

DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF 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 (2016 Repl. & 2020 Supp.)), and Section 6(6) of the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.05(6) (2018 Repl.)), hereby gives notice of the adoption of, on an emergency basis, and the intent to adopt, on a permanent basis, a new Chapter 90 (Home and Community-Based Services Waiver for Individual and Family Support), of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

The Department on Disability Services (DDS), Developmental Disabilities Administration (DDA), will operate the new Medicaid Home and Community-Based Services (HCBS) Waiver for Individual and Family Support (IFS Waiver) under the supervision of the Department of Health Care Finance (DHCF). The proposed IFS Waiver was submitted to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), requesting approval for a five (5) year period beginning November 1, 2020. The IFS Waiver will serve some of the District of Columbia's most vulnerable residents.

The new IFS Waiver establishes a program that will allow District residents with intellectual and developmental disabilities who live in an independent environment, either in their own home or with family or friends, to receive HCBS services and supports tailored to their specific needs. DHCF and DDS are proposing to create a streamlined IFS Waiver to meet the needs of persons who can leverage supports from family or friends and do not need residential services. In this way, the IFS Waiver will offer person-centered services that meet the person's needs in the least restrictive setting needed, applying the highest standards of quality and national best practices. The IFS Waiver has a seventy-five thousand dollar (\$75,000) per person, aggregate spending maximum per Individual Support Plan (ISP) year, and is intended to serve a maximum number of thirty (30) unduplicated participants in its first year, with a projected increase of thirty (30) participants each waiver year thereafter.

Structurally, the new 29 DCMR Chapter 90 (Home and Community-Based Services Waiver for Individual and Family Support) is comprised of thirty-five (35) total sections. The first sixteen (16) sections create the infrastructure and other regulatory requirements that govern the individuals and the providers, the next nineteen (19) sections establish the services that will be available to persons in the IFS Waiver, and the final section includes the definitions of terms and phrases. With the exception of the new Education Supports Services and additional information in the General Provisions, the language and general content of all of these proposed sections are taken from the corresponding provisions in 29 DCMR Chapter 19 (Home and Community-Based Services Waiver for Individuals With Intellectual and Developmental Disabilities) for the HCBS IDD Waiver program. The key differences from the IDD Waiver are:

- (1) There are no residential services included in the array of services covered under the IFS Waiver, so the IFS Waiver may not be the appropriate program for people who require residential services;
- (2) Aggregate spending on covered IFS Waiver services will be limited to seventy-five thousand (\$75,000) per person per Individual Support Plan year. Utilization against this spending limit will be monitored by the DDS Service Coordinator to ensure the spending limit is not exceeded; and
- (3) The IFS Waiver includes coverage of a new HCBS service, Education Supports Services.

The sixteen (16) sections that create the infrastructure and other non-services program requirements, and include the final definitions section, are as follows:

- (1) General Provisions, 29 DCMR § 9000 (*cf.* 29 DCMR§ 1900);
- (2) Covered Services and Rates, 29 DCMR § 9001 (*cf.* 29 DCMR § 1901);
- (3) Eligibility Requirements, 29 DCMR § 9002 (*cf.* 29 DCMR § 1902);
- (4) Level of Care and Freedom of Choice, 29 DCMR § 9003 (*cf.* 29 DCMR §1903);
- (5) Individual Support Plan, 29 DCMR § 9004 (*cf.* 29 DCMR§ 1907);
- (6) Individual Rights, 29 DCMR § 9005 (*cf.* 29 DCMR §1911);
- (7) Records and Confidentiality of Information, 29 DCMR § 9006 (*cf.* 29 DCMR §1909);
- (8) Initiating, Changing, or Terminating Any Approved Services, 29 DCMR § 9007 (*cf.* 29 DCMR 1912);
- (9) Home and Community-Based Setting Requirements, 29 DCMR § 9008 (*cf.* 29 DCMR §1938);
- (10) Provider Enrollment Process, 29 DCMR § 9009 (*cf.* 29 DCMR § 1905);
- (11) Provider Qualifications, 29 DCMR § 9010 (*cf.* 29 DCMR §1904);
- (12) Requirements for Direct Support Professionals, 29 DCMR § 9011 (*cf.* 29 DCMR § 1906);
- (13) Cost Reports and Audits, 29 DCMR § 9012 (*cf.* 29 DCMR § 1937);
- (14) Reporting Requirements, 29 DCMR § 9013 (*cf.* 29 DCMR § 1908);
- (15) Waiting List, 29 DCMR § 9014 (*cf.* 29 DCMR § 1940); and
- (16) Definition, 29 DCMR § 9099 (*cf.* 29 DCMR§ 1999).

The IFS Waiver will offer a full range of health and clinical services necessary to help persons with complex support needs and their families to choose an alternative to institutional service that promotes community inclusion and independence by enhancing and not replacing existing informal networks. The IFS Waiver will offer eighteen (18) services that are identical to those currently available under the Medicaid HCBS IDD Waiver and adds one (1) new service, Education Supports Services, for a total of nineteen (19) services as follows:

- (1) Assistive Technology Services, 29 DCMR § 9015 (*cf.* 29 DCMR § 1941);
- (2) Behavioral Support Services, 29 DCMR § 9016 (*cf.* 29 DCMR §1919);
- (3) Companion Services, 29 DCMR § 9017 (*cf.* 29 DCMR § 1939);
- (4) Creative Arts Therapies Services, 29 DCMR § 9018 (*cf.* 29 DCMR § 1918);
- (5) Day Habilitation Services, 29 DCMR § 9019 (*cf.* 29 DCMR § 1920);

- (6) Education Support Services, 29 DCMR § 9021 (new IFS Waiver service);
- (7) Employment Readiness Services, 29 DCMR § 9022 (*cf.* 29 DCMR § 1922);
- (8) Family Training Services, 29 DCMR § 9023 (*cf.* 29 DCMR § 1924);
- (9) Individualized Day Supports Services, 29 DCMR § 9024 (*cf.* 29 DCMR § 1925);
- (10) In-Home Supports Services, 29 DCMR § 9025 (*cf.* 29 DCMR § 1916);
- (11) Occupational Therapy Services, 29 DCMR § 9026 (*cf.* 29 DCMR § 1926);
- (12) Parenting Supports Services, 29 DCMR § 9027 (*cf.* 29 DCMR § 1942);
- (13) Personal Care Services, 29 DCMR § 9028 (*cf.* 29 DCMR § 1910);
- (14) Physical Therapy Services, 29 DCMR § 9029 (*cf.* 29 DCMR § 1928);
- (15) Respite Services, 29 DCMR § 9030 (*cf.* 29 DCMR § 1930);
- (16) Skilled Nursing Services, 29 DCMR § 9031 (*cf.* 29 DCMR § 1931);
- (17) Speech, Hearing and Language Services, 29 DCMR § 9032 (*cf.* 29 DCMR § 1932);
- (18) Supported Employment Services – Individual and Small Group Services, 29 DCMR § 9033 (*cf.* 29 DCMR § 1933); and
- (19) Wellness Services, 29 DCMR § 9034 (*cf.* 29 DCMR § 1936).

The new Education Supports Services (29 DCMR § 9021) includes tuition and general fees for adult post-secondary classes; on-campus peer supports that are designed to enable the person to function with greater independence, receive post-secondary education, and be integrated in the community; communication classes for a person who is deaf or hard of hearing; and adult education or tutoring for reading or math instruction. These services are only available to the extent the person has fully utilized services available under related services as defined in Sections (22) and (25) of the Individuals with Disabilities Education Act (20 U.S.C. § 1400 *et seq.*).

To facilitate stakeholder input, copies of the application submitted to CMS and this Notice of Emergency and Proposed Rulemaking are available on the DDS website at: <https://dds.dc.gov/ifs-waiver-application>.

The IFS Waiver will serve some of the District's most vulnerable residents. In order to prevent impediments that adversely affect access to quality Medicaid services delivered by eligible Medicaid providers, DHCF is taking emergency action for the immediate preservation of the health, safety and welfare of persons that will become eligible for IFS services upon initiation of the program.

The emergency rulemaking was adopted on December 23, 2020, and will become effective on the date CMS approves the IFS Waiver application or November 1, 2020, whichever is later. The emergency rules shall remain in effect for no longer than one hundred and twenty (120) days from the adoption date or until April 22, 2021, 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*.

A new Chapter 90, HOME AND COMMUNITY-BASED SERVICES WAIVER FOR INDIVIDUAL AND FAMILY SUPPORT, of Title 29 DCMR, PUBLIC WELFARE, is adopted to read as follows:

**CHAPTER 90 HOME AND COMMUNITY-BASED SERVICES
WAIVER FOR INDIVIDUAL AND FAMILY SUPPORT**

9000	GENERAL PROVISIONS
9001	COVERED SERVICES AND RATES
9002	ELIGIBILITY REQUIREMENTS
9003	LEVEL OF CARE AND FREEDOM OF CHOICE
9004	INDIVIDUAL SUPPORT PLAN (ISP)
9005	INDIVIDUAL RIGHTS
9006	RECORDS AND CONFIDENTIALITY OF INFORMATION
9007	INITIATING, CHANGING, OR TERMINATING ANY APPROVED SERVICES
9008	HOME AND COMMUNITY-BASED SETTING REQUIREMENTS
9009	PROVIDER ENROLLMENT PROCESS
9010	PROVIDER QUALIFICATIONS
9011	REQUIREMENTS FOR DIRECT SUPPORT PROFESSIONALS
9012	COST REPORTS, AUDITS, AND OVERSIGHT MONITORING
9013	REPORTING REQUIREMENTS
9014	WAITING LIST
9015	ASSISTIVE TECHNOLOGY SERVICES
9016	BEHAVIORAL SUPPORT SERVICES
9017	COMPANION SERVICES
9018	CREATIVE ARTS THERAPIES SERVICES
9019	DAY HABILITATION SERVICES
9020	[RESERVED]
9021	EDUCATION SUPPORTS SERVICES
9022	EMPLOYMENT READINESS SERVICES
9023	FAMILY TRAINING SERVICES
9024	INDIVIDUALIZED DAY SUPPORTS SERVICES
9025	IN-HOME SUPPORTS SERVICES
9026	OCCUPATIONAL THERAPY SERVICES
9027	PARENTING SUPPORT SERVICES
9028	PERSONAL CARE SERVICES
9029	PHYSICAL THERAPY SERVICES
9030	RESPIRE SERVICES
9031	SKILLED NURSING SERVICES
9032	SPEECH, HEARING, AND LANGUAGE SERVICES
9033	SUPPORTED EMPLOYMENT SERVICES – INDIVIDUAL AND SMALL GROUP SERVICES
9034	WELLNESS SERVICES
9099	DEFINITIONS

9000 GENERAL PROVISIONS

- 9000.1 The purpose of this chapter is to establish criteria governing Medicaid eligibility for services under the Home and Community-Based Services (HCBS) Waiver for Individual and Family Support (IFS Waiver) and to establish conditions of participation for providers of Waiver services.
- 9000.2 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 1, 2025, and any extensions thereof.
- 9000.3 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).
- 9000.4 Enrollment of people eligible to receive Waiver services shall not exceed the ceiling established by the approved Waiver application.
- 9000.5 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.
- 9000.6 Under the IFS Waiver, the District's aggregate spending will be limited to seventy-five thousand (\$75,000) per person per Individual Support Plan (ISP) year. The DDS Service Coordinator shall monitor utilization of IFS Waiver services throughout the ISP year and spending against the annual aggregate spending limit.
- 9000.7 A person whose service utilization exceeds, or will exceed, the aggregate spending limit shall be given the option to transition into the HCBS Waiver for People with Intellectual and Developmental Disabilities (IDD Waiver).

9001 COVERED SERVICES AND RATES

- 9001.1 Services available under the Waiver shall include the following:
- (a) Assistive Technology Services, 29 DCMR § 9015;
 - (b) Behavioral Support Services, 29 DCMR § 9016;
 - (c) Companion Services, 29 DCMR § 9017;
 - (d) Creative Arts Therapies Services, 29 DCMR § 9018;
 - (e) Day Habilitation Services, 29 DCMR § 9019;

- (f) Education Support Services, 29 DCMR § 9021;
- (g) Employment Readiness Services, 29 DCMR § 9022;
- (h) Family Training Services, 29 DCMR § 9023;
- (i) Individualized Day Supports Services, 29 DCMR § 9024;
- (j) In-Home Supports Services, 29 DCMR § 9025;
- (k) Occupational Therapy Services, 29 DCMR § 9026;
- (l) Parenting Supports Services, 29 DCMR § 9027;
- (m) Personal Care Services, 29 DCMR § 9028;
- (n) Physical Therapy Services, 29 DCMR § 9029;
- (o) Respite Services, 29 DCMR § 9030;
- (p) Skilled Nursing Services, 29 DCMR § 9031;
- (q) Speech, Hearing and Language Services, 29 DCMR § 9032;
- (r) Supported Employment Services – Individual and Small Group Services, 29 DCMR § 9033; and
- (s) Wellness Services, 29 DCMR § 9034.

9001.2 The Medicaid provider reimbursement rate(s) to be paid for the Waiver services identified in § 9001.1 shall be posted on the District of Columbia 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) for Waiver services.

9001.3 No Waiver provider shall provide Waiver services unless in receipt of a Service Authorization from the Department on Disability Services, Developmental Disabilities Administration (DDS/DDA), for that Waiver service. A Service Authorization is an approval for a prescribed Waiver service issued by DDS/DDA to the provider prior to rendering service and is located on MCIS, DDS/DDA's case management information system, or its successor. DDS/DDA will not retroactively authorize services, except in the event of an emergency in which the provider has notified DDS and provided the services in good faith to avoid any service disruptions for the person, and subject to the approval of the Deputy Director for DDA.

9001.4 DHCF shall not reimburse any Waiver provider for services if the provider:

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

9001.5 Each Waiver provider shall agree to accept, as payment in full, the amount determined by DHCF as reimbursement for the authorized Waiver services provided to beneficiaries.

9001.6 Each Waiver provider shall agree to bill any and all known third-party payers prior to billing Medicaid.

9001.7 A standard unit of fifteen (15) minutes requires that the provider provide a minimum of eight (8) minutes of service in a span of fifteen (15) continuous minutes in order to be billed as a unit of service.

9002 ELIGIBILITY REQUIREMENTS

9002.1 In order to receive Waiver services a person shall be currently receiving services from DDS/DDA and meet all of the following requirements:

- (a) Have a special income level up to three hundred percent (300%) of the SSI federal benefit or be aged and disabled with income up to one hundred percent (100%) of the federal poverty level or be medically needy as set forth in 42 C.F.R. §§ 435.320, 435.322, 435.324 and 435.330;
- (b) Have an intellectual disability as defined in D.C. Official Code § 7-1301.03(15A), which, when establishing qualifying intelligence quotient (IQ), includes consideration of the standard error of measurement associated with the particular IQ test, and requires adaptive deficits across at least two (2) of the following three (3) domains: conceptual, practical, and social;
- (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) Have 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 § 9002.4; and
- (f) Meet all other eligibility criteria applicable to Medicaid recipients including citizenship and alienage requirements.

9002.2 Waiver services shall not be furnished to a person who is an inpatient of a hospital, ICF/IID, or nursing facility.

9002.3 Each person enrolled in the Waiver shall be re-certified annually as having met all of the eligibility requirements as set forth in § 9002.1 for continued participation in the Waiver.

9002.4 A person shall meet the LOC determination set forth in § 9002.1(e) if one of the following criteria has been met, taking into consideration the standard error of measurement for the IQ test:

- (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 § 9002.4(c)(1) through § 9002.4(c)(8), and has one (1) of the following diagnoses:
- (1) Autism;
 - (2) Cerebral Palsy;
 - (3) Prader Willi; or
 - (4) Spina Bifida.

9003 LEVEL OF CARE AND FREEDOM OF CHOICE

- 9003.1 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.
- 9003.2 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 § 9002.4.
- 9003.3 The person shall meet the LOC as described under § 9002. The following describes the process for the initial evaluation and re-evaluation:
- (a) A Qualified Intellectual Disabilities Professional (Q/IDP), 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.
- 9003.4 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.
- 9003.5 Once a person has been determined eligible for services under the Waiver, the person or legal representative shall document the choice of institutional or HCBS Waiver on a Freedom of Choice form.

9003.6 The Freedom of Choice form shall consist of choices between:

- (a) Institutional services; and
- (b) HCBS IDD Waiver and Individual Family Support Waiver services.

9003.7 A person who is not given the choice of HCBS as an alternative to institutional care in an ICF/IID as set forth in § 9002.1(e), shall be entitled to a fair hearing in accordance with 42 C.F.R. Part 431, Subpart E.

9004 INDIVIDUAL SUPPORT PLAN (ISP)

9004.1 The Individual Support Plan (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, based on what is important to and for the person, specifically including identifying the person's interest in employment, identifying goals for community integration and inclusion, and determining the most integrated setting available to meet the person's needs.

9004.2 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.

9004.3 The ISP shall be developed by the person and his or her support team using Person-Centered Thinking and Discovery tools and skills.

9004.4 At a minimum, the composition of the support team shall include the person being served, his or her substitute decision maker, if applicable, the DDS Service Coordinator and other individuals chosen by the person.

9004.5 The ISP shall be reviewed and updated annually by the support team. The ISP shall 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.

9004.6 The Plan of Care shall be derived from the ISP and shall describe the frequency and types of services to be provided to the person, and the providers of those services.

9004.7 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 the documents described under § 9006.2(i), including goals and objectives, 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.

9004.8 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.

9004.9 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.

9004.10 Each provider shall submit to the DDS Court Liaison and to the person's DDS Service Coordinator an annual court status report not less than fifteen (15) business days prior to the annual review hearing for the person, pursuant to the Citizens with Intellectual Disabilities Constitutional Rights and Dignity Act of 1978, effective March 3, 1979 (D.C. Law 2-137; D.C. Official Code §§ 7-1301.02 *et seq.*), as implemented by the Superior Court of the District of Columbia. Each provider shall provide the annual court status report to the person's court appointed attorney not less than ten (10) business days prior to the annual review hearing of the person. Each provider shall cooperate with DDS to ensure that any necessary corrections to the annual court status report are made and submitted promptly and prior to the annual review hearing for the person.

9005 INDIVIDUAL RIGHTS

9005.1 Each Waiver provider shall develop and adhere to policies which ensure that each person receiving services has the right to the following:

- (a) Be treated with courtesy, dignity, and respect;
- (b) Direct the person-centered planning of his or her supports and services;
- (c) Receive treatment, care, and services consistent with the ISP;
- (d) Receive services by competent personnel who can communicate with the person;
- (e) Refuse all or part of any treatment, care, or service and be informed of the consequences;

- (f) Be free from mental and physical abuse, neglect, and exploitation from staff providing services;
- (g) 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) Voice a complaint regarding treatment or care, lack of respect for personal property by staff providing services without fear of retaliation;
- (i) Have access to his or her records; and
- (j) 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 including how to file an anonymous complaint;
 - (6) The name, address, and telephone number of the provider;
 - (7) The telephone number of the DDS customer complaint line;
 - (8) How to report an allegation of abuse, neglect and exploitation;
 - (9) For people receiving residential supports, the person's rights as a tenant, and information about how to relocate and request new housing.

9006**RECORDS AND CONFIDENTIALITY OF INFORMATION**

9006.1

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, whether the visit is announced or unannounced, to all waiver provider locations, including access to the people receiving supports and all records, in any form. For purposes of this section, the term "records" includes, but is not limited to, all information

relating to the provider, the services and supports being provided, and the people for whom services are provided; any information which is generated by or in the possession of the provider; the information required by the Citizens with Intellectual Disabilities Constitutional Rights and Dignity Act of 1978, effective March 3, 1979 (D.C. Law 2-137; D.C. Official Code §§ 7-1301.02 *et seq.*) or its successor; and any information required by the regulations implementing the HCBS Waiver program. The release of records shall be in accordance with applicable federal and District privacy laws and regulations.

9006.2

Each Waiver provider entity shall maintain the following records at the site of service delivery, where applicable, 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;
- (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) The person's financial records;
- (g) A discharge summary;
- (h) A written staffing plan, if applicable;
- (i) 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;
- (j) Documents which contain the following information:
 - (1) The results of the provider's functional analysis for service delivery;
 - (2) A schedule of the person's activities in the community, if applicable, including strategies to execute goals identified in the ISP and the

date and time of the activity, the staff as identified in the staffing plan;

- (3) Teaching strategies utilized to execute goals in the ISP and the person's response to the teaching strategy as further described in § 9006.12; and
- (4) A support plan with SMARTER goals and outcomes using the information from the DDS approved person-centered thinking and discovery tools, the functional analysis, the ISP, Plan of Care, and other information as appropriate to assist the person in achieving his or her goals;
- (k) Any records relating to adjudication of claims;
- (l) Any records necessary to demonstrate compliance with all rules and requirements, guidelines, and standards for the implementation and administration of the Waiver;
- (m) 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) Evidence of all community integration and inclusion activities attended by the person and related to the person's ISP goals and for each, a response to the following questions: "What did the person like about the activity?" and "What did the person not like about the activity?" DDS recommends the use of the Person-Centered Thinking Learning Log for recording this information;
 - (4) The start time and end time of each shift for any services received including the signature, or if progress notes are written using an electronic record system, the electronic signature, of the Direct Support Professional (DSP);
 - (5) For services that require awake overnight shifts, the progress notes shall include the support provided as indicated in the specific residential schedule; and

- (6) The matters requiring follow-up on the part of the Waiver service provider or DDS.
- (n) Reports on a quarterly basis, which DDS recommends recording using the Person-Centered Thinking 4+1 Tool, 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) For providers of In-Home Supports, Day Habilitation, Individualized Day Supports, and Employment Readiness, the quarterly report shall include information on the person's employment, including place of employment, job title, hours of employment, salary/hourly wage, information on fringe benefits, and current checking, savings and burial fund balances, as applicable;
 - (5) Any modifications or recommendations that may be required to be made to the documents described under § 9006.2(j), ISP, and Plan of Care from the summary analysis; and
 - (6) For providers of In-Home Supports, documentation of the review, implementation, and update, if applicable, of the person's Health Care Management Plan, in accordance with the DDS Health and Wellness Standards.
- 9006.3 For people receiving In-Home Supports, the person and his or her support team make the determination of which records to store in the person's home and which are kept off-site.
- 9006.4 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.
- 9006.5 Each Waiver provider agency and independent practitioner shall maintain records to document staff training and licensure requirements, for a period of at least six (6) years.

- 9006.6 Each Waiver provider shall ensure the person's privacy and limit access to the person's records to only authorized individuals, including the person. Waiver providers shall not publicly post mealtime protocols, clinical therapy schedules, or any other health information.
- 9006.7 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.
- 9006.8 Providers shall archive their records annually and ensure that they are available upon request.
- 9006.9 Each Waiver provider shall implement a written strategy that outlines where and how records are stored. For residential programs, the written strategy will be unique to each home and developed in coordination with the people who live there. For non-facility based programs, the written strategy shall identify the location for the records and shall include the process for making them available when audits and other reviews are conducted.
- 9006.10 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) Have 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 the appropriate level of security for records to comply with federal requirements for safeguarding information.
- 9006.11 DHCF shall retain the right to conduct audits at any time. 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.
- 9006.12 For purposes of § 9006.2(j)(3), the teaching strategy used to execute goals in the ISP shall include enough information so that any provider staff member or DSP could step in to assist the person in completing the goal. At minimum, the teaching strategy shall contain:

- (a) The goal statement;
- (b) The purpose of the goal/measurable outcome;
- (c) The materials needed to implement the goal;
- (d) The preferred learning/teaching style for the person;
- (e) The learning steps (*i.e.* individual actions that need to be completed for success); and
- (f) The method for measuring success.

9006.13 A staff member, designated by the provider, shall develop and implement an annual supervision plan for each staff member who is classified as a DSP. The annual supervision plan shall contain the following information:

- (a) The name of the DSP and date of hire;
- (b) The DSP's place of employment, including the name of the provider entity or day services provider;
- (c) The name of the DSP's supervisor who shall have at least two (2) years' experience working with persons with intellectual and developmental disabilities;
- (d) A documentation of performance goals for the DSP;
- (e) A description of the DSP's duties and responsibilities;
- (f) A comment section for the DSP's feedback;
- (g) A statement of affirmation by the DSP's supervisor confirming statements are true and accurate;
- (h) The signature, date, and title of the DSP; and
- (i) The signature, date, and title of the DSP's supervisor.

9007 INITIATING, CHANGING, OR TERMINATING ANY APPROVED SERVICES

9007.1 A provider shall hold a support team meeting and provide each person receiving Waiver services at least thirty (30) calendar days advance written notice of intent to initiate, suspend, reduce, or terminate services and shall offer a meeting to

explain the notice. A copy of the notice shall also be provided to DDS and DHCF. If DDS intends to suspend, reduce or terminate services, DDS shall also provide written notice which complies with the requirements set forth in this section.

- 9007.2 In accordance with 42 C.F.R. § 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.
- 9007.3 The written notice shall comply with the requirements of 42 C.F.R. § 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.
- 9007.4 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 an HCBS is no longer an appropriate alternative.
- 9007.5 The provider shall notify DDS in writing whenever any of the following circumstances occur:
- (a) The person's death;
 - (b) The hospitalization of the person;
 - (c) Any other circumstance in which Waiver services are interrupted for more than seven (7) days;
 - (d) The person is discharged or terminated from services; or
 - (e) Any other delay in the implementation of Waiver services.
- 9007.6 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/page/policies-and-procedures-dda>.
- 9007.7 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 C.F.R. § 431.210 and D.C. Official Code § 4-205.55(a)(2).

9007.8 Each person enrolled in the Waiver shall be provided a fair hearing in accordance with 42 C.F.R. § 431 and D.C. Official Code § 4-210.01 if the government:

- (a) Fails to offer the person a choice of either institutional care in an ICF/IID or home and community-based waiver services;
- (b) Denies a waiver service requested by the person;
- (c) Terminates, suspends, or reduces a waiver service; or
- (d) Fails to give the person the provider of his or her choice.

9007.9 DDS or the provider shall be responsible for issuing each required notice to the person enrolled in the Waiver or their representative regarding the right to request a hearing as described under § 9007.8.

9007.10 The content of the notice issued pursuant to § 9007.8 and 9007.9 shall comply with the requirements of 42 C.F.R. § 431.210 and D.C. Official Code § 4-205.55.

9008 HOME AND COMMUNITY-BASED SETTING REQUIREMENTS

9008.1 All Day Habilitation, Small Group Day Habilitation, Individualized Day Supports, Companion, Supported Employment, Small Group Supported Employment and Employment Readiness settings shall:

- (a) Be chosen by the person from HCBS settings options including non-disability settings. For residential settings, this includes, but is not limited to, ensuring that:
 - (1) The person selects their home and knows that they have protections against eviction;
 - (2) The person chooses their roommates and knows how to request a roommate change; and
 - (3) When the person has a roommate, they are offered the choice of available residential settings with a private bedroom, if they have the ability to pay.
- (b) Ensure the person's right to privacy, dignity, and respect, and freedom from coercion and restraint. This includes, but is not limited to, ensuring that:
 - (1) The person is provided personal care assistance in private, as appropriate;

- (2) Information is provided to the person on how to make an anonymous complaint;
 - (3) The person's health and other personal information (e.g., mealtime protocols, therapy schedules) is kept private;
 - (4) Staff do not talk about the person's private information in front of others who do not have a right and/ or need to know; and
 - (5) Staff address the person by her/his name or preferred nickname.
- (c) Be physically accessible to the person and allow the person access to all common areas. For residential settings, this includes, but is not limited to, ensuring that:
 - (1) The person has full access to the kitchen, dining area, living room, laundry, and all other common areas of their home; and
 - (2) The home is fully accessible to meet the needs of the person living there, including all common areas and supports as needed, such as grab bars and ramps.
- (d) Support the person's community integration and inclusion, including relationship-building and maintenance, support for self-determination and self-advocacy;
- (e) Provide opportunities for the person to seek employment and meaningful non-work activities in the community. This is evidenced in part by the following:
 - (1) A person who desires to work is supported to pursue work in the community; and
 - (2) The person engages in meaningful non-work activities in the community.
- (f) Provide information on individual rights;
- (g) Optimize the person's initiative, autonomy, and independence in making life choices including, but not limited to, daily activities, physical environment, and with whom to interact;
- (h) Facilitate the person's choices regarding services and supports, and who provides them;

- (i) Create individualized daily schedules for each person receiving supports, that includes activities that align with the person's goals, interests and preferences, as reflected in his or her ISP, in accordance with DDS guidance;
- (j) Provide opportunities for the person to engage in community life, as evidenced in part by people being able to shop, attend religious services, schedule appointments, have lunch with friends and family, etc. in the community, as they choose;
- (k) Provide opportunities to receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS, as evidenced in part by the person using community resources, such as parks, recreational centers, community health clinics, etc.;
- (l) Control over his or her personal funds and bank accounts, as evidenced in part by the person being able to access their funds, when they want to, and without advanced notice;
- (m) Allow visitors at any time within the limits of the lease or other residency agreement;
- (n) Be integrated in the community and support access to the greater community. This is evidenced in part by the following:
 - (1) The person receives the supports they need to see family and friends and spend time doing activities of their choosing in the community; and
 - (2) The person is encouraged to learn travel skills so that they can use public transportation.
- (o) Allow full access to the greater community.

9008.2 All Day Habilitation, Small Group Day Habilitation, Individualized Day Supports, Supported Employment, Small Group Supported Employment, Companion and Employment Readiness settings must develop and adhere to policies which ensure that each person receiving services has the right to the following:

- (a) A secure place to keep their belongings;
- (b) Access to snacks at any time;
- (c) Privacy for telephone calls, texts and/or emails, or any other form of electronic communication, *e.g.* FaceTime or Skype, with or without support, based on the person's preference; and

(d) Meals at the time and place of a person's choosing.

9008.3 Any deviations from the requirements in §§ 9008.1(l) and (m) and § 9008.3 must be supported by a specific assessed need, justified and documented in the person's person-centered ISP, as well as reviewed and approved as a restriction by the Provider's Human Rights Committee (HRC). There must be documentation that the Provider's HRC review and person-centered planning meeting included discussion of the following elements:

- (a) What the person's specific individualized assessed need is that results in the restriction;
- (b) What prior interventions and supports have been attempted, including less intrusive methods;
- (c) Whether the proposed restriction is proportionate to the person's assessed needs;
- (d) What the plan is for ongoing data collection to measure the effectiveness of the restriction;
- (e) When the HRC and the person's support team will review the restriction again;
- (f) Whether the person, or his or her substitute decision-maker, gives informed consent; and
- (g) Whether the HRC and the person's support team has assurance that the proposed restriction or intervention will not cause harm.

9009 PROVIDER ENROLLMENT PROCESS

9009.1 Prospective providers shall send a letter of intent to DDA to enroll as a Medicaid provider of Waiver services to the Letter of Intent mailbox at letterofintent.potentialproviders@dc.gov. DDA will provide a written response of disposition to the prospective provider within three (3) business days of receipt of the letter of intent.

9009.2 With acceptance of a qualified letter of intent, prospective providers will receive an invitation to the DDA Quarterly Prospective Provider's Information Session. Prospective providers shall be notified by DDA of the DHCF contractor schedule for the Provider Data Management Systems (PDMS) training. After the PDMS training, providers shall access the PDMS to initiate the Medicaid provider enrollment application.

- 9009.3 Upon receipt of the Medicaid provider enrollment application by DDA, prospective providers shall receive a denial letter or an invitation to be interviewed. 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 § 9009.5.
- 9009.4 If the Medicaid provider enrollment application is incomplete, the prospective provider will be notified by the DHCF contractor. DDA may issue a denial letter, in accordance with § 9009.5, within sixty (60) business days from the time a Medicaid provider enrollment application is received.
- 9009.5 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.
- 9009.6 Prior to enrollment, prospective Waiver providers shall be required to interview with the DDA Provider Review Committee (PRC) Panel. Prospective providers shall receive written notification from DDA to attend a DDA scheduled interview with the PRC Panel.
- 9009.7 Pursuant to the committee's recommendation and the overall merit of the application, DDA shall either issue a denial letter to the prospective provider or send the application of the DDA-recommended provider to DHCF for its review within five (5) business days of the committee's review date. The denial letter shall be issued in accordance with the requirements set forth in § 9009.5. If a denial letter was issued by DDA, the prospective provider may submit a written dispute for reconsideration in no more than five (5) business days and/or appeal the denial of the application to the Office of Administrative Hearings in accordance with Chapter 94 of Title 29 DCMR.
- 9009.8 Upon approval by DDA, the DDA Provider Relationship Specialist shall facilitate the newly enrolled provider's acknowledgement of final approval to DHCF via the DHCF's contractor portal PDMS.
- 9009.9 If a denial letter was issued by DDA and there was no reconsideration requested or granted 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 denial letter was issued.

9009.10 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; to all policies and procedures promulgated by DDS that are applicable to providers during the provider's participation in the Waiver program; and to participation and cooperation in the reporting requirements pursuant to the Citizens with Intellectual Disabilities Constitutional Rights and Dignity Act of 1978, effective March 3, 1979 (D.C. Law 2-137; D.C. Official Code §§ 7-1301.02 *et seq.*), as implemented by order of the Superior Court of the District of Columbia.

9009.11 Each provider who has been terminated or has voluntarily withdrawn from the Waiver program may not reapply to the Waiver program for a period of at least one (1) year.

9010 PROVIDER QUALIFICATIONS

9010.1 Home and Community-Based Services (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 (3) 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, unless waived by the Department on Disability Services Deputy Director for the Developmental Disabilities Administration;
- (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 percent (5%) or more outstanding shares;

- (e) To the extent its corporate structure includes a Board of Directors, a list of Board members representing a diverse spectrum of the respective community 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 statements of the agency performed by a third-party Certified Public Accountant or auditing company (not applicable for a new organization);
- (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 assurance and improvement plan that includes, but is not limited to, requirements of the applicable Waiver services, and community integration and person-centered thinking principles and values as intentional outcomes for persons supported;
- (m) A copy of professional/business liability insurance of at least one million dollars (\$1,000,000) prior to the initiation of services, or more as required by the applicable Human Care Agreements;
- (n) A sample of all documentation templates, such as progress notes, evaluations, intake assessments, discharge summaries, and quarterly reports;
- (o) For providers of In-Home Supports, Day Habilitation, Individualized Day Supports, and Employment Readiness, evidence of fiscal and organizational accountability; and
- (p) Any other documentation deemed necessary to support the approval as a provider.

- 9010.2 Professional service provider applicants who are in private practice as an independent clinician and are not employed by an enrolled HCBS Waiver provider agency of residential or day/vocational services 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 million dollars (\$1,000,000) in liability insurance.
- 9010.3 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.
- 9010.4 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 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 and relevant regulations;
- (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://dds.dc.gov/publication/language-access-policy>;
- (i) Offer the Hepatitis B vaccine to all employees;
- (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, procedures, transmittals, District regulations, and issued guidance. This includes, but is not limited to: 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/page/policies-and-procedures-dda>;
- (l) For providers of In-Home Supports, Day Habilitation, Individualized Day Supports, and Employment Readiness services, complete mandatory training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics as determined by DDS, and in accordance with the most current DDS Training Policy and Procedure;
- (m) Provide a written staffing schedule for each site where services are provided, if applicable;
- (n) Maintain a written staffing plan, if applicable;

- (o) Develop and implement a continuous quality assurance and improvement system, that includes person-centered thinking, community integration, and compliance with the HCBS Settings Rule, to evaluate the effectiveness of services provided;
- (p) Ensure that a certificate of occupancy is obtained, if applicable;
- (q) Obtain approval from DDS for each site where 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;
- (u) Participate, and support willing waiver recipients to participate, in the National Core Indicators surveys, or successors surveys, as requested by DDS and/ or its assigned contractors; and
- (v) Adhere to the specific provider qualifications in each service rule.

9010.5 Each service provider under the Waiver for which transportation is included or otherwise provided shall:

- (a) Ensure that each vehicle used to transport a person has a valid license plate;
- (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, except in circumstances where transportation is not included in the Waiver service;
- (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, except in circumstances where transportation is not included in the Waiver service;
- (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 § 9011 of these rules, except that a staff/employee/contractor who works exclusively as a driver is exempt from § 9011.1(h), but must be trained on use of the vehicle safety restraints and any specific safety needs of the person being transported;
- (o) Ensure that each staff/employee/contractor providing services be certified in Cardiopulmonary Resuscitation (CPR) and First Aid; and
- (p) Encourage the use of community-based transportation, as appropriate and described in the ISP.

9010.6 In order to provide services under the Waiver and qualify for Medicaid reimbursement, a Qualified Intellectual Disabilities Professional (QIDP), also known as a Qualified Developmental Disabilities Professional or QDDP as defined in D.C. Official Code § 7-1301.03(21), shall oversee the initial habilitative assessment of a person; develop, monitor, and review ISPs; and integrate and coordinates Waiver services. The QIDP shall have at least one (1) of the following qualifications:

- (a) A psychologist with at least a master's degree from an accredited program and with specialized training or one (1) year of experience in intellectual disabilities;
- (b) A physician licensed to practice medicine in the District and with specialized training in intellectual disabilities or with one (1) year of experience in treating persons with intellectual disabilities;
- (c) An educator with a degree in education from an accredited program and with specialized training or one (1) year of experience in working with persons with intellectual disabilities;
- (d) A social worker with a master's degree from an accredited school of social work and with specialized training in intellectual disabilities or with one (1) year of experience in working with persons with intellectual disabilities;
- (e) A rehabilitation counselor who is certified by the Commission on Rehabilitation Counselor Certification and who has specialized training in intellectual disabilities or one (1) year of experience in working with persons with intellectual disabilities;
- (f) A therapeutic recreation specialist who is a graduate of an accredited program and who has specialized training or one (1) year of experience in working with persons with intellectual disabilities;
- (g) A human service professional with at least a bachelor's degree in a human services field (including, but not limited to: sociology, special education, rehabilitation counseling, and psychology) and who has specialized training in intellectual disabilities or one (1) year of experience in working with persons with intellectual disabilities; or
- (h) A registered nurse with specialized training in intellectual disabilities or with one (1) year of experience in working with persons with intellectual disabilities.

9010.7 Authorized service providers under the District's Medicaid HCBS Waiver for People with Intellectual and Developmental Disabilities in accordance with 29 DCMR §§ 1900 *et seq.* are automatically authorized as service providers for the same services under the IFS Waiver.

9011 REQUIREMENTS FOR DIRECT SUPPORT PROFESSIONALS

9011.1 The basic requirements for all employees and volunteers providing direct services, with the exception of peer support employees as set forth in § 9011.3, 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;
- (c) Possess a high school diploma, Certificate of Individual Educational Program Completion, general educational development (GED) certificate, or, if the person was educated in a foreign country, its equivalent;
- (d) Possess an active CPR and First Aid certificate and ensure that the CPR and First Aid certifications are renewed every two (2) years, with CPR certification and renewal via an in-person class;
- (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, with reasonable accommodation as appropriate in accordance with the Americans with Disabilities Act;
- (h) Have participated 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 who may foreseeably come in direct contact with Waiver recipients or patients.

- (j) Be acceptable to the person for whom they are providing supports.

9011.2 Volunteers who work under the direct 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 § 9011.1(i).

9011.3 The basic requirements for peer support employees providing direct services in Parenting Supports and Family Training services are as follows:

- (a) Be at least eighteen (18) years of age;
- (b) Comply with the requirements of 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.*);
- (c) Complete DDS required training for peer support employees;
- (d) Be acceptable to the person for whom they are providing supports; and
- (e) Is a person with a disability, or the family member or other unpaid caregiver of a person with a disability, with at least two of the following:
 - (1) Experience advocating on behalf of people with disabilities;
 - (2) Training in advocacy on behalf of people with disabilities by an advocacy organization;
 - (3) Training and certification in peer counseling by a certified peer counseling organization;
 - (4) Knowledge about the scope of services provided by DDS/DDA and the Child and Family Services Agency;
 - (5) Skills in Engagement, Relationship Building, and Collaboration with Families and Caregivers; and/or
 - (6) Knowledge about Community Systems, Partnerships and Resources

9012 COST REPORTS, AUDITS, AND OVERSIGHT MONITORING

- 9012.1 Each Waiver provider of day habilitation, in-home supports, individualized day supports, respite, employment readiness, and supported employment services shall report costs 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, on request. Such cost reporting will be for the purpose of informing rate setting parameters to be the most cost-effective for the government and to reimburse allowable costs for the providers. All cost reports shall cover a twelve (12) month cost reporting period.
- 9012.2 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.
- 9012.3 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.
- 9012.4 DHCF shall evaluate expenditures subject to the requirements in this Section through annual review of cost reports.
- 9012.5 DHCF, or its designee, shall review each cost report for completeness, accuracy, compliance, and reasonableness.
- 9012.6 Every five (5) years, for purposes of renewing the Waiver, DHCF shall rely on audited cost reports submitted by Waiver providers to DHCF. In the absence of audited cost reports, Waiver providers may submit unaudited costs reports or financial statements.
- 9012.7 DHCF, 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.
- 9012.8 The audit process shall be routinely conducted by DHCF to determine, by statistically valid scientific sampling, the appropriateness of services that are rendered to the IFS Waiver program beneficiaries and billed to Medicaid.
- 9012.9 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 the process for administrative review as outlined below:

- (a) DHCF shall issue a Notice of Proposed Medicaid Overpayment Recovery (NPMOR), 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;
- (b) The Provider shall have thirty (30) days from the date of the NPMOR to submit documentary evidence and written argument to DHCF against the proposed action;
- (c) The documentary evidence and written argument shall include a specific description of the item to be reviewed, the reason for the request for review, the relief requested, and documentation in support of the relief requested;
- (d) Based on review of the documentary evidence and written argument, DHCF shall issue a Final Notice of Medicaid Overpayment Recovery (FNMOR);
- (e) Within fifteen (15) days of receipt of the FNMOR, the Provider may appeal the written determination by filing a written notice of appeal with the Office of Administrative Hearings (OAH), 441 4th Street, NW, Suite 450 North, Washington, DC 20001; and
- (f) Filing an appeal with the OAH shall not stay any action to recover any overpayment.

9012.10 The recoupment amounts for denied claims shall be determined by the following formula:

- (a) A fraction shall be calculated with the numerator consisting of the number of denied paid claims resulting from the audited sample; and
- (b) The denominator shall be the total number of paid claims from the audit sample. This fraction shall be multiplied by the total dollars paid by DHCF to the Provider during the audit period, to determine the amount recouped.

9012.11 All participant, personnel, and program administrative and fiscal records shall be maintained so that they are accessible and readily retrievable for inspection and review by authorized government officials or their agents, as requested.

9012.12 All records and documents required to be kept under this chapter and other applicable laws and regulations which are not maintained or accessible in the operating office visited during an audit shall be produced for inspection within twenty-four (24) hours, or within a shorter reasonable time if specified, upon the request of the auditing official.

- 9012.13 The failure of a provider to release or to grant access to program documents and records to the DHCF auditors in a timely manner, after reasonable notice by DHCF to the provider to produce the same, may constitute grounds to terminate the Medicaid Provider Agreement, in accordance with the notice and process requirements set forth in 29 DCMR § 9400.
- 9012.14 DHCF shall retain the right to conduct audits or reviews at any time. Each waiver provider shall grant full access, during announced or unannounced on-site audits or review by DHCF, DHCF's designee, other District of Columbia officials, and representatives of the U.S. Department of Health and Human Services auditors, to relevant financial records, statistical data to verify costs previously reported to DHCF, program documentation, and any other documents relevant to the administration and provision of the Waiver service.
- 9012.15 As part of the audit process, providers shall grant access to any of the following documents to DHCF Program Integrity personnel, which may include, but are not limited to the following:
- (a) A record of all service authorization and prior authorizations for services;
 - (b) A record for all request for change in services;
 - (c) A written staffing plan, if applicable;
 - (d) A schedule of the beneficiary's activities in the community, if applicable, including strategies to execute goals in the Individualized Service Plan, the date and time of the activities, and staff, as identified in the staffing plan;
 - (e) Any records relating to adjudication of claims, including, the number of units of the delivered service, the period during which the service was delivered and dates of service, and the name, signature, and credentials of the service provider;
 - (f) Progress notes, as described in 29 DCMR § 9006; and
 - (g) Any record necessary to demonstrate compliance with rules, requirements, guidelines, and standards for implementation and administration of the Waiver.
- 9012.16 DHCF's Long Term Care Administration's Waiver Oversight and Monitoring team shall conduct monitoring reviews as follows:
- (a) Quarterly oversight and monitoring reviews to ensure compliance with established federal and District regulations and applicable laws governing the operations and administration of the Waiver Program; and

- (b) Quarterly oversight and monitoring reviews to monitor progress and performance against quality measures.

9012.17 As part of the oversight monitoring process, providers shall grant access to any of the following documents to the DHCF monitor, which may include, but shall not be limited to the following:

- (a) Programmatic records including Person-Centered Service Plan, Plan of Care/service delivery plan and documents supporting service delivery;
- (b) Employee records including training records;
- (c) A signed, 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.

9013 REPORTING REQUIREMENTS

9013.1 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.

9013.2 For purposes of reporting, the first quarter shall begin on the effective date of a person's ISP.

9013.3 Each Waiver provider shall submit assessments, quarterly reports as set forth in § 9006.2(n), documents as described in § 9006.2(i), and physician's orders, if applicable, to the DDS Medicaid Waiver unit for the authorization of services.

9013.4 Each Waiver provider shall complete all documents required for the service(s) as set forth in each service rule and upload the documents into MCIS, DDS/DDA's case management information system, ninety (90) days prior to the person's ISP meeting.

9013.5 Failure to submit all required documents may result in sanctions by DDS up to and including a ban on authorizations for new service recipients. Service interruptions to the waiver participant due to the service provider's failure to submit required documentation will initiate referrals to a choice of a new service provider to ensure a continuation of services for the waiver participant. 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.

9013.6 Each Waiver provider shall report on a quarterly basis to the person served, his or her family, as applicable, guardian and surrogate decision maker 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 recommended 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.

9013.7 Each Waiver provider shall report all reportable incidents and 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/page/policies-and-procedures-dda>.

9014 WAITING LIST

9014.1 The DDS, through DDA, may establish a waiting list for individuals who are otherwise eligible for and requesting services and supports through enrollment in the IFS waiver, consistent with the approved IFS waiver, and in accordance with the requirements of the Department on Disability Services Establishment Act (D.C. Law 16-264; D.C. Official Code § 7-761.05(7)), and as further amended.

9014.2 An individual is considered "eligible" if he or she meets the requirements for DDA services as set forth in D.C. Official Code §§ 7-1301.01 *et seq.*, and the eligibility criteria for participation in the IFS waiver program, which are found in the approved IFS waiver application, and are linked to the ICF/IID level of care criteria, and are set forth in 29 DCMR §§ 9002.1 to 9002.4.

9014.3 All eligible individuals requesting supports, services, and IFS waiver enrollment shall be treated in a manner that is consistent with the terms of the IFS waiver, in accordance with the order of priority specified below.

9014.4 An eligible individual seeking HCBS supports and services may do so through application to the IFS waiver program. The IFS waiver program is approved by the federal Centers for Medicare and Medicaid Services (CMS) to serve up to a set number of participants each year based on the approved IFS waiver application, as may be amended. If IFS waiver openings are not available because the maximum number of participants is being served, taking into account reserved capacity, DDA will establish a waiting list for deferred IFS waiver enrollment.

9014.5 Consistent with CMS requirements and based on the availability of appropriated funds for these services, DDA will make every reasonable effort to ensure that eligible individuals on the waiting list will be enrolled and begin to receive IFS

waiver supports and services as quickly as feasible given the availability of waiver slots and the order of priority established by the terms of the waiver and these rules.

- 9014.6 The application of each eligible individual who applies for IFS waiver supports and services will be reviewed by DDA using the DDA Level of Need Assessment and Screening Tool (LON), or its successor.
- 9014.7 Individuals on the waiting list for the IFS waiver will be enrolled and begin to receive IFS waiver services in the following priority order, based upon the results of the LON assessment, or its successor:
- (a) An eligible individual determined to have a priority need for IFS waiver services, as defined at § 9014.8, will be enrolled and receive them before all other eligible individuals;
 - (b) An eligible individual determined to have an emergency need for IFS waiver services, as defined at § 9014.9, will be enrolled and receive them after all identified priority needs have been met and before all other remaining eligible individuals;
 - (c) An eligible individual determined to have an urgent need for IFS waiver services, as defined at § 9014.10, will be enrolled and receive them after all identified priority and emergency needs have been met and before all other remaining eligible individuals; and
 - (d) An eligible individual determined to have a non-urgent need for IFS waiver services, as defined at § 9014.11, will be enrolled and receive them only after all identified priority, emergency, and urgent needs have been met; there is available enrollment space in the waiver; and sufficient appropriated resources are available.
- 9014.8 An individual is considered to have a “priority need” for enrollment in the IFS waiver if:
- (a) The individual has no family or other natural support system to meet his/her assessed need; or
 - (b) The individual is a ward of the District of Columbia who has aged out of the D.C. Child and Family Services Agency (CFSA), has been in an out-of-home placement, and returning to a parental/natural home is not an option for the individual.
- 9014.9 An individual is considered to have an “emergency need” for enrollment in the IFS waiver if the health and safety of the individual or others is in imminent danger and the situation cannot be resolved absent the provision of such services available from the IFS waiver program. Criteria for determining an emergency need include, but are not limited to:

- (a) There is clear evidence of abuse, neglect, or exploitation;
 - (b) The individual's primary caregiver is deceased and the individual lacks an alternative primary caregiver; or
 - (c) The individual is homeless or at imminent risk of becoming homeless as these terms are defined in the Homeless Services Reform Act of 2005, effective October 22, 2005 (D.C. Law 16-35; D.C. Official Code § 4-751.01(18) and (23)).
- 9014.10 An individual is considered to have an "urgent need" for enrollment in the IFS waiver if he or she is at significant risk of having his or her basic needs go unmet. Basic needs include the need for shelter, to eat, maintain one's health and to be free from harm, injury or threats to one's person or property.
- 9014.11 An individual is considered to have a "non-urgent need" for enrollment in the IFS waiver if he or she:
- (a) Meets eligibility criteria for supports through the IFS waiver; and
 - (b) Does not meet any of the priority, emergency, or urgent needs criteria.
- 9014.12 For individuals with the same priority status, when there are openings available in the IFS waiver, DDA shall review all candidates and, based upon their needs as determined by the LON, shall make a determination of order of placement. Length of time on the waiting list shall be a factor considered, but is not solely considered to determine order of placement.
- 9014.13 Based on funding availability, DDA will provide immediate non-waiver services to individuals on the waiting list who have been identified as having a priority or emergency need:
- (a) If the individual is homeless or at imminent risk of becoming homeless as these terms are defined in D.C. Official Code §§ 4-751.01(18) and (23); or
 - (b) If there is reasonable belief that the individual is in imminent danger, or would be subject to abuse or neglect if the individual does not receive immediate support or services.
- 9014.14 The application of each individual on the waiting list will be reviewed by DDA at least quarterly to determine any change in the support needs of the individual, the individual's family, and other relevant circumstances affecting the support needs of the individual. A review of a change in priority status will also be initiated within five (5) business days of the request by the individual, or any member of his or her support team.

- 9014.15 Once a individual's application has been approved for IFS waiver enrollment, the individual will be assigned a service coordinator, who shall assist the individual with completing his/her IFS waiver application and with development of their ISP and IFS waiver Plan of Care.
- 9014.16 If the individual is seeking out of home residential services through enrollment in the IFS waiver program, the individual must be Medicaid-eligible and the individual and his or her caregiver must be willing to accept available residential opportunities if necessary that meet the individual's primary needs at the time of assessment.
- 9014.17 DDA will refer and assist individuals on the waiting list to identify, apply for and, when appropriate, obtain services from other District of Columbia or community based agencies for which they might be eligible, including services through the Medicaid State Plan.
- 9014.18 An individual may be removed from the waiting list for IFS waiver service for any of the following reasons:
- (a) The individual or his or her substitute decision-maker requests removal;
 - (b) The individual is no longer eligible for services from DDA; or
 - (c) If, as part of the quarterly review of the individual's priority status, the individual's service coordinator is unable to reach the individual or his or her family after three (3) documented attempts each at least one week apart. However, the service coordinator must first send a written notice by certified mail to the last known address notifying the individual/family of DDA's intent to remove the individual's name from the waiting list. For purposes of this provision, DDA need not make contact in order to remove the individual from the waiting list but need only send written notice to the last address provided by the individual/family.
- 9014.19 Each individual on the waiting list and his or her legal representative shall be provided sufficient information and opportunity to request an agency review of any DDA decision with which they disagree relating to the individual's placement on the waiting list, priority status or removal from the waiting list for reasons other than enrollment and initiation of IFS waiver services.
- 9014.20 The agency review contemplated by this provision is an informal process by which the individual and his or her legal representative may seek reconsideration of a DDA decision by the DDS Deputy Director for DDA, or his or her designee, and requires a written request for reconsideration setting forth the factual and legal basis for the disagreement relating to the individual's placement on the waiting list, determination of order of priority status, or removal from the waiting list. Request for agency review must be made within thirty (30) days plus five (5) for mailing)

from the date the written notice in §§ 9014.22 and 9014.23 was mailed, unless there is good cause for a late request.

9014.21 Each individual placed on the waiting list or removed from the waiting list for reasons other than enrollment and initiation of IFS waiver services shall be entitled to a fair hearing at the Office of Administrative Hearings (OAH) in accordance with 42 CFR 43, D.C. Official Code §§ 4-210.01 *et seq.*, and 29 DCMR §§ 9006.1 to 9006.3. Each individual on the waiting list and their legal representative shall have thirty (30) calendar days from receipt of the written notice in §§ 9014.22 and 9014.23 to demand a fair hearing.

9014.22 DDA shall provide to each individual on the waiting list and their legal representative timely and adequate written notice of the DDA decision to place the individual on the waiting list or to remove the individual from the waiting list (for reasons other than enrollment and initiation of IFS waiver services) as follows:

- (a) Timely notice means that the written notice is sent by first-class U.S. Mail, postage prepaid, within five (5) business days of the decision to the last known address for the individual and their legal representative as included in the completed application or entered in the DDA database for the individual.
- (b) Adequate notice means that the written notice includes:
 - (1) A statement of the action taken by DDA;
 - (2) The reason for the action and, if the action is placement on the waiting list, the individual's rank on the waiting list and estimate of how long the individual can expect to wait for IFS waiver supports and services;
 - (3) That the individual can contact his or her service coordinator at any time to report a change in his or her circumstances and request a review of his or her priority status;
 - (4) An explanation of the individual's right to an informal agency review and/ or fair hearing at the OAH;
 - (5) The method by which the individual may request an informal agency review or demand a fair hearing;
 - (6) That the informal agency review is not required and does not toll the time that a individual has to file with OAH; and that the individual may immediately file a fair hearing request with OAH;

(7) That the individual may represent himself or herself, or use legal counsel, a relative, a friend or other individual for assistance; and

(8) Referral information for area legal services organizations.

9014.23 In addition to the written notice provided under § 9014.21, DDA shall send each individual on the waiting list and their legal representative written notice of the DDA's decision to continue the individual's placement on the waiting list beyond the first six (6) months, and twice annually thereafter.

9014.24 DDS shall publish an annual report on the waiting list during the prior fiscal year, which shall include a demographic profile of individuals on the waiting list; aggregate information on the level of need and requested supports and services of individuals on the waiting list; information about the length of time individuals have been on the waiting list; provide projected annual costs to meet the aggregate needs of all individuals on the waiting list; and discuss methods to reduce the waiting list and maximum waiting period.

9014.99 DEFINITIONS

When used in this section, the following terms and phrases shall have the meanings ascribed:

Aged Out – Refers to the threshold age when people receiving services from certain agencies are no longer eligible for those services, and may then become eligible for services and supports from DDA. These include wards of the state that are residentially funded by the Children and Family Services Agency and, upon turning the age of twenty two (22), if they choose to continue to receive supports and meet the eligibility criteria for DDA, DDA provides those supports.

CMS - The Centers for Medicare and Medicaid Services is the federal agency under Title XIX of the Social Security Act responsible for approving HCBS waiver applications and monitoring the operation of waiver programs in the states and the District of Columbia.

Department on Disability Services (DDS) - The agency that provides services to District of Columbia residents with intellectual and other disabilities through its Developmental Disabilities Administration and Rehabilitation Services Administration.

Home and Community-Based Services Waiver for Individual and Family Support (IFS waiver) - The IFS waiver is a District of Columbia Medicaid program as approved by the Council of the District of Columbia and CMS that funds home and community-based services and supports as an alternative to receiving services in an Intermediate Care Facility for

Individuals with Intellectual Disabilities (ICF/IID).

IFS Waiver Waiting List - The list of individuals who have been reviewed and assessed by DDA, have been assigned a priority ranking, and are waiting for an opening in the DDA HCBS IFS waiver program to be enrolled and receive services.

Intermediate Care Facility for Individuals With Intellectual Disabilities (ICF/IID) - ICFs/IID are Medicaid State Plan funded residential settings that provide all residential (room and board), day/vocational, therapeutic, habilitative, supervision and transportation services as specified in the person's Person Support Plan. ICF/IID homes are certified and licensed by the D.C. Department of Health.

ICF/IID Level of Care Criteria – These criteria establish the diagnostic and functional eligibility criteria for IFS waiver services and are set forth in 29 DCMR §§ 9002.1 to 9002.4, as amended.

Reserved Capacity - Reserve capacity is a number of waiver slots set aside as a commitment to wards of the State who are transitioning from the Children and Family Services Agency (CFSA) to adult services in DDS/DDA that are placed in out-of-home services to assure a seamless transfer to adult services.

9015 ASSISTIVE TECHNOLOGY SERVICES

9015.1 The purpose of this section is to establish standards governing eligibility for assistive technology services for persons enrolled in the Home and Community-Based Services Waiver for Individual and Family Support (IFS Waiver), and to establish conditions of participation for professionals and providers of assistive technology services to receive reimbursement.

9015.2 Assistive technology services include both goods and services that are designed to enable the person to function with greater independence, avoid institutionalization, and reduce the need for human assistance as follows:

- (a) Assistive technology goods are an item, piece of equipment, service animal or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities and can also support increased community inclusion, including in employment settings. Assistive technology goods must not be otherwise available through another funding source.
- (b) Assistive technology service means a service that directly assists a person in the selection, acquisition, or use of an assistive technology device and includes, but is not limited to:

- (1) The evaluation of assistive technology needs, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the person in his/her customary environment;
 - (2) Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for persons served through the waiver;
 - (3) Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
 - (4) Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;
 - (5) Training or technical assistance for the person or, where appropriate, his/her family members, guardians, advocates, or authorized representatives who provide unpaid support, training, companionship or supervision; and
 - (6) Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of the person served.
- (c) Assistive technology specifically includes Personal Emergency Response System (PERS), an electronic device that enables persons who are at high risk of institutionalization to secure help in an emergency in accordance with the following:
- (1) The person may also wear a portable "help" button to allow for mobility;
 - (2) The system is connected to the person's phone and programmed to signal a response center once the "help" button is activated;
 - (3) Trained professionals staff the response center;
 - (4) PERS is available to those persons who live alone, who are alone for significant parts of the day, or who would otherwise require extensive routine supervision;

- (5) Coverage of the PERS is limited to the rental of the electronic device;
- (6) PERS services shall include maintenance costs, training the recipient to use the equipment, and twenty-four (24) hour, seven (7) day a week response center services;
- (7) Reimbursement shall be made for an installation fee for the PERS unit; and
- (8) A monthly fee shall be paid for the maintenance of the PERS.

9015.3 A person qualifies for assistive technology services when he or she requests the service and/or it is recommended by the person's support team to enhance or maintain the person's independence, increase, maintain, or improve functional capabilities, and/or support increased community inclusion; or there is a physician's order for the service. Assistive technology services must be included in the person's Individual Support Plan (ISP) and Plan of Care.

9015.4 In order to be eligible for Medicaid reimbursement, each professional providing assistive technology services shall:

- (a) Conduct a comprehensive assessment within the first four (4) hours of service delivery, which shall include the following:
 - (1) A background review and current functional review of the person's capabilities in different environments;
 - (2) An environmental review in places of employment, residence, and other sites as necessary; and
 - (3) A needs assessment for the use of assistive technology.
- (b) Develop and implement an assistive technology plan within the first four (4) hours of service delivery that describes strategies, including recommended assistive technology goods, coordination with professional services, training of caregivers, monitoring requirements and instructions, and the anticipated and measurable, functional outcomes, based upon what is important to and for the person as reflected in his or her Person-Centered Thinking tools and the goals in his or her ISP and Plan of Care.

9015.5 If the person enrolled in the Waiver is between the ages of eighteen (18) and twenty-one (21) years old, the DDS Service Coordinator shall ensure that Early Periodic Screening and Diagnostic Treatment (EPSDT) services under the District of Columbia State Plan for Medical Assistance are fully utilized before accessing assistive technology services under the Waiver.

- 9015.6 Assistive technology services may be provided by the following professionals:
- (a) Approved Waiver providers of occupational therapy, physical therapy, and speech, hearing and language services, who are licensed pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.*) and implementing rules; and
 - (b) Assistive technology professionals who are certified through the Rehabilitation Engineering and Assistive Technology Society of North America, or another comparable national accreditation body, as approved by DDS.
- 9015.7 Assistive technology services may be provided by the following agency provider types:
- (a) An Assistive Technology Professional Agency or Supplier that is an approved vendor for the Rehabilitation Services Administration; or
 - (b) A licensed provider agency of occupational therapy, physical therapy, and speech, hearing and language pathology.
- 9015.8 A provider who is enrolled as an In-Home Supports Services provider with a current Medicaid provider agreement is automatically qualified as an Assistive Technology Services provider for people who receive services from that provider.
- 9015.9 Each provider of Medicaid reimbursable assistive technology services shall comply with Section 9010 (Provider Qualifications) and Section 9009 (Provider Enrollment Process) of Chapter 90 of Title 29 DCMR.
- 9015.10 Each provider of Medicaid reimbursable assistive technology services shall maintain the following documents for monitoring and audit reviews:
- (a) A copy of the assistive technology assessment and treatment plan;
 - (b) A copy of the physician's order, if applicable;
 - (c) A copy of receipts documenting the date, item, amount expended, and any related warranty; and
 - (d) Any other applicable documents required to be maintained under Section 9006 (Records and Confidentiality of Information) of Chapter 90 of Title 29 DCMR, where applicable.

9015.11 In order to be eligible for Medicaid reimbursement, each provider shall comply with Section 9013 (Reporting Requirements) and Section 9005 (Individual Rights) of Chapter 90 of Title 29 DCMR.

9015.12 In order to be eligible for reimbursement, each Medicaid provider of assistive technology services must obtain a written Service Authorization from the Department on Disability Services (DDS) before providing assistive technology services.

9015.13 Assistive technology services are subject to the following limitations:

- (a) There is a maximum dollar amount per participant over a five-year period for this service. A person may be able to exceed this limitation on a case-by-case basis with the approval of DDS, based upon documented need, but shall be authorized prior to rendering the Waiver service; and
- (b) Assistive technology provided through the Waiver is available only after the person has fully utilized services available under the Medicaid State Plan, or programs funded under Section 110 of the Rehabilitation Act of 1973, enacted September 26, 1973, as amended (Pub. L. 93-112; 29 USC §§ 720 *et seq.*), or Sections 602(16) and (17) of the Individuals with Disabilities Education Act, enacted April 13, 1970, as amended (Pub. L. 91-230; 20 USC §§ 1400 *et seq.*), and the assistive technology is not the obligation of the individual's employer.

9015.14 The Medicaid reimbursable billable unit of service for assistive technology services shall be fifteen (15) minutes. A provider shall provide at least eight (8) minutes of service in a span of fifteen (15) continuous minutes to bill a unit of service that is reimbursable by Medicaid.

9016 BEHAVIORAL SUPPORT SERVICES

9016.1 The purpose of this section is to establish standards governing Medicaid eligibility for behavioral support services for persons enrolled in the Home and Community-Based Services Waiver for Individual and Family Support (IFS Waiver), and to establish conditions of participation for providers of behavioral support services.

9016.2 Behavioral support services are designed to assist people who exhibit behavior that inhibits their ability to live safely in the community or who need support to:

- (a) Build alternative and more communication skills;
- (b) Achieve positive personal outcomes including their Individual Support Plan (ISP) goals, based on what is important to and important for people; and
- (c) Interact more effectively in the community.

- 9016.3 Medicaid reimbursable behavioral support services shall be:
- (a) Recommended by the person's support team;
 - (b) Identified in the person's ISP and Plan of Care;
 - (c) Approved by the Department on Disability Services (DDS) Restrictive Controls Review Committee or Health and Wellness Unit for one-to-one behavioral supports;
 - (d) Recommended by a physician or Advanced Practice Registered Nurse (APRN) if the services are one-to-one behavioral supports related to a medical condition; and
 - (e) Prior authorized by DDS before the commencement of services.
- 9016.4 Medicaid reimbursable behavioral support services may include the following activities, as needed by the person:
- (a) Development of a Diagnostic Assessment Report (DAR) in accordance with the requirements described under § 9016.22 to 9016.23;
 - (b) Development of a Behavior Support Plan (BSP) in accordance with the requirements described under § 9016.24 to 9016.26;
 - (c) Implementation of positive behavioral support strategies and principles based on the DAR and BSP;
 - (d) Training of the person, his or her family, support team, and providers of their residential services and day services, to implement the BSP;
 - (e) Evaluation of the effectiveness of the BSP by monitoring the plan at least monthly, or more often as necessary, developing a system for collecting BSP-related data, and revising the BSP;
 - (f) Consultation services for the person, his or her family and/or support team;
 - (g) Counseling services for the person, if pre-approved by DDS; and
 - (h) Participating in the person's quarterly psychotropic medication review.
- 9016.5 Behavioral support services shall be provided in one of three (3) tiers, based upon the assessed needs of the person:

- (a) Tier 1, or Low Intensity Behavioral Support, shall assist a person with behavior that is not dangerous to himself or herself or others but whose behavior may interfere with the person's ability to achieve ISP goals;
- (b) Tier 2, or Moderate Behavioral Support, shall assist a person whose behavior impacts his or her ability to retain a baseline level of independence or that interferes with the person's quality of life; and
- (c) Tier 3, or Intensive Behavioral Support, shall assist a person who exhibits behavior that is extremely challenging and may be complicated by medical or mental health factors.

9016.6 Medicaid reimbursement for Tier 1 Low Intensity Behavioral Support Services shall provide up to twelve (12) hours of support per year for the services listed below. Services provided that exceed the limitations shall not be reimbursed except as provided in § 9016.10.

- (a) Training of the person, his or her family, the support team, and residential and day staff; and
- (b) On-site consultation and observations.

9016.7 Medicaid reimbursement for Tier 2 Moderate Behavioral Support Services shall provide up to fifty (50) hours of support per year for the services listed below; and Medicaid reimbursement for Tier 3 Intensive Behavioral Support Services shall provide up to one hundred (100) hours of support per year for the services listed below. Services provided that exceed these limitations shall not be reimbursed except as provided in § 9016.10.

- (a) Development of a new BSP;
- (b) Reviewing and updating the existing BSP, which shall be limited to up to three (3) hours for Tier 2 and eight (8) hours for Tier 3;
- (c) Training of the person, his or her family, the support team, and residential and day staff;
- (d) On-site consultation and observations;
- (e) Participation in behavioral review or treatment team meetings, delivering notes including emergency case conferences, hospital discharge meetings, interagency meetings, pre-ISP and ISP meetings, and human rights meetings;
- (f) Completion of quarterly reports, diagnostic updates and monitoring monthly data; and

- (g) Participation in psychotropic medication review meetings to deliver notes.
- 9016.8 In order to be eligible for Medicaid reimbursement, requests for more than seventy-five (75) hours of behavior support services must be reviewed and approved by a DDS designated staff member.
- 9016.9 In addition, a person receiving Tier 2 Moderate Behavioral Support Services may receive up to twenty-six (26) hours of counseling per year, if approved by DDS; and a person receiving Tier 3 Intensive Behavioral Support Services may receive up to fifty-two (52) hours of counseling per year, if approved by DDS.
- 9016.10 In order to be eligible for Medicaid reimbursement, requests for additional hours beyond the annual limits may be approved by DDS upon the submission of a diagnostic update to amend the DAR and accompanying worksheet.
- 9016.11 In order to be eligible for Medicaid reimbursement, requests for counseling as a behavioral support service shall be approved by a DDS designated staff member and shall be limited to counseling services that are not available under the District of Columbia State Plan for Medical Assistance.
- 9016.12 To qualify for Medicaid reimbursable one-to-one behavioral supports, a person shall meet at least one (1) of the following criteria:
- (a) Exhibit elopement resulting in serious risk to the safety of self or others;
 - (b) Exhibit behavior that is life threatening to self and others;
 - (c) Exhibit destructive behavior causing serious property damage;
 - (d) Exhibit sexually predatory behavior;
 - (e) Exhibit self-injurious behavior that poses a serious risk to the person's safety; or
 - (f) Have a medical condition that requires one-to-one services.
- 9016.13 Medicaid reimbursable one-to-one behavioral supports related to a medical condition shall be approved by DDS, and shall be based upon a physician or APRN order for one-to-one behavioral supports associated with a medical condition that meets the requirements of DDS's policies and procedures. The order shall include, at a minimum, the following information:
- (a) A specific time period or duration for the delivery of services;

- (b) A description of the medical condition that causes the person's health or safety to be at risk;
 - (c) The responsibilities of each staff person delivering supports; and
 - (d) A justification of the need for one-to-one behavioral supports.
- 9016.14 Medicaid reimbursable one-to-one behavioral support services provided by a DSP shall not be provided concurrently with in-home supports, day habilitation, companion or individualized day supports one-to-one services unless authorized by DDS, required by court order or otherwise necessary to support a person or persons who have complex behaviors or medical needs that involve a risk to the health, safety or well-being of the person based on the intensity of the person's behavioral or medical needs.
- 9016.15 Within the service authorization period, a provider of Medicaid reimbursable behavioral supports services shall:
 - (a) Complete the diagnostic assessment;
 - (b) Complete the DAR and the accompanying behavioral support referral worksheet ("worksheet") based on the results of the diagnostic assessment; and
 - (c) Complete the BSP when recommended by the DAR.
- 9016.16 The DAR shall be effective for three (3) years except as indicated in § 9016.17, or for a person receiving one-to-one behavioral supports, which shall be updated annually. Reauthorization of behavioral support services within the three (3) year period shall be requested in a diagnostic update with accompanying referral worksheet submitted to the DDS Service Coordinator.
- 9016.17 When a person experiences changes in psychological or clinical functioning, the behavioral supports provider shall submit a diagnostic update with an accompanying worksheet to amend the DAR to the DDS Service Coordinator at any time during the three (3) year period, upon the recommendation of the support team.
- 9016.18 The worksheet accompanying the DAR shall include the number of hours requested for professional services, paraprofessional services, and one-to-one behavioral support services to address recommendations in the DAR.
- 9016.19 The diagnostic update shall include a written clinical justification supporting the reauthorization of services.

- 9016.20 The diagnostic update shall be reviewed by the person and his or her support team in consultation with behavioral supports staff.
- 9016.21 The BSP shall be effective for up to two (2) calendar years, which shall correspond with the person's ISP year unless revised, updated or discontinued when no longer necessary in accordance with the recommendations of the DAR and accompanying worksheet.
- 9016.22 To be eligible for Medicaid reimbursement, the diagnostic assessment shall include the following activities:
- (a) Direct assessment techniques such as observation of the person in the setting in which target behaviors are exhibited, and documentation of the frequency, duration, and intensity of challenging behaviors;
 - (b) Indirect assessment techniques such as interviews with the person's family members and support team, written record reviews, and questionnaires; and
 - (c) An explanation of how existing environmental, psychological, and/or medical influences impact the occurrence of behavioral problems.
- 9016.23 To be eligible for Medicaid reimbursement, the DAR shall include the following:
- (a) The names of individuals to contact in the event of a crisis;
 - (b) A summary of the person's cognitive and adaptive functioning status;
 - (c) A full description of the person's behavior including background, and environmental contributors;
 - (d) The counseling and problem-solving strategies used to address behavioral problems and their effectiveness;
 - (e) A list of positive, non-restrictive or less restrictive interventions utilized, the results, and an explanation of why the interventions were unsuccessful;
 - (f) A list of proposed goals for achieving changes in target behaviors; and
 - (g) The recommendations to initiate, continue, or discontinue behavioral support services.
- 9016.24 In order to be eligible for Medicaid reimbursement, the BSP shall be developed utilizing the following activities:
- (a) Interviews with the person and their support team;

- (b) Observations of the person at his or her residence and in the community, if applicable; and
 - (c) Review of the person's medical and psychiatric history including laboratory and other diagnostic studies, and behavioral data.
- 9016.25 In order to be eligible for Medicaid reimbursement, the behavioral supports staff that develops the BSP shall be responsible for:
 - (a) The coordination of the delivery of behavioral support services in the person's residential and day activity settings; and
 - (b) Obtaining the person's written informed consent and the approval of the person's substitute decision-maker, the support team, the provider's human rights committee, and DDS, when required by DDS's policies and procedures.
- 9016.26 In order to be eligible for Medicaid reimbursement, the BSP shall include the following:
 - (a) A clear description of the targeted behavior(s) that is consistent with the person's diagnosis;
 - (b) The data reflecting the frequency of target behaviors;
 - (c) A functional behavioral analysis of each target behavior;
 - (d) A description of techniques for gathering information and collecting data;
 - (e) The proactive strategies utilized to foster the person's positive behavioral support;
 - (f) The measurable behavioral goals to assess the effectiveness of the BSP;
 - (g) If restrictive techniques and procedures are included, the rationale for utilizing the procedures and the development of a fade-out plan; and
 - (h) Training requirements for staff and other caregivers to implement the BSP.
- 9016.27 Each provider of behavioral support services shall comply with Sections 9010 (Provider Qualifications) and 9009 (Provider Enrollment) of Chapter 90 of Title 29 DCMR and consist of one (1) of the following provider types:
 - (a) A professional service provider in private practice as an independent clinician, as described in Section 9010 (Provider Qualifications) of Chapter 90 of Title 29 DCMR;

- (b) A Mental Health Rehabilitation Services agency (MHRS) certified in accordance with the requirements of Chapter 34 of Title 22-A DCMR;
- (c) A home health agency as described in Section 9010 (Provider Qualifications), of Chapter 90 of Title 29 DCMR; or
- (d) A HCBS Provider, as described under Section 9010 (Provider Qualifications), of Chapter 90 of Title 29 DCMR.

9016.28 In order to be eligible for Medicaid reimbursement, each MHRS agency shall serve as a clinical home by providing a single point of access and accountability for the provision of behavioral support services and access to other needed services.

9016.29 Individuals authorized to provide professional behavioral support services without supervision shall consist of the following professionals:

- (a) A psychiatrist;
- (b) A psychologist;
- (c) An APRN or a Nurse Practitioner (NP); and
- (d) A Licensed Independent Clinical Social Worker (LICSW).

9016.30 Individuals authorized to provide paraprofessional behavioral support services under the supervision of qualified professionals described under § 9016.29 shall consist of the following behavior management specialists:

- (a) A licensed Professional Counselor;
- (b) A licensed Social Worker (LISW);
- (c) A licensed Graduate Social Worker (LGSW);
- (d) A board Certified Behavior Analyst;
- (e) A board Certified Assistant Behavior Analyst; and
- (f) A registered Nurse.

9016.31 In order to receive Medicaid reimbursement, the person who drafts the BSP shall be a psychologist with at least a master's level degree working under the supervision of a licensed psychologist or an LICSW.

- 9016.32 In order to receive Medicaid reimbursement, the minimum qualifications for a person providing consultation are: a master's level degree in psychology, an APRN, an LICSW, an LGSW, or a licensed professional counselor, with at least one (1) year of experience in serving people with developmental disabilities. Knowledge and experience in behavioral analysis shall be preferred.
- 9016.33 In order to receive Medicaid reimbursement, an LGSW may only provide counseling under the supervision of an LICSW or a LISW in accordance with the requirements set forth in Section 3413 of Chapter 34 of Title 22-A DCMR.
- 9016.34 In order to receive Medicaid reimbursement, each DSP providing behavioral support services or one-to-one behavioral supports shall meet the following requirements:
- (a) Comply with Section 9011 (Requirements for Persons Direct Support Professionals) of Chapter 90 of Title 29 DCMR; and
 - (b) Possess specialized training in physical management techniques where appropriate, and all other training required for implementing the person's specific BSP.
- 9016.35 Each provider of Medicaid reimbursable behavioral support services shall meet the requirements established under Section 9013 (Reporting Requirements) and Section 9005 (Individual Rights) of Chapter 90 of Title 29 DCMR.
- 9016.36 In order to be eligible for Medicaid reimbursement, each provider of Medicaid reimbursable behavioral supports services shall maintain the following documents for monitoring and audit reviews, as applicable:
- (a) A copy of the DARs and accompanying worksheets;
 - (b) A copy of the BSPs;
 - (c) A current copy of the behavioral support clinician's professional license to provide clinical services;
 - (d) The documentation and data collection related to the implementation of the BSP;
 - (e) The records demonstrating that the data was reviewed by appropriate staff; and
 - (f) The documents required to be maintained under Section 9006 (Records and Confidentiality of Information) of Chapter 90 of Title 29 DCMR.

- 9016.37 The Medicaid reimbursement rate for each diagnostic assessment shall be a flat fee rate and the assessment shall be at least three (3) hours in duration and include the development of the DAR and accompanying worksheet.
- 9016.38 There shall be a Medicaid reimbursement rate for behavioral support services provided by professionals identified in § 9016.29, which shall be billed at the unit rate of fifteen (15) minutes. A standard unit of fifteen (15) minutes requires a minimum of eight (8) minutes of continuous service to be billed.
- 9016.39 There shall be a Medicaid reimbursement rate for behavioral support services provided by paraprofessionals identified in § 9016.30, which shall be billed at the unit rate of fifteen (15) minutes. A standard unit of fifteen (15) minutes requires a minimum of eight (8) minutes of continuous service to be billed.
- 9016.40 There shall be a Medicaid reimbursement rate for one-to-one behavioral support services provided by DSPs, which shall be billed at the unit rate of fifteen (15) minutes. A standard unit of fifteen (15) minutes requires a minimum of eight (8) minutes of continuous service to be billed.

9017 COMPANION SERVICES

- 9017.1 The purpose of this section is to establish standards governing the eligibility for Medicaid reimbursement of companion services for people enrolled in the Home and Community-Based Services Waiver for Individual and Family Support (IFS Waiver) and to establish the conditions of participation for providers of companion services.
- 9017.2 Companion services provide non-medical assistance and supervision to support a person's goals, desires, and needs as identified in the person's Individual Support Plan (ISP), and reflected in his or her Person-Centered Thinking and Discovery tools. Goals may be related to the person's safety, promotion of independence, community integration, and/or retirement.
- 9017.3 To be eligible for Medicaid reimbursement of companion services, the services shall be identified in the person's ISP, Plan of Care and Summary of Supports for each person enrolled in the Waiver, and each person shall:
- (a) Demonstrate a need for non-medical support and supervision at home or in the community; and
 - (b) Have the service recommended by the person's support team, after having considered the appropriateness of other waiver services and the staffing ratio, if any, in the person's home.
- 9017.4 Companion services may be provided in a person's home or in the community.

- 9017.5 To be eligible for Medicaid reimbursement, companion services cannot be provided at the same time as In-Home Supports, Personal Care Services, Respite, and/or Behavioral Supports Non-Professional.
- 9017.6 To be eligible for Medicaid reimbursement, companion services may be provided outside of regular Monday to Friday daytime hours when supervision or other non-medical support is necessary to ensure the person's safety.
- 9017.7 To be eligible for Medicaid reimbursement, companion services shall not:
- (a) Exceed eight (8) hours per twenty-four (24) hour day;
 - (b) Exceed forty (40) hours per week when used-in combination with Personal Care Services or any other Waiver day or vocational support services, including but not limited to Day Habilitation, Employment Readiness, Supported Employment, Small Group Supported Employment, or Individualized Day Supports as part of a person's traditional Monday to Friday day/vocational programming time;
 - (c) Include the provider/employee's transportation time to or from the person's home, or the provider employee's break time; and
 - (d) Be provided to a person who requires a 24-hour medical one-to-one for supervision at home or in the community.
- 9017.8 In order to be reimbursed by Medicaid, companion services may be provided in a residential setting at the same ratio as is required of a DSP for that setting.
- 9017.9 In order to be reimbursed by Medicaid, each provider of companion services shall:
- (a) Be a Waiver provider agency;
 - (b) Be certified by the Department on Disability Services (DDS) as a Companion Provider Agency per the DDS Provider Certification Review (PCR) Policy;
 - (c) Provide verification of passing the DDS PCR for in-home support, supported living, or respite services for the last three (3) years. For providers with less than three (3) years of PCR certification, provide verification of a minimum of three (3) years of experience providing residential or respite services to the IFS waiver population, evidence of certification or licensure from the jurisdiction in which the service was delivered, and evidence of PCR certification for each year that the provider was enrolled as a waiver provider in the District of Columbia if applicable; and

- (d) Comply with Sections 9010 (Provider Qualifications) and 9009 (Provider Enrollment Process) of Chapter 90 of Title 29 DCMR.

9017.10 To be eligible for Medicaid reimbursement, the provider shall:

- (a) Use the DDS-approved Person-Centered Thinking and Discovery tools to develop a support plan, based upon what has been identified as important to and for the person. For people who receive companion services during waking hours, this should include a flexible list of proposed leisure and recreational activities at home and in the community, based upon the person's interests. The support plan must be completed within first week of service, and reviewed and revised quarterly, or more frequently, as needed; and
- (b) Participate in the person's support team meeting, at the person's preference.

9017.11 In order to be eligible for Medicaid reimbursement each provider/ employee rendering companion services shall:

- (a) Be at least eighteen (18) years of age;
- (b) Be acceptable to the person for whom they are providing supports;
- (c) Obtain annual documentation from a physician or other health professional that he or she is free from tuberculosis;
- (d) Complete competency-based training in:
 - (1) Communication with people with intellectual disabilities;
 - (2) Infection control procedures consistent with the requirement of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 C.F.R. § 1910.1030; and
 - (3) Emergency procedures; and incident management;
- (e) Possess a high school diploma, GED certificate, or, if the person was educated in a foreign country, its equivalent;
- (f) Possess an active CPR and First Aid certificate and ensure that the CPR and First Aid certifications are renewed every two (2) years, with CPR certification and renewal via an in-person class;
- (g) Have the ability to communicate with the person to whom services are provided;

- (h) Be able to read, write, and speak the English language;
 - (i) Participate in competency based training needed to address the unique support needs of the person, as detailed in his or her ISP; and
 - (j) 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.*).
- 9017.12 An employee may not provide Medicaid reimbursable companion services to a person if he or she is the person's relative; legal guardian; or is otherwise legally responsible for the person.
- 9017.13 Medicaid reimbursable companion services shall be authorized in accordance with the following provider requirements:
- (a) The DDS shall provide a written service authorization before the commencement of services;
 - (b) The service name and provider delivering services shall be identified in the ISP;
 - (c) The ISP shall document the amount and frequency of services to be received; and
 - (d) The provider shall submit each quarterly review to the person's DDS Service Coordinator no later than seven (7) business days after the end of the first quarter, and each subsequent quarter thereafter.
- 9017.14 In order to be eligible for Medicaid reimbursement each provider of companion services shall comply with Section 9006 (Records and Confidentiality of Information) of Chapter 90 of Title 29 DCMR, except that progress notes as described in § 9006.2(m) shall be kept on a daily basis.
- 9017.15 In order to be eligible for Medicaid reimbursement each provider shall comply with the requirements under Section 9013 (Reporting Requirements) and Section 9005 (Individual Rights) of Chapter 90 of Title 29 DCMR.
- 9017.16 Medicaid reimbursable companion services shall be billed at the unit rate. Companion services shall not exceed eight (8) hours per twenty-four (24) hour day. A standard unit of fifteen (15) minutes requires a minimum of eight (8) minutes of continuous service to be billed. Medicaid reimbursement shall be

limited to those time periods in which the provider is rendering services directly to the person. There shall be a Medicaid reimbursement rate for:

- (a) Companion services provided at a one-to-one ratio; and
- (b) Companion services provided in a small group of no more than one-to-three per person.

9018 CREATIVE ARTS THERAPIES SERVICES

9018.1 The purpose of this section is to establish standards governing Medicaid eligibility for Creative Arts Therapies services for persons enrolled in the IFS Waiver, and to establish conditions of participation for providers of these services.

9018.2 Creative Arts Therapies services utilize art, dance, drama, and music therapy to provide therapeutic supports to help a person with disabilities express and understand emotions through artistic expression and the creative process. Creative Arts Therapies shall be based upon what is important to and for the person as reflected in his or her Person-Centered Thinking tools and the goals in his or her ISP.

9018.3 Creative Arts Therapies services are available as a one-to-one service for a person.

9018.4 To be eligible for reimbursement, the services shall be:

- (a) Ordered by a physician or a practitioner listed in § 9018.7;
- (b) Reasonable and necessary for the treatment of social and emotional difficulties related to a number of mental health issues including disability, illness, trauma, loss, and physical and cognitive problems; and
- (c) Recommended by a person's support team, and included in the person's ISP and Plan of Care.

9018.5 The types of services eligible for reimbursement shall be:

- (a) Art therapy;
- (b) Dance therapy;
- (c) Drama therapy; and
- (d) Music therapy.

9018.6 Each person providing Creative Arts Therapies services shall:

- (a) Conduct an assessment within the first two (2) hours of delivering the service;
- (b) Develop and implement an individualized art, dance, drama, or music plan for the person that is in keeping with their choices, goals and prioritized needs that includes the following:
 - (1) Treatment strategies including direct therapy, caregiver training, monitoring requirements and instructions, and anticipated outcomes; and
 - (2) Identification of specific anticipated and measurable, functional outcomes, based upon what is important to and for the person as reflected in his or her Person-Centered Thinking tools and the goals in his or her ISP.
- (c) Deliver the completed plan to the person, family, guardian or other caregiver, and DDS Service Coordinator prior to the Support Team meeting;
- (d) Participate in the ISP and Support Team meetings, when invited by the person, to provide consultative services and recommendations specific to the expert content with the focus on how the person is doing in achieving the functional goals that are important to him or her;
- (e) Provide necessary information to the individual, family, guardian or caregivers, and team, to assist in planning and implementing the approved ISP and Plan of Care;
- (f) Record progress notes on each visit;
- (g) Submit quarterly reports in accordance with the requirements in Section 9006 (Records and Confidentiality of Information) of Chapter 90 of Title 29 DCMR;
- (h) Conduct periodic examinations and modify treatments for the person receiving services as necessary; and
- (i) Meet all of the requirements in Section 9011 (Requirements for Direct Support Professionals) of Chapter 90 of Title 29 DCMR.

9018.7 Services shall be provided by a certified practitioner in an independent practice or a practitioner employed by a Waiver provider.

9018.8 Creative Arts Therapies services shall be delivered by the following practitioners:

- (a) Art therapists certified to practice art therapy by the American Art Therapy Association, Inc. or credentialing of the Art Therapy Credentialing Board;
- (b) Dance therapists authorized to practice dance therapy pursuant to Chapter 71 (Dance Therapy) of Title 17 DCMR (Business, Occupations, and Professionals);
- (c) Drama therapists certified by the National Association for Drama Therapy; and
- (d) Music therapists certified by the Certification Board for Music Therapists, which is managed by the American Music Therapy Association.

9018.9 Each Waiver provider or certified practitioner in an independent practice shall meet the requirements as set forth in Section 9010 (Provider Qualifications) and Section 9009 (Provider Enrollment Process) of Chapter 90 of Title 29 DCMR.

9018.10 Creative Arts Therapies practitioners, without regard to their employer of record, shall be selected by the person or his/her authorized representative and shall be answerable to the person receiving services.

9018.11 Any Waiver provider substituting practitioners for more than a two (2) week period or four (4) visits due to emergency or availability events shall request a case conference with the DDS Service Coordinator to evaluate continuation of services.

9018.12 Services shall be authorized for reimbursement in accordance with the following provider requirements:

- (a) DDS shall provide a written service authorization before the commencement of services;
- (b) The provider shall conduct an assessment and develop a Creative Arts Therapies treatment plan with training goals and techniques that will assist the caregivers, within the first two (2) hours of service delivery;
- (c) The service name and provider delivering services shall be identified in the ISP and Plan of Care;
- (d) The ISP, Plan of Care, and Summary of Supports and Services shall document the amount and frequency of services to be received; and
- (e) Services shall not conflict with the service limitations described under § 9018.15.

9018.13 Each certified practitioner or Waiver provider shall maintain records required under Section 9013 (Reporting Requirements) and Section 9006 (Records and Confidentiality of Information) of Chapter 90 of Title 29 DCMR.

- 9018.14 Each certified independent practitioner or Waiver provider shall comply with Section 9005 (Individual Rights) under Chapter 90 of Title 29 DCMR.
- 9018.15 Any combination of Creative Arts Therapies services shall be limited to a maximum dollar amount per person, per calendar year, and delivered in accordance with the person's ISP and Plan of Care.
- 9018.16 The Medicaid reimbursement rate for Creative Arts Therapies services shall be billed per person per forty-five (45) minutes for art, dance, drama or music therapy as an individual service.
- 9018.17 The Medicaid reimbursable billable unit of service for Creative Arts Therapies services shall be fifteen (15) minutes. A provider shall provide at least eight (8) minutes of service in a span of fifteen (15) continuous minutes to bill a unit of service. Creative Arts Therapies may be billed on the same day, but cannot be billed concurrently with day vocational services, including Day Habilitation and Employment Readiness services.

9019 DAY HABILITATION SERVICES

- 9019.1 The purpose of this section is to establish standards governing Medicaid eligibility for day habilitation for persons enrolled in the IFS Waiver, and to establish conditions of participation for providers of day habilitation services.
- 9019.2 Day habilitation services are aimed at developing meaningful adult activities and skills acquisition to: support or further community integration, inclusion, and exploration, improve communication skills; improve or maintain physical, occupational or speech and language functional skills; foster independence, self-determination and self-advocacy and autonomy; support persons to build and maintain relationships; facilitate the exploration of employment or integrated retirement opportunities; help a person achieve valued social roles; and to foster and encourage persons on their pathway to community integration, employment and the development of a full life in the person's community.
- 9019.3 Day habilitation services are intended to be different and separate from residential services. These services are delivered in group settings or can be provided as day habilitation one-to-one services.
- 9019.4 Medicaid reimbursable day habilitation services may also be delivered in small group settings at a ratio of 1:3 for persons who are medically or behaviorally complex, as verified by the DDA LON Assessment and Screening Tool, or its successor tool, or the person's BSP, and who would benefit from day habilitation services in a smaller setting. Small group day habilitation settings must include integrated skills building in the community and support access to the greater community. In order to be Medicaid reimbursable, small group day habilitation:

- (a) Shall not be provided in the same building as a large day habilitation facility setting;
- (b) Shall be located in places that facilitate community integration and inclusion;
- (c) Shall fully comply with the requirements of the HCBS Settings Rule; and
- (d) Shall not be delivered in settings that have a daily census larger than fifteen (15) persons;

9019.5 To be eligible for day habilitation services:

- (a) The person shall request the service and the service shall be recommended by the person's Support Team and included in the ISP and Plan of Care; and
- (b) A person shall have a demonstrated personal or social adjustment need that can be addressed through participation in a habilitation program that is individualized to meet their goals, preferences, and needs.

9019.6 Day habilitation one-to-one services shall consist of:

- (a) Intense behavioral supports that require a behavioral support plan; or
- (b) Services for a person who has medical needs that require intensive staffing and supports.

9019.7 To be eligible for day habilitation one-to-one services, a person shall meet at least one of the following requirements:

- (a) Exhibit elopement which places the health, safety, or well-being of the person at risk;
- (b) Exhibit behavior that poses serious bodily harm to self or others;
- (c) Exhibit destructive behavior that poses serious property damage, including fire-setting;
- (d) Have any other intense behavioral problem that has been deemed to require one-to-one supervision;
- (e) Exhibit sexually predatory behavior; or
- (f) Have a medical history of, or high risk for, falls with injury, be physically fragile or have physical needs that do not require professional nursing but require intensive staffing, and have a physician's order for one-to-one staffing support.

- 9019.8 Day habilitation one-to-one services shall be authorized and approved in accordance with DDS/DDA policies and procedures available at <http://dds.dc.gov/page/policies-and-procedures-dda>.
- 9019.9 Day habilitation services shall be provided pursuant to the following service delivery criteria:
- (a) The service may be provided in a group setting. However, persons within the group shall also receive individualized services to meet their goals, preferences and needs;
 - (b) The services provided in a community-based venue shall offer skill-building activities to enhance the person's habilitation needs; and
 - (c) The service shall be provided in the most integrated setting appropriate to the needs of the person.
- 9019.10 In order to be reimbursed by Medicaid, day habilitation services shall consist of the following age-appropriate learning or habilitative activities that are based on what is important to and for the person as documented in his or her Individualized Support Plan and reflected in his or her Person-Centered Thinking and Discovery tools:
- (a) Training and skills development that increase participation in community activities, enhance community inclusion, and foster greater independence, self-determination and self-advocacy;
 - (b) A diversity of activities that allow the person the opportunity to choose and identify his or her own areas of interest and preferences;
 - (c) Activities that provide opportunities for socialization and leisure activities in the community, community explorations, and activities that support the person to build and maintain relationships;
 - (d) Training in the safe and effective use of one or more modes of accessible public transportation;
 - (e) Coordination of transportation to enable the person to participate in community activities;
 - (f) Activities to support community integration and inclusion:
 - (1) These must occur in the community in groups not to exceed four (4) participants for regular day habilitation or three (3) participants for persons in small group day habilitation;

- (2) The activities, frequency and duration of these activities shall be based on a person's interests and preferences as reflected in his or her ISP and Person-Centered Thinking and Discovery tools;
 - (3) There shall be a system to match persons together in community outings based on common interests, goals, and friendships, including that a person is given a choice as to whom he or she would like to spend time with during these activities;
 - (4) Except when a person's ISP indicates a lower frequency, each person must be offered the opportunity to engage in community integration and inclusion activities at least once per week, and more if indicated by the ISP;
 - (5) DDS recommends the use of learning logs for documentation of community integration and inclusion activities;
 - (6) At least quarterly, there must be a community integration activity for each person in which a Day Habilitation Program Coordinator, Assistant Director, or a Qualified Intellectual and Developmental Disabilities Professional participates to ensure: proper matching of participants; that the community outings reflect each person's interests, goals, or friendships; that each person receiving supports has opportunities to engage with people while in the community and to coach DSPs on the skills needed to successfully connect persons receiving supports with the broader community, progress being made and this must be fully documented in the quarterly report; and
 - (7) Each day habilitation provider must have, and must train their DSP staff on, written protocols regarding how DSPs are expected to support persons in the community and requirements for documenting progress notes regarding community engagement activities; and
- (g) Individualized or group services that enable the person to attain his/her maximum functional level based on the ISP and Plan of Care.

9019.11 Day habilitation services shall include a Registered Nurse for the purposes of:

- (a) Medication administration;
- (b) Staff training in components of the Health Care Management Plan (regardless of the author of the plan); and

- (c) Oversight of Health Care Management Plans (regardless of the author of the plan).

9019.12 Day habilitation services shall include a nutritionally adequate meal for participants who live independently or in the family home and who select to receive a meal. The meal shall be provided during lunch hours, meet one-third of a person's daily Recommended Dietary Allowance, be based on the person's preferences, and not be medically contraindicated.

9019.13 Each day habilitation provider shall develop a day habilitation plan for each person in accordance with the following:

- (a) In order to develop the day habilitation plan, the provider shall first develop a Positive Personal Profile (PPP) and Job Search and Community Participation Plan within thirty (30) days of the initiation of services and shall update at least annually.
- (b) The day habilitation plan shall correspond with the person's ISP and Plan of Care and support the interests, choices, goals and prioritized needs of the person;
- (c) Activities set forth in the day habilitation plan shall be functional, chosen by the person, correspond with habilitation needs and provide a pattern of life experiences common to other persons of similar age and the community-at-large.
- (d) To develop the person's day habilitation plan, the provider shall:
 - (1) Use observation, conversation, and other interactions, including assessments such as a vocational assessment, as necessary, to develop a functional analysis of the person's capabilities within the first month of participation and annually thereafter;
 - (2) Use the functional analysis, the ISP and Plan of Care, Person-Centered Thinking and Discovery tools, and other information available to identify what is important to and for the person and to develop a plan with measurable outcomes that develops to the extent possible the skills necessary to allow the person to reside and work in the community while maintaining the person's health and safety; and
 - (3) Focus on enabling each person to attain his or her maximum functional level by coordinating Waiver services with other services provided by any licensed professionals listed in the person's ISP and Plan of Care.

- 9019.14 Each provider of Medicaid reimbursable day habilitation services shall develop, with the person, an individualized schedule of daily activities that meets all requirements in the DDS guidance on daily schedules, including that it is based upon the person's goals and activities as identified in his or her ISP, and consistent with what is in his or her Person-Centered Thinking and Discovery tools, of meaningful adult activities that support the person on his or her pathway to employment and community integration and inclusion.
- 9019.15 Day habilitation providers may not pay a stipend to a person for attendance or participation in activities at the day habilitation program.
- 9019.16 Each day habilitation provider shall meet the following provider qualification and enrollment requirements:
- (a) Comply with the requirements described under Section 9010 (Provider Qualifications) and Section 9009 (Provider Enrollment Process) of Chapter 90 of Title 29 DCMR;
 - (b) Maintain the required staff-to-person ratio, indicated on the person's ISP and Plan of Care, to a maximum staffing ratio of 1:4 for regular day habilitation or 1:3 for persons in small group day habilitation;
 - (c) Shall have at least one individual on staff as a full-time employee or consultant basis that has experience developing adult education programs for a person with intellectual disabilities, to ensure outcome-based learning is taking place; and
 - (d) Shall have one individual on staff as a full-time employee or consultant basis that has experience developing adult senior curriculums for persons with intellectual disabilities, to ensure outcome-based learning is taking place.
- 9019.17 In addition to the requirements at § 9019.16, each small group day habilitation provider shall meet the following provider qualifications and enrollment requirements:
- (a) Fully comply with all requirements of the HCBS Settings Rule as that phrase is defined in Section 9099 (Definitions); and
 - (b) Provide documentation that the program manager of the HCBS Waiver provider agency has at least three (3) years of experience working with persons with intellectual and developmental disabilities who have complex medical or behavioral needs.

- 9019.18 Each DSP providing day habilitation services for a provider shall comply with Section 9011 (Requirements of Direct Support Professionals) of Chapter 90 of Title 29 DCMR.
- 9019.19 To receive Medicaid reimbursement, day habilitation services shall be provided in the community or in a facility-based setting that provides opportunities for community engagement, inclusion and integration. There shall be no increase in the number of facility-based settings authorized for current providers. No facility-based settings will be authorized for newly enrolling providers, with the exception of small group day habilitation.
- 9019.20 Each provider of Medicaid reimbursable day habilitation services shall comply with the requirements under Section 9008 (Home and Community-Based Settings Requirements) of Chapter 90 of Title 29 DCMR.
- 9019.21 All day habilitation services shall be authorized in accordance with the following requirements:
- (a) DDS shall provide a written service authorization before the commencement of services;
 - (b) The day habilitation DSP providing one-to-one services shall be trained in physical management techniques, positive behavioral support practices and other training required to implement the person's health care management plan and behavioral support plan, as applicable;
 - (c) The service name and provider entity delivering services shall be identified in the ISP and Plan of Care;
 - (d) The ISP, Plan of Care, and Summary of Supports and Services shall document the amount and frequency of services to be received;
 - (e) Completion of the person's day habilitation plan;
 - (f) Approval of the behavioral support plan or the physician's order for one-to-one staffing support for persons receiving day habilitation one-to-one services; and
 - (g) When required by a person's BSP, accurate completion by the DSP of the behavioral data sheets for persons receiving day habilitation one-to-one services.
- 9019.22 Each provider shall comply with the requirements described under Section 9013 (Reporting Requirements) and Section 9005 (Individual Rights) of Chapter 90 of Title 29 DCMR. Additionally, quarterly reports shall include a description of the person's activities in the community that support community integration and

inclusion using the Person-Centered Thinking Learning Log, available on-line at: <https://dds.dc.gov/publication/person-centered-thinking-tools-procedure>.

- 9019.23 Each provider shall comply with the requirements described under Section 9006 (Records and Confidentiality of Information) of Chapter 90 of Title 29 DCMR.
- 9019.24 There shall be a Medicaid reimbursement rate for regular day habilitation services. Services shall be provided for a maximum of eight (8) hours per day. The billable unit of service for regular day habilitation services shall be fifteen (15) minutes. A provider shall provide at least eight (8) minutes of service in a span of fifteen (15) continuous minutes to be able to bill a unit of service.
- 9019.25 There shall be a Medicaid reimbursement rate for day habilitation one-to-one services. The billable unit of service for day habilitation one-to-one services shall be fifteen (15) minutes. A provider shall provide at least eight (8) minutes of service in a span of fifteen (15) continuous minutes to be able to bill a unit of service.
- 9019.26 There shall be a Medicaid reimbursement rate for small group day habilitation services. The billable unit of service for small group day habilitation shall be fifteen (15) minutes. A provider shall provide at least eight (8) minutes of service in a span of fifteen (15) continuous minutes to be able to bill a unit of service.
- 9019.27 For persons who live independently or with family and select to receive a meal, the rate shall be increased by a dollar amount per day that the person receives a meal, and an additional dollar amount per day that the person receives a meal, if that meal is delivered by a third-party vendor.
- 9019.28 Small group day habilitation services shall be provided for a maximum of eight (8) hours a day, not to exceed forty (40) hours per week and two thousand eighty hours (2,080) hours annually.
- 9019.29 Day habilitation services shall not be provided concurrently with Individualized Day Supports, Companion, Supported Employment, or Employment Readiness services.
- 9019.30 No payment shall be made for care and supervision normally provided by the family or natural caregivers, residential provider, or employer.
- 9019.31 Provisions shall be made by the day habilitation provider for persons who arrive early and depart late.
- 9019.32 Time spent in transportation to and from the program shall not be included in the total amount of services provided per day.
- 9019.33 Any day habilitation setting must fully comply with the requirements of the HCBS Settings Rule. The daily census of any new setting may not exceed fifty (50)

people. The daily census includes people who receive support through the IFS Waiver, the IDD Waiver, and people who receive ICF/IID supports and are engaged in active treatment at the setting. However, the daily census does not include people who are in the setting only for morning arrival and afternoon departure and who spend the remainder of their day in the community.

9019.34 Non-small group day habilitation settings established prior to the effective date of these regulations that have a daily census under fifty (50) people may only receive authorizations for services for new participants up to a daily census of fifty (50) people in the setting. Current non-small group day habilitation settings that have a daily census of fifty (50) people or more in the setting will not be eligible for authorizations for services for new participants until their daily census is less than fifty (50) people in the setting.

- (a) The daily census includes people who receive support through the IFS Waiver and people who receive ICF/IID supports and are engaged in active treatment at the setting; and
- (b) The daily census does not include people who are in the setting only for morning arrival and afternoon departure and who spend the remainder of their day in the community.

9019.35 The following service limitations apply to new enrollees in non-small group day habilitation services:

- (a) No new enrollee may attend non-small group day habilitation for more than twenty-four (24) hours per week;
- (b) People who are sixty-four (64) years old and younger and have a LON Day Composite score of two (2) or less would not be eligible to attend day habilitation services, unless approved by DDA due to extenuating circumstances or barriers that are expected to be resolved within six (6) months:
 - (1) This limitation is applicable to small group day habilitation services;
 - (2) Exceptions may only be granted by DDA for six (6) month periods and must be accompanied by an ISP goal aimed at addressing the barrier to participation in other day or employment Waiver supports; and
 - (3) Alternative services, including Employment Readiness, Small Group Supported Employment, Individualized Day Supports, and Companion services that are offered during regular day service hours, shall be available, in combination, for up to forty (40) hours per week.

- (c) People who are sixty-four (64) years old and younger and have a LON Day Composite score of three (3) or higher shall not be eligible to attend day habilitation services, unless they already have tried other day and employment options for at least one year:
 - (1) This limitation is not applicable to small group day habilitation services;
 - (2) DDS may approve an exception to this prohibition due to extenuating circumstances or barriers that are expected to be resolved within six (6) months. Any exceptions shall be accompanied by an ISP goal aimed at addressing the barrier to participation in other day or employment Waiver supports;
 - (3) Alternative services including Supported Employment, Individualized Day Supports, Employment Readiness and Companion would be available, in combination, for up to forty (40) hours per week.

9019.36 The following service limitations apply to people who are currently attending non-small group day habilitation services:

- (a) Within one (1) year from the Waiver effective date, any person with a LON Day Composite score of one (1) or two (2) shall no longer be eligible for day habilitation services and services may no longer be authorized:
 - (1) For any person with a LON Day Composite score of one (1) or two (2), the person shall be offered employment services, either through the Waiver, the Rehabilitation Services Administration, or other community-based options;
 - (2) The transition from day habilitation services shall be implemented on a rolling basis over the course of the year, with the new service limitation discussed and choice of alternative options offered at the person's next ISP meeting, subject to the exception described in subparagraph (3) of this subsection; and
 - (3) For a person with an ISP meeting that is scheduled within ninety (90) days of the Waiver effective date, DDA may authorize day habilitation services for up to ninety (90) days following the ISP meeting to ensure a smooth transition.
- (b) Within one (1) year from the effective date of the Waiver, non-small group day habilitation services may not be authorized for any Waiver participant

with a LON Day Composite score above two (2) for more than twenty-four (24) hours per week, subject to the exception described below:

- (1) Wrap around services are available, including Supported Employment, Individualized Day Supports, Employment Readiness and Companion, in combination, for up to forty (40) hours per week;
 - (2) For people with an ISP meeting that is scheduled within ninety (90) days of the Waiver effective date, DDA may authorize up to forty (40) hours of day habilitation services per week for up to ninety (90) days following the ISP meeting to ensure a smooth transition; and
 - (3) This limitation is not applicable to small group day habilitation services.
- (c) For any person who is currently receiving non-small group day habilitation services who will be subject to a reduction in authorized service hours due to the service limitations identified in these provisions, DDA shall provide timely and adequate due process notice of the change in services and the person's appeal rights, using the process described in the DDS Person-Centered Planning Process and Individual Support Plans policy and procedures, or the successor documents.

9020 [RESERVED]

9021 EDUCATION SUPPORTS SERVICES

9021.1 The purpose of this section is to establish standards governing Medicaid eligibility for education supports services for persons enrolled in the IFS Waiver, and to establish conditions of participation for providers of education supports services in order to receive Medicaid reimbursement.

9021.2 Education supports services include tuition and general fees for adult post-secondary classes; on-campus peer supports that are designed to enable the person to function with greater independence, receive post-secondary education, and be integrated in the community; communication classes for a person who is deaf or hard of hearing; and adult education or tutoring for reading or math instruction.

9021.3 Education supports services will be authorized when:

- (a) The person requests the service or is recommended by the person's support team;
- (b) The person has a demonstrated need for the service to enhance or maintain independence; to increase, maintain, or improve education; or to support increased community inclusion;

- (c) The person has an employment outcome or outcome-related goals for skill attainment or development that is documented in the service plan and is related to the need for education supports services;
- (d) Education supports services is included in the person's ISP and Plan of Care;
- (e) The person demonstrates that a previous application for Rehabilitation Services Administration (RSA) funded post-secondary education was made, by the submission of a letter documenting either ineligibility for RSA services or documenting that the person has fully utilized services available under related services as defined in Sections (22) and (25) of the Individuals with Disabilities Education Act (20 U.S.C. §§ 1400 *et seq.*);
- (f) The person submits a financial aid application annually to the following:
 - (1) The post-secondary institution the individual is attending or to which the individual has applied;
 - (2) The D.C. Tuition Assistance Grant, if applicable;
 - (3) All other District or state funded educational assistance programs and school grants or financial aid;
 - (4) The U.S. Department of Education (The Free Application for Federal Student Aid (FAFSA));
 - (5) All federal grant programs, including the Pell Grant; and
 - (6) The Leverage Educational Assistance Program (LEAP);
- (g) The person provides DDA with a copy of the FAFSA Student Aid Report (SAR) and any other aid award from each source; and
- (h) The person signs DDA's form authorizing the post-secondary institution to provide DDA with information relating to the person's training or educational program, including, but not limited to:
 - (1) A copy of the person's official transcript;
 - (2) A copy of the person's grades at the conclusion of each quarter or semester;
 - (3) Attendance records;
 - (4) Financial awards;

(5) Notice of any disciplinary or adverse action; and

(6) A copy of the person's Americans with Disabilities Act (ADA) accommodation plan.

9021.4 Medicaid-eligible reimbursement for education supports services shall be limited to the following:

- (a) Payment of tuition for adult education classes offered by a college, community college, technical school or university (*i.e.* institution of post-secondary education), which includes classes for which the person receives credit, classes that a person audits, classes that support paid or unpaid internships, remedial classes and comprehensive transition programs. At least seventy-five (75) percent of the time the person spends on campus must be integrated with the general student population.
- (b) Payment to those institutions of post-secondary education for general fees charged to all students, which includes but is not limited to fees such as technology fees, student facilities fees, university services fees and laboratory fees.
- (c) Reimbursement for on-campus peer support, which is provided by staff of the institution of post-secondary education, and not contracted staff, or by other students attending the institution of post-secondary education. These supports assist the person to learn roles or tasks that are related to the campus environment such as homework assistance, interpersonal skills and residential hall independent living skills.
- (d) Payment for classes to teach people who are deaf American Sign Language, Visual Gestural Communication, or another form of communication, which shall be in one-to-one classes with a communication education professional or group classes of no more than four (4) persons taught by communication education professional. In order to participate in these communication classes, the person shall:
 - (1) Be twenty-one (21) years of age or older (or have a high school diploma if under twenty-one (21) years of age); and
 - (2) Have been assessed as benefitting from learning American Sign Language, Visual Gestural Communication, or another form of communication.
- (e) Payment for adult education or tutoring program for reading or math instruction.

- 9021.5 Medicaid-eligible reimbursable education supports services shall be services that are delivered in the District of Columbia, Maryland, and Virginia within a twenty-five (25) mile radius of the District of Columbia.
- 9021.6 Medicaid-eligible reimbursement for education supports services shall not include:
- (a) Room and board;
 - (b) Payment for books or supplies;
 - (c) Payment for recreational classes, activities and programs offered through recreational commissions, townships, boroughs, or other governmental entities;
 - (d) Tuition for adult education classes offered by online universities;
 - (e) Tuition for online classes; or
 - (f) Tuition for adult education classes provided on disability-specific campuses.
- 9021.7 Medicaid-eligible reimbursement for education supports services shall not be authorized concurrently with the following Waiver services:
- (a) Companion;
 - (b) Creative Arts Therapies;
 - (c) Day Habilitation and Day Habilitation (small group);
 - (d) Employment Readiness;
 - (e) Individualized Day Supports;
 - (f) In-Home Supports;
 - (g) Respite;
 - (h) Supported Employment; and
 - (i) Wellness.
- 9021.8 Medicaid reimbursable education supports services shall not be authorized concurrently when on-campus peer support is offered by the institution of post-secondary education and authorized in the ISP.

- 9021.9 In order to be eligible for Medicaid reimbursement, each provider of education supports services shall comply with Section 9013 (Reporting Requirements) and Section 9005 (Individual Rights) of Chapter 90 of Title 29 DCMR.
- 9021.10 In order to be eligible for Medicaid reimbursement, each provider of education supports services must first obtain a written Service Authorization from DDS before providing education supports services. DDS shall not be responsible for the payment of any post-secondary educational institution costs that the person may incur before receiving DDS's written commitment to fund the eligible costs at the post-secondary educational institution.
- 9021.11 Services shall only be authorized for Medicaid reimbursement in accordance with the following provider requirement procedures:
- (a) DDS shall provide a written service authorization before the commencement of services;
 - (b) The service name and Waiver provider delivering services shall be identified in the ISP and Plan of Care;
 - (c) The ISP, Plan of Care, and Summary of Supports and Services shall document the amount and frequency of services to be received; and
 - (d) The services to be provided shall not conflict with the service limitations described under § 9021.12.
- 9021.12 Education supports services are subject to the following limitations:
- (a) Education supports services provided through the IFS Waiver are available only to the extent that the person has fully utilized services available under related services as defined in Sections (22) and (25) of the Individuals with Disabilities Education Act (20 U.S.C. §§ 1400 *et seq.*), or available for funding by the Rehabilitation Services Administration;
 - (b) If used in combination with other day services or vocational support services (including day habilitation, employment readiness, small group supported employment, and individualized day supports), the combined hours for education supports services and these other services shall not exceed forty (40) hours per week, including the amount of time spent in classes and on-campus receiving on-campus peer supports;
 - (c) The maximum amount of reimbursement for education supports services a person may receive may not exceed either thirty-five thousand dollars (\$35,000) toward tuition or one hundred twenty (120) credit hours for post-secondary education in the person's lifetime; and

- (d) A person receiving education supports services may not exceed five thousand dollars (\$5,000) per semester of on-campus peer support for a person taking at least six (6) credit hours of classes per semester. On-campus peer support cannot be reimbursed through education supports services when the person takes fewer than six (6) credit hours of classes per semester.
- 9021.13 In order to be eligible for Medicaid reimbursement, an institution of post-secondary education providing education supports services shall be a post-secondary institution or program accredited by the United States Department of Education.
- 9021.14 In order to be eligible for Medicaid reimbursement, each adult education program providing education supports services shall:
 - (a) Have a Waiver service location in the District of Columbia, Maryland, or Virginia;
 - (b) Have a signed Waiver provider agreement on file with DDS;
 - (c) Have at least one staff person with a four (4) year degree and state teaching credentials; and
 - (d) Comply with DDS standards related to provider qualifications.
- 9021.15 Staff providing on-campus peer supports, as well as volunteers utilized in providing education supports services if they will spend any time alone with the person, must meet the following minimum standards:
 - (a) Be acceptable to the person;
 - (b) Be at least eighteen (18) years of age; and
 - (c) Comply with the requirements of 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.*).
- 9021.16 In order to be eligible for Medicaid reimbursement, each communication education agency providing education supports services to teach communications to people who are deaf or hard of hearing must:
 - (a) Have a Waiver service location in the District of Columbia, Maryland, or Virginia;

- (b) Have a signed Waiver provider agreement on file with DDS;
- (c) Complete standard DDS-required provider orientation and training;
- (d) Demonstrate compliance with DDS standards through completion of a self-assessment and validation of required documentation, policies and procedures;
- (e) Comply with DDS standards related to provider qualifications; and
- (f) Utilize teachers who, at a minimum, possess Qualified Level Certification from the American Sign Language Teachers Association (ASLTA).

9021.17 In order to be eligible for Medicaid reimbursement, each communication education professional employed by a communication education agency providing education supports services, as well as volunteers utilized in providing education supports services if they will spend any time alone with the person, must meet the following minimum standards:

- (a) Be acceptable to the person;
- (b) Be at least eighteen (18) years of age;
- (c) Have at least advanced or higher Sign Language Skills as determined by the Sign Language Proficiency Interview (SLPI); and
- (d) Comply with the requirements of 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.*).

9021.18 In order to be eligible for Medicaid reimbursement, each communication education professional providing education supports services to teach communications to people who are deaf or hard of hearing must:

- (a) Be acceptable to the person;
- (b) Be at least eighteen (18) years of age;
- (c) Have a Waiver service location in the District of Columbia, Maryland, or Virginia;
- (d) Have a signed Waiver provider agreement on file with DDS;

- (e) Complete standard DDS-required provider orientation and training;
- (f) Demonstrate compliance with DDS standards through completion of a self-assessment and validation of required documentation, policies and procedures;
- (g) Comply with DDS standards related to provider qualifications;
- (h) Have at least advanced or higher Sign Language Skills as determined by the SLPI; and
- (i) Comply with the requirements of 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.*).

9021.19 Each provider of Medicaid reimbursable education supports services shall comply with Section 9009 (Provider Enrollment Process) and Section 9010 (Provider Qualifications) of Chapter 90 of Title 29 DCMR.

9021.20 Education supports services may be offered in individual one-to-one or in small group one-to-three (or one-to-four).

9021.21 There shall be a total of four (4) Medicaid reimbursement rates for education supports services for communication classes for people who are deaf or hard of hearing: for 1:1 services and for small group services (*i.e.* 1:2, 1:3 and 1:4 staffing ratios).

9021.22 There shall be a Medicaid reimbursement rate for education supports on-campus peer support services. The billable unit of service for education supports on-campus peer supports services shall be fifteen (15) minutes. A provider shall provide at least eight (8) minutes of service in a span of fifteen (15) continuous minutes to bill a unit of service.

9022 EMPLOYMENT READINESS SERVICES

9022.1 This section establishes standards governing Medicaid eligibility for employment readiness services for persons enrolled in the IFS Waiver and establishes conditions of participation for providers of employment readiness services.

9022.2 Employment readiness services occur over a defined period of time with specific outcomes to be achieved, and provide learning and work experiences, including volunteer work, where a person enrolled in the Waiver can develop general, non-job-task-specific strengths and new employment related skills that contribute to

employability in paid employment in an integrated community setting. A person receiving employment readiness services may pursue employment opportunities at any time to enter the general work force.

9022.3 To be eligible for Medicaid reimbursable employment readiness services, the services shall be identified in the ISP, Plan of Care, and Summary of Supports for each person enrolled in Waiver, and each person shall:

- (a) Demonstrate a need for employment readiness services; and
- (b) Have employment related goals included in the ISP.

9022.4 To be eligible for Medicaid reimbursement, employment readiness services shall support a person on his/her pathway to competitive, integrated employment and shall consist of the following:

- (a) Providing opportunities for persons enrolled in the Waiver to develop general, non-job, task-specific strengths and skills that contribute to employability and are consistent with the person's goals;
- (b) Assessment activities that occur annually or more frequently based upon the needs of the person, which require, at a minimum, a Positive Personal Profile and Job Search and Community Participation Plan, and may also include a customized employment assessment, and/or conducting a person-centered vocational and situational assessment and employment readiness assessments provided at community businesses and other community settings;
- (c) Social and soft skills training, including, but not limited to, the following:
 - (1) Following and interpreting instructions;
 - (2) Interpersonal skills, including building and maintaining relationships;
 - (3) Communication skills for communicating with supervisors, co-workers, and customers;
 - (4) Travel skills;
 - (5) Respecting the rights of others and understanding personal rights and responsibilities;
 - (6) Decision-making skills and strategies;
 - (7) Support for self-determination and self-advocacy; and

- (8) Budgeting and money management;
- (d) Developing work skills which shall include, at a minimum, teach the person the following:
 - (1) Appropriate workplace attire, attitude, and conduct;
 - (2) Work ethics;
 - (3) Attendance and punctuality;
 - (4) Task completion;
 - (5) Job safety;
 - (6) Attending to personal needs, such as personal hygiene or medication management; and
 - (7) Interviewing skills;
- (e) Coordinating transportation to community activities utilizing the Medicaid Non-Emergency Transportation Broker;
- (f) Employment exploration and employment preparation in the community; and
- (g) Coordinating community-based, integrated, volunteer experiences as set forth in § 9022.5.

9022.5 Volunteer experiences, as part of employment readiness, shall be time limited and shall allow the person to develop experience and build skills to further the person's employment goal, as identified in his or her ISP. A person enrolled in the Waiver may volunteer at a for-profit private sector entity, a not-for-profit organization or an approved government agency, but may not volunteer for the provider agency or another business affiliated with the provider. Volunteering at a for-profit business shall meet any requirements released by the U.S. Department of Labor. Guidance for those requirements can be found at:
<http://www.dol.gov/whd/regs/compliance/whdfs71.pdf>.

9022.6 To be eligible for Medicaid reimbursement, a Positive Personal Profile and Job Search and Community Participation Plan shall be developed within thirty (30) days of the date when the person began receiving services. An additional vocational assessment, completed by a qualified professional, shall be conducted within the first ninety (90) days of participation, and shall include an assessment of the following:

- (a) Employment-related goals based on a person's strengths, interests, and areas for improvement;
- (b) Available natural or community supports;
- (c) Personal concerns and preferences, based upon what is important to and for the person;
- (d) Work and career interests based on exploration and/or discovery; and
- (e) Accommodations and supports, including an assessment of assistive technology, which may be required once the person is employed.

9022.7 To be eligible for Medicaid reimbursement, a Positive Personal Profile, Job Search and Community Participation Plan, and additional vocational assessment shall be conducted at least annually by the provider to evaluate each person enrolled in the Waiver's acquisition of employment-related skills based on the person's career preferences and goals as specified in their ISP and Plan of Care.

9022.8 Each provider of Medicaid reimbursable employment readiness services shall develop an individualized service delivery plan reflecting the person enrolled in the Waiver's interests, career preferences, choices, goals and prioritized needs. The plan shall:

- (a) Define the specific outcomes to be achieved over a specified period of time;
- (b) Describe the activities in the plan that are developed with the person and support the person on his or her pathway to competitive, integrated employment;
- (c) Describe how the plan shall support a person in the development of employment related skills, including social skills such as interviewing skills, professionalism, building and maintaining relationships, self-determination and self-advocacy, and attending to the person's needs; and
- (d) Describe community-based employment preparation experiences that are related to the person's employment goals.

9022.9 Each provider of Medicaid reimbursable employment readiness services shall submit reports to the DDS service coordinator on a quarterly basis, consistent with the record maintenance requirements described under Section 9006 (Records and Confidentiality of Information) of Chapter 90 of Title 29 DCMR. These reports shall also include the following information:

- (a) Volunteer activities provided;

- (b) Employment exploration and preparation in the community; and
 - (c) Other employment readiness service activities provided.
- 9022.10 Each provider of Medicaid reimbursable employment readiness services shall develop, with the person, an individualized schedule of daily activities based upon the person's goals and activities as identified in his or her ISP, and consistent with what is in his or her Person-Centered Thinking and Discovery tools, of meaningful adult activities that support the person on his or her pathway to integrated, competitive employment.
- 9022.11 Each provider of Medicaid reimbursable employment readiness services shall maintain the following documents for monitoring and review, in addition to the record maintenance requirements described under Section 9006 (Records and Confidentiality of Information) of Chapter 90 of Title 29 DCMR:
 - (a) A copy of the Positive Personal Profile, Job Search and Community Participation Plan, and additional comprehensive vocational assessment; and
 - (b) A written daily schedule identifying the utilization of employment readiness services.
- 9022.12 To receive Medicaid reimbursement, employment readiness services shall provide opportunities for community engagement, inclusion and integration.
- 9022.13 To receive Medicaid reimbursement, each provider of employment readiness services shall be a HCBS Provider agency and shall meet the following requirements:
 - (a) Comply with the requirements described under Section 9010 (Provider Qualifications) and Section 9009 (Provider Enrollment Process) of Chapter 90 of Title 29 DCMR;
 - (b) Demonstrate, through experience or academic attainment of the executive staff, the ability and qualification to provide employment readiness services for persons with intellectual and developmental disabilities with varying habilitation needs; and
 - (c) Have at least one (1) staff member with a bachelor's degree in vocational rehabilitation or a similar discipline, and one (1) year of combined supervisory and "job coaching" experience or experience providing employment services to person with disabilities.

- 9022.14 Each provider of Medicaid reimbursable employment readiness services shall comply with the requirements under Section 9008 (Home and Community-Based Settings Requirements) of Chapter 90 of Title 29 DCMR.
- 9022.15 When employment readiness services are provided in a facility, each facility shall comply with all applicable federal, District, or state and local laws and regulations in order to receive Medicaid reimbursement. Effective November 1, 2020, no increase in the number of facility-based settings shall be authorized. Current providers shall be prohibited from increasing the number of facility-based settings at which services are provided; and newly enrolling providers shall be prohibited from providing services at any facility-based settings.
- 9022.16 All payment for employment related training services shall be in accordance with the United States Fair Labor Standards Act of 1985.
- 9022.17 The employment readiness Medicaid reimbursement rate shall include coverage for any personal care services provided by an employment readiness services provider.
- 9022.18 To be eligible for Medicaid reimbursement, each DSP shall meet the following requirements:
- (a) Comply with Section 9011 (Requirements for Direct Support Professionals) of Chapter 90 of Title 29 DCMR; and
 - (b) Have at least one (1) year of experience working with people with intellectual and developmental disabilities, or one year of comparable experience.
- 9022.19 Employment readiness services shall be authorized for Medicaid reimbursement if:
- (a) DDS provided a written service authorization before the commencement of services;
 - (b) The provider develops a Positive Personal Profile and Job Search and Community Participation Plan, conducts an additional initial vocational assessment and then an annual Positive Personal Profile and Job Search and Community Participation Plan and additional vocational assessment thereafter; and develops an employment readiness plan with training goals and techniques that will assist the person to achieve employment readiness goals and outcomes based upon the person's interests and preferences. The initial Positive Personal Profile and Job Search and Community Participation Plan shall be completed within the first thirty (30) days of service delivery and the additional vocational assessment shall be completed within the first ninety (90) days of service delivery;

- (c) The service name and provider delivering services are identified in the ISP and Plan of Care;
- (d) The ISP, Plan of Care, and Summary of Supports and Services documents the amount and frequency of services to be received; and
- (e) Services shall not conflict with the service limitations described under § 9022.20.

9022.20 Medicaid reimbursement shall only cover services furnished to a person enrolled in the Waiver for up to eight (8) hours per day, not to exceed forty (40) hours per week, which will not include reimbursement for travel time spent in transportation to and from the program.

9022.21 Medicaid reimbursable employment readiness services shall not be provided, or billed at the same time as the following services:

- (a) Day Habilitation;
- (b) Supported Employment;
- (c) In-Home Supports;
- (d) Companion;
- (e) Personal Care Services; and
- (f) Individualized Day Supports.

9022.22 Employment readiness providers shall not pay a stipend to a person for attendance or participation in activities at the employment readiness program.

9022.23 An employment readiness provider shall not concurrently employ a person and be his or her provider of Medicaid employment readiness services.

9022.24 Employment readiness services are not available to people who are eligible to participate and are fully supported in programs funded under Section 110 of the Rehabilitation Act of 1973, enacted September 26, 1973, as amended (Pub. L. 93-112; 29 USC §§ 720 *et seq.*), or Sections 602(16) and (17) of the Individuals with Disabilities Education Act, enacted April 13, 1970, as amended (Pub. L. 91-230; 20 USC §§ 1400 *et seq.*). However, employment readiness services may be used to provide additional supports for employment for persons eligible for and participating in those programs.

9022.25 Each provider of employment readiness services shall maintain the required staff-to-person ratio, as indicated in the person's ISP and Plan of Care, with a maximum

staffing ratio of 1:4. For a person that requires 1:1 supports (behavioral and/or medical) in an Employment Readiness setting:

- (a) The DSP providing 1:1 employment readiness services shall be trained in physical management techniques, positive behavioral support practices and other training required to implement the person's health care management plan and behavioral support plan (BSP), in accordance with DDS's Training policy and procedure;
- (b) There shall be an approved BSP or physician's order for 1:1 staffing support; and
- (c) When required by a person's BSP, the DSP shall accurately complete the behavioral data sheets.

9022.26 The billable unit of service for Medicaid reimbursable employment readiness services shall be fifteen (15) minutes. A provider shall provide at least eight (8) minutes of service in a span of fifteen (15) continuous minutes in order to be able to bill a unit of service.

9022.27 No Employment Readiness setting may have a daily census that exceeds fifty (50) people who are in the setting for more than twenty (20) percent of the day, inclusive of people who receive supports through the Waiver and people who live in intermediate care facilities for individuals with intellectual disabilities and are engaged in active treatment at the setting.

9022.28 The following time limitations apply to the use of employment readiness services:

- (a) For people who are not currently enrolled in employment readiness services, the service shall only be authorized for up to one (1) year, except that DDS may approve up to a one-year extension if there is documentation that the person is making progress towards competitive integrated employment and would benefit from extended services;
- (b) For people who are currently enrolled in employment readiness services, the service shall only be reauthorized for up to one (1) year from the person's next ISP effective date, except that DDS may approve up to a one-year extension if there is documentation that the person is making progress towards competitive integrated employment and would benefit from extended services. For people who have an ISP meeting scheduled within ninety (90) days of the Waiver renewal effective date, DDS may authorize an additional ninety (90) days of employment readiness services if needed to ensure a smooth transition;
- (c) If a person has exhausted employment readiness services and has had at least one (1) year since the end of that service; expresses an interest in

employment; and the support team has identified specific goals around building employment skills that are reflected in the ISP, then DDS may authorize employment readiness services one time for up to one (1) year;

- (d) Any time that a person loses his or her job, voluntarily leaves employment, or is employed and is seeking to learn new job skills, DDS may authorize employment readiness services for up to one (1) year; and
- (e) For any person who is currently receiving employment readiness services who will be subject to a reduction in authorized service hours due to the service limitations listed above, DDS will provide timely and adequate due process notice of the change in services and the person's appeal rights in accordance with 90 DCMR § 9007 (Initiating, Changing, or Terminating Any Approved Service) and using the process described in the DDS Person-Centered Planning Process and Individual Support Plans policy and procedures, or the successor documents.

9022.29 As of the effective date of this regulation, any new Employment Readiness setting shall be fully compliant with the requirements of the HCBS Settings Rule.

9022.30 Within one (1) year of the effective date of this § 9022.30, all existing Employment Readiness providers must become enrolled as a provider for Rehabilitation Services Administration services. Any new Employment Readiness providers must become enrolled as a provider for Rehabilitation Services Administration services within one (1) year of becoming an HCBS Waiver Employment Readiness provider.

9023 FAMILY TRAINING SERVICES

9023.1 This section shall establish conditions of participation for Medicaid providers enumerated in § 9023.9 ("Medicaid Providers") and family training services professionals and peer employees enumerated in § 9023.8 to provide family training services to caregivers of persons enrolled in the IFS Waiver.

9023.2 Medicaid reimbursable family training services are training, counseling, and other professional support services offered to uncompensated caregivers who provide support, training, companionship, or supervision to persons enrolled in the IFS Waiver, in accordance with the following:

- (a) Family training services includes instruction about treatment regimens and other services included in the plan of care, use of equipment specified in the plan of care, and includes updates as necessary to safely maintain the individual at home;
- (b) Counseling may be aimed at assisting the unpaid caregiver in meeting the needs of the individual;

- (c) All training and counseling must be included in the individual's plan of care;
 - (d) Family training services are available as a one-to-one (1:1) service for a person, based upon the recommendation of the person's support team as reflected in the person's ISP;
 - (e) Family training services may be provided by professionals or peer employees who meet the qualifications at § 9011.3; and
 - (f) A person served through the IFS Waiver may utilize both one-to-one (1:1) family training services and services provided by professionals and qualified peer employees, subject to the limitations in § 9023.14.
- 9023.3 Uncompensated caregivers include any family member, neighbor, friend, companion, or co-worker who regularly provides uncompensated care to the person.
- 9023.4 In order to be eligible for reimbursement, each Medicaid provider must obtain prior authorization from the DDS prior to providing, or allowing any professional to provide, family training services. In its request for prior authorization, the Medicaid provider shall document the following:
- (a) The person's need for additional, uncompensated support;
 - (b) The family training services professional who will provide the family training services; and
 - (c) The individual caregivers who will receive the family training services.
- 9023.5 In order to be eligible for Medicaid reimbursement, each family training services professional shall conduct an assessment of family training needs within the first four (4) hours of service delivery, and shall develop a training plan with training goals and techniques that will assist the unpaid caregivers of the person in the IFS Waiver. The training plan shall include measurable outcomes and a schedule of approved family training services to be provided, and shall be submitted by the Medicaid provider to DDS before services are delivered.
- 9023.6 In order to be eligible for Medicaid reimbursement, each Medicaid provider shall document the following in the person's ISP and Plan of Care:
- (a) The date and amount of family training services provided;
 - (b) The nature of the family training services provided;
 - (c) The professional who provided the family training services; and
 - (d) The individual caregivers who received the family training services.

9023.7 Medicaid reimbursable family training services shall include the following activities:

- (a) Instruction about treatment regimens and other services included in the person's ISP and Plan of Care;
- (b) Instruction on the use of equipment specified in the person's ISP and Plan of Care;
- (c) Counseling aimed at assisting the unpaid caregiver in meeting the needs of the person; and
- (d) Follow up training necessary to safely maintain the person at home.

9023.8 Medicaid reimbursable family training services shall be provided by either professionals or peer employees as follows:

- (a) Professionals shall be qualified as at least one (1) of the following:
 - (1) Special Education Teacher;
 - (2) Licensed Graduate Social Worker;
 - (3) Licensed Clinical Social Worker;
 - (4) Physical Therapist;
 - (5) Occupational Therapist;
 - (6) Registered Nurse; or
 - (7) Speech Pathologist.
- (b) Peer employees shall meet the basic requirements set forth in 29 DCMR § 9011.3.

9023.9 In order to be eligible for Medicaid reimbursement, each family training services professional shall be employed by the following Medicaid providers:

- (a) An IFS Waiver Provider enrolled by DDS; or
- (b) A Home Health Agency as defined in Section 9099 of Chapter 90 of Title 29 of the DCMR.

- 9023.10 Each Medicaid provider shall comply with Section 9010 (Provider Qualifications) and Section 9009 (Provider Enrollment Process) of Chapter 90 of Title 29 of the DCMR.
- 9023.11 Each Medicaid provider shall maintain the following documents for monitoring and audit reviews:
- (a) A copy of the most recent DDS approved ISP and Plan of Care, which shall include the documentation required by § 9023.6;
 - (b) The training plan developed in accordance with the requirements of § 9023.5; and
 - (c) The documents required to be maintained under Section 9006 (Records and Confidentiality of Information) of Chapter 90 of Title 29 of the DCMR.
- 9023.12 Each Medicaid provider shall comply with Section 9013 (Reporting Requirements) and Section 9005 (Individual Rights) of Chapter 90 of Title 29 of the DCMR.
- 9023.13 Medicaid reimbursable family training services shall not exceed a total of four (4) hours per day and one hundred (100) hours per year. Any hours in excess of these limits must be pre-approved by DDS pursuant to § 9023.14.
- 9023.14 In order to be eligible for Medicaid reimbursement, professionals requesting pre-approval from DDS to provide family training services in excess of four (4) hours per day and one hundred (100) hours per year must demonstrate the need for such services. The decision of DDS to approve or disapprove the request for additional services, in whole or in part, shall be final.
- 9023.15 The billable unit of service for Medicaid reimbursable family training services shall be fifteen (15) minutes. A provider shall provide at least eight (8) minutes of service in a span of fifteen (15) continuous minutes in order to be able to bill a unit of service.

9024 INDIVIDUALIZED DAY SUPPORTS SERVICES

- 9024.1 This section establishes standards governing Medicaid eligibility for individualized day supports services for persons enrolled in the IFS Waiver, and shall establish conditions of participation for providers of individualized day supports services seeking Medicaid reimbursement.
- 9024.2 The following rules pertain only to Medicaid reimbursable individualized day supports services to be received by a person enrolled in the IFS Waiver, hereinafter referred to as “person” or “persons”.

9024.3 In order to receive Medicaid reimbursement for individualized day supports services, the person's ISP and Plan of Care must document that the need for the service is consistent with the person's assessed needs and personally chosen goals including what is important to and for the person as documented in his or her Person-Centered Thinking and Discovery Tools and recorded in the ISP and Plan of Care, and show at least one of the following:

- (a) That the person chooses to participate in habilitation services in a variety of integrated and inclusive community-based settings which enable the person to attain or maintain his or her maximum functional level and gain greater independence;
- (b) That the person is transitioning into retirement or is retired and chooses to continue habilitation services in a variety of integrated and inclusive community-based settings;
- (c) That the person has person-centered ISP goals for community integration and participation including building, strengthening and maintaining relationships with persons not paid to be with the person or vocational exploration that may lead to further employment services and supports;
- (d) That the person is likely to be successful in achieving one or more of his or her ISP goals through individualized day supports; or
- (e) That the person has a documented need for individualized day supports due to medical or safety issues that are consistent with the Health Care Management Plan (HCMP) and Behavioral Support Plan.

9024.4 Medicaid reimbursable individualized day supports services shall:

- (a) Be habilitative in nature;
- (b) Be delivered in integrated, inclusive community settings; and
- (c) Be provided in a group consisting of no more than two (2) persons.

9024.5 Medicaid reimbursable individualized day supports (IDS) services shall provide:

- (a) Highly individualized, pre-planned activities and opportunities that occur within integrated and inclusive community settings and that emphasize the development of skills to support community participation and involvement, self-determination, community membership, community contribution, retirement or vocational exploration, and life skills training;

- (b) Activities that maximize the person's functional abilities for successful participation in integrated community activities and opportunities that match a person's interests and goals;
- (c) Activities that support the person's informed choice in identifying his or her own areas of interest and preferences, including but not limited to community mapping, employment exploration and discovery where appropriate;
- (d) Activities that provide community-based opportunities for personal and adult skill development through socialization, participation in membership-based community groups and associations, and forming and maintaining relationships with other community members;
- (e) Training in the safe and effective use of one or more modes of accessible public transportation and/or coordination and provision of transportation by the individualized day supports provider to support participation in community activities consistent with the intent of this service; and
- (f) For persons who live in their own home or with their family and who select this, IDS may include provision of one (1) nutritionally adequate meal including preparation, packaging, and delivery, as needed. The provision of meals shall take place during typical lunchtime hours (11 a.m. to 1 p.m.), prepared based on the person's specific needs as per the Level of Need Assessment (LON), and when necessary, the nutritionist/doctor's recommendation. This meal must be one-third (1/3) of a person's Recommended Dietary Allowance (RDA) and must be comprised of foods the person enjoys eating when not medically contraindicated.

9024.6 In order to be eligible for Medicaid reimbursement, each individualized day supports provider entity shall:

- (a) Comply with Section 9010 (Provider Qualifications) and Section 9009 (Provider Enrollment Process) of Chapter 90 of Title 29 DCMR;
- (b) For current providers, provide verification of passing the Department on Disability Services (DDS) Provider Certification Review (PCR) for the last three (3) years. For providers with less than three (3) years of PCR certification, provide verification of a minimum of three (3) years of experience providing day, employment, residential or respite services to the IFS waiver population, evidence of certification or licensure from the jurisdiction in which the service was delivered, and evidence of PCR certification for each year that the provider was enrolled as a waiver provider in the District of Columbia, if applicable;

- (c) Provide oversight, supervision and training of all DSP providing individualized day supports; and
- (d) Maintain a staff-to-person ratio as indicated in the ISP and Plan of Care up to a maximum ratio of one to two (1:2), while always ensuring that services meet the person's needs and are provided appropriately and safely.

9024.7 Services shall only be authorized for Medicaid reimbursement if the following conditions are met:

- (a) DDS provides a written service authorization before service delivery begins;
- (b) The IDS service name and enrolled provider are identified in the ISP, Plan of Care, and Summary of Support Services;
- (c) The amount and frequency of services to be received is documented in the ISP, Plan of Care, and Summary of Support Services;
- (d) Services shall not conflict with the service limitations described under § 9024.12;
- (e) The staffing plan and initial community integration plan described under § 9024.10 are submitted within five (5) business days of the start of services using the template required by DDS;
- (f) An on-going community integration plan, using the template required by DDS, and described under § 9024.10 is submitted thirty (30) calendar days, plus seven (7) business days, from the start date of the individualized day supports service and then within seven (7) business days after the conclusion of each ISP quarter; and
- (g) A quarterly report, using the template required by DDS, is submitted within seven (7) business days after the conclusion of each ISP quarter.

9024.8 Each DSP providing individualized day supports shall meet all of the requirements in Section 9011 (Requirements for Direct Support Professionals) of Chapter 90 of Title 29 DCMR, and requirements in § 9024.9 in order to be eligible for Medicaid reimbursement.

9024.9 In order to be eligible for Medicaid reimbursement, each DSP providing IDS services shall meet the following requirements:

- (a) To the extent the DSP is providing 1:1 individualized day supports services based upon the person's medical or behavioral support needs, have at least

one year of experience supporting people with Intellectual and Developmental Disabilities;

- (b) Meet additional training requirements for an Individualized Day Supports DSP, as required by DDS policy and procedure, within one year of the effective date of the waiver amendment;
- (c) Assist with the development of the initial and on-going community integration plans to implement the individualized day supports services;
- (d) Coordinate the scheduled activities specified under the initial and on-going community integration plans;
- (e) Assist with the writing of quarterly reports;
- (f) Utilize positive behavioral support strategies and crisis interventions as described in the approved Behavioral Support Plan to address emergency situations; and
- (g) Support persons enrolled in the Waiver to learn to use public transportation.

9024.10

Each provider approved to provide IDS services shall, in order to be eligible for Medicaid reimbursement, maintain documents for monitoring and audit reviews as described under Section 9006 (Records and Confidentiality of Information) of Chapter 90, of Title 29 DCMR, and maintain the following additional records:

- (a) A contingency plan that describes how the IDS will be provided when the primary DSP is unavailable; and, if the lack of immediate support poses a serious threat to the person's health and welfare, how the support will be provided when back-up DSPs are also unavailable;
- (b) An initial community integration plan, during the first thirty (30) days a person is receiving IDS, utilizing the template required by DDS and containing the following information:
 - (1) The name of the person receiving the service;
 - (2) Service start date;
 - (3) The names of the primary and back-up DSPs that will be delivering the service during the first thirty (30) days of service;
 - (4) The back-up staffing plan if neither the primary or back-up DSPs are available to deliver the service;

- (5) Goals in ISP that trigger authorization for individualized day supports;
 - (6) Schedule of service and calendar of activities for the first thirty (30) days;
 - (7) Back-up activities for the first thirty (30) days that relate to the person's individualized day supports goals and/or exploration and discovery; and
 - (8) Goals to be achieved in the first thirty (30) days of service and methods that will be used to achieve the goals.
- (c) After a person has received IDS for thirty (30) calendar days, an on-going community integration plan utilizing the template required by DDS and containing the following information:
- (1) The name of the person receiving the services;
 - (2) The names of the primary and back-up DSPs delivering services;
 - (3) The back-up staffing plan if neither the primary or back-up DSPs are available to deliver the service;
 - (4) Goals for the service falling under any of the following categories: Community Membership; Relationships & Natural Supports; Career Exploration & Employment; Retirement (for individuals 61 or older); Community Contribution; Self-Determination; Community Navigation; Wellness/Fitness, or others as listed in the community integration plan template;
 - (5) The highly individualized, integrated community activity/activities or opportunity/opportunities that will support achievement of the goals;
 - (6) Specific skills the person will be assisted to learn that can help with achievement of his/her goals and help the person participate successfully, and as independently as possible, in the Activities/Opportunities;
 - (7) Measurable outcomes promoting community integration which are expected and will indicate the goals have been achieved;
 - (8) Calendar of activities for the quarter and back-up activities for the quarter; and

- (9) Teaching objectives, strategies and measurable outcomes for skill development goals;
- (d) Within seven (7) business days of the conclusion of each ISP quarter, submit to the DDS service coordinator a quarterly report, utilizing the template required by DDS and containing the following information:
 - (1) Description of person's attendance and participation;
 - (2) Description of person's relationship with the assigned DSPs;
 - (3) Description of the person's relationships with others paired with the person to receive the service, if applicable;
 - (4) Description of how the activities and opportunities offered through individualized day supports contributed to the achievement of the person's service goals;
 - (5) Description of skill development gains and next steps to continue progress on skill development; and
 - (6) Description of career and vocational exploration activities and outcomes for working-age participants in individualized day supports.
- (e) A Positive Personal Profile and Job Search and Community Participation Plan shall be developed annually and reviewed at least quarterly, and that is updated as needed, based upon what is being learned about the person's needs and interests by the individualized day supports provider. Positive Personal Profile and Job Search and Community Participation Plan shall be used to inform, and attached to, the initial and on-going community integration plans.

9024.11 In order to be eligible for Medicaid reimbursement, each Provider approved to provide individualized day supports services shall comply with Section 9013 (Reporting Requirements); Section 9006 (Records and Confidentiality of Information), except that quarterly reports shall meet the requirements within § 9024.10 above; and Section 9005 (Individual Rights) of Chapter 90 of Title 29 DCMR.

9024.12 Medicaid shall only reimburse individualized day supports services for a minimum of two (2) and a maximum of six (6) hours per day; and a minimum of four (4) and a maximum of thirty (30) hours per week. This service may be offered in combination with Day Habilitation, Employment Readiness, Supported Employment services as a wraparound service in combination with any of the

aforementioned services. When two or more of these services are offered, a person may not receive more than a combined total of forty (40) hours per week of services.

- 9024.13 Individualized day supports are an alternative to facility-based day programs and shall take place during regular Monday to Friday day program hours; except that individualized day supports may occur during non-traditional hours for persons who are employed during the day and would benefit from the service. Additional variances may be approved by the DDS Director, or his or her designee, based upon the person's assessed needs, schedule of other activities, and recommendations of the person's support team.
- 9024.14 Time spent in transportation to and from IDS generally shall not be included in the total amount of services provided per day. However, IDS may include the time a DSP spends accompanying the person on public transportation (excluding Medicaid funded non-emergency transportation) for the purposes of training the person to travel using public transportation, including when the person's IDS day begins and ends at the person's residence. IDS and Medicaid funded non-emergency transportation may not be billed during the same period of time. Medicaid funded non-emergency transportation may not be used during the provision of IDS. Medicaid funded non-emergency transportation may be used to transport the person to and from IDS; however, it should not preclude opportunities for the person to learn to use public transportation as part of participation in IDS.
- 9024.15 Personal care/assistance may be a component of individualized day supports as necessary to meet the needs of a person but may not comprise the entirety of the service.
- 9024.16 This service shall not provide reimbursement to Senior Centers funded by the federal Older Americans Act authorized to provide services to older adults.
- 9024.17 The Individualized Day Program does not include activities that are the responsibility of the In-Home Supports provider, such as cooking or laundry activities.
- 9024.18 A person receiving individualized day supports may meet his or her DSP at a facility-based day habilitation or employment readiness setting, but only if this is necessary and appropriate for the person receiving the services. Individualized day services shall not occur in a facility-based setting. On site attendance at the facility-based day habilitation or employment readiness program is not a requirement to receive services that originate from that setting.
- 9024.19 A DSP may be the person's relative, but may not be legally responsible for the person, or the person's legal guardian.

- 9024.20 A person receiving IDS may start and end his or her day at his or her place of residence, if that is the person's preference and/or is recommended by the person's support team and reflected in his or her IDS Community Participation Plan.
- 9024.21 Each provider of Medicaid reimbursable individualized day supports services shall comply with the requirements under Section 9008 (Home and Community-Based Settings Requirements) of Chapter 90 of Title 29 DCMR.
- 9024.22 Individualized day supports may be authorized as either a one-to-one service for a person, or in in small group settings not to exceed 1:2 based upon the person's assessed needs; and for limited times, as approved by DDS, based on the ability to match the participant with an appropriate peer to participate with for small group IDS.
- 9024.23 Individualized day supports shall be billed at the unit rate established for the staffing ratio noted in the service authorization. There shall be a Medicaid reimbursement rate for 1:1 staffing ratio and 1:2 staffing ratio. For persons who live independently or with family and select to receive a meal, the rate is increased by a dollar amount per day that the person receives a meal. This service shall not exceed one thousand, five hundred and sixty (1,560) hours per year or six thousand two hundred and forty (6,240) units annually. A standard unit of service is fifteen (15) minutes and the provider shall provide at least eight (8) continuous minutes of services to bill for one (1) unit of service.
- 9024.24 The individualized day supports rate includes funding for transportation and activities for the person and the DSP. When the person and/or his support team identifies activities with costs that would create a hardship for the individualized day supports provider, and the person has the ability to pay, the provider may submit a written request for approval from the DDS Director, or his or her designee, to have the person contribute to the cost of the individualized day supports activities.
- 9024.25 Persons receiving individualized day supports services may receive two (2) or more types of non-residential habilitation services, (*e.g.*, Supported Employment, Small Group Supported Employment, Employment Readiness, Companion, and/or Day Habilitation); however, more than one (1) service may not be billed during the same period of time (*e.g.*, the same fifteen (15) minute unit).

9025 IN-HOME SUPPORTS SERVICES

- 9025.1 The purpose of this section is to establish standards governing Medicaid eligibility for in-home supports services for persons enrolled in the Home and Community-Based Services Waiver for Individual and Family Support (IFS Waiver), and to establish conditions of participation for providers of these services.

9025.2 In order to be reimbursed by Medicaid, in-home supports are services that may only be provided to people enrolled in the Waiver who have an assessed need for assistance with acquisition, retention or improvement in skills related to activities of daily living that are necessary to enable the person to reside successfully at home in his or her community and participate in community activities based upon what is important to and for the person as documented in his or her ISP and reflected in his or her Person-Centered Thinking and Discovery tools.

- (a) Services may be provided to people in the home or community, with the place of residence as the primary setting. A person may receive in-home supports services when his or her place of residence is his or her own home, a family home, a friend's home, or transitional housing.
- (b) Services may be provided in person, by phone or by any other technology device that supports the use of video-audio communication, such as Skype, FaceTime, etc., as approved by the person and his or her support team and documented in the ISP. In-home supports services using technology to communicate with the person shall not exceed twenty (20) percent of the total hours of in-home supports services that the person receives each week.
- (c) For people with higher intensity support needs, high acuity in-home supports services are available with the additional supports described below in § 9025.4.

9025.3 To be eligible for reimbursement, in-home supports services shall be:

- (a) Included in a person's ISP and Plan of Care and related to the person's ISP goals;
- (b) Habilitative in nature; and
- (c) Provided to a person living independently or with family or friends and not receiving other residential supports.

9025.4 In order to be reimbursed by Medicaid, in-home supports services shall include a combination of hands-on care, habilitative supports, skill development and assistance with activities of daily living. Supports provided shall be aimed at teaching the person to increase his or her skills and self-reliance. In addition to the direct in-home supports eligible for reimbursement below in § 9025.5, high acuity in-home supports shall also include the following:

- (a) Assistance in the coordination of behavioral, health and wellness services that a person may receive, including working with the person's natural supports, if any, to ensure that each person enrolled in the Waiver receives the professional services required to meet his or her goals as identified in the person's ISP and Plan of Care;

- (b) Development and implementation of the person's Health Care Management Plan, in accordance with the DDS Health and Wellness Standards;
- (c) Training on the Health Care Management Plan for high acuity in-home supports DSPs and any other residents of the person's home who provide natural (unpaid) supports; and
- (d) Supports to ensure that staff delivering day habilitation, individualized day supports, companion, employment readiness, or supported employment services shall receive training about the person's health care needs as identified in the person's Health Care Management Plan, and are informed about those needs that are relevant to the person in those settings and that are identified in the person's Health Care Management Plan and Behavior Support Plan, if applicable.

9025.5 In-home supports eligible for reimbursement shall include the following:

- (a) Training and support in activities of daily living and independent living skills;
- (b) Support to enhance opportunities for meaningful adult activities and skills acquisition that support community integration and a person's independence, including management of financial and personal affairs and awareness of health and safety precaution;
- (c) Support to enhance opportunities for community exploration aimed at discovery of new and emerging interests and preferences, including activities aimed at supporting the person to have one or more new relationships;
- (d) Support to build community membership;
- (e) Training on, and assistance in the monitoring of health, nutrition, and physical wellness;
- (f) Implementation of a home therapy program under the direction of a licensed clinician;
- (g) Training and support to coordinate or manage tasks outlined in the Health Care Management Plan, if applicable;
- (h) Assistance in performing personal care, household, and homemaking tasks that are specific to the needs of the person, except that this may not comprise the entirety of the service;

- (i) Assistance with developing the skills necessary to reduce or eliminate behavioral episodes by implementing a Behavioral Support Plan (BSP) or positive strategies;
- (j) Opportunities for the person to seek employment and vocational supports to work in the community in a competitive and integrated setting;
- (k) Assistance with the acquisition of new skills or maintenance of existing skills based on individualized preferences and goals identified in the In-Home Supports Plan, ISP, and Plan of Care; and
- (l) Coordinating transportation to participate in community events consistent with this service.

9025.6 Each provider rendering in-home supports services shall:

- (a) Be a Waiver provider agency; and
- (b) Comply with Sections 9010 (Provider Qualifications) and 9009 (Provider Enrollment Process) of Chapter 90 of Title 29 DCMR.

9025.7 Each DSP rendering in-home supports services shall comply with Section 9011 (Requirements for Direct Support Professionals) of Chapter 90 of Title 29 DCMR.

9025.8 In-home support services shall be authorized in accordance with the following provider requirements:

- (a) DDS shall provide a written service authorization before the commencement of services;
- (b) The service name and provider delivering services shall be identified in the ISP and Plan of Care;
- (c) The ISP and Plan of Care shall document the amount and frequency of services to be received;
- (d) The In-Home Supports Plan, ISP, and Plan of Care shall be submitted to and authorized by DDS annually or as needed; and
- (e) The provider shall submit each quarterly review to the person's DDS Service Coordinator no later than seven (7) business days after the end of the first quarter, and each subsequent quarter thereafter.

9025.9 Each provider shall comply with the requirements under Section 9013 (Reporting Requirements), Section 9006 (Records and Confidentiality of Information), and

Section 9005 (Individual Rights) of Chapter 90 of Title 29 DCMR, except that the progress notes as described in § 9006.2(m) shall be maintained on a per visit basis.

9025.10 Each provider of Medicaid reimbursable in-home support services shall assist each person in the acquisition, retention, and improvement of skills related to activities of daily living, such as personal grooming, household chores, eating and food preparation, and other social adaptive skills necessary to enable the person to reside in the community. To accomplish these goals, the provider shall:

- (a) Use the DDS-approved person-centered thinking tools and the person's Positive Personal Profile and Job Search and Community Participation Plan to develop a functional assessment that includes what is important to and for the person, within the first thirty (30) calendar days of providing services. This assessment shall be reviewed and revised annually or more frequently as needed;
- (b) Assist with and actively participate in the development of the person's In-Home Supports Plan, ISP, and Plan of Care, at the person's preference;
- (c) Review the person's In-home Supports Plan, ISP and Plan of Care goals, DDS-approved person-centered thinking tools, Positive Personal Profile and Job Search and Community Participation plan, objectives, and activities at least quarterly, and more often as necessary and submit quarterly reports to the person, family or representative, as appropriate, guardian, and the DDS Service Coordinator no later than seven (7) business days after the end of the first quarter or each subsequent quarter thereafter and in accordance with the requirements described under Section 9013 (Reporting Requirements) and Section 9006 (Records and Confidentiality of Information) of Chapter 90 of Title 29 DCMR.

9025.11 In order to be reimbursed by Medicaid, an In-Home Supports Plan shall be developed by the provider within thirty (30) days of the start of the service authorization and shall be revised as needed and on an annual basis. The In-Home Supports Plan shall be maintained in the home where services are provided with a copy also maintained at the Provider's main office. The In-Home Supports Plan shall include:

- (a) Activities and supports that will be provided during the service, based upon what is important to and important for the person, as identified in the Person-Centered Thinking and Discovery tools and reflected in the person's ISP;
- (b) A staffing plan and schedule;
- (c) A list of licensed non-medical professionals who will be providing services, if applicable; and

- (d) Emergency and contingency plans to address potential behavioral, health or emergency events.
- 9025.12 In-home supports services shall only be provided for up to eight (8) hours per day unless there is a temporary emergency. In the event of a temporary emergency, DDS may authorize up to sixteen (16) hours per day for up to one hundred and eighty (180) days, during the person's ISP year.
- 9025.13 In the event of a temporary emergency, a written justification for an increase in hours shall be submitted with the In-Home Supports Plan, ISP, and Plan of Care by the provider to DDS. The written justification must include:
- (a) An explanation of why no other resource is available;
 - (b) A description of the temporary emergency;
 - (c) An explanation of how the additional hours of in-home supports services will support the person's habilitative needs;
 - (d) A revised copy of the in-home Supports Plan, ISP, and Plan of Care reflecting the increase in habilitative supports to be provided; and
 - (e) The service authorization from the Medicaid Waiver Supervisor or other Department on Disability Services Administration designated staff.
- 9025.14 All DSPs, including family members, who provide in-home supports services shall comply with Section 9011 (Requirements for Direct Support Professionals) of Chapter 90 of Title 29 DCMR.
- 9025.15 Family members who provide in-home supports services and reside in the same home as the person receiving services may only be paid for in-home support services that are in accordance with the person's ISP goals.
- 9025.16 In-home supports services shall not be provided to persons receiving residential services.
- 9025.17 In-home supports services may be used on the same day, or in combination with Medicaid State Plan Personal Care Aide (PCA) services, IFS waiver PCA services, and Companion services, provided the services are not rendered at the same time.
- 9025.18 In-home supports services shall not be used to provide supports that are normally provided by medical professionals.
- 9025.19 In-home supports services, including those provided in the event of a temporary emergency, shall be billed at the unit rate of fifteen (15) minutes and shall not

exceed eight (8) hours per twenty-four (24) hour day. A standard unit of fifteen (15) minutes requires a minimum of eight (8) minutes of continuous service to be billed. There shall be a Medicaid reimbursement rate for both the in-home supports identified in § 9025.5 and the high acuity in-home supports identified in § 9025.4. Reimbursement shall be limited to those time periods in which the provider is rendering services directly to the person.

9025.20 Reimbursement for in-home supports services shall not include:

- (a) Room and board costs;
- (b) Routine care and general supervision normally provided by the family or unpaid individuals who provide supports, or for services furnished to a minor by the child's parent or step-parent or by a person's spouse;
- (c) Services or costs for which payment is made by a source other than Medicaid;
- (d) Travel or training of travel skills to Supportive Employment, Day Habilitation, Individualized Day Supports, or Employment Readiness; and
- (e) Costs associated with the DSP engaging in community activities with the people they support.

9026 OCCUPATIONAL THERAPY SERVICES

9026.1 This section shall establish conditions of participation for Medicaid providers enumerated in § 9026.9 (Medicaid Providers) and occupational therapy professionals enumerated in § 9026.8 (professionals) to provide occupational therapy services to persons enrolled in the Home and Community-Based Services Waiver for Individual and Family Support (IFS Waiver).

9026.2 Occupational therapy services are services that are designed to maximize independence, prevent further disability, and maintain health.

9026.3 In order to be eligible for reimbursement, each Medicaid provider must obtain prior authorization from the Department on Disability Services (DDS) before 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 person's need for occupational therapy services as demonstrated by a physician's order; and
- (b) The name of the professional who will provide the occupational therapy services.

- 9026.4 In order to be eligible for Medicaid reimbursement, each occupational therapy professional shall conduct a comprehensive assessment of occupational therapy needs within the first four (4) hours of service delivery, and develop a therapy plan to provide services.
- 9026.5 In order to be eligible for Medicaid reimbursement, the therapy plan shall include therapeutic techniques, training goals for the person's caregiver, and a schedule for ongoing services. The therapy plan shall include:
- (a) The anticipated and measurable functional outcomes, based upon what is important to and for the person as reflected in his or her Person-Centered Thinking tools and the goals in his or her ISP;
 - (b) A schedule of approved occupational therapy services to be provided; and
 - (c) Shall be submitted by the Medicaid provider to DDS before services are delivered.
- 9026.6 In order to be eligible for Medicaid reimbursement, each Medicaid provider shall document the following in the person's ISP and Plan of Care:
- (a) The date, amount, and duration of occupational therapy services provided;
 - (b) The scope of the occupational therapy services provided; and
 - (c) The name of the professional who provided the occupational therapy services.
- 9026.7 Medicaid reimbursable occupational therapy services shall consist of the following activities:
- (a) Consulting with the person, their family, caregivers and support team to develop the therapy plan;
 - (b) Implementing therapies described under the therapy plan;
 - (c) Recording progress notes and quarterly reports during each visit. Progress notes shall contain the following:
 - (1) Progress in meeting each goal in the ISP;
 - (2) Any unusual health or behavioral events or changes in status;
 - (3) The start and end time of any services received by the person; and

- (4) Any matter requiring follow-up on the part of the service provider or DDS;
 - (d) Routinely assessing (at least annually and more frequently as needed) the appropriateness, quality and functioning of adaptive equipment to ensure it addresses the person's needs;
 - (e) Completing documentation required to obtain or repair adaptive equipment in accordance with insurance guidelines and Medicare and Medicaid guidelines, including required timelines for submission;
 - (f) Participating in ISP and Support Team meetings to provide consultative services and recommendations specific to the expert content with a focus on how the person is doing in achieving the functional goals that are important to him or her; and
 - (g) Conducting periodic examinations and modified treatments for the person, as needed.
- 9026.8 Medicaid reimbursable occupational therapy services shall be provided by a licensed occupational therapist.
- 9026.9 Occupational therapy service providers, without regard to their employer of record, shall be selected by and be acceptable to the person receiving services, their guardian, or legal representative.
- 9026.10 In order to be eligible for Medicaid reimbursement, an occupational therapist shall be employed by the following providers:
- (a) An IFS Waiver provider enrolled by DDS; and
 - (b) A Home Health Agency as defined in Section 9099 of Title 29 DCMR.
- 9026.11 Each Medicaid provider shall comply with Section 9010 (Provider Qualifications) and Section 9009 (Provider Enrollment Process) of Chapter 90 of Title 29 DCMR.
- 9026.12 Each Medicaid provider shall maintain the following documents for monitoring and audit reviews:
- (a) The physician's order;
 - (b) A copy of the occupational therapy assessment and therapy plan in accordance with the requirements of §§ 9026.4 and 9026.5; and

- (c) Any documents required to be maintained under Section 9006 (Records and Confidentiality of Information) of Chapter 90 or Title 29 DCMR, that are applicable to this service.

9026.13 If the person enrolled in the IFS Waiver is between the ages of eighteen (18) and twenty-one (21) years, the DDS Service Coordinator shall ensure that Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits under the Medicaid State Plan are fully utilized and the IFS Waiver service is neither replacing nor duplicating EPSDT services.

9026.14 Medicaid reimbursable occupational therapy services shall be limited to four (4) hours per day and one-hundred (100) hours per year. Requests for additional hours may be approved when accompanied by a physician's order documenting the need for additional occupational therapy services and approved by a DDS staff member designated to provide clinical oversight.

9026.15 There shall be a Medicaid reimbursement rate for occupational therapy services. The billable unit of service shall be fifteen (15) minutes. A standard unit of fifteen (15) minutes requires a minimum of eight (8) minutes of continuous service to be billed.

9027 PARENTING SUPPORT SERVICES

9027.1 The purpose of this section is to establish standards governing eligibility for parenting support services for persons enrolled in the IFS Waiver, and to establish conditions of participation for professionals and providers of parenting support services to receive Medicaid reimbursement.

9027.2 Parenting support services assist people who are or will be parents in developing appropriate parenting skills. Parents will receive training that is individualized and focused on the health and welfare and developmental needs of their child, as well as building necessary parenting skills. Close coordination will be maintained with informal and other formal supports.

- (a) Parenting support services may include training of individuals who provide unpaid support, training, companionship or supervision to persons served through the waiver to reinforce strategies provided to the person served;
- (b) Parenting support services is available both as a 1:1 service for a person, and in small group settings not to exceed 1:4. For persons enrolled in small group parenting support services, the provider must make every effort to match the person with another person or persons of his or her choosing, or with a person who has similar skills or interests;
- (c) Parenting support services may be provided by professionals or qualified peer employees;

- (d) Parenting support services shall be provided in the person's home or in a variety of community based settings, based upon the person's needs and choices; and
- (e) A person served through the IFS Waiver may utilize both 1:1 and small group parenting support, and services provided by professionals and qualified peer employees and both services combined are subject to the limitations in § 9027.10.

9027.3 Parenting support services will be authorized when:

- (a) The person is an expectant parent, a parent with physical custody or visitation with his or her child, or a parent who is pursuing reunification with his or her child;
- (b) The person requests the service and/or it is recommended by the person's support team; and
- (c) Parenting support services is included in the person's ISP and Plan of Care.

9027.4 In order to be eligible for Medicaid reimbursement, each parenting support services provider shall comply with the following service delivery requirements:

- (a) Conduct an assessment, within the first four (4) hours of service delivery, which shall include the following:
 - (1) A background review and current functional review of the person's parenting capabilities in different environments;
 - (2) An environmental review in the person's home, and other community site as necessary; and
- (b) Develop and implement a parenting support plan, within the first four (4) hours of service delivery, that describes strategies, and the anticipated and measurable, functional outcomes, based upon what is important to and for the person as reflected in his or her Person-Centered Thinking tools and the goals in his or her ISP and Plan of Care.

9027.5 Parenting support services may be provided by In-Home Supports agency providers.

9027.6 Medicaid reimbursable parenting support services shall be provided by either professionals or peer employees:

- (a) Professionals shall meet the following qualifications:

- (1) Comply with the requirements of 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.*);
 - (2) Documented completion of required training in accordance with the DDS Training policy;
 - (3) Master's degree in field related to supporting people with disabilities, including but not limited to social services, education, and psychology;
 - (4) At least five (5) years of experience working with people with intellectual disabilities and/or their families; and
 - (5) Demonstrated ability, experience and education to teach adult learners; conduct support needs assessments; implement service/ support plans; assist parent in specific areas of support described in the plan; serve as an advocate; and work with people of varied ethnic and cultural backgrounds.
- (b) Peer employees shall meet the basic requirements set forth in 29 DCMR § 9011.3 and may be the person's relative, but may not be legally responsible for the person, or the person's legal guardian.
- 9027.7 Each Medicaid provider of parenting support services shall comply with Section 9010 (Provider Qualifications) and Section 9009 (Provider Enrollment Process) of Chapter 90 of Title 29 DCMR.
- 9027.8 Each Medicaid provider of parenting support services shall maintain the following documents for monitoring and audit reviews:
- (a) A copy of the most recent DDS approved ISP and Plan of Care, which shall include the documentation required by § 9027.4;
 - (b) The parenting support plan developed in accordance with the requirements of § 9027.4; and
 - (c) The documents required to be maintained under Section 9006 (Records and Confidentiality of Information) of Chapter 90 of Title 29 DCMR.
- 9027.9 Each Medicaid provider of parenting support services shall comply with Section

9013 (Reporting Requirements) and Section 9005 (Individual Rights) of Chapter 90 of Title 29 DCMR.

9027.10 There shall be a total of four (4) Medicaid reimbursement rates for parenting support services: for 1:1 services and for small group services (*i.e.* 1:2, 1:3 and 1:4 staffing ratios) based on whether the services are provided by a professional or peer employee. Parenting support services shall not exceed one thousand four hundred sixty (1,460) hours per ISP year. Support is available from the first trimester until the eligible participant's child transitions from high school.

9027.11 The billable unit of service for parenting support services shall be fifteen (15) minutes. A provider shall provide at least eight (8) minutes of service in a span of fifteen (15) continuous minutes to bill a unit of service.

9028 PERSONAL CARE SERVICES

9028.1 The purpose of this section is to establish standards governing Medicaid eligibility for personal care services for individuals enrolled in the IFS Waiver and to establish conditions of participation for providers of personal care services.

9028.2 Personal care services are identical in scope to those described in 29 DCMR § 5000. Personal care services may be delivered at home, in the day setting, at school or work, or in the community.

9028.3 To be eligible for Medicaid reimbursement for personal care services under the IFS Waiver, the person shall:

- (a) Exhaust all available personal care services provided under the State Plan for Medical Assistance (Medicaid State Plan) prior to receiving personal care services under the IFS Waiver;
- (b) Be unable to independently perform one or more activities of daily living for which personal care services are needed;
- (c) Be in receipt of a written order for PCA services by a physician in accordance with § 5006.1 and 5006.2 of Title 29 DCMR; and
- (d) Be authorized for personal care services based on a comprehensive assessment of the person's support needs and risk screening using the DDA Level of Need Assessment and Screening Tool (LON), or its successor, and reflected in the person's ISP and Plan of Care.

9028.4 Persons eligible for personal care services under the IFS Waiver shall be exempt from the requirement to obtain an authorization for services from DHCF or its agent under Section 5003 of Chapter 50 of Title 29 DCMR.

- 9028.5 Personal care services eligible for Medicaid reimbursement shall include, but not be limited to the activities identified under § 5006.7 of Chapter 50 of Title 29 DCMR.
- 9028.6 Medicaid reimbursable personal care services shall not include:
- (a) Services that require the skills of a licensed professional as defined by the District of Columbia Health Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.*);
 - (b) Tasks usually performed by chore workers or homemakers, such as cleaning of areas not occupied by the beneficiary and shopping for items not used by the person receiving services; and
 - (c) Money management.
- 9028.7 Personal care services delivered by a personal care aide shall be supervised by a registered nurse. The registered nurse shall review the person's health management care plan, if available, in order to make the initial assessment for personal care services
- 9028.8 The registered nurse shall conduct an initial assessment with the person enrolled in the IFS Waiver within seventy-two (72) hours of receiving authorization for personal care services from DDS.
- 9028.9 A plan of care for the delivery of personal care services shall be developed in accordance with § 5005.2 of Chapter 50 of Title 29 DCMR.
- 9028.10 In order to be eligible for Medicaid reimbursement for personal care services, the provider shall review the plan of care at least once every sixty (60) days, and shall update or modify the plan of care as needed. The registered nurse shall notify the person's physician of any significant change in the beneficiary's condition.
- 9028.11 If an update or modification to the plan of care requires any change in the frequency, duration, or scope of personal care services provided to the person enrolled in the IFS Waiver, the provider shall obtain an updated authorization for personal care services from DDS in accordance with § 9028.3(d).
- 9028.12 To be eligible for Medicaid reimbursement for personal care services, a provider shall:
- (a) Be a home care agency licensed pursuant to the requirements for home care agencies as set forth in the Health Care and Community Residence Facility, Hospice and Home 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.* (2012 Repl.)), and implementing rules;

- (b) Be enrolled as a Medicare home health agency qualified to offer skilled services as set forth in Sections 1861(o) and 1891(e) of the Social Security Act and 42 CFR § 484;
- (c) Comply with the requirements under Section 9010 (Provider Qualifications) and 9009 (Provider Enrollment Process) of Chapter 90 of Title 29 DCMR; and
- (d) Comply with all of the requirements for Medicaid State Plan personal care service providers.

- 9028.13 A home care agency shall meet the requirements described under Section 5008 (Staffing) and Section 5010 (Staffing Agencies) of Chapter 50 of Title 29 of the DCMR.
- 9028.14 In order to be eligible for Medicaid reimbursement, each DSP including personal care aides providing personal care services shall comply with Section 9011 (Requirements of Direct Support Professionals) of Chapter 90 of Title 29 DCMR.
- 9028.15 In order to be eligible for Medicaid reimbursement, each personal care services provider shall comply with the requirements described under Section 9013 (Reporting Requirements) and Section 9005 (Individual Rights) of Chapter 90 of Title 29 DCMR.
- 9028.16 In order to be eligible for Medicaid reimbursement, each personal care services provider shall comply with the record maintenance requirements described under Section 9006 (Records and Confidentiality of Information) of Chapter 90 of Title 29 DCMR, and Section 5013 of Chapter 50 of Title 29 DCMR.
- 9028.17 In order to be eligible for Medicaid reimbursement, each provider of personal care services shall comply with the denial, suspension, reduction or termination of services requirements under Section 5007 of Chapter 50 of Title 29 DCMR.
- 9028.18 In order to be eligible for Medicaid reimbursement, each provider of personal care services shall develop contingency staffing plans to provide coverage for a person receiving personal care services if the assigned personal care aide cannot provide the service or is terminated by the provider.
- 9028.19 If person receiving personal care services seeks to change providers, the DDS service coordinator shall assist the person in selecting a new provider. In order to be eligible for Medicaid reimbursement for personal care services, the current provider shall continue to provide services until the transfer to the new provider has been completed.

- 9028.20 Personal care services shall not be provided in a hospital, nursing facility, intermediate care facility, or other living arrangement that includes personal care as part of the reimbursed service.
- 9028.21 Personal care services may be provided by family members other than the person's spouse, parent, guardian, or any other individual legally responsible for the person receiving services who ordinarily would perform or be responsible for performing services on the person's behalf.
- 9028.22 Family members who provide personal care services, with the exception of those listed under § 9028.21, shall meet the requirements for DSPs referenced under § 9028.14.
- 9028.23 The Medicaid reimbursement rate for personal care services shall be the same as the rate listed in § 5015.1 (Reimbursement) of Chapter 50 (Medicaid Reimbursement for Personal Care Aide Services) of Title 29 (Public Welfare) of the DCMR.

9029 PHYSICAL THERAPY SERVICES

- 9029.1 This section establishes the conditions for Medicaid providers enumerated in § 9029.10 ("Medicaid Providers") and physical therapy services professionals enumerated in § 9029.8 ("professionals") to provide physical therapy services to persons enrolled in the IFS Waiver.
- 9029.2 Physical therapy services are services that are designed to treat physical dysfunctions or reduce the degree of pain associated with movement, prevent disability and regression of functional abilities, promote mobility, maintain health and maximize independence. These services are delivered in a location of the person's choice, including his or her home, day service setting, or community.
- 9029.3 In order to be eligible for reimbursement, each Medicaid provider must obtain prior authorization from DDS before 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 IFS Waiver participant's need for physical therapy services as demonstrated by a physician's, physician's assistant's, or nurse practitioner's order; and
 - (b) The name of the professional who will provide the physical therapy services.

- 9029.4 In order to be eligible for Medicaid reimbursement, 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 to provide services.
- 9029.5 In order to be eligible for Medicaid reimbursement, the therapy plan shall include therapeutic techniques, training goals for the person's caregiver, and a schedule for ongoing services. The therapy plan shall include the anticipated and measurable, functional outcomes, based upon what is important to and for the person as reflected in his or her Person-Centered Thinking tools and the goals in his or her ISP and a schedule of approved physical therapy services to be provided, and shall be submitted by the Medicaid provider to DDS before services are delivered.
- 9029.6 In order to be eligible for Medicaid reimbursement, each Medicaid provider shall document the following in the person's ISP and Plan of Care:
- (a) The date, amount, and duration of physical therapy services provided;
 - (b) The scope of the physical therapy services provided; and
 - (c) The name of the professional who provided the physical therapy services.
- 9029.7 Medicaid reimbursable physical therapy services shall consist of the following activities:
- (a) Consulting with the person, his or her family, caregivers, and support team to develop the therapy plan;
 - (b) Implementing therapies described under the therapy plan;
 - (c) Recording progress notes on each visit and submitting quarterly reports. Progress notes shall contain the following:
 - (1) Progress in meeting each goal in the ISP;
 - (2) Any unusual health or behavioral events or change in status;
 - (3) The start and end time of any services received by the person; and
 - (4) Any matter requiring follow-up on the part of the service provider or DDS.
 - (d) Routinely assess (at least annually and more frequently as needed) the appropriateness and quality of adaptive equipment to ensure it addresses the person's needs;

- (e) Completing documentation required to obtain or repair adaptive equipment in accordance with insurance guidelines and Medicare and Medicaid guidelines, including required timelines for submission; and
 - (f) Conducting periodic examinations and modified treatments for the person, as needed.
- 9029.8 Medicaid reimbursable physical therapy services shall be provided by a licensed physical therapist or a Physical Therapy Assistant working under the direct supervision of a licensed physical therapist.
- 9029.9 Physical therapy service providers, without regard to their employer of record, shall be selected by and be acceptable to the person receiving services, his or her guardian, or legal representative.
- 9029.10 In order to be eligible for Medicaid reimbursement, a physical therapist shall be employed by the following providers:
 - (a) An IFS Waiver Provider enrolled by DDS; and
 - (b) A Home Health Agency as defined in Section 9099 of Title 29 DCMR.
- 9029.11 Each Medicaid provider shall comply with Section 9010 (Provider Qualifications) and Section 9009 (Provider Enrollment Process) of Chapter 90 of Title 29 DCMR.
- 9029.12 Each Medicaid provider shall maintain the following documents for monitoring and audit reviews:
 - (a) The physician's, physician's assistant's, or nurse practitioner's order;
 - (b) A copy of the physical therapy assessment and therapy plan in accordance with the requirements of § 9029.4 and 9029.5; and
 - (c) Any documents required to be maintained under Section 9006 (Records and Confidentiality of Information) of Chapter 90 of Title 29 DCMR.
- 9029.13 Each Medicaid provider shall comply with the requirements described under Section 9013 (Reporting Requirements) and Section 9005 (Individual Rights) of Chapter 90 of Title 29 DCMR.
- 9029.14 In order to be eligible for Medicaid reimbursement, each individual providing physical therapy services shall participate in ISP and Support Team meetings to provide consultative services and recommendations specific to the expert content with a focus on how the person is doing in achieving the functional goals that are important to him or her.

- 9029.15 If the person enrolled in the IFS Waiver is between the ages of eighteen (18) and twenty-one (21) years, the DDS Service Coordinator shall ensure that Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits under the Medicaid State Plan are fully utilized and the IFS Waiver service is neither replacing nor duplicating EPSDT services.
- 9029.16 Medicaid reimbursable physical therapy services shall be limited to four (4) hours per day and one hundred (100) hours per year. Requests for additional hours may be approved when accompanied by a physician's order documenting the need for additional physical therapy services and approved by a DDS staff member designated to provide clinical oversight.
- 9029.17 There shall be a Medicaid reimbursement rate for physical therapy services. The billable unit of service shall be fifteen (15) minutes. A standard unit of fifteen (15) minutes requires a minimum of eight (8) minutes of continuous service to be billed.

9030 RESPITE SERVICES

- 9030.1 The purpose of this chapter is to establish standards governing Medicaid eligibility for respite services for persons enrolled in the IFS Waiver and to establish conditions of participation for respite providers.
- 9030.2 Respite services provide relief to a person's family or primary caregiver to enable them to participate in scheduled or unscheduled time away from the person, and to prevent gaps in the delivery of the person's services.
- 9030.3 Medicaid-eligible respite services shall:
- (a) Consist of daily or hourly respite;
 - (b) Be authorized by the person's support team and provided in accordance with the ISP and Plan of Care; and
 - (c) Be provided to persons who live in their own home, or their families' home.
- 9030.4 To be eligible for Medicaid reimbursement, providers shall ensure that each person receives hands-on supports including, but not be limited to, the following areas:
- (a) Assistance with activities of daily living;
 - (b) Ensuring access to community activities, including coordination and provision of transportation to participate in community activities consistent with the person's ISP and Plan of Care to allow the person's routine not to be interrupted; and
 - (c) Monitoring of the person's health and physical condition, as well as assistance with medication administration or other medical needs.

- 9030.5 Medicaid reimbursable daily respite services shall be provided in:
- (a) A Group Home for a Person with an Intellectual Disability (GHPID) meeting the requirements set forth in Chapter 35 of Title 22 of the DCMR and certified as an ICF/IID in accordance with the federal conditions of participation;
 - (b) A DDS certified Residential Habilitation Services facility unless the respite placement will cause the setting to have greater than four (4) people in the home; or
 - (c) A DDS certified Supported Living Residence operated by a provider who has an approved human care agreement with DDS that stipulates the conditions for accepting respite placements.
- 9030.6 Medicaid reimbursable hourly respite services shall:
- (a) Be provided by 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.*) in accordance with the requirements of Chapter 39 of Title 22-B of the DCMR; and
 - (b) In a person's home or another residential setting that would meet the requirements of certifications issued by DDS.
- 9030.7 To be eligible for Medicaid reimbursement all respite providers shall:
- (a) Be certified by DDS as a Respite Provider Agency pursuant to the DDS Provider Certification Review Policy; and
 - (b) Comply with Sections 9010 (Provider Qualifications) and 9009 (Provider Enrollment Process) of Chapter 90 of Title 29 of the DCMR.
- 9030.8 Each provider of Medicaid reimbursable respite services shall comply with the requirements under Section 9006 (Records and Confidentiality of Information) of Chapter 90 of Title 29 DCMR, except that no quarterly report is required for respite hourly services.
- 9030.9 Each provider of Medicaid reimbursable respite services shall comply with the requirements under Section 9013 (Reporting Requirements) and Section 9005 (Individual Rights) of Chapter 90 of Title 29 DCMR, except that no quarterly report is required for respite hourly services.

- 9030.10 To be eligible for Medicaid reimbursement, each DSP providing respite services shall comply with Section 9011 (Requirements for Direct Support Professionals) of Chapter 90 of Title 29 of the DCMR.
- 9030.11 Medicaid reimbursement shall not be available if respite services are provided by the following individuals or provider:
- (a) The person's primary caregiver; or
 - (b) A spouse, parent of a minor child, or legal guardian of the person receiving respite services.
- 9030.12 A relative not listed under Section 9030.11(b), including the person's sibling, aunt, uncle, or cousin, may deliver respite services if they meet the DSP requirements referenced under Section 9030.10 and are employed and trained by the respite provider.
- 9030.13 Medicaid reimbursement for hourly respite services shall be limited to seven hundred twenty (720) hours per calendar year.
- 9030.14 The limitation set forth in § 9030.14 may be extended in situations when the primary caretaker is hospitalized or otherwise unable to continue as a primary caretaker and may only be extended until other arrangements are made for the person.
- 9030.15 Any request for reimbursement of hours in excess of seven hundred and twenty (720) shall be submitted to DDS for approval and include a justification and supporting documentation.
- 9030.16 To be eligible for Medicaid reimbursement, hourly respite services billed on the same day cannot exceed the reimbursement rate for daily respite services.
- 9030.17 Medicaid reimbursement for daily respite services shall be limited to thirty (30) days per calendar year.
- 9030.18 Daily respite service may be extended in situations when the primary caretaker is hospitalized or otherwise unable to continue as a primary caretaker and may only be extended until other arrangements are made for the person.
- 9030.19 Any request for hours in excess of thirty (30) calendar days shall be submitted to DDS for approval and include a justification and supporting documentation.
- 9030.20 Each provider of Medicaid reimbursable respite daily services shall comply with the requirements under Section 9008 (Home and Community-Based Settings Requirements) of Chapter 90 of Title 29 DCMR.

9031 SKILLED NURSING SERVICES

- 9031.1 The purpose of this section is to establish standards governing Medicaid eligibility for skilled nursing services under the IFS Waiver and to establish conditions of participation for providers of skilled nursing services.
- 9031.2 Skilled nursing services are medical and educational services that address healthcare needs related to prevention and primary healthcare activities. These services include health assessments and treatment, health related trainings and education for persons receiving Waiver services and their caregivers. Skilled nursing services may be delivered in the home and/or in the community.
- 9031.3 To be eligible for Medicaid reimbursement, the person shall first exhaust all available skilled nursing visits provided under the State Plan for Medical Assistance (Medicaid State Plan) prior to receiving skilled nursing services under the Waiver.
- 9031.4 To be eligible for Medicaid reimbursement, the person shall have a condition of circulatory or respiratory function complications, gastrointestinal complications, neurological function complications, or the existence of another severe medical condition that requires monitoring or care at least every other hour.
- 9031.5 To be eligible for Medicaid reimbursement, skilled nursing services shall:
- (a) Be ordered by a physician when it is reasonable and necessary to the treatment of the person's illness or injury, and include a letter of medical necessity, a summary of the person's medical history and the duties that the skilled nurse would perform; and a skilled nurse checklist.
 - (b) Be authorized in accordance with each person's ISP and Plan of Care after all Medicaid State Plan skilled nursing visits have been exhausted.
- A Prior Authorization Form - 719A from the Department of Health Care Finance will suffice as the physician's order in accordance with the requirements set forth in this section.
- 9031.6 The physician's order described in § 9031.5 shall include the scope, frequency, and duration of skilled nursing services; shall be updated at least every sixty (60) calendar days; and shall be maintained in the person's records.
- 9031.7 In order to be eligible for Medicaid reimbursement, the duties of a registered nurse (RN) delivering skilled nursing services shall be consistent with the scope of practice standards for registered nurses set forth in § 5414 of Title 17 of the District of Columbia Municipal Regulations (DCMR). They may include, at a minimum, but are not limited to the following duties:

- (a) Performing a nursing assessment in accordance with the Developmental Disabilities Administration's Health and Wellness Standards;
- (b) Assisting in the development of the Health Care Management Plan (HCMP);
- (c) Coordinating the person's care and referrals;
- (d) Administering medications and treatment as prescribed by a legally authorized healthcare professional licensed in the District of Columbia or consistent with the requirements in the jurisdiction where services are provided;
- (e) Administering medication or oversight of licensed medication administration personnel;
- (f) Providing oversight and supervision to the licensed practical nurse (LPN), when delegating and assigning nursing interventions;
- (g) Providing updates to Department on Disability Services (DDS) quarterly and more frequently as needed, if there are any changes to the person's needs or physician's order;
- (h) Training the person, licensed practical nurse (LPN), family, caregivers, and any other individual, as needed; and
- (i) Recording progress notes during each visit that meet standards of nursing care and include the following:
 - (1) Any unusual health or behavioral events or changes in status;
 - (2) Any matter requiring follow-up on the part of the service provider or DDS; and
 - (3) Clearly written records that contain a statement of the person's progress or lack of progress, medical conditions, functional losses, and treatment goals that demonstrate that the person's services are and continue to be reasonable and necessary.
- (j) Submit summary notes at least quarterly and submit quarterly reports in accordance with the requirements in Section 9006 (Records and Confidentiality of Information) of Chapter 90 of Title 29 DCMR.

9031.8

In order to be eligible for Medicaid reimbursement, the duties of an LPN delivering skilled nursing services shall be consistent with the scope of practice standards for

a licensed practical nurse set forth in Chapter 55 of Title 17 DCMR. They may include, at minimum, but are not limited to the following duties:

- (a) Immediately reporting, any changes in the person's condition, to the supervising registered nurse;
- (b) Providing wound care, tube feeding, diabetic care, and other treatment regimens prescribed by the physician; and
- (c) Administering medications and treatment as prescribed by a legally authorized healthcare professional licensed in the District of Columbia. If services are provided in another jurisdiction, the services shall be consistent with that jurisdiction's requirements.

- 9031.9 Medicaid reimbursable skilled nursing services shall be provided by an RN or LPN under the supervision of an RN, in accordance with the standards governing delegation of nursing interventions set forth in Chapters 54 and 55 of Title 17 DCMR.
- 9031.10 In order to be eligible for Medicaid reimbursement, each person providing skilled nursing services shall be employed by a home health agency that has a current District of Columbia Medicaid Provider agreement authorizing the service provider to bill for skilled nursing services.
- 9031.11 In order to be eligible for Medicaid reimbursement, each home health agency providing skilled nursing services shall comply with Section 9010 (Provider Qualifications) and Section 9009 (Provider Enrollment Process) of Chapter 90 of Title 29 DCMR. All IFS Waiver providers of skilled nursing services must comply with all of the requirements for Medicaid State Plan skilled nursing providers.
- 9031.12 To be eligible for Medicaid reimbursement, skilled nursing services shall have prior authorization from DDS.
- 9031.13 In order to be eligible for Medicaid reimbursement, the RN shall monitor and supervise the provision of services provided by the licensed practical nurse, including conducting a site visit at least once every thirty (30) days, or more frequently, if specified in the person's ISP.
- 9031.14 In order to be eligible for Medicaid reimbursement, each provider shall maintain records pursuant to the requirements described under Section 9013 (Reporting Requirements) and Section 9006 (Records and Confidentiality of Information) under Chapter 90 of Title 29 DCMR.
- 9031.15 In order to be eligible for Medicaid reimbursement, each home health agency providing skilled nursing services shall ensure that the LPN receives ongoing supervision and that the service provided is consistent with the person's ISP.

- 9031.16 Each skilled nursing provider shall review and evaluate skilled nursing services provided to each person, at least every sixty (60) days.
- 9031.17 The skilled nursing provider shall maintain a contingency plan that describes how skilled nursing will be provided when the scheduled nurse is unavailable; and, if the lack of immediate care poses a serious threat to the person's health and welfare, how the service will be provided when back-up staff are unavailable.
- 9031.18 Services shall only be authorized for Medicaid reimbursement in accordance with the following provider requirements:
- (a) The person has exhausted all nursing visits allowable under the Medicaid State Plan;
 - (b) DDS provides a written service authorization before the commencement of services;
 - (c) The service name and home health agency delivering services must be identified in the ISP and Plan of Care;
 - (d) The ISP, Plan of Care, and Summary of Supports and Services documents the amount and frequency of services to be received; and
 - (e) Services shall not conflict with the service limitations described under § 9031.
- 9031.19 Upon exhaustion of the number of hours available for skilled nursing services under the Medicaid State Plan, Medicaid reimbursement may be available for additional skilled nursing services based upon medical need when required to support a person to live in the community, for persons who would otherwise be required to live in a nursing facility.
- 9031.20 Upon exhaustion of the hours available for skilled nursing services under the Medicaid State Plan, Medicaid reimbursement may be available for one-to-one extended skilled nursing services for twenty-four (24) hours a day, for up to three hundred and sixty-five (365) days, with prior approval from DDS, for persons on a ventilator or requiring frequent tracheal suctioning.
- 9031.21 Prior approval for one-to-one extended skilled nursing services shall be obtained from the Medicaid Waiver Supervisor or designated DDS staff person after submission of documentation demonstrating the need for the extended services.
- 9031.22 Medicaid reimbursement governing the provision of skilled nursing and extended skilled nursing services shall be based on whether the Waiver services are being delivered by an RN or an LPN under the supervision of an RN.

9031.23 The Medicaid reimbursement rates for skilled nursing services and extended skilled nursing services shall be the same as the rates for skilled nursing services under the Medicaid State Plan as set forth in the Medicaid fee schedule. The Medicaid reimbursement rate for an initial assessment is a flat fee rate. The initial assessment for skilled nursing services shall be used for new admissions and any significant health condition changes that may warrant changes in a person's supports and services. The Medicaid reimbursement rate for quarterly reassessments and supervisory visits shall be the RN rate for each fifteen (15) minute unit of service not to exceed a total of eight (8) units of service per reassessment or supervisory visit.

9031.24 Any future increases in the Medicaid reimbursement rate for skilled nursing services under the Medicaid State Plan, listed in Title 29 (Public Welfare) of the DCMR, shall be applied equally to skilled nursing services and extended skilled nursing services through the Waiver.

9032 SPEECH, HEARING, AND LANGUAGE SERVICES

9032.1 The purpose of this section is to establish standards governing Medicaid eligibility for speech, hearing, and language services for persons enrolled in the IFS Waiver and to establish conditions of participation for providers of speech, hearing, and language services.

9032.2 Speech, hearing, and language services are therapeutic interventions to address communicative and speech disorders to maximize a person's expressive and receptive communication skills.

- (a) These services may be delivered at a person's home, day service setting, and/or in the community.
- (b) These services are available as an individual service based upon the recommendation of the person's support team as reflected in the person's ISP. A person may use individual services, subject to the service limitations described in § 9032.16.

9032.3 To qualify for Medicaid reimbursement, speech, hearing, and language services shall be:

- (a) Ordered by a physician, if the person has a medically-related condition such as a history of aspiration, swallowing problems, tube feeding, or a tracheotomy;
- (b) Recommended by the Support Team, if the person has a non-medical condition such as a receptive or expressive speech delay or disorder;

- (c) Delivered to a person that is over the age of twenty-one (21), except that services may also be provided to a person enrolled in the Waiver who is between the ages of eighteen (18) and twenty-one (21) years old, in accordance with § 9032.15;
- (d) Reasonable and necessary to treat the person's medical or non-medical communicative disorder; and
- (e) Included in the person's ISP and Plan of Care.

9032.4 In order to be eligible for Medicaid reimbursement, speech, hearing and language services shall be used to address the following conditions:

- (a) Swallowing and feeding disorders;
- (b) Receptive and expressive communication disorders;
- (c) Voice impairments; and
- (d) Articulatory and motor speech disorders.

9032.5 In order to be eligible for Medicaid reimbursement, each individual providing speech, hearing and language services shall comply with the following service delivery requirements:

- (a) Conduct a comprehensive assessment, within the first four (4) hours of service delivery, which shall include the following:
 - (1) A background review and current functional review of communication capabilities in different environments;
 - (2) An environmental review of communication in places of employment, residence, and other sites as necessary;
 - (3) The potential for use of augmentative and alternative speech devices, methods, or strategies;
 - (4) The potential for sign language or other expressive communication methods; and
 - (5) A needs assessment for the use of adaptive eating equipment.
- (b) Develop and implement a speech, hearing, and language treatment plan, within the first four (4) hours of service delivery, that describes treatment strategies, including direct therapy, training of caregivers, monitoring requirements and instructions, and the anticipated and measurable,

functional outcomes, based upon what is important to and for the person as reflected in his or her Person-Centered Thinking tools and the goals in his or her ISP;

- (c) Assist persons with voice disorders to develop proper control of vocal and respiratory systems for correct voice production, if applicable;
- (d) Conduct aural rehabilitation by teaching sign language and lip reading to people who have hearing loss, if applicable;
- (e) Participate in ISP and Support Team meetings to provide consultative services and recommendations specific to the expert content with a focus on how the person is doing in achieving the functional goals that are important to him or her;
- (f) Record progress notes on each visit and submit quarterly reports;
- (g) Verify that the speech, hearing, and language assessment and treatment plan, and daily notes and quarterly reports, are delivered to the person, family or other caregiver, physician, and the Department on Disability Services (DDS) Service Coordinator prior to the person's Support Team meeting;
- (h) Assess the need for the use of adaptive equipment;
- (i) Routinely assess (at least annually and more frequently as needed) the appropriateness and quality of adaptive equipment to ensure it addresses the person's needs;
- (j) Conduct periodic examinations to modify treatments, as appropriate, for the person receiving services and ensure that the speech pathologist's or audiologist's recommendations are incorporated into the ISP; when necessary; and
- (k) Complete documentation required to obtain or repair adaptive equipment in accordance with insurance requirements and Medicare and Medicaid guidelines, including required timelines for submission.

9032.6 In order to be eligible for Medicaid reimbursement, each individual providing speech, hearing, and language services shall:

- (a) Be employed by a home health agency or a Waiver provider;
- (b) Be a speech pathologist or audiologist in a private practice; or

- (c) Be an assistant working under the direct supervision of a licensed speech pathologist or audiologist.

9032.7 In order to be eligible for Medicaid reimbursement, each individual providing speech, hearing, and language services shall also comply with the following requirements:

- (a) Be a speech-language pathologist or audiologist licensed pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201 *et seq.*) and implementing rules;
- (b) Have a minimum of two (2) years of experience as a licensed speech-language pathologist or audiologist;
- (c) Have a Certificate of Clinical Competence in the area of Audiology or Speech Pathology granted by the American Speech-Language-Hearing Association; and
- (d) Comply with Section 9010 (Provider Qualifications) and 9009 (Provider Enrollment Process) of Chapter 90 of Title 29 DCMR.

9032.8 In order to be eligible for Medicaid reimbursement, a speech pathologist assistant or audiologist assistant shall meet the following requirements:

- (a) Be personally supervised by the speech pathologist or audiologist. Personal supervision requires the speech pathologist or audiologist to be in the room during the performance of the service; and
- (b) Be employed by the speech pathologist or audiologist or by the speech pathologist or audiologist's employer; and
- (c) Comply with Section 9011 (Requirements for Direct Support Professionals) of Chapter 90 of Title 29 DCMR.

9032.9 Speech, hearing and language service providers, without regard to their employer of record, shall be selected by the person receiving services, their guardian, or legal representative and shall be answerable to the person receiving services.

9032.10 Any provider substituting professionals for more than a two (2) week period or four (4) visits due to emergency or availability events shall request a case conference with the DDS Service Coordinator to evaluate the continuation of services.

9032.11 In order to be eligible for Medicaid reimbursement, the speech pathologist or audiologist in a private practice shall meet all of the following conditions:

- (a) Maintain a private office, even if services are always furnished in the person's home;
- (b) Meet all state and local licensure laws and rules;
- (c) Maintain a minimum of one (1) million dollars in liability insurance;
- (d) Ensure that speech, hearing, and language services are provided consistent with the person's ISP and Plan of Care; and
- (e) Maintain a space that is owned, leased or rented by the private practice and is used exclusively for the purpose of operating the private practice.

9032.12 In order to be eligible for Medicaid reimbursement, services shall only be authorized for reimbursement in accordance with the following provider requirements:

- (a) DDS shall provide a written service authorization before the commencement of services;
- (b) The provider shall conduct an assessment within the first four (4) hours of service delivery and develop a speech, hearing, and language treatment plan with training goals and techniques that will assist the caregivers;
- (c) The service name and provider delivering services shall be identified in the ISP and Plan of Care;
- (d) The ISP, Plan of Care, and Summary of Supports and Services shall document the amount and frequency of services to be received; and
- (e) Services shall be provided consistent with the service limitations described under Section 9032.16.

9032.13 In order to be eligible for Medicaid reimbursement, each home health agency, Waiver provider, or licensed speech pathologist or audiologist shall maintain the following documents for monitoring and audit reviews:

- (a) A copy of the speech, hearing, and language assessment and treatment plan;
- (b) A copy of the physician's orders and other pertinent documentation of the person's progress;
- (c) A copy of the daily progress notes, containing the following information:
 - (1) Progress in meeting each goal in the ISP;
 - (2) Any unusual health or behavioral events or change in status;

- (3) The start and end time of any services received by the person; and
 - (4) Any matter requiring follow-up on the part of the service provider or DDS.
 - (d) A copy of the quarterly reports used to verify the functioning of the person's adaptive equipment; and
 - (e) Any other documents required to be maintained under Section 9006 (Records and Confidentiality of Information) of Chapter 90 of Title 29 DCMR.
- 9032.14 In order to be eligible for Medicaid reimbursement, each provider shall comply with Section 9013 (Reporting Requirements) and Section 9005 (Individual Rights) of Chapter 90 of Title 29 of the DCMR.
- 9032.15 If the person enrolled in the Waiver is between the ages of eighteen (18) and twenty-one (21) years old, the DDS Service Coordinator shall ensure that Early Periodic Screening and Diagnostic Treatment (EPSDT) services under the District of Columbia State Plan for Medical Assistance are fully utilized before accessing speech, hearing and language services under the Waiver.
- 9032.16 Speech, hearing, and language services shall be limited to four (4) hours per day and one hundred (100) hours per year. Requests for additional hours may be approved when accompanied by a physician's order documenting the need for additional speech, hearing, and language services or if approved by a designated staff member at DDA.
- 9032.17 There shall be a Medicaid reimbursement rate for a speech, hearing and language assessment. The billable unit of service shall be fifteen (15) minutes. A provider shall provide at least eight (8) minutes of service in a span of fifteen (15) continuous minutes to bill a unit of service.
- 9032.18 There shall be a Medicaid reimbursement rate for individual speech, hearing and language services. The billable unit of service for speech, hearing and language therapy services shall be fifteen (15) minutes. A provider shall provide at least eight (8) minutes of service in a span of fifteen (15) continuous minutes to bill a unit of service.
- 9033 SUPPORTED EMPLOYMENT SERVICES - INDIVIDUAL AND SMALL GROUP SERVICES**
- 9033.1 This section shall establish standards governing Medicaid eligibility for supported employment services for persons enrolled in the IFS Waiver and shall establish conditions of participation for providers of supported employment services.

- 9033.2 Medicaid reimbursable supported employment services are designed to provide opportunities for persons with disabilities to obtain competitive work in integrated work settings, at minimum wage or higher and at a rate comparable to workers without disabilities performing the same tasks. All Medicaid reimbursable supported employment services must fully comply with the requirements of the HCBS Settings Rule.
- 9033.3 Medicaid reimbursable supported employment services may be delivered individually or in a small group, based upon the recommendations of the person and his or her support team, as reflected in the person's ISP and Plan of Care. For persons enrolled in small group supported employment services, the provider must make every effort to match the person with another person or persons of his or her choosing, or with a person who has similar skills or interests.
- 9033.4 Medicaid reimbursable small group supported employment services are services and training activities that are provided in regular business, industry, or community setting for groups of two (2) to four (4) workers.
- 9033.5 Small group supported employment services is intended to enable the person to become part of a competitive, integrated work setting.
- 9033.6 In order to receive Medicaid reimbursement for supported employment services, the person receiving services shall:
- (a) Be interested in obtaining full-time or part-time employment in an integrated work setting; and
 - (b) Demonstrate that a previous application for the District of Columbia Rehabilitation Services Administration (RSA) funded supported employment services was made, by the submission of a letter documenting either ineligibility for RSA services or the completion of RSA services with the recommendation for long-term employment support.
- 9033.7 Medicaid reimbursable supported employment services shall:
- (a) Provide opportunities for persons with disabilities to achieve successful integrated employment consistent with the person's goals;
 - (b) Be recommended by the person's Support Team; and
 - (c) Be identified in the person's ISP, Plan of Care, and Summary of Supports.
- 9033.8 The three (3) models of supported employment services eligible for Medicaid reimbursement are as follows:

- (a) An Individual Job Support Model, which evaluates the needs of the person and places the person into an integrated competitive or customized work environment through a job discovery process;
 - (b) A Small Group Supported Employment Model, which utilizes training activities for groups of two (2) to four (4) workers with disabilities to place persons in an integrated community based work setting; and
 - (c) An Entrepreneurial Model, which utilizes training techniques to develop on-going support for a small business that is owned and operated by the person.
- 9033.9 Medicaid reimbursable supported employment services for the entrepreneurial model shall include the following activities:
 - (a) Assisting the person to identify potential business opportunities;
 - (b) Assisting the person in the development of a business and launching a business;
 - (c) Identification of the supports that are necessary in order for the person to operate the business; and
 - (d) Ongoing assistance, counseling and guidance once the business has been launched.
- 9033.10 Medicaid reimbursable supported employment individual services shall consist of the following activities:
 - (a) Intake and assessment;
 - (b) Job placement and development;
 - (c) Job training and support; and
 - (d) Long-term follow-along services.
- 9033.11 Medicaid reimbursable supported employment small group services shall consist of the following activities:
 - (a) Job placement and development;
 - (b) Job training and support; and
 - (c) Long-term follow-along services.

- 9033.12 Intake and assessment services determine the interests, strengths, preferences, and skills of the person in order to ultimately obtain competitive employment and to further identify the necessary conditions for the person's successful participation in employment. The purpose of the intake and assessment is to facilitate and ensure a person's success in integrated competitive employment.
- 9033.13 Medicaid reimbursable intake and assessment activities include, but are not limited to, the following:
- (a) Conducting a person-centered vocational and situational assessment based upon what is important to and for the person as reflected in his or her Person-Centered Thinking and Discovery tools and related ISP goals;
 - (b) Developing a person-centered employment plan that includes the person's job preferences and desires, through a discovery process and the development of a Positive Personal Profile and Job Search and Community Participation Plan;
 - (c) Assessing person-centered employment information, including the person's interest in doing different jobs, transportation to and from work, family support, and financial issues;
 - (d) Engaging in community mapping to identify available community supports and assisting the person to establish a network for job development, placement and mentoring;
 - (e) Counseling an interested person on the tasks necessary to start a business, including referral to resources and nonprofit associations that provide information specific to owning and operating a business;
 - (f) Providing employment counseling, which includes, but is not limited to, the person's rights as an employee with a disability; and
 - (g) Providing or coordinating access to benefits counseling, defined as analysis and advice to help the person understand the potential impact of employment on his or her public benefits, including, but not limited to Supplemental Security Income, Medicaid, Social Security Disability Insurance, Medicare, and Supplemental Nutrition Assistance Program (SNAP).
- 9033.14 After intake and completion of the assessments, each provider of Medicaid reimbursable supported employment services shall complete and deliver a comprehensive vocational assessment report prior to the end of the intake and assessment service authorization period, to the DDS Service Coordinator that includes the following information:

- (a) Employment-related strengths and weaknesses of the person;
 - (b) Availability of family and community supports for the person;
 - (c) The assessor's concerns about the health, safety, and wellbeing of the person;
 - (d) Accommodations and supports that may be required for the person on the job; and
 - (e) If a specific job or entrepreneurial effort has been targeted:
 - (1) Individualized training needed by the person to acquire and maintain skills that are commensurate with the skills of other employees;
 - (2) Anticipated level of interventions that will be required for the person by the job coach;
 - (3) Type of integrated work environment in which the person can potentially succeed; and
 - (4) Activities and supports that are needed to improve the person's potential for employment, including whether the person has natural supports that may help him or her to be successful in the specific job or entrepreneurial effort.
- 9033.15 Medicaid reimbursable job placement and development includes activities to facilitate the person's ability to work in a setting that is consistent with their strengths, abilities, priorities, and interests, as well as the identification of potential employment options, as determined through the supported employment intake and assessment process.
- 9033.16 Job placement and development activities eligible for Medicaid reimbursement include, but are not limited to, the following:
- (a) Conducting workshops or other activities designed to assist the person in completing employment applications or preparing for interviews;
 - (b) Conducting workshops or other activities to instruct the person on appropriate work attire, work ethic, attitude, and expectations;
 - (c) Assisting the person with the completion of job applications;
 - (d) Assisting the person with job exploration and placement, including assessing opportunities for the person's advancement and growth, with a consideration for customized employment, as needed;

- (e) Visiting employment sites, participating in informational interviews, attending employment networking events, and job shadowing;
- (f) Making telephone calls and conducting face-to-face informational interviews with prospective employers, individuals in the person's network, utilizing the internet, social media, magazines, newspapers, and other publications as prospective employment leads;
- (g) Collecting descriptive data regarding various types of employment opportunities, for purposes of job matching and customized employment;
- (h) Negotiating employment terms with or on behalf of the person;
- (i) Working with the person to develop and implement a plan to start a business, including developing a business plan, developing investors or start-up capital, and other tasks necessary to starting a small business;
- (j) Providing or coordinating access to benefits counseling; and
- (k) Working with the person and employer to develop group placements.

9033.17 Job training and support activities are those activities designed to assist and support the person after he or she has obtained employment. The expectation is that the person's reliance upon job training and support activities will decline as a result of job skills training and support from supervisors and co-workers in the existing work setting to maintain employment.

9033.18 Medicaid reimbursable job training and support activities include, but are not limited to, the following:

- (a) On-the-job training in work and work-related skills required to perform the job;
- (b) Work site support that is intervention-oriented and designed to enhance work performance and support the development of appropriate workplace etiquette
- (c) Supervision and monitoring of the person in the workplace;
- (d) Training in related skills essential to obtaining and maintaining employment, such as the effective use of community resources, break or lunch rooms, attendance and punctuality, mobility training, re-training as job responsibilities change, and attaining new jobs; including, where appropriate, the use of assistive technology, *i.e.* calendar alerts, timers,

alarm clocks and other devices that assist a person with meeting employment requirements;

- (e) Monitoring and providing information and assistance regarding wage and hour requirements, appropriateness of job placement, integration into the work environment, and need for functional adaptation modifications at the job site;
- (f) Providing or coordinating access to ongoing benefits counseling, including but not limited to prior to the person reaching the end of his or her Trial Work period and/or attaining Substantive Gainful Activity (SGA);
- (g) Consulting with other professionals and the person's family, as necessary;
- (h) Providing support and training to the person's employer, co-workers, or supervisors so that they can provide workplace support, as necessary; and
- (i) Working with the person and his or her support network to identify a plan to develop his or her skills that facilitate workplace independence and confidence so that the person is less reliant upon job training and support activities.

9033.19 Medicaid reimbursable long-term follow-along activities are stabilization services needed to support and maintain a person in an integrated competitive employment site or in their own business.

9033.20 Medicaid reimbursable long-term follow-along activities include, but are not limited to, the following:

- (a) Periodic monitoring of job stability with a minimum of two (2) visits per month;
- (b) Intervening to address issues that threaten job stability;
- (c) Providing re-training, cross-training, and additional supports as needed, when job duties change;
- (d) Facilitating integration and natural supports at the job site;
- (e) Providing or coordinating access to benefits counseling prior to and after the person reaching the end of his or her Trial Work period and/or attaining SGA, and to ensure a person maintains eligibility for benefits and that earnings are being properly reported;
- (f) Working with the person and his or her support network to identify a plan to develop his or her skills that facilitate workplace independence and

confidence so that the person is less reliant upon job training and support activities; and

- (g) Facilitating job advancement, professional growth, and job mobility.

9033.21 Each provider of Medicaid reimbursable supported employment services shall be responsible for delivering ongoing supports to the person to promote job stability after they become employed.

- (a) Once the person exhibits confidence to perform the job without a job coach present, the provider shall make a minimum of two (2) visits to the job site per month for the purpose of monitoring job stability.
- (b) On the job coaching supported employment services may be provided in person, or by phone or by any other technology device that supports the use of Skype, FaceTime, etc., where approved by the person and his or her support team and documented in the ISP. Supported employment services by phone or other technology to communicate cannot exceed twenty (20) percent of the total hours of supported employment services that the person receives each week.

9033.22 When applicable, each provider of Medicaid reimbursable supported employment services shall coordinate with DDS and the employer to provide functional adaptive modifications for each person to accomplish basic work related tasks at the work site.

9033.23 When applicable, each provider of Medicaid reimbursable supported employment services shall coordinate with the employer to ensure that each person has an emergency back-up plan for job training and support.

9033.24 Each provider of Medicaid reimbursable supported employment services shall be a Waiver provider agency and shall comply with the following requirements:

- (a) Participate in the person's support team meetings, at the person's preference;
- (b) Be certified by the U.S. Department of Labor, if applicable;
- (c) Comply with the requirements described under Section 9010 (Provider Qualifications) and Section 9009 (Provider Enrollment Process) of Chapter 90 of Title 29 DCMR; and
- (d) Enroll as a supported employment provider for the District of Columbia Rehabilitation Services Administration by September 23, 2016, for current providers, or, for new Medicaid waiver supported employment provider agencies, within one year after enrollment as a waiver provider.

- 9033.25 Each professional or paraprofessional providing Medicaid reimbursable supported employment services for a Waiver provider shall meet the requirements in Section 9011 (Requirements for Direct Support Professionals) of Chapter 90 of Title 29 DCMR.
- 9033.26 Professionals authorized to provide Medicaid reimbursable supported employment activities without supervision shall include the following:
- (a) A Vocational Rehabilitation Counselor;
 - (b) An individual with a Master's degree and a minimum of one (1) year of experience working with persons with intellectual and developmental disabilities in supported employment;
 - (c) An individual with a bachelor's degree and two years of experience working with persons with intellectual and developmental disabilities in supported employment; or
 - (d) A Rehabilitation Specialist.
- 9033.27 Paraprofessionals shall be authorized to perform Medicaid reimbursable supported employment activities under the supervision of a professional. Supervision is not intended to mean that the paraprofessional performs supported employment activities in the presence of the professional, but rather that the paraprofessional has a supervisor who meets the qualifications of a professional as set forth in § 9033.26.
- 9033.28 Paraprofessionals authorized to perform Medicaid reimbursable supported employment activities are as follows:
- (a) A Job Coach, which shall be an individual with at least one of the following:
 - (1) A four-year college degree and a minimum of one (1) year of experience in a supported employment program or equivalent;
 - (2) A college degree in a social services discipline and certification from the Commission on Rehabilitation Counselor Certification or a similar national organization; or
 - (3) A high school degree and three (3) years of experience in a supported employment program, or the equivalent.

(b) An Employment Specialist, which shall be an individual with at least one of the following:

- (1) A four-year college degree and a minimum of one (1) year of experience in a supported employment program or equivalent;
- (2) A four-year college degree and certification from the Commission on Rehabilitation Counselor Certification or a similar national organization; or
- (3) A high school degree and three (3) years of experience in a supported employment program, or the equivalent.

9033.29 Services shall be authorized for Medicaid reimbursement in accordance with the following Waiver provider requirements:

- (a) DDS provides a written service authorization before the commencement of services;
- (b) The provider conducts a comprehensive vocational assessment, at minimum consisting of a Positive Personal Profile and Job Search and Community Participation Plan, if the person does not already have a comprehensive assessment. If the person does have a comprehensive vocational assessment, this must be reviewed to ensure that it is current and reflects what is important to and for the person, and updated as needed;
- (c) The provider develops an individualized employment plan with training goals and techniques within the first two (2) hours of service delivery;
- (d) The service name and provider delivering services are identified in the ISP and Plan of Care;
- (e) The ISP, Plan of Care, and Summary of Supports and Services document the amount and frequency of services to be received;
- (f) The provider completes an employment progress plan, using the template required by DDS, and submits it as an attachment to the required quarterly report; and
- (g) Services shall not conflict with the service limitations described under §§ 9033.31 - 9033.42.

9033.30 If extended services are required, the provider shall submit a supported employment extension request. The request is a written justification that must be submitted to the Service Coordinator at least fifteen (15) calendar days before the exhaustion of Supported Employment hours. Failure to submit all required documents may result

in a delay of the approval of services. Any failure on the part of the provider to submit required documents to approve service authorizations will result in sanctions by DDS up to and including a ban on authorizations for new service recipients. Service interruptions to the waiver participant due to the service provider's failure to submit required documentation will initiate referrals to a choice of a new service provider to ensure a continuation of services for the waiver participant.

- 9033.31 Supported employment services are not available to people who are eligible to participate and are fully supported in programs funded under Title I of the Rehabilitation Act of 1973, Section 110, enacted September 26, 1973 (Pub. L. 93-112; 29 USC §§ 720 *et seq.*), or Section 602(16) and (17) of the Individuals with Disabilities Education Act, 20 USC §§ 1401(16) and (71), enacted October 30, 1990 (Pub. L. 91-230; 20 USC §§ 1400 *et seq.*). However, supported employment services may be used to provide additional supports for employment for persons eligible for and participating in those programs.
- 9033.32 Court-ordered vocational assessments authorizing intake and assessment services qualify for Medicaid reimbursement under the Waiver if services provided through programs funded under the Acts referenced in § 9033.31 cannot be provided in the timeframe set forth in the Court's Order.
- 9033.33 Medicaid reimbursement is available for supported employment services that are provided either exclusively as a vocational service or in combination with individualized day supports, employment readiness, or day habilitation services if provided during different periods of time, including during the same day.
- 9033.34 Medicaid reimbursement is not available if supported employment services are provided in specialized sheltered workshop or other similar type facilities that are not part of the general workforce. Medicaid reimbursement is not available for volunteer work.
- 9033.35 Medicaid reimbursable supported employment services shall not include payment for supervision, training, support, adaptations, or equipment typically available to other workers without disabilities in similar positions.
- 9033.36 Medicaid reimbursable supported employment services shall be provided for a maximum of eight (8) hours per day, five (5) days per week.
- 9033.37 Medicaid reimbursement is not available for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
- (a) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment services program;
 - (b) Payments that are processed and paid to users of supported employment service programs; and

- (c) Payment for vocational training that is not directly related to the person's success in the supported employment services program.
- 9033.38 Supported employment providers may not pay a stipend to a person for attendance or participation in activities at the day habilitation program.
- 9033.39 A supported employment provider may not concurrently employ a person and be his or her provider of Medicaid supported employment services.
- 9033.40 Medicaid reimbursement shall not be available for time spent in transportation to and from the employment program and shall not be included in the total amount of services provided per day. Time spent in transportation to and from the program for the purpose of training the person on the use of transportation services shall be Medicaid reimbursable and may be included in the number of hours of services provided per day for a period of time specified in the person's ISP and Plan of Care.
- 9033.41 Medicaid reimbursement shall only be available for adaptations, supervision and training for supported employment services provided at the work site in which persons without disabilities are employed. Medicaid reimbursement shall not be available for supervisory activities, which are rendered as a normal part of the business setting.
- 9033.42 Medicaid reimbursable intake and assessment activities shall be billed at the unit rate. This service shall not exceed three-hundred and twenty (320) units or eighty (80) hours annually. A standard unit of service is fifteen (15) minutes and the provider shall provide at least eight (8) continuous minutes of service to bill one (1) unit of service. Individual supported employment intake and assessment activities shall be reimbursable by Medicaid only if:
- (a) Performed by a professional listed in § 9033.26; or
- (b) Performed by a paraprofessional listed in § 9033.28 under the supervision of a professional.
- 9033.43 Medicaid reimbursable job preparation, developmental and placement activities shall be billed at the unit rate. This service shall not exceed nine hundred and sixty (960) units or two-hundred and forty (240) hours annually for both individual and group services, combined. A standard unit of service is fifteen (15) minutes and the provider shall provide at least eight (8) continuous minutes of service to bill for one (1) unit of service. There shall be a Medicaid reimbursement rate for individual supported employment job preparation, developmental and placement activities (a) if performed by a professional listed in § 9033.26; and (b) if performed by a paraprofessional listed in § 9033.28 under the supervision of a professional. For small group supported employment job preparation, developmental and placement

activities, there shall be a Medicaid reimbursement rate for each person in a group of two (2) to four (4) people enrolled in the Waiver.

9033.44 Medicaid reimbursable on the job training and support activities shall not exceed three hundred and sixty hours (360) or one thousand, four hundred and forty (1,440) units per ISP year, unless additional hours are prior authorized by DDS. A standard unit of service is fifteen (15) minutes and the provider shall provide at least eight (8) continuous minutes of service to bill one (1) unit of service. There shall be a Medicaid reimbursement rate for individual supported employment job training and support activities (a) if performed by a professional listed in § 9033.26; and (b) if performed by a paraprofessional listed in § 9033.28 under the supervision of a professional. For small group supported employment on the job training and support activities, there shall be a Medicaid reimbursement rate for each person in a group of two (2) to four (4) people enrolled in the Waiver.

9033.45 Medicaid reimbursable long-term follow-along activities shall not exceed one thousand four hundred eight (1,408) units per ISP year. A standard unit of service is fifteen (15) minutes and the provider shall provide at least eight (8) continuous minutes of service to bill one (1) unit of service. There shall be a Medicaid reimbursement rate for both professionals and paraprofessionals for individual supported employment long-term follow-along activities. For small group supported employment long-term follow-along activities, there shall be a Medicaid reimbursement rate for each person in a group of two (2) to four (4) people enrolled in the Waiver.

9033.46 DDS shall only approve an extension for Job Training and Supports when there is documentation in the employment progress plan that the person continues to demonstrate progress on the job, including but not limited to: learning the job and related tasks, following directions, interaction with others, following supervision, reluctance or reliance on the job coach. However, if recommended by the person or his or her support team and reflected in the ISP, DDS shall authorize long-term follow-along supported employment services as needed to support the person on an ongoing basis.

9033.47 In order to be eligible for Medicaid reimbursement, each Waiver provider of supported employment services shall comply with Section 9013 (Reporting Requirements); Section 9006 (Records and Confidentiality of Information); and Section 9005 (Individual Rights) of Chapter 90 of Title 29 DCMR.

9034 WELLNESS SERVICES

9034.1 The purpose of this section is to establish standards governing Medicaid eligibility for wellness services for persons enrolled in the IFS Waiver, and to establish conditions of participation for providers of wellness services in order to receive reimbursement.

- 9034.2 Wellness services are designed to promote and maintain good health, the provision of these services shall be based upon what is important to and for the person as reflected in his or her Person-Centered Thinking tools and the goals in his or her ISP. Wellness services assist in increasing the person's independence, participation, prevent further disability, maintain health and increase emotional well-being, and productivity in their home, work, and community.
- 9034.3 The wellness services eligible for Medicaid reimbursement are:
- (a) Bereavement Counseling;
 - (b) Fitness Training;
 - (c) Massage Therapy;
 - (d) Nutrition Evaluation/Consultation; and
 - (e) Sexuality Education.
- 9034.4 Fitness training is available as either an individual service, or in small group settings of 1:2 based upon the person's request or recommendation of the person's support team. A person may utilize 1:1 fitness services subject to the limitations in § 9034.21.
- 9034.5 To be eligible for Medicaid reimbursement of bereavement counseling:
- (a) The person shall have experienced a loss through death, relocation, change in family structure, or loss of employment;
 - (b) The services shall be requested by the person or recommended by the person's support team; and
 - (c) The service shall be identified as a need in the person's ISP and Plan of Care.
- 9034.6 To be eligible for Medicaid reimbursement of sexuality education, the services shall be:
- (a) Requested by the person or recommended by the person's support team; and
 - (b) Identified as a need in the person's ISP and Plan of Care.
- 9034.7 To be eligible for Medicaid reimbursement of fitness training and massage therapy, the services shall be:
- (a) Requested by the person or recommended by the person's support team;

- (b) Identified as a need in the person's ISP and Plan of Care; and
 - (c) Ordered by a physician.
- 9034.8 To be eligible for Medicaid reimbursement of nutritional evaluation/consultation services, each person shall meet one or more of the following criteria:
 - (a) Have a history of being significantly above or below body weight;
 - (b) Have a history of gastrointestinal disorders;
 - (c) Have received a diagnosis of diabetes;
 - (d) Have a swallowing disorder; or
 - (e) Have a medical condition that can be a threat to health if nutrition is poorly managed.
- 9034.9 In addition to the requirements set forth in § 9034.8, nutritional evaluation/consultative services shall be:
 - (a) Recommended by the person's support team;
 - (b) Identified as a need in the person's ISP and Plan of Care based upon the Stage of Change the person is in;
 - (c) Ordered by a physician; and
 - (d) Targeted to the identified Stage of Change.
- 9034.10 The specific wellness service delivered shall be consistent with the scope of the license or certification held by the professional. Service intensity, frequency, and duration shall be determined by the person's individual needs and documented in the person's ISP and Plan of Care.
- 9034.11 In order to be eligible for Medicaid reimbursement, each professional providing wellness services shall:
 - (a) Conduct an initial assessment within the first four (4) hours of service delivery with long term and short term goals;
 - (b) Develop and implement a person-centered plan consistent with the person's choices, goals and prioritized needs that describes wellness strategies and the anticipated and measurable, functional outcomes, based upon what is important to and for the person as reflected in his or her Person-Centered

Thinking tools and the goals in his or her ISP. The plan shall include treatment strategies including direct therapy, caregiver training, monitoring requirements and instructions, and specific outcomes;

- (c) Deliver the completed plan to the person, family, guardian, residential provider, or other caregiver, and the DDS Service Coordinator prior to the Support Team meeting;
- (d) Participate in the ISP and Support Team meetings, when invited by the person, to provide consultative services and recommendations specific to the wellness professional's area of expertise with the focus on how the person is doing in achieving the functional goals that are important to him or her;
- (e) Provide necessary information to the person, family, guardian, residential provider, or other caregivers and assist in planning and implementing the approved ISP and Plan of Care;
- (f) Record progress notes on each visit which contain the following information:
 - (1) The person's progress in meeting each goal in the ISP;
 - (2) Any unusual health or behavioral events or change in status;
 - (3) The start and end time of any services received by the person; and
 - (4) Any matter requiring follow-up on the part of the service provider or DDS.
- (g) Submit quarterly reports in accordance with the requirements in Section 9006 (Records and Confidentiality of Information) of Chapter 90 of Title 29 DCMR; and
- (h) Conduct periodic examinations and modify treatments for the person receiving services, as necessary.

9034.12 In order to be eligible for Medicaid reimbursement, each professional providing nutrition evaluation/consultation services shall comply with the following additional requirements, as needed:

- (a) Conduct a comprehensive nutritional assessment within the first four (4) hours of delivering the service;
- (b) Conduct a partial nutritional evaluation to include an anthropometric assessment;

- (c) Perform a biochemical or clinical dietary appraisal;
- (d) Analyze food-drug interaction potential, including allergies;
- (e) Perform a health and safety environmental review of food preparation and storage areas;
- (f) Assess the need for a therapeutic diet that includes an altered/textured diet due to oral-motor problems;
- (g) Conduct a needs assessment for adaptive eating equipment and dysphagia management;
- (h) Conduct a nutrition evaluation and provide consulting services on a variety of subjects, including recommendations for the use of adaptive equipment, to promote improved health and increase the person's ability to manage his or her own diet or that of his or her child(ren) in an effective manner; and
- (i) Provide education to include menu development, shopping, food preparation, food storage, and food preparation procedures consistent with the physician's orders.

9034.13 Each professional providing wellness services shall be employed by a Home and Community-Based Services Waiver provider agency or by a professional service provider who is in private practice as an independent clinician as described in § 9010.2 of Title 29 DCMR.

9034.14 Each provider shall comply with the requirements set forth under Section 9010 (Provider Qualifications) and Section 9009 (Provider Enrollment Process) of Chapter 90 of Title 29 DCMR.

9034.15 In order to be eligible for Medicaid reimbursement, professionals delivering wellness services shall meet the following licensure and certification requirements:

- (a) Bereavement counseling services shall be performed by a professional counselor licensed 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.* (2016 Repl.)) and certified by the American Academy of Grief Counseling as a grief counselor or other equivalent national certification as approved by DDS;
- (b) Fitness services shall be performed by professional fitness trainers who have been certified by any of the following national or international certifications, or other equivalent national certification as approved by DDS: the American Fitness Professionals and Associates, the National

Athletic Training Association, the National Academy of Sports Medicine, the Aerobics and Fitness Association of America, and the American College of Sports Medicine; or professional fitness trainers who have a bachelor's degree in physical education, health education, exercise, science or kinesiology; or recreational therapists;

- (c) Dietetic and nutrition counselors shall be licensed 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.* (2016 Repl.)); and
- (d) Massage Therapists shall be licensed 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.* (2016 Repl.)) and certified by the National Certification Board for Therapeutic Massage and Bodywork, or other equivalent national certification as approved by DDS.

9034.16 In order to be eligible for Medicaid reimbursement, sexuality education services shall be delivered by:

- (a) A Sexuality Education Specialist who is certified to practice sexuality education by the American Association of Sexuality Educators, Counselors and Therapists Credentialing Board, or other equivalent national certification as approved by DDS; or
- (b) Any of the following professionals with specialized training in Sexuality Education:
 - (1) Psychologist;
 - (2) Psychiatrist;
 - (3) Licensed Clinical Social Worker; or
 - (4) Licensed Professional Counselor.

9034.17 Each Wellness service provider, and professional, regardless of their employer of record, shall be selected by the person receiving services or his or her authorized representative, and shall be answerable to the person receiving services.

9034.18 Any provider substituting treating professionals for more than a two (2) week period or four (4) visits due to emergency or availability events shall request a case conference with the DDS Service Coordinator to evaluate the continuation of services.

- 9034.19 In order to be eligible for Medicaid reimbursement, services shall be authorized in accordance with the following requirements:
- (a) DDS shall provide a written service authorization before the commencement of services;
 - (b) The provider shall conduct an initial assessment and develop a person-centered plan within the first four (4) hours of service delivery which:
 - (1) Describes wellness strategies and the anticipated and measurable, functional outcomes, based upon what is important to and for the person as reflected in his or her Person-Centered Thinking tools; and
 - (2) Includes training goals and techniques in the ISP that will assist the caregivers;
 - (c) The service name and provider entity delivering services shall be identified in the ISP and Plan of Care; and
 - (d) The ISP, Plan of Care, and Summary of Supports and Services shall document the amount and frequency of services to be received.
- 9034.20 Each Provider shall comply with the requirements described under Section 9013 (Reporting Requirement), Section 9006 (Records and Confidentiality of Information), and Section 9005 (Individual Rights) of Chapter 90 of Title 29 DCMR.
- 9034.21 Medicaid reimbursement of Wellness services shall be limited as follows:
- (a) Massage Therapy shall be limited to fifty-two (52) hours per ISP year. Additional hours up to one hundred (100) hours per year may be authorized before the expiration of the ISP year with approval by DDS Deputy Director for DDA based upon assessed medical or clinical need;
 - (b) Sexuality Education shall be limited to fifty-two (52) hours per ISP year. Additional hours up to one hundred (100) hours per year may be authorized before the expiration of the ISP year with approval by DDS Deputy Director for DDA.
 - (c) Fitness Training and Small Group Fitness Training shall be limited to fifty-two (52) hours per ISP year for people receiving host home, supported living, residential habilitation or in-home supports services, or who otherwise have natural supports available that can assist the person practice the fitness skills they need to achieve their fitness goals. Additional hours up to one hundred four (104) hours per year may be authorized before the expiration of the ISP year, and when the person's health and safety are at

risk, for people who live in natural homes without in-home supports services and do not have such natural supports available that can assist the person practice the fitness skills they need to achieve their fitness goals. Requests for additional hours may be approved when accompanied by a physician's order or if the request passes a clinical review by staff designated by DDS;

- (d) Nutrition Counseling shall be limited to twenty-six (26) hours per ISP year and to people who have natural or paid supports to help them implement the learning and nutrition goals outside of the time with the dietician or nutritionist. Additional hours up to one hundred four (104) may be authorized before the expiration of the ISP year with approval by DDS Deputy Director for DDA based upon assessed medical or clinical need; and
- (e) Bereavement Counseling shall be limited to one hundred (100) hours per ISP year. Additional hours may be authorized before the expiration of the ISP year and when the person's health and safety are at risk and the person is demonstrating progress towards achieving established outcome or maintenance of goals.

9034.22 The person may utilize one (1) or more wellness services in the same day, but not at the same time.

9034.23 The Medicaid reimbursable billable unit of service for wellness services shall be fifteen (15) minutes. A provider shall provide at least eight (8) minutes of service in a span of fifteen (15) continuous minutes to bill a unit of service.

9099 DEFINITIONS

9099.1 When used in this chapter, the following terms and phrases shall have the meanings 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.

Advance Practice Registered Nurse (APRN) or Nurse Practitioner (NP) - An individual who is licensed to practice nursing pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1202 *et seq.*), or licensed to practice nursing in the jurisdiction where the services are being provided.

Anthropometric assessment - A clinical approach utilizing noninvasive methods to assess the size or body composition of an individual.

Archive – Maintenance and storage of records.

Audiologist - A person who meets the education and experience requirements for a Certificate of Clinical Competence in the area of audiology granted by the American Speech and Hearing Association or is licensed or certified as an audiologist in the state where the services are provided.

Audiologist Assistant - Support personnel who, following academic or on-the-job training, perform tasks prescribed, directed, and supervised by ASHA-certified audiologists.

Behavior Management Specialist - An individual who has the training and experience in the theory and technique of changing the behavior of individuals to enhance their learning of life skills and adaptive behaviors, and to decrease maladaptive behaviors, and who works under the supervision of a licensed practitioner.

Behavioral Support Plan - A plan that is a component of the ISP that outlines positive supports and strategies to help a person ameliorate and/or eliminate the negative impact of one or more challenging behaviors that have a negative impact on a person's ability to achieve his/her goals.

Benefits Counseling – Analysis and advice provided to a person to help him/her understand the potential impact of employment on his/her public benefits, including but not limited to Supplemental Security Income, Medicaid, Social Security Disability Insurance, Medicare, and Food Stamps.

Bereavement counseling - A form of psychotherapy that aims to help a person cope with grief and mourning following a major life change or the death of a loved one.

Board Certified Behavior Analyst - An individual with at least a Master's Degree and a certificate from the Behavioral Analyst Certification Board (BCABA), in the jurisdiction where the credential is accepted.

Board Certified Assistant Behavior Analyst - An individual with at least a Bachelor's Degree and a certificate from the BACBA in the jurisdiction where the credential is accepted.

Community integration plan - A plan that includes structured activities and practical experiences by incorporating goals and strategies that best meets the person's interests, needs and learning styles, and that can be implemented within a flexible time period.

Competitive Integrated Employment - Full or part-time work at minimum wage or higher, with wages and benefits, and opportunities for advancement similar to those without disabilities performing the same work, and fully integrated with co-workers without disabilities.

Continuous Quality Assurance Plan – A plan that has a systematic approach to assessing Waiver services and supports designed to ensure Waiver requirements are implemented on an ongoing basis including activities that emerge from a systematic and organized framework that tracks improvement.

Couples - Married or unmarried persons in a relationship, including same-sex relationships.

Day Habilitation Plan - A person-centered plan developed by the day habilitation provider, based on a person-centered planning process that takes into account the results of a functional analysis, ISP, Plan of Care and other available information which lists services and outlines preferences, interests, and measurable outcomes to enable the person to reside, work and participate in the community, and maintain the person's health.

Diagnostic Assessment Report – A report that summarizes the person's psychological and behavioral functioning to determine whether the person may benefit from a Behavioral Support Plan based upon the person's presenting problems and individual goals.

Direct Support Professional (DSP) - An individual who works directly with people with developmental disabilities with the aim of assisting the person to become integrated into his or her community or the least restrictive environment.

EPSDT - Early and Periodic Screening, Diagnostic, and Treatment Services designed for Medicaid-eligible children under the age of twenty-one (21) that include periodic screenings to identify physical and mental conditions, vision, hearing, and dental, as well as diagnostic and treatment services to correct conditions identified during screenings.

Fade-out plan - A plan used by providers to ensure that the restrictive technique or processes utilized are gradually and ultimately eliminated in the person's plan of care.

Family - Anyone who is related to the person by blood, marriage, or adoption.

Fitness training - Instruction using exercise and weight training to promote a person's overall health and physical well-being to maintain a healthy weight range.

Functional Analysis - The process of identifying a person's specific strengths, preferences, developmental needs, and need for services by identifying the person's present developmental level, health status, expressed needs and desires of the person and his or her family, and environmental or other conditions that would facilitate or impede the person's growth and development.

Functional Behavioral Analysis – A comprehensive and individualized process for identifying events that precede and follow a target behavior in order to develop hypotheses regarding the purpose of the target behavior and identify positive changes to be made.

Group Home for a Person with an Intellectual Disability – The same as the definitions and licensure requirements as set forth in 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.

Group Supported Employment - An integrated setting in competitive employment in which a group of two (2) to four (4) persons or four to eight (8) persons are working at a particular work setting. The persons may be disbursed throughout the company or among workers without disabilities.

HCBS Settings Rule – The Centers for Medicare & Medicaid Services (CMS) final rule on Medicaid home and community-based services (HCBS), effective March 17, 2014. *See* 79 Fed. Reg. 2947 (Jan. 16, 2014).

Health Care Management Plan - A written document designed to evaluate a person's health care status and to provide recommendations regarding the treatment and amelioration of health care issues by identifying types of risk, interventions to manage identified risks, persons responsible for carrying out interventions, and persons responsible for providing an evaluation of outcomes and timeframes.

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.

Host Home - The residence owned or leased by the homeowner or principal care provider who provides host home services to the person enrolled in the ID/DD Waiver.

Individual Habilitation Plan - The plan as set forth in Section 403 of the Citizens with Intellectual Disabilities Constitutional Rights and Dignity Act of 1978, effective March 3, 1979 (D.C. Law 2-137; D.C. Official Code § 7-1304.03).

Individual Support Plan (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.

Individual Supported Employment - A supported employment strategy in which a job coach places a person into competitive or customized employment through a job discovery process, provides training and support, and then gradually reduces time and assistance at the work site.

Integrated Work Setting - A work setting that provides a person enrolled in the Waiver with daily interactions with other employees without disabilities or the general public.

Intellectual Disability - Means a substantial limitation in capacity that manifests before eighteen (18) years of age and is characterized by significantly below-average intellectual functioning, existing concurrently with two (2) or more significant limitations in adaptive functioning as defined in D.C. Official Code § 7-1301.03(15A). The determination of intellectual functioning includes consideration of the standard error of measurement associated with the particular intelligence quotient test. The adaptive functioning deficits must cross at least two of the following three domains: conceptual, practical, and social.

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

ISP Year - The three hundred and sixty five (365) day period during which a person's ISP is in effect.

Licensed Independent Clinical Social Worker - An individual who is licensed to practice social work pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1208 *et seq.*) or licensed to practice social work in the jurisdiction where the services are being provided.

Licensed Graduate Social Worker - An individual who is licensed to practice social work pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1208 *et seq.*) or licensed to practice social work in the jurisdiction where the services are being provided.

Licensed Independent Social Worker - An individual who is licensed to practice social work pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1208 *et seq.*) or licensed to practice social work in the jurisdiction where the services are being provided.

Licensed Professional Counselor - An individual who is licensed to practice counseling pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1207 *et seq.*) or licensed to practice counseling in the jurisdiction where the services are being provided.

Living Wage - Living Wage refers to minimum hourly wage requirements as set forth in Title I of the Living Wage Act of 2006, effective June 9, 2006 (D.C. Law 16-18; D.C. Official Code §§ 2-220.01 to .11).

Long-term follow along activities - Ongoing support services considered necessary to assure job retention.

Massage therapy - The therapeutic practice of manipulating the muscles and limbs to ease tension, reduce pain, enhance function, aid in the healing process, and promote relaxation and well-being.

Medical Professionals – Individuals who are trained clinicians and deliver medical services.

Mental Health Habilitation Services – Mental health services provided by a Department of Behavioral Health (DBH) certified community mental health provider to consumers to assist consumers in partially or fully acquiring or improving skills and functioning in accordance with the District of Columbia State Medicaid Plan, the DHCF/DBH Interagency Agreement, and Chapter 34 of Title 22-A DCMR.

Non-job, task-specific skills – General skills designed to support employment goals, such as resume writing, interviewing skills, and the ability to communicate effectively.

Nutrition evaluation/consultation- The evaluation and assessment of a person's nutritional status based on their symptoms, health goals, and diet to maximize the person's overall health.

Occupational Therapist – An individual who is licensed to practice occupational therapy pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201 *et seq.*) or licensed to practice occupational therapy in the jurisdiction where services are provided.

Person – An individual enrolled in the HCBS Waiver for Individual and Family Support (IFS Waiver) program.

People – Individuals enrolled in the HCBS Waiver for Individual and Family Support (IFS Waiver) program.

Person centered – An approach that focuses on what is important to the person based on his or her needs, goals, and abilities rather than using a general standard applicable to all people.

Person's home - The natural home of the person, which does not include an institutional or residential facility or foster home.

Physical Therapist – An individual who is licensed to practice physical therapy pursuant to Section 501 of the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1205.01) or licensed to practice physical therapy in the jurisdiction where services are provided.

Plan of Care - A written service plan that meets the requirements set forth in § 9004.6 of Title 29 DCMR, is signed by the person receiving services, and is used to prior authorize Waiver services.

Positive behavioral support strategies – An alternative to traditional or punitive approaches for managing challenging behaviors that focuses on changing the physical and interpersonal environment and increasing skills so that the person is able to get his/her needs met without having to resort to challenging behavior.

Private Practice - An individual whose practice is an unincorporated solo practice or unincorporated partnership. Private practice also includes an individual who is practicing therapy as an employee of an unincorporated practice, a professional corporation, or other incorporated therapy practice. Private practice does not include individuals when they are working as employees of a hospital, nursing facility, clinic, home health agency, rehabilitation facility or any other entity that has a Medicaid provider agreement which includes physical therapy in the provider's reimbursement rate.

Proactive strategies – Specific interventions such as staff actions or environmental modifications that prevent the occurrence of target behaviors.

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.

Provider for the agency – The roommate of the person receiving waiver supports, who is hired as a contract employee by the Waiver provider to provide shared living supports to the person.

Psychiatrist - An individual licensed to practice psychiatry pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1202 *et seq.*) or licensed as a psychiatrist in the jurisdiction where the services are being provided.

Psychologist - An individual licensed to practice psychology pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1202 *et seq.*) or licensed as a psychologist in the jurisdiction where the services are being provided.

Qualified Intellectual Disabilities Professional- Also known as Qualified Developmental Disabilities Professional or QDDP as defined in D.C. Official Code § 7-1301.03(21), is someone who oversees the initial habilitative assessment of a person; develops, monitors, and review ISPs; and integrates and coordinates Waiver services.

Rehabilitation Specialist - An individual with a Master's degree in Rehabilitation Counseling or a similar degree from an accredited university; an individual with a Master's degree in a social services discipline and a minimum of one (1) year of experience in a supported employment program or equivalent; or an individual with a Master's degree in a social services discipline and certification from the Commission on Rehabilitation Counselor Certification or a similar national organization.

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.

Sensorimotor - Functioning in both sensory and motor aspects of bodily activity.

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.

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

Sexuality education - A comprehensive training about various aspects of sexuality, including information about family planning; reproduction; body image; sexual orientation; sexual pleasure and decision making; communication; sexually transmitted infections; safe sexual practices; birth control methods; and how to reduce the likelihood of sexual victimization.

Situational Assessment - A type of assessment that provides the person an opportunity to explore job tasks in work environments in the community to identify the type of employment that may be beneficial to the person and the support required by each person to succeed in his/her work environment. This assessment shall include observation of the person at the work site, identification of work site characteristics, training procedures, identification of supports needed for the person, and recommendations and plans for future services, including the appropriateness of continuing supported employment.

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.

Small Group Day Habilitation – Day habilitation services delivered in small group settings at a ratio of one-to-three for persons with higher intensity support needs in a setting not to exceed fifteen (15) people.

SMARTER Goals –Goals that are: Specific, Measurable, Attainable, Relevant and Time-Bound, Evaluated, and Revisable.

Special Education Teacher - An individual with a Master's Degree in Special Education from an accredited college or university and a teacher's certificate in the jurisdiction where services are provided.

Speech Pathologist – An individual who meets the education and experience requirements for a Certificate of Clinical Competence in the areas of speech pathology granted by the American Speech and Hearing Association

(ASHA) or is licensed or certified as a speech pathologist in the state where the services are provided.

Speech Pathologist Assistant - Support personnel who, following academic or on-the-job training, perform tasks prescribed, directed, and supervised by ASHA-certified speech language pathologists.

Staffing Plan - A written document that includes the numbers and titles of staff assigned to the particular person, for a specified time period and scheduled for a given site and/or shift to successfully provide oversight and to ensure the maintenance of the health, safety and well-being of the person receiving services.

Stipend – Nominal fee paid to a person for attendance or participation in activities designed to achieve his or her employment goal, as identified in the person's ISP.

Substantial Gainful Activity (SGA) – A level of work activity and earning that is consistent with 20 CFR §§ 404.1510 and 404.1571-404.1576.

Summary of Supports and Services - A written document that lists the various supports and services to be received by a person and a component of the person's ISP.

Support Team - A group of individuals providing support to a person with an intellectual/developmental disability, who have the responsibility of performing a comprehensive person-centered evaluation to support the development, implementation, and monitoring of the person's ISP and Plan of Care.

Supported Living Residence - A residence owned or leased by the provider or a residence owned or leased by the person receiving services.

Target behavior - The challenging behaviors to be addressed by staff.

Temporary Emergency – A sudden change in the medical condition or behavioral status of a person receiving in-home supports services or their caregiver that warrants additional hours of in-home supports services.

Trained Medication Employee – An individual employed to work in a program who has successfully completed a training program approved by the Board of Nursing and is certified to administer medication to program participants.

Travel Skills Training – Training the person to use public transportation to travel safely to their job or training work site.

Treatment Plan - A written plan that includes diagnostic findings, preventative care, and treatment recommendations resulting from a comprehensive evaluation of the person's dental health needs.

Vocational Assessment - An assessment designed to assist a person, their family and service providers with specific employment related data that will generate positive employment outcomes. The assessment should address the person's life, relationships, challenges, and perceptions as they relate to potential sources of community support and mentorship.

Waiver - HCBS Waiver for Individual and Family Support (IFS Waiver) as approved by CMS.

Comments on these emergency and proposed rules shall be submitted in writing to Melisa Byrd, Senior Deputy Director/Medicaid Director, Department of Health Care Finance, Government of the District of Columbia, 441 4th Street NW, Suite 900, Washington, DC 20001, via telephone at (202) 442-8742, by 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 may be obtained from the above address.