DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of Department of Health Care Finance (DHCF), pursuant to the authority set forth in An Act to enable the District of Columbia (District) to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02 (2019 Repl.)) and Section 6(6) of the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.05(6) (2018 Repl.)), hereby gives notice of the adoption, on an emergency basis, of amendments to Chapter 42 (Home and Community-Based Services Waiver for Persons who are Elderly and Individuals with Physical Disabilities) and Chapter 50 (Medicaid Reimbursement for Personal Care Aide Services) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

The current 1915(c) Home and Community-Based Services (HCBS) Waiver for Persons who are Elderly and Individuals with Physical Disabilities (EPD Waiver) was approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) for a five (5)-year renewal period beginning April 4, 2017. CMS approved a subsequent waiver amendment, effective July 1, 2018. On August 7, 2020, DHCF submitted an updated EPD Waiver amendment request with a proposed effective date of October 1, 2020.

In accordance with the changes proposed in the submitted request for amendment, this emergency and proposed rulemaking modifies the scope of covered waiver services, clarifies restrictions related to participant enrollment and provider reimbursement, and updates requirements for service providers under the EPD Waiver program. Specifically, these emergency and proposed rules make the following changes to Title 29 DCMR Chapter 42:

Coverage of physical therapy and occupational therapy under the EPD Waiver is removed due to the underutilization of these services by waiver participants. Physical therapy and occupational therapy were added to the EPD Waiver in 2015 to ensure that waiver participants could receive these services on a more frequent and continuous basis than was offered under the state plan benefit. However, to date, waiver participants have not requested physical and occupational therapy in their person-centered service plans, due primarily to the sufficient access to these services under the state plan home health benefit.

Coverage of respite services for eighteen (18) to twenty-four (24) hours per day is removed from the EPD Waiver. Respite services are currently offered to all waiver participants at two (2) different rates: An hourly rate for individuals needing between one (1) and (17) seventeen hours per day and a daily rate for those needing eighteen (18) to twenty-four (24) hours per day. This rulemaking ends waiver coverage of eighteen (18) to twenty-four (24) hours-per-day respite services, a benefit which has not been utilized by waiver participants since November 2015.

Coverage of Personal Emergency Response System (PERS) services is removed from the EPD Waiver. Instead, as proposed in a corresponding rulemaking and State Plan Amendment (SPA), PERS services will be covered as a state plan benefit. Waiver participants will continue to be

eligible for PERS, but as a result of this change, coverage will also be extended to beneficiaries not enrolled in the waiver but for whom PERS is determined necessary. DHCF is also proposing updates to the scope of PERS services to be covered under the state plan, a detailed description of which can be found in the corresponding rulemaking referenced above.

Personal Care Aide (PCA) services for waiver participants is limited to sixteen (16) hours per day. PCA services under the waiver are currently delivered to waiver participants as an extension of the state plan PCA services benefit. State plan PCA services are capped at eight (8) hours per day and PCA services under the waiver are capped at sixteen (16) hours per day; this means that waiver participants can receive up to twenty-four (24) hours of PCA services per day total. This rulemaking changes the designation of PCA under the waiver from an "extended state plan" service to an "other" service, based on the availability of a delivery modality (participant direction) that is different from what is included under the state plan PCA services benefit. The effect of this change is to limit PCA services for waiver participants to sixteen (16) hours per day total. Beneficiaries currently receiving more than sixteen (16) hours per day of PCA services will have no change to the hours of services allotted until otherwise determined by their annual face-to-face reassessment for long term care services and supports.

The daily cap of sixteen (16) combined hours of PCA services and Adult Day Health services is removed for beneficiaries determined eligible for and/or receiving both types of services.

The duplicative reimbursement of PCA services hours for waiver participants residing in assisted living facilities is no longer permitted; the provision allowing assisted living residents to receive additional assistance with activities of daily living through the receipt of waiver PCA services is removed. This rulemaking also clarifies that Medicaid reimbursement will not be made for twenty-four (24) hour skilled care or skilled supervision; removes the fifty (50) bed limit for assisted living facilities; and increases the reimbursement rate for assisted living services to better reflect provider responsibilities and reasonable costs.

The billing process for Community Transition Services (CTS) is updated to include the requirement that an individual be successfully enrolled in the EPD Waiver prior to the submission of a bill for reimbursement for CTS. This rulemaking also reduces the number of days prior to discharge that an individual in a long term care facility is eligible for CTS from one-hundred and twenty (120) days prior to discharge to sixty (60) days prior to discharge.

The language imposing a caseload limit on case managers is revised to clarify that each case manager is limited to a maximum of forty-five (45) cases total, across all case management agencies, at any given point in time. A new provision is also added requiring that the client caseload of each case manager must be commensurate with the number of hours worked per week.

Eligibility criteria is updated to clarify that enrollment in the waiver is restricted to those individuals not currently enrolled in another 1915(c) waiver and that a beneficiary is not permitted to concurrently participate in multiple 1915(c) HCBS waiver programs.

The tuberculosis (TB) testing requirements for direct care staff is modified to align with national standards by replacing the current annual TB testing requirement with a requirement that testing

be done in accordance with the guidelines published by the U.S. Centers for Disease Control (CDC).

This rulemaking also includes corresponding changes to Chapter 50 of Title 29 DCMR, which governs PCA services covered under the State Plan.

Emergency action is necessary for the immediate preservation of the health, safety, and welfare of waiver participants who are in need of the long-term care services covered under the EPD Waiver. The EPD Waiver services some of the District's most vulnerable residents. The changes included in this emergency and proposed rulemaking collectively enhance service delivery and coordination and ensure the continued access to services under the waiver, thereby making their immediate implementation integral to preserving the health, safety, and welfare of District residents enrolled in the EPD Waiver.

These emergency and proposed rules correspond to a related 1915(c) HCBS waiver amendment, which requires approval by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). Accordingly, the implementation of the changes proposed in this rulemaking shall become effective on October 1, 2020, or on an alternative effective date established by CMS in its approval of the corresponding waiver amendment, whichever is later.

Finally, DHCF is proposing emergency changes to the administration of the Medicaid program to maintain the accessibility of services to Medicaid beneficiaries if the risk of coronavirus disease (COVID-19) or any other public health emergency in the District requires beneficiaries to quarantine or impedes access to the 1915(c) HCBS EPD Waiver or State Plan PCA services. In accordance with recent emergency legislation and Mayor's Order No. 2020-052, DHCF has made changes to EPD Waiver and State Plan PCA service requirements via guidance published in the *D.C. Register* and on DHCF's website during the public health emergency prompted by COVID-19, as declared by the Mayor. To the extent possible, DHCF will offer any additional flexibilities approved by our federal partners to facilitate administration of the EPD Waiver and service authorizations that promote continuity of services during this public health emergency. Providers, beneficiaries, and other stakeholders can find guidance on these changes on DHCF's website at https://dhcf.dc.gov/page/long-term-care-administration.

These emergency rules were adopted on September18, 2020, and shall become effective on October 1, 2020, contingent upon approval of the corresponding waiver amendment by CMS. These emergency rules shall remain in effect for one hundred and twenty (120) days from the adoption date or until January 16, 2021, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*.

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

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

Subsection 4200.1 of Section 4200, GENERAL PROVISIONS: IDENTIFICATION OF SERVICES; PROGRAM RESPONSIBILITIES; AND SERVICE SETTING REQUIREMENTS, is amended to read as follows:

4200.1 The following Home and Community-Based Services (HCBS) Waiver services are included in the Persons who are Elderly and Individuals with Physical Disabilities waiver (EPD Waiver), consistent with the regulations set forth in this chapter:

(a) Case management services;

(b) Personal Care Aide (PCA) services;

(c) Respite services;

(d) Homemaker services;

(e) Chore aide services;

(f) Assisted living services;

(g) Environmental Accessibility Adaptation services;

(h) Adult Day Health services;

(i) Individual-Directed Goods and Services;

(j) Participant-Directed Community Supports services; and

(k) Community transition services.

Subsections 4201.1, 4201.2, 4201.5, and 4201.6 of Section 4201, ELIGIBILITY, are amended to read as follows:

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

4201.2 To be eligible for the EPD Waiver services described in this chapter, a beneficiary shall:

(a) Require the level of care furnished in a nursing facility as determined by DHCF's Long Term Care Services and Supports contractor using the

standardized face-to-face assessment tool, in accordance with Subsections 4201.4 and 4201.5;

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

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

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

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

(f) Reside in the District of Columbia in a community setting, such as a natural home or approved Community Residential Facility or EPD Waiver assisted living facility; and

(g) Not currently be a participant in any other 1915(c) HCBS waiver, including but not limited to the HCBS Waiver for Individuals with Intellectual and Developmental Disabilities) under Chapter 19 of Title 29 DCMR.

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

4201.6 Eligibility for all EPD Waiver services shall be recertified on an annual basis in accordance with any procedures established by the Department of Health Care Finance (DHCF) in this chapter and 29 DCMR § 989.

Subsections 4202.1 through 4202.3 of Section 4202, APPEAL RIGHTS FOR APPLICANTS/BENEFICIARIES, are amended to read as follows:

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

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

(b) They are not given the choice between EPD Waiver services or institutional care;

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

(d) DHCF or its designee takes action to deny, discontinue, suspend, reduce, or terminate services, or disenroll a beneficiary or applicant from the EPD Waiver program.

4202.2 An EPD Waiver provider shall issue a written notice in cases of intended actions to deny, discontinue, discharge, suspend, transfer, or terminate services to any applicant or beneficiary in accordance with the requirements set forth in Section 4205.

4202.3 The notice required under Subsection 4202.2 must include the following information:

(a) The intended action;

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

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

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

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

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

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

New Subsections 4202.4 and 4202.5 are added to read as follows:

4202.4 The notice shall be issued at least thirty (30) calendar days prior to the effective date of the proposed action, except:

(a) When the intended action is the termination of services based on the applicant or beneficiary's failure to meet eligibility criteria set forth at Subsection 4201.2, in which case the notice shall be issued at least seven (7) calendar days prior to the effective date of the proposed action; or

(b) As provided in Subsection 4205.17.

4202.5 DHCF or its designee shall issue a written notice in cases where it intends to take action to deny, discontinue, discharge, suspend, or reduce Waiver services, or disenroll applicants or beneficiaries from the EPD Waiver program. The notice shall be issued at least thirty (30) calendar days prior to the effective date of the proposed action and shall state the following information:

(a) The intended action;

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

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

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

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

Section 4204 is amended to read as follows:

4204 WRITTEN PERSON-CENTERED SERVICE PLAN REQUIRED

Subsection 4204.5 is amended to read as follows:

4204.5 A Person-Centered Service Plan (PCSP) shall, at a minimum, address and document the following:

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

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

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

(b) The beneficiary's goals, including:

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

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

will be provided;

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

(d) End of life plan, as appropriate;

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

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

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

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

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

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

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

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

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

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

Subsection 4204.7 is amended to read as follows:

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

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

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

Section 4205 is amended to read as follows:

4205 DISCHARGE, SUSPENSION, TRANSFER, TERMINATION, AND DISENROLLMENT

Subsections 4205.1 through 4205.6 are deleted in their entirety.

Subsection 4205.11 is amended to read as follows:

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

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

(b) The provider is unable to meet the needs of the beneficiary; if a service provider is requesting the discharge or transfer, the provider has demonstrated compliance with all requirements set forth in Subsection 4205.12; or

(c) The behavior of a beneficiary poses an immediate threat to the safety and well-being of the waiver provider or provider's staff.

Subsection 4205.13 is amended to read as follows:

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

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

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

Subsection 4205.15 is amended to read as follows:

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

(a) Issue written notice pursuant to Subsections 4202.2 – 4202.4;

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

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

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

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

A new Subsection 4205.17 is added to read as follows:

4205.17 If the behavior of a beneficiary, or the environment in which services are being provided, poses an immediate threat to the safety and well-being of the provider or provider's staff, the provider has the right to immediately suspend the beneficiary's services or discharge the beneficiary.

Section 4207 is amended to read as follows:

4207 RECORDS AND CONFIDENTIALITY OF INFORMATION

Section 4210 is amended to read as follows:

4210 REIMBURSEMENT: CASE MANAGEMENT SERVICES

Subsections 4210.1 and 4210.3 are amended to read as follows:

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

4210.3 In order for a case management agency to receive reimbursement for case management services, each case manager must perform case management duties either on a full-time or on a part-time basis, in accordance with the following:

(a) At any point in time, a case manager shall be assigned no more than forty-five (45) persons total (inclusive of Medicaid and non-Medicaid beneficiaries) across all case management agencies; and

(b) The caseload of each case manager must be commensurate with the number of hours worked per week.

Section 4211 is amended to read as follows:

4211 REIMBURSEMENT: PERSONAL CARE AIDE (PCA) SERVICES

Section 4212, REIMBURSEMENT RATES: PERSONAL EMERGENCY RESPONSE SERVICES (PERS), is deleted in its entirety.

Section 4213 is amended to read as follows:

4213 REIMBURSEMENT: RESPITE SERVICE

Subsections 4213.3 through 4213.7 are amended to read as follows:

4213.3 Effective July 1, 2020, DHCF reimbursement for respite services shall be limited to a total of seventeen (17) hours per day per beneficiary.

4213.4 Consistent with Section 4232, respite services shall be limited to a total of four hundred and eighty (480) hours per year per beneficiary unless the need for additional services is prior authorized by DHCF or its designee.

4213.5 DHCF shall not reimburse a provider of respite services for services provided by the waiver beneficiary's spouse, or other legally responsible relative or court-appointed guardian, with the exception of parents of adult children. Non-legally responsible relatives, including parents of adult children, may provide and be reimbursed for respite services provided they meet the requirements of Section 4231.

4213.6 DHCF shall not reimburse for the cost of room and board except when provided as part of respite care furnished in a facility approved by the District of Columbia that is not a private residence.

4213.7 When respite is provided in a facility, including an Assisted Living Facility, group home, or other Community Residential Facility, the facility must meet all HCBS setting requirements consistent with Section 4200.

Section 4214 is amended to read as follows:

4214 REIMBURSEMENT: HOMEMAKER SERVICES

Subsection 4214.3 is amended to read as follows:

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

Section 4215 is amended to read as follows:

4215 REIMBURSEMENT: CHORE AIDE SERVICES

Subsections 4215.4 and 4215.5 are amended to read as follows:

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

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

Section 4216 is amended to read as follows:

4216 REIMBURSEMENT: ASSISTED LIVING SERVICES

Subsections 4216.3 through 4216.6 are amended to read as follows:

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

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

4216.5 Beneficiaries may seek subsidies outside of the EPD Waiver to pay for room and board through the Optional State Supplemental Payment Program.

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

(a) Homemaker services;

(b) Chore Aide services;

(c) Respite services;

(d) Environmental Accessibility Adaptation (EAA) services; or

(e) PCA services.

Subsection 4216.7 is deleted in its entirety.

Section 4217 is amended to read as follows:

4217 REIMBURSEMENT: ENVIRONMENTAL ACCESSIBILITY ADAPTATION (EAA)

Section 4218 is amended to read as follows:

4218 REIMBURSEMENT: ADULT DAY HEALTH

Subsections 4218.2, 4218.4, and 4218.5 are amended to read as follows:

4218.2 A provider shall not be reimbursed for adult day health services when provided concurrently with the following services:

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

(b) Personal Care Aide services;

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

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

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

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

Subsection 4218.6 is deleted in its entirety.

Section 4219, REIMBURSEMENT RATES: PHYSICAL THERAPY, is deleted in its entirety.

Section 4220, REIMBURSEMENT RATES: OCCUPATIONAL THERAPY, is deleted in its entirety.

Section 4221 is amended to read as follows:

4221 REIMBURSEMENT: COMMUNITY TRANSITION SERVICES

Subsection 4221.1 is amended to read as follows:

4221.1 In accordance with Section 4252, reimbursement for the household set up items specified under Subsection 4252.2 shall not exceed five thousand dollars ($5,000) per Waiver period and shall only be reimbursed beginning sixty (60) calendar days before a beneficiary's discharge and up to six (6) months after discharge from an institution or long term care facility.

Subsections 4222.11 and 4222.14 of Section 4222, PROVIDER REQUIREMENTS: GENERAL, are amended to read as follows:

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

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

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

(c) Been informed, upon initial enrollment and on an annual basis thereafter, on the recognition and prevention of abuse, neglect, and exploitation, including how to safely report concerns.

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

Subsections 4223.1 through 4223.8 of Section 4223, SPECIFIC PROVIDER REQUIREMENTS: CASE MANAGEMENT SERVICES, are amended to read as follows:

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

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

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

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

(d) Be able to read and write English;

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

(f) Confirm, in accordance with published CDC guidelines, that he or she is free of active tuberculosis by undergoing a purified protein derivative skin test;

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

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

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

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

4223.2 Effective March 25, 2016, except as provided in Subsection 4223.3, an individual providing case management services, who is employed or under contract to an EPD Waiver case management service provider shall self-attest to meeting the CMS conflict-free standards in accordance with 42 CFR § 441.301(c)(1)(vi) using the DHCF Conflict-Free Case Management Self-Attestation Form.

4223.3 Under the CMS standards, individual case managers shall not:

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

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

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

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

4223.4 An individual providing EPD Waiver case management services shall have met the requirements of Subparagraph 4223.1(h)(2) by no later than July 1, 2016.

4223.5 EPD Waiver case management service providers shall ensure they have a copy of the DHCF Conflict-Free Case Management Self-Attestation Form on file for each case manager prior to submission of any claims for case management services provided by that case manager on or before July 1, 2016. DHCF Conflict-Free Case Management Self-Attestation Forms are subject to inspection and audit and must be produced upon request.

4223.6 Individuals conducting case management services shall meet one of the following educational requirements:

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

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

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

4223.7 Case management service providers shall not provide medical, financial, legal, or other services or advice for which they are not qualified or licensed to provide (except for providing referrals to qualified individuals, agencies, or programs).

4223.8 As of March 25, 2016, in accordance with 42 CFR § 441.301(c)(1)(vi), the following providers are not eligible to provide case management services:

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

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

Subsection 4224.14 of Section 4224, PROGRAM SERVICES: CASE MANAGEMENT SERVICES, is amended to read as follows:

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

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

(b) Conducting an evaluation of each beneficiary's health status at least once every twelve (12) months or upon a significant change in the beneficiary's health status and completing the case manager evaluation form following each evaluation;

(c) Assisting the beneficiary in requesting a level of care assessment from DHCF or its designee on an annual basis, or when there is a change in health status, as determined by the evaluation described in Paragraph 4224.14(b);

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

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

(f) Reevaluating the beneficiary's goals, level of service and support needs, and updating and/or revising the Person-Centered Service Plan (PCSP) to reflect any changes;

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

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

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

Subsection 4225.1 of Section 4225, CASE MANAGEMENT AGENCY AND CASE MANAGER RESPONSIBILITIES, is amended to read as follows:

4225.1 Case management agencies shall ensure compliance with the following requirements:

(a) At any point in time, no case manager has a client caseload exceeding forty-five (45) persons total (inclusive of Medicaid and non-Medicaid beneficiaries) across all case management agencies; and

(b) The caseload of each case manager is commensurate with the number of hours worked per week.

Subsection 4226.1 of Section 4226, SPECIFIC PROVIDER REQUIREMENTS: PERSONAL CARE AIDE SERVICES, is amended to read as follows:

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

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

(b) Staffing and administration requirements; and

(c) Notice requirements.

Section 4227, SPECIFIC ELIGIBILITY REQUIREMENTS: PERSONAL CARE AIDE SERVICES, is amended to read as follows:

4227.1 To be eligible for Medicaid reimbursement of PCA services under the EPD Waiver program, a beneficiary shall have an assessed need for PCA services, as established by the conflict-free face-to-face assessment.

Subsection 4228.4 of Section 4228, PROGRAM SERVICES: PERSONAL CARE AIDE SERVICES, is amended to read as follows:

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

Subsection 4228.5 is deleted in its entirety.

Section 4229, SPECIFIC PROVIDER REQUIREMENTS: PERSONAL EMERGENCY RESPONSE SERVICES (PERS), is deleted in its entirety.

Section 4230, PROGRAM SERVICES: PERS, is deleted in its entirety.

Subsection 4231.6 of Section 4231, SPECIFIC PROVIDER REQUIREMENTS: RESPITE SERVICES, is amended to read as follows:

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

(a) Is licensed to practice registered nursing in the District of Columbia in accordance with the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.* (2016 Repl.)), and implementing rules, Chapter 54 (Registered Nursing) of Title 17 DCMR; and

(b) Is employed by or contracted for by an approved home care agency.

Subsections 4232.5 through 4232.8 of Section 4232, PROGRAM SERVICES: RESPITE SERVICES, are amended to read as follows:

4232.5 A unit of Medicaid reimbursable service for respite care shall be one (1) hour spent performing allowable tasks.

4232.6 Medicaid reimbursable respite services shall be limited to a maximum of seventeen (17) hours per day and four hundred and eighty (480) hours per year.

4232.7 Medicaid reimbursable respite services shall not be billed in combination with or at the same time as PCA services.

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

Subsections 4233.2 through 4233.6 of Section 4233, SPECIFIC PROVIDER REQUIREMENTS: HOMEMAKER SERVICES, are amended to read as follows:

4233.2 In order to receive Medicaid reimbursement for homemaker services, all individual homemaker service staff shall:

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

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

(c) Pass a criminal background check;

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

(e) Meet the qualification and training requirements under Subsection 4233.3 or 4233.4.

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

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

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

4233.4 In order to receive Medicaid reimbursement for homemaker services, a business with a general business license issued by the D.C. Department of Consumer and Regulatory Affairs to provide housekeeping services shall require that all individual homemaker staff obtain a minimum of eight (8) hours of training annually in the following areas:

(a) Beneficiary rights;

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

(c) Preventing abuse, neglect, and exploitation;

(d) Controlling the spread of disease and infection;

(e) Changing linens and bed bug prevention;

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

(g) Handling hazardous waste;

(h) Blood-borne pathogens and bodily fluids;

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

(j) Instructions on the following:

(1) Dusting;

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

(3) Trash handling;

(4) Laundry and safe use of detergents;

(5) Cleaning the walls and ceiling; and

(6) Kitchen and bathroom cleaning and maintenance.

4233.5 Supervisory staff employed by the homemaker service provider shall develop a written homemaker service delivery plan, which shall be approved by the beneficiary's case manager prior to implementation.

4233.6 The homemaker service provider shall document each in-home visit and telephone contact in the beneficiary's service delivery plan within thirty (30) calendar days of the visit or contact.

Subsections 4234.2 and 4234.3 of Section 4234, PROGRAM SERVICES: HOMEMAKER SERVICES, are amended to read as follows:

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

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

(b) General household cleaning such as:

(1) Cleaning bathrooms;

(2) Vacuuming;

(3) Dusting;

(4) Mopping floors;

(5) Sweeping floors;

(6) Bed making;

(7) Linen changing;

(8) Wiping appliances;

(9) Washing dishes; and

(10) Doing laundry and ironing clothes.

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

4234.3 A unit of service for reimbursement of homemaker services shall be one (1) hour spent performing the allowable task(s).

Section 4237 is amended to read as follows:

4237 SPECIFIC PROVIDER REQUIREMENTS: ASSISTED LIVING SERVICES

Subsections 4237.1 and 4237.2 are amended to read as follows:

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

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

Section 4238, PROGRAM SERVICES: ASSISTED LIVING SERVICES, is amended to read as follows:

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

4238.2 Assisted living services shall include all of the following services, as necessary to meet a beneficiary's needs, in accordance with his or her written PCSP:

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

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

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

(d) Coordination of social and recreational activities;

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

(f) Coordination of scheduled transportation to community-based activities.

4238.3 Consistent with Subsection 4238.2(e), the assisted living provider shall coordinate the delivery of all services provided by third parties, including but not limited to home care agencies, hospitals, clinics, and Adult Day Health providers.

Subsection 4239.15 of Section 4239, SPECIFIC PROVIDER REQUIREMENTS: EAA, is amended to read as follows:

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

Subsections 4241.1, 4241.2, and 4241.5 of Section 4241, SPECIFIC PROVIDER REQUIREMENTS: ADULT DAY HEALTH, are amended to read as follows:

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

(a) Provider qualifications;

(b) Program Administration; and

(c) Staffing requirements.

4241.2 Each adult day health provider under the EPD Waiver shall meet all HCBS setting requirements consistent with Subsection 4200.6 and DHCF's Provider Readiness Review process.

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

Subsection 4242.2 of Section 4242, PROGRAM SERVICES: ADULT DAY HEALTH, is amended to read as follows:

4242.2 In order to receive Medicaid reimbursement, adult day health services shall include all of the following:

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

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

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

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

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

(f) Medication administration services provided by an RN;

(g) Nutrition services; and

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

Section 4243, SPECIFIC PROVIDER REQUIREMENTS: PHYSICAL THERAPY, is deleted in its entirety.

Section 4244, PROGRAM SERVICES: PHYSICAL THERAPY, is deleted in its entirety.

Section 4245, SPECIFIC PROVIDER REQUIREMENTS: OCCUPATIONAL THERAPY, is deleted in its entirety.

Section 4246, PROGRAM SERVICES: OCCUPATIONAL THERAPY, is deleted in its entirety.

Subsection 4252.6 of Section 4252, PROGRAM SERVICES: COMMUNITY TRANSITION SERVICES, is amended to read as follows:

4252.6 Community Transition funds shall be utilized for a period not to exceed sixty (60) calendar days before discharge and up to six (6) months after discharge from an institution or long term care facility.

A new Subsection 4252.7 is added to read as follows:

4252.7 Claims for reimbursement for Community Transition Services shall not be submitted prior to the beneficiary's enrollment in the EPD Waiver.

Subsection 4254.6 of Section 4254, INCIDENTS AND COMPLAINTS, is amended to read as follows:

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

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

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

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

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

(e) Informing a beneficiary or responsible party of the outcome of death within three (3) business days of incident investigation closure.

Section 4299 is amended to read as follows:

4299 DEFINITIONS

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

Abuse - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the District Medicaid

program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Activities of Daily Living (ADLs) - The ability to bathe, transfer, dress, eat and feed oneself, engage in toileting, and maintain bowel and bladder control (continence).

Admissions Hold - A process by which a provider is prohibited from admitting new waiver beneficiaries.

Advanced Practice Registered Nurse - A person who is licensed or authorized to practice as an advanced practice registered nurse pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.*).

Assisted Living Facility - An entity that shall have the same meaning as set forth in D.C. Official Code § 44-102.01(4).

Case Management Agency - An agency under contract with the Department of Health Care Finance to provide case management services to waiver beneficiaries.

Case Manager - A staff person from the case management agency who performs case management services.

Change in Service - A request to modify the type, amount, duration, or scope of services based on the beneficiary's current level of functioning, which is supported by the assessment tool.

Chore Aide - A person who performs tasks intended to place the home environment in a clean, sanitary, and safe condition, and to prepare the home environment for ongoing routine home care services.

Communicable Disease - Any disease defined in D.C. Official Code § 7-132 and 22-B DCMR § 299.

Cueing - Using verbal prompts in the form of instructions or reminders to assist beneficiaries with activities of daily living.

Discharge - A request to release a beneficiary from a particular service provider.

Environmental Accessibility Adaptation - Physical adaptations to the home that are necessary to ensure the health, welfare, and safety of the individual, or that enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization.

EPD Waiver - The District's 1915(c) Home and Community Based Services Waiver for the Elderly and Persons with Disabilities as approved by the Centers for Medicare and Medicaid Services.

Family - Any person related to the beneficiary by blood, marriage, or adoption.

Fraud - An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person, including any act that constitutes fraud under federal or District law.

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

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

Licensed Independent Clinical Social Worker– A person who is licensed or authorized to practice as an independent clinical social worker 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*. (2016 Repl.)).

Limited English Proficient Individuals - Individuals who do not speak English as their primary language, and individuals who have a limited ability to read, write, speak, or understand English.

Medicaid - A federal-state program established by Title XIX of the Social Security Act, which provides payment of medical expenses for eligible persons who meet income and/or other criteria.

Natural Home - A home owned or leased by the beneficiary, the beneficiary's family member or another private individual; the lease/deed must be held by the beneficiary, the beneficiary's family member, or another private individual.

Participant/Representative-Employer - The *Services My Way* participant or the participant's authorized representative, as applicable, who performs employer-related duties including recruiting, hiring, supervising and discharging participant-directed workers.

Person-Centered Service Plan - Individualized service plan developed by the case manager that identifies the supports and services to be provided to the person enrolled in the Waiver and the evaluation of the person's progress

on an on-going basis to assure that the person's needs and desired outcomes are being met.

Personal Care Aide - A person who has successfully completed the relevant jurisdiction's (the person's home state or District of Columbia) established training program and meets the competency evaluation requirements. Tasks include assistance with activities of daily living and instrumental activities of daily living.

Physical Disability - A functionally determinable impairment that substantially limits an individual's ability to perform manual tasks, to engage in an occupation, or to live independently, or to walk, see, or hear.

Physician - A person who is licensed or authorized to practice medicine pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.).*

Plan of Care - A plan prepared by the EPD Waiver service provider that outlines the service delivery plans for the services being delivered by that provider. This is also referred to as a service delivery plan.

Provider - Any entity that meets the waiver service requirements, has signed an agreement with DHCF to provide waiver services, and is enrolled by DHCF to provide services to waiver beneficiaries.

Registered Nurse - An individual who is licensed or authorized to practice registered nursing pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.*), as amended, or licensed as a registered nurse in the jurisdiction where services are provided.

Respite Service - Services that include the provision of assistance with activities of daily living and instrumental activities of daily living for waiver beneficiaries in their home or temporary place of residence in the temporary absence of the primary caregiver. Respite services may also be provided in a Medicaid certified community setting or a group home.

Suspension - Ending the delivery of services to a beneficiary for a temporary period not to exceed thirty (30) calendar days.

Termination - The discontinuation of services under the Waiver or a disenrollment from the EPD Waiver Program.

Theft - Wrongfully obtaining or using the property of another with intent to deprive the other of a right to the property or a benefit of the property or to

appropriate the property to an individual's own use or to the use of a third person.

Transfer - A request to move a beneficiary from one service provider to another service provider.

Vendor - A corporate entity providing individual-directed goods or services.

Vendor Fiscal/Employer Agent) Financial Management Services Support Broker Entity - An entity operating in accordance with 26 USC § 3504 and Rev. Proc. 70-6, as modified by REG-137036 and Rev. Proc. 2013-39, which provides financial management services and information and assistance services to *Services My Way* participants and their representatives, as appropriate.

Waiver – See EPD Waiver.

Waiver Period - Each five (5) year term for which the Waiver is approved by CMS, beginning with the initial effective date of the Waiver.

Wrongfully Obtain or Use - Taking or exercising control over property; making an unauthorized use, disposition, or transfer of an interest in or possession of property; or obtaining property by trick, false pretense, false token, tampering, or deception. The term "wrongfully obtain or use" includes conduct previously known in the District as larceny, larceny by trick, larceny by trust, embezzlement, and false pretenses.

Chapter 50, MEDICAID REIMBURSEMENT FOR PERSONAL CARE AIDE SERVICES, of Title 29 DCMR, PUBLIC WELFARE, is amended as follows:

Subsection 5000.2 of Section 5000, GENERAL PROVISIONS, is amended to read as follows:

5000.2 Medicaid reimbursable PCA services support and promote the following goals:

(a) To provide cueing, safety monitoring, and hands-on assistance during activities of daily living for beneficiaries who are unable to perform one or more activities of daily living; and

(b) To encourage home and community-based care as a preferred and cost-effective alternative to institutional care.

Subsection 5003.6 of Section 5003, PCA SERVICE AUTHORIZATION REQUEST AND SUBMISSION, is amended to read as follows:

5003.6 PCA services authorized under this chapter may be provided for up to eight (8) hours per day, seven (7) days per week. The amount and scope of PCA services available to individuals deemed eligible for participation in the Elderly or Individuals with Physical Disabilities (EPD Waiver) or Individuals with Intellectual and Developmental Disabilities Waiver (IDD Waiver) are set forth in Chapter 42 and Chapter 19 of Title 29 DCMR, respectively.

Subsections 5006.7 through 5006.9 of Section 5006, PROGRAM REQUIREMENTS, are amended to read as follows:

5006.7 PCA services shall be limited to the following:

(a) Cueing or hands-on assistance with performance of activities of daily living (e.g., bathing, transferring, toileting, dressing, feeding, and maintaining bowel and bladder control);

(b) Assisting with incontinence, including bed pan use, changing urinary drainage bags, changing protective underwear, and monitoring urine input and output;

(c) Assisting beneficiaries with transfer, ambulation, and range of motion exercises;

(d) Assisting beneficiaries with self-administered medications by providing reminders or other verbal cues;

(e) Reading and recording temperature, pulse, blood pressure, and respiration;

(f) Measuring and recording height and weight;

(g) Observing, documenting, and reporting to the supervisory health professional, changes in the beneficiary's physical condition, behavior, and appearance and reporting all services provided on a daily basis;

(h) Simple meal preparation, such as warming, cutting up, and pouring food or beverages, in accordance with dietary guidelines;

(i) Assistance with eating;

(j) Performing tasks related to keeping areas occupied by the beneficiary in a condition that promotes the beneficiary's safety;

(k) Implementing universal precautions to ensure infection control;

(l) Accompanying the beneficiary to medical and dental appointments or place of employment and recreational activities if approved in the beneficiary's plan of care;

(m) Shopping for items that are related to promoting a beneficiary's nutritional status in accordance with dietary guidelines and other health needs as described in the beneficiary's plan of care; and

(n) Providing safety monitoring to prevent accidents and injuries to the beneficiary in the course of performing activities of daily living.

5006.8 PCA 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 aides or homemakers, such as cleaning of areas not occupied by the beneficiary, shopping for items not related to promoting the beneficiary's nutritional status and other health needs, and shopping for items not used by the beneficiary; and

(c) Money management.

5006.9 PCA services shall not be provided in a hospital, nursing facility, intermediate care facility, assisted living facility, or other living arrangement which includes personal care as part of the reimbursed service if the beneficiary has been admitted for care. For outpatient hospital services, emergent care, or circumstances where the beneficiary is being discharged or transitioning to a home-based setting, PCA services may be provided to an eligible beneficiary in circumstances where there is no duplication of PCA services until the time that a beneficiary is admitted for care.

Subsection 5007.5 of Section 5007, DENIAL, SUSPENSION, REDUCTION, OR TERMINATION OF SERVICES, is amended to read as follows:

5007.5 If the behavior of a beneficiary, or the environment in which services are being provided, poses an immediate threat to the safety or well-being of the PCA or PCA provider staff, the provider must immediately review the threat and initiate an investigation.

(a) The provider has the right to immediately discharge the beneficiary or suspend the beneficiary's services for a period not to exceed thirty (30) calendar days.

(b) A provider that discharges or suspends services for a beneficiary under this subsection remains subject to the requirements set forth at § 5007.9

Subsection 5009.1 of Section 5009, PERSONAL CARE AIDE QUALIFICATIONS, is amended to read as follows:

5009.1 Each PCA, whether an employee of the Provider or secured through a staffing agency, shall meet the following requirements:

(a) Obtain or have an existing Home Health Aide certification in accordance with Chapter 93 of Title 17 DCMR;

(b) Confirm, consistent with CDC published guidance , that he or she is free from communicable diseases including tuberculosis and hepatitis, by initially undergoing an purified protein derivative test and receiving a hepatitis vaccine during physical examination by a physician, and subsequently obtaining, on an annual basis, written and signed documentation from the examining physician confirming freedom from communicable disease;

(c) Provide evidence of current cardio pulmonary resuscitation and first aid certification;

(d) Pass a criminal background check pursuant to 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.*);

(e) Pass a reference check and a verification of prior employment;

(f) Have an individual National Provider Identifier (NPI) number obtained from National Plan and Provider Enumeration System (NPPES);

(g) Obtain at least twelve (12) hours of continuing education or in-service training annually in accordance with the Department of Health's Home Care Agency training requirements under 22-B DCMR § 3915; and

(h) Meet all of the qualifications for Home Health Aide trainees in accordance with Chapter 93 of Title 17 DCMR, which includes the following:

(1) Be able to understand, speak, read, and write English at a fifth (5^{th}) grade level or higher;

(2) Be knowledgeable about infection prevention, including taking standard precautions; and

(3) Possess basic safety skills including being able to recognize an emergency and be knowledgeable about emergency procedures.

Subsections 5015.5 and 5015.6 of Section 5015, REIMBURSEMENT, are amended to read as follows:

5015.5 Reimbursement for PCA services provided as a benefit under the District's Medicaid State Plan shall not exceed eight (8) hours per day, seven (7) days a week, and shall be limited to the amount, duration, and scope of services set forth in the PCA Service Authorization and the plan of care, as described in Section 5003.

5015.6 Claims for PCA services submitted by a Provider in any period during which the beneficiary is an in-patient at a health care facility, including a hospital, nursing home, psychiatric facility or rehabilitation program shall be denied except on the day when a beneficiary is admitted or discharged.

Subsection 5015.9 is deleted in its entirety.

Subsection 5015.12 is amended to read as follows:

5015.12 All reimbursable claims for PCA services shall include the NPI numbers for the:

(a) Billing Provider;

(b) Physician or Advanced Practice Registered Nurse (APRN) who ordered the PCA services;

(c) Staffing agency, if applicable; and

(d) PCA who provided the PCA services, regardless of whether the PCA is an employee of the Provider or is from another staffing agency.

Section 5099 is amended to read as follows:

5099 DEFINITIONS

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

Activities of Daily Living - The ability to bathe, transfer, dress, eat and feed oneself, engage in toileting, and maintain bowel and bladder control (continence).

Advanced Practice Registered Nurse - A person who is licensed or authorized to practice as an advanced practice registered nurse pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2016 Repl.)).

Authorized representative – Any person other than a provider:

(a) Who is knowledgeable about a beneficiary's circumstances and has been designated by that beneficiary to represent him or her; or

(b) Who is legally authorized either to administer a beneficiary's financial or personal affairs or to protect and advocate for his/her rights.

Cueing - Using verbal prompts in the form of instructions or reminders to assist persons with activities of daily living.

Department of Health Care Finance – The executive agency of the government responsible for administering the Medicaid program within the District of Columbia, effective October 1, 2008.

Family - Any person related to the beneficiary by blood, marriage, or adoption.

Licensed Independent Clinical Social Worker– A person who is licensed or authorized to practice as an independent clinical social worker 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.* (2016 Repl.)).

Limited English Proficient - Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak or understand English.

Order – A formal, written instruction signed by a physician or APRN in the form of the Prescription Order Form or any successor document supplied by DHCF or its agent.

PCA Service Authorization Form – A form that has been developed or approved by DHCF that identifies the amount, duration and scope of PCA services and the number of hours authorized based upon a face-to-face assessment in accordance with § 5003.

Physician - A person who is licensed or authorized to practice medicine 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.* (2016 Repl.)).

Registered Nurse - A person who is licensed or authorized to practice registered 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 §§ 3-1201 *et seq.*), as amended, or licensed as a registered nurse in the jurisdiction where services are provided.

Significant change - Changes in a beneficiary's health status that warrants an increase of decrease of supports/services outlined in their plan of care.

Staffing Agency – Shall have the same meaning as set forth in the Nurse Staffing Agency Act of 2003, effective March 10, 2004 (D.C. Law 15-74; D.C. Official Code §§ 44-1051.01 *et seq.*).

Start of Care – The first date upon which a beneficiary receives or is scheduled to receive PCA services.

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