District of Columbia by the DCRA, or shall be licensed to do business in the jurisdiction in which EAA services are to be provided.

4239.9 The evaluation or home inspection shall:

(a) Determine that the beneficiary's residence is structurally sound;

(b) Determine whether the residence can accommodate the recommended EAA services;

(c) Identify any construction stipulations; and

(d) Recommend how the EAA home modifications should be constructed.

4239.10 After receiving the evaluation by the Certified Third Party Construction Inspector, or the Licensed Contractor, the case manager shall assist the beneficiary seeking EAA services to secure three (3) bids from building contractors for cost comparison of EAA services.

4239.11 DHCF may review documentation for approval when three (3) bids cannot be obtained for cost comparison.

4239.12 Each bid submitted by the building contractor for consideration for the receipt of a contract for the delivery of EAA services shall meet the following:

(a) Accept the job specifications contained in the home inspection by the Certified Third Party Construction Inspector, or the Licensed Contractor, unless otherwise agreed to and determined by DHCF;

(b) Be responsible for the costs associated with bringing to completion the EAA modifications described in the home adaptation assessment, including but not limited to, the costs of all construction materials, labor, and any subsequent inspections should the work be found to be substandard.

4239.13 Each building contractor shall be licensed to conduct business in the District of Columbia by the District of Columbia DCRA, or licensed to do business in the jurisdiction where the EEA adaptation services are provided. Each building contractor shall ensure that all construction staff has the training and skill level required to make the allowable in-home modifications.

4239.14 Services shall only be authorized for Medicaid reimbursement in accordance with the following provider requirements:

(a) For home-owners, verification of the denial letter issued by the DHCD HAIP program;

(b) Identification in the PCSP of the EAA service providers (Certified Third Party Contractor/Licensed Contractor and building contractor);

(c) Receipt of a copy of the home inspection;

(d) Receipt of a copy of the three (3) bids or bid submitted to the case manager for consideration of the contract to provide EAA services; and

(e) Verification that the EAA home modifications do not conflict with the service limitations outlined in Section 4240.

4239.15 EAA service providers shall be exempt from the annual tuberculosis (TB) testing requirements.

4239.16 The EAA providers shall maintain a copy of the beneficiary's home inspection, and a copy of the bids submitted, and related documentation, for a period not to exceed ten (10) years.

4240 PROGRAM SERVICES: EAA

4240.1 In order to receive Medicaid reimbursement, in-home modifications for EAA services include, but are not limited to, the following:

(a) Installation of ramps and grab-bars or hand-rails;

(b) Widening of doorways;

(c) Installation of lift systems;

(d) Modifications of bathroom facilities; and

(e) Installation of specialized electric and plumbing systems necessary to accommodate medical equipment and supplies.

4240.2 Modifications or improvements to the home which are of general utility, meaning having no direct medical or remedial benefit to the recipient, shall not be reimbursed by Medicaid as allowable modifications for waiver services. Examples of disallowed EAA modifications include, but are not limited to, the following: carpeting; roof repair; and installation of central air conditioning.

4240.3 In-home modifications adding to the total square footage of the home shall be excluded from Medicaid reimbursement this benefit, except when necessary to complete an adaptation as determined by the Case Manager and DHCF or its designee.

4241 SPECIFIC PROVIDER REQUIREMENTS: ADULT DAY HEALTH

4241.1 In order to receive Medicaid reimbursement, an Adult Day Health provider under the Waiver shall meet the requirements set forth in Chapter 97 (Adult Day Health Program Services) of Title 29 DCMR. These include, but shall not be limited to:

(a) Provider qualifications;

(b) Program Administration; and

(c) Staffing requirements.

4241.2 Each Adult Day Health Program (ADHP) waiver provider shall ensure that they meet all the HCBS setting requirements consistent with Subsection 4200.6 and DHCF's Provider Readiness Review process.

4241.3 Each ADHP waiver provider shall ensure that an ADHP plan of care is developed for each beneficiary that outlines services to be received at the ADHP.

4241.4 Each ADHP waiver provider shall ensure that the ADHP plan of care is shared with the case manager and other individual service providers to facilitate the coordination of all services for the beneficiary under the PCSP.

4241.5 The plan of care shall incorporate the goals and principles of the PCSP and be developed in accordance with the ADHP Plan of Care requirements set forth in Chapter 97 of Title 29 DCMR.

4242 PROGRAM SERVICES: ADULT DAY HEALTH

4242.1 Adult day health services shall encourage adults enrolled in the EPD Waiver to live in the community by offering non-residential medical supports and supervised, therapeutic activities in an integrated community setting, to foster opportunities for community inclusion, and to deter more costly facility-based care.

4242.2 In order to receive Medicaid reimbursement, Adult Day Health services shall consist of the following:

(a) Medical and nursing consultation services including health counseling to improve and maintain the health, safety, and psycho-social needs of the beneficiary;

(b) Individual and group therapeutic activities which may include various social, recreational, and educational activities;

(c) Social service supports including consultations to determine the beneficiary's need for services and, guidance through counseling and teaching on matters related to the beneficiary's health, safety, and general welfare;

(d) Direct care supports including personal care assistance, and offering guidance in performing self-care and activities of daily living;

(e) Instruction on accident prevention and the use of special aides;

(f) Medication administration services provided by a R.N.;

(g) Nutrition services; and

(h) Coordination of transportation services for therapeutic activities that are scheduled off-site.

4242.3 Consistent with Chapter 97 of Title 29 DCMR, ADHP Waiver providers shall not be reimbursed separately for transportation services, including therapeutic activities occurring off-site. However, providers shall coordinate transportation provided under the DHCF non-emergency medical transportation benefit.

4242.4 All services shall be provided in accordance with the requirements set forth in Chapter 97 of Title 29 DCMR.

4243 SPECIFIC PROVIDER REQUIREMENTS: PHYSICAL THERAPY

4243.1 Physical Therapy services shall only be reimbursed by Medicaid if they are provided by the following Medicaid-enrolled providers:

(a) A home care agency licensed pursuant to Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code, §§ 44-501 *et seq.*), and implementing rules; or

(b) An independent licensed physical therapist.

4243.2 Physical therapy services shall be reimbursed by Medicaid if they are provided by a physical therapist or a physical therapy assistant working under the direct supervision of a physical therapist.

4243.3 In order to receive Medicaid reimbursement, all practitioners shall meet the following requirements:

(a) Be licensed to practice physical therapy in accordance with the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.* (2016 Repl.)), and implementing rules, Chapter 67 (Physical Therapy) of Title 17 DCMR; or

(b) Be a physical therapy assistant who is licensed to practice as a physical therapy assistant in accordance with the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.* (2016 Repl.)), and implementing rules, Chapter 82 (Physical Therapy Assistants) of Title 17 DCMR.

4243.4 In order to be eligible for reimbursement, each Medicaid provider must obtain prior authorization from DHCF or its designee prior to providing, or allowing any professional to provide physical therapy services. In its request for prior authorization, the Medicaid provider shall document the following:

(a) The EPD Waiver beneficiary's need for physical therapy services as demonstrated by a physician's order; and

(b) The name of the professional or home care agency that will provide the physical therapy services.

4243.5 In order to be eligible for Medicaid reimbursement, each individual providing physical therapy services shall participate in PCSP and interdisciplinary team meetings to provide consultative services and recommendations to focus on how the beneficiary is doing in achieving the functional goals that are important to him or her;

4243.6 Each Medicaid provider shall maintain the following documents for monitoring and audit reviews:

(a) The physician's order;

(b) A copy of the physical therapy assessment and therapy plan developed in accordance with the requirements of this Section; and

(c) Any documents required to be maintained by DHCF as specified in Section 4255 (Audits and Monitoring/Oversight Reviews).

4244 PROGRAM SERVICES: PHYSICAL THERAPY

4244.1 Physical Therapy (PT) services shall maximize independence, prevent further disability, maintain health, and the beneficiary's functionality, and be targeted at the treatment of identified physical dysfunction or the degree to which pain associated with movement can be reduced.

4244.2 Physical therapy services shall be provided in accordance with the beneficiary's PCSP and delivered in the beneficiary's home or in a day service setting.

4244.3 Each physical therapy professional shall conduct an assessment of physical therapy needs within the first four (4) hours of service delivery, and develop a therapy plan (Plan of Care) to provide services.

4244.4 The therapy plan shall include the anticipated and measurable, functional outcomes, based upon what is important to and for the beneficiary as reflected in his or her person-centered goals in his or her PCSP and a schedule of approved physical therapy services to be provided.

4244.5 The therapy plan shall be submitted by the Medicaid provider to the beneficiary or authorized representative, and the case manager before services are delivered.

4244.6 Medicaid reimbursable physical therapy services shall consist of the following ongoing activities:

(a) Conducting an initial assessment and annual re-assessment;

(b) Consulting with the beneficiary, his or her family, caregivers and interdisciplinary team to develop the therapy plan;

(c) Implementing therapies described in the therapy plan;

(d) Recording progress notes during each visit which shall contain the following:

(1) Progress in meeting each goal in the therapy plan;

(2) Any unusual health or behavioral events or change in status;

(3) The start and end time of any services received by the beneficiary; and

(4) Any matter requiring follow-up on the part of the service provider, case manager, or DHCF.

(e) Developing quarterly reports based on the progress notes and indicating progress in meeting each goal in the therapy plan, and any progress made on matters requiring follow-up in the progress notes;

(f) Submitting quarterly reports to DHCF, which shall be uploaded in the EPD Waiver electronic case management system;

(g) Routinely assessing (at least annually and more frequently as needed) the appropriateness and quality of adaptive equipment to ensure it addresses the beneficiary's needs;

(h) Completing documentation required to obtain or repair adaptive equipment in accordance with insurance guidelines and Medicare and Medicaid guidelines, including required timelines for submission;

(i) Conducting periodic examinations (at least annually and more frequently as needed) and modified treatments for the beneficiary, as needed to determine which services are most appropriate to enhance the beneficiary's well-being and meet the therapeutic goals; and

(j) Updating the therapy plan and communicating with the case manager to make any updates to the PCSP with any modifications to the therapy plan.

4245 SPECIFIC PROVIDER REQUIREMENTS: OCCUPATIONAL THERAPY

4245.1 Occupational Therapy services shall only be reimbursed by Medicaid if they are provided by the following Medicaid-enrolled providers:

(a) A home care agency licensed pursuant to the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code, §§ 44-501 *et seq.*), and implementing rules; or

(b) An independent licensed occupational therapist.

4245.2 Medicaid reimbursable occupational therapy services shall be provided by an occupational therapist or an occupational therapy assistant working under the direct supervision of an occupational therapist.

4245.3 In order to receive Medicaid reimbursement all practitioners shall meet the following requirements:

(a) Be licensed to practice occupational therapy in accordance with the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.* (2016 Repl.)), and implementing rules, Chapter 63 (Occupational Therapy) of Title 17 DCMR; or

(b) Be an occupational therapy assistant who is licensed to practice as an occupational therapy assistant in accordance with the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.* (2016 Repl.)), and implementing rules, Chapter 73 (Occupational Therapy Assistants) of Title 17 DCMR.

4245.4 In order to be eligible for reimbursement, each Medicaid provider must obtain prior authorization from the DHCF or its designee prior to providing, or allowing any professional to provide occupational therapy services. In its request for prior authorization, the Medicaid provider shall document the following:

(a) The EPD Waiver beneficiary's need for occupational therapy services as demonstrated by a physician's order; and

(b) The name of the professional or home care agency that will provide the occupational therapy services.

4245.5 In order to be eligible for Medicaid reimbursement, each individual providing occupational therapy services shall participate in the PCSP and interdisciplinary team meetings to provide consultative services and recommendations specific to the expert content with a focus on how the beneficiary is doing in achieving the functional goals that are important to him or her.

4245.6 Each Medicaid provider shall maintain the following documents for monitoring and audit reviews:

(a) A physician's order;

(b) A copy of the occupational therapy assessment and therapy plan developed in accordance with the requirements of this section; and

(c) Any documents required to be maintained by DHCF per Section 4255 (Audits and Monitoring/Oversight Reviews).

4246 PROGRAM SERVICES: OCCUPATIONAL THERAPY

4246.1 In order to receive Medicaid reimbursement, Occupational Therapy (OT) services shall be designed to maximize independence, prevent further disability, maintain health, and the beneficiary's functionality.

4246.2 Occupational therapy services shall be provided in accordance with the beneficiary's PCSP and delivered in the beneficiary's home or in a day service setting.

4246.3 Each occupational therapy professional shall conduct an assessment of the occupational therapy needs within the first four (4) hours of service delivery, and develop a therapy plan (Plan of Care) to provide services.

4246.4 The therapy plan shall include the anticipated and measurable, functional outcomes, based upon what is important to and for the beneficiary as reflected in his or her person-centered goals in his or her PCSP and a schedule of approved occupational therapy services to be provided, and shall be submitted by the Medicaid provider to the case manager before services are delivered.

4246.5 Medicaid reimbursable occupational therapy services shall consist of the following ongoing activities:

(a) Conducting an initial assessment and annual re-assessment;

(b) Consulting with the beneficiary, his or her family, caregivers and interdisciplinary team to develop the therapy plan;

(c) Implementing therapies described in the therapy plan;

(d) Recording progress notes during each visit, which shall contain the following:

(1) Progress in meeting each goal in the therapy plan;

(2) Any unusual health or behavioral events or change in status;

(3) The start and end time of any services received by the beneficiary; and

(4) Any matter requiring follow-up on the part of the service provider, case manager, or DHCF.

(e) Developing quarterly reports based on the progress notes and indicating progress in meeting each goal in the therapy plan, and any progress made on matters requiring follow-up in the progress notes;

(f) Submitting quarterly reports to DHCF, which shall be uploaded in the EPD Waiver electronic case management system;

(g) Routinely assessing (at least annually and more frequently as needed) the appropriateness and quality of adaptive equipment to ensure it addresses the beneficiary's needs;

(h) Completing documentation required to obtain or repair adaptive equipment in accordance with insurance guidelines and Medicare and Medicaid guidelines, including required timelines for submission;

(i) Conducting periodic examinations (at least annually and more frequently as needed) and modified treatments for the beneficiary, as needed to determine which services are most appropriate to enhance the beneficiary's well-being and meet the therapeutic goals; and

(j) Updating the therapy plan and communicating with the case manager to make any updates to the PCSP with any modifications to the therapy plan.

4247 SPECIFIC PROVIDER REQUIREMENTS: INDIVIDUAL-DIRECTED GOODS AND SERVICES

4247.1 In order to receive Medicaid reimbursement, individual-directed goods and services shall only be provided to EPD Waiver beneficiaries enrolled as participants in the *Services My Way* program.

4247.2 In order to receive Medicaid reimbursement, all individuals and vendors providing individual-directed goods and services shall meet the following minimum qualifications:

(a) All individuals providing individual-directed goods and services shall be at least eighteen (18) years of age;

(b) All individuals and vendors providing individual-directed goods and services shall be able to demonstrate to the participant that:

(1) The individual or vendor has the capacity to perform the requested work;

(2) The individual or vendor has the ability to successfully communicate with the participant; and

(3) The individual or vendor has all the necessary professional and/or commercial licenses required by federal and District law.

4247.3 In order to receive Medicaid reimbursement individuals and vendors providing non-medical transportation as an individual-directed service shall meet the following additional qualifications:

(a) The individual or vendor shall have a valid driver's license; and

(b) The individual or vendor shall have the minimum amounts of property damage liability, third party personal liability, uninsured motorist bodily

injury, and uninsured motorist property damage insurance coverage required by the District of Columbia for the type of vehicle used to provide the transportation, in accordance with the Compulsory/No-Fault Motor Vehicle Insurance Act, effective September 18, 1982 (D.C. Law 4-155; D.C. Official Code §§ 31-2401 *et seq.*).

4247.4 No individual or vendor shall be reimbursed by Medicaid for any individual-directed good or service that is not:

(a) Documented in the participant's PCSP and participant-directed services (PDS) budget; and

(b) Approved by the *Services My Way* Program Coordinator.

4247.5 An individual or vendor selected by a participant to provide individual-directed goods or services on a recurrent basis may be required to enter into a Medicaid provider agreement with DHCF prior to providing the goods or services. The Medicaid provider agreement shall be executed by the Vendor Fiscal/Employer Agent (VF/EA) Financial Management Services (FMS)-Support Broker entity supporting the *Services My Way* program on behalf of DHCF.

4247.6 The VF/EA FMS-Support Broker entity shall verify that an individual or vendor selected by the participant to provide individual-directed goods and services meets all applicable requirements set forth in Subsections 4247.2 and 4247.3 at the time of enrollment into the VF/EA FMS-Support Broker entity's provider payment system and thereafter, as necessary.

4248 PROGRAM SERVICES: INDIVIDUAL-DIRECTED GOODS AND SERVICES

4248.1 Individual-directed goods and services are only available to EPD Waiver beneficiaries who are enrolled as participants in the *Services My Way* program, and are purchased from the participant's PDS budget.

4248.2 Individual-directed goods and services are services, equipment or supplies not otherwise provided through the EPD Waiver or the Medicaid State Plan that address an identified need in the participant's PCSP, including improving and maintaining the participant's opportunities for full membership in the community. Individual-directed goods and services shall meet the following requirements in order to be reimbursed by Medicaid:

(a) The requested item or service would decrease the participant's need for other Medicaid services;

(b) The requested item or service would promote the participant's inclusion in the community; or

(c) The requested item or service would increase the participant's safety in the home environment.

4248.3 Allowable goods and services shall include, but not be limited to, the following:

(a) Cleaning services from firms or individuals to clean the participant's personal areas including bedroom, bathroom, kitchen, etc., only if necessary in addition to those services otherwise available through the EPD Waiver;

(b) Food preparation and delivery services, including grocery delivery and delivery of prepared foods (but not payment for the food itself);

(c) Transportation services not currently available under Medicaid or the District's accessible transportation programs or through natural supports that are related to activities of daily living, and meet an objective outlined in the participant's PCSP;

(d) Small electric appliances which allow the participant to safely prepare meals;

(e) Laundry services;

(f) The cost of changing locks at the participant's home, as necessary, when a participant-directed worker (PDW) stops working for the participant; and

(g) Maintenance of items that meet the criteria of allowable individual-directed goods described in § 4248.2.

4248.4 Payment for allowable transportation services shall be made in the form of reimbursement for mileage documented on a Mileage Reporting Form provided by DHCF or its agent or reimbursement for public transit costs documented as specified by DHCF or its agent and submitted to the VF/EA FMS-Support Broker entity.

4248.5 For purposes of Medicaid reimbursement, non-allowable goods and services shall include, but not be limited to, the following:

(a) Gifts for PDWs, family or friends, including bonus payments to PDWs;

(b) Loans to PDWs, family or friends;

(c) Food, beverages and nutritional supplements;

(d) Entertainment equipment or supplies such as videos, VCRs, televisions, stereos, CDs, DVDs, audio and video tapes;

(e) Air conditioners, heaters, fans and similar items;

(f) Electronic devices that do not meet the requirements of § 4248.2 and do not meet an objective outlined in the participant's PCSP;

(g) Illegal drugs;

(h) Alcoholic beverages or tobacco products;

(i) Costs associated with advertising for prospective PDWs;

(j) Costs associated with travel (airfare, lodging, meals, etc.) for vacations or entertainment;

(k) Utility, rent or mortgage payments;

(l) Clothing or shoes;

(m) Comforters, towels, linens or drapes;

(n) Paint or related supplies;

(o) Furniture or other household furnishings;

(p) Cleaning or laundry for other household members or areas of a home that are not used as part of the participant's personal care;

(q) Large household or kitchen appliances such as washers, dryers, dishwashers, refrigerators, or freezers;

(r) Exercise equipment;

(s) Medications, vitamins or herbal supplements;

(t) Experimental or prohibited treatments;

(u) Laundry detergent and household cleaning supplies;

(v) Vehicle expenses, including routine maintenance, repairs, or insurance costs;

(w) Transportation services that are otherwise available under Medicaid or the District's accessible transportation programs or through natural supports or that are not related to activities of daily living;

(x) Landscaping and yard work;

(y) Pet care and supplies, except when provided for service animals; and

(z) Massages, manicures or pedicures.

4248.6 Participants in the *Services My Way* program may purchase individual-directed goods and services that are included in their PCSP, meet the requirements of Subsections 4248.2 and 4248.3, and are within their PDS budget to purchase.

4248.7 Individual-directed goods and services shall be documented in the participant's PDS budget and PCSP. The participant's support broker shall assist participants to revise their PDS budgets, as necessary, to account for new, appropriate individual-directed goods and services they would like to purchase. All revisions to a participant's PDS budget to account for new, appropriate individual-directed goods and services shall be accompanied by justification supporting the revision.

4248.8 Upon revising a PDS budget to reflect a new individual-directed good or service, the support broker shall submit the revised PDS budget and justification to the *Services My Way* Program Coordinator for approval.

4248.9 The *Services My Way* Program Coordinator shall review all requested individual-directed goods and services.

4248.10 The VF/EA FMS-Support Broker entity shall only authorize payment of invoices submitted for individual-directed goods and services that are included in the participant's PCSP and PDS budget and that have been approved by the *Services My Way* Program Coordinator.

4249 SPECIFIC PROVIDER REQUIREMENTS: PARTICIPANT-DIRECTED COMMUNITY SUPPORT SERVICES

4249.1 Participant Directed Community Support Services (PDCS) services shall only be reimbursed to EPD Waiver beneficiaries enrolled as participants in the *Services My Way* program.

4249.2 Qualified PDWs shall provide PDCS services as employees of *Services My Way* participants.

4249.3 Medicaid reimbursable PDCS services may be provided by family members and individuals other than a participant's spouse, other legally responsible relative, or court-appointed guardian. A legally responsible relative does not include parents

of adult children, so parents of adult children are not precluded from providing PDCS services. Each family member providing PDCS services shall comply with the requirements set forth in this chapter and Chapter 101 of this title.

4249.4 In order to be reimbursed by Medicaid, all PDWs shall meet the following qualifications:

(a) Be at least eighteen (18) years of age;

(b) Complete and pass a criminal background check in accordance with the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999, as amended by Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, April 13, 2002 (D.C. Law 14-98; D.C. Official Code §§ 44-551 *et seq.* (2016 Repl.));

(c) Receive customized training provided by the participant or the participant's authorized representative that is related to the participant's functional needs and goals as outlined in the PCSP;

(d) Be able and willing to perform the service-related responsibilities outlined in the participant's PCSP; and

(e) Be certified in cardiopulmonary resuscitation (CPR) and First Aid through an in-person training course approved by the American Red Cross or an alternative course approved by the *Services My Way* Program Coordinator and maintain current certifications.

4249.5 *Services My Way* participants shall not serve as PDWs.

4249.6 The VF/EA FMS-Support Broker entity shall be responsible for verifying that criminal background checks are conducted on all prospective PDWs in accordance with Subsection 4249.4(b), and providing participants, authorized representatives, prospective PDWs, and the *Services My Way* Program Coordinator with the results of all criminal background checks performed on prospective PDWs.

4249.7 The participant, or the participant's authorized representative if designated as the "common law employer" of the PDW, shall verify that a prospective PDW meets all qualifications set forth in Subsection 4249.4 prior to hiring the PDW to provide PDCS services.

4249.8 The VF/EA FMS-Support Broker entity shall verify that a PDW meets all qualifications set forth in Subsection 4249.4 prior to enrolling the PDW into its payroll system.

4249.9 The VF/EA FMS-Support Broker entity shall execute a Medicaid provider agreement with each PDW on behalf of DHCF at the time a PDW is enrolled into its payroll system.

4250 PROGRAM SERVICES: PARTICIPANT-DIRECTED COMMUNITY SUPPORT SERVICES

4250.1 Medicaid will only reimburse PDCS services for EPD Waiver beneficiaries enrolled as participants in the *Services My Way* program.

4250.2 In order to receive Medicaid reimbursement, PDCS services shall be detailed in the participant's PCSP and PDS budget and shall be designed to promote independence and ensure the health, welfare, and safety of the participant.

4250.3 The participant or his or her authorized representative, as applicable, shall serve a "common law employer" of the PDW providing services. In the role of "common law employer," the participant or authorized representative shall be responsible for recruiting, hiring, supervising and discharging PDWs providing PDCS services.

4250.4 Supports shall be available to assist the participant or representative-employer with his or her own employer-related responsibilities as described in Subsection 4250.3 through the VF/EA FMS-Support Broker entity.

4250.5 PDCS services shall include cueing and assistance with activities of daily living and instrumental activities of daily living.

4250.6 All PDCS services provided by a PDW shall be prior authorized by DHCF or its agent in order to be reimbursed under the *Services My Way* program.

4250.7 To be eligible for PDCS services, a participant shall be in receipt of a service authorization for PCA from DHCF or its designated agent that specifies the amount, duration, and scope of services authorized to be provided to the beneficiary, in accordance with 29 DCMR § 5003.

4250.8 Payment for PDCS services shall be provided in accordance with the participant's PDS budget, at an hourly wage set by the participant or representative-employer which falls within the wage range established by DHCF as set forth in Subsection 4250.9.

4250.9 The hourly wage paid to a PDW shall be no lower than the living wage in the District, set in accordance with the Living Wage Act of 2006, effective June 8, 2006 (D.C. Law 16-118; D.C. Official Code §§ 2-220.01 *et seq.*), and no higher than the wage paid by DHCF for services provided by a personal care aide in accordance with Chapter 42 of Title 29 DCMR.

4250.10 PDCS services shall not include the following:

(a) Services that require the skills of a licensed professional, as defined in the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.*); or

(b) Tasks usually performed by chore workers or homemakers, such as cleaning of areas not occupied by the participant, laundry for family members, shopping for items not used by the participant, or money management.

4250.11 An agency-based provider of personal care aide services shall not be designated as an emergency back-up provider of PDCS services.

4250.12 In order to ensure PDCS services are provided in a manner that ensures the participant's health and safety, if a participant has been assessed for one hundred twelve (112) or more hours of PCA services per week in accordance with 29 DCMR § 5003, PDCS services must be provided by at least two (2) PDWs each week.

4251 SPECIFIC PROVIDER REQUIREMENTS: COMMUNITY TRANSITION SERVICES

4251.1 Each case manager providing Community Transition services shall:

(a) Work with the beneficiary to identify household items needed to facilitate transition to the community;

(b) Work with the vendor to ensure that the beneficiary has access to the identified household items to facilitate a successful transition to the community;

(c) Complete and forward the beneficiary's demographic information on documents provided by DHCF, or its designee;

(d) Submit a purchase order /transition fund request to DHCF or its designee for processing;

(e) Act as primary point of contact with DHCF and the vendor for coordination of transition payments;

(f) Schedule pick-up of checks from the vendor's site;

(g) Keep records to ensure that beneficiary's purchase order requests do not exceed the maximum amount of five thousand ($5,000) allowed per beneficiary; and

(h) Provide documentation of all services provided, and beneficiary records to be made available to DHCF or its designee for monitoring and oversight and/or audit reviews.

4251.2 Community Transition services shall not be provided to waiver beneficiaries who:

(a) Are not transitioning to the community from a long term care facility; or

(b) Have duplicative household set-up items in their possession.

4252 PROGRAM SERVICES: COMMUNITY TRANSITION SERVICES

4252.1 Community Transition Services are non-recurring set-up expenses for beneficiaries who are transitioning from an institution or other long term care facility to a more integrated and less restrictive community setting. Allowable expenses are those necessary to enable an individual to establish a basic household that does not constitute room and board.

4252.2 Household set-up expenses provided under community transition services may include the following:

(a) Rental application fees and security deposits in the amount of the first month's rent or greater that are required to obtain a lease on an apartment or home;

(b) Essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;

(c) Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;

(d) Services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy;

(e) Moving expenses;

(f) Necessary home accessibility adaptations; and,

(g) Activities to assess need, arrange for, and procure needed resources.

4252.3 Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the transition planning process, and clearly identified in the beneficiary's transition plan or PCSP once they are enrolled in the EPD Waiver.

4252.4 The household set-up items shall be approved by the Case Manager as part of the beneficiary's PCSP.

4252.5 Community Transition Services for the household set up items specified under § 4252.2 shall be provided up to an amount of five thousand dollars ($5,000) and may be used as determined in the transition plan development, from the time a tentative discharge date from the long term care facility has been established and EPD Waiver eligibility has been established.

4252.6 Community Transition funds shall be utilized for a period not to exceed one hundred and twenty days (120) before discharge and up to six (6) months after discharge from an institution or long term care facility.

4253 TERMINATIONS AND ALTERNATIVE SANCTIONS

4253.1 In order to qualify for Medicaid reimbursement, EPD Waiver Providers shall comply with programmatic requirements as part of its Provider Readiness Review and enrollment. The programmatic requirements include adherence to acceptable standards in the following areas:

(a) Service Delivery as governed by the provider requirements and duties established in this chapter;

(b) Program administration as governed under mandated policies and procedures;

(c) EPD Waiver-related Performance Measures;

(d) Staffing and training; and

(e) Home and Community Based Services (HCBS) setting requirements.

4253.2 In accordance with the approved Waiver, DHCF may impose alternative sanctions against an EPD Waiver Provider in response to receiving complaints and/or incident reports via the electronic case management system or EPD waiver complaint database, or upon recommendation by the Department's Division of Program Integrity or Long Term Care Administration's EPD Waiver Monitoring Unit.

4253.3 DHCF shall determine the appropriateness of alternative sanctions against a Waiver provider based on the following factors:

(a) Seriousness of the violation(s);

(b) Number and nature of the violation(s);

(c) Potential for immediate and serious threat(s) to EPD Waiver participants;

(d) Potential for serious harm to Waiver participants;

(e) Any history of prior violation(s) and/or sanction(s);

(f) Actions or recommendations by the Department's Division of Program Integrity or Long Term Care Administration's EPD Waiver Monitoring Unit; and

(g) Other relevant factors.

4253.4 DHCF may impose one (1) or more alternative sanctions against an EPD Waiver Provider, if the violation does not place the beneficiary's health or safety in immediate jeopardy, as set forth below:

(a) Impose a corrective action plan (CAP);

(b) Prohibit new admissions or place a cap on enrollment;

(c) Place the provider on an enhanced monitoring plan;

(d) Withhold payments; or

(e) Temporarily suspend the provider from the EPD Waiver Program.

4253.5 DHCF shall publicize the imposition of an alternative sanction on its website.

4253.6 A CAP may include actions such as publicizing information during the EPD Waiver mandatory monthly meeting, and posting provider performance cards on DHCF's website.

4253.7 DHCF shall issue a written notice of provider termination where the agency determines that the sanctions listed under Subsection 4253.4 are not appropriate to address the incident(s) and/or complaint(s). DHCF shall reserve the right to terminate a Medicaid provider agreement without a sanction depending on the severity of the violations.

4253.8 If DHCF initiates an action to terminate a provider agreement, DHCF shall follow the procedures set forth in Chapter 13 of Title 29 DCMR governing termination of the Medicaid provider agreement.

4253.9 The DHCF may also take actions in lieu of or in addition to an alternative sanction when appropriate. These include the following:

(a) Referral of the incident to another entity, including but not limited to the Medicaid Fraud Control Unit of the Office of the Inspector General for investigation; or

(b) Referral to Adult Protective Services (APS).

4253.10 If DHCF initiates an action to impose an alternative sanction, a written notice shall be issued to each EPD Provider notifying the provider of the imposition of an alternative sanction.

4253.11 The written notice shall inform the provider that DHCF intends to impose an alternative sanction.

4253.12 The notice shall also include the following:

(a) The basis for the proposed action;

(b) The specific alternative sanction that DHCF intends to take;

(c) The provider's right to dispute the allegations and to submit evidence to support his or her position; and

(d) Specific reference to the particular sections of the statutes, rules, provider's manual, and/or provider agreements involved.

4253.13 The EPD Waiver provider may submit documentary evidence to DHCF's Long Term Care Administration, 441 4th St. NW, Ste. 1000, Washington D.C. 20001 to refute DHCF's argument for imposition of an alternative sanction within thirty (30) days of the date of the notice described in Subsections 4253.10 through 4253.12.

4253.14 DHCF may extend the thirty (30) day period prescribed in Subsection 4253.13 for good cause on a case-by-case basis.

4253.15 If DHCF decides to impose an alternative sanction against the EPD provider after the provider has issued a response under Subsection 4253.13, DHCF will send a written notice at least fifteen (15) days before the imposition of the alternative sanction. The notice shall include the following:

(a) The reason for the decision;

(b) The effective date of the sanction; and

(c) The provider's right to request a hearing by filing a notice of appeal with the District of Columbia Office of Administrative Hearings.

4253.16 If the provider files a notice of appeal within fifteen (15) days of the date of the notice of the alternative sanction under Subsection 4253.15, then the effective date of the proposed action shall be stayed until the D.C. Office of Administrative Hearings has rendered a final decision.

4253.17 The Director of DHCF shall consider modifying the alternative sanction upon occurrence of one of the following:

(a) Circumstances have changed and resulted in changes to the programmatic requirement violation(s) in such a manner as to immediately jeopardize a beneficiary's health, safety, and welfare; or

(b) The EPD Provider makes significant progress in achieving compliance with the programmatic requirements through good faith efforts.

4253.18 A provider shall be prohibited from submitting an application for participation in the EPD Waiver program for two (2) consecutive years from the date of receipt of the final notice of termination of a Medicaid Provider Agreement.

4253.19 A provider that has been terminated from the District's Medicaid EPD Waiver program shall be precluded from submitting any claims for payment, either personally or through claims submitted by any entity for any services provided under the EPD Waiver program, for dates of service on or after the effective date of the termination decision after the provider exhausts all appeal rights and an official decision of termination has been made.

4254 INCIDENTS AND COMPLAINTS

4254.1 Providers are required to report critical incidents that may threaten the beneficiary's health or welfare for review and follow-up by DHCF and/or other designated agencies. The critical incidents consist of the following categories:

(a) Serious reportable incidents (SRI); and

(b) Reportable incidents (RI).

4254.2 SRI are those incidents which due to their significance or severity to the beneficiary require immediate response, notification, internal review and investigation by the provider agency and DHCF.

4254.3 RI are significant events or situations that involve harm or risk to the beneficiary.

4254.4 SRI include, but are not limited to:

(a) Unexpected death due to abuse, negligence, or accident;

(b) Abuse;

(c) Neglect or abandonment;

(d) Exploitation;

(e) Theft of consumer personal property;

(f) Serious physical injury;

(g) Inappropriate or unauthorized use of restraints;

(h) Suicide threats;

(i) Serious medication errors; and

(j) Suicide attempts or serious fire incidents that could have resulted in serious bodily harm or death.

4254.5 RI include, but are not limited to:

(a) Medication errors;

(b) Hospitalization;

(c) Injuries;

(d) Emergency Room visits;

(e) Fire Occurrences involving property damage;

(f) Police Incidents;

(g) A temporary relocation due to emergencies; and

(h) Other events or situations that involve harm or risk of harm to beneficiaries.

4254.6 Each service provider shall develop internal policies and procedures regarding incident reporting and investigation that meets the following minimum criteria:

(a) Notifying DHCF staff via the electronic management system within twenty four (24) hours or the next business day of an occurrence of an SRI or RI;

(b) Documenting of the incident on an established incident report form in the electronic management system;

(c) Completing of an internal investigation within five (5) business days of the SRI or RI's occurrence; and

(d) Reporting for all SRIs involving death, neglect, abuse, and theft of consumer personal property occurring at a beneficiary's natural home to Adult Protective Services and DHCF.

4254.7 All providers shall establish an internal process for tracking information related to the occurrence of incidents and the outcome of investigations to predict and mitigate recurring incidents.

4254.8 Each provider shall maintain a copy of all incidents and keep them on file for a minimum period of ten (10) years, or until any DHCF, law enforcement, or Adult Protective Services' investigation of an incident has concluded, whichever is longer.

4254.9 A complaint is an expression of dissatisfaction or a formal charge of wrong-doing brought against an EPD Waiver Provider or individual providing services. Complaints include but are not limited to the following:

(a) Denials or reductions of service;

(b) Delays in the process resulting in a denial of eligibility;

(c) Provider tardiness or poor quality of care;

(d) Restriction of individual rights;

(e) Lack of choice of service provider;

(f) Obstructing the beneficiary's choice of preferred service provider when available; and

(g) Violations of privacy and confidentiality policies as outlined under a providers' privacy plan as required in accordance with the requirements set forth in Section 4207.

4254.10 Each service provider shall develop internal policies and procedures regarding complaint documentation and a review process that meets the following minimum criteria:

(a) An explanation of types of complaints that shall be addressed;

(b) The identification of a designated complaint officer who shall manage the complaint process;

(c) The timelines for addressing the complaints which shall specify the following:

(1) All complaints that pose an immediate risk to the beneficiary shall be addressed by the complaints officer within twenty four (24) hours or next business day of the receipt of the complaint;

(2) Complaints pertaining to Medicaid eligibility determination and denial or reduction of service shall be addressed by the complaints officer within five to seven (5 – 7) business days;

(3) All other complaints will be addressed by the complaints officer within ten (10) business days;

(d) Procedures verifying that all complaints are resolved within thirty (30) business days of the reporting of the complaint to the designated complaint officer; and

(e) The procedures that are used to resolve the complaints.

4254.11 All provider entities shall establish an internal process for tracking and trending information related to the occurrence of complaints and the outcome of investigations.

4254.12 Each provider shall maintain a copy of all complaints on file for a minimum period of ten (10) years.

4254.13 DHCF shall issue a transmittal notifying providers to log complaints into the EPD Waiver Complaint Database upon its operation.

4255 AUDITS AND MONITORING/OVERSIGHT REVIEWS

4255.1 The DHCF's Division of Program Integrity shall perform ongoing audits to ensure that the provider's services for which Medicaid payments are made are consistent with programmatic duties, documentation, and reimbursement requirements as required under this chapter.

4255.2 The audit process shall be routinely conducted by DHCF to determine, by statistically valid scientific sampling, the appropriateness of services rendered to EPD Waiver program beneficiaries and billed to Medicaid.

4255.3 Each EPD Waiver provider shall allow access, during an on-site audit or review (announced or unannounced) by DHCF, other District of Columbia government officials, and representatives of the United States Department of Health and Human Services, to relevant records and program documentation.

4255.4 The failure of a provider to timely release or to grant access to program documents and records to the DHCF auditors, after reasonable notice by DHCF to the provider to produce the same, shall constitute grounds to terminate the Medicaid Provider Agreement.

4255.5 If DHCF denies a claim during an audit, DHCF shall recoup, by the most expeditious means available, those monies erroneously paid to the provider for denied claims, following notice and the period of Administrative Review set forth in Subsection 4255.7 of this chapter.

4255.6 The recoupment amounts for denied claims during audits shall be determined by the following formula:

(a) The number of denied paid claims resulting from the audited sample shall be divided by the total number of paid claims from the audited sample; and

(b) The amount derived from (a) as referenced in Subsection 4255.6 shall be multiplied by the total dollars paid by DHCF to the provider during the audit period to determine the amount to be recouped.

4255.7 In accordance with the formula referenced in Subsection 4255.6, DHCF would recoup ten percent (10%) of the amount reimbursed by Medicaid during the audit period, or one thousand dollars ($1000), if a provider received Medicaid reimbursement of ten thousand dollars ($10,000) during the audit period, and during a review of the claims from the audited sample, it was determined that ten (10) claims out of one hundred (100) claims are denied.

4255.8 DHCF shall issue a Notice of Proposed Recovery for Medicaid Overpayment (NPRMO) which sets forth the reasons for the recoupment, including the specific reference to the particular sections of the statute, rules, or Provider agreement, the amount to be recouped, and the procedures for requesting an administrative review.

4255.9 The timelines for responding to the NPRMO and the provider's appeal rights are governed by Section 4256.

4255.10 The DHCF's Long Term Care Administration's EPD Waiver Oversight and Monitoring team shall conduct two (2) types of reviews as follows:

(a) Annual oversight and monitoring reviews to ensure compliance with established federal and District regulations and applicable laws governing the operations and administration of the EPD Waiver Program; and

(b) Quarterly compliance reviews to ensure adherence with the EPD Waiver Program's performance measures.

4255.11 Each waiver services provider shall allow the EPD Waiver oversight and monitoring team access, during an on-site oversight/monitoring process (announced or unannounced).

4255.12 As part of the oversight and monitoring process, providers shall grant access to any of the following documents, which may include, but shall not be limited to the following:

(a) Person-Centered Service Plan (PCSP) and Plan of Care/ service delivery plan;

(b) Employee records;

(c) A signed, and current copy of the Medicaid Provider Agreement;

(d) Licensure information;

(e) Policies and Procedures;

(f) Incident Reports and Investigation Reports; and

(g) Complaint related reports.

4255.13 DHCF's EPD Waiver Oversight and Monitoring Team shall issue a Statement of Findings and Opportunities for Improvement Plan ("improvement plan") within fifteen (15) calendar days of the annual oversight and monitoring exit meeting. Providers shall subsequently submit a plan of correction within fifteen (15) calendar days of the date of receipt of DHCF's improvement plan.

4255.14 DHCF's EPD Waiver Oversight and Monitoring team shall generate a performance measures discovery/remediation report ("remediation report") within five (5) business days of completion of the quarterly performance measures-related review. Providers shall subsequently submit a performance measures-related remediation plan ("remediation plan") within ten (10) business days of receipt of the report.

4255.15 The failure to provide an acceptable plan of correction, remediation plan or adherence to the improvement plan or remediation report may result in alternative sanctions such as a prohibition of new admissions and referral to the DHCF's Division of Program Integrity for further investigation.

4256 APPEAL RIGHTS FOR PROVIDERS AGAINST WHOM A RECOUPMENT IS MADE

4256.1 The provider shall have thirty (30) calendar days from the date of the NPRMO to respond in writing. The response shall be submitted to the DHCF's Director of the Division of Program Integrity.

4256.2 The provider's written response to the NPRMO shall include a specific description of the item(s) to be reviewed, the reason for the request for review, the relief requested, and documentary evidence in support of the relief requested.

4256.3 The DHCF's Division of Program Integrity shall mail a written determination no later than one hundred and twenty (120) calendar days from the date of receipt of the provider's response to the NPRMO.

4256.4 Payments otherwise authorized to be made to a provider under the District of Columbia Medicaid Program may be suspended or recouped, in whole or in part, by DHCF to recover or aid in the recovery of overpayments that have been made to the provider.

4256.5 The DHCF shall notify the provider of its intention to recoup payments, in whole or in part, and the reasons for the recoupment in a Final Notice of Medicaid Overpayment Recovery (FNPRMO). The Final Notice to providers shall include the following:

(a) The factual basis for the determination of overpayments including the dollar value of the overpayment;

(b) How the overpayment was computed;

(c) Specific reference to the section of the statute, rule, provider's manual, or provider agreement that is the basis for the recoupment; and

(d) Information about the government entity who checks shall be made payable to and the corresponding mailing address.

4256.6 Any provider that disagrees with the reason for a recoupment or the amount of the recoupment shall have fifteen (15) calendar days from the date of the FNPRMO to request a hearing by filing an appeal with the District of Columbia Office of Administrative Hearings (OAH).

4256.7 Filing an appeal with the OAH shall not stay any action to recover any overpayment to the provider. The provider shall be liable to the Medicaid Program for any overpayments as set forth in the FNPRMO.

4256.8 The provider shall file a written Notice of Appeal with the Office of Administrative Hearings, 441 4th Street, NW, Suite 450 North, Washington, D.C. 20001. The provider shall also send a copy of that Notice of Appeal to the DHCF Office of General Counsel.

4299 DEFINITIONS: WAIVER SERVICES

4299.1 When used in this chapter, the following terms shall have the meaning ascribed:

Abuse - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the District Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Activities of Daily Living (ADLs) - The ability to bathe, transfer, dress, eat and feed self, engage in toileting, and maintain bowel and bladder control (continence).

Advanced Practice Registered Nurse - A person who is licensed or authorized to practice as an advanced practice registered nurse pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.*).

Admissions Hold - A process by which a provider is prohibited from admitting new Waiver beneficiaries.

Assisted Living Residence – An entity that shall have the same meaning as set forth in D.C. Official Code § 44-102.01(4).

Case Management Agency - An agency under contract with the Department of Health Care Finance (DHCF) to provide case management services to waiver beneficiaries.

Case Manager - A staff person from the case management agency who performs case management services.

Cueing - Using verbal prompts in the form of instructions or reminders to assist beneficiaries with activities of daily living and instrumental activities of daily living.

Chore Aide – A person who performs tasks intended to place the home environment in a clean, sanitary, and safe condition, and to prepare the home environment for ongoing routine home care services.

Communicable Disease – Any disease defined in D.C. Official Code § 7-132 and 22-B DCMR § 299.

Environmental Accessibility Adaptation (EAA) - Physical adaptations to the home that are necessary to ensure the health, welfare, and safety of the individual, or that enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization.

Fraud - An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person, including any act that constitutes fraud under federal or District law.

Family - Any person related to the beneficiary by blood, marriage, or adoption.

Home Care Agency – An entity licensed pursuant to the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code §§ 44-501 *et seq.)*

Limited English Proficient Individuals - Individuals who do not speak English as their primary language, and individuals who have a limited ability to read, write, speak, or understand English.

Medicaid - A federal-state program established by Title XIX of the Social Security Act, which provides payment of medical expenses for eligible persons who meet income and/or other criteria.

Natural Home - A home owned or leased by the beneficiary, the beneficiary's family member or another private individual; the lease/deed must be held by the beneficiary, the beneficiary's family member, or another private individual.

Participant/Representative-Employer - The *Services My Way* participant or the participant's authorized representative, as applicable, who performs employer-related duties including recruiting, hiring, supervising and discharging participant-directed workers.

Person-Centered Service Plan (PCSP) – Individualized service plan developed by the case manager that identifies the supports and services to be provided to the person enrolled in the Waiver and the evaluation of the

person's progress on an on-going basis to assure that the person's needs and desired outcomes are being met.

Personal Care Aide - A person who has successfully completed the relevant jurisdiction's (the person's home state or District of Columbia) established training program and meets the competency evaluation requirements. Tasks include assistance with activities of daily living and instrumental activities of daily living.

Personal Care Aide services - Services involving assistance with one or more activities of daily living that is rendered by a qualified personal care aide under the supervision of a registered nurse.

Physical Disability - A functionally determinable impairment that substantially limits an individual's ability to perform manual tasks, to engage in an occupation, to live independently, to walk, to see, or hear.

Physician - A person who is licensed or authorized to practice medicine pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.).*

Plan of Care - A plan prepared by the EPD Waiver service provider that outlines the service delivery plans for the services being delivered by that provider. This is also referred to as a service delivery plan.

Provider - Any entity that meets the waiver service requirements, has signed an agreement with DHCF to provide waiver services, and is enrolled by DHCF to provide services to waiver beneficiaries.

Purified Protein Derivative (PPD) - A tuberculin solution that is used in skin tests for tuberculosis.

Registered Nurse - An individual who is licensed or authorized to practice registered nursing pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.),* as amended, or licensed as a registered nurse in the jurisdiction where services are provided.

Respite Service - Services that include the provision of assistance with activities of daily living and instrumental activities of daily living for waiver beneficiaries in their home or temporary place of residence in the temporary absence of the primary caregiver. Respite services may also be provided in a Medicaid certified community setting or a group home.

Theft - Wrongfully obtaining or using the property of another with intent to deprive the other of a right to the property or a benefit of the property or to appropriate the property to an individual's own use or to the use of a third person.

Vendor - A corporate entity providing individual-directed goods or services.

Vendor Fiscal/Employer Agent (VF/EA) Financial Management Services (FMS)-Support Broker Entity - An entity operating in accordance with 26 USC § 3504 and Rev. Proc. 70-6, as modified by REG-137036 and Rev. Proc. 2013-39, which provides financial management services and information and assistance services to *Services My Way* participants and their representatives, as appropriate.

Waiver- The home and community-based Waiver for the Elderly and Persons with Disabilities (EPD) as approved by the Council of the District of Columbia (Council) and CMS, as may be further amended and approved by the Council and CMS.

Waiver Period - Each five (5) year term for which the Waiver is approved by CMS, beginning with the initial effective date of the Waiver.

Wrongfully Obtain or Use - Taking or exercising control over property; making an unauthorized use, disposition, or transfer of an interest in or possession of property; or obtaining property by trick, false pretense, false token, tampering, or deception. The term "wrongfully obtain or use" includes conduct previously known in the District as larceny, larceny by trick, larceny by trust, embezzlement, and false pretenses.