

DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Health Care Finance (DHCF), pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes approved December 27, 1967 (81 Stat.774; D.C. Official Code § 1-307.02 (2014 Repl.)) and Section 6(6) of the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.05(6) (2012 Repl.)), hereby gives notice of the adoption, on an emergency basis, of an amendment to Chapter 50 (Medicaid Reimbursement for Personal Care Services), of Title 29 (Public Welfare), of the District of Columbia Municipal Regulations (DCMR).

Personal Care Aide (PCA) services are health-related services that are provided to individuals because they are unable to perform one or more activities of daily living such as bathing, dressing, toileting, ambulation, or feeding oneself as a result of a medical condition or cognitive impairment causing a substantial disability. These amendments provide DHCF with the tools to increase oversight and closely monitor the quality and appropriateness of services being delivered to beneficiaries. Emergency action is necessary to preserve the safety, health, and wellness of existing recipients of PCA services by ensuring that beneficiaries have continued and uninterrupted access to quality services. These rules govern eligibility for Medicaid reimbursement of PCA services. These emergency and proposed rules amend the previously published rules by: (1) establishing that an order for PCA services can be written by an Advanced Practice Registered Nurse, in addition to a physician; (2) changing the re-assessment period to once every twelve (12) to eighteen (18) months to align the assessment date with the Medicaid renewal date, instead of every six (6) months; (3) expanding PCA services by adding the following reimbursable tasks – (a) “cueing” to assist a beneficiary with the performance of routine activities of daily living; (b) measuring and recording a beneficiary’s height and weight; (c) implementing universal precautions to ensure infection control; (d) assisting with telephone use; and (e) shopping for items related to promoting the patient’s nutritional status and other health needs that relate – to the scope of services; (4) eliminating the need for a physician’s signature on plans of care subsequent to the initial plan of care but requiring that all subsequent plans of care be approved by DHCF or its agent; (5) requiring that records be maintained for a period of ten (10) years, or when all audits have been completed, whichever is longer; (6) removing the one thousand and forty (1040) hour cap on receipt of services, and establishing that the limit on a beneficiary’s PCA service hours shall be determined by the PCA service authorization in an amount not to exceed eight (8) hours per day, seven (7) days per week; (7) establishing that although Medicaid reimbursement of PCA is prohibited in living arrangements which includes personal care as part of the reimbursed service, beneficiaries residing in assisted living facilities may receive reimbursement of PCA services upon prior authorization by DHCF or its agent; (8) clarifying that parents of adult children are not considered legally responsible relatives and may provide PCA services; (9) adding that if a beneficiary is also receiving Adult Day Health Program (ADHP) services under the 1915(i) State Plan Option on the same day that PCA services are

delivered, the combination of both PCA and ADHP services shall not exceed a total of twelve (12) hours per day; (10) clarifying existing terms to eliminate ambiguity and simplify interpretation; and (11) adjusting the rates to incorporate: (a) the benefits requirement under the Patient Protection and Affordable Care Act of 2010, approved March 23, 2010 (Pub. L. No. 111-148, 124 Stat. 119), as amended, and supplemented by the Health Care and Education Reconciliation Act of 2010, approved January 5, 2010 (Pub. L. No. 111-152, 124 Stat. 1029) and the District of Columbia Accrued Sick and Safe Leave Act of 2008, effective May 13, 2008 (D.C. Law 17-152; D.C. Official Code §§ 32-131.10 and 131.33 (2012 Repl.)); and (b) administrative costs following the recent review of the FY 2013 Home Health Agencies cost reports.

The corresponding amendment to the District of Columbia State Plan for Medicaid Assistance (State Plan) requires approval by the Council of the District of Columbia (Council) and the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). Except for Section 5015 governing reimbursement, implementation of these emergency and proposed rules is contingent upon approval of the corresponding State Plan amendment by CMS, with an effective date of October 27, 2015 or the effective date established by CMS in its approval of the corresponding State Plan amendment, whichever is later.

The emergency rulemaking was adopted on October 27, 2015. Section 5015 governing reimbursement became effective for dates of services beginning October 27, 2015. The remaining rules will become effective October 27, 2015 if the corresponding State Plan amendment is approved by CMS with an effective date of October 27, 2015 or the effective date established by CMS in its approval of the corresponding State Plan amendment, whichever is later. The emergency rules shall remain in effect for one hundred and twenty (120) days or until February 24, 2016, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*. The Director of DHCF also gives notice of the intent to take final rulemaking action to adopt these proposed rules in not less than thirty (30) days after the date of publication of this notice in the *D.C. Register*.

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

CHAPTER 50 MEDICAID REIMBURSEMENTS FOR PERSONAL CARE AIDE SERVICES

5000 GENERAL PROVISIONS

5000.1 These rules establish the standards and conditions of participation for home care agencies providing Medicaid reimbursable personal care aide (PCA) services under the District of Columbia Medicaid Program's State Plan for Medical Assistance (Medicaid State Plan).

- 5000.2 Medicaid reimbursable PCA services support and promote the following goals:
- (a) To provide cueing or necessary hands-on assistance with the activities of daily living to beneficiaries who are unable to perform one or more activities of daily living; and
 - (b) To encourage home and community-based care as a preferred and cost-effective alternative to institutional care.

5001 PROVIDER QUALIFICATIONS

- 5001.1 A Provider receiving Medicaid reimbursement for PCA services shall:
- (a) Be a home care agency licensed pursuant to the requirements for home care agencies as set forth in the Health Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code, §§ 44-501 *et seq.* (2012 Repl.)), and implementing rules; and
 - (b) Be enrolled as a Medicare home health agency qualified to offer skilled services as set forth in Sections 1861(o) and 1891(e) of the Social Security Act (42 U.S.C. §§ 1395x and 1395bbb), and 42 C.F.R. § 484.
- 5001.2 An applicant seeking Medicaid reimbursement as a Provider under the Medicaid Program shall submit a Medicaid Provider Enrollment Application to the Department of Health Care Finance (DHCF), execute a Provider Agreement and be enrolled as a Provider.
- 5001.3 A Provider seeking Medicaid reimbursement under an executed Medicaid Provider Agreement shall comply with all legal obligations under Federal and District laws, including the provider's obligations to take reasonable steps to provide beneficiaries who are Limited English Proficient (LEP) with meaningful access to their services pursuant to the D.C. Human Rights Act of 1977, effective December 13, 1977 (D.C. Law 20-39; D.C. Official Code §§ 2-1401.01 *et seq.*) and Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352; 42 U.S.C. §§ 2000d *et seq.*), Section 504 of the Rehabilitation Act of 1973 (Pub. L. No. 93-112; 29 U.S.C. §§ 701 *et seq.*), 42 C.F.R. Parts 80, 84, and 90, and the Americans with Disabilities Act of 1990, effective January 1, 2009 (Pub. L. No. 101-336; 42 U.S.C. §§ 12101 *et seq.*).

- 5001.4 Each Provider application shall contain, but not be limited to, the following:
- (a) Name, address, and business email of the applicant's organization and location of the applicant's place of business. An applicant shall submit a separate application for each place of business from which the applicant intends to offer District of Columbia Medicaid program services;
 - (b) Answers sufficient to meet requirements as set forth in 42 C.F.R. § 455, subpart B: Disclosure of Information by Providers and Fiscal Agents;
 - (c) Names, license numbers, and National Provider Identifier (NPI) numbers of all individuals providing PCA services or nursing services from the National Plan and Provider Enumeration System (NPPES) as of the date of the application to become a District of Columbia Medicaid Provider;
 - (d) The applicant's U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) Medicare Supplier Letter issued pursuant to 42 C.F.R. § 424.510 to evidence enrollment of the applicant in the Medicare program;
 - (e) A copy or copies of all contracts held between the applicant and any staffing agency pertaining to the delivery of PCA services;
 - (f) A copy or copies of license(s) held by the employees of any staffing agency or agencies used by the Provider for the delivery of PCA services;
 - (g) The applicant's NPI number as required by the Health Insurance Portability and Accountability Act of 1996, approved August 21, 1996 (Pub.L. No 104-191; 110 Stat. 1936);
 - (h) A copy of the applicant's surety bond, pursuant to requirements set forth in § 5011 of this chapter; and
 - (i) A copy of a Certificate of Registration or Certificate of Authority, if required by District law or rules.
- 5001.5 A Provider shall submit a new Medicaid Provider Enrollment Application within thirty (30) days after any change in business ownership. Re-enrollment or continued enrollment in the Medicaid program after any change in business

ownership shall be conditioned upon the Provider's compliance with all applicable Federal and District requirements.

5001.6 A Provider shall submit a new Medicaid Provider Enrollment Application and successfully re-enroll in the D.C. Medicaid program at least every five (5) years starting from the date of execution of its most recent Provider Agreement.

5001.7 A Provider shall accept referrals from, and provide requested information to DHCF or its designated agent.

5002 ELIGIBILITY REQUIREMENTS

5002.1 To be eligible to receive PCA services, a Medicaid beneficiary must meet all of the following qualifications:

- (a) Be unable to independently perform one or more activities of daily living for which PCA services are needed;
- (b) Be in receipt of a written order for PCA services in accordance with Subsections 5006.1 and 5006.2; and
- (c) Be in receipt of a PCA Service Authorization in accordance with Section 5003.

5003 PCA SERVICE AUTHORIZATION REQUEST AND SUBMISSION

5003.1 Except as provided in Subsection 5003.8, in order to be reimbursed by Medicaid, PCA services shall not be initiated or provided on a continuing basis by a Provider without a PCA Service Authorization from DHCF or its designated agent that, for each beneficiary, identifies the amount, duration and scope of PCA services authorized and the number of hours authorized.

5003.2 A Medicaid beneficiary who is seeking PCA services for the first time shall submit a request for a PCA Service Authorization to DHCF or its designated agent in writing, accompanied by a copy of the physician's or Advanced Practice Registered Nurse's (APRN) written order for PCA services that complies with the requirements set forth under this chapter.

5003.3 DHCF or its designated agent shall be responsible for conducting a face-to-face assessment of each beneficiary using a standardized assessment tool to determine each beneficiary's need for assistance with activities of daily living that the beneficiary is unable to perform. The assessment shall:

- (a) Confirm and document the beneficiary's functional limitations and personal goals with respect to long-term care services and supports;
 - (b) Be conducted in consultation with the beneficiary or the beneficiary's representative;
 - (c) Document the beneficiary's unmet need for services, taking into account the contribution of informal supports and other resources in meeting the beneficiary's needs for assistance; and
 - (d) Document the amount, frequency, duration, and scope of PCA services needed.
- 5003.4 Based upon the results of the face-to-face assessment conducted in accordance with Subsection 5003.3, DHCF or its authorized agent shall issue to the beneficiary a PCA Service Authorization that specifies the amount, frequency, duration, and scope of PCA services authorized to be provided to the beneficiary.
- 5003.5 Payment shall not exceed the maximum authorized units specified in the PCA Service Authorization and must be consistent with the plan of care in accordance with Section 5015.
- 5003.6 If authorized, PCA services may be provided up to eight (8) hours per day seven (7) days per week.
- 5003.7 A Registered Nurse (R.N.) employed by DHCF or its designated agent shall conduct the initial face-to-face assessment following the receipt of a request for service authorization and shall conduct a face-to-face reassessment at least every twelve (12) months, or upon significant change in the beneficiary's condition. A request for service authorization may be made by a Medicaid beneficiary, family member, the beneficiary's representative or a health care professional.
- 5003.8 DHCF may authorize the face-to-face reassessment for a period not to exceed eighteen (18) months, if necessary, to align the assessment date with the Medicaid renewal date.
- 5003.9 If, based upon the assessment conducted pursuant to this section, a beneficiary is found to be ineligible for PCA services, or the amount, duration or scope of PCA services is reduced, DHCF or its agent shall issue a Beneficiary Denial, Termination or Reduction of Services Letter informing the beneficiary of his or her right to appeal the denial, termination, or reduction of services in accordance with federal and District law and regulations.

5004 REFERRALS

5004.1 Upon completion of the PCA Service Authorization, DHCF or its designated agent shall make a referral to the beneficiary's choice of a qualified Provider.

5004.2 A referral to a qualified Provider shall not be considered complete unless it includes all of the following:

- (a) A copy of the physician or APRN's order for PCA services issued in accordance with Section 5006;
- (b) A copy of the completed written face-to-face assessment of the beneficiary undertaken in accordance with Subsection 5003.3; and
- (c) A copy of the completed PCA Service Authorization issued in accordance with Subsection 5003.4.

5005 PLAN OF CARE

5005.1 An R.N. employed by the Provider shall conduct an initial face-to-face visit with the beneficiary to develop a plan of care for delivering PCA services no later than seventy-two (72) hours after receiving the referral for services from DHCF or its designated agent.

5005.2 The plan of care shall:

- (a) Be developed by an R.N. in consultation with the beneficiary or the beneficiary's representative based upon the initial face-to-face visit with the beneficiary;
- (b) Specify how the beneficiary's need, as identified in the assessment conducted in accordance with Subsection 5003.3, will be met within the amount, duration, scope, and hours of services authorized by the PCA Service Authorization as set forth in Subsection 5003.4;
- (c) Consider the beneficiary's preferences regarding the scheduling of PCA services;
- (d) Specify the detailed services to be provided, their frequency, and duration, and expected outcome(s) of the services rendered consistent with the PCA Service Authorization;

- (e) Be approved and signed by the beneficiary's physician or an APRN within thirty (30) days of the start of care, provided that the physician or APRN has had a prior professional relationship with the beneficiary that included an examination(s) provided in a hospital, primary care physician's office, nursing facility, or at the beneficiary's home prior to the prescription of the PCA services; and
- (f) Incorporate person-centered planning principles that include:
 - (1) Ensuring that the planning process includes individuals chosen by the beneficiary;
 - (2) Ensuring that the planning process incorporates the beneficiary's needs, strengths, preferences, and goals for receiving PCA services;
 - (3) Providing sufficient information to the beneficiary to ensure that he/she can direct the process to the maximum extent possible;
 - (4) Reflecting the beneficiary's cultural considerations and is reflected by providing all information in plain language or consistent with any LEP considerations in accordance with Subsection 5001.3;
 - (5) Strategies for solving conflicts or disagreements; and
 - (6) A method for the beneficiary to request updates to the plan.

5005.3 After an initial plan of care is developed, all subsequent annual updates and modifications to plans of care shall be submitted to DHCF or its agent for approval in accordance with Subsection 5005.2, with the exception of the signature requirements prescribed under Subsection 5005.2(e).

5005.4 An R.N. who is employed by the Provider shall review the beneficiary's plan of care at least once every sixty (60) days, and shall update or modify the plan of care as needed. The R.N. shall notify the beneficiary's physician of any significant change in the beneficiary's condition.

5005.5 If an update or modification to a beneficiary's plan of care requires an increase or decrease in the number of hours of PCA services provided to the beneficiary, the Provider must obtain an updated PCA Service Authorization from DHCF or its designated agent after the reassessment for services.

5005.6 Each Provider shall coordinate a beneficiary's care by sharing information with all other health care and service providers, as applicable, to ensure that the beneficiary's care is organized and to achieve safer and more effective health outcomes.

5005.7 If a beneficiary is receiving Adult Day Health Program (ADHP) services under the § 1915(i) State Plan Option and PCA services, a provider shall coordinate the delivery of PCA services to promote continuity and avoid the duplication of care.

5006 PROGRAM REQUIREMENTS

5006.1 PCA services shall be ordered, in writing, by a physician or APRN who is enrolled in the D.C. Medicaid program and has had a prior professional relationship with the beneficiary that included an examination(s) provided in a hospital, primary care physician's office, nursing facility, or at the beneficiary's home prior to the order for the PCA services. A written order for PCA services constitutes a certification that the beneficiary is unable to perform one (1) or more activities of daily living for which PCA services are needed.

5006.2 A written order for PCA services issued in accordance with § 5006.1 shall be renewed every twelve (12) months.

5006.3 Each written order for PCA services under this section shall include the prescriber's NPI number obtained from NPPES.

5006.4 A Provider has an on-going responsibility to verify that each beneficiary that receives PCA services from the Provider has current eligibility for the District of Columbia Medicaid program and is eligible for and authorized to receive PCA services.

5006.5 An individual or family member other than a spouse, parent of a minor child, any other legally responsible relative, or court-appointed guardian may provide PCA services. Legally responsible relatives shall not include parents of adult children. Each family member providing PCA services shall comply with the requirements set forth in these rules.

5006.6 The Provider shall initiate services no later than twenty-four (24) hours after completing the plan of care unless the beneficiary's health or safety warrants the need for more immediate service initiation or the beneficiary or beneficiary's representatives agree to begin the services at a later date.

5006.7 PCA services shall include, but not be limited to, the following:

- (a) Cueing or hands-on assistance with performance of routine activities of daily living (such as, bathing, transferring, toileting, dressing, feeding, and maintaining bowel and bladder control);
- (b) Assisting with incontinence, including bed pan use, changing urinary drainage bags, changing protective underwear, and monitoring urine input and output;
- (c) Assisting beneficiaries with transfer, ambulation and range of motion exercises;
- (d) Assisting beneficiaries with self-administered medications;
- (e) Reading and recording temperature, pulse, blood pressure and respiration;
- (f) Measuring and recording height and weight;
- (g) Observing, documenting and reporting the beneficiary's physical condition, behavior, and appearance and reporting all services provided on a daily basis;
- (h) Preparing meals in accordance with dietary guidelines and assistance with eating;
- (i) Performing tasks related to keeping areas occupied by the beneficiary in a condition that promotes the beneficiary's safety;
- (j) Implementing universal precautions to ensure infection control;
- (k) Accompanying the beneficiary to medical or dental appointments or place of employment and recreational activities if approved in the beneficiary's plan of care;
- (l) Recording and reporting to the supervisory health professional, changes in the beneficiary's physical condition, behavior or appearance;
- (m) Shopping for items that are related to promoting a beneficiary's nutritional status in accordance with dietary guidelines and other health needs; and

- (n) Assistance with telephone use.
- 5006.8 PCA services shall not include:
- (a) Services that require the skills of a licensed professional as defined by the District of Columbia Health Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.*);
 - (b) Tasks usually performed by chore workers or homemakers, such as cleaning of areas not occupied by the beneficiary, shopping for items not related to promoting the beneficiary's nutritional status and other health needs, and shopping for items not used by the beneficiary; and
 - (c) Money management.
- 5006.9 PCA services shall not be provided in a hospital, nursing facility, intermediate care facility, or other living arrangement which includes personal care as part of the reimbursed service. However, persons residing in assisted living may receive PCA services upon prior authorization by DHCF or its agent.
- 5006.10 PCA services may be provided at the beneficiary's place of employment.
- 5006.11 A PCA is not authorized to make decisions on behalf of a beneficiary.
- 5006.12 A PCA shall immediately report to the R.N. any significant change in the beneficiary's health status in the case of emergency, or within four (4) hours for other situations, unless indicated otherwise in the beneficiary's plan of care.
- 5006.13 If the beneficiary seeks to change his or her Provider, the Provider shall assist the beneficiary in transferring to the new Provider. Until the beneficiary is transferred to a new PCA services Provider, the Provider shall continue providing PCA services to the beneficiary until the transfer has been completed successfully and the beneficiary is receiving PCA services from the new Provider.
- 5006.14 Each Provider shall immediately terminate the services of a PCA and instruct the PCA to discontinue all services to the beneficiary, in any case where the Provider believes that the beneficiary's physical or mental well-being is endangered by the care or lack of care provided by the PCA, or that the beneficiary's property is at risk. The Provider is responsible for assigning a new PCA and ensuring that the beneficiary's needs continue to be met.

- 5006.15 Each Provider shall conduct annual performance assessments of all PCAs who deliver services to beneficiaries served by the Provider, regardless of whether the PCA is an employee or is secured through another staffing agency. The initial performance assessment shall be conducted no later than three (3) months after the PCA first provides services to any beneficiary served by the Provider.
- 5006.16 Each Provider shall develop contingency staffing plans to provide coverage for each beneficiary in the event the assigned PCA cannot provide the services or is terminated.
- 5007 DENIAL, SUSPENSION, REDUCTION OR TERMINATION OF SERVICES**
- 5007.1 When PCA services are no longer desired by the beneficiary or their authorized representative, each Provider shall discontinue PCA services only after:
- (a) Giving the beneficiary written notice that meets the requirements set forth in Subsection 5007.2;
 - (b) The thirty (30) day notice period prescribed in Subsection 5007.2 elapses; and
 - (c) The time for an appeal has expired, and the beneficiary has not filed an appeal.
- 5007.2 Except as provided in Subsections 5007.4 and 5007.5, for Provider initiated suspensions, discharges or reductions of service, each Provider shall notify DHCF or its designated agent and the beneficiary or the beneficiary's authorized representative, in writing, no less than thirty (30) calendar days prior to any suspension, discharge or reduction in service, consistent with the requirements set forth in District and Federal law and rules. The beneficiary's record shall contain a copy of the notice and documentation of the date the notice was either personally served upon or mailed to the beneficiary or the beneficiary's designated agent.
- 5007.3 For denials, suspensions, terminations or reductions of service initiated by DHCF or its agent, DHCF or its designated agent shall notify the beneficiary or the beneficiary's authorized representative, in writing, no less than thirty (30) calendar days prior to any denial, suspension, termination or reduction of services, consistent with the requirements set forth in District and Federal law and rules.

- 5007.4 If the behavior of a beneficiary poses an immediate threat to the safety and well-being of the PCA or PCA Provider staff, the Provider has the right to immediately suspend the beneficiary's services or discharge the beneficiary. Suspension of services shall not exceed thirty (30) calendar days.
- 5007.5 Within seventy-two (72) hours of suspension, the Provider shall notify the beneficiary or authorized representative in writing of the following:
- (a) The grounds for suspension or discharge; and
 - (b) The beneficiary's right to appeal the suspension or discharge.
- 5007.6 At the end of the suspension period, the Provider may re-instate the beneficiary's services or discharge the beneficiary. The Provider shall assist the beneficiary in transferring to another provider.
- 5007.7 The beneficiary or the beneficiary's representative shall be provided with a written notice of discharge at least fifteen (15) days before the effective date of the discharge, if the decision is made to discharge the beneficiary following suspension. The written notice shall comply with District and federal law and rules.
- 5007.8 In the event of a suspension or discharge, the Provider shall be responsible for ensuring that the beneficiary's health, safety, and welfare are not threatened during the period of suspension or during the period after the beneficiary has been discharged and before transfer to another provider.

5008 STAFFING

- 5008.1 Each Provider shall utilize an R.N. to manage and provide supervision to PCAs who are qualified to perform all of the functions described in Subsection 5008.3.
- 5008.2 Each Provider shall verify that each PCA used to deliver services, regardless of whether the PCA is an employee of the Provider or is secured through another staffing agency, meets the qualifications set forth in Section 5009.
- 5008.3 Each Provider shall employ an R.N. who is responsible for the following:
- (a) Accepting and reviewing the beneficiary's PCA Service Authorization and initial assessment or reassessment of need for PCA services;

- (b) Developing a written plan of care in accordance with Section 5005 that meets the beneficiary's assessed needs and preferences within the service limitations authorized in the PCA Service Authorization;
- (c) Updating each beneficiary's written plan of care based upon subsequent reassessments of need;
- (d) Maintaining a clinical record in accordance with Section 5013;
- (e) Reviewing the beneficiary's plan of care with each assigned PCA and ensuring that each assigned PCA has the requisite training, skills and ability to meet the beneficiary's identified needs and preferences;
- (f) Monitoring the quality of PCA services on a regular basis and ensuring that PCA services are delivered in accordance with the beneficiary's Plan of Care;
- (g) Supervising all PCAs, regardless of whether the PCA is an employee of the Provider or is secured through a staffing agency. Supervision shall include on-site supervision at least once every sixty (60) days;
- (h) Coordinating the provision of PCA services with other home health services, as appropriate and communicating with each beneficiary's physician or APRN regarding changes in the beneficiary's condition and needs;
- (i) Gathering information regarding the beneficiary's condition and the need for continued care;
- (j) Communicating and coordinating with DHCF or its designated agent regarding changes in the beneficiary's condition and needs. At a minimum the Provider must communicate to DHCF or its designated agent:
 - (1) Any failure or inability of the provider to deliver authorized services within three (3) business days of the scheduled visit; and
 - (2) Any change in the beneficiary's status requiring a modification in the amount, duration, or scope of service authorized; and
- (k) Counseling the beneficiary and the beneficiary's family regarding nursing and related needs.

5008.4 The R.N., at minimum, shall visit each beneficiary within forty-eight (48) hours of initiating PCA services, and no less than every sixty (60) days thereafter, to monitor the implementation of the plan of care and the quality of PCA services provided to the beneficiary.

5008.5 The R.N. shall provide additional supervisory visits to each beneficiary if the situation warrants additional visits, such as in the case of an assignment of a new personal care aide or change in the beneficiary's health status.

5009 PERSONAL CARE AIDE REQUIREMENTS

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

- (a) Obtain or have an existing Home Health Aide certification in accordance with Chapter 93 of Title 17 of the District of Columbia Municipal Regulations;
- (b) Confirm, on an annual basis, that he or she is free from communicable diseases including tuberculosis and hepatitis, by undergoing an annual purified protein derivative (PPD) test and receiving a hepatitis vaccine during physical examination by a physician, and obtaining written and signed documentation from the examining physician confirming freedom from communicable disease;
- (c) Provide evidence of current cardio pulmonary resuscitation and first aid certification;
- (d) Pass a criminal background check pursuant to the Licensed Health Professional Criminal Background Check Amendment Act of 2006, effective March 6, 2007 (D.C. Law 16-222; D.C. Official Code § 3-1205.22) and 17 DCMR § 9303;
- (e) Pass a reference check and a verification of prior employment;
- (f) Have an individual NPI number obtained from NPPES;
- (g) Obtain at least twelve (12) hours of continuing education or in-service training annually in accordance with the Department of Health's Home Care Agency training requirements under 22-B DCMR § 3915; and
- (h) Meet all of the qualifications for Home Health Aide trainees in accordance with Chapter 93 of Title 17 DCMR, which includes the following:

- (1) Be able to understand, speak, read, and write English at a fifth (5th) grade level or higher;
- (2) Be knowledgeable about infection prevention, including taking standard precautions; and
- (3) Possess basic safety skills including being able to recognize an emergency and be knowledgeable about emergency procedures.

5010 STAFFING AGENCIES

5010.1 A Provider may contract with a licensed staffing agency to secure staff to deliver PCA services. Agreements between the Provider and the staffing agency providing personal care staffing services shall be in writing and include at a minimum, the following:

- (a) A provision requiring the staffing agency to provide the Provider with the staffing agency's NPI number obtained from the NPPES and the NPI numbers of all individuals providing PCA services to the home care agency throughout the duration of the contract;
- (b) A business address and e-mail address for each staffing agency;
- (c) Provisions making explicit and delineating the Provider's responsibility to:
 - (1) Manage, supervise and evaluate the PCA services secured through a staffing agency; and
 - (2) Be accountable for all services delivered by non-employee PCAs to the same extent as if the PCAs were employees of the Provider;
- (d) The duration of the agreement, including provisions for renewal, if applicable; and
- (e) Assurances that the staffing agency shall comply with all applicable federal and District laws and rules, including all relevant licensing requirements imposed by the District of Columbia.

5010.2 Each Provider contracting with a staffing agency to provide staffing for PCA services shall:

- (a) Ensure that the staffing agency obtains an NPI number for itself and all personnel performing PCA services through the agency;
- (b) Provide DHCF with a copy of any and all contract(s) entered into with a staffing agency; and
- (c) Ensure that each beneficiary's records shall be the property of the beneficiary's Provider and are maintained at the Provider's place of business in accordance with Section 5013.

5010.3 A staffing agency supplying staff to the provider for the delivery of PCA services shall be considered an agent of the Provider.

5010.4 A Provider is prohibited from having a financial relationship with any staffing agency providing staffing unless the relationship meets one of the exceptions applicable to ownership interests and compensation arrangements established in 42 U.S.C. § 1320a-7b(b)(3) and 42 C.F.R. § 1001.952. A financial relationship includes but is not limited to:

- (a) A direct or indirect ownership or investment interest (including an option or non-vested interest) by the Provider in a staffing agency. This interest may be in the form of partnership shares, limited liability company memberships, loans, bonds, equity, debt, or other means; and
- (b) A direct or indirect compensation arrangement other than the contract referenced in § 5010.1 between the Provider and the staffing agency for the provision of staff to perform PCA services provided the contract meets the requirements of 42 C.F.R. § 1001.952(d).

5010.5 A Provider is prohibited from contracting with a staffing agency that is or has engaged in any of the following:

- (a) Advertising or marketing directly to Medicaid beneficiaries;
- (b) Misrepresenting the staffing agency as the provider of PCA services; or
- (c) Offering financial or other types of inducements to individuals for the referral of Medicaid beneficiaries, their names, or other identifying information to any health care provider.

5011 INSURANCE

- 5011.1 Each applicant or Provider shall maintain the following minimum amounts of insurance coverage:
- (a) Blanket malpractice insurance for all employees in the amount of at least one million dollars (\$1,000,000) per incident;
 - (b) General liability insurance covering personal property damages, bodily injury, libel and slander of at least one million dollars (\$1,000,000) per occurrence; and
 - (c) Product liability insurance, when applicable.
- 5011.2 Each applicant or Provider shall post a continuous surety bond in the amount of fifty thousand dollars (\$50,000) against all PCA services claims, suits, judgments, or damages including court costs and attorney's fees arising out of the negligence or omissions of the Provider in the course of providing services to a Medicaid beneficiary or a person believed to be a Medicaid beneficiary. The number of bonds required shall be predicated upon the number of Provider offices enrolled by the applicant or Provider in the Medicaid program.

5012 ADMINISTRATION

- 5012.1 NPI numbers for Providers and staffing agencies, and all personnel delivering PCA services shall be included in all Medicaid billings.
- 5012.2 Each Provider shall have a current organizational chart that clearly describes the organizational structure, management responsibilities, staff responsibilities, lines of authority, and use of any contractors.
- 5012.3 Each Provider shall maintain current copies of all fully executed contracts including all staffing agency contracts pertaining to the delivery of PCA services, in the Provider's office and make them available to DHCF, CMS, and other authorized government officials or their agents when requested.
- 5012.4 Each Provider shall maintain a copy of each license held by their employees and employees of any staffing agency utilized by the Provider for the delivery of PCA services.
- 5012.5 A Provider shall be prohibited from waiving liability or assigning contract authority to any other entity for covered services provided to Medicaid beneficiaries.

- 5012.6 Each Provider shall provide to all employees and contractors (such as staffing agencies providing staffing) a current policy manual which sets forth all of its policies and procedures.
- 5012.7 Each policy manual shall include, but not be limited to, the following information:
- (a) A description of the services to be provided;
 - (b) Procedures for beneficiary care;
 - (c) The reimbursement methodology or fee schedules;
 - (d) Operational schedules;
 - (e) Quality assurance standards;
 - (f) A statement of beneficiary rights and responsibilities;
 - (g) Financial and record-keeping requirements;
 - (h) Procedures for emergency care, infection control and reporting of incidents;
 - (i) A description of staff positions and personnel policies, which shall be reviewed annually, revised as necessary, and dated at time of review;
 - (j) Policies and procedures for hiring, performance assessments, grievances, and in-service training of all PCAs who deliver services, regardless of whether the PCA is an employee of the Provider or is secured through a staffing agency;
 - (k) An up to date listing of professional staff licensure and registration information;
 - (l) An up to date listing of PCA certifications;
 - (m) Policies and procedures for providing advance notice to beneficiaries in accordance with Section 5007; and
 - (n) Policies, procedures, and presentation materials for owners, managers, employees and contractual staff for in-service training on the following subjects:

- (1) Compliance with these regulations;
- (2) Compliance with federal and District False Claims Acts;
- (3) Preventing, detecting, and reporting fraud, waste, and abuse;
and
- (4) Rights of employees to be protected as whistleblowers.

5013 RECORDS

- 5013.1 Each Provider shall maintain complete and accurate records reflecting the specific PCA services provided to each beneficiary for each unit of service billed. Such records must be maintained for a period of ten (10) years or when all audits have been completed, whichever is longer.
- 5013.2 Each Provider shall be responsible for maintaining the confidentiality of each beneficiary's care, treatment, and records. The disclosure of personal health information by the Provider is subject to all of the provisions set forth in applicable District and Federal laws and rules.
- 5013.3 Each beneficiary's record shall be readily retrievable and shall be kept in a locked room or file maintained and safeguarded against loss or unauthorized use at the location of the Provider's place of business that is identified on the Provider's Medicaid Provider application.
- 5013.4 Each Provider shall permit reviews and on-site inspections to be conducted by CMS and its agents, and DHCF, and its agents to determine Provider compliance with all applicable laws.
- 5013.5 Each Provider shall comply with the terms of its Medicaid Provider Agreement with respect to the maintenance of all beneficiary and financial records.
- 5013.6 Each beneficiary's record shall include, but is not limited to, the following information:
- (a) General information including the beneficiary's name, Medicaid identification number, address, telephone number, age, sex, name and telephone of emergency contact person, authorized representative (if applicable), and primary care physician's or advanced practice registered nurse's name, address, and telephone number;

- (b) Health care information, including all referrals, assessments, service authorizations, plans of care, and progress notes;
- (c) Dates and description of PCA services rendered, including the name and NPI of the personal care aide performing the services;
- (d) Documentation of each supervisory visit of the R.N., including signed and dated clinical progress notes;
- (e) Discharge summary, if applicable;
- (f) Copies of any written notices given to the beneficiary; and
- (g) Any other appropriate identifying information that is pertinent to beneficiary care.

5014 BENEFICIARY RIGHTS AND RESPONSIBILITIES

- 5014.1 Each Provider shall develop a written statement of a beneficiary's rights and responsibilities consistent with the requirements of this section, which shall be given to each beneficiary in advance of receiving services or during the initial care planning visit before the initiation of services.
- 5014.2 The written statement of the beneficiary's rights and responsibilities shall be prominently displayed at the Provider's business location and available at no cost upon request by a member of the general public.
- 5014.3 Each Provider shall develop and implement policies and procedures outlining the following beneficiary's rights:
- (a) To be treated with courtesy, dignity and respect;
 - (b) To control his or her own household and lifestyle;
 - (c) To participate in the planning of his or her care and treatment;
 - (d) To receive treatment, care, and services consistent with the plan of care and to have the plan of care modified for achievement of outcomes;
 - (e) To receive services by competent personnel who can communicate with the beneficiary in accordance with the Language Access Act of 2004, effective June 19, 2004 (D.C. Law 15-167; D.C. Official Code §§ 2-1931 *et seq.*);

- (f) To refuse all or part of any treatment, care, or service and be informed of the consequences;
- (g) To be free from mental and physical abuse, neglect and exploitation from persons providing services;
- (h) To be assured that for purposes of record confidentiality, the disclosure of the contents of the beneficiary's records is subject to all the provisions of applicable District and federal laws;
- (i) To voice a complaint or grievance about treatment, care, or lack of respect for personal property by persons providing services without fear of reprisal;
- (j) To have access to his or her records; and
- (k) To be informed orally and in writing of the following:
 - (1) Services to be provided, including any limits;
 - (2) Amount charged for each service, the amount of payment required from the beneficiary and the billing procedures, if applicable;
 - (3) Whether services are covered by health insurance, Medicare, Medicaid, or any other third party sources;
 - (4) Acceptance, denial, reduction or termination of services;
 - (5) Complaint and appeal procedures;
 - (6) Name, address and telephone number of the Provider;
 - (7) Telephone number of the District of Columbia Medicaid fraud hotline;
 - (8) Beneficiary's freedom from being forced to sign for services that were not provided or were unnecessary; and
 - (9) A statement, provided by DHCF, defining health care fraud and ways to report suspected fraud.

5014.4 Each beneficiary shall be responsible for the following:

- (a) Treating all Provider personnel with respect and dignity;
- (b) Providing accurate information when requested;
- (c) Informing Provider personnel when instructions are not understood or cannot be followed;
- (d) Cooperating in making a safe environment for care within the home; and
- (e) Reporting suspected fraud, waste and abuse to DHCF via the fraud and abuse complaint form available at www.dc-medicaid.com.

5014.5 Each Provider shall take appropriate steps to ensure that each beneficiary, including beneficiaries who cannot read or those who have a language or communication barrier, has received the information required pursuant to this section. Each Provider shall document in the records the steps taken to ensure that each beneficiary has received the information.

5015 REIMBURSEMENT

5015.1 Each Provider shall be reimbursed five dollars (\$5.00) per unit of service for allowable services as authorized in the approved plan of care, of which no less than three dollars and forty-five cents (\$3.45) shall be paid to the PCA to comply with the Living Wage Act of 2006, effective June 8, 2006 (D.C. Law 16-118; D.C. Official Code §§ 2-220.01 *et seq.* (2012 Repl.)). A unit of service is fifteen (15) minutes. A provider must provide at least eight (8) minutes of care to bill one unit of service.

5015.2 Each Provider shall maintain adequate documentation substantiating the delivery of allowable services provided in accordance with the PCA service authorization and the beneficiary's plan of care for each unit of service submitted on every claim.

5015.3 Reimbursement for PCA services, when provided through the D.C. Medicaid program's State Plan PCA benefit, shall not exceed eight (8) hours per day, seven (7) days a week, and shall be limited to the amount, duration, and scope of services set forth in the PCA Service Authorization and the plan of care, as described in Section 5003.

5015.4 Claims for PCA services submitted by a Provider in any period during which the beneficiary is an in-patient at another health care facility including a hospital, nursing home, psychiatric facility or rehabilitation program shall be denied except on the day when a beneficiary is admitted or discharged.

- 5015.5 When a beneficiary is discharged from a health care facility to the beneficiary's home and requires PCA services on the date of discharge, the number of PCA hours on that day shall be authorized in accordance with the beneficiary's discharge plan.
- 5015.6 Claims for PCA service submitted by a Provider for any hour in which the beneficiary was receiving ADHP services under the § 1915(i) State Plan Option, or other similar service in which PCA services are provided concurrently to the beneficiary. shall be denied.
- 5015.7 If a beneficiary is also receiving ADHP services on the same day that PCA services are delivered, the combination of both PCA and ADHP services shall not exceed a total of twelve (12) hours per day.
- 5015.8 Each Provider shall agree to accept as payment in full the amount determined by DHCF as Medicaid reimbursement for the authorized services provided to beneficiaries. Providers shall not bill the beneficiary or any member of the beneficiary's family for PCA services.
- 5015.9 Each Provider shall agree to bill any and all known third-party payers prior to billing Medicaid.
- 5015.10 All reimbursable claims for PCA services shall include the NPI numbers for the:
- (a) Provider;
 - (b) Physician or APRN who ordered the PCA services;
 - (c) The staffing agency, if applicable; and
 - (d) PCA who provided the PCA services, regardless of whether the PCA is an employee of the Provider or is from another staffing agency.
- 5015.11 Pursuant to 42 C.F.R. § 424.22(d), the Department shall deny PCA service claims or recoup paid claims when Provider records or other evidence indicate that the primary care physician or APRN ordering a beneficiary's treatment has a direct or indirect financial relationship, compensation, ownership or investment interest as defined in 42 C.F.R. § 411.354 in the Provider billing for the services, unless the financial relationship, compensation, ownership or investment interest meets an exception as defined in 42 C.F.R. § 411.355.

5015.12 Claims resulting from marketing by a staffing agency (including face-to-face solicitation at doctors' offices, home visits, requests for beneficiary Medicaid numbers, or otherwise directing beneficiaries to any Medicaid Provider) shall not be reimbursed.

5016 AUDITS AND REVIEWS

5016.1 DHCF shall perform audits to ensure that Medicaid payments are consistent with efficiency, economy and quality of care and made in accordance with federal and District rules governing Medicaid.

5016.2 The audit process shall routinely be conducted by DHCF to determine, by statistically valid scientific sampling, the appropriateness of services rendered and billed to Medicaid. These audits shall be conducted on-site or through an off-site, desk review.

5016.3 Each Provider shall allow access to relevant records and program documentation upon request and during an on-site audit or review by DHCF, other District of Columbia government officials and representatives of the United States Department of Health and Human Services.

5016.4 If DHCF denies a claim, DHCF shall recoup, by the most expeditious means available, those monies erroneously paid to the Provider for denied claims, following the period of Administrative Review as set forth in § 5017 of these rules.

5016.5 The recoupment amounts for denied claims shall be determined by the following formula:

- (a) A fraction shall be calculated with the numerator consisting of the number of denied paid claims resulting from the audited sample. The denominator shall be the total number of paid claims from the audit sample; and
- (b) This fraction shall be multiplied by the total dollars paid by DHCF to the Provider during the audit period, to determine the amount recouped. For example, if a Provider received Medicaid reimbursement of ten thousand dollars (\$10,000) during the audit period, and during a review of the claims from the audited sample, it was determined that ten (10) claims out of one hundred (100) claims are denied, then ten percent (10%) of the amount reimbursed by Medicaid during the audit period, or one thousand dollars (\$1000), would be recouped.

5016.6 DHCF shall issue a Notice of Proposed Medicaid Overpayment Recovery (NR), which sets forth the reasons for the recoupment, including the specific reference to the particular sections of the statute, rules, or provider agreement, the amount to be recouped, and the procedures for requesting an administrative review.

5017 APPEALS FOR PROVIDERS AGAINST WHOM A RECOUPMENT IS MADE

5017.1 The Provider shall have sixty (60) days from the date of the NR to request an administrative review of the NR. The request for administrative review of the NR shall be submitted to “Manager, Division of Program Integrity, DHCF”.

5017.2 The written request for administrative review shall include a specific description of the item to be reviewed, the reason for the request for review, the relief requested, and documentation in support of the relief requested.

5017.3 DHCF shall mail a written determination relative to the administrative review to the provider no later than one hundred twenty (120) days from the date of the written request for administrative review pursuant to § 5017.1.

5017.4 Within fifteen (15) days of receipt of the Medicaid Program’s written determination, the Provider may appeal the written determination by filing a written notice of appeal with the Office of Administrative Hearings (OAH), 441 4th Street, NW, Suite 450 North, Washington, D.C. 20001.

5017.5 Filing an appeal with the OAH shall not stay any action to recover any overpayment.

5099 DEFINITIONS

When used in this chapter, the following terms and conditions shall have the following meanings:

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

Advanced Practice Registered Nurse - A person who is licensed or authorized to practice as an advanced practice registered nurse pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.)).

Authorized representative – Any person other than a provider:

- (a) Who is knowledgeable about a beneficiary's circumstances and has been designated by that person to represent him or her; or
- (b) Who is legally authorized either to administer a beneficiary's financial or personal affairs or to protect and advocate for his/her rights.

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

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

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

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

Order – A formal, written instruction signed by a physician or APRN, regarding a specific patient's medical care, treatment or management. An order for PCA services may only be written by a physician or APRN in accordance with § 5006.1.

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

Primary care physician - A person who is licensed or authorized to practice medicine pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.)).

Registered Nurse - A person who is licensed or authorized to practice registered nursing pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.)).

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

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

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