

## 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 926 of Chapter 9 of Title 29 of the District of Columbia Municipal Regulations (DCMR), entitled "Environmental Accessibility Adaptation Services." These rules establish standards governing reimbursement by the District of Columbia Medicaid Program for environmental accessibility adaptation ("EAA") services provided by qualified building 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 on August 22, 2003 (50 DCR 6989) by defining clear limits on EAA service. The previous lifetime limit of \$10,000 per participant for EAA changed to a limit of \$10,000 in expenditures on EAA services over a five-year period per participant and to no more than two residences in the five-year period.

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 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 7, 2007 (54 DCR 011730). No comments on the proposed rulemaking 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 926 (Environmental Accessibility Adaptation Services) of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

**926 ENVIRONMENTAL ACCESSIBILITY ADAPTATION SERVICES**

926.1 Environmental accessibility adaptation (EAA) 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 Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver) subject to the requirements set forth in this section.

926.2 EAA services are physical adaptations to a home, required by a person's Individual Habilitation Plan (IHP) or Individual Support Plan (ISP) and Plan of Care that are

necessary to ensure the health, welfare, and safety of a person, or that enable a person to live with greater independence in the home, and without which the person would require institutionalization. EAA services shall be intended to cover the difference between construction or renovation costs to make the home accessible and not to cover basic construction or renovation costs. For example, EAA services shall be intended to cover the costs associated with construction or renovation work under subsections 926.3(a)(b) (d) and (e), but may not cover all of the costs associated with construction or renovation work under subsection 926.3(c).

926.3 EAA services may include:

- (a) Installing ramps and grab-bars;
- (b) Widening doorways;
- (c) Modifying bathroom facilities;
- (d) Installing lift systems; and
- (e) Installing specialized electric and plumbing systems that are necessary to accommodate medical equipment and supplies.

926.4 EAA services shall:

- (a) Be necessary to ensure the health, welfare, or safety of the person and enable the person to function with greater independence; and
- (b) Not be provided or reimbursed for persons eligible for the Department of Housing and Community Development, Handicap Accessibility Improvement Program.

926.5 To be eligible for reimbursement, EAA services shall be:

- (a) Pre-authorized by the Department on Disability Services (DDS);
- (b) Installed in one of the following:
  - (1) The person's own home;
  - (2) The home of the person's family, guardian, or other primary caretaker who is not providing Residential Habilitation Services under the Waiver;
  - (3) A foster home in which the person resides;
  - (4) An apartment or other rental property in which the person resides, provided that the participant obtains the property owner's written consent

prior to making environmental accessibility adaptations; or

- (5) A Supported Living residence as defined in Section 993 (Supported Living Services) of Title 29 DCMR.

- 926.6 EAA services shall not include carpeting, roof repair, central air conditioning, exterior fencing, general repair or maintenance, or those adaptations or improvements to the home that are of general utility; make no direct medical or remedial benefit to the person; and shall not include adaptations that increase the total square footage of the home.
- 926.7 A DDS case manager shall assist all eligible persons to gain access to the Department of Housing and Community Development, Handicap Accessibility Improvement Program.
- 926.8 EAA services shall be authorized by the interdisciplinary team and provided in accordance with the person's IHP or ISP and Plan of Care
- 926.9 Each provider of EAA services shall:
- (a) Be a non-profit organization, home health agency, social service agency, or other business entity;
  - (b) Have a current District of Columbia Medicaid Provider Agreement that authorizes the provider to bill for EAA services under the Waiver; and
  - (c) Comply with applicable contractor licensing requirements in the District of Columbia or in the jurisdiction where EAA services are provided.
- 926.10 Before approving EAA services, except for installation of pre-fabricated ramps for wheel-chair accessibility, an evaluation or home inspection shall be required from a licensed contractor or Certified Third Party Construction Inspector that:
- (a) Establishes that the home is structurally sound;
  - (b) Determines whether the home can accommodate the EAA services;
  - (c) Identifies any construction stipulations; and
  - (d) Recommends how the EAA should be constructed.
- 926.11 EAA services shall be provided consistent with any stipulations or recommendations from the licensed contractor or Certified Third Party Construction Inspector.
- 926.12 EAA services shall be provided in accordance with the applicable District, state or local building codes.
- 926.13 Reimbursement for EAA services shall be limited to ten thousand dollars (\$10,000)

per participant over a five-year period and shall be limited to modifications not to exceed two (2) residences in a five-year period. Exceptions to the five-year limitations in this section on EAA services may be approved by DDS on a case by case basis, with adequate supporting documentation outlined in section 926.14, based on demonstrated need, but shall be pre-authorized.

926.14 Evaluation or home inspection shall be reimbursed at a rate not to exceed five hundred dollars (\$500) per inspection, but shall only be payable as a separate service if the home is found structurally unsound or otherwise inappropriate for the EEA modification requested. Reimbursement of all other EAA services shall require:

- (a) Written documentation of the building inspection;
- (b) Development of a construction plan;
- (c) Acquisition of permits;
- (d) Purchase of materials; and
- (e) Labor for construction, renovation, or installation services to be provided.

#### 926.99 DEFINITIONS

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

**Certified Third Party Construction Inspector** – an inspector certified under the District of Columbia Department of Consumer and Regulatory Affairs Third Party Inspector program.

**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 Contractor** – a contractor licensed to do business in the District of Columbia by the District of Columbia Department of Consumer and Regulatory Affairs, or licensed to do business in the jurisdiction in which the environmental accessibility adaptation services are to be 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 pre-authorize Waiver services.

**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. 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 930 of Chapter 9 of Title 29 of the District of Columbia Municipal Regulations (DCMR), entitled "Nutrition Evaluation and Consultation Services." These rules establish standards governing reimbursement by the District of Columbia Medicaid Program for nutrition evaluation and consultation services provided by licensed nutritionists and dietitians to participants in the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver).

This rulemaking amends the previously published rules, 49 DCR 244 (January 11, 2002), to change the name of the rule, to add more effective planning of follow up reporting and to set limits on the amount of nutrition evaluation and consultation 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 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 7, 2007 (54 DCR 011735). 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 930 (Nutritional Counseling Services) of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

**930 NUTRITION EVALUATION AND CONSULTATION SERVICES**

930.1 Nutrition evaluation and consultation 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.

930.2 To be eligible for reimbursement, nutrition evaluation and consultation services shall be:

- (a) Ordered by a physician if the individual has any history of weight that is significantly above or below recommended body weight, a history

of gastrointestinal disorders, diabetes, swallowing disorders, or other medical conditions that can be a threat to health if nutrition is poorly managed;

- (b) Recommended by the interdisciplinary team if the issues are not medical in nature;
- (c) Reasonable and necessary to the treatment of the person's illness, injury, or long term disability or for the restoration or maintenance of function affected by the injury, illness or long term disability; and
- (d) Included in the person's IHP or ISP and Plan of Care.

930.3 Nutrition evaluation and consultation services may be used to address:

- (a) Evidence of weight gain or loss that creates health risk;
- (b) The need for a therapeutic diet;
- (c) The need for a diet with altered texture due to oral-motor problems;
- (d) The need for a diet related to allergies or other food intolerances or drug-nutrient interactions;
- (e) The need for counseling for the person and staff on the specifics of the needed diet plan;
- (f) The need for counseling on shopping, cooking, meal planning or meal preparation;
- (g) The need for counseling on safe storage and cooking of food;
- (h) The need for counseling on nutritional information about foods;
- (i) The need for counseling on how to eat a healthy, balanced diet within the constraints of special dietary needs, etc.; and/or,
- (j) The need for counseling the individual on how to develop a cycle of menus that incorporates his/her preferences and choices and ensures optimal outcomes.

930.4 Nutrition evaluation and consultation services shall include, as necessary, the following:

- (a) Comprehensive nutritional assessments;

- (b) Partial nutritional evaluations to include anthropometric assessments;
- (c) Biochemical, clinical dietary appraisals;
- (d) Food-drug interaction potential;
- (e) Health and safety environmental review of food preparation and storage areas;
- (f) Needs assessments for adaptive eating equipment and dysphagia management; or
- (g) Nutrition evaluation and consultation services on a wide variety of issues to promote improved health and increase the person's ability to manage their own diet in an effective manner including menu development, shopping, food preparation, food storage, and food preparation procedures based on physician's orders.

930.5 Nutritional counselors, without regard to their employer of record, shall be selected by the person receiving services or their guardian or legal representative to provide services to the person receiving services, and will be answerable to the person receiving services. Any organization substituting practitioners for more than a two week period or four visits due to emergency or lack of availability will request a case conference with the Department on Disability Services (DDS) Case Manager so that the person receiving services can select a new practitioner.

930.6 The nutrition evaluation and consultation services provider shall be responsible for providing written documentation in the form of reports, assessments, physician's orders, visit notes, progress notes, and other pertinent documentation of the person's progress or lack of progress, medical conditions, functional gains and 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 nutrition evaluation and consultation services provider in private practice shall maintain a copy of the documentation for at least six (6) years after the person's date of service.

930.7 Each person providing nutrition evaluation and consultation services shall meet all of the following requirements:

- (a) Be licensed to practice dietetics or nutrition pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201 *et seq.*) or licensed to practice dietetics or nutrition in the jurisdiction where services are provided;
- (b) Have a minimum of one (1) year of experience working with persons with mental

retardation and developmental disabilities;

- (c) Have the ability to develop and implement a nutrition plan based on an assessment of the person's nutritional condition and needs;
- (d) Be acceptable to the consumer and be able to communicate with the consumer;
- (e) Demonstrate annually that he or she is free from communicable disease as confirmed by an annual PPD skin test or documentation from a physician stating that the person is free from communicable disease; and
- (f) Have a current District of Columbia Medicaid Provider Agreement or be employed by a home health agency or social services agency that has a current District of Columbia Medicaid Provider Agreement that authorizes the service provider to bill for Nutrition Evaluation and Consultation Services under the Waiver.

930.8 The reimbursement rate for nutritional assessments shall be fifty-five dollars (\$55.00) an hour for a full nutritional assessment of the individual, preparation of summary documentation and delivery of that documentation. The tasks shall include updating medical records and verification 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. The billable unit of service for nutrition evaluation and consultation 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.

930.9 The reimbursement rate for ongoing nutrition evaluation and consultation services shall be fifty-five dollars (\$55.00) per hour for the period specified in the nutritional assessment.

930.10 Nutrition evaluation and consultation services shall be limited to one hundred twenty (120) hours per year unless approved for additional hours by a physician.

#### **930.99 DEFINITIONS**

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

**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 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. 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 942 of Chapter 9 of Title 29 of the District of Columbia Municipal Regulations (DCMR), entitled "Family Training Services." These rules establish standards governing reimbursement by the District of Columbia Medicaid Program for family training services provided by qualified 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 rule amends existing section 942, previously published at 50 DCR 8476 (October 10, 2003), to provide more effective reporting, to update the prohibition against concurrent payments to reflect the new Waiver services, and to expand family training services to include uncompensated caregivers other than family. 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 Waiver modification, and the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services has also approved the modified Waiver with an effective date of November 20, 2007.

A notice of emergency and proposed rulemaking was published in the *DC Register* on December 7, 2007 (54 DCR 011753). 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 942 (Family Training Services) of Chapter 9 of Title 29 DCMR is amended to read as follows:

**942 FAMILY TRAINING SERVICES**

- 942.1 The District of Columbia Medicaid Program shall provide reimbursement for family training services for each participant with mental retardation and developmental disabilities in the Home and Community-based Services Waiver for Persons with Developmental Disabilities and Mental Retardation (Waiver) subject to the requirements set forth in this section.
- 942.2 Family training services are training, counseling, coordination, and other professional support services offered to the families of persons enrolled in the Waiver or other uncompensated individuals providing support to Waiver participants. For purposes of family training services, an uncompensated

individual may be a neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship or support to a Waiver participant.

- 942.3 Each family training provider, within the first four (4) hours of service, shall conduct an assessment and develop a Training Plan with training goals and techniques that will assist the caregivers to better support the participant in achieving the choices, goals and prioritized needs identified in the individual habilitation plan (IHP) or individual support plan (ISP) and Plan of Care.
- 942.4 If the caregivers decide to continue with the training, the Training Plan shall include measurable outcomes and a schedule for ongoing services. The family training provider shall send the Training Plan to the Department on Disability Services (DDS) Case Manager for prior authorization of ongoing services.
- 942.5 Family training services eligible for reimbursement shall include the following services:
- (a) Instruction on strategies to assist the participant in meeting his or her IHP or ISP and Plan of Care goals;
  - (b) Training on the use of equipment specified in the participant's IHP or ISP and Plan of Care;
  - (c) Training on meeting the needs of the participant;
  - (d) Counseling to address the psychological needs of the family;
  - (e) Training and supports to prepare a family to make informed decisions on how to select and coordinate the services of a family member; and
  - (f) Follow up training necessary to safely maintain the participant at home.
- 942.6 Family training services may be used by the participant, family, guardian, or other uncompensated caregiver to help with the development of the participant's IHP or ISP and Plan of Care.
- 942.7 Family training services may be used by the participant, family, guardian, or other uncompensated caregiver to help coordinate the delivery of behavioral support services, community support services, and other professional, therapeutic or support services under the Waiver.
- 942.8 Each provider of family training services shall:
- (a) Be a public or private agency or home health agency licensed to do business in the District of Columbia, Maryland or Virginia;

- (b) Have a current District of Columbia Medicaid Provider Agreement that authorizes the provider to bill for family training services under the Waiver;
- (c) Ensure that all family training services staff are qualified and properly supervised;
- (d) Ensure that the service provided is consistent with the participant's IHP or ISP and Plan of Care;
- (e) Maintain a copy of the participant's most recent IHP or ISP and Plan of Care;
- (f) Participate in the participant's annual IHP or ISP and Plan of Care meeting or case conferences when indicated;
- (g) Maintain records which document staff training and licensure, for a period of not less than six (6) years;
- (h) Offer the Hepatitis B vaccination to each caregiver providing services pursuant to these rules and maintain a copy of the acceptance or declination of the vaccine;
- (i) 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 CFR § 1910.1030; and
- (j) Maintain documentation in each participant's clinical record regarding the initial assessment of the family's training needs, the goals to be accomplished, the training provided on each visit, and the outcomes of each training.

942.9 Each person providing family training services shall:

- (a) Be licensed to practice graduate social work, independent clinical social work, occupational therapy, physical therapy, speech, hearing and language therapy or registered nursing pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 *et seq.*);
- (b) Be licensed to practice his or her profession within the jurisdiction where services are provided; or
- (c) Be a special education teacher with a Master's Degree in Special Education from an accredited college or university with an emphasis in

developmental disabilities and have experience working with persons with mental retardation and developmental disabilities.

942.10 Each person providing family training services shall meet all of the following requirements:

- (a) Be at least eighteen (18) years of age;
- (b) Be acceptable to the participant 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;
- (e) Have at least one (1) year of experience working with persons with mental retardation and developmental disabilities;
- (f) Agree to carry out the responsibility to provide services consistent with the person's IHP or ISP;
- (g) Complete pre-service and in-service training approved by DDS;
- (h) Have the ability to communicate with the participant 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; D.C. Official Code § 44-551 *et seq.*).

942.11 The reimbursement rate for family training services shall be sixty dollars (\$60) per hour. The billable unit of service for family training services shall be fifteen (15) minutes. A provider shall provide at least eight (8) minutes of service in a span of fifteen (15) continuous minutes to bill a unit of service.

942.12 Family training services shall not be used concurrently with:

- (a) Supported Living;
- (b) Residential Habilitation; or
- (c) Host Home.

#### **942.99 DEFINITIONS**

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

ascribed:

**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.

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

**Community support services** – Services that are designed to address immediate crisis events and to improve and maintain outcomes in the health, attitude and behavior of the person.

**Family** – Any person who is related to the participant receiving services by blood, marriage, adoption, or some other legal relationship, such as a foster relative, who lives with or provides care to the participant. A family member may include a parent, spouse, child, relative, foster relative, or in-law. The term does not include individuals who are employed to care for the participant.

**Individual Habilitation Plan (IHP)** – The plan 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*.

**Participant** – 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.

**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.

**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 994 to Chapter 9 of Title 29 of the District of Columbia Municipal Regulations (DCMR), entitled "Respite Care Services." These rules establish standards governing reimbursement by the District of Columbia Medicaid Program for respite care services, which is being renamed "Respite Services," to be provided by qualified providers to persons 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 4943 (June 20, 2003), to change the name to respite services, to provide for both hourly and daily rates, to allow services to be provided in a person's home or in a provider's residential facility, to permit direct care staff to provide services, and to change the rates. Currently, respite care service is skilled nursing or personal care service that has hourly rates. Respite services is being modified to be provided as either hourly respite or daily respite, with in home respite being an hourly service that can only be delivered in the home of a primary caregiver who is not providing a Waiver residential service or in a community setting and daily respite being provided in a residential facility. In addition, respite has been modified so that both hourly and daily respite services may use direct care staff rather than skilled nursing staff or personal care staff, and skilled nursing services can be used concurrently with respite services. The total hour limits, without regard to which service option is chosen, have not changed, and the prohibition against concurrent payments has been modified to reflect the new Waiver services. Rates have been adjusted to reflect the change from skilled nursing or personal care services to unlicensed staff delivering respite services, and coordinating respite services that address more effective delivery of oversight and emergency procedures.

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 7, 2007 (54 DCR 011759). 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 994 (Respite Care Services) of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

**994 RESPITE SERVICES**

- 994.1 Hourly or daily respite 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.
- 994.2 Hourly or daily respite services consist of services provided to a person on a short-term basis because of the absence or need for relief of the primary caregiver.
- 994.3 Hourly respite services shall be provided in person's private residence or the residence of the family or in a community setting approved by the primary caretaker.
- 994.4 The following entities or individuals are not eligible to provide hourly respite services:
- (a) The person's primary caregiver;
  - (b) A spouse, parent of a minor child or legal guardian; or
  - (c) A provider already being compensated for the general care of the participant.
- 994.5 Individuals providing hourly respite services may be an adult family member, such as a sibling, aunt, uncle or cousin, if employed and trained by the Waiver service provider and subject to the limitations set forth in section 994.4.
- 994.6 Each provider of hourly or daily respite services shall be a:
- (a) Respite Provider Agency, certified by the Department on Disability Services (DDS);
  - (b) Supportive Living Provider;
  - (c) Residential Habilitation Provider; or
  - (d) Home health agency as defined in Chapter 19 of Title 29 DCMR.
- 994.7 Each support staff person providing hourly or daily respite services shall meet all of the conditions designated in Title 29 DCMR, Chapter 19, Section 1911 in addition to the requirements set forth below:
- (a) Complete competency based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910.1030;
  - (b) Complete competency based training in emergency procedures;

- and
- (c) Be certified annually in cardiopulmonary resuscitation and First Aid.
- 994.8 Each provider of hourly or daily respite services shall:
- (a) Have a current Medicaid Provider agreement to provide and bill Respite Services; and
- (b) Maintain a copy of the person's most recent individual habilitation plan (IHP) or individual support plan (ISP) and Plan of Care and a description of all services the person is using.
- 994.9 Each provider of hourly or daily respite services shall ensure that each person receives hands-on supports including but not be limited to the following areas as needed:
- (a) Eating and drinking;
- (b) Toileting;
- (c) Personal hygiene;
- (d) Dressing;
- (e) Grooming;
- (f) Monitoring health and physical condition and assistance with medication or other medical needs;
- (g) Communications; and
- (h) Opportunity for social, recreational, and religious activities utilizing community resources.
- 994.10 Each provider of hourly or daily respite services shall ensure that each person has access to community activities as delineated in the person's IHP or ISP and Plan of Care. Planning community activities or continuing already planned activities and accompanying the person to those activities, including coordinating transportation, is included in the rate for hourly or daily respite services. These activities include ensuring day program or employment attendance or other activities the person would receive if they were not in respite services.
- 994.11 Hourly respite services shall be reimbursed at the rate of twenty dollars and forty-four cents (\$20.44) per hour and shall be limited to seven hundred twenty (720) hours per calendar year. Any request for hours in excess of 720 hours shall be submitted to DDS for approval and include a justification and supporting documentation. Hourly respite services are provided as an hourly service and can be scheduled for portions of a day. Group respite services offered in or from community based (*e.g.* community centers, schools, non-profit organizations) locations that offer community activities and opportunities for socialization shall be reimbursed at a rate of eleven dollars (\$11.00) per hour or three dollars and seventy-five cents (\$3.75) per fifteen minute unit assuming a staff to participant ratio of no more than one respite support person to three

participants. A minimum of eight (8) minutes of continuous services must be provided to bill for a fifteen (15) minute unit. Hourly respite services may be extended in situations when the primary caretaker is hospitalized or otherwise unable to continue as a primary caretaker. Hourly respite services may only be extended for the time necessary for arrangements to be made for long term residential supports.

- 994.12 Day Habilitation, Prevocational Habilitation, or Supported Employment Services shall continue while the person is receiving hourly respite services, but shall not be billed concurrently.
- 994.13 Hourly respite services shall not be provided for persons receiving Supported Living, Host Home or Residential Habilitation Services, and shall only be provided in the person's current place of residence or in a community location.
- 994.14 Daily respite services shall be provided in:
- (a) A Group Home for Mentally Retarded Persons (GHMRP) licensed pursuant to the Health Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code § 44-501 *et seq.*) meeting the requirements set forth in Chapter 35 of Title 22 DCMR and certified as an intermediate care facility for persons with mental retardation in accordance with the federal conditions of participation or a Residential Habilitation Services provider. The GHMRP and Residential Habilitation Services provider shall have a Medicaid Provider Agreement for Respite Services;
  - (b) A Supported Living Residence (SLR) that meets the Department on Disability Services (DDS) Certification Standards and is operated by a provider with a Medicaid Provider Agreement for Respite Services and a Human Care Agreement that stipulates the conditions for accepting respite placements; or
  - (c) A dedicated respite facility that meets the DDS/DDA Certification Standards and is operated by a provider with a Medicaid Provider Agreement for Respite Services and a Human Care Agreement that stipulates the conditions for accepting respite placements. Respite facilities shall meet the standards of GHMRPs or SLRs.
- 994.15 Daily respite service shall be reimbursed at the rate of three hundred ten dollars (\$310) per day and shall be limited to thirty (30) days per calendar year. Daily respite service may be extended in situations when the primary caretaker is hospitalized or otherwise unable to continue as a primary caretaker. Daily respite services may only be extended for the time necessary for arrangements to be made for long term residential supports. Daily respite service is provided as a daily service and a minimum of fourteen (14) hours of

continuous service must be provided to bill for a day.

- 994.16 The provider shall maintain documentation of the date and amount of time the service is delivered, and shall record the activities engaged in, the person's response to those activities, and any unusual event or circumstance involving the person's health and welfare while respite services were delivered.

## 994.99 DEFINITIONS

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

**Direct Care Staff** – Individuals employed to work in the person's home who render the day-to-day personal assistance that person's require in order to meet the goals of their IHP or ISP and Plan of Care.

**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.

**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.

**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. 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 a new section 1912 of Chapter 19 of Title 29 of the District of Columbia Municipal Regulations (DCMR), entitled "Community Support Team 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 dual diagnosis of mental retardation and mental illness in the Home and Community-based Services Waiver for persons with Mental Retardation and Developmental Disabilities (Waiver).

The former Preventive, Consultative and Crisis Support Services rules in Section 937 of Chapter 29 DCMR incorporate 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 adopts a new rule focusing on the crisis portion of the former rule and changes the name of the service to Community Support Team 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 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 28, 2007 (54 DCR 012699). 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 1912 (Community Support Team Services) of Chapter 19 of Title 29 DCMR is adopted to reads as follows:

**1912 COMMUNITY SUPPORT TEAM SERVICES**

1912.1 Community support team (CST) 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.

- 1912.2 To be eligible for CST services, the following criteria shall be identified during each participant's Diagnostic Assessment:
- (a) An ongoing pattern of behavior that includes physical harm to self or others and /or behaviors/psychiatric symptoms which have led to institutionalization in the past or have a high probability of resulting in institutionalization (*e.g.*, self-injurious behavior, physical aggression, illegal or inappropriate sexual acts, reckless endangerment, psychiatric conditions leading to the denial of self-preservation or extremely poor hygiene);
  - (b) An imminent risk of institutionalization; or
  - (c) A need for twenty-four (24) hour supports and crisis planning to support health and safety.
- 1912.3 CST services shall not include onsite crisis intervention services and is not designed to adequately serve people who threaten or attempt suicide or homicide or who have a pattern of felony violations involving violence or the victimization of others.
- 1912.4 CST services are designed to support and encourage the participant in his or her decision to reside within the community; decrease the impact of a behavioral and/or psychiatric event; assist the participant in developing alternative and more effective communication skills, adaptive and coping mechanisms; and enable the participant to achieve positive personal outcomes.
- 1912.5 CST services provide intensive behavioral and psychiatric supports for participants who are at imminent risk of institutionalization. The CST is a specialized professional treatment team that consists of a psychologist, psychiatrist, licensed independent clinical social worker, advance practice registered nurse, licensed professional counselor, registered nurse, and/or behavior management specialist, as needed. The most clinically appropriate CST member(s) represents the CST in providing direct services to the participant. Each CST member shall be involved as needed, but CST member(s) shall spend a minimum of one (1) hour weekly meeting with the participant and/or care givers at the onset of treatment. Each CST member shall review summary data at least weekly with other CST staff who are involved in participant's care. Written behavioral support strategies shall be reviewed and updated at least monthly, based on the participant's response to services.
- 1912.6 CST services shall include the following services:
- (a) Medication/Somatic Treatment services, which may be delivered onsite or offsite;

- (b) Crisis/Emergency services, which may be delivered face-to-face or by telephone; and
  - (c) Assertive Community Treatment (ACT) services, which shall be delivered onsite.
  
- 1912.7 CST 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.
  
- 1912.8 The provider shall provide Medication/Somatic Treatment services in accordance with the Diagnostic Assessment Report.
  
- 1912.9 Medication/Somatic Treatment services shall be delivered by the following professionals:
  - (a) Psychiatrist;
  - (b) Advance Practice Registered Nurse; or
  - (c) Registered Nurse.
  
- 1912.10 Medication/Somatic Treatment services shall be reimbursed at one hundred twenty-nine dollars (\$129.00) per hour. The billable unit of service shall be fifteen (15) minutes at a rate of thirty-three dollars and twenty-five cents (\$33.25) per billable unit. 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.
  
- 1912.11 Crisis/Emergency services shall be provided to a participant involved in an active mental health crisis and shall consist of an immediate response to evaluate and screen the presenting situation, assist in immediate crisis stabilization and resolution, and ensure the participant's access to care at the appropriate level.
  
- 1912.12 Crisis/Emergency services may be delivered in natural settings and the Crisis/Emergency provider shall adjust its staffing levels, as needed to provide an immediate response. Each Crisis/Emergency provider shall provide consultation, locate other services and resources, and provide written and oral information to assist the participant in obtaining follow-up services.
  
- 1912.13 Crisis/Emergency services may be provided based on a recommendation from DDS but shall not be extended beyond ten (10) hours unless the services are included in the Diagnostic Assessment Report.
  
- 1912.14 Crisis Emergency services shall be delivered by the following professionals:
  - (a) Psychiatrist;
  - (b) Psychologist;
  - (c) Advanced Practice Registered Nurse;

- (d) Licensed Independent Clinical Social Worker; or
  - (e) A registered nurse, licensed professional counselor, or behavior management specialist working under the supervision of any of the professionals set forth in sections 1912.14 (a), (b), (c) or (d).
- 1912.15 Crisis/Emergency services shall be reimbursed at one hundred thirty-four dollars and sixteen cents (\$134.16) per hour. The billable unit of service shall be fifteen (15) minutes at a rate of thirty-three dollars and fifty-four cents (\$33.54) per billable unit. 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.
- 1912.16 Eligibility for Assertive Community Treatment (ACT) services is established in the Diagnostic Assessment Report and services shall be provided in accordance with the report. Service coverage by the ACT Team shall be available twenty-four (24) hours per day, seven (7) days per week. After the initial intervention, the ACT Team shall complete a self care-oriented Community-based Intervention plan that focuses on:
- (a) Diffusing the current situation to reduce the likelihood of a recurrence;
  - (b) Coordinating access to mental health services; and
  - (c) Providing support interventions for participants that develop and improve the ability of parents, legal guardians or significant others to care for the participant in the community.
- 1912.17 Services offered by the ACT team shall include:
- (a) Mental health-related medication prescription, administration and monitoring;
  - (b) Crisis assessment and intervention;
  - (c) Symptom assessment, management, and individual support therapy;
  - (d) Substance abuse treatment for persons with a co-occurring addictive disorder;
  - (e) Psychosocial rehabilitation and skill development;
  - (f) Interpersonal social and interpersonal skill training; and
  - (g) Education, support and consultation to participant's families and/or their support system, which is directed exclusively to the well being and benefit of the participant.
- 1912.18 ACT services shall be reimbursed at one hundred five dollars and ninety-two cents (\$105.92) per hour. The billable unit of service shall be fifteen (15) minutes at a rate of twenty-six dollars and forty-eight cents (\$26.48) per billable unit. 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.
- 1912.19 ACT services shall be delivered by the following professionals:

- (a) Psychiatrist;
- (b) Registered Nurse: or
- (c) Addiction Counselor.

1912.20 Each provider of CST services shall be:

- (a) A provider of residential habilitation services as defined in Title 29 DCMR, Chapter 9, Section 946;
- (b) A home health agency as defined in Title 29 DCMR, Chapter 19 General Provisions, Section 1903.3;
- (c) A provider of supportive living services as defined in Title 29 DCMR, Chapter 9, Section 993; or
- (d) A Freestanding Mental Health Clinic as defined in Title 29 DCMR, Chapter 8.

1912.21 Each provider shall have a current Medicaid Provider Agreement that authorizes the provider to bill for CST Services.

1912.22 Each person providing CST services shall have a minimum of two (2) years experience providing professional services to persons with developmental disabilities or receive supervision by professional staff that have the requisite experience. Psychologists shall provide support clinical leadership and provide supports consistent with person-centered practices and positive behavioral support practices.

1912.23 Each person providing CST services shall meet the requirements set forth in section 1911 of Chapter 19, Title 29 DCMR.

## 1912.99 DEFINITIONS

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

**Addiction Counselor-** A person who provides addiction counseling services to persons with co-occurring psychiatric and addictive disorders and is licensed or certified in accordance with applicable District laws and regulations.

**Advanced Practice Registered Nurse** – 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.

**Assertive Community Treatment (ACT)** - An intensive integrated rehabilitative, crisis, treatment and mental health rehabilitative community support provided by an interdisciplinary team to children and youth with serious emotional disturbance and to adults with serious and persistent mental illness. .

**Assertive Community Treatment team or ACT Team-** The mobile interdisciplinary of qualified practitioners and other staff involved in providing ACT to a participant.

**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.

**Community Support Team Services** – Services set forth in this section that is designed as an ongoing, preventive service to improve and maintain outcomes in the health, attitude and behavior of the person.

**Crisis/Emergency Services-** Face-to-face or telephone immediate response to an emergency situation experienced by a participant that is available twenty-four (24) hours per day, seven (7) days per week.

**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.

**Diagnostic Assessment Report** – The report that summarizes the results of the Diagnostic Assessment.

**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 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 § 3-1201.01 *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 § 3-1201.01 *et seq.*) or licensed as a professional counselor in the jurisdiction where the services are being provided.

**Medication/Somatic Treatment** – Are medical interventions including: physical examinations; prescription, supervision or administration of mental health-related medications; monitoring and interpreting results of laboratory diagnostic procedures related to mental health-related medications; and medical interventions needed for effective mental health treatment provided as either an individual or group intervention.

**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.

**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 § 3-1201.01 *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 § 3-1201.01 *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 § 3-1201.01 *et seq.*) or licensed as a registered nurse in the jurisdiction where the services are being provided.

**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. 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 a new section 1913 of Chapter 19 of Title 29 of the District of Columbia Municipal Regulations (DCMR), entitled "One-Time Transitional Services." These rules establish standards governing reimbursement by the District of Columbia Medicaid Program for one-time transitional services provided by qualified providers to participants with dual diagnosis of mental retardation and mental illness in the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver).

These rules establish standards governing the provision of OTT services for persons participating in the Waiver. OTT service is a new one-time service designed to facilitate the transition of a person from an institutional setting to a more integrated and less restrictive community setting. The service is limited to one use and will provide a maximum of \$5000.00 to purchase furniture, cooking utensils, and other items essential to living in the community, and to cover moving expenses.

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 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 012366). 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 1913 (One-Time Transitional Services) of Chapter 19 of Title 29 DCMR is added to reads as follows:

**1913 ONE-TIME TRANSITIONAL SERVICES**

1913.1 One-time transitional (OTT) services shall be reimbursed by the District of Columbia Medicaid Program for each person 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.

- 1913.2 OTT services are non-recurring set-up expenses for persons in the Waiver who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the participant is directly responsible for their own living expenses.
- 1913.3 Reimbursement for OTT services may include:
- (a) Security deposits that are required to obtain a lease for an apartment or home;
  - (b) Essential household furnishings and moving expenses required to occupy and use an apartment or home, including furniture, window coverings, food preparation items, and bed/bath linens;
  - (c) Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
  - (d) Services necessary for the person's health and safety such as pest eradication and one-time cleaning prior to occupancy;
  - (e) Moving expenses; and
  - (f) Activities to procure needed resources.
- 1913.4 To be reimbursable, OTT service shall:
- (a) Be reasonable and necessary as determined by the person's Individual Habilitation Plan (IHP) or Individual Support Plan (ISP) and Plan of Care;
  - (b) Be clearly identified in the IHP or ISP and Plan of Care;
  - (c) Be unable to be purchased by the person due to the expense;
  - (d) Be necessary to enable the person to function with greater independence; and
  - (e) Not be obtainable from other sources.
- 1913.5 OTT services shall not include:
- (a) Monthly rental or mortgage expense;
  - (b) Food;
  - (c) Regular utility charges;
  - (d) Household appliances or items that are intended for purely diversional or

recreational purposes (*e.g.* television, cable or satellite installation for television programming, stereo or other audio equipment, or computerized gaming equipment); or

- (e) Specialized electric and plumbing systems that are necessary to accommodate medical equipment and supplies.

1913.6 To be approved as an OTT service, the services shall be:

- (a) Prior authorized by the Department on Disability Services; and
- (b) Installed in one of the following:
  - (1) The person's own home; or
  - (2) An apartment or other rental property in which the person resides where the owner or service provider does not provide and is not compensated for furnishings, utensils and other items necessary to operate a household.

1913.7 Each provider of OTT service shall:

- (a) Be a non-profit organization, home health agency, social service agency, or other business entity and shall meet the requirements set forth in Chapter 19 of Title 29 DCMR;
- (b) Have a current District of Columbia Medicaid Provider Agreement that authorizes the provider to bill for OTT services under the Waiver; and
- (c) Comply with all applicable business licensing requirements in the District of Columbia or in the jurisdiction where OTT services are provided.

1913.8 Reimbursement for OTT service shall be limited to a maximum of five thousand dollars (\$5,000) per person as a one-time non-recurring expense. Reimbursement for OTT service shall require written documentation of the specific expenditure or purchase for which reimbursement is claimed.

### **1913.99 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*.

**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.

**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 a new section 1914 of Chapter 19 of Title 29 of the District of Columbia Municipal Regulations (DCMR), entitled "Vehicle Modification Services." These rules establish standards governing reimbursement by the District of Columbia Medicaid program for vehicle modification services provided by qualified 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).

These rules establish standards governing the provision of VM services for persons participating in the Waiver. VM services is a new service designed to help the participant living in a natural home or with a primary caregiver to function with greater independence by adapting the vehicle to make it accessible to the participant (such as by installation of a wheelchair lift) or for the participant to drive. The service is limited to two (2) vehicles in a five (5) year period and a maximum of \$10,000 for this service per participant in a five (5) year period.

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 rules was published in the *DC Register* on December 7, 2007 (54 DCR 011765). 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*.

New section 1914 (Vehicle Modification Services) of Chapter 19 of Title 29 DCMR is added to reads as follows:

**1914           VEHICLE MODIFICATION SERVICES**

1914.1           Vehicle modification (VM) services shall be reimbursed 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.

- 1914.2 VM services are physical adaptations to a vehicle, required by a person's individual habilitation plan (IHP) or individual service plan (ISP) and Plan of Care that are necessary to ensure the health, welfare, and safety of a person, or that enable a person to live with greater independence in the community, and without which the person would be more likely to require institutionalization.
- 1914.3 VM services eligible for reimbursement shall be as follows:
- (a) Hydraulic lifts;
  - (b) Access ramps;
  - (c) Modified doors;
  - (d) Modified seating;
  - (e) Installing equipment to secure a wheelchair or other assistive technology device; and
  - (f) Installing equipment to make access, egress, or travel more comfortably, safe and secure.
- 1914.4 VM services shall be necessary to ensure the health, welfare, or safety of the person and enable the person to function with greater independence.
- 1914.5 To be approved as VM services, the services shall be:
- (a) Pre-authorized by the Department on Disability Services (DDS);
  - (b) Installed in one of the following:
    - (1) The person's vehicle; or
    - (2) The vehicle of the person's family, guardian, or other primary caretaker who is not providing Residential Habilitation Services or Supported Living Services.
- 1914.6 VM services shall not include the purchase or installation of child car seats; or the purchase of a vehicle or modification, adaptations or improvements to the vehicle that are of general utility or aesthetics and make no direct medical or remedial benefit to the person.
- 1914.7 VM services shall be authorized by the interdisciplinary team and provided in accordance with the person's IHP or ISP and Plan of Care.
- 1914.8 Each provider of VM services shall:

- (a) Be a non-profit organization or other business entity;
  - (b) Have a current District of Columbia Medicaid Provider Agreement that authorizes the provider to bill for VM services under the Waiver; and
  - (c) Comply with all applicable business licensing requirements in the District of Columbia or in the jurisdiction where VM services are provided.
- 1914.9 Before approving VM services, the provider of VM services shall perform an evaluation which:
- (a) Confirms that the vehicle is structurally sound;
  - (b) Confirms that the vehicle can accommodate the proposed VM services; and
  - (c) Recommends how the VM services should be installed.
- 1914.10 VM services shall be provided consistent with any stipulations or recommendations from the dealer of the vehicle's make and model.
- 1914.11 VM services shall be provided in accordance with the applicable federal, District, state, or local vehicle codes.
- 1914.12 Reimbursement for VM services shall be limited to ten thousand dollars (\$10,000) per participant over a five (5) year period and shall be limited to modifications to no more than two (2) vehicles in a five (5) year period. Exceptions to the five (5) year limitations in this paragraph on VM services may be approved by DDS on a case by case basis, with adequate supporting documentation.
- 1914.13 Reimbursement for VM services shall require written documentation of the specific expenditure or purchase for which reimbursement is claimed.

#### **1914.99 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*.

**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.

**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.