

DEPARTMENT OF HEALTH

NOTICE OF EMERGENCY AND PROPOSED 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, on an emergency basis, 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.

Emergency action is necessary for the immediate preservation of the health, safety, and welfare of Waiver participants who are in need of PERS services. These emergency rules are needed so that, on the effective date of the Waiver as modified, there will be rules in place consistent with the provisions of the Waiver as modified to update 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. The emergency rulemaking was adopted on November 19, 2007, and became effective on November 20, 2007. The emergency rules will remain in effect for 120 days or until March 17, 2008, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*, whichever comes first.

The Director also gives notice of the intent to take final rulemaking action to adopt these proposed rules not less than thirty (30) days from the date of publication of this notice in the *D.C. 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 1911 of 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.

Comments on the proposed rules shall be submitted in writing to Robert T. Maruca, Senior Deputy Director, Medical Assistance Administration, Department of Health, 825 North Capitol Street, N.E., 5th Floor, Washington, DC 20002, within thirty (30) days from the date of publication of this notice in the *D.C. Register*. Copies of the proposed rules may be obtained from the same address.

DEPARTMENT OF HEALTH

NOTICE OF EMERGENCY AND PROPOSED 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, on an emergency basis, of an amendment of section 934 (Physical Therapy 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 physical therapy services provided 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 53 DCR 97 (January 6, 2006) by providing for more effective planning and follow-up reporting. Emergency action is necessary for the immediate preservation of the health, safety, and welfare of Waiver participants who are in need of physical therapy services. These emergency rules are needed so that, on the effective date of the Waiver as modified, there will be rules in place consistent with the provisions of the Waiver as modified to include more effective planning and follow-up reporting.

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. The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, has also approved the corresponding Waiver with an effective date of November 20, 2007. The emergency rulemaking was adopted on November 19, 2007, and became effective on November 20, 2007. The emergency rules will remain in effect for one hundred twenty (120) days or until March 17, 2008, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*, whichever comes first.

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

Section 934 of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

934 PHYSICAL THERAPY SERVICES

- 934.1 Physical therapy 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.
- 934.2 To be eligible for reimbursement, physical therapy services shall be:
- (a) Ordered by the person's physician;
 - (b) 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
 - (c) Included in the person's individual habilitation plan or individual support plan and Plan of Care.
- 934.3 Each individual providing physical therapy services shall be an employee of a home health agency or a physical therapist in private practice with a current District of Columbia Medicaid Provider Agreement that authorizes the provider to bill for physical therapy services under the Waiver.
- 934.4 In addition to the other requirements of this section, a physical therapist 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 million dollars in professional 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) Physical therapy assistants and physical therapy aides shall be personally supervised by the physical therapist. Assistants and aids shall also be employed by the physical therapist or the partnership group to which the physical therapist belongs or the same private practice that employs the physical therapist. Personal supervision requires the physical therapist to be in the room during the performance of the service.

- 934.5 Each individual providing physical therapy services shall:
- (a) Be a licensed physical therapist;
 - (b) Have a minimum of two (2) years of experience as a physical therapist;
 - (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 thereof 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
 - (g) 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.*).
- 934.6 Each physical therapist, at least annually, shall provide the Department on Disability Services (DSS) and the Department of Health, Medical Assistance Administration, with a brochure, in printed or electronic form, listing his or her academic background, licensure information, experience, and the nature of his or her practice to assist Waiver enrollees in making provider selection decisions.
- 934.7 Physical therapists, without regard to their employer of record, shall be selected by the person to receive services, or that person's 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 availability events shall request a case conference with the DDS Case Manager so that the person receiving services may select a new practitioner.
- 934.8 The duties of each provider shall include, at a minimum, the following:
- (a) Preparing a report that summarizes the physician's order, measures the person's strength, range of motion, balance and coordination, posture, muscle performance, respiration, and motor functions. Additionally, developing and describing treatment plans that provide treatment strategies, including direct therapy, training caregivers, monitoring

requirements, monitoring instruments, monitoring instructions, and anticipated outcomes;

- (b) Maintaining ongoing involvement and consultation with other service providers and caretakers;
- (c) Ensuring that the person's needs are met in accordance with the physician's order;
- (d) Providing consultation and instruction to the person, family, or other caregivers;
- (e) Recording progress notes on each visit; and
- (f) Conducting periodic examinations and modifying treatments for the person receiving services, when necessary.

934.9 The physical therapist shall be responsible for providing written documentation in the form of reports, assessments for physical therapy services, physician's orders, 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 as authorized for physical therapy services in the physician's order. The home health agency or physical therapist in private practice shall maintain a copy of the documentation for at least six (6) years after concluding services to the person.

934.10 The reimbursement rate for physical therapy services shall be sixty-five dollars (\$65.00) an hour for a full assessment of the individual, preparation of summary documentation, and delivery of that documentation. The billable unit of service for physical 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 in order to bill a unit of service. Billable services shall include updating medical records and verifying that the summary documentation was delivered to the person, or his or her guardian or legal representative, to the physician, and to DDS.

934.11 The reimbursement rate for ongoing physical therapy services shall be sixty-five dollars (\$65.00) per hour for the period specified in the physical therapy report and approved by the physician. The billable unit of service for physical 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 in order to bill a unit of service.

934.12 For persons between the ages of 18 and 21 years, EPSDT under the District of Columbia State Plan for Medical Assistance shall be fully utilized before accessing physical therapy services under the Waiver.

934.99 **DEFINITIONS**

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

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 – The successor to the IHP as defined in the 2001 Plan for Compliance and Conclusion of *Evans v. Williams*.

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

Physical Therapy Services – The practice of physical therapy, as defined by section 102(12)(A) of the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.02(12)(A)).

Physical Therapy Aide – An individual who works only under the direct supervision of a physical therapist, and whose activities do not require advanced training in, or complex application of, therapeutic procedures or other standard procedures involved in the practice of physical therapy.

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

Physician – An individual who is licensed to practice medicine pursuant to section 501 of the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1205.01) or licensed to practice medicine 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 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.

Private Practice – An individual whose practice is a partnership or an unincorporated solo practice. Private practice also includes an individual who is practicing physical therapy as an employee of an unincorporated practice, a professional corporation, or other incorporated therapy practice. Private practice does not include individuals 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 physical therapy services team that summarizes facts about a person's care and response to treatment during a given period of time.

Provider – An individual or business entity that provides physical therapy services pursuant to this chapter.

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.

Comments on the proposed rules shall be submitted in writing to Robert T. Maruca, Senior Deputy Director, Medical Assistance Administration, Department of Health, 825 North Capitol Street, N.E., 5th Floor, Washington, D.C. 20002, within thirty (30) days from the date of publication of this notice in the *D.C. Register*. Copies of the proposed rules may be obtained from the same address.

DEPARTMENT OF HEALTH**NOTICE OF EMERGENCY AND PROPOSED 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, on an emergency basis, 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.

Emergency action is necessary for the immediate preservation of the health, safety, and welfare of Waiver participants who are in need of behavioral support services. These emergency rules are needed so that, on the effective date of the Waiver as modified, there will be rules in place consistent with the provisions of the Waiver as modified to change the name of the services to Behavioral Support Services, focus on the preventive and consultative services while removing some of the crisis services which will be duplicative of Community Support Team Services, and modify 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. The emergency rulemaking was adopted on November 19, 2007 and will become effective on November 20, 2007. The emergency rules will remain in effect for 120 days or until March 18, 2008, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*, whichever comes first.

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

Comments on the proposed rules shall be submitted in writing to Robert T. Maruca, Senior Deputy Director, Medical Assistance Administration, Department of Health, 825 North Capitol Street, N.E., 5th Floor, Washington, DC 20002, within thirty (30) days from the date of publication of this notice in the *D.C. Register*. Copies of the proposed rules may be obtained from the same address.

DEPARTMENT OF HEALTH

NOTICE OF EMERGENCY AND PROPOSED 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, on an emergency basis, 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).

Emergency action is necessary for the immediate preservation of the health, safety, and welfare of Waiver participants who are in need of personal care services. These emergency rules are needed so that, on the effective date of the Waiver as modified, there will be rules in place consistent with the provisions of the Waiver as modified to establish standards for personal care services and update the prohibition against concurrent payments to reflect new Waiver services.

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. The emergency rulemaking was adopted on November 19, 2007, and will become effective on November 20, 2007. The emergency rules will remain in effect for 120 days or until March 18, 2008, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*, whichever comes first.

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

Comments on the proposed rules shall be submitted in writing to Robert T. Maruca, Senior Deputy Director, Medical Assistance Administration, Department of Health, 825 North Capitol Street, N.E., 5th Floor, Washington, D.C. 20002, within thirty (30) days from the date of publication of this notice in the *D.C. Register*. Copies of the proposed rules may be obtained from the same address.

DEPARTMENT OF HEALTH

NOTICE OF EMERGENCY AND PROPOSED 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, on an emergency basis, of a new section 1915 of Chapter 19 of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR), entitled "Host Home Services." These rules establish standards governing reimbursement by the District of Columbia Medicaid program for host home services provided by community homeowners and 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 is a new rule that pays homeowners in the community to support persons in the Waiver to live in their home. The homeowner will utilize a portion of the participant's benefits and income for room and board as determined by the Department on Disability Services (DDS). Direct support services and supervision are funded through the Waiver under foster care payment rules. Host Home Services shall be operated by Residential Habilitation Services and Supported Living Services providers who will recruit, train, supervise, and support the homeowner. The service will have a daily rate that includes the direct service and a portion of the rate to be applied to the contract provider to coordinate services and provide respite and supports as necessary.

Emergency action is necessary for the immediate preservation of the health, safety, and welfare of Waiver participants who are in need of host home services. These emergency rules are needed so that, on the effective date of the Waiver as modified, there will be rules in place consistent with the provisions of the Waiver as modified to permit homeowners in the community to support persons in the Waiver to live in their home.

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. The emergency rulemaking was adopted on November 19, 2007, and will become effective on November 20, 2007. The emergency rules will remain in effect for 120 days or until March 18, 2008, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*, whichever comes first.

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

New section 1915 (Host Home Services) of Chapter 19 of Title 29 DCMR is added to read as follows:

1915 HOST HOME SERVICES

- 1915.1 Host Home services shall be reimbursed by the District of Columbia Medicaid Program for each participant 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.
- 1915.2 To be eligible for reimbursement, Host Home services shall be provided in a Host Home that meets the Department on Disability Services (DDS) Certification Standards as set forth in the Human Care Agreement between the Host Home and DDS.
- 1915.3 Each Host Home located out-of-state shall be licensed or certified in accordance with the host state's laws and regulations and consistent with the terms and conditions set forth in an agreement between the District of Columbia and the host state. Each out-of-state provider shall comply with the following additional requirements:
- (a) Remain in good standing in the jurisdiction where the program is located;
 - (b) Submit a copy of the annual certification or survey performed by the host state and provider's corrective action to DDS; and
 - (c) Allow authorized agents of the District of Columbia government, federal government, and governmental officials of the host state full access to all sites and records for audits and other reviews.
- 1915.4 Host Home services shall only be available to a person with a demonstrated need for continuous training, assistance, and supervision, and shall be authorized and provided in accordance with the person's current Individual Habilitation Plan (IHP) or Individual Support Plan (ISP) and Plan of Care.
- 1915.5 Host Home services refer to a residential arrangement in which a homeowner provides room, board, personal supports and assistance to a person in a Host Home. The services provided by a Host Home shall include, but are not limited to:
- (a) Room and board (not included in the Waiver reimbursement rate);
 - (b) Light homemaker tasks, such as assistance with meal preparation;
 - (c) Light chore tasks, such as assistance with laundry, shopping, and general housekeeping;
 - (d) General supervision of the person as described in the IHP or ISP and Plan of Care;
 - (e) Maintenance of medical records;

- (f) Maintenance of financial records;
- (g) Maintenance of the IHP or ISP and Plan of Care;
- (h) Assistance with attending health care appointments, including coordinating, but not providing, transportation to and from the appointments;
- (i) Assistance with planning and attending community events; and
- (j) Providing habilitative support in activities of daily living as described in the IHP or ISP and Plan of Care.

1915.6

Host Home services shall be administered by Supported Living Service or Residential Habilitation Service providers, which in this section shall be referred to as the Contract Provider. Each Contract Provider of Host Home services shall be a social services agency as described in Chapter 19 of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR), Section 1903.1. In addition, the Contract Provider agrees to:

- (a) Be a member of the person's interdisciplinary team;
- (b) Have a current District of Columbia Medicaid Provider Agreement that authorizes the provider to bill for Residential Habilitation Services or Supported Living 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/MRDDA for each person;
- (d) Ensure that all persons associated with Host Home services are qualified and properly supervised to include having a plan to provide staff interpreters for non-English speaking residents;
- (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.*).

1915.7

Each person providing Host Home services shall meet all of the requirements in Chapter 19 to Title 29 of the District of Columbia Municipal Regulations (DCMR), section 1911, "Requirements for employees providing direct services."

- 1915.8 Each person providing host home services agrees to cooperate and attend mandatory training sessions provided by DDS and the Contract Provider and to allow DDS case managers and other DDS employees free and unfettered access to the Host Home.
- 1915.9 The role of the Contract Provider in Host Home placement shall be to:
- (a) Receive and review packets submitted by the DDS requesting development of a Host Home for a particular applicant;
 - (b) Respond to inquiries for Host Home development in a timely manner;
 - (c) Recruit appropriate Host Home settings for persons;
 - (d) Identify and develop on-going working relationships with needed local professional resources (*e.g.*, dentist, physician, psychiatrist, psychologist, occupational therapist, physical therapist, etc.);
 - (e) Provide for a minimum of one (1) visit by the participant to the prospective home, one of which may be an overnight stay if more visits are possible;
 - (f) Coordinate transportation in cooperation with the DDS case manager for visits to the prospective Host Home;
 - (g) Participate in a person centered planning process to develop the participant's IHP or ISP and Plan of Care;
 - (h) Arrange for essential supports to be in place prior to a participant's move into a Host Home setting, including provision of training to support persons and provision of necessary supplies and equipment;
 - (i) Arrange for non-essential but recommended and necessary supports to be put into place subsequent to a participant's move into a Host Home setting; and
 - (j) Provide information as needed to the participant and responsible party, DDS and the Host Home.
- 1915.10 The Contract Provider shall be responsible for coordinating compliance with DDS policies and procedures governing reporting of unusual incidents, human rights, behavior management, and protection of person's funds using, but not limited to, by the following means:
- (a) Contract Providers shall provide Host Homes with appropriate training on DDS policies;
 - (b) Contract Providers shall provide Host Homes with appropriate training on incident reporting procedures; and
 - (c) Contract Providers shall coordinate each incident investigation at Host Homes.
- 1915.11 The Contract Provider shall coordinate the delivery of professional services to persons in Host Homes that may include, but are not limited to, the following disciplines or services:

- (a) Health Care;
- (b) Dentistry;
- (c) Education;
- (d) Nutrition;
- (e) Nursing;
- (f) Occupational therapy;
- (g) Physical therapy;
- (h) Behavioral Support;
- (i) Community Supports;
- (j) Social work;
- (k) Speech, hearing and language therapy; and
- (l) Recreation.

1915.12 The Contract Provider shall coordinate the use of transportation for persons in Host Homes to day programs, places of employment, and/or community outings as needed.

1915.13 The Contract Provider shall coordinate general support monitoring at least twice per month to update activity schedules, reviewing medical and other appointments, making progress notes, and reviewing conditions in the Host Home and the status of the person.

1915.14 The Contract Provider shall coordinate health care monitoring for persons in Host Homes including, at a minimum, monitoring by a registered nurse at least every sixty (60) days for persons with no medications, and monthly for charting, progress notes, and a general review of persons receiving medications.

1915.15 The Contract Provider shall provide respite to the caregiver and emergency support up to a total of fourteen (14) days per year. If respite and emergency support services are provided in the Host Home, then host home services payments shall continue. If respite and emergency support services are provided in another location, then the host home services percentage of the reimbursement rate shall be paid to the Contract Provider.

1915.16 Each Host Home and Contract Provider shall assist residents in the acquisition, retention, and improvement of skills related to activities of daily living, such as personal grooming, household chores, eating and food preparation, and other social adaptive skills necessary to enable the person to reside in the community. To accomplish these goals, the Host Home and Contract Provider shall:

- (a) Within the first month of residence, use observation, conversation, and other interactions as necessary to develop a functional analysis of the person's capabilities;

- (b) Develop a plan with measurable outcomes using the functional analysis, the IHP or ISP and Plan of Care, and other information available to identify to the extent possible the skills necessary to enable the person to reside in the community while maintaining the person's health and safety; and
 - (c) On a quarterly basis, report to the person, family, guardian, DDS Case Manager on the programming and support provided to help the person to achieve the identified outcomes.

- 1915.17 Each Contract Provider of host home services shall ensure the coordination of transportation services to enable the person to gain access to Waiver and other community services and activities.

- 1915.18 Each Contract Provider of host home services shall maintain all records and reports for at least six (6) years after the person's date of discharge.

- 1915.19 The following individuals shall not be permitted to provide host home services:
 - (a) Legal guardian;
 - (b) Parent of a minor child; or
 - (c) Spouse.

- 1915.20 The reimbursement rate for host home services is a daily inclusive rate based on acuity of the participant. The acuity level will be determined by DDS based on the results of the Support Intensity Scale as documented in the person's ISP or IHP. The basic support rate shall be seventy-six dollars (\$76.00) per day; the moderate support rate shall be ninety dollars (\$90.00) per day; and the intensive support rate shall be one hundred twenty-one dollars (\$121.00) per day. The host home services reimbursement rate shall include:
 - (a) All training for Host Home workers;
 - (b) Programmatic supplies;
 - (c) General and administrative fees for waiver services;
 - (d) Relief of the caregiver and emergency support; and
 - (e) All direct support costs.

- 1915.21 Seventy-five (75) percent of the daily reimbursement rate shall be paid to the Host Home by the Contract Provider for support services. The remaining twenty-five (25) percent of the daily reimbursement rate shall be retained by the Contract Provider for training, general and administrative fees for waiver services, general supervision, and relief and emergency coverage.

- 1915.22 Host Home services shall not be payable or be billed for the same day that the following other Waiver services are provided to the person:

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

1915.23 Host Home services shall not be payable or be billed when the person is hospitalized, on vacation, or for any other period in which the person is not residing at the Host Home.

1915.99 DEFINITIONS

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

Contract Provider – A Supported Living Service provider or Residential Habilitation Service provider which, in accordance with this section, is administering Host Home Services at a Host Home on behalf of a Homeowner.

Direct Care Staff – Individuals employed to work in the Host 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.

Homeowner – A person(s) who is(are) the primary owner or leasor of a residential property. Evidence satisfactory to the Department on Disability Services of a title or a lease must be provided annually or any time a move is proposed.

Host Home – The residence owned or leased by the Home Owner where the person will reside for purposes of Host Home services under the Waiver.

Licensed Practical Nurse – A person who is licensed to practice practical nursing pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986, (D.C. Law 6-99; D.C. official Code § 3-1201 *et seq.*) or licensed as a practical nurse 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 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.

Registered Nurse – A person who is licensed to practice registered nursing pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986, (D.C. Law 6-99; D.C. Official Code § 3-1201 *et seq.*) or licensed as a registered nurse in the jurisdiction where services are provided.

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.

Comments on the proposed rules shall be submitted in writing to Robert T. Maruca, Senior Deputy Director, Medical Assistance Administration, Department of Health, 825 North Capitol Street, N.E., 5th Floor, Washington, DC 20002, within thirty (30) days from the date of publication of this notice in the *D.C. Register*. Copies of the proposed rules may be obtained from the same address.

D.C. DEPARTMENT OF HUMAN RESOURCES**NOTICE OF EMERGENCY RULEMAKING**

The Director, D.C. Department of Human Resources, with the concurrence of the City Administrator, pursuant to Mayor's Order 2000-83, dated May 30, 2000, and in accordance with Title XI of the District of Columbia Government Comprehensive Merit Personnel Act of 1978 (CMPA), effective March 3, 1979 (D.C. Law 2-139; D.C. Official Code § 1-611.01 *et seq.*) (2001), as amended on an emergency basis by the Operation Enduring Freedom and Operation Iraqi Freedom Active Duty Pay Differential Extension Emergency Amendment Act of 2007, effective October 17, 2007 (D.C. Act 17-143, published at 54 DCR 10745 (November 9, 2007)), and any similar succeeding legislation (jointly referred to as the "Act"), hereby gives notice of the adoption of the following emergency rules. The Act continues the authorization for the pay differential to District government employees called to active duty from reserve units of the United States Armed Forces as a result of Operation Enduring Freedom, or in preparation for or as a result of Operation Iraqi Freedom; and requires that rules be issued to implement its provisions. Because the emergency and proposed rules on the pay differential effective April 3, 2007 and published in the *D.C. Register* at 54 DCR 5048 (May 18, 2007) have expired; to ensure the welfare of the public; and communicate the provisions of the Act to the public and affected employees, action was taken on November 29, 2007 to adopt the following rules on an emergency basis effective November 29, 2007, to add a new section 1155 to Chapter 11, Classification and Compensation, of Title 6 of the District of Columbia Municipal Regulations, implementing the provisions of the Act. These rules will remain in effect for up to one hundred twenty (120) days from November 29, 2007, unless earlier superseded by another rulemaking notice.

CHAPTER 11**CLASSIFICATION AND COMPENSATION**

A new section 1155 is added to read as follows:

**1155 OPERATION ENDURING FREEDOM AND OPERATION IRAQI FREEDOM
PAY DIFFERENTIAL**

- 1155.1 (a) Any full-time permanent employee, term employee, or an employee on a Temporary Appointment Pending Establishment of a Register (TAPER) who serves in a reserve component of the armed forces and who has been ordered to active duty, or was retained for duty as a result of Operation Enduring Freedom, or in preparation for a potential conflict with Iraq, or as a result of Operation Iraqi Freedom, shall be entitled to apply for and receive, or continue to receive, as applicable, a pay differential to compensate the employee for any difference between the employee's District government basic pay and basic military pay.

- (b) For the purposes of this section, the phrase “any full-time permanent employee, term employee, or an employee on a Temporary Appointment Pending Establishment of a Register (TAPER)” in section 1151.1 (a) of this section, shall include at-will employees.
- 1155.2 An employee as described in section 1155.1 of this section shall not be required to be released from active duty before making application for and receiving the pay differential. However, if the employee has not been released from active duty when he or she makes application for the pay differential, the employee shall provide all documentation required in section 1155.9 of this section, except that in lieu of providing a copy of the military orders releasing the employee from active duty, the employee shall provide a letter from his or her commanding officer attesting to the fact that the employee, as of the date of application for the pay differential, is still in an active duty status.
- 1155.3 A pay differential received pursuant to this section shall not be considered basic pay for any purpose.
- 1155.4 Any eligible employee, upon making application for the pay differential and upon approval of the application by his or her department or agency head, shall receive a pay differential that equals the difference between the employee’s District government basic pay reduced by the employee’s basic military pay.
- 1155.5 The estate of any eligible employee who has been killed while in active duty or who is missing in action as a result of active duty shall be eligible to collect any pay differential to which the employee would have been entitled upon making application on behalf of the employee and upon approval of the application by the employee’s department or agency head.
- 1155.6 The period of entitlement to the pay differential shall not exceed:
- (a) The period following the formal inception of Operation Enduring Freedom through the date the employee is released from active duty occasioned by Operation Enduring Freedom; or
- (b) The period following the formal inception of the preparations for a potential conflict with Iraq and the period following the formal inception of Operation Iraqi Freedom through the date the employee is released from active duty occasioned by, the preparation for, or, Operation Iraqi Freedom.
- 1155.7 The pay differential shall not be payable for any period following the employee’s release from active duty and the employee’s return to his or her District government position.
- 1155.8 The pay differential shall not be payable for any days for which the employee received pay by reason of any annual leave, military leave, compensatory time, or any other form of paid leave taken by the employee.

- 1155.9 In making application for the pay differential, the employee shall:
- (a) Provide a copy of the military orders activating the employee for full-time active military service for the Operation Enduring Freedom conflict, or, in preparation for, or, as a result of, the Operation Iraqi Freedom conflict;
 - (b) Provide a copy of the military orders releasing the employee from full-time active military service for the Operation Enduring Freedom conflict, or, for the preparation for, or, the Operation Iraqi Freedom conflict; and
 - (c) Provide all military pay documentation required to calculate the differential amount.
- 1155.10 A pay differential under this section shall be paid by the agency that last employed the eligible employee before the employee was ordered to active duty as specified in section 1155.1 of this section, out of the agency's funds or appropriations then currently available for salaries and expenses.

1155.99 DEFINITIONS

Active duty – full-time duty in the active military service of the United States for the Operation Enduring Freedom conflict, or, in preparation for, or, for the Operation Iraqi Freedom conflict.

Armed forces – has the meaning prescribed in 10 U.S.C. § 101 (a)(4).

Basic military pay – the basic pay under 37 U.S.C. § 204.

Basic pay – the employee's scheduled rate of pay plus any additional pay that is defined as basic pay for annuity computation purposes in the retirement system in which the employee is a participant.

Employee – any full-time permanent employee, term employee, or an employee on a TAPER appointment who serves in a reserve component of the United States Armed Forces and who has been called to active duty as a result of the Operation Enduring Freedom conflict, or in preparation for, or as a result of the Operation Iraqi Freedom conflict.

Operation Enduring Freedom – the period encompassed within Executive Order 13223 Ordering the Ready Reserve of the Armed Forces to Active Duty and Delegating Certain Authorities to the Secretary of Defense and the Secretary of Transportation, effective September 14, 2001, and amended by Amendment to Executive Order 13223, effective January 16, 2002 and ending on the date the employee is released from active duty occasioned by Operation Enduring Freedom.

Operation Iraqi Freedom – the period encompassed within the Joint Resolution entitled Authorization for Use of Military Force Against Iraq Resolution of 2002, approved October 16, 2002 (P.L. 107-243) and ending on the date the employee is released from active duty occasioned by Operation Iraqi Freedom.

Reserve component – has the meaning prescribed in 37 U.S.C. § 101 (24).

**DISTRICT OF COLUMBIA
DEPARTMENT OF INSURANCE, SECURITIES, AND BANKING**

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Commissioner of the Department of Insurance, Securities, and Banking, pursuant to the authority set forth in section 22 of the Captive Insurance Company Act of 2004, effective March 17, 2005 (D.C. Law 15-262; D.C. Official Code § 31-3931.21), hereby gives notice of the adoption on an emergency basis of the following amendments to Title 26 (Insurance) of the District of Columbia Municipal Regulations. This emergency action is necessary to ensure that regulations governing the licensing and regulation of reciprocal insurers are in place to protect the policyholders of such companies operating in and from the District. The purpose of the rules is to provide a regulatory scheme that will allow captive insurance companies to organize or reorganize in the District as reciprocal insurance companies.

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

These emergency regulations were adopted on October 29, 2007 and shall be effective on November 26, 2007. The emergency regulations shall expire 120 days after their effective date, or upon publication in the *D.C. Register* of a Notice of Final Rulemaking, whichever occurs first.

A new chapter 40 of Title 26 of the DCMR is added to read as follows:

CHAPTER 40 RECIPROCAL INSURANCE COMPANIES

4001 AUTHORIZATION AND APPLICABILITY

4001.1 Any captive insurer may organize or reorganize and operate as a reciprocal insurer, subject to the act and these regulations. These regulations shall apply to all captive insurers organized as reciprocal insurers. It specifies the terms on which a reciprocal insurer may receive a certificate of authority and operate in the District of Columbia. These regulations provide for the licensing and regulation of reciprocal insurers, the conversion of a domestic stock or mutual insurance company into a domestic reciprocal insurer, the merger of a domestic reciprocal insurer with another reciprocal insurer, and the conversion of a domestic reciprocal insurer into a stock or mutual insurance company.

4002 EXISTING RECIPROCAL

4002.1 Existing authorized reciprocal insurers shall, after January 1, 2009, comply with these regulations and shall make such amendments to their subscribers' agreement, power of attorney, policies, and other documents and accounts and perform such other acts as may be required for such compliance.

and accounts and perform such other acts as may be required for such compliance.

4003 INSURING POWERS OF RECIPROCAL

4003.1 A reciprocal insurer may, upon qualifying under the act, transact any kind or kinds of insurance defined by the act.

4003.2 A reciprocal insurer may purchase reinsurance upon the risk of any subscribers and may grant reinsurance as to any kind of insurance it is authorized to transact directly.

4004 NAME, SUITS, AND POWERS

4004.1 No reciprocal insurer shall be authorized to transact business in the District unless the name under which reciprocal contracts are to be exchanged shall include the word "reciprocal" or be supplemented by the following words immediately below the name under which such contracts are exchanged: "A reciprocal".

4004.2 A reciprocal insurer may sue and be sued in its own name.

4004.3 A reciprocal insurer may own property in its own name.

4004.4 A reciprocal insurer shall have the power to borrow and lend money from or to any person.

4004.5 A reciprocal insurer shall have the power to the fullest extent permitted by law to indemnify its officers, employees, or agents and members of the subscriber's advisory committee.

4004.6 A reciprocal insurer shall have and exercise all powers necessary or convenient to effect any and all of the purposes for which it is formed and which are authorized by the act.

4005 ATTORNEY, SUBSCRIBERS, AND RECIPROCAL INSURER A SINGLE ENTITY

4005.1 "Attorney", as used in this chapter, means the attorney-in-fact of a reciprocal insurer. The attorney may be an individual, firm, or corporation.

4005.2 The attorney of a foreign reciprocal insurer, which insurer is duly authorized to transact insurance in the District, shall not, by virtue of discharge of its duties as such attorney with respect to the insurer's transactions in the District, be thereby deemed to be doing business in the

District within the meaning of any laws of the District applying to foreign persons, firms, or corporations.

4005.3 The subscribers and the attorney-in-fact comprise a reciprocal insurer and are a single entity for:

- (a) All fees, charges, and taxes imposed by the act; and
- (b) Any operation conducted under the reciprocal insurer's certificate of authority.

4006 ORGANIZATION OF RECIPROCAL INSURER

4006.1 Three or more persons may organize a domestic reciprocal insurer and make application to the Commissioner for a certificate of authority to transact insurance.

4006.2 The proposed attorney shall fulfill the requirements of and shall execute and file with the Commissioner when applying for a certificate of authority, a declaration verified by the oath of such attorney, or when such attorney is a corporation by the oath of an officer thereof, setting forth:

- (a) The name of the insurer;
- (b) The location of the insurer's registered office, which shall be the same as the registered office of the attorney and shall be maintained within the District;
- (c) The kinds of insurance proposed to be transacted;
- (d) The names and addresses of the original subscribers;
- (e) The designation and appointment of the proposed attorney and a copy of the power of attorney;
- (f) The names and addresses of the officers and directors of the attorney, if a corporation, or of its members, if a firm;
- (g) The powers of the subscribers' advisory committee and the names and terms of office of the members thereof;
- (h) That all moneys paid to the reciprocal shall, after deducting therefrom any sum payable to the attorney, be held in the name of the insurer and for the purposes specified in the subscribers' agreement;

- (i) A statement that each of the original subscribers has in good faith applied for insurance of a kind proposed to be transacted and that the insurer has received from each such subscriber the full premium or premium deposit required for the policy applied for, for a term of not less than three months at the rate provided therein; and
- (j) A pro-forma statement of the financial condition of the insurer, a schedule of its assets and a statement that the surplus as required by the act is available.

4006.3 Any domestic stock or mutual insurance company may convert to a domestic reciprocal insurer in accordance with a plan filed with and approved by the Commissioner. Upon approval of a plan the Commissioner shall issue a new or amended certificate of authority which shall be the final act of conversion. The new domestic reciprocal insurer shall be the continuation of the converted stock or mutual company and be deemed organized on the date the converted stock or mutual company was organized.

4006.4 No declaration shall be required under this section for any reciprocal insurer organized in the District as a result of a conversion under subsection (3) of this section.

4007 CERTIFICATE OF AUTHORITY

4007.1 The certificate of authority of a reciprocal insurer shall be issued to its attorney in the name of the insurer.

4007.2 The Commissioner may refuse to issue, suspend, or revoke the certificate of authority, in addition to any other applicable grounds, for failure of the attorney to comply with any applicable provision of the act or this chapter.

4008 POWER OF ATTORNEY

4008.1 The rights and powers of the attorney of a reciprocal insurer shall be as provided in the power of attorney given it by the subscribers.

4008.2 The power of attorney must set forth:

- (a) The powers of the attorney;
- (b) The general services to be performed by the attorney;

- (c) The maximum amount to be deducted from advance premiums or deposits to be paid to the attorney and the general items of expense in addition to losses to be paid by the insurer; and
- (d) A provision for a contingent several liability of each subscriber who is issued an assessable policy in a specified amount, which amount shall not be less than one or more than ten times the premium or premium deposit stated in the policy.

4008.3

The power of attorney may:

- (a) Provide for the right of substitution of the attorney and revocation of the power of attorney and rights thereunder;
- (b) Impose such restrictions upon the exercise of the power as are agreed upon by the subscribers;
- (c) Provide for the exercise of any right reserved to the subscribers directly or through their advisory committee;
- (d) Provide that only non-assessable policies shall be issued; and
- (e) Contain other lawful provisions deemed advisable.

4008.4

The terms of any power of attorney or agreement collateral thereto shall be reasonable and equitable, and no such power or agreement or modification thereof shall be used by a domestic reciprocal or be effective in the District until approved by the Commissioner.

4009**MODIFICATIONS**

4009.1

Modifications of the terms of the subscribers' agreement or of the power of attorney of a domestic reciprocal insurer shall be made jointly by the attorney and the subscribers' advisory committee. Without additional notice, execution, or acceptance, every subscriber shall be bound by any modification of the subscriber agreement or power of attorney. However, no such modification shall be effective retroactively nor as to any insurance contract issued prior thereto unless agreed to by the affected subscriber.

4010**ATTORNEY'S BOND**

4010.1

Concurrently with the filing of the declaration provided for in section 4006 of this chapter, the attorney of a domestic reciprocal insurer shall file with the Commissioner a bond in favor of the reciprocal for the benefit of all persons damaged as a result of breach by the attorney of the conditions

of the attorney's bond as set forth in subsection (2) of this section. The bond shall be executed by the attorney and by an authorized corporate surety and shall be subject to the Commissioner's approval.

4010.2 The amount of the bond shall be \$250,000, in aggregate form, and be conditioned so that the attorney will faithfully account for all moneys and other property of the insurer coming into the attorney's hands, and that such attorney will not withdraw, or appropriate for his/her own use, the funds of the insurer or any moneys or property to which he/she is not entitled under the power of attorney.

4010.3 The bond shall provide that it is not subject to cancellation unless 30 days advance notice in writing of cancellation is given to both the attorney and the Commissioner.

4011 DEPOSIT IN LIEU OF BOND

In lieu of the bond required under section 4011 of this chapter, the attorney may maintain on deposit, through the office of the Commissioner, a like amount in cash or in value of securities qualified under section 8 of the act.

4012 ACTION ON BOND

Action on the attorney's bond or to recover against any such deposit made in lieu thereof may be brought at any time by the subscriber's advisory committee or by a receiver or liquidator of the insurer. Amounts recovered on the bond shall be deposited in and become part of the insurer's funds. The total aggregate liability of the surety shall be limited to the amount of such bond

4013 SERVICE OF PROCESS

Legal process shall be served upon a domestic reciprocal insurer by serving the insurer's attorney at the attorney's registered offices or by serving the Commissioner as the insurer's process agent under the "Insurers Service of Process Act of 1994," effective March 21, 1995 (D.C. Law 10-233; D.C. Official Code § 31-202).

4014 CONTRIBUTIONS TO INSURER

The attorney or other parties may advance to a domestic reciprocal insurer upon reasonable terms such funds as it may require from time to time in its operations. Sums so advanced shall not be treated as a liability of the insurer and, except upon liquidation of the insurer, shall not be withdrawn or repaid except out of the insurer's realized earned surplus in excess of its

minimum required surplus. No such withdrawal or repayment shall be made without the advance approval of the Commissioner. This section does not apply to commercial loans or to other loans made upon security.

4015**METHOD OF DETERMINING FINANCIAL CONDITION**

4015.1

In determining the financial condition of a reciprocal insurer, the Commissioner shall apply the following rules:

- (a) The Commissioner shall charge as liabilities the same reserves as are required of incorporated insurers issuing nonassessable policies on a reserve basis.
- (b) The surplus deposits of subscribers shall be allowed as assets, except that any premium deposits delinquent for 90 days shall first be charged against such surplus deposit.
- (c) The surplus deposits of subscribers shall not be charged as a liability.
- (d) The subscribers' and other accounts as provided in subsection 4016.2 of this section shall not be charged as a liability unless and until the subscriber or other person entitled to the account has a right to withdraw the account.
- (e) All premium deposits delinquent less than 90 days shall be allowed as assets.
- (f) An assessment levied upon subscribers and not collected shall not be allowed as an asset.
- (g) The contingent liability of subscribers shall not be allowed as an asset.
- (h) The computation of reserves shall be based upon premium deposits other than membership fees and without any deduction for expenses and the compensation of the attorney.
- (i) The Commissioner shall permit any reciprocal that is a captive insurer or risk retention group to use such accounting rules, principles, procedures and practices as are permitted for mutual captive insurers or risk retention groups.

4015.2

A reciprocal insurer may establish one or more categories or types of subscriber and other surplus accounts with such terms and conditions as may be provided in the subscriber's agreement or power of attorney and

allocate to such accounts amounts as may be determined by the subscribers advisory committee.

4016**SUBSCRIBERS**

4016.1

Subscribers are persons, including any association, aggregate of individuals, purchasing group, business company, corporation, individual, joint stock company, Lloyds type organization, cooperative, partnership, receiver, reciprocal, interinsurance exchange, trustee or society or government or governmental agencies, state or political subdivisions thereof, boards, associations, estates, trustees or fiduciaries that exchange reciprocal interinsurance contracts with each other. Any officer, representative, trustee, receiver or legal representative of any such subscriber shall be recognized as acting for or on its behalf for the purpose of such contract but shall not be personally liable upon such contract by reason of acting in such representative capacity. The right to exchange such contracts is incidental to the purposes for which corporations are organized. No subscriber shall be found to be in the business of insurance as a result of exchanging reciprocal interinsurance contracts.

4017**SUBSCRIBERS' ADVISORY COMMITTEE**

4017.1

The advisory committee of a domestic reciprocal insurer exercising the subscribers' rights shall be selected under such rules as the subscribers adopt. The advisory committee may be known as and referred to as a board of directors, board of trustees, or such other designation as the committee chooses.

4017.2

Not less than two thirds of such committee shall be subscribers other than the attorney or any person employed by, representing or having a financial interest in the attorney, unless the reciprocal insurer and the attorney are under common "control" as that word is defined pursuant to section 2(2) of the Holding Company System Act of 1993, effective October 21, 1993 (D.C. Law 10-44; D.C. Official Code §31-701(2)).

4017.3

The committee shall:

- (a) Supervise the finances of the insurer;
- (b) Supervise the insurer's operations to such extent as to assure conformity with the subscribers' agreement and power of attorney;
- (c) Procure the audit of the accounts and records of the insurer and of the attorney at the expense of the insurer; and

- (d) Have such additional powers and functions as may be conferred by the subscribers' agreement.

4018**SUBSCRIBERS' LIABILITY GENERALLY**

- 4018.1 Subscribers shall be nonassessable unless specifically provided otherwise in the written power of attorney or in the written subscribers' agreement.
- 4018.2 The liability of each assessable subscriber under an assessable policy for the obligations of the reciprocal insurer shall be an individual, several, and proportionate liability, and not joint. Each subscriber under an assessable policy shall have a contingent assessment liability, in the amount provided for in the power of attorney or in the subscribers' agreement, for payment of actual losses and expenses incurred while the subscriber's policy was in force. Such contingent liability may be at the rate of not less than one nor more than ten times the premium or premium deposit stated in the policy, and the maximum aggregate thereof shall be computed in the manner set forth in section 4023 of this chapter.
- 4018.3 No policy issued by the insurer shall be assessable unless it contains a statement of the contingent liability set in type of the same prominence as the insuring clause.

4019**SUBSCRIBERS' LIABILITY ON JUDGMENT**

- 4019.1 No action shall lie against any subscriber upon any obligation claimed against the insurer.

4020**ASSESSMENTS**

- 4020.1 Assessments may from time to time be levied upon subscribers of a domestic reciprocal insurer having contingent liability under the terms of their policies by the attorney upon approval in advance by the subscribers' advisory committee and the Commissioner or by the Commissioner during rehabilitation or liquidation of the insurer.
- 4020.2 Each subscriber's share of a deficiency for which an assessment is made shall not exceed the subscriber's aggregate contingent liability as computed in accordance with section 4023 of this chapter, and shall be computed by applying to the premium earned on the subscriber's policy or policies, during the period to be covered by the assessment, the ratio of the total deficiency to the total premiums earned from all policies subject to the assessment.
- 4020.3 In computing the earned premiums for the purposes of this section, the gross premium received by the insurer for the policy shall be used as a

base from which charges not recurring upon the renewal or extension of the policy shall be deducted.

- 4020.4 Retrospective, audit, or other premium adjustments provided for in any policy of insurance shall not be considered assessments.
- 4020.5 No subscriber shall have an offset against any assessment for which such subscriber is liable on account of any claim for unearned premium or losses payable.

4021 TIME LIMIT FOR ASSESSMENTS

- 4021.1 Every subscriber of a domestic reciprocal insurer having contingent liability shall be liable for and shall pay the subscriber's share of any assessment, as computed and limited in accordance with this chapter if:
- (a) While the subscriber's policy is in force or within three years after its termination, the subscriber is notified by either the attorney or the Commissioner of his/her intention to levy such assessment, or
 - (b) An Order to Show Cause why a receiver, conservator, rehabilitator or liquidator of the insurer should not be appointed is issued while the subscriber's policy is in force or within three years after its termination.

4022 AGGREGATE OR CONTINGENT LIABILITY

- 4022.1 No one policy or subscriber as to such policy shall be assessed or charged with an aggregate or contingent liability as to obligations incurred by a domestic reciprocal insurer in any one calendar year in excess of the amount provided for in the power of attorney or in the subscribers' agreement, computed solely upon premium earned on such policy during that year.

4023 NONASSESSABLE POLICIES

- 4023.1 Any domestic reciprocal insurer may issue nonassessable policies.
- 4023.2 If a reciprocal insurer has a surplus of assets over all liabilities at least equal to the minimum capital stock and surplus required to be maintained by a domestic stock insurer authorized to transact like kinds of insurance, upon application of the attorney and as approved by the subscribers' advisory committee, the Commissioner shall issue a certificate authorizing the insurer to extinguish the contingent liability of subscribers under all its policies previously issued.

4023.3 If required by the laws of another state in which the reciprocal insurer is transacting insurance as an authorized insurer, the reciprocal insurer may issue policies providing for the contingent liability of such of its subscribers as may acquire such policies in such state and need not extinguish the contingent liability applicable to policies theretofore in force in such state.

4023.4 Retrospective, audit or other premium adjustments provided for in any policy of insurance shall not be considered assessments. Any policy of insurance issued by a reciprocal may provide for a minimum and maximum premium.

4024 SUBSCRIBERS' SHARE IN ASSETS

4024.1 Upon the liquidation of a domestic reciprocal insurer, its remaining assets shall be distributed according to such reasonable plan as the Commissioner may approve.

4024.2 No subscriber shall receive any distribution from a liquidated domestic reciprocal insurer until:

- (a) All indebtedness and policy obligations are discharged;
- (b) Any contributions of the attorney or other persons to the surplus of the reciprocal insurer have been returned; and
- (c) Any unused premium, savings, or credits held by the reciprocal insurer are returned.

4025 MERGER, CONVERSION, REORGANIZATION

4025.1 A domestic reciprocal insurer may merge with another reciprocal insurer or be converted to a stock or mutual insurer upon affirmative vote of not less than two thirds of its subscribers who are authorized to vote on such a merger or conversion, provided that timely notice of the proposed action is provided to the Commissioner and that the Commissioner approves in advance of all of the terms of the proposed merger or conversion.

4025.2 Such a stock or mutual insurer shall be subject to the same capital or surplus requirements and shall have the same rights as a like domestic insurer transacting like kinds of insurance.

4025.3 The Commissioner shall not approve any plan for such merger or conversion which is inequitable to subscribers, or which, if for conversion to a stock insurer, does not give each subscriber preferential right to acquire stock of the proposed insurer proportionate to each subscriber's

interest in the reciprocal insurer as determined in accordance with section 4025 of this chapter and a reasonable length of time within which to exercise such right.

4025.4 A domestic reciprocal may enter into any reorganization transaction with one or more other insurers where the reciprocal is the surviving or disappearing entity.

4026 IMPAIRED RECIPROCAL

4026.1 Whenever the assets of a domestic reciprocal insurer are insufficient to discharge its liabilities (other than any liability on account of funds contributed by the attorney or others) and to maintain the required surplus, its attorney shall forthwith make up the deficiency or levy an assessment upon the subscribers that have been issued assessable policies. Such assessment shall not be in excess of any limitation set forth in the power of attorney or the insurance policy issued to the subscriber by the reciprocal.

4026.2 If the attorney fails to make up such deficiency or to make the assessment within 30 days after the Commissioner orders such attorney to do so or if the deficiency is not fully made up within 60 days after the date the assessment was made, the insurer shall be deemed insolvent and shall be proceeded against as authorized by Insurers Rehabilitation and Liquidation Act of 1993, effective October 15, 1993 (D.C. Law 10-35; D.C. Official Code § 31-1301 *et seq.*).

4026.3 If liquidation of such an insurer is ordered, an assessment shall be levied upon the subscribers that have been issued assessable policies for such an amount, subject to limits as provided by this act, as the Commissioner determines to be necessary to discharge all liabilities of the insurer, exclusive of any funds contributed by the attorney or other persons but including the reasonable cost of the liquidation.

4099 DEFINITIONS

Where applicable, the words and phrases used in this chapter shall have the same meaning as is found in the Captive Insurance Company Act of 2004, effective March 17, 2005 (D.C. Law 15-262; D.C. Official Code § 31-3131.01 *et seq.*). Additionally, for purpose of this chapter, the term:

“Act” means the Captive Insurance Company Act of 2004, effective March 17, 2005 (D.C. Law 15-262; D.C. Official Code § 31-3131.01 *et seq.*).

“Assessable policy” means an insurance policy that permits an insurer to require its policyholders to contribute additional monies to the insurer in

the event that the insurer has insufficient funds to cover losses it is obligated to pay.

“Reciprocal insurers” or “reciprocals” mean an unincorporated insurance company, under a common name, in which subscribers exchange insurance policies through an Attorney in Fact, having the authority to obligate each subscriber both as insured and insurer, for the purpose of transferring and distributing insurance risks among its subscribers.

“Reciprocal interinsurance contract” means an insurance policy that is used to transfer and distribute insurance risks in a reciprocal insurance company.

“Risk retention group” has the same meaning as that term is defined in section 2(12) of the Risk Retention Act of 1993, effective October 21, 1993 (D.C. Official Code § 31-4101(12)).

“Subscriber” means one or more persons who obtain insurance through the exchange of agreements of indemnity in a reciprocal insurer and who are obligated under a reciprocal insurance agreement.

All persons interested in commenting on the subject matter in the proposed rulemaking may file comments in writing, not later than thirty (30) days after the publication of this notice in the *D.C. Register*, with Dana Sheppard, Associate Commissioner, Risk Finance Bureau, Department of Insurance, Securities and Banking, 1400 L Street, NW, Suite 400, Washington, DC 20005. Comments may also be sent electronically to dana.sheppard@dc.gov. Copies of the proposed rulemaking are available, at cost, by writing to the above address. Copies of the proposed rulemaking also may be obtained from the Department at the same address during the hours of 8:30 a.m. and 4:30 p.m., Monday through Friday, excluding holidays.

DISTRICT OF COLUMBIA TAXICAB COMMISSION

NOTICE OF EMERGENCY RULEMAKING

The District of Columbia Taxicab Commission ("Commission"), pursuant to the authority set forth under §8(b)(1)(A) of the District of Columbia Taxicab Commission Establishment Act of 1985, effective March 25, 1986 (D.C. Law 6-97; D.C. Official Code §50-307(b)(1)(A)) (2001), hereby gives notice of its emergency rulemaking action on Wednesday, November, 14, 2007, at its Full Commission meeting, to add a fuel surcharge to the current rates for taxicab service in the District of Columbia. Through its emergency rulemaking action, the Commission voted to amend Appendix 8-2 in Chapter 8 of Title 31 of the District of Columbia Municipal Regulations by adding a fuel surcharge of one dollar (\$1.00) per taxicab trip effective at 12:01 a.m., Friday, November 30, 2007, for a period of sixty (60) days that will remain in effect until midnight Tuesday, January 29, 2008, unless terminated by the Commission.

The emergency rulemaking action is an attempt by the Commission to offset the rising increases in fuel cost. Without the fuel surcharge, taxicab operators may not be able to continue to meet their public service obligations to provide vital transportation service to the public and preserve the status quo. The increased costs of fuel may cause many taxicab operators to leave the industry or discontinue taxicab service because they may not earn a fair return on their investment. Also, taxicab operators may not be able to meet basic health and welfare needs for themselves or their families. The potential termination of taxicab service may affect senior citizens and persons with disabilities who rely on taxicab service for medical care, extended health services, physical therapy, social, and other supportive services.

The Commission has determined that its emergency rulemaking action will be reviewed within the sixty (60) day fuel surcharge period and it will be removed if gasoline prices trend downward. Therefore, the emergency fuel surcharge will become effective at 12:01 a.m., Friday, November 30, 2007, and will remain in effect until midnight Tuesday, January 29, 2008 unless terminated by the Commission before the date of expiration. The fuel surcharge will only affect current zone fares. It does not apply to interstate fares.

The emergency fuel surcharge in effect during this period adds one dollar (\$1.00) to the current zone rates listed below:

<u>Number of Zones Traveled</u>	<u>Current Fares</u>	<u>Fares Plus Surcharge</u>
1	\$6.50	\$7.50
2	\$8.80	\$9.80
3	\$11.00	\$12.00
4	\$12.60	\$13.60
5	\$14.00	\$15.00
6	\$15.50	\$16.50
7	\$17.80	\$18.80
8	\$18.90	\$19.90