DEPARTMENT OF HEALTH

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health, 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), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption of an amendment to section 907 (Personal Emergency Response System Services) of Chapter 9 (Medicaid Program) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR). These rules establish standards governing reimbursement by the District of Columbia Medicaid Program for personal emergency response system (PERS) services provided by professionals to participants with mental retardation and developmental disabilities in the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver).

This rulemaking amends the previously published rules at 50 DCR 4395 (June 6, 2003) by updating the prohibition against concurrent payments to reflect the new Waiver services.

The District of Columbia Medicaid Program also is modifying the Waiver to reflect these changes. The Council of the District of Columbia has approved the corresponding Waiver. The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, has also approved the Waiver with an effective date of November 20, 2007.

A notice of emergency and proposed rulemaking was published in the *DC Register* on December 14, 2007 (54 DCR 012063). No comments on the proposed rules were received. No substantive changes have been made. These rules shall become effective on the date of publication of this notice in the *DC Register*.

Section 907 of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

907 PERSONAL EMERGENCY RESPONSE SYSTEM SERVICES

907.1 Personal emergency response system (PERS) services shall be reimbursed by the District of Columbia Medicaid Program for each participant with mental retardation and developmental disabilities in the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver) subject to the requirements set forth in this section.

907.2 PERS services shall provide access to emergency assistance through a two-way communication system that dials a twenty-four (24) hour response center. The system shall include a console or receiving base, which is connected to the user's telephone, a portable emergency response activator, and a response center that monitors calls.

907.3 PERS services eligible for reimbursement shall include:

(a) In-home installation of all equipment necessary to make the system operational;

(b) Person and caregiver instruction on usage, maintenance, and emergency protocol;

(c) Equipment maintenance;

(d) Twenty-four (24) hour, seven (7) days per week response center monitored by trained operators capable of determining if an emergency exists and notifying emergency services and the person's responder; and

(e) Equipment testing and monitoring.

907.4 PERS services shall only be provided to persons who:

(a) Live alone or who are alone for significant parts of the day;

(b) Have no regular caregiver for extended periods of time;

(c) Would otherwise require extensive routine supervision; and

(d) Have and demonstrate the capacity to understand how properly to use the system.

907.5 PERS services shall:

(a) Have activation by a remote wireless device, such as a portable "help" button to allow for mobility;

(b) Have hands-free voice-to-voice communication with the response center through the PERS console unit;

(c) Be repaired or replaced by the provider within twenty-four (24) hours after the provider has been notified of a malfunction;

(d) Have an emergency response activator that:

(1) Is activated by breath or touch and is usable by persons who have vision or hearing impairments or have a physical disability; and

(2) Will operate during a power failure for a minimum of twenty-four (24) hours; and

(e) Submit to the appropriate Department on Disability Services case manager within twenty-four (24) hours of an emergency signal response, a written repeat detailing, at a minimum, the date and time of each emergency response to a

person receiving PERS services. Emergency signal responses do not include test signals or activations a person made in error.

907.6 All PERS equipment shall comply with all applicable Federal Communication Commission laws, rules, and the applicable Underwriter's Laboratories, Inc. standards.

907.7 The person for whom PERS services are provided shall choose the respondent that will answer emergency calls through the PERS. Respondents may be relatives, friends, neighbors, or medical personal.

907.8 Medical personnel that the person selects to serve as respondents shall be licensed to practice medicine, registered nursing, practical nursing, or physician assistance pursuant to section 501 of the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1205.01), or be licensed to practice their respective profession within the jurisdiction where they provide service.

907.9 PERS services shall be authorized by the interdisciplinary team and provided in accordance with each person's individual habilitation plan (IHP) or individual support plan (ISP) and Plan of Care.

907.10 Each provider of PERS services shall:

(a) Be a non-profit, home health agency, social service agency, or another business entity;

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

(c) Ensure that all staff are qualified and properly supervised;

(d) Ensure that the services provided are consistent with the person's IHP or ISP and Plan of Care; and

(e) Have a plan (or access to necessary personnel) effectively to meet the needs of English speaking, non-English speaking, and non-verbal persons.

907.11 Each person providing PERS services for a provider who will be in direct contact with the person shall meet all of the requirements set forth in section 1911of Title 29 DCMR. In addition, each person providing PERS skills who will be in direct contact with the person also shall have the language and communication skills to respond to emergency contacts (*i.e.*, calling emergency 911 on behalf of the person).

907.12 The billable units for PERS services shall be:

(a) The initial installation; and

(b) The monthly rental and service fee.

907.13 PERS services shall be reimbursed as follows:

(a) Fifty dollars ($50.00) for the initial installation; and

(b) Thirty dollars ($30.00) for the monthly rental and service fee.

907.14 Providers of PERS services shall maintain records related to the provision of PERS services for a period of not less than six (6) years.

907.15 PERS shall not be provided to persons receiving Supported Living Services or Residential Habilitation Services, and shall only be provided in the person's place of residence.

907.99 DEFINITIONS

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

Individual Habilitation Plan (IHP) – That plan as set forth in section 403 of the Mentally Retarded Citizens 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) – The successor to the IHP as defined in the 2001 Plan for Compliance and Conclusion of *Evans v. Williams*.

Interdisciplinary Team – A group of persons with special training and experience in the diagnosis and habilitation of mentally retarded persons and who have the responsibility of performing a comprehensive evaluation of the person while participating in the development, implementation, and monitoring of the person's IHP or ISP and Plan of Care.

Person – An individual with intellectual and developmental disabilities who has been determined eligible to receive services under the Waiver.

Plan of Care – A written service plan that meets the requirements set forth in section 1904.4 of Title 29 DCMR, is signed by the person receiving services, and is used to pre-authorize Waiver services.

Waiver – The Home and Community-based Waiver for Persons with Mental Retardation and Developmental Disabilities as approved by the Council of the District of Columbia (Council) and the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), as may be further amended and approved by the Council and CMS.

DEPARTMENT OF HEALTH

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health, 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), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption of an amendment to repeal Sections 927 (Attendant Care Services), 928 (Adaptive Equipment Services), 938 (Homemaker Services), 939 (Chore Services), 940 (Case Management Services), and 944 (Adult Companion Services) of Chapter 9, "Medicaid Program," to Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR). The repealed sections established standards governing reimbursement by the District of Columbia Medicaid Program for six (6) services that are no longer available as separate services under the Home and Community-based Services Waiver for Persons with Developmental Disabilities (Waiver), which recently was approved by the District of Columbia Council and the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), effective November 20, 2007.

This rulemaking repeals section 927 (Attendant Care Services), previously published at 54 DCR 6429 (June 29, 2007); section 928 (Adaptive Equipment Services), previously published at 50 DCR 6175 (August 1, 2003); section 938 (Homemaker Services), previously published at 50 DCR 7832 (September 19, 2003); section 939 (Chore Services), previously published at 50 DCR 6703 (August 15, 2003); section 940 (Case Management Services), previously published at 50 DCR 2042 (March 7, 2003); and section 944 (Adult Companion Services), previously published at 50 DCR 8188 (October 3, 2003). The six repealed sections identify services that are included as a blend of services within the twenty-five (25) Waiver services that are available to participants in the new Waiver as approved by the CMS (*i.e.* Attendant Care Services, Homemaker Services, Chore Services, and Adult Companion), are available under the State Plan for Medical Assistance only (*i.e.* Adaptive Equipment Services), or are no longer reimbursable as a separate service (*i.e.* Case Management Services). Providers must bill the Medicaid Program within 180 days of the date of service for the repealed services, since these services will not be available separately under the Waiver on or after November 20, 2007. Residential Habilitation Services under section 946, Supported Living Services under section 993, and In-Home Supports Services under section 1916, provides a blend of the previously-available services under the former Waiver (*i.e.* Attendant Care Services, Homemaker Services, Chore Services, Adult Companion Services, Personal Care Services under section 1910 and the State Plan for Medical Assistance) that under the new Waiver will be delivered based on the individual habilitation plan or individual supports plan and plan of care developed by the person and his/her support team.

A notice of emergency and proposed rulemaking was published in the *DC Register* on December 28, 2007 (54 DCR 012667). No comments on the proposed rules were received. No substantive changes have been made. These rules shall become effective on the date of publication of this notice in the *DC Register*.

Section 927 (Attendant Care Services) of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

927 **[REPEALED]**

Section 928 (Adaptive Equipment Services) of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

928 **[REPEALED]**

Section 938 (Homemaker Services) of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

938 **[REPEALED]**

Section 939 (Chore Services) of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

939 **[REPEALED]**

Section 940 (Case Management Services) of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

940 **[REPEALED]**

Section 944 (Adult Companion Services) of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

944 **[REPEALED]**

DEPARTMENT OF HEALTH

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health, 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), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption of an amendment to section 932 of Chapter 9 of Title 29 of the District of Columbia Municipal Regulations (DCMR), entitled "Speech, Hearing and Language Services." These rules establish standards governing reimbursement by the District of Columbia Medicaid Program for speech, hearing, and language services provided by licensed or certified speech pathologists or audiologists to participants with mental retardation and developmental disabilities in the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver).

This rulemaking amends the rules previously published at 49 DCR 8716 (September 20, 2002) by adding more effective planning and follow up reporting.

The District of Columbia Medicaid Program also is modifying the Waiver to reflect these changes. The Council of the District of Columbia has approved the corresponding Waiver. The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services has also approved the Waiver effective November 20, 2007.

A notice of emergency and proposed rulemaking was published in the *DC Register* on December 7, 2007 (54 DCR 011740). No comments on the proposed rules were received. No substantive changes have been made. These rules shall become effective on the date of publication of this notice in the *DC Register*.

Section 932 (Speech, Hearing and Language Services) of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

932 SPEECH, HEARING, AND LANGUAGE SERVICES

932.1 Speech, hearing and language services shall be reimbursed by the Medicaid Program for each participant with mental retardation and developmental disabilities in the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver) subject to the requirements set forth in this section.

932.2 To be eligible for reimbursement, speech, hearing, and language services shall be:

(a) Ordered by a physician if the individual has any history of aspiration, swallowing problems, tube feeding, or other medical issues;

(b) Recommended by the interdisciplinary team if the issues are not medical;

(c) Reasonable and necessary to the treatment of the person's illness, injury, or long term disability or to the restoration or maintenance of function affected by the injury, illness or long term disability; and

(d) Included in the person's individual habilitation plan (IHP) or individual support plan (ISP) and Plan of Care.

932.3 Speech, hearing and language services may be used to:

(a) Address swallowing disorders;

(b) Assess communicative disorders;

(c) Assess potential for clearer speech;

(d) Assess potential for use of augmentative and alternative speech devices, methods, or strategies;

(e) Assess potential for sign language or other expressive communication methods;

(f) Conduct environmental reviews of communication in places employment, residence, and other sites as necessary; or

(g) Assist with recovery from a vocal disorder.

932.4 Speech, hearing and language services shall include, as necessary, the following:

(a) A comprehensive assessment to determine the presence or absence of swallowing disorders (dysphagia);

(b) A comprehensive assessment of communicative disorders;

(c) A background review and current functional review of communication capabilities in different environments;

(d) A needs assessment for the use of augmentative and alternative speech devices, methods, or strategies;

(e) A needs assessment for the use of adaptive eating equipment;

(f) Assisting persons with voice disorders to develop proper control of vocal and respiratory systems for correct voice production;

(g) Teaching and training the person, family, provider caregivers, or other caregivers to augment the speech-language communication program; and

(h) Aural rehabilitation by teaching sign language and/or lip reading to people who have hearing loss.

932.5 Speech, hearing and language service providers, without regard to their employer of record, shall be selected by the person receiving services or their guardian or legal representative and shall be answerable to the person receiving services. Any organization substituting practitioners for more than a two (2) week period or four (4) visits due to emergency or lack of availability shall request a case conference with the Department on Disability Services Case Manager in order to arrange for the person receiving services to select a new practitioner.

932.6 The speech, hearing and language service provider shall be responsible for providing written documentation in the form of reports, assessments for speech, hearing and language services, physician's orders, visitation notes, progress notes, and other pertinent documentation of the person's progress or lack of progress, medical conditions, functional losses, and treatment goals that demonstrate that the services are and continue to be reasonable and necessary. The documentation shall include evidence that services did not exceed the authorized frequency and duration. The agency or speech, hearing and language service provider in private practice shall maintain a copy of the documentation for at least six (6) years after the person's date of service.

932.7 Each person providing speech, hearing and language services shall be an employee of a home health agency or social service agency or a speech pathologist or audiologist in private practice with a current District of Columbia Medicaid Provider Agreement that authorizes the provider to bill for Speech, Hearing and Language Services under the Waiver.

932.8 In addition to the other requirements of this section, the speech pathologist or audiologist in 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) If services are provided in a private practice office space, the space

shall be owned, leased or rented by the private practice and be used exclusively for the purpose of operating the private practice; and

(e) An assistant or aide shall be personally supervised by the speech pathologist or audiologist and employed by the speech pathologist or audiologist, by the partnership group to which the speech pathologist or audiologist belongs, or by the same private practice that employs the speech pathologist or audiologist. Personal supervision requires the speech pathologist or audiologist to be in the room during the performance of the service.

932.9 Each person providing speech, hearing and language services shall be a speech pathologist or audiologist who meets all of the following requirements:

(a) Have the ability to develop and implement a plan of care based on an assessment of the person's speech, hearing and language needs;

(b) Have a minimum of two (2) years of experience as a speech pathologist or audiologist;

(c) Be acceptable to the person to whom services are provided;

(d) Demonstrate annually that he or she is free from communicable disease as confirmed by an annual PPD Skin Test or documentation from a physician;

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

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

(h) Comply with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, as amended, effective April 13, 2002 (D.C. Law 14-98; D.C. Official Code § 44-551 *et seq.*).

932.10 The reimbursement rate for speech, hearing and language services assessments shall be sixty-five dollars ($65.00) an hour for a full assessment of the person, preparation of summary documentation, and delivery of that documentation. 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. The tasks shall include updating medical records and verifying that the documentation was delivered to the primary care physician (as necessary), DDS Case Manager, and the place of residence of the person receiving services.

932.11 The reimbursement rate for ongoing speech, hearing and language services shall be sixty-five dollars ($65.00) per hour for the period specified in the speech, hearing and language report and approved by a physician for treatment of a swallowing disorder. 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.

932.12 For persons between the ages of 18 and 21 years old, Early Periodic Screening and Diagnostic Treatment services under the District of Columbia State Plan for Medical Assistance shall be fully utilized before accessing speech, hearing and language services under the Waiver.

932.99 DEFINITIONS

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

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 Hearing Language Association or is licensed or certified as an audiologist in the state where the services are provided.

Clinical Record – A comprehensive compilation of medical and other data that identifies the person and justifies and describes the diagnosis and treatment of the person.

EPSDT – Early and Periodic Screening, Diagnostic, and Treatment Services are 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.

Individual Habilitation Plan (IHP) – That plan as set forth in section 403 of the Mentally Retarded Citizens 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) – The successor to the individual habilitation plan (IHP) as defined in the 2001 Plan for Compliance and Conclusion of *Evans v. Williams*.

Physician – A person who is 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.*) or licensed as a physician in the jurisdiction where services are provided.

Person – An individual with intellectual and developmental disabilities who has been determined eligible to receive services under the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver).

Plan of Care – A written service plan that meets the requirements set forth in section 1904.4 of Title 29 DCMR, is signed by the person receiving services, and is used to prior authorize Waiver services.

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.

Progress Note – A dated, written notation by a member of the health care team that summarizes facts about a person's care and response to treatment during a given period of time.

Provider – Any non-profit, home health agency, social service agency or other business entity that provides services pursuant to these rules.

Speech Pathologist – A person who meets the education and experience requirements for a Certificate of Clinical Competence in the areas of speech pathology granted by the American Speech Hearing Language Association or is licensed or certified as a speech pathologist in the state where the services are provided.

Waiver – Shall mean the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities as approved by the Council of the District of Columbia (Council) and the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), as may be further amended and approved by the Council and CMS.

DEPARTMENT OF HEALTH

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health, 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. 774; D.C. Official Code § 1-307.02), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption of an amendment to section 937 of Chapter 9 of Title 29 of the District of Columbia Municipal Regulations (DCMR), entitled "Preventive, Consultative and Crisis Support Services." These rules establish standards governing reimbursement by the District of Columbia Medicaid Program for preventive, consultative and crisis support services provided by health care professionals to participants with mental retardation and developmental disabilities in the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver).

The former Preventative, Consultative and Crisis Support Services rules incorporates two discrete services into a single rule: preventive and consultative services, which focus on long-term behavioral support, and crisis services, which focuses on short-term response to an immediate crisis. This rule amends the previously published rules at 54 DCR 2348 (March 16, 2007), by changing the name of the services to Behavioral Support Services, by focusing on the preventive and consultative services while removing some of the crisis services which will be duplicative of Community Support Team Services, and by modifying the rate structure that covers professionals, paraprofessionals, and other staff.

The District of Columbia Medicaid Program also is modifying the Waiver to reflect these changes. The Council of the District of Columbia has approved the corresponding Waiver. The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services have also approved the Waiver with an effective date of November 20, 2007.

A notice of emergency and proposed rulemaking was published in the *DC Register* on December 14, 2007 (54 DCR 012074). Comments were untimely received and considered. No substantive changes have been made. These rules shall become effective on the date of publication of this notice in the *DC Register*.

Section 937 (Preventive, Consultative and Crisis Support Services) of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

937 BEHAVIORAL SUPPORT SERVICES

937.1 Behavioral support services shall be reimbursed by the District of Columbia Medicaid Program for each person in the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver) subject to the requirements set forth in this section.

937.2 Behavioral support services are services designed to support and encourage the person in his or her decision to reside within the community; decrease the impact of a behavioral event; assist the person in developing alternative and more effective communication, adaptive and coping mechanisms; and enable the person to achieve positive personal outcomes. These services shall be available to all Waiver-eligible persons to prevent any unnecessary change in placement; placement in a more restrictive environment; prevent a psychiatric hospitalization; enhance the person's ability to lead a more typical life; and support the positive development of community living skills and social relationships.

937.3 Behavioral support services shall be authorized and provided in accordance with each person's Individual Habilitation Plan (IHP) or Individual Support Plan (ISP) and Plan of Care. To qualify for this service, each person must be referred by the support team to address specific behavioral support needs that jeopardize the person's health and welfare, and/or interfere with the person's ability to gain independent living skills.

937.4 To be eligible for any additional behavioral support services, the provider shall develop a Diagnostic Assessment that is a clinical and functional evaluation of a person's psychological and behavioral condition. Based on this evaluation, the provider shall develop a Diagnostic Assessment Report, including recommendations as to whether to continue or discontinue services. The Diagnostic Assessment shall also determine whether the person may benefit from a Behavior Support Plan (BSP), based upon the person's presenting problems and behavioral goals. The Diagnostic Assessment shall also evaluate the person's level of readiness and motivation to respond to behavioral intervention. The Diagnostic Assessment Report shall include the following information:

(a) The names of individuals to contact in the event of a crisis;
(b) Conflict resolution counseling and problem solving strategies used to date and their effectiveness;
(c) A written evaluation, including a full description of the target behavior; antecedents to the target behavior; history of reinforcers used and their effectiveness; environmental contributors to the target behavior; contributing medical and psychiatric diagnoses; and proposed interventions as needed; and
(d) Recommendation for any needed continuing services.

937.5 Development of the required plan set forth in section 937.4 shall be based on the following activities:

(a) Interviews with the person and his/her support staff as well as others as appropriate;
(b) Observations of the person at his/her residence and in the community;

(c) Conversations with family members, friends and other professionals;
(d) Review of all available and pertinent data;
(e) Interpreting results of laboratory or other medical diagnostic studies; and
(f) Medical and psychiatric history.

937.6 If the Diagnostic Assessment requires development of a BSP, that plan shall be consistent with the following guideline:

The goal of developing and implementing a Behavior Support Plan is to identify techniques and strategies that will build on a person's skills, abilities, and motivations to help him or her develop positive alternatives to identified challenging behavior. The BSP should emphasize positive, proactive and effective strategies, and should minimize and seek to eliminate the use of restricted or intrusive procedures for the individual and circumstance. The BSP may also include the limited use of restrictive procedures, but only with the consent and approval of the person and/or their guardian, the agreement of the individual's support team, and the written approval of the Department on Disability Services (DDS) Human Rights Committee or its Restricted Control Review Committee. The form for including the use of restricted controls is available from DDS. A formal BHP includes:

(a) A description of the techniques for gathering information;
(b) The goals of the BSP;
(c) Strategies for positive behavior support;
(d) Requirements for training staff and other caregivers;
(e) Support strategy tracking documentation;
(f) Review schedule of BSP progress toward goals; and
(g) Regular (at least quarterly) professional assessments of BSP progress toward goals.

937.7 Ongoing behavioral support services eligible for reimbursement include, but shall not be limited to, the following services:
(a) Training to create positive environments and coping mechanisms, as well as developing interventions, teamwork, and evaluation strategies to assess the effectiveness of interventions;
(b) Consultative services to assist in the development of person-specific strategies; and
(c) Follow-up services, including personal progress assessment.

937.8 Behavioral support services shall be available to family members, service providers, or other individuals that provide support and/or services to the person.

937.9 Behavioral support services may be provided to supplement traditional medical and clinical services available under the District of Columbia State Plan for Medical Assistance.

937.10 Each provider of behavioral support services shall be:

(a) An independent professional in private practice as defined in Title 29 DCMR, Chapter 19, General Provisions, Section 1903.2;
(b) A Freestanding Mental Health Clinic as defined in Chapter 8 of Title 29 DCMR;
(c) Employed by a home health agency as defined in Title 29 DCMR, Chapter 19,General Provisions, Section 1903.3; or
(d) Employed by a social service agency as defined in Title 29 DCMR, Chapter 19, General Provisions, Section 1903.

937.11 The agency or therapist in private practice shall have a current Medicaid Provider Agreement that authorizes the service provider to bill for behavioral support services. Persons authorized to provide all services without supervision shall be as follows:

(a) Psychologist;
(b) Psychiatrist;
(c) Licensed Independent Clinical Social Worker;
(d) Advance Practice Registered Nurse or Nurse-Practitioner;
(e) Licensed Professional Counselor;
(f) Licensed Graduate Social Worker; and
(g) Certified Behavior Analysts® in jurisdictions where that credential is accepted.

937.12 Persons authorized to provide behavioral support services under the supervision of qualified practitioners set forth in section 937.11 shall be as follows:

(a) Registered Nurse;
(b) Behavior Management Specialists; and
(c) Associate Behavior Analysts® in jurisdictions where that credential is accepted.

937.13 Each professional in section 937.11 shall have at least one (1) year of experience in a setting providing habilitation and positive behavioral support services to persons with developmental disabilities and possess professional knowledge of psychological principles, theories, and methods with an ability to develop and implement treatment and behavior support plans.

937.14 Each non-licensed professional in section 937.12 shall have a minimum of one (1) year of experience developing, implementing, and monitoring behavior

intervention plans and developing effective positive behavioral interventions aimed at reducing and replacing challenging behaviors with more typical and appropriate ones.

937.15 Diagnostic Assessments shall be requested as a service in the IHP or ISP and Plan of Care. All other services in this rule shall be authorized based on the recommendations of a Diagnostic Assessment completed within the previous eighteen (18) months.

937.16 The reimbursement rate for each Diagnostic Assessment under section 937.4 shall be two hundred forty dollars ($240.00) and shall be at least three (3) hours in duration, including the development of the written Diagnostic Assessment.

937.17 The reimbursement rate for the development of the BSP under section 937.5 and professional follow-up visits performed by professionals under section 937.10 shall be one hundred three dollars and twenty cents ($103.20) per hour.

937.18 The reimbursement rate for the development of ongoing behavioral support services under section 937.6 shall be sixty dollars ($60.00) per hour.

937.19 Individualized supervision shall be permitted with prior authorization of the DDS Human Rights Committee and shall be reimbursed at the hourly rate of twenty-two dollars ($22.00) for behavioral support one-to-one services. These behavioral support one-to-one services shall be provided by an intensive behavioral support direct care paraprofessional and shall be formally reviewed every three (3) months by the behavioral support services provider, and the reports shall be submitted to the DDS Human Rights Committee and Case Management. To be eligible for reimbursement for behavioral support one-to-one services, the person shall be required to have a Behavioral Support Plan (BSP) and shall meet at least one of the characteristics set out in section 979.12 for paraprofessional one to one services. For purposes of this section 937.19, in addition to the requirements for paraprofessional one-to-one services as set out in section 979.99, behavioral support one-to-one services means services provided to one person exclusively by a behavioral support services provider who has been trained in all general requirements, who possesses specialized training in physical management techniques and positive behavior support practices, and who possesses all other training required to implement the person's specific BSP, including behavioral and/or clinical protocols, for a pre-authorized length of time.

937.99 DEFINITIONS

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

Advanced Practice Registered Nurse or Nurse-Practitioner – A person who is licensed to practice as a 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.*), and meets the additional licensure requirements for practice in a particular area as an advance practice registered nurse or nurse-practitioner in accordance with D.C. Official Code § 3-1206.08(a) or (c), or is licensed as a registered nurse and meets additional national certification standards for practice in a particular area as an advance practice registered nurse or nurse-practitioner in the jurisdiction where services are provided.

Behavioral support services – Services that are designed as an ongoing preventive and consultative service to improve and maintain outcomes in the health, attitude and behavior of the person.

Certified Behavior Analysts® – A person who meets the Behavior Analyst Certification Board (BCBA®) requirements to become a Board Certified Behavior Analyst.

Associate Behavior Analysts® – A person who meets the Behavior Analyst Certification Board (BCABA®) requirements to become a Board Certified Associate Behavior Analyst.

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

Diagnostic Assessment – Includes (1) indirect assessment techniques such as interviews, written record reviews and questionnaires; (2) direct assessment techniques such as observation of the person, documentation of the frequency, duration and intensity of problem behaviors; and (3) the evaluation of the relationship between the environmental and emotional variables and the occurrence of problem behaviors.

Freestanding mental health clinic – The same meaning as set forth in Chapter 8 of Title 29 DMCR.

Individual Habilitation Plan (IHP) – That plan as set forth in section 403 of the Mentally Retarded Citizens 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) – The successor to the individual habilitation plan (IHP) as defined in the 2001 Plan for Compliance and Conclusion of *Evans v. Williams*.

Licensed Graduate Social Worker – A person who is licensed as a graduate 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 § 3-1202 *et seq.*)

or licensed as a graduate social worker in the jurisdiction where the services are being provided.

Licensed Independent Clinical Social Worker – A person who is licensed 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 § 3-1202 *et seq.*) or licensed as an independent clinical social worker in the jurisdiction where the services are being provided.

Licensed Professional Counselor – A person who is licensed to practice professional 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 § 3-1202 *et seq.*) or licensed as a professional counselor in the jurisdiction where the services are being provided.

Person – An individual with intellectual and developmental disabilities who has been determined eligible to receive services under the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver).

Plan of Care – A written service plan that meets the requirements set forth in section 1904.4 of Title 29 DCMR, is signed by the person receiving services, and is used to prior authorize Waiver services.

Private Practice – An individual whose practice is an unincorporated solo practice or unincorporated partnership. Private practice also includes an individual who is practicing as an employee of an unincorporated practice, a professional corporation, or other incorporated 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 behavior support services in the provider's reimbursement rate.

Psychiatrist – A person who is 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 – A person who is 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.

Registered Nurse – A person who is licensed as a 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 § 3-1202 *et seq.*), or licensed as a registered nurse in the jurisdiction where the services are being provided.

Regular Work Hours – The hours of 9:00 a.m. to 5:00 p.m., Monday through Friday, except days determined to be holidays by the District of Columbia government.

Waiver – The Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities as approved by the Council of the District of Columbia (Council) and the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), as may be further amended and approved by the Council and CMS.

DEPARTMENT OF HEALTH

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health, 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), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption of an amendment to section 945 of Chapter 9 of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR), entitled "Day Habilitation Services." These rules establish standards governing reimbursement by the District of Columbia Medicaid Program for Day Habilitation Services, a habilitative service provided by qualified professionals to participants with mental retardation and developmental disabilities in the Home and Community-based Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver).

This rulemaking amends the rules previously published at 54 DCR 2356 (March 16, 2007) by reducing the billing rate based on the new rate methodology. The rules have also been modified to increase the daily limit of service provision to eight (8) hours, to establish a minimum staffing ratio, and to require the development of a service plan with identified outcomes that will more clearly define the service being provided.

The District of Columbia Medicaid Program is also modifying the Waiver to reflect these changes. The Council of the District of Columbia has approved the corresponding Waiver. The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services with an effective date of November 20, 2007.

A notice of emergency and proposed rulemaking was published in the *DC Register* on November 9, 2007 (54 DCR 010860). No comments on the proposed rules were received. No substantive changes have been made. These rules shall become effective on the date of publication of this notice in the *DC Register*.

Section 945 (Day Habilitation Services) of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

945 DAY HABILITATION SERVICES

945.1 Day habilitation services shall be reimbursed by the Medicaid Program for each participant with mental retardation and developmental disabilities in the Home and Community-based Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver) subject to the requirements set forth in this section.

945.2 To be eligible for day habilitation services under the Waiver, an individual must have demonstrated personal and/or social adjustment needs which

can be acquired or maintained through participation in an individualized habilitation program.

945.3 Day habilitation services are intended to be different and separate from residential services. Day habilitation services shall be designed to support the person, whenever possible, outside the home through training and skills development, which enable the person to experience greater participation in community integrated activities and to move to the most integrated vocational setting appropriate to his or her needs.

945.4 If services are provided in the person's home, the day habilitation provider must provide documented evidence to the Department on Disability Services (DDS) that providing day habilitation services in the person's home is necessitated by the person's medical or safety needs and is consistent with the Health Care Management Plan (HCMP) and Individual Habilitation Plan (IHP) or Individual Support Plan (ISP) and Plan of Care. When persons are provided services in their homes, out-of-home activities should be provided in keeping with health and safety needs. In addition, there should be a written plan included in the IHP or ISP for activities in the home, and that plan should address the goals of transitioning the person to receive day services outside the home to the maximum extent possible and as health and safety permit.

945.5 Day habilitation services eligible for reimbursement shall be as follows:

(a) Training and skills development that increases participation in community activities and fosters independence;
(b) 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;
(d) Training in the safe and effective use of one or more modes of accessible public transportation; and
(e) Coordination of transportation to participate in community activities necessary to carry out this service.

945.6 Each day habilitation provider shall develop an IHP for each person that is in keeping with the person's interests, choices, goals and prioritized needs. The activities should be functional, chosen by the person, and provide a pattern of life experiences common to other persons of similar age and the community at large. To develop the plan, the provider shall:

(a) Use observation, conversation, and other interactions as necessary to develop a functional analysis of the person's capabilities within the first month of participation and annually thereafter;

(b) Use the functional analysis, the IHP or ISP and Plan of Care, and other information available to develop a plan with measurable outcomes that develops to the extent possible the skills necessary to enable the person to reside and work in the community while maintaining the person's health and safety; and

(c) On a quarterly basis, report to the person, family, guardian, and DDS Case Manager on the programming and support provided to help the person achieve the outcomes identified in the plan.

945.7 Day habilitation services shall be provided in the most integrated setting appropriate to the needs of each individual and be least restrictive of the person's liberty.

945.8 Day habilitation services may be provided in non-facility- based or facility-based settings as determined by the needs of the person in accordance with the IHP or ISP and Plan of Care. When services are provided in a facility-based setting, each facility shall comply with all applicable federal, District, or state and local laws and regulations.

945.9 Day habilitation services shall be pre-authorized and provided in accordance with the IHP or ISP and Plan of Care. The IHP or ISP and Plan of Care shall indicate if the staffing plan requires the participation of a licensed professional and identify the type of professional to provide the service in accordance with the person's needs.

945.10 Each professional providing day habilitation services shall be licensed to practice his or her respective profession 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 § 3-1202 *et seq.*) or be licensed to practice his or her profession in the jurisdiction where services are provided.

945.11 A copy of the person's IHP or ISP and Plan of Care shall be maintained by the day habilitation provider.

945.12 Each provider shall:

(a) Be a public or private agency licensed to do business in the District of Columbia, Maryland or Virginia, if required;

(b) Have a current District of Columbia Medicaid Provider Agreement that authorizes the provider to bill for Day Habilitation Services;

(c) Ensure that all staff are qualified and properly supervised;

(d) Ensure that the service provided is consistent with the person's IHP or ISP and Plan of Care, and that services are coordinated with all other providers;

(e) Develop a quality assurance system to evaluate the effectiveness of services provided;
(f) Maintain the required staff-to-person ratio, indicated on the person's IHP or ISP and Plan of Care, to a maximum staffing ratio of 1:4;
(g) Participate in the annual IHP or ISP and Plan of Care meeting or case conferences when indicated;
(h) Ensure that services are provided appropriately and safely;
(i) Develop a staffing plan which includes licensed professionals, where applicable and appropriate;
(j) Maintain records which document staff training and licensure, for a period of not less than ten (10) years;
(k) Offer the Hepatitis B vaccination to each person providing services, pursuant to these rules;
(l) Provide training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor, as set forth in 29 C.F.R. § 1910.1030; and
(m) Provide interpreters for non-English speaking persons and those with hearing impairments that are enrolled in the program.

945.13 Each provider of day habilitation services shall provide appropriate supervision of all day habilitation staff. The supervisor shall be an employee of the day habilitation services provider and make site visits to assess the level of services provided. Periodic site visits shall be conducted and documented at least four (4) times per year and more frequently, if warranted.

945.14 Each person providing day habilitation services for a provider under section 945.12 shall meet all of the following requirements:

(a) Be at least eighteen (18) years of age;
(b) Be acceptable to the person to whom services are provided;
(c) Demonstrate annually that he or she is free from communicable disease as confirmed by an annual PPD Skin Test or documentation from a physician;
(d) Have a high school diploma or general educational development (GED) certificate;
(e) Have at least one (1) year of experience working with persons with mental retardation and developmental disabilities;
(f) Agree to carry out the responsibilities to provide services consistent with the person's IHP or ISP and Plan of Care;
(g) Complete pre-service and in-service training approved by DDS;
(h) Have the ability to communicate with the person to whom services are provided;
(i) Be able to read, write, and speak the English language; and

(j) 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), 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.*).

945.15 Day habilitation services shall not be provided concurrently with day treatment, supported employment, or prevocational services.

945.16 The reimbursement rate for day habilitation services shall be fifteen dollars and eighty cents ($15.80) per hour. Services shall be provided for a maximum of eight (8) hours per day, and shall not include travel time. The billable unit of service for 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. The reimbursement rate for day habilitation services shall be three dollars and ninety-five cents ($3.95) per billable unit. Provisions shall be made by the provider for participants who arrive early and depart late.

945.17 No payment shall be made for routine care and supervision, which is the responsibility of the family, residential provider, or employer.

945.99 DEFINITIONS

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

Communicable Disease – Shall have the same meaning as set forth in section 201 of Chapter 2 of Title 22, District of Columbia Municipal Regulations.

Family – Any person who is related to the person receiving services by blood, marriage, or adoption.

Individual Habilitation Plan (IHP) – That plan as set forth in section 403 of the Mentally Retarded Citizens 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) – The successor to the individual habilitation plan (IHP) as defined in the 2001 Plan for Compliance and Conclusion of *Evans v. Williams*.

Person – An individual with intellectual and developmental disabilities who has been determined eligible to receive services under the Home and Community-based Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver).

Plan of Care – A written service plan that meets the requirements set forth in section 1904.4 of Chapter 19 of Title 29 DCMR, is signed by the person receiving services, and is used to pre-authorize Waiver services.

Provider – Any non-profit, home health agency, social service agency, or other business entity that provides services pursuant to these rules.

Waiver – Shall mean the Home and Community-based Waiver for Persons with Mental Retardation and Developmental Disabilities as approved by the Council of the District of Columbia (Council) and the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), as may be further amended and approved by the Council and CMS.

DEPARTMENT OF HEALTH

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health, 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), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption of an amendment to section 945 (Day Habilitation Services) of Chapter 9 (Medicaid Program) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR). These rules establish standards governing reimbursement by the District of Columbia Medicaid Program for day habilitation services, a habilitative service provided by qualified professionals to participants with mental retardation and developmental disabilities in the Home and Community-based Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver), which was approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), with an effective date of November 20, 2007.

This rulemaking amends the rules previously published at 54 DCR 2356 (March 16, 2007), as further amended recently by the notice of emergency and proposed rulemaking published at 54 DCR 10860 (November 9, 2007), to include language to pre-authorize and reimburse day habilitation services providers for professional one-to-one services. The recently published rulemaking reduces the billing rates based on the new rate methodology, increases the daily limit of service provision to eight (8) hours, establishes a minimum staffing ratio, and requires the development of a service plan with identified outcomes that will more clearly define the service being provided. The emergency rulemaking for day habilitation services published on November 9, 2007 at 54 DCR 10860 was effective on November 20, 2007, which was also the effective date of the CMS-approved Waiver.

A notice of emergency and proposed rulemaking was published in the *DC Register* on December 21, 2007 (54 DCR 012364). No comments on the proposed rules were received. No substantive changes have been made. These rules will become effective on the date of publication of this notice in the *DC Register*.

Section 945 of Chapter 9 of Title 29 DCMR is amended to include a new subsection 945.18 to read as follows:

945.18 To the extent pre-authorized by DDS, provided in accordance with the person's IHP or ISP and Plan of Care and DDS's restrictive controls policies and procedures, and otherwise consistent with the requirements of sections 945.7, 945.9 and 945.10, one-to-one services shall be available as a day habilitation service. The reimbursement rate for one-to-one services shall be thirty-one dollars and sixty cents ($31.60). Day habilitation one-to-one services shall be provided for a maximum of eight (8) hours a day, and shall not include travel time. 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. The reimbursement rate for day habilitation one-to-one services shall be seven dollars and ninety cents ($7.90) per billable unit. To be eligible for reimbursement for day habilitation one-to-one services, the person shall be required to have a behavior support plan and meet at least one of the characteristics set out in section 979.12 for paraprofessional one-to-one services and at least one of the characteristics set out in section 979.13 for professional one-to-one services. For purpose of this subsection, in addition to the requirements for paraprofessional one-to-one services and professional one-to-one services as defined in section 979.99, day habilitation one-to-one services means services provided to one person exclusively by a day habilitation services provider who has been trained in all general requirements and possesses all training required to implement the person's specific behavioral and/or clinical protocols and support plans for a pre-authorized length of time.

DEPARTMENT OF HEALTH

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health, 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), Reorganization. Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption of an amendment to Sections 1900 (General Provisions), 1901 (Covered Services), 1903 (Provider Qualifications), and 1999 (Definitions), and of a new Section 1911 (Requirements for Persons Providing Direct Services), of Chapter 19 to Title 29 of the District of Columbia Municipal Regulations (DCMR), entitled "Home and Community-Based Waiver Services for Persons with Mental Retardation and Developmental Disabilities."

This rulemaking amend sections 1900 (General Provisions), 1901 (Covered Services), 1903 (Provider Qualifications), and 1999 (Definitions) of the rules previously published at 51 DCR 10207 (November 5, 2004), in connection with the approval by the District of Columbia Council and the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), effective November 20, 2007, of the new District of Columbia Medicaid Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver). These four sections identify the Waiver as approved by the CMS, specify the twenty-five (25) Waiver services that are available to participants, set forth provider qualifications, and provide updated definitions. In addition, this rulemaking amends Chapter 19 by including a new section 1911 to set forth minimum standards for persons providing direct services to Waiver participants.

A notice of emergency and proposed rulemaking was published in the *DC Register* on December 28, 2007 (54 DCR 012691). No comments on the proposed rules were received. No substantive changes have been made. These rules shall become final upon publication of this notice in the *DC Register*.

Section 1900 (General Provisions) of Chapter 19 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

1900 GENERAL PROVISIONS

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

1900.2 The Waiver is authorized pursuant to section 1915 (c) of the Social Security Act, approved by the Centers for Medicare and Medicaid Services of the

United States Department of Health and Human Services (CMS), and shall be effective through November 19, 2012, plus any extensions thereof.

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

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

Section 1901 (Covered Services) of Chapter 19 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

1901 COVERED SERVICES

1901.1 Services available under the Waiver shall include the following:

(a) Behavioral Supports, as set forth in section 937 of Title 29 DCMR;
(b) Community Support Team, as set forth in section 1912 of Title 29 DCMR;
(c) Day Habilitation, as set forth in section 945 of Title 29 DCMR;
(d) Dental, as set forth in section 936 of Title 29 DCMR;
(e) Environmental Accessibilities Adaptations, as set forth in section 926 of Title 29 DCMR;
(f) Family Training, as set forth in section 942 of Title 29 DCMR;
(g) Host Home, as set forth in section 1915 of Title 29 DCMR;
(h) In-Home Supports, as set forth in section 1916 of Title 29 DCMR;
(i) Live-in Caregiver, as set forth in section 1917 of Title 29 DCMR;
(j) Nutrition Evaluation and Consultation, as set forth in section 930 of Title 29 DCMR;
(k) Occupational Therapy, as set forth in section 935 of Title 29 DCMR;
(l) One-time Transitional, as set forth in section 1913 of Title 29 DCMR;
(m) Personal Care Services as an extended service under the State Plan for Medical Assistance as set forth in sections 5004 and 1910 of Title 29 DCMR;
(n) Personal Emergency Response System (PERS), as set forth in section 907 of Title 29 DCMR;
(o) Physical Therapy, as set forth in section 934 of Title 29 DCMR;
(p) Prevocational, as set forth in section 920 of Title 29 DCMR;
(q) Professional Services, as set forth in section 1918 of Title 29 DCMR
(r) Residential Habilitation, as set forth in section 946 of Title 29 DCMR,
(s) Respite, as set forth in section 994 of Title 29 DCMR;
(t) Skilled Nursing, as an extended service under the State Plan for Medical Assistance and as set forth in section 933 of Title 29 DCMR;

(u) Speech, Hearing and Language, as set forth in section 932 of Title 29 DCMR;
(v) Supported Employment, as set forth in section 929 of Title 29 DCMR;
(w) Supported Living, as set forth in section 993 of Title 29 DCMR;
(x) Transportation, as set forth in section 943 of Title 29 DCMR; and
(y) Vehicle Modifications, as set forth in section 1914 of Title 29 DCMR.

Section 1903 (Provider Qualifications) of Chapter 19 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

1903 PROVIDER QUALIFICATIONS

1903.1 Social Service Agency or Sole Proprietor Agency applicants shall complete an application to participate in the Medicaid Waiver program and shall submit to DDS both the application and following organizational information:

(a) A description of ownership and a list of major owners or stockholders owning or controlling five (5) percent or more outstanding shares;
(b) A list of Board members and their affiliations;
(c) A roster of key personnel, with qualifications, resumes, and a copy of their position descriptions;
(d) A copy of the most recent audited financial statement of the organization;
(e) A completed copy of the waiver provider application;
(f) A copy of the basic organizational documents of the provider, including an organizational chart, and current Articles of Incorporation or partnership agreement, if applicable;
(g) A copy of the Bylaws or similar documents regarding conduct of the provider's internal affairs;
(h) A copy of the business license and or certificate of good standing;
(i) A copy of professional/business liability insurance of at least one (1) million dollars;
(j) Organizational policies and procedures, such as personnel policies and procedures, human rights, incident reporting, behavioral support policies, staff training, protection of consumer funds, and others as required by DDS;
(k) A continuous quality improvement plan; and
(l) Any other documentation deemed necessary to support the approval as a provider.

1903.2 Professional service provider applicants who are in private practice as an independent practitioner shall complete an application to participate in the Medicaid Waiver program and shall agree to:

(a) Maintain a private office, even if services are always furnished in the home of the person receiving services;
(b) Meet all state and local licensure laws and rules;
(c) Maintain at least one (1) million dollars in liability insurance;
(d) Ensure that services provided are consistent with the individual habilitation plan (IHP) or individual service plan (ISP) and Plan of Care;
(e) Ensure that, if services are furnished in a private practice office space, that space shall be owned, leased, or rented by the private practice and shall be used for the exclusive purpose of operating the private practice; and
(f) Personally 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. Personal supervision requires the independent practitioner to be in the room during the performance of the service.

1903.3 Home Health Agency or Skilled Nursing Service provider applicants shall complete an application to participate in the Medicaid Waiver program and shall meet the definitions and licensure requirements to participate as a Home Health Agency or Skilled Nursing Service as follows:

(a) 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; and
(b) Skilled Nursing Service – 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.*), and implementing rules.

1903.4 Each service provider under the Waiver for which transportation is included in the Waiver service shall:

(a) Ensure that each vehicle used to transport an individual has valid license plates;
(b) Ensure that each vehicle used to transport an individual has at least the minimum level of motor vehicle insurance required by law;
(c) Present each vehicle used to transport an individual for inspection by a certified inspection station every six months (or as required in the jurisdiction where the vehicle is registered) and provide proof that the

vehicle has passed the inspection by submitting a copy of the Certificate of Inspections to DDS upon request;

(d) Ensure that each vehicle used to transport an individual is maintained in safe, working order,

(e) Ensure that each vehicle used to transport an individual meets the needs of the individual;

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

(g) Ensure that each vehicle used to transport an individual has operational seat belts;

(h) Ensure that each vehicle used to transport an individual has temperature conducive to comfort;

(i) Ensure that each vehicle used to transport an individual is certified by the Washington Metropolitan Area Transit Commission;

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

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

(l) Ensure that each individual 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 person providing services meet the requirements set forth in section 1911 of these rules; and

(o) Ensure that each person providing services be certified in cardiopulmonary resuscitation and First Aid.

1903.5 MAA shall notify each prospective provider, in writing, of the approval or disapproval to become a provider of Waiver services, no later than fifteen (15) days of receipt of all required documentation. If additional information is requested by MAA, the provider shall have thirty (30) days from the date of the request to submit the additional information. If an application is disapproved, the notice shall set forth the reason for disapproval. Failure to submit all required documentation may result in disapproval.

1903.6 Each provider shall enter into a provider agreement with MAA for the provision of Waiver services.

1903.7 The provider agreement shall specify the services to be provided, methods of operation, financial and legal requirements, and identification of the population to be served.

1903.8 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 Basic Assurance Standards Authorization process), and to all policies and procedures promulgated by

DDS that are applicable to providers during the provider's participation in the Waiver program.

1903.9 Each provider shall comply with all applicable provisions of District and federal law and rules applicable to the Title XIX of the Social Security Act, and all District and federal law and rules applicable to the service or activity provided pursuant to these rules.

A new Section 1911 (Requirements for Persons Providing Direct Services) of Chapter 19 of Title 29 DCMR is adopted to read as follows:

1911 REQUIREMENTS FOR PERSONS PROVIDING DIRECT SERVICES

1911.1 The basic requirements for all employees providing direct services are as follows:

(a) Be at least eighteen (18) years of age;
(b) Be acceptable to the person to whom services are provided;
(c) Demonstrate annually that he or she is free from communicable disease as confirmed by an annual PPD Skin Test or documentation from a physician;
(d) Possess a high school diploma or general educational development (GED) certificate;
(e) Complete pre-service and in-service training as required by DDS;
(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; and
(h) 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), 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.*).

Section 1999 (Definitions) of Chapter 19 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

1999 DEFINITIONS

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

Client – An individual who has been determined eligible to receive services under the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities.

Individual Habilitation Plan (IHP) – That plan as set forth in section 403 of the Mentally Retarded Citizens 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) – The successor to the individual habilitation plan (IHP) as defined in the 2001 Plan for Compliance and Conclusion of *Evans v. Williams*.

Intermediate Care Facility for Persons with Mental Retardation – Shall have the same meaning as set forth in section 1905(d) of the Social Security Act.

Mentally retarded – Shall have the same meaning as set forth in D.C. Official Code § 7-1301.03(19).

Quality Assurance Plan – A written plan that describes the process by which the provider shall evaluate the quality and appropriateness of services delivered to each individual. The plan should describe the process and frequency of implementation for identifying, evaluating and resolving any problem related to the services rendered.

Qualified mental retardation professional – Shall have the same meaning as set forth in 42 CFR § 483.430(a).

Plan of Care – A written service plan that meets the requirements set forth in section 1904.4 of Title 29 DCMR, is signed by the person receiving services, and is used to prior authorize Waiver services.

Person or Participant – An individual who has been determined eligible to receive services under the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities.

Person's home – Shall mean the natural home, but shall not include an institutional or residential facility or foster home.

Provider – Any entity that meets the Waiver service requirements, has signed an agreement with MAA to provide those services, and is enrolled by MAA to provide Waiver services.

Registered Nurse – A person 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 § 3-1202 *et seq.*) or licensed as a registered nurse in the jurisdiction where services are provided.

Waiver – Shall mean the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities as approved by the Council of the District of Columbia (Council) and the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), as may be further amended and approved by the Council and CMS.

DEPARTMENT OF HEALTH

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health, 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), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption of an amendment to section 1910 of Chapter 19 of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR), entitled "Personal Care Services." These rules establish standards governing reimbursement by the District of Columbia Medicaid Program for Personal Care Services, a service provided by personal care aides to participants with mental retardation and developmental disabilities in the Home and Community-based Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver).

This rulemaking amends the previously published rules at 52 DCR 11281(December 30, 2005), by establishing standards for personal care services and updating the prohibition against concurrent payments to reflect new Waiver services. Personal care services include assistance with eating, bathing, dressing, personal hygiene and activities of daily living. These personal care services are to be provided as an extension of services under the District of Columbia State Plan for Medical Assistance as set forth in Chapter 50 of Title 29 DCMR, entitled "Medicaid Reimbursement for Personal Care Services," 50 DCR 3957 (May 23, 2003).

The District of Columbia Medicaid Program is also modifying the Waiver to reflect these changes. The Council of the District of Columbia has approved the corresponding Waiver. The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services have also approved the Waiver with an effective date of November 20, 2007.

A notice of emergency and proposed rulemaking was published in the *DC Register* on December 14, 2007 (54 DCR 012082). No comments were received. No substantive changes have been made. These rules shall become effective upon publication of this notice in the *DC Register*.

Section 1910 (Personal Care Services) of Chapter 19 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

SECTION 1910 PERSONAL CARE SERVICES

1910.1 Personal care services shall be reimbursed by the District of Columbia Medicaid Program for each participant in the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities that:

(a) Has exhausted the personal care services of Chapter 50 of Title 29 DCMR Sections 5009.1 and 5009.2; and
(b) Meets the eligibility requirements of Chapter 50 of Title 29 DCMR Section 5005.1.

1910.2 Personal care services shall:

(a) Provide necessary hands-on personal care assistance with the activities of daily living that would maintain a clean, sanitary and safe condition for a participant in the home; and
(b) Encourage home-based care as a preferred and cost-effective alternative to institutional care.

1910.3 Consistent with Chapter 50 of Title 29 DCMR Section 5004.4, personal care services shall only be provided to the person. Personal care services eligible for reimbursement shall include, but shall not be limited to, the following services:

(a) Basic personal care including assistance with bathing and personal hygiene, dressing, grooming, lifting and transferring, feeding, and bowel and bladder care;
(b) Household services including assistance with meal preparation in accordance with dietary guidelines, shopping, cleaning and laundry;
(c) Cognitive services including assistance with money management, use of medications, and providing instructions with adaptive skills;
(d) Mobility services including escorting the person to medical appointments, place of employment, socialization activities, approved recreational activities, and errands;
(e) Changing urinary drainage bags;
(f) Assisting persons with range of motion exercises;
(g) Reading and recording temperature, pulse, respiration, and blood pressure; and
(h) Observing and documenting the person's status and reporting all services provided.

1910.4 Personal care services shall not include services that require the skills of a licensed professional or person certified to perform such functions, such as catheter insertion, administration of medications, or procedures requiring the use of sterile techniques or invasive methods.

1910.5 Personal care services shall be supervised by a registered nurse who is responsible for supervising the delivery of personal care services. The registered nurse shall provide an initial assessment within forty-eight (48) hours of the initiation of services and an on-site assessment at least once

every sixty-two (62) days thereafter, and shall coordinate services and provide documentation consistent with Chapter 50 of Title 29 DCMR Sections 5002.5 and 5002.6.

1910.6 Personal care services shall not be provided in a hospital; nursing facility; intermediate care facility for persons with mental retardation; institution for mental disease; or for persons receiving Residential Habilitation, Supported Living or Host Home Services.

1910.7 Personal care services eligible for reimbursement shall be provided in the following settings:

(a) A home belonging to the person's family, guardian, or other non-paid primary caregiver;
(b) A home that the person owns, leases, or otherwise controls the operation of;
(c) Places of employment;
(d) Medical appointments; or
(e) Locations where the person travels for other services or recreation.

1910.8 Personal care services shall be authorized and provided in accordance with each person's individual habilitation plan (IHP) or individual support plan (ISP) and Plan of Care.

1910.9 Each provider of personal care services shall be a home health agency meeting the conditions of participation for home health agencies set forth in §§ 1861(0) and 1891(e) of the Social Security Act and 42 CFR § 484, and shall comply with the requirements set forth in the Health-Care and Community Residence Facility Act, 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. In addition, the provider agrees to:

(a) Have a current District of Columbia Medicaid Provider Agreement that authorizes the provider to bill for Personal Care Services under the Waiver;
(b) Maintain a copy of the most recent IHP or ISP and Plan of Care that has been approved by DDS for each person;
(c) Ensure that all personal care services staff are qualified and properly supervised to include having a plan to provide staff interpreters for non-English speaking persons;
(d) Maintain a written staffing plan; and
(e) Provide a written staffing schedule for each site where services are provided.

1910.10 Consistent with Chapter 50 of Title 29 DCMR Section 5001.1, providers must maintain at least:

(a) Blanket malpractice insurance for all employees in the amount of at least one million ($1,000,000) dollars per incident; and
(b) General liability insurance covering personal property damages, bodily injury, libel and slander of at least one million ($1,000,000) dollars.

1910.11 Each person providing personal care services shall meet the standards set forth in Chapter 50 of Title 29 DCMR Sections 5003.1 through 5003.3.

1910.12 Personal care services shall not be administered by a spouse, parent or guardian, or any other legally responsible individual who ordinarily would perform or be responsible for performing services on behalf of the person. A family member who is not legally responsible for the individual shall be eligible to administer personal care services. Each family member administering personal care services pursuant to this section shall be employed by a provider under subsection 1910.9, shall meet all of the requirements in Chapter 19 of Title 29 DCMR Section 1911, "Requirements for people providing direct services," and shall meet the standards set forth in Chapter 50 of Title 29 DCMR Sections 5003.1 through 5003.3.

1910.13 Consistent with Chapter 50 of Title 29 DCMR Sections 5006.1 through 5006.6, each provider shall develop and maintain a plan of care. The plan of care shall be available for inspection by representatives of DDS upon request.

1910.14 Consistent with Chapter 50 of Title 29 DCMR Sections 5007.1 through 5007.8, records shall be maintained and available for inspection by representatives of DDS upon request.

1910.15 Consistent with Chapter 50 of Title 29 DCMR Section 5002.9, providers shall notify DDS in writing no less than seven (7) calendar days in advance of discharge.

1910.16 If the person seeks to change providers, the DDS case manager shall assist the person in selecting a new provider. The current provider shall continue to provide services until the transfer has been completed. Each provider shall develop contingency staffing plans to provide coverage to each person in the event that the assigned personal care aide cannot provide the services or is terminated by the provider.

1910.17 The billable unit of service for personal care services shall be one (1) hour. Each provider shall be reimbursed at sixteen dollars and thirty cents

($16.30) per hour for personal care services. Consistent with Chapter 50 of Title 29 DCMR Sections 5009.2 through 5009.5, service limits of eight (8) hours per day and one thousand forty (1040) hours per year shall be maintained. The limits shall not be exceeded without prior authorization for additional hours from DDS.

1910.18 Personal care services shall not be billed concurrently with the following Waiver services:

(a) Prevocational Habilitation;
(b) Residential Habilitation;
(c) Supported Living;
(d) Host Home;
(e) Live-In Caregiver; or
(f) In-Home Supports.

1910.99 DEFINITIONS

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

Activities of daily living – Shall mean the ability to get in and out of bed, bathe, dress, eat, take medications prescribed for self-administration and/or engage in toileting.

Case manager – A professional who assists persons in gaining access to needed Waiver services and other State Plan services, as well as needed medical, social, educational, and other services regardless of the funding source for the service to which access is gained.

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

Group setting – a setting in which two or more persons who are receiving Waiver services reside.

Individual Habilitation Plan (IHP) – That plan as set forth in section 403 of the Mentally Retarded Citizens 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) – The successor to the individual habilitation plan (IHP) as defined in the 2001 Plan for Compliance and Conclusion of *Evans v. Williams, No. 76-293.*

Person – An individual with mental retardation and developmental disabilities who has been determined eligible to receive services under the Home and

Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities.

Person's home – Shall mean the natural home, but shall not include an institutional or residential facility or foster home.

Plan of Care – A written service plan that meets the requirements set forth in section 1904.4 of Title 29 DCMR, is signed by the person receiving services, and is used to prior authorize Waiver services.

Provider – For purposes of this section, any home health agency or social service agency that provides services pursuant to these rules.

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

Waiver – Shall mean the Home and Community-based Waiver for Persons with Mental Retardation and Developmental Disabilities as approved by the Council of the District of Columbia (Council) and the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), as may be further amended and approved by the Council and CMS.

DEPARTMENT OF HEALTH

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health, 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), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption of a new section 1916 of Chapter 19 of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR), entitled "In-Home Supports Services." These rules establish standards governing reimbursement by the District of Columbia Medicaid Program for in-home supports services provided by licensed or supervised professionals to participants with mental retardation and developmental disabilities in the Home and Community-based Services Waiver for Persons with Developmental Disabilities (Waiver), which was approved the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, with an effective date of November 20, 2007.

This is a new rule that was developed from section 993, of Chapter 9 of Title 29 DCMR, entitled "Independent Habilitation Services." The name of this new service under the Waiver has been changed to reflect a new focus. In-home supports services provides a blend of the previously available services under the former Waiver (*i.e.* Homemaker Services, Chore Services, Adult Companion Services, Personal Care Services, Attendant Care Services, and Independent Habilitation) that under the modified Waiver, which was effective November 20, 2007, will be delivered based on an in-home supports plan developed by the person and his or her support team. This service delivery approach will address the problems encountered when multiple provider agencies and support staff were needed to deliver supports in a natural home due to the different provider qualifications and restrictions for each service. The new rule is intended to resolve staffing issues which had made it difficult to effectively support individuals in natural homes. In-home supports services are limited to delivery only in person's natural homes or the home of an unpaid caregiver. The service will be limited to no more than eight (8) hours per day of service, and is not available to participants receiving Host Home, Residential Habilitation or Supported Living Services.

A notice of emergency and proposed rulemaking was published in the *DC Register* on December 21, 2007. (54 DCR 012370) Comments were received and considered. No substantive changes have been made. These rules shall become effective on the date of publication of this notice in the *DC Register*.

New section 1916 (In-Home Supports Services) of Chapter 19 of Title 29 DCMR is added to read as follows:

1916 IN-HOME SUPPORTS SERVICES

1916.1 In-home supports services shall be reimbursed by the District of Columbia Medicaid Program for each participant with mental retardation and

developmental disabilities in the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver) subject to the requirements set forth in this section.

1916.2 A person shall only be eligible for in-home supports services when living in one of the following types of residences:

(a) His or her own home;
(b) The person's family home; or,
(c) The home of an unpaid caregiver.

1916.3 In-home supports services provide periodic support to assist the primary caregiver and/or enable the person to live independently and participate in community activities to the fullest extent possible.

1916.4 In-home supports services include a combination of hands-on care, habilitative support, and assistance with activities of daily living. In-home supports services eligible for reimbursement shall be as follows:

(a) Training and support in activities of daily living and independent living skills;
(b) Assistance in performing personal care tasks;
(c) Assistance with light household tasks specific to the needs of the person;
(d) Assistance with homemaking tasks such as food preparation and laundering clothes that are specific to the needs of the person;
(e) Training and support on understanding and utilizing community resources;
(f) Training on, and assistance in the monitoring of health, nutrition, and physical condition;
(g) Training and support in adapting to a community and home environment, including management of financial and personal affairs, and awareness of health and safety precautions; and
(h) Coordinating transportation to community events.

1916.5 In-home supports services shall not be used to provide supports that are normally provided by medical professionals.

1916.6 In-home supports services shall be authorized by the person's interdisciplinary team and provided in accordance with each person's individual habilitation plan (IHP) or individual support plan (ISP) and Plan of Care.

1916.7 In-home supports services require an In-Home Supports Services Plan (Plan) prior to the initiation of services. A copy of the Plan shall be maintained

where services are delivered, at the provider's main office, and with the Department on Disability Services (DDS) Case Manager. The Plan will detail:

(a) Activities and supports that will be provided and identify anticipated outcomes;
(b) A staffing plan and schedule;
(c) As necessary, the participation of professionals to meet the person's individual needs; and
(d) Emergency and contingency plans to address potential behavioral, health or emergency events.

1916.8 Each provider of in-home supports services shall be a social services agency as described in Chapter 9 of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR), Section 1903.1. In addition, the provider agrees to:

(a) Be a member of the resident's interdisciplinary team;
(b) Have a current District of Columbia Medicaid Provider Agreement that authorizes the provider to bill for In-Home Supports Services under the Waiver;
(c) Maintain a copy of the most recent IHP or ISP and Plan of Care that has been approved by DDS for each person;
(d) Ensure that all in-home support services staff are prepared to facilitate interpreters for non-English speaking persons;
(e) Ensure that the service provided is consistent with the person's IHP or ISP and Plan of Care;
(f) Offer the Hepatitis B vaccination to each person providing services pursuant to these rules;
(g) Provide staff training in infection control procedures consistent with the standards established by the Federal Centers for Disease Control and Prevention; and
(h) Ensure compliance with DDS policies governing reporting of unusual incidents, human rights, behavior management, and protection of person's funds.

1916.9 Each person providing in-home supports services shall meet all of the requirements in Chapter 19 to Title 29 of the District of Columbia Municipal Regulations (DCMR), section 1911 in addition to the requirements set forth below:

(a) Complete competency based training in communication with people with intellectual disabilities;
(b) Complete competency based training in emergency procedures; and
(c) Be certified annually in cardiopulmonary resuscitation (CPR) and First Aid.

1916.10 Each provider of in-home supports services shall maintain progress notes on a weekly basis, or more frequently if indicated, on the IHP or ISP and Plan of Care. The provider shall also maintain current financial records of expenditures of private funds for each person if applicable. Progress notes shall include at a minimum: (a) progress in meeting each goal in the ISP assigned to the in-home supports services provider; (b) list of all community activities the person participates in with the in-home supports provider and the person's response to each activity; (c) any unusual health events, side effect to medication, change in health status, behavioral event, use of a restrictive procedure or unusual incident; (d) any visitor the person receives, special events, and any situation or event requiring follow-up during the delivery of the in-home supports services; and the dates and times services are delivered.

1916.11 Each provider of in-home supports services shall review the person's IHP or ISP and Plan of Care goals, objectives and activities at least quarterly and more often as needed. The provider shall propose modifications to the IHP or ISP and Plan of Care as appropriate. The results of these reviews shall be submitted to the person's DDS Case Manager within 30 days of the end of each quarter (i.e. by January 30th, April 30th, July 30th, and October 30th).

1916.12 The reimbursement rate shall be twenty dollars and sixty cents ($20.60) per hour billable in units of fifteen minutes at a rate of five dollars and fifteen cents ($5.15), and shall not exceed eight (8) hours per 24-hour day. A fifteen minute unit requires a minimum of eight (8) minutes of continuance service to be billed. Reimbursement shall be limited to those time periods in which the provider is rendering services directly to the person. Each provider of in-home supports services shall assist the primary caregiver and/or participant with the coordination of the delivery of necessary day/vocational program, behavioral support, skilled nursing, transportation, and other required services from approved Waiver providers of those services in accordance with the requirements of the IHP or ISP and Plan of Care and the Plan. DDS may authorize an increase in hours in the event of a temporary emergency need for which there is no other resource available or demonstrated need based on the DDS-authorized utilization process.

1916.13 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 natural caregivers;
(c) Services or costs for which payment is made by a source other than Medicaid; or
(d) Travel or travel training to Supportive Employment, Day Habilitation or Pre-Vocational Services.

1916.14 In-home supports services may be used in combination with Medicaid State Plan Personal Care and Home Health Services so long as the services are not provided during the same period of the day.

1916.15 In-home supports services are not available to participants receiving Host Home, Residential Habilitation or Supported Living Services.

1916.99 DEFINITIONS

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

Family – Any individual related to the person by blood, marriage or adoption.

Individual Habilitation Plan (IHP) – That plan as set forth in section 403 of the Mentally Retarded Citizens 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) – The successor to the individual habilitation plan (IHP) as defined in the 2001 Plan for Compliance and Conclusion of *Evans v. Williams*.

In-Home Supports Services Plan – That plan required by these rules prior to the initiation of services which details the activities and supports that will be provided and identify anticipated outcomes; a staffing plan and schedule; as necessary, the participation of professionals to meet the person's individual needs; and emergency and contingency plans to address potential behavioral, health or emergency events.

Interdisciplinary Team – A group of persons with special training and experience in the diagnosis and habilitation of mentally retarded persons who have the responsibility of performing a comprehensive person evaluation while participating in the development, implementation, and monitoring of the person's IHP or ISP and Plan of Care.

Person or Participant– An individual with intellectual and developmental disabilities who has been determined eligible to receive services under the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver).

Plan of Care – A written service plan that meets the requirements set forth in section 1904.4 of Title 29 DCMR, is signed by the person receiving services, and is used to prior authorize Waiver services.

Provider – Any non-profit, home health agency, social service agency or other business entity that provides services pursuant to these rules.

Waiver – Shall mean the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities as approved by the Council of the District of Columbia (Council) and the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), as may be further amended and approved by the Council and CMS.

DEPARTMENT OF HEALTH

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health, 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), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption of a new section 1917 of Chapter 19 of Title 29 of the District of Columbia Municipal Regulations (DCMR), entitled "Live-In Caregiver Services." These rules establish standards governing reimbursement by the District of Columbia Medicaid Program for live-in caregiver services provided by or supervised by direct care staff to participants with mental retardation in the Home and Community-based Services Waiver for Persons with Developmental Disabilities (Waiver), which was approved the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, with an effective date of November 20, 2007.

This is a new rule that authorizes support to persons in the Waiver who own or lease their own home. Live-in caregiver services are provided in the participant's home by a caregiver who lives as a roommate in exchange for room and board. The live-in caregiver also provides needed In-Home Supports Services as detailed in the Plan of Care.

A notice of emergency and proposed rules was published in the *DC Register* on December 21, 2007 (54 DCR 012376). Comments to the proposed rulemaking were received and considered. No substantive changes have been made. These rules shall become effective on the date of publication of this notice in the *DC Register*.

New section 1917 (Live-In Caregiver Services) of Chapter 19 of Title 29 DCMR is added to read as follows:

1917 LIVE-IN CAREGIVER SERVICES

1917.1 Live-in caregiver services shall be reimbursed by the District of Columbia Medicaid Program for each participant with mental retardation and developmental disabilities in the Home and Community-based Services Waiver for Persons with Developmental Disabilities (Waiver) subject to the requirements set forth in this section.

1917.2 A person shall only be eligible for live-in caregiver services when the person is living in his or her own home. Caregiver services shall not be provided by an individual related to the person.

1917.3 Live-in caregiver services provide support to enable persons to live independently and participate in community activities to the fullest extent possible.

1917.4 Live-in caregiver services are provided in the person's home by a caregiver who lives as a roommate in exchange for room and board..

1917.5 The live-in caregiver shall assist in implementing the needed supports as identified in the Plan of Care which enable the person to retain or improve skills related to health, activities of daily living, money management, community resources, community safety and other adaptive skills needed to live in the community.

1917.6 Live-in caregiver services shall be authorized by the person's interdisciplinary team and provided in accordance with each person's individual habilitation plan (IHP) or individual support plan (ISP) and Plan of Care.

1917.7 Live-in caregiver services shall require a Live-In Caregiver Services Agreement (Agreement) prior to the initiation of services. A copy of the Agreement shall be maintained where services are delivered, at the provider's main office, and with the Department on Disability Services (DDS) Case Manager. Revisions to this Agreement shall be done by the Plan of Care Team and may occur at any time at the request of the participant, the Caregiver or the provider.

1917.8 Each provider of live-in caregiver services shall be a provider of residential habilitation services or supported living services. In addition, the provider agrees to:

(a) Be a member of the resident's interdisciplinary team;
(b) Have a current District of Columbia Medicaid Provider Agreement that authorizes the provider to bill for Live-In Caregiver Services under the Waiver;
(c) Maintain a copy of the most recent IHP or ISP and Plan of Care that has been approved by DDS/DDA for each person;
(d) Ensure that all live-in caregiver services staff are prepared to facilitate interpreters for non-English speaking persons;
(e) Ensure that the service provided is consistent with the person's IHP or ISP and Plan of Care;
(f) Offer the Hepatitis B vaccination to each person providing services pursuant to these rules;
(g) Provide staff training in infection control procedures consistent with the standards established by the Federal Centers for Disease Control and Prevention;
(h) Ensure compliance with DDS policies governing reporting of unusual incidents, human rights, behavior management, and protection of person's funds; 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), 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.*).

1917.9 Live-In Caregiver services shall be arranged by the provider organization. The caregiver may be subject to additional standards identified by the provider. The provider has twenty-four (24) hour responsibility for arranging and overseeing the delivery of services, providing emergency services as needed, and arranging for two (2) weeks of relief for the live-in caregiver per year as needed. The participant's home shall receive an initial inspection by the provider as well as periodic inspections with a frequency determined by the provider. The provider shall contact the caregiver at least once per month .

1917.10 Each person providing live-in caregiver services to a participant in the Waiver shall meet all of the requirements in Chapter 19 to Title 29 of the District of Columbia Municipal Regulations (DCMR), section 1911 in addition to the requirements set forth below:

(a) Complete competency based training in emergency procedures; and
(b) Be certified annually in cardiopulmonary resuscitation (CPR) and First Aid.

1917.11 The reimbursement rate shall be predetermined for each participant based on a signed lease agreement and standardized food and utility reimbursement per diem. Reimbursement shall be limited to those time periods in which the provider is rendering services directly to the person in the person's place of residence.

1917.12 Live-in caregiver services shall not be billed on the same day as Residential Habilitation, Supported Living, Respite or Host Home Services.

1917.99 DEFINITIONS

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

Individual Habilitation Plan (IHP) – That plan as set forth in section 403 of the Mentally Retarded Citizens 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) – The successor to the individual habilitation plan (IHP) as defined in the 2001 Plan for Compliance and Conclusion of *Evans v. Williams*.

Interdisciplinary Team – A group of persons with special training and experience in the diagnosis and habilitation of mentally retarded persons who have the responsibility of performing a comprehensive person evaluation while participating in the development, implementation, and monitoring of the person's IHP or ISP and Plan of Care.

Live-In Caregiver Services Agreement – A written agreement required by these rules prior to the initiation of services and developed as part of the participant's Plan of Care, which shall define at a minimum all shared responsibilities between the Caregiver and the participant , including provisions for overnight stays of a t least eight (8) hours in duration and no more than four (4) hours per day of support by the caregiver, activities provided by the caregiver, a typical weekly schedule and payment for both parties personal needs, utilities and food.

Person or Participant– An individual with intellectual and developmental disabilities who has been determined eligible to receive services under the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver).

Plan of Care – A written service plan that meets the requirements set forth in section 1904.4 of Title 29 DCMR, is signed by the person receiving services, and is used to prior authorize Waiver services.

Provider – Any non-profit, home health agency, social service agency or other business entity that provides services pursuant to these rules.

Waiver – Shall mean the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities as approved by the Council of the District of Columbia (Council) and the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), as may be further amended and approved by the Council and CMS.

DEPARTMENT OF HEALTH

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health, 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), Reorganization Plan No. 4 of 1996, effective January 13, 1997, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption of a new section 1918 to Chapter 19 of Title 29 of the District of Columbia Municipal Regulations (DCMR), entitled "Professional Services." These rules establish standards governing reimbursement by the District of Columbia Medicaid Program for professional services to be provided by licensed or certified professionals to participants in the Home and Community-based Services Waiver for Persons with Developmental Disabilities (Waiver).

This is a new rule which authorizes a variety of professional services that are beneficial and support the general health of Waiver participants. These professional services also increase opportunities for community inclusion of persons enrolled in the Waiver. The services included in this rule are Massage Therapy, Sexuality Education, Acupuncture, Art Therapy, Music Therapy, Dance Therapy, Drama Therapy, and Fitness Training. This rule sets reimbursement rates for these professional services and limits the total expenditure to $2,250.00 per participant per year.

The District of Columbia Medicaid Program also is modifying the Waiver to reflect these changes. The Council of the District of Columbia has approved the corresponding Waiver. The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services have also approved the corresponding Waiver with an effective date of November 20, 2007.

A notice of emergency and proposed rulemaking was published in the *DC Register* on December 21, 2007 (54 DCR 012381). No comments on the proposed rules were received. No substantive changes have been made. These rules shall become effective on the date of publication of this notice in the *DC Register*.

A new section 1918 (Professional Services) of Chapter 19 of Title 29 DCMR is adopted to reads as follows:

1918 PROFESSIONAL SERVICES

1918.1 Professional services shall be reimbursed by the District of Columbia Medicaid Program for each participant in the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver) subject to the requirements set forth in this section.

1918.2 To be eligible for reimbursement, professional services shall be:

(a) Recommended by a physician for massage therapy, fitness training, or acupuncture;
(b) Reasonable and necessary for the treatment, restoration or maintenance of function affected by injury, illness or long term disability; and
(c) Included in the person's Individual Habilitation Plan (IHP) or Individual Support Plan (ISP) and Plan of Care.

1918.3 The professional services eligible for reimbursement shall be:

(a) Massage Therapy;

(b) Sexuality Education;

(c) Art Therapy;

(d) Dance Therapy;

(e) Drama Therapy;

(f) Fitness Training;

(g) Acupuncture; and

(h) Music Therapy.

1918.4 The specific professional 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 individual need. The professional services may be short-term, intermittent, or long-term, depending on the need. The interdisciplinary team developing the plan of support shall determine service utilization.

1918.5 Sexuality Education shall be delivered by:

(a) A Sexuality Education Specialist; 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.

1918.6 The following professional services shall be delivered by credentialed professionals as set forth in the definition section of this rule:

(a) Massage Therapy;
(b) Art Therapy;
(c) Dance Therapy;
(d) Drama Therapy;
(e) Fitness Training;
(f) Acupuncture; and
(g) Music Therapy.

1918.7 Each professional, within the first two (2) hours of services, shall conduct an assessment and develop an individualized plan for the person that is in keeping with his or her choices, goals and prioritized needs. The individualized plan shall identify specific outcomes for the person. The completed plan shall be delivered to the person, family, guardian, other caretaker, or Department on Disability Services (DDS) Case Manager.

1918.8 Professional services may be utilized to:

(a) Provide training in sexuality and personal awareness, reproduction education, how to avoid victimization and safe sexual practices;
(b) Assist in increasing the individual's independence, participation, emotional well-being and productivity in their home, work and community;
(c) Provide training or therapy to an individual necessary to either develop critical skills that may be self-managed by the individual or maintained according to the individuals needs;
(d) Perform assessments and/or re-assessments and recommendations;
(e) Provide consultative services and recommendations specific to the expert content; and
(f) Provide necessary information to the individual, family, caregivers, and/or team to assist in planning and implementing plans per the approved IHP or ISP and Plan of Care.

1918.9 Services shall be provided by an agency or professional in private practice. Each professional and agency shall meet the requirements set forth in Chapter 19 of Title 29 DCMR.

1918.10 The agency or professional in private practice shall have a current Medicaid Provider Agreement that authorizes the service provider to bill for Professional Services.

1918.11 Each person providing professional services shall be acceptable to the person.

1918.12 Each professional shall provide DDS and the Department of Health, Medical Assistance Administration a brochure listing his or her academic background, licensure information, experience and the nature of his or her practice to assist those who will receive services in making their provider selection.

1918.13 Professionals, without regard to their employer of record, shall be selected by the person receiving services or his or her guardian or legal representative and shall be answerable to the person receiving services. Any provider substituting professionals for more that a two (2) week period or four (4) visits due to emergency or availability events shall request a case conference with the DDS Case Manager to evaluate continuation of services.

1918.14 Each professional shall be responsible for providing written documentation in the form of reports, visit notes, progress notes, and other pertinent documentation of the person's progress or lack of progress. The documentation shall include evidence that services did not exceed the authorized frequency and duration as authorized in the individualized plan required pursuant to section 1918.7. The agency or professional in private practice shall maintain a copy of the documentation for at least six (6) years after the person's date of service.

1918.15 The reimbursement rate for professional services shall be:

(a) Sixty dollars ($60.00) per hour for Massage Therapy;

(b) Seventy five dollars ($75.00) per hour for Sexuality Education;

(c) Forty five dollars ($45.00) per hour for Art Therapy;

(d) Forty five dollars ($45.00) per hour for Dance Therapy;

(e) Forty five dollars ($45.00) per hour for Drama Therapy;

(f) Seventy five dollars ($75.00) per hour for Fitness Trainer;

(g) Seventy dollars ($70.00) per hour for Acupuncture; and

(h) Forty five dollars ($45.00) per hour for Music Therapy.

1918.16 The billable unit of service for professional 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.

1918.17 Professional services shall be limited to a maximum of two thousand, two hundred and fifty dollars ($2,250.00) per participant per year and in accordance with the person's IHP or ISP and Plan of Care. Additional

services may be prior authorized if the participant reaches the limitation before the expiration of the IHP or ISP and Plan of Care year and the participant's health and safety are at risk. The need for ongoing services shall be approved by a physician and DDS.

1918.99 **DEFINITIONS**

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

Acupuncture – A professional service under this section which shall be provided by a person who is authorized to practice acupuncture pursuant to Chapter 47 of Title 17 of the District of Columbia Municipal Regulations (DCMR).

Art Therapy – A professional service under this section which shall be provided by a person who is certified to practice art therapy pursuant to certification by the American Art Therapy Association, Inc. and/or credentialing of the Art Therapy Credentialing Board.

Clinical Record – A comprehensive compilation of medical and other data that identifies the person and justifies and describes the diagnosis and treatment of the person.

Dance Therapy – A professional service under this section which shall be provided by a person who is authorized to practice dance therapy pursuant to Chapter 71 (Dance Therapy) of Title 17 DCMR.

Drama Therapy – A professional service under this section which shall be provided by a person who is certified to practice drama therapy pursuant to the National Association for Drama Therapy.

Fitness Trainer – A person who is certified to practice fitness training pursuant to Fitness Standards Council (FSC) Personal Trainer Accreditation.

Individual Habilitation Plan (IHP) – That plan as set forth in section 403 of the Mentally Retarded Citizens 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) – The successor to the individual habilitation plan (IHP) as defined in the 2001 Plan for Compliance and Conclusion of *Evans v. Williams*.

Interdisciplinary Team – A group of persons with special training and experience in the diagnosis and habilitation of mentally retarded persons who have the responsibility of performing a comprehensive person evaluation while participating in

the development, implementation, and monitoring of the person's IHP or ISP and Plan of Care.

Licensed Clinical Social Worker – A person who is licensed 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 § 3-1202 *et seq.*) or licensed as an independent clinical social worker in the jurisdiction where the services are being provided.

Licensed Professional Counselor – A person who is licensed to practice professional 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 § 3-1202 *et seq.*) or licensed as a professional counselor in the jurisdiction where the services are being provided.

Massage Therapy – A professional service under this section provided by a person who is authorized to practice massage therapy pursuant Chapter 75 of Title 17 DCMR.

Music Therapy – A professional service under this section provided by a person who is certified by the Certification Board for Music Therapists, which is managed by the American Music Therapy Association.

Person – An individual with intellectual and developmental disabilities who has been determined eligible to receive services under the Home and Community-based Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver).

Physician – A person who is 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.*) or licensed as a physician in the jurisdiction where services are provided.

Plan of Care – A written service plan that meets the requirements set forth in section 1904.4 of Title 29 DCMR, is signed by the person receiving services, and is used to prior authorize Waiver services.

Progress Note – A dated, written notation by a member of the health care team that summarizes facts about a person's care and response to treatment during a given period of time.

Psychiatrist – A person who is 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 – A person who is 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.

Sexuality Education Specialist – A person who is certified to practice sexuality education pursuant to certification by the American Association of Sexuality Educators, Counselors and Therapists (AASECT) Credentialing Board.

Waiver – The Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities as approved by the Council of the District of Columbia (Council) and the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), as may be further amended and approved by the Council and CMS.