

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.774; D.C. Official Code § 1-307.02 (2012 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 final rulemaking 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.

These final rules amend the existing rules by establishing a process for an independent assessment of need and authorization for PCA services. This change is needed to eliminate any conflicts of interest that may exist when an agency that is assessing the need for the amount, duration and scope of services to be delivered is the same agency that will deliver the services and receive financial compensation for so doing. They also: eliminate the provision that prohibits a home care agency from claiming more than ten (10) percent of billed service units for PCA services provided through the use of staffing agency personnel; clarify the responsibilities of home care agencies for managing and supervising all PCAs, regardless of employment status; and lastly, establishes accountability for compliance with all rules associated with PCA service delivery.

In addition, the final rules: (1) clarify the level of disability that a Medicaid beneficiary must have in order to qualify for PCA services; (2) state the requirements for giving advance notice to beneficiaries whenever the Provider proposes to terminate a beneficiary from the provider's care or to reduce or terminate the provision of PCA services; (3) strengthen the prohibitions regarding financial relationships between home care agencies, physicians, nurse practitioners and staffing agencies; (4) provide additional information on record keeping requirements; and (5) restate the reimbursable unit of PCA service and the commensurate payment rate. The change in the stated payment rate reflects the Medicaid program's current payment rate and does not represent any change in the amount to be paid for PCA services.

The Notice of Proposed Rulemaking was published in the *D.C. Register* on September 13, 2013 at 60 DCR 012923. Several comments were received, but no substantive changes have been made. These rules were adopted by the Director on October 22, 2013 and shall become effective on November 20, 2013.

Chapter 50, MEDICAID REIMBURSEMENT FOR PERSONAL CARE AIDE SERVICES, of Title 29, PUBLIC WELFARE, of the DCMR is deleted in its entirety and replaced to read as follow:

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 personal care aide (PCA) services under the District of Columbia Medicaid Program (Medicaid Program).

5000.2 The rules are in support and furtherance of the following goals:

- (a) To provide 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-based care as a preferred and cost-effective alternative to institutional care.

5001 PROVIDER QUALIFICATIONS

5001.1 A Provider receiving 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.* (2005 Repl. & 2012 Supp.)), 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 and 42 CFR § 484.

5001.2 An applicant seeking 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 such a Provider.

5001.3 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 personal care 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 personal care 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 personal care 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.

5001.4 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.

5001.5 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 from the date of execution of its most recent Provider Agreement.

5001.6 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 personal care services are needed;
 - (b) Be in receipt of a written order for PCA services in accordance with Sections 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 Section 5003.8, 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 his or her request for a PCA Service Authorization to DHCF or its designated agent in writing, accompanied by a copy of the physician's written order for PCA services that complies with the requirements set forth in Section 5006.
- 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 developed in consultation with the beneficiary and/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;
 - (d) Document the amount, frequency, duration, and scope of PCA services needed; and
 - (e) Specify the expected outcome(s) of the delivery of the PCA services.
- 5003.4 Based upon the results of the face-to-face assessment conducted in accordance with Section 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 Authorization for PCA services in accordance with these rules, when provided through the DC Medicaid program's State Plan PCA benefit, shall not exceed eight (8) hours per day or one thousand and forty (1,040) hours in any twelve (12) month period, unless specifically authorized by DHCF or its agent in accordance with this Section.
- 5003.6 If authorized, PCA services may be provided seven (7) days per week.
- 5003.7 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 reassessment at least every one hundred and eighty (180) days or upon significant change in the beneficiary's condition. A request for service authorization may be made by a Medicaid beneficiary, the beneficiary's representative or a Provider.
- 5003.8 For beneficiaries who were receiving PCA services on the effective date of these rules, the provisions of Sections 5003.1 through 5003.7 pertaining to assessments and PCA Service Authorizations shall take effect on a phased-in basis on a schedule to be established by DHCF not to exceed twelve (12) months from the effective date of these rules.
- 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 or Reduction of Services Letter informing the beneficiary of his or her right to appeal the denial 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's order for PCA services issued in accordance with Section 5006;
 - (b) A copy of the completed written assessment of the beneficiary undertaken in accordance with Section 5003.3; and
 - (c) A copy of the completed PCA Service Authorization issued in accordance with Section 5003.4.

5005 PLAN OF CARE

5005.1 Each 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 in consultation with the beneficiary or the beneficiary's representative;
- (b) Specify how the beneficiary's need, as identified in the assessment conducted in accordance with Section 5003.3, will be met within the amount, duration, scope, and hours of services authorized by the PCA Service Authorization as set forth in Section 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; and
- (e) Be approved and signed by the beneficiary's physician or an advanced practice registered nurse within thirty (30) days of the start of care, provided that the physician or advanced practice nurse 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 personal care services.

5005.3 A registered nurse (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.

5005.4 If an update or modification to a beneficiary's plan of care requires any change in the frequency, duration or scope of PCA services provided to the beneficiary, the Provider must obtain an updated PCA Service Authorization from DHCF or its designated agent.

5006 PROGRAM REQUIREMENTS

5006.1 PCA services shall be ordered, in writing, by a physician who 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 personal care 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 personal care services are needed.

- 5006.2 A written order for PCA services issued in accordance with § 5006.1 shall be renewed every six (6) months and after any interruption of service greater than fourteen (14) days, including hospital admission.
- 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 Personal Care Services.
- 5006.5 An individual or family member other than a spouse, parent of a minor beneficiary, any other legally responsible relative, or court-appointed guardian may provide PCA services. 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) 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) Measuring and recording temperature, pulse, blood pressure and respiration;
 - (f) Observing, documenting and reporting the beneficiary's physical condition, behavior, and appearance and reporting all services provided on a daily basis;

- (g) Preparing meals in accordance with dietary guidelines and assistance with eating;
- (h) Performing tasks related to keeping areas occupied by the beneficiary in a condition that promotes the beneficiary's safety;
- (i) Accompanying the beneficiary to medical or dental appointments or place of employment and recreational activities if approved in the beneficiary's plan of care; and
- (j) Recording and reporting to the supervisory health professional, changes in the beneficiary's physical condition, behavior or appearance.

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 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 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 personal care services Provider, the Provider shall continue providing personal care services to the beneficiary until the transfer has been completed successfully and the beneficiary is receiving personal care 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 aide, 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 personal care aides who deliver services to beneficiaries served by the Provider, regardless of whether the personal care aide 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 or required in the amount, duration or scope authorized, each Provider shall discontinue or reduce personal care services only after:

- (a) Giving the beneficiary written notice that meets the requirements set forth in Section 5007.2,
- (b) The thirty (30) day notice period prescribed in Section 5007.2 elapses; and
- (c) The beneficiary has not appealed the discontinuation.

5007.2 For Provider initiated denials, suspensions, terminations 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 denial, suspension, termination or reduction of services, 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 shall immediately suspend or terminate the beneficiary's services. Suspension of services shall not exceed thirty (30) 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; and
 - (b) The beneficiary's right to appeal the suspension.
- 5007.6 At the end of the suspension period, the Provider may re-instate or terminate the beneficiary's services.
- 5007.7 The beneficiary or the beneficiary's representative shall be provided with a written notice of termination at least fifteen (15) days before the effective date of termination, if the decision is made to terminate services following suspension. The written notice shall comply with District and federal law and rules.
- 5008 STAFFING**
- 5008.1 Each Provider shall utilize registered nurses to manage and provide supervision to PCAs who are qualified to perform all of the functions described in Section 5008.3.
- 5008.2 Each Provider shall verify that each PCA used to deliver services, regardless of whether the personal care aide 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 personal care 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 personal care 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 advanced practice R.N., 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.
- (k) Counseling the beneficiary and the beneficiary’s family regarding nursing and related needs.

5008.4 The R.N. nurse shall visit each beneficiary within forty-eight (48) hours of initiating personal care 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. may provide an additional supervisory visit to each beneficiary if the situation warrants an additional visit, 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 QUALIFICATIONS

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

- (a) Be at least eighteen (18) years of age;
- (b) Be a citizen of the United States or an alien who is lawfully authorized to work in the United States;
- (c) Be mentally, physically and emotionally competent to provide services as certified by a physician;
- (d) Be able to accept instruction from an R.N.;
- (e) Be certified and meet all of the qualifications, including training requirements, in accordance with the Practice of Nursing Amendment Act of 2009, effective July 7, 2009 (D.C. Law 18-18; 56 DCR 3624).
- (f) Be certified in cardiopulmonary resuscitation (CPR) and maintain current CPR certification;
- (g) Complete three (3) hours of continuing education at quarterly intervals, in addition to annual CPR recertification and be trained on the beneficiary's plan of care;
- (h) Be able to read and write the English language at least at the fifth (5th) grade level and carry out instructions and directions in English;
- (i) Be able to recognize an emergency and be knowledgeable about emergency procedures;
- (j) Be knowledgeable about infection control procedures;
- (k) Confirm on an annual basis that he or she is free from tuberculosis by undergoing an annual purified protein derivative (PPD) skin test;
- (l) Confirm, on an annual basis, that he or she is free from communicable disease by undergoing an annual physical examination by a physician, and obtaining written and signed documentation from the examining physician confirming freedom from communicable disease;
- (m) Pass a criminal background check pursuant to the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238; D.C. Official Code, §§ 44-551 *et seq.* (2005 Repl. & 2012 Supp.));
- (n) Pass a reference check and a verification of prior employment;
- (o) Provide documentation of acceptance or declination of the hepatitis vaccine; and
- (p) Have an individual NPI number obtained from NPPES.

- 5010.1 A Provider may contract with a licensed staffing agency to secure staff to deliver PCA services. Agreements between the Provider and the a 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 personal care services to the home care agency throughout the duration of the contract.
 - (b) Business address and e-mail address of 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 personal care services shall:
- (a) Ensure that the staffing agency obtains an NPI number for itself and all personnel performing personal care 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 personal care 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 personal care 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 personal care 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 personal care 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 personal care 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 personal care 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 personal care services provided to each beneficiary.
- 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, its agents, 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 registered nurse 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 the 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.

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 four dollars and eight cents (\$4.08) per fifteen minutes for services rendered by a PCA.

5015.2 Reimbursement for PCA services, when provided through the DC Medicaid program's State Plan PCA benefit, shall not exceed eight (8) hours per day and shall be limited to the amount, duration, and scope of services set forth in the PCA Service Authorization described in Section 5003.

5015.3 Claims for PCA services submitted by a Provider in any period during which the beneficiary has been admitted to another health care facility including a hospital, nursing home, psychiatric facility or rehabilitation program shall be denied.

5015.4 Claims for PCA service submitted by a Provider for any hours in which the beneficiary was receiving adult day health or other similar service in which PCA services are provided to the beneficiary shall be denied.

5015.5 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.

5015.6 Each Provider shall agree to bill any and all known third-party payers prior to billing Medicaid.

5015.7 All reimbursable claims for PCA services shall include the NPI numbers for the:

- (a) Provider;
- (b) Physician who ordered the personal care services;
- (c) The staffing agency, if applicable; and
- (d) Personal care aide who provided the personal care services, regardless of whether the personal care aide is an employee of the Provider or is from another staffing agency.

5015.8 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 ordering a beneficiary's treatment has a direct or indirect financial relationship, compensation, ownership or investment interest as defined in 42 CFR § 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 CFR § 411.355.

5015.9 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 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.

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, DC 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 resident's circumstances and has been designated by that resident to represent him or her; or
- (b) Who is legally authorized either to administer a resident's financial or personal affairs or to protect and advocate for a resident's rights.

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.

Order – A formal, written instruction signed by a physician or advanced practice R.N. regarding a specific patient's medical care, treatment or management. An order for PCA services may only be written by a physician 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.