DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF SECOND EMERGENCY AND PROPOSED 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.)) 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, on an emergency basis, of amendments to Chapter 19 (Home and Community-based Waiver Services for Individuals with Intellectual and Developmental Disabilities) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

The notice of second emergency and proposed rules amends the previously published standards governing providers who participate in the Home and Community-based Waiver for Individuals with Intellectual and Developmental Disabilities (ID/DD Waiver). These rules amend the previously published rules by: (1) describing the cost report submission procedures and establishing requirements for the frequency of the submission of cost-reports; (2) specifying the on-site audit procedures and specifying the frequency of on-site visits by representatives of the U.S. Department of Health and Human Services and the Department of Health Care Finance; (3) revising and clarifying the components of a supervision plan; (4) clarifying words and/or phrases to reflect more person-centered language and simplify interpretation of the rule.

Emergency action is necessary for the immediate preservation of the health, safety, and welfare of ID/DD Waiver participants who are in need of ID/DD Waiver services. The ID/DD Waiver serves some of the District's most vulnerable residents. The welfare of these residents highly depends on the availability of the multiple services made available under the waiver. In order to ensure that the residents' health, safety, and welfare are not threatened by the lapse in access to the approved services under the waiver, it is necessary that that these rules be published on an emergency basis.

An initial notice of emergency and proposed rulemaking was published in the *D.C. Register* on July 12, 2013 at 60 DCR 10162. Numerous comments were received and taken into account in the release of this notice of emergency and proposed rulemaking which responds to the comments. This emergency rulemaking was adopted on October 9, 2013 and became effective on that date. The emergency rules shall remain in effect for one hundred and twenty (120) calendar days or until February 5, 2014, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*.

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

Chapter 19, HOME AND COMMUNITY-BASED WAIVER SERVICES FOR PERSONS WITH MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES, of Title 29, PUBLIC WELFARE, of the DCMR, is amended as follows:

Section 1900, GENERAL PROVISIONS, through Section 1909, FAIR HEARINGS are deleted in their entirety and amended to read as follows:

CHAPTER 19 HOME AND COMMUNITY-BASED WAIVER FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

1900 GENERAL PROVISIONS

1900.1 The purpose of this chapter is to establish criteria governing Medicaid eligibility for services under the Home and Community-Based Services (HCBS) Waiver for Individuals with Intellectual and Developmental Disabilities (Waiver) and to establish conditions of participation for providers of Waiver services.

1900.2 The Waiver is authorized pursuant to Section 1915 (c) of the Social Security Act, approved by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services (CMS), and shall be effective through November 19, 2017, plus any extensions thereof.

1900.3 The Waiver shall be operated by the Department on Disability Services (DDS), Developmental Disabilities Administration (DDA), under the supervision of the Department of Health Care Finance (DHCF).

1900.4 Enrollment of people eligible to receive Waiver services shall not exceed the ceiling established by the approved Waiver application.

1900.5 Each provider shall be subject to the administrative procedures set forth in Chapter 13 of Title 29 of the District of Columbia Municipal Regulations (DCMR) during the provider's participation in the program.

1901 COVERED SERVICES AND RATES

1901.1 Services available under the Waiver shall include the following:

(a) Art Therapies
(b) Behavioral Supports
(c) Day Habilitation
(d) Dental
(e) Employment Readiness
(f) Environmental Accessibilities Adaptations
(g) Family Training
(h) Host Home without Transportation
(i) Individualized Day Supports
(j) In-Home Supports
(k) Occupational Therapy
(l) One-Time Transitional Services
(m) Personal Care Services
(n) Personal Emergency Response System (PERS)
(o) Physical Therapy

(p) Residential Habilitation
(q) Respite
(r) Shared Living
(s) Skilled Nursing
(t) Small Group Supported Employment
(u) Speech, Hearing and Language Services
(v) Supported Employment
(w) Supported Living
(x) Supported Living with Transportation
(y) Vehicle Modifications
(z) Wellness Services

1901.2 Medicaid provider reimbursement for Waiver services shall be made according to the District of Columbia Medicaid fee schedule available online at https://www.dc-medicaid.com/dcwebportal/nonsecure/feeScheduleDownload.

1902 ELIGIBILITY REQUIREMENTS

1902.1 Any person eligible to receive Waiver services shall meet all of the following requirements:

(a) Has a special income level up to 300% of the SSI federal benefit or be aged and disabled with income up to 100% of the federal poverty level or be medically needy as set forth in 42 CFR §§ 435.320, 435.322, 435.324 and 435.330;

(b) Be a person that has an intellectual disability;

(c) Be eighteen (18) years of age or older;

(d) Be a resident of the District of Columbia as defined in D.C. Official Code § 7-1301.03(22);

(e) Has a Level of Care (LOC) determination that the person requires services furnished in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or be a person with related conditions pursuant to the criteria set forth in § 1902.4; and

(f) Meets all other eligibility criteria applicable to Medicaid recipients including citizenship and alienage requirements.

1902.2 Waiver services shall not be furnished to a person who is an inpatient of a hospital, ICF/IID, or nursing facility.

1902.3 Each person enrolled in the Waiver shall be re-certified annually as having met all of the eligibility requirements as set forth in § 1902.1 for continued participation in the Waiver.

1902.4 A person shall meet the LOC determination set forth in § 1902.1(e) if one of the following criteria has been met:

(a) The person's primary disability is an intellectual disability with an intelligence quotient (IQ) of fifty-nine (59) or less;

(b) The person's primary disability is an intellectual disability with an IQ of sixty (60) to sixty-nine (69) and the person has at least one (1) of the following additional conditions:

(1) Mobility deficits;
(2) Sensory deficits;
(3) Chronic health problems;
(4) Behavior problems;
(5) Autism;
(6) Cerebral Palsy;
(7) Epilepsy; or
(8) Spina Bifida.

(c) The person's primary disability is an intellectual disability with an IQ of sixty (60) to sixty-nine (69) and the person has severe functional limitations in at least three (3) of the following major life activities:

(1) Self-care;
(2) Understanding and use of language;
(3) Functional academics;
(4) Social skills;
(5) Mobility;
(6) Self-direction;
(7) Capacity for independent living; or
(8) Health and safety.

(d) The person has an intellectual disability, has severe functional limitations in at least three (3) of the major life activities as set forth in § 1902.4(c)(1) through § 1902.4(c)(8), and has one (1) of the following diagnoses:

(1) Autism;
(2) Cerebral Palsy;
(3) Prader Willi; or
(4) Spina Bifida.

1903 LEVEL OF CARE AND FREEDOM OF CHOICE

1903.1 The DC Level of Need (LON) is a comprehensive assessment tool, initiated by the Service Coordinator and completed with the person, their advocate and other

members of their support team who serve as the resource for providing the information that is entered into the LON.

1903.2 The LON is reviewed on an annual basis and/or whenever the person experiences a significant change in their life anytime during the year. The LON documents the person's health, intellectual and developmental health diagnoses, and support needs in all major life activities to determine the LOC determination criteria specified in §1902.4.

1903.3 The person shall meet the LOC as described under § 1902. The following describes the process for the initial evaluation and re-evaluation:

(a) A Qualified Developmental Disabilities Professional (Q/DDP), employed by DDS, shall perform the initial evaluation and re-evaluation of the LOC and make a LOC determination; and

(b) Re-evaluations of the LOC shall be conducted every twelve (12) months or earlier when indicated.

1903.4 Written documentation of each evaluation and re-evaluation shall be maintained by DDS for a minimum period of three (3) years, except when there is an audit or investigation, in which case, the records shall be maintained by DDS until the review has been completed.

1903.5 Once a person has been determined eligible for services under the Waiver, the person and/or legal representative shall document the choice of institutional or HCBS on a Freedom of Choice form.

1903.6 The Freedom of Choice form shall consist of:

(a) The choice of institutional services; and

(b) The choice of HCBS.

1903.7 Each person who is not given the choice of HCBS as an alternative to institutional care in an ICF/IID as set forth in § 1902.1(e), shall be entitled to a fair hearing in accordance with 42 CFR Part 431, Subpart E.

1904 PROVIDER QUALIFICATIONS

1904.1 HCBS Waiver provider agencies shall complete an application to participate in the Medicaid Waiver program and shall submit to DDS both the Medicaid provider enrollment application and the following organizational information:

(a) A resume and three letters of reference demonstrating that the owner(s)/operators(s) have a degree in the Social Services field or a related field with at least three (3) years of experience of working with

people with intellectual and developmental disabilities; or a degree in a non-Social Services field with at least five (5) years of experience working with people with intellectual and developmental disabilities;

(b) Documentation proving that the program manager of the HCBS Waiver provider agency has a Bachelor's degree in the Social Services field or a related field with at least five (5) years of experience in a leadership role or equivalent management experience working with people with intellectual and developmental disabilities or a Master's degree in the Social Services field or a related field with at least three (3) years of experience in a leadership role or equivalent management experience working with people with intellectual and developmental disabilities;

(c) A copy of the business license issued by the Department of Consumer and Regulatory Affairs (DCRA);

(d) A description of ownership and a list of major owners or stockholders owning or controlling five (5%) percent or more outstanding shares;

(e) A list of Board members and their affiliations;

(f) A roster of key personnel, with qualifications, resumes, background checks, local license, if applicable, and a copy of their position descriptions;

(g) A copy of the most recent audited financial statement of the agency, if available;

(h) A copy of the basic organizational documents of the provider, including an organizational chart, and current Articles of Incorporation or partnership agreements, if applicable;

(i) A copy of the Bylaws or similar documents regarding conduct of the agency's internal affairs;

(j) A copy of the certificate of good standing from the DCRA;

(k) Organizational policies and procedures, such as personnel policies and procedures required by DDS and available at http://dds.dc.gov/DC/DDS/Developmental+Disabilities+Administration/Policies?nav=1&vgnextrefresh=1;

(l) A continuous quality improvement plan;

(m) A copy of professional/business liability insurance of at least one (1) million dollars;

(n) A sample of all documentation templates, such as progress notes, evaluations, intake assessments, discharge summaries, and quarterly reports; and

(o) Any other documentation deemed necessary to support the approval as a provider.

1904.2 Professional service provider applicants who are in private practice as an independent clinician and are not employed by an enrolled HCBS Waiver provider agency or a Home Health Agency, shall complete and submit to DDS the Medicaid provider enrollment application and the following:

(a) Documentation to prove ownership or leasing of a private office, even if services are always furnished in the home of the person receiving services;

(b) A copy of a professional license in accordance with District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 *et seq.*), as amended, and the applicable state and local licenses in accordance with the licensure laws of the jurisdiction where services are provided; and

(c) A copy of the insurance policy verifying at least one (1) million dollars in liability insurance.

1904.3 Home Health Agencies shall complete and submit to DDS the Medicaid provider enrollment application and the following documents:

(a) A copy of the Home Health Agency license 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; and

(b) If skilled nursing is utilized, a copy of the registered nurse or licensed practical nurse license in accordance with District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 *et seq.*), as amended, and the applicable state and local licenses in accordance with the licensure laws of the jurisdiction where services are provided.

1904.4 In order to provide services under the Waiver and qualify for Medicaid reimbursement, DDS approved HCBS Waiver providers shall meet the following requirements:

(a) Maintain a copy of the approval letter issued by DHCF;

(b) Maintain a current District of Columbia Medicaid Provider Agreement that authorizes the provider to bill for services under the Waiver;

(c) Obtain a National Provider Identification (NPI) number from the National Plan and Provider Enumeration System website;

(d) Comply with all applicable District of Columbia licensure requirements and any other applicable licensure requirements in the jurisdiction where services are delivered;

(e) Maintain a copy of the most recent Individual Support Plan (ISP) and Plan of Care that has been approved by DDS for each person;

(f) Maintain a signed copy of a current Human Care Agreement with DDS for the provision of services, if determined necessary by DDS;

(g) Ensure that all staff are qualified, properly supervised, and trained according to DDS policy;

(h) Ensure that a plan is in place to provide services for non-English speaking people pursuant to DDA's Language Access Policy available at http://dc.gov/DC/DDS/Developmental+Disabilities+Administration/Policies/VI.+Administrative+DDA/Language+Access+Policy;

(i) Ensure that each staff person providing services has the Hepatitis B vaccination and tested negative for tuberculosis;

(j) Ensure that staff are trained in infection control procedures consistent with the standards established by the Federal Centers for Disease Control and Prevention (CDC) and the U.S. Department of Labor, Occupational Safety and Health Administration (OSHA), as set forth in 29 CFR § 1910.1030;

(k) Ensure compliance with the provider agency's policies and procedures and DDS policies such as, reporting of unusual incidents, human rights, language access, employee orientation objectives and competencies, individual support plan, most integrated community based setting, health and wellness standards, behavior management, and protection of the person's funds, available at http://dds.dc.gov/DC/DDS/Developmental+Disabilities+Administration/Policies?nav=1&vgnextrefresh=1;

(l) Provide a written staffing schedule for each site where services are provided, if applicable;

(m) Maintain a written staffing plan, if applicable;

(n) Develop and implement a quality assurance system to evaluate the effectiveness of services provided;

(o) Ensure that a certificate of occupancy is obtained, if applicable;

(p) Ensure that a certificate of need is obtained, if applicable;

(q) Obtain approval from DDS for each site where residential, day, employment readiness, and supported employment services are provided prior to purchasing or leasing property;

(r) Ensure that, if services are furnished in a private practice office space, spaces are owned, leased, or rented by the private practice and used for the exclusive purpose of operating the private practice;

(s) Ensure that a sole practitioner shall individually supervise assistants and aides employed directly by the independent practitioner, by the partnership group to which the independent practitioner belongs, or by the same private practice that employs the independent practitioner.

(t) Complete the DDA abbreviated readiness process, if applicable; and

(u) Adhere to the specific provider qualifications in each service rule.

1904.5 Each service provider under the Waiver for which transportation is included shall:

(a) Ensure that each vehicle used to transport a person has valid license plates;

(b) Ensure that each vehicle used to transport a person has at least the minimum level of motor vehicle insurance required by law;

(c) Present each vehicle used to transport a person for inspection by a certified inspection station every six (6) months, or as required in the jurisdiction where the vehicle is registered, and provide proof that the vehicle has passed the inspection by submitting a copy of the Certificate of Inspections to DDS upon request;

(d) Ensure that each vehicle used to transport a person is maintained in safe, working order;

(e) Ensure that each vehicle used to transport a person meets the needs of the person;

(f) Ensure that each vehicle used to transport a person has seats fastened to the body of the vehicle;

(g) Ensure that each vehicle used to transport a person has operational seat belts;

(h) Ensure that each vehicle used to transport a person can maintain a temperature conducive to comfort;

(I) Ensure that each vehicle used to transport a person is certified by the Washington Metropolitan Area Transit Commission;

(j) Ensure that each person is properly seated when the vehicle is in operation;

(k) Ensure that each person is transported to and from each appointment in a timely manner;

(l) Ensure that each person is provided with an escort on the vehicle, when needed;

(m) Ensure that each vehicle used to transport a person with mobility needs is adapted to provide safe access and use;

(n) Ensure that each staff/employee/contractor providing services meets the requirements set forth in § 1906 of these rules; and

(o) Ensure that each staff/employee/contractor providing services be certified in Cardiopulmonary Resuscitation (CPR) and First Aid.

1905 PROVIDER ENROLLMENT PROCESS

1905.1 Prospective providers shall send a letter of interest to DDA to enroll as a Medicaid provider of Waiver services.

1905.2 Upon receipt of the letter of interest, prospective providers shall be invited by DDA via email to attend an informational meeting at DDA. Preceding the meeting, providers shall obtain a copy of the Medicaid provider enrollment application at DDS.dc.gov.

1905.3 Upon receipt of the Medicaid provider enrollment application by DDA, prospective providers shall receive an invitation to be interviewed or a denial letter. The denial letter shall be issued by DDA within sixty (60) business days from the time a Medicaid provider enrollment application is received by DDA and shall meet the requirements set forth in § 1905.5.

1905.4 If the Medicaid provider enrollment application is incomplete, DDA shall issue a denial letter, in accordance with § 1905.5, within sixty (60) business days from the time a Medicaid provider enrollment application is received.

1905.5 The denial letter shall include the following:

(a) The basis and reasons for the denial of the prospective provider's Medicaid provider enrollment application;

(b) The prospective provider's right to dispute the denial of the application and to submit written argument and documentary evidence to support its position; and

(c) Specific reference to the particular sections of relevant statutes and/or regulations.

1905.6 The provider interviews shall be conducted by an application review committee at DDA.

1905.7 Pursuant to the committee's recommendation and the overall merit of the application, DDA shall either issue a denial letter to the prospective providers or send the application of the DDA-recommended provider to DHCF for its review within thirty-five (35) business days of the committee's review date. The denial letter shall be issued in accordance with the requirements set forth in § 1905.5.

1905.8 Within thirty (30) business days of DHCF's receipt of DDA's recommendation, DHCF shall issue an approval or denial letter to the prospective providers. The denial letter shall be issued in accordance with the requirements set forth in § 1905.5.

1905.9 If a denial letter was issued by DDA or DHCF, the prospective provider shall be prohibited from submitting an application to enroll as a provider for a period of one year from the date the Medicaid provider enrollment application was received by DDA.

1905.10 Each provider shall be subject to the administrative procedures set forth in Chapter 13 of Title 29 DCMR; to the provider certification standards established by DDS, currently known as the Provider Certification Review process; and to all policies and procedures promulgated by DDS that are applicable to providers during the provider's participation in the Waiver program.

1906 REQUIREMENTS FOR DIRECT SUPPORT PROFESSIONALS

1906.1 The basic requirements for all employees and volunteers providing direct services are as follows:

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

(b) Obtain annual documentation from a physician or other health professional that he or she is free from tuberculosis and hepatitis B;

(c) Possess a high school diploma or general educational development (GED) certificate;

(d) Possess an annual CPR and First Aid certificate;

(e) Complete pre-service and in-service training as described in DDS policy;

(f) Have the ability to communicate with the person to whom services are provided;

(g) Be able to read, write, and speak the English language;

(h) Participate in competency based training needed to address the unique support needs of the person, as detailed in his or her ISP; and

(i) Have proof of compliance with the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238; D.C. Official Code § 44-551 *et seq.*); 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.*) for the following employees or contract workers:

(1) Individuals who are unlicensed under Chapter 12, Health Occupations Board, of Title 3 of the D.C. Official Code, who assist licensed health professionals in providing direct patient care or common nursing tasks;

(2) Nurse aides, orderlies, assistant technicians, attendants, home health aides, personal care aides, medication aides, geriatric aides, or other health aides; and

(3) Housekeeping, maintenance, and administrative staff for whom it is foreseeable to come in direct contact with Waiver recipients or patients.

1906.2 Volunteers who work under the supervision of an individual licensed pursuant to Chapter 12 of Title 3 of the D.C. Official Code shall be exempt from the unlicensed personnel criminal background check requirement set forth in § 1906.1(i).

1907 INDIVIDUAL SUPPORT PLAN (ISP)

1907.1 The ISP is the plan that identifies the supports and services to be provided to the person 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.

1907.2 The ISP shall include all Waiver and non-waiver supports and services the person is receiving or shall receive consistent with his or her needs.

1907.3 The ISP shall be developed by the person and his or her support team.

1907.4 At a minimum, the composition of the support team shall include the person being served, his or her substitute decision maker and other individuals directly involved in the person's life as agreed to by the person and the DDS Service Coordinator.

1907.5 The ISP shall be reviewed and updated annually by the support team. The ISP may be updated more frequently if there is a significant change in the person's status or any other significant event in the person's life which affects the type or amount of services and supports needed by the person or if requested by the person.

1907.6 The Plan of Care shall be derived from the ISP and shall describe services to be furnished to the person, the frequency of the services, and the type of provider to furnish the services.

1907.7 The provider shall:

(a) Ensure that the service provided is consistent with the person's ISP and Plan of Care;

(b) Participate in the annual ISP and Plan of Care meeting or Support Team meetings when indicated; and

(c) Develop a service delivery plan, within thirty (30) days of the initiation of services, which shall address how the service will be delivered to each person, after notification by DDS that a service has been authorized.

1907.8 DHCF shall not reimburse a provider for services that are not authorized in the ISP, not included in the Plan of Care, furnished prior to the development of the ISP, furnished prior to receiving a service authorization from DDS, or furnished pursuant to an expired ISP.

1907.9 Each provider shall submit to the person's DDS Service Coordinator a quarterly report which summarizes the person's progress made toward achieving the desired goals and outcomes and identification and response to any issue relative to the provision of the service.

1908 REPORTING REQUIREMENTS

1908.1 Each Waiver provider shall submit quarterly reports to the DDS Service Coordinator no later than seven (7) business days after the end of the first quarter, and each subsequent quarter thereafter.

1908.2 For purposes of reporting, the first quarter shall begin on the effective date of a person's ISP.

1908.3 Each Waiver provider shall submit assessments, quarterly reports as set forth in § 1909.2(o), service delivery plans as set forth in § 1909.2(i), and physician orders, if applicable, to the DDS Medicaid Waiver unit for the authorization of services.

1908.4 Each Waiver provider shall complete all documents required for authorization of services as set forth in each service rule and shall submit the documents to the DDS Service Coordinator at the ISP meeting. Failure to submit all required documents prior to the effective date of the ISP may result in a delay of the approval of services. The date of the authorization of services shall be the date of receipt of the required documents by the Medicaid Waiver Unit, if the documents are submitted after the effective date of the ISP.

1908.5 Each Waiver provider shall report on a quarterly basis to the person served, his or her family and/or guardian, and the DDS Service Coordinator about the programming and support provided to fulfill the objectives and outcomes identified in the ISP and Plan of Care, and any revisions to the ISP and Plan of Care, when necessary, to promote continued skill acquisition, no later than seven (7) business days after the end of the first quarter, and each subsequent quarter thereafter.

1908.6 Each Waiver provider shall report all serious reportable incidents to DDS pursuant to the timelines established under DDA's Incident Management and Enforcement Policy and Procedures, available at http://dds.dc.gov/DC/DDS/Developmental+Disabilities+Administration/Policies?nav=1&vgnextrefresh=1.

1909 RECORDS AND CONFIDENTIALITY OF INFORMATION

1909.1 Each Waiver provider shall allow appropriate personnel of DHCF, DDS and other authorized agents of the District of Columbia government or of other jurisdictions where services are provided, and the federal government full access to all records during announced and unannounced audits and reviews.

1909.2 Each Waiver provider entity shall maintain the following records for each person receiving services for monitoring and audit reviews:

(a) General information including each person's name, Medicaid identification number, address, telephone number, date of birth, sex, name and telephone number of emergency contact person, physician's name, address and telephone number, and the DDS Service Coordinator's name and telephone number;

(b) A copy of the most recent DDS approved ISP and Plan of Care indicating the requirement for and identification of a provider who shall provide the services in accordance with the person's needs, if applicable;

(c) A record of all service authorization and prior authorizations for services;

(d) A record of all requests for change in services;

(e) The person's medical records;

(f) A discharge summary, if applicable;

(g) A written staffing plan, if applicable;

(h) A back-up plan detailing who shall provide services in the absence of staff when the lack of immediate care poses a serious threat to the person's health and welfare;

(i) A service delivery plan containing the following information:

(1) The name of the person receiving services;

(2) The results of the provider's functional assessment for service delivery, if applicable;

(3) A schedule of the person's activities in the community, if applicable, including strategies to execute goals identified in the service delivery plan and the date and time of the activity, if applicable;

(4) The staff as identified in the staffing plan, if applicable;

(5) Age-appropriate and measurable goals based on the assessment tool consistent with the duration of time spent at the person's home, provider's facility or the community venue, as applicable; and

(6) Teaching strategies utilized to execute goals in the service delivery plan and the person's response to the teaching strategy, if applicable.

(j) Any records relating to adjudication of claims;

(k) Any records necessary to demonstrate compliance with all rules and requirements, guidelines, and standards for the implementation and administration of the Waiver;

(l) A supervision plan for each staff member who is classified as a Direct Support Professional (DSP), developed and implemented by a provider designated staff member, containing the following information:

(1) The name of the DSP and date of hire;

(2) The DSP's place of employment, including the name of the provider entity or day services provider;

(3) The name of the DSP's supervisor who shall have at least three (3) years' experience working with persons with intellectual and developmental disabilities;

(4) A documentation of performance goals for the DSP;

(5) A description of the DSP's duties and responsibilities;

(6) A comment section for the DSP's feedback;

(7) A statement of affirmation by the DSP's supervisor confirming statements are true and accurate;

(8) The signature, date, and title of the DSP; and

(9) The signature, date, and title of the DSP's supervisor.

(m) Daily progress notes, as set forth in each service rule, containing the following information:

(1) The progress in meeting the specific goals in the ISP and Plan of Care that are addressed on the day of service and relate to the provider's scope of service;

(2) The health or behavioral events or change in status that is not typical to the person;

(3) A listing of all community activities attended by the person;

(4) The start time and end time of any services received including the DSP's signature; and

(5) The matters requiring follow-up on the part of the Waiver service provider or DDS.

(n) Reports on a quarterly basis, containing the following information:

(1) An analysis of the goals identified in the ISP and Plan of Care and monthly progress towards reaching the goals;

(2) The service interventions provided and the effectiveness of those interventions;

(3) A summary analysis of all habilitative support activities that occurred during the quarter;

(4) Any modifications or recommendations that may be required to the service delivery plan, ISP, and Plan of Care from the summary analysis; and

(5) A copy of any ISP amendments to the provider's service delivery plan to implement the changes made pursuant to the summary analysis under (3).

1909.3 Each Waiver provider shall maintain all records, including but not limited to, progress reports, financial records, medical records, treatment records, and any other documentation relating to costs, payments received and made, and services provided, for six (6) years from service initiation or until all audits, investigations, or reviews are completed, whichever is longer.

1909.4 Each Waiver provider agency and independent practitioner shall maintain records to document staff training and licensure requirements, for a period of no less than six (6) years.

1909.5 Each Waiver provider shall secure service records for each person in a locked room or file cabinet and limit access only to authorized individuals.

1909.6 The disclosure of treatment information by a Waiver provider shall be subject to all provisions of applicable federal and District laws and rules, for the purpose of confidentiality of information.

1909.7 For residential providers, the records, including program, medical, and financial records for the current ISP, shall be located at the person's residence. Providers shall archive their records annually and ensure that they are available upon request.

1909.8 For non-facility based providers, including Supported Employment and Individualized Day, a policy that identifies where records are located and archived, and that ensures that the records are available upon request, shall be developed;

1909.9 If the provider maintains electronic records, the electronic records shall be immediately available in an established electronic record keeping system. The electronic record keeping system shall meet the following requirements:

(a) Has reasonable controls to ensure the integrity, accuracy, authenticity, and reliability of the records kept in electronic format;

(b) Be capable of retaining, preserving, retrieving, and reproducing the electronic records;

(c) Be able to readily convert paper originals stored in electronic format back into legible and readable paper copies;

(d) Be able to create back-up electronic file copies; and

(e) Provide appropriate level of security for records to comply with federal requirements for safeguarding information.

Section 1911, REQUIREMENTS FOR PERSONS PROVIDING DIRECT SERVICES, is deleted in its entirety and amended to read as follows:

1911 INDIVIDUAL RIGHTS

1911.1 Each Waiver provider shall develop and adhere to policies which ensure that each person receiving services has the following rights:

(a) To be treated with courtesy, dignity, and respect;

(b) To participate in the planning of his or her supports and services;

(c) To receive treatment, care, and services consistent with the ISP;

(d) To receive services by competent personnel who can communicate with the person;

(e) To refuse all or part of any treatment, care, or service and be informed of the consequences;

(f) To be free from mental and physical abuse, neglect, and exploitation from staff providing services;

(g) To be assured that for purposes of record confidentiality, the disclosure of the contents of his or her personal records is subject to all the provisions of applicable District and federal laws and rules;

(h) To voice a complaint regarding treatment or care, lack of respect for personal property by staff providing services without fear of retaliation;

(i) To have access to his or her records; and

(j) To be informed orally and in writing of the following:

(1) Services to be provided, including any limitations;

(2) The amount charged for each service, the amount of payment received/authorized for him or her and the billing procedures, if applicable;

(3) Whether services are covered by health insurance, Medicare, Medicaid, or any other third party source;

(4) Acceptance, denial, reduction, or termination of services;

(5) Complaint and referral procedures;

(6) The name, address, and telephone number of the provider; and

(7) The telephone number of the DDS customer complaint line.

1911.2 Each provider shall notify DDS of any incidents as set forth in DDS's Policy and Procedure entitled "Incident Management and Enforcement".

Section 1912, COMMUNITY SUPPORT TEAM SERVICES, is deleted in its entirety and amended to read as follows:

1912 INITIATING, CHANGING, OR TERMINATING ANY APPROVED SERVICE

1912.1 A provider shall provide DDS and DHCF, at least thirty (30) calendar days advance written notice of intent to initiate, reduce, or terminate services.

1912.2 In accordance with 42 CFR § 431.210 and D.C. Official Code § 4-205.55(a)(2), a provider shall give people receiving services or the person's representative and the DDS Service Coordinator at least thirty (30) calendar days advance written notice prior to the effective date of the termination or reduction of services, and be responsible for notifying DDS of any person who is undergoing treatment of an acute condition.

1912.3 The written notice shall comply with the requirements of 42 CFR §431.210 and D.C. Official Code §4-205.55(a)(2) and the provider shall transfer the person's original record to the new service provider at the time of the transfer, unless the person is deceased or no longer chooses to participate in the Waiver program.

1912.4 The DDS Service Coordinator shall be responsible for initiating, changing, or terminating Waiver services for each person in accordance with the ISP and identifying those people for whom HCBS are no longer an appropriate alternative.

1912.5 The provider shall notify DDS in writing whenever any of the following circumstances occur:

(a) Death of a person;

(b) Hospitalization of a person or any other circumstance in which Waiver services are interrupted for more than seven (7) days;

(c) The person is discharged or terminated from services; or

(d) Any other delay in the implementation of Waiver services.

1912.6 In the event of a person's death, a provider shall comply with all written notice requirements and any policies established by DDA in accordance with DDA's Incident Management and Enforcement Policy and Procedures available at http://dds.dc.gov/DC/DDS/Developmental+Disabilities+Administration/Policies?nav=1&vgnextrefresh=1.

1912.7 When the health and safety of the person or provider agency personnel is endangered, the thirty (30) calendar days advance notice shall not be required. The provider shall notify the person or the person's representative and the DDS Service Coordinator as soon as possible and send a written notice on the date of termination in accordance with 42 CFR § 431.210 and D.C. Official Code § 4-205.55(a)(2).

A new Section 1937 (Cost Reports and Audits) is added to read as follows:

1937 COST REPORTS AND AUDITS

1937.1 Each waiver provider shall report costs annually to DHCF no later than ninety (90) days after the end of the provider's cost reporting period, which shall correspond to the fiscal year used by the provider for all other financial reporting purposes, unless DHCF has approved an exception. All cost reports shall cover a twelve (12) month cost reporting period.

1937.2 A cost report that is not completed shall be considered an incomplete filing, and DHCF shall notify the waiver provider within thirty (30) days of the date on which DHCF received the incomplete cost report.

1937.3 All of the facility's accounting and related records, including the general ledger and records of original entry, and all transaction documents and statistical data, shall be permanent records and be retained for a period of not less than five (5) years after the filing of a cost report.

1937.4 DHCF shall evaluate expenditures subject to the requirements in this Section through annual review of cost reports.

1937.5 DHCF, or its designee, shall review each cost report for completeness, accuracy, compliance, and reasonableness through a desk audit.

1937.6 On-site audits shall be conducted no less than once every three (3) years. Each waiver provider shall allow access, during on-site audits or review by DHCF or U.S. Department of Health and Human Services auditors, to relevant financial records and statistical data to verify costs previously reported to DHCF.

Section 1999, DEFINITIONS, is deleted in its entirety and amended to read as follows:

1999 DEFINITIONS

When used in this chapter, the following terms and phrases shall have the meaning ascribed:

Abbreviated Readiness Process- A process that assures that existing providers that have been approved as HCBS Waiver providers possess and demonstrate the capability to effectively serve people with disabilities and their families by providing the framework for identifying qualified providers ready to begin serving people in the Waiver and assisting those providers already in the DDS/DDA system who may need to improve provider performance.

Archive – Maintenance and storage of records.

Home Health Agency - Shall have the same meaning as "home care agency" and shall meet the definitions and licensure requirements as 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.*), and implementing rules.

Individual Support Plan (ISP) - An ISP identifies the supports and services to be provided to the person 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.

Intermediate Care Facility for Individuals with Intellectual Disabilities - Shall have the same meaning as an "Intermediate Care Facility for Individuals with Mental Retardation" as set forth in Section 1905(d) of the Social Security Act.

Qualified Developmental Disabilities Professional - A qualified developmental disabilities professional shall oversee the initial habilitative assessments of people, develop, monitor, and review ISPs, and integrate and coordinate Waiver services.

Plan of Care - A written service plan that meets the requirements set forth in Section 1907.6 of Title 29 DCMR, is signed by the person receiving services, and is used to prior authorize Waiver services.

Provider - Any entity that meets the Waiver service requirements, has signed a Medicaid Provider Agreement with DHCF to provide those services, and is enrolled by DHCF to provide Waiver services.

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 *et seq.*), as amended, or licensed as a registered nurse in the jurisdiction where services are provided.

Service Coordinator – The DDS staff responsible for coordinating a person's services pursuant to their ISP and Plan of Care.

Service Delivery Plan- The plan that specifies how the authorized services will be delivered to the person.

Serious Reportable Incident - Events that due to severity require immediate response, notification to, and investigation by DDS in addition to the internal review and investigation by the provider agency. Serious reportable incidents include death, allegations of abuse, neglect or exploitation, serious physical injury, inappropriate use of restraints, suicide attempts, serious medication errors, missing persons, and emergency hospitalization.

Skilled Nursing- - Health care services that are delivered by a registered or practical nurse acting within the scope of their practice and shall meet the definitions and licensure requirements as set forth 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 *et seq.*), as amended, and implementing rules.

Waiver - Shall mean the HCBS Waiver for Individuals with Intellectual and Developmental Disabilities 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.

Comments on these rules should be submitted in writing to Linda Elam, Ph.D., M.P.H., Medicaid Director, Department of Health Care Finance, Government of the District of Columbia, 899 North Capitol Street, NE, 6th Floor, Washington DC 20002, via telephone on (202) 442-9115, via email at DHCFPubliccomments@dc.gov, or online at www.dcregs.dc.gov, within thirty (30) days of the date of publication of this notice in the *D.C. Register*. Additional copies of these rules are available from the above address.