DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF EMERGENCY & 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.744; D.C. Official Code § 1-307.02 (2016 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 who 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 emergency and proposed rules will allow DHCF to: (1) provide reimbursement for safety monitoring tasks performed by PCAs in connection with assisting beneficiaries with activities of daily living; (2) align re-assessment requirements for beneficiaries receiving PCA services under the District of Columbia State Plan for Medical Assistance (State Plan) with requirements for beneficiaries receiving PCA services under the Home and Community-Based Services Waiver for the Elderly and Individuals with Physical Disabilities (EPD Waiver); and (3) impose alternative sanctions for providers of State Plan PCA services that mirror those for EPD Waiver providers. Emergency action is necessary in order to ensure that DHCF is able to administer the State Plan PCA services program in accordance with the federally approved requirements of the PCA services benefits under the EPD Waiver and deliver these critically important services to beneficiaries whose health and safety depend on the receipt of PCA services.

These rules correlate to a proposed amendment to the State Plan. The corresponding State Plan Amendment (SPA) requires approval by the Council of the District of Columbia (Council) and the Centers for Medicare and Medicaid Services (CMS). The Council approved the corresponding SPA through the Fiscal Year 2017 Budget Support Act of 2016, effective October 8, 2016 (D.C. Law 21-160; 63 DCR 10775 (August 26, 2016)). This rule is contingent upon approval of the corresponding SPA by CMS. If the corresponding SPA is approved, DHCF will publish a notice setting forth the effective date.

These emergency rules were adopted on May 25, 2017 and became effective on that date. The emergency rules shall remain in effect for not longer than one hundred and twenty (120) days from the adoption date or until September 22, 2017, 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:

The title for Chapter 50 is amended to read as follows: CHAPTER 50 MEDICAID REIMBURSEMENTS FOR PERSONAL CARE AIDE SERVICES

Section 5000, GENERAL PROVISIONS, is amended as follows:

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, hands-on assistance, and safety monitoring related to 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.

Section 5003, PCA SERVICE AUTHORIZATION REQUEST AND SUBMISSION, is amended as follows:

5003 PCA SERVICE AUTHORIZATION REQUEST AND SUBMISSION

5003.1 Except as provided in Subsection 5003.11, 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. The request may be submitted by the beneficiary, the beneficiary's representative, family member, physician or APRN.

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, 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. Additional hours may be authorized if a person is deemed eligible under the Elderly or Individuals with Physical Disabilities (EPD Waiver) or Individuals with Intellectual and Developmental Disabilities Waiver (IDD Waiver).

5003.7 PCA services shall be provided in a manner consistent with the requirements of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. A beneficiary under the age of twenty-one (21) shall have access to all medically necessary Medicaid services, including PCA services, provided by any willing and qualified Medicaid provider of the beneficiary's choice.

5003.8 When total DHCF reimbursement for PCA services, in addition to other home care services, for a beneficiary exceeds the cost of institutional care over a six (6) month period, DHCF may limit or deny PCA services for the beneficiary on a prospective basis.

5003.9 The supervisory nurse employed by the home health agency shall conduct an evaluation of each beneficiary's need for the continued receipt of State Plan PCA services at least once every twelve (12) months or upon a significant change in the beneficiary's health status, as follows:

(a) The evaluation shall determine whether there is a significant change in the beneficiary's health status;

(b) If the evaluation results in a determination that there is no significant change, the supervisory nurse shall take the following actions:

(1) The supervisory nurse shall complete the form provided by DHCF or its agent attesting that the beneficiary has had no significant change in health status and that a face-to-face re-assessment is not required; and

(2) The supervisory nurse shall obtain a new PCA Service Authorization for the beneficiary;

(c) If the evaluation results in a determination that there is a significant change, the supervisory nurse shall take the following actions:

(1) The supervisory nurse shall refer the beneficiary for a face-to-face re-assessment conducted in accordance with § 5003.3; and

(2) The supervisory nurse shall obtain a new physician's or APRN's written order in order to obtain a new PCA Service Authorization for the beneficiary.

5003.10 Requests to conduct a face-to-face re-assessment based upon a significant change in the beneficiary's health status may be made at any time by the beneficiary, the beneficiary's representative, family member, physician or APRN and shall be made in accordance with the requirements of Subsection 5003.2.

5003.11 An R.N. employed by DHCF or its agent shall conduct a face-to-face re-assessment in accordance with the requirements of Subsection 5003.3 of each beneficiary referred by the supervisory nurse as described in Subsection

5003.9 and for whom a re-assessment is requested pursuant to Subsection 5003.10 to determine PCA service needs.

5003.12 Through December 31, 2017, 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.

5003.13 If, based upon the assessment conducted pursuant to this section, a beneficiary is found to be eligible for PCA services, DHCF or its agent shall issue a Beneficiary Approval Letter informing the beneficiary of the assessment score, the amount, duration and scope of authorized PCA services, and the dates of the authorization period, as well as confirming the provider selected by the beneficiary during the assessment.

5003.14 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 the reasons for the intended action, the specific law and regulations supporting the action, his or her right to appeal the denial, termination, or reduction of services in accordance with federal and District law and regulations, and the circumstances under which PCA services will be continued if a hearing is requested (See 42 CFR §§ 431.200 *et seq.*, D.C. Official Code § 4-205.55).

Section 5006, PROGRAM REQUIREMENTS, is amended as follows:

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, with the exception of beneficiaries for whom the supervisory nurse attests that there has been no significant change in health status, in accordance with § 5003.9.

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 ongoing 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 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 to the supervisory health professional, changes in 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) Shopping for items that are related to promoting a beneficiary's nutritional status in accordance with dietary guidelines and other health needs;

(m) Providing safety monitoring related to assisting the beneficiary with routine activities of daily living by performing tasks to prevent accidents and injuries to the beneficiary during these activities; 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.

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 In accordance with Subsection 5006.7(g), 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.

A new Section 5018, ALTERNATIVE SANCTIONS, is added as follows:

5018 ALTERNATIVE SANCTIONS

5018.1 DHCF may impose alternative sanctions against a Provider in response to receiving complaints or incident reports or upon a recommendation by the Department's Division of Program Integrity or the Long Term Care Administration.

5018.2 DHCF shall determine the appropriateness of alternative sanctions against a Provider based on the following factors:

(a) Seriousness of the violation(s);

(b) Number and nature of the violation(s);

(c) Potential for immediate and serious threat(s) to beneficiaries;

(d) Potential for serious harm to beneficiaries;

(e) Any history of prior violation(s) or sanction(s);

(f) Actions or recommendations by the Department's Division of Program Integrity or the Long Term Care Administration; and

(g) Other relevant factors.

5018.3 DHCF may impose one (1) or more alternative sanctions against a Provider, if the violation does not place the beneficiary's health or safety in immediate jeopardy, as set forth below:

(a) Impose a corrective action plan (CAP);

(b) Prohibit new admissions or place a cap on enrollment;

(c) Place the Provider on an enhanced monitoring plan;

(d) Withhold payments; or

(e) Temporarily suspend the Provider from the DC Medicaid program.

5018.4 A Provider that also provides EPD Waiver services shall be subject to all alternative sanctions set forth in Chapter 42 of Title 29 DCMR.

5018.5 DHCF shall publicize the imposition of an alternative sanction on its website.

5018.6 A CAP may include actions such as publicizing information during regular provider meetings and posting provider performance cards on DHCF's website.

5018.7 DHCF shall issue a written notice of provider termination if DHCF determines that the sanctions listed under Subsection 5018.3 are not appropriate to address the incident(s) and/or complaint(s). DHCF shall reserve the right to terminate a Medicaid provider agreement without a sanction depending on the severity of the violations.

5018.8 If DHCF initiates an action to terminate a provider agreement, DHCF shall follow the procedures set forth in Chapter 13 of Title 29 DCMR governing termination of the Medicaid provider agreement.

5018.9 DHCF may also take actions in lieu of or in addition to an alternative sanction when appropriate. These include the following:

(a) Referral of the incident to another entity, including but not limited to the Medicaid Fraud Control Unit of the Office of the Inspector General for investigation; or

(b) Referral to Adult Protective Services (APS).

5018.10 If DHCF initiates an action to impose an alternative sanction, DHCF shall issue a written notice to the Provider notifying the Provider of the imposition of an alternative sanction.

5018.11 The notice shall include the following:

(a) The basis for the proposed action;

(b) The specific alternative sanction that DHCF intends to take;

(c) The Provider's right to dispute the allegations and to submit evidence to support his or her position; and

(d) Specific reference to the particular sections of the statutes, rules, provider's manual, and/or provider agreements involved in the sanction.

5018.12 The Provider may submit documentary evidence to DHCF's Long Term Care Administration, 441 4th St. N.W., Ste. 1000, Washington D.C. 20001 to refute DHCF's argument for imposition of an alternative sanction within thirty (30) days of the date of the notice described in Subsections 5018.10 and 5018.11.

5018.13 DHCF may extend the thirty (30) day period prescribed in Subsection 5018.12 for good cause on a case-by-case basis.

5018.14 If DHCF decides to impose an alternative sanction against the Provider after the Provider has submitted documentary evidence in accordance with Subsection 5018.12, DHCF shall send a written notice to the Provider at least fifteen (15) days before the imposition of the alternative sanction. The notice shall include the following:

(a) The reason for the decision;

(b) The effective date of the sanction; and

(c) The Provider's right to request a hearing by filing a notice of appeal with the District of Columbia Office of Administrative Hearings.

5018.15 If the Provider files a notice of appeal within fifteen (15) days of the date of the notice of the alternative sanction under Subsection 5018.14, then the effective date of the proposed action shall be stayed until the D.C. Office of Administrative Hearings has rendered a final decision.

5018.16 The Director of DHCF may consider modifying the alternative sanction upon occurrence of one of the following:

(a) Circumstances have changed and resulted in changes to the programmatic requirement violation(s) in such a manner as to immediately jeopardize a beneficiary's health, safety, and welfare; or

(b) The Provider makes significant progress in achieving compliance with the programmatic requirements through good faith efforts.

5018.17 A Provider shall be prohibited from submitting an application for participation in the DC Medicaid program for two (2) consecutive years from the date of receipt of the final notice of termination of a Medicaid Provider Agreement.

5018.18 A Provider that has been terminated from the DC Medicaid program shall not be paid for claims submitted for dates of service on or after the effective date of the termination decision after the provider exhausts all appeal rights and an official decision of termination has been made.

Section 5099, DEFINITIONS, is amended as follows:

5099 DEFINITIONS

5099.1 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.* (2016 Repl.)).

Authorized representative – Any person other than a provider:

(a) Who is knowledgeable about a beneficiary's circumstances and has been designated by that beneficiary 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 in the form of the Prescription Order Form or any successor document supplied by DHCF or its agent.

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*. (2016 Repl.)).

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*. (2016 Repl.)).

Significant change - Changes in a beneficiary's health status that warrants an increase of decrease of supports/services outlined in their plan of care.

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 and State Medicaid Director, Department of Health Care Finance, Government of the District of Columbia, 441 4th Street, N.W., Suite 900 South, Washington D.C. 20001, via telephone at (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.