

DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF FINAL 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. 744; D.C. Official Code § 1-307.02 (2016 Repl. & 2017 Supp.)), and 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 final adoption of an amendment to Section 903 of Chapter 9 (Medicaid Program) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR), entitled “Outpatient and Emergency Room Services.”

The effect of these rules is to extend the provision of supplemental payments to eligible hospitals located within the District of Columbia that participate in the Medicaid program for outpatient hospital services rendered through September 30, 2018.

The corresponding amendment to the District of Columbia State Plan for Medical 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). The Council has approved the State Plan through the Fiscal Year 2018 Budget Support Act of 2017, signed July 31, 2017 (D.C. Act 22-130; 64 DCR 7652 (August 11, 2017)). CMS approved the State Plan Amendment on October 10, 2017 with an October 1, 2017 effective date. The estimated annual increase in aggregate expenditures associated with the State Plan Amendment is \$17,932,860. These rules shall become effective for outpatient hospital services provided by Medicaid participating hospitals located within the District of Columbia occurring on or after October 1, 2017.

A Notice of Emergency and Proposed Rulemaking was published in the *D.C. Register* on September 29, 2017 at 64 DCR 009647. No comments were received and no changes have been made for these final rules.

The Director adopted these rules as final on January 4, 2018 and they shall become effective on the date of publication of this notice in the *D.C. Register*.

Chapter 9, MEDICAID PROGRAM, of Title 29 DCMR, PUBLIC WELFARE, is amended as follows:

Subsection 903.31 of Section 903, OUTPATIENT AND EMERGENCY ROOM SERVICES, is amended as follows:

903.31 Beginning FY 2018, each eligible hospital shall receive a supplemental hospital access payment calculated as set forth below:

- (a) For visits and services beginning October 1, 2017 and ending on September 30, 2018, quarterly access payments shall be made to each eligible private hospital. Each payment shall be an amount equal to each hospital's District Fiscal Year (DFY) 2015 outpatient Medicaid payments divided by the total in District private hospital DFY 2015 outpatient Medicaid payments multiplied by one quarter (1/4) of the total outpatient private hospital access payment pool. The total outpatient private hospital access payment pool shall be equal to the total available spending room under the private hospital outpatient Medicaid upper payment limit for DFY 2018;
- (b) For visits and services beginning October 1, 2017 and ending on September 30, 2018, quarterly access payments shall be made to the United Medical Center as follows: (1) Each payment shall be equal to one quarter (1/4) of the total outpatient public hospital access payment pool; and (2) The total outpatient public hospital access payment pool shall be equal to the total available spending room under the District-operated hospital outpatient Medicaid upper payment limit for DFY 2018;
- (c) Payments shall be made fifteen (15) business days after the end of the quarter for the Medicaid visits and services rendered during that quarter; and
- (d) For purposes of this section, the term District Fiscal Year shall mean dates beginning on October 1st and ending on September 30th.

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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. 744; D.C. Official Code § 1-307.02 (2016 Repl. & 2017 Supp.)) 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 final adoption of a new Section 947, entitled “Private Duty Nursing Services,” of Chapter 9 (Medicaid Program) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

These final rules establish general standards governing reimbursement for Private Duty Nursing services provided to beneficiaries under the District of Columbia State Plan for Medical Assistance (State Plan) and establish specific conditions of participation for providers of these services. These rules also clarify prior authorization requirements and establish higher reimbursement rates for delivering Private Duty Nursing services. DHCF determined that the existing provider reimbursement rates were not sufficient to ensure an adequate supply of providers willing and able to provide Private Duty Nursing services to District Medicaid beneficiaries.

Private Duty Nursing services provide care to some of the most vulnerable Medicaid beneficiaries who are technology-dependent. A technology-dependent beneficiary is a beneficiary who is dependent on ventilator equipment or other life-sustaining technology and requires constant nursing supervision, visual assessment, and monitoring. Private Duty Nursing services are provided to those technology-dependent beneficiaries who need more individualized and continuous care due to an illness or injury than what may be provided under the Skilled Nursing State Plan benefit. The information previously contained in the State Plan, in combination with the absence of a related rulemaking, has contributed to inconsistent quality of care and has hampered DHCF’s ability to hold providers accountable for care delivery and provide effective oversight. Additionally, the rate increases established in this rulemaking are needed to enable Home Health service providers to hire and retain the staff necessary to ensure continued access to Private Duty Nursing services under the State Plan.

The corresponding amendment to the State Plan must be approved by the U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS). The State Plan Amendment (SPA) was approved by the Council of the District of Columbia (Council) through the Fiscal Year 2016 Budget Support Act of 2015, effective October 22, 2015 (D.C. Law 21-0036; 62 DCR 10905). CMS approved the SPA on November 29, 2017 with an effective date of October 1, 2017. The increase in aggregate expenditures related to the update in the reimbursement rates for Private Duty Nursing services is approximately \$2,094,365 for FY 2018.

An initial Notice of Proposed Rulemaking was published in the *D.C. Register* on July 15, 2016 at 63 DCR 009539. No comments were received in response to the Notice of Proposed Rulemaking. However, a Notice of Emergency and Second Proposed Rulemaking was published in the *D.C. Register* on September 29, 2017 at 64 DCR 009649 in order to make changes related to: the definition of “technology-dependent;” the criteria for exceeding the twelve (12) hour per day service limitation; the reimbursement structure for Private Duty Nursing assessments; reassessments and supervisory nurse visits; and the service limitations applicable to concurrent delivery of Private Duty Nursing and personal care aide services. These changes were made as a result of discussions with both internal and external stakeholders regarding implementation of these services and will assist beneficiaries, providers and advocates by clarifying various aspects of service delivery for Private Duty Nursing. DHCF received no comments in response to the Notice of Emergency and Second Proposed Rulemaking and no changes have been made for these final rules.

The Director adopted these rules as final on January 4, 2018, and they shall become effective on the date of publication of this notice in the *D.C. Register*.

Chapter 9, MEDICAID PROGRAM, of Title 29 DCMR, PUBLIC WELFARE, is amended as follows:

A new Section 947, PRIVATE DUTY NURSING SERVICES, is added to read as follows:

947 PRIVATE DUTY NURSING SERVICES

947.1 This section shall establish general standards for conditions of participation for Medicaid providers of Private Duty Nursing services, and delineate specific standards governing reimbursement for these services.

947.2 Private Duty Nursing services are services for technology-dependent beneficiaries as defined in Subsection 947.5. These beneficiaries require more individualized and continuous care than is available from a visiting nurse under the Skilled Nursing Home Health Services benefit available under the State Plan for Medical Assistance, or routinely provided by nursing staff in a hospital or skilled nursing facility.

947.3 In order to be eligible for Medicaid reimbursement, Private Duty Nursing services must be ordered by a physician and provided at the beneficiary’s residence in accordance with a plan of care developed by a Registered Nurse (R.N.).

947.4 A beneficiary shall be eligible for Medicaid reimbursement of Private Duty Nursing services if he or she is in receipt of the following:

- (a) An order for Private Duty Nursing services from the beneficiary’s physician certifying that the services are medically necessary in accordance with the requirements set forth in this section; and

- (b) A prior authorization from the Department of Health Care Finance (DHCF) or its designee in accordance with the requirements set forth in this section.

947.5 Private Duty Nursing services shall be considered medically necessary only if a beneficiary is technology-dependent. A beneficiary shall only be considered technology-dependent if the beneficiary meets the following criteria:

- (a) The beneficiary is dependent on ventilator equipment or other life-sustaining technology; and
- (b) Constant nursing supervision, visual assessment, and monitoring of both the beneficiary and the technology is required.

947.6 In order to be reimbursed by Medicaid, an order for Private Duty Nursing services shall be signed by a physician knowledgeable about the beneficiary's needs and conditions, and shall state the amount, frequency, scope and duration of Private Duty Nursing services ordered. The physician's signature on the order constitutes a certification by the physician that the services ordered reflect the health status and needs of the beneficiary, and that the beneficiary is technology-dependent and eligible for the service.

947.7 For all Medicaid reimbursable Private Duty Nursing services, the ordering physician shall:

- (a) Document that a face-to-face encounter, related to the primary reason the beneficiary requires Private Duty Nursing services, occurred between the beneficiary and the health practitioner, as defined in Subsection 947.8, within the ninety (90) days before or within the thirty (30) days after the start of services; and
- (b) Indicate on the order the name of the practitioner who conducted the face-to-face encounter, and the date of the encounter.

947.8 The face-to-face encounter required to provide Medicaid reimbursement of Private Duty Nursing services must be related to the primary reason the beneficiary requires Private Duty Nursing services and may be conducted by one of the following health practitioners:

- (a) The ordering physician;
- (b) A nurse practitioner working in collaboration with the physician;
- (c) A certified nurse mid-wife as authorized under District law;
- (d) A physician assistant acting under the supervision of the ordering physician; or
- (e) The attending acute or post-acute physician.

- 947.9 The attending acute or post-acute physician shall only conduct face-to-face encounters for those beneficiaries receiving Private Duty Nursing services immediately after an acute or post-acute stay.
- 947.10 The plan of care referenced in Subsection 947.3 shall be developed and signed by an R.N. who is employed or under contract to the Private Duty Nursing services provider. The signature of the R.N. on the plan of care constitutes a certification that the plan of care accurately reflects the health status and needs of the beneficiary and that the services identified in the plan of care are in accordance with the physician's order defined in Subsection 947.6.
- 947.11 The beneficiary's physician shall approve the initial plan of care by signing it within thirty (30) days of the development of the plan of care, and noting his or her license number and National Provider Identification number on the plan of care.
- 947.12 The plan of care shall be reviewed and signed by the physician every sixty (60) calendar days.
- 947.13 The signature of the physician on an initial or subsequent plan of care constitutes a certification that the plan of care accurately reflects the health status and needs of the beneficiary.
- 947.14 Medicaid reimbursable Private Duty Nursing services shall be provided by a Home Care Agency that meets the requirements of Subsection 947.15.
- 947.15 In order to be eligible for Medicaid reimbursement, a Home Care Agency providing Private Duty Nursing services shall meet the following requirements:
- (a) Be enrolled as a Medicare Home Care Agency qualified to offer skilled nursing services as set forth in Sections 1861(o) and 1891(e) of the Social Security Act and 42 CFR § 484;
 - (b) Have sufficient funds or "initial reserve operating funds" available for business expenses determined in accordance with federal special capitalization requirements for home care agencies participating in Medicare as set forth under 42 CFR § 489.28;
 - (c) Meet the District of Columbia Department of Health licensure requirements in accordance with Chapter 39 (Home Care Agencies) of Title 22-B DCMR;
 - (d) Be enrolled as a Medicaid provider of Private Duty Nursing services and meet all requirements as set forth under Chapter 94 (Medicaid Provider and Supplier, Screening, Enrollment, and Termination) of Title 29 DCMR; and

- (e) Have a surety bond, in accordance with federal requirements for home care agencies participating in Medicaid as set forth under 42 CFR § 441.16 and Subsection 947.15.
- 947.16 Except for government-operated Home Care Agencies, each Home Care Agency that is a Medicaid participating Home Care Agency or that seeks to become a Medicaid participating Home Care Agency shall:
- (a) Obtain a fifty thousand dollar (\$50,000) surety bond that meets the requirements as set forth under 42 CFR § 441.16; and
- (b) Furnish a copy of the surety bond to DHCF.
- 947.17 In accordance with the Health Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983 (D.C. Law 5-48, D.C. Official Code §§ 44-501 *et seq.*), and 22-B DCMR § 3924, a Home Care Agency shall accept a ventilator-dependent beneficiary only if:
- (a) The beneficiary is ventilator stabilized;
- (b) A successful home equipment trial has been conducted by the Home Care Agency provider; and
- (c) The Home Care Agency has developed a plan for emergency services notification.
- 947.18 Medicaid reimbursable Private Duty Nursing services shall be provided by an R.N. or licensed practical nurse (L.P.N.) licensed in accordance with 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.*) and implementing rules.
- 947.19 Medicaid reimbursable Private Duty Nursing services shall be responsible for the following duties:
- (a) Conducting initial assessments and periodic reassessments every sixty (60) calendar days to develop and update a plan of care;
- (b) Coordinating the beneficiary's care and referrals among all Home Care Agency providers;
- (c) Implementing preventive and rehabilitative nursing procedures;
- (d) Administering medications and treatment as prescribed by a licensed physician, pursuant to 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 *et seq.*), as outlined under the plan of care;

- (e) Recording daily progress notes and summary notes at least once every sixty (60) calendar days;
- (f) Making necessary updates to the plan of care, and reporting any changes in the beneficiary's condition to his or her physician;
- (g) Instructing the beneficiary on treatment regimens identified under the plan of care;
- (h) Updating the physician on changes in the beneficiary's condition and obtaining orders to implement those changes; and
- (i) For R.N.s who supervise nursing services delivered by skilled nurses and services delivered by Home Health Aides and Personal Care Aides, duties shall include, at minimum, the following:
 - (1) Supervising the beneficiary's skilled nurse and aide on site, at least once every sixty (60) calendar days;
 - (2) Ensuring that new or revised physician orders have been obtained from the treating physician initially, as needed, and every sixty (60) calendar days thereafter, to promote continuity of care;
 - (3) Reviewing the beneficiary's plan of care;
 - (4) Monitoring the beneficiary's general health outcomes, including taking vital signs, conducting a physical examination, and determining mental status;
 - (5) Determining if the beneficiary has any unmet needs;
 - (6) Ensuring that all home health services are provided safely and in accordance with the plan of care;
 - (7) Ensuring that the beneficiary has received education on any needed services;
 - (8) Ensuring the safe discharge or transfer of the beneficiary;
 - (9) Ensuring that the physician receives progress notes when the beneficiary's health condition changes, or when there are deviations from the plan of care;
 - (10) Ensuring that a summary report of the visit has been sent to the physician every sixty (60) calendar days; and

- (11) Reporting any instances of abuse, neglect, exploitation or fraud to DHCF to promote a safe and therapeutic environment in accordance with 17 DCMR § 5414.
 - (j) Maintaining the beneficiary's equipment and supplies;
 - (k) Providing ventilator and/or tracheostomy tube maintenance;
 - (l) Applying independent emergency measures to counteract adverse developments; and
 - (m) Updating the physician on changes in the beneficiary's condition and obtaining orders to implement those changes.
- 947.20 Initial assessments and periodic reassessments shall only be conducted by an R.N. The Private Duty Nurse conducting an initial assessment or periodic reassessment in accordance with this section shall certify in writing that the assessment is true and accurate.
- 947.21 Consistent with the Department of Health regulations at 22-B DCMR § 3917, Private Duty Nursing provided by an L.P.N. shall be supervised by an R.N.
- 947.22 When an L.P.N. provides Private Duty Nursing services, the duties shall not include supervisory duties.
- 947.23 In order to be eligible for Medicaid reimbursement, the R.N. shall monitor and supervise the provision of services provided by the L.P.N. or R.N., including conducting a site visit at least once every sixty (60) calendar days, or more frequently, if specified in the beneficiary's plan of care.
- 947.24 Progress notes during each visit shall meet the standards of nursing care established under 17 DCMR §§ 5414 and 5514, and include notations regarding the following:
- (a) Any unusual health or behavioral events or changes in status;
 - (b) Any matter requiring follow-up on the part of the service provider or DHCF; and
 - (c) A clearly written statement of the beneficiary's progress or lack of progress, medical conditions, functional losses, and treatment goals as outlined in the plan of care that demonstrates that the beneficiary's services continue to be reasonable and necessary.
- 947.25 The nurse shall prepare summary notes every sixty (60) calendar days which summarizes the daily progress notes and bring attention to any matter requiring follow-up on the part of the service provider or DHCF.

- 947.26 Private Duty Nursing services shall be reimbursed by Medicaid for up to twelve (12) hours a day with a prior authorization issued by DHCF, in accordance with the requirements set forth under Subsection 947.27. Beneficiaries may also qualify for additional hours if they meet the requirements referenced under Subsection 947.28.
- 947.27 In order to be eligible for Medicaid reimbursement, all requests for Private Duty Nursing services shall be prior authorized by DHCF or its designee. Prior authorization shall be determined by ensuring that the beneficiary meets the following criteria:
- (a) The beneficiary is technology-dependent, as set forth in Subsection 947.5; and
 - (b) The beneficiary requires services by an R.N. or L.P.N. on a more individualized and continuous basis which cannot be provided at a lower level of care, pursuant to the Skilled Nursing Home Health Services benefit available under the State Plan for Medical Assistance.
- 947.28 DHCF may authorize additional hours of Medicaid reimbursable Private Duty Nursing services above the twelve (12) hour per day limit for a beneficiary if DHCF determines that:
- (a) Additional hours are medically necessary, as set forth in Subsection 947.5;
 - (b) That the beneficiary's needs can be safely met in the home; and
 - (c) That the beneficiary's Medicaid-funded services are being delivered in a cost-effective manner appropriate to the beneficiary's level of care.
- 947.29 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.
- 947.30 The audit process shall be routinely 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.
- 947.31 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.
- 947.32 Each provider shall maintain complete and accurate records reflecting the specific Private Duty Nursing services provided to each beneficiary for each unit of service billed. Such records shall be maintained for a period of ten (10) years or when all audits have been completed, whichever is longer.

- 947.33 The Medicaid reimbursement rate for Private Duty Nursing services shall be fifteen dollars (\$15.00) for each fifteen (15) minute unit of service for services provided by an R.N., and twelve dollars and fifty cents (\$12.50) for each fifteen (15) minute unit of service provided by a L.P.N.
- 947.34 The Medicaid reimbursement rate for an initial assessment, reassessment or supervisory visit by an R.N. is a flat rate of one hundred and twenty dollars (\$120).
- 947.35 In order to bill for a fifteen (15) minute unit of Private Duty Nursing services, a provider shall ensure that documentation of the visit shows Private Duty Nursing services were provided for at least eight (8) minutes during the fifteen (15) minute unit.
- 947.36 Medicaid reimbursable Private Duty Nursing services shall have the following service limitations:
- (a) Assessments, reassessments or supervisory visits of a skilled nurse or aide shall not be included in the calculation of the daily Private Duty Nursing cap;
 - (b) When a private duty nurse performs the duties described under Subsections 947.19(b) – (h), and (j) – (m) during an initial assessment, reassessment, or supervisory visit, these services shall not be billed separately as Private Duty Nursing services under the twelve hour (12) daily cap, but shall be included as part of the rate paid for an initial assessment, reassessment, or supervisory visit; and
 - (c) When a private duty nurse provides assistance with activities of daily living during an assessment, or supervisory, or Private Duty Nursing visit, the Home Care agency shall ensure that activities performed during the assessment, supervisory, or Private Duty Nursing visit are only billed as Private Duty Nursing services and may not also be billed as personal care aide services.
- 947.37 DHCF shall not reimburse a home care agency for concurrent delivery of Private Duty Nursing and personal care aide services unless the home care agency is able to demonstrate that concurrent services are necessary in order to maintain the beneficiary's health and safety, as determined by DHCF.
- 947.38 In order to receive Medicaid reimbursement for Private Duty Nursing services, a beneficiary shall not concurrently receive Skilled Nursing services under the State Plan.

Section 999, DEFINITIONS, § 999.1, is amended to include the following terms:

Order – A formal, written instruction signed by a physician regarding a beneficiary’s medical care, treatment or management which specifically requests the provision of a specific service.

Plan of Care - A written document developed by the R.N. hired by the home health provider that delineates the various treatments of the beneficiary.

Surety bond - One or more bonds issued by one or more surety companies under 31 USC 9304 to 9308 and 31 CFR parts 223, 224, and 225.