

DEPARTMENT OF HEALTH

NOTICE OF PROPOSED RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth under § 302(14) of the D.C. Health Occupations Revision Act of 1985, effective March 15, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1203.02(14)), and Mayor's Order 98-140, dated August 20, 1998, hereby gives notice of his intent to adopt the following amendment to Chapter 73 of Title 17 DCMR (Business, Occupations & Professions) (May 1990) in not less than thirty (30) days from the date of publication of this notice in the D.C. Register. The proposed rule amends Chapter 73 for the purpose of strengthening the academic coursework and experience necessary for registration.

Section 7303 of Title 17 (DCMR (Business, Occupations & Professions) (May 1990) is amended to read as follows:

Section 7303.1 is amended to read as follows:

7303.1 An applicant shall furnish proof satisfactory to the Director that the applicant has successfully completed an educational program by obtaining a high school diploma or its equivalent.

Section 7303.2 is amended to read as follows:

7303.2 In addition to the requirement in § 7303.1, the Director shall register an applicant who furnishes proof satisfactory to the Director that the applicant has obtained the equivalent of two (2) years full-time experience, that is, at least three thousand (3,000) hours, providing direct, supervised addiction counseling services to persons with the primary problem of chemical dependency, and has completed a minimum of two hundred (200) hours of training or education in the following knowledge and skill areas:

- (a) Twelve (12) hours in Pharmacology;
- (b) Twelve (12) hours in Signs and Symptoms;
- (c) Six (6) hours in Rules and Regulations;
- (d) Twelve (12) hours in Models of Counseling Service and Treatment;
- (e) Eighty (80) hours in Counseling Theory and Dynamics which shall include a Family Dynamics component;
- (f) Twelve (12) hours in Assessment and Treatment Planning;

- (g) Twenty (24) hours in Human Development;
- (h) Twelve (12) hours in Ethics;
- (i) Six (6) hours in HIV/AIDS;
- (j) Six (6) hours in DSM-IV(R) Mental Health/Dual Diagnosis which shall include a Relapse Prevention component;
- (k) Six (6) hours of Case Management; and
- (l) Twelve (12) hours of electives.

A new section 7303.3 is added to read as follows:

7303.3 The applicant shall submit the following directly to the Director:

- (a) Original transcripts mailed from the school; and
- (b) Documentation of training.

A new section 7303.4 is added to read as follows:

7303.4 In addition to the requirements in § 7303.1, an applicant shall furnish proof satisfactory to the Director that he or she has completed two hundred (200) hours of clinical supervision under one (1) or more licensed mental health providers with substance abuse training who have documented the required hours and evaluated the quality of the supervised work.

A new section 7303.5 is added to read as follows:

7303.5 The Director shall register an applicant who furnishes proof satisfactory to the Director that the applicant holds a current and valid certificate as an addition counselor from a regulatory board in another jurisdiction of the United States, the Washington Metropolitan Area Addictions Counselors Credentialing Board, or its successor, the DC Certification Board/Alcohol and other Drugs of Abuse, or its successor, or the National Association of Alcoholism and Drug Abuse Counselors, or its successor.

All persons desiring to comment on the subject matter of this proposed rulemaking should file comments in writing not later than thirty days after the date of publication of this notice in the D.C. Register. Comments should be sent to the Department of Health, Office of the General Counsel, 825 North Capitol Street, N.E., 4th Floor, Washington, D.C. 20002. Copies of the proposed rule may be obtained from the Department at the same address during the hours of 9:00 a.m. and 5:00 p.m., Monday through Friday, excluding holidays.

DEPARTMENT OF HEALTH

NOTICE OF PROPOSED RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth in section 5 of the Newborn Hearing Screening Act of 2000, effective April 4, 2001 (D.C. Law 13-276; D.C. Official Code § 7-854), Mayor's Order 2002-12, dated January 25, 2002, section 4 of the District of Columbia Newborn Screening Requirement Act of 1979, effective April 29, 1980 (D.C. Law 3-65; D.C. Official Code § 7-833), Mayor's Order 2004-172, dated October 20, 2004, sections 2003(e) and 2006 of the Childhood Lead Poisoning Screening and Reporting Act of 2002, Title XX of the Fiscal Year 2003 Budget Support Act of 2002, effective October 1, 2002 (D.C. Law 14-190; D.C. Official Code §§ 7-1033(e) and 7-1036), and Mayor's Order 2005-23, dated January 25, 2005, hereby gives notice of his intent to adopt the following amendments to Title 22 of the District of Columbia Municipal Regulations (DCMR) in not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

The proposed rule will clarify and consolidate the portions of Chapters 22 and 73 of Title 22, DCMR that relate to the screening of newborns. Specifically, the rule will amend section 2099 to add definitions, rename section 2204 as "Neonatal Screening Services", add new metabolic disorders to the list of disorders that newborns are tested for, move the text of existing Chapter 73 to the renamed section 2204 and clarify these provisions, add subsections 2204.10 through 2204.13 to establish standards for indigency and residency for parents to qualify to receive benefits for metabolic disorder testing, amend § 2600.8 to require maternity centers to comply with the requirements of section 2204, and rename Chapter 73 as "Childhood Lead Poisoning Prevention".

The renamed Chapter 73 will add provisions establishing the requirements for universal childhood lead screening, diagnostic and follow-up testing for a child with an elevated blood lead level, case management for a lead-poisoned child, and the reporting of all blood lead level results for each child less than six (6) years of age residing in the District of Columbia. The universal lead screening, testing, and case management provisions in this proposed rulemaking are based on the guidelines issued by the United States Centers for Disease Control and Prevention in *Preventing Lead Poisoning in Young Children* (October 1991) and *Screening Young Children for Lead Poisoning: Guidance for State and Local Public Health Officials* (November 1997). Revised chapter 73 implements the provisions of the Childhood Lead Poisoning Screening and Reporting Act of 2002, effective October 1, 2002 (D.C. Law 14-403; D.C. Official Code § 7-1031 *et seq.*), and provides the minimum standards for the periodicity of blood lead level screenings. These standards are in addition to the requirements of the Student Health Care Act of 1985, effective December 3, 1985, as amended (D.C. Law 6-66; D.C. Official Code § 38-601 *et seq.*), for childhood blood lead screening for a child who attends a school or child development center located in the District of Columbia.

Title 22 (Public Health and Medicine) (August 1986) of the DCMR is amended as follows:

I. The table of contents is amended as follows:

A. Strike the phrase "2204: NEWBORN HEARING SCREENING SERVICE" and insert the phrase "2204: NEONATAL SCREENING SERVICES" in its place.

B. Strike the phrases "CHAPTER 73. NEONATAL TESTING FOR METABOLIC DISORDERS" and "22-7300. NEONATAL TESTS; INFORMED CONSENT" and insert the following phrases in their place:

Chapter 73 CHILDHOOD LEAD POISONING PREVENTION

7300 GENERAL PROVISIONS

7301 UNIVERSAL CHILDHOOD LEAD SCREENING

7302 TESTING AND CASE MANAGEMENT FOR A CHILD WITH AN ELEVATED BLOOD LEAD LEVEL

7303 REPORTING BLOOD LEAD LEVEL TEST RESULTS

7304-7398 RESERVED

II. Section 2099 of Chapter 20 (Hospitals and Clinics) is amended by adding or amending the following terms with the ascribed meanings as follows:

2,4-Dienoyl-CoA reductase deficiency - an autosomal recessive genetic disorder characterized by a deficiency of 2,4 Dienoyl CoA Reductase necessary for the degradation of unsaturated fatty acids with an even number of double bonds. Symptoms include sepsis, hypotonia, decreased feeding, and intermittent vomiting. Low carnitine levels can be detected and respiratory acidosis may occur.

2-Methylbutryl-CoA dehydrogenase deficiency - an autosomal recessive genetic disorder resulting from a defect in the metabolism of the branched chain amino acid isoleucine. Symptoms include poor feeding, lethargy, hypoglycemia, and metabolic acidosis. Symptomatic patients display developmental delay, seizure disorders, and progressive muscle weakness in infancy and childhood.

3-Methylcrotonyl-CoA carboxylase deficiency (3MCC) - a progressive autosomal recessive genetic disorder characterized by failure to thrive, hypotonia, muscle atrophy, seizures, mental retardation, and dermatological changes.

3-Methylglutaconyl-CoA hydratase deficiency - an autosomal recessive genetic disorder involving an enzyme in the metabolism of the amino acid leucine. Symptoms

appear in a wide range of clinical severity and may include acute life-threatening cardiopulmonary symptoms soon after birth, psychomotor retardation, hypotonia, failure to thrive, microcephaly, seizures, and spasticity. Some patients may have acute episodes of vomiting, metabolic acidosis, and lethargy progressing to coma.

3-OH 3-CH3 glutaric aciduria or 3-hydroxy-3-methylglutaryl-CoA lyase deficiency (HMG) - an autosomal recessive genetic disorder. Symptoms may include metabolic acidosis, hypoglycemia, sensitivity to dietary leucine, carnitine deficiency, hepatomegaly, fever, somnolence, and coma. If this disorder is untreated, it is likely to result in death during childhood.

5-Oxoprolinuria (pyroglutamic aciduria) - a group of autosomal recessive genetic conditions including glutathione synthetase deficiency, glutamylcysteine synthetase deficiency, and 5-oxoprolinase deficiency caused by a deficiency of one (1) of three (3) enzymes in the gamma glutamyl cycle and characterized by metabolic acidosis, hemolytic anemia, electrolyte imbalance, and jaundice.

Argininemia - an autosomal recessive genetic condition that presents from two (2) months to four (4) years of age. Symptoms include progressive spastic paraplegia, failure to thrive, delayed milestones, hyperactivity, and irritability, with episodic vomiting, hyperammonemia, seizures, microcephaly, and cerebral atrophy resulting in mental retardation.

Argininosuccinic acidemia (ASA) - an autosomal recessive genetic disorder of the urea cycle. Symptoms are hyperammonemia accompanied by lack of appetite, vomiting, listlessness, seizures, and coma. Onset is usually at birth, but symptoms may not be noticeable for days or weeks. The build up in ASA, if too high, ultimately causes a build up in ammonia. Build up of ammonia is toxic and can cause brain damage. ASA is also characterized by excessive urinary excretion of argininosuccinic acid, epilepsy, ataxia, mental retardation, liver disease, and friable, tufted hair.

Beta-ketothiolase deficiency (BKT) - an autosomal recessive genetic disorder characterized by recurrent severe metabolic acidosis. Symptoms include increased plasma glycine level, metabolic acidosis, episodic ketosis, vomiting, dehydration, coma, and cardiomyopathy, with on average onset of five (5) to twenty-four (24) months.

Biotinidase deficiency (BIOT) - an autosomal recessive genetic disorder characterized by a lack of the enzyme biotinidase that can lead to seizures, developmental delay, eczema, and hearing loss that are treated with free biotin. Symptoms include hypotonia, ataxia, alopecia, seborrheic dermatitis, and optic nerve atrophy. Metabolic acidosis can result in coma and death.

Carbamoylphosphate synthetase deficiency (CPS def.) - an autosomal recessive genetic condition that presents within seventy-two (72) hours with symptoms of lethargy, vomiting, hypothermia, respiratory alkalosis, and seizures progressing to coma. Survivors of the newborn period have recurrent episodes of hyperammonemia associated

with viral infections or increased dietary protein intake. Some patients have a later onset with less severe symptoms.

Carnitine uptake defect (CUD) - a class of autosomal recessive genetic disorders characterized by hypoketotic hypoglycemia, seizures, vomiting, lethargy progressing to coma, cardiomyopathy, and hepatomegaly. This disorder includes carnitine palmitoyl transferase deficiency type I and carnitine acylcarnitine translocase deficiency.

Citrullinemia (CITR) - an autosomal recessive genetic disorder characterized by a deficiency of argininosuccinic acid synthetase, hyperammonemia accompanied by lack of appetite, vomiting, listlessness, seizures, and coma. Onset is usually at birth, but symptoms may not be noticeable for days or weeks. When left untreated, brain damage, coma, and death will occur.

Congenital adrenal hyperplasia (CAH) - a set of inherited disorders that occurs in both males and females as a result of the excess production of male hormones and an underproduction of the enzyme 21-hydroxylase, severe acne, excess facial or body hair, early development of pubic hair, receding scalp hairline, menstrual disturbances in females, and infertility in males and females in its mild form and ambiguous genitalia in newborn girls and salt and hormonal imbalances in girls and boys in more severe forms. If not treated, CAH can cause heart failure and death within a few days from birth. CAH can not be cured; however, it can be effectively treated.

Cystic fibrosis (CF) - an autosomal recessive genetic disorder characterized by progressive chronic damage to the respiratory system, chronic digestive system problems, and can affect other organs. CF affects mucus-producing glands producing thick mucus that can obstruct air passages in the lungs, affects sweat and salivary glands, and blocks enzymes secreted by the pancreatic duct. Cystic Fibrosis can cause lung disease, failure to grow, clubbed fingers and toes, muscular weakness, and visual impairment.

Galactosemia - a condition involving the inability to convert galactose to glucose.

Glucose-6-phosphate dehydrogenase deficiency (G6PD) - a condition resulting in anemia or jaundice that is made worse by certain medications and some foods.

Glutaric acidemia type I (GA-I) - an autosomal recessive enzyme deficiency genetic disorder characterized by hypoglycemia, dystonia, and dyskinesia. After a period of apparently normal development, the disorder may appear suddenly and present as vomiting, metabolic acidosis, hypotonia, and central nervous system degeneration. It is not yet known how or why Glutaric Acid causes brain damage, yet damage occurs when a crisis causes an acidic environment in the blood created by excess protein byproducts. Crises can be provoked by common childhood illnesses such as colds, flu, ear infections, stomach virus, fever, etc.

Homocystinuria - a condition resulting from one of several genetically determined errors of methionine metabolism.

Hemoglobinopathy - a class of disorders caused by the presence of abnormal hemoglobin production in the blood, due to genetic variations that can result in production of hemoglobin with different structures or thalassemias and reduction in the amount of normal hemoglobin produced. This term includes the following hemoglobin variants: HbS, HbC, HbE, HbD, and alpha/beta thalassemias.

Hyperammonemia, hyperornithinemia, homocitrullinemia syndrome (HHH) – an autosomal recessive genetic disorder that may present at birth or in later childhood. Newborns on high protein formulas or foods may vomit with feeding, refuse to eat, become lethargic, or develop hyperammonemic coma. Patients gravitate to diets low in milk and meat during childhood.

Hyperornithine with gyrate deficiency – an autosomal recessive genetic disorder characterized by slow progressive vision loss leading to blindness. Myopia and decreased night vision appear as early symptoms in the patient's teens and early twenties.

Hypothyroidism - those clinical conditions that result from abnormally low circulating levels of thyroid hormone.

Isobutyryl-CoA dehydrogenase deficiency – an autosomal recessive genetic disorder involving the inability to metabolize valine with a highly variable presentation.

Isovaleric acidemia (IVA) - an autosomal recessive genetic disorder caused by a defect in the breakdown of the molecule isovaleryl-CoA that presents in acute or intermittent episodes. IVA can present as an acute episode of illness during the first few weeks of a newborn's life, or it may present chronically with intermittent episodes of illness throughout life. Both forms of IVA are caused by the same biochemical defect. Infants who survive an acute neonatal episode will go on to exhibit the chronic intermittent form. Symptoms of acute IVA are attacks of vomiting, lack of appetite, and listlessness; lethargy, neuromuscular irritability, and hypothermia are other characteristics. Episodes can be triggered by upper respiratory infections or by excessive consumption of high-protein foods. Early detection through newborn screening and good treatment of IVA generally leads to normal development. Permanent neurologic damage can occur if an acute episode is not prevented or is misdiagnosed.

Long-chain L-3-OH acyl-CoA dehydrogenase deficiency (LCHADD) - an autosomal recessive genetic disorder characterized by failure to oxidize fatty acids due to a missing or malfunctioning enzyme. Symptoms include hypoglycemia, lethargy, failure to thrive, cardiomyopathy and developmental delay. Early identification and treatment can prevent life-threatening episodes.

Malonic aciduria – an autosomal recessive genetic disorder caused by a deficiency of malonyl-CoA decarboxylase (MCD) with a variable presentation ranging from acute neonatal onset to later in childhood. Symptoms include developmental delay, seizures, hypotonia, diarrhea, vomiting, metabolic acidosis, hypoglycemia, and ketosis.

Maple syrup urine disease - a condition resulting from the impairment of branched chain alpha-ketoacid dehydrogenase.

Maternity center - a facility or other place, other than a hospital or the mother's home, that provide antepartal, intrapartal, and postpartal care for both mother and newborn infant during and after normal, uncomplicated pregnancy.

Medium chain acyl-CoA dehydrogenase deficiency (MCADD) - an autosomal recessive genetic disorder characterized by inability to convert fat to energy. Fasting is not tolerated well in people with MCADD. Symptoms generally begin in infancy or early childhood, however, there are some with no apparent symptoms at birth. Low blood sugar, seizures, brain damage, cardiac arrest and serious illness can occur very quickly in children who are not feeding well. Some experience recurrent episodes of metabolic acidosis, hypoglycemia, lethargy, and coma. If not detected and treated appropriately, MCADD can result in mental retardation and death. Those treated are expected to have normal life expectancy.

Metabolic disorder - a disorder that results in a defect in the function of a specific enzyme or protein.

Methylmalonic acidemia - one of two variations of an autosomal recessive genetic disorder caused by an enzymatic defect in the oxidation of amino acids characterized by lethargy, failure to thrive, vomiting, dehydration, respiratory distress, hypotonia, and hepatomegaly. Acute episodes may include drowsiness, coma, and seizures, with subsequent developmental delays. This disorder includes methylmalonic acidemia CblA, methylmalonic acidemia CblB, and methylmalonic acidemia mutase deficiency.

Multiple acyl-CoA dehydrogenase deficiency (MADD) - an autosomal recessive genetic disorder, also known as glutaric acidemia type II, with three (3) different clinical presentations. Symptoms include hypotonia, hepatomegaly, severe nonketotic hypoglycemia, metabolic acidosis, and variable body odor of sweaty feet.

Multiple carboxylase deficiency (MCD) - an autosomal recessive genetic disorder characterized by a biotin deficiency. Symptoms include seizures, developmental delay, eczema, and hearing loss. Other symptoms are immune system impairment, skin rashes, hair loss and mental retardation that are treatable with oral biotin supplements.

Neonatal carnitine palmitoyl transferase deficiency-type II (CPT-II) - an autosomal recessive genetic disorder of mitochondrial fatty acid oxidation that presents in three (3) forms. The classic form has adult onset of exercise-induced muscle weakness, often with rhabdomyolysis and myoglobinuria that may be associated with renal failure. A second form that is often fatal between three (3) and eighteen (18) months of age with symptoms of hepatomegaly, non-ketotic hypoglycemia, cardiomyopathy, hypotonia, and muscle weakness. A severe form presents in newborns with non-ketotic hypoglycemia, cardiomyopathy, hypotonia, muscle weakness, and renal dysgenesis in some patients.

Newborn--an infant under four (4) weeks of age.

Phenylketonuria (PKU) - the metabolic disease of the newborn in which metabolites of phenylalanine appear in the urine.

Propionic acidemia (PROP) - an autosomal recessive genetic disorder characterized by protein intolerance, vomiting, failure to thrive, lethargy, and profound metabolic acidosis. If not treated early, brain damage, coma, seizures and death can occur.

Short chain acyl-CoA dehydrogenase deficiency (SCAD) – an autosomal recessive genetic disorder of fatty acid beta oxidation with a usual clinical onset between the second (2nd) month and second (2nd) year of life, with some presenting within a few days of birth and some in adulthood. Symptoms include hypotonia, progressive muscle weakness, developmental delay, and seizures. Symptoms worsen with seemingly innocuous illness that may lead to lethargy, coma, apnea, cardiopulmonary arrest, or sudden unexplained death.

Short chain hydroxy acyl-CoA dehydrogenase deficiency (SCHAD) – an autosomal recessive genetic disorder of mitochondrial fatty acid beta oxidation for which a complete spectrum of presentation has not been defined. Most patients have hypoglycemia as the major symptom along with seizures, neurologic sequela or death as the outcome. Several present in the first days or months of life with hypoglycemic seizures secondary to hyperinsulinism. Some patients present after one (1) year with acute onset of vomiting, lethargy, and hyponatremic seizures.

Sickle Hemoglobinopathy - repealed.

Trifunctional protein deficiency (TFP) - an autosomal recessive mitochondrial fatty acid oxidation genetic disorder characterized by an inability to break down long-chain fatty acids into an energy source. Metabolic crises can occur when fasting, as well as hypoglycemia, lethargy, hypotonia, myopathy, failure to thrive, cardiomyopathy, and neuropathy. Severe untreated cases may present as SIDS.

Tyrosinemia type I (TYRO-I) - an autosomal recessive genetic disorder that causes severe liver disease in infancy. Affected persons develop cirrhosis of the liver and eventually require liver transplantation. The most severe form causes symptoms within the first months of life. These infants experience poor weight gain, enlarged liver and spleen, swelling of the legs, increased tendency of bleeding. Even with therapy death frequently occurs within six (6) to nine (9) months of life for those with the severe form. Children with a less severe form also suffer from enlargement of the liver, spleen, poor weight gain, vomiting and diarrhea.

Very long-chain acyl-CoA dehydrogenase deficiency (VLCAD) - an autosomal recessive genetic disorder in which the body cannot oxidize fatty acids because of a missing or mal-functioning enzyme. Symptoms include hypoketotic hypoglycemia,

hepatocellular disease, and cardiomyopathy. Fatal infantile encephalopathy may be the only indication of the condition.

III. Section 2204 of Chapter 22 (Categories of Hospital Services) is amended to read as follows:

2204 Neonatal Screening Services

2204.1 Each institution shall establish a Newborn Hearing Screening Service according to the following requirements:

- (a) Each institution shall designate a person to be responsible for the newborn hearing screening service in that institution.
- (b) An audiologist, otolaryngologist, or other qualified person, including a neonatal nurse or a hospital technician, shall oversee each newborn hearing screening service. The person assigned to oversee the newborn hearing screening service may be full or part time, on or off site, an employee of the institution, or under contract or other arrangement that allows him or her to oversee the newborn hearing screening service. This person shall advise the institution about all aspects of the newborn hearing screening service, including screening, and recommendations for follow-up testing and treatment.
- (c) Each institution shall provide hearing screening services pursuant to this section, unless any of the following occurs:
 - (1) The procedure is contrary to the parents' religious beliefs;
 - (2) The parents withhold consent to perform the screening; or
 - (3) The institution transfers the newborn to another institution for treatment before hearing screening can be completed, provided that the transferring institution informs the Maternal and Family Health Administration of the Department within twenty-four (24) hours.

- (d) Newborn hearing screening may be performed by any of the following:
 - (1) An audiologist;
 - (2) An otolaryngologist;
 - (3) A neonatal nurse appropriately trained to perform hearing screening and under supervision by an audiologist or otolaryngologist;
 - (4) A hospital technician appropriately trained to perform hearing screening and under supervision by an audiologist or otolaryngologist; or
 - (5) A hospital volunteer appropriately trained to perform hearing screening and under supervision by an audiologist or otolaryngologist.

2204.2

Before discharging the newborn, each institution shall do the following:

- (a) Provide the newborn's parents with oral information and written materials that describe the benefits and purpose of hearing screening, the procedures used for hearing screening, and the consequences of hearing loss;
- (b) Provide the newborn's parents with oral and written information about whether it performed a hearing screening on the newborn;
- (c) After performing the hearing screening, provide the newborn's parents, the newborn's primary care provider, if known, and the Maternal and Family Health Administration of the Department with oral and written results of the hearing screening; and
- (d) After performing the hearing screening, recommend to the newborn's parents and the newborn's primary care provider, if known, appropriate follow-up testing and treatment that may be necessary.

- 2204.3 If the parents do not understand English well enough to comprehend the information, the institution shall provide the information required by § 2204.2 in the parents' native language.
- 2204.4 For newborns that require additional procedures to complete the screening after being discharged from the institution, the institution shall provide the newborn's parents and the newborn's primary care provider, if known, with written notice about the availability and importance of additional screening procedures.
- 2204.5 An institution that completes a newborn hearing screening and finds that the newborn did not pass the screening shall provide the newborn's parents, the Department, and the newborn's primary care provider, if known, with written results of the screening, recommended diagnostic procedures, and resources available for newborns with hearing impairment.
- 2204.6 Each institution shall make available to each newborn delivered or cared for at the institution blood tests to screen for the following metabolic disorders:
- (a) 2,4-Dienoyl-CoA reductase deficiency;
 - (b) 2-Methylbutryl-CoA dehydrogenase deficiency;
 - (c) 3-Methylcrotonyl-CoA carboxylase deficiency (3MCC);
 - (d) 3-Methylglutaconyl-CoA hydratase deficiency;
 - (e) 3-OH 3-CH₃ glutaric aciduria (HMG);
 - (f) 5-Oxoprolinuria (pyroglutamic aciduria);
 - (g) Argininemia;
 - (h) Argininosuccinic acidemia (ASA);
 - (i) Beta-ketothiolase deficiency (BKT);
 - (j) Biotinidase deficiency (BIOT);
 - (k) Carbamoylphosphate synthetase deficiency (CPS def.);
 - (l) Carnitine uptake defect (CUD);
 - (m) Citrullinemia (CITR);

- (n) Congenital adrenal hyperplasia (CAH);
- (o) Cystic fibrosis (CF);
- (p) Galactosemia (GALT);
- (q) Glucose-6-Phosphate Dehydrogenase Deficiency (G6PD);
- (r) Glutaric acidemia type I (GA I);
- (s) Hemoglobinopathy;
- (t) Homocystinuria (HCY);
- (u) Hyperammonemia, hyperornithinemia, homocitrullinemia syndrome (HHH);
- (v) Hyperornithine with gyral atrophy;
- (w) Hypothyroidism;
- (x) Isobutyryl-CoA dehydrogenase deficiency
- (y) Isovaleric acidemia (IVA);
- (z) Long-chain L-3-OH acyl-CoA dehydrogenase deficiency (LCHADD);
- (aa) Malonic aciduria;
- (bb) Maple Syrup Urine Disease (MSUD);
- (cc) Medium chain acyl-CoA dehydrogenase deficiency (MCAD);
- (dd) Methylmalonic acidemia;
- (ee) Multiple acyl-CoA dehydrogenase deficiency (MADD);
- (ff) Multiple carboxylase deficiency (MCD);
- (gg) Neonatal carnitine palmitoyl transferase deficiency-type II (CPT-II);
- (hh) Phenylketonuria (PKU);
- (ii) Propionic acidemia (PROP);

- (jj) Short chain acyl-CoA dehydrogenase deficiency (SCAD);
 - (kk) Short chain hydroxy acyl-CoA dehydrogenase deficiency (SCHAD);
 - (ll) Trifunctional protein deficiency (TFP);
 - (mm) Tyrosinemia type I (TYRO-I); and
 - (nn) Very long-chain acyl-CoA dehydrogenase deficiency (VLCAD).
- 2204.7 Each institution shall inform the parent or parents of the availability and purpose of the tests for the conditions set forth in subsection 2204.6 and shall document in the newborn's health record that the parent or parents were properly informed and understood the purpose of the tests.
- 2204.8 Each institution shall provide the parent or parents a reasonable opportunity to object to performance of the tests and shall document in the newborn's health record whether the parent or parents consented or withheld consent to have the testing done.
- 2204.9 Each institution that has obtained parental consent to have the newborn tested shall take from the newborn a blood sample of sufficient quantity to enable a laboratory designated by the Mayor to analyze the sample for the tests identified in subsection 2204.6, unless an identical test has been performed. Each institution shall send the sample to the designated laboratory.
- 2204.10 A newborn's parent is indigent for the purpose of § 9 of the District of Columbia Newborn Screening Requirement Act of 1979, effective April 29, 1980 (D.C. Law 3-65; D.C. Official Code § 7-838), if the parent does not have coverage by Medicaid or third party medical or health insurance coverage and has a total pre-tax household income, including child support payments, alimony, rent payments received, and any other income received on a regular basis, equal to or less than three hundred per cent (300%) of the federal poverty level.
- 2204.11 A newborn's parent shall document income to satisfy the requirements of § 2204.10 as follows:
- (a) For a person whose source of income is earned income, one of the following:
 - (1) Originals or copies of all earnings statements received within the previous thirty (30) days;

- (2) A copy of the first two (2) pages of a District of Columbia tax return for the most recent tax year;
 - (3) A copy of the first page of a Federal tax return for the most recent tax year; or
 - (4) For a newly employed parent, a copy of an offer of employment that states the amount of salary to be paid.
- (b) For a parent whose source of income is unearned income, one of the following;
- (1) A copy of a Social Security or worker's compensation benefit statement;
 - (2) Proof of child support or alimony received; or
 - (3) A copy of a Federal tax return for the most recent tax year, including all schedules and attachments.

2204.12 A newborn is a resident of the District of Columbia for the purpose of § 9 of the District of Columbia Newborn Screening Requirement Act of 1979, effective April 29, 1980 (D.C. Law 3-65; D.C. Official Code § 7-838), if the newborn's mother is a resident of the District of Columbia on the date on which the newborn was born.

2204.13 The mother of a newborn shall document residency to satisfy the requirements of § 2204.12 by providing one of the following:

- (a) A valid motor vehicle operator's permit issued by the District;
- (b) A non-driver's identification card issued by the District;
- (c) A voter registration card issued by the District of Columbia Board of Elections and Ethics;
- (d) A copy of a lease or a rent receipt for real property located in the District;
- (e) A utility bill for real property located in the District; or
- (f) A copy of the most recent federal income tax return or Earned Income Credit Form.

IV. Subsection 2600.8 of Chapter 26 (Maternity Centers) is amended to read as follows:

2600.8 Each maternity center shall, in addition to the other requirements of this chapter, comply with the requirements of section 2004 regarding newborn hearing screening and newborn testing for metabolic disorders.

V. Chapter 73 is amended to read as follows:

CHAPTER 73 – CHILDHOOD LEAD POISONING PREVENTION

Sections

7300 General Provisions
 7301 Universal Childhood Lead Screening
 7302 Testing and Case Management
 7303 Reporting
 7304 -
 7398 Reserved
 7399 Definitions

7300 GENERAL PROVISIONS

7300.1 Each health care provider or health care facility shall inform the parent or guardian of every child under the age of six (6) years residing in the District of Columbia, served by the provider or the facility, of the requirement for periodic blood lead level (BLL) screening tests, as required by this chapter. Each health care provider or health care facility shall document in the child's health record that the parent or guardian was informed of this requirement and understood the purpose of the tests.

7300.2 Each health care provider or health care facility offering care to pregnant women and breast feeding mothers shall inform the patient of the risks of lead poisoning, specifically the risks from lead-based paint hazards, including lead-contaminated dust, lead-contaminated soil, and lead-contaminated paint that is deteriorated or present in accessible surfaces; lead in drinking water; and lead in improperly prepared or unsafe foods, folk remedies, toys, and other consumer products.

7301 UNIVERSAL CHILDHOOD LEAD SCREENING

7301.1 Each health care provider or health care facility that has obtained parental consent shall, as part of a well-child care visit, perform a BLL screening test on every child who resides in the District of Columbia and who is served by the provider or facility, unless an identical test was performed not more than twelve (12) months before the well-child visit. Blood lead

level screening tests shall be performed according to the following schedule:

- (a) Once between the ages of six (6) and nine (9) months;
- (b) Once between the ages of twenty-two (22) and twenty-six (26) months; and
- (c) At least twice if a child over the age of twenty-six (26) months has not previously been tested for BLL. The tests for children over the age of twenty-six (26) months shall be conducted before the child attains the age of six (6) years and shall be conducted at least twelve (12) months apart, or according to a schedule determined appropriate by the health care provider or health care facility.

7301.2 When a health care provider or health care facility required to provide testing pursuant to this chapter does not administer a BLL test during a well-child visit and according to the schedule provided in subsection 7301.1, the health care provider or health care facility shall document in the child's health record the reason for not performing the BLL test.

7301.3 Each health care provider and health care facility shall conduct additional BLL screening when any of the following circumstances are present:

- (a) When a child is at risk for high-dose lead exposure based on the child's living conditions, a parent's occupational exposure to lead, a history of lead poisoning in siblings or playmates, or as indicated because of the child's behavior or development. In determining whether a child is at risk for high-dose lead exposure, each health care provider and health care facility shall determine, through the use of a personal-risk questionnaire or by other appropriate means, whether any of the following risk indicators are present:
 - (1) The child lives in, or frequently visits, deteriorated housing built before 1978;
 - (2) The child lives in, or frequently visits, housing built before 1978, with recent, ongoing, or planned renovation or remodeling;
 - (3) The child's siblings, housemates, or playmates have confirmed lead poisoning;
 - (4) The child's parent, guardian, or other household members participate in occupations or hobbies that may result in exposure to lead; or

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- (5) The child lives, or has lived, near industrial facilities or operations that may release atmospheric lead;
 - (b) The child exhibits pica, which consists of repeated ingestion of nonfood substances, or has frequent hand-to-mouth activity; or
 - (c) The child has unexplained seizures, neurological symptoms, abdominal pain, or other symptoms consistent with lead poisoning, including growth failure, developmental delay, attention deficit, hyperactivity, behavioral disorders, school problems, hearing loss, or anemia.
- 7301.4 Each health care provider or health care facility shall provide family lead education and appropriate referrals for social and environmental services to the family of a child with an elevated blood lead level.
- 7302 TESTING AND CASE MANAGEMENT**
- 7302.1 This section establishes best practices for providing diagnostic, follow-up testing, and case management when a child under the age of six (6) has a BLL screening that indicates an elevated BLL.
- 7302.2 Each health care provider or health care facility should provide:
- (a) Diagnostic and follow-up testing, treatment, and care for a child with an elevated BLL; and
 - (b) Case management for a lead-poisoned child, according to generally accepted medical standards and the guidelines established in this section. The guidelines in this section should be applied in conjunction with pertinent information regarding the child's medical condition and risk of exposure to lead hazards.
- 7302.3 Each health care provider or health care facility should give a child with an elevated blood level, based on the BLL in a screening test, a diagnostic test according to the following schedule:
- (a) If the results of a BLL screening test are equal to ten (10) micrograms per deciliter (μ /dL), or between ten (10) and nineteen (19) micrograms per deciliter (μ /dL), the child should receive a diagnostic test within three (3) months after the screening test; and
 - (b) If the results of a BLL screening test are equal to or greater than twenty (20) micrograms per deciliter (μ /dL), the child should receive a diagnostic test according to the following schedule:

- (1) Between one (1) week and one (1) month after the screening test when the BLL was between twenty (20) and forty-four (44) micrograms per deciliter (μ /dL);
- (2) Not later than forty-eight (48) hours after the screening test when the BLL was between forty-five (45) and fifty-nine (59) micrograms per deciliter (μ /dL);
- (3) Not later than twenty-four (24) hours after the screening test when the BLL was between sixty (60) and sixty-nine (69) micrograms per deciliter (μ /dL); or
- (4) Immediately, as an emergency laboratory test, when the BLL was equal to or greater than seventy (70) micrograms per deciliter (μ /dL).

7302.4 If a child twelve (12) months of age or younger has an elevated BLL on a screening test, or the health care provider has reason to believe that the child's BLL is increasing rapidly, the health care provider may provide the diagnostic test sooner than indicated in subsection 7302.3. Generally, there is a direct correlation between the elevation of the BLL and the urgency for performing a diagnostic test.

7302.5 Each health care provider or health care facility should provide a child with an elevated BLL equal to or greater than ten (10) micrograms per deciliter (μ /dL), as indicated in a diagnostic test, with the following services:

- (a) Case management; and
- (b) Follow-up testing within two (2) months of the diagnostic test.

7302.6 A child receiving case management pursuant to this section should receive follow-up testing at not sooner than thirty (30) days and not more than sixty (60) day intervals until all of the following conditions are met:

- (a) The child's BLL is less than ten (10) micrograms of lead per deciliter (μ /dL) for at least two (2) follow-up tests;
- (b) The lead hazards that caused, or that are likely to have caused, the child's elevated BLL have been removed; and
- (c) There is no new exposure and no increased likelihood of exposure to lead hazards.

- 7302.7 After all the conditions in § 7302.6 have been met, the child should be tested approximately once every three (3) months, until the child reaches thirty-six (36) months of age and typically no longer requires follow-up testing.
- 7303 REPORTING**
- 7303.1 Each time a health care provider or health care facility draws blood or orders a blood draw for a BLL test for a child residing in the District of Columbia, the health care provider or health care facility shall collect and record the information listed in § 7303.3. The provider or facility shall transmit the information to the laboratory performing the BLL analysis at the same time the provider or facility transmits the blood specimen to the laboratory.
- 7203.2 Each laboratory that analyzes a blood sample taken from a child residing in the District of Columbia shall, immediately upon completion of the analysis, submit a report that meets the requirements in § 7303.3, as follows:
- (a) The laboratory shall submit a written report to the health care provider or the health care facility where the sample was taken;
 - (b) The laboratory shall submit a report to the Childhood Lead Poisoning Prevention Program (Program), both in writing and through the Program's electronic reporting system; and
 - (c) The laboratory shall immediately notify the health care provider or the health care facility and the Childhood Lead Poisoning Prevention Program of the results by telephone and fax if the child's BLL equals or exceeds ten (10) micrograms of lead per deciliter (μ /dL).
- 7303.3 The laboratory reports for BLL tests shall include the following information:
- (a) Full name, date of birth, gender, and race of the child;
 - (b) Social Security Number of the child;
 - (c) Medicaid Identification Number of the child, if applicable;
 - (d) Complete home address of the child at the time the blood sample was drawn, including the house or apartment number, street, and zip code;

- (e) Full name, address, and telephone number of the parent or guardian;
- (f) Name, address, and telephone number of the health care provider or health care facility, including the name and telephone number of the physician ordering the test;
- (g) Type of specimen (venous or capillary), and date on which the specimen was drawn;
- (h) Draw site name, address, and telephone number, if different from the health care provider or health care facility;
- (i) Laboratory identification number, name, address, and telephone number;
- (j) Blood lead level, in micrograms per deciliter (μ /dL);
- (k) Name, address, and telephone number of any insurance company that may provide coverage for the child, and the group number and member identification number of the primary insured; and
- (l) Any other information that may be required in any reporting forms or instructions that the Childhood Lead Poisoning Prevention Program may issue.

7303.4 Immediately upon receipt of a laboratory report indicating an elevated BLL in a child, the health care provider or health care facility shall inform the child's parent or guardian of the results and the measures recommended for follow-up treatment and care. Upon request, the provider or facility shall furnish the parent or guardian with a copy of the laboratory report free of charge.

7303.5 Each health care provider or health care facility shall report a lead-poisoned child to the Childhood Lead Poisoning Prevention Program (Program) as follows:

- (a) Report a lead-poisoned child by telephone within seventy-two (72) hours after receiving information of a lead-poisoned child from a laboratory or another health care provider or health care facility;
- (b) Supply the child's name and address; and
- (c) Supply the name and telephone number of the child's parent or guardian.

- 7303.6 The health care provider or health care facility shall, upon a parent's or guardian's request, provide to the child's parent or guardian, a certificate of testing for lead poisoning that includes the date of the test and the test results.
- 7303.7 Except as provided in this section, each health care provider, health care facility, laboratory, and the Childhood Lead Poisoning Prevention Program shall keep confidential the laboratory report prepared pursuant to this section and the underlying transmittal information from the health care provider or health care facility to the laboratory.
- 7303.8 An employee or agent of the District of Columbia Government may disclose the following information concerning a child with an elevated BLL to the Department, to the owner of the affected property, and to the owner's attorney:
- (a) The name of the child;
 - (b) The child's home address;
 - (c) The name and telephone number of the child's parent or guardian; and
 - (d) Any other information contained in a laboratory report prepared pursuant to this section, except that the child's Social Security Number shall not be disclosed to the owner of the affected property or the owner's attorney.
- 7303.9 An employee or agent of the District of Columbia Government may disclose the address of an affected property, but not the name of a child who may have become lead-poisoned at the affected property, or any other information contained in a laboratory report prepared pursuant to this section concerning that child, to the following:
- (a) The Department of Housing and Community Development;
 - (b) The Department of Consumer and Regulatory Affairs;
 - (c) The Housing Authority;
 - (d) The Water and Sewer Authority; and
 - (e) An individual or business entity retained to conduct lead-based paint activities at the affected property, provided the individual or business entity is certified pursuant to the Lead-Based Paint Abatement and Control Act of 1996, effective April 9, 1997, as

amended (D.C. Law 11-221, D.C. Official Code § 8-115.01 *et seq.*).

7303.10 Except as provided in this section, no person other than an employee or agent of the Department of Health may disclose the name of the child or any other information contained in a laboratory report prepared pursuant to this section, to any other person without the express consent of the parent or guardian.

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7399 **DEFINITIONS**

7399.1 When used in this chapter, the following terms have the meanings ascribed:

Affected property - a residence where a child with an elevated blood lead level resides or regularly visits and which is a likely source of the lead contributing to the elevated blood lead level.

Blood lead level or BLL - the concentration of lead in a sample of whole blood expressed in micrograms per deciliter (μdL).

Child - a person under six (6) years of age.

Childhood Lead Poisoning Prevention Program or Program - the office in the Department of Health or a successor program or agency responsible for receiving reports and results concerning a child's blood lead level.

Case management - the interdisciplinary treatment and care of a child with an elevated blood lead level, consisting of coordinated medical, social, and environmental services. This term includes diagnostic testing and medical evaluation for complications of lead poisoning; pharmacological treatment, if appropriate; follow-up testing at appropriate intervals; family lead education, housekeeping, and nutritional intervention; appropriate referrals, including referral to the Childhood Lead Poisoning Prevention Program and referral for child development and social services; environmental investigation and assessment; and the elimination or reduction of lead hazards, including source control measures necessary to eliminate or control any lead-based paint hazard to which a lead-poisoned child is exposed.

Department - unless otherwise indicated, the Department of Health.

Diagnostic test - the first venous blood level test performed within six (6) months on a child with a previously elevated blood level of lead on a screening test. A test performed more than six (6) months after the original screening test is a new screening test, with decisions about further testing and treatment based on the new screening test.

Elevated blood lead level - the concentration of lead in a sample of whole blood equal to or greater than ten (10) micrograms of lead per deciliter (μ /dL).

Follow-up test - a venous blood lead level test used to monitor the status of a child with a prior diagnostic test indicating an elevated blood lead level.

Health care facility - a facility providing individual care or treatment of diseases or other medical, physiological, or psychological conditions, including hospitals, clinics, laboratories, nursing homes, or homes for the aged or chronically ill, but excluding private medical offices.

Health care provider - a physician, clinic, hospital, or neighborhood health center, licensed by the District of Columbia, that is responsible for providing primary care and coordinating referrals, when necessary, to other health care providers.

Lead-based paint activities - that term as used in § 2(9) of the Lead-Based Paint Abatement and Control Act of 1996, effective April 9, 1997, as amended (D.C. Law 11-221; D.C. Official Code § 8-115.01(9)).

Lead-poisoned child - a child with a confirmed blood lead level equal to or greater than fifteen (15) micrograms per deciliter (μ /dL), or any other lower threshold that the United States Centers for Disease Control and Prevention may establish in written guidance or regulation.

Lead hazard - any source or pathway that results, or that may result, in exposure to lead, including lead-based paint; lead-contaminated dust or soil; sources related to occupations or work sites of parents, guardians, and caregivers (take-home exposure); airborne lead; and lead in water, food, ceramics, traditional remedies, cosmetics, and materials used in hobbies and other home activities.

Owner - a person who, alone or jointly or severally with others, meets either of the following criteria:

- (a) Has legal title to any building arranged, designed, or used (in whole or in part) to house one or more dwelling or rooming units: or
- (b) Has charge, care, or control of any building arranged, designed, or used (in whole or in part) to house one or more dwelling or rooming units, as owner or agent of the owner, as fiduciary of the estate of the owner, or as an officer appointed by the court.

Person - an individual, corporation, partnership, firm, conservator, receiver, trustee, executor, or legal representative.

Screening test - a laboratory test for lead poisoning that is performed on a blood sample from an asymptomatic child to determine the child's blood lead level.

Comments on the proposed rules should be sent in writing to the Department of Health, Office of the General Counsel, 4th Floor, 825 North Capitol Street, NE, Washington, DC 20002, not later than thirty (30) days from the date of publication of this notice in the *D.C. Register*. Copies of the proposed rules may be obtained Monday through Friday, excepting holidays, between the hours of 8:30 A.M. and 4:45 P.M. at the same address.

DEPARTMENT OF HEALTH

NOTICE OF PROPOSED RULEMAKING

The Director of the State Health Planning and Development Agency with the Department of Health, pursuant to the authority set forth in § 22 of the Health Services Planning Program Re-establishment Act of 1996 (Act), effective April 9, 1997 (D.C. Law 11-191; D.C. Official Code § 44-421 (2001)), hereby gives notice of her intent to take final rulemaking action to adopt the following amendments to Chapter 44 of Title 22 of the District of Columbia Municipal Regulations (DCMR) in not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*. The purpose of the proposed rule is to revise the requirements for health care facilities for providing uncompensated care to persons who cannot afford health services consistent with re-establishment of the Health Services Planning Program and changes implemented through the Health Services Planning and Development Amendment Act of 2004, effective April 22, 2004 (D.C. Law 15-149).

Pursuant to § 22 of the Act, the proposed rules are being transmitted to the Council of the District of Columbia, and the proposed rules will not become effective until the expiration of the forty-five (45) day period of Council review or upon approval by Council resolution, whichever occurs first, and publication of a notice of final rulemaking in the *D.C. Register*.

Chapter 44 of Title 22 DCMR (Public Health & Medicine) (August 1986) is amended by striking Chapter 44 in its entirety and replacing it with a new Chapter 44 to read as follows:

CHAPTER 44 PROVISION OF UNCOMPENSATED CARE**4400 GENERAL PROVISIONS**

- 4400.1 This chapter implements the requirements of the District of Columbia Health Services Planning Program Re-Establishment Act of 1996 (Act), effective April 9, 1997 (D.C. Law 11-191; D.C. Official Code § 44-401 *et seq.*), for the provision by health care facilities of uncompensated care as a condition of holding a Certificate of Need (CON).
- 4400.2 As a condition for issuance of a CON to a health care facility or health service that operates on a payment for services rendered basis, the health care facility or health service shall provide uncompensated care in an amount not less than three percent (3%) of the health care facility's or health service's annual operating expenses, less the amount of reimbursements it receives from Titles XVIII and XIX of the Social Security Act (Medicaid and Medicare), without regard for contractual allowances. In addition, the health care facility or health service shall comply with any uncompensated care obligations required pursuant to the Act in a previous CON.
- 4400.3 The State Health Planning and Development Agency (SHPDA) may require each health care facility or health service subject to an uncompensated care obligation through a CON to submit data to verify compliance with the uncompensated care obligation.
- 4400.4 Each health care facility or health service subject to an uncompensated care obligation shall provide uncompensated care at the annual compliance level required

by § 4400.2, for each fiscal year, or any part thereof, in which it is subject to the uncompensated care obligation.

4400.5 Each health care facility or health service that has an uncompensated care obligation shall make uncompensated care available to the extent of that obligation to all eligible persons, without discrimination on the grounds of race, color, creed, national origin, sex, age, marital status, personal appearance, sexual orientation, family responsibilities, matriculation, political affiliation, physical handicap, source of income, or any other grounds unrelated to an individual's need for the service or the availability of the needed service.

4401 RESERVED

4402 CERTIFICATE OF NEED HOLDER PARTICIPATION IN THIRD PARTY PAYER PROGRAMS

4402.1 Each CON holder may make arrangements, if eligible to do so, for reimbursement for services from:

- (a) Those principal District and state third party payers that provide reimbursement for services; and
- (b) Federal governmental third-party programs, including Medicare and Medicaid.

4402.2 Each CON holder shall take all actions necessary to ensure that admission to and receipt of its services are available to beneficiaries of the governmental programs specified in § 4402.1, without discrimination or preference because they are beneficiaries of those programs.

4403 PROHIBITION OF EXCLUSIONARY ADMISSIONS POLICIES

4403.1 A CON holder shall be out of compliance with § 4400.4, if it uses an admissions practice that has the effect of excluding persons who are eligible for uncompensated care under § 4406.

4403.2 Prohibited admissions practices include the following:

- (a) Limiting admission to patients who are referred by physicians with staff privileges at the CON holder's facility (or facilities);
- (b) Maintaining an operational structure that includes few or no physicians with staff privileges who will treat persons who are eligible for uncompensated care; or
- (c) Requiring advance deposits (pre-admission or pre-service deposits) from persons who qualify or appear to qualify for uncompensated care before admitting or serving these persons.

- 4403.3 A CON holder may have in effect a policy or practice described in § 4403.2(a) and still comply with this chapter if the CON holder makes alternative arrangements to treat those persons who would otherwise be unable to gain admission to, or obtain services available from, the CON holder. Alternative arrangements may include the following:
- (a) Authorizing the individual's physician, if licensed and otherwise qualified, to treat the patient at the facility even though the physician does not have staff privileges at the facility;
 - (b) Obtaining the voluntary agreement of physicians with staff privileges at the facility to accept referrals regularly of patients who do not have a physician (*e.g.* rotating referrals to the physicians with staff privileges);
 - (c) Requiring acceptance of referrals of patients who do not have a physician as a condition of obtaining or renewing staff privileges;
 - (d) Establishing a hospital-based primary care clinic through which patients needing hospitalization may be admitted; or
 - (e) Hiring or contracting with qualified physicians to treat patients who do not have private physicians.
- 4403.4 A CON holder need not require all its staff physicians to accept Medicaid or Medicare patients to remedy a violation of § 4403.2(b). If the Department of Health, Medical Assistance Administration, determines that a CON holder or CON applicant is out of compliance with Medicaid or Medicare obligations, the CON applicant or CON holder shall be deemed out of compliance with admissions and service requirements until the CON applicant or CON holder takes steps to ensure that Medicaid and Medicare program beneficiaries have full access to all of the CON applicant's or CON holder's available services.
- 4403.5 A CON holder that engages in a practice prohibited by § 4403.2(c) is not required to forego the use of a deposit policy in all situations. The CON holder can remedy this violation by making alternative arrangements to ensure that persons who probably can pay for services are not denied them simply because they do not have the available cash at the time services are requested. A CON holder shall not deny admission or a service to a person who probably can pay because of the person's inability to pay a deposit at the time the person requests admission or a service.
- 4404 UNCOMPENSATED CARE COMPLIANCE REQUIREMENTS**
- 4404.1 Each CON holder shall provide uncompensated care pursuant to § 4400.2 to eligible persons. The uncompensated care to be provided shall be based upon these rules or contractual obligations between the health care provider and the District of Columbia Government, whichever standard provides the higher dollar value.

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- 4404.2 If, during any fiscal year, a CON holder fails to meet its annual uncompensated care obligation, the CON holder shall, during a subsequent fiscal year, provide uncompensated care in a dollar value sufficient to remediate that deficit, pursuant to a compliance plan under § 4413 approved by the SHPDA. The compliance plan shall include the following:
- (a) The conditions or circumstances that caused or contributed to the deficit;
 - (b) Specific actions the CON holder plans to take to remediate the deficit;
 - (c) Specific actions the CON holder plans to take to prevent further deficits;
 - (d) The name of a staff person who will be responsible for administering the compliance plan; and
 - (e) The dates on which the compliance plan will begin and is expected to be completed.
- 4404.3 A deficit incurred during any fiscal year shall be made up within not more than three (3) fiscal years after the end of the fiscal year during which the deficit occurred.
- 4404.4 A CON holder shall begin to make up a deficit during the fiscal year immediately following the fiscal year during which it incurred the deficit.
- 4404.5 The SHPDA shall complete its review of the compliance plan within forty-five (45) days of receipt from the CON holder. The compliance plan shall expire after the CON holder remedies the deficit for which it submitted the compliance plan.
- 4404.6 The Director may extend the period of time within which a CON holder may make up a deficit.
- 4404.7 The amount of an uncompensated care deficit for any fiscal year shall be the difference between a CON holder's annual compliance level for that fiscal year and the amount of uncompensated care provided during that fiscal year.
- 4404.8 If a CON holder provides uncompensated care during a fiscal year in an amount exceeding its annual compliance level, the CON holder may request that the Director apply the excess amount as a credit towards an existing deficit or its annual compliance level for any subsequent fiscal year. To be eligible for a credit, the excess dollar value above the annual compliance level must have been provided pursuant to the requirements of this chapter.
- 4405 NOTICE OF AVAILABILITY OF UNCOMPENSATED CARE**
- 4405.1 Each CON holder shall publish, in a newspaper of general circulation within the District of Columbia, and submit to the Director before the beginning of the CON holder's fiscal year, a notice of its uncompensated care obligation. The notice shall

include:

- (a) The dollar value of uncompensated care that the CON holder intends to make available during the fiscal year or a statement that the CON holder will provide uncompensated care to all persons unable to pay for treatment who request uncompensated care;
- (b) An explanation of the difference between the amount of uncompensated care the CON holder proposes to make available and the annual compliance level for the CON holder, if any; and
- (c) A statement whether the CON holder has satisfied all outstanding uncompensated care obligations from previous reporting periods, or a statement indicating that it will, during a specified period, satisfy any outstanding obligations.

4405.2 The CON holder shall post the following notice:

“Under District of Columbia law, this health care provider must make its services available to all people in the community. This health care provider is not allowed to discriminate against a person because of race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, family responsibilities, matriculation, political affiliation, physical handicap, source of income, or place of residence or business, or because a person is covered by a program such as Medicare or Medicaid.

“This health care provider is also required to provide a reasonable volume of services without charge or at a reduced charge to persons unable to pay. Ask the staff if you are eligible to receive services either without charge or at a reduced charge. If you believe that you have been denied services or consideration for treatment without charge or at a reduced charge without a good reason, contact the Admissions or Business Office of this health care provider, and call the State Health Planning and Development Agency through the Citywide Call Center at 202-727-1000.

“If you want to file a complaint, forms are available from the State Health Planning and Development Agency.”

4405.3 The notice required by § 4405.2 shall also include the CON holder’s eligibility criteria for uncompensated care.

4405.4 The CON holder shall post the notice required by § 4405.2 in plain view in areas of the CON holder’s facility or service that are easily accessible to the public. Those areas shall include the admissions areas, the business office, and the emergency room.

4405.5 The notice required by § 4405.2 shall be printed in the following languages:

- (a) English;

- (b) Spanish; and
 - (c) Any other language that is the usual language of households of ten percent (10%) or more of the population of the District of Columbia, according to the most recent figures published by the Bureau of Census.
- 4405.6 Each CON holder shall communicate the contents of the posted notice to any person who the CON holder has reason to believe cannot read the notice.
- 4405.7 During any period of a fiscal year when uncompensated care is available in the CON holder's facility or service, the CON holder shall provide written notice of the availability of the services to each person who seeks services from the CON holder, whether on his or her own behalf or on behalf of another. The written notice of availability shall include the following:
- (a) The information set out in the notice in § 4405.2.
 - (b) The location in the CON holder's facility or service where any person seeking uncompensated care may request it; and
 - (c) A statement that the CON holder is required to make a written determination whether the person will receive uncompensated care; and
 - (d) The date by, or period within which, the determination will be made.
- 4405.8 Each CON holder shall provide the written notice required by § 4405.7 before providing services, except where the emergency nature of the services makes prior notice impractical. In emergency situations, the CON holder shall provide the written notice to the patient as soon as practical, or to the next of kin. The CON holder shall give the notice not later than when presenting the first bill for services.
- 4406 UNCOMPENSATED CARE ELIGIBILITY CRITERIA**
- 4406.1 A person is eligible to receive uncompensated care if the person is unable to pay for health services and satisfies the following additional requirements:
- (a) Is not covered, or receives services that are not covered, under a third-party insurer or governmental program;
 - (b) Has an annual individual or family income that is not greater than two hundred percent (200%) of the federal poverty level; and
 - (c) Requests services.
- 4406.2 Financial eligibility for uncompensated care shall be calculated by either of the following methods:
- (a) Multiplying by four (4) the person's individual or family income, as

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applicable, for the three (3) months preceding the request for uncompensated care; or

- (b) Using the person's or family's actual income, as applicable, for the twelve (12) months preceding the request for uncompensated care.

4406.3 For purpose of determining income eligibility for uncompensated care pursuant to § 4406.1(b), revisions to the federal poverty level used to calculate eligibility shall be effective sixty (60) days after the date of publication in the *Federal Register*.

4407 RESERVED

4408 WRITTEN DETERMINATION OF ELIGIBILITY FOR UNCOMPENSATED CARE

4408.1 Each CON holder shall give written notice of its determination of eligibility for uncompensated care in response to each request for uncompensated care to the person requesting care. The CON holder shall give notice in person at the time uncompensated care is requested or by regular mail to the address the person requesting services provided. If the person requesting care has not provided an address and is not available to receive notice in person, the CON holder may post at the facility, in a conspicuous place such as the admissions office or the emergency services department, a notice that the person's eligibility status is available in the administrative office within that facility.

4408.2 Each CON holder shall communicate the contents of the written determination to any person requesting uncompensated care that the CON holder has reason to believe cannot read the determination.

4408.3 Each determination of eligibility for uncompensated care shall include the following statements:

- (a) That the CON holder will, will with conditions, or will not provide uncompensated care;
- (b) That there will be no charge for uncompensated care;
- (c) The date on which the person requested care;
- (d) The date on which the CON holder made the determination;
- (e) The annual individual or family income, as applicable, and family size of the person who requested uncompensated care;
- (f) The date on which services were, or will be, provided; and
- (g) The reason for denial, if applicable.

- 4408.4 As a condition of providing uncompensated care, a CON holder may:
- (a) Require the person requesting uncompensated care to furnish any information that is reasonably necessary to substantiate eligibility; and
 - (b) Require each person requesting uncompensated care to apply for any benefits under third party insurer or governmental programs to which the person requesting uncompensated care is, or could be, entitled upon application.
- 4408.5 A conditional eligibility determination shall state the conditions that the person requesting uncompensated care must satisfy to be eligible.
- 4408.6 CON holders shall make eligibility determinations as follows:
- (a) Each hospital shall make an eligibility determination for uncompensated care within five (5) business days of a request for an outpatient service or before discharge for an inpatient service;
 - (b) Each ambulatory surgical facility shall make an eligibility determination for uncompensated care within five (5) business days of a request for an outpatient service; and
 - (c) Any other CON holder shall make a determination of eligibility for uncompensated care within ten (10) business days following the date of admission or delivery of services.
- 4409 RESERVED**
- 4410 UNCOMPENSATED CARE REPORTING REQUIREMENTS**
- 4410.1 Each CON holder shall submit an annual report to the SHPDA on uncompensated care. The report shall be on a schedule prescribed by the SHPDA. The report shall be submitted within one hundred and twenty (120) days after the close of the CON holder's fiscal year. The report shall include:
- (a) The dollar value of uncompensated care that the CON holder was required to provide;
 - (b) The dollar value of uncompensated care the CON holder actually provided, with the dollar value of charity care and bad debt reported separately;
 - (c) A copy of the CON holder's audited financial statement for that fiscal year;
 - (d) Other documentation SHPDA may require to determine if a CON holder has met its annual compliance level for the period covered by the report;
 - (e) The dollar value of services and care provided to District residents;

- (f) A copy of the notice required by § 4405.1, including the date the notice was published and the name of the newspaper that printed the notice;
- (g) If the CON holder failed to provide the required annual level of uncompensated care, the reason and any documentation that supports its reason for failing to meet the annual compliance level;-and
- (h) Any other documentation the Director may request.

4410.2 The Director may require a CON holder to submit the report required by § 4410.1 more frequently when:

- (a) The Director determines that during the preceding fiscal year the CON holder did not provide uncompensated care at its required annual compliance level; or
- (b) The Director notifies the CON holder, in writing, that additional reports are needed for proper administration of the CON program.

4410.3 If the Director requests additional reports pursuant to § 4410.2, the CON holder shall submit the report within ninety (90) days after receiving the request or within ninety (90) days after the close of the fiscal year, whichever is later. The Director may, for good cause shown, extend the time within which the CON holder must submit the report.

4410.4 Not later than ten (10) days after being served with a summons or complaint regarding uncompensated care or any other activity relating to the CON, each CON holder shall notify the Director of any legal action brought against it that alleges that it has failed to comply with the requirements of this chapter.

4411 UNCOMPENSATED CARE RECORDS MAINTENANCE REQUIREMENTS

4411.1 Each CON holder shall maintain and provide to the Director, upon request, any records necessary to document the CON holder's compliance with the requirements of this chapter. Each CON holder shall make available for public inspection the records it maintains to document its compliance. Patient identifying information shall be removed from records provided for public inspection.

4411.2 The CON holder shall maintain uncompensated care records, including the following:

- (a) Any documents from which the information required to be reported under § 4410 was obtained;
- (b) Documents that clearly segregate uncompensated care from other accounts;
- (c) Copies of written determinations of eligibility under § 4408; and

- (d) Documentation that verifies compliance with the requirements of this chapter during any fiscal year, including documents from which information required to be reported under § 4410.1 was obtained.

4411.3 Each CON holder shall retain records to document its compliance with this chapter for five (5) years from the date of the last entry for a particular fiscal year. The Director may require a CON holder to maintain the records for a longer period.

4412 INVESTIGATION AND CERTIFICATION OF COMPLIANCE

4412.1 Any person may file a complaint with the Director that a CON holder is not complying with the requirements of this chapter.

4412.2 Each complaint shall include the following information:

- (a) The name and address of the complainant;
- (b) The name and address of the CON holder;
- (c) The date or approximate date on which the event or incident being complained of occurred; and
- (d) A statement describing the event or incident that the complainant believes violates the requirements of this chapter.

4412.3 The filing date of a complaint shall be the date of receipt by the SHPDA.

4412.4 The Director shall provide a copy of the complaint to the CON holder named in the complaint within ten (10) business days after receiving the complaint.

4412.5 The Director shall initiate an investigation of each complaint filed pursuant to the provisions of this section within thirty (30) business days of its receipt.

4412.6 The CON holder shall provide the Director with documents, records, or other requested information that may assist in investigating the complaint.

4412.7 A CON holder shall be out of compliance with its uncompensated care obligations if it fails to provide documentation the Director requests to determine the CON holder's compliance with this chapter.

4412.8 The Director shall determine the merit of a complaint based on:

- (a) Information contained in the complaint;
- (b) Documents the CON holder provides; and
- (c) Other credible information the Director receives.

- 4412.9 If the Director determines that a complaint is not substantiated, the Director shall dismiss the complaint.
- 4412.10 The Director shall make periodic reviews of the uncompensated care requirements and activities of each CON holder to determine whether a CON holder is complying with its obligations.
- 4412.11 The Director shall conduct audits to determine each CON holder's compliance with its uncompensated care obligation according to standard audit procedures.
- 4412.12 After completing the audit the Director may certify that a CON holder has substantially complied with its uncompensated care obligation for a specific fiscal year or years. The certification shall confirm that the CON holder has provided the uncompensated care stated for the period covered by the certification.
- 4412.13 The Director shall base each certification of substantial compliance on the amount of uncompensated care properly claimed by the CON holder, using procedures and reviewing individual account data the Director determines to be sufficient to establish that the CON holder has substantially complied with its uncompensated care obligation for the period covered by the certification.
- 4412.14 The Director may certify substantial compliance when he or she determines that, for the period covered by the certification, the CON holder provided uncompensated care to eligible persons who had equal opportunity to apply for uncompensated care.
- 4412.15 To determine whether a CON holder has substantially complied with its obligations, the SHPDA shall consider each of the following in descending order of importance:
- (a) Whether the CON holder took corrective action prescribed pursuant to § 4413;
 - (b) Whether the CON holder's noncompliance with its uncompensated care obligation may be remedied by corrective action under § 4413; and
 - (c) Whether the CON holder had procedures in place that complied with the applicable notice, eligibility, and record keeping requirements of §§ 4405, 4406, 4408, 4410, and 4411, and systematically and correctly followed the procedures.
- 4412.16 The Director shall determine and certify the amount of creditable service required by each CON holder for the three (3) fiscal years ending prior to the effective date of these rules. The Director shall base the determination on information necessary to establish the CON holder's substantial compliance with its uncompensated care obligation during the period being reviewed.
- 4412.17 To determine creditable service during the three (3) fiscal years ending prior to the effective date of these rules, each CON holder shall submit to the Director for each fiscal year the following:

- (a) The number of persons to whom it provided care without charge or below its normal and customary charge;
- (b) The total dollar amount of uncompensated care it provided in each fiscal year and the method used to determine that dollar amount; and
- (c) A description of the eligibility criteria it used for providing uncompensated care.

4413 UNCOMPENSATED CARE ENFORCEMENT

4413.1 If the Director finds, based on an investigation, review, or audit under § 4412, that a CON holder has not complied with the requirements of this chapter, the Director may take any action authorized by law to secure compliance, including:

- (a) Voluntary agreement;
- (b) Judicial enforcement of the obligations under this chapter; and
- (c) Denial or withdrawal of a CON.

4413.2 Each CON holder that has denied uncompensated care to any person because it failed to comply with its uncompensated care obligation shall be out of compliance until it takes the actions necessary to remedy fully the noncompliance, including:

- (a) Providing uncompensated care to applicants improperly denied;
- (b) Repaying amounts improperly collected from persons eligible to receive uncompensated care; and
- (c) Other corrective action the Director may prescribe.

4413.3 The Director may disallow all of the uncompensated care claimed in a fiscal year if the Director finds that a CON holder was in substantial noncompliance with its uncompensated care obligation because it failed to do any of the following:

- (a) Have a system for providing notices to eligible persons as required by § 4405;
- (b) Comply with the applicable reporting requirements of § 4410;
- (c) Have a system for maintaining records of uncompensated care provided;
- (d) Take corrective action pursuant to § 4413.2;
- (e) Comply with the applicable eligibility standards in § 4406; or

(f) Comply with the written determination procedures in § 4408.

4413.4 If the Director determines, based on investigation, audit, or review under § 4412, that a CON holder has limited its services in violation of its uncompensated care obligation, the Director may require the CON holder to establish a compliance plan to ensure that the CON holder's services are available according to the requirements of this chapter.

4413.5 In the absence of a finding of noncompliance in any fiscal year, the Director may disallow uncompensated care claimed by a CON holder in the fiscal year to the extent that the services are not documented as uncompensated care according to this chapter.

4414 RESERVED

4499 DEFINITIONS

4499.1 The provisions of § 4099 of Chapter 40 of this title and the definitions set forth in that section shall apply to this chapter.

4499.2 When used in this chapter, the following terms and phrases shall have the meaning ascribed below:

Act - the Health Services Planning Program Re-establishment Act of 1996, effective April 9, 1997 (D.C. Law 11-191; D.C. Official Code § 44-401 *et seq.*).

Certificate of Need or CON – authorization for a health care facility or health service to develop a new institutional health service, purchase major medical equipment, or obligate a capital expenditure to obtain an asset worth more than two million five hundred thousand dollars (\$2,500,000).

Certificate of Need applicant or CON applicant - a person who applies for a CON.

Certificate of Need holder or CON holder - a person who has applied for and received a Certificate of Need pursuant to this chapter. For the purpose of this chapter, a person continues to be a CON holder after the completion of the project for which the CON was obtained.

Compliance plan - the means by which a CON holder that violates this chapter or is out of compliance with its uncompensated care obligations proposes to remedy the violations or other noncompliance.

Director--Director of the District of Columbia State Health Planning and Development Agency, Department of Health

Health care facility--a private general hospital, psychiatric hospital, other specialty hospital, rehabilitation facility, skilled nursing facility, intermediate care facility, ambulatory care center or clinic, ambulatory surgical facility, kidney disease treatment center, freestanding hemodialysis facility, diagnostic health care facility, home health agency, hospice, or other comparable health

care facility that has an annual operating budget of at least \$500,000. This term shall not include Christian Science sanitariums operated, listed, and certified by the First Church of Christ Scientist, Boston, Massachusetts; the private office facilities of a health professional or group of health professionals, where the health professional or group of health professionals provides conventional office services limited to medical consultation, general non-invasive examination, and minor treatment, or a health care facility licensed or to be licensed as a community residence facility, or an Assisted Living Residence as defined by § 102.01(4) of the Assisted Living Residence Regulatory Act of 2000, effective June 24, 2000 (D.C. Law 13-127; 44-102.01(4)).

Health service - any medical or clinical related service, including services that are diagnostic, curative, or rehabilitative, as well as those related to alcohol abuse, inpatient mental health services, home health care, hospice care, medically supervised day care, and renal dialysis. This term shall not include those services provided by physicians, dentists, HMOs, and other individual providers in individual or group practice.

Request for uncompensated care - any indication by or on behalf of an individual seeking health care from a CON holder of the individual's inability to pay for the services that is made at any time, including following institution of a collection action against the individual.

SHPDA - State Health Planning and Development Agency, Department of Health.

Comments on the proposed rules should be sent in writing to the Department of Health, Office of the General Counsel, 4th Floor, 825 North Capitol Street, N.E., Washington, D.C. 20002, not later than thirty (30) days after the date of publication of this notice in the *D.C. Register*. Copies of the proposed rules may be obtained Monday through Friday, excepting holidays, between the hours of 8:30 A.M. and 4:45 P.M. at the same address.

DISTRICT OF COLUMBIA
DEPARTMENT OF MOTOR VEHICLESNOTICE OF PROPOSED RULEMAKING

The Director of the Department of Motor Vehicles, pursuant to the authority set forth in Section 1825 of the Department of Motor Vehicles Establishment Act of 1998, effective March 26, 1999 (D.C. Law 12-175; D.C. Official Code § 50-904); Section 6(a) of the District of Columbia Administrative Procedure Act, approved October 21, 1968 (82 Stat. 1206; D.C. Official Code § 2-505(a)); Section 7 of An Act to provide for the annual inspection for all motor vehicles in the District of Columbia, approved February 18, 1938 (52 Stat. 78, D.C. Official Code § 50-1107); Section 201 of the District of Columbia Traffic Adjudication Act of 1978 (D.C. Law. 2-104; D.C. Official Code § 50-2302.01); Section 9 of the International Registration Plan Agreement Act of 1996, effective September 5, 1997 (D.C. Law 12-14; D.C. Official Code § 50-1507.01); and Mayor's Order 03-58, effective April 21, 2003, hereby gives notice of the intent to amend Chapters 6 and 30 of Title 18 of the District of Columbia Municipal Regulations (DCMR) (Vehicles and Traffic). These amendments will temporarily suspend reinspections at reinspection stations and establish a means to serve notices of infraction for violations of the International Registration Plan Agreement Act. Final rulemaking action to adopt these amendments shall be taken in not less than ten (10) days from the date of publication of this notice in the *D.C. Register*.

The Director finds good cause for the shortened comment period based upon the following:

As to Section A of the rulemaking, the Department of Motor Vehicles ("DMV") is installing new hardware and updating software for the computer system at the southwest inspection station. This is necessary to maintain compliance with federal requirements and to prevent a complete system failure of antiquated equipment, and therefore must be accomplished as expeditiously as possible. Unfortunately, this does not allow sufficient time or resources to integrate the new software with the computers located at the reinspection stations throughout the District. Without such integration, DMV will only be able to verify the reinspection of vehicles that failed a previous inspection at its own inspection station. DMV will no longer be able to determine that vehicles requiring reinspection were reinspected at a reinspection station. In order to ensure vehicles that fail inspection are properly tracked and reinspected, reinspections at the reinspection stations must therefore be suspended in an expeditious manner.

As to Section B of the rulemaking, the DMV promulgated an emergency rule, effective July 27, 2005, allowing the imposition of civil fines for violations of the International Registration Plan Agreement Act ("IRP act"). The IRP act establishes that fines for certain violations of its provisions must be issued to the owner. However, neither law enforcement personnel nor the DMV have a readily available means by which they can determine the address of out of state owners. Therefore, a regulation is needed to deem service of a notice of infraction upon an operator to be service upon the owner. These additional rules need to be implemented quickly to close any enforcement gaps.

A. Chapter 6, INSPECTION OF MOTOR VEHICLES, section 605, REINSPECTION OF REJECTED VEHICLES, subsection 605.2 is amended by adding a new paragraph (c) to read as follows:

- (c) Beginning September 19, 2005, and extending for a temporary period to be determined by the Director, reinspections shall only be conducted by personnel described in paragraph (a) of this subsection.

B. Chapter 30, ADJUDICATION AND ENFORCEMENT, Section 3004, SERVICE OF THE NOTICE OF INFRACTION, is amended as follows:

1) Subsection 3004.2 is amended to read as follows:

3004.2 Personal service shall be used for moving violations, except as otherwise provided in this section, and for parking violations when the operator is present.

2) A new subsection 3004.8 is added to read as follows:

3004.8 When a notice of infraction is issued for a violation of Section 4 of the International Registration Plan Agreement Act of 1996, effective September 5, 1997 (D.C. Law 12-14; D.C. Official Code 50-1507.03), the operator of the vehicle shall be deemed the agent of the owner or apportioned operator for the purposes of receiving service of the notice.

All persons desiring to comment on the subject matter of this proposed rulemaking should file comments, in writing, to Corey Buffo, General Counsel, D.C. Department of Motor Vehicles, 95 M Street, S.W., Washington, D.C. 20024. Comments must be received not later than ten (10) days after the publication of this notice in the D.C. Register. Copies of this proposal may be obtained by writing to the above address.

DEPARTMENT OF PUBLIC WORKS

NOTICE OF PROPOSED RULEMAKING

The Director, D.C. Department of Public Works, pursuant to the authority of Section 12 of the Removal and Disposition of Abandoned and Other Unlawfully Parked Vehicles Reform Act of 2003, effective October 28, 2003 (D.C. Law 15-35: D.C. Official Code §50-2421.12 ("Act") Sections IV(A) and V of Reorganization Plan No. 4 of 1983, 30 DCR 6428 (December 16, 1983), effective March 2, 1984, and Mayor's Order 84-55, 31 DCR 1323 (March 16, 1984), hereby gives notice of intent to adopt the following amendments to Chapter 24, Title 18 of the *District of Columbia Municipal Regulations*. These proposed rules amend the fees for towing and storing vehicles to conform with the Removal and Disposition of Abandoned and other Unlawfully Parked Vehicles Reform Act of 2003, D.C. Law 15-35, effective October 28, 2003, and to provide that the fee that the District of Columbia charges when towing a vehicle to a private parking lot may be collected in the same manner as the fine for the violation that was the reason for impounding the vehicle.

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

Chapter 24 is amended as follows:

By amending subsection 2421.3 by deleting "seventy-five dollar (\$ 75.00)" and replacing it with "one hundred (\$ 100.00)", and by deleting "one hundred seventy-five dollars (\$ 175.00)" and replacing it with "two hundred seventy-five dollars (\$ 275.00)".

By adding a new subsection 2421.3a to read as follows:

2421.3a Notice of any vehicle towing fee imposed under 18 DCMR 2421.1 may be given in the same manner as notice of the violation of the traffic regulation that was the reason for impounding the vehicle is given.

By adding a new subsection 2421.3b to read as follows:

2421.3b Any vehicle towing fee imposed under 18 DCMR 2421.1 may be collected in the same manner and to the same extent as is any fine set forth in 18 DCMR 2601.1.

By amending subsection 2422.1 by deleting "ten dollars (\$10.00)" and replacing it with "twenty dollars (\$20.00)".

Comments on these proposed regulations should be submitted, in writing, to Ms Christine V. Davis, General Counsel, D.C. Department of Public Works, 2001 14th St, N.W., 6th

Floor, Washington, D.C. 20009, within thirty (30) days of the date of publication of this notice in the *D.C. Register*.

Additional copies of these proposed regulations are available during business days from the above address between the hours of 9 a.m. and 5 p.m.